NHS
Derby and Derbyshire
Clinical Commissioning Group

Derby and Derbyshire CCG Governing Body Meeting in Public
Held on
3rd February 2022 via Microsoft Teams

CONFIRMED

Present:

Dr Avi Bhatia	AB	Clinical Chair
Dr Penny Blackwell	PB	Governing Body GP
Dr Bruce Braithwaite	BB	Secondary Care Consultant
Richard Chapman	RCp	Chief Finance Officer
Dr Chris Clayton	CC	Chief Executive Officer
Dr Ruth Cooper	RC	Governing Body GP
Jill Dentith	JD	Lay Member for Governance
Dr Robyn Dewis	RD	Director of Public Health - Derby City Council
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
Brigid Stacey	BS	Chief Nursing Officer
Dr Greg Strachan	GS	Governing Body GP
Dean Wallace	DW	Director of Public Health - Derbyshire County Council
Dr Merryl Watkins	MW	Governing Body GP
Martin Whittle	MWh	Lay Member for Patient and Public Involvement / Vice Chair

Apologies: None received

In attendance:

Dawn Litchfield	DL	Executive Assistant to the Governing Body / Minute Taker
Suzanne Pickering	SP	Head of Governance

Item No.	Item	Action
GBP/2122/234	**Welcome, Apologies & Quoracy** Dr Avi Bhatia (AB) welcomed members to the meeting. No apologies were received. It was confirmed that the meeting was quorate.	
GBP/2122/235	**Questions received from members of the public** No questions were received from members of the public.	

GBP/2122/236	**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 Item GBP/2122/239 – COVID vaccination and treatment update – All GPs declared a conflict of interest in this item as PCNs, of which practices are members, receive Directly Enhanced Services (DES) funding for administering the COVID-19 vaccines. As this is not a decision item it was agreed that all GPs would remain in the meeting but would not partake in any discussions which may arise in relation to this matter. Item GBP/2122/246 – Primary Care Commissioning Committee (PCCC) Assurance Report – January 2022 – Dr Penny Blackwell (PB) declared a conflict of interest in this item as discussions were held at the PCCC on the Brailsford and Hulland Medical Practice; PB is a Partner of the practice that has taken over the Hulland and Brailsford practice. As this is not a decision item it was agreed that PB would remain in the meeting but would not partake in any discussions which may arise in relation to this matter. No further declarations of interest were made, and no changes were requested to the Register of Interests.	
GBP/2122/237	**Chair's Report – January 2022** AB presented a report, a copy of which was circulated with the meeting papers; the report was taken as read and the pertinent points noted included the pressures on the System, the forthcoming move from a CCG to an Integrated Care Board (ICB), the impacts of COVID-19, and the ongoing pressures on General Practices and the mitigations around that. **The Governing Body NOTED the content of the report provided**	
GBP/2122/238	**Chief Executive Officer's Report – January 2022** Dr Chris Clayton's (CC) 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: • This continues to be a challenging time for the whole System. • Although a reduction in the numbers of COVID cases has been seen in hospitals, it is important to note that patients are still being admitted and are dying with COVID, hence the need to remain vigilant. • There have been increases in the community COVID prevalence which are being carefully monitored. • The position in General Practice has seen changes in terms of the asks. December and January saw receipt of a national letter advising practices to undertake more routine work as the booster programme diminishes in scale. • Section 2 listed the meetings CC has attended over the last few weeks.	

	• Section 3 highlights national developments, research, and reports. • Section 4 highlights local developments. CC will be sorry to see Angie Smithson, CRHFT CEO, retire in April; Dr Hal Spencer will take on the interim CEO role. A link was provided to the Joined-Up Care Derbyshire January Newsletter. The following points of note were made / questions raised: • General Practices were thanked for increasing the number of appointments provided. • The System was thanked for the work they are doing in providing services. The System is still extremely stretched, and people have been working very hard for a long time now. • It was enquired how the increase in waiting lists for surgery and treatment are being monitored in terms of the overall picture of deterioration in health during the wating period, and whether there is a collective System overview of what this looks like. CC responded that this is being carefully monitored. Prior to the Omicron wave the backlog was being overseen; this backlog was exacerbated by Omicron. There is clarity on the waiting list position, and the different types of waits within it. There are many types of backlogs across the System including General Practice, in terms of Long-Term Condition Management which is not as easy to quantify as hospital waiting lists. There are also backlogs in community care, with many things not being attended to in the usual manner in order to free up resources; for example, MSK physiotherapy where the physiotherapists were utilised to support the urgent care discharge position. The health and care System is acutely aware of the backlog in social care; the NHS has had an accelerated focus on discharge and flow, in conjunction with its social care colleagues. It is important to understand the backlogs in routine domiciliary social care in order to maintain the current care capacity and provide additional new capacity. The strategic planning team will be undertaking a stocktake to determine the current care gaps. Although the numbers are understood at a patient level regarding the care gap, there are challenges in understanding the health gap, which is more difficult to measure due to the time lag attached to it; thought will be given to this through the strategic intent and health inequalities work. • Reassurance was provided by Dr Buk Dhadda (BD) that the health and care gaps are on the radar of the Quality and Performance Committee. Over time, both locally and nationally, the impact of the pandemic on waiting lists will emerge; however, although those patients most at risk are being prioritised and treated urgently, the waiting lists continue to increase as new patients are added, assessed, and prioritised accordingly. • Dr Robyn Dewis (RD) added that there are individuals on waiting lists who are impacted by the capacity of services to provide care, and there are also individuals that have not yet presented themselves for treatment. There will have been behaviour and lifestyle changes over the course of the pandemic which have been difficult to quantify, for example obesity and alcohol intake; it will take time to understand the impact of this. It was noted that the MMR uptake has fallen, and this could also be the case with other immunisation programmes. These issues will affect communities differently, impacting hardest on those most disadvantaged. • It was queried whether consideration is being given to a national vaccination strategy. CC has received no official instruction from NHSE on the next stages of the vaccine programme. There is a need to work	

	through what this would look like and how it would be delivered; it would be reasonable to think that the Government and NHSEI are working through this. The message is well understood around how to go into a business-as-usual setting regarding vaccination programmes in order to prevent surge occurrences having an adverse impact on routine care. **The Governing Body NOTED the content of the report provided**	
GBP/2122/239	**South Yorkshire and Bassetlaw (SYB) Integrated Care System (ICS) Joint Committee of Clinical Commissioning Groups (JCCCG) Transitional Arrangements** CC advised that DDCCG is a formal member of SYB ICS JCCCG, linked to North Derbyshire and Hardwick CCGs' patient flows into Chesterfield and Sheffield. CC regularly attends the committee on behalf of the Governing Body. It has become clear that only specific items pertain to Derbyshire, for example service reconfiguration. The position of Derbyshire is an associate member as opposed to a standing member; however, CC has been made most welcome and values the learning from it. As the legislation for the creation of ICBs has been delayed, there is a need to maintain the JCCCG committee structure until ICBs are created in statute on 1st July 2022. CC recommended supporting the continuation of the JCCCG, and his attendance, and for the Governing Body to continue to receive updates. South Yorkshire will change as Bassetlaw moves into Nottinghamshire; a conversation will be held with SYB ICS on the continued need for Derbyshire to be involved in committees in common. The following questions were rasied: • Clarity was sought as to whether there is a requirement for the Governing Body to approve the proposal or note it as an associate member. The Derbyshire position is slightly different as it only has one CCG whereas SYB has several CCGs, hence the proposal to take this arrangement forward. CC stated that the paper has been written principally for the core members of SYB ICS, it is not particularly set out for associate members; his advice was that a decision to support the proposal from a position as an associate member perspective is required. • It was enquired whether the Glossop situation would have an impact and whether Derbyshire would be required to do something similar. CC advised that formal confirmation is awaited from NHSEI as to whether the boundary change will be effective from 1st April or 1st July; if it is effective from 1st April, it will require a change in the CCG's boundary, whereas any changes from the 1st July will be included in the ICB's boundary. The need to create a formal committee with Tameside and Glossop is not anticipated. • Insofar as Bassetlaw and Mansfield Hospitals will be used by our patients, it was queried whether there is a need for a relationship with Doncaster and Bassetlaw Hospital Trusts. CC responded that there are patient flows both in and out of Derbyshire; this has always been the case and will continue to be so. Where there is a significant patient flow, a proportionate oversight arrangement is established. Where smaller numbers are involved, DDCCG acts in the associate commissioner space, working through the Lead Commissioner. A lot of work is done with the Nottinghamshire and Leicestershire Systems through associate commissioners. DDCCG is the Lead Commissioner for the EMAS 111 contract and has worked closely with the associates to this contract. A	

	new set of relationships will need to be defined post July in terms of ICBs and their remits. A different commissioning landscape will be developed with larger ICBs and less commissioning bodies to link in with. **The Governing Body APPROVED the proposed changes to the SYB ICS Joint Committee of CCGs (JCCCG) for its continued operation until the end of June 2022, on an associate member basis**	
GBP/2122/240	**COVID vaccination and Treatment Update** All GPs declared an interest in this item Dr Steve Lloyd (SL) gave a presentation providing an update on the current COVID-19 vaccination programme, the treatment response, and the journey undertaken to reach this point. An update on the flu programme was also provided. A copy of presentation will be shared with members post meeting. SL considered that the point has now been reached to turn away from an urgent response to a business-as-usual programme going forward; however, there are a number of constraints to this. Boosters are not an optimal way to use vaccines; further guidance is awaited on this. A move to 6-month boosters for the most vulnerable members of society and 12 months for everyone else would be preferable. A vaccine to target the virus on a 12-month basis is currently in development. Conversations are ongoing as to what the future infrastructure would look like in order to prevent drawing down on the whole System. The necessary emergency response has seen teams stood up to meet the challenge of the vaccination programme to protect communities however it is impractical to continue it on this basis. The charge now is to develop a service line for System delivery through a different infrastructure, looking at what existing assets could be included in the ongoing mix. The huge contribution made by General Practice throughout the pandemic is not sustainable in the long term. The rise in the community pharmacy delivery needs to be expanded. The Vaccination Operational Cell (VOC) will continue to be required in the ICS space to provide a powerful emergency response vehicle of coordination across the whole System; this was led by the CCG, but cut across the whole System, with input from providers, and silver and gold command elements feeding into the SORG and SEC. The following questions points of note were made / questions raised: • The performance on the vaccination programme is exemplary. • It was enquired whether the inequality and ethnicity data were developed through postcodes for the vaccines. SL responded that data has been a challenge both nationally and regionally; locally postcode data is being used however the work of public health is being drawn upon, which is a powerful vehicle with which to reach into the community. This will also provide the potential to address health inequalities in the future. • The presentation clearly highlights the success of the vaccination programme and the new nMAB antiviral service; the communications around the nMAB service have been exceptional, and one of the main reasons why it is running so successfully. • RD advised that Derby City has received funding for community vaccine champions and is working with Community Action Derby to establish a service; this will enable the champions to hold individual conversions with	

	concerned individuals. The challenge now is to manage the incorrect narrative that COVID is going away. • SL's leadership of the programme is legendary, going above and beyond, which is very impressive; his commitment has been translated to the principle of addressing health inequalities in a comprehensive manner. • It was enquired what lessons could be learnt about reaching hard to reach groups from the work undertaken with COVID and, given that COVID has been a well-funded programme with no resource constraints, it was asked how the focus will be kept on the inequalities alongside existing budget pressures. SL responded that this is not about resources but about how best to use the people available; it has become clear that there are champions within our own organisations. The concept of the NHS as an anchor organisation is a powerful one and translating the ambition of the ICS to support socio-economic growth is important. Our staff are members of communities and they have taken it to heart to get the messages into their communities. It is not only about informing people but about training the trainer and incorporating people into the programme as leaders and champions themselves. There will be a different approach to reaching out into communities which does not require a significant amount of funding to achieve. Building on the good work already undertaken, it will be a powerful evolution in the way health inequalities are dealt with, by thinking about what is already available and providing a more comprehensive offer. • A move to 6 monthly boosters for the clinically vulnerable was suggested; a definition of clinically vulnerable was requested. SL stated that the JCVI will define this; although the cohort framework will be useful, it does not lend itself easily to strategic planning. Research would suggest that the antibody levels for the most vulnerable, as defined by the JCVI, will reach critical levels at around 6 months; however, repeat boosters are not the optimal way to use vaccinations. Although the vaccination programme went well in the UK, other countries have found it challenging due to a lack of vaccine availability; unvaccinated populations are a breeding-ground for new variants, which is a danger on a global scale. • There is no doubting the successful nature of the Derbyshire programme, however it has taken a lot of clinical time out of the System which is not sustainable in the long term. The move towards community pharmacy sites, using pharmacists to deliver vaccines, has been good. It was enquired whether there are plans to train up a new cohort to deliver the vaccines to prevent the use of health and social care staff. This is probably going to be an ongoing programme therefore the longevity of it requires further thought. SL advised that conversations are now being held not just in terms of the delivery of future programmes but the infrastructure to undertake it within a separate service line. It will demand a new approach to prevent drawing down on the System through emergency responses that are not sustainable; more resources will be required to deliver it in a different way. A plan cannot be developed without a national framework; to date the System has been faced with directives which it has had to urgently respond to however challenging this may have been. • The important aspect of any future programme will be the staffing; there are many other things that the GPs and Consultants undertaking the vaccinations could be doing; there is a need to ensure that the right staff are stratified into the right place. SL highlighted the huge effort the CCG's teams have made for the vaccination programme; resources have been drawn down from every directorate to support the programme directly at sites, and as volunteers	

	across the whole System. There has been a mammoth effort by the whole organisation and SL gave his grateful thanks to everyone for the huge and enthusiast effort made above and beyond; the way in which this organisation has mobilised to support the programme is admirable and was recognised. AB concurred with this statement. **The Governing Body NOTED the update provided**	
GBP/2122/241	**Finance Report – Month 9** Richard Chapman (RCp) provided an update on the financial position as at Month 9 (H2). The following points of note were made: • All targets will have been met with a year-to-date surplus of £875k. • A further £2.27m COVID reimbursement is expected, giving a total year to date surplus of £3.145m. • Forecast outturn has moved to a £604m surplus from breakeven following receipt of additional allocations for the community diagnostic hub programme and discharge funding which is unlikely to be spent in year as the capacity will not be available. • Running costs remain underspent year to date, however, these have reduced as they will be required to fund the development of the ICS; this reduces the forecast outturn underspend to £824k against a year-to-date surplus of just over £1m. • £2.284m of the H2 contingency has been released into the year-to-date position in line with the plan signed off by the Governing Body. • A straight-line extrapolation of year-to-date expenditure against forecast outturn was provided for information. The largest variations are in Additional Roles Reimbursement Scheme (ARRS) expenditure and winter access funds in primary care services. This also includes material sums in mental health, with some movements the other way, reducing the year to date run rate in acute and primary care services where expenditure was incurred against specific funding in H1 but is not anticipated for H2. • £9m of elective recovery funding was received in H1; however, it is not anticipated that this will be repeated in H2. • There are some potential flexibilities for resources not yet committed however it is anticipated that they will be committed by the year end for cancer recovery, ambulance services and discharge support. • CHC pressures continue with increased discharge pressures being felt across the System; controls remain in place to manage this. **The Governing Body is requested to NOTE the following:** • **Allocations have been received for the full year at £2.090bn** • **The YTD reported underspend at month 8 is £3.146m** • **Retrospective allocations received for Half 1 COVID spend on the Hospital Discharge Programme were £5.498m; further additional funding is expected of £1.358m relating to Quarter 3** • **Additional anticipated funding includes:** - **Elective Recovery Fund reimbursed £0.761m for April to December with an additional £0.306m forecast** - **Winter Access fund forecast to spend and reimbursed £3.472m** - **Additional Roles Reimbursement Scheme (ARRS) forecast to spend and receive £5.759m** • **The year-end position is forecast at £6.403m underspent**	

GBP/2122/242	**Joint CCG Finance Committee / System Finance and Estates Committee (SFEC) Assurance Report – January 2022** Andrew Middleton (AM) provided a verbal update following the Joint CCG Finance Committee / SFEC meeting held on 27th January 2022. The following points of note were made: • This is the first time that both System partners and CCG Finance Committee members have met as one Committee. The current performance of both the CCG and the System are in positive forecast outturn territory therefore did not warrant extensive discussion. It is an unusual scenario that we find ourselves in, however normal financial disciples are expected to return, with efficiency challenges and less COVID allocations. Going forward, in the five further meetings before the demise of the CCG, there will be an intrinsic benefit from having both future partners and current CCG people in the same meeting with shared agendas, providing the ability to learn from each side of the argument. This scenario was recommended for other Committees. • A new element for the System partners was the inclusion of GP members, who are very astute and not afraid to ask questions, adding value to the discussions. • Next month a progress report will be provided on the System's intelligence and the plans for System efficiencies, given the underlying deficit of circa £150m. It is anticipated that the discussions will become more challenging as savings need to be found. **The Governing Body NOTED the verbal update provided for assurance purposes**	
GBP/2122/243	**Audit Committee Assurance Report – January 2022** Ian Gibbard (IG) provided an update following the Audit Committee meeting held on 20th January 2022. The report was taken as read and the following points of note were made: • The Committee received the External Audit Plan from KPMG; no significant risks were identified. KMPG will be forming a view based on the CCG as a going concern. • As the surplus at year end is deemed to be minimal, the month 12 estimations, accruals and transfers across the System will be closely examined for appropriateness; however, the Committee felt confident that this would not be challenged as a report presented by Internal Audit on the quality and accuracy of the integrity of the general ledger and financial reporting provided significant assurance. **The Governing Body NOTED the paper for assurance purposes**	
GBP/2122/244	**Clinical and Lay Commissioning Committee (CLCC) Assurance Report – January 2022** Dr Ruth Cooper (RC) provided an update following the CLCC meeting held on 13th January 2022. 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/2122/245	**Derbyshire Engagement Committee – January 2022** Martin Whittle (MWh) provided an update following the Derbyshire Engagement Committee meeting held on 18th January 2022. The report was taken as read and the following points of note were made: • The Committee received an update on the progress made towards creating the ICB, including the delay in its establishment from April to July 2022. The current position regarding the formal ICB committee structure will be progressed over the next few months with an update provided at the March meeting. An update was also received on the ICS Communications and Engagement Plan. • Communications and engagement response to the vaccination programme and System pressures – A presentation was given on the work undertaken on the COVID-19 vaccination programme (including the approach to tackling vaccine inequalities) and the activities in support of ongoing System pressures. • Accessible services for deaf people – A proposal was made to work with the British Deaf Association and local deaf people to set up a discussion session to highlight experiences in accessing health services. The feedback will be presented to the Committee, with an action plan for developments to help ensure that the voice of deaf people is heard, and reasonable adjustments agreed and made. **The Governing Body NOTED the paper for assurance purposes**	
GBP/2122/246	**Primary Care Commissioning Committee (PCCC) Assurance Report – January 2022** Dr Penny Blackwell (PB) declared a conflict of interest in this item Simon McCandlish (SM) provided a verbal update following the PCCC meeting held on 26th January 2022. The following points of note were made: • No items for decision were received. • A finance update was provided. • No changes were made to the Risk Register. • A positive change has been seen at the Brailsford and Hulland Medical Practice; it is now being rated as good. **The Governing Body NOTED the verbal update provided for assurance purposes**	
GBP/2122/247	**Quality and Performance Committee (Q&PC) Assurance Report – January 2022** Dr Buk Dhadda (BD) provided an update following the Q&PC meeting held on 27th January 2022. The report was taken as read and the following points of note were made: • The Committee received the Annual Report for the Children's Safeguarding Overview Panel. Assurance was provided that the teams have maintained a very high standard, whilst working in difficult circumstances due to the pandemic. Thanks were recorded for the achievements of the team. The following question was raised:	

	• Breast screening – Clarification was requested on the current position. BD explained that although there has been a dip in performance, the data is from November 2021 when there were issues around staffing. It was assured that if the pandemic had not occurred, a new cancer 28-day faster diagnosis standard would have been implemented from April 2020; on that standard both Trusts would be close to target, however the Omicron variant and staffing pressures, caused a slight dip. It was assured that once patients were diagnosed, they were treated in a timely manner, and the standard was only slighted missed. The Q&PC will be relooking at this again to ensure that the position has been recovered. It was noted that Hull Royal Infirmary had the same figures as Derbyshire and were escalated to Region; Region fed back that the service would close in Hull and patients would have to travel to Leeds, which is a 126-mile round trip; it was enquired whether, should improvements not be seen, the service in Derbyshire may not be sustainable. BD is aware of the issues in Hull and reassured that Derbyshire's issues are not the same. It was noted that the breast service is nationally challenged; this is not unique to Derbyshire. **The Governing Body NOTED the paper for assurance purposes**	
GBP/2122/248	**CCG Risk Register – January 2022** HD advised that this report highlights areas of organisational risk recorded in DDCCG's Corporate Risk Register as at 31st January 2022. 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. Closure of Risk 32 – It was proposed through the Governance Committee that the risk of exploitation by malevolent third parties if vulnerability is identified within any of the Microsoft Office 2010 applications after 14th October 2020 be closed on the basis that NECS has confirmed that a complete upgrade has been undertaken to remove all unsupported devices from the network. **The Governing Body RECEIVED and NOTED:** • **The Risk Register Report** • **Appendix 1 as a reflection of the risks facing the organisation as at 31st January 2022;** • **Appendix 2 which summarises the movement of all risks in January 2022** • **The decrease in risk score for Risk 16 relating to a lack of standardised process in CCG commissioning arrangements** **And APPROVED the closure of 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**	
GBP/2122/249	**Ratified Minutes of DDCCG's Corporate Committees:** • Audit Committee – 18.11.2021 / 17.12.2021 • Derbyshire Engagement Committee – 16.11.2021	

	• Primary Care Commissioning Committee – 22.12.2021 • Quality and Performance Committee – 23.12.2021 **The Governing Body RECEIVED and NOTED these minutes**	
GBP/2122/ 250	**South Yorkshire and Bassetlaw – ICS Development Update – January 2022** **The Governing Body RECEIVED and NOTED to update provided**	
GBP/2122/ 251	**Minutes of the Governing Body meeting in public held on 13th January 2022** **The minutes of the above meeting were agreed as a true and accurate reflection of the discussions held**	
GBP/2122/ 252	**Matters Arising / Action Log** Action Log – January 2022 – No outstanding items	
GBP/2122/ 253	**Forward Planner** **The Governing Body NOTED the Planner for information**	
GBP/2122/ 254	**Any Other Business** None raised	
DATE AND TIME OF NEXT MEETING – Thursday 3rd March 2022 at 9.30am via MST		

Signed by: ……Dr Avi Bhatia……. Dated: …3.3.2022……
(Chair)