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Creating a healthier Hull

NHS Hull Clinical Commissioning Group

Item 2

CLINICAL COMMISSIONING GROUP BOARD

MINUTES OF THE MEETING HELD ON FRIDAY 24 SEPTEMBER 2021, 9.30 AM
Via MS Teams

PART 1

PRESENT:

Dr D Roper	Chair, NHS Hull CCG
Dr B Ali	GP Member, NHS Hull CCG
Dr M Balouch	GP Member, NHS Hull CCG
E Daley	Interim Chief Operating Officer, NHS Hull CCG
E Latimer	Accountable Officer, NHS Hull CCG
D Lowe	Interim Director of Nursing & Quality, NHS Hull CCG
K Marshall	Lay Representative (Audit, Remuneration & Conflict of Interest Matters), NHS Hull CCG
Dr J Moult	GP Member, NHS Hull CCG
Dr A Oehring	GP Member, NHS Hull CCG
Dr V Rawcliffe	GP Member, NHS Hull CCG
J Stamp	Lay Representative (Patient & Public Involvement) and CCG Vice-Chair, NHS Hull CCG

IN ATTENDANCE:

S Lee	Associate Director of Communications & Engagement, NHS Hull CCG
M Napier	Associate Director of Corporate Affairs, NHS Hull CCG
E Shakeshaft	Head of Communications, NHS Hull CCG
D Storr	Deputy Chief Finance Officer – Finance, NHS Hull CCG
J Weldon	Director of Public Health, Hull City Council
M Shepherd	Personal Assistant to the Interim Director of Nursing & Quality, NHS Hull CCG - Minute Taker

PUBLIC ATTENDANCE:

J Gerrard	Journalist, Hull Daily Mail
T Illsley	Key Account Manager, Bayer PLC

1. APOLOGIES FOR ABSENCE

Apologies for absence were received and noted from:-

I Goode	Lay Member (Strategic Change), NHS Hull CCG
E Sayner	Chief Finance Officer, NHS Hull CCG
M Whitaker	Practice Manager Representative, NHS Hull CCG

2. MINUTES OF THE PREVIOUS MEETING HELD ON 23 JULY 2021

The minutes of the CCG Board meeting held on 23 July 2021 were submitted for approval and agreed as a true and accurate record of the meeting subject to the following amendment:-

- Page 2, item 3 – Matters Arising/Action List from the Minutes. 2nd paragraph should read *'The Vice Chair **stated** that there were three elements around the next steps for Integrated Care Systems (ICSs).*

Resolved

(a)	CCG Board Members approved the minutes of the meeting held on 23 July 2021 subject to the agreed amendment and these would be signed by the Chair.

3. MATTERS ARISING / ACTION LIST FROM THE MINUTES

The action list from the meeting held on 23 July 2021 was presented for information with the following updates provided:-

22/01/21 - 6.2 - Next Steps for Integrated Care System.
A Future Board Development session is to be arranged, structured around how we begin to move things forward, to include the future of committees and Place and how to retain the skills and expertise both in relation to PCNs and Board members.
Update 24/09/21 – Action agreed to be removed from the action list as this was now a standing agenda item for discussion. The Lay Member highlighted there were two elements the Board need to ensure was captured 1) Update on progress and what this would mean for Hull and 2) Assurance around the transition process i.e. functions/staff and to not lose sight on this. Moving forward Hull CCG's Accountable Officer would produce a formal report on the 'Readiness to Operate' with RAG rating to ensure safe transition of functions and staff. The Lay Member for Audit, Remuneration & Conflict of Interest informed the Board that assurances around transition were now part of the Integrated Audit & Governance Committee agenda.

The area of support for people with long term conditions and complex needs in the last year of life would be taken away and brought back to the next meeting in terms of what specific work had been done around this. A Deep Dive across the Planning and -Commissioning and Quality and Performance Committees into End Of Life Care was planned. **Update 24/09/21 - Scoping completed although areas of focus had increased. A meeting would be held beginning of October 2021. This would be led through the Quality and Performance Committee with the outcome noted in the minutes and subsequent report to the Board if required.**

Resolved

(a)	Board Members reviewed the Action List from the meeting held on 23 July 2021 which would be updated as agreed.

4. NOTIFICATION OF ANY OTHER BUSINESS

Any proposed item to be taken under Any Other Business must be raised and subsequently approved, at least 24 hours in advance of the meeting by the Chair.

Resolved

(a)	There were no items of Any Other Business to be discussed at this meeting.

5. GOVERNANCE

5.1 DECLARATIONS OF INTEREST

In relation to any item on the agenda of the meeting Board Members were reminded of the need to declare:

(i) any interests which were relevant or material to the CCG;
(ii) any changes in interest previously declared; or
(iii) any financial interest (direct or indirect) on any item on the agenda.

Any declaration of interest should be brought to the attention of the Chair in advance of the meeting or as soon as they become apparent in the meeting. For any interest declared the minutes of the meeting must record:

(i) the name of the person declaring the interest;
(ii) the agenda number to which the interest relates;
(iii) the nature of the interest and the action taken;
(iv) be declared under this section and at the top of the agenda item which it relates to;

Name	Agenda No	Nature of Interest and Action Taken
Dr James Moult		Declared a General Interest in relation to his honorary contract for Cardiology at HUTHT. The declaration was noted, and no further action was required to be taken.
Dr Bushra Ali		Declared a General Interest as her spouse worked at HUTHT. The declaration was noted, and no further action was required to be taken.
Dr Bushra Ali	6.3	Declared an interest in relation to the Sentinal Asthma Project, whose Practice and PCN had been involved. The declaration was noted, and no further action was required to be taken.
Dr Amy Oehring	6.3	Declared an interest in relation to the Sentinal Asthma Project, whose Practice and PCN had been involved. The declaration was noted, and no further action was required to be taken.

Resolved

(a)	The above declarations of interest were noted, and no further action was required to be taken.

5.2 DECLARATIONS OF GIFTS AND HOSPITALITY

Board Members were provided with details of the Gifts and Hospitality Declarations made since the last Board Meeting on 23 July 2021.

Resolved

(a)	Board Members noted the declaration of gifts and hospitality submitted to the Board since the last meeting.

5.3 ACCOUNTABLE OFFICER'S UPDATE REPORT

The Accountable Officer presented the above regular update report which provided Members with a summary of key areas. See embedded document below for further detail:-

We Are Primary Care Campaign. Having reflected on General Practice, the Chair noted the other aspects of primary care i.e. pharmacy and dentistry where staff across all 3 areas showed full employment. With a million vacancies particularly in hospitality, those jobs would become increasingly attractive to people and would receive less levels of abuse. This ran the risk of undermining and worsening the situation the CCG was trying to improve. Younger members of staff were also more vulnerable to social media.

Volunteering. The Lay Representative for Patient & Public Involvement noted one of the key successes arising from Covid-19 was the mobilisation of volunteers and the support given, not only to the vaccination programme, but also to communities which provided the CCG with a massive opportunity to think creatively about what to do next with volunteering and how it could support the system in a more coordinated way.

The evaluation of the centralised National Volunteer Responders Scheme, launched at the start of Covid-19, showed a preference across HCV for local volunteering with a real sense they would make the biggest difference. A conversation was needed around how the CCG built on what was currently in place, where would volunteers fit in terms of booster campaigns and support with system challenges at present. The Accountable Officer noted several volunteers were now moving into paid work and was keen to see the impact of this and to review feedback from the evaluation to build into plans moving forward.

Resolved

(a)	Board Members noted the content of the Accountable Officer's Update Report and the key areas highlighted.

5.4 ANNUAL DECLARATIONS OF MEMBERS INTERESTS

The Associate Director of Corporate Affairs presented the Annual Declarations of Members Interests to note. The CCG had maintained a robust and transparent Declaration of Interest process which was formally updated on an annual basis and informally in between. Once received by the Board, declarations were published on the CCG website for public scrutiny.

Resolved

(a)	Board Members noted the Declarations of Interest for Board Members

5.5 ANNUAL GENERAL MEETING

The Associate Director of Communications and Engagement updated members on the running order for Hull CCG's Annual General Meeting (AGM) to be held virtually on Tuesday 28 September via Facebook and You Tube with the opportunity for members of the public to dial in. There would also be an opportunity to view a screening of the AGM at the Wilberforce Court office with 3 allotted timeslots for those that didn't have access to a digital device. The agenda would follow the usual presentations interspersed with various video highlights and, at the end of the formal session, a 'Question and Answer' session would be hosted by Hull CCG's Lay

Representative for Patient and Public Involvement. The Chair noted the significant number of questions received this year with a meeting to be held on 27 September 2021 where these would be reviewed in detail and grouped together to ensure everyone's concerns were heard.

5.6 EQUALITY STANDARDS REPORT: WORKFORCE RACE EQUALITY STANDARD (WRES), WORKFORCE DISABILITY EQUALITY STANDARD (WDES), EQUALITY DELIVERY SYSTEM (EDS)

The Associate Director of Communications and Engagement presented the above report which provided Members with an update on the above NHS England equality standards which formed part of the CCG's Equality, Diversity & Inclusion (EDI) Outcomes Plan.

The CCG was required to collect data on its workforce, produce an annual report and action plan and publish this. The two standards were as follows:-

- WRES – CCG required to report to NHSE. There were 9 indicators within this (4 related to workforce data collected on ESR, 4 on staff survey information and 1 on Board membership).
- WDES – CCG not required to report on this standard (this was for providers only) but anticipated, as a commissioning organisation, the CCG would be required to report on this as an ICS next year. The CCG did collect information about disability as part of its internal staff survey but was not required to report on this.

The indicators within these standards reflected overall representation of BME and disabled staff across the CCG and pay structures, the relative likelihood of BME and disabled candidates being shortlisted and appointed to roles within the CCG, the likelihood of entering disciplinary process. The standards also provide an update of mandatory training, experience of bullying and harassment, identifying whether staff feel reasonable adjustments have been made and Board representation.

The EDS was a toolkit and framework that indicated how NHS organisations were performing with regard to equality and diversity. The CCG had not formally done a re-assessment, but plans were kept under review in line with engagement activities. The release of EDS 3 was anticipated next year which would be picked up by the ICS to develop those action plans.

WRES reporting. The table within Section 3 outlined the definition of BME. The template was completed and submitted in August 2021. Report was signed off by Hull CCG's Vice Chair, who holds the Board responsibility for the statutory Equality duty, and the SLT had oversight of this submission.

With regard to the data set out in 3.1, any figures lower that 5%, the CCG were required to supress this information for publication purposes as individual staff members could be identified. Unredacted information was submitted to NHSE and reviewed by SLT. Under 3.1, only 5 of the 9 indicators were reported on as per the NHSE requirement over the last two years. The CCG did not partake in the national staff survey but undertook their own staff survey, however uptake was low and information insufficient to draw any conclusions from. The CCG would look to do further work around this and explore some of the themes.

At the time of reporting there were 108 overall staff. Number of staff who were reported as BME was less than 5% which was lower than the population in Hull at 6% however the Board membership was reported at 7%. Under indicator 4 relating to non-mandatory training, at present CCG systems did not allow for effective recording of this in a consistent way which would be looked at moving forward. The CCG had not made significant progress in attracting and recruiting more BME staff. This would be progressed within the action plan and work was ongoing across the ICS in terms of leadership skills within BME communities.

Provider Assurance for WRES Reporting – As part of CCG outcomes plan, the CCG received positive confirmation from both HUTHT and HTFT that reports had been submitted, action plans were in place and assurance received that significant progress had been made. CHCP was an independent provider and was awaiting further guidance for this year's submission date. Data for 2020 was published on their website.

Workforce Disability Standard – The CCG was not required to formally report on this but had looked at some of the metrics involved and further work is to be done via staff surveys and the staff wellbeing group to make tangible progress against the actions. Disability disclosure for CCG staff was 5.5% compared to the average for the whole population at 25% however this figure included more than just working age and so was difficult to make an accurate comparison. The number of staff who self-declared a disability within the staff survey was higher than those that were recorded on ESR. Further work would be undertaken to understand this disparity.

The Action Plan was included at Appendix 1 with the majority of actions relating to Human Resources with support from the Communications team.

With reference to item 3.2 (Provider WRES Report) Dr Moult asked whether Primary Care Networks were required to provide some of this data. There was no requirement at present however scoping sessions had taken place with PCN Directors and work was due to commence next month to look at racial equality and could also look at how the CCG worked with PCNs to collect this data, develop action plans and provide support in terms of training requirements.

With reference to 'Indicator 1' within the WRES, Dr B Ali queried why there was a marked difference in the percentage of NHS staff from BME backgrounds in Hull compared to the rest of the country and was it the whole system that was significantly more white or just the CCG. The Associate Director of Communications and Engagement advised this was something the CCG would explore further but, as a small employer, it was difficult to evaluate but as the CCG moved into an ICS, with a larger workforce, collective work could be undertaken with partner organisations. In terms of providers, the percentage was higher as was the case for Board Members due to clinical input. Further work is to be done with communities to ensure opportunities were advertised and promoted in the right way. Figures were based on the 2011 census data.

The Chair raised a question around the action plan which focussed on the collection and analysis of information which may flag up more specific actions. Where would these specific actions fit in and how would they be followed up. The action plan was quite non-specific and required monitoring and developing with outcome indicators. During this period of transition, to ensure this work remained high on the agenda, the

HR team had already commenced work on a wider footprint and had amalgamated data held by various organisations.

With reference to why people did not apply/get appointed into roles, The Lay Representative for Patient and Public Involvement stated this was key when considering future workforce and, through the ICS workforce workstream, to accept the challenge ahead and opportunity for a more blended workforce. There was a need to challenge the current recruitment system/processes and invest in community leadership. The ICS had agreed to fund a pilot BME Community Leadership Programme which would run across all 6 'Places' with Hull as one of the the pilot sites. This was designed to co-produce with communities a programme to unlock potential. The other recruitment challenge was to look at barriers to communities accessing the system, to go back to the start of the process, move away from every organisation recruiting full time posts and instead to request particular skills for a shorter period of time. When considering future workforce, this was not just about Doctors and Nurses.

In terms of the completeness of the data that the work is referenced, The Associate Director of Corporate Affairs noted a high percentage of staff that did not complete the ethnicity section of the staff record. Although this was voluntary, there was a strand of work to better understand the reason for this as, unless the data was complete, it was difficult to draw significance from this.

Resolved

(a)	Board Members endorsed the CCG Workforce Race Equality Standard (WRES) Report,
(b)	Endorsed the CCG's approach to the Workforce Disability Equality Standard (WDES,
(c)	Noted the CCG's WRES findings and action plan with the caveat to monitor and develop this and,
(d)	Noted the proposed CCG approach to the Equality Delivery System (EDS).

5.7 CORPORATE RISK REGISTER

The Associate Director of Corporate Affairs presented the updated CCG's Corporate Risk Register to consider, which was a live document, received at various forums including the Integrated Audit & Governance Committee prior to submission to the Board. There were currently 37 risks on the CCG risk register. Of these, 18 had a current risk rating of high or extreme (8 or above) and were therefore included for Board consideration. Progress on the individual management of each risk was shown within the register.

The two highest rated risks were risk 919 and risk 929 which related to the provision of CQC nursing beds in the community and the homecare market within Hull and pressure on these beds which impacted the wider operation of the system. Mitigations were in place and actions being followed through but there was a dependence on the external market to ensure the availability of those beds. The Interim Chief Operating Officer added that the CCG worked closely with the Local Authority (LA) across contracting and commissioning and the above issue had been raised at the A&E Delivery Board and with system partners at the Humber Gold Command meetings to further understand the risks, how these could be mitigated and to support the LA and providers. There was a dedicated Care Home Support Group that enhanced the input

and support into care home providers with workforce issues presenting as the biggest challenge.

Dr Moult queried how the mandatory Covid-19 vaccination of care home staff had potentially affected the workforce. The Director of Public Health reported coverage for vaccination in Hull's residential care homes and in homecare was above the national average but there were some staff within residential care homes that would have to leave work or be dismissed as a result of the mandate. This was a small number but due to pressures within this setting, was of concern. Every effort was being made to work with all providers and NHS colleagues to support people to decide and address any issues they may have. Hull had performed better in comparison to other places.

With regard to risks 919 and 929, the Interim Director of Nursing and Quality reported additional work undertaken between the CCG and Local Authority around regulatory practice and over the last year, during the pandemic, there had not been the same level of scrutiny and inspection by the CQC as seen previously. Work was underway within the Quality forums to ensure that care homes received the support they needed to meet the regulatory practice and standards.

The Chair noted Dr Balouch's comment around GPs being asked for exemption letters for the Covid-19 vaccination by several care workers. Dr Balouch confirmed that care workers did not qualify for this exemption.

Resolved

(a)	Board Members noted the updates provided and commented, where appropriate, on the adequacy of the controls, assurances and mitigations within the corporate risk register.

5.8 USE OF CORPORATE SEAL REPORT

There had been no use of the Corporate Seal since the last Board meeting.

5.9 BOARD COMMITTEE'S TERMS OF REFERENCE UPDATE

The Associate Director of Corporate Affairs presented the above report which provided Members with an update on the proposed changes to be made to the Planning and Commissioning Committee's (P&CC) Terms of Reference. Changes were considered at the Integrated Audit & Governance Committee which related to organisation names and to the quoracy of the Committee to ensure that key members were present, but to allow deputisation/cross representation to help improve quoracy rates.

With regard to the Integrated Commissioning Committees in Common (CiC), The Terms of Reference were viewed as fit for purpose at present but as the CCG moved toward shadow arrangements for the Integrated Care System (ICS), partnership arrangements with the Local Authority were being worked through to determine the new arrangement to replace the CiC.

Resolved

(a)	The updated Terms of Reference for the Board's P&CC Committee were approved by the Board.

6. QUALITY AND PERFORMANCE

6.1 COMMITTEE CHAIR'S ANNUAL REPORTS

The Committee's Chair's Annual Reports, which covered the work of the following Committees throughout the 2020/2021 financial year, were provided to the Board for approval:-

i. The Integrated Audit and Governance Committee
ii. Planning and Commissioning Committee
iii. Primary Care Commissioning Committee
iv. Quality and Performance Committee
v. Integrated Commissioning Committee (Committees in Common)

The Chair queried what the arrangements would be for the Annual Reports of these Committees at the end of March 2022. The Associate Director of Corporate Affairs informed that NHSE were issuing further guidance on a regular basis around due diligence and closedown arrangements for CCGs, predominantly focussed on formal closedown of the CCG Annual Report and Annual Accounts. It was anticipated a similar conversation would be held with the then substantial ICB/ICS Executive Team around arrangements for CCGs and other elements of the formal closedown that were required and would look to develop a consistent approach across all 6 CCGs. Content would be reduced, without losing the assurance, of what the Committee Annual Reports would contain, with an aim for completion by the end of March 2022.

There was also a transition hybrid arrangement so that the new ICB, to be formed on 1 April 2022, may have a one-off meeting to formally receive the Committee Annual Reports post April, in order for them to be made available in the public domain.

Resolved

(a)	The Board approved the Committee's Chair's Annual Reports for 2020/2021.

6.2 QUALITY AND PERFORMANCE REPORT (INCLUDING CONTRACTS, FINANCE AND PERFORMANCE – PART 1

The Deputy Chief Finance Officer provided the Board with a corporate summary of the current financial position with the following key points noted:-

Month 4 reporting was in line with budgets with the exception of expenditure on the Hospital Discharge Scheme and Elective Recovery Fund which was due to the CCG being reimbursed retrospectively for both these elements of funding from NHSE. The table outlining the financial position showed, for these, a combined £575k forecast in a £575k overspend, however this was not of concern as the money would be recovered throughout the year. Running cost expenditure was in line with the budgets.

The Statement of Financial Position showed a £51.3m excess of liabilities over assets. This was expected for an NHS commissioning organisation and was higher than previous financial years due to the CCG hosting system related funding that was paid over through NHS provider contracts. It was also higher in July due to the Elective Recovery Fund for the ICS.

Closing cash for July was £140k. As in 2020/21 there was no requirement to manage cash to minimal levels, however the CCG was not retaining excess amounts of cash.

Better Payment Practice Code, which the CCG reported on to ensure suppliers were paid in a timely manner, was at 96% for non-NHS organisations which was above the 95% target.

The Interim Director of Nursing and Quality provided Members with an update on the Performance Indicator Exceptions as detailed below:-

HUTHT A&E performance, in terms of waiting times, had deteriorated in July 2021 but was now back to pre-Covid-19 levels and was seeing the impact of access to healthcare services within A&E but also on Ambulance wait times and demand on this service. The review and oversight of this, at an operation level, was through the A&E Delivery Board and through HUTHT.

Referral To Treatment 18 weeks waiting times reported a static position in July 2021 and diagnostic 6 week waiting times was consistent for patients compared to July 2021 with breaches mainly in endoscopy, colonoscopy and gynaecology.

There was a reduction in the number of 52 week waits but still reporting pressures around ENT, Plastics and General Surgery. Breaches over 52 weeks were closely monitored with the Trust.

In terms of the management of quality and performance, the Quality Risk Profile (QRP) work with HUTHT as a system with all health partners continued. Areas where there were challenges and key risks were being supported by the CCG to manage this but also assurance in respect of what could be put in place across the system to support this. The Quality Delivery Group (QDG), which was the CCG's substantive quality forum around assurance with a focus on patient harm, quality, safety and experience continued. HUTHT were still in an enhanced surveillance position, but significant work was underway across the system and health partners to support the Trust to return to a better position and reduce the identified risks. Overall, there was good oversight with established forums and attendance at the Trust's internal meetings i.e. Quality Board and Serious Incident Panel.

With regard to A&E performance, Dr Moult queried whether there was benefit in having a PCN representative on the A&E Delivery Board to feedback pressures faced by primary care but equally to learn from the Trust as to how best to manage their flow of patients. The Interim Chief Operating Officer noted there was representation from Hull and East Riding PCNs but to enhance this conversation it was proposed two one-off sessions could be held between primary and secondary care, leading up to winter, to share some of this which would help to avoid admissions and attendances. The Chair also noted it would be useful to get some congruence around IT systems and communications as variations hindered the process.

Resolved

(a)	Board Members noted the content of the Quality and Performance Report Part 1.
(b)	A&E performance. To enhance the conversation around current pressures discussions would be taken forward between primary and secondary care.

6.3 RESEARCH AND DEVELOPMENT (R&D) ANNUAL REPORT

Dr Bushra Ali and Dr Amy Oehring declared an interest in this item in relation to the Sentinal Asthma Project, whose practice and PCN had been involved. The declaration was noted and no further action was required to be taken.

The Interim Director of Nursing and Quality presented the above report to note which updated Members on the annual R&D activity for the period 1 April 2020 to 31 March 2021. The report had been received at the Quality and Performance Committee, where the R&D Manager presented the findings and provided an update on the R&D response to the Covid-19 pandemic and the locally grown non-Covid-19 R&D studies and development opportunities that had still been attained in 2020-21.

The report outlined all current and completed projects undertaken within the reporting period and provided a status update on CCG grants and funded projects, the excess treatment costs and the strategic development of the service. The CCG had increased the number of asks in respect of R&D during the pandemic but would now return to a normal research cycle. For the previous year there were 3 key research areas around Frailty, Education for Young People and the Moving with Dignity project, findings of which were detailed within the report.

Moving forward the CCG would develop the strategy and vision for research with a keen eye on the requirements of people in Hull, where development and improvement could be made, but also looking at this across a bigger footprint i.e., from a Humber perspective in terms of partnership approach. Research teams were currently working across a number of CCGs which would continue and grow as the CCG moved into an ICS.

The Chair asked what practices direct involvement with Covid-19 related research was and were they indirectly involved with any of the funded Covid-19 trials. The Interim Director of Nursing and Quality informed that research teams had worked with PCNs directly on a number of areas and could provide Board Members with further detail around this.

The Chair asked what the transition arrangements were for R&D or was there an ongoing process that would be developed into an ICS policy for research. At present research sat within different portfolios across the CCGs and work was underway with the ICS Director of Nursing with the aim to have one research approach across the ICS with reflection of local place-based needs.

Where there had been a delay in the study progressing due to Covid-19 and winter pressures, Dr Moult asked when research areas would be completed. The Board were advised a 6 monthly update would be provided to the Quality and Performance Committee that would update Members on the aims of each research study, where they were in terms of completion and the evaluation of completed studies to understand the impact of population health and outcomes for the people of Hull.

Resolved

(a)	The Board noted the contents of the Hull CCG R&D Annual Report 2020-21, were assured by the continued commitment to R&D and,
(b)	noted both the Covid-19 response and the non-Covid development work that had been progressed in 2020-21.

(c)	The Interim Director of Nursing and Quality would provide Board Members with further detail around practice involvement with Covid-19 related research.

7. STRATEGY

7.1 HUMBER COAST AND VALE INTEGRATED CARE SYSTEM (ICS) HUMBER PARTNERSHIP UPDATE

The Accountable Officer provided a verbal update on the Humber Coast and Vale ICS Humber Partnership with the following key highlights noted:-

There were a number of documents due to be released around the ICS and links to these would be included in the formal reports moving forward. The 'Readiness to Operate' framework would be submitted and also included within the report to ensure staff around transition. The main focus of work had been refining the operating model. The ICS operated via two strategic partnerships (Humber and North Yorkshire & York) but 'Place' would have primacy moving forward. The Integrated Care Board and the Integrated Care Partnership needed to be strong along with 'Place' to make the difference to our communities.

Each of the Places in Humber had a model in place which focussed on 'Lift and Shift' as the employment guarantee meant pay and terms and conditions could not change. 1 April 2021 was the start of the transition with confidence given that the majority of staff and functions would transfer safely on this date. Work continued to determine what this would mean for some of the CCG's Executive Directors who were not covered by the initial employment guarantee, but the Board was assured this would be worked through over the next two months. The aim was to adopt a consistent approach across the whole system.

Clinical and professional guidance had been released and work commenced on the model for this which linked in with HCV work. Work would also be undertaken to explore how the lay challenge/patient engagement would represent itself in the new arrangements moving forward. There were existing Health & Wellbeing Boards, but consideration is being given as to how could this role be strengthened. Further clarity was required around the aforementioned to enable wider circulation but would need to be signed off by the Chief Executive, the Chair and the HCV Partnership Board planned for October 2021. Once the two key appointments had been made, the Executive of the Integrated Care Board would be appointed to and could then start to populate the Integrated Care Partnership, with work underway around the consultation of this. A positive meeting was held with the Humber LMC Collaborative however it was noted there was no PCN Clinical Director representation from Hull. This would be addressed as PCNs were the cornerstone of the Long-Term Plan.

Resolved

(a)	Board Members noted the update provided on the Humber, Coast and Vale ICS Humber Partnership.
(b)	Hull PCN Clinical Director representation was required at the Humber LMC Collaborative.

7.2 INTEGRATED CARE SYSTEM (ICS) TRANSITION ARRANGEMENTS

The Interim Chief Operating Officer provided a presentation on the ICS transition arrangements for Hull. See embedded document below for further detail:-

Item 7.2 - Hull CCG Board Presentation I

The following areas were highlighted from the presentation and a brief overview provided:-

- Managing The Transition
- Supporting CCG Staff
- CCG Staff Communication and Engagement
- Approach to Close Down & Due Diligence
- Place Based Partnerships
- Place Arrangements
- Work to Date in Hull
- Self-Assessment Outcome September 2021 (Draft)
- Some Common Themes Emerging

(a)	Board members noted the update provided on the ICS Transition Arrangements.

8. REPORTS FOR INFORMATION ONLY

8.1 INTEGRATED AUDIT & GOVERNANCE COMMITTEE CHAIR'S ASSURANCE REPORT AND APPROVED MINUTES FROM 6 JULY 2021

The Chair of the Integrated Audit & Governance Committee provided the above reports for information.

Resolved

(a)	Board Members noted the Integrated Audit & Governance Committee Chair's Assurance Report and approved minutes from 6 July 2021.

8.2 PLANNING AND COMMISSIONING COMMITTEE CHAIR'S UPDATE REPORT AND APPROVED MINUTES FROM 4 JUNE 2021

The Chair of the Planning and Commissioning Committee provided the above reports for information.

Resolved

(a)	Board Members noted the Planning and Commissioning Committee Chair's Update Report and approved minutes from 4 June 2021.

8.3 PRIMARY CARE COMMISSIONING COMMITTEE CHAIR'S UPDATE REPORT AND APPROVED MINUTES

There were no reports submitted to the Board as they had not yet been approved by the above Committee.

8.4 QUALITY AND PERFORMANCE COMMITTEE CHAIR'S UPDATE REPORT AND APPROVED MINUTES FROM 18 JUNE 2021

The Chair of the Quality and Performance Committee provided the above reports for information.

Resolved

(a)	Board Members noted the Quality and Performance Committee Chair's Update Report and approved minutes from 18 June 2021.

8.5 COMMITTEES IN COMMON APPROVED MINUTES FROM 28 JULY 2021

Hull CCG's Interim Chief Operating Officer provided the above approved minutes for information.

Resolved

(a)	Board Members noted the Committees In Common approved minutes from 28 July 2021.

9. GENERAL

There were no reports assigned to this item.

9.1 POLICIES

There were no policies assigned to this item.

10. ANY OTHER BUSINESS

There were no items of Any Other Business received.

11. DATE AND TIME OF NEXT MEETING

The next meeting will be held on Friday 26 November 2021 at 9.30 am

Signed: _____

Dr Dan Roper
Chair of NHS Hull Clinical Commissioning Group

Date: _____

Abbreviations

ADCA	Associate Director of Corporate Affairs
A&E	Accident & Emergency
CCG	Clinical Commissioning Group
CHCP	City Health Care Partnership
D diff	Clostridium Difficile
CLES	Centre for Local Economic Strategies
CoM	Council of Members
CRS	Commissioner Requested Services
CVS	Community Voluntary Service
DOIC	Director of Integrated Commissioning
ED	Emergency Department
E.coli BSI	Escherichia coli Blood Stream Infections
EIA	Equality Impact Assessment
ENT	Ear, Nose and Throat
HASR	Humber Acute Services Review
HCC	Hull City Council
HCV	Humber Coast & Vale
HSJ	Health Service Journal
HUTHT	Hull University Teaching Hospitals NHS Trust
HPBP	Hull Place Based Plan
Humber FT	Humber Teaching NHS Foundation Trust
H&WB	Health and Wellbeing Board
IAGC	Integrated Audit & Governance Committee
ICB	Integrated Care Board
ICC	Integrated Care Centre
ICS	Integrated Care System
ICP	Integrated Care Partnership
IPC	Infection Prevention and Control
JCC	Joint Commissioning Committee
JCVI	Joint Committee on Vaccination and Immunisation
LA	Local Authority
LRF	Local Resilience Form
LTP	Long Term Plan
MD	Managing Director
MRSA BSI	MRSA Blood Stream Infections
NHSE/I	NHS England/Improvement
NL	North Lincolnshire
OSC	Overview and Scrutiny Commission
P&CC	Planning & Commissioning Committee
PCCC	Primary Care Commissioning Committee
PCNs	Primary Care Networks
PCQ&PC	Primary Care Quality and Performance Sub-Committee
PHE	Public Health England
Q&PC	Quality & Performance Committee
QIPP	Quality, Innovation, Productivity and Prevention
QDG	Quality Delivery Group
QRP	Quality Risk Profile
SI	Serious Incident
SLT	Senior Leadership Team
Spire	Spire Hull and East Riding Hospital

STP	Sustainable Transformation Partnership