Erewash Clinical Commissioning Group
Hardwick Clinical Commissioning Group
North Derbyshire Clinical Commissioning Group
Southern Derbyshire Clinical Commissioning Group

DERBYSHIRE CCGs GOVERNING BODIES IN COMMON – Meeting in public Held on Thursday 24th January 2019

CONFIRMED

Present:

Derbyshire-wide Executives

Dr Chris Clayton	CC	Chief Executive Officer
Helen Dillistone	HD	Executive Director Corporate Strategy & Delivery
Sandy Hogg	SH	Turnaround Director
Zara Jones	ZJ	Executive Director of Commissioning Operations
Brigid Stacey	BS	Chief Nursing Officer
Steve Lloyd	SL	Medical Director
Deborah Hayman	DH	Interim Chief Finance Officer
Jane Chapman	JC	NHSE England

ECCG

Dr Avi Bhatia	AB	ECCG Chair (Meeting Chair)
Dr Markus Henn	MH	Governing Body GP
Ian Shaw	ISh	Lay Member
Dr Kath Bagshaw	KB	Governing Body GP
Pamela Watson	PWa	Lay Member
Karen Ritchie	KR	Healthwatch Derbyshire
Dr Duncan Gooch	DG	Governing Body GP
Margaret Amos	MA	Lay Member

HCCG

Jill Dentith	JD	Lay Member
Gillian Orwin	GO	Lay Member
Dr Ruth Cooper	RC	Governing Body GP
Anne Hayes	AH	Public Health Representative

NDCCG

Dr Ben Milton	BM	NDCCG Chair
Dr Anne-Marie Spooner	AMS	Governing Body GP
Dr Debbie Austin	DA	Governing Body GP
Ian Gibbard	IG	Lay Member
Isabella Stone	ISt	Lay Member
Gary Apsley	GA	Lay Member
Jill Dentith	JD	Lay Member

SDCCG

Dr Paul Wood	PW	SDCCG Chair
Dr Nick Bishop	NB	Governing Body GP
Dr Andy Mott	AM	Governing Body GP
Dr Buk Dhadda	BD	Governing Body GP
Dr Richard Crowson	RCr	Governing Body GP
Dr Merryl Watkins	MWa	Governing Body GP

Margaret Amos	MA	Lay Member
Martin Whittle	MWh	Lay Member
Perveez Sadiq	PS	Derby City Council Representative

In attendance:

Dawn Litchfield	DL	Executive Assistant / Minute Taker
Greg Rourke	GR	Public Health SHO Derbyshire County Council
Suzanne Pickering	SP	Head of Governance
Robyn Dewis	RD	Consultant in Public Health Derby City Council

Item No.	Item	Action
GBIC/1819/72	**WELCOME, APOLOGIES AND QUORACY** The Chair welcomed governing body members and members of the public to the meeting. Introductions were made. It was confirmed that all 4 CCGs were quorate. Apologies for absence were received from Dr Arvind Mistry, Dr Bruce Braithwaite, Dean Wallace and Dr Andrew Maronge.	
GBIC/1819/73	**Questions from members of the public** No questions were received from members of the public in advance of the meeting. The Chair stated that any questions should be submitted in advance, in order for them to be addressed prior to the meeting, as opposed to taking them during the meeting. This is meeting is public not a public meeting. A member of the public commented that the CCGs are considering the new Constitution today which contains lots of information about accountability and engagement; the CCG should be able to hear the opinions and points of view of members of the public relating to that item.	
GBIC/1819/74	**Declarations of Interest** Dr Bhatia reminded committee members of their obligation to declare any interests they may have on any issues arising from committee meetings which might conflict with the business of the governing bodies. Any declarations made by the members of the governing bodies are listed in the individual CCG's Register of Interests. ISt declared an interest in item 77 - he is a professor of the University of Nottingham, although it is not currently holding an MIHR grant. DH stated that she has no declarations of interest; the register will be updated accordingly. JD has updated her declarations of interest but the update did not relate to today's agenda; the register will be updated accordingly. **Declarations of Interest from today's meeting:** No further declarations of interest were raised.	

GBIC/1819/75	**Chief Executives Report** CC provided a verbal update this month. The 3 main priorities he has requested the CCGs to focus on in the latter half of 2018/19 are: • Financial recovery is on the agenda today; although it is on track there remains a risk in its delivery; the governing body will be kept informed of the work being undertaken. • Linked to this is the 2019/20 and beyond Commissioning Strategy which includes the Medium Term Financial Plan (MTFP) in development and will be presented to the governing body in due course. Early drafts of this have been consideration however further iterations will be provided as it is developed. • Creating the new CCG is also on the agenda today. The stabilisation of the commissioning system is well on track, as is the staff restructure into a single management team; over the winter months the CGGs have been working carefully through the recruitment processes around the new structure, which is nearing completion, although there are still elements of this to complete during January and February. Progress is being made regarding the governance of creating a single CCG. AB stated that no Chair's report was provided due to the logistics of having 4 CCG Chairs; moving forward into a single organisation this will be addressed. The governing bodies received and noted the Chief Executive's update.	
	DECISION	
GBIC/1819/76	**Emergency Preparedness, Resilience and Response (EPPR) Core Standards- Derbyshire wide** HD advised that each year the CCGs are required to submit an annual return demonstrating compliance with the national core standard in respect to EPRR. HD reported that in 2017/18 all 4 CCGs achieved full compliance following peer evaluation and scrutiny by NHS England's emergency planning team. For 2018/19 the format was revised and there are 9 domains which include 43 individual standards that the CCG will have to demonstrate compliance against. In addition to those core standards there are some changes to 2017/18; for the first time NHSE require CCGs to coordinate completion of the core standards by providers. In October the governance team, together with the EPRR leads of all providers and the Regulators, undertook a substantial peer review of the standards which make up the 9 domains; the report summarised the findings of the review. Each of the organisations have been awarded substantial or full level of assurance. JD, as Chair of the Governance Committee, provided assurance that this has been discussed on several occasions by the Governance Committee which should aid the decision making process. The CCGs currently have a trade loggist; it is important that this post is carried forward in the new organisation in order to facilitate a response in an emergency situation The governing bodies approved the EPRR core standards submission.	
GBIC/1819/77	**Excess treatment costs** SL requested agreement of the delegation of the commissioning function	

	of Excess Treatment Costs (ETC) to NHS Nottingham City CCG as the lead CCG for ETC commissioning for the East Midlands Local Commissioning Research Network. Included in the pack are policy statements for ETCs, the legal framework, the resource implications and delegation for this. The background is complex; CCGs have a responsibility to support NHS research. Any ETCs arising from such research that is outside normal funding mechanisms are picked up by the CCGs. The National Institute of Health Research (NIHR) will partner CCGs and local clinical research networks to manage the costings arising from this. The CCG cannot delegate this function to NIHR but can delegate it to a regional CCG to act as host for such costs; it has been agreed that this CCG will be Nottingham City. The resource implications equate to 5.2p per head of population for Derbyshire (£54k). The finance team is already aware of the implications and has included it in baseline financial calculations. ISh stated that the delegation sounds sensible however previously, when governing bodies have been blind-sided by costs, it is usually due to a service being delegated to another organisation. As the CCGs move to a single organisation its exposure to ETCs is likely to increase. ISh queried whether there will be a cost envelope communicated to Nottingham City CCG for ETCs and asked how information will be presented to governing bodies. SL confirmed that this is 2 way process and that the delegated CCG should be feeding back on the position on a regular basis. ISh stated that there will be the costs of running the service and the costs of ETCs themselves. Erewash CCG has a clear envelope for ETC exposure whereby £100k could not be exceeded; there is no evidence of this in the report provided. ISh asked if a limit needs to be agreed or if assurance will be provided on a continual basis. In the current financial climate any increase would need to be planned for. SL to explore this. JD supported the question raised by ISh on the financial arrangements; this needs to be identified as a risk and mitigations identified to support it. JD asked how the research element fits in with the north as some patients migrate across borders. SL advised that the approach has been to partner up with the most appropriate local research networks, which is why Derby is in the East Midlands. All networks will have borderline areas; the responsibility will sit with individual CCGs to define costings. JD stated the need to ensure that the people who live in the north of the county have access to the relevant research arrangements. The governing bodies agreed the delegation of the commissioning function for ETCs to NHS Nottingham City CCG with the caveats raised.	**SL**
GBIC/1819/78	**Creating the new CCG** <u>CCG Constitution</u> – HD presented the draft new CCG Constitution. In December permission was given by the governing bodies to launch a consultation with the 4 CCGs' member practices; this consultation was launched from 14th December to 9th January and no comments/feedback was received from the member practices therefore it is assumed that the membership is comfortable with the content. The Constitution sets out specific areas; it is a technical document and is designed to reflect the statutory framework by which CCGs operate and how it is going to deal with its statutory responsibilities. This version of the Constitution is quite different to the ones used previously in that it is a nationally driven process and template. SP has led on this piece of work.	

	There is a new CCG handbook which enables the CCG to make changes and update Terms of Reference without having to go back out to the membership or apply to NHSE to make amendments. JD acknowledged the work that has gone into producing this and thanked HD/SP and the team. All previous comments have been incorporated into this revised version. JD raised an issue in relation to quoracy; if the vice chair is a lay member, as opposed to a clinician, and if quoracy requires either a clinical chair or the vice chair, then this is not a clinical majority even though the meeting is quorate – HD/SP agreed to look at this. HD thanked JD for the helpful feedback/input she has provided into this document and confirmed that it will be reviewed. The intention is that voting clinicians are the lay clinicians; the 3 x voting clinicians will come from the GP clinical members and/or include the secondary care doctor, not the executive officers. HD agreed to make this clearer. There is a need to work through the numbers around a clinical / lay vice chair once governing body members have been appointed; the vice chair appointment will be at the discretion of the Chair.	**HD/SP**
	PW raised the length of term of office for appointments, which are all 3 years; he is unsure whether this is sound practice as after 3 years everyone will need to be reappointed. It would be advantageous to phase the appointment tenures in order to prevent a sudden transition. CC advised that there is a difference between term of office and end of term; the CCG needs to give further thought to staggering.	**CC**
	The governing bodies approved the draft Constitution, recognising the comments made. HD confirmed that the proposed amendments will be actioned and the draft Constitution will be submitted for approval to NHSE by 28th January 2019. The new CCG, at its first meeting in April, will formally adopt the Constitution. The governing bodies provided delegated authority to the executive team to make non-material changes to the Constitution prior to its submission. <u>Staff Property Assets and Liability Transfers</u> – HD advised that at the December meeting delegated authority was provided to the Audit Committee to review the staff property assets and liability transfers. The Audit Committee meeting in common was held on 18th December 2018 and full assurance was provided around the process and the documents presented. <u>Recruitment to governing body roles</u> – The process to recruit to all roles was launched 2 weeks ago and a lot of interest has been received; the shortlisting process is shortly taking place for recruitment in to these roles mid-February. The deadline for GP applications is next Monday. The new governing body composition was provided for information. <u>Feedback from the risk review meeting with NHSE</u> – The CCGs are required to set out the risks relating to the merger process; discussions were held with NHSE in detail around this. A copy of the letter received from NHSE on the progress made was circulated to governing body members. All, apart from 2 risks, were rated as low/green; the 2 risks rated as medium/amber relate to the development of the medium term financial plan, which is currently being worked through, and the staff consultation; there is a potential risk for staff to conflate the consultation around the merger with the consultation on staff bases and buildings. A further meeting will be held with NHSE on 5th February to confirm that the conditions have been met.	

	Staff views – Staff have been made aware of the merger and its progress through regular briefings and newsletters. The CCG is formally seeking the views of staff through a consultation from 2nd January until 15th February 2019. The plan is to TUPE staff over to the new organisation on 31st March 2019. Clinical leadership model – CC gave a presentation on the proposals around clinical leadership, recognising the importance of the clinical in 'Clinical Commissioning Group' and the importance that the governing bodies have placed upon this. A formal paper will be brought to February's meeting with additional suggestions around the proposed model. CC stated this is a proposed direction of travel for discussion and does not currently require a decision. CC confirmed that GP members of the governing body will have crucial roles providing clinical leadership into corporate committees and the Place Board. A north, south and city representation model is proposed. The mirroring of clinical and lay leadership in these areas will be important. The membership has been broken down again into another layer. The proposal is to support clinical leadership at Place with 8 clinical leaders, 1 in each Place. There are 2 broad roles within this which the commissioner feels are important. The first role is to support the bringing together of the Place Alliance Groups to provide leadership in facilitating integrated care partnerships at Place level; the second is to provide a conduit to the membership by having a membership engagement role at Place level which will evolve and change over time. Combined roles of governance and clinical pathway leadership have previously been supported; these roles are to be separated out and are required to be considered carefully. Further details are to be provided on these roles which will be taken out of the governing body arena and included in the medical directorate. There are a proposed 14 clinical lead roles, spanning the remit of the required clinical areas. There will also be 2 deputy Medical Directors supporting SL. This will align the work of the strategy and executive team. The remuneration of these roles will be managed in the same manner as the governing body roles. Formal representative input into the STP position from general practice is required as a matter of urgency. General practice is a significant provider in terms of scale and spend and needs to be at the STP table, but it needs support to do this. It was proposed that the current Place arrangement is mirrored. A coordinating role is proposed to support general practice at a Derbyshire level in the provider arm and general practice leadership in each Place to support the GP provider response into Place. Although it will be funded by the CCG it will be independent from it, in order to establish a strong general practice provider response. This will coordinate GP provider input into the system both at Derbyshire and Place level and lead the development of GP strategy from a provider point of view and stop the questioning of GP representation at system level. BM raised a question in relation to the recently published long term plan and primary care networks; it clearly discusses population sizes of 30 to 50K which do not necessary map to the Place alliances currently identified in Derbyshire. BM stated that in terms of general practice provider development, there is a need to be mindful of the emerging geography in primary care networks and ensure that general practice is supported to ensure that the networks interact as efficiently as possible with Place alliances. CC concurred with this point and will give it further thought.	**CC**

GBIC/1819/79	**Livewell Consultation** Derby City Council is currently undertaking a public consultation on proposals to reduce the funding, service capacity and provision of the Livewell service. It is proposed that with the reduced funding it will only be able to maintain the core functions of Livewell: the delivery of smoking cessation and weight management services. Comment was made that if public health spend is not available to facilitate life style changing services, the cuts will have a knock on effect on tertiary services funded by CCGs and will also impact on health services and budgets. It was asked what impact assessments have been undertaken on the decisions and how the council has approached it. It is worth exploring what the impact on health and CCGs would be through the quality team to determine the formal response required. RD welcomed this opportunity to inform the process. QIAs, as well as the EIAs, will need to be taken into account. One of the CCGs strategic objectives is to reduce health inequalities; not having such services in place will impact on this objective. On a technical point, CC is not sure that the council should be putting this into the prevention spend; and asked whether the work-well initiative should be included in the corporate spend. It is difficult to understand the impacts of this without looking at global spend. The totality of spend, transferred with public health years ago, in monetary terms was requested. Care needs to be taken that prevention is not just the spend that was transferred; this does not mean that the Local Authority should not deliver against that spend. CC requested sight of the advice to the LA from the director of public health on this matter, who has a dual role as an employee and as an independent officer. CC proposed that a collective response be submitted to the council, as post April the implications of these decisions will be collective. The closing date for receipt of concerns is 1st February, however due to the comments made today and the work required on the EIA/QIAs there is a need for a further week's extension. RD to request this. The governing bodies noted the paper, raised the above concerns and requested CC to sign off the collective response on behalf of all 4 CCGs. Members of the public present were encouraged to also respond personally to the consultation.	**BS** **RD** **RD**
GBIC/1819/80	**Primary Care Co-Commissioning Committees in Common – Terms of Reference** SL presented this paper for consideration and approval; the key changes to the previous Terms of Reference (ToR) were highlighted in red. BM is conscious that the CCG is still addressing ToRs for CsIC which is appropriate for the ongoing business until 31st March 2019; however ToR will be required for the new committee going forward. BM requested assurance that this this work is taking place and the CCG will be in a position to appropriately sign these off after 1st April. SP confirmed that work is ongoing with the new CCG committees' ToR which will form part of the CCG handbook. All ToRs will be taken to Transitional Working Group on 14th March and will be approved at the first meeting of new CCG in April 2019, together with Constitution.	

	ISt apologised that these ToR have been presented so late; they have been taken to the Primary Care Co-Commissioning Committee for discussion; the difficulty has been with the quoracy requirements for the 4 organisations. This is now the final version. The governing bodies approved the changes to the ToR following assurance that work is ongoing to create the ToR of the new committee following the merger.	
CORPORATE ASSURANCE		
GBIC/1819/81	**Update on Operating Plan for 2019/20** ZJ advised that the report sets out a summary of the wider planning context that the CCGs are required to work within to deliver the details set out within the NHS Operating Plan Guidance for 2019/20 and to start to deliver the ambitions set out in the NHS Long Term Plan through continued working under the STP to deliver improved health care outcomes for patients over the next 10 years. The paper sets out the key sections which will take the CCG through this process up to the end of March 2019. The paper sets out specific requirements around this. The CCGs are still working to the same challenging deadlines; the contracts have to be signed by 21st March 2019. There is a significant amount of work going on with providers on contract negotiations. Weekly activity planning meetings are held with providers to agree set baselines and growth assumptions and associated work in order to achieve common and aligned plans for submission to the Regulators. Within the CCG governance there is a robust process through the Financial Recovery Group to provide weekly updates on progress made on contract negotiations and confirm how the activity plans are coming together in order to ensure oversight. The following points of note were made: • A 3.8% uplift has been applied • There has been a reduction in CQIN to 1.25% in order to simplify the indicators and align it to some of the key areas of the long term plan • There is a minimum efficiency requirement of 1.1% on the NHS • There are strong signals around transformation and different contractual approaches which the CCG would be looking to embark upon in 2019/20 to build transformation going forward, one of which is around emergency care activity and blended tariff. SH advised that the paper includes a section on the financial settlement for the NHS in Derbyshire. There is currently a deficit control total of £44m in 2018/19 which the CCGs remain on track to deliver through the hard work of its teams. At the last meeting it was reported that the CCG would have a £61.5m underlying recurrent deficit at the end of this year. The Medium Term Financial Plan, which was presented to governing bodies and to the Regulators in December, was updated to reflect the 5 year allocations, national planning guidance and the NHS Long Term Plan. A table was provided which summarised the allocation for Derbyshire over the next 5 years and the distance from target allocation. On the face of it there appears to be a 5% uplift. The overall uplift, including primary care medical allocation and running costs, is 5.7%. It is important to note that this uplift includes 'pass through funds' which are resources that currently providers receive directly from NHSE; in 2019/20 the CCG's allocation includes these funds. The CCGs are currently working out the net uplift to allocations taking account of these changes. It is expected that the uplift	

	will be closer to 2 or 3 % and the CCG will not have a 5% uplift to apply as general growth to the commissioning situation. In relation to the control total for 2019/20, SH reported that the CCG has been formally notified of a deficit control total of £29m and that it will have access for £29m of Commissioner Sustainability Funding. The CCGs are required to put together a financial plan to cover the £29m deficit; this will be discussed in detail at the next Finance Committee meeting and presented to governing bodies in February. The level of savings required in Derbyshire means that the CCG will no longer be able to afford to commission all of its current services at the same level, as it needs to be ensured that there is sufficient funding to maintain essential health care services for the local population; savings programmes will be built upon this basis. QIA / EIAs will be undertaken for each saving programme as it is developed in order to inform decision making. JD commented that the document states there will be a separate technical group to discuss blended payments; she queried if this will be specifically in Derbyshire and if the CCG be reliant on neighbouring CCGs to negotiate this position in other STP or ICS areas, and asked what the likely impact of this would be in the longer term. ZJ advised that the blended tariff guidance relates to where spend is £10m or above in terms of activity. In terms of the contractual arrangements where the CCG is an associate to contracts, it works closely with the lead commissioner in order to influence negotiations. The guidance sets out the threshold as to where this would be applied. This process is being worked through across Derbyshire to ascertain how it would work and mapping it out. MWh stated that the ambition to have a system control total is good and asked how each organisation will be held to account for their constituent part of that. SH advised that although it is important to note the direction of travel to have a system control total, there will not be a formal system control total in 2019/20. All organisations have received control totals as separate statutory organisations; through the STP they will work in collaboration to ensure that these control totals are delivered. RC enquired how the CCGs are going to organise themselves in relation to planning approaches; the proposed direction of travel is towards an integrated care system with a single strategic commissioner, 8 provider/Place Alliances, underpinned by 14 Primary Care Networks and a single financial system control total. RC asked where 14 comes from for Primary Care Networks and what the logic was behind it. If this is established then how will the primary care networks be organised, as this is going to cause difficulties and potential upset with Places. RC also asked if this will fit with the natural groups that already exist, as Networks will depend on geography and upon the relationships of the GP practices within those networks. CC advised that the assurance he has received is that there are an emerging 14 groupings of Primary Care Networks that are joining together across Derbyshire which will fit with the overarching 8 Places. There are a few areas where differences need to be worked through but in the main they are forming themselves on pre-existing natural groupings. The governing bodies noted this report.	

GBIC/1819/82	**Medicines Management Annual Report** SL presented the Derbyshire CCGs Medicines Management Annual Report 2017-18 which outlines the strategic, key quality and patient safety work undertaken by the team, and its future priorities. Historically the medicines management team have made a substantial contribution to the QIPP target, delivering 8% QIPP. It has been instrumental in improving the quality and cost effectiveness of prescribing in primary and secondary care. GO stated that the medicines management team do an increasingly good job year and year and there is a need to feed this work into the Engagement Committee to communicate the messages to patients in a more formal way. SL to feed this back to the team. ISh enquired whether horizon scanning is undertaken for expensive drugs coming into the system and if this has been fed into next year's QIPP. AM confirmed that thorough horizon scanning is undertaken to look at all new emerging drugs commissioned and ascertain any potential risks to CCGs, together with patient benefit. The governing bodies approved this report.	**SL**
GBIC/1819/83	**Finance and QIPP Assurance Report Month 8** DH presented the finance report which covers the period up to month 8 / 30th November 2018. There is a significant assurance process around the QIPP and financial position; it is taken through the Financial Recovery Group and Finance Committee on a regular basis. The 4 CCGs are delivering the financial duties required of them; however the forecast savings are not predicted to be delivered in line with financial plans. <u>Acute Services</u> - There is a year to date overspend on acute services of £3.9m as a result of not being able to contractualise savings and delivery quickly enough. This is being partially off-set by a £0.9m underspend at DBUH Trust. <u>Mental Health Services</u> - There is a £2.4m overspend to date which is being driven by Psychiatric Intensive Care Unit costs and Section 117 caseloads. High cost patients and crisis team costs have also increased. <u>Community Services</u> - The year to date position remains in line with plan however there is a forecast overspend of £2.9m due mainly to an under delivery of savings and an overspend on Better Care Closer to Home, high cost patients, ophthalmic and audiology services. Partially offsetting this is a £2.6m underspend following agreement with the provider on the expected year-end outturn. <u>Primary care and prescribing</u> - The overall year to date position is an underspend of £3.1m. Prescribing is £1.3m overspent due to prescribing activity, Category M and NCSO. The overspends are being managed by budget flexibilities identified at the start of the year and the contingency that the CCGs are required to provide as part of good financial management.	

	The CCGs are on track to meet the £44m control total in order to access Commissioner Sustainability Funding and therefore break even at year-end. The underlying deficit has improved significantly but it has deteriorated significant from the start of year due to the way in which the savings have impacted. SH advised that to month 8 year to date the CCGs have delivered £26m against a plan of £27.1m; at this point the CCGs are forecasting £44.7m against a £51m target, an underperformance of £7.6m; of that forecast outturn the £7m is non-recurrent. Positively there is a full year effect of savings where some of the delays have occurred to mobilise £7.6m which will help with 2019/20. There is a total savings risk of £7.7m; this is the £6m and further £1.7m which is outside the forecast outturn, where the Finance Committee reviewed the risks of achieving the stated forecast outturn. The key issues are the CCGs ability to reduce avoidable non-elective admissions to the acute sector: there is a QIPP scheme around this through Place delivery, and for savings schemes which where contract variations were not signed by providers. SH reported that the month 9 position has been signed off with providers; the forecast outturn has now improved by £1m, therefore there is a £46m overall QIPP and the total risk has reduced to £1m. This risk is being mitigated through the hard work of the teams. The governing bodies noted: • The month 8 overall financial performance • The month 8+ savings performance • The level of risk on the 2018/19 savings programme at month 8 and month 8+ • The use of contingencies and budget flexibilities to manage savings under-delivery and cost pressures	
GBIC/1819/84	**Quality and Performance Committee Assurance Report** MWh presented the key quality and performance highlights and the actions being taken to mitigate any risks. Performance has been largely static over the last couple of months. The following points of note were made: • 18 week Referral To Treatment (RTT) – This is required to be recovered to the March 2018 position; it is broadly on track with weekly monitoring occurring. UHDBFT and CRHFT account for the majority of activity; CRHFT is reporting recovery to the March 2018 position whilst UHDBFT have more challenges and the work in ongoing, as it is with other Trusts outside of the 2 main providers, to try to bring this round to a whole CCG position by the end of the year. • A&E – There has been a slight improvement in the CRHFT position; it has now recruited to the consultant posts, 1 started in December and 5 started last week. DBUHFT has not seen any improvement; the main issue being the acuity of patients being admitted which is affecting hospital flow. A contract performance notice has been issued and ongoing monitoring is taking place. • Joint Quality ED visit – This was undertaken at both the Derby and Burton sites between NHSE/NHSI/CCGs to look at the preparations for winter and the quality processes; despite UHDBFT not meeting their numerical targets, assurance was provided on the quality of care being received.	

	• Mock CQC inspection – This was held at Derby and Burton across 5 sites on 3rd and 4th December 2018; the team visited all areas. It was chaired by BS. The team provided good constructive feedback which will be used to inform the actual inspection due early this year. DA requested assurance regarding the issues across the CCG with 2 week breast referrals, particularly the acute problems in the high peak with Stockport shutting down to referrals. DA asked if, when this issue is being discussed, if this is part of the discussions; although the CCGs are only an associate commissioner this issue has had a huge impact on some patients. DA asked for confirmation of when referrals can recommence. MWh confirmed that all relevant providers are discussed at the Quality and Performance Committee; it tries to exert as much influence as possible when dealing with associate commissioners. ZJ advised that the CCGs have been working closely with the lead commissioner and the provider; The CCGs have been going through a careful process with regard to this as they do not want to re-open this facility to refer too soon and thus flood the system. Currently the provider and lead CCG are advising that the capacity for Derbyshire patients will be re-opened imminently. This will be formally confirmed within the next few days. The governing bodies noted this report.	
GBIC/1819/85	**Clinical and Lay Commissioning Committee Assurance Report** DA advised that the information for November's meeting was provided; at the next meeting December and January information will be provided. The Clinical and Lay Reference Committee is currently usefully devoting it's time to the clinical aspects of the PIDs and QIPP. The governing bodies noted this report.	
GBIC/1819/86	**Governance Committee Assurance Report** JD highlighted the data security and protection toolkit and the concern that some providers appear to be lacking in terms of some of the information they are able to provide to the CCGs. This was raised as a possible area of risk to the CCGs. HD confirmed that this will be taken through the formal contract route. The governing bodies noted this report.	
GBIC/1819/87	**Audit Committee Assurance Report** JD confirmed that there have been 2 meetings of the Audit Committee recently. The first meeting was an extraordinary meeting held to consider delegated responsibility for approving and confirming assurance arrangements for movement to the new Derby and Derbyshire CCG and the second meeting was a normal Audit Committee. The governing bodies noted this report.	
GBIC/1819/88	**Risk Register Exception Report December 2018** HD presented the Risk Register Exception Report. One change has occurred since November 2018:	

	Risk 006 – Across Derbyshire there are a number of residents in care homes who are placed within non-AQP homes, this may result in financial and quality assurance implications. This was originally rated as 16 however it is now believed that this risk could be reduced to 12 recognising the AQP provider framework in place during December 2018. The governing bodies noted this report.	
GBIC/1819/89	**Governing body Assurance Framework Report December 2018** HD presented the Governing Body Assurance Framework which identifies the 9 principal/strategic risks across the 4 organisations. The following movements since November 2018 were highlighted: Risk 005 – The Derbyshire health economy may not be sustainable unless there is a delivery of transformational change through the Derbyshire Sustainability and Transformation Partnerships (STP). It was recommended that this risk be reduced from 16 to 12 on the basis that there is further progress in place around the joint planning for the system going forward. Risk 006 – Failure to effectively manage demands, activity and cost pressures across the health system may impact on delivery of the CCGs financial plan. It was recommended that this risk be reduced from 16 to 12 on the basis that the CCGs are on track to meet their overall control total. ISh raised a question in relation to the Objective 1 of the GBAF – to reduce the health inequalities by improving the physical and mental health for the people of Derbyshire. He pointed out that we can improve the physical and mental health for people in Derbyshire and increase inequalities at the same time; this does not read well. Although a target score is provided ISh asked what this actually looks like. There is a need for inequality profiles around each of the clinical priority areas and targets for reducing inequalities across those areas to feed into the BAF. Inequalities are likely to be increased through cuts in public health spending which also need to be factored in. HD advised that this is a complex area which is not reflected in the narrative; it needs to be considered further in the new organisation going forward. The governing bodies noted this report.	
GBIC/1819/90	**Committees in Common Minutes (for information only)** The governing bodies received and noted the contents of the minutes of the following committees: • Quality & Performance Committee meeting – 8.11.2018 / 6.12.2018 • Audit Committee meeting – 5.11.2018 • Governance Committee meeting – 8.11.2018	
GBIC/1819/91	**Minutes from other meetings for information** The minutes of the Derby City Health & Wellbeing Board held on 22nd November 2018 were received for information and the contents noted.	

MINUTES AND MATTERS ARISING		
GBIC/1819/92	**Minutes of the Derbyshire CCGs GB Meeting in Common meeting held on 13th December 2018** The minutes of the Derbyshire CCG's governing bodies in common meeting held on 13th December 2018 were accepted as an accurate record with the requested minor amendments.	
GBIC/1819/93	**Action Log / Matters Arising from the Minutes not elsewhere on the agenda** Item GBIC1819/57 – Creating the new CCG – The final draft Constitution is to be presented in January for approval; this item was included on the agenda today. Item closed.	
GBIC/1819/94	**Any Other Business** None raised	
Date and Time of Next Meeting: Thursday 28th February 2019, at 11.30am at the Coney Green Business Centre, Clay Cross, Derbyshire.		

Signed by: ……. Dated: ……
(Chair)