NHS
Derby and Derbyshire
Clinical Commissioning Group

Derby and Derbyshire CCG Governing Body Meeting in Public
Held on
13th January 2022 via Microsoft Teams

CONFIRMED

Present:

Dr Avi Bhatia	AB	Clinical Chair
Dr Bruce Braithwaite	BB	Secondary Care Consultant
Richard Chapman	RCp	Chief Finance Officer
Dr Chris Clayton	CC	Chief Executive Officer (part meeting)
Dr Ruth Cooper	RC	Governing Body GP
Jill Dentith	JD	Lay Member for Governance
Dr Buk Dhadda	BD	Governing Body GP
Helen Dillistone	HD	Executive Director of Corporate Strategy and Delivery
Ian Gibbard	IG	Lay Member for Audit
Zara Jones	ZJ	Executive Director of Commissioning Operations
Dr Steven Lloyd	SL	Medical Director
Simon McCandlish	SM	Lay Member for Patient and Public Involvement
Andrew Middleton	AM	Lay Member for Finance
Dr Emma Pizzey	EP	Governing Body GP
Professor Ian Shaw	IS	Lay Member for Primary Care Commissioning (part meeting)
Dr Greg Strachan	GS	Governing Body GP
Dr Merryl Watkins	MW	Governing Body GP
Martin Whittle	MWh	Lay Member for Patient and Public Involvement / Vice Chair

Apologies:

Dr Penny Blackwell	PB	Governing Body GP
Dr Robyn Dewis	RD	Director of Public Health - Derby City Council
Suzanne Pickering	SP	Head of Governance
Brigid Stacey	BS	Chief Nursing Officer
Dean Wallace	DW	Director of Public Health - Derbyshire County Council

In attendance:

Helen Hipkiss	HH	Director of Quality
Dawn Litchfield	DL	Executive Assistant to the Governing Body / Minute Taker
Maria Muttick	MM	Executive Assistant
Fran Palmer	FP	Corporate Governance Manager
Sean Thornton	ST	Deputy Director Communications and Engagement

Item No.	Item	Action
GBP/2122/214	**Welcome, Apologies & Quoracy** Dr Avi Bhatia (AB) welcomed members to the meeting. Apologies were received and noted as above. It was confirmed that the meeting was quorate.	
GBP/2122/215	**Questions received from members of the public** No questions were received from members of the public.	

GBP/2122/216	**Declarations of Interest** AB reminded Committee members and visiting delegates of their obligation to declare any interests that they may have on any issues arising at Committee meetings which might conflict with the business of the CCG. Declarations declared by members of the Governing Body are listed in the CCG's Register of Interests and included with the meeting papers. The Register is also available either via the Executive Assistant to the Governing Body or the CCG website at the following link: www.derbyandderbyshireCCG.NHS.uk No further declarations of interest were made, and no changes were requested to the Register of Interests.	
GBP/2122/217	**Chair's Report – December 2021** AB presented a report, a copy of which was circulated with the meeting papers; the report was taken as read and the following points of note were made: • It was announced in December that there will be a delay in the setting up of Integrated Care Boards (ICBs), from April 2022 to July 2022, mainly due to the operational pressures currently being experienced across the health and social care system. • An update was provided on the work of the Clinical Professional and Leadership Group (CPLG); the CPLG aims to ensure that a full range of clinicians and care professionals are embedded in the decision-making process in order to ensure that balanced decisions are taken to manage the risks to the delivery of safe care, within the finite resources available. The following questions were raised in relation to the report: • One interpretation of the delay to the ICB was that it presents an opportunity for system-focused development work for the new members of the Board. Moving from CCGs to a System will be a significant cultural change and there is a need for long term emersion to achieve osmosis on the differences; it was enquired if any thought had been given to acceleration of joint development work with a System focus. AB agreed that the delay provides opportunities, as well as issues. Discussions have been held on how the ICB Board will shadow the CCG's Governing Body; the work already undertaken with the Corporate Committees will be built upon and used to benefit the incoming individuals. Helen Dillistone (HD) added that there are pros and cons and risks and benefits to the delay. As already stated, one of the main benefits is that it provides more time for the development work and for the ICB to engage with and learn from the CCG. It will also enable further testing and formalisation of governance. • The opportunity was taken to pay tribute to all NHS and care staff who have worked so hard over the past few months during a very challenging time; it has been difficult for all concerned. Nationally data is captured in terms of COVID-19 infections, hospital admissions and deaths however the numbers of staff available to look after patients is rarely captured. The NHS was already stretched prior to the pandemic however over the last few months it has become more challenging due to staff contracting COVID-19 and self-isolating. The fact that a good	

	quality health service has been maintained despite this is testament to the hard work of its staff. AB concurred with this; it is important that staff are looked after, and their goodwill maintained. Many staff are working beyond their contracted hours on a continual basis to help care for patients. • Patients and their relatives were also commended for stepping up due to the staff shortages. The lower paid staff that are working above and beyond their normal hours and covering extra clinics are also very much appreciated. The CCG's teams have been helpful in finding solutions for the vaccination clinics and this was much appreciated. • It was noted that the focus is on undertaking the most urgent levels of surgery during this period; it was enquired whether the delay to the ICS will change the coherent picture for patients, as most people know someone who has had their surgery delayed. AB suspected that the concerns on the delay at a strategic level are very different to the concerns on the front line where the care is delivered. There are measures in place operationally to deal with the movement of resources to keep the NHS running and cope with the most important matters going forward. AB does not anticipate that the delay will affect operational issues, the hope is that integrated working will improve things moving towards and the lessons learnt from the first wave of the pandemic will be remembered and built upon; there is a lot of work going on behind the scenes to manage all of this. • Dr Bruce Braithwaite (BB) added that hospitals are fairly autonomous in dealing with their patients; staff are doing their best to treat the patients that need to be treated first. He also advised that the independent sector has been contracted to take extra patients. AB considers that the Governing Body has a good understanding of what is happening on the ground. **The Governing Body NOTED the content of the report provided**	
GBP/2122/218	**Chief Executive Officer's Report – December 2021** HD presented Dr Chris Clayton's (CC) report, a copy of which was circulated with the meeting papers. The report was taken as read and the following points of note were made: • The importance of System resilience was reiterated. The Christmas and new year periods are always challenging times of the year, but even more so this year. The report outlines the escalation processes implemented across the broader System partnership; it is helpful to know that the processes are tested and work, building upon the history of working together to overcome the many challenges experienced over the last few years. • The important work on the vaccination and booster programme continues. • There is ongoing communications work to encourage people to access services should they have urgent health requirements or are experiencing worrying symptoms. • Many CCG staff are also currently supporting operational services. The work of the CCG is being reprioritised over the following four areas: - Support to the vaccination programme - Support to System operational resilience	

	- Maintaining CCG business continuity, operating at level 4 activities only - Transition – statutory activities only • All staff were thanked and their hard work over the current difficult time was recognised. The following question was raised: • It was enquired whether the staff survey results are yet available. HD confirmed that the results are imminent, and the headlines will be available for either the February or March Governing Body meetings. It was noted that the response rate had improved by 1% on last year. **The Governing Body NOTED the content of the report provided**	
GBP/2122/219	**2022-23 NHS Priorities and Operational Planning Guidance** Zara Jones (ZJ) introduced the planning guidance for 2022/23, received on 24th December 2021. Guidance is expectedly shortly on the requirements for the Annual Plan for the next financial year; further detailed technical guidance on specific requirements is also expected; however, an overview has been provided on the key areas upon which to focus the efforts with System partners, over the next few weeks, in order to pull together a plan for what will be a challenging 12-month period, with a number of priority areas to be focused upon. The following key points were made: • A timetable has been set for the submission of the final plan by the end of April 2022 to address the key areas of the guidance. • The plan includes ambition around managing the elective programme, particularly the concerns around the effects of the pandemic on non-COVID routine care. There is a clear, strong emphasis on recovering the position as far as possible over the next 12 months. • It is not known how the pandemic will continue to progress and what further impacts may be seen. The System is stressed and strained operationally at the present time which could continue into the next financial year; this is recognised in the guidance however an assumption of stability has been made if the plans set out are to be achieved. • There is a welcome focus on staff health and wellbeing; the strain on capacity as a result of front-line absences was noted. • A significant focus is made on the vaccination programme, which Derbyshire has performed well against, and the longer-term effects of COVID, prioritising long COVID and its associated work. • Elective care - the ambition is to reach 110% of pre-pandemic elective activity, which is a very tall order; it will take a lot, particularly around the workforce and capacity issues, to be able to address this target. Other targets have been set relating to patients waiting long periods of time and improving the backlog. • Cancer – The System has, in terms of recovery, done exceptionally well in terms of cancer waiting times despite increased referrals being made; it is encouraging that people are coming forward for diagnosis. The guidance requests a focus on cancer alliances to ensure improvement and reiterates the importance of screening restoration. • Diagnostics – There is a level of ambition to increase community diagnostics; funding has been made available to support and develop this further.	

	• Maternity care – The forthcoming second Ockendon report and resultant actions will receive funding to invest in the workforce requirements. • Urgent and emergency care – There are challenging targets to achieve, both around length of waits in Emergency Departments for admission, and ambulance delays; targets have been set to ensure that patients are treated and moved through the System in a timely manner to receive the care they need. The provision of rapid response community crisis care to proactively support urgent care provision is welcomed. • Primary Care – The guidance builds on the access plans already developed, looking at supporting practices through their PCNs. There is a focus on digital as an enabler for the System. • Mental health – Traditionally a separate return has been made for the mental health planning process, however this has now been aligned with the operating plan. Clear ambitions are reiterated around the mental health implementation plan, supporting people with learning disabilities and/or autism, and aligning funding flows to maintain continued mental health investment to transform and expand community health services and improve access. The children's mental health programme is also being worked through. • Population health management – Health inequalities have been highlighted due to the widening gaps seen during the pandemic. A focus needs to be maintained on prevention and providing help upstream. The final plan will be submitted towards the end of April, with a draft plan submitted in March. Governing Body members will be kept appraised of the situation accordingly. The following questions were raised: • Building on the work already being undertaken in the organisation and across the System, it is pleasing to see that workforce is a key priority area, as the workforce position underpins all activity; should staff not be available, it will become an area of concern. • Although the establishment of the ICB has moved to 1st July, the planning guidance indicated the need to continue to work collaboratively; it was enquired how Glossop will continue to be included in the conversations to ensure that a System response is provided. ZJ responded that working groups have been established to go through the detail, and assurance was provided that Glossop is being linked into discussions considering the contracting and commissioning side of the transition; this work is being included in the overall planning position. The delay may now allow more time for broader engagement to be undertaken with stakeholders. • Although the plan includes expected and reasonable aspirations, none of them will be achieved without the available workforce. The delay presents a 5 ½ month opportunity to address the staffing issue however the ability to influence the core clinical workforce is out with the CCG's control. Retaining the staff already in place is important. It is pleasing to note that the ICB is appointing an independent member and executive lead for workforce. It was enquired how this essential aspiration will be used to accelerate and grow a substantive workforce in a local context using different types on entrants and apprenticeships; this may require further consideration of the remuneration of low paid staff. It is hoped that the ICB and CCG will give the workforce agenda the prominence it deserves. ZJ agreed that, when the updates on the development of the plan are presented to the Governing Body, a key spotlight will be given to workforce developments; this issue needs to be worked through with the workforce Leads. HD added that the delivery of the plan is dependent	

	upon having a skilled and available workforce in situ. The ICB has a different role, remit, and scope to the CCG, particularly in relation to workforce; it will have an opportunity to drive the workforce through System leadership. Conversations are required around the demand being delivered by the workforce and whether clinicians are being enabled to deliver the right care. A broader strategic conversation is also required with the public on what realistically the NHS will be able to deliver in future. • The guidance assumes that COVID levels will return to a low level; however, the last couple of years has taught us that this cannot be foreseen. It was enquired whether wording will be included in the response to the plan that, although planning is being undertaken for a favourable context regarding COVID, measures will have to be implemented should something happen. ZJ responded that scenario planning will continue to be undertaken in conjunction with the System's research and analytical group to develop modelling and examine trends and variables against national data. It is helpful that the planning guidance recognises that any further waves may impact on the delivery of some of the initiatives included in the plan. • Communication with the public is required, primarily around primary care but also on a different skill mix going forward. There is now a mix of competent professionals in primary care, however there is a misconception that people must see a doctor; 38% of GPs are over 50 and approaching retirement, GPs are not coming in at the same rate as they are leaving therefore a different skill mix will be required going forward. The message that a doctor is not necessarily the best person to solve a problem needs to be communicated widely and it was requested that this be included in the plan. AB added that the message around the different model of General Practice is a positive one, in that patients are able to see the best person to help them. ZJ agreed and will work with the communications team to accelerate this. • A 110% proposed turnover was disheartening when the hospital is not currently achieving 100%. The public may assume that more routine operations will be undertaken however, cancer and emergency work will be prioritised. Concern was expressed for staff morale when they are already working so hard. ZJ agreed with the need for clear communications to support this, although there is an ambition to recover the backlog if the situation allows. • The ambitions included in the paper were saluted and although some new money is to be made available, there is talk of a return to a normal financial regime and an affordability gap, with reference to efficiency targets and convergence adjustments that could mean a reduction in the money available. Pre-pandemic, the overall strategy was to shift towards prevention and primary care to address health inequalities. It is hoped that this ambition will be retained, as if there is an ambition to increase hospital turnover, the money may need to go to the Acute Hospitals; it was enquired how this will be reconciled. Richard Chapman (RCp) advised that every System will be required to make an efficiency saving next year. The change in the external financial environment for Systems is that all support monies previously directed at organisations within CCGs will now be put into a single financial envelope to be distributed according to a fair shares formula on a System basis, including the Commissioner Support Funding and Provider Support Funding received. As the CCG was in receipt of such large amounts it is above target; the contractual value was based on what was received in the last financial year, based on the costs of running a system rather than a fair shares formula. A national efficiency saving is required, and convergent	

	adjustments will have to be contended with to bring us closer to a fair shares formula. Derbyshire will receive less in 2022/23 than in 2021/22, the greatest reduction being COVID funding; if the COVID funding was removed, the CCG would have received more in 2022/23. The guidance references £2.3m of elective recovery funding to be earned by Acute Trusts for going above 110%; this would be additional money into the System if it is delivered. Preventing avoidable admissions will help to free up avoidable acute bed occupation and drive efficiencies. • Currently 20% of beds are taken up by patients that cannot be discharged due to unavailability of care packages, and 20% of beds are taken up by avoidable respiratory admissions; if these problems were solved, 40%. Capacity would be gained. • The focus on primary care must shift away from patients' dissatisfaction should they not be able to get an appointment with a doctor; the primary issue is having a concern addressed and resolved in a timely manner. If the focus were to be shifted to this measurement of primary care, it would prevent unnecessary criticism of GPs who are only trying to guide patients in the right direction. A national campaign may be needed to achieve this, however with only 42 ICBs, there will be a better chance of reaching a coherent agreement. • Helen Hipkiss (HH) confirmed that there is a significant programme of work underway to review all discharges; the issue is not only around social care, but also a lack of NHS staffing with significant numbers of staff off with COVID or self-isolating. A three-week programme of work commenced yesterday which will focus on how to move things forward. AB concluded that General Practice is a complex and emotive subject and a very difficult issue to fix; all points made were very valid and will be taken on board for transfer into the ICB. **The Governing Body NOTED the content of the guidance and will be updated further as the planning work proceeds over coming weeks**	
GBP/2122/220	**Update to Transition Timeline and implications for consideration** HD outlined the implications of the change in the timeline for the ICS transition which were included in the planning guidance received in December 2021. There will be a slippage in the closedown of the CCG and creation of the ICB, from 1st April to 1st July 2022. Consequently, the implications of the revision need to be understood. The revised establishment timeline is still awaited. The CCG's Transition Working Group (TWG) and System's Transition Assurance Committee (TAC) have overseen the key areas of development over the last 7 months and will consider the implications of the delay. It is not expected that there will be a significant amount of slippage in the key milestone dates therefore the work will continue as planned. There is a need to ensure that an effective operational ICB is in situ until 1st July 2022 and that the Governing Body is able to function appropriately. Areas for consideration included: • Preparation for the establishment of the ICB • Continuation of corporate governance processes • Clarity on the timetabling of Annual Reports and the logistics as to whether it could be undertaken as a 15-month report • The implications and impact of the delay on financial planning • Audit planning	

	• HR matters including continued staff support for the protracted period of uncertainty • The impact on operational and technical matters, including contracting • The boundary change relating to Glossop and the associated activities to support it. It is unclear whether this will be April or July; further national advice is being taken on this. **The Governing Body NOTED the contents of the paper and letter, and considered the issues outlined that highlight some of the implications which need to be worked through as a consequence of the delay**	
GBP/2122/221	**Finance Report – Month 8** RCp provided an update on the financial position as at Month 8 (H2). The following points of note were made: • It was confirmed that all targets will be met assuming receipt of COVID reimbursement and Elective Recovery Funding. • Forecast outturn as at month 8 remains at breakeven, with additional reimbursement expected of £7.759m for the Additional Roles' Reimbursement Scheme (ARRS) for Primary Care Co-Commissioning. • £1.631m of the H2 contingency has been released into the year-to-date position. • A straight-line extrapolation of the Year-To-Date (YTD) expenditure to forecast outturn was presented. • There is circa £2.5m retained flexibility for the current financial year. • Continuing Health Care (CHC) pressures continue with increased discharge pressures across the System; controls remain in place. • Prescribing pressures, driven by volumes as opposed to prices of prescriptions, continue in primary care services. **The Governing Body NOTED the following:** • **Allocations have been received for the full year at £2.079bn** • **The YTD reported underspend at month 8 is £0.730m** • **Retrospective allocations received for H1 Covid spend on the Hospital Discharge Programme were £5.498m, further funding is expected of £1.358m relating to month 7 and 8** • **The Elective Recovery Fund has been reimbursed £0.756m for April to November with an additional £5k anticipated** • **The year-end position is forecast at £0.03m underspent**	
GBP/2122/222	**Finance Committee Assurance Report – December 2021** Andrew Middleton (AM) provided a verbal update following the Finance Committee meeting held on 23rd December 2021. The following points of note were made: • These are exceptional times and there are risks attached to this budget, one being CHC, which receives constant attention. • The Finance Committee, in its deep dive agenda, continues to focus on matters that will not come to fruition before the demise of the CCG; nevertheless, the System needs to understand them. These include the Better Care Fund and Personal Health Budgets. • Double running costs relating to the setup of the ICB are now being incurred; for financial governance purposes, RCp has been requested to identify the components of the ICS preparation costs, the costs of	

	which will be absorbed by the CCG as there is no national fund for this purpose. RCp advised that, at the start of the financial year, it was anticipated that there were likely to be transitional double running costs and a reserve was set aside to cover them. RCp is not aware of a national requirement to keep a record of the transition costs incurred, however the CCG will be able to collate the local costs. **The Governing Body NOTED the verbal update provided for assurance purposes**	
GBP/2122/223	**Audit Committee Assurance Report – December 2021** Ian Gibbard (IG) provided an update following the Extraordinary Audit Committee meeting held on 17th December 2021. The report was taken as read and the following point of note was made: • The Committee signed off the due diligence checklist and finance transition plan; although both good reports, this is clearly still a work in progress on which the change of ICB implementation date will have an impact. The Committee will receive updates at its February meeting. **The Governing Body NOTED the update provided for assurance purposes**	
GBP/2122/224	**Clinical and Lay Commissioning Committee (CLCC) Assurance Report – December 2021** Dr Ruth Cooper (RC) provided an update following the CLCC meeting held on 9th December 2021. The report was taken as read and no questions were raised. **The Governing Body NOTED the paper for assurance purposes and RATIFIED the decisions made by the CLCC**	
GBP/2122/225	**Primary Care Commissioning Committee (PCCC) Assurance Report – December 2021** Simon McCandlish (SM) provided a verbal update following the PCCC meeting held on 22nd December 2021. The following points of note were made: • There were no items for discussion at the meeting. • The financial position was noted. • Assurance was provided on the improving position at the Brailsford and Hulland practice. • No changes were made to the to Risk Register. **The Governing Body NOTED the verbal update provided for assurance purposes**	

GBP/2122/226	**Quality and Performance Committee (Q&PC) Assurance Report – December 2021** Dr Buk Dhadda (BD) provided an update following the Q&PC meeting held on 23rd December 2021. The report was taken as read and the following points of note were made: • SEND re-inspection in Derby City – Prior to the pandemic, significant areas requiring urgent action were identified. A reinspection took place in October 2021 by Ofsted and the CQC, the outcome of which was that significant progress has been made in addressing the previous weaknesses. The quarterly support and challenge visits from NHSEI will now cease. This is an ongoing piece of work, with some improvements still to be made. Thanks were recorded to the Local Authority and CCG teams for their hard work in pulling this together. • Workforce – The Q&PC is aware of the workforce challenges which are affecting performance and have invited Linda Garnett, the System's workforce lead, to a Q&PC meeting to provide an oversight of the work being undertaken at a System level. The sickness rates at Derbyshire Community Health Service are concerning and underline the importance of having a good staff base from which to call upon. Through the System work, it is hoped that such issues can be addressed, and resolved. It was disappointing to note that the System's People and Culture Committee meeting was cancelled yesterday. BD added that the Q&PC has been addressing this over the last few months and saw the challenge ahead. The operational planning guidance was welcomed, and the Committee is keen to understand what is happening with the workforce at a System level; a close eye is being kept on this and the Governing Body will be updated accordingly. **The Governing Body NOTED the paper for assurance purposes**	
GBP/2122/227	**Governing Body Assurance Framework Quarter 3** HD presented the Governing Body Assurance Framework (GBAF) for Quarter 3 detailing the organisation's strategic risks and the processes that underpin their ongoing monitoring, support, and delivery. The following changes were noted: • Risk 7 relates to CCG staff retention and morale. It is overseen by the Governance Committee. It was requested that this risk be increased from 6 to 12, due to concern around losing staff, particularly with the change and uncertainly of the ICB timeframe. The scoring of this risk will be aligned with the overarching Transition Plan. • Risk 8 relates to the transfer of functions and the work to close down the CCG and transition it into the ICB. It was requested that this risk be reduced as a result of the systems and processes now implemented and the signing off of the due diligence by the Audit Committee. The following questions were raised: • It was enquired whether Risk 7 relates to a general reading of the uncertainties of the transition or whether it is based on hard evidence from resignations to date. HD confirmed that some turnover has been	

	seen across the organisation however it is not necessarily related to the transition and the uncertainty; many people have moved into System wide roles. It was recognised that as people move on, during a period of transition, it is harder to recruit staff therefore the organisation is having to rely on agency staff or use its teams differently. There could potentially be an increase in this risk. Given that the ICB will embrace the concept of one workforce, it was asked if there will be any opportunity to trial this when CCG vacancies arise. HD advised that all vacancies are advertised in the most appropriate way. Of the people moving on, there is a cohort of individuals moving to providers, some moving to the Regulator and some leaving the NHS altogether. Good interest is being received for the substantive roles advertised; however, as some roles need to be filled on a fixed term or secondment basis, they are not all being appointed to; the need to support staff to develop must be balanced with business continuity. It was enquired what changes have been seen to warrant an increase in Risk 7. HD responded that additional support has been implemented for staff and teams, with regular communications held to balance business continuity with staff being able to progress and apply for secondments. Conversations are being held to prevent the creation of a bigger problem for the organisation as roles are lifted and shifted into the ICB. The redeployment of some teams due to the pandemic was also recognised. The Senior Leadership Team meets twice weekly, and these types of issues are discussed and escalated appropriately. **The Governing Body AGREED the 2021/22 Quarter 3 (October to December 2021) Governing Body Assurance Framework**	

GBP/2122/228	**CCG Risk Register – December 2021**
	
	HD advised that this report highlights areas of organisational risk recorded in DDCCG's Corporate Risk Register as at 31st December 2021. All risks in the Register are allocated to one of the CCG's Corporate Committees which reviews them on a monthly basis to ascertain if any amendments in risk score are required. The paper was taken as read and no questions were raised.
	
	The Governing Body RECEIVED and NOTED:
	
	• **The Risk Register Report**
	• **Appendix 1 as a reflection of the risks facing the organisation as at 31st December 2021**
	• **Appendix 2 which summarises the movement of all risks in December 2021**
	• **The decrease in risk score for:**
	  • **Risk 06 relating to the demand for Psychiatric intensive Care Unit beds**
	  • **Risk 32 relating to the risk of exploitation by malevolent third parties if vulnerability is identified within any of the Microsoft Office 2010 applications after 14th October 2020 and not patched**
	• **The increase in risk score for:**
	  • **Risk 09 relating to sustainable digital performance**	

	• **Risk 23 relating to CCG staff capacity compromised** • **New risk 42 relating to climate change** **And APPROVED the closure of risk 38 relating to the quality of care potentially being impacted by patients not receiving a care needs review in a timely way as a result of the COVID pandemic and the requirement for some of the Midland and Lancashire Commissioning Support Unit Individual Patient Activity/Continuing Health Care**	
GBP/2122/229	**Ratified Minutes of DDCCG's Corporate Committees:** • Primary Care Commissioning Committee – 24.11.2021 • Quality and Performance Committee – 25.11.2021 **The Governing Body RECEIVED and NOTED these minutes**	
GBP/2122/230	**Minutes of the Governing Body meeting in public held on 2nd December 2021** **The minutes of the above meeting were agreed as a true and accurate reflection of the discussions held**	
GBP/2122/231	**Matters Arising / Action Log** Action Log – December 2021 – No outstanding items	
GBP/2122/232	**Forward Planner** **The Governing Body NOTED the Planner for information**	
GBP/2122/233	**Any Other Business** None raised	
DATE AND TIME OF NEXT MEETING – Thursday 3rd February 2022 at 9.30am via MST		

Signed by: ……. Dated: ……
(Chair)