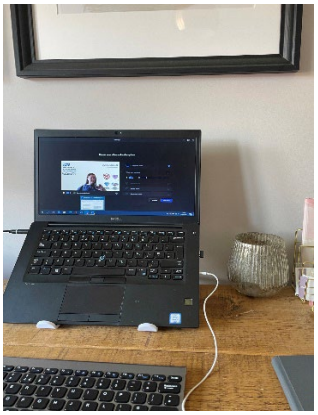
NHS
Derby and Derbyshire
Clinical Commissioning Group


NHS Derby and Derbyshire Clinical Commissioning Group Annual Report & Accounts 2021–2022



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FOREWORD

In our previous Annual Report, I spoke in my introduction of the unprecedented challenge that had presented itself to us all in 2020. At that time, we were remembering the many members of our families and friends, and our colleagues from work, who had been lost to the pandemic. Thankfully in the year that has past, whilst we have seen specific challenges posed by omicron variants and the Covid-19 disease in general, we have seen lower volumes of disease at the most severe end of the spectrum although individual tragedies and loss of life have persisted.

At the time of writing the annual report in 2021, we were hearing of the Government's Roadmap for easing lockdown restrictions in England, and we started to sense a return to some form of normality. In NHS Derby and Derbyshire Clinical Commissioning Group, we were talking with staff in the early months of 2021/22 about how we might develop our model of hybrid working, with staff starting to return to the office where they wished to do so, and had implemented much of this before omicron emerged in November. Once again, we saw an unprecedented impact on our country, this time with less severe illness and death, but with significant numbers of people having to take time away from work to either isolate themselves or look after loved ones who had contracted the virus and needed to remain at home.

As a result, we have seen perhaps the most sustained pressure in the history of the NHS. Our staff have continued to provide the best possible care for local people, but with sickness absence at record highs due to omicron, there have been times where it has been very challenging to maintain the service. Often in winter we are constrained by the number of beds available; this has been, in part, true again this winter, but equally we have been constrained by the numbers of available staff, with beds available but not enough staff available to open them safely.

As a GP, we have experienced the same challenge with staff absences, but in general practice, with much smaller teams and less ability to be resilient, there have been different issues to tackle. It is well documented that access to general practice has changed through the pandemic, with much more care being provided either over the telephone or by video, and less face-to-face contact required. The pandemic has accelerated what was already a desired direction of travel.

However, in December, practices were asked to scale back routine appointments to focus resources on the delivery of the Covid-19 booster vaccinations, as a first line of defence in managing the impact of omicron. Many practices managed to maintain much of their routine work, and by the spring, we have avoided some of the additional backlogs of care that might have been required. Keeping our patients and staff safe has been at the heart of our response to the pandemic throughout and we will continue with that approach.

The year has also seen us progressing with our plans to build our Integrated Care System, with new legislation that the Chief Executive Officer discusses in his foreword. From a clinical perspective, some of the health and care system's lead clinicians and professionals have been further reviewing the model of leadership in all aspects of system decision-making, to create a Clinical and Professional Leadership Group. The Group can act as a consultee and powerhouse in policy development, and is available to all elements of system clinical and care development as a reference group, creating a culture that embraces shared learning and supports clinical and care professional leaders to collaborate and innovate with a wide range of partners, including patients and local communities.

The Clinical and Professional Leadership Group will play an important role as a strategic decision-making group where we are seeking to improve population health outcomes, as well as binding clinical and professional leadership together through stronger connections and acting as the facilitators to enable this. It is an exciting development and I am delighted to have co-chaired the group with my colleague Hal Spencer, Medical Director at Chesterfield Royal Hospital.

Every day our colleagues have put themselves on the line and every day we hear remarkable stories where people have gone much more than the extra mile to do all they can to care for and support our patients. Harnessing the knowledge and ideas of these staff is crucial if we are to truly improve the services and care experienced by local people, and to help people stay healthy, live longer and have fulfilling lives.

Dr Avi Bhatia
Clinical Chair
NHS Derby and Derbyshire Clinical Commissioning Group
10 June 2022

PERFORMANCE REPORT

Dr Chris Clayton

Accountable Officer

NHS Derby and Derbyshire CCG

10 June 2022

Chief Executive Officer's Statement

The last year has been very significant for health and care services in Derby and Derbyshire. The speed at which the world changed in 2020/21, and the devastating impact that the pandemic had on so many lives, has been matched by steady – but no-less significant – progression through 2021/22.

There have been a range of significant matters that have occupied our attention during the last year, in addition to our teams ensuring NHS Derby and Derbyshire Clinical Commissioning Group remains compliant with our various legal duties. Our ongoing response to the Covid-19 pandemic has itself been multi-faceted; the continued support to local providers of care to ensure they have been able to treat those patients affected by Covid-19 as well as other illnesses has remained at the heart of our work.

All teams across our hospitals, community services, General Practice, ambulance services, adult care and out-of-hours provision have continued to go the extra mile to look after our citizens. We say thank you very often for these efforts, but each time it is meant with full heart and gratitude for the incredible service that has been maintained in such difficult circumstances. We remain indebted to our clinical and professional staff and we will continue to do all that is possible to help them stay safe and well.

As the initial waves and pressures of the pandemic subsided during 2021, attention turned to the recovery of care that had been backed up within our services. This included an extended waiting list for operations, where only the most urgent surgery had been carried out during the height of the lockdown period. It is no secret that waiting lists have grown across the country, and we have given significant focus to ensuring we continue to review all patients who are on waiting lists, and had begun to make inroads into the backlog before omicron arrived in November. We have a continued focus in this area and are working closely with NHS England and NHS Improvement to treat all patients as quickly as possible, with the understanding that our physical resources are stretched, and our staff cannot be pushed too hard following a very difficult two years.

These efforts to reduce waiting lists have been hampered by omicron. Surgical wards and staff have been commandeered by general medical units during winter. The variants so far have not seen as large a number of patients being admitted, as with the first waves, but the devastating impact on our workforce, mainly through their need to self-isolate, has meant that already depleted community teams have been unable to provide packages of care that can support patients at the point of discharge from hospital. Our hospitals have therefore been filling up and through January our system conversations were increasingly concerning as we tried to find the right solutions to the challenge. We have undoubtedly placed burdens on families that we would not usually wish to place, looking after relatives at home or providing some elements of care that we have simply been unable to routinely provide, such as giving medication or changing dressings. Our aim is always to seek to treat those patients who are most poorly, and we have managed that, but it has been a very close call at times this year.

Omicron also saw our Covid-19 vaccination centres working additionally hard in December to meet the Prime Minister's pledge of offering vaccination boosters to all adults by the end of 2021. We achieved this in Derbyshire, and as with the rest of the vaccination programme, we have performed very well across all measures respective to other health systems and

continue to do so. We are anticipating the guidance on the future of the Covid-19 vaccination programme and will continue to make this a priority for our system.

The challenges of the pandemic have impacted our overall performance during 2021/22. Analysis of data illustrates that as of the 31st March 2022, 6 of the 21 constitutional or mandated standards for our patients have been delivered during the year. Although a number of the standards have not been achieved, they compare favourably with nationally reported performance.

Finally, there has been the ongoing progression of our Integrated Care System through Joined Up Care Derbyshire. One of the strengths of the past two years has been our track record of partnership, and this has come to the fore as we have worked in very different ways to deliver the pandemic response. Much of the wider transformation work of the Integrated Care System, which was driven by local priorities and the NHS Long Term Plan, has seen a pause during the pandemic while our focus was elsewhere. However, with the introduction of the draft Health and Social Care Bill and the establishment of Integrated Care Systems in law, we have made incredible progress in determining the shape of our system, the priorities which we believe we need to tackle, and the transition towards the abolition of Clinical Commissioning Groups on the 30th June 2022, to be replaced by Integrated Care Boards from the 1st July 2022, subject to legislation.

Overall, there has been a tremendous amount of work across our various priorities, and I continue to feel extremely proud and humbled to be part of a system that can mobilise and work together on such as scale, with a team spirit that is second to none. Thank you again to everyone who has played a part as we continue to work through one of the greatest challenges the NHS and our country has ever faced.

Dr Chris Clayton
MA MB BChir DRCOG PGCGPE MRCGP
Chief Executive Officer
NHS Derby and Derbyshire Clinical Commissioning Group
10 June 2022

Performance Overview

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

Purpose and Activities of the CCG

NHS Derby and Derbyshire CCG brings together local General Practices and other NHS organisations to plan and help shape local health services for the people of Derby and Derbyshire. The CCG has representation from 112 General Practices from the area and has a Governing Body, which is made up of local GPs, supported by Specialist Doctors and Nurses, Lay Members and experienced officers. More information on our Governing Body Members can be found on the CCG's website here[1].

Our CCG area covers residents across Derbyshire, including the populations of Derby city, Chesterfield, Ilkeston and Long Eaton, Amber Valley, Derbyshire Dales, Bolsover District and High Peak. The CCG serves a population of around 1,075,000.

Our mission and values

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

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

There are clear health inequalities within the CCG area. Working together with partner organisations is part of the whole system approach to tackling them, as articulated in our Derbyshire Sustainability and Transformation Plan. The latest update on developments can be found on the Joined Up Care Derbyshire's website here[2].

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

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

[1] https://www.derbyandderbyshireccg.nhs.uk/about-us/who-we-are/governing-body/
[2] https://joinedupcarederbyshire.co.uk/get-involved/patient-participation-group-ppg-network

progress in how we delivered the requirements set by the Government in the NHS Mandate and the NHS Constitution.

The key issues and risks to the organisation achieving its objectives are described in the Governance Statement section of this report. The CCG's strategic risks identified during 2021/22 can be found here[3].

Adoption of the Going Concern Approach

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

Our relationships

Patients in our area have access to services from a wide range of providers, including Derbyshire Healthcare NHS Foundation Trust (DHcFT), Derbyshire Community Health Services NHS Foundation Trust (DCHSFT) and East Midlands Ambulance Service NHS Trust (EMAS). Our largest contracts are with Chesterfield Royal Hospital NHS Foundation Trust (CRHFT) and University Hospitals of Derby and Burton NHS Foundation Trust (UHDBFT), and account for approximately 40.7% of our spending.

System Working and Collaboration

It has been a significant year for Integrated Care Systems (ICSs) across the country, including Joined Up Care Derbyshire (JUCD), the health and care partnership for Derby and Derbyshire. Following a relatively fallow year in implementing our transformation plan in 2020/21 due to our focus on the Covid-19 pandemic, there has been an acceleration of activity in 2021/22.

ICSs have had no footing in legislation since their inception as Sustainability and Transformation Partnerships in 2015. As a 'partnership of the willing', JUCD has made significant progress due to a track record of extensive partnership working between the NHS, local authorities and other partners. In February 2021, the Government issued a draft Health and Care Bill which would put ICSs on a statutory footing, see the replacement of Clinical Commissioning Groups with Integrated Care Boards, and the creation of a statutory committee to be known as the Integrated Care Partnership.

Changes to the organisational form aside, the remits and duties of these statutory bodies – and the benefits we expect they will have on the health of local citizens – fell largely in line with the planned direction of travel for JUCD. Our system had begun a conversation last year about the ICS purpose, restating our focus and re-affirming our intention as an NHS, public health and social care partnership. In addition, we had been discussing in much more detail the wider determinants of health, with the aim to be clear what we could achieve for ourselves and where we needed further partnership with others. The establishment of the Integrated Care Partnership will be the vehicle through which we can make these connections.

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

JUCD has also been agreeing its priorities, and will spend some of 2022/23 widening this discussion with local citizens as we seek to write our Integrated Care Strategy. Understanding the known disease priorities and the areas in which we need to make operational transformation will ensure we are able to prioritise, with the aim of:

1. confirming our joint strategic commissioning priorities for health and social care, seeing increased formal collaboration between the NHS and local authorities;
2. continuing our prioritisation of health protection, through our response to the Covid-19 pandemic and the vaccination programme;
3. capitalising on the ability to make reductions in health inequality and implementing a clear clinical care strategy;
4. pushing innovation and technology to advance our clinical policies.

Our desire has always been to focus on the enabling aspects of organisational change, instead focusing on what is needed by our communities, with increased collaboration between our Primary Care Networks (PCNs), district and borough councils, community mental health teams, the leisure sector and others on a geographic footprint. We have agreed two Place Partnerships – one for Derby city, the other for Derbyshire county, which will build on the existing work of place alliances and will have greater levels of delegated authority to make commissioning decisions under the new regulations. The other prism has been to look at our pathways of care and specialisms, delivering care at a larger scale through collaboratives between service providers.

With the introduction of the draft Health and Social Care Bill and the mandatory establishment of ICSs, NHS Derby and Derbyshire Integrated Care Board (ICB) will be established from the 1st July 2022. The Secretary of State for Health and Social Care decreed in July 2021 that the new ICS for Derby and Derbyshire should have a boundary that was coterminous between the NHS and local authorities. It was decided that Glossop would therefore become part of Derby and Derbyshire ICS, with effect from the 1st July 2022. Glossop is currently part of the Greater Manchester ICS, with its convenient links to services in Tameside. We have been working with partners across the current border to ensure the same transfer of service commissioning and contracting into Derbyshire, and we do not foresee any significant change to services received by Glossop residents in the early phases of this transition but look forward to understanding how we can enhance the 'place' approach from both a Glossop and Derby and Derbyshire perspectives.

A reflection of our maturity as a system has been our distributed leadership across our main programmes. Our system Chief Executives have taken active leads on behalf of the wider system to progress areas including urgent care, planned care, mental health care and the place and provider collaborative developments mentioned above. This 'matrix' approach has been supported by Chief Operating Officers and other Directors working outside of their traditional organisational boundaries on system issues. In addition, our upper tier local authorities have always been very heavily engaged in system working, and we have broadened that to begin to include our district and boroughs councils to help shape our strategic approach. We have also taken forward the work with colleagues in other sectors, such as industry, further education and other anchor institutions, to ensure we are combining our thoughts and energy on matters such as employment and the green agenda. Much of the conversation has historically been about the NHS, with others coming to our table; the future direction of travel is very much about a jointly hosted party, with all guests invited equally.

Our future priorities will also include fully embracing the digital agenda, with shared electronic care records now possible across services and to be further rolled out; solving the workforce gap that we see across many of our services in collaboration with medical schools and technical colleges while fully supporting those staff who already work within our services; and further developing our approach to citizen engagement, which will be vital in maximising the use of the knowledge of our communities to help find solutions to the challenges we face. We aim to complete recruitment to the ICB Board by the end of May 2022 and will spend the first half of 2022/23 confirming the membership and priorities for the Integrated Care Partnership.

All of this remains in the context of the Covid-19 pandemic, and while we seek to restore and transform services, we will have to continue to deal with the aftermath of the pandemic, such as the impact on tired staff and the backlogs created by depleted or socially-distanced services. However, our continued ability to collaborate and keep what is important to local citizens at the heart of what we do, will be crucial in the success of the new ICS architecture for Derby and Derbyshire, and we are determined to provide a long-lasting legacy for our people.

Place Development and Delivery

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

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

Coordinated by the Integrated Community Place Board, LPAs either lead or contribute to a wide variety of work which supports system integration and the health and social care needs of our vibrant and varied communities across the county. Some key priorities are shared below.

Team Up Derbyshire (including Ageing Well)

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

PCNs are developing their home visiting service implementation plans which form one element of the Team Up programme. Derby City and Chesterfield PCNs are implementing their plans while other areas such as Derbyshire Dales; Alfreton, Ripley, Crich and Heanor;

and Belper PCNs have either had plans approved and/or are implementing pilots. Citizen/patient feedback on the Derby City home visiting service has been very good, with 98% of the 75 people asked saying they would recommend to friends and family.

Home visiting services offer a multi-disciplinary team approach for supporting housebound individuals. When a person requests a home visit from their GP, it is passed through to the home visiting team who will triage to the most appropriate member of staff to undertake the visit, for example, a community matron. Due to competing demands on the time of our GPs, they have naturally had limited time available to them to spend on each home visit and have often needed to prioritise the principal problem that has required the home visit, often only being able to focus on the immediate presenting medical problem. The home visiting team is able to spend much longer with an individual and link other services (including the voluntary sector) into the person to offer support, enabling a much more holistic approach. This way of working also supports the other parts of the Team Up programme, especially those linked to anticipatory care, which aims to reduce a person's need for crisis support by taking a much more proactive approach.

More information on Team Up Derbyshire can be found on the JUCD website here[4] and on the Team Up Derbyshire blog here[5].

Team Up Derbyshire in Action case study – courtesy of Dr Natalie Craven of Alfreton, Ripley, Crich and Heanor PCN

Team Up Derbyshire received a referral for a patient aged in their late 90s suffering from acute vertigo. The person lived alone in a ground floor flat and had a package of care twice-a-day. In the 48 hours prior to the visit, the patient had been seen by three other teams – EMAS, out-of-hours GP and the surgery GP.

Team Up Derbyshire was able to assess the individual, chase up the delayed prescription for the vertigo symptoms and also discuss advanced directives regarding her care. This involved the completion of a 'Respect' form not previously considered or completed. The Team Up community GP was able to speak to the person's family regarding this conversation as they were not living in the local area.

The patient's neighbour had been staying with her all day and overnight for the last 48 hours as the patient was unable to walk to the toilet independently. Team Up Derbyshire liaised with the community access point and arranged an urgent therapy response for assessment, and delivery of a walking frame and commode, meaning the patient was able to safely remain at home while symptomatic. This was achieved within two hours of the Team Up community GP visit. The care co-ordinators also received a referral.

The individual was booked for follow-up support from Team Up Derbyshire to optimise their blood pressure, and was forwarded to the multi-disciplinary team for an increased package of care. The patient made a full recovery within a week of starting medication and was managing independently at home with their new care package.

[4] https://joinedupcarederbyshire.co.uk/about/our-governance-1/team-up
[5] https://teamupderbyshire.wixsite.com/website

Living Well

Our Place Team is delighted to be a key partner in enabling the Living Well programme to be extended across Derbyshire. The High Peak pilot of the Living Well Mental Health work has had consistent and extensive support from our High Peak leads since its initiation in January 2021. The High Peak Place Alliance laid the groundwork for the new integrated way of working, by hosting a mental health event in November 2020 to bring together the relevant parties, before the introduction of the Innovation Unit, a social enterprise who are experts in service redesign and co-production. Derby City Place has built a multi-disciplinary Living Well mental health team, and our Place colleagues have supported this work.

The 'next wave' Places for the project, already underway for launch in 2022, have been embedded into the existing mental health subgroups which exist in each Place across Derbyshire. The three next wave Places (Derbyshire Dales, Chesterfield, and North East Derbyshire and Bolsover) are driving the progress and working with the Innovation Unit to engage with system partners and encourage collective effort, to support and deliver on our exciting plans to completely change the way adult mental health services are delivered. All Places will benefit from this approach by 2023. Within Chesterfield there is a real appetite to enable people with lived experience to co-lead this change and work is underway to think differently about how we might do this. For Derbyshire Dales planning is underway to create a 'Festival of Wellness' to support the mental health and wellbeing of the Dales population, and a similar event is being planned in the High Peak.

The 'wave three' sites: South Derbyshire, Erewash and Amber Valley Places, all have proactive subgroups that enable positive change to support the mental health needs of their local population. Developments include the:

- mental health subgroup in Amber Valley, which has connected GPs directly to housing support and the most appropriate contact in mental health teams to swiftly resolve patient specific issues, join up the services and create a personalised plan for the patient; and
- establishment of Children and Younger People's Mental Health Forums at Place level across the county, working with locality children's partnerships; to create a network of professionals who can identify and act upon gaps and opportunities for better care.

Population Health Management and addressing Health Inequalities

Much of our work at Place is an enabler and a driver of the prevention agenda – to keep people living longer in better health. Place partners lead or are involved in multiple workstreams and some key examples from across the eight Places are outlined below.

Physical activity

Physical activity and weight management are key priorities across the county. It is widely known that having an increased body-mass index can cause and exacerbate health issues. Physical activity not only supports better physical health, but it can also promote improved mental wellbeing.

Erewash Place-PCN Alliance Group two-pronged physical activity approach

At the ground level

The physical activity work in Erewash is moving forward, via the Active Erewash Group, which is a sub-group of the Health and Wellbeing Partnership. The group is a collective of colleagues from Erewash Borough Council, Active Erewash, Public Health, the CCG and others who have collaboratively developed the shared vision and strategic priorities for the area. One of these strategic priorities goes under the name of 'All Move in Erewash'. Part of our plans is to bring together stakeholders, who are supporting residents in Erewash, who have long-term health conditions, disabilities and limiting illness to understand how day-to-day life impacts on their physical activity.

At the Place Alliance level

Working with the Public Health lead, we use data on the County Council's 'Live Life Better Derbyshire' service to look at the number of weight management, physical activity and exercise referrals made in Erewash. The breakdown of these referrals, by the Index of Multiple Deprivation, provides reassurance that the people from the most deprived areas are being referred into the service. We are comparing the number of referrals from across Derbyshire. This information stimulates discussions and helps us to look at ways that we might work better together as a Place Alliance, and with the 'Live Life Better Derbyshire' service, to increase uptake.

Active Derbyshire is heavily involved in work with other Place areas to understand local needs, assets and barriers relating to physical activity. Derbyshire Dales, North East Derbyshire and Bolsover Places each have a proactive subgroup of multi-agency representatives who can implement a variety of initiatives to increase levels of physical activity. In the High Peak, Place is supportive of High Peak Borough Council-led 'High Peak Move More'.

Using a Population Health Management approach

Derby City is one of our LPAs that is using population health management to provide a targeted approach to personalisation, with a focus on people that are high users of services (particularly emergency or out-of-hours services), and for whom an alternative, holistic approach may be better suited to their needs.

Chesterfield is at the start of its journey and will use the opportunity of working with system experts to better understand how a population health management approach can be used by the partner organisations to target and agree change that addresses identified inequalities.

Supporting people who depend on services

Amber Valley is working in an integrated way across organisations including Local Authorities, alongside nursing and therapy teams and the voluntary sector, to develop a pathway for mutual support and partnership working to support people in need of equipment, home improvements and adaptations. The High Peak Place has a physical site at the Hub which is located at the Cavendish Hospital in Buxton, where a similar multi-agency approach allows better communication between partners who are co-located.

Most Places will be developing similar arrangements as part of our Team Up transformation and also have well established and regular local meetings between key partners with front-line staff, to ensure an efficient flow of patients from hospital through to community-based care.

Social Prescribing

For several years, Place has been influential in creating the networks and structures to embed social prescribers into primary care and the voluntary sector. The successful programme is expanding rapidly and developing in line with population need. For example:

- green social prescribing is being prioritised in some of our Places;
- Chesterfield Place identified a need for social prescribing resource specifically to support people with musculoskeletal (MSK) health issues;
- North East Derbyshire and Bolsover introduced social prescribing for children and young people; and
- there are also social prescribers with backgrounds in dementia care, diabetes and other conditions who have been recruited to use their specialist skills.

Dementia Care

In the High Peak, a Place Alliance has formed a subgroup to focus on dementia, with public representation from dementia carers and a cross-section of colleagues including older adults psychiatry, social prescribers, the voluntary sector, GPs, commissioners, adult care and multiple other key partners who regularly serve and support people living with dementia, not forgetting their family and carers. The dedicated time to work together on dementia support has led to county-wide escalations and challenges about how better to deliver services which meet the needs of those affected by dementia. In the High Peak, there has been an increase in the number of dementia support worker roles due to identification of need of this skillset in that part of the county.

Public Representation

Public representation, participation and engagement is a fundamental part of our accountability and planning structure at Place. In North East Derbyshire and Bolsover, nominated individuals insightfully input to Place Alliance meetings and subgroups. Our High Peak Place has had consistent public representation for several years. Dales and Chesterfield Places are other areas that benefit from proactive public representation. We are proud to have such great individuals holding us to account and providing constructive critique.

Other Place Alliances co-produce and plan with the public in different ways, based on their existing networks and engagement work. Amber Valley works alongside system colleagues to extend the reach of Place most effectively into the community.

Increased Collaboration with other system partners

For several years, Chesterfield Place has been part of an overarching Strategic Forum, alongside other key partnerships; the Health and Wellbeing Partnership; the Children's Partnership; and the Community Safety Partnership. The purpose is to gain insight from all perspectives of the needs of the local population and better align and integrate our strategic plans to deliver the key aim of enhancing the health and wellbeing of the population of Chesterfield. Erewash Place has merged with the local PCN to form a single partnership, and Derbyshire Dales has merged with the Health and Wellbeing Partnership, in what is called Derbyshire Local Integration Group. The emergent forum 'High Peak Together' is for all partnerships and key organisations outside of the JUCD Alliance, such as Police and Fire services, to gain a wider network, avoid duplication and deliver on common objectives. For the High Peak, this includes Glossopdale, which will become part of the Derbyshire ICS in July 2022.

Other Places also work with different system partners on common objectives. In Amber Valley there has been a series of workshops to review the support available for children and young people around emotional wellbeing and mental health. It has also aided in identifying gaps and targeting priorities for high need areas. High Peak Place worked together with Derbyshire Dales on a similar project for emotional wellbeing.

Derby Health Inequalities Partnership

The Derby Health Inequalities Partnership is a joint endeavour between Derby City Council and Community Action Derby and was started in response to the Covid-19 pandemic which shone a light on inequalities in the city and on the good work and potential of communities to respond to this scale of challenge.

The Derby Health Inequalities Partnership consists of approximately 25 members from the community and faith sector. Membership is inclusive and growing. It has identified three themes of development work:

1. community consultation and engagement to understand what health issues are most important within our communities;

2. health promotion/education: supporting the development of knowledge, skills and confidence in health issues; and

3. an advisory function to health services and providers to improve their offer for our communities and holding to account for actions following that advice.

The five PCNs in the City are working well together to deliver the ambitious Team Up programme alongside other health and social care colleagues and the voluntary sector. More than ever, health and care are planning and delivering across a City-wide footprint; with increased input from UHDBFT, mental health and voluntary sector colleagues.

Primary Care Networks and Collaboration

Primary Care Network Development

Despite the on-going pandemic, General Practices have continued to work together and develop their PCN infrastructure. During the period covered by this annual report, Derby and Derbyshire has 15 PCNs, covering all 112 General Practices and the whole population. PCNs are based on GP-registered lists, typically serving communities of around 30,000 to 50,000 people. This scale is small enough to provide personal care valued by both patients and GPs, but large enough to have significant impact and economies of scale through better collaboration between General Practices and other service providers. From the 1st April 2022, Glossop PCN will also be joining the Derbyshire ICS bringing an additional six General Practices into the area.

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

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

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

The development of each PCN is rated against a Maturity Matrix. When this was completed in March 2020, all 15 PCNs were rated as foundation for all areas. In October 2021, PCNs had improved the most across; Leadership; Organisational Development; Clinical Director Leadership; and Asset Based Community Development rating at step 1 and step 2.

All PCNs have submitted plans indicating how they will spend their 2021/22 Leadership and Management funds. The initiatives include supporting organisation development; providing additional PCN management capacity; clinical leadership; strategic planning; and analytical support which are all designed to release time for the existing workforce to provide clinical care.

Additional Roles Reimbursement Scheme

Expanding the workforce is the top priority for Primary Care. The Additional Roles Reimbursement Scheme (ARRS) enables each PCN to employ additional staff across 21 direct and non-direct patient care roles within Primary Care. The latest addition to this ARRS scheme includes Adult and Children's Mental Health Practitioners, Advanced Clinical Practitioners and Nursing and Trainee Nursing Associates. Currently, PCNs have recruited 77% of the ARRS whole time equivalent target for 2022/23.

Recruitment to these roles required a large degree of planning and joint working across the wider system. Health Education Derbyshire (HED) has been pivotal in supporting the PCNs with their workforce plans. It conducted a survey across all ARRS staff employed within PCNs to measure job satisfaction and training and development needs. This has helped to design training and supervision packages to support new ARRS staff. It has undertaken investigation to explore which staff mix would suit the PCN best. Intelligence gained from this work has led to all the training available being collated into one online portal on HED's website. Courses provided by Secondary Care have been made available to Primary Care staff which is supporting the development of a 'training passport' meaning staff from across the system can parachute in and provide clinical care, no matter where they are normally based as their competencies will be consistent.

It has been encouraging to see relationships develop between PCNs and provider organisations, including the Voluntary, Community and Social Enterprise Sector (VCSE), EMAS, DHcFT and DHCSFT to help deploy roles that are new to Primary Care. DCHSFT is actively supporting PCNs with securing further workforce under the scheme by factoring in the 2022/23 and 2023/24 PCN workforce intentions with their own workforce planning. This will also support the development of rotational staff models that have been difficult to launch during the pandemic.

PCNs escalated the recruitment of ARRS roles from November 2021 and deployed staff flexibly, across PCNs and the system, to meet demand. The Unclaimed Funding process was implemented, and funds were distributed to PCNs that were able to over-recruit, who have now secured additional staff and worked with third party providers to source temporary staff to support PCNs throughout the winter.

Health and Wellbeing Boards and Health Improvement Scrutiny Committee

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

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

Directors of Public Health. The CCG reports on progress of the strategic objectives through its Governing Body Assurance Framework.

Derbyshire's Health and Wellbeing Strategy for 2018-23 sets out five priorities for improving health and wellbeing across Derbyshire, focusing on actions to address factors that can influence people's health. The Health and Wellbeing Strategy can be viewed here[6].

The five priorities are:

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

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

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

Information on Derbyshire County Council's Health and Wellbeing Board can be found here[7] and information on Derby City Council's Health and Wellbeing Board can be found here[8].

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 and present reports to Derby City Council and Derbyshire County Council Councillors.

Joint working with the Local Authority

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

[6] https://www.derbyshire.gov.uk/social-health/health-and-wellbeing/about-public-health/health-and-wellbeing-board/health-and-wellbeing-strategy/health-and-wellbeing-strategy.aspx
[7] https://www.derbyshire.gov.uk/social-health/health-and-wellbeing/about-public-health/health-and-wellbeing-board/health-and-wellbeing-board.aspx
[8] https://www.derby.gov.uk/health-and-social-care/public-health/hwb/

Derbyshire Anchor Institutions

During 2021/22, a System Anchor Group was established as part of the next steps in the development of the ICS. This group brings together a number of Anchor Institutions, which are defined by the Health Foundation (2018) as:

> *"An institution that, alongside its main function, plays a significant and recognised role in a locality by making a strategic contribution to the local economy. Anchor institutions are so called because they are effectively anchored in their local communities and are unlikely to relocate. They have sizeable assets that can be used to build wealth in and develop their local community through procurement and spending power; workforce and training; and buildings and land."*

The Derbyshire Anchor Institutions' aims are to have a positive impact on the following five key areas through their commitment to long-term collaboration, improving collective wellbeing and creating a strong, resilient and inclusive Derbyshire economy:

Employment	Widening access to work.
Partnering in place	Across organisations and the voluntary and community sector.
Procurement	Purchasing more locally and for social benefit.
Buildings	Using buildings and spaces to help communities.
Environment	Reducing environmental impact.

An 'Anchor Charter' was developed as a way of securing commitment from the Derbyshire Anchor Institutions and providing a framework to benefit communities across Derby and Derbyshire. The Anchor Charter has been formally approved by both the JUCD Board, and Health and Wellbeing Boards across the county. It has also been rolled out to system organisations to ensure that it is embedded within their organisational strategies and plans.

Within Derby and Derbyshire, the signatories to the Anchor Charter include:

- NHS organisations
- Joined Up Care Derbyshire
- Derbyshire County Council
- Derby City Council
- Rolls Royce
- Derby County Community Trust
- University of Derby

Performance Analysis

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

How Performance is measured

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

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

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

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

Covid-19 Pandemic Response

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

In line with national guidance, an Incident Control Centre was set up to manage all Covid-19 related communications. This ran between 8am and 8pm, seven-days-per-week, and a staffing rota and Standard Operating Procedure were developed. As themes for support and additional work emerged, more 'cells' were established to manage the situation. The Incident

Control Centre moved to a virtual operation in March 2020 when the CCG's offices were closed, and staff were required to work from home.

Further information on other cells established in 2020/21, and which have continued to operate during 2021/22, can be found in Table 1.

How the CCG has operated throughout the Covid-19 Pandemic

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

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

The CCG continued to adapt to the changing nature of the pandemic and collaborated with and supported the Derbyshire system to respond effectively. This included the development of a System Escalation Call Risk Register, a Covid-19 Risk Register and a Vaccination Operation Centre Risk Log. A specific CCG Covid-19 Risk Register was also compiled in early April 2020 which was later amalgamated with the Operational Risk Register and reviewed, updated and reported to Committees and Governing Body on a monthly basis. These arrangements have continued into 2021/22.

As part of its adaptation and given the benefits of home working, the CCG consulted with staff on the introduction of a hybrid model, to allow a mixed pattern of home and office working for staff. The offices have been organised to support Covid-19-safe working, with one-way systems, socially distanced workspaces and hygiene controls in place. Where Covid-19 conditions have permitted, staff have been able to book workspaces and come into the office where that is their choice, and having fully read the standard operating procedure for working safely in the offices and testing negatively via Lateral Flow Test.

Cell	Dates (when in operation)	Immediate priorities at the beginning of the pandemic	Key activities during the pandemic
Vaccine Operations Cell	September 2020 to present	Coordinate and oversee the JUCD Covid-19 vaccination programme (Covid-19, Flu and Antiviral Programme), operational seven days-a-week, 9am-5pm	• Senior leadership, lead provider, workstream leads appointed, team identified, with email inbox and dedicated phone • Standard Operating Procedure developed to include full programme management support and leads assigned to specific areas for continuity • Estates – sites identified (NHS and non-NHS compliant to national requirements) to support vaccine delivery across Derbyshire

Cell	Dates (when in operation)	Immediate priorities at the beginning of the pandemic	Key activities during the pandemic
			• Cycle of meetings and briefings established with appropriate governance and project support to maintain good communication across the Derbyshire system relating to the vaccination programme • Progressing a substantive Vaccines Operation Cell structure to support the vaccination programme from April 2022 onwards
Staff Testing Cell	11 April 2020 to present	• Develop a coordinated Derbyshire process for testing public sector staff members or staff family members who may be displaying symptoms associated with Covid-19 • Implement a solution for satellite sites for testing symptomatic key workers • Develop and implement symptomatic testing following notification of an outbreak in Care Homes • Operational every two weeks with health and social care representation	• Regular Derbyshire System Testing Cell meetings to coordinate health and Local Authority testing for symptomatic staff • Development of a Derbyshire-wide Standard Operating Procedure for key workers testing public sector staff members or staff family members • Daily coordination for receiving and booking all public sector referrals for symptomatic testing for Derbyshire organisations • Working closely with Derbyshire Health United to set up and run the two Derbyshire satellite testing sites • Supporting Public Health England with testing for symptomatic care home staff and residents • Siting of mobile testing units in Derbyshire to respond to symptomatic testing requirements • Working with health and social care partners in relation to lateral flow devices and anti-body testing
Care Homes Cell (now external)	April 2020 to present	To provide multi-agency oversight of the care homes and provide support with respect to: • personal protective equipment • capacity tracker	• Microsite was set up to communicate key messages and provider guidance and support • Development of Care Home Support Team • Infection, Prevention and Control training set up weekly

Cell	Dates (when in operation)	Immediate priorities at the beginning of the pandemic	Key activities during the pandemic
		• nursing cover • communication of key messages • development of microsite • emotional support • testing • training • oversight of market, financial viability • digital support, NHS mail • vaccination • outbreaks Now occurs every 28 days and is led by the Local Authority. Task and finish groups were set up to oversee the elements outlined above.	• Call to action rolled out – personal protective equipment/infection prevention and control/testing • Development of Outbreak Control Team meetings to monitor outbreaks, providing support and guidance where needed • Effective joint working across organisations • Prompt action to crisis such as staffing level challenges for homes with outbreaks • iPad and laptop roll-out to all homes • Financial support to sector from Infection, Prevention and Control grants and Local Authority support • Guidance and support on visiting arrangements

Discharge Cell	April 2020 to present	To provide oversight of the discharge process out of acute hospitals (including acute and community, mental health, Local Authorities and transport) during the Covid-19 pandemic by:
		• overseeing local delivery of the National Discharge Guidance
		• checking services available in the community and escalation/ resolution of discharge delays
		• commissioning of temporary designated capacity (Covid-19-positive isolation beds)
		• communication of key messages
		• emotional support to providers
		• oversight of market, financial viability
			• More than 100 actions were put in place across providers to deliver the national discharge requirements to respond to Covid-19 (across acute hospitals, community health, social care, mental health trust, patient transport and voluntary sector) to ensure that good patient flow was maintained
			• Effective joint working across organisations
			• Development of:
			  ○ Derbyshire Pathway Guidance
			  ○ Derbyshire Service Operating Procedures
			  ○ discharge to assess capacity data reporting
			  ○ designated capacity monitoring
			• Support to people being discharged to nursing care homes
			• Prompt action to crisis, such as staffing level challenges for providers with outbreaks

Cell	Dates (when in operation)	Immediate priorities at the beginning of the pandemic	Key activities during the pandemic

		• management of capacity due to outbreaks
		• acting as operational escalation route for all discharge to assess concerns
		• the setting up of sub-groups to manage the above including:
		  ○ The Derbyshire Pathway Group
		  ○ Operational Group
		  ○ Pathway Data Group
		
		Operational weekly with system partners.
			• Financial support to sector from National Hospital Discharge programme

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

Performance Summary 2021/22

In 2020/21 the CCG reported meeting 9 of the 21 constitutional or mandated standards. As of 31st March 2022, our overall performance has shown that 6 of the 21 constitutional or mandated standards for our patients have been delivered during the year (see Table 2). A few of the standards are below the nationally reported figures although the CCG mental health performance compares very favourably. Those standards that were not achieved are detailed by exception in the performance analysis section of this report.

Performance Analysis up to the end of Quarter 4

Indicator		Standard	DDCCG	NHSE&I
Referral to Treatment	18 weeks Referral to Treatment – Elective Surgery	92%	65.3%	65.4%
	18 weeks Referral to Treatment – 52+ week wait	0	70398	3760598
Diagnostic waits	Diagnostic test waiting more than six weeks from referral	1%	33.45%	25.31%
A&E waits	A&E less than four hours	95%	70.8%	74.6%
Cancer waits less than 14 days	Urgent GP referral to first outpatient appointment	93%	80.4%	82.1%
	Urgent GP referral to first outpatient appointment (breast symptoms)	93%	48.2%	64.1%
Cancer waits less than 31 days	Diagnosis to first definitive treatment for all cancers	96%	91%	93.5%
	Subsequent surgery within 31 days of decision to treat	94%	77.9%	84.3%
	Subsequent drugs treatment within 31 days of decision to treat	98%	98.1%	98.8%
	Subsequent radiotherapy treatment within 31 days of decision to treat	94%	94.9%	95.1%
Cancer waits less than 62 days	Urgent GP referral to first definitive treatment for cancer	85%	63%	68.8%
	NHS screening service to first definitive treatment for all cancers	90%	64.3%	72.5%
	104+ days wait for first treatment	0	353	13643
Mental Health	CPA seven days follow-up (Retired Dataset)	95%	N/A	N/A
	IAPT access	25.2%	31.02%	–
	IAPT recovery	50%	52.9%	50.0%
	IAPT waiting times (six weeks)	75%	87.9%	91.2%
	IAPT waiting times (18 weeks)	95%	100.0%	98.6%
	Early Intervention in Psychosis – completed	60%	56.3%	67.7%
	Early Intervention in Psychosis – wait <2weeks	60%	44.1%	27.5%
	Dementia diagnosis	67%	64.3%	62.8%

Table 2 – CCG performance against constitutional or mandated standards during 2021/22, as at 31st March 2022

2021/22 Performance Exceptions

Referral to Treatment Time (18 weeks)

At the end of 2020/21, 65.3% of CCG patients on the incomplete pathways list had been waiting less than 18 weeks for their treatment. The number of CCG patients on the incomplete pathways list increased from 71,347 in March 2021 to 100,552 at the end of March 2022.

During the year, trusts were asked to complete two operational plans, each covering six months, April to September 2021 (H1) and October 2021 to March 2022 (H2). The focus has been away from performance and more on increasing planned care activity to the levels experienced during 2019/20 before the pandemic, focusing on day case and overnight elective activity.

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

Patients waiting more than 52 weeks for treatment

At the end of March 2021, there were 8,261 CCG patients who had been waiting more than 52 weeks for their treatment with the largest number on the Trauma and Orthopaedic waiting list. By the end of March 2022, this had been reduced to 5,269. The majority of these patients are on the waiting list of UHDBFT and CRHFT, but 1,255 are waiting for treatment at various trusts around the country.

There were 434 CCG patients who had been waiting more than two years for their treatment at the end of March 2022. NHS England and NHS Improvement (NHSE&I) have stipulated that there should be no patients who have waited for more than two years for their treatment by the end of June 2022.

Diagnostics

This standard has not been met throughout the year. Unfortunately, due to the infection prevention and control regulations as a result of the pandemic there was not capacity to undertake as many diagnostics tests as previously.

As with other standards, there has been less focus on actual performance but more about increasing activity to the levels undertaken during 2019/20, this has been difficult for some of the diagnostic tests.

At the end of March 2021, the CCG had 18,773 patients awaiting a diagnostic test, by March 2022 this had increased to 28,867, an increase of around 50% as a result of capacity issues and an increase in referrals across all diagnostic tests.

In March 2021, 25.4% of patients had been waiting more than six weeks for their diagnostic procedure, a substantial improvement over the previous year, however CCG performance steadily declined during the year and at the end of March 2022, the performance was at 35%. The standard is less than 1% of patients should wait more than six weeks.

Restoration of diagnostic activity is part of the 2022/23 Operational Plan whereby all trusts are required to recover their activity to 120% of the 2019/20 level of activity.

Accident and Emergency Waiting Time – proportion with total time in Accident and Emergency under four hours

The majority of Derby and Derbyshire patients attend UHDBFT and CRHFT for their emergency needs. During the pandemic first wave, the attendances drastically reduced, leading to an improvement in performance during 2020/21. However, during 2021/22 the numbers have increased and performance at the end of Q4 was 70.8%. This is despite the establishment of co-located Urgent Treatment Centres (UTCs) at the acute trusts to treat more minor cases, with the number of streamed patients increasing by 270% at CRHFT and by 232% at UHDBFT.

Along with the rise in attendances, the Accident and Emergency departments are still divided according to whether patients are Covid-19 symptomatic or not, ensuring safety but meaning less flexibility in how the spaces could be used. Children's attendances were significantly higher during the autumn due to rises in cases of suspected respiratory syncytial virus and bronchiectasis. The biggest factor affecting other patient flow occurred at the opposite end of the patient pathway, with severe shortages in social care Packages of Care leading to long delays in patient discharge.

12 Hour Trolley Breaches

The NHS has a zero target for 12-hour trolley waits (12 hours from decision to admit to being moved to a bed). There were 987 breaches reported up to the end of March 2022, with 16 taking place at CRHFT and 971 taking place at Royal Derby Hospital (RDH). Not all of these patients were Derbyshire patients.

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

- 910 RDH breaches were due to patients awaiting a bed on the Medical Assessment Unit. This area is also divided according to whether patients are Covid-19 symptomatic or not (limiting space flexibility);
- 60 RDH patients (plus one at Burton) were awaiting a mental health bed elsewhere. At the RDH, these patients are cared for in a bedded area away from the ED, even though they are still kept on ED systems; and
- 10 of the CRHFT delays were due to medical bed availability, with the remaining six due to the availability of mental health beds within the Derbyshire system.

Cancer

It has been another challenging year for cancer performance nationally as well as for our two main acute providers. The CCG achieved two of the eight main cancer standards (31 days to subsequent surgery and 31 days to subsequent drug treatments). Despite not achieving the remaining six standards, performance has varied against the nationally reported figures.

During the year we have worked with our partners across Derby and Derbyshire to encourage the public to see their GP with any worrying symptoms that could be cancer. The public were offered reassurance that cancer services were being maintained throughout the

pandemic, although some services may have been delivered in a slightly different way. We did this through the local media, social media, patient and public forums and text messaging.

Two-week wait (2WW) referrals for cancer treatment increased nationally by around 115% and the CCG performance has suffered as a result. The standard has not been hit at all during the year.

As part of the H1 and H2 recovery plans, the trusts and CCG were asked to give trajectories for the number of patients seen as a 2WW appointment each calendar month, the CCG has exceeded the agreed trajectory throughout the whole of the year.

Breast referrals, both 2WW and symptomatic, increased significantly again during 2021 and also gynaecology referrals, particularly affecting UHDBFT. Breast pain clinics were introduced in June 2021 in an effort to divert some patients to those clinics to increase capacity in the other clinics. Although numbers were small at the outset, these have gradually increased during the year.

From April 2021, the 28-day Faster Diagnosis standard has been monitored and has been reported nationally since Q3. The CCG was above the 75% standard until September and has been below the standard since. This performance target was included in the H1 and H2 recovery plans. At this time, it was still not clear when the 2WW standard will be replaced completely with the 28-day faster diagnosis standard.

There continues to be a significant challenge to deliver the 85% performance for 62-day treatment, both locally and nationally. As numbers referred have increased, this has resulted in more patients being tracked and going through the cancer pathway. As a CCG this standard has not been met throughout the year and has varied from 59% up to 72.5%. Although performance has been below standard the number of patients is above the 2019/20 levels.

Radiotherapy and chemotherapy treatments continued during the year at the same levels as the previous year although there were some delays in surgery due to capacity, however the numbers of surgical treatments were good in comparison to the previous year, and in many months have exceeded the previous year.

We have reviewed data to look at areas of Derbyshire where cancer referrals were very low during the pandemic compared to previous years to understand where we need to focus on working with GPs to address this.

Early Diagnosis of Cancer

There is a national ambition to diagnose 75% of cancers at an early stage by 2028 and to improve the number of patients who survive for longer following a cancer diagnosis. We are following national guidelines to implement Faster Diagnosis Standards by giving early access to diagnostics so we can detect cancer or rule out cancer as soon as possible. In particular, we have focused on breast, colorectal and prostate cancer pathways and will be focusing on head and neck, and gynaecological cancer pathways next.

Cancer screening programmes

Due to the Covid-19 pandemic, there has been some delays in delivering screening programmes. The cervical and bowel screening programmes have been fully restored in Derbyshire and waiting times are in line with national standards. The bowel screening programme is now being extended to a wider age range enabling more bowel cancers to be picked up at an earlier stage. Breast cancer screening is still recovering and is not yet fully restored, and we are working closely with NHSE&I to reduce the backlog.

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.

The mixed sex accommodation data was not captured throughout the pandemic, however the collection of data commenced again in October 2021 and the CCG has had 10 breaches of this standard. The trusts provide our Quality Team with a report for the breaches detailing the circumstances and actions taken.

Planned Care

Outpatients

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

We are continuing to work with providers to develop digital opportunities for patients to have more control over their care. This will be through self-help resources and/or digital resources that offer patient-initiated follow-ups, allowing patients to access clinical teams as and when their condition might need support from a specialist.

Advice and Guidance

Advice and guidance covers non-face-to-face communication between services to enhance the patient pathway. Digital communication channels allow peer-to-peer conversations across the system to discuss individual cases.

Advice and guidance continues to be provided across the Electronic Referral System and Consultant Connect Platforms through a variety of non-face-to-face methods including calls, messages and photos to support decision-makers to make the most clinically appropriate referrals.

Since there have been a significant number of changes over the last two years, a review of all advice and guidance in the Derbyshire system is to be undertaken with a view to ensuring that this will be offered in all specialties (where clinically appropriate), optimising use of different approaches to support clinical decision-making.

Tele-Dermatology

Continuing with work commenced at the start of the pandemic, tele-dermatology advice and guidance services have continued, sharing images of lesions and rashes (excluding suspected cancer). The rapid access to specialist advice and guidance continues to support primary care clinicians to care for their patients in the community, avoiding unnecessary hospital referrals and contributing to recovery plans. In 2021 (available data from January to December), there were 3,514 requests submitted via Consultant Connect, and of these, 46% avoided the need for referral to hospital (either did not need to be referred, or were offered treatment advice and/or seen within a community service).

The dermatoscope funding secured in February 2021 has enabled 84 practices to be provided with high quality dermatoscopes and basic training for a lead GP in each practice, supported by consultant-led mentoring sessions and additional one-to-one mentoring as required.

Recovery plans for dermatology services have included pilots in the use of the Electronic Referral Service to support new ways of working, enabling triage of referrals and ensuring patients are seen when required, allowing two-way communications with a referring clinician when necessary and faster response time for patients who need to be seen in clinics.

In October 2021, a pilot project for paediatric dermatology referrals was launched at UHDBFT with all paediatric referrals being sent for advice and guidance via the Electronic Referral Service rather than referred in. This allows the hospital to offer advice and guidance to the GP referrer or convert the advice and guidance request to a referral if needed. Data is showing around 50% of requests only need advice and guidance. A similar pilot has also been launched at CRHFT for all adult referrals. The providers are working together via the Expert Advisory Forum (EAF) to ensure the learning is shared across the system.

Patient initiated follow-ups

Patient initiated follow-ups give patients and their carers the flexibility to arrange their follow-up appointment as and when they need them. Both local NHS providers have implemented this across a range of specialties.

Clinical Specialties

A number of EAFs have met regularly to progress clinically-led redesign to support ongoing restoration and recovery of services. There are currently EAFs for the following specialties:

1. Gynaecology
2. Ear, Nose and Throat
3. Paediatrics
4. Dermatology
5. Urology
6. Ophthalmology

The following pages highlight examples of some of the work undertaken during 2021/22.

Gynaecology

Ring pessary insertion training for Physiotherapists by Consultants at both CRHFT and UHDBFT is due to start shortly. This will enable trained Physiotherapists to support women as part of their physiotherapy and discharge the patient back to the GP for longer term care. A menopause clinic has also been implemented at CRHFT. The EAF is also currently reviewing a number of clinical pathways, including polycystic ovarian syndrome, heavy menstrual bleeding, post-menopausal bleeding, pelvic pain, and continence.

Dermatology

In addition to the work around teledermatology, several condition-specific pathways have been developed, which include atopic eczema pathway, acne pathway and actinic keratoses pathways.

Urology

Work has continued to address the current challenges around the number of patients waiting to be seen and exploring a range of options, including:

Community Urology Model	This is in the early planning stages of development and would include clinics to address flow rate, bladder/haematuria, urinary tract infections, erectile dysfunction and testicular and penile pain.
Prostate-Specific Antigen Testing	Implementation of new NICE guidelines.
Consultant Connect	This has enabled a change in approach at CRHFT where they have implemented Consultant of the Day, running 8am-5pm, Monday to Friday, which has enabled emergency cases to be prioritised where referrals are reviewed daily as well as improving expedited discharges. Patients are also seen face-to-face on the Surgical Assessment Unit. UHDBFT has been using Consultant Connect for some time to support patient referrals when further advice and guidance is required prior to a decision being made.
Updates to clinical pathways	Haematospermia, urinary tract infections in women and testicular pain.
Referral Assessment System and Clinical Assessment Service	As part of a review of the effectiveness of the new Referral Assessment System, a review of urology referrals through the Referral Assessment Service and direct 2WW referrals has been completed. Due to restrictions in place following Covid-19 guidance, there was a reduction of approximately 27% for all referral types during 2020/21, compared to 2019/20. Support was given to clinicians when referring urology patients to CRHFT and UHDBFT through a new referral assessment service and the already implemented clinical assessment service (rolled out in Derby). The aim of these services is to provide advice and guidance to ensure the patient is referred to the right service and reduce repeated conversations on the best treatment plan. During 2021/22 there was a 36% increase in all referrals compared to 2020/21 and the total number of referrals had returned to levels previously seen in 2019/20.

Ophthalmology

Due to Covid-19, the Minor Eye Conditions Service (MECS) was paused. The service enables patients experiencing minor eye conditions like red eye, or dry eyes, to be seen in Primary Care and reduces the need to be seen in hospital. It was replaced by a service called Covid-19 Urgent Eye Service (CUES), which CCGs were required to have in place during the pandemic. Associated funding for CUES ceased in June 2021, but the CCG was able to reinstate the MECS trial to ensure there was no gap in service provision. JUCD approved ongoing funding for the MECS, as it demonstrated best use of resources in Primary Care, reduced the need for Hospital Eye Service contacts and was provided close to patients' homes. Taking examples of best practice from CUES, the service was expanded to enable General Practices to signpost patients and fast track those in need of an optical coherence tomography scan, without the need to attend hospital.

Work has continued on the following three transformation projects in Ophthalmology:

1. Moving post-operative cataracts patient check-ups out of Secondary Care and into community Optometrists for low risk, non-complex patients
2. Moving the monitoring of stable glaucoma patients out of Secondary Care and into community Optometrists
3. Implementing a virtual Ophthalmology triage service trial in the south of the area

All three projects have the same aims – to reduce impacts on Secondary Care hospital eye services, provide services closer to home for patients and access to a range of services in a timely manner. All projects are due to mobilise in early 2022.

Three new contracts were awarded to providers of cataract services for Derby city, High Peak and Chesterfield during the year. These contracts have supported the recovery of cataract services across the area due to the impact of the Covid-19 pandemic on Secondary Care services and will continue to do so for the foreseeable future.

Musculoskeletal Services

The MSK Delivery Board remit has been extended to include the MSK community pathway as well as Orthopaedics which will ensure that it has an overview of the whole patient pathway.

Representatives on the MSK Delivery Board worked during the Covid-19 pandemic to support and review the backlog of patients waiting for treatments where possible.

Funding has been secured for £1.064m to support the Digital MSK solution in Derbyshire. This funding is being used to develop a Digital MSK Platform for use system-wide by patients and providers. Its aim is to maximise opportunities to address self-care, prevention, rehabilitation and condition management. Following a robust evaluation process, a provider has now been procured and planning for the mobilisation of the platform has begun. The provider is Getubetter, who have experience in launching similar platforms for multiple other ICSs. Digital MSK funding will be used to support stakeholder engagement sessions and waiting list initiatives with MSK and Orthopaedics. A further options appraisal on waiting list initiatives to ensure best use of finances is imminent, and a commitment to purchase is expected by June 2022.

Funding has been secured to develop a systemwide workforce plan for Derbyshire in 2022/23. This will ensure services are aligned to forecasted needs of the Derbyshire population, and enable recruitment of clinical professionals to meet those needs. It will ensure that we are using and developing our Allied Health Professional workforce effectively and for the best outcomes of patients.

Work is underway on developing a system-wide Community MSK model from feedback gathered at a stakeholder review that was undertaken in October 2021. This will ensure that it is co-produced with patients and is not limited to NHS services.

Physiotherapy

Work is underway on a system-wide MSK outpatient physiotherapy review. We completed an initial patient engagement review and a collaborative engagement with all Physiotherapy service providers across Derby and Derbyshire.

A suite of self-management advice and information was compiled and made available to patients to enable them to manage their MSK conditions while waiting for treatment. Patients who have had their appointment cancelled have been provided with the link to the site to support them during their extended waiting times.

Integrated Community Care

Throughout 2021/22, the Joint and Community Commissioning Team continued to focus on working collaboratively with health and social care service providers, voluntary and independent partners to develop strong integrated community services across Derbyshire. Transformation work has been targeted at projects which will enable the health and social care system to operate as effectively as possible in extremely challenging circumstances.

Covid-19 Support and Recovery Projects

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

Care Homes Support	Continue to coordinate and support care homes across Derby and Derbyshire throughout the pandemic to ensure they have access to training and support. Building opportunities for care home staff to access support for mental wellbeing and to be part of a collaborative response across Derby and Derbyshire.
Local Resilience Forum Community Response and Recovery Cells	Strengthen a joint approach among partner organisations in mitigating the impact of the pandemic in communities through the support of community hubs and partner forums.
Enhanced Support for Patients with delirium and dementia	Continue to support patients with delirium and dementia to ensure that, as far as possible, they can be cared for away from hospital settings, either in their own home or in a care home.

Discharge to Assess	Build a strong, collaborative discharge to assess model which enables and supports Derbyshire people to be discharged from our two acute hospital trusts, community providers and from out-of-area hospitals. Together, with partner organisations, we have developed more than 70 temporary beds across residential and nursing settings and ensured that the commissioned services have been able to deliver even in the most difficult of circumstances. We have maximised our packages of care to discharge people home as quickly as possible.

Transformation Projects

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

Palliative and End of Life Provision

Providing high quality, coordinated care to people at the end of their life is a key priority locally and nationally. The Community Commissioning Team has supported the JUCD End of Life Programme throughout 2021/22. Specific projects have included:

- ensuring that the Shared Care Record includes the right information and functionality to facilitate coordinated care for people at the end of their lives;
- piloting a 'Palliative Care Urgent Response Service' to ensure that patients wishing to die at home have access to support, including pain management, within two hours;
- modelling the required levels of care at home, inpatient beds and community nursing capacity required for Derbyshire's population.

Voluntary, Community and Social Enterprise Sector

There are many VCSE organisations working across Derby and Derbyshire to support the health and wellbeing of local people. The CCG is committed to engaging with the sector in the development of community-focused services and supporting nationally promoted initiatives such as development of VCSE leadership roles.

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

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

VCSE organisations have played an essential role throughout the Covid-19 pandemic, working together with the CCG and other partners to ensure that people receive local help. This included supporting the reduction of food poverty; providing emotional support to help reduce the likelihood of emerging mental health problems; delivering prescriptions to people who are shielding and isolating; and supporting the NHS vaccine programme.

Social Prescribing

Social prescribing is accessed through General Practices and connects people to community services and activities that can help them take steps towards their health and wellbeing goals. Some of the link workers, while connecting with the General Practice, are hosted by a local voluntary sector organisation and are a great example of working in partnership. Since last year, the number of Social Prescribing Link Workers in each PCN has nearly doubled from 30 to more than 50 workers. Several collaborations have been set up with the VCSE sector, including developing a young person's link worker, and MSK link workers. While these new roles are not commissioned by the CCG, we have taken an active involvement in supporting PCNs to make the most of the opportunities they present. We established the Social Prescribing Advisory Group, which brings key stakeholders together on a regular basis, to facilitate a coordinated, joined-up approach. The Group provides a forum for link workers and promotes collaboration with the wider community including the Local Area Coordination network and community wellbeing coaches.

In March 2022, the Social Prescribing Advisory Group oversaw a successful tender for a social prescribing platform which will allow all link workers, GPs and partners to manage caseloads, record outcomes and performance data and share wider marketplace intelligence in one place. It is a proof-of-concept project that will evaluate and test the platform during 2022/23.

In addition, the Social Prescribing Advisory Group is overseeing the second year of a county/city-wide cross-sector test and learn project called 'Greenspring' which has secured funding of £500k over two years. To date, the project has tested several green interventions for people recovering from/living with mental ill health and will be further testing across each place during 2022/23. The project delivery started in April 2021 and will run until March 2023.

Community Equipment

The team has worked with colleagues at Derby City Council and Derbyshire County Council to ensure that local people are supported to be as independent as possible, and to receive care closer to home, through the provision of enabling equipment. This ranges from basic items such as walking sticks and Zimmer frames, through to bespoke specialist seating and sleeping systems. In 2021/22, the CCG took on the lead commissioner role for the Derby Integrated Community Equipment Service. The service was put out to tender, and Medequip Assistive Technologies Ltd was awarded the contract, which commenced on the 1st July 2021.

The team has developed and procured a new service, also provided by Medequip, to supply medical equipment and the consumables needed to operate them, to patients being cared for at home.

Urgent Care

Hospital capacity continued to be organised in new ways because of the pandemic to treat patients with and without Covid-19 separately and safely. Beds and staff continued to be deployed differently in both emergency and planned care settings within the hospitals.

A key focus remained to support the system during the pandemic including supporting NHS111 First, virtual consultations at various urgent care services, and maintaining strong links between service providers. Our main aims were to improve access to urgent care services; a summary is shown below.

Transformation

When not at the height of the pandemic, meetings with service providers continued remotely to deliver the Urgent Care Transformation Programme. The Accident and Emergency Delivery Board continued alongside the Senior Leadership Board, meeting as and when required virtually. However, the Covid-19 pandemic impact meant we had to put a slight pause on our transformation projects, progressing what we could while reacting to the operational challenges. As a system we are looking to restart transformation from March 2022 and as part of the Urgent and Emergency Care Transformation Programme several different projects will be worked on, which are highlighted below.

Virtual Consultations

Virtual consultations by NHS111 continue to be successful and are also being introduced by the five UTCs. Virtual consultations are also being considered in our EDs to enable conversations between clinicians in different trusts.

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

Operational Support

The System Operational Resilience Group, at silver command-level, has met twice weekly to coordinate and deliver the actions necessary to respond to significant operational issues affecting the health and social care system. The system has worked well together during periods of significantly high pressure due to Covid-19, with mutual aid and redeployment of staff.

System Escalation Call meetings, at gold command-level, also continued to respond to the challenges and demand from the pandemic. These meetings were stepped up and down as required and proved how well the system could work collaboratively and in an agile manner to respond.

Demand Management

The system continued to work together throughout 2021/22 to identify areas of opportunity for alternative ways of providing care, reducing pressure in EDs, and managing Covid-19 demand alongside the significant non-Covid-19 demand.

Below are the key areas of demand management work that remained priorities for 2021/22:

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

NHS111 First

The NHS aims to continuously improve the patient experience and find new ways to see patients. During the Covid-19 pandemic this became more vital, keeping our patients and staff safe when coming into an ED. A national programme, NHS111 First, was launched during the pandemic, which we rolled out in Derbyshire in autumn 2020. As part of the evaluation process, we have gathered the data, patient and staff feedback across the system. Clinical audits were undertaken and the findings and recommendations will be used for making further improvements. Furthermore, frequently asked questions were developed for staff within EDs, the five UTCs and Primary Care.

Same Day Emergency Care

Same Day Emergency Care continues to be maximised across the system and organisations have worked collaboratively to improve their Same Day Emergency Care service for patients. Work also continues to progress direct referrals from EMAS and to increase the Same Day Emergency Care offer across specialty areas allowing patients to be seen, treated, and discharged the same day wherever appropriate. In line with the Urgent and Emergency Care 10-point recovery plan, Same Day Emergency Care remains a priority and will be an ongoing focus for the system.

Urgent Treatment Centres

UTCs continue to provide valuable locally accessible, urgent care services to the Derbyshire population and more so during the Covid-19 pandemic. Our UTC services are working towards achieving the new National Standards which, for example, includes the use of digital technology to provide appointments booking options and telephone/video consultations. As we move towards becoming an established ICS for Derbyshire, we are focused on working together with other Derbyshire health and care services to integrate our UTC services offer with those in Primary Care and the health community.

Integrated Urgent Care Clinical Assessment Service

The Integrated Urgent Care Service Specification was published on the 25th August 2017 outlining a national specification for the provision of an integrated 24/7 urgent care access, clinical advice and treatment service that incorporates NHS111 and Out of Hours services, called an integrated urgent care clinical assessment service.

This is an opportunity to design an integrated urgent care model that best suits the population of Derby City and Derbyshire that incorporate NHS111, clinical assessment service, and Primary Care Out of Hours. Urgent and Emergency Care system partners are actively involved in producing the proposal for an integrated urgent care model. In addition, as part of the core Derbyshire Urgent and Emergency Care strategy refresh, we will commission and implement a clinical assessment service.

Primary Care

Derbyshire's vision for Primary Care

Our vision has been developed by our local GPs, with the aim of providing high quality, patient-centred, General Practice-led care which has the freedom to innovate to meet patients' needs; with organisations and professionals behaving in a mutually supportive manner. The vision outlines three goals, which will be supported by, and help us deliver, the national priorities as set out in the NHS Long Term Plan; Primary Care System Development Programmes (previously known as the General Practice Forward View) and General Practice Contract over the course of five years.

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

Derbyshire General Practice Workforce

The total permanent General Practice workforce for Derbyshire as of the 31st March 2022 is 3,684. Within the workforce there are four main staff groups; these are:

General Practitioners	882 headcount (698 FTE)
General Practice Nursing	495 headcount (352 FTE)
Direct Patient Care (those other than GPs and Nurses who provide care to patients, e.g. Health Care Assistants, Physiotherapists, Pharmacists or Paramedics)	342 headcount (249 FTE)
Administration and Non-Clinical	1,965 headcount (1,409 FTE)

Table 3 – Primary Care Workforce staff group data as of 31st March 2022 (latest available data)

The General Practice workforce in Derbyshire is stable, with a steady increase in all staffing groups over the past 12 months.

In terms of age profile, our workforce is comparable with other areas of the country. For our GP workforce, 26% are under the age of 39 and 22% over the age of 55. For our nursing workforce, 19% are under the age of 39 and 20% are over the age of 55. Alongside our retention and recruitment initiatives, we are collaboratively working with partners and stakeholders to develop a five-year workforce plan to share with General Practice.

It is important to note that the data above does not include staff recruited by PCNs under ARRS. The scheme is available to PCNs via participating in the PCN Direct Enhanced Service Contract. The ARRS scheme began in July 2019 and allows PCNs to recruit additional staff, outside of GPs and nurses, to work in General Practice and be reimbursed by NHSE&I for salary and on-costs. As of March 2022, PCNs had recruited 354.04 whole time equivalents under the scheme and 268.34 WTE who are permanent staff.

Extended Access

Following on from the General Practice Forward View, Extended Access has been included in the PCN Direct Enhanced Service Contract to help General Practice deliver more of its potential to improve the care available to patients. Longer opening times (via geographically-based hubs which operate additional appointments on weekday evenings, and weekend mornings, including bank holidays) for patients in Primary Care have been rolled out across Derby and Derbyshire and significantly increased access to Primary Care.

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

In March 2022, General Practice in Derbyshire provided approximately 574,647 appointments, which is a 74,000 (5% corrected for working days) increase on March 2019 (pre-pandemic). Most appointments were face-to-face (approximately 65%) and 42.5% were a same-day appointment. Any Extended Access appointments are additional to these statistics.

Primary Care Estates

The Primary Care Estates Strategy was approved by the Primary Care Commissioning Committee in November 2020, providing a framework for the development of the Primary Care estate across Derbyshire to 2025. The strategy identified 20 activities. Work has commenced on the five highest priority actions, which will determine what is required for the estate. Feasibility studies have been undertaken in the South East Derby, South West Derby, Mickleover and Mackworth, North East Derbyshire Southern (Area D) and Swadlincote areas.

The South East Derby strategic work is primarily being taken forward through the development of an Outline Business Case for a new system-owned building at Sinfin, one of six national pilot sites being supported by NHSE&I. The Mickleover and Mackworth feasibility study has progressed to two Strategic Outline Cases, completed in December 2021, with discussions to follow around how the project proceeds to the Outline Business Case stage. The South East Derby feasibility is being taken forward by a piece of work to identify the potential to relocate some administrative functions and to convert existing practice space for clinical use. The draft report on the feasibility study for North East Derbyshire Southern (Area D) was completed in March 2022 and is undergoing an internal review before being finalised. The Swadlincote feasibility study was finalised in March 2022.

Quality

Quality Assurance Visiting Programme

The Quality Assurance (QA) Visit programme for General Practices was relaunched in Autumn 2021. QA visits are scheduled on a yearly rolling programme across Derbyshire. The visit is a systematic and transparent process of checking to see whether a practice is meeting specified requirements and involves the assessment of quality of care against agreed thresholds and standards, to determine the level of quality within the practice. This also includes assurance that actions identified are implemented via reviews against progress and improvement in quality.

QA visits are intended to be an informal way for practices to have an open discussion about areas of their practice, and review and reflect on the wealth of current health care information in relation to individual practice quality and performance. This is intended to be a supportive process and part of the on-going dialogue with practices and the CCG. QA visits continue to be a mechanism for encouraging practice development and sharing good practice.

National Screening and Immunisation Programmes

Throughout 2021/22 the National Screening programmes have continued their recovery and restoration plans in response to the Covid-19 pandemic:

Diabetic eye screening	High risk patients and previous 'did not attends' continue to be invited for their screening. All patients with a previous R0M0 screen are being invited, within two years from their last screen.
Antenatal and new-born screening programme	Continuing as normal.
Breast cancer screening programme	Remains open for screening and services continue to be restored at CRHFT, UHDBFT, Sherwood Forest Hospital NHS Foundation Trust and Nottingham University Hospitals NHS Trust. High risk breast screening also continuing.
Cervical screening programme	Continuing as normal. Colposcopy clinics are running as normal.
Bowel cancer screening	Programme has restored the service, routine invitations and test kits are being sent, and additional precautions are being taken to ensure the pathway for colonoscopy is Covid-19 secure.
Abdominal aortic aneurysm	Programme has restored the service, primary screening and surveillance patients continue to be invited. Additional measures are in place to ensure attendance is Covid-19 secure.
National childhood immunisations schedule	Maintained throughout 2021/22.

The national influenza vaccination campaign for 2021/22, despite the continuing pressures experienced by General Practice, has delivered a successful vaccination programme with uptake in the adult eligible cohorts higher than that achieved the previous year and higher than the last non-Covid-19 year. The CCG was placed in the top 25% of performing CCGs in the Midlands region. Unfortunately, uptake in the pregnant and 2 to 3-year-olds cohorts is down when compared to last year but remains higher than the uptake met in 2019/20.

Table 4 below shows the number of people vaccinated during 2021/22, and the difference in uptake for 2020/21 compared to 2021/22:

Category	Number vaccinated in 2021/22	2021/22 uptake (%)	2020/21 uptake (%)	Difference in uptake (%)
Over 65 years	187,595	86.4	83.4	+3
Under 65 'at risk' groups	89,266	59.8	57.8	+2
Pregnant women	5,443	47.7	50.6	-2.9
2-year-olds	6,319	59.9	61.8	-1.9
3-year-olds	6,567	60.6	65.1	-4.5
Aged 50–64 (not at risk)	79,591	53.3	43.1	+10.2
Aged 50–64 (at risk)	54,444	71.8	70.9	+0.9

Table 4 – Influenza vaccination uptake during 2021/22 and 2020/21

General Practice Nursing

The CCG works closely with HED to support General Practice Nurses across membership practices. This has involved the development of the JUCD 'Our Primary Care Nursing Strategy' in 2021 which outlines the forward view for General Practice Nurses. To achieve these ambitions, a Practice Nurse Working Group and General Practice Workforce Steering Group were established. Aims include, to:

- raise the profile of General Practice Nursing and promote General Practice in Derbyshire;
- extend leadership and educator roles;
- increase the number of pre-registration placements in General Practice;
- establish induction and preceptorship/new to practice programmes;
- improve access to return to practice programmes and support nurses who need to return to the NMC register;
- support access to educational programmes;
- increase access to clinical academic careers and advanced clinical practice programmes, including nurses working in advanced practice roles in general practice;
- develop healthcare support worker, apprenticeship and nursing associate career pathways; and
- improve retention.

From these aims, the following achievements were made in 2021/22:

- increased student supervision and assessment transitioned General Practice Nurses by 49%;
- increased Trainee Nurse Associates by 83%;
- increased Pre-Registration Nurse placements by 16%;
- increased practices taking Pre-Registration Nurse placements by 17%; and
- increased newly qualified Nurses in General Practice by 27%.

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 General 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 5 identifies the ratings awarded to General Practices by the CQC for the reporting period up to the 31st March 2022:

Rating	Total General Practices
Outstanding	20
Good	89
Requires improvement	2
Inadequate	1

Table 5 – CQC ratings awarded to General Practices up to 31st March 2022

CQC launched its strategy for 2021–2026 in May 2021. The new strategy combines learning and experience, and it has been developed with contributions from the public, service providers and partners. It means the regulation will be more relevant to the way care is now delivered, more flexible to manage risk and uncertainty, and will enable CQC to respond in a quicker and more proportionate way as the health and care environment continues to evolve. Further Information can be found here[9]. The Primary Care Quality Team continued to meet with the CQC on a bi-monthly basis during the pandemic.

Digital Development

The Digital Development Team supports the digitalisation of Primary Care and the corporate information technology (IT) requirements of the CCG. Most of this work is undertaken through the underlying General Practice IT and corporate IT contracts with NECS, which the team manages on behalf of the CCG and Primary Care. Increasingly, the team is involved in programmes of work across the Derbyshire health and social care system and emerging ICS – providing information governance and digital support and expertise.

Focus on activity

For 2021/22 our main goals included:

- supporting regional and national programmes including Digital First Primary Care; Electronic Eyecare Referral System; and the Derbyshire Shared Care Record;

[9] https://www.cqc.org.uk/about-us/our-strategy-plans/new-strategy-changing-world-health-social-care-cqcs-strategy-2021

- completing a technical re-evaluation of the Derbyshire pathfinder referral optimisation programme and developing plans to expand the system to include other Derbyshire NHS partner organisations;
- successful delivery of national targets for the number of online consultations taking place across the Derbyshire Primary Care system;
- working as part of the system Enhanced Health in Care Homes group to lead the discussion around digital development of care homes to support remote monitoring of patients and the delivery of Primary Care services to patient without requiring GP visits.

System-wide working

2020/21 saw a marked increase in the number of collaborative digital projects taking place across Derbyshire, working on the prioritisation of digital projects and the practicalities of implementing these in a system which is accustomed to working in digital silos.

Under the remit of the JUCD Data and Digital Board, cross-organisational groups have addressed a variety of issues ranging from cyber security and a co-ordinated response to the Log4j/Log4Shell vulnerabilities that emerged in December 2020 through to recognition of the need to address challenges, such as shared infrastructure and the requirement for an ICS Digital Office to provide resources and support to system programmes.

Support for Third Party Organisations

The Covid-19 pandemic has seen the need to support the virtual delivery of care into third party organisations such as care homes. Building on the previous year's deployment of laptops and other technology into care homes, this year has seen the recruitment of dedicated posts within the Digital Development Team to focus on service improvements and resolving issues such as data security compliance, access to NHS mail and other pre-requisites for permitting information regarding a patient and their care to flow around the wider health and social care system within the appropriate governance structure.

The Digital Development and Information Governance teams have been instrumental in supplementing the national and regional support available to organisations, offering local advice and guidance where needed and acting as subject matter experts into commissioning and operational groups as required.

Information Governance Support

During 2021/22, the Information Governance support for General Practices was moved into the CCG, to allow the service to be more visible and in line with their evolving needs.

This year also saw the creation of a General Practice Information Governance Assurance Forum, providing the CCG (and other system members) with an opportunity to have Information Governance-related discussions with GPs, members of the Local Medical Committee and other interested parties. The forum connects into the Derby and Derbyshire Information Governance Working Group, as part of the wider JUCD governance structures. The group is instrumental in allowing Primary Care to have early sight of agreements around information and data sharing, allowing feedback to be submitted at the draft stage and ensuring that Primary Care concerns are taken into account in subsequent revisions.

Information Governance support developments during 2021/22 have included liaison with practice leads, PCN meetings and the sharing of key Information Governance updates within newsletters.

Digital First Primary Care

The procurement and management of online consultation, video consultation, patient questionnaires and other systems has been the main focus of the team's work in Primary Care. This has removed the requirement for a patient to physically present within General Practice and hence help to address issues around patient access for some of the population.

Covid-19 has made it a necessity for the team to work with developers and partners across Derbyshire to put the NHS App at the forefront of all digital patient interactions and to ensure that all data captured through these applications can eventually flow into the Derbyshire Shared Care Record. We have worked with suppliers on the incorporation of surge capacity within these systems, allowing triage to take place within other General Practices or at PCN-level.

We are reflecting upon lessons learnt through the rapid deployment of digital tools and services across the past two years and working with General Practices and PCNs to make the most of the investments made through offering training and support, and holding them to account on national directives around utilisation.

Long-Term Conditions

The 2021/22 planning and performance priorities focused on the Long-Term Conditions (LTCs) of respiratory, cardio-vascular disease, stroke, gastroenterology, and diabetes, which were aligned to NHS Long Term Plan objectives. In each of these conditions, outcomes have focused on improving the quality-of-care provision; addressing health inequalities; promoting local access to services; improving prevention support; recovering and restoring services during the pandemic; and targeting differences in quality of clinical treatment and care.

In addition, the Strategic Clinical Conditions and Pathways Team lead on key NHSE&I funded and system programmes that include tobacco dependency treatment services, Long Covid-19 assessment and rehabilitation, and LTC Hubs.

The condition-specific priorities are agreed at the Joined Up Care Derbyshire LTC Board and are overseen by monthly delivery group meetings attended by system clinical leads, service providers, and third sector organisations.

During the Covid-19 pandemic, Joined-Up Care Derbyshire requested that some non-Covid-19 initiatives and meetings be stood down at key pressure points to free up the capacity of clinical staff, service managers and commissioners to support the Covid-19 response.

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

Long-Term Conditions Pathways

Respiratory	
Respiratory service review	A service review has been completed to identify variation in services across the county, the findings of which will be considered when re-designing the pathway.
Spirometry (recovery and restoration)	To support the recovery of spirometry within Primary Care, a temporary service was commissioned which delivered more than 1,300 spirometry investigations and funding has been secured to upskill primary care staff to meet future training needs.
Pulmonary rehabilitation (recovery and restoration)	Additional funding has been secured to increase service provision to reduce the backlog of patients awaiting the service, while continuing to enhance the virtual offer.

Cardiovascular Disease	
Home blood pressure monitors	A further supply of NHSE&I funded blood pressure monitors led to the expansion of the programme of self-management at home for high risk/vulnerable patients.
Hypertension case finding	General Practice searches have been developed to identify high-risk patients who are not registered with high blood pressure. This will lead to a review of those patients and prevention of associated health conditions and escalations. Training sessions for staff have been established.
Improved referrals to cardiology	Improved quality of referrals into Secondary Care has been achieved through the introduction of a new cardiology referral form. It is expected this will mean a reduction in the number of unnecessary referrals.
Cardiac rehabilitation (recovery and restoration)	In response to the Covid-19 pandemic, a shift towards a hybrid model of delivery for cardiac rehabilitation has been achieved with clinical support/advice provided by a mix of face-to-face and virtual methods. A hybrid model of cardiac rehabilitation support works well and offers greater patient choice.
Gastroenterology	
Inflammatory bowel disease remote monitoring	Secured funding and implemented a home testing solution for inflammatory bowel disease patients to measure disease activity, effectiveness of treatments, as well as predicting relapses.
Diabetes	
Derbyshire footcare pathway	Develop and implement a Derbyshire footcare pathway, resulting in service equity across the county footprint. The primary care pathway has been agreed for implementation and the secondary care pathway is under development.
Three treatment targets and eight care processes (recovery and restoration)	An incentive scheme has been implemented utilising NHSE&I funding to support the reinstatement of primary care annual reviews.
Diabetes education portal-single point of access for clinicians	Worked collaboratively with HED to develop the diabetes education portal, optimising education offers for clinicians, via this single point of access.
National Diabetes Prevention programme (recovery and restoration)	Continued to support the service provider to increase referrals and completion rates for the course, targeting low referring areas. In addition, developed and implemented a referral pathway for patients diagnosed with gestational diabetes.
Low Calorie Diet Programme	Implemented the pilot programme in line with NHSE&I requirements. To date, more than 150 patients have accessed the programme in Derbyshire to help patients fight type 2 diabetes.

Stroke	
Stroke pathway review	Working in partnership with the East Midlands Integrated Stroke Delivery Network to benchmark services against the National Stroke Service Model to support service redesign.

NHSE&I/System Programmes

Long Covid-19	
Post Covid-19 Syndrome Assessment Clinic	Service delivered in line with NHSE&I guidance to provide patients with access to multi professional advice all in one place with pathway developed to interface with the Long Covid-19 rehabilitation centres.
Long Covid-19 Rehabilitation Centres	Developed a rehabilitation pathway to interface with assessment clinic. Commenced implementation of two rehabilitation centres in the north and south of the county to provide breathlessness, psychological, chronic fatigue and vocational rehabilitation support. Allowed a seamless process from assessment to rehabilitation giving an overall post-Covid-19 management service to patients.
Tobacco Dependency Treatment Services	
Tobacco Dependency Programme	Established a stakeholder group to drive implementation of NHSE&I programme to offer smoking cessation services to acute patients, mental health patients, and pregnant women and their partners in a hospital setting. Commenced implementation within maternity services and phased roll-out of acute and mental health inpatients.
LTC Hub	
LTC Hub Project	Planned and developed a 12-month proof of concept to provide patients with a more holistic approach to care and self-management of their conditions. All patients to receive a personalised health plan.

Medicines, Prescribing and Pharmacy

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

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

The Covid-19 pandemic continued to have a significant impact on the planned work of the team during 2021/22. The team prioritised activity in line with the CCG business continuity levels in order to focus on statutory functions and Covid-19 pandemic support across the system, as well as the restoration and recovery of other functions and services.

Covid-19 response

Continued support to the system-wide Covid-19 effort was provided for the vaccination programme and restoration and recovery work; this included:

- staff re-deployment (clinical and non-clinical) within vaccination sites including Midland House Vaccination Centre, School Age Immunisation Service, the Covid-19 Vaccination Allergy Service and acute providers to support essential medicines-related work;
- Covid-19 vaccination incident management and investigation;
- supporting the development of the Covid-19 Antiviral Service;
- providing assurance visits and pharmacy sign-off visits for all of the PCN Local Vaccination Sites as well as extension of the programme to additional cohorts, enhanced pop-up sites and roving sites as necessary within Derbyshire;
- worked with the Local Pharmaceutical Committee to support NHSE&I in Community Pharmacy site selection and assurance visits;
- providing pharmaceutical support to all vaccination pillars, including community pharmacy;
- management of pharmaceutical aspects of Covid-19 vaccine mutual aid requests (seven-days-a-week);
- support to General Practice; and
- providing pharmaceutical support to system inequalities work.

Derbyshire Medicines Management and Clinical Policies Team functions

In addition to the Covid-19 response, the team continued to deliver the functions below, including statutory functions:

Clinical Policies Team

Managing Individual Funding Requests

Managing Individual Funding Requests as a statutory function continued throughout the year with limited Public Health input, which had been reduced due to the pandemic, being re-instated towards the end of 2021. Although we saw a reduction in the number of referrals being processed due to the pandemic, Individual Funding Requests panels continued to be held monthly when required and decisions made within the agreed timescales.

Clinical Policies Advisory Group

Due to the reduced capacity for non-essential activities, it was agreed to hold the Clinical Policies Advisory Group meetings on a three-monthly basis, for those items which required an in-depth discussion. For monthly meetings which fell in-between, routine papers continued to be circulated for virtual agreement. Despite resources being diverted to support the Covid-19 programme of work, the Clinical Policies Advisory Group has continued to review and agree several new and updated clinical policies. Similar to the Joint Area Prescribing Committee, the group has been flexible with the demands diverted to Covid-19 related work and in the latter part of 2021/22 stepped up to alternate monthly Microsoft Teams meetings.

Prior approvals

Prior approvals and cosmetic referrals have continued throughout the year. Despite seeing a reduction in the number of requests because of the pandemic, a gradual increase in referrals was noted in the second half of the year.

Joint Area Prescribing Committee/Guideline Group

The Joint Area Prescribing Committee in 2021/22 has been flexible in how it undertakes its duties in response to the changing environment and demands of Covid-19. It has operated as a three-monthly virtual team meeting, and in the latter part of the financial year to every month for virtual agreement. The Guideline Group has continued to operate as monthly virtual attended meetings.

The Clinical Policies Team continued to commit to attending and supporting the Secondary Care drugs and therapeutic meetings with provider trusts.

High-Cost Drugs – CCG-Commissioned

At the beginning of the pandemic, all CCG-commissioned High-Cost Drugs (HCD) were taken into a block contract. Monthly finance meetings with providers were stood down. However, the Clinical Policies Team continued to monitor HCD expenditure, answering HCD commissioning queries, horizon scanning for new drugs in 2022/23 and has re-started the HCD finance meetings on a quarterly basis. Furthermore, the Clinical Policies Team

continues to monitor and adopt new NICE technology appraisals, approving CCG-commissioning policies and seeking assurance and compliance through Blueteq.

Medicines Optimisation and Delivery Team

Derbyshire Prescribing Group

The Derbyshire Prescribing Group continued to meet routinely throughout the year to ensure that the work to support the Derbyshire system to improve the safety and quality of prescribing was delivered.

Prescribing Leads forums were held periodically throughout the year to update practices on key work relating to medicines safety, quality and cost-effective prescribing.

Primary Care Prescribing Support

The medicines management team has continued to focus on roll-out and training for the use of Eclipse Live software to support delivery of prescribing quality, safety and cost improvements and to help PCNs with the PCN Direct Enhanced Services and Investment and Impact Fund contractual requirements. There has been preparation for the transfer of Glossop practices to Derbyshire with consideration for medicines management and prescribing implications which will continue into the next year.

Greener NHS

The work of the medicines management team has focused on improving the environmental impact of inhaler prescribing. There have been several strands to this work, including hosting awareness, training and education sessions.

Training and education

Regular education sessions have taken place throughout the year and these are available to all pharmacy teams (CCG, PCN and practice-employed) across the CCG. The aim is to roll out some sessions to General Practice members (GPs, nurses, associated health care practitioners) where appropriate.

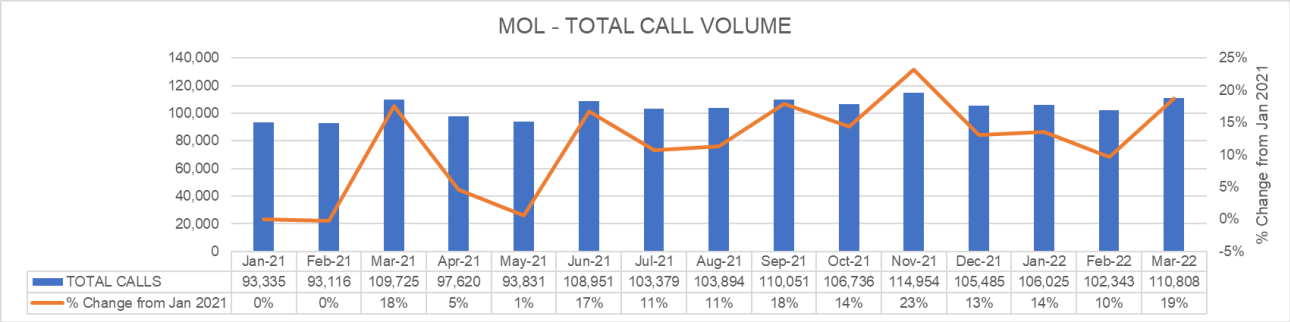
Sessions offered this year have included:

- chronic obstructive pulmonary disease;
- polypharmacy and deprescribing;
- corticosteroids and emergency steroid cards;
- atrial fibrillation;
- chronic pain;
- shared decision making;
- chronic kidney disease and
- environmental impact of inhalers.

On average around 60 Pharmacists and Pharmacy Technicians attended each session.

Medicines Order Line

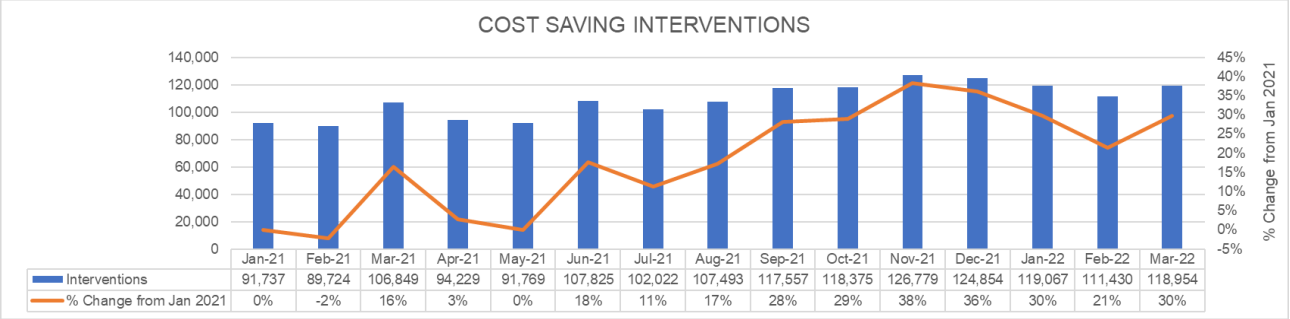
The start of 2021/22 saw the Medicines Order Line sustain high levels of patient demand, with continued growth delivered each quarter of the year. Patients from existing General Practices continued to utilise the service, while a concentrated effort was initiated to further increase stakeholder inclusion, through the continued roll-out of the service across Derbyshire.



	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
TOTAL CALLS	93,335	93,116	109,725	97,620	93,831	108,951	103,379	103,894	110,051	106,736	114,954	105,485	106,025	102,343	110,808
% Change from Jan 2021	0%	0%	18%	5%	1%	17%	11%	11%	18%	14%	23%	13%	14%	10%	19%

Figure 1 – total call volume January 2021 to March 2022

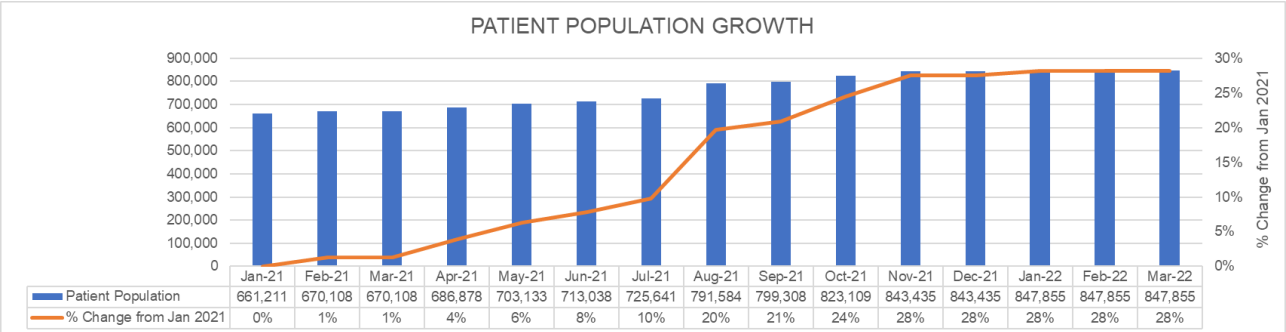
Cost saving intervention activity increased by 30% during the year, averaging 1.1 interventions made per call received to the service.



	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Interventions	91,737	89,724	106,849	94,229	91,769	107,825	102,022	107,493	117,557	118,375	126,779	124,854	119,067	111,430	118,954
% Change from Jan 2021	0%	-2%	16%	3%	0%	18%	11%	17%	28%	29%	38%	36%	30%	21%	30%

Figure 2 – total cost interventions January 2021 to March 2022

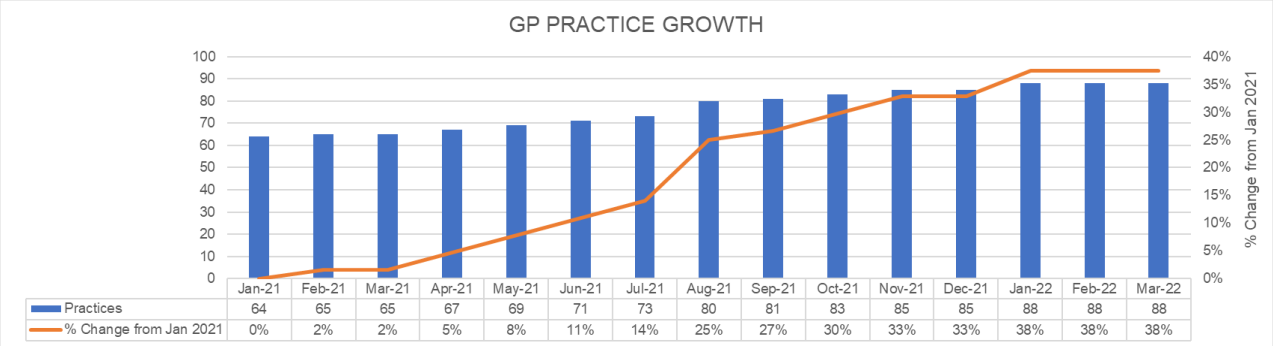
Patient inclusion significantly increased by 28% throughout the year, enabling the service to be accessible to a far wider proportion of Derbyshire patients, with continued expansion planned for next year.



	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Patient Population	661,211	670,108	670,108	686,878	703,133	713,038	725,641	791,584	799,308	823,109	843,435	843,435	847,855	847,855	847,855
% Change from Jan 2021	0%	1%	1%	4%	6%	8%	10%	20%	21%	24%	28%	28%	28%	28%	28%

Figure 3 – patient population with access to the Medicines Order Line from January 2021 to March 2022

Support given to primary care continued to grow at a high rate with the addition of 24 General Practices utilising the service. This equates to system-wide coverage of 80%. The remaining 20% practices are either ineligible (8% non-Electronic Prescription Service) or have chosen currently not to participate in the service (6%), with 6% planning to join next year (with capacity for Glossop practices to join as well).



	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Practices	64	65	65	67	69	71	73	80	81	83	85	85	88	88	88
% Change from Jan 2021	0%	2%	2%	5%	8%	11%	14%	25%	27%	30%	33%	33%	38%	38%	38%

Figure 4 – General Practices utilising the Medicines Order Line from January 2021 to March 2022

Strategy, Assurance and RightCare Team

Integrated Pharmacy and Medicines Optimisation

During 2021/22, work began on a Derbyshire-wide strategic plan with the ambition of integrating Pharmacy and Medicines Optimisation across the system, within Pharmacy services and wider, ensuring optimal use of medicines to reduce the avoidable and unjust differences in health outcomes for the population of Derby and Derbyshire.

Controlled Drugs

During 2021/22, prescribing data for controlled drugs and drugs with dependence potential was circulated to practices throughout the year to highlight variation in prescribing and thus promote safe prescribing of controlled drugs.

Medicines Safety

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

A process to report and share learning from incidents related to the Covid-19 vaccines was developed, supporting system wide, regional, and national dissemination of relevant learning and preventative actions resulting from vaccination incidents.

Investigation and analysis of critical non-vaccine, medication-related incidents also continued during 2021/22.

Antimicrobial Stewardship

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

The Derbyshire Antimicrobial Resistance (AMR) and Infection Prevention and Control Committee developed the System AMR Strategy. The strategy defines system priorities and actions to reduce AMR within Derbyshire in line with the National AMR plan. During 2021/22, work began on developing a project promoting effective hydration within the community, one of the priorities within the strategy.

General Practice Community Pharmacist Consultation Service and Extended Care Services

During 2021/22, NHSE&I asked systems to support with NHSE&I nationally and regionally commissioned Community Pharmacy services, including General Practice Community Pharmacist Consultation Service (GP-CPCS) and Extended Care Services. GP-CPCS is highlighted in the Planning Guidance 2021/22 to support the management of low acuity patients in alternative settings, supporting General Practice workload pressures. The team is part of the Midlands GP-CPCS Implementation Oversight Group and has worked with the General Practice Commissioning Team, Local Pharmaceutical Committee, NHSE&I programme managers, PCNs and community pharmacies to promote and develop local plans for implementation, troubleshoot and monitor uptake.

Contracting and Procurement

Medicines Management and Clinical Policies Team contracts that were due to expire in 2021/22 were reviewed and procured in line with current governance processes. The Contracting and Performance Team was regularly updated on the governance process and procurement status of contracts that were due to expire within the year.

Transfer of Community Pharmacy commissioning

During 2021/22 engagement began on preparing for the transfer of community pharmacy commissioning from NHSE&I to ICB ready for April 2023. The team supported the primary care team with engagement and feedback to NHSE&I.

Ambulance and 111 Commissioning

The Regional Ambulance Coordinating Commissioning Team manages regional contracts for EMAS and Derbyshire Health United 111 (East Midlands) Community Interest Company (DHU111) on behalf of all East Midlands commissioners. It is hosted by the CCG and manages all aspects of the contracts, including performance and quality. During 2021/22, the Regional Ambulance Coordinating Commissioning Team has continued to follow national guidance released in relation to the contracting and monitoring of the DHU 111 and EMAS contracts.

East Midlands Ambulance Service Performance

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

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

Ambulance performance against the national standards for the region has deteriorated in all six categories since 2020/21, the performance position shown to date for 2021/22 is shown in Table 6 below. The 90th centile measures the time in which 9 out of 10 patients received a response, with the mean measuring the average time in which patients receive a response.

EMAS	Category 1		Category 2	
	Mean	90th Centile	Mean	90th Centile
	2021/22	2021/22	2021/22	2021/22
National Standard	**00:07:00**	**00:15:00**	**00:18:00**	**00:40:00**
Quarter 1	00:07:53	00:14:03[10]	00:33:38	01:10:07
Quarter 2	00:09:05	00:16:26	00:49:28	01:46:25
Quarter 3	00:09:16	00:16:33	00:56:38	02:03:37
Quarter 4	00:09:05	00:16:28	00:50:46	01:50:38

EMAS	Category 3	Category 4
	90th Centile	90th Centile
	2021/22	2021/22
National Standard	**02:00:00**	**03:00:00**
Quarter 1	04:30:07	04:43:53
Quarter 2	07:17:52	06:45:03
Quarter 3	08:24:09	06:55:08
Quarter 4	07:00:04	07:00:31

Table 6 – quarterly national standards and actual response times

At a trust-level, EMAS achieved one of the six national standards (Category 1 (C1) 90th) during Quarter 1 (Q1) 2021/22. This position was replicated in all counties with the exception of Lincolnshire, where none of the six standards were achieved in any quarter.

Performance saw a deterioration in Quarter 2 (Q2) and a further deterioration in Q3 across all standards. The trust position was replicated in Derbyshire and Lincolnshire in Q2 and Q3, with none of the six national performance standards being met. Leicestershire did not meet

[10] *Green indicates achievement of national standard*

any of the standards in Q2, however performance improved in Q3 to meet one of the national standards (C1 90th). Northamptonshire and Nottinghamshire both achieved C1 90th centile in both Q2 and Q3.

During Q4, performance times were comparable to that of Q3, with none of the six national performance standards being achieved at a regional level. The trust position was replicated across Derbyshire, Leicestershire and Lincolnshire. For Leicestershire this was a deterioration on Q3 performance, when one of the six national performance standards were achieved (C1 90th). Northamptonshire and Nottinghamshire both achieved C1 90th centile.

An extraordinary Clinical Quality Review Group meeting was held on the 16th December 2021, which focused on gaining assurance regarding the increase in delayed response to serious incidents. The Clinical Quality Review Group acknowledged that system measures were required to address all the contributory factors, and these were being addressed in local systems. The majority of serious incidents reported as 'delayed response serious incidents' did not identify any new learning for EMAS and there are actions in place to address system factors contributing to the serious incidents. EMAS has a comprehensive action plan which the Clinical Quality Review Group will continue to monitor.

The deteriorating performance position has been seen across the country, with all ambulance services operating at Resource Escalation Action Plan level four. NHSE&I recognised there was a need for immediate and substantial action in order to ensure all patients were being reached as soon as possible. £55m of additional non-recurrent funding was made available across the ambulance sector during 2021/22 in order to support improved performance, including recruitment of additional call handlers and additional front-line crews.

How Covid-19 affected service delivery

EMAS has seen an increase in the number of calls received this year, as can be seen in Table 7, rising to 34.7% above plan in October 2021. One of the driving factors behind the number of calls has been duplicate calls which have increased significantly during 2021/22. On average, 15.6% of the total calls presented as a duplicate call during 2020/21, rising to an average of 21.8% in 2021/22. The increase in duplicate calls could be attributed to a decrease in performance and patients calling back to chase awaited ambulances. The decrease in performance has also resulted in a significant increase in non-ambulance systems indicators hear and treat activity, through patients either calling back to cancel their ambulance, to report that they had recovered or made their own way to hospital.

EMAS		Apr 2021	May 2021	Jun 2021	Jul 2021	Aug 2021	Sep 2021
Calls	Actual	89,178	102,959	107,915	118,396	107,928	110,059
	Plan	79,148	85,286	82,130	89,241	83,545	84,057
	Variance	12.7%	20.7%	31.4%	32.7%	29.2%	30.9%
EMAS		**Oct 2021**	**Nov 2021**	**Dec 2021**	**Jan 2022**	**Feb 2022**	**Mar 2022**
Calls	Actual	115,589	105,950	107,743	96,300	92,858	112,756
	Plan	85,788	87,048	94,755	90,261	86,920	93,891
	Variance	34.7%	21.7%	13.7%	6.7%	6.8%	20.1%

Table 7 – call activity in 2021/22

As detailed in Table 8 below, EMAS incidents (where a patient receives a face-to-face response or a clinical assessment over the telephone) were significantly higher than the plan at the start of the year and continued to rise in Q1. However, from July onwards incidents had reduced month-on-month and from December onwards incidents were below plan. This can be attributed to a shortage of crews being available. EMAS has experienced a higher-than-average sickness rate since Q1, which has been seen in the reducing number of hours resourced. During Q1 EMAS resourced above plan (+7%), this fell to resourcing to plan during Q2 (+0.2%), falling further to resourcing below plan (-2.5%) for Q3. Resourcing against actual activity has been lower than required for all three quarters to date (please note that quarter four data on resources was not available at the time of reporting). Extended pre- and post-hospital handovers have also contributed to reduced staffing levels, impacting on the resource available to respond to incidents.

EMAS		Apr 2021	May 2021	Jun 2021	Jul 2021	Aug 2021	Sep 2021
Incidents	Actual	67,409	72,471	70,417	70,872	66,581	64,753
	Plan	58,014	61,067	58,811	62,580	59,394	59,440
	Variance	16.2%	18.7%	19.7%	13.3%	12.1%	8.9%
EMAS		**Oct 2021**	**Nov 2021**	**Dec 2021**	**Jan 2022**	**Feb 2022**	**Mar 2022**
Incidents	Actual	67,230	65,287	67,236	64,829	57,917	65,079
	Plan	63,778	64,647	69,269	68,221	62,983	66,682
	Variance	5.4%	1.0%	-2.9%	-5.0%	-8.0%	-2.4%

Table 8 – incidents activity in 2021/22

Post-hospital handover times increased during 2021/22. This was due to the many challenges facing EMAS crews in relation to infection control and prevention due to the Covid-19 pandemic. These higher post-hospital handover delays have remained above the 15-minute national standard during 2021/22, as shown in Table 9 below.

Average Post-Hospital Handover Times	Apr 2021	May 2021	Jun 2021	Jul 2021	Aug 2021	Sep 2021
2021/22	0:19:57	0:20:08	0:20:37	0:20:23	0:20:21	0:20:19
2020/21	0:20:31	0:19:56	0:19:42	0:19:41	0:19:32	0:18:54
Average Post-Hospital Handover Times	**Oct 2021**	**Nov 2021**	**Dec 2021**	**Jan 2022**	**Feb 2022**	**Mar 2022**
2021/22	0:20:22	0:20:32	0:20:40	0:20:33	0:20:38	0:20:15
2020/21	0:18:57	0:18:47	0:19:08	0:19:16	0:19:43	0:20:14

Table 9 – average post-hospital handover times for 2021/22, compared to 2020/21

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

All counties have continued to work on developing alternative pathways for ambulance services, such as same day emergency care, access to UTCs and clinical assessment services, enabling patients to avoid ED when safe and appropriate. Work has taken place nationally to ensure the most commonly referred into pathways by ambulance services are profiled and visible on the Urgent and Emergency Care Directory of Services so that ambulance crews can access these alternatives consistently across the country, thus improving referrals to non-ED settings when safe and appropriate. EMAS implemented the NHS Service Finder tool on the 1st October 2021 to enable crews to access these alternative pathways. The Pathways Clinical Consultation Support system was installed in October

2021 which allows EMAS teams to have up-to-date access to local service information and referrals to further support reduced conveyance.

The Derbyshire Rough Sleepers Paramedic scheme has successfully run during 2021/22. The initiative continues to prevent demand into EMAS through working directly with people to improve any health conditions before the need to call an ambulance arises. As a result, commissioners have agreed additional funding to expand the scheme.

A proportion of the additional mental health funding received via NSHE&I, as part of the NHS Mental Health Implementation plan, is being allocated to EMAS to support additional mental health resource in the Emergency Operations Centre through additional staff, training and key project staff. The aim is to ensure patients with mental health illness are responded to by the most appropriate services in a more timely manner. EMAS took part in phase two of the national Category 3 (C3) and Category 4 (C4) validation pilot to extend the number of codes eligible for clinical validation, with the final report recommending that this extension of codes should be extended to all ambulance services.

DHU111 (East Midlands) Community Interest Company Performance

The NHS111 contract with DHU111 contains five KPIs and a further KPI associated with the C3 Ambulance Validation Service. A summary of performance this year can be seen in Table 10 below. Performance against the call handling measures (calls abandoned after 60 seconds and call answering times) has seen a significant and continued deterioration since August 2021. This is mainly due to a significant increase in demand coupled with staffing shortages. Following a challenging December, January 2022 figures saw a significant improvement for both 'calls abandoned' and 'call-answering time'. The decrease in 'calls abandoned' continued and this KPI was met in February and March 2022. It should be noted that the increase in demand and deterioration in performance has been seen across England, and so DHU111 continues to be one of the best performing 111 providers in the country.

Calls abandoned after 30 seconds	Apr 2021	May 2021	Jun 2021	Jul 2021	Aug 2021	Sep 2021
Actual	1.0%	0.7%	0.9%	1.1%	3.1%	5.4%
Target	5%	5%	5%	5%	5%	5%
Calls abandoned after 30 seconds	**Oct 2021**	**Nov 2021**	**Dec 2021**	**Jan 2022**	**Feb 2022**	**Mar 2022**
Actual	7.0%	8.1%	16.0%	8.8%	1.8%	5.0%
Target	5%	5%	5%	5%	5%	5%

Average call answer time	Apr 2021	May 2021	Jun 2021	Jul 2021	Aug 2021	Sep 2021
Actual	00:00:15	00:00:13	00:00:19	00:00:26	00:01:00	00:01:47
Target	00:00:27	00:00:27	00:00:27	00:00:27	00:00:27	00:00:27
Average call answer time	**Oct 2021**	**Nov 2021**	**Dec 2021**	**Jan 2022**	**Feb 2022**	**Mar 2022**
Actual	00:02:23	00:03:13	00:05:06	00:02:59	00:00:42	00:01:47
Target	00:00:27	00:00:27	00:00:27	00:00:27	00:00:27	00:00:27

Of call triaged, proportion transferred to a clinician	Apr 2021	May 2021	Jun 2021	Jul 2021	Aug 2021	Sep 2021
Actual	66.5%	68.0%	66.5%	64.5%	66.0%	65.2%
Target	50%	50%	50%	50%	50%	50%
Of call triaged, proportion transferred to a clinician	**Oct 2021**	**Nov 2021**	**Dec 2021**	**Jan 2022**	**Feb 2022**	**May 2022**
Actual	69.2%	66.7%	66.6%	66.90%	63.8%	65.2%
Target	50%	50%	50%	50%	50%	50%
Of call triaged, proportion closed with self-care within 111	**Apr 2021**	**May 2021**	**Jun 2021**	**Jul 2021**	**Aug 2021**	**Sep 2021**
Actual	17.3%	17.1%	18.1%	19.0%	17.2%	17.4%
Target	17%	17%	17%	17%	17%	17%
Of call triaged, proportion closed with self-care within 111	**Oct 2021**	**Nov 2021**	**Dec 2021**	**Jan 2022**	**Feb 2022**	**Mar 2022**
Actual	19.0%	18.8%	19.2%	18.5%	18.5%	19.4%
Target	17%	17%	17%	17%	17%	17%
Proportion of callers satisfied with their experience	**Apr 2021**	**May 2021**	**Jun 2021**	**Jul 2021**	**Aug 2021**	**Sep 2021**
Actual	84%					
Target	85%					
Proportion of callers satisfied with their experience	**Oct 2021**	**Nov 2021**	**Dec 2021**	**Jan 2022**	**Feb 2022**	**Mar 2022**
Actual	This data is obtained from a report that is updated on a six-monthly basis					
Target	85%					

Table 10 – DHU111 performance 2021/22

How Covid-19 affected the delivery of the service

The DHU111 telephone service has continued to experience various challenges due to the pandemic, including high levels of staff absence which increased significantly with omicron. DHU111 reported in January 2022 that the absence rate had improved and it was expected further reductions would be seen over the coming months. In addition to the high absence levels, DHU111 experienced challenges in relation to recruitment and retention of call takers which has caused additional pressure throughout the service.

DHU111 has identified a significant change in the distribution of activity throughout Covid-19, with a significant increase in weekday calls between the hours of 8am and 10am. An increase has been observed in the total number of in-hours weekday calls triaged. Activity

increased by 59% during the daytime when compared to 2019[11]. DHU111 has reported that dental-related activity continues to increase.

National contingency has been invoked across the country on an increasing number of instances throughout 2021/22 as NHS111 providers experience pressures through Covid-19. This has resulted in extra pressure on the remaining providers who have responded to the redirected activity. Due to the unpredictability and short-term nature of national contingency, it has not been possible for DHU111 to resource for the surge in such activity.

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

DHU111 has been challenged by staff shortages and retention of staff. It has commenced a programme to increase the workforce to support delivery against performance standards. Initiatives have been implemented to improve the recruitment process which included a more streamlined approach to processing successful applicants and offering incentives to encourage more applicants and retain staff. DHU111 maintained a high standard of effectiveness as evidenced by their quality audits.

Clinical Assessment Services and Emergency

DHU111 validates significantly more C3 and C4 ambulance dispositions than plan, as shown in Table 11 below. However, this has seen a reduction in recent months due to a combination of staffing shortage through Covid-19, and increased demand meaning that clinicians are redirected to respond to 'core' demand rather than C3 validations. The number of patients receiving a clinical validation remains high and the percentage which are downgraded remains positive.

Category 3 Validations	Apr 2021	May 2021	Jun 2021	Jul 2021	Aug 2021	Sep 2021
Patients available for validation	14,067	16,047	15,173	16,408	15,691	15,035
Total clinically validated	13,116	15,482	14,295	14,994	14,613	9,361
% clinically validated (target 50%)	93.24%	96.48%	94.21%	91.38%	93.13%	62.26%
Category 3 Validations	**Oct 2021**	**Nov 2021**	**Dec 2021**	**Jan 2022**	**Feb 2022**	**Mar 2022**
Patients available for validation	16,319	14,477	14,014	13,999	13,137	14,923
Total clinically validated	10,382	9,213	10,719	11,162	10,172	10,669
% clinically validated (target 50%)	63.62%	63.64%	76.49%	79.7%	77.4%	71.5%

Table 11 – Category 3 validations for 2021/22

[11] *Please note, due to Covid-19, 2021 activity has been compared to 2019 rather than 2020.*

Directory of Services

The Directory of Services is the tool used to identify the most appropriate service to manage patients' clinical needs. Work achieved last year included the introduction of appointment bookings for patients at ED following contact with 111. This helps patients avoid lengthy waits in ED waiting rooms, which was particularly helpful during the pandemic. During the latter part of the year, a streaming and redirection tool has been introduced at CRHFT ED and is about to be commenced at RDH ED. This new tool helps patients who attend ED to carry out a self-triage so they are directed to the best service to receive the treatment they may need.

Service Finder takes a feed from the Directory of Services which is used by professional colleagues to find services for their patients. Work has been targeted at reviewing and improving the pathways used by EMAS to meet the requirements of the National Joint Ambulance Improvement Group.

The national NHS Pathways team has also significantly increased the number of pathways releases each year from 2 to 10. This is to enable the Directory of Services to be more resilient and responsive to change which was found to be essential during the Covid-19 pandemic.

Mental Health

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

Adult Mental Health

We continue to work alongside a wide range of VCSE and statutory partners to design and deliver support for adults with mental health needs, to achieve NHSE&I Long Term Plan ambitions. Achievements and progress made in 2021/22 includes:

Community Mental Health	Commencing significant transformation of community level support for adults with Severe Mental Illness (SMI) in High Peak and expansion into Derby City. This approach will be phased across the rest of Derbyshire from 2022–24.
	Creating multi-agency, community-level collaboratives, bringing key agencies and the voice of lived experience to improve pathways and improve outcomes and health equalities for people with SMI.
	Co-producing and co-designing a new 'Living Well' model – integrated working with VCSE, Local Authorities and health.
Inpatient Care	Making progress to improve the local inpatient environment, within DHcFT.
	Developing our provision of Psychiatric Intensive Care Units (PICU).
Covid-19 response: Staff Wellbeing	Increasing access to talking therapies for frontline NHS staff working at RDH, CRHFT and community hospitals across Derbyshire. Two of the four talking therapy service providers are working in RDH and CRHFT to ensure staff can get rapid access to support when needed.
Reducing health inequalities	Increasing access to key services has included working closely with the Polish and Romanian communities in Derbyshire to raise awareness of talking therapies and building links with the four service providers. Some of the talking therapy service providers have been engaging with carers and carer organisations to increase access from older adults.
	A multi-agency pilot is underway to provide health coaching and the provision of personal fitness trackers to people with a SMI, to support their physical health outcomes.

Co-production and Collaborative Working	New ways of working alongside the local VCSE sector have been explored. For example, an 'open statement' has been circulated widely to communicate key priorities and to identify how organisations and providers can help to shape local delivery.
	Maternity and Neonatal Voices Partnership has resulted in valuable insights emerging from engagement with women who have experienced trauma or loss as a result of their maternity experience. This work will inform our new Maternal Mental Health Service, starting in spring 2022.
Crisis Alternatives Development	We have undertaken widespread engagement with local people, professionals, and groups and providers of services to explore what our model of Crisis Alternatives for people with urgent mental health care needs should look like. This work will form the foundations of our Crisis Café provision (out-of-hours mental health support within the community) within 2022.

Learning Disabilities and Autism

JUCD was asked to produce a 'Learning Disability and Autism Roadmap' by NHSE&I. This proved an invaluable opportunity for partners across Derby and Derbyshire to identify where and how improvements can be made to care and support for people with autism and those with a learning disability, their families, and carers. During 2021/22 there has been significant activity to achieve these improvements, including:

Implementing new approaches to crisis and inpatient support	Expanded our learning disability Intensive Support Teams to bring into scope of the service those autistic people who do not have a learning disability.
	Explored how we can work alongside the health and social care provider market to develop specialist learning disability and autism 'crisis in-reach' and 'crisis accommodation' services.
	Accelerated plans to improving our approach to inpatient care, with the objective being a Full Business Case for change to be developed during the 2022/23 financial year.
	Initial designs for a new 'children and young people key worker' role approved by NHSE&I. This role, a commitment of the Long-Term Plan, will initially focus on children who are inpatients or at risk of inpatient admission. Attention now turns to refining the delivery model with a view to launch during 2022/23.

Ensuring the quality and availability of care and support services	Successfully bid to be a part of the Autism in Schools Accelerator Programme, which aims to improve the experience of education for autistic children and young people and their families. The focus for Derby and Derbyshire is on 'transitions', whether that is between schools, classes or key stages.
	Sought the opportunity to contribute to the Oliver McGowan Mandatory Learning Disability and Autism Training Pilot. Training has been provided to staff from CRHFT, local advocacy services and Derbyshire County Council.
	Worked across the CCG, two acute trusts and DHcFT to understand the demand for neurodiverse diagnostic services for children and young people and put in place plans to reduce waiting lists and times.
Building strong and sustainable community assets	Co-designed a new approach to working in more equal collaboration with the VCSE sector. This includes commissioning a new 'lead organisation' through which we can invest in services to meet the strategic priorities of the ICS, VCSE providers and local people.
	Successfully applied for funding to improve and innovate in support for people following their autism diagnosis. Our focus is on improving the interface between diagnostic and community services, the use of peer coaches/mentors and exploring the concept of 'no discharge'.

Alongside these various programmes and projects, partners across JUCD have looked at how we can make best use of local assets and resources to support the delivery of the roadmap. All this has been guided by autistic people and people with a learning disability and their families; NHSE&I praising our commitment to co-production in their appraisal of our roadmap.

Children, Young People and Young Adult Mental health

During 2021/22 we have seen a steady rise in the number of children and young people (0-17 years) having at least one meaningful contact with NHS-funded mental health services in a rolling 12-month period, reaching 12,562 in February 2022. These contacts are with mental health services across the Derby and Derbyshire graduated pathway including specialist Children Adolescent Mental Health Services (CAMHS), Derby and Derbyshire Emotional Health and Wellbeing service for Children in Care, Changing Lives (mental health support teams in education), Build Sound Minds (Targeted Early Intervention Services) and our universal digital offer with Kooth.

In April 2021, we introduced two new Mental Health Support Teams (MHSTs) in education settings at Bemrose School and Noel Baker Academy, with staff commencing specialist training. These teams arrived alongside our more established MHSTs at Bolsover School, Ormiston Academy Ilkeston, Lady Manners Bakewell and Kingsmead special school and PRU. We have NHSE&I funding to increase our MHST offer to 11 teams by 2024.

We have invested nearly £1.9m in CAMHS urgent care and crisis response and are recruiting staff to expand the current offer to be able to provide the NHSE&I required 24/7 assessment and brief response to all children and young people in crisis by 2024.

Our universal digital service continues with Kooth, an anonymous service which young people report is *"accessible for all ages"*, *"easy to navigate and easy to understand"*, and *"enables people to talk about their experiences so that they don't feel alone".*

We have expanded capacity for online Cognitive Behavioural Therapy and Autism Post Diagnosis Interventions to help reduce waiting times. We are mindful that online does not suit everyone and these offers complement our CAMHS face-to-face service. There have been increases in eating disorder presentations and capacity has been expanded in specialist eating disorder teams. We are planning to further improve the offer for children and young people with eating difficulties, particularly for those with autism.

There has been work undertaken by a small multi-agency working group to look at how we assist integration between schools and the mental health pathway. This has resulted in new school pathway guidance which is distributed across the school settings.

Our young adults work is looking at how we improve our mental health support to 18-25-year-olds who can find that services become disjointed after 18 years and they fall between children and young people, and adult services. This work has involved experts by experience. We have an initial pilot service planned to start soon with VCSE partners providing Peer Workers, Wellbeing Workers and Engagement Workers which will particularly support young adults transitioning from CAMHS.

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

During the year, alongside Derby City Council and system partners we have successfully delivered the requirements of the Written Statement of Action. We have co-produced plans to address neuro-development assessment waiting times across our footprint for the next three years. The work was led in conjunction with the JUCD Children and Young People Board. We are ensuring that these intentions and learning gained are considered for all ages to improve the experience for adults too.

We are driving forward the Children and Young People's Physical Health Transformation Programme, aligned to the NHS Long Term Plan, with initial focus across our system on obesity and asthma.

During the year, we have continued to focus on rapidly supporting individual children to help ensure the risks of Covid-19, and associated issues that lockdown brought within families, could be mitigated as far as possible.

Finance Review

Addressing Our Financial Challenge during 2021/22

The Covid-19 pandemic has affected all aspects of the NHS in 2021/22, including its financial regime. National NHS contracting arrangements were brought forward into the current financial year based on expenditure in the prior year, in contrast to the independent sector and non-NHS organisations where contracting resumed. These contracting arrangements were alongside the gradual reintroduction of financial efficiency deliverables; thus ensuring all available resources could be directed at delivering front-line services.

These arrangements were put in place for the first six months of the financial year (H1), and largely were extended for the second six months (H2). Whilst funding was received from H1 to support the NHS Long Term Plan and the recovery of elective activity, additional funding was available from H2 to recognise the ongoing increased levels of non-elective activity. These priorities, alongside healthcare in relation to the pandemic, has required the CCG and the Derbyshire system to be flexible, whilst maintaining the highest standard of financial governance to remain within the system's financial envelope.

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

Financial Position

Total resources of £2120.7m for the year were available, made up of an income of £7.1m and £2,113.6m of allocations from the Department of Health and Social Care. The CCG committed expenditure totalling £2,120.5m, leaving the CCG with a surplus of £0.2m. Further details can be found in the Annual Accounts section of this report.

Considerable work has been undertaken to understand the extent of the financial challenges being faced across the system as we head into 2022/23, and the ongoing impact of the pandemic, as well as the backlog of routine healthcare that has built up. Contracting and funding arrangements for 2022/23 will be largely in line with H2 of the current financial year. It is anticipated that the CCG will transition to an ICB and continue with this financial regime as a Derbyshire system, whilst also delivering a high level of transformation to achieve financial efficiencies.

Gross Operating Costs 2021/22

Category of Expenditure	2021/22 Spend	2020/21 Spend
	£m	£m
Services from Foundation Trusts	1,173.3	1,062.0
Services from Other NHS Trusts	124.4	107.9
Purchase of healthcare from Non-NHS bodies	311.6	243.4
Prescribing	162.1	161.6
Primary Care	193.0	173.6
Staff	25.3	23.4
Supplies and Services – General	5.6	3.1
Services from other CCGs and NHSE&I	10.1	9.1
Other	11.4	9.5
Covid-19	103.7	106.9
TOTAL	**2,120.5**	**1,900.5**

Table 12 – Gross Operating Costs 2021/22 and 2020/21

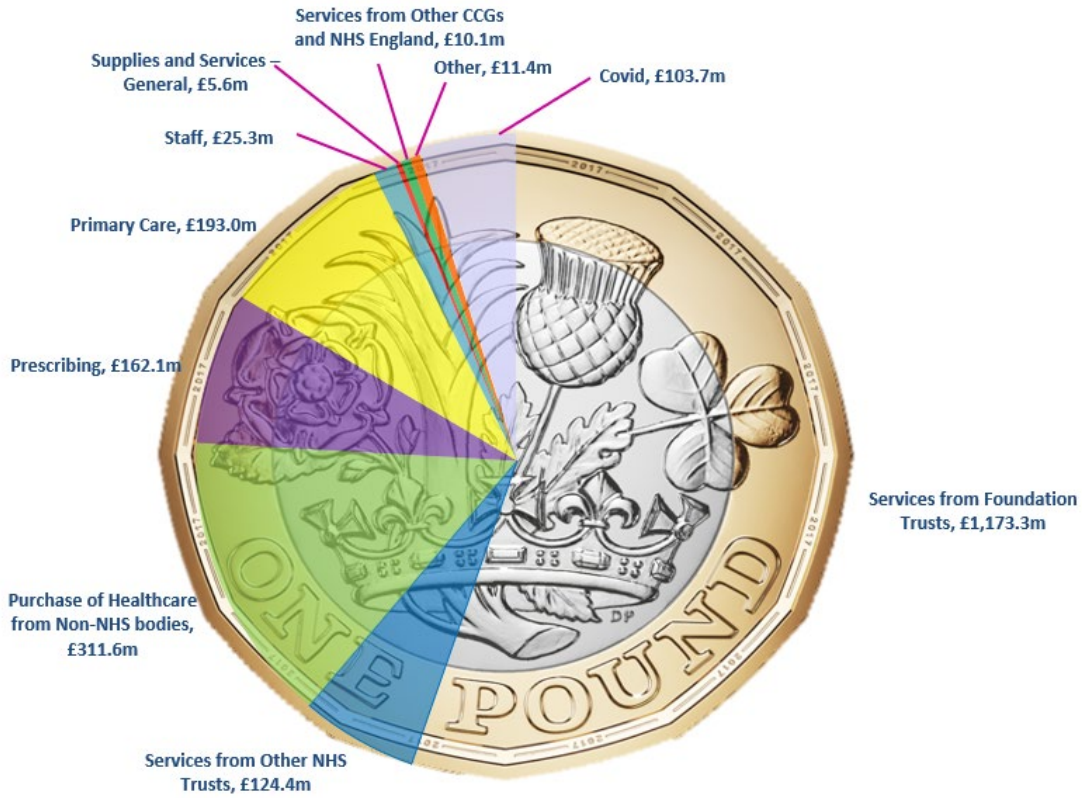


Figure 5 – Gross Operating Costs 2021/22 – 'The Derbyshire Pound'

Covid-19 Expenditure

The CCG has committed considerable expenditure in tackling the pandemic, much of this being funded from within system financial envelopes. The funding received during this year supported the whole of the Derbyshire health care system; and agreed with system partners how the resources would be utilised and shared. The CCG was able retrospectively to claim reimbursement for elements that were not funded in the prospective Covid-19 system allocation.

	H1	H2		2021/22 Total
	£'m	Reclaimable £'m	In Allocation £'m	£'m
Block Payments	0.000	0.000	43.200	43.200
Hospital Discharge Programme	21.201	18.410	0.000	39.611
Primary Care Costs	3.434	0.000	5.083	8.517
DHU Testing Service and Calls	3.104	0.000	2.048	5.152
Mental Health Services	1.233	0.000	0.628	1.861
Community After Care and Support	0.418	0.000	0.365	0.783
Mental Health After Care and Support	1.625	0.000	0.340	1.965
Acute Remote Management of Patients	0.963	0.000	0.000	0.963
Other Remote Management of Patients	0.693	0.000	0.000	0.693
Running Costs	0.256	0.000	0.142	0.398
Continuing Health Care After Care	0.018	0.000	0.285	0.303
Other	0.375	0.000	0.263	0.638
	33.320	**18.410**	**52.354**	**104.084**

Table 13 – Covid-19 expenditure 2021/22

Statement of Financial Position

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

For comparative purposes, the 2020/21 statement is provided which shows there has been a reduction in both the trade assets and liabilities in the 12-month period. This movement in trade assets and liabilities has occurred as a result of the revised financial arrangement for NHS contracting and payments during the Covid-19 pandemic, which allowed NHS providers certainty around their income. As a result of the emergency financial regime, the system saw

a reduction in NHS invoicing, as well as the release of previous year Statement of Financial Position opening balances into the financial position.

	31st March 2022	31st March 2021
	£'000	£'000
Non-current assets		
Property, plant and equipment	267	355
Total non-current assets	**267**	**355**
Current assets		
Trade and other receivables	4,965	5,330
Cash and cash equivalents	27	110
Total current assets	**4,992**	**5,440**
Total assets	**5,259**	**5,795**
Current liabilities		
Trade and other payables	(98,756)	(96,343)
Provisions	(5,847)	(3,896)
Total current liabilities	**(104,603)**	**(100,239)**
Non-current assets plus/less Net current assets/liabilities	**(99,344)**	**(94,444)**
Non-current liabilities		
Provisions	(532)	(522)
Total non-current liabilities	**(532)**	**(522)**
Total assets less liabilities	**(99,876)**	**(94,966)**
Financed by Taxpayers' Equity		
General Fund	(99,876)	(94,966)
Total Taxpayers' Equity	**(99,876)**	**(94,966)**

Table 14 – Statement of Financial Position 2021/22

Financial Trend Data

Since the CCG's inception in April 2019, the organisation has followed a different financial regime in each of the financial years of its existence. The 2019/20 year was the commencement of usual business to deliver healthcare to Derbyshire patients as a newly-merged CCG representing the whole county. However, national contracting replaced this in 2020/21 as the Covid-19 pandemic hit the UK, which was further changed in 2021/22 to reinstate independent sector contracting. Due to these differing financial regimes and priorities for healthcare delivery, financial trend analysis is not considered to be meaningful to the users of this report.

Our Duties

Improvement in quality of services

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

Patient Safety

Derbyshire was chosen as an early adopter of the new Patient Safety Incident Response Framework (PSIRF). PSIRF is a key part of the NHS Patient Safety Strategy (published July 2019). It supports the strategy's aim to help the NHS improve its understanding of safety by drawing insight from patient safety incidents, developing improvement plans and working alongside our quality improvement colleagues.

PSIRF has been slowly embedded into the five organisations that were chosen in Derbyshire as part of the early adopter's programme. Introduced over 12 months ago, the PSIRF has evaluated well and was seen to be a framework that supports systematic, compassionate, and proficient response to patient safety incidents; anchored in the principles of openness, fair accountability, learning and continuous improvement.

The plan is to roll this out from April 2022 to those providers which are not part of the early adopter programme.

There have been many changes within patient safety over the past year with the introduction of Patient Safety Specialists, Patient Safety Partners and a national education programme. These elements were all part of the Patient Safety Strategy and are now seen as key to improving patient safety for all.

Healthcare-associated infections

Healthcare-associated infections (HCAIs) can develop either as a direct result of healthcare interventions such as medical or surgical treatment, or from being in contact with a healthcare setting. HCAIs pose a serious risk to patients, clients, staff and visitors to health and social care premises. They can incur significant costs and cause significant morbidity and mortality for those infected. As a result, infection prevention and control is a key priority for the NHS in order to prevent HCAIs and any associated risks to health.

The NHS Standard Contract 2021/22 includes quality requirements for NHS Trusts and NHS Foundation Trusts with a zero-tolerance approach across all organisations to Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia and the aim to minimise rates of both Clostridioides difficile (CDI) and of Gram-negative bloodstream infections to threshold levels set by NHSE&I.

Methicillin-resistant Staphylococcus aureus

Since April 2021, two cases of MRSA bacteraemia were reported relevant to the population of Derby and Derbyshire. One case was identified as a hospital onset infection within UHDB and the other in an external NHS acute trust. 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. In the case of the UHDB infection, no lapses in care or quality were found and the external trust found a delay in acting upon MRSA swab results and the prescription of appropriate decolonisation therapy.

Methicillin-sensitive Staphylococcus aureus

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

During 2021/22, 262 MSSA bloodstream 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 associated cases (63% of CCG cases).

Clostridioides difficile Infection

Annual objectives for each organisation are set by NHSE&I, with the CCG's objective being set at no more than 229 CDI cases during 2021/22. During 2021/22, 251 CDI cases have been reported across Derby and Derbyshire.

Acute provider organisations are also subject to an annual objective set by NHSE&I. While UHDB finished the year slightly over their objective of 103 cases during 2021/22, with a final count of 104 cases, there has been year-on-year reductions since 2019/20. CRHFT were under their objective of 39 cases, with a total count of 31 cases. Reviews of CDI and lapses identified were predominantly around appropriate antibiotic prescribing and delays in sample collection, isolation and initiating treatment.

Gram-negative bloodstream 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) bloodstream infections. The Government has since revised this ambition and now aims to halve healthcare associated Gram-negative bloodstream infections by 2024/25. This also now includes bloodstream infections caused by Pseudomonas and Klebsiella species.

Case numbers for Derby and Derbyshire residents in all Gram-negative bloodstream infections have demonstrated downward trends over the last five years with all three below the NHSE&I trajectory for this year.

Reducing Gram negative bloodstream infections

Infection Prevention and Control teams continue to work collaboratively across the JUCD system to support the reduction of Gram-negative bloodstream infections, including an initiative to support hydration across care homes. Work will continue with the Derbyshire health and social care system to implement the JUCD's system antimicrobial resistance strategic action plan as this will play a key role in supporting the ambitions to reduce the numbers of Gram-negative bloodstream infections.

Never Events

Never Events are patient safety incidents that are entirely preventable, with guidance or safety recommendations providing strong systemic protective barriers at a national level and which should be implemented by all healthcare providers.

There were six Never Events during 2021/22. The investigations are completed as part of the PSIRF as thorough Patient Safety Incident Investigations. Learning from Never Events are shared at the Clinical Quality Review Groups to ensure oversight and scrutiny.

Safeguarding Children, Looked after Children and Adults at risk

The CCG remains highly committed to ensuring that the population of Derby and Derbyshire are safe, never more so during this Covid-19 pandemic where some children, young people and adults in the community have been at an increased risk of vulnerability and harm. The CCG has continued to work in close partnership with partner agencies to continuously improve systems and processes to safeguard children, young people and adults in our community. The CCG Safeguarding Children and Adults' Team has continued to ensure that the CCG meets its statutory safeguarding responsibilities and functions and that it has clear governance processes to monitor the safeguarding arrangements of commissioned health services to provide assurance that children and adults at risk of abuse are safeguarded.

End of Life Services

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

During the pandemic, the operational group has continued to function in terms of further developing programmes of work, while the workstreams were stood down. These included end of life care during out-of-hours, including the development of the Palliative Care Urgent Response Service. Work has continued on implementing ReSPECT documentation and digital enablers such as Electronic Palliative Care Co-ordination Systems. Other areas of work have continued with a new initiative for end-of-life patients with dementia in pilot stage and development work with EMAS to train Paramedics in this specific vulnerable group.

The following workstreams have now been re-established and are being re-focused: Single Point of Access/Coordinated Care; Compassionate Communities; Symptom Management; People Driving Change; and Sharing Information.

Patient Experience and Involvement in Our Services

The CCG gathers patient experience from many different sources and works in partnership with patients, carers and local partners to ensure that the services we commission are responsive to the needs of our population. In the last year, the focus of the team has changed to enable work to focus on key priorities in response to the Covid-19 pandemic. This has seen the deployment of the Patient Experience Team to support essential and mandated initiatives such as the delivery of the Covid-19 vaccination programme. This has resulted in a reduction of patient experience work plans. The CCG recognises the importance of this aspect of its work and plans are in place for a phased return of the function with an initial focus on supporting the Derby and Derbyshire end of life care and the Derbyshire special educational needs agendas.

Care Homes

Following on from changes in the first year of the pandemic, care homes have continued to work incredibly hard to keep both staff and residents as safe as possible.

Care homes have continued to report on a daily basis on the National Capacity tracker tool to record the number of Covid-19 outbreaks, both for residents and staff, the level of personal protective equipment available, bed capacity, staffing levels and vaccination uptake. This has given both Derby City and Derbyshire County Local Authorities and the CCG valuable information to be able to respond to issues identified by the sector.

Covid-19 prevalence has been monitored daily to ensure appropriate action and support is provided to the sector as appropriate. Local Infection, Prevention and Control and Public Health teams continue to support the care homes with clinical and practical advice. The number of outbreaks has fluctuated across residential and nursing homes during the year due to higher or lower community transmission, with over half of the sector closed to admissions and visitors at its worst point. Outbreak Control Team meetings have continued to meet weekly, led by Public Health to assess and manage the risk for individual services, putting in appropriate support where needed. Staffing levels, which have been a huge challenge have been monitored closely.

The vaccination programme successfully rolled out the first and second dose of vaccinations in all care homes across Derby City and Derbyshire including the booster for both staff and residents.

The local multi-agency information sharing meetings have continued weekly in order to monitor and respond to emerging risk promptly, including the Local Authority, CCG, CQC and the Continuing Care Team. All agencies have adapted their monitoring methodology during this year, only visiting services where extreme risk was identified or to undertake focused visits such as Infection, Prevention and Control inspections. Instead, the joint quality assurance methods of monitoring, using a mixture of virtual and desktop monitoring has been adopted.

The Enhanced Health in Care Homes Steering Group has continued to provide a programme of work to support the wider agenda of support within the sector. The Enhanced Health in Care Homes programme forms one element of the national Ageing Well programme alongside Anticipatory Care and Urgent Community Response. These workstreams contribute to Team Up Derbyshire, a programme of transformation which requires effective system governance and leadership. A system-wide approach to care homes for older people is needed to lead and coordinate all complementary workstreams to promote a safe, sustainable and high-quality care home sector for our vulnerable populations of Derby and Derbyshire. The Integrated Care Homes Strategic Group has been

formed that will act within a leadership and strategic capacity to promote collaboration and an integrated approach to ensure that:

- the care home market is robust, fit for purpose and effectively regulated and supported to ensure delivery of personalised, effective, safe and quality care;
- people who reside in care homes are supported to have a positive experience, maintain optimum levels of independence and wellbeing and receive high quality and safe care;
- care home staff are supported by the system to carry out their roles effectively and confidently;
- care homes have access to high quality training and education to support them in their roles;
- care homes are valued as system providers and their role in supporting the most vulnerable and complex people in our population is respected and acknowledged; and
- the Enhanced Health in Care Homes programme is implemented effectively in Derby and Derbyshire as part of the Ageing Well programme.

Continuing Health Care and Discharge to Assess

In March 2020, multi-agency guidance was issued in respect of enabling safe and effective discharge of patients from hospital. The CCG established a group with members from UHDBFT, CRHFT, DCHSFT, Midlands and Lancashire Commissioning Support Unit – Continuing Healthcare (CHC) Team, Derby City Council and Derbyshire County Council. A clear discharge pathway was defined which reflected the requirements of the guidance supported by multi-agency Standard Operating Procedures.

Covid-19 has spurred unprecedented co-operation and collaboration, between different NHS organisations and with partners in Local Authorities and the private sector, especially the care home sector. The CHC Team has become a much more visible and stronger system partner, leading on a Trusted Assessor model for assessing individuals care needs following discharge from hospital. The team has developed new ways of supporting people who receive NHS CHC, or personal health budgets; responding to people's individual needs, adapting care plans where necessary, and making sure their budget meets the costs of the new arrangements.

The use of technology to support the CHC process has been rapidly introduced with technologies such as video conferencing ensuring that people can attend multi-disciplinary team meetings regardless of where they live. Access to Microsoft Teams and Zoom has made this a reality for all, including CCGs, Local Authorities, individuals and their families.

Using these technologies has allowed CHC teams to restart their processes with confidence that they can complete high quality CHC assessments and reviews while being compliant with the National Framework.

Feedback from families involved in our CHC reviews has confirmed that by completing them on Zoom, we were able to 'include all the family in mum's review' which we would almost never have been able to do before Covid-19. Using video conferencing has also allowed for a greater level of flexibility.

The CCG Commissioning of NHS Continuing Healthcare for Adults Policy has recently been refreshed and ratified. The policy describes the way in which the CCG plans and commissions services for people who have been assessed as eligible for an episode of fully funded NHS CHC, and patients who are eligible for CHC who wish to have a Personal Health Budget. It also sets out CCG principles for joint funded packages of health and social care.

The CCG has a prime responsibility to ensure that services it procures are clinically appropriate and meet agreed quality standards. The safety, welfare and potential risks to the individual are considered in care purchased, and the personalisation of support and care for an individual, are central to decision-making once the principles of the policy have been assured. The need to balance personal choice, alongside safety and effective use of finite resources in the provision of CHC services, is also embedded within the policy. This provides the panel with a framework which ensures consistent and equitable decisions can be made around the provision of care regardless of the person's age, condition or disability. All procurement decisions need to provide transparency and fairness in the allocation of resources.

Commissioning for individuals

The CCG, in meeting its responsibility to commission health services to meet all the reasonable requirements of its resident population, is required to commission packages of care, interventions, assessment or treatment or 'placements' for 'individuals' on a case-by-case/individual basis. While many care packages are provided through the National Framework for CHC, or the National Framework for Children and Young Peoples Continuing Care, the CCG also funds other care packages that are non-CHC, either via a national or local directive with accompanying policies and documentation. The CCG also commissions and funds interventions, equipment and other health provision that locally commissioned services do not provide.

The Commissioning for Individuals Panel was established to provide governance and a decision-making process for these individualised packages of care. To ensure there is a fair and consistent approach, the panel is chaired by a lay representative who is joined by finance, contracting, commissioning and quality colleagues. The panel considers the appropriateness, safety, quality and cost effectiveness of requests for complex/specialist care placements/packages and interventions and ensures that people in need of NHS healthcare funding are in receipt of a package of care which meets their needs; respects their wants; is safe and sustainable.

The panel has been active for more than 12 months and has significantly improved governance processes. This has enabled the CCG to provide care in a timely manner that reflects the choice and preferences of individuals and balances the need for commissioners to procure care that is safe and effective, and makes best use of available resources across the system, while taking into consideration the wishes of clients and their families.

Learning from lives and deaths of people with a learning disability and autistic people – the Learning Disability and Autistic People Programme

In March 2021, the national Learning Disability and Autistic People (LeDeR) Policy 2021 set out its core aims and values and the expectations of different parts of the health and social care system in delivering the programme. In Derbyshire we have worked to this policy while continuing to meet targets set by NHSE&I in relation to completing reviews within six months of notification, which allows valuable learning to be produced in a timely way. A clear part of the national policy is that LeDeR governance and oversight remain across new health and social care systems as they are implemented. In Derbyshire, partnership working is a key part of the success of the LeDeR programme, which is demonstrated through the following work:

- learning and themes are collated that have emerged through the completed LeDeR reviews and shared and discussed through the LeDeR Steering Group;
- reviews are quality assured and actions agreed at the LeDeR Clinical Quality Review Group;
- a Derbyshire LeDeR Strategy has been produced, including a vision, aims and objectives for the next three years, agreed and owned by the LeDeR Steering Group; and
- the LeDeR Team are working closely with the Learning Disability Health Facilitation Team to deliver workshops across Derbyshire which share learning from the LeDeR programme with emphasis on key themes and learning, such as the importance of learning disabilities annual health checks.

LeDeR is a service improvement programme which aims to improve care, reduce health inequalities and prevent premature mortality of people with a learning disability and autistic people by reviewing information about the health and social care support people received. Key themes and learning that have identified and worked on in 2021/22 are:

- the production of a Derbyshire video highlighting the importance of being aware of constipation for people with a learning disability;
- a learning disabilities annual health check video has been produced which highlights the importance of annual health checks for people with a learning disability, both the awareness of having a check but also the importance of the quality of the health check and the health action plan;
- an ethnic minority report has been produced which aims to highlight the disproportionate under-reporting of deaths of children and adults from some communities; and
- epilepsy pathways have been identified as a key area where there are potential service improvements to be made. Case studies have been produced to identify these gaps which are being shared and discussed with epilepsy service providers in Derbyshire.

Developing robust Derbyshire Host Commissioner arrangements

The CCG has a well-established oversight for our seven local Independent Hospitals. During 2021 we have developed robust local Host Commissioner arrangements following the publication of national guidance by NHSE&I in January 2021. This describes a clear framework and expectation that local CCGs maintain ongoing assurance, surveillance and oversight for Independent Hospitals located within their geographical area.

Specifically, the guidance relates to the quality of care for people with a diagnosis of a learning disability and/or autism only. However, we have widened our Host Commissioner role out to surveillance of all Derbyshire Independent Hospitals including those providing mental health care. During the year we have also offered support to other CCGs as they develop their own Host roles, and we have shared examples of our governance tools and processes.

Transforming Care Partnership

The CCG continues to work with partners through the Transforming Care Partnership (TCP). The TCP consists of the CCG, CRHFT, UHDBFT, DCHSFT, DHcFT, Derby City Council, Derbyshire County Council, service users and carers. The TCP continues to develop collaborative ways of working to improve health and care services so that more individuals with learning disabilities and/or autism can live in the community, with the right support closer to home.

Through earlier intervention and support, the aim is that fewer individuals will be admitted to hospital for their care associated with their learning disability, autism and/or mental health needs.

For those individuals for whom a clinically led evidence-based need is indicative of hospital admission, the aim of the admission, assessment and treatment pathway and discharge plan from hospital, will be clear from the point of admission.

The TCP Team, hosted within DHcFT since the 1st October 2021, has contributed to improvements in quality and services in the following ways:

- in line with the national policy and guidance we are ensuring that as a health and social care system we better understand the needs of individuals with a learning disability and/or autism who are likely to need additional support in the community to reduce the likelihood of clinically inappropriate admissions to hospital;
- when appropriate to do so, proactive community Care, Education and Treatment Reviews are being facilitated as an alternative to admission avoidance meetings;
- during the Covid-19 pandemic, post-admission community Care, Education and Treatment Reviews have largely been held virtually;
- the review and evaluation of the local Dynamic Support Register which has been in place since December 2020, highlighted the need to utilise a new clinically-led, evidence-based tool. As a system we have established a multi-agency Task and Finish group to identify an appropriate inter-related tool to underpin the local Dynamic Support Register;

- at the beginning of November 2021, the Senior Responsible Officer for the TCP programme tasked the TCP Team with identification of 12 inpatients to focus on, expediting a robust discharge from inpatient services by the end of Q3. All 12 inpatients were discharged within Q3 with the exception of one who was discharged in early February 2022 following a successful period trial leave from their hospital setting;

- as a direct outcome of collaborative working, three individuals with learning disability and/or autism have been discharged form inpatient hospitals, one had been an inpatient since 2009, one since 2012 and the third since 2018; and

- safe and wellbeing reviews, initially referred to as Five Eyes reviews have been completed for all learning disability and/or autism individuals who were inpatients on the 1st October 2021. We are now in the process of undertaking ICS Scrutiny Panels to identify trends and themes identified within the reviews.

Maternity and Neonatal Transformation

The CCG takes a leadership role in the Derbyshire Local Maternity and Neonatal System (LMNS) and has continued to steer the programme of work to respond to the recommendations of the Better Births report, the NHS Long Term Plan maternity commitments and the actions following the Kirkup and Ockenden Reports. The LMNS has formed a tripartite buddy relationship with Staffordshire and Stoke-on-Trent LMNS and Shropshire, Telford and Wrekin LMNS, offering peer support, sharing and learning.

During 2021/22 the Derbyshire LMNS has progressed an ambitious work programme across the following key areas:

- reopening services which have been suspended as a result of Covid-19, and supporting the system which has suffered from sustained workforce pressures and high activity and acuity of the caseload as a consequence of the pandemic;

- delivering four key actions to enhance the support for ethnic minority pregnant people, including a survey to gather service user feedback and the new Pregnancy Outcome Inequality Reduction by Optimising Vitamin D Quality Improvement Project;

- re-launching the Derbyshire Maternity and Neonatal Voices Partnership, a multi-disciplinary advisory and action forum led by service users, working in partnership to co-design and co-produce our plans, evaluate their effectiveness and gather feedback;

- developing our quality surveillance processes and structure which enables us to gain system-wide assurance of maternity and neonatal quality and safety, including delivery of the seven Immediate and Essential Actions from the Ockenden Report and the Saving Babies Lives Care Bundle (version 2);

- personalised Maternity Care and Support Plans, with additional funding secured to recruit Personalised Care Champion Midwives to help promote and embed this way of working which puts pregnant people at the centre of their care;

- smoke-free pregnancy pathways, as part of the system-wide tobacco dependence work programme which will see Tobacco Dependence Advisors integrated into the hospital maternity setting;
- refinement of the pathway which offers Continuous Glucose Monitoring for all pregnant people with type 1 diabetes;
- development of a highly commended Equity and Equality Analysis for the LMNS, which sets out our local evidence base to help inform our action plan to achieve equity in outcomes for service users, and equality in experience for staff;
- worked closely with providers to develop the midwifery Continuity of Carer to become the default model of care, including how we will deliver an enhanced model of care for people from ethnic minorities and the most deprived communities which has been piloted in one of our Derby city communities; and
- worked with the Yorkshire and Humber and East Midlands Neonatal Operational Delivery Networks to implement the recommendations of the Neonatal Critical Care Review and strengthened the way we gather and utilise neonatal family experiences.

Reducing Health Inequality

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

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

Equality Delivery System

The CCG has demonstrated a proactive approach to meeting the requirements of the Public Sector Equality Duty through use of the NHS Equality Delivery System 2 (EDS2).

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

- Domain 1: Commissioned or provided services;
- Domain 2: Workforce health and wellbeing; and
- Domain 3: Inclusive leadership.

The CCG's EDS2 return can be found here[12].

Derby and Derbyshire's approach to Equality 2021/22

The impact of the Covid-19 pandemic over the past two years on society and the NHS cannot be underestimated. From November 2020, the vaccination programme became one of the biggest priorities for the NHS.

Derbyshire's Covid-19 Vaccination Programme commenced on the 8th December 2020, with the Government's Joint Committee on Vaccination and Immunisation priority group one – those aged 80 and over. By mid-January, following the receipt of one month's data, it was clear that certain community groups and those in deprived communities were not accessing vaccinations to the same level which was attributed to vaccine inequality or hesitancy.

A strategy was produced to agree the approach to be taken across JUCD in its ambition to reach equity of access for the Derby and Derbyshire population in Phase 3 of the Covid-19 vaccination programme and the 2021/22 influenza programme.

Phases 1 and 2 of the Covid-19 vaccination programme took place during 2021 and during this time a significant response to inequality has taken place. The strategy for Phase 3 builds

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

on this work and aims to provide a planned approach across each of the inclusion groups for the booster programme.

All actions of the vaccine inequality programme are overseen by the Vaccine Inequalities Group. This group is chaired by a Public Health representative, coordinated by the JUCD System Vaccination Operation Centre and has membership from across the JUCD system. The group is held to account by its members and also via a robust reporting structure; scrutiny is welcomed, listened to and acted upon.

To ensure that the strategy delivers on its ambitions, a strategy stock-take was held in January 2022. This highlighted a number of immediate actions needed and the next steps. A copy of the stock take and associated documents can be found within our EDS2 submission here[13].

Equality considerations for corporate committees

The process around Quality and Equality Impact Assessments (QEIA) are now embedded in the CCG. Each proposed change to services has to have a completed QEIA form which outlines any risks and mitigations to the proposed change. This information is then included in the cover sheet on all of the decision-making committees to ensure that risks and mitigations are understood, and robust decisions can be made.

Where the panel seeks further information then the QEIA is updated and reviewed again. An updated version of the QEIA is reviewed as per the needs of the project.

In addition to the QEIA process, the CCG Engagement Committee receives a monthly update on the completed Section 14Z2 forms which supports the assessment of legal duties around patient engagement or consultation.

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

Procurement

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

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

Equality Statement

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

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

Equality Analysis and 'Due Regard'

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

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

Workforce

NHS Workforce Race Equality Standard

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

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

Key initiatives have included:

- celebrating and promoting key dates in the inclusion calendar;
- introducing a programme of reverse mentoring with senior directors;
- raising awareness of the lived experiences of under-represented staff;
- informing the Derby and Derbyshire healthcare systems approach to engagement with diverse communities relating to the Covid-19 vaccination programme and vaccine hesitancy;

- learning and development: hidden disabilities and unconscious bias training; and
- informing the WRES, Workforce Disability Equality Standard (WDES) and Staff Survey action plans.

The Senior Leadership Team (SLT) has recently agreed to updated terms of reference for the Network that provides a clear purpose, line of accountability and clarification of how the Network is to be integrated into the decision making of the CCG. This includes the Network:

- reporting directly to SLT;
- having representatives at the SLT with regards to decision-making, especially on issues which may impact diversity and inclusion; and
- receiving protected time to undertake their roles.

Whilst no internal targets have been set with regard to workforce representation, the CCG aims to have a workforce that is representative of the community at all levels of the organisation.

CCG Ethnic Minority Groups

The proportion of the CCG's population that belong to ethnic minority groups is estimated at 6.7%, based on the 'covered by population' data from the 2011 census and Office for National Statistics mid-year population estimates in 2017. The 2011 census data stated the proportion of the population belonging to ethnic minority within Derby City as 24.7%.

At the 31st March 2022, the proportion of employees within the CCG from ethnic minority groups is 11.35%. This is an increase of 1.71% since 2019.

	2019	2020	2021	2022
CCG employees from an ethnic minority group	9.64%	9.41%	10.34%	11.35%

Table 15 – percentage of CCG employees from an ethnic minority group between 2019 and 2022

A breakdown of proportion of CCG staff from an ethnic minority group across the banding structure within the CCG is detailed below. Table 16 shows that these employees are underrepresented at a senior level:

CCG employees from an ethnic minority group	2019	2020	2021	2022
Band 8d/VSM	4.55%	4.35%	4.76%	4.35%
Bands 8a–8c	12.4%	13.38%	15.28%	15.97%
Bands 1–7	8.49%	7.99%	8.54%	9.85%

Table 16 – proportion of CCG staff from an ethnic minority group across the banding structure between 2019 and 2022

The senior management team within the CCG has been stable over the past four years with minimal turnover, which represents a barrier to achieving a diverse workforce at all levels across the organisation. To address this, the CCG has undertaken a review of the recruitment and selection procedure, working with the Diversity and Inclusion Network. The

CCG is also working with partners in the Derbyshire Healthcare system to promote development opportunities for staff from underrepresented groups and participating in an expert-led system-wide cultural intelligence programme.

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

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

NHS Workforce Disability Equality Standard

The WDES is a set of 10 specific measures which enable NHS organisations to compare the workplace and career experiences of disabled and non-disabled staff.

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

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

Public Involvement and Consultation

Engaging People and Communities – Duty to Involve

The CCG would like to thank all constituent partners and stakeholders including provider organisations, Healthwatch, the VCSE sector and all individuals and groups who have contributed to our communication and engagement activities during 2021/22.

We have listened to the experiences and opinions of local people as the pandemic continues to expose inequalities across the city. This has renewed our commitment to listening and hearing from those most affected. We continue to refine and develop our use of digital technology and this approach has enabled us to continue conversations and see an increase in the numbers of people engaging in decision-making processes and providing feedback to help shape services.

Our Engagement Committee, which has continued to meet virtually, reports to the Governing Body and JUCD Board and is comprised of a broad spectrum of representatives across the health and social care system. These range from statutory engagement bodies such as Healthwatch to the VCSE sector, foundation trust governors and members of the public. The objectives of the committee are to assure service changes and plans are developed via effective engagement with those most affected by potential changes to the service and that patients, carers and the public are at the centre of shaping the future of health and care in Derbyshire.

The footprints for the CCG and JUCD are aligned as we move towards an ICB. Our teams have worked closely together on our ‘Get Involved’ page of the JUCD website, which directs

members of the public to opportunities to become involved in work being carried out by the organisation. The website also includes key information to the Covid-19 response including details of pop-up vaccination clinics.

Involvement with the CCG

Over the last year there have been many opportunities for our population to get involved in our work and help shape the direction of future services, made possible by digital technology developments during the pandemic, examples include:

Long Term Condition Hubs

Two engagement sessions took place in Autumn 2021 to gather the views of patients, carers and the public on the development of LTC Hubs. The purpose of the sessions was to look at how we could improve the current experience of people with LTCs and introduce the concept of a centralised hub where all the care for people's LTC needs could be delivered in one place at one time.

One participant, Adam Slater, from the Derby West Indian Community Association, said:

> *"I have been pleased to form relationships with the CCG as it looked to share its findings from our community-led research report looking into the Black Caribbean relationship with Social Care in Derby. The CCG has given us the opportunity to share our findings at the Long-Term Conditions Hub focus group as well as share thoughts with like-minded individuals and organisations in the city at the Insights Group meeting. This promotion of our work has been invaluable and hope it can lead to an improved system for all in Derby."*

Ophthalmology

On the 30th June 2021 via Microsoft Teams, we brought together 14 people to talk about proposed changes to the way that Ophthalmology services would be delivered. This included hearing about their experiences and their views on the proposals including any issues/challenges/concerns. A summary of the themes and questions were fed into the implementation of the changes.

Mental Health Crisis Café Development

Figure 6 – Mental Health Crisis Café Development

We carried out a number of engagement activities in relation to the creation of Mental Health Crisis Cafés in September and October 2021. These cafés are vital for supporting people with a mental health crisis and offer a drop-in facility, out-of-hours. They provide preventative, peer and non-clinical support and help people to feel safe.

Following a survey and focus groups, we produced a report summarising the feedback. A checklist for potential providers of Crisis Cafés to consider when expressing an interest in delivering this service was developed. A market engagement session was held on the 20th January 2022 with organisations and groups who have expressed an interest in providing Crisis Cafes, to hear more about the feedback received to date, review the draft specification, and make comments on the delivery model.

The transition of Glossop to Derby and Derbyshire's Integrated Care System

Beginning winter 2021, engagement has aimed to put the voice and lived experience of people and communities in Glossop at the heart of the transition, by embedding a culture of listening, learning, and taking action together. We set up an online engagement platform, with polls, discussion forums and other interactive tools to engage Glossop residents in a conversation about the transition and gauge public opinion. We ran focus groups and are maintaining a document which sets out feedback received and responses given.

Patient Participation Group Network

A Patient Participation Group (PPG) represents the patient population of a General Practice and is generally made up of a group of volunteer patients, the practice manager and one or more GPs. They meet to discuss the services on offer and how improvements can be made for the benefit of patients and the practice.

The implementation of PPGs across the city and county is inconsistent, with some General Practices having exceptionally well-run PPG groups, while others have no PPG group at all. The pandemic increased this inconsistency due to some groups feeling more confident than others to move to an online format.

We have responded by creating a county-wide PPG network to bring PPG Chairs and their members together, offering support with moving their meetings to an online platform, and a forum for discussing other areas of interest and concern.

You can find information about upcoming meetings here[14].

One of our PPG Network members, Ann Hillyard, said this about the network:

"For four years I was chair of the Dronfield Network. The four practices met four times a year with a CCG member of staff in attendance and the occasional speakers from other organisations. Since the formation of the PCN, the PPG network meetings have been most helpful in getting to know the other chairs and learning what happens in other PPG's...The agendas are always interesting, and members are asked if there is anything in particular, they would like to discuss… As a PPG network we can learn from you but also you can learn from us. I look forward to every meeting and find the presentations excellent."

[14] https://joinedupcarederbyshire.co.uk/get-involved/patient-participation-group-ppg-network

Derbyshire Dialogue

Derbyshire Dialogue is a monthly session available through Microsoft Teams, launched by our Chief Executive Officer, Dr Chris Clayton. Each Dialogue focuses on a different area, helping people to understand how we plan and deliver services in Derbyshire and work in partnership with providers and commissioners in the system. Recordings, agendas and slide sets for all sessions are available here[15].

A regular participant of Derbyshire Dialogue, Jocelyn Street, said:

> *"The fact that they provide an opportunity for people to raise questions and enter into a discussion is a really good example of engagement with the wider public and I know that they attract people who do not otherwise engage with the NHS. It is good to note that the numbers participating are steadily increasing. As a member of the Engagement Committee, I strongly feel that Derbyshire Dialogue is playing its part in wider-ranging and more effective communication with the public."*

Urgent Treatment Centre review

In Derby and Derbyshire, we have five UTCs and in January 2022 we launched the pre-engagement work for the UTC review which had two phases. Phase 1 saw a general approach involving an online survey, development of an online engagement platform and email and phone feedback. Phase 2 focused on engagement with those who are most likely to be impacted by any change(s) made to urgent care services and also those who are seldom heard. This consisted of focus groups and attending groups within the community by invitation.

Patient and Public Partners

Patient and Public Partners are lay members who want to be involved in improving health and care. They have extensive experience either as a patient, family member or caregiver; others have been part of the health system in a professional manner.

Our partners get involved in various aspects of work in the ICS to help develop and improve services.

We currently have 14 Patient and Public Partners. Here's the experience two Partners:

Professor Paula J Holt MBE

"I was keen to become a Patient and Public Partner for the Diabetes Board, as I have learned through my many years as a nurse, and as an academic responsible for educating our Nursing and Allied Healthcare workforce, that the voice of service users/patients is the most important voice in the health and care system. I wanted to be a Patient and Public Partner representative to advocate for patients and reflect their lived experiences, to champion care that is kind, innovative and equitable, and importantly to promote the need for care that is holistic. It remains a frustration that having more than one health need

[15] https://derbyshireinvolvement.co.uk/derbyshiredialogue

necessitates involvement of different groups of health professionals that don't always seem to collaborate or communicate effectively to ensure joined up care for the individual… but with more patient voices articulating their lived experience I hope that truly integrated care becomes a reality."

Trevor Parkerson

"In 2020, I underwent major cardiac surgery and received excellent cardiac rehabilitation care from the team at Queen's Hospital, Burton. From my work as a Hospital Chaplain, I had learned that cancer patients do not always receive a consistent level of rehabilitation, that is if they receive any at all. I was very pleased to have the opportunity to join the Living with Cancer workstream and I was surprised to learn that the provision of cancer rehabilitation and rehabilitation is not mandatory in the NHS. The Patient and Public Partners in our group have a wide range of backgrounds and experience and are able to comment objectively at the meetings. It is still early days for the group and it will continue to develop ideas to improve the aftercare offered to cancer patients with set objectives and dates already agreed."

If you are interested in recruiting Patient and Public Partners for a Board or Committee within the ICS, please get in touch via ddccg.enquiries@nhs.net and we can provide you with support.

Sharing your thoughts

Citizens' Panel

Our Citizens' Panel has approximately 1,000 members, with a recruitment campaign set to further increase membership. The panel aims to hold a representative cohort of people that mirrors the population of Derbyshire by age, gender, ethnicity and district. The only restriction to membership is that people need to be aged 16 years and over and live in Derbyshire. The panel can be used to get a quick population 'temperature check' on a particular topic and check out insight from other engagement methods. You can find out how to join the panel here[16].

Online Engagement Platform

As part of our wide-reaching engagement programme, we launched the Joined Up Care Derbyshire Engagement Platform[17]. It provides interactive feedback and analytical tools to make it easier for communities to be involved in decisions being made around system transformation. Some key features includes access to various tools such as surveys, quick polls, Q&As, maps, document sharing and ideas boards.

[16] https://joinedupcarederbyshire.co.uk/get-involved/citizens-panel
[17] https://derbyshireinvolvement.co.uk/

Developments within Engagement and Insight

System Insight Group

The group meets about every eight weeks via Microsoft Teams. It has a diverse membership, including patient and public engagement and experience leads from across the system. Any professional with an interest in patient and public insight can join. The vision of the Insight Group is to 'develop a culture of being insight-led across the system when making decisions' – insight could be from evidence, research, reflections, conversations and observations, from any number of different sources. In the short term, the aim has been to gain an accurate and deep understanding of people's experiences during the Covid-19 pandemic. Other work has included:

Patient and Public Insight Hub	The group aims to develop a solution for collecting and collating insight gathered across all system partners in Derbyshire that is easily accessible and searchable by a wide variety of professionals to inform decision-making. As a result, we now have a 'Patient and Public Insight Library' set up on the NHS Futures Platform.
Remote access to Health and Care	This report pulls together a large proportion of insight about remote access to health and care, summarising the key themes and consideration for decision-makers. The report will help inform the recovery of services going forward. A 'digital inclusion checklist' was developed in the report, and has been incorporated into the system's Digital Strategy, to be promoted to all service providers to ensure good practice in remote access implementation programmes.

Integration Index

The NHS Long Term Plan signalled the development of a new integration index that will be *"developed jointly with patient groups and the voluntary sector which will measure from patient's, carer's and the public's point of view, the extent to which the local health service and its partners are genuinely providing joined-up, personalised and anticipatory care".* NHSE&I is looking to develop both a national index and local indices. We will be looking at measuring integration using an approach that is relevant locally and has local ownership, alongside a metric to generate data that is comparable at a national level.

Black and Minority Ethnic Partnership

We have been working in partnership with Derbyshire County Council and Links CVS, to build relationships with the Black and Minority Ethnic Partnership that currently exists in the County. The partnership is a sustained and coordinated engagement mechanism, which provides an infrastructure to enable the community to be actively engaged with decisions being made about Derbyshire County Council services. Participants are supported to give feedback on policy and service development, via a two-way communication channel, which aids better understanding and response to the needs of communities. Participants are supported to plan and conduct engagement with their communities and raise issues on their behalf via the partnership. We have added a number of health-related issues to the agenda over the past year and are looking at how we conduct more comprehensive pieces of work with the forum to gather insight about significant future transformational service changes.

Engagement Model

To embed engagement at the heart of the planning, priority setting and decision-making process across the system, we have created an Engagement Model and are in the process of writing an accompanying guide. The model aims to ensure that we always co-produce and redesign services and tackle system priorities in partnership with people and communities. The model will ensure we meet our legal duty to inform, involve or consult patients and members of the public for all service change and transformation programmes. The model takes commissioners through the steps to achieving legal compliance.

Sustainable Development

In 2020, the NHS launched the campaign 'For a Greener NHS' and an Expert Panel, chaired by Sir Simon Stevens, set out a practical, evidence-based and quantified path to a 'Net Zero' NHS.

Two clear and feasible targets emerged for the NHS Net Zero commitment, based on the scale of the challenge posed by climate change, current knowledge, and the interventions and assumptions that underpin this analysis:

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

Eight early steps have been identified that will support an overall reduction as follows:

1	**Our care**	By developing a framework to evaluate carbon reduction associated with new models of care being considered and implemented as part of the NHS Long Term Plan.
2	**Our medicines and supply chain**	By working with our suppliers to ensure that all meet or exceed our commitment on net zero emissions before the end of the decade.
3	**Our transport and travel**	By working towards road-testing for what would be the world's first zero-emission ambulance by 2022, with a shift to zero emission vehicles by 2032 feasible for the rest of the fleet.
4	**Our innovation**	By ensuring the digital transformation agenda aligns with our ambition to be a net zero health service and implementing a net zero horizon scanning function to identify future pipeline innovations.
5	**Our hospitals**	By supporting the construction of 40 new 'net zero hospitals' as part of the Government's Health Infrastructure Plan with a new Net Zero Carbon Hospital Standard.
6	**Our heating and lighting**	By completing a £50 million LED lighting replacement programme, which, expanded across the entire NHS, would improve patient comfort, and save over £3 billion during the coming three decades.
7	**Our adaptation efforts**	By building resilience and adaptation into the heart of our net zero agenda, and vice versa, with the third Health and Social Care Sector Climate Change Adaptation Report in the coming months.
8	**Our values and our governance**	By supporting an update to the NHS Constitution to include the response to climate change, launching a new national programme for a greener NHS, and ensuring that every NHS organisation has a board-level net zero lead, making it clear that this is a key responsibility for all our staff.

Figure 7 below sets out what is within scope for achievement of an overall reduction in emissions. There are four areas ('scopes' – as defined by The Greenhouse Gas Protocol) and are categorised for the NHS as either NHS Carbon Footprint, or NHS Carbon Footprint Plus.

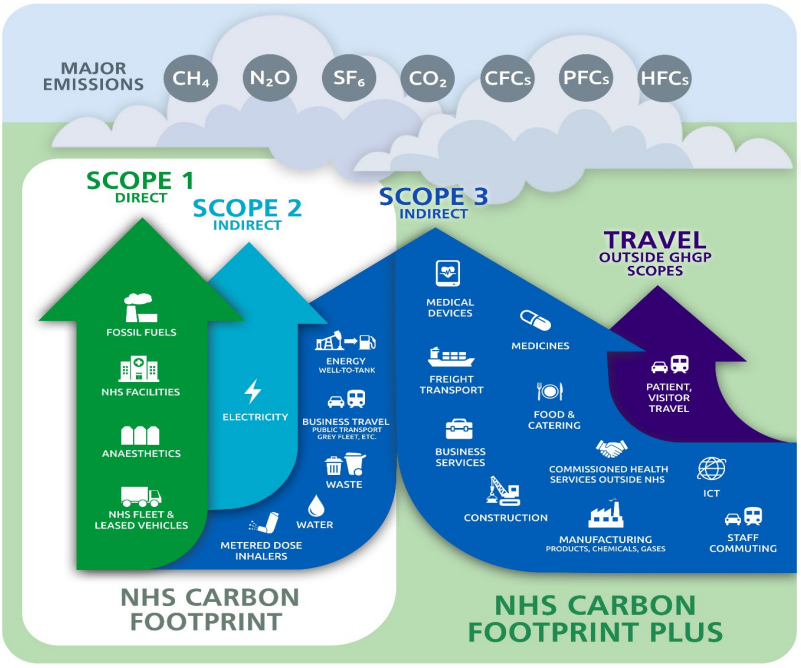


Figure 7 – GHGP scopes in the context of the NHS (Source: NHSE&I)

The NHS will work towards net zero for a NHS Carbon Footprint Plus that includes as well as the three scopes above, emissions from patient and visitor travel to and from NHS services and medicines used within the home.

It is recognised that the NHS has already made considerable contribution to an overall reduction however every area of the NHS will need to act if net zero is to be achieved. Observing the wider scope of the NHS Carbon Footprint Plus, Figure 8 below shows that the greatest areas of opportunity, or challenge, for change are in the supply chain, estates and facilities, pharmaceuticals and medical devices, and travel.

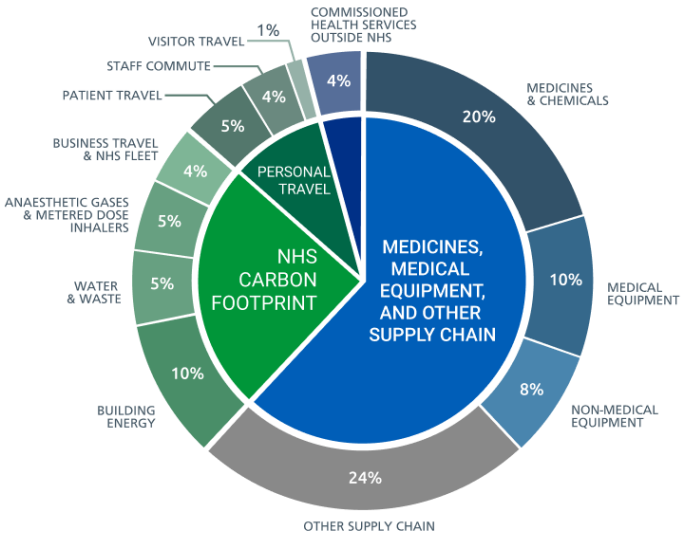


Figure 8 – Sources of carbon emissions by proportion of NHS Carbon Footprint Plus (Source: NHSE&I)

The main areas of action for the NHS and its partners can be categorised into:

- Direct interventions within estates and facilities, travel and transport, supply chain and medicines; and
- Enabling actions, including sustainable models of care, workforce, networks and leadership, and funding and finance mechanisms.

Greener Governance

NHS Midlands Regional Delivery Board

The JUCD ICS is a member of the NHS Midlands Regional NHS Delivery Board which was established in June 2021. The CCG's Executive Director for Corporate Strategy and Delivery is the Senior Responsible Officer for Net Zero and represents the JUCD ICS. The Board meets bi-monthly. The Midlands Regional NHS Delivery Board defined three priorities for carbon reduction as follows:

Medicines

- Reducing the proportion of desflurane used in surgery to less than 10% of overall volatile anaesthetic gases volume in all trusts, in line with the proposed 2021/22 NHS Standard Contract.
- Implementing approaches to optimise use of medical gases, including reducing nitrous oxide waste and preventing the atmospheric release of medical gases.
- Reducing the carbon impact of inhalers, in line with the commitment of a 50% reduction by 2028 and a 6% reduction in 2021/22 on a 2019/20 baseline, by:
    - supporting patient choice of less carbon intensive inhalers, for example dry powder inhalers, where clinically appropriate, resulting in a 2% reduction of emissions by March 2022; and
    - working with the national team to ensure schemes for green disposal of inhalers are rolled out across the region.

Travel and transport

- Ensuring that systems solely purchase and lease cars that are ultra-low emissions vehicles (ULEVs) or zero emission vehicles (ZEVs), and work towards purchasing vans (under 3.5 tonne) that are ULEVs or ZEVs, in line with the LTP and Net Zero Strategy commitments.
- Ensuring that only ULEVs or ZEVs are available to staff through car salary sacrifice schemes.
- Identifying a cycle-to-work lead in every trust, as outlined in the People Plan.
- Ensuring all systems have:
    - a salary sacrifice cycle-to-work scheme in place for staff; and

- where appropriate all sites have facilities available to encourage staff and visitors to cycle-to-work.

- Working with the national Greener NHS team to undertake a review of the existing fleet within the region.

Midlands Region Priority Deliverables

These regional priorities are linked to the recovery, sustainability and resilience improvement across our systems and organisations and will support the adoption of national policies or strategies at scale to accelerate greener change:

Plastics	Following a significant organisational uptake in the Plastics Pledge in February 2020, we will lead regional projects aimed at reducing the use of clinical single-use plastics.
Paper	Ensuring all systems only purchase 100% recycled content paper for all office-based functions as soon as possible and across non-office-based functions as soon as practically possible.
PPE usage and waste management	Supporting sustainable PPE procurement and use, and PPE improved waste management solutions. For example, adopting the national PPE gown pilot regionally if successful.

Joined Up Care Derbyshire Integrated Care System Greener Delivery Group

JUCD established a Greener Delivery Group in June 2021, meeting bi-monthly. The CCG's Executive Director of Corporate Strategy and Delivery is the Group Chair. The Derbyshire Provider Trust Sustainability Leads are members of the group together with specialist Lead Pharmacists within the Derbyshire ICS.

The group agreed the following local priority areas:

- governance;
- medicines;
- travel and transport;
- estates and facilities;
- Midlands region priority deliverables: single use plastics, paper, PPE usage; and
- waste management.

The Derbyshire provider trusts have approved their individual Green Plans and worked together to develop the JUCD ICS Green Plan, approved by the Derbyshire Trust Boards during March and April and the CCG Governing Body on the 7th April 2022. The ICB Board will formally approve the Green Plan in July 2022, when the ICB is a statutory organisation.

Our Commitments

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 aware of its responsibilities as a socially responsible commissioner and includes this within procurement programmes. The Governing Body Lay Member for Finance is the CCG's Sustainability Champion.

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

Our key commitments to sustainability are as follows:

Leadership and Workforce Development

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

Carbon Hotspots

One in every 100 tonnes of domestic waste generated in the UK comes from the NHS, with the vast majority going to landfill. The New Economic Foundation calculates that recycling all the paper, cardboard, magazines and newspapers produced by the NHS in England and Wales could save up to 42,000 tonnes of carbon dioxide. Travel by patients, staff and visitors, is a crucial part of the way the NHS delivers services. The NHS accounts for 5% of all road traffic in England and travel is responsible for 18% of the NHS carbon footprint in England. This is an important area for reducing carbon impact, improving sustainability, convenience and safety, as well as saving time and money.

Table 17 below shows our energy consumption for the last three years, for our CCG headquarters at Cardinal Square, Derby:

	2021/22	2020/21	2019/20
Electricity (kWh)	107,389	94,142	169,927
Water (m^3)	590	589	1,177

Table 17 – CCG headquarters' energy consumption for 2021/22 and 2020/21

Commissioning and Procurement

In England more than £212.1bn of public money is spent on health and care services. The commissioning of services and the procurement of products are powerful levers to influence the delivery of sustainable services. The CCG recognises that we can develop and use

criteria to stimulate more ambitious and innovative approaches to delivering care that costs less, creates less environmental harm and reduces inequalities.

Creating Social Value

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

Reducing the carbon impact of inhalers

A priority for the Derbyshire system is to reduce the use of high-volume salbutamol metered dose inhalers (MDIs) and switch to using a lower carbon alternative. Salbutamol MDIs are our most commonly prescribed inhaler and switching could reduce our inhaler carbon footprint by up to a third. Although work is only just starting, figures from Open Prescribing (www.openprescribing.net) show that our mean carbon emission per salbutamol inhaler has reduced significantly over the last few months:

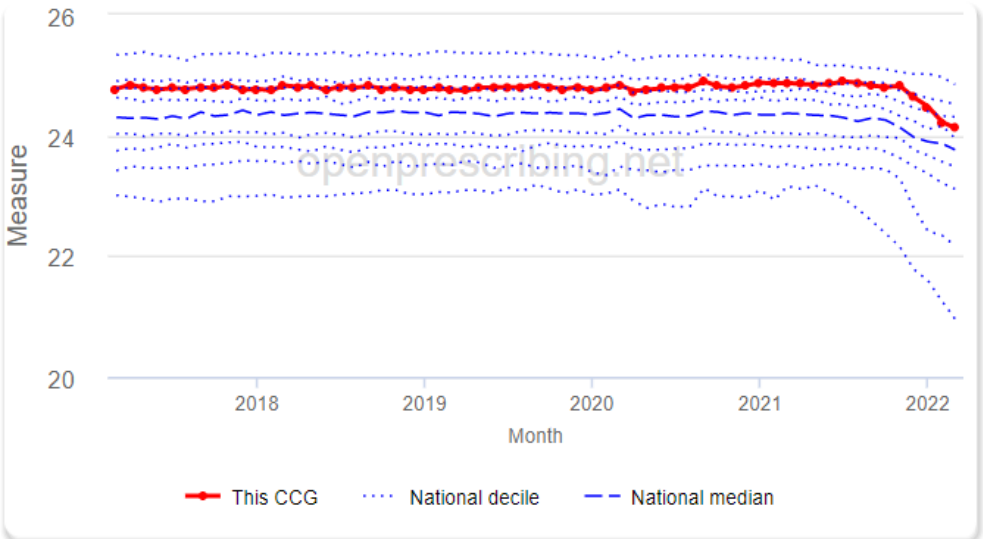


Figure 9 – mean carbon impact (KgCO2e) per salbutamol inhaler prescribed

Switching to a lower carbon alternative has to date produced a reduction of 40,850 KgCO2e (3.7%) per month and this trend will continue as more practices switch.

Our second priority is to utilise more dry powder inhalers, which have a much lower carbon footprint than MDIs. This is a more complicated piece of work, with patients needing an individual review in order to change inhalers, and traditionally Derbyshire has been a very

high user of MDIs. However, there has also been some recent progress made in reducing the prescribing of MDIs:

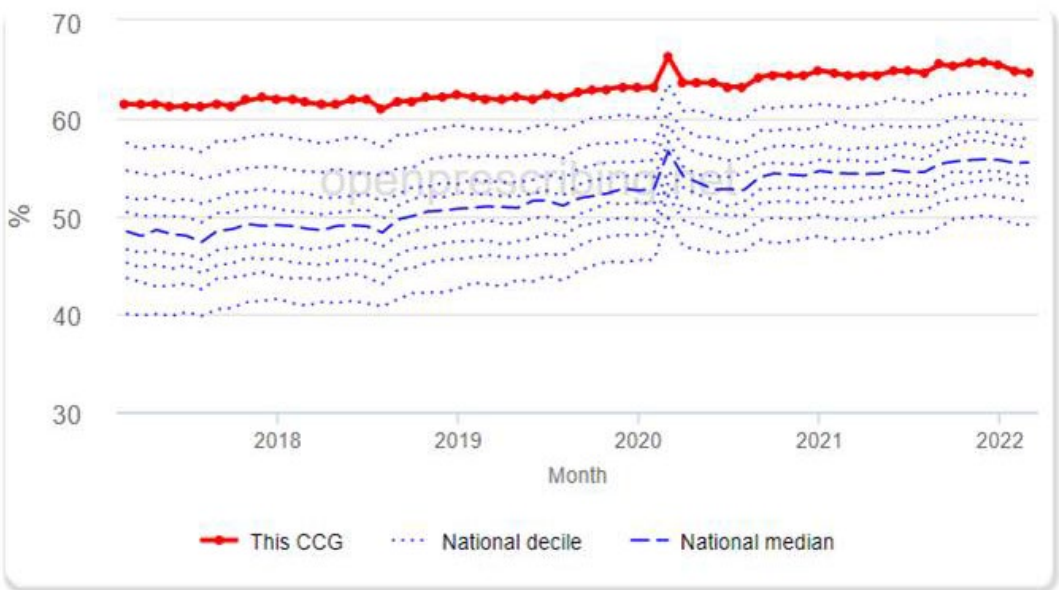


Figure 10 – MDIs prescribed as a proportion of all inhalers in BNF Chapter 3, excluding salbutamol

Taking all inhalers together, the inhaler carbon emissions for Derbyshire from April to June 2021 were 6,429,419 KgCO2e. The latest figures from PrescQIPP (December 2021 to February 2022) show that this has reduced to 4,881,953 KgCO2e, a reduction of some 24%. However, it should be noted that this latter time period covers Christmas and New Year, which may have a significant effect on prescribing patterns.

Sustainability and the impact of Covid-19

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

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

ACCOUNTABILITY REPORT

Dr Chris Clayton

Accountable Officer

NHS Derby and Derbyshire CCG

10 June 2022

Accountability Report Overview

The Accountability Report describes how we meet key accountability requirements and embody best practice to comply with corporate governance norms and regulations. It comprises three sections:

Corporate Governance Report

The Corporate Governance Report sets out how we have governed the organisation during 2021/22, including membership and organisation of our governance structures and how they supported the achievement of our objectives.

Remuneration and Staff Report

The Remuneration and Staff Report describes our remuneration polices for executive and non-executive directors, including salary and pension liability information. It also provides further information on our workforce, remuneration and staff policies.

Parliamentary Accountability and Audit Report

The Parliamentary Accountability and Audit Report brings together key information to support accountability, including a summary of fees and charges, remote contingent liabilities, and an audit report and certificate.

Corporate Governance Report

Members Report

Member Practices

The CCG is comprised of 112 member General Practices and a further 56 branch surgeries, which are detailed in Table 18 below:

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

Main Practice	Branch Surgery
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
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	Hathersage 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

Main Practice	Branch Surgery
Lister House Surgery	Oakwood Medical Centre
Littlewick Medical Centre	The Dales Medical Centre
Macklin Street Surgery	Park Farm Surgery
Mickleover Medical Centre	–
Mickleover Surgery	–
Moir Medical Centre	Sawley Surgery Draycott Surgery
Newbold Surgery	–
Newhall Surgery	–
North Wingfield Medical Centre	–
Oakhill Medical Practice	–
Old Station Surgery	Cotmanhey Surgery Kirk Hallam Surgery
Osmaston Surgery	–
Overdale Medical Practice	Breaston Surgery
Park Farm Medical Centre	Vernon Street Surgery
Park Lane Surgery	–
Park Medical Practice	Borrowash Surgery University Surgery Oakwood Surgery
Park Surgery	–
Park View Medical Centre	–
Parkfields Surgery	–
Parkside Surgery	–
Peak and Dales Medical Partnership	Tideswell Surgery
Peartree Medical Centre	–
Ripley Medical Centre (DCHSFT partnership)	–
Riversdale	–
Royal Primary Care	Rectory Road Medical Centre Inkersall Family Health Centre
Sett Valley Medical Centre	The Old Bank Surgery, Market Street
Shires Healthcare	Shires Healthcare, Bishops Walk
Somercotes Medical Centre	–
Springs Health Centre	–
St. Lawrence Road Surgery	–
St. Thomas Road Surgery	–
Staffa Health	Stonebroom Surgery Pilsley Surgery Holmewood Surgery

Main Practice	Branch Surgery
Stewart Medical Centre	–
Stubley Medical Centre	–
Swadlincote Surgery	–
The Surgery at Wheatbridge	–
The Valleys Medical Partnership	Moss Valley Medical Practice
Thornbrook Surgery	Chinley Surgery
Vernon Street Medical Centre	The Lane Medical Centre
Village Surgery, Alfreton	–
Village Surgery, Derby	–
Welbeck Road Surgery	Glapwell Surgery
Wellbrook Medical Centre	–
West Hallam Medical Centre	–
Whitemoor Medical Centre	–
Whittington Moor Surgery	–
Willington Surgery	–
Wilson Street Surgery	Taddington Road Surgery
Wingerworth Medical Centre	–
Woodville Surgery	–

Table 18 – list of CCG General Practices

Composition of Governing Body

The Governing Body members for the CCG are shown in Table 19 below.

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

Table 19 – members of the CCG's Governing Body in 2021/22

Audit Committee

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

Full details of other sub-committees can be found in the Governance Statement on page 107.

Audit Committee Membership

The membership of the Audit Committee of the CCG is shown in Table 20 below.

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

Table 20 – members of the CCG's Audit Committee in 2021/22

Register of Interests

The CCG holds a register of interests for all individuals who are engaged by the CCG. The registers are viewable here[18] and available on request at the CCG Headquarters.

Personal Data Related Incidents

There have been no Information Governance incident during 2021/22 that met the criteria for reporting through the Data Protection and Security Toolkit to the Information Commissioner's Office.

Statement of Disclosure to Auditors

Each individual who is a member of the CCG at the time the Members' Report is approved confirms:

- so far as the member is aware, there is no relevant audit information of which the CCG's auditor is unaware that would be relevant for the purposes of their audit report; and
- the member has taken all the steps that they ought to have taken in order to make him or herself aware of any relevant audit information and to establish that the CCG's auditor is aware of it.

Modern Slavery Act

NHS Derby and Derbyshire CCG fully supports the Government's objectives to eradicate modern slavery and human trafficking. Our Slavery and Human Trafficking Statement for the financial year ending on the 31st March 2022 is published on our website at https://www.derbyandderbyshireccg.nhs.uk/.

[18] https://www.derbyandderbyshireccg.nhs.uk/about-us/conflict-of-interest/

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

10 June 2022

Governance Statement

Introduction and Context

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

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

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

The CCG brings together local General Practices (General Practitioners) and other healthcare professionals to commission hospital and community NHS services for Derbyshire, comprising of 112 member General Practices with a registered population of around 1,075,000.

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

The CCG has a revenue income of circa £7.1m for 2021/22 and has a workforce of around 502 employees.

Scope of Responsibility

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

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

Governance Arrangements and Effectiveness

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

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

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

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

Corporate Governance Framework

The Corporate 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 December 2021.

Governing Body

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

The Governing Body was appointed in accordance with section 14L of the National Health Service Act 2006 (as amended). The appointment process for Governing Body members varies according to the role they undertake and the appointment process specific to each role is therefore specified in detail within Appendix 3 (Standing Orders) to the Constitution. The CCG has therefore necessarily had to depart from sections B2 and B3 of the Code in that it is not in a position to have a Nomination Committee as set out in the Code. The Governing Body is supported by a Head of Governance and its composition is described in Table 21 below, each with a single non-transferable vote unless detailed otherwise.

Governing Body Member	Position
Voting	
Dr Avi Bhatia	Clinical Chair
Martin Whittle	Lay Member for Patient and Public Involvement and Vice Governing Body Chair
Dr Chris Clayton	Chief Executive Officer
Richard Chapman	Chief Finance Officer
Brigid Stacey	Chief Nurse Officer
Dr Steven Lloyd	Executive Medical Director
Helen Dillistone	Executive Director of Corporate Strategy and Delivery
Zara Jones	Executive Director of Commissioning Operations

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

Table 21 – members of the CCG's Governing Body in 2021/22

Since January 2021, the Governing Body has been operating at business continuity level four as a result of the Covid-19 pandemic. The Governing Body agreed the quorum necessary for the transaction of business during business continuity level four escalation as:

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

The Governing Body met in public and confidentially 12 times during the year. They also met twice extraordinarily. All meetings in 2021/22 were fully quorate.

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

Governing Body Performance

The Governing Body has continued to meet on a virtual basis via Microsoft Teams each month throughout 2021/22, both in public and confidentially. From the 1st April 2021, the Governing Body meeting in public has been livestreamed to the public every month.

On the 6th May 2021, the Governing Body reviewed and agreed the 2021/22 CCG strategic objectives. The strategic objectives and strategic risks are managed through the Governing Body Assurance Framework (GBAF) to support the delivery and management of organisational risk. The final 2021/22 strategic objectives are reflective of our final year of operation as a CCG and recognise the transition into the ICS. These can be found here[19].

Three Development Sessions took place during the early part of the year in April, May and July These focused specifically on the development of the ICS, with an emphasis on:

- the key features of the White Paper;
- the CCG Governance to manage the transition;
- CCG functions mapping work;
- Strategic Intent development; and
- ICS guidance.

During the year, the Governing Body established two specific groups to oversee the ICB transition, a System JUCD Transition Assurance Sub-Committee (STAC) and a CCG ICS Transition Working Group (TWG).

The first meeting of the STAC, chaired by the CCG's Clinical Chair, took place on the 29th April 2021 and has met monthly throughout 2021/22. The primary purpose of the STAC is to provide expertise and assistance to support the JUCD Board in providing the oversight of the transition of the current system into a statutory ICS. The STAC oversees the iterative process and is influenced by emerging national guidance. The STAC is a time-limited sub-committee to oversee the safe and legal transition process during 2021/22, after which it is envisaged to be stood down or replaced with another governance group.

The inaugural meeting of the TWG was held on the 6th May 2021 and the group meets monthly following the CCG Governing Body meetings. TWG is also chaired by the CCG's Clinical Chair and attended by members of the Governing Body and CCG Officers. The group is accountable to the Governing Body and provides updates to and receives assurance from the CCG Transition Project Group, which ensure the delivery of the transition actions required. The TWG was established to oversee the transition plan to:

- facilitate the movement from the CCG's existing arrangements to the transfer of functions to the Derbyshire ICS;
- implement the engagement plan to ensure that the Governing Body, membership, staff and the public are appropriately informed of the process to implement the new arrangements;
- provide assurance that the transfer and closure of CCG functions meets with legislative requirements to support the new ICB Constitution; and
- provide assurance of the safe and legal transfer of staff to appropriate roles within the ICS.

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

The group reviewed its Terms of Reference and the governance of this programme of work, including the agreement that a standing item be included on Governing Body agendas for reporting progress. A detailed action plan was produced which incorporated both system and CCG-level actions. The group also reviewed progress on the current thinking around mapping the future locations of the CCG's commissioning functions.

As a result in the national delay to the establishment of the ICB to the 1st July 2022, Governing Body members have been asked to extend their contracts to the 30th June 2022. The Governing Body will continue to meet monthly until the planned demise of the organisation on the 30th June 2022.

Corporate Committees of the Governing Body

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

The governance structure of the CCG comprises:

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

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

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

Audit Committee

The Audit Committee is constituted in line with the provisions of the NHS Audit Committee Handbook and the 'Towards Excellence' guidance. It has overseen internal and external audit plans and the risk management and internal control processes (financial and quality), including control processes around counter fraud.

The duties of the Audit Committee are driven by the priorities identified by the CCG, and the associated risks. It operates to a programme of business, agreed by the CCG, which is flexible to new and emerging priorities and risks. The Audit Committee also monitors the integrity of the financial statements of the CCG and any other formal reporting relating to the CCG's financial performance.

Audit Committee Membership

The composition of the Audit Committee is shown in Table 22 below.

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

Table 22 – members of the CCG's Audit Committee in 2021/22

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 2021/22 are shown in Table 23 below.

Significant items approved/discussed by Audit Committee 2021/22	
Governance, Risk Management and Internal Control	
Accounting policies	Finance staff journal limits
Aged debt report	Financial transition project
Annual Governance Statement	Freedom to speak up report
Annual Report and Accounts 2020/21	Governing Body Assurance Framework
Audit Committee Annual Report 2020/21	IFRS16 updates
Audit Committee self-assessment	Losses and special payments
CCG closedown – draft due diligence checklist	National Audit Office Guide on Climate Change risk assessment
Committee meeting business log	Risk register exception reports
Conflicts of interest	Single tender waivers
Contracts oversight project	Write off reports
Direct award of NHS Standard Contracts for existing spot purchase placements	

Significant items approved/discussed by Audit Committee 2021/22	
Internal Audit	
Conflicts of interest	ICS transitional financial arrangements
Continuing Healthcare	JUCD decision-making
Data security standards	Progress reports
Head of Internal Audit Opinion	Primary Medical Care arrangements
Integrity of the general ledger and financial reporting	
External Audit	
KPMG External Audit Plan 2021/22	KPMG year-end report 2020/21 – ISA260
KPMG technical report	Value for money risk assessment
Counter Fraud	
Counter Fraud progress reports	Counter Fraud 2020/21 Annual Report

Table 23 – significant items approved/discussed by Audit Committee in 2021/22

A benchmark of one meeting per quarter at appropriate times in the reporting and audit cycle is suggested. The Committee met seven times in 2021/22 and also met five times confidentially.

All meetings in 2021/22 were fully quorate. The quorum necessary for the transaction of business is two members.

Primary Care Commissioning Committee

The role of the Primary Care Commissioning Committee is to carry out the functions relating to the commissioning of primary medical services under section 83 of the NHS Act 2006 (as amended). This enables the members, as detailed in Table 24 below, to make collective decisions on the review, planning and procurement of Primary Care services in the CCG, under delegated authority from NHSE&I. The functions of the Committee are undertaken in the context of a desire to promote increased co-commissioning to increase quality, efficiency, productivity and value for money and to remove administrative barriers.

Primary Care Commissioning Committee Membership

Primary Care Commissioning Committee Member	Position
Professor Ian Shaw	Chair – Lay Member for Primary Care Commissioning
Simon McCandlish	Deputy Chair – Lay Member for Patient and Public Involvement
Jill Dentith	Lay Member for Governance and Freedom to Speak Up Guardian
Richard Chapman	Chief Finance Officer
Brigid Stacey	Chief Nurse Officer
Dr Steven Lloyd	Executive Medical Director

Table 24 – members of the CCG's Primary Care Commissioning Committee in 2021/22

Significant items that were discussed and approved during 2021/22 are shown in Table 25 below.

Significant items approved/discussed by Primary Care Commissioning Committee 2021/22	
360 independent review findings	Pharmacy, optometry and dentistry
2022/23 contracting arrangements	Primary Care Commissioning Committee Annual Report 2021/22
Annual flu report	Primary Care Estates Steering Group highlight reports
Care Quality Commission inspection updates	Primary Care Estates Strategy
Contract extensions	Primary medical services contract variations
Covid-19 Vaccination Programme	Primary Care Networks
Derbyshire Shared Care Record	Provision of General Practice services – Christmas 2021
Digital/cyber resilience report	Quality and performance review visits
Feasibility studies	Quarterly Primary Care quality and performance public assurance
Finance updates	Recovery and Restoration Programme
Flexible staffing pools	Risk register reports
General Practice contracts and variations	S106 process
General Practice boundary amendments, mergers and closures	SinFin project
General Practice Contracts	Specialist Allocation Service
General Practice project initiation documentation	Summary of General Practice contracts
Health needs assessments for asylum seekers in contingency accommodation	Team Up Derbyshire
Minor surgery	Winter access
National Access Plan for Improving Access for Patients and Supporting General Practice	

Table 25 – significant items approved/discussed by Primary Care Commissioning Committee in 2021/22

The Committee met a total of 12 times during 2021/22 and all meetings were quorate. They also met 12 times confidentially. The quorum necessary for the transaction of business is four members, at least two of whom are Lay Members and include the Chair or Deputy Chair.

Remuneration Committee

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

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

The Governing Body has delegated specific functions and responsibilities, in relation to remuneration, as specified in the Terms of Reference and the CCG'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 are the only members of the Remuneration Committee, their own remuneration is set directly by the Governing Body. The Lay Members who are conflicted are not part of the decision-making.

Remuneration Committee Membership

The composition of the Remuneration Committee is shown in Table 26 below.

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

Table 26 – members of the CCG's Remuneration Committee in 2021/22

Significant items that were discussed and approved during 2021/22 are shown in Table 27 below.

Significant items approved/discussed by Remuneration Committee 2021/22	
Executive Director pay review process	CEO deputising arrangements
Functional Director pay progression	VSM pay awards
Running cost position	Annual pay increase for VSMs
Salary recommendations	

Table 27 – significant items approved/discussed by Remuneration Committee in 2021/22

The Committee meets as required but as a minimum annually. The Committee met five times during 2021/22. The quorum necessary for the transaction of business is two of the four members of the Remuneration Committee. The meetings were fully quorate and in accordance with its Terms of Reference.

Clinical and Lay Commissioning Committee

The purpose of the Clinical and Lay Commissioning Committee is to provide a clinical forum within which discussions can take place; recommendations are made on the clinical direction of the CCG; and it helps secure the continuous improvement of the quality of services. The membership detailed below in Table 28 has delegated authority to make financial recommendations as set out in the Standing Financial Instructions on disinvestment/ de-commissioning decisions.

Clinical and Lay Commissioning Committee Membership

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

Table 28 – members of the CCG's Clinical and Lay Commissioning Committee in 2021/22

Significant items that were discussed and approved during 2021/22 are detailed below in Table 29.

Significant items approved/discussed by Clinical and Lay Commissioning Committee 2021/22	
2021/22 Operational Plan	Learning disabilities and autism
2022/23 contracting	Mental health engagement
Acute front door redesign	Mental health in-patient services
Adult attention deficit hyperactivity disorder choice referral guidance	Mental health support teams in schools: children's wellbeing practitioners
Adult sexual abuse therapy services	MSK
Ambulatory wound care	ONS nutrition review and education project
Better Care Fund Guidance	Ophthalmology

Significant items approved/discussed by Clinical and Lay Commissioning Committee 2021/22	
Children and young persons' mental health	Orthotics
Children and Young Persons' Digital Mental Health Service	Parenteral methotrexate
Clinical policies	Podiatry Commissioning Plan
Commissioning Intentions	Procurements
Committee Annual Report 2020/21	Psychiatric intensive care unit
Community vasectomy commissioning	Pulmonary rehabilitation
Contract awards, uplifts, extensions and renewals	Reconfiguration of services
Continuing Healthcare	Risk register
County home care capacity	Section 75 arrangements
Derby City Community Mental Health Framework	Severe mental illness
Domiciliary care services	Social and repeat prescribing
East Midlands familial hypercholesterolemia service	Spirometry provision
End of Life Strategy and Commissioning Intentions	System Delivery Board procurement recommendations
Improving access to psychological therapies	Team Up Derbyshire
In vitro fertilisation	UHDBFT Rheumatology Biologics Pharmacist
Interim beds and surge demand	Voluntary community and social enterprise

Table 29 – significant items approved/discussed by Clinical and Lay Commissioning Committee in 2021/22

The Committee met a total of 12 times during 2021/22. 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 2021/22 were fully quorate.

Engagement Committee

The Engagement Committee meets with the purpose of assuring the Governing Body that the CCG is involving patients in its decisions about health services and that robust processes are in place to ensure that the CCG is fully compliant with their statutory obligations. Members are detailed in Table 30 and include representatives from the Governing Body, public representatives from communities, Foundation Trust Governors, Healthwatch and the voluntary sector. Staff from the CCG are invited to attend the Engagement Committee to update on the programme or scheme that they are working on, including an update on the communications and engagement strategy in place for that specific piece of work. This approach provides oversight and facilitates confirm and challenge opportunities for the Engagement Committee.

Engagement Committee Membership

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

Table 30 – members of the CCG's Engagement Committee in 2021/22

Significant items that were discussed and approved during 2021/22 are detailed below in Table 31.

Significant items approved/discussed by Engagement Committee 2021/22	
Accessible services for deaf people	London Road Wards 1 and 2
Committee Annual Report 2020/21	Newholme Hospital
Communications and engagement performance reporting schedule	Older people's mental health
Dormitory Eradication Programme	Place engagement approach
Engagement on patient reluctance to access services	Pregnancy and Covid-19
Equality Delivery System	Primary Care access insight
Florence Shipley Community Hospital	Risk report
Glossop workstream	Section 14Z2 Log
Governing Body Assurance Framework	Sinfin Health Centre
General Practice and Urgent Care access insight	St. Thomas Road Surgery
ICS Communications and Engagement Plan	System pressures
ICS governance requirements and future committees	Urgent Treatment Centres
ICS Transition	Vaccination Programme
Integration index	Waiting time stratification
JUCD Communications and Engagement Strategy	Winter Communications and Engagement Plan

Table 31 – significant items approved/discussed by Engagement Committee in 2021/22

The Committee met a total of nine times during 2021/22. 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 2021/22 were quorate.

Finance Committee

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

Finance Committee Membership

The composition of the Finance Committee is detailed in Table 32 below.

Finance Committee Member	Position
Andrew Middleton	Chair – Lay Member for Finance and Sustainability Champion
Martin Whittle	Deputy Chair – Lay Member for Patient and Public Involvement and Vice Governing Body Chair
Ian Gibbard	Lay Member for Audit and Conflicts of Interest Guardian
Dr Ruth Cooper	Governing Body GP
Dr Bukhtawar Dhadda	Governing Body GP
Richard Chapman	Chief Finance Officer
Brigid Stacey	Chief Nurse Officer

Table 32 – members of the CCG's Finance Committee in 2021/22

Significant items that were discussed and approved during 2021/22 are detailed in Table 33.

Significant items approved/discussed by Finance Committee 2021/22	
2022/23 Financial Planning	Finance Committee Self-Assessment
Business as Usual Capital Finance Plan	Governing Body Assurance Framework
Budget Virement	Integrated Single Financial Environment Metrics
Care Home AQP Tariff Uplift	Local Estates Strategy
CHC Domiciliary Home Care (Adult Care) Fees 2021/22	Medium-Term Financial Plan
Committee Meeting Log	Mental Health Deep Dive
Continuing Healthcare	Monthly reports
Corporate Contract Extensions	Operational Planning 2021/22
Credit Card Policy	Policies and Procedures
Derby City Community Mental Health Framework	Prescribing
Draft ICB Functions and Decision Map	Process to Develop a Framework for non-NHS Contracts
Draft ICB Scheme of Delegation and Reservation	Risk Register
Executive Revenue Budget Approvals	S117 Deep Dive
Finance Committee Annual Report 2020/21	System Finance and Estates Committee Updates

Table 33 – significant items approved/discussed by Finance Committee in 2021/22

The Committee met a total of 12 times during 2021/22. The quorum necessary for the transaction of business is five members, to include one Executive Lead (Chief Finance Officer); at least one Clinical Representative and at least two Governing Body Lay Members. All meetings were quorate for 2021/22.

During 2021/22 the Finance Committee progressively increased its focus on preparing for the CCG's transition to an ICS for Derby and Derbyshire. This is being achieved through:

- focus by the Senior Finance Team on ensuring financial systems and Derbyshire system relationships are well developed for the new organisation from the 1st July 2022;
- the Chief Finance Officer and Chair of the Finance Committee have attended throughout the year the System Finance and Estates Committee. This attendance has reinforced positive relationships and mutual understanding;
- between January–March 2022, the CCG Finance Committee and System Finance and Estates Committee have met as a joint meeting and will continue to do so until the end of June 2022;
- initiatives by the CCG Chief Finance Officer have led to the creation of the following system-wide developments, each of direct relevance to current and future financial activities in Derbyshire. These are:
    - creation of a central data and business intelligence unit;
    - re-establishment of a system efficiencies unit; and
    - development of a mechanism for analysing comparative value of healthcare investments,

    these initiatives are essential preparatory steps for the future ICB board and finance committee to manage ever-increasing service demand within finite resource allocations;
- CCG Finance and Governance Officers have been working with officers from NHS Tameside and Glossop CCG to ensure the smooth transfer of responsibility for the Glossop area population into the Derbyshire system from the 1st July 2022.

The CCG's Finance Team has always pursued the highest standards in its financial transactions. An example of this is consistent payment of suppliers within agreed timescales, which was achieved for almost 100% of payments throughout the year. Another performance indicator is an independent judgement against Integrated Single Financial Environment metrics, an NHS Shared Business Services range of comparator measures of financial business transactions. In February 2022, the CCG was ranked fourth out of 109 CCGs. These outstanding performances bode well for continuation of such financial rigour in the ICS.

Governance Committee

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

Governance Committee Membership

The composition of the Governance Committee is detailed in Table 34 below.

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

Table 34 – members of the CCG's Governance Committee in 2021/22

Significant items that were discussed and approved during 2021/22 are detailed in Table 35.

Significant items approved/discussed by Governance Committee 2021/22	
Apprenticeship Scheme	ICB Constitution Update
Approval of Corporate and HR Policies and Procedures	Information Governance and GDPR
Business Continuity, Emergency Planning, Resilience and Response	Local Security – Violence Reduction Standards
CCG Recovery and Restoration	Mandatory Training
Consideration of Staff Recognition	Non-Clinical Adverse Incidents
Cyber Security	Procurement Decisions in ICS Transition
Contracts Oversight Report	Procurement Highlight Reports
Digital Development	Quarterly and Annual Complaint Reports
EPRR Core Standards Self-Assessment Submission for 2020/21	Quarterly Freedom of Information Reports
Estates Updates	Reprocurements
Gender Pay Gap Report	Risk Register
Governance Committee Annual Report 2020/21	Staff Survey Results and Action Plan
Governing Body Assurance Framework	Violence Prevention and Reduction Standards

Significant items approved/discussed by Governance Committee 2021/22	
Health and Safety	Workforce Disability Equality Standard Action Plan
HR Performance Report	Workforce Race Equality Standard
Hyper Acute Stroke Unit	Workforce Review

Table 35 – significant items approved/discussed by Governance Committee in 2021/22

The Committee met a total of five times during 2021/22. The Committee also met once extraordinarily to discuss the implementation of the 'Working Differently Model'. The quorum necessary for the transaction of business is four members, to include two Governing Body Lay Members, one clinician and the Executive Lead (or nominated deputy). All meetings in 2021/22 were quorate.

Quality and Performance Committee

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

Quality and Performance Committee Membership

The composition of the Quality and Performance Committee is detailed in Table 36 below.

Quality and Performance Committee Member	Position
Dr Bukhtawar Dhadda	Chair – Governing Body GP
Andrew Middleton	Deputy Chair – Lay Member for Finance and Sustainability Champion
Dr Emma Pizzey	Governing Body GP
Dr Greg Strachan	Governing Body GP
Dr Merryl Watkins	Governing Body GP
Simon McCandlish	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
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 2021/22

Significant items that were discussed and approved during 2021/22 are detailed in Table 37.

Significant items approved/discussed by Quality and Performance Committee 2021/22	
Breast Pain Pathway	LeDeR 2020/21 Annual Report
Business Cases	Maternity Services in Derbyshire
Cancer Deep Dive	Medicines Management
Care Homes	Mental Health Pathway Deep Dive
Care Quality Commission Reports	Patient Safety
Children and Young People	Provider Collaborative Review Learning Disability & Autism
Continuing Healthcare	Quality Accounts Statements
Controlled Drugs Annual Report	Quality and Performance Committee Annual Report 2020/21
EMAS Quarterly Report	Risk Register
End of Life Care Project	Risk Stratification
Feedback from visits to UHDBFT and CRHFT Emergency Departments	Safeguarding Children and Adults
Governing Body Assurance Framework	Special Educational Needs and Disability
Infection, Prevention and Control	Stroke Services
Integrated Quality & Performance Report	Transforming Care Partnership
JUCD QEIA	Transforming Care Programme Annual Report

Table 37 – significant items approved/discussed by Quality and Performance Committee in 2021/22

The Committee met a total of 12 times during 2021/22. 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 2021/22 were quorate.

UK Corporate Governance Code

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

The Governance Statement is intended to demonstrate how the CCG has regard to the principles set out in the Code considered appropriate for CCGs for the financial year ended the 31st March 2022.

For the financial year ended the 31st March 2022, and up to the date of signing this statement, the CCG had regard to the provisions set out in the Code. All aspects that NHS Derby and Derbyshire CCG must reference within this statement are fully compliant.

Discharge of Statutory Functions

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

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

Risk Management Arrangements and Effectiveness

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

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

This integrated risk management system includes a risk management framework (strategy and procedural documents), Governing Body Assurance Framework, and the Corporate Risk Register. It enables the organisation to have a clear view of the risks and issues affecting each area of its activity; how those risks are being mitigated, the likelihood of occurrence and their potential impact on the successful achievement of the CCG objectives.

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

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

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

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

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

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

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

Stakeholder involvement in managing risks

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

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

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

Prevention and deterrence of risk

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

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

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

Each year the CCG is required to complete an annual self-assessment against the EPRR National Core Standards and submit to NHSE&I. In 2021/22 the CCG submitted a ‘substantial’ self-assessment. The CCG submitted a letter of assurance on the above process to NHSE&I on behalf of the CCG and Derbyshire providers, which was also confirmed by NHSE&I as 'substantial' assurance.

Capacity to Handle Risk

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

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

Governing Body	Oversight and holding CCG management to account
Finance Committee	Development and implementation of risk management processes
Audit Committee	Reviewing the effectiveness of the GBAF and risk management systems
Governance Committee	Ensuring that the CCG complies with the principles of good governance whilst effectively delivering the statutory functions of the CCG
Accountable Officer	Ensuring the CCG has an effective risk management system in place for meeting all statutory requirements
Executive Team	Supporting the Accountable Officer and collectively and individually managing risk

Executive Director of Corporate Strategy and Delivery	Ensuring the delivery of risk management
Risk Group	Reviewing, monitoring and managing the risks on the CCG's Risk Register, and ensuring the risk management process is firmly embedded within the organisation. The group supports the Committees' understanding and parity in relation to risk, enabling them to provide assurance to Governing Body
Head of Governance	Development, implementation and maintenance of the risk management arrangements for the CCG
All Staff	Identifying, reporting and managing risks within their areas

The GBAF was presented quarterly to the Governing Body, Audit Committee and relevant lead committees during 2021/22 for scrutiny and assurance. The Governing Body approved the 2021/22 opening GBAF on the 1st July 2021.

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

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

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

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

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

Risk Assessment

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

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

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

The Operational Risk Register is reviewed, updated and reported to the Corporate Committees and Governing Body on a monthly basis.

Significant risks identified during 2021/22

In context, the most significant risks we faced during 2021/22 were:

- failure to meet the CCG's Constitutional standards and quality statutory duties in regard to Accident and Emergency;
- transforming care plans are unable to maintain and sustain the performance, pace and change required to meet national Transforming Care Plan requirements;
- failure of General Practices across Derbyshire results in failure to deliver quality Primary Care services, resulting in negative impact on patient care;
- patients deferring seeking medical advice for non-Covid-19 issues due to the belief that Covid-19 takes precedence. This may impact on health issues outside of Covid-19, LTCs, cancer patients etc.;
- risk of the Derbyshire health system being unable to manage demand, reduce costs and deliver sufficient savings to enable the CCG to move to a sustainable financial position;
- risk to patients on waiting lists as a result of their delays to treatment as a direct consequence of the Covid-19 pandemic. Provider waiting lists have increased in size and it is likely that it will take significant time to fully recover the position against these; and
- sustainable digital performance for the CCG and General Practice owing to the threat of a cyber-attack, network outages and the impact of migration of NHS Mail onto the national shared tenancy.

Other Anticipated risks for 2022/23

- Failure to meet statutory financial duties in 2022/23.
- The CCG does not have adequate arrangements in place to achieve financial sustainability in the medium term; due to the current underlying deficit at both the CCG and ICS-level, as well as uncertainty surrounding future funding arrangements.
- Impact of removal of restrictions and living with Covid-19.

Sources of Assurance

Internal Control Framework

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

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

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

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

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

Annual Audit of Conflicts of Interest Management

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

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

To further strengthen the scrutiny and transparency of the decision-making processes, the Lay Member for Audit is the CCG's Conflicts of Interest Guardian. The Conflicts of Interest Guardian provides support and advice to CCG employees, General 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 General Practice staff with CCG involvement; all of which can be found here[20].

The CCG also requests declarations from all staff and sub-committee members. These declarations are provided at CCG meetings in the form of a register to enable the decision-making processes to be transparent and managed effectively. Conflicts can also arise in the form of Gifts and Hospitality, and within the commissioning cycle from contracts and procurements. CCG employees are all requested to declare these when they arise and details of those declared within 2021/22 can also be found at the web link above.

The revised statutory guidance on managing conflicts of interest for CCG's (published June 2017) requires CCGs to undertake an annual internal audit of conflicts of interest management. To support CCGs to undertake this task, NHSE&I published a template audit framework. 360 Assurance carried out an audit of the CCG's management of conflicts of interest in September 2021. The objective of the audit was to evaluate the design of the arrangements that the CCG has in place to manage conflicts of interest and gifts and hospitality, and to ensure this complies with NHSE&I's guidance on managing conflicts of interest. The assurance opinion for this audit was 'substantial assurance'.

In previous years, the CCG was required to produce a quarterly return to NHSE&I. This was approved by the Accountable Officer and Conflicts of Interest Guardian; and included a self-assessment on the management of Declarations of Interests, Gifts and Hospitality, Procurement and Breaches. On the 13th July 2021 the Chief Executive Officer was notified by NHSE&I that this would no longer be a requirement of the CCG.

All CCG staff were required to complete Managing Conflicts of Interest training in 2021/22, which is made up of three modules, with Module 1 being mandatory for all staff. By the 31st March 2022, 91% of staff had completed Module 1. This training is constructed by NHSE&I and NHS Clinical Commissioners.

[20] https://www.derbyandderbyshireccg.nhs.uk/about-us/conflict-of-interest/

Freedom to Speak Up Guardian

The CCG has a Raising Concerns at Work (Whistleblowing) Policy which supports employees in reporting genuine concerns about wrongdoing at work without any risk to themselves. The Freedom to Speak Up Guardian supports employees to speak up when they feel that they are unable to do so by any other means. The CCG's Lay Member for Governance is our Freedom to Speak Up Guardian, and they act as an independent and impartial source of advice to staff at any stage of raising a concern.

In October 2021, the CCG recruited three members of staff to become Freedom to Speak Up Ambassadors. The Freedom to Speak Up Ambassador's role is to support and advise CCG staff, usually when they are unable to resolve problems locally when raising concerns. This role does not replace the role of line managers or Human Resources (HR), but it does provide an avenue for speaking up where staff do not feel able to go to their line manager or HR. The Freedom to Speak Up Ambassadors work within the CCG to improve speaking up and to ensure that lessons are learnt and things are improved when workers do speak up.

The Raising Concerns at Work (Whistleblowing) Policy is the responsibility of the Governance Committee, and a Freedom to Speak Up Guardian report is presented at each Audit Committee meeting to update it of any concerns that have been raised. During 2021/22 the CCG has had five concerns raised through the freedom to speak up process. The CCG's whistleblowing arrangements act as a deterrent to unacceptable behaviour by encouraging openness and promoting transparency. It underpins the risk management systems and helps to protect the reputation of the CCG and senior management.

Data Quality

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

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

Information Governance

In order to provide assurance publicly that the CCG understands and complies with national requirements around confidentiality, integrity, and availability for data sources we hold, each year we complete a DSPT.

For 2021/22, the CCG is required to submit their DSPT on the 30th June 2022. In anticipation of this, an audit of the CCG's compliance has been completed, and the CCG was found to have 'significant' assurance of its compliance.

Part of the requirements of the DSPT is to have a public facing clear description of the data we hold, and how access to that data is controlled. Further detail about this for the CCG can be found at https://www.derbyandderbyshireccg.nhs.uk/privacy/.

CCG Information Governance policies have been reviewed in-year, and the understanding of our staff has been tested through an Information Governance Awareness questionnaire which provided a positive picture.

The governance and oversight of Information Governance activities has been continued in year through the Information Governance Assurance Forum. This forum is chaired by the Senior Information Risk Owner, and attended by the Caldicott Guardian and Data Protection Officer, reporting to the Governance Committee as part of the overall CCG Governance structure. Included in the forum's annual forward plan are reviews of DSPT compliance activities and policies, access to information, cyber security updates, Information Governance incidents, training and staff communications. The CCG has not had any incidents which have necessitated report to the Information Commissioner's Office.

The forum met seven times during 2021/22. From the Information Governance Assurance Forum's minutes and papers, there is evidence of challenge, appropriate reporting and action being taken where required.

Assurance has been provided within the meeting regarding compliance with requirements regarding information flow mapping, Caldicott activity, and Data Protection Officer involvement in all completed Data Protection Impact Assessments (Stage 2).

The annual DSPT audit was undertaken by 360 Assurance during February and March 2022, and the CCG received a 'significant' assurance opinion. The CCG expect to submit a 'standards met' DSPT submission for 2021/22.

Business Critical Models

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

Third party assurances

Table 38 shows the range of services which are provided by third party providers.

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

Table 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:

Quality and Performance - Mental Health and Dementia

Perinatal Access

JUCD was an early adopter of video technology to increase face to face contacts and mitigate some of the impact of the pandemic on performance. There was additional investment planned for community perinatal services in 2021/22, bringing the service up to the expected in-year spend in line with the Long-Term Plan. The team have embraced additional training for working with partners and spouses to broaden the service benefit. Additional recruitment has taken place and may well out-turn around the national target level in 2022/23.

Severe Mental Health and Physical Health

This target has been badly affected by the impact of Covid-19 on Primary Care. A physical health champion role was included in each locality as part of the Community Mental Health Framework developments and JUCD's 18 electrocardiogram machines are being utilised as part of the NHSX digital initiative around remote monitoring. We created a new initiative focused on health coaching and the provision of personal fitness trackers amongst defined cohorts of people with a SMI.

Activity begins in 2022/23 under-target and additional actions are in place to correct this include strengthening more links to the Community Mental Health Framework implementation. The use of an additional £270k fair shares funding will go towards increasing the vaccination outreach pilot, whilst also utilising 'making every contract count', risk stratification using QRISK scoring, and creating SMI peer support networks in VCSE (part of the Community Mental Health Framework).

Out of Area Placements

At month 12 Derbyshire continued to be non-complaint with the requirement for no out-of-area acute mental health placements. Although significant progress was made in the plans described in month 9 and occupancy dropped, assisted further by a series of MADE events, out-of-area bed use came within the target of zero. Unfortunately, the new wave of omicron and the Ukraine war seem to have had an effect nationally on mental health admissions, especially for males, and this target has slipped slightly at month 12. New PICU contracts have been agreed for 2022/23 and a full business case is in development for the establishment of the Derbyshire PICU service from March 2024.

Transforming Care Performance

This remained over-target in all three domains and was subject to national escalation and involvement of the national team who understood the Derbyshire position and received assurances that the measures being taken were helpful. On 31st March 2022, there were 10 adults and two children and young people in beds over-trajectory. A new cohorting approach has been adopted by DHcFT to make clinical activity a priority.

Attention deficit hyperactivity disorder, and autism spectrum disorder assessments

This is an area of unprecedented and largely unfunded growth demand. Demand was beyond the capacity of all commissioned services and nationally waiting times were growing. There was an NHSE&I working group, which the CCG participated in, to look at solutions as well as the expectation that local services redesign is needed. The Derbyshire waiting list was around 4,000 people for neurodevelopment diagnostics. Covid-19 severely impacted productivity and helped fuel the online diagnostic provider boom being accessed through 'right to choose'. The neurodevelopment pathway is a workstream under the Mental Health System Delivery Board. Waiting well and triage initiatives are being looked at as well as the use of system development funding slippage to help create new approaches.

By March 2022, agreed funds from SDF slippage have been received to expand assessment capacity and embed online provisions as part of the pathway to help reduce the waiting lists, whilst the neurodevelopment pathway and assessment hubs and triage approaches into 2022/23 are reengineered.

Quality and Performance – Accident and Emergency

Derbyshire failed to deliver against the national 95% 4-hour standard for 2021/22 the standard was (70.8%). Underperformance for the CCG is attributed predominantly to underperformance at UHDBFT and CRHFT.

University Hospitals of Derby and Burton NHS Foundation Trust

The RDH ED failed to deliver against the four hour national standard for 78 consecutive months, with Type 1 performance deteriorating for March 2022 at 44.3%, as opposed to 69.5% in March 2020. A further deterioration was seen at the ED site/network, performance for March (including Minor Injury Units and Derby UTC) was 66.1%, compared to 78.5% in March 2020.

The physical configuration remained altered, with ED and assessment areas separated into red/green areas according to Covid-19 symptoms, to ensure infection control. This limits to space and therefore flexibility of patient flow, with waits for Covid-19 results, led to delays in transfers to the appropriate red/green assessment areas. In addition, there was an autumnal surge in paediatric patients presenting with respiratory syncytial virus symptoms, causing unprecedented pressure in the children's ED. A major capital programme expanded physical ED capacity into an adjoining area to provide more physical capacity and to improve patient flow while ensuring infection control.

In addition, the use of 'ready rooms' to create Covid-19-safe treatment areas and utilising the space more effectively improved patient flow. The opening of a co-located UTC at Derby has made a significant improvement; treating the patients who would otherwise have presented as 'minor' category patients at ED. The volume of these attendances increased by 301% but Type 1 at other UTCs and Derby UTC numbers still remained lower pre pandemic levels.

12-hour Trolley Breaches

From April 2021 to the end of March 2022 there was 987, 12-hour trolley breaches. Of these 987 breaches, 920 were due to limited availability of medical beds, mainly in the assessment units which were divided into red/green areas according to Covid-19 symptoms to ensure infection control. The remaining 67 were attributable to unavailability of a mental health bed.

Chesterfield Royal Hospital NHS Foundation Trust

CRHFT failed to deliver against the 4-hour national standard for three consecutive months, with Type 1 performance for March 2022 at 67.3.0%, a deterioration from their performance of 69.5% in March 2020. The physical configuration remained altered, with ED and assessment areas separated into red/green areas according to Covid-19 symptoms to ensure infection control. This limited space and therefore flexibility of patient flow, with waits for Covid-19 results leading to delays in transfers to the appropriate red/green assessment areas. In addition, a shortage of packages of care availability in the county delayed discharges and therefore patient flow through the hospital. CRHFT expanded the GP streaming service at the door, developing it into a co-located UTC. The physical footprint of the 'major's' area in ED was expanded to enable faster treatment of these patients and specific assessment areas expanded.

12-hour Trolley Breaches

From April 2021 to the end of March 2022 there were 16, 12-hour trolley breaches at CRHFT, 10 due to limited availability of medical beds and 6 due to the availability of mental health beds.

For both CRHFT and UHDBFT, the co-located UTCs were seeing the patients who would otherwise have presented as 'minor' category patients at ED and were classed as Type 1s. Combined Type 1 and co-located UTC activity numbers showed a 4% decrease in numbers at UHDBFT.

Quality and Performance – Diagnostics

Derbyshire failed to deliver against the national 1.0% standard during March 2022 (35.03% with a year-to-date figure of 33.45%). As last year, Covid-19 severely affected performance for all diagnostic tests, with limited capacity due to social distancing as well as an increase in referrals during the year. UHDBFT failed this standard for 25 months and CRHFT for 24 months. Work was undertaken through the rapid diagnostic project and mobile imaging/scans were used in an attempt to reduce the waiting lists. Finance was secured for a Community Diagnostic Centre and work was progressing in developing this, with equipment being ordered and expected to commence in the Spring of 2022.

Quality and Performance – Cancer and 62 Day Standard

Cancer

In line with the national picture, cancer 2WW demand increased during the year after the reduction during the Spring and Summer of 2020. The national increase in referrals was around 100–110%, across Derbyshire this number is slightly more, particularly at UHDBFT where the referral rate was around 130–135% of the 2019 figure during the year. Although UHDBFT and CRHFT were not meeting the standard, extra clinics were arranged, and the numbers of patients seen as a 2WW during the year exceeded the planned trajectories for the CCG and for both acute providers. Eight of the nine standards were non-compliant at Derbyshire-level in March 2022, with 31-day subsequent radiotherapy treatments being the only one compliant. Focus was given on reducing those patients who have been waiting longer than 62-days for their treatment and the backlog from this. CRHFT are currently at their proposed trajectory with UHDBFT showing excess numbers.

62-day Standard

The CCG failed this standard for 37 consecutive months, with UHDBFT not achieving for 47months and CRHFT for the last 32 months. It was not expected that this standard would be achieved within the remaining months of 2021/22, due to the increase in 2WW referrals which was causing delays at the beginning part of the pathway with patients in some specialties, particularly breast and gynaecology, not being seen until day 30. Although both CRHFT and UHDBFT struggled with this standard, once a patient is diagnosed, the majority of patients are seen within 31 days of their diagnosis with both achieving over 85% during March 2022. Cancer treatment has on the whole been protected during the pandemic although there have been some delays due to lack of Intensive Care Unit beds.

Quality and Performance ‑ Referral to Treatment/52-week waits

18-week Referral to Treatment

Incomplete pathways continued to be non-compliant for Derbyshire in March 2022 (62.3%), and both UHDBFT and CRHFT failed to meet the 92% standard (59.2% and 64.1% respectively). Those patients who had been prioritized at Priority 2 or Priority 3 received their surgery in a timelier manner but there was still a large number of patients waiting over 52 weeks.

During the year, GP urgent and routine referrals continued to be less than those received during 2019, although urgent referrals started to increase, routine referrals remained lower.

H2 Recovery Plans

Plans were submitted during November 2021 and trusts submitted plans up to the end of March 2022. At the end of March 2022, day case spells had reached 75.6% of activity, against a plan of 87.9% and elective spells had achieved 85.3% against a plan of 98.7%. It was not certain whether the omicron variant would affect the ability of CRHFT and UHDBFT to keep to the level of activity required to achieve targets, whether due to the number of Covid-19 admissions or workforce issues through sickness and isolation.

52+ week waits

At the end of March 2021 there were 8,261 patients waiting over 52 weeks for their surgery which was reduced to 5,269 at the end of March 2022. 4,014 of these patients were under the care or UHDBFT or CRHFT, with the remaining 1,255 waiting at various NHS Trusts around the country. The largest number of long waiters were under the care of general surgery, trauma, and orthopaedics. At the end of March 2022, UHDBFT had 5,090 patients over 52 weeks and CRHFT had 1,089 patients – this number had been reducing over the previous few months although the number of those waiting over 104 weeks was increasing. There were a number of bariatric patients who were very long waiters but were classed as Priority 4. Conversations took place with some independent sector providers to provide some support with surgery for these patients.

Quality and Performance – East Midlands Ambulance Services NHS Trust

During Q1 EMAS only achieved one of the six national quarterly performance standards, C1 90th centile. There was then a deterioration from Q2 onwards when they failed to deliver any of the national quarterly performance standards. Whilst in December 2021, they showed an improved position compared to November 2021 on four of the standards, the overall trend lines for all six standards continued to deteriorate.

During 2021/22 EMAS maintained the reduced percentage of patients conveyed to an ED and work continues to take place in each system to maintain this with a focus on access to alternative pathways and clinical advice. The deteriorating performance position was seen across the country, with all ambulance services operating at Resource Escalation Action Plan Level 4.

£55m of additional non-recurrent funding was made available across the ambulance sector in order to support improved performance. A performance improvement trajectory was developed using a set of assumptions along with an action plan detailing how the funding was to be used in order to facilitate an improvement in performance. EMAS failed to meet the performance trajectories set to date, whilst actual demand remained lower than the assumptions set, acuity remained much higher.

An extraordinary Clinical Quality Review Group meeting was held on the 16th December 2021, which focused on gaining assurance regarding the increase in delayed response to serious incidents. The Clinical Quality Review Group acknowledged that system measures were required to address all the contributory factors, and these were being addressed in local systems. The majority of serious incidents reported as 'delayed response' serious incidents did not identify any new learning for EMAS and there are actions in place to address system factors contributing to the serious incidents. EMAS has a comprehensive action plan which the Clinical Quality Review Group will continue to monitor.

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

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

The review of the effectiveness of the system of internal control is informed by the work of the internal auditors and the executive directors and clinical leads within the CCG who have responsibility for the development and maintenance of the internal control framework. The recommendations from external auditors in their annual audit letter and other reports are also taken into consideration.

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

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

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

Table 39 shows the CCG's running costs for the last two financial years and the plan for 2022/23.

	Allocation	Expenditure
	£'000	£'000
2019/20	23,431	17,864
2020/21	18,986	18,210
2021/22	19,824	19,824
2022/23	20,548	20,548

Table 39 – CCG's running costs for 2019/20, 2020/21, 2021/22 and plan for 2022/23

Table 40 identifies how the CCG's running costs were used in 2021/22.

Breakdown of 2021/22 expenditure	
Expenditure	**£'000**
Pay costs	13,811
Travel expenses	6
Premises costs	1,148
Charges from Commissioning Support Unit	1,208
Other non-pay costs	2,936
Commissioning income	-476

Table 40 – breakdown of 2021/22 expenditure

The CCG's end-of-year assessment process for 2021/22 will be simplified due to the continued impact of the Covid-19 pandemic and the change in priorities in response to this. A letter will be provided by NHSE&I which will give a narrative assessment of our CCG's performance. The latest assessment is from 2019/20, which rated the CCG as good.

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. During the period reported, the CCG amended these delegations as a result of the ongoing response to the pandemic; ensuring senior clinical staff could continue to prioritise the delivery of healthcare to its patients in relation to Covid-19.

The CCG has two external delegation chains:

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

Counter Fraud Arrangements

Effective from the 1st April 2021, the NHS Counter Fraud Authority implemented the Government Functional Standard 013: Counter Fraud within the NHS. During the year, the NHS Counter Fraud Authority have developed their requirements in relation to the Functional Standard and all NHS funded services are required to comply with this. Progress against the requirements of the Functional Standard is overseen by the CCG's Chief Finance Officer and Audit Committee.

The CCG's Chief Executive Officer and Chief Finance Officer are jointly responsible for ensuring adherence to the Functional Standard. The CCG is required to self-assess against the requirements of the Functional Standard annually by completing and submitting the CCG's Counter Fraud Functional Standard Return. This requires prior sign off by the CCG's Chief Finance Officer and the Audit Committee Chair. Further detail of the CCG's

submission can be found in the Counter Fraud Annual Report. The CCG aligns counter fraud, bribery and corruption work to the NHS Counter Fraud Authority's counter fraud, bribery and corruption strategy.

In May 2021, the CCG's Fraud, Bribery and Corruption Policy was reviewed by the CCG's Accredited Counter Fraud Specialist, approved by the Governance Committee, 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 Functional Standard.

Head of Internal Audit Opinion

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

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

During the year, Internal Audit, 360 Assurance completed the following audit assignments, as detailed below in Table 41.

Audit Assignment	Assurance Level/Comments
Contracting for Continuing Healthcare	Significant
Conflicts of Interest	Substantial (NHSE&I opinion level)
Primary Medical Care Services – Finance Arrangements	Full (NHSE&I opinion level)
Integrity of the General Ledger and Financial Reporting	Significant
Section 117, CHC and Prescribing Benchmarking	N/A
Data Protection Security Toolkit	Significant
ICB Transition Financial Arrangements	N/A
Financial Governance Decision Making During Covid-19 Pandemic	Significant
Future People Services Project Assurance	Draft report issued
JUCD Transformation and Efficiency Review	Final draft report issued
Personal Health Budgets	Fieldwork ongoing

Table 41 – Internal Audit reports issued in 2021/22 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 has been reviewed.

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

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

My review is also informed via assurances provided by:

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

Conclusion

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

Remuneration and Staff Report

Remuneration Report

Remuneration Committee

The CCG has an established Remuneration Committee. The committee makes recommendations on determinations about the remuneration, fees and other allowances for employees and for people/organisations providing services to the CCG. The Committee is chaired by a Lay Member. The composition of the Remuneration Committee is shown in Table 26 on page 115.

Policy on the remuneration of senior managers

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

Remuneration of Very Senior Managers (subject to audit)

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

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

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

Tables 42 and 43 show the Senior Manager total salary for 2021/22 and 2020/21.

Salaries and allowances 2021/22

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
Dr Avi Bhatia	Clinical Chair		95-100	0	0	0	0	95-100
Dr Chris Clayton	Chief Executive Officer		170-175	0	0	0	57.5-60	230-235
Richard Chapman	Chief Finance Officer		140-145	0	0	0	52.5-55	195-200
Brigid Stacey	Chief Nurse Officer		125-130	0	0	0	55-57.5	180-185
Dr Steven Lloyd	Executive Medical Director		115-120	0	0	0	52.5-55	165-170
Dr Penny Blackwell	GP Member		35-40	0	0	0	0	35-40
Dr Ruth Cooper	GP Member		35-40	0	0	0	0	35-40
Dr Bukhtawar Dhadda	GP Member		35-40	0	0	0	0	35-40
Dr Emma Pizzey	GP Member		35-40	0	0	0	0	35-40
Dr Greg Strachan	GP Member		35-40	0	0	0	0	35-40
Dr Merryl Watkins	GP Member		35-40	0	0	0	0	35-40
Jill Dentith	Lay Member for Governance		10-15	0	0	0	0	10-15
Ian Gibbard	Lay Member for Audit		15-20	0	0	0	0	15-20
Andrew Middleton	Lay Member for Finance		10-15	0	0	0	0	10-15

Name	Title	Notes	(a) Salary (bands of £5,000)	(b) Expense payments (taxable) total to nearest £100	(c) Performance pay and bonuses (bands of £5,000)	(d) Long term performance pay and bonuses (bands of £5,000)	(e) All pension-related benefits (bands of £2,500)	(f) TOTAL (a to e) (bands of £5,000)
			£000	£	£000	£000	£000	£000
Professor Ian Shaw	Lay Member for Primary Care Commissioning		10-15	0	0	0	0	10-15
Martin Whittle	Lay Member for Patient and Public Involvement and Vice GB Chair		20-25	0	0	0	0	15-20
Dr Bruce Braithwaite	Secondary Care Consultant		5-10	0	0	0	0	05-10
Helen Dillistone	Executive Director of Corporate Strategy and Delivery		120-125	0	0	0	57.5-60	180-185
Zara Jones	Executive Director of Commissioning Operations		125-130	0	0	0	62.5-65	185-190
Simon McCandlish	Lay Member for Patient and Public Involvement		10-15	0	0	0	0	10-15
Robyn Dewis	Derby City Council Representative		0	0	0	0	0	0
Dean Wallace	Derbyshire County Council Representative		0	0	0	0	0	0

Table 42 – Senior Manager remuneration for 2021/22

Notes to Salaries and Allowance - 2021/22

1. 'All Pension related benefits' shows the increase in 'lifetime' pension which has arisen in 2021/22. The sum reported reflects the amount by which the annual pension received on retirement age has increased in 2021/22, multiplied by 20 (the average number of years a pension is paid to members of the NHS scheme following retirement), plus the lump sum increase in 2021/22. 'All pension related benefits' exclude employee contributions as directed in the Finance Act 2004.
2. No payments were made to Local Authority Representatives nor were recharges made by their employers.
3. Where a salary amount sits exactly on a pay boundary then the salary is reported at the lower band. For example, if an employee had a salary of £50,000 they would be shown in the salary band (£'000) 45-50.
4. The total remuneration disclosed in the table above for Dr Bukhtawar Dhadda and Dr Penny Blackwell includes clinical advisory services provided to the CCG unrelated to their roles as senior managers.
5. Dr Chris Clayton's salary disclosed in the table above includes 10% additional remuneration for his role as the Integrated Care Board Chief Executive Officer.

Salaries and allowances 2020/21

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

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
Martin Whittle	Lay Member for Patient and Public Involvement and Vice Governing Body Chair		15-20	0	0	0	0	15-20
Bruce Braithwaite	Secondary Care Consultant		5-10	0	0	0	0	5-10
Simon McCandlish	Lay Member for Patient and Public Involvement		10-15	0	0	0	0	10-15
Robyn Dewis	Derby City Council Representative		0	0	0	0	0	0
Dean Wallace	Derbyshire County Council Representative		0	0	0	0	0	0

Table 43 – Senior Manager remuneration for 2020/21

Notes to Salaries and Allowance – 2020/21

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

Pension Benefits as at 31st March 2022

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 2021 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2021 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2020	Real Increase/ (Decrease) in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2021	Employers Contribution to Stakeholder Pension
		£000	£000	£000	£000	£000	£000	£000	£000
Chris Clayton	Chief Executive Officer	2.5-5	0-2.5	30-35	35-40	388	36	450	0
Richard Chapman	Chief Finance Officer	2.5-5	2.5-5	45-50	90-95	720	44	789	0
Brigid Stacey	Chief Nurse Officer	2.5-5	2.5-5	50-55	130-135	888	27	938	0
Steven Lloyd	Executive Medical Director	2.5-5	7.5-10	25-30	85-90	0	0	0	0
Helen Dillistone	Executive Director of Corporate Strategy and Delivery	2.5-5	2.5-5	35-40	60-65	515	46	580	0
Zara Jones	Executive Director of Commissioning Operations	2.5-5	2.5-5	30-35	50-55	371	35	427	0

Table 44 – pension benefits as at 31st March 2022

Cash equivalent transfer values (subject to audit)

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

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

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

Real increase in CETV

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

Compensation on early retirement or for loss of office

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

Payments to past members (subject to audit)

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

Fair Pay Disclosure (subject to audit)

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director in their organisation against the 25th percentile, median and 75th percentile of remuneration of the organisation's workforce. Total remuneration is further broken down to show the relationship between the highest paid director's salary component of their total remuneration against the 25th percentile, median and 75th percentile of salary components of the organisation's workforce.

The banded remuneration of the highest paid director/member in NHS Derby and Derbyshire CCG in the financial year 2021/22 was £197,500 (2020/21: £197,500). The relationship to the remuneration of the organisation's workforce is disclosed in Table 45.

The calculation of the 25th percentile, median and 75th percentile remuneration of the workforce includes the remuneration of members of the Governing Body but excludes the highest paid member. 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.

In 2021/22, nil employees received remuneration in excess of the highest-paid director/member (2020/21: nil). Remuneration ranged from £22,500 to £197,500 (2020/21: £17,500–£197,500). Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind, but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions

Table 45 shows the relationship between the remuneration of the highest-paid director in their organisation against the 25th percentile, median and 75th percentile of remuneration of the organisation's workforce. This increase change reflects the Agenda for Change Pay Award for staff employed by the CCG during 2021/22.

Year	25th Percentile Pay Ratio	25th Percentile Total Remuneration Ratio	Median Pay Ratio	Median Total Remuneration Ratio	75th Percentile Pay Ratio	75th Percentile Total Remuneration Ratio
2021/22	7.94	7.94	4.69	4.69	3.71	3.71
2020/21	8.18	8.18	4.83	4.83	3.82	3.82
Change in ratio	0.24	0.24	0.14	0.14	0.11	0.11
Percentage change in ratio	3%	3%	3%	3%	3%	3%

Table 45 – Fair Pay Multiples

Staff Report

Number of Senior Managers and Staff Composition

Table 46 shows the gender and pay band of VSMs and gender of the other CCG Employees for 2021/22.

	Male	Female	Total
Executive Members (including Functional Directors)	8	10	18
Band 8d	2	3	5
Band 8c	4	19	23
Band 8b	8	29	37
Band 8a	22	62	84
Other banded CCG employees	36	299	335
Total CCG employees	**80**	**422**	**502**
Other non-permanent engagements including non-executive directors and lay members	30	28	58
Total	**110**	**450**	**560**

Table 46 – number of senior managers and staff composition in 2021/22

Staff numbers and costs (subject to audit)

The staff costs for 2021/22 and 2020/21 are shown in Tables 47 and 48.

Employee Benefits 2021/22

Employee Benefits	2021/22		
	Permanent Employees	Other	Total
	£000	£000	£000
Salaries and wages	19,032	638	19,670
Social security costs	1,991	-	1,991
Employer Contributions to NHS Pension scheme	3,627	-	3,627
Other pension costs	6	-	6
Apprenticeship Levy	83	-	82
Other post-employment benefits	-	-	-
Other employment benefits	-	-	-
Termination benefits	-	-	-
Gross employee benefits expenditure	**24,739**	**638**	**25,377**
Less recoveries in respect of employee benefits	(295)	-	(295)
Total - Net admin employee benefits including capitalised costs	**24,444**	**638**	**25,082**
Less: Employee costs capitalised	-	-	-
Net employee benefits excluding capitalised costs	**24,443**	**638**	**25,082**

Table 47 – staff numbers and costs in 2021/22

Employee Benefits 2020/21

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

Table 48 – staff numbers and costs in 2020/21

Average number of people employed

Table 49 shows the average number of staff employed by the CCG, excluding non-executive members and lay members.

	2021/22			2020/21		
	Permanently employed	Other	Total	Permanently employed	Other	Total
Total	441.86	15.55	**457.41**	423.26	4.19	**427.45**

Table 49 – average number of people employed by the CCG in 2021/22 compared to 2020/21

During 2021/22 the staff turnover for the CCG was 14.64%.

Sickness absence data

The average number of working days lost during 2021/22 is unavailable at present. Please refer to the NHS Digital website here[21] for the NHS Sickness Absence rates.

Supporting and Developing Our People

Support during the Pandemic

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

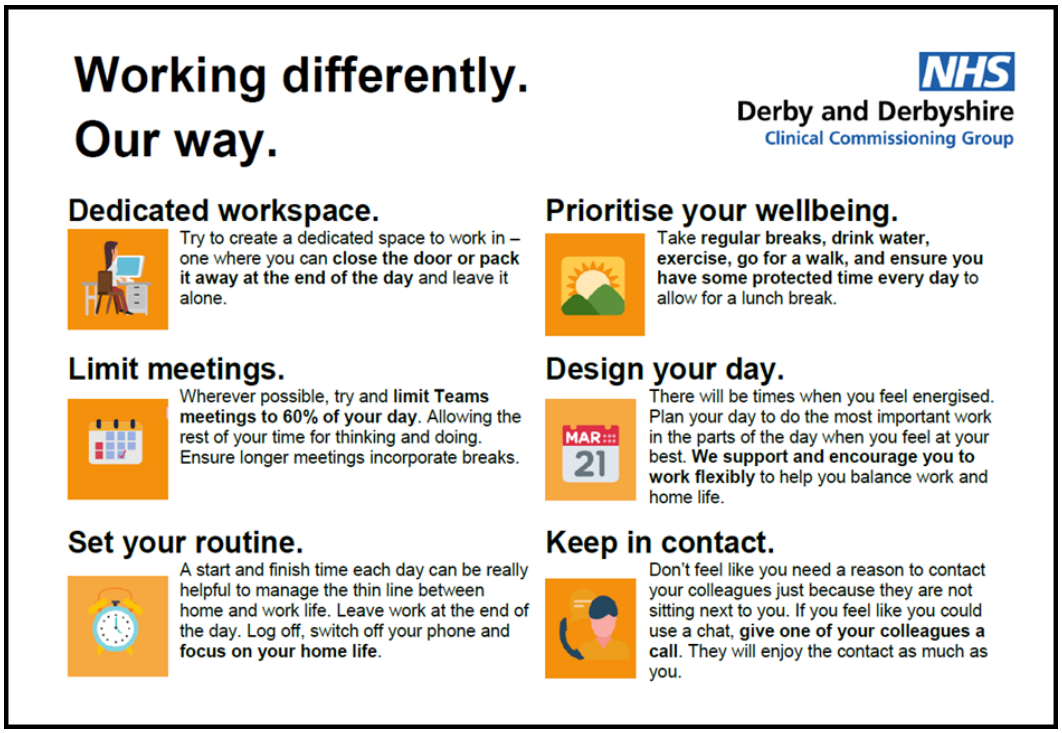


Figure 11 – Working Differently. Our Way

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

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

The CCG has supported colleagues who needed to work from a CCG base for health and wellbeing reasons. A new operating model has also been introduced ensure that Government guidance, Covid-19 related safety procedures and general health and safety processes are shared and adhered to by all staff attending a CCG site for any reason, or for any period of time. The new operating model takes into account covid transmission rates and enables a mix of working from home and a CCG base.

Disability Confident

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

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

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

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

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

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

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

Mental Health First Aiders

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

Human Resources Policies

We are committed to ensuring equal opportunities in employment and have appropriate HR policies in place to ensure they are compliant with the relevant employment law as appropriate. Due to prioritising support for the Covid-19 response and vaccination programme the development of new HR policies was temporarily paused during 2021/22. Over the course of the year the Raising Concerns at Work (Whistleblowing) Policy, and Flexible Working Policy have been reviewed and updated.

The CCG has introduced Freedom to Speak up Ambassadors provide enhanced opportunities for colleagues to speak up on a variety of issues including, but not limited to the following:

- When things might go wrong or have gone wrong to ensure lessons are learnt
- Offering a suggestion for improvement
- Bullying, harassment or dignity at work concerns
- Making a complaint or taking out a grievance
- Whistleblowing

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

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

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

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

Joint Partnership Working Forum

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

Staff Network

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

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

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

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

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

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

The CCG Senior Leadership Team recognise the importance of the Diversity and Inclusion Network and have agreed to updated terms of reference for the Network that provide a clear purpose, line of accountability and clarification how the Network is to be integrated into the decision making of the CCG. This includes the Diversity and Inclusion Network:

- reporting directly to the Senior Leadership Team;
- having representatives at the Senior Leadership Team with regards to decision making, especially on issues which may impact diversity and inclusion; and
- receiving protected time to undertake their roles.

Health and Safety

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

Staff Engagement

Staff Survey

The 2021 NHS Staff Survey was open to all staff, and is the third year the CCG participated in the survey. The purpose of the survey is to collect staff views about working in the CCG. Data is used to improve local working conditions for staff, and ultimately to improve patient care. It also allows the CCG to compare the experiences of staff in similar organisations, and to compare the experiences of staff in the CCG with the national picture.

This year, our response rate was 87%, which is higher than the comparative average of 78% for similar organisations. Figure 12 provides a summary of the results.

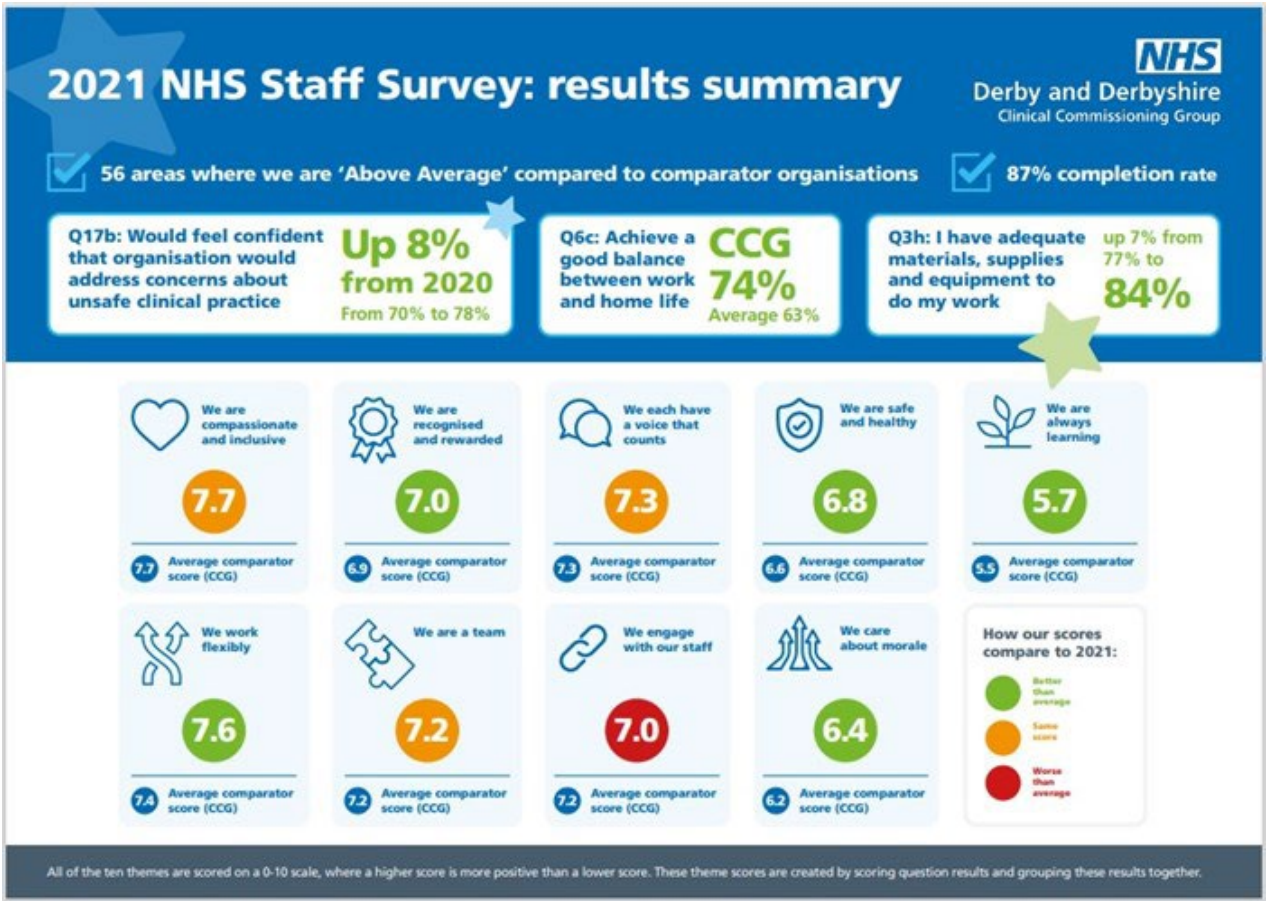


Figure 12 – 2021 NHS Derby and Derbyshire CCG Staff Survey Results

Organisation Effectiveness and Improvement Group

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

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

Social Connectivity	Maintaining social connections whilst working remotely, including social 'buddies', virtual interest groups, virtual coffee breaks
Think Green	Introducing various initiatives to make it easier to 'go green' and also raise awareness of the wider sustainability agenda in the NHS
Mental Health First Aiders	The CCG has nine qualified employees
Freedom to Speak up Ambassadors	The CCG has three employees who have undergone the National Ambassadors Office speak up training to become Freedom to Speak Up Ambassadors

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

Figure 13 – Our Values and Behaviours

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

We have conducted a number of 'health and wellbeing' surveys to help us to understand how staff were feeling and also identify what further interventions, actions and support they would find most helpful. On the back of the survey, we have introduced a number of measures aimed at

improving the physical and mental wellbeing of our staff whilst working remotely, including wellbeing checks, Covid-19 individual risk assessments and access to advice/support.

Staff Flu Immunisation

On the 17th July 2021, the Department for Health and Social Care and Public Health England communicated detail on the national flu immunisation programme 2021/22. The letter placed a requirement for the CCG to commission a service which made access easy to the vaccine for all frontline staff, encouraged staff to get vaccinated and monitored the delivery of their programmes.

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

As at the 31st March 2022, 51% of all CCG staff confirmed that they had received the flu jab. Next year we will continue to promote the benefits of the flu vaccination to staff via the CCG weekly staff bulletin and Team Talk meetings, ensuring our Executive and Senior Leaders lead the messaging. We will also continue to offer staff a variety of options to access a flu.

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 2022.

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 50 – 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 51 – 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 52 – 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 53 – paid Trade Union activities

Expenditure on consultancy

The expenditure on consultancy for 2021/22 for the CCG was £45,457.21

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

Off-payroll engagements

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

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

Length of all highly paid off-payroll engagements

Table 54 shows all highly paid off-payroll engagements as at the 31st March 2022 for more than £245 per day.

	Number
Number of existing engagements as of the 31st March 2021	0
Of which, the number that have existed:	
for less than one year at the time of reporting	0
for between one and two years at the time of reporting	0
for between 2 and 3 years at the time of reporting	0
for between 3 and 4 years at the time of reporting	0
for 4 or more years at the time of reporting	0

Table 54 – off-payroll engagements longer than six months in 2021/22

Off-payroll workers engaged at any point during the financial year

Table 55 shows all off-payroll engagements between the 1st April 2021 and the 31st March 2022, for more than £245 per day:

	Number
Number of temporary off-payroll workers engaged between the 1st April 2021 and 31st March 2022	1
Of which:	
Number not subject to off-payroll legislation	0
Number subject to off-payroll legislation and determined as in-scope of IR35	0
Number subject to off-payroll legislation and determined as out of scope of IR35	1
Number of engagements reassessed for compliance or assurance purposes during the year	0

Of which:	
Number of engagements that saw a change to IR35 status following review	0

Table 55 – new off-payroll engagements 2021/22

Off-payroll engagements/senior official engagements

Table 56 shows any off-payroll engagements of Board members and/or senior officials with significant financial responsibility, between the 1st April 2021 and the 31st March 2022:

	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)	22

Table 56 – off-payroll engagements/senior official engagements 2021/22

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

During the year, no exit packages have been agreed or paid. A provision has been made to recognise the risk of redundancy for CCG members following the transition into the ICB.

Dr Chris Clayton

Accountable Officer

NHS Derby and Derbyshire CCG

10 June 2022

Parliamentary Accountability and Audit Report

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

One complaint was accepted for investigation by the Parliamentary Ombudsman during 2021/22. The complaint was upheld and a list of recommendations was provided for completion by the 18th October 2021. The outcome of this complaint was reported through the Governance Committee during October 2021. The recommendations have been considered by the CCG.

FINANCIAL STATEMENTS

Dr Chris Clayton

Accountable Officer

NHS Derby and Derbyshire CCG

10 June 2022

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The Primary Statements:

Notes to the Accounts

Statement of Comprehensive Net Expenditure for the year ended 31 March 2022

	Note	2021-22 £'000	2020-21 £'000
Income from sale of goods and services	2	(6,961)	(4,489)
Other operating income	2	(144)	(117)
Total operating income		**(7,105)**	**(4,606)**
Staff costs	4	25,377	23,641
Purchase of goods and services	5	2,091,894	1,873,539
Depreciation and impairment charges	5	175	147
Provision expense	5	2,577	2,609
Other Operating Expenditure	5	464	524
Total operating expenditure		**2,120,487**	**1,900,460**
Net Operating Expenditure		**2,113,382**	**1,895,854**
Finance income		-	-
Finance expense		-	-
Net expenditure for the Year		**2,113,382**	**1,895,854**
Net (Gain)/Loss on Transfer by Absorption		-	-
Total Net Expenditure for the Financial Year		**2,113,382**	**1,895,854**
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		**2,113,382**	**1,895,854**

The notes on pages 172 to 192 form part of this statement.

Statement of Financial Position as at 31 March 2022

	Note	2021-22 £'000	2020-21 £'000
Non-current assets:			
Property, plant and equipment	8	267	355
Total non-current assets		267	355
Current assets:			
Trade and other receivables	9	4,965	5,330
Other financial assets		-	-
Other current assets		-	-
Cash and cash equivalents	10	27	110
Total current assets		**4,992**	5,440
Non-current assets held for sale		-	-
Total current assets		**4,992**	5,440
Total assets		**5,259**	5,795
Current liabilities			
Trade and other payables	11	(98,756)	(96,343)
Provisions	12	(5,847)	(3,896)
Total current liabilities		**(104,603)**	(100,239)
		(99,344)	(94,444)
Non-current liabilities			
Provisions	12	(532)	(522)
Total non-current liabilities		**(532)**	(522)
Assets less Liabilities		**(99,876)**	(94,966)
Financed by Taxpayers' Equity			
General fund		(99,876)	(94,966)
Revaluation reserve		-	-
Other reserves		-	-
Charitable Reserves		-	-
Total taxpayers' equity:		**(99,876)**	(94,966)

The notes on pages 172 to 192 form part of this statement.

The financial statements on pages 168 to 171 were approved by the Audit Committee on 10 June and signed on its behalf by:

Chief Accountable Officer
Dr Chris Clayton

Statement of Changes In Taxpayers Equity for the year ended 31 March 2022

		General fund £'000	Revaluation reserve £'000	Other reserves £'000	Total reserves £'000
Changes in taxpayers' equity for 2021-22					
Balance at 01 April 2021		(94,966)	0	0	**(94,966)**
Transfer between reserves in respect of assets transferred from closed NHS bodies		0	0	0	**0**
Adjusted NHS Clinical Commissioning Group balance at 31 March 2021		**(94,966)**	**0**	**0**	**(94,966)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2021-22					
Net operating expenditure for the financial year		(2,113,382)			**(2,113,382)**
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	0	0
Net gain (loss) on revaluation of assets held for sale		0	0	0	0
Impairments and reversals		0	0	0	0
Net actuarial gain (loss) on pensions		0	0	0	0
Movements in other reserves		0	0	0	0
Transfers between reserves		0	0	0	0
Release of reserves to the Statement of Comprehensive Net Expenditure		0	0	0	0
Reclassification adjustment on disposal of available for sale financial assets		0	0	0	0
Transfers by absorption to (from) other bodies		0	0	0	0
Reserves eliminated on dissolution		0	0	0	0
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial year		**(2,113,382)**	**0**	**0**	**(2,113,382)**
Net funding		2,108,474	0	0	**2,108,474**
Balance at 31 March 2022		**(99,876)**	**0**	**0**	**(99,876)**

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

The notes on pages 172 to 192 form part of this statement.

Statement of Cash Flows for the year ended
31 March 2022

	Note	2021-22 £'000	2020-21 £'000
Cash Flows from Operating Activities			
Net operating expenditure for the financial year		(2,113,382)	(1,895,854)
Depreciation and amortisation	5	175	147
Impairments and reversals	5	0	0
Non-cash movements arising on application of new accounting standards		0	0
Movement due to transfer by Modified Absorption		0	0
Other gains (losses) on foreign exchange		0	0
Donated assets received credited to revenue but non-cash		0	0
Government granted assets received credited to revenue but non-cash		0	0
Interest paid		0	0
Release of PFI deferred credit		0	0
Other Gains & Losses		0	0
Finance Costs		0	0
Unwinding of Discounts		0	0
(Increase)/decrease in inventories		0	0
(Increase)/decrease in trade & other receivables	9	365	4,434
(Increase)/decrease in other current assets		0	0
Increase/(decrease) in trade & other payables	11	2,413	(5,766)
Increase/(decrease) in other current liabilities		0	0
Provisions utilised	12	(616)	(466)
Increase/(decrease) in provisions	12	2,577	2,609
Net Cash Inflow (Outflow) from Operating Activities		**(2,108,468)**	(1,894,896)
Cash Flows from Investing Activities			
Interest received		0	0
(Payments) for property, plant and equipment	8	(87)	(69)
(Payments) for intangible assets		0	0
(Payments) for investments with the Department of Health		0	0
(Payments) for other financial assets		0	0
(Payments) for financial assets (LIFT)		0	0
Proceeds from disposal of assets held for sale: property, plant and equipment		0	0
As the cash requirements of NHS England are met through the Estimate process, financial instruments play a more limited role i		0	0
Proceeds from disposal of investments with the Department of Health		0	0
Proceeds from disposal of other financial assets		0	0
Proceeds from disposal of financial assets (LIFT)		0	0
Non-cash movements arising on application of new accounting standards		0	0
Loans made in respect of LIFT		0	0
Loans repaid in respect of LIFT		0	0
Rental revenue		0	0
Net Cash Inflow (Outflow) from Investing Activities		**(87)**	(69)
Net Cash Inflow (Outflow) before Financing		**(2,108,555)**	(1,894,965)
Cash Flows from Financing Activities			
Grant in Aid Funding Received		2,108,471	1,895,035
Other loans received		0	0
Other loans repaid		0	0
Capital element of payments in respect of finance leases and on Statement of Financial Position PFI and LIFT		0	0
Capital grants and other capital receipts		0	0
Capital receipts surrendered		0	0
Non-cash movements arising on application of new accounting standards		0	0
Net Cash Inflow (Outflow) from Financing Activities		**2,108,471**	1,895,035
Net Increase (Decrease) in Cash & Cash Equivalents	10	**(83)**	70
Cash & Cash Equivalents at the Beginning of the Financial Year	**2E+05**	**110**	40
Effect of exchange rate changes on the balance of cash and cash equivalents held in foreign currencies		0	0
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year		**27**	110

The notes on pages 172 to 192 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 2021-22 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 Clinical Commissioning Group is a going concern and the financial statements are prepared on the going concern basis.

As explained more fully on page 192 following the approval of the Health and Care Bill on 27th April 2022 NHS Derby and Derbyshire CCG (the CCG) will be dissolved on 30 June 2022. Whilst the CCG as an entity will cease to exist on that date, the activities undertaken by the CCG will continue to be undertaken by Derby and Derbyshire Integrated Care Board In accordance with the Department of Health and Social Care Group Accounting Manual, the continuation of the provision of services within the public sector means that the accounts of the CCG should be prepared on a 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 Gorup are outside the scope of IFRS 3 BusinessCombinations. Where fundtions transfer between two public sector bodies, the Department of Health and Social Care GAM requires the application of apsorption 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.
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.

1.5 **Pooled Budgets.**

The Clinical Commissioning Group has entered into a pooled budget arrangement for better care with NHS Tameside & Glossop Clinical Commissioning Group and Derbyshire County Council; and separately with Derby City Council [both arrangements are in accordance with section 75 of the NHS Act 2006]. Under the arrangements, the two funds are separately pooled for the Derbyshire County "Better Care Fund", and Derby City "Better Care Fund", respectively. The Better Care funds aim to improve the provision of health and social care, with the overarching objective to support the integration of health and social care and align commissioning, as agreed between the partners.

Additionally the Clinical Commissioning Group is a partner of the "Children and Young People with Complex Needs" pooled budget with Derbyshire County Council. Under the arrangement, funds are pooled for children with a range of health and special educational needs that cannot collectively be addressed by local or ordinary services.

The Clinical Commissioning Group is also in a pooled arrangement with Derby City Council for the "Integrated Disabled Children's Centre and Services in Derby". This arrangement provides funds for the purchase and supply of equipment and technological aids for disabled children in Derby.

The Derbyshire County "Better Care Fund" and "Children and Young People with Complex Needs" pools are both hosted by Derbyshire County

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 service are recognised as income in accordance with IAS 20, Accounting for Government Grants. Where these funds are paid directly to an accredited training provider, non-cash income and 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 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 recognised in these accounts represents the contributions payable for the year. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions.

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.

Notes to the financial statements

1.10.3 Subsequent Expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses.

1.10.4 **Depreciation, Amortisation & Impairments**

Freehold land, properties under construction, and assets held for sale are not depreciated.

Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the clinical commissioning group expects to obtain economic benefits or service potential from the asset. This is specific to the clinical commissioning group and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over the shorter of the lease term and the estimated useful life.

At each reporting period end, the clinical commissioning group checks whether there is any indication that any of its property, plant and equipment assets or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.

A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

1.11 **Leases**

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

1.11.1 **The Clinical Commissioning Group as Lessee**

Property, plant and equipment held under finance leases are initially recognised, at the inception of the lease, at fair value or, if lower, at the present value of the minimum lease payments, with a matching liability for the lease obligation to the lessor. Lease payments are apportioned between finance charges and reduction of the lease obligation so as to achieve a constant rate on interest on the remaining balance of the liability. Finance charges are recognised in calculating the clinical commissioning group's surplus/deficit.

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

Where a lease is for land and buildings, the land and building components are separated and individually assessed as to whether they are operating or finance leases.

1.12 **Cash & Cash Equivalents**

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the clinical commissioning group's cash management.

1.13 **Provisions**

Provisions are recognised when the Clinical Commissioning Group has a present legal or constructive obligation as a result of a past event, it is probable that the Clinical Commissioning Group will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rate as follows:

All general provisions are subject to four separate discount rates according to the expected timing of cashflows from the Statement of Financial Position date:

-A nominal short-term rate of 0.47% (2020-21: -0.02%) for inflation adjusted expected cash flows up to and including 5 years from Statement of Financial Position date.
-A nominal medium-term rate of 0.70% (2020-21: 0.18%) 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 0.95% (2020-21: 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 0.6% (2020-21: 1.99%) for inflation adjusted expected cash flows exceeding 40 years from the Statement of Financial Position date.

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

A restructuring provision is recognised when the Clinical Commissioning Group has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with on-going activities of the entity.

1.14 **Clinical Negligence Costs**

NHS Resolution operates a risk pooling scheme under which the clinical commissioning group pays an annual contribution to NHS Resolution, which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with clinical commissioning group.

1.15 **Non-clinical Risk Pooling**

The clinical commissioning group participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the clinical commissioning group pays an annual contribution to the NHS Resolution and, in return, receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses as and when they become due.

Notes to the financial statements

1.16 **Contingent liabilities and contingent assets**

A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the clinical commissioning group, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the clinical commissioning group. A contingent asset is disclosed where an inflow of economic benefits is probable.

Where the time value of money is material, contingent liabilities and contingent assets are disclosed at their present value.

1.17 **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.

1.18 **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.

1.19 **Third Party Assets**

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the clinical commissioning group has no beneficial interest in them.

1.20 **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 accruals 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).

1.21 **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.

1.21.1 **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.

1.21.2 **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.

1.23 **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 2021-22. These Standards are still subject to HM Treasury FReM adoption, with IFRS 16 being for implementation in 2022/23, and the government implementation date for IFRS 17 still subject to HM Treasury consideration.

IFRS 16 Leases will replace IAS 17 Leases, IFRIC 4 Determining whether an arrangement contains a lease and other interpretations and is applicable in the public sector for periods beginning 1 April 2022. The standard provides a single accounting model for lessees, recognising a right of use asset and obligation in the statement of financial position for most leases: some leases are exempt through application of practical expedients explained below. For those recognised in the statement of financial position the standard also requires the remeasurement of lease liabilities in specific circumstances after the commencement of the lease term. For lessors, the distinction between operating and finance leases will remain and the accounting will be largely unchanged

IFRS 16 changes the definition of a lease compared to IAS 17 and IFRIC 4. The clinical commissioning group will apply this definition to new leases only and will grandfather its assessments made under the old standards of whether existing contracts contain a lease.

On transition to IFRS 16 on 1 April 2022, the clinical commissioning group will apply the standard retrospectively without restatement and with the cumulative effect of initially applying the standard recognised in the income and expenditure reserve at that date. For existing operating leases with a remaining lease term of more than 12 months and an underlying asset value of at least £5,000, a lease liability will be recognised equal to the value of remaining lease payments discounted on transition at the clinical commissioning group's incremental borrowing rate. The clinical commissioning group's incremental borrowing rate will be a rate defined by HM Treasury. For 2022, this rate is 0.95%. The related right of use asset will be measured equal to the lease liability adjusted for any prepaid or accrued lease payments. No adjustments will be made on 1 April 2022 for existing finance leases.

For leases commencing in 2022/23, the clinical commissioning group will not recognise a right of use asset or lease liability for short term leases (less than or equal to 12 months) or for leases of low value assets (less than £5,000). Right of use assets will be subsequently measured on a basis consistent with owned assets and depreciated over the length of the lease term.

The CCG has performed an impact forecast for the implementation of IFRS 16 in 2022/23. Existing property leases which meet the recognition criteria of the new standard will be bought onto the Statement of Financial Position with a total asset value of £1,281,000. In 2022/23, this will have a presentational impact on the Statement of Comprehensive Net Expenditure in recategorising of the associated expenditure.

Several assumptions have been made in the calculation of the forecast impact of IFRS 16 implication.

-NHS Property Services' properties without formalised lease agreement have been included in this forecast providing the substance of the transaction indicates an implicit lease arrangement and meets the recognition criteria outlined by IFRS 16.

-Where no formal lease agreement exists, lease values and lengths have been determined in line with current rental statements and expected occupancy of the property in line with the continued provision of CCG and ICB services.

- IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2021. Standard is not yet adopted by the FReM which is expected to be April 2023: early adoption is not therefore permitted.

The CCG does not have insurance contracts therefore no impact is expected from the implementation of this standard.

2 Other Operating Revenue

	2021-22 Admin	2021-22 Programme	2021-22 Total	2020-21 Total
	£'000	£'000	£'000	£'000
Income from sale of goods and services (contracts)				
Education, training and research	-	9	**9**	24
Non-patient care services to other bodies	494	6,117	**6,611**	4,311
Patient transport services	-	-	**-**	-
Prescription fees and charges	-	0	**0**	3
Dental fees and charges	-	-	**-**	-
Income generation	-	-	**-**	-
Other Contract income	-	46	**46**	46
Recoveries in respect of employee benefits	231	64	**295**	105
Total Income from sale of goods and services	**725**	**6,236**	**6,961**	**4,489**
Other operating income				
	-	-	**-**	-
Rental revenue from operating leases	-	-	**-**	-
Charitable and other contrib. to revenue expenditure: NHS	-	-	**-**	-
Charitable and other contrib. to revenue expenditure: non-NHS	-	-	**-**	17
Receipt of donations (capital/cash)	-	-	**-**	-
Receipt of Government grants for capital acquisitions	-	-	**-**	-
Continuing Health Care risk pool contributions	-	-	**-**	-
Non cash apprenticeship training grants revenue	59	-	**59**	47
Other non contract revenue	1	84	**85**	53
Total Other operating income	**60**	**84**	**144**	**117**
Total Operating Income	**785**	**6,320**	**7,105**	**4,606**

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	Non-patient care services to other bodies	Other Contract income	Recoveries in respect of employee benefits
	£'000	£'000	£'000	£'000
Source of Revenue				
NHS	9	1,120	6	194
Non NHS	-	5,491	40	101
Total	**9**	**6,611**	**46**	**295**

	Education, training and research	Non-patient care services to other bodies	Other Contract income	Recoveries in respect of employee benefits
	£'000	£'000	£'000	£'000
Timing of Revenue				
Point in time	-	-	-	-
Over time	9	6,611	46	295
Total	**9**	**6,611**	**46**	**295**

3.2 Transaction price to remaining contract performance obligations

NHS Derby and Derbyshire Clinical Commisioning Group had no contract revenue expected to be recognised in future period, relating to contract performance obligations not yet completed at the reporting date.

4. Employee benefits and staff numbers

4.1.1 Employee benefits

	Total		2021-22
	Permanent Employees £'000	**Other £'000**	**Total £'000**
Employee Benefits			
Salaries and wages	**19,032**	**638**	**19,670**
Social security costs	**1,991**	**-**	**1,991**
Employer Contributions to NHS Pension scheme	**3,627**	**-**	**3,627**
Other pension costs	**6**	**-**	**6**
Apprenticeship Levy	**83**	**-**	**83**
Other post-employment benefits	**-**	**-**	**-**
Other employment benefits	**-**	**-**	**-**
Termination benefits	**-**	**-**	**-**
Gross employee benefits expenditure	24,739	638	25,377
Less recoveries in respect of employee benefits (note 4.1.2)	**(295)**	**-**	**(295)**
Total - Net admin employee benefits including capitalised costs	24,444	638	25,082
Less: Employee costs capitalised	**-**	**-**	**-**
Net employee benefits excluding capitalised costs	24,444	638	25,082

	Total		2020-21
	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits			
Salaries and wages	**18,050**	**250**	18,300
Social security costs	**1,880**	**-**	1,880
Employer Contributions to NHS Pension scheme	**3,363**	**-**	3,363
Other pension costs	**2**	**-**	2
Apprenticeship Levy	**76**	**-**	**76**
Other post-employment benefits	**-**	**-**	**-**
Other employment benefits	**-**	**-**	**-**
Termination benefits	**20**	**-**	**20**
As the cash requirements of NHS England are met through the Estimate process, fina	23,391	250	23,641
Less recoveries in respect of employee benefits (note 4.1.2)	**(105)**	**(0)**	**(105)**
Total - Net admin employee benefits including capitalised costs	23,286	250	23,536
Less: Employee costs capitalised	**-**	**-**	**-**
Net employee benefits excluding capitalised costs	23,286	250	23,536

No Exit Packages have arisen in year (2020-21; two).

4.1.2 Recoveries in respect of employee benefits

			2021-22	2020-21
	Permanent Employees £'000	**Other £'000**	**Total £'000**	Total £'000
Employee Benefits - Revenue				
Salaries and wages	**(235)**	**-**	**(235)**	**(84)**
Social security costs	**(27)**	**-**	**(27)**	**(10)**
Employer contributions to the NHS Pension Scheme	**(33)**	**-**	**(33)**	**(11)**
Other pension costs	**-**	**-**	**-**	**-**
Other post-employment benefits	**-**	**-**	**-**	**-**
Other employment benefits	**-**	**-**	**-**	**-**
Termination benefits	**-**	**-**	**-**	**-**
Total recoveries in respect of employee benefits	(295)	-	(295)	(105)

4.2 Average number of people employed

	2021-22			2020-21		
	Permanently employed Number	**Other Number**	**Total Number**	Permanently employed Number	Other Number	Total Number
Total	**437**	**16**	**453**	423	4	427
Of the above:						
Number of whole time equivalent people engaged on capital	-	-	-	-	-	-

4.3 Exit packages agreed in the financial year

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. Ill-health retirement costs are met by the NHS Pension Scheme and are not included in the tables.

The Remuneration Report includes the disclosure of exit payments and early retirements relating to individuals named in that Report.
No exit packages have been agreed in year.

One Exit Package relating to the compulsory redundancy of a single employee was agreed in 2020-21.
The value of this payment was £20,000.

4.4 Pension Costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. 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 2022, is based on valuation data as 31 March 2021, updated to 31 March 2022 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% of pensionable pay.

The 2016 funding valuation also tested the cost of the Scheme relative to the employer cost cap that was set following the 2012 valuation. There was initially a pause to the cost control element of the 2016 valuations, due to the uncertainty around member benefits caused by the discrimination ruling relating to the McCloud case.

HMT published valuation directions dated 7 October 2021 (see Amending Directions 2021) that set out the technical detail of how the costs of remedy are included in the 2016 valuation process. Following these directions, the scheme actuary has completed the cost control element of the 2016 valuation for the NHS Pension Scheme, which concludes no changes to benefits or member contributions are required. The 2016 valuation reports can be found on the NHS Pensions website at https://www.nhsbsa.nhs.uk/nhs-pension-scheme-accounts-and-valuation-reports.

5. Operating expenses

	2021-22 Total £'000	2020-21 Total £'000
Purchase of goods and services		
Services from other CCGs and NHS England	10,145	10,078
Services from foundation trusts	1,247,778	1,098,756
Services from other NHS trusts	137,633	114,495
Provider Sustainability Fund	-	-
Services from Other WGA bodies	4	6
Purchase of healthcare from non-NHS bodies	264,702	249,044
Purchase of social care	61,940	50,404
General Dental services and personal dental services	-	-
Prescribing costs	162,084	161,614
Pharmaceutical services	143	79
General Ophthalmic services	346	485
GPMS/APMS and PCTMS	193,748	176,523
Supplies and services – clinical	2	-
Supplies and services – general	5,638	5,949
Consultancy services	45	30
Establishment	3,822	2,308
Transport	-	(1)
Premises	2,314	2,537
Audit fees	192	182
Other non statutory audit expenditure		
· Internal audit services	-	-
· Other services	14	10
Other professional fees	775	577
Legal fees	230	329
Education, training and conferences	280	86
Funding to group bodies	-	-
CHC Risk Pool contributions	-	-
Non cash apprenticeship training grants	59	48
Total Purchase of goods and services	**2,091,894**	**1,873,539**
Depreciation	175	147
Amortisation	-	-
Impairments and reversals of property, plant and equipment	-	-
Impairments and reversals of intangible assets	-	-
Impairments and reversals of financial assets	-	-
· Assets carried at amortised cost	-	-
· Assets carried at cost	-	-
· Available for sale financial assets	-	-
Impairments and reversals of non-current assets held for sale	-	-
Impairments and reversals of investment properties	-	-
Total Depreciation and impairment charges	**175**	**147**
Provision expense		
Change in discount rate	-	-
Provisions	2,577	2,609
Total Provision expense	**2,577**	**2,609**
Other Operating Expenditure		
Chair and Non Executive Members	459	450
Grants to Other bodies	-	-
Clinical negligence	-	-
Research and development (excluding staff costs)	-	60
Expected credit loss on receivables	2	9
Expected credit loss on other financial assets (stage 1 and 2 only)	-	-
Inventories written down	-	-
Inventories consumed	-	-
Other expenditure	3	5
Total Other Operating Expenditure	**464**	**524**
Total operating expenditure	**2,095,110**	**1,876,819**

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 (£160k excluding VAT).

The non-statutory audit of Mental Health Investment is disclosed as "Other non-statutory audit expenditure - Other service". The Clinical Commissioning Group is yet to agree the fee for this audit for 2021-22, therefore an accrual of the estimated expenditure has been made in-year.

6.1 Better Payment Practice Code

Measure of compliance	**2021-22 Number**	**2021-22 £'000**	2020-21 Number	2020-21 £'000
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	51,296	337,917	42,138	298,856
Total Non-NHS Trade Invoices paid within target	51,059	336,913	41,871	297,827
Percentage of Non-NHS Trade invoices paid within target	**99.54%**	**99.70%**	**99.37%**	**99.66%**
NHS Payables				
Total NHS Trade Invoices Paid in the Year	2,120	1,406,167	2,636	1,241,869
Total NHS Trade Invoices Paid within target	2,111	1,406,010	2,628	1,241,769
Percentage of NHS Trade Invoices paid within target	**99.58%**	**99.99%**	**99.70%**	**99.99%**

The Better Payment Practice Code requires the Clinical Commissioning Group to aim to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later. The target is 95% across all indicators, which has been achieved.

6.2 The Late Payment of Commercial Debts (Interest) Act 1998

NHS Derby and Derbyshire Clinical Commissioning Group incurred £nil during 2021-22 (2020-21: £Nil) relating to claims made under this legislation.

7. Operating Leases

7.1 As lessee

Property rental charges are received from NHS Property Services Limited, for the office accommodation at Cardinal Square, Derby and Scarsdale, Chesterfield.
Future minimum lease payments have increased this year due to the reassessment of lease break clauses as part of preparation for the implementation of IFRS 16. Guidance receieved from NHSE indicated that NHSPS premises leases must be recognised as leases agreements despite the absence of formal contracts, therefore, these properties have also been recognised in future minimum lease payments in line with this.

NHS Derby and Derbyshire Clinical Commissioning Group also have lease contracts in place for reprographic equipment with CSP Systems, Ricoh and Grenke.

7.1.1 Payments recognised as an Expense

			2021-22			2020-21
	Buildings £'000	**Other £'000**	**Total £'000**	Buildings £'000	Other £'000	Total £'000
Payments recognised as an expense						
Minimum lease payments	441	4	**445**	485	7	**492**
Contingent rents	-	-	**-**	-	-	**-**
Sub-lease payments	-	-	**-**	-	-	**-**
Total	**441**	**4**	**445**	**485**	**7**	**492**

7.1.2 Future minimum lease payments

		2021-22			2020-21	
	Buildings £'000	**Other £'000**	**Total £'000**	Buildings £'000	Other £'000	Total £'000
Payable:						
No later than one year	441	2	**443**	127	2	**129**
Between one and five years	873	3	**876**	142	4	**146**
After five years	-	-	**-**	-	-	**-**
Total	**1,314**	**5**	**1,319**	**269**	**6**	**275**

7.2 As lessor

NHS Derby and Derbyshire Clinical Commisioning Group is not party to any leasing arrangements where it acts in the capacity of a lessor.

8 Property, plant and equipment

2021-22	Information technology £'000	Total £'000
Cost or valuation at 01 April 2021	502	502
Additions purchased	87	87
Cost/Valuation at 31 March 2022	**589**	**589**
Depreciation 01 April 2021	147	147
Charged during the year	175	175
Depreciation at 31 March 2022	**322**	**322**
Net Book Value at 31 March 2022	**267**	**267**
Purchased	267	267
Donated	-	-
Government Granted	-	-
Total at 31 March 2022	**267**	**267**
Asset financing:		
Owned	267	267
Held on finance lease	-	-
On-SOFP Lift contracts	-	-
PFI residual: interests	-	-
Total at 31 March 2022	**267**	**267**

Revaluation Reserve Balance for Property, Plant & Equipment

		Information technology £'000	Total £'000
Balance at 01 April 2021		-	-
Revaluation gains		-	-
Impairments		-	-
Release to general fund		-	-
Other movements		-	-
Balance at 31 March 2022	#	**-**	**-**

The information technology equipment purchased during the year will be depreciated over 3 years, in line with existing equipment held, and with the accounting policies.

9. Trade and other receivables	**Current 2021-22 £'000**	**Non-current 2021-22 £'000**	Current 2020-21 £'000	Non-current 2020-21 £'000
NHS receivables: Revenue	1,197	-	1,229	-
NHS prepayments	4	-	1	-
NHS accrued income	5	-	-	-
NHS Contract Receivable not yet invoiced/non-invoice	479	-	1,645	-
Non-NHS and Other WGA receivables: Revenue	803	-	475	-
Non-NHS and Other WGA prepayments	1,591	-	1,412	-
Non-NHS and Other WGA Contract Receivable not yet invoiced/non-invoice	99	-	6	-
Expected credit loss allowance-receivables	(3)	-	(3)	-
VAT	789	-	562	-
Private finance initiative and other public private partnership arrangement prepayments and accrued income	-	-	-	-
Other receivables and accruals	1	-	3	-
Total Trade & other receivables	**4,965**	**-**	**5,330**	**-**
Total current and non current	**4,965**		**5,330**	

There are no prepaid pension contributions included in note 9.

9.2 Receivables past their due date but not impaired

	2021-22 DHSC Group Bodies £'000	**2021-22 Non DHSC Group Bodies £'000**	2020-21 DHSC Group Bodies £'000	2020-21 Non DHSC Group Bodies £'000
By up to three months	455	417	43	116
By three to six months	-	17	29	74
By more than six months	-	-	-	1
Total	**455**	**434**	**72**	**191**

9.3 Loss allowance on asset classes	**Trade and other receivables - Non DHSC Group Bodies £'000**	**Other financial assets £'000**	**Total £'000**
Balance at 01 April 2020	(3)	-	**(3)**
Lifetime expected credit loss on credit impaired financial assets	-	-	**-**
Lifetime expected credit losses on trade and other receivables-Stage 2	(4)	-	**(4)**
Lifetime expected credit losses on trade and other receivables-Stage 3	-	-	**-**
Credit losses recognised on purchase originated credit impaired financial assets	-	-	**-**
Amounts written off	-	1	**1**
Financial assets that have been derecognised	-	-	**-**
Changes due to modifications that did not result in derecognition	-	-	**-**
Other changes	3	-	**3**
Total	**(4)**	**1**	**(3)**

10 Cash and cash equivalents

	2021-22 £'000	2020-21 £'000
Balance at 01 April 2021	110	40
Net change in year	(83)	70
Balance at 31 March 2022	**27**	**110**
Made up of:		
Cash with the Government Banking Service	27	110
Cash with Commercial banks	-	-
Cash in hand	-	0
Current investments	-	-
Cash and cash equivalents as in statement of financial position	**27**	**110**
Bank overdraft: Government Banking Service	-	-
Bank overdraft: Commercial banks	-	-
Total bank overdrafts	**-**	**-**
Balance at 31 March 2022	**27**	**110**

NHS Derby and Derbyshire Clinical Commisioning Group does not hold patients' money.

11 Trade and other payables	**Current 2021-22 £'000**	**Non-current 2021-22 £'000**	Current 2020-21 £'000	Non-current 2020-21 £'000
NHS payables: Revenue	3,626	-	1,959	-
NHS accruals	2,248	-	3,070	-
Non-NHS and Other WGA payables: Revenue	6,272	-	8,613	-
Non-NHS and Other WGA accruals	67,518	-	67,973	-
Social security costs	309	-	285	-
Tax	239	-	223	-
Payments received on account	-	-	13	-
Other payables and accruals	18,544	-	14,207	-
Total Trade & Other Payables	**98,756**	**-**	**96,343**	**-**
Total current and non-current	**98,756**		**96,343**	

NHS Derby and Derbyshire Clinical Commisioning Group does not have any liabilities included for arrangements to buy out the liability for early retirement over 5 years (£nil at 31 March 2021).

Other payables include £1.751m outstanding pension contributions at 31 March 2022 (2020-21: £1.453m). Other payables include GP pensions.

12 Provisions

	Current 2021-22 £'000	**Non-current 2021-22 £'000**	Current 2020-21 £'000	Non-current 2020-21 £'000
Pensions relating to former directors	-	-	-	-
Pensions relating to other staff	-	-	-	-
Restructuring	-	-	-	-
Redundancy	-	-	-	-
Agenda for change	-	-	-	-
Equal pay	-	-	-	-
Legal claims	13	-	3	-
Continuing care	1,430	-	646	-
Other	4,404	532	3,247	522
Total	**5,847**	**532**	**3,896**	**522**
Total current and non-current	**6,379**		**4,418**	

	Legal Claims £'000	**Continuing Care**	**Other £'000**	**Total £'000**
Balance at 01 April 2021	**3**	**646**	**3,769**	**4,418**
Arising during the year	13	1,112	1,452	**2,577**
Utilised during the year	(3)	(328)	(285)	**(616)**
Reversed unused	-	-	-	**-**
Unwinding of discount	-	-	-	**-**
Change in discount rate	-	-	-	**-**
Transfer (to) from other public sector body	-	-	-	**-**
Transfers under absorption	-	-	-	**-**
Balance at 31 March 2022	**13**	**1,430**	**4,936**	**6,379**
Expected timing of cash flows:				
Within one year	13	1,430	4,404	**5,847**
Between one and five years	-	-	532	**532**
After five years	-	-	-	**-**
Total	**13**	**1,430**	**4,936**	**6,379**

Other Provisions

Legal claims are calculated from the number of claims currently lodged with NHS Resolution and the probabilities provided by them. One claim totalling £3k was provided for in 202-21; this has been utilised following conclusion during 2021-22 and is detailed in note 20. A further claim The continuing healthcare retrospective claims and disputes have been reviewed with £1.112m of new liability identified, and £328k being utilised during the year.

The Clinical Commissioning Group has "other" provisions, including that for the Cardinal Square and Scarsdale offices in Derby and Chesterfield respectively, known as 'dilapidation cost provision' (£533k, 2020-21 £522k) to cover the cost of putting the offices back to an Other provisions include the following balances carried forward from 2020-21:

- Minor Surgery Backlog, £1.06m brought forward. No amounts utilised in 2021-22
- Primary Care Network Roles, £0.52m brought forward. No amounts utilised in 2021-22.
- Primary Care Estates and Technology Transformation Fund, £0.50m brought forward. £0.01m utilised in 2021-22.
- Digital Transformation, £0.47m brought forward. No amounts utilised in 2021-22.
- Pension Shortfall, £0.29m brought forward. No amounts utilised in 2021-22.
- On-Line Consultation, £0.26m brought forward. £0.22 utilised in 2021-22
- Acute service improvement post, £0.09m brought forward. £0.07 utilised in 2021-22
- Corporate Education and Training, £0.06. Increase arising in 2021-22 of £0.02.

Other provisions also include the following balance wholly arising in the 2021-22 year:

- Acute Waiting List Backlog, £1.43m

13 Contingencies
A contingent liability of £107,000 has been recognised in respect of possible legal fees to be incurred in relation to an ongoing legal matter (2020-21: £nil).

14 Commitments
NHS Derby and Derbyshire Clinical Commissioning Group had £nil capital commitments or other financial commitments (2020-21: £nil).

15 Financial instruments

15.1 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.

15.1.1 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.

15.1.2 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.

15.1.3 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.

15.1.4 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.

15.1.5 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.

15 Financial instruments cont'd

15.2 Financial assets

	Financial Assets measured at amortised cost 2021-22 £'000	Equity Instruments designated at FVOCI 2021-22 £'000	Total 2021-22 £'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	511		511
Trade and other receivables with other DHSC group bodies	1,170		1,170
Trade and other receivables with external bodies	903		903
Other financial assets	-		-
Cash and cash equivalents	27		27
Total at 31 March 2022	**2,611**	**-**	**2,611**

15.3 Financial liabilities

	Financial Liabilities measured at amortised cost 2021-22 £'000	Other 2021-22 £'000	Total 2021-22 £'000
Loans with group bodies	-		**-**
Loans with external bodies	-		**-**
Trade and other payables with NHSE bodies	297		**297**
Trade and other payables with other DHSC group bodies	5,597		**5,597**
Trade and other payables with external bodies	92,315		**92,315**
Other financial liabilities	-		**-**
Private Finance Initiative and finance lease obligations	-		**-**
Total at 31 March 2022	**98,209**	**-**	**98,209**

16 Operating segments

NHS Derby and Derbyshire Clinical Commissioning Group considers that it has one operating segment, the commissioning of healthcare services.

17. Joint arrangements - interests in joint operations

The "Better Care Funds", "Children and Young People with Complex Needs" and "Integrated Disabled Children's Centre and Services in Derby", are pooled individually under the Section 75 arrangements of the NHS Act 2006. The total of the Clinical Commissioning Group's share of all pooled budgets are as follows:

	2021-22 £'000	2020-21 £'000
Income	(94,042)	(79,158)
Expenditure	93,858	78,992
	(184)	**(166)**

Better CareFund (BCF)
The Clinical Commissioning Group has two BCFs: The Derbyshire County BCF; and the Derby City BCF, which both became operational in 2015.

NHS Derby and Derbyshire Clinical Commissioning Group is a partner to the Derbyshire County BCF, along with NHS Tameside and Glossop Clinical Commissioning Group and Derbyshire County Council. NHS Derby and Derbyshire Clinical Commissioning Group is also a partner to the Derby City BCF, along with Derby City Council. The operation of the pools is ultimately managed by the Derbyshire Health and Wellbeing Board represented by members from each of the partners. The Funds operate as Section 75 pooled budgets.

Total agreed contributions to the Derbyshire County BCF Pool are £118,604,202 including iBCF funding (£83,922,168 excluding iBCF). Total agreed contributions to the Derby City BCF Pool are £33,799,489, including iBCF funding (£22,108,632 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 2021-22 the Derbyshire County Council received additionally £31,054,728 (2020-21: £34,682,034); and Derby City Council additionally £10,542,289 (2020-21: £11,690,858) 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:

	2021-22	**2021-22 Pool Share**	2020-21	2020-21 Pool Share
	£'000	**%**	£'000	%
Income				
NHS Derby and Derbyshire CCG	(71,139)	59.98	(57,255)	55.06
NHS Tameside and Glossop CCG	(2,627)	2.22	(2,501)	2.41
Derbyshire County Council	(44,838)	37.80	(44,227)	42.53
Total Income	**(118,604)**	**100.00**	(103,983)	100.00

	2021-22	2020-21
Edpenditure	**£'000**	£'000
CCG schemes aimed at reducing non elective activity	22,670	21,575
CCG schemes - wheelchairs	1,088	1,035
Derbyshire County Council schemes	7,898	7,898
ICES (Integrated Community Equipment Service)	6,533	5,770
Reablement	17,535	11,007
7 Day working	0	1,477
Administration, Performance and Information Sharing	551	538
Care Bill	2,304	2,259
Delayed Transfer of Care	8,108	7,606
Carers	2,208	2,154
Integrated Care	12,396	1,643
Workforce Development	441	2,820
Dementia Support	421	1,781
Autism and Mental Health	1,769	1,738
iBCF	31,055	31,055
Winter Pressures Grant	3,627	3,627
Total Expenditure	**118,604**	103,983
Net position for Pool	**0**	0

17. Joint arrangements - interests in joint operations, continued.

The memorandum account for the "Derby City Better Care Fund" pooled budget is:

	2021-22	**2021-22 Pool Share**	2020-21	2020-21 Pool Share
	£'000	**%**	£'000	%
Income				
NHS Derby and Derbyshire CCG	(19,516)	57.74	(18,557)	56.51
Derby City Council	(14,284)	42.26	(14,284)	43.49
Total Income	**(33,800)**	**100.00**	(32,841)	100.00

	2021-22	2020-21
Expenditure	**£'000**	£'000
CCG schemes aimed at reducing non elective activity	3,938	3,744
Derby City Council schemes	2,323	2,323
Community Health Services	6,227	5,935
Social Care	8,890	8,453
Winter Pressures Grant	551	524
Accident & Emergency	180	171
iBCF	10,542	10,542
Winter Pressures Grant	1,149	1,149
Total Expenditure	**33,800**	32,841
Net position for Pool	**0**	0

NHS Derby and Derbyshire Clinical Commissioning Group is also a partner of the "Children and Young People with Complex Needs" pooled budget along with Derbyshire County Council. This pool is hosted by Derbyshire County Council.

The memorandum account for the "Children and Young People with Complex Needs" pooled budget is:

	2021-22	**2021-22 Pool Share**	2020-21	2020-21 Pool Share
	£'000	**%**	£'000	%
Income				
NHS Derby and Derbyshire CCG	2,376	33.00	(2,335)	33.00
Derbyshire County Council	4,824	67.00	(4,740)	67.00
Total Income	**7,200**	**100.00**	**(7,075)**	**100.00**

	2021-22	2020-21
Expenditure	**£'000**	£'000
Purchase of equipment and healthcare services	7,200	(7,075)
Total Expenditure	**7,200**	(7,075)
Net position for Pool	**0**	0

17. Joint arrangements - interests in joint operations, continued.

NHS Derby and Derbyshire Clinical Commissioning Group is also a partner of the "Integrated Disabled Children's Centre and Services in Derby" pooled budget, along with Derby City Council. This pool is hosted by Derby City Council.

The memorandum account for the "Integrated Disabled Children's Centre an Services in Derby" pooled budget is:

	2021-22	**2021-22 Pool Share**	2020-21	2020-21 Pool Share
	£'000	**%**	£'000	%
Income				
NHS Derby and Derbyshire CCG	(1,011)	43.71	(1,011)	43.62
Derby City Council	(1,302)	56.29	(1,307)	56.38
Total Income	**(2,313)**	**100.00**	(2,318)	100.00

	2021-22	2020-21
Expenditure	**£'000**	£'000
Residential Services	1,052	1,033
Community Service Team (Outreach Service)	243	276
Disability and Fieldwork Social Work Services	12	4
Management and Administration	795	797
Total Expenditure	**2,102**	2,110
Net position for Pool	**(211)**	(208)
Balance brought forward as at 1 April	(381)	(173)
Balance carried forward as at 31 March	**(592)**	(381)
NHS Derby and Derbyshire CCG share of surplus as at 31 March	**260**	(166)

The Integrated Disabled Chldren's Centre and Services in Derby pooled budget reported an underspend of £211k for the year (2020-21: £208k), with a total accumulated underspend of £592k at 31 March 2022 (2020-21: £381k).
NHS Derby and Derbyshire Clinical Commissioning Group's share of the accumulated underspend was £260k (2020-21: £166k). This amount has been carried forward in the pool.

18 Related party transactions

Details of related party transactions with individuals are as follows:

Body	Payments to Related Party	Receipts from Related Party	Amounts owed to Related Party	Amounts due from Related Party
	£'000	£'000	£'000	£'000
College Street Medical	2	-	-	-
Derby City Council	25,082	(269)	3,343	(135)
Derbyshire County Council	87,916	(522)	9,096	(339)
Emmett Carr Surgery	666	-	-	-
Erewash Health Partnership	3,198	-	-	-
Hannage Brook Medical Centre	23	-	-	-
Killamarsh Medical Practice	1,108	-	-	-
Lakhani Jordan Bhatia & Partners	1,744	-	-	-
Lindop Williams Merrick & Partners	1,269	-	-	-
Littlewick Medical Centre	2,416	-	-	-
Moir Medical Centre	8	-	-	-
NHSE Central and Midlands	-	(577)	-	(498)
Sheffield Teaching Hospitals NHS Foundation Trust	1,221	-	-	
Nottingham University Hospitals NHS Trust	43,765	-	-	-
Ramchandran & Partners	772	-	-	-
Sheffield Teaching Hospitals NHS Foundation Trust	27,758	-	-	-
St Lawrence Road Surgery	688	-	1	-
Staffa Health	2,603	-	-	-
Swadlincote Surgery	1,805	-	-	-
University Hospitals Of Derby And Burton NHS Foundation Trust	598,370	(7)	755	(2)
University Hospitals of Leicester NHS Trust	1,304	-	-	-
Vernon Street Medical Centre	1,215	-	-	-
Purnell and Partners	545	-	-	-

All transactions have been at arm's length as part of NHS Derby and Derbyshire Clinical Commissioning Group's healthcare commissioning.

The Department of Health is regarded as a related party. During the year the Clinical Commissioning Group has had a significant number of material transactions with entities for which the Department is regarded as the parent Department. For example:
• NHS England including: NHS England Midlands; NHS Arden & GEM Commissioning Support Unit; NHS Midlands and Lancashire Commissioning Support Unit; NHS North of England Commissioning Support Unit
• NHS Foundation Trusts including: Chesterfield Royal Hospitals NHS Foundation Trust; Derbyshire Community Healthcare Services NHS Foundation Trust; Derbyshire Healthcare NHS Foundation Trust; and University Hospitals of Derby and Burton NHS Foundation Trust
• NHS Trusts including: East Midlands Ambulance Service NHS Trust; and Nottingham University Hospitals NHS Trust
• NHS Resolution
• NHS Business Services Authority

NHS Derby and Derbyshire Clinical Commissioning Group also has material transactions with all the GP Practices within its locality and membership.

In addition, NHS Derby and Derbyshire Clinical Commissioning Group has had a number of material transactions with other Government departments and other central and local government bodies. Most of these transactions have been with Derby City Council; and Derbyshire County Council, in respect of joint enterprises.

During 2020-21 the following related party transactions were made with NHS Derby and Derbyshire Clinical Commissioning Group (transactions identified were not with the member but between the Clinical Commissioning Group and the related party):

Body	Payments to Related Party £'000	Receipts from Related Party £'000	Amounts owed to Related Party £'000	Amounts due from Related Party £'000
College Street Medical	56	-	-	-
Derby City Council	30,346	(130)	3,309	(127)
Derbyshire County Council	73,858	(449)	7,766	(126)
Emmett Carr Surgery	696	-	-	-
Erewash Health Partnership	1,561	-	148	-
Hannage Brook Medical Centre	43	-	-	-
Killamarsh Medical Practice	1,103	-	-	-
Lakhani Jordan Bhatia & Partners	1,772	-	-	-
Lindop Williams Merrick & Partners	1,266	-	-	-
Littlewick Medical Centre	2,531	-	-	-
Moir Medical Centre	26	-	-	-
NHSE Central And Midlands	42	(239)	30	(2,033)
North Eastern Derbyshire Healthcare Ltd	1,075	-	-	-
Nottingham University Hospitals NHS Trust	43,505	-	-	-
Ramchandran & Partners	168,387	-	-	-
St Lawrence Road Surgery	636	-	-	-
Staffa Health	2,343	-	-	-
Swadlincote Surgery	1,751	-	-	-
The Rotherham Nhs Foundation Trust	233	(2)	3	-
University Hospitals Of Derby And Burton NHS Foundation Trust	499,822	(3)	75	(3)
University Hospitals Of Leicester NHS Trust	1,251	-	29	-
Vernon Street Medical Centre	1,118	-	-	-

19 Events after the end of the reporting period

On 28 April 2022 the Health and Care Bill was approved by Parliament. The Health and Care Bill approves the formation of Integrated Care Boards and for them to take over the functions of Clinical Commissioning Groups. As a result NHS Derby and Derbyshire CCG will be dissolved on 30 June 2022 and Derby and Derbyshire Integrated Care Board will be formed from the following day. In line with the provisions of the Group Accounting Manual the assets and liabilities of the CCG will transfer to the newly formed Integrated Care Board at book value.

20 Losses and special payments

20.1 Losses

The total number of NHS clinical commissioning group losses and special payments cases, and their total value, was as follows:

	Total Number of Cases 2021-22 Number	**Total Value of Cases 2021-22 £'000**	Total Number of Cases 2020-21 Number	Total Value of Cases 2020-21 £'000
Administrative write-offs	2	1	3	11
Fruitless payments	-	-	-	-
Store losses	-	-	-	-
Book Keeping Losses		-	-	-
Claims abandoned	-	-		-
Constructive loss	-	-	-	-
Cash losses	-	-	-	-
Claims abandoned	-	-	-	-
Total	**2**	**1**	**3**	**11**

In 2021-22, £731 of staff costs were written off in relation to two salary overpayments (2020-21, £681). No further write-offs were made in the financial year (2020-21, £10,000 relating to a historical debt owed to NHS Southern Derbyshire Clinical Commissioning Group was also written off).

20.2 Special payments

	Total Number of Cases 2021-22 Number	**Total Value of Cases 2021-22 £'000**	Total Number of Cases 2020-21 Number	Total Value of Cases 2020-21 £'000
Compensation payments	1	3	1	10
Compensation payments Treasury Approved	-	-	-	-
Extra Contractual Payments	-	-	-	-
As the cash requirements of NHS England are met through the Estimate proce	-	-	-	-
Ex Gratia Payments	-	-	-	-
Ex Gratia Payments Treasury Approved	-	-	-	-
Extra Statutory Extra Regulatory Payments	-	-	-	-
Extra Statutory Extra Regulatory Payments Treasury Approved	-	-	-	-
Special Severance Payments Treasury Approved	-	-	-	-
Total	**1**	**3**	**1**	**10**

During the year, a settlement of £3,000 was agreed for a legal claim against NHS Derby and Derbyshire CCG (2020-21, £10,000 special payment was agreed for a historic personal injury claim with NHS Erewash Clinical Commissioning Group).

21 Financial performance targets

NHS Clinical Commissioning Group have a number of financial duties under the NHS Act 2006 (as amended).
NHS Clinical Commissioning Group performance against those duties was as follows:

	2021-22 Target	**2021-22 Performance**	**Duty Achieved**	2020-21 Target	2020-21 Performance	Duty Achieved
Expenditure not to exceed income	2,121,306	2,120,665	Yes	1,900,759	1,900,461	Yes
Capital resource use does not exceed the amount specified in Directions	650	87	Yes	60	60	Yes
Revenue resource use does not exceed the amount specified in Directions	2,113,550	2,113,473	Yes	1,896,152	1,895,854	Yes
Capital resource use on specified matter(s) does not exceed the amount specified in Directions	-	-	N/A	-	-	N/A
Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	168,343	168,380	Yes	152,099	152,092	Yes
Revenue administration resource use does not exceed the amount specified in Directions	20,905	18,633	Yes	21,005	18,210	Yes

NHS Derby and Derbyshire Clinical Commissioning Group achieved an in-year surplus of £214k (2020-21: £298k).

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 2022 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 2022 and of its income and expenditure for the year then ended; and
- have been properly prepared in accordance with the accounting policies directed by NHS England with the consent of the Secretary of State as being relevant to CCGs in England and included in the Department of Health and Social Care Group Accounting Manual 2021/22.

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.

Emphasis of matter – going concern

We draw attention to the disclosure made in note 1 to the financial statements which explains that on 1 July 2022, NHS Derby and Derbyshire CCG will be dissolved and its services transferred to Joined Up Care Derbyshire Integrated Care Board. Under the continuation of service principle, the financial statements of the CCG have been prepared on a going concern basis because its services will continue to be provided by the successor public sector entity. Our opinion is not modified in this respect.

Going concern basis of preparation

The Accountable Officer has prepared the financial statements on the going concern basis as they have not been informed by the relevant national body of the intention to dissolve the CCG without the transfer of its services to another public sector entity. They have also concluded that there are no material uncertainties that could have cast significant doubt over its ability to continue as a going concern for at least a year from the date of approval of the financial statements ("the going concern period").

In our evaluation of the Accountable Officer's conclusions, we considered the inherent risks to the CCG's operating model and analysed how those risks might affect the CCG's financial resources or ability to continue operations over the going concern period.

Our conclusions based on this work:

- we consider that the Accountable Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate; and
- we have not identified, and concur with the Accountable Officer's assessment that there is not, a material uncertainty related to events or conditions that, individually or collectively, may cast significant doubt on the CCG's ability to continue as a going concern for the going concern period.

However, as we cannot predict all future events or conditions and as subsequent events may result in outcomes that are inconsistent with judgements that were reasonable at the time they were made, the above conclusions are not a guarantee that the CCG will continue in operation.

Fraud and breaches of laws and regulations – ability to detect

Identifying and responding to risks of material misstatement due to fraud

To identify risks of material misstatement due to fraud ("fraud risks") we assessed events or conditions that could indicate an incentive or pressure to commit fraud or provide an opportunity to commit fraud. Our risk assessment procedures included:

- Enquiring of management, the Audit Committee and internal audit and inspection of policy documentation as to the CCG's high-level policies and procedures to prevent and detect fraud, including the internal audit function, and the CCG's procedure for "whistleblowing", as well as whether they have knowledge of any actual, suspected or alleged fraud
- Assessing the incentives for management to manipulate reported expenditure as a result of the need to achieve statutory targets delegated to the CCG by NHS England.
- Reading Governing Body and Audit Committee minutes.
- Using analytical procedures to identify any unusual or unexpected relationships.
- Reviewing the CCG's accounting policies.

We communicated identified fraud risks throughout the audit team and remained alert to any indications of fraud throughout the audit.

As required by auditing standards, and taking into account possible pressures to meet delegated statutory resource limits, we performed procedures to address the risk of management override of controls, in particular the risk that CCG management may be in a position to make inappropriate accounting entries.

On this audit we did not identify a fraud risk related to revenue recognition because of the nature of funding provided to the CCG, which is transferred from NHS England and recognised through the Statement of Changes in Taxpayers' Equity. However, in line with the guidance set out in Practice Note 10 Audit of Financial Statements of Public Sector Bodies in the United Kingdom we recognised a fraud risk related to expenditure recognition.

We did not identify any additional fraud risks.

In determining the audit procedures, we took into account the results of our evaluation and testing of the operating effectiveness of some of CCG-wide fraud risk management controls.

We also performed procedures including:

- Identifying journal entries to test based on risk criteria and comparing the identified entries to supporting documentation. These included journal entries that were considered outside of the normal course of business and other unusual journal characteristics.
- Assessing the completeness of disclosed related party transactions and verifying they had been accurately recorded within the financial statements.
- Assessing the existence and accuracy of recorded expenditure through specific testing over accruals.
- Assessing the completeness of disclosed related party transactions and verifying they had been accurately recorded within the financial statements.

Identifying and responding to risks of material misstatement related to non-compliance with laws and regulations

We identified areas of laws and regulations that could reasonably be expected to have a material effect on the financial statements from our general sector experience and through discussion with the directors and other management (as required by auditing standards), and from inspection of the CCG's regulatory and legal correspondence and discussed with the directors and other management the policies and procedures regarding compliance with laws and regulations.

As the CCG is regulated, our assessment of risks involved gaining an understanding of the control environment including the entity's procedures for complying with regulatory requirements.

We communicated identified laws and regulations throughout our team and remained alert to any indications of non-compliance throughout the audit.

The potential effect of these laws and regulations on the financial statements varies considerably.

The CCG is subject to laws and regulations that directly affect the financial statements including the National Health Service Act 2006 and financial reporting legislation. We assessed the extent of compliance with these laws and regulations as part of our procedures on the related financial statement items and our work on the regularity of expenditure incurred by the CCG in the year of account.

Whilst the CCG is subject to many other laws and regulations, we did not identify any others where the consequences of non-compliance alone could have a material effect on amounts or disclosures in the financial statements.

Context of the ability of the audit to detect fraud or breaches of law or regulation

Owing to the inherent limitations of an audit, there is an unavoidable risk that we may not have detected some material misstatements in the financial statements, even though we have properly planned and performed our audit in accordance with auditing standards. For example, the further removed non-compliance with laws and regulations is from the events and transactions reflected in the financial statements, the less likely the inherently limited procedures required by auditing standards would identify it.

In addition, as with any audit, there remained a higher risk of non-detection of fraud, as these may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal controls. Our audit procedures are designed to detect material misstatement. We are not responsible for preventing non-compliance or fraud and cannot be expected to detect non-compliance with all laws and regulations.

Other information in the Annual Report

The Accountable Officer is responsible for the other information presented in the Annual Report together with the financial statements. Our opinion on the financial statements does not cover the other information and, accordingly, we do not express an audit opinion or, except as explicitly stated below, any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether, based on our financial statements audit work, the information therein is materially misstated or inconsistent with the financial statements or our audit knowledge. Based solely on that work:

- we have not identified material misstatements in the other information;
- in our opinion the other information included in the Annual Report for the financial year is consistent with the financial statements; and
- in our opinion the other information has been prepared in accordance with the requirements of the Department of Health and Social Care Group Accounting Manual 2021/22.

Annual Governance Statement

We are required to report to you if the Annual Governance Statement has not been prepared in accordance with the requirements of the Department of Health and Social Care Group Accounting Manual 2021/22. We have nothing to report in this respect.

Remuneration and Staff Reports

In our opinion the parts of the Remuneration and Staff Reports subject to audit have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2021/22.

Accountable Officer's responsibilities

As explained more fully in the statement set out on pages 107-108, the Accountable Officer is responsible for the preparation of financial statements that give a true and fair view. They are also responsible for such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; assessing the CCG's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the CCG without the transfer of its services to another public sector entity.

Auditor's responsibilities

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue our opinion in an auditor's report. Reasonable assurance is a high level of assurance, but does not guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements.

A fuller description of our responsibilities is provided on the FRC's website at www.frc.org.uk/auditorsresponsibilities

REPORT ON OTHER LEGAL AND REGULATORY MATTERS

Opinion on regularity

We are required to report on the following matters under Section 25(1) of the Local Audit and Accountability Act 2014.

In our opinion, in all material respects, the expenditure and income recorded in the financial statements have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them.

Report on the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice, we are required to report if we identify any significant weaknesses in the arrangements that have been made by the CCG to secure economy, efficiency and effectiveness in its use of resources.

We have nothing to report in this respect.

Respective responsibilities in respect of our review of arrangements for securing economy, efficiency and effectiveness in the use of resources

As explained more fully in the statement set out on pages 141-144, the Accountable Officer is responsible for ensuring that the CCG exercises its functions effectively, efficiently and economically. We are required under section 21(1)(c) of the Local Audit and Accountability Act 2014 to be satisfied that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

We are not required to consider, nor have we considered, whether all aspects of the CCG's arrangements for securing economy, efficiency and effectiveness in the use of resources are operating effectively.

We planned our work and undertook our review in accordance with the Code of Audit Practice and related statutory guidance, having regard to whether the CCG had proper arrangements in place to ensure financial sustainability, proper governance and to use information about costs and performance to improve the way it manages and delivers its services. Based on our risk assessment, we undertook such work as we considered necessary.

Statutory reporting matters

We are required by Schedule 2 to the Code of Audit Practice issued by the Comptroller and Auditor General ('the Code of Audit Practice') to report to you if we refer a matter to the Secretary of State and NHS England under section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the CCG, or an officer of the CCG, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency.

We have nothing to report in this respect.

THE PURPOSE OF OUR AUDIT WORK AND TO WHOM WE OWE OUR RESPONSIBILITIES

This report is made solely to the Members of the Governing Body of NHS Derby and Derbyshire CCG, as a body, in accordance with Part 5 of the Local Audit and Accountability Act 2014. Our audit work has been undertaken so that we might state to the Members of the Governing Body of the CCG, as a body, those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Members of the Governing Body, as a body, for our audit work, for this report or for the opinions we have formed.

CERTIFICATE OF COMPLETION OF THE AUDIT

We certify that we have completed the audit of the accounts of NHS Derby and Derbyshire CCG for the year ended 31 March 2022 in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Andrew Cardoza
for and on behalf of KPMG LLP
Chartered Accountants
1 Snow Hill Queensway
Birmingham
B4 6GH

17 June 2022

APPENDICES

Appendix One: CCG Attendance at Meetings 2021/22

Governing Body Attendance Record 2021/22

Governing Body Member	1 Apr 2021	6 May 2021	3 Jun 2021	1 Jul 2021	5 Aug 2021	2 Sep 2021	7 Oct 2021	4 Nov 2021	2 Dec 2021	13 Jan 2022	3 Feb 2022	3 Mar 2022
Dr Avi Bhatia *Clinical Chair*	✓	✓	✓	✓	✓	✓	✓	X	✓	✓	✓	✓
Martin Whittle *Vice Chair, Lay Member for Patient and Public Involvement*	✓	✓	✓	X	✓	✓	✓	✓	✓	✓	✓	✓
Dr Chris Clayton *Chief Executive Officer*	✓	✓	X	✓	✓	✓	X	✓	✓	✓	✓	✓
Richard Chapman *Chief Finance Officer*	✓	✓	X	✓	✓	✓	✓	✓	✓	✓	✓	✓
Brigid Stacey *Chief Nurse Officer*	✓	X	✓	✓	✓	✓	✓	✓	✓	X*	✓	X*
Dr Steven Lloyd *Executive Medical Director*	✓	✓	✓	✓	✓	X*	X	✓	✓	✓	✓	X
Dr Penny Blackwell *GP Member*	✓	X	X	✓	X	✓	✓	✓	✓	X	✓	✓
Dr Ruth Cooper *GP Member*	✓	✓	X	✓	✓	✓	✓	✓	✓	✓	✓	✓
Dr Bukhtawar Dhadda *GP Member*	✓	✓	✓	✓	X	✓	✓	✓	✓	✓	✓	✓
Dr Emma Pizzey *GP Member*	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Dr Greg Strachan *GP Member*	X	✓	X	✓	✓	✓	✓	✓	✓	✓	✓	✓
Dr Merryl Watkins *GP Member*	✓	✓	X	✓	✓	X	✓	✓	✓	✓	✓	✓

* Indicates where a member was deputised.

Governing Body Member	1 Apr 2021	6 May 2021	3 Jun 2021	1 Jul 2021	5 Aug 2021	2 Sep 2021	7 Oct 2021	4 Nov 2021	2 Dec 2021	13 Jan 2022	3 Feb 2022	3 Mar 2022
Jill Dentith *Lay Member for Governance and Freedom to Speak Up Guardian*	✓	✓	✓	✓	✓	X	✓	✓	✓	✓	✓	✓
Ian Gibbard *Lay Member for Audit and Conflicts of Interest Guardian*	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Andrew Middleton *Lay Member for Finance and Sustainability Champion*	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Simon McCandlish *Lay Member for Patient and Public Involvement*	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Professor Ian Shaw *Lay Member for Primary Care Commissioning*	✓	✓	✓	✓	X	✓	X	X	✓	X	✓	✓
Dr Bruce Braithwaite *Secondary Care Consultant*	✓	✓	✓	X	✓	✓	✓	✓	✓	✓	✓	X
Helen Dillistone *Executive Director of Corporate Strategy and Delivery*	✓	✓	✓	X	✓	✓	✓	✓	✓	✓	✓	✓
Zara Jones *Executive Director of Commissioning Operations*	✓	✓	X	✓	✓	✓	✓	✓	✓	✓	✓	✓
Dr Robyn Dewis *Derby City Council Representative*	X	X	X	✓	X	X	X	X	X	X	✓	X
Dean Wallace *Derbyshire County Council Representative*	X	✓	✓	X	X	X	X	✓	X	X	✓	X

Audit Committee Attendance Record 2021/22

Audit Committee Member	28 Apr 2021	25 May 2021	16 Sep 2021	18 Nov 2021	17 Dec 2021	20 Jan 2022	17 Mar 2022
Ian Gibbard *Chair, Lay Member for Audit and Conflicts of Interest Guardian*	✓	✓	✓	✓	✓	✓	✓
Jill Dentith *Deputy Chair, Lay Member for Governance and Freedom to Speak Up Guardian*	✓	✓	X	✓	✓	✓	✓
Andrew Middleton *Lay Member for Finance and Sustainability Champion*	✓	✓	✓	✓	✓	✓	✓
Dr Bruce Braithwaite *Secondary Care Consultant*[+]	X	X	X	X	X	X	X

Primary Care Commissioning Committee Attendance Record 2021/22

Primary Care Commissioning Committee Member	28 Apr 2021	26 May 2021	23 Jun 2021	28 Jul 2021	25 Aug 2021	22 Sep 2021	27 Oct 2021	24 Nov 2021	22 Dec 2021	26 Jan 2022	23 Feb 2022	23 Mar 2022
Professor Ian Shaw *Chair, Lay Member for Primary Care Commissioning*	✓	✓	X	✓	✓	✓	X	✓	✓	X	✓	✓
Simon McCandlish *Deputy Chair, Lay Member for Patient and Public Involvement*	✓	✓	✓	✓	✓	X	✓	✓	✓	✓	✓	X
Jill Dentith *Lay Member for Governance and Freedom to Speak Up Guardian*	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Brigid Stacey *Chief Nurse Officer*	X*	X	X*	X	X	X*	X*	X*	X*	X*	X*	X*
Richard Chapman *Chief Finance Officer*	X*	✓	X*	X*	X*	X*	X*	X*	✓	X*	X*	X*
Dr Steven Lloyd *Executive Medical Director*	✓	X*	✓	X*	X*	✓	✓	✓	✓	✓	X	✓

[+] 'By invitation' in accordance with the Committee's workplan or where clinical input is required.
* Indicates where a member was deputised.

Remuneration Committee Attendance Record 2021/22

Remuneration Committee Member	25 May 2021	5 Oct 2021	2 Dec 2021	4 Jan 2022	7 Mar 2022
Martin Whittle *Chair, Lay Member for Patient and Public Involvement*	X	✓	✓	✓	X
Ian Gibbard *Lay Member for Audit and Conflicts of Interest Guardian*	✓	✓	✓	✓	✓
Jill Dentith *Lay Member for Governance and Freedom to Speak Up Guardian*	✓	✓	X	X	X
Andrew Middleton *Lay Member for Finance and Sustainability Champion*	✓	✓	✓	✓	✓

Clinical and Lay Commissioning Committee Attendance Record 2021/22

Clinical and Lay Commissioning Committee Member	8 Apr 2021	13 May 2021	10 Jun 2021	8 Jul 2021	12 Aug 2021	9 Sep 2021	14 Oct 2021	11 Nov 2021	9 Dec 2021	13 Jan 2022	10 Feb 2022	10 Mar 2022
Dr Ruth Cooper *Chair, GP Member*	✓	✓	✓	X	✓	X	✓	✓	✓	✓	✓	X
Professor Ian Shaw *Deputy Chair, Lay Member for Primary Care Commissioning*	✓	✓	✓	X	X	X	X	X	✓	✓	✓	X
Dr Bukhtawar Dhadda *GP Member*	✓	✓	✓	✓	✓	✓	✓	X	✓	✓	✓	X
Dr Emma Pizzey *GP Member*	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Dr Greg Strachan *GP Member*	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Dr Merryl Watkins *GP Member*	✓	✓	✓	✓	✓	✓	X	✓	X	✓	✓	✓
Dr Bruce Braithwaite *Secondary Care Consultant*	✓	✓	✓	X	✓	X	✓	X	X	X	✓	X
Simon McCandlish *Lay Member for Patient and Public Involvement*	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Ian Gibbard *Lay Member for Audit and Conflicts of Interest Guardian*	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	X	✓
Brigid Stacey *Chief Nurse Officer*	X*	X	X*	X*	X*	X*	✓	X*	✓	X*	✓	X*
Richard Chapman *Chief Finance Officer*	✓	✓	✓	✓	X*	✓	X*	X*	X*	X*	✓	✓

* Indicates where a member was deputised.

Clinical and Lay Commissioning Committee Member	8 Apr 2021	13 May 2021	10 Jun 2021	8 Jul 2021	12 Aug 2021	9 Sep 2021	14 Oct 2021	11 Nov 2021	9 Dec 2021	13 Jan 2022	10 Feb 2022	10 Mar 2022
Dr Steven Lloyd *Executive Medical Director*	X*	X*	X	✓	✓	✓	✓	✓	✓	X	✓	X*
Dr Robyn Dewis *Public Health Representative*	X	X	X	X	X	X*	X*	X*	X*	X*	X	X
Zara Jones *Executive Director of Commissioning Operations*	✓	✓	✓	✓	X*	✓	✓	✓	✓	✓	✓	✓

Engagement Committee Attendance Record 2021/22

Engagement Committee Member	20 Apr 2021	18 May 2021	15 June 2021	20 July 2021	17 Aug 2021	21 Sep 2021	16 Nov 2021	18 Jan 2022	15 Mar 2022
Martin Whittle *Chair, Lay Member for Patient and Public Involvement*	✓	✓	✓	✓	✓	✓	✓	✓	X
Simon McCandlish *Deputy Chair, Lay Member for Patient and Public Involvement*	✓	✓	✓	✓	✓	X	✓	✓	✓
Professor Ian Shaw *Lay Member for Primary Care Commissioning*	✓	✓	✓	X	X	✓	✓	✓	✓
Maura Teager *Foundation Trust Governor – Secondary Care*	X	X	✓	✓	X	✓	✓	✓	X
Margaret Rotchell *Foundation Trust Governor – Secondary Care*	✓	✓	✓	✓	✓	✓	✓	✓	✓
Lynn Walshaw *Foundation Trust Governor – Community*	✓	✓	✓	✓	✓	X	✓	✓	✓
Kevin Richards *Foundation Trust Governor – Mental Health*	X	✓	✓	X	X	X	✓		
Chris Mitchell *Foundation Trust Governor – Mental Health*[22]							✓	✓	✓
Ram Paul *Derby City Council Representative*	X	X	X	X	X	X	X	X	X
Jocelyn Street *Place Engagement Representative*	✓	✓	X	✓	X	✓	✓	✓	✓
Ruth Grice *Place Engagement Representative*	✓	✓	X	X	X	X	X	X	X
Roger Cann *Place Engagement Representative*	✓	✓	✓	X	X	X	X	X	X
Trevor Corney *Place Engagement Representative*	X	X	X	X	X	X	X	X	X
Steve Bramley *Place Engagement Representative*	✓	✓	✓	✓	✓	✓	✓	✓	✓
Tim Peacock *Place Engagement Representative*	✓	✓	✓	X	✓	X	✓	✓	✓

* Indicates where a member was deputised.

[22] Chris Mitchell replaced Kevin Richards in November 2021 as Foundation Trust Governor – Mental Health for the Engagement Committee.

Engagement Committee Member	20 Apr 2021	18 May 2021	15 June 2021	20 July 2021	17 Aug 2021	21 Sep 2021	16 Nov 2021	18 Jan 2022	15 Mar 2022
Helen Dillistone *Executive Director of Corporate Strategy and Delivery*	✓	✓	✓	✓	✓	✓	✓	✓	X
Beth Soraka *Healthwatch Derby Representative*	X	X	✓	✓	✓	✓			
Rebecca Johnson *Healthwatch Derby Representative*[23]							✓	✓	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	✓
Vikki Taylor *Director, Joined Up Care Derbyshire*	X*	✓	✓	X*	X*	✓	✓	✓	✓
Sean Thornton *Assistant Director Communications and Engagement, CCG*	✓	✓	✓	✓	✓	✓	✓	✓	✓
Karen Lloyd *Head of Engagement, Joined Up Care Derbyshire*	X	✓	✓	X	✓	X	✓	✓	✓

Finance Committee Attendance Record 2021/22

Finance Committee Member	29 Apr 2021	27 May 2021	24 Jun 2021	29 Jul 2021	26 Aug 2021	30 Sep 2021	28 Oct 2021	25 Nov 2021	23 Dec 2021	27 Jan 2022	2 Mar 2022	31 Mar 2022
Andrew Middleton *Chair, Lay Member for Finance and Sustainability Champion*	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Martin Whittle *Lay Member for Patient and Public Involvement*	✓	X	✓	✓	✓	✓	✓	✓	X	X	X	✓
Ian Gibbard *Lay Member for Audit and Conflicts of Interest Guardian*	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Dr Bukhtawar Dhadda *GP Member*	✓	X	✓	X	✓	✓	✓	✓	✓	✓	X	✓
Dr Merryl Watkins *GP Member*	X	✓	✓	✓	X	✓	✓	✓	✓	✓	✓	✓
Richard Chapman *Chief Finance Officer*	✓	✓	✓	✓	X*	✓	✓	✓	✓	✓	✓	x
Brigid Stacey *Chief Nurse Officer*	X	✓	✓	✓	X	✓	✓	X*	✓	X*	✓	x

[23] Rebecca Johnson replaced Beth Soraka in November 2021 as Healthwatch Derby Representative for the Engagement Committee.
* Indicates where a member was deputised.

Governance Committee Attendance Record 2021/22

Governance Committee Member	20 May 2021	22 Jul 2021	23 Sep 2021	11 Nov 2021	10 Feb 2022
Jill Dentith *Chair, Lay Member for Governance and Freedom to Speak Up Guardian*	✓	✓	✓	✓	✓
Ian Gibbard *Lay Member for Audit and Conflicts of Interest Guardian*	✓	✓	✓	✓	X
Martin Whittle *Lay Member for Patient and Public Involvement*	✓	✓	✓	✓	✓
Dr Emma Pizzey *GP Member*	✓	✓	✓	✓	✓
Dr Greg Strachan *GP Member*	✓	✓	✓	✓	✓
Helen Dillistone *Executive Director of Corporate Strategy and Delivery*	✓	✓	✓	✓	X

Quality and Performance Committee Attendance Record 2021/22

Quality and Performance Committee Member	29 Apr 2021	27 May 2021	24 Jun 2021	29 Jul 2021	26 Aug 2021	30 Sep 2021	28 Oct 2021	25 Nov 2021	23 Dec 2021	27 Jan 2022	24 Feb 2022	31 Mar 2022
Dr Bukhtawar Dhadda *Chair, GP Member*	✓	X	✓	X	✓	✓	✓	✓	✓	✓	✓	✓
Dr Emma Pizzey *GP Member*	✓	✓	X	✓	X	✓	X	✓	✓	✓	✓	✓
Dr Greg Strachan *GP Member*	✓	✓	✓	✓	X	✓	✓	✓	✓	✓	✓	✓
Dr Merryl Watkins *GP Member*	✓	✓	✓	✓	X	✓	✓	✓	✓	✓	X	✓
Andrew Middleton *Lay Member for Finance and Sustainability Champion*	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Simon McCandlish *Lay Member for Patient and Public Involvement*	✓	✓	✓	✓	✓	✓	✓	✓	X	✓	✓	✓
Martin Whittle *Lay Member for Patient and Public Involvement*	✓	✓	✓	✓	✓	✓	✓	✓	X	X	✓	✓
Brigid Stacey *Chief Nurse Officer*	X	X*	✓	✓	X*	X*	✓	X*	✓	✓	✓	✓
Dr Steven Lloyd *Executive Medical Director*	X*	X*	X*	✓	X*	✓	X	X*	X	X*	X*	X*
Dr Bruce Braithwaite *Secondary Care Consultant*	X	X	X	✓	✓	X	X	✓	X	✓	✓	x
Zara Jones *Executive Director of Commissioning Operations*	X*	X*	X*	X	X*	X*	X*	X*	X*	X*	X*	x
Helen Henderson-Spoors *Healthwatch Derbyshire Representative*	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
AMR	Antimicrobial Resistance
ARRS	Additional Roles Reimbursement Scheme
Bn	Billion
C1, C2, C3, C4	Category 1, Category 2, Category 3, Category 4
CAMHS	Children Adolescent Mental Health Services
CCG	Clinical Commissioning Group
CETV	Cash Equivalent Transfer Value
CHC	Continuing Healthcare
CPA	Care Programme Approach
CQC	Care Quality Commission
CRHFT	Chesterfield Royal Hospital NHS Foundation Trust
CUES	Covid-19 Urgent Eye Service
DCHSFT	Derbyshire Community Health Services NHS Foundation Trust
DHcFT	Derbyshire Healthcare NHS Foundation Trust
DHU111	Derbyshire Health United 111 (East Midlands) Community Interest Company
DSPT	NHS Data Security and Protection Toolkit
EAF	Expert Advisory Forum
ED	Emergency Department
EDS2	NHS Equality Delivery System 2
EMAS	East Midlands Ambulance Service NHS Trust
EPRR	Emergency Preparedness, Resilience and Response
FTE	Full Time Equivalent
GBAF	Governing Body Assurance Framework
GP	General Practitioner
GP-CPCS	General Practice Community Pharmacist Consultation Service

H1	April to September 2021
H2	October 2021 to March 2022
HCAI	Healthcare-associated infections
HCD	High-Cost Drugs
HED	Health Education Derbyshire
HR	Human Resources
IAPT	Improving Access to Psychological Therapies
ICB	Integrated Care Board
ICS	Integrated Care System
IT	Information Technology
JUCD	Joined Up Care Derbyshire
K	Thousand
KPI	Key Performance Indicator
LeDeR	Learning Disability and Autistic People
LMNS	Local Maternity and Neonatal System
LPA	Local Place Alliance
LTC	Long Term Condition
m	Million
MDI	Metered Dose Inhalers
MECS	Minor Eye Conditions Service
MHST	Mental Health Support Team
MRSA	Methicillin-resistant Staphylococcus aureus
MSK	Musculoskeletal
MSSA	Methicillin-sensitive Staphylococcus aureus
NECS	North of England Commissioning Support
NHS	National Health Service
NHSE&I	NHS England and NHS Improvement
NICE	National Institute for Health and Care Excellence

OEIG	Organisation Effectiveness and Improvement Group
PCN	Primary Care Network
PICU	Psychiatric Intensive Care Units
PPG	Patient Participation Group
PSC	Personal Services Company
PSIRF	Patient Safety Incident Response Framework
Q1, Q2, Q3, Q4	Quarter 1, Quarter 2, Quarter 3, Quarter 4
QA	Quality Assurance
QEIA	Quality and Equality Impact Assessments
RDH	Royal Derby Hospital
SMI	Serious Mental Illness
STAC	System JUCD Transition Assurance Sub-Committee
TCP	Transforming Care Partnership
TWG	Transition Working Group
UHDBFT	University Hospitals of Derby and Burton NHS Foundation Trust
UTC	Urgent Treatment Centre
VCSE	Voluntary, Community and Social Enterprise Sector
VSM	Very Senior Manager
WDES	Workforce Disability Equality Standard
WRES	Workforce Race Equality Standard

About NHS Derby and Derbyshire Clinical Commissioning Group

NHS Derby and Derbyshire Clinical Commissioning Group brings together the combined expertise of 112 local General Practices to commission health services on behalf of over 1,062,000 patients in Derby and Derbyshire. Our vision is to continuously improve the health and wellbeing of the people of Derby and Derbyshire, using all resources as fairly as possible.

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