NHS
County Durham
Clinical Commissioning Group

NHS COUNTY DURHAM CCG
GOVERNING BODY

Tuesday 14 December 2021
1.00pm to 3.10pm

THE MEETING TOOK PLACE BY VIDEO CONFERENCE
Due to the exceptional circumstances linked to the Coronavirus Covid-19 pandemic, the meeting was not held in public.

CONFIRMED MINUTES

Present:

Andrew Atkin	AA	Lay Member (**Chair**)
Nicola Bailey	NB	Chief Officer
Dr James Carlton	JCa	Medical Director
Richard Henderson	RH	Chief Finance Officer
Feisal Jassat	FJ	Lay Member – Patient and Public Involvement
Ian Spencer	IS	Secondary Care Clinician
John Whitehouse	JW	Lay Member, Audit and Governance

In Attendance:

Sarah Burns	SB	Joint Head of Integrated Strategic Commissioning
Joseph Chandy	JCh	Director of Commissioning Strategy and Delivery
Keith Holyman	KH	Patient Reference Group (PRG) Chair, North Durham locality
Diane Murphy	DM	Director of Strategy and Delivery (Continuing Health Care), Tees Valley and County Durham CCGs
Sue Parr	SP	Executive Assistant (Minutes)
Jane Robinson	JR	Corporate Director, Adult and Health Services, Durham County Council
Angela Seward	AS	PRG Chair, Durham Dales Locality

Apologies:

Chris Allan	CA	Public Health representative, Durham County Council
Linda Allinson	LA	Interim PRG Chair, Easington Locality
Mike Brierley	MBr	Director of Commissioning Strategy and Delivery
Chris Cunnington-Shore	CS	Patient Reference Group (PRG) Chair, Sedgefield Locality
Dr Ian Davidson	ID	Medical Director
Dr Stewart Findlay	SF	Chief Officer
Anne Greenley	AG	Director of Nursing and Quality (Interim)
Amanda Healy	AH	Director of Public Health, Durham County Council
Jennifer Mole	JM	Vice-Chair PRG, North Durham Locality
Dr Chris Markwick	CM	Elected Health Care Professional (GP)
Dr Neil O'Brien	NO'B	Accountable Officer/Clinical Chief Officer
Dr Jonathan Smith	JS	Clinical Chair

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GB/21/77	**Apologies for absence** Apologies were received as recorded above. The Chair declared the meeting was not quorate and therefore no decisions could be made. The Chair explained that, due to the exceptional circumstances linked to the Coronavirus pandemic, unfortunately the meeting could not take place in public. The meeting was however being live streamed with the video uploaded to a media platform for public viewing.	
GB/21/78	**Declarations of conflicts of interest** The Chair reminded members of the Governing Body of their obligation to declare any interest they might have on any issues arising at the meeting, which might conflict the business of NHS County Durham CCG. Declarations made by members of the Governing Body are listed in the CCG's Register of Interests. The Register is available either via the secretary to the Governing Body or via the CCG's website at the following link: https://countydurhamccg.nhs.uk/documents/declarations-conflict-interest/ There were no conflicts of interest highlighted at this point in the discussion.	
GB/21/079	**Identification of any other business** One item of other business was identified: • update on the current position in regard to COVID-19 - NB	
GB/21/080	**Minutes and matters arising from the Governing Body meeting held on Tuesday 14 September 2021** The minutes of the Governing Body meeting held on Tuesday 14 September 2021 were agreed as a correct record. **Matters arising** There were no matters arising.	
GB/21/081	**Minutes and matters arising from the Extra Ordinary Governing Body meeting held on 12 October 2021** The minutes of the Extra Ordinary Governing Body meeting held on Tuesday 12 October 2021 were agreed as a correct record. **Matters arising** NB advised that at the Extra Ordinary Joint Governing Body meeting held with colleagues from County Durham, Sunderland and South Tyneside	

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	CCGs, members received an update on the Integrated Care Board (ICB) Constitution. The draft ICB Constitution had been submitted to NHS England by the deadline; in terms of early feedback there had been no issues raised however the size of the Central ICB Board had been acknowledged as one of the largest. The constitution may be subject to amendments as legislation was passed by Government. There may also be potential changes in terms of job titles or portfolios when the new Chief Executive, Samantha Allen, starts in post and influenced the structure of the ICB. The advert for the director posts would be published before Christmas 2021.	
GB/21/084	**Action Log** The action log was updated.	
	ITEMS FOR DECISION	
GB/21/083	**The Choice and Equity Policy** *Director of Strategy and Delivery (CHC), Tees Valley CCG and County Durham CCG* *- Diane Murphy,* With the meeting not being quorate it was agreed that those in attendance would discuss the policy, raise any queries that they had, and then reach a decision that would then be subject to approval by the Governing Body clinical members. Members noted that the Choice and Equity Policy (the Policy) had been considered by the CCG's Executive Committee and their recommendation had been to submit it to the Governing Body for approval. The Policy described the way in which the continuing health care team (CHC) would commission care in a manner which reflected the choice and preferences of individuals but balanced the need for the CCG to commission care that was safe and effective and made the best use of available resources. Long in development, the Policy had become necessary due to the almost weekly challenges faced by the CCG when looking at packages of care, particularly high-cost cases. The Continuing Health Care (CHC) team also had to make difficult decisions about what to commission in the absence of a policy framework. The Policy had been produced based on the work done at a national level with the CHC Improvement Team and, more recently, work that had been done across Greater Manchester by a collaboration of CHC leads. The Policy had been recommended and implemented in Greater Manchester. It was now being considered more locally in County Durham and Tees Valley and across the Integrated Care System (ICS) meaning it had been shared with not just health and CHC colleagues but also with local	

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	authority representatives who had indicated their support. The intention would be to ultimately align the Policy with similar Local Authority policies however currently it was specific to the CCG and CHC. It was noted that the Policy was lengthy and detailed but for good reason, not least because of the potential legal challenges that could be made following decisions. It was one of the reasons why it had taken so long (years) to get to the position of implementing such a policy. DM drew attention to the following key points: • The Policy referred consistently throughout to the NHS Framework for CHC and that was something the CCG should always be mindful of and implement. • Any package of continuing care that the CCG offered to a patient must meet the assessed needs of that patient, with due regard to their wishes and preferences. • The CCG did not have to fully implement those wishes and preferred outcomes, but it did have to consider them as part of the overall assessment. • The Policy did not apply to packages of care for those under the age of 18, nor did it apply to the provision of aftercare services under Section 117 of the Mental Health Act. It only applied where individuals had been found to be eligible for Joint Funding or NHS CHC and applied only to the commissioning of that CHC provision. • Whilst there was no set upper limit on the cost of care, the expectation was that the most cost-effective option would be commissioned that met the eligible individual's assessed health needs and circumstances. • The needs assessment of an individual would include psychological and social needs and the impact on the individual in terms of their home and family life. • In terms of care home placements, the CCG would always use the preferred provider list although there were some challenges to that, particularly when an individual moved out of area. Often, when an individual moved out of area to be closer to family, the care home costs were significantly more expensive to those in County Durham and Tees Valley. • The CCG would always look for the most cost-effective care home provider. Individuals could not 'top-up' their assessed needs to pay for more expensive out of area placements however they could pay for some additional things such as hairdressing. • If the eligible individual was unwilling to accept any of the offers made by the CCG, the CCG would have fulfilled its duties to the eligible individual and would not be required to take further steps to provide services to him or her. This may trigger a safeguarding alert as the CCG had a Duty of Care to make sure the individual and others were safe from harm. • In terms of CHC funded packages of care at home, although the CCG	

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	did state its position on 24-hour nursing care or equivalent within the policy as not something it could generally afford to do due to cost effectiveness, it would always undertake a robust assessment based on the individual person's needs and other exceptional circumstances such as end of life wishes (Fast Track applications). DM explained that it was not a 'blanket' policy and that every case would be considered individually. In exceptional circumstances a decision could be made at a director level to approve a package of care. Tees Valley CCG had approved the policy and it had been implemented for the last two months. Cumbria CCG had also implemented their own version of the policy but it was very similar to the proposed one. Other CCGs across the ICS were looking to implement similar polices throughout 2022. The CCG's lawyers had commenced important training of the CHC team (the team worked across Tees and Cumbria) and that had been very helpful and well received. The Policy was not only new, but implementation would be quite difficult and challenging at an operational level. The Chair invited questions and comments from Members. Following a point raised by JCa in regard to the advantages of adopting the Policy it was noted that as well assisting with decision making in terms of placements, which could be challenging, it would also help to manage family expectations by being open and honest about what CHC was and what the CCG's obligations were. Conversations with families were not always easy but having a policy framework in place helped support the CHC team with that. In response to FJ's query with regard to the financial allocation to support the implementation of CHC, RH advised that the CCG did not have a ring-fenced pot of funding for CHC, it would be from the overall CCG allocations. The CCG would have a budget at the start of the financial year but it generally overspent on CHC so costs would be in excess of budget. If an individual was eligible for CHC then the financial element of it would be considered when agreeing a package of care but it would never override the decision and the CCG would always fund from the wider CCG allocation. A CHC package had never been refused on a financial basis. NB highlighted that as the profile of the population had altered the number of CHC applications had increased exponentially, having a policy framework in place would help support the CHC Team in managing their workload. Having a similar policy across the ICS would avoid the risk of a 'postcode lottery' in the provision of CHC. IS raised his concern in regard to the possibility of budget overspend which he believed had been recognised as a concern, particularly when	

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	children moved into the adult phase of CHC, to the extent that it had been registered as an ongoing risk to the CCG's finances. In response, RH advised that at times CHC costs had been recorded as a risk to the financial position along with other areas such as prescribing. There had been an overspend for a number of years for CHC, however the CCG had managed the cost as part of the overall CCG allocation. NB added that CHC was a risk for the CCG not only from a financial perspective but also a reputational one in terms of ensuring the CCG met an individual's health and care needs. The Policy would cover the whole breadth and depth of need for adults, some with very complex needs that would be at a significant cost to the CCG. It was the CCG's duty to make sure that it did the right thing for individuals in need of CHC. DM advised that some of the more expensive packages of care commissioned by the CCG were in the hundreds of thousands of pounds a year at an individual level, so that it was right that the CCG could actively manage those packages of care. However, along with some cost improvements, there had been some significant quality improvements within the year. Bringing the discussion to a close, the Chair proposed that following the meeting the Policy would be circulated to those clinical members not in attendance asking them to raise any issues that would mean they would not want to adopt the Policy. If no issues were raised then it would be assumed that they were in agreement with the decision to adopt the Policy. ***Action:*** *The Choice and Equity Policy to be circulated to clinical members not in attendance to provide them with an opportunity to raise any issues that would reverse the decision to approve the implementation of the policy.* The Governing Body: • considered the content of the report, • approved the implementation of The Choice and Equity Policy. *DM left the meeting at the conclusion of this item.* ***Post meeting update:*** *No issues had been raised by clinical members of the Governing Body. The Policy was approved for implementation.*	**SP**
	ITEMS FOR DISCUSSION	
GB/21/084	**Clinical Chair, Accountable Officer and Chief Officers' Report: March 2021** *Nicola Bailey, Chief Officer* *Dr Stewart Findlay, Chief Officer* *Dr Neil O'Brien, Accountable Officer/Clinical Chief Officer,* *Dr Jonathan Smith, Clinical Chair*	

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	The purpose of the report was to provide an update on key issues affecting County Durham CCG including: • report from Clinical Chair (verbal), • Section one Accountable Officer/Chief Clinical Officer, • Section two reports from Chief Officers. There were no specific risks associated with the report. It was intended to provide an overview of the key issues and activities facing the Chief Officers and the executive team. Where necessary, more detailed reports on specific issues would be prepared for future Governing Body meetings or would be considered at a development session. NB highlighted the follow key points: **Integrated Care System (ICS) Update** GB Members were reminded that the ICS Constitution had been proposed by the CCG to NHS England. The Integrated Care Board (ICB) makeup had now been determined and agreed with Sam Allen, the new Chief Executive who would take up the post on 31 January 2022. The consultation process for affected Board members would start week commencing 20 December 2021. All ICB posts had now been advertised. The fifth Joint Management Executive Group (JMEG) meeting would be held week commencing 13 December 2021 with a further meeting planned to determine the structure and membership of the Integrated Care Partnership (ICP). NB clarified that the ICPs would be the proposed legislation partnership, i.e., it was a committee of all the local authorities (LAs) involved within the ICB for North Cumbria and the North East – 13 LAs in total. The ICP would have a clear set of recommendations around integrated strategies for health and wellbeing, health inequalities, joint strategic needs etc. Some LAs had said they would like to have sub-partnerships and that would be discussed at a meeting to be held the following week. The programme board continued the work on the transition of the CCGs to the ICB including due diligence, which would be the final action for the CCG in terms of handing over its statutory duties and staff. RH, the CCG's Senior Responsible Officer for due diligence, and Jill Matthewson, Head of Corporate Services, had been working with AuditOne in regard to this. HR actions included the TUPE transfer of staff into the new organisation. **NHS Recovery / Covid-19 and Flu Vaccination Programmes** NB drew attention to the sections on NHS Recovery and the Covid-19 and Flu Vaccination Programmes. In addition it was noted that, due to the significant concerns around the spread of the Omicron variant, the Government had raised the alert level to 4 which meant the healthcare system was again under a 'command and control' situation. A letter had been circulated by the Government detailing what the	

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	expected healthcare response would be to an anticipated surge in infection such as the reprioritization of work and the redeployment of staff to support the expansion of the vaccination programme to seven days per week, 8am to 8pm with an ask to be flexible over the Bank Holidays during the Christmas period. This directive would cover the next three weeks but had come with very little notice. CCG staff would continue to support the programme including the Medicines Optimisation team; they were currently supporting the local authority with organising pop-up vaccination clinics. The letter also outlined the Government's expectations in regard to: • at scale delivery of vaccinations to vulnerable people such as the housebound, • the use of antivirals to support people who remained in the community, • the improvement to emergency care system responses including a reduction in ambulance handover delays and an increase in call handling staff for 999 and 111 calls. **Urgent and Emergency Care pressure** Significant pressures continued within urgent and emergency services. A range of actions were being implemented to help reduce the pressure including: • A continued focus on critical care and elective care where that is urgent such as cancer. • Community Services had set up a 2 Hour Crisis Response service to avoid admissions. • Focused work on hospital discharges across seven days. • Ensuring that supply chains were in order in terms of oxygen supplies etc. • A reduction in the cohort of patients in hospital under the 'right to reside'. This meant that a person medically fit to leave an acute hospital would not have a right to remain in the hospital until their preferred place of discharge became available. It was not expected to be an issue for County Durham and Darlington NHS Foundation Trust (CDDFT) as they had few patients within this cohort however there was an expectation that some patients would be discharged to home, particularly those who did not require social care. • An increase in capacity around hospice care. • An expansion of virtual wards and hospital at home schemes. Planning guidance and funding was expected in regard to these schemes. NB added that hospital services had not as yet been significantly impacted by Omicron but it was the fastest growing variant. As highlighted above, GPs, hospitals, CCGs and local government had been asked to reprioritize their work and staff have been encouraged to get their booster vaccinations to help the NHS respond to the variant and cope with the significant pressures within urgent care. The Local Resilience Forum had	

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	been stepped up with a meeting taking place this afternoon to look at what could be done at system level. NB referred Members to the report for the Chief Officer update. Chair invited questions and comments from Members. JW had three questions to raise; (i) was there a timescale for when the legislation would go through for the Health and Social Care Bill (CCG transition in to the ICB); (ii) had the short notice to step up the vaccination programme impacted the supply of the Covid-19 vaccine; (iii) would it be appropriate for the Governing Body to express its gratitude to all staff that had had to reprioritize their efforts and thank them on behalf of the Governing Body. NB responded to each in turn. (i) The emergency legislation for the ICB had already been submitted to the House of Lords. The main issue to be picked up was around workforce but the expectation was that it would be considered in the House of Lords in January 2022. (ii) Healthcare leaders had been told at a national webinar on 13 December 2021 that there would be a doubling of the supply of vaccine from Wednesday 15 December 2021 and that it would be a push model rather than pull model. (iii) In terms of expressing gratitude, NB had done that earlier that day at the Staff Briefing when she had also asked staff to be flexible in terms of work priorities, working weekends and taking holidays over the Christmas and New Year period. She felt that, without a doubt, staff would step up to the ask. Referring to section 4.2 of the report – NHS Recovery - and specifically to the action by County Durham and Darlington NHS Foundation Trust (CDDFT) in relation to patient initiated follow-ups, IS asked if it was likely to be a long-term strategy for the follow up of chronic conditions or whether it was a short-term response to help recovery from the pandemic. If the former, then IS had similar concerns to other clinical bodies and would like to see a robust audit process in place in order to avoid patients being lost in the system. In response JCa said that it was likely to be a longer-term strategy; IS was right to raise his concerns but the intention would be to slowly introduce the scheme in a controlled manner, looking at areas of lowest risk. It would do away with the situation where patients would be routinely reviewed year after year on a standard rolling basis. The scheme would be clinical led with the clinical team deciding as to whether or not it was appropriate to move a patient on to the initiated follow up strategy. It would not be a default position. JCa added that patient initiated follow ups had already being introduced for patients being treated for or living with cancer. Those patients were being very closely monitored with robust safety netting and audit schemes in place, which was what IS was seeking assurance about. The Governing Body: • received and discussed the report, noting the range of work being undertaken.	

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GB/21/085	**Risk Management Report** *Richard Henderson, Chief Finance Officer* The report provided a risk management update, including a summary of the corporate risks facing the organisation together with a full copy of the latest risk register position. County Durham CCG currently had 24 risks, two of which are corporate risks which were brought to the attention of the Governing Body, relating to: • the delivery of Constitutional Standards, • COVID-19. One new risk has been added to the risk register since the previous report: • CD/0026 – Antimicrobial Stewardship (AMS). County Durham CCG was the highest ranked in England and far above the national ambition for prescribing antimicrobial items. There was no risk around potential harm to patients, which had been an area of focus, but clearly it was a concern. No risks had been closed since the previous report. There had been minor changes to two risks scores: (i) the risk score around the financial risk had been slightly reduced due to the CCG receiving the funding envelopes and a confirmed position for the second half of the financial year, (ii) there had been a slight increase to the risk score around system resilience plans, which was now 12 to reflect the additional pressures within the healthcare system. This would be revisited in light of the spread of Omicron cases. The Governing Body: • received the report and appendices, • noted the current risks facing the CCG, • received assurance that mitigating actions were in place to ensure that all of the CCG's risks were being appropriately managed.	
GB/21/086	**County Durham CCG Finance Report** *Richard Henderson, Chief Finance Officer* The report captured the financial position for NHS County Durham CCG for the six months ended 30 September 2021. RH highlighted the following key points: **H1 2020/21** • The temporary financial arrangements continued to apply for the six months to 30 September 2021 ('H1'). These arrangements were	

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	similar to those in the second half of 2020/21. • Funding allocations were largely based on 'H2' 2021/22 values with elements of growth applied. • The CCG's financial plan for H1 2021/22 showed an expected surplus of £1.114m. • At Month 6, the CCG was reporting an overspend against that plan position of £0.661m. • This variance related to costs of the Hospital Discharge Programme (HDP) of £0.643m and Reducing Inequalities funding of £0.018m, for which retrospective funding was expected. • Once expected retrospective funding was received, the CCGs financial position would be back in line with plan. • At this stage of the year there was still very limited data available for the majority of commissioned services therefore there was still significant uncertainty and a high degree of estimation in the position. **H2 2020/21:** Given the recent publication of the H2 position, RH was able to provide an update to the reported position. • The financial framework for H2 remained very similar to H1 with system financial envelopes comprising CCG allocations along with system top-up, covid and growth funding. The block payment process for NHS providers continued. • There had been a balanced financial plan submitted for H2 with the surplus from H1 still in place, therefore at the end of the year the CCG expected to deliver a surplus of just over £1.1m. • At Month 8, the CCG still expected to be in line with that plan and was currently reporting a forecast overspend against plan of almost £4m. • However, funding was expected to come in retrospectively for hospital discharge, programme costs, elective recovery and some additional funding related to the PCN additional roles reimbursement scheme. • The key message was that, when the retrospective funding had been received, the CCG expected to be back in line with the plan for the year The Governing Body: • considered the report, • noted the financial position for H1 2020/21, • noted that a further retrospective allocation adjustment was anticipated which would take the CCG to the planned surplus position, • noted the update in respect of H2 financial plans.	
GB/21/087	**County Durham CCG Performance Report** *Richard Henderson, Chief Finance Officer, County Durham CCG* The report provided a summary of performance against key Constitutional Standards and other performance indicators. Provider and CCG level performance had been provided as part of Appendix 1. Given the impact of COVID-19, the report focused on the recovery plan	

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	for elective activity, long waiters and cancer performance in particular. This included an update on performance against the Phase 3 recovery plans submitted to NHS England and NHS Improvement, along with a summary of Independent Sector acute activity.
	
	RH drew attention to:
	
	• Page 5, Elective Recovery Plan and the provisional activity data for October 2022.
	• Page 8 and the tables which showed the total numbers of patients waiting over 52 weeks (10,558) and patients waiting over 104 weeks (508) across all trusts within the Integrated Care System (ICS).
	• Page 9 and the summary of over 52 weeks waits (1,419) and over 104 week waits (45) by Trust for County Durham CCG patients only. It was noted that Trauma and Orthopaedics and Ophthalmology were the two main pathways impacted.
	• Page 10 and the table showing the range of recovery actions by CCDFT, which had also been touched on within the Accountable Officer update above. The aim was to clear all 104 week waits by 31 March 2022.
	• Pages 11 and 12 provided an update on the latest cancer position. It highlighted:
	  ○ the main issues around diagnostics and endoscopy capacity. Additional colorectal funding had been agreed and work was ongoing with Gateshead Health NHS Foundation Trust and Spire Washington Hospital to increase radiology capacity,
	  ○ the pressures around dermatology and chemotherapy-recruitment was underway but in the interim the clinics were supported by locum and agency staff.
	• Page 13 and the A&E Performance data that had again been picked up during the Accountable Officer's update.
	
	The Chair invited questions and comments from Members.
	
	NB pointed out that, despite the difficult position in regard to what could be done to improve the performance position given Covid-19, it remained important that the CCG did not lose sight of the individuals who were waiting a long time for their treatment or operations etc. The CCG still had a responsibility to monitor performance measures, and to make sure the 52 week waiters and the over 104 week waiters were prioritised and their needs were met.
	
	In response to AA's query as to what the CCG could practically do in regard to influencing performance measures, NB advised that, in addition to national directives and pathway work etc., the CCG was working very closely with the council to make sure that people were not disadvantaged for any reason and were prioritised in terms of health inequalities.
	
	JCa drew attention to the work on improvement measures for the recovery of services for areas such as cancer, urgent emergency care,	

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	autism assessments, mental health etc. He explained that the system had responded to the pressures in a more joined up approach than ever before and that, despite the performance indicators, the CCG was committed to delivering for the people of County Durham. In response to IS's query with regard to the elective recovery fund (ERF), RH advised that the added complication with regard to the ERF was that it was measured at a system level rather than at an individual trust level. CDDFT may or may not achieve the activity levels set on its own but depended on the performance of all trusts within the ICS. The funding for ERF would come down from the ICS. IS raised two further queries with regard to: (i) why were so many patients (long waiters) being seen in private hospitals, was it linked to those clinicians also being NHS clinicians, (ii) mental health recovery plans referenced SPA assessments, were they initial assessments and reviews or did they provide therapy as well. It was agreed that, without the information to hand, RH (i) and JCa (ii) would respond to IS out with the meeting. ***Action:*** *RH and JCa to provide further information in response to IS's queries in regard to the use of private hospitals and SPA assessments.* The Governing Body: • considered the content of the report.	**RH / JCa**
GB/21/088	**County Durham Quality Assurance Report December 2021** *Dr James Carlton, Medical Director* *Anne Greenley, Director of Nursing and Quality (Interim)* The purpose of the report was to provide the Governing Body with information and assurance on the quality of services that are either commissioned by the CCG, or that the CCG had a legal duty to support with regard to quality improvement. JCa asked Members to be mindful that the report had been based on data from October 2021 and, as has been alluded to during the meeting, things had been changing very rapidly within the healthcare system. **County Durham and Darlington NHS Foundation Trust (CDDFT)** The serious incidents (SIs) related to maternity were currently being more closely monitored. CDDFT had shared an update at the Quality Assurance Committee of on-going actions the Trust had been completing. A regional review was also being undertaken. **Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV)** Members noted that following the release of the Care Quality Commission (CQC) update the position had changed to that reported. The Trust's overall rating had not changed from 'requires improvement'	

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	but ratings had gone up and down in certain areas. The CCG was working with TEWV around their forensic services, staff culture and a number of other significant issues were being managed nationally in regard to mental health services and workforce. Key stakeholders would be meeting in early January 2022 to discuss a system approach to support children, young people and their families. This could be through work in school, through family support arrangements or using the community voluntary sector. It was noted that at the next meeting of the Governing Body which would be held in March 2022, members would receive an update from on the stakeholder summit to be held in January, and Brent Kilmurray, Chief Executive of TEWV (or one of his clinicians) would attend to provide an update covering the three areas: • forensic services, • child and adolescent mental health services (CAMHS) which included autism diagnostic services, • some aspects of the adult mental health services. **North East Ambulance Service NHS Foundation Trust (NEAS)** Reference was made to the issues around NHS 111 and 999 call handling which had been raised earlier on in the agenda. Discussion was taking place nationally about the introduction of a single telephony system for the NHS 111 Service from the end of March 2022. The key benefits were having one single queue, ensuring clinical resource was shared and being able to buddy up systems. **Cygnet** A regional Clinical Quality Review Group (CQRG) had been established to have a more focused oversight of quality across the provider. <u>Appletree</u> The Quality and Safeguarding team were undertaking frequent assurance visits to Cygnet Appletree to oversee clinical quality actions / improvements. The CCG did not have any patients placed at Appletree but had introduced weekly calls with placing commissioners. AG had spent significant time to establish the process for oversight of the provider. The Chair invited questions and comments. IS raised two concerns (i) if established, the IT infrastructure supporting the single virtual contact centre (SVCC) may not be robust enough to manage the volume of calls. Should it fail, would there be a backup system in place. (ii) during busy periods, would the NHS 111 service be able to transfer patients to quieter hospitals as was currently the case. Before responding JCh advised that the resilience of the NHS 111 service	

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	was currently challenged and the number of 999 calls had been 30% above the expected levels in October 2021. Ambulance trusts across the country had a 'buddy up' system in place to provide mutual support which could be triggered when having to respond to particularly challenging situations. In response to the concerns IS raised, JCh advised that the intended organisational structure of the SCCC was still an unknown however, with it being a 'virtual' contact centre, he envisaged the structure to be a network of the existing call handling centres. The objective would be to build upon the existing systems and infrastructure to improve resilience within the system. JCh believed that local intelligence would still be held within the regional (Newcastle) call centre, but he would look to get more information from the North East Ambulance Service NHS Foundation Trust (NEAS). ***Action:*** *JCh to contact NEAS to seek further information on the SVCC in order to respond more accurately to IS's concerns.* The Governing Body: • considered the content of the report.	**JCa**
GB/21/089	**Integrated Care Partnership (ICP) / Integrated Care System (ICS) Update** *Nicola Bailey, Chief Officer* NB advised that she had nothing further to add to the discussion under agenda item GB/21/084: Clinical Chair, Accountable Officer and Chief Officers' Report.	
GB/21/090	**Primary Care Commissioning Committee (PCCC) Update** *Feisal Jassat,* *Chair of the Primary Care Commissioning Committee* FJ advised that the standard reports had been received by the Primary Care Commissioning Committee (PCCC) at the meeting held on 26 October 2021. These included the Primary Care Quality report, the Primary Care Finance Report, the Risk Management Report, and an update on Primary Care / Primary Care Networks. In addition, the PCCC had received a report on NHS England's plan to improve access for patients to primary care and supporting general practice. The plan included an additional £250m for a new Winter Access Fund that had been established to support the implementation of the plan, and specifically to improve patient face-to-face access to urgent, same day care, outside of hospital. During discussion of the report it had been noted that the challenge for clinicians was not so much around funding but rather having the staff in place to deliver face-to-face appointments. Staffing levels within primary care continued to be a challenge. The Governing Body received the verbal update.	

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GB/21/091	**Audit and Assurance Committee Update** *John Whitehouse,* *Chair of the Audit and Assurance Committee* JW advised that the Audit and Assurance Committee (AAC) had met just the once since his previous update and discussion had focused on establishing what the AAC had to do to support the due diligence process before the CCG's transition in to the ICB. A flexible approach would be required as a number of AAC outputs had been scheduled to close after the end of the financial year when the CCG no longer existed. The process would be changed if necessary between now and the end of March 2022 in order that the AAC could leave the CCG with an up-to-date audit position statement. The Governing Body received the verbal update.	
GB/21/092	**Patient and Public Involvement Update** *Feisal Jassat,* *Lay Member for Patient and Public Involvement* FJ advised that in addition to the standard reports and updates from local authority, voluntary and community sector colleagues, the October 2021 Patient, Public and Carer Engagement Committee had received: • the Quarter 2 Engagement Activity report, • a report on the Great North Care Record (GNCR). The update on the development of the GNCR by Dr Mark Westwood had been well received. FJ felt it was exciting project which would be rolled out to patients to provide electronic access to their health records. The Governing Body received the verbal update.	
	FOR INFORMATION	
GB/21/093	**Information Governance Update (Report of the Senior Information Risk Officer (SIRO) – Quarter 2 2021/22** *Nicola Bailey, Chief Officer* The purpose of the report was to provide assurance of the work underway within the CCG and with the North of England Commissioning Support (NECS) Information Governance Team whose services are commissioned by the CCG to support information governance. The report covered the period 1 July 2021 to 30 September 2021. The Governing Body: • received the report for information.	
GB/21/094	**County Durham Clinical Commissioning Group (CCG) Quarterly Engagement Activity Report: July – September 2021 (Q2)** *Sarah Burns, Joint Head of Integrated Strategic Commissioning,*	

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	County Durham CCG and Durham County Council The purpose of the report was to provide an update on the range of engagement activities that took place during July - September 2021 (Q2) in County Durham CCG. The areas covered in the report included: **Engagement projects** • Co-production development (part of County Durham Together) • Primary Care Networks (PCNs) and public involvement • Shotley Bridge Community Hospital services • Wingate GP practice patient survey • Developing future approaches – Learning Disabilities, Autism and Children and Young People • SEND (special educational needs and disabilities) services • Community Services Task and Finish Groups • Community Equipment Services • Home Oxygen Service • Little Orange Book • GP practice Access • Maternity service survey **Patient Groups** • Patient, Public and Carer Engagement Committee • Locality Patient Representative Groups The Governing Body: • received the update regarding the engagement activity for County Durham CCG during Quarter 2, 2021-22.	
GB/21/095	**<u>QUESTIONS FROM THE PUBLIC</u>** No questions had been received from members of the public.	
GB/21/096	**<u>MINUTES TO RECEIVE</u> – previously circulated** **Audit and Assurance Committee of County Durham CCG:** • 7.6.21 **Durham County Council Health and Wellbeing Board** • 17.6.21 **Executive Committee of County Durham CCG** • 10.8.21 • 14.9.21 • 12.10.21 **County Durham Care Partnership and CCG Executives in Common**	

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	▪ 24.8.21 ▪ 28.10.21 ▪ 26.10.21 **Patient, Public, Carer and Engagement Committee of County Durham CCG** ▪ 26.8.21 **Primary Care Commissioning Committee of County Durham CCG** • 25.8.21 **Quality Committee of County Durham CCG** ▪ 3.8.21 ▪ 7.9.21 ▪ 5.10.21	
GB/21/097	**Other Business** There were no items of other business. NB had provided her update on Covid-19 during the discuss of agenda item GB/21/84 - Clinical Chair, Accountable Officer and Chief Officers' Report.	
GB/21/098	**Risk round up** No new risks had been identified but the CCG may potentially need to reconsider the scores of some of the risks.	
	Next Meeting The next meeting could potentially be held on Tuesday 18 January 2022 but it had yet to be confirmed as to whether the meeting would be a formal Governing Body meeting or a Governing Body Development Session.	
	Contacts for the meeting: Susan Parr, Executive Assistant Tel: 0191 389 8621 susan.parr@nhs.net Mags Wells,Governance Administrator Tel: 0191 371 3224 margaret.wells1@nhs.net	

Signed: *Approved via email*.

Chair: Andrew Atkin

Date: *29 March 2022*