Hampshire, Southampton and Isle of Wight
Clinical Commissioning Group

HSI21/092

GOVERNING BODY

Title of paper	**Minutes of last Governing Body meeting**		
Agenda item	**13**	**Date of meeting**	8 December 2021
Director lead	Margaret Scott, Chair		
Clinical lead (if applicable)	Dr Nicola Decker, Clinical Lead		
Author	Jack Zabiela, Governance Manager		

Purpose	For decision	☒
	To ratify	☐
	To discuss	☐
	To note/receive	☐

Executive Summary	
This paper sets out the minutes and actions arising from the last meeting of the Governing Body of NHS Hampshire, Southampton and Isle of Wight CCG held on 3 November 2021.	
Recommendations	**The Governing Body is asked to consider whether the minutes and actions of the meeting reflect an accurate record and, if so, to approve them, noting any updates.**
Publication	**Include on public website** ✓

Please provide details on the impact of following aspects	
Equality and quality impact assessment	This paper does not request decisions that impact on equality and diversity.
Patient and stakeholder engagement	Not applicable

Financial and resource implications / impact	Not applicable
Legal implications	There are no legal implications arising from this paper.
Principal risk(s) relating to this paper	Not applicable
Key committees / groups where evidence supporting this paper has been considered.	Not applicable

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DRAFT

GOVERNING BODY

Minutes of the meeting of the Governing Body held at 14:00 on Wednesday 3 November 2021 via Zoom

Present

Margaret Scott	Independent Chair
Julie Dawes	Chief Nursing Officer
Nicola Decker	Clinical Leader
Judy Gillow	Non-Executive Director (Patient and Public Involvement)
Karl Graham	Clinical Director, South West Hampshire
Zaid Hirmiz	Clinical Director, South East Hampshire
Charlotte Hutchings	Clinical Director, North and Mid Hampshire
Michele Legg	Clinical Director, Isle of Wight
Ed Palfrey	Secondary Care Clinician (Non-Executive)
Roshan Patel	Chief Finance Officer
Derek Sandeman	Medical Director
Matt Stevens	Non-Executive Director (Primary Care Commissioning)

In attendance

Inger Bird	Non-Executive Advisor, South East Hampshire
Simon Bryant	Director of Public Health, Hampshire County Council
Debbie Chase	Director of Public Health, Southampton City Council
Elaine Budd	Non-Executive Advisor, South West Hampshire
Joanna Clifford	Acting Deputy Director of Quality & Nursing, South West Hampshire
Steve Cummins	Governance Manager
Jenny Erwin	Director of Mental Health Transformation and Delivery / COVID-19 Incident Commander and Deputy Accountable Emergency Officer
Paul Gray	Executive Director of Strategy
Tessa Harvey	Executive Director of Performance
Helen Ives	Executive Director of Workforce *(part meeting)*
Emma McKinney	Director of Communications and Engagement
Stephanie Ramsey	Managing Director, Southampton
Terry Renshaw	Governance Manager (minutes – *part meeting*)
Michael Ridgwell	Director of Delivery
Lena Samuels	Chair, Hampshire and Isle of Wight Integrated Care System
Suki Sitaram	Non-Executive Advisor, Southampton
Alison Smith	Managing Director, Isle of Wight

Apologies

Simon Garlick	Non-Executive Director (Governance)
Maggie MacIsaac	Chief Executive
Sarah Young	Clinical Director, Southampton

The meeting was taken out of order in order to accommodate the availability of attendees, however the minutes have been sent out in accordance with the agenda for ease of reference.

1	**Welcome and Introductions**
1.1	The Chair welcomed everyone present to the fourth meeting in public of the Hampshire, Southampton and Isle of Wight CCG Governing Body, including members of the public viewing the proceedings, which were being streamed live. A link to a video of the meeting would be published on the CCG website following the meeting. Apologies for absence were noted.
1.2	A formal response to one query raised at the meeting of 28 April 2021 had not been concluded, pending dialogue with the requestor.
2.	**Declarations of Interest *(Paper HSI21/062)***
2.1	The Register of Board Members Interests was received and noted.
2.2	No interests were declared where there may be a potential or perceived conflict of interest in relation to any of the business items on the agenda.
2.3	**AGREED** **The Governing Body accepted the Register of Board Members' Interests.**
3	**Chief Executive's Report *(Paper HSI21/063)***
3.1	The Executive Director of Strategy introduced a brief report which brought together a number of strategic issues relevant to the wider health sector that impact on the work of the CCG. He explained that the agenda had been structured to allow more time to focus in detail on the items contained within the paper and drew particular attention to the following ***The Hampshire, Southampton and Isle of Wight system response to the COVID-19 pandemic, including the continued roll out of the vaccination programme with particular emphasis on booster vaccination and increasing uptake among young people aged 12-15.*** • More people continued to be seen with COVID-19 and the number was rising but the number of people in hospital was significantly reduced compared to the same time a year ago. The clinical teams continued to work hard to deliver the vaccination programme across Hampshire and the Isle of Wight (HIOW). Members of the public were strongly encouraged to come forward and receive a vaccination. ***System Performance*** • System performance across HIOW continued to show a challenging picture and operational pressures were directly impacting on patients across the NHS in primary care, community care, mental health services and in hospitals. Work continued to be focused on actions that were already taking place and to identify what further actions were required to improve health outcomes / find sustainable solutions. • In the face of all these challenges clinical teams and managers had stepped up and gone above and beyond the day to day work to improve services for both individuals and groups of patients. Hospitals and services were supporting each other across HIOW through joint working and strong clinical leadership.

3.2	**AGREED** **The Governing Body noted the Chief Executive's Report (November 2021).**
4	**Integrated Quality and Performance Report *(Paper HSI21/064)***
4.1	Following local area scrutiny, key quality and performance risks and issues requiring escalation to the Quality, Performance and Finance Committee (QPF) were agreed and summary reports, including deep dive slides on key areas provided to the QPF; the last meeting took place on 20 October 2021. The Director of Performance presented the key items agreed for escalation to Governing Body as detailed in the report provided.
4.3	The Chief Nursing Officer also reported: • The impact of service pressures was starting to be seen in terms of patient experience and safe care, with an increased number of risks having been seen across providers for both elective and emergency pathways. A paper had been received at the Quality and Safety Committee relating to harm reviews on individuals who had experienced delays and Serious Incidents were beginning to be reported with regard to treatment delays. A HIOW harm review was being undertaken on the impact more generally which would be reported though QPF. Three Serious Incidents in relation to SCAS delays were being investigated as a cluster investigation. It was clarified that Suzanne van Hoek, Deputy Director of Nursing, South East Hampshire was the key quality lead supporting SCAS in terms of the harm review and looking at learning / ways to reduce risks. • Increased pressures were being seen in maternity services; no Serious Incidents had been reported however this was being closely monitored. Providers were managing pressures by doing things such as cancelling the home birth service to ensure 1:1 service provision. This kept mothers and babies safe however did mean that patient choices had been limited and therefore the experience for mothers had been compromised.
4.4	The following points were raised: • With regard to Tier 4 Psychiatric Intensive Care Unit (PICU) beds, it was queried if the work that had been ongoing with NHS England (NHSE) (SE) to commission more beds had come to fruition. It was reported that whilst more beds were commissioned, as these were brought on stream there were others that had gone out of commission e.g. due to staffing issues; plans were in place to address this. • Clarification was sought as to whether there was any data from secondary care providers / impact on A&E attendance as a result of demand on primary care. It was advised that all parts of the urgent care system were experiencing pressure and it was possible to see that patients were trying to access the urgent care system in multiple ways e.g. 111; the abandoned call rate went up and correlated with increased attendance in emergency departments. Primary care data showed an increase in the number of appointments, however people often felt frustrated that they were not always able to get through to practices quickly and so accessed ED. There was therefore frustration in all parts of the pathway which is why surge plans looked at all parts of the system, particularly coming into the winter to ensure that people were seen in the most appropriate place to meet their needs.

	• It was observed that patients only became abusive when they did not understand the pressures that services were under and it was therefore queried what communications were being undertaken to remedy this. A national campaign was in planning about respecting staff, which was due to launch in the next few weeks. The HIOW communications teams were also working on local communications to describe pressures across the system and asking members of the public to be respectful. This should begin to be broadcast in the next few weeks. • The Clinical Leader observed that as patient demand had gone up, it was often difficult to respond because of workforce limitations. There needed to be a two way conversation with the public about compromises that may need to be made between previous service ambitions / aspirations with the reality post-pandemic in order to set a more realistic offer moving forwards. As such there needed to be a forum working with patients and the public in order to determine those trade-offs in a mature way. This would be considered further outside the meeting, linking with the communications workstreams which were already underway.
4.5	**AGREED** **The Governing Body received the Integrated Quality and Performance Report.**
	<u>Workforce Update (October 2021)</u> *<u>(Paper HSI21/065)</u>*
4.6	The Executive Director of Workforce ran through a paper which provided a high level overview of workforce metrics across Hampshire and the Isle of Wight for the months of July and August 2021. The following details was provided in addition to the information within the reports: **High Staff Vacancy Rates** • Trusts had well established reporting and information systems in place so there was a good line of sight on the level of vacancies. • The workforce vacancy rate in HIOW compared favourably with other neighbouring systems in the SE Region as focussed work had been undertaken through the Nursing Supply Board to bring additional workforce into Trusts through schemes such as international recruitment, nursing apprenticeships and other entry level roles. The greater difficulty was in relation to roles that took longer to train, such as psychiatry professions, where there had been chronic shortages which had increased over a number of years. The education supply commissioned through Health Education England and NHSE had needed to be increased and workforce leads were looking at skill mixing, deploying new roles and looking at where new international recruitment pipelines could be opened up. It would therefore not be quick or easy to resolve workforce shortages, which were in the context of national shortages. • With regard to primary care, unlike Trusts there was no standardised reporting / intelligence systems. Data was collated manually and there was not the same approach to workforce planning within primary care; each practice had their own workforce plans rather than national standardised plans. There was a shortage of GPs in HIOW and nationally which was likely to increase. This was why the national Additional Roles Reimbursement Scheme (ARRS) was initiated, with more than 300 roles in a variety of professions to be recruited to. • As we head into winter there would be extreme demands on the services being provided and consequently on the people that provided those services.

	It was therefore incumbent on employers to carefully hold the balance to respond to the needs of the population they served, ensuring that clinical safety was paramount whilst at the same time looking after the safety of the workforce as without them it would not be possible to recover services in the way aspired to. **Sickness Absence** • A key area of concern was in relation to sickness absence, occupational health and wellbeing. HIOW had experienced higher levels of sickness absence, of particular concern being the very high rate due to stress and other anxiety related matters. This was an area where HIOW had been performing less well than neighbouring systems. A targeted absence improvement plan had been put in place over the last few months and the absence rate had come down to 4.9% from a peak of 5.7% which put HIOW on par with neighbouring ICSs.
4.7	It was queried if any scenario planning were taking place i.e. if it were found that it was not possible to continue services in the same way as staff were not available. In addition if there was any more that could be done to support staff, particularly when mental health and stress / anxiety were key factors. In response it was advised that there was a very strong relationship between Chief Operating Officers, Chief Nurses, Chief Medical Officers and Workforce Directors across the HIOW system, the local delivery systems and the Trusts. There was continual work within Trusts around scenario planning, how staff might be moved from one area to another, if a service were to run 'hot' how could another be stepped down in order to respond etc. The need now was to consider how this was taken beyond organisational boundaries. There were good examples of this through the COVID-19 response / vaccination period. There was a staff sharing Memorandum of Understanding across providers and CCGs that enabled staff to be shared without the worry of paperwork and 'passporting' etc. There was also an on call service in place to respond to urgent staffing requirements. The next step would be to consider how a proactive response was developed i.e. not in response to an emergency. This would be a broader conversation with medical and nursing leaders; it was pointed out that preferably this should also link with the local authorities / social care.
4.8	It was recognised that consideration needed to be given to how investment could be made into additional preventative activities to help people stay well, build capacity in the hospital system and how solutions that worked well in other parts of the world were replicated here. All these conversations were interrelated and an interrelated solution needed to be found.
4.9	**AGREED** **The Governing Body received the Quality, Performance and Finance Report (period ending 31 August 2021)**
5	**Hampshire and Isle of Wight (HIOW) Covid-19 Vaccination Programme (Paper HSI21/066)**
5.1	The Executive Director of Workforce introduced a paper which gave an overview of the Hampshire and Isle of Wight Covid-19 (HIOW) Vaccination Programme, prepared on 26 October 2021, and provided a current view of key areas of focus, uptake across the population and risks. She reported that there was no aspect of the HIOW vaccination programme which was under performing; all delivery strands were

	performing well, particularly the 12-15 year old vaccinations for which HIOW were one of the top 5 performing ICS' in the country.
5.2	It would be some time before COVID-19 became endemic and therefore the vaccination programme would continue to roll-out with more delivery strands likely to open up for the population. It was likely that this would require new and innovative delivery. A priority would be to build on the use of unregistered roles and deploy as many as safely possible into delivery models alongside the registered workforce. As reported in the media that day, mandatory vaccination for NHS staff would be coming in with a need to ensure that all were vaccinated by April 2022; HIOW staff COVID-19 vaccination was already at a very high level.
5.3	The Chair commended and thanked everyone who had been involved in the vaccination programme on behalf of the Governing Body, including GP and nursing colleagues who had also taken turns in some of the vaccination centres.
5.4	**AGREED** **The Governing Body received the update on the COVID-19 Vaccination Programme in Hampshire and the Isle of Wight.**
6	**Finance Update *(Paper HSI61/067)***
6.1	The Chief Finance Officer (CFO) reported that the 2021/22 financial year comprised two halves H1 (April to September) and H2 (October to March). The financial results for the first half of this financial year were as expected, with the CCG having achieved the intended surplus of £2.3m as part of the wider HIOW ICS for which the intention was to break even as a system. H2 financial plans were being prepared in line with the National timetable and were due for submission on 16 November 2021.
6.2	Clarification was sought on the Elective Recovery Fund (ERF) i.e. the statement that HIOW were not anticipating any further income. The ERF was part of the national NHS recovery programme to reduce waiting lists and deal with backlogs. In the first half of the financial year, the Government / NHS England (NHSE) created the ERF, which was a separate pot of money held nationally to incentivise systems to do as much as they could in order to bring down waiting lists. This had a methodology that changed through H1 so if systems delivered a set amount of activity against an activity baseline (pre-Covid), those systems would receive extra funds. This was money that HIOW had already committed to spending to reduce waiting lists. Originally HIOW ICS anticipated that based on modelling we would probably achieve around £60m ERF. However during the first 6 months of the year, the rules regarding how ERF was earnt changed, so we received less. Due to additional pressures within other areas of the NHS particularly within emergency pathways it meant that in some cases resources had to be diverted and so HIOW were not able to deliver the level of capacity we wanted to. HIOW received just over £40m across all of our organisations. Although less funding had been received than originally envisaged, the balance had been achieved as HIOW did not spend what was originally intended as support had to be diverted to other areas of the health sector
6.3	The service development fund was a separate allocation with very specific requirements as to what needed to be achieved / funding could be spent on. The majority of this was about achieving the five year goals within the HIOW plan and had to be accounted in the overall financial position of the CCG / ICS. The CFO stated that he was confident that the money could be spent, whilst being mindful about the

	reality of what money could be spent on when organisations were competing to find the workforce / ways to spend wisely. This was monitored very closely.
6.4	**AGREED** **The Governing Body received the update on the financial position for Half Year 1 (1 April to 30 September 2021)**
7	**Winter Planning Update *(Verbal Update)***
7.1	The Director of Delivery reported that winter planning was an ongoing and dynamic piece of work and a large proportion was a standard operating procedure that described how we worked across the system to manage the demands on it and the staff, adding that it was evident that demand did not just arise in winter; it was high before and would likely continue to be high.
7.2	The escalation plan described how risk was managed in the system and related to both Urgent and Emergency Care (UEC) and Elective / Planned Care; one of the best ways to support elective care was to deliver UEC care well. The HIOW winter planning process was built on lessons learnt, particularly through COVID-19, with a key area being modelling and understanding the demand we needed to match against the supply
7.3	The plan also included bids to NHSE for targeted investment funding to improve services which were part capital and part revenue. Feedback was still awaited regarding the schemes that had been bid against, however HIOW had already gone at risk on some of those bids in order to build infrastructure. The Winter Access Fund was a key component to build resilience across all parts of the system including primary care
7.4	Given the time of year, it was queried how realistic it would be to spend capital funding. It was advised that to some extent HIOW had already gone out at risk on some items. Capital was not just about large schemes; it could be about digital offers that could offset some of the workforce constraints, some of which could be facilitated quite quickly e.g. purchasing equipment.
7.5	It was highlighted that capital funding could sometimes materialise at short notice. The Autumn Budget identified quite a bit of additional budget that would come to the NHS in next 3 years; this year some additional capital budget had been allocated however there were also some quite significant lead times and so there was the issue regarding ability to spend. When capital schemes and programmes were developed across the ICS, some were held in readiness so that if the opportunity to do so should arise, they could be mobilised quite quickly.
7.6	**AGREED** **The Governing Body received the update on Winter Planning for 2021/22.**
8	**Emergency Planning Resilience & Response (EPRR) Annual Report *(Paper HSI/068)***
8.1	The HIOW ICS Director of Mental Health Transformation and Delivery / COVID-19 Incident Commander and Deputy Accountable Emergency Officer introduced the Emergency Planning Resilience and Response (EPRR) annual report which detailed

	how EPRR corporate responsibilities under the Civil Contingencies Act 2004 were met and provided assurance that the CCG complied with relevant legislation and guidance (as summarised by the NHS England's core standards for EPRR).
8.2	There was an expectation that the CCG undertook its own self-assessment regarding its own EPRR processes, and also link with providers to ensure assurance regarding their arrangements. The outcome of the peer review undertaken the previous week was that the CCG was fully compliant in twenty six of the core standards and partially compliant in three areas; this was acceptable, particularly given the extensive learning through the pandemic. A clear action plan was in place to reach full compliance by March 2022. An update will be provided to the Governing Body in March 2022 and actions would be monitored through Audit and Risk Committee. The key area for next year was business continuity for primary care.
8.3	It was queried what was the advice to the Governing Body in terms of areas for concentration over the next 6 months to ensure the best possible arrangements were in place, both over the winter but also in preparation for bringing Hampshire, Southampton and Isle of Wight CCG and Portsmouth CCG into an Integrated Care Board (ICB) that would inherent arrangements. It was advised that the winter planning framework and delivery aspect was important, but in terms of EPRR in its true sense CCGs were undertaking responsibilities under delegation, which essentially meant that HIOW would become a Category 1 Responder. This would be a key part of action planning over the next 6 months working with NHSE for when HIOW ICB became responsible in April 2022.
8.4	Clarification was also requested as to whether IT arrangements were established in various parts of the geography so that if a major incident arose it would be possible to have a hub to work from should the need arise. It was advised that IT provision was a fundamental element of business continuity across the system; there were limitations as to what the CCG could do in relation to this. As part of the development into the ICS there was a need to consider the EPRR / business community plans, which services needed IT access and for how long. It was more about how the system planned for working through those issues, rather than having a clear plan for every issue that could potentially arise.
8.5	**AGREED** **The Governing Body received and noted the Emergency Planning Resilience & Response Annual Report for 2020/21.**
9	**Governing Body Assurance Framework *(Paper HSI/069)***
9.1	The Chief Finance Officer introduced the latest iteration of the Governing Body Assurance Framework (GBAF) which had been updated in light of recommendations made when last presented to the Governing Body and Audit and Risk Committee in September 2021. The GBAF was a dynamic document and its development was an iterative process that would change as the position of the CCG changed and programmes of work progressed. It was pointed out that many of the risks and issues within the GBAF had been discussed earlier in the meeting and that there should be nothing additional that the Governing Body was not already aware or would be discussing later in the meeting. Updates were provided on the three risks where there had been movement since the last meeting: • **ID 03 Financial Performance**: there had been a deterioration. As referenced earlier whilst the CCG had achieved financial plans in H1, this was

	deteriorating given that the NHS was operating in November with no formal signed off financial plan with NHSE and the regulators. The national planning process was still underway and so with the lack of a clear financial plan signed off by the both the ICS and CCG it was felt appropriate that the risk should increase for November, albeit the work that was being undertaken to minimise this is in order to try and achieve balance this financial year. • **ID 04 System Reform and New Ways of Working**: there had been a reduction in the risk score in light of the progress made to date working with partners in creating the HIOW ICS and the operating model. • **ID 10 Mental Health Care:** significant risks had been identified as discussed / outlined in earlier papers. This was high on the CCG's agenda given the complexity and issues and so it was deemed that the risk should increase.
9.2	The following comments were raised during discussion: • The Chair reported that the Non-Executive Director (Governance) had queried whether there should be an additional overarching risk that summed up the complex agenda and how many risks that were being carried; when looking at the challenges and risk ratings collectively they could potentially be more than the sum of the parts. The Director of Performance acknowledged that the volume of risks to be managed and the complexity of that challenge was quite significant, at the same time as transitioning to a new body. However, it was difficult to know what the mitigations would be if we were to do this other than how this was already detailed. The Chair stated that the Governing Body needed to acknowledge that as a Board the CCG was carrying a large number of very substantial risks and that collectively this was a very major challenge. • It was pointed out that there was also a question about priority and enabling the Governing Body and Executive Team to think about the priority of risks that needed to be dealt with. There needed to be realism about what could be tackled now, identifying mitigations, when they would work etc. • As flagged in the paper, Primary Care resilience was a major risk. The risk would not reduce and was likely to escalate and if not managed would impact on other parts of the system and conversely put pressure from other parts of the health system back onto primary care. • It was reflected that many of the risks currently lead back to workforce and the ability to have a resilient workforce in place. The reality was that care could no longer be provided in the same traditional way. The challenge was that making changes whilst delivering care at a time of unprecedented demand was difficult. New workforce and delivery models needed to be developed to make the best use of the resources available. • It was observed that good relationships with primary care were key to identifying and supporting resilience issues. Teams had worked hard to develop relationships, particularly in light of the recent issues raised by the BMA etc that GPs now felt the CCG was really listening to them. As mentioned earlier, it was also important to ensure appropriate communications both locally and nationally as the public needed to know how pressured primary care were. • The Medical Director gave reassurance to the Board that when in discussion with providers, they are asked to do the right thing and not to let finances hold things back if there was a significant risk. They have been instructed that if an initiative would make a difference, they should proceed. • In linking primary care resilience to workforce challenge, the Clinical Leader considered that everyone would value some time together as a group. Whilst this would be difficult a way should be found to give practices an afternoon of

	time together to embed some of the changes which they have had to adapt to as this would be more meaningful; this could also help signal in a practical way that the CCG was trying to support primary care. • In terms of the deterioration in the Mental Health risk rating, workforce was the key limiting factor. A Mental Health Workforce / People Plan had been developed for the next 3 to 4 months alongside the Mental Health Needs Assessment which was being undertaken which would help determine the investments needed to make change. For example, current indications were that within the next 18 months there would be around 600 staff short in terms of mental health provisions across HIOIW ICS, however, only 73 graduates were due to qualify next year. Consideration therefore needed to be given about diversifications and also how there could be more integration / working together e.g. conversations with providers regarding how a provider collaborative could be built across Solent NHS Trust, Southern Health NHS Foundation Trust and Isle of Wight NHS Trust to consider the more fragile mental health service components that could be better delivered at scale. The pressure of demand on Mental Health services was similar to the acute hospitals in that people were more unwell, there were many more challenges working in Mental Health. These were more difficult to quantify however acuity was higher and workforce was a challenge.
9.3	**AGREED** **The Governing Body reviewed and approved the strategic risks as part of the Governing Body Assurance Framework and were assured that all reasonably practicable actions were being taken to control and mitigate the risks to delivery of the CCG's objectives.**
10	**ICS Development Update *(Paper HSI21/070)***
10.1	The Chair welcomed Lena Samuels, Chair Designate of the HIOW Integrated Care Board (ICB), who had been in regular attendance at Governing Body meetings as part of joined up working arrangements.
10.2	The Director of Strategy and Transformation introduced a paper which outlined progress to date on delivery of the ICS Development Programme with specific detail relating to the Safe Transfer Workstream , which held responsibility for the safe transfer of people, contracts and assets from both Portsmouth and Hampshire, Southampton and Isle of Wight CCGs and from NHS England/Improvement (NHSE/I) to the new organisation, transfer of commissioning responsibilities from NHSE to the ICS, and the establishment of the ICS (including the Integrated Care Board and Integrated Care Partnership). This was intended to highlight the specific collective responsibilities of CCGs within the ICS Development programme.
10.3	Whilst organisations were already working together in systems across the country, the Health and Care Bill which was making its way through parliament would make ICS' statutory bodies and make it easier for NHS organisations to work collaboratively together as well as with local government, voluntary sector etc on joint endeavours to improve services and reduce inequalities etc. Work was on track although there was more to be done. Getting to April 2022 would be the first step; work beyond that would be to take steps to make those improvements.
10.4	The Chair Designate of HIOW ICB reinforced the message that the aim was to transfer as safely as possible. Insights from earlier transitions would be used to

	design the new system e.g. being inclusive and transparent, harnessing the best of everyone and bringing things together in a more powerful way. It was an opportunity to 'explore the art of the possible' in a considered and measured way, observing the guidance but with as much flexibility as needed to ensure arrangements were fit for purpose to ultimately provide the best care for the population.
10.5	It was highlighted that the Non-Executive Directors for Patient and Public Involvement and Primary Care Commissioning, along with the Chair and colleagues from Portsmouth CCG were part of the Safe Transfer Project Board which reviewed monthly preparations for safe transfer.
10.6	**AGREED** **The Governing Body noted the progress of the ICS Development Programme including the delivery of the specific CCG responsibilities addressed within the Safe Transfer Workstream.**
11	**CCG Policies *(Paper HSI21/071)***
11.1	The Chief Finance Officer presented a paper which outlined progress on the development of the Policy Development and Review Programme including the establishment of a Policy Sub Group with oversight via the Audit and Risk Committee to bring together historic policies of predecessor CCGs that could be streamlined and then carried over to ICS. The Policy Sub Group had met on two occasions since the last update report was provided to the Governing Body on 8 September 2021 and approved the following documents for ratification / adoption: ***HR Policies*** • Performance Improvement (Management) Policy HR/003/V1.0 • Disciplinary Policy HR/004/V1.0 • Grievance Policy HR/005/V1.0 • Recruitment and Selection Policy HR/006/V1.0 • Secondment Policy HR/007/V2.0 • Probationary Policy HR/008/V1.0 ***Information Governance Policies / Documentation*** • Staff Fair Processing Notice (IG/012/V1.1) • Data Protection Impact Assessment Template (IG/013/V7.0) • Information Asset Owner / Data Custodian Handbook (IG/009/V1.1) • Information Governance Training Needs Analysis 2021/22 • Information Risk Management Programme (IG/011/V1.2) • Records Management Policy (IG/010/V1.2) • Privacy Statement / Fair Processing Notice (IG/001/V1.5) – *Updated* ***Corporate Policies*** • Social Value Policy CORP/007/V5.2 • Corporate Prepaid Card Policy CORP/008/V1.0
11.2	The Policy Sub Group also approved the adoption of the following Information Technology Security Policies, which CCG staff were required to adhere to: ***Mainland sites where IT support is provided by South Central and West Commissioning Support Unit i.e. SCWCSU owned IT Policies*** • Information Security Policy V4 • Anti-Virus Policy V4 • Asset Management Policy V2

	• Clear Screen & Desk Policy V4 • IT Disposal Policy V4 • Network Security Policy V4 • Password Policy V4 • Patch Management Policy V3 • System Level Security Policy V4 • Acceptable Use Policy V4 • Access Control Policy V4 • Remote Working & Portable Devices Policy V3 • IT Change Management Policy V5.3 • Registration Authority Policy V4.2 ***Sites based on Isle of Wight where IT support is provided by Isle of Wight NHS Trust IT Services i.e. IoW Trust owned IT Policies*** • Acceptable Use of ICT Policy V2 • Information Security Policy V4 • Remote Working & Portable Devices Policy V4
11.3	The following comments and queries were raised: • Clarification was sought on the Policy Sub Group membership; this included representatives from Finance, HR, Information Governance (IG), Staff Forums, Business Managers, Equality & Diversity lead, Local Counter Fraud Specialist with about 10 – 12 people normally in attendance, plus subject experts when needed. • Reassurance was requested that issues seen in the past around IG requirements blocking the sharing of information that would be useful for patient care and development in the system had been recognised and that hold ups would not be experienced. The Chief Finance Officer reported that, as Senior Information Risk Owner he had seen fewer issues in respect to IG and the ability to share data appropriately. The COVID-19 pandemic had brought significant changes to the data that could be shared and much of those protocols remained in place. The Chief Nursing Officer added that as Caldicott Guardian, she had received a number of requests and to date had been able to authorise them all. • It was reported that an issue had recently arisen around the Population Health Management approach and the request to practices that they share their practice information to take a more proactive approach to support people in the right, joined up way. This had worked well when worked through locally, however there were one or two practices that were not happy and raised concerns through the Local Medical Committee; the CCG therefore needed to be clear and proactive to work that through together with practices / LMC. It was stated that of most importance was communications with patients and the population; involving Patient Participation Groups in those conversations had resolved many concerns within practices. In addition IG policies were clear that patient information was confidential and they could opt out of some services if they did not want to have their information shared. • It was highlighted that the CCG Privacy Statement had been updated to ensure that it was completely up to date and aligned to statutory requirements so that the CCG was able to process data in a way that was appropriate and safe and to take forward statutory duties. There may be some misconceptions regarding data protection and processing that could in some cases get in the way. The Data Protection Act 2018 was crafted in such a way to allow NHS Health to be delivered and recognised the specific requirements around health, as well as consent and confidentially and responding appropriately. • IG was one of the core responsibilities of the Audit and Risk Committee,

	including oversight of any IG breaches / anything untoward. It was suggested that in order to provide assurance to the Governing Body, a stock take should be undertaken of any issues that had been seen which could be reviewed by Audit and Risk Committee, following which any issues identified for escalation could be brought back to the Governing Body. **ACTION: Chief Finance Officer to arrange for a stock take of any Information Governance related issues / concerns to be undertaken and reported to Audit and Risk Committee.**
11.4	**AGREED** **The Governing Body noted the progress to date of the Policy Sub Group and ratified the CCG policies listed above following review by the group.**
12	**Committees of the Governing Body *(Paper HSI21/072)***
12.1	The Governing Body received the approved minutes and summary reports from the following meetings: • Primary Care Commissioning Committee held on 22 September 2021, chaired by Matt Stevens • Quality, Performance and Finance Committee held on 22 September and 20 October 2021, chaired by Edward Palfrey
12.2	<u>Primary Care Commissioning Committee</u> • The Non-Executive Director (Primary Care Commissioning) and Chair of the Primary Care Commissioning Committee reported that the issue that had dominated recent discussions / workload of the members of staff tasked to deal with it was the extra monies that had been announced nationally for GPs, the application process and how those funds were distributed to GPs
12.3	<u>Quality, Performance and Finance Committee</u> • The Secondary Care Clinician and Chair of the Quality, Performance and Finance Committee (QPF) noted that the major issues of workforce and demand had already been covered earlier in the meeting. The most exciting development from his perspective was that workforce now had a reporting line into QPF, which had broadened the outlook and understanding of the group. It was confirmed that issues that had been identified for escalation to the Governing Body had been raised in earlier discussions.
12.4	**AGREED** **The Governing Body received the approved minutes and summary reports from the following meetings:** • **Primary Care Commissioning Committee held on 22 September 2021** • **Quality, Performance and Finance Committee held on 22 September and 20 October 2021**
13	**Minutes of Last Meeting *(Paper HSI21/073)***
13.1	The Governing Body received the draft minutes of the meeting held on 8 September 2021.

13.2	**AGREED** **The Governing Body approved the minutes of the Governing Body meeting held on 8 September 2021.**
14	**Any Other Business**
14.1	No additional items of business were raised.
14.2	On behalf of Governing Body, the Chair thanked everyone present at the meeting as well as all the colleagues who were working so hard on so many fronts, including NHS and local authority partners with whom we were working very closely in unprecedented times.
15	**Date of next meeting**
15.1	The next meeting of the Governing Body to be held in public was scheduled to take place on 8 December 2021.

I confirm the minutes of the meeting were agreed as an accurate record

Signed by

Chair: …… **Date: ……**