Agenda Item 4: Paper 4a

Minutes

Buckinghamshire CCG Governing Body – in public

11/03/2021. 13:30-15:30

Microsoft Teams

Due to a technical issue on the day of the meeting, an audio only recording of the meeting is also published on the CCG website.

Members			
Name	**Role and Organisation**	**Initials**	**Attendance**
Dr Raj Bajwa	**GP Clinical Chair (Chair)**	**RB**	Present
Tony Dixon	Lay Member / Chair of Finance Committee	**TD**	Present
Kate Holmes	Interim Chief Finance Officer	**KH**	Present
Dr James Kent	Chief (Accountable) Officer	**JK**	Present
Robert Majilton	Deputy Chief Officer	**RM**	Present
Crystal Oldman	Registered Nurse	**CO**	Present
Robert Parkes	Lay Member / Vice Lay Chair / Chair of Audit Committee	**RP**	Present
Dr Dal Sahota	Clinical Director – Urgent and Emergency Care	**DS**	Present
Dr Rashmi Sawhney	Clinical Director – Health Inequalities and The Primary Care Network DES	**RS**	Apologies
Graham Smith	Lay Member, Chair of Primary Care Committee	**GS**	Present
Dr Karen West	Member GP/Clinical Director Quality and Integration/Caldicott Guardian	**KW**	Present
Dr Robin Woolfson	Secondary Care Specialist Doctor	**RW**	Present
Others: (Standing Invitees or In attendance)			
Russell Carpenter	Board Secretary/Head of Governance (minutes)	**RC**	Present
Neil Flint	Head of Commissioning for Planned Care / Restoration and Recovery Lead	**NF**	Present (item 10)
David Williams	Deputy Director of Quality	**DD**	Apologies

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Standing Agenda Items		
1	**Welcome and introductions** The Chair welcomed everyone to the meeting.	
2	**Apologies for Absence** Noted as above.	
3	**Declaration of Interest** The Chair reminded members of their obligation to declare any interest they may have on any issue arising at Governing Body meetings that might conflict with the business of Buckinghamshire CCG. **Item 12b: Anticoagulation primary care improvement scheme** Member GPs who are also CCG Clinical Directors and partners in their practices are directly conflicted given their practice partner status and therefore subsequent status as pecuniary beneficiaries of Locally Commissioned Services. Member GPs are free to remain in the meeting of the Governing Body as it is being held in public, and can participate in discussion on the clinical elements and outcomes. Materially conflicted GPs will not be included in quorate decision. **Declaration of Gifts & Hospitality** The Chair reminded those present of their obligation. None were declared.	
4	**Minutes of the Meetings held on** 12/11/2020 These were agreed as a true record of that meeting, subject to Page 7 – "exists" to read as "exit" as regards continuity of EU medicines supply.	
5	**Action Log/Matters arising:** as described on the separate log. RB confirmed actions on the log as either closed or ongoing and therefore not further discussed. There were no further comments.	
6	**Questions in advance** RC reported questions received as regards critical care capacity: • Have resources originally dedicated to critical care been given over to COVID-19 patients? Has critical surgery been cancelled / deferred / delayed due to the admission of COVID-19 patients? if so • Who made this decision and was it made on the basis of clinical, financial or political considerations? Will you now restore and ring-fence critical care resources? JK confirmed that additional "surge" critical care capacity had been created above a baseline of 91 beds across all three CCG geographies (calculated per head of population). This was a clinical decision taken consistently by all systems across the south east region. It formed part of the national Level 4 command and control emergency alert response with regular oversight by NHS England. Nearly 260 patients were cared at the second wave peak in mid-January. But we have sustained priority 1 surgery throughout, and also the majority of priority 2 surgery. A gradually reducing number of COVID-19 admissions since the peak has meant we have almost returned to normal capacity. Further work is ahead to address the resultant backlog in priority 3 and 4 surgery.	

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	A more detailed response will be published on the CCG website and with the meeting minutes. **FINAL RESPONSE:** For the majority of 2020/21 the NHS has been working under national and regional direction to ensure a consistent response to the pressures that it has been under in terms of responding to the COVID-19 pandemic. This has covered both the financial/contractual arrangements we have been working under and also nationally agreed priorities for service delivery. CCG Governing Bodies have discussed this pandemic response, and are also aware that NHS England is reimbursing additional costs incurred. Since early November 2020 systems nationally have been operating at the highest level of command and control emergency alert (Level 4) with regular oversight by NHS England. All critical care resources, driven by clinical priorities, have been utilised to: 1. Support clinical management of patients with COVID who require critical care 2. Maintain services for patients who require emergency or urgent surgery such as for those with cancer To ensure that all patients can access the critical care they need all our local hospitals have worked together to create additional "surge" critical care capacity. They have also linked into the wider South East and national picture in a process known as "mutual aid". Our baseline number of funded critical care beds across Buckinghamshire, Oxfordshire and Berkshire West is 91 and at the peak of the pandemic in January we were caring for nearly 260 patients in critical care. However we have sustained priority 1 surgery throughout, and also the majority of priority 2 surgery. A gradually reducing number of COVID-19 admissions since the peak has meant we have almost returned to normal capacity, with further work ahead to address the resultant backlog in priority 3 and 4 surgery. RC reported questions received 24 hours before the meeting: • So far this financial year how much have the Primary Care Networks cost this CCG? • What have they implemented so far and how many Clinical Pharmacists and Social Prescribers are currently undergoing their duties? RC advised the majority of funding is national, with further returns on costs anticipated between now and into April as the financial year ends. Depending upon the timing, this may also be referred to within a formal FOI response within 20 working days. The response will also be included in the final version of the meeting minutes. A Section 21 exemption (Information accessible by other means) applies to workforce data already published by NHS Digital. **FINAL RESPONSE:** 1. So far this financial year how much have the Primary Care Networks cost this CCG. £3,851,257.61 (Amount reimbursed to CCGs under the terms of the NHS England/Improvement/Primary Care Network (PCN) Directed Enhanced Service (DES) 2020/2021)	

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	2. What have they implemented so far? • All Primary Care Networks (PCNs) are now supporting Multi-Disciplinary Teams (MDTS) across all our Care Homes and Community Care • PCNs are playing a key part in the Population Health Management (PHM) programme identifying and addressing key cohorts patients • All PCNs have undertaken management and team development programmes • All Care Homes have a designated Primary Care Lead • All PCNs have built and are continuing to build vital capacity and roles to support discharges, admissions avoidance, patient self-management especially for long term conditions 3. How many Clinical Pharmacists and Social Prescribers are currently contracted and undergoing their duties. Section 21 applies (This information is accessible by other means – NHS Digital listings)	
7	**Questions from the floor.** None received.	
8	**Accountable Officer's and Deputy Accountable Officer's Report** The number of critical care patients has further fallen to 120 across the three CCG geographies which mirrors the media reported national trend. As regards vaccinations, the top 4 cohort aim was met by the end of February. Our further aim to vaccinate the top 9 cohorts by mid-April is on target thanks to an anticipated threefold increase in supply. RW thanked all staff for their phenomenal efforts during a challenging second wave. Is there an opportunity to create more resource appropriate for future clinical needs, especially given advance in other untreated disease which may require future additional capacity? JK noted the current baseline as offering limited resilience and credited providers in having successfully increased capacity. Greater flexibility in resource deployment can be achieved with a net increase in both bed and staffing capacity baselines. A system level review of funding to begin next month will aim for this. It will also take into account a capital funding bid by Oxford University Hospitals NHS Foundation Trust for an additional 50 critical care beds. RW queried staff vaccinations for COVID-19. JK reported that local providers have experienced hesitancy among Black, Asian, and Minority Ethnic (BAME) groups, but at a lower prevalence than the national trend. Existing flu communications channels have been utilised with increased vigour to encourage uptake. We are exceeding in every cohort compared to flu. TD questioned how a system estates function would see through existing primary care transformation, including new build centres planned at Beaconsfield and Berryfields (Aylesbury). RM advised these would continue as planned. Further improvement is needed in joining up place based and system level plans which is aligned to known population growth and housing development. JK added the budget had not referred to funding, with hope that the next spending review will. The Governing Body received and **NOTED** the report.	

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	Risk Management and Assurance	
9	**Risk Management and Assurance** Actions have been taken in response to the recent risk management internal audit. Work is also ongoing across the three CCGs to achieve design consistency. As regards provider capacity and resource (Corporate Risk Register), the FOI response as alluded to earlier will provide further confirmation of what primary care networks have implemented to date. As regards GPIT capital funding (Corporate Risk Register), KH confirmed discussions remain ongoing with NHS England to confirm the position. <u>COVID-19 risk register</u> RW observed that there has been delay in treatments and investigations, so it is essential to understand what harm may result. The CCG and providers are at great risk when "*There is also anecdotal patient feedback that Two week wait* (Cancer) *first appointments are being cancelled rather than postponed".* This is worrying. JK reported a focus on cancer resilience, with the position much improved compared to a year ago. DS added a need to consider that some may have been downgraded to routine rather than cancelled. RB noted there are two ongoing actions detailed to capture harms and review cancer diagnostic data. **ACTION: circulate latest cancer data and check whether "2WW cancelled" anecdote remains a true reflection of the position.** RC noted the financial challenges as well known, there will be a learning exercise at the end of the pandemic, and the vaccination programme is continuing at pace. TD questioned the status of the current continuing healthcare backlog and when it may reach a steady state. RM explained that assessments had been deferred with some staff redeployment to pandemic support. But we are expecting to clear these. The number of assessments in hospitals prior to discharge had fallen, an improvement outcome resulting from the hospital Discharge Programme (Discharge 2 Assess – D2A). KH added that a level of anticipated growth (£3.6m) and conversion has not materialised, so this has been released from the forecast outturn position. The Governing Body received and **<u>NOTED</u>** as **<u>ASSURANCE</u>** a) Risk reports and highlighted escalations as described. b) Actions taken in response to the CCG's risk management internal audit report for 2020/2021	**JK (NF)**
	Operational Performance	
10	**Performance and Quality Report (Including Restoration and Recovery)** An acronym referred to within the report confirmed: MOFD = "Medically Optimised for Discharge" (patients occupying an inpatient bed that no longer need to be in hospital if the services were in place across the community and primary care tiers). A glossary of terms is to be added.	

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	KW emphasised a focus to: • Assess clinical harms arising from the pandemic • Continue investment in mental health with burden expected to increase over the coming year as systems recover. RP asked whether stated investment in continuing healthcare has been successful. KW confirmed that, although flow has much improved, it is not sustainable long term. RM clarified the investment referred to in the report related to investment in the CHC team to clear deferred assessments from Wave 1. RM that Buckinghamshire numbers of patients medically fit for discharge were higher in comparison compared to Oxfordshire and Berkshire West despite the concerted effort and investment. It is a priority to look at the hospital discharge pathway going forward, both at "place" and ICS. RW quoted report referring to "*introduction of system wide green rapid diagnostic pathways for colorectal and lung pathways*" and highlighted variance in provider performance on cancer targets. What is the true ambition? Patients would move to there the resource is, replicating the model for vascular surgery where it is now specialist centred (at Oxford University Hospitals NHS Foundation Trust). KW advised this has been discussed at less formal monthly quality and performance meetings (business as usual stood down). JK added future provider collaborative will be central to this, as will a commissioning role for the Thames Valley Cancer Alliance. Additional critical care beds at Oxford University Hospitals NHS Foundation Trust will also form part of how we utilise resource for cancer and other tertiary services, with some activity repatriated to other providers. The Governing Body received and **NOTED** the report.	
11	**Finance Update / Month 11 Finance Report** A continuing healthcare £3.6m cost pressure was confirmed not to have materialised. This gives confidence in a forecast deficit reduced from £4.9 to £1.2m with aim for break even by financial year end. We are working hard across the system to achieve it. The mental health investment standard is expected to continue unchanged. Significant pressure will continue given the combined effect of long term plan expectations, long COVID, no savings targets met, and activity shift for untreated disease unrelated to COVID-19. It is currently unknown whether the Hospital Discharge Programme will continue to be funded in 2021/2022. The current funding regime excluding the programme is expected to continue into Q1, but whether it will remain for Q2 is to be confirmed. TD queried the expected underlying position. KH advised analysis of run rates would report to Finance Committee. Assumptions would need to be agreed across the system between providers and commissioners. The outcomes would provide assurance to Governing Body.	

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	CO noted the benefits of the hospital discharge programme. Given the known number of deaths, future funding needs a community focus to support people to have a good death at home. KH commented our previous allocation did include community investment. This is expected to remain unchanged long term despite the financial regime having changed during the pandemic. The needs of an ageing population will need to be considered, with Population Health Management a technique we will be using to address this. DS observed that finances need to mirror the sentiment. KH added although future allocations are uncertain, we are working with mental health providers to understand their priorities. When allocations are confirmed we can review our budgets against these priorities. RB added levels of integration will influence success. JK noted this tests the ability for us and local authority colleagues to prioritise and reduce backlogs. We have good experience and learning from new models of care which have improved patient flow. CO noted national work on resourcing community nurses to evolve and work in different ways. A national steering group, headed up by Baroness Judith Jolley, needs a local link individual. Professor Alison Leary is also looking at workforce modelling with 23 providers, focused to demonstrate needs for community and district nursing teams. **ACTION: local linked agreed as DS for national steering group on community nursing transformation (action documented in order to report on progress)** The Governing Body received and **NOTED** the report.	**DS**
	Decisions	
12	**a. Process and arrangements for the Audit Committee to review and approve the Annual Report and Annual Accounts** TD observed this process as the same from previous years with no need to change. RP echoed this. The Governing Body **APPROVED** the process and arrangements for the Audit Committee to review and approve the Annual Report and Annual Accounts for 2020/2021. **b. Anticoagulation primary care improvement scheme** RC noted • The paper requesting 90k funding had escalated to Governing Body by virtue of the improvement scheme as "new" rather than financial value. Alignment of schemes of delegation across CCGs is likely to reduce future re-occurrence. • An error in the circulated papers – Joint Working Agreement authorisation level cited as £24,9999 when it should read £24,999. The website published version has been corrected. RB handed the chair of the meeting to RP given the direct and material conflicts of interest. Member GPs are able to contribute to clinical discussion	

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	as appropriate. JB described the GP education programme as outlined in the paper as a means to ensure primary care engagement to audit prescriptions. It's a two-step process with payment levels according to population size. Practices will be asked to champion clinical leads to attend additional training to give them confidence. In response to a question about risks, JB replied without appropriate education GPs may not be competent, or they may initiate without competence. RW referred to a new class of Sodium-glucose co-transporter-2 (SGLT2) inhibitor oral medications used for treating type 2 diabetes chronic kidney disease and other conditions. These will give dramatic survival advantage and need to be rolled out from primary care. It is therefore important to audit. GS added it important the scheme pays for itself. JB echoed these points given concern about monitoring prescribing behaviour, effectiveness and safety implications. There is a heightened risk of stroke or bleed if inappropriate or wrong dose. Advice and guidance can continue to be sought from secondary care before initiation. A current Direct oral anticoagulants (DOAC) initiation clinic through Buckinghamshire Healthcare NHS Trust receives 230 referrals a month. The costs for this fall within a block contract but may not remain so. KW asked whether costs would increase due to more prescribing. JB said there had been a steady rise over a number of years though Buckinghamshire is average against national comparison. Continued increase is initiation is anticipated with increasing familiarly and less need for active monitoring compared to warfarin. It is expected that prescribing continues to rise, given increasing continue to rise; increasing number of indications of use and patients more familiar and no monitoring as with warfarin. RB added the scheme is a great means to safely and effectively introduce a new class of medications which transfers initiation from secondary care to primary care. This group could be prescribed by primary care when first released some years ago. However locally our experience was allowed to evolve and primary care would learn from the secondary care clinic. It is now an appropriate time to transfer given the embedded learning. DS observed this does set a future precedent for equivalent education led initiatives. TD asked for a report on success including lessons learned. **ACTION: It was agreed to report in Q3.** RP commented knowledge has a value and therefore reference in paper to "nil transfer value" is incorrect and needs to be amended for any published version of the paper. RC replied this was in relation to financial value and so the paper will be amended. The Governing Body **APPROVED** the anticoagulation primary care improvement scheme	**JB**

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	Governance and Assurance	
13	**Corporate Governance Report** RC emphasised compliance with module one conflict of interest training as lower than required by NHS England as regulator at 31 January. It is still expected we shall report despite the current suspension of the self-certification process. Reminders have circulated by email to relevant staff, and emphasised at all staff briefings. A letter from NHS England dated 26 January 2021 had quoted "Reduce other mandatory training as appropriate". However, it has been deemed essential to continue conflicts of interest module one and data security awareness given regulator reporting requirements. TD unable to take course on unconscious bias. RC believes there were plans to arrange further unconscious bias training but these have not yet been arranged. JK added that unconscious bias training may return in a new and improved form at some time in the future. JK reported that he had been unable to complete the assessment and be certified for module one conflicts of interest training, which may also affect other staff. **ACTION: explore and resolve technical issue preventing this** The Governing Body received and **NOTED** the supplied paper as **ASSURANCE**	**RC**
	For Information	
14	Committee reports and minutes (CCG and stakeholders e.g. safeguarding adults board, HWB) a) Integrated Commissioning Executive Team (ICET) summary Governing Body received and **NOTED** the report for information.	
15	**Published reports as required** **a) Safeguarding Annual Report** **b) Communications and Engagement Q3 2021/2022** These were received **FOR INFORMATION**	
	Date of Next Meeting: 10 June 2021, 13:30 –15:30 , "in common" with Oxfordshire CCG and Berkshire West CCG	
	Meeting Closed: 15:30	

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