NHS
Buckinghamshire
Clinical Commissioning Group

Executive Committee Meeting
Minutes

Thursday 25th July 2019 – 13:00 – 15:30
Chair: - Robert Majilton, Deputy Chief Officer

Executive Committee Voting Members:

Louise Patten	LP	Chief Officer	**Present** (from 15.00)
Robert Majilton	RM	Deputy Chief Officer (Chair)	**Present**
Gary Heneage	GH	Chief Finance Officer	**Present** (from 14.15)
Nicola Lester	NL	Director of Transformation	**Present**
Dr Karen West	KW	Clinical Director - Integration	Apologies Received
Dr Malcolm Jones	MJ	Clinical Director – Locality Lead – South	Apologies Received
Dr Juliet Sutton	JS	Clinical Director – Children's	**Present (**from 14.00)
Dr Rashmi Sawhney	RS	Clinical Director – Locality Lead - Wycombe	**Present**
Dr Dal Sahota	DS	Clinical Director – Urgent Care	Apologies Received
Dr Sian Roberts	SR	Clinical Director - Mental Health & Learning Disabilities	**Present**
Other Attendees			
Dr Rodger Dickson	RD	Clinical Director – Locality Lead	**Present**
Dr Shona Lockie	ShL	Clinical Director - Medicines Management	Apologies Received
Dr Peter Newman	PN	Clinical Director – Locality Lead	**Present**
Dr Raj Bajwa	RB	Clinical Chair	**Present**
Dr Raj Thakkar	RT	Clinical Director – Planned Care	**Present** (from 14.25)
Dr Stuart Logan	SL	Clinical Director – LTC	**Present** (from 14.15)
Russell Carpenter	RC	Board Secretary / Head of Governance	**Present**
Dr Rebecca Mallard Smith	RMS	Clinical Director – Unplanned Community Care	**Present** (to 14.00)
Julie Hoare	JH	Managing Director ICS	**Present**
Jane Butterworth	JB	Associate Director Medicines Management	**Present** (for items 5 & 8)
Noel Burkett	NB	Head of ICS PMO	**Present** (for items 6 & 7)
Frances Burdock	FB	Associate Director Contracts and Performance	**Present** (for item 11)
Minute Taker			
Sarah Edwards	SE	EA to Chief Officer & Deputy Chief Officer	**Present**

No	Agenda Item	Discussion
1.	**Welcome & Apologies**	Dr Dal Sahota, Dr Karen West, Dr Malcolm Jones, Dr Shona Lockie

2.	**Declarations of Interest**	The Chair reminded committee members of their obligation to declare any interest they may have on any issues arising at committee meetings which might conflict with the business of Buckinghamshire CCG, the standing declarations were as noted in the Declarations of interest register. https://www.buckinghamshireccg.nhs.uk/public/about-us/how-we-make-decisions/registers-of-interests/ There were no additional declarations of interest at today's meeting. **Quorum** Accountable Officer or Deputy AO or Chief Finance Officer ✓ Two other Management Directors ✓ Four Clinical Directors ✓ **Item 8: Approval for Primary Care Rebate Schemes that are amber rated by PrescQIPP (Insulin Aprida & Insulin Insuman)** Voting GP members, as partners/shareholders in member practices, have a direct conflict of interest with any proposal for a practice discount/rebate scheme in which they would benefit which switches practice prescriptions from formulary to non-formulary drugs. However this paper relates to a specific scheme which would benefit the CCG prescribing budget and therefore no further mitigating action is required, and given that this scheme also relates to an existing formulary drug.
3.	**Review & Approval of Minutes & Action log updates**	Minutes of the meeting held on 27th June 2019 were approved as an accurate record of the meeting **but** the following area was noted: NL commented that the minutes need editing further to improve readability. Update on actions: Action 128: Update provided at previous meeting – action closed Action 132: MM provided her thoughts and RM to pick this up with SR – action closed Action 136: Cardiology – London activity – LP to feedback – action open Action 137: Inequalities in CVD RT to send to RB – report received – action closed Action 138: Commissioning architecture slides to be circulated - still awaited - action open Action 139: Review of clinical leadership – NL has started working on this – a request is to go to the Clinical & Care Forum to agree a system-wide meeting – action open Action 141: TVPC A set of principles around who is looking at TVPC policies. JB raised this at the Quality Committee – action closed Action 142: JB to update the next report – action closed Action 143: GH to work through financial implications in relation to the closure of Chartridge Ward – action open Action 144: Q&P – SE to pick up with FB. Email sent to FB on 29/6/19 - action closed Action 145: ICET – RM to provide a verbal update on Unitary position at this

		meeting – action closed. Action 146: Workforce – Feedback has been received from HR and further update awaited.
4.	**Chief Officer's Report**	RM presented the Chief Officer's report and highlighted the following areas: Long Term Plan – Implementation Framework The Implementation Framework has now been published and sets out the approach that Sustainability & Transformation Partnerships (STPs) / Integrated Care Systems (ICSs) are asked to take to create their five-year strategic plans by November 2019 covering the period 2019/20 to 2023/24. BOB STP update The Buckinghamshire, Oxfordshire & Berkshire West (BOB) STP has applied to be a "wave 3" Integrated Care System operating in shadow form in 2019/20 before becoming an approved ICS from April 2020. NHS England have announced that this application was successful. David Clayton-Smith has been appointed as the Independent Chair of the BOB ICS. A link to the latest BOB ICS LTP Briefing paper is included in the report. Population Health Management Approach Buckinghamshire & Oxfordshire have expressed an interest in joining the next cohort of systems on a programme to develop their Population Health Management approach. Berkshire West took part in the first wave of this. Baselining work is due to start in September. An initial meeting with the NHS England team and representatives from the BOB has been arranged for August. Unitary update Rachael Shimmin has been appointed as CEO for new Buckinghamshire Unitary Council. The next two tiers of the management structure across the Council are to be finalised. RM said we will work with Local Authority colleagues on what this will mean for integrated commissioning opportunities. **Action 147: JBow/RM will pull together a paper on what does Integrated Commissioning mean.**
5.	**Update on Ways of Working and CCG Accommodation – including decision to trial extending agile working**	The CCG Executive are asked to: • **Approve** the proposed trial for agile working as recommended by the Staff Partnership Forum • **Note** the update on accommodation and the need to develop a contingency plan. This may require delegated / management actions between Executive meetings to manage operational risk and to respond to the evolving situation. NB reported that a policy on agile working has been developed with a view to reducing the office footprint. The Staff Partnership Forum (SPF) had not supported the policy but had recommended a pilot scheme of agile working took place over a 3 month period to build trust, reduce the office footprint collect information on what does/doesn't work. NL added the decision at SPF was for a proposal of a trial period. The Agile Working Document circulated to the Committee has been tested back with the SPF and responses have been favourable. LP has also suggested this would work best if every member of staff/team has their own work-plan with

		outputs/inputs identified. RS asked what does "there is no change in position regarding Amersham mean"? NB advised that BHT have notified us that they will at some point require us to move out of Amersham. NL asked for clarification on the statement on Page 82 "current predictions are we would need 96 hot desks"? NB confirmed that this includes those moving in-house from the CSU. **Decision: The Executive Committee approved the Agile working pilot pending the implementation of work-plans across all teams and noted the update on CCG accommodation.**
6.	**Approval for Primary Care Rebate Schemes that are amber rated by PresQIPP (Insulin Aprida and Insulin Insuman)**	The CCG Executive Committee is asked to: **AGREE** that Buckinghamshire CCG will accept the rebate schemes for: • Insulin Aprida. • Insulin Insuman ***It was noted that any rebate derived from the above schemes would be a CCG only rebate and therefore there is no conflict for clinicians who work in prescribing practices.*** JB provided background on the suggested rebates and confirmed that they were on the amber list because of their financial benefit which was deemed to be of too lower value to recommend. JB went on to say that this is a good example of whether we should set levels by which we do not look at rebate schemes. This rebate would generate approximately £6k per annum to the CCG but will involve us invoicing quarterly and asking the CSU to pull data to generate the invoice. JB asked the Committee to consider whether there was a particular sum which is deemed too low to incur costs by generating additional work to get rebate? Further discussion followed and agreement was reached that low income generating rebates would only return to the Executive Committee by exception with the responsibility delegated to the Medicines Optimisation Board to make a decision on whether to accept the rebate. **Decision: The Executive Committee approved the rebate scheme for Insulin Aprida and Insulin Insuman with future low value rebates only returning to the Committee by exception.**
7.	**Future Plans for Engagement Steering Group**	NL reported that the final meeting of the Engagement Steering group will be held shortly as it is recognised that this is now duplicated by the newly formed Getting Bucks Involved Group. The responsibility for commissioning projects will move to the Getting Bucks Involved Group and the continued development of Patient Participation Groups (PPGs) will move to Primary Care Networks (PCNs) supported by Healthwatch over the next 12 months. NL acknowledged that the folding of the Engagement Steering Group had caused some disappointment. The final meeting will be held next week. Governing Body to recognise the work of the Engagement Steering Group as this is an amendment to the constitution. RM expressed thanks to NL for her work with the Engagement Steering Group which is a viable entity to hand over to the Getting Bucks Involved Group. LP is preparing a video message to thank the volunteers for their participation.

8.	**Finance report (Month 3)**	GH delivered an update on the current financial position. The CCG did meet the Quarter 1 control total but we took a decision as a system that we would support Provider Sustainability Fund (PSF) / Commissioner Sustainability Fund (CSF) and to support BHT to achieve their PSF we have had to put in a re-payable system support of £2.5m The CCG are on target for Quarter 2 with pressures emerging and the challenge will be if BHT were short again for their PSF what we could do as a system? In terms of where the CCG is currently at there are two main pressures to highlight. Acute pressure, mainly T&O driven, a lot of work is going on to try and get this back into a reasonable level Continuing healthcare – not delivering current QIPPS due to various reasons and significant over performance. Discussions have been held at the Finance Committee and a significant investment needs to be made as a "non-recurrent one off investment" to clear the back-log of CHC cases waiting review or appeal against the national framework decision. A further staff will be recruited to support the team in achieving this. The backlog of cases needs to be reviewed as they represent a quality issue for the CCG. GH advised we have the potential to earn £3.2m CSF during this quarter and £5.4m next quarter. RT highlighted a small risk in that BHT are pushing referrals (i.e. dermatology) back to GPs and the risk is that GPs may re-refer to out of county providers. GH identified that another potential challenge is the temporary closure of the community ward at Amersham and flow from Wexham and this was being monitored as part of system oversight of the temporary closure.
9.	**Quality & Performance (Month 3)**	FB joined the meeting to provide highlights from the July Q&P report. • Cancer performance has improved although the number of breaches is increasing – nineteen breaches identified in May with an un-validated June position of twenty-three. We need to look at the cause of the breaches and possible remedies. • RT advised there were multiple issues, some due to local issues and some associated with the pathway in Oxford and an issue with their PET scanning capacity – patients were being referred to Mount Vernon but they then went into over-capacity. BHT has still to order a parametric MRI scanner. 104 breaches were due to complex cases, patient choice/treatments/co-morbidities and played a big part in relation to the overall number of breaches and we have asked the Quality Team to look at the schematics month on month to see what is going on. RT went on to say we are also looking at other trusts to see why their performance is better (i.e Kingston & Frimley). In addition, a joint cancer meeting is being held with Oxford CCG to gain a better view of overall pathway. RB

		asked if cancer is being looked at as a system across the ICP? RT replied we have asked for a more joined up approach across system to have a "one pathway approach". • RTT – BHT has maintained their 0/52 week waiters and is now focussing on 40/45 week waiters. This is good news for patients but if the wait length increases there is a potential risk for over performance. • Diagnostics – the short term capacity for endoscopy diagnostics has been resolved. A long term demand and capacity plan needs to be implemented to ensure sustainability. • Urgent Care/A&E have been very stretched over the past 4 weeks with lots of attendances due to minor injuries • RT highlighted a risk with endoscopy – BHT is aware and a Vague Symptoms Unit is being piloted with FIT testing as part of the work-up. • SR felt that PCNs could be doing learning disability checks at the same cost and could be a quality improvement. SR advised that we are re-looking at the model for learning disability.
10.	**Integrated Commissioning (Executive Team headlines)**	• An Integrated Commissioning Executive Team meeting was held this morning and a Joint SMT meeting with the Integrated Commissioning Team was held earlier this month. Feedback has been really positive and everyone felt they had gained an understanding of each other's roles. This exercise will be repeated in September with a deep dive into PCNs requested for a sharing of knowledge and to scope opportunities that could be offered by the Integrated Commissioning Team. • The CHC brokerage service has moved to Buckinghamshire County Council and a review will be undertaken in six months to look at the benefits. • Conversations were held at ICET about the wider CHC positon. • The Looked After Children position and wider children's services were discussed. Improvement has been seen in looked after children assessment rates which are back up to 100% in May but the feeling was there is little confidence that this is sustainable. It was agreed to schedule in a risk summit linked to demand and capacity and ideas are being developed as to how this can be taken forwarded. • Future opportunities for integrated commissioning were discussed. • There is an on-going review of ICET terms of reference • Better Care Fund (BCF) guidance recently issued – we are ok for 19/20 with a long term review of the future of what the BCF looks like.
11.	**Update on PCNS**	NL provided an updated on Primary Care Networks (PCNs). Contracts were signed on 1st July, all 50 practices joined so there are no stranded practices. Accountable clinical directors have attended the Partnership Board with two PCN clinical directors nominated to join the board. Money for PCNs will come through the ICS but as yet we do not know how it can be accessed or spent as yet. More information is becoming available regularly. The ICS is in discussion with providers and in collaboration with the training hub for organisational development training. The training hub and the BHT training & development department are in contact to see if they can work together and if this option

		becomes available we will try and use it, however it is not yet confirmed we will have this as an option. RB confirmed that the CCGs have met with the national primary care team and it was identified there is a need for accountable clinical directors to undergo organisational development training and no-one knew of any existing training package to fulfil that need. NL replied that the prospectus does recognise this but the needs vary significantly from individual to individual and we need to form a view of what is required by our own 12 PCN clinical directors and develop something to meet their requirements. On-going governance challenges with PCN networks remain and RC advised he is lending support to help make sure arrangements are robust. The Public health team have released their first drafts at PCN level.
12.	**HR Policies**	The Executive Committee is asked to: • **RATIFY** the policy above based on the assurance that it has been reviewed and is recommended by the Staff Partnership Forum. Following ratification, the new policy will be issued to all staff. • Capability Policy v1.5 • Capability User Policy v1.3 NL confirmed there were no material changes and extra paragraphs had only been added to provide additional clarity on process There were no questions raised. **Decision: The Executive Committee ratified the revised policy and user guide.**
13.	**Approved Minutes**	The following minutes were noted by the Committee • Staff Partnership Forum June 19 • ICDG June 19 – SR commented that this group is not accountable to the Executive Committee and therefore will not be needed going forwards. • A&ED June 19

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Minutes

Thursday 22nd August 2019 – 13:00 – 14:30
Chair: - Robert Majilton, Deputy Chief Officer

Executive Committee Voting Members:

Louise Patten	LP	Chief Officer	Apologies Received
Robert Majilton	RM	Deputy Chief Officer (Chair)	**Present**
Gary Heneage	GH	Chief Finance Officer	Apologies Received
Nicola Lester	NL	Director of Transformation	**Present**
Dr Raj Bajwa	RB	Clinical Chair	**Present**
Dr Karen West	KW	Clinical Director - Integration	Apologies Received
Dr Malcolm Jones	MJ	Clinical Director	Apologies Received
Dr Juliet Sutton	JS	Clinical Director – Children's	**Present**
Dr Rashmi Sawhney	RS	Clinical Director	Apologies Received
Dr Dal Sahota	DS	Clinical Director – Urgent Care	**Present**
Dr Sian Roberts	SR	Clinical Director - Mental Health & Learning Disabilities	**Present**
Dr Rodger Dickson	RD	Clinical Director	**Present**
Dr Shona Lockie	ShL	Clinical Director – Medicines Management	**Present**
Dr Peter Newman	PD	Clinical Director	Apologies Received
Dr Raj Thakkar	RT	Clinical Director – Planned Care	Apologies Received
Dr Stuart Logan	StL	Clinical Director - LTC	Apologies Received
Dr Rebecca Mallard Smith	RMS	Clinical Director – Unplanned Community Care	Apologies Received
Other Attendees			
Russell Carpenter	RC	Board Secretary / Head of Governance	**Present**
Kate Holmes	KH	Deputy Chief Finance Officer (covering for the CFO)	**Present**
Julie Hoare	JH	Managing Director ICS	Apologies Received
Noel Burkett	NB	Head of ICS PMO	**Present** (for items 6 & 7)
Frances Burdock	FB	Associate Director Contracts and Performance	**Present** (for item 11)
Bashak Onal	BO	System Resilience Manager	**Present** (for item 6)
Minute Taker			
Sarah Edwards	SE	EA to Chief Officer & Deputy Chief Officer	**Present**

No	Agenda Item	Discussion
1.	**Welcome & Apologies**	Louise Patten, Gary Heneage, Dr Rebecca Mallard Smith, Dr Stuart Logan, Dr Peter Newman, Dr Karen West, Dr Malcolm Jones, Dr Raj Thakkar,

		Dr Rashmi Sawhney.
2.	**Declarations of Interest**	The Chair reminded committee members of their obligation to declare any interest they may have on any issues arising at committee meetings which might conflict with the business of Buckinghamshire CCG, the standing declarations were as noted in the Declarations of interest register. https://www.buckinghamshireccg.nhs.uk/public/about-us/how-we-make-decisions/registers-of-interests/ There were no additional declarations of interest at today's meeting. **Quorum** Accountable Officer or Deputy AO or Chief Finance Officer: ✓ Two other Management Directors: ✓ (with Kate Holmes acting for CFO) Four Clinical Directors: ✓
3.	**Review & Approval of Minutes & Action log updates**	Minutes of the meeting held on 25th July 2019 were approved as an accurate record of the meeting. Update on actions: Action 136: Cardiology – London activity – LP to feedback – action open Action 138: Commissioning architecture slides to be circulated - action open Action 139: Review of clinical leadership – NL has started working on this – a request has gone to the Clinical & Care Forum to agree a system-wide meeting. This is now with the Forum to take a view and RB will add to Forum agenda – action closed Action 143: GH to work through financial implications in relation to the closure of Chartridge Ward. A FIG meeting with BHT reported no internal impact. Frimley impact will become apparent in next few months – action open Action 146: Workforce – Benchmarking paper on agenda - Action closed Action 147: Unitary Update – JB/RM to pull together a paper describing what Integrated Commissioning looks like – draft circulated to Integrated Commissioning Directors. Feedback at the September meeting – action open Action 148: JB to circulate impact assessment on Gluten Free – action open
4.	**Chief Officer's Report**	RM presented the Chief Officer's report and highlighted the following areas: BOB ICS update Communications regarding the timescales for proposal to move to a single CCG for ICS from April 2021 has been circulated. The Interim Director structure is now in place across BCCG & OCCG. The BOB/ICS response to the Long Term Plan (LTP) has been shared and the process is being co-ordinated through the ICS Chief Executives Group who have divided up the sections of the LTP in the BOB response. Templates and sections

		will be shared for comments and input. The deadline is 27/08/19 for the first draft of sections with the first submission on 27/09/19. Final submission will be in December. Governing Body will be required to sign off the various sections. NHSE/I are not expecting every organisation across BOB to have taken this through their formal governance process by September. It will be up to local organisations to go through their governance arrangements to flag dates. An update will go to Health & Wellbeing Board in early September. The ICS team are aiming to produce consistent briefs. Population Health Management Work is on-going with NHS England who have been supporting a small number of systems on a programme to develop their Population Health Management approach. Berkshire West has been on the first wave of this and now Buckinghamshire and Oxfordshire have expressed an interest in joining a further cohort to (a) support learning from Berkshire West (b) provide additional support (via workshops and accelerated events) to Bucks & Oxon and (c) use the opportunity to explore any areas that are suitable and would bring benefit working at a BOB scale. RB asked if Portfolio Leads have established their own networks with West Berkshire and Oxfordshire? SR replied that networks had not been established in relation to integrated working but relationships have been established. DS said that she has established a relationship with Oxford but not yet with Berkshire West and questioned what the current benefit to the system would be whilst acknowledging that it might be helpful to establish the networks for future work. Topical, legal and regulatory issues The NHS Legislation Engagement Team are now considering the responses to the Consultation on the NHS Long Term Plan and will publish a report which sets out the views received and makes firm recommendations for the Secretary of State. However there are currently no confirmed national timescales given for either publication of the report or when any changes to legislation will be debated and come into effect. Corporate Risk Register This is currently being reviewed and aligned to the new interim director structure. CCG On-Call A consultation with existing staff on the Director on call rota was launched on 12 August with the proposal to move to a joint on-call director across Oxfordshire & Buckinghamshire. If the proposals in the consultation are adopted then the on-call rota would be a 1 in 13 (the current Bucks CCG rota would become a 1 in 6 in October without affecting this change)
5.	**Business Cases**	In-housing PALs & Complaints Service The Executive Committee are asked to: **AGREE the recommendation** to in-house the PALS/Complaints service provision from NHS South Central and West CSU (CSU), and in doing so **APPROVES** the supporting business case and direction of travel;

		• **AGREE** to provide the CCG Chief Finance Officer and the Director of Nursing and Quality (Sula Wiltshire) delegated authority to agree final business case submission to NHS England. NB explained the rationale behind the proposals to in-house the PALs and Complaints team which is supported by our internal Quality team and Sula Wiltshire the Director of Nursing & Quality. Finance have already signed off the costings for the in-housing. The new team will be further equipped to carry out the role by strengthening the team as and when required. The funding for this will come out of the savings made through in-housing. By making the team part of the system this will enhance the quality of the service and improve their connectivity and response. **Decision: The Executive Committee approved the recommendation to in-house the PALS/Complaints service from NHS South Central & West CSU and supported the business case and direction of travel. The Executive Committee also agreed for the Director of Nursing & Quality (Sula Wiltshire) to have delegated authority to agree the final business case submission to NHS England.** In-housing GPI/IT Services The Executive Committee are asked to: **AGREE** to provide the CCG Chief Finance Officer and the ICP Joint Strategic Director - Information Assets and Digital Development delegated authority to agree final business case submission to NHS England. NB explained why the full business case had not come to the Committee at this meeting which was due to further work being required to rationalise why we wanted this service to be in-housed at place. The revised Business Case will come back to the Committee in the next few months. **Decision: The Committee discussed and approved the rationale to delegate authority to the ICP Joint Strategic Director – Information Assets and Digital Development to the CFO to agree the final business case submission to NHS England. A revised Business case will come to the Executive Committee within the next couple of months.**
6.	**Business Continuity**	The Executive Committee are asked to: 1. **APPROVE AND RATIFY** the following in support of our self-assessment: i. Major Incident Framework/Incident Response ii. CCG Business Continuity Plan iii. Surge and Escalation Plan RC presented the above papers and advised that a check and challenge event is due to be held on Friday 30th August and a number of people from the Urgent Care team will be attending. The CCG Business Continuity Plan is focused on our contingency arrangements and will go to Governing Body for ratification. Last year the Virgin Media connection went down at Amersham, we haven't had a similar incident since but

		we have had adverse weather events where we have had to put our business continuity plans in place. Major Incident Framework & Surge & Escalation Plan – both of these focus on our relationship management with the system. NL highlighted that the Major Incident response plan needs further updating. BO joined the meeting and took feedback from the Committee on areas within the framework that still require updating. DS suggested BO make contact with the Trust and ask them to display the Framework in their command centres. NL felt that due to the aligned director role with Oxfordshire CCG the on call-rota the process also needs to be aligned with Oxfordshire CCG. **Action 149: To agree a single framework across both CCGs with Catherine Mountford.** **Decision: The Executive Committee approved and ratified the above policies pending the updates required to the Major Incident Framework/Incident Response plan and noted the assurance report on the progress of the Emergency Preparedness, Resilience & Response (EPRR) process and assurance on compliance which will be submitted to Governing Body on the 12th September 2019.**
7.	**HR Policies for Approval**	The Executive Committee are asked to: • **RATIFY** the policies above based on the assurance that they have been reviewed and are recommended by the Staff Partnership Forum. Following ratification, the new policies will be issued to all staff. a. Procedure for Nuisance Calls b. Disciplinary Policy & User Guide c. Mobile Devices – RC highlighted a reference to DPA 98 which needs to be changed to DPA 2018. **Decision: The Executive Committee approved the above policies with the small amendment required to the Mobile Devices Policy.**
8.	**Bucks Flu Outbreak Plan**	The Executive Committee are asked to: • **NOTE** the proposed contingency plan and next steps in place for the provision of antiviral prophylaxis to care home residents and staff in the event of an influenza outbreak. RC advised that the paper provided assurance that the CCG has a flu plan in place for antiviral prophylaxis for care home residents which is an NHSE requirement DS advised that she had not yet seen the full version of the plan. The decision on investment will be delegated to the CFO. DS agreed to liaise with GH and Sue Barber, Infection Prevention & Control Lead Nurse to review the full plan. RB asked what process does this go through within the system before it is agreed? RM replied it is usually done by the Infection Control Nurse and the Quality Team working with the Clinical Director – Urgent Care. The plan is then signed off by the Senior Management team before coming to the Executive Committee for ratification. **Action: DS to follow-up on governance processes with the quality team and infection control nurse.**

		Decision: The Executive Committee noted the flu contingency plan and agreed to passing delegated authority to the CFO to make a final decision on investment.
9.	**Finance Report (Month 4)**	KH present the M4 financial report and highlighted the following areas: CCG performance against our key financial indicators in M4 is green for outturn and year-to-date Running costs – we will be within our forecast running costs at year end Creditor/Better payment practice fund – our target is 95% and we 100% on target The QIPP position remains constant Risks and opportunities – deteriorated due to national pressures around category M and also the BCF increase. M4 there is a £24k favourable position year-to-date, however there are still pressures across the acute spend. £1m cost pressure around Milton Keynes and the independent sector – Across Mk issues relate to critical care activity, emergency hip surgery, increase in stroke and pressure on excess bed days. **Action: RD to support review of the Milton Keynes contract with support from the contracting team.** Independent sector pressure relates to T&O activity – action is being taken to triangulate this across acute sector so we can understand what is happening with referrals. Frimley – we were underspent against the contract – we are seeing a reduction in the level of underspend but pressures are coming forward on electives and we are working with the trust to understand why this is happening. We have agreed with Frimley that we will have a dedicated Bucks meeting to discuss Bucks element of the Frimley contract. We will keep an eye on the impact of Chartridge ward closure and how this impacts out of county. Currently we are holding our own in acute. Mental Health there is a small overspend relating to joint funded patients and one specific high cost patient. Small overspend in Community which relates to continence and equipment CHC – there is a £500k overspend. There is a risk activity will keep growing over activity levels. This will be escalated to the CHC Programme Board via the Deputy AO and CFO. Underspend in prescribing as a result of a prior year benefit. QIPP mitigations include: Running costs underspend. £2.5m of contingency to offset amount put to BHT. £3.2m in PSF/CSF - £1m came to the CCG and £2.2m went to the Trust and

		was received in M4. BHT income guarantee contract – activity position for BHT was circulated and at M4 there is £3.3m of uncoded activity which makes it difficult to understand the impact of that activity and as well impacts of local prices which haven't been agreed for 19/20. Significant amount relates to change in pathway on PDU. Agreed at FIG pack reporting Risks Holding risks over 1st quarter of £34m – increased to £36m due to Cat M and BCF risk which was planned for 1.79% but has come in at 5.7%. Continued pressures: 900 total estimated effect of category M over the year. SR advised that there has been slippage in mental health crisis pathway – agreed through CCG to invest in IAT. Non elective areas of pressure – DS advised that Frimley are doing a telephone advice line for paediatrics (during office hours) and his has reduced non-elective attendance at A&E. JS replied that this has been explored around the development of children's hubs etc. DS reported that that there is evidence that the live virtual clinic letter sent out to parents outlining the result provides immediate confidence. DS agreed to link with Nicola Newstone. RD agreed to support reviewing the Milton Keynes contract with support from the contracting team. RB said we also need to think about how we link the networks into these areas.
10.	**Q&P (July 2019) with August exceptions**	FB presented the following highlights for August: Cancer improvements in the number of 62 day screening remains an issue. Planned care team addressing issues that arose for four specific patients. RTT is constant for May across all providers Frimley looking to do an RTT initiative and this could be a cost pressure to us – this will discussed at the Frimley meeting next week. GP referrals continue to decrease, identified increasing number of referrals to dermatology from Healthy Balance to Hillingdon – increasing activity over plan within London. FB went on to say that we have seen an increase in allergy referrals to Hillingdon – need to understand how we stem the flow to Hillingdon. DS said our dermatology service is not able to provide referrals for allergy and this is why there is a backflow to Hillingdon. ShL suggested looking at the service across the system. FB reported that Royal Berkshire have advised their service will re-start in September. **Action 150: DS queried consultant connect and agreed to pick up with RT.** Diagnostics – we are maintaining local trajectory with an improvement seen since May Dementia rate - July rate was 64.8% against a target of 66% The service specification for dementia pathway has been rejected by BHT – we need to go back to find out what issue is with quality side. Until the service

		specification is agreed and included in the CVO we are not going to get any progress with BHT to improve the rate. **Action 151: FB to liaise with SR to progress the service specification.** SCAS achieved 3 of 6 standards – this is an improvement since May. Significant decrease in DeTOCS at BHT and OUH but increases at Frimley and MK Issue with management of discharge for spinal cord injury patients – needs earlier identification in the pathway to ensure their support after discharge is ready at the point they are medically fit. DS said the change for BHT is nothing as the change is where the bill is received. **Action 152: DS to follow this up with BO.** RD asked what the system and process is for a quality dashboard for PCNs? RM replied this is still a work in progress and under discussion at the Partnership Board.
11.	**Q1 Workforce report**	The quarterly workforce report was presented to the Executive Committee for assurance. It summarised key workforce information, benchmarked where possible against information for other CCGs. A request made by Executive Committee to revise the benchmarking information is still under consideration and was not able to be accommodated in time for this report. There were no questions on the report. **Outcome: The Workforce Report was noted by the Committee.**
12.	**Approved Minutes**	There were no minutes circulated for approval this month.
13.	**AOB**	NL advised the Committee that Dr Peter Newman has resigned from his post as Clinical Director in order to pursue other avenues and he was thanked for his past contribution to the Committee. It was noted that this was NL's final Executive Committee as she leaves the CCG on 12th September. RB expressed the Committee's thanks for her valuable and dedicated contribution over the last few years and wished her well for the future.

NHS
Buckinghamshire
Clinical Commissioning Group

Executive Committee Meeting
Minutes

Thursday 26th September 2019 – 13:00 – 16:30
Chair: - Robert Majilton, Deputy Chief Officer

Executive Committee Voting Members:

Louise Patten	LP	Chief Officer	Apologies Received
Robert Majilton	RM	Deputy Chief Officer (Chair)	**Present**
Gary Heneage	GH	Chief Finance Officer	**Present**
Dr Karen West	KW	Clinical Director - Integration	**Present**
Dr Malcolm Jones	MJ	Clinical Director – South	Apologies Received
Dr Juliet Sutton	JS	Clinical Director – Children's	**Present**
Dr Rashmi Sawhney	RS	Clinical Director - Wycombe	**Present**
Dr Dal Sahota	DS	Clinical Director – Urgent Care	**Present**
Dr Sian Roberts	SR	Clinical Director - Mental Health & Learning Disabilities	**Present**
Other Attendees			
Dr Rodger Dickson	RD	Clinical Director	Apologies Received
Dr Shona Lockie	ShL	Clinical Director - Medicines Management	**Present**
Dr Peter Newman	PN	Clinical Director	Apologies Received
Dr Raj Bajwa	RB	Clinical Chair	Apologies Received
Dr Raj Thakkar	RT	Clinical Director – Planned Care	Apologies Received
Dr Stuart Logan	SL	Clinical Director – LTC	**Present**
Russell Carpenter	RC	Board Secretary / Head of Governance	**Present**
Dr Rebecca Mallard Smith	RMS	Clinical Director – Unplanned Community Care	**Present**
Jane Butterworth	JB	Associate Director Medicines Management	**Present**
David Williams	DW	Associate Director Quality and Safeguarding	**Present** *(Item 3 only)*
Frances Burdock	FB	Associate Director Contracts and Performance	**Present** *(Item 10 only)*
Robin Woolfson	RW	Secondary Care	**Present** *(Item 3 only)*
Steve Goldensmith	SG	Head of LTC & Prevention	**Present** *(Item 3 only)*
Minute Taker			
Gemma Richardson	GR	Corporate Governance Manager	**Present**
Sarah Edwards	SE	EA to Chief Officer & Deputy Chief Officer	Apologies Received

No	Agenda Item	Discussion
1.	**Welcome & Apologies**	Louise Patten, Sarah Edwards, Malcolm Jones, Raj Bajwa, Rodger Dickson
2.	**Declarations of Interest**	The Chair reminded committee members of their obligation to declare any interest they may have on any issues arising at committee meetings which might conflict with the business of Buckinghamshire CCG, the standing declarations were as noted in the Declarations of interest register. https://www.buckinghamshireccg.nhs.uk/public/about-us/how-we-make-decisions/registers-of-interests/

		There were no additional declarations of interest at today's meeting other than as noted within the meeting papers. **Quorum** Accountable Officer or Deputy AO or Chief Finance Officer ✓ Two other Management Directors ✓ Four Clinical Directors ✓
3.	**Long Term Plan 5 Year Strategy- Buckinghamshire, Oxfordshire & Berkshire West (BOB ICS) submission**	The Chair gave an overview of the status of the Buckinghamshire, Oxfordshire and Berkshire West (BOB) Long Term Plan. Outline of Key Deadlines: • The CCG requested discussion and feedback on the public facing LTP document, from Clinical colleagues at today's meeting. • The first draft 'technical submission' of the Long Term Plan will be submitted on the 27th September to NHSE/I. • Peer Review with NHS England/Improvement will take place within the 2nd week of October. • Executive Summary for all staff-18th October for feedback in terms of the public facing document. • Health & Wellbeing Board briefing session in Buckinghamshire on 16th October • Further opportunity to comment at the Executive Committee on the 24th October. • Final submission of the BOB ICS Long Term Plan is on the 1st November 2019 **<u>Discussion and Questions</u>** There was challenge as to why the Committee had not had sight of the document for comment and input, prior to its submission tomorrow. The Chair advised this was because it was not yet ready. The Committee commented that, overall the document seemed vague on detail. <u>Section 2- Vision and Aims</u> It was felt that this section needed to be bolder, with stronger statements to encompass the following; • Address how resources will be distributed (e.g. Emergency Inpatient care, Chronic Disease management, Care in the Community). • should state the LTC will 'resource and support' these services as the public are concerned about the issues that are relevant to them. • difficulties for Access in secondary care should also be addressed with more being offered out to the Community. • what Primary and Community investment would there be and link to where individuals may take ownership of their own health. • Most interaction with the health service is not with A&E-change focus away from the acute. • Not enough stated in the document about educating younger people and patients in how to manage health- this is missing from the vision. • This document should be focused more around how people use services and having 'conversations' with the public rather than consultations. Expectations from the public differ from what a consultation might derive. • Matching funding to new pathways needs to be stipulated *DW left the meeting* In response to queries regarding the purpose of the document, the Chair clarified that the document was re-introducing and re-branding BOB as an ICS to the public. The Committee raised concern over our members not being made aware that this is being socialised to the public. The Chair will address this in the AO' update to the Executive.

Section 3- About Us: Does not include Herts Partnership NHSFT. The Chair advised not all of the provider would be listed and also they are not formally recognised as part of the BOB control total, but this should be clarified within the document.

Section 5- Challenges: Query as to how the listed challenges had been derived, and as to whether clinicians in BOB had been involved.

- Deprivation needs to be noted as the biggest challenge that the system needs to address.
- A change to wording- 'in our most deprived areas, the population are more likely to be homeless, have long term conditions' etc. It was felt the current wording gave an exaggerated image.
- Page 10**:** The Committee felt the wording regarding Services Struggling to meet demand, suggested that GP's were not working hard. The section does not state that Primary Care is struggling due to resources and recruitment.
- "Finances" should be included in the Challenges and wording should state that "Limited financial resources mean BOB are having to make difficult decisions. The current way services are organised make it difficult to meet demand."

Section 6- How we work together

- The geographical ranges noted for Primary Care Networks are incorrect for BOB.
- Statements/expectations at bottom of page 11, but the rest of the document does not state how we are addressing and actioning the expectations.

Section 7- How care is planned for and delivered

- Digital should be noted as key, under Care.
- 3rd bullet point should state: "Better access to the care that is *offered*, from the Multidisciplinary Team within your PCN, for example from…"
- Transport is not mentioned in document and this is one of the failings in the system for patients.

Section 9- Our Priorities

- The priority areas do not match against the Challenges noted previously.

Section 10- Developing our five year plan

- Self-care is not highlighted strongly enough.
- Repeated bullet points from the 1st page.

Section 11- How are decisions made?

The Chair clarified our internal governance regarding our own decision making process for sign-off. Processes have not been mandated by the ICS for the CCGs, as this is for each to manage. Bucks CCG delegations for sign-off have been agreed through the Governing Body to the Executive Committee in September and October meetings. SR advised the PPG would need to engage as this is already a published document.
The Chair reported that these comments are to be fed into the final version of the LTP.

Long Term Plan: work stream/slide feedback

1. There is no separate description for Children's, Medicines and health inequalities

2. Some of the deliverables are National – many slides do not make a distinction between national and local initiatives/deliverables

3. It was difficult to triangulate these work streams with the other document reviewed and discussed (Improving health and care in Buckinghamshire, Oxfordshire and Berkshire West) as there appeared no direct relationship

		between the two. 4. There were no specific timelines for feedback – it was assumed that this forms part of the overall Long Term Plan submission timescales. 5. It was unclear how these work streams had been selected – it was assumed that they had some link to specific requirements within the overarching Long Term Plan. **ACTION:** Executive Committee agreed, as a follow up action, each of the CCG leads for the LTP work stream areas would, by **Friday 4 October**, provide their separate feedback on each work stream (to the Head of Governance) for the benefit of the ICS team as authors of the LTP submission.
4.	**Review & Approval of Minutes & Action log updates**	Minutes of the meeting held on 22nd August 2019 were approved as an accurate record of the meeting**,** subject to the inclusion of actions not captured regarding; • **Item 9- Finance report Month 4:** ***RD to support review of the Milton Keynes contract with support from the contracting team.*** GR to contact RD for update on progress for next (October) meeting. • **Item 8- Bucks Flu Outbreak plan:** ***DS to follow-up on governance processes with the quality team and infection control nurse.*** DS reported that follow-up with the teams has been actioned since the August meeting and assured the Committee that proper governance processes had been followed. **<u>Action Log-update on actions:</u>** • EC136: London Activity Cardiology- Update from LP required: action *Remains Open* • EC138: Supporting the Long Term Plan: *Remains Open* • EC143: Finance: *Remains Open* • EC147: Unitary Update: *Close* • EC148: Gluten Free Consultation Case- update from JB required: action *Remain Open* • EC149: Major Incident Framework- *Closed* • EC150: Q&P- Consultant Connect issues with RT- *Close* • **NEW ACTION: Consultant Connect- GH to liaise with BHT directly.** • EC151:Q&P- Discharge for spinal cord patients- *Open*
5.	**Corporate Risk Register (quarterly)**	**A) <u>Report September 2019</u>** The Executive Committee is asked to **Review**, **Confirm Corporate Risk Scores** and **Escalate** risks within the Corporate Risk Register report (to the GBAF where 15 and above). • **Request** any additional controls, assurances and actions to mitigate gaps in control and gaps in assurances as it deems necessary. • **Agree** moderated Corporate Risk Scores for those 'new' risks presented. As detailed within the report, RC advised as at 11 September 2019 there are 14 risks on the Corporate Risk Register, broken down as: • 12 existing risks at or above the escalation threshold of 12 for corporate risk score. • Of these, 5 risks score at 16, which if they remain the same will escalate to the Governing Body Assurance Framework (GBAF). • **LAC Health assessments**- JS advised recent and significant improvements have been made however the risk score should remain the same, for monitoring. There have previously been issues with improvement sustainability and continued working. • **Bucks TCP Cost Pressures**; Risk to remain as scored. • **Increased Non-Elective short stay activity;** Risk to remain as scored.

		• **MSK contract status; ACTION** to obtain Clinical Chair's update following meeting with MSK. **RT to advise** on the appropriateness of the corporate score remaining at 16 for Governing Body escalation. • **Section 117 Placement demand and additional cost pressure**; Agreed to close. • **Medicines management AQP & Warfarin;** Reduce corporate score to 8. Anti-coagulation team to review and advise if any new risks require escalation. DS risk query: DVT is currently provided by UTC outside of any governance or contract. Previously there was an SLA between BHT and Care UK to provide additional care for patients presenting with DVT. Since the formation of the UTC the provision has continued but with no contract to hold them to account to deliver the service and provide quality assurances. Patients are not receiving equitable care. DS requested support through the Exec to follow this up. **ACTION: Executive Committee advised DS to liaise with Frances and GH on contractual elements and quality to determine if this is a risk to be added to the register.** **New Risks at or above Escalation threshold: for Moderation** • **Medicines Management-over the counter medications;** The Executive Committee agreed the corporate risk score should be moderated at 12. **ACTION: New separate risk to be added to the register regarding Category M drugs**- **SL and JB to scope.** • **ICP framework for large scale changes:** The Executive Committee agreed the corporate risk score should be moderated at 12. **ACTION: RM to update and report on risk at the October Executive Committee.** • **EU Exit**: The Chair drew attention to the risk. Risk score to remain at 12. **B) <u>Integrated Commissioning Risk register escalations- August 2019</u>** The Executive Committee is asked to **NOTE** risk escalations for integrated commissioning. • The report was **noted.**
6.	**Accountable Officer's Report**	The Chair presented a brief from the Clinical Chair and highlighted the following updates; There is now a **BOB ICS Merger Oversight Group**, chaired by David Clayton-Smith the ICS independent Chair. Membership of the group includes the 3 CCG Clinical Chairs across BOB, the CCG Accountable officers and Fiona Wise as the ICS Executive Lead, CCG Lay member representatives and local Government representatives. The group is responsible for ensuring there is appropriate oversight and assurance to the Governing Bodies of the CCG and NHSE/I regarding a single accountable officer and the supporting management structure and any future possible CCG configuration. The Oversight Group have already convened and will meet again on the 2nd October. The group have discussed the next steps in the relevant future commissioner arrangements and have agreed a set of **Principles and Actions** (**ACTION; circulate to Committee**). There will be a period of engagement with CCG member practices, staff and range of stakeholders, for their opinions on a proposal that there be one strategically focused CCG by April 2021. The engagement exercise will be undertaken prior to, and will help to inform any Case for Change document. The engagement is proposed to commence on the 8th October for a period of 8 weeks. The CCG clinical chair has requested that this be postponed until after the Bucks PLT session on 15th October, for a softer launch to Member practices.

		An engagement document will be published and will set out the benefits, reasons for change and set them within the wider context of the BOB ambitions for health and wellbeing. The document will address potential concerns for members and stakeholders. Feedback will be considered by the Member Oversight Group, expected in December. And will be brought to the CCG Governing Body for a member vote in accordance with the CCG constitution. The engagement document is owned by the Merger Oversight Group. It is likely that Member Practices would vote in July 2020, with any applications for merger submitted via the NHSE process by September 2020. **<u>Comments from the Committee</u>** • The Committee supported the soft launch proposal for the 15th October. • There was challenge as to the title of the Merger Oversight Group, already suggesting the merger is happening before process is followed, and this is unsettling to staff. • The Committee felt that, as the engagement work regards a CCG merger and one Accountable Officer, the CCG Membership should first feedback on the engagement piece before it goes out to stakeholders. • Clarity as to exactly *what* the Membership is to be asked to vote for is essential.
7.	**Development of Integrated Commissioning in Bucks**	The CCG Executive are asked to: •**Note** the progression of health and social care integration in Bucks to date •**Note** the addition of the Clinical Director of Mental Health and Chief Finance Officer to the membership of the Integrated Commissioning Executive Team (ICET) •**Agree** the proposal to further develop the role and scope of place-based integrated commissioning in Buckinghamshire. •**Agree** that the detailed implementation proposals for the enhanced service are overseen by the Health and Wellbeing Board and reported through to the Integrated Care Partnership. •**Noting** that approval of the integrated commissioning arrangements will be via the Council and CCG Governing Body. •**Note** the timetable set out in the paper. **Decision: The Executive Committee AGREED the proposals summarised in the paper.**
8.	**Common governance for commissioning priority statements**	The CCG Executive Committee is asked to to endorse proposed direction of travel towards common governance across BOB for commissioning priority statements. JB presented the *DRAFT Outline for Direction of travel towards BOB ICS common agreement of Clinical Commissioning Statements* which has been developed by all members of the ICS. The proposal explores how we could have consistent approvals and decision making across BOB at ICS level. The proposal recognises the need to ensure there is adequate delegation of authority by each CCG Governing Body, to the appropriate committee (e.g. TVPC Priorities Committee or other Committees in common. Keeping to the same timetable across the CCG's would save time and resource in the decision and consultations process as it would be done at the same time. There could be potential implications for one part of the system which may be greater than another, for delivery of a pathway – appropriate limitations, caviats and scope would need to be agreed in order to mitigate this. The committee felt that the proposal had merit and was in the right direction of travel, but

		recognised that local clinical input would need to be earlier in the process, with the correct clinicians being able to feed in to policy development. **ACTION: GH, JB & RC to establish some of the governance and parameters that would need be accounted for when delegating financial authority.** **DECISION: the Executive committee SUPPORTED the initial proposal for further exploration of the process.** JB reported that the ICP Clinical and Care Forum would not be meeting until early December, and is likely to be held as a quarterly meeting. The next set of TVPC policies would be submitted to the October Executive Committee. **DECISION:** In absence of CCF meeting between longer periods, TVPC policies will be sent to the CCF Chair to decide the appropriate review and approval route based on the content of the policy.
9.	**Finance Report (Month 5)**	GH provided an overview of Month 5 and summarised the M5 Forecast presentation: • The Forecast presentation was noted at Finance Committee in September, with recommendation's to continue to report on M6. • Continue to report net risk position of £5m • Refresh FOT at M9 (depending on whether risk materialises) • Anticipating CSF of £2.5m in M6 Position statement: • At M5 - in year position is a £24k favourable variance and forecast £2k favourable variance. • Pressures (already in the position) of £8,626k have been fully mitigated. • Gross risks of £8.0m identified covering acute and CHC activity which have been mitigated by £3m leaving a net risk position of £5m (the net risk is consistent with risk at planning stage) • Mitigations of £8.6m already built into FOT. Net of contingency, the over-performance is £4.9m Risks: • M5 risks have been reviewed and re categorised. • Risk to Frimley position of £3.0m (this can be fully mitigated). • Potential for Cat M to be nationally funded. • Still net risk position of £5m. **GH advised the risks will be re-assessed during Qtr3 for a reforecast ahead of M9.** Regarding Transformation, GH advised there is money left over from the 2018/19 financial year. CCG is in the process of pulling together business cases which are proposed to go through the Directors of Finance Group on 4th October for scrutiny, before submission to the Partnership Board.
10.	**Quality & Performance (August 2019) with Sept Verbal exceptions**	FB joined the meeting to provide verbal update to the September Quality and Performance report. No questions were raised from the August report circulated with the papers. **<u>September highlights</u>** • RTT- 18 weeks shows a small deterioration in July performance. • Maintaining 0-52 week waits at all Providers. • Diagnostics shows improvement. The local and National trajectory were met. There is need to determine if the level of Waits is sustainable. As reported this week, BHT are continue to report 49 patients waiting in Colonoscopy and Gastroscopy. Need to establish with BHT if this is additional capacity that has been found, or if this will

		report back to long waits. • Diagnostics is impacting on Cancer waits; 32 62 Day GP Urgent Referral breaches were reported, across a range of specialities (Gynae, Breast, Urology, Dermatology, Haematology and Lung). FB advised, there needs to be an understanding of the impact of Diagnostics, capacity and demand on all areas- as this is a significant area of risk. KW advised the Quality team are liaising with the TVPC planning to look at a pathway approach. They are trying to do drop-in assessments of service over the next few months. • FB reported the 62 day screening target was achieved. Sustainability needs to be established. • Urgent Care- August reported deterioration as 5 of the 6 targets for SCAS failed. DS advised that the Chiltern end were underperforming, and will forward the breakdown to FB. • A&E Performance reported; deterioration at BHT (83.4% in August). Milton Keynes continues to underperform (92.7%) and OUH at (84.1%). DS advised there are schemes in place that may begin to show a difference in time. FB will be completing an Analysis of attendances by time and by practice. The Milton Keynes contract is significantly over performing. A deep dive analysis is expected from the CSU, who have advised this is case-mix driven as opposed to numbers of activity. The CCG commissioned a lower rate of growth (23k less) the pressure being seen is far greater than the growth. This has been challenged and re-assigned to Spec Com. RM informed FB of a prior Action for RD to work with FB, RD will pick up. **ACTION: Formal report for the next Executive Committee to show movement in Milton Keynes and Stoke Mandeville.**
11.	**Better Care Fund Plan 19/20**	September report submitted to **For Information.** Report was **Noted** by the Committee.
12.	**Approved Minutes**	There were no minutes for approval.

Finance Committee Meeting – Minutes

Wednesday 25th September 2019, 08.45 – 09.45am
Bevan Meeting Room, Buckinghamshire CCG Offices, Aylesbury, HP19 8FF

Present:

Members

Tony Dixon	TD	Lay Member and Finance Committee Chair (Chair)
Robert Parkes,	RP	Lay Member and Audit Committee Chair
Lou Patten	LP	Chief Executive Officer
Gary Heneage	GH	Chief Finance Officer
Kate Holmes	KH	Deputy Chief Finance Officer
Alan Cadman	AC	Deputy Chief Finance Officer
Robert Majilton	RM	Deputy Accountable Officer

In attendance

Dawn Riddell	DRi	EA to Chief Finance Officer & Director of Transformation (minutes)

1.	**Introduction, Apologies & Quoracy**	
	TD welcomed the committee members to the meeting. Apologies were received from: • Graham Smith, Lay Member • Barry Jenkins, Director of Finance, Buckinghamshire HealthCare Trust • Russell Carpenter, Head of Governance/Board Secretary The meeting was declared quorate.	
2.	**Declarations of Interest**	
	The Chair reminded committee members of their obligation to declare any interest they may have on any issues arising at committee meetings which might conflict with the business of the Buckinghamshire Clinical Commissioning group. No declarations were received. No existing declarations were deemed to have materiality to items on the agenda. All published CCG registers of declarations of conflicts of interest can be found on the Buckinghamshire CCG website: https://www.buckinghamshireccg.nhs.uk/public/about-us/how-we-make-decisions/business-conduct/conflicts-of-interest-policy/ There were no conflicts with materiality to items on the agenda.	
3.	**Review & Approval of Minutes for 28th August 2019**	
	The minutes were approved as an accurate record.	
4.	**Action & Decision Logs**	
	The action log was updated as discussed.	
5.	**M05 Update & Financial Recovery Plan**	
	GH ran through the Financial Recovery plan and M05 update, the Finance Committee are requested to **NOTE** the position and **APPROVE:** • To continue to report on plan for M6	

- To continue to report net risk position of £5m
- To refresh Forecast Out Turn (FOT) at M9 (depending on whether risk materialises)

The main points/discussion were:

- Updated guidance regarding changes to FOT has been received:
  - The CCG can only move their position in the last month of the quarter (M6 or M9)
  - System level (BOB) sign off is required.
  - Requirement for Region approval
  - Requirement for Chair and Audit Committee Chair approval
- Impact of CSF/PSF to be agreed at the Finance Committee in Common on 4th October (although CCG anticipating hitting Qtr2 CSF of £2.5m)

Key assumptions

- The Risk reserve of £2.5m is returned to the CCG in Q3, this will be required to meet our position. Written confirmation from BHT is still required.

TD asked if there was an understanding that the risk reserve would be received back in Q2. GH stated that the agreement has been made to receive back in Q3 (from M7 onwards).

- Transformation monies of £1.8m are fully committed, currently awaiting approval of MOU to draw-down the funds.

Position Statement

- In year position is a £24k favourable variance and slight upside on FOT of £2k.
- There have been pressures equating to £8.6m into Income and Expenditure this year which have been fully mitigated.
- Gross risk of £8m identified with £3m of mitigations identified leaving a net risk of £5m which is consistent with risk at the planning stage.

Pressures

The £8.6m is broken down as:

- Acute pressures of £4,208k relating to Independent Sector, Milton Keynes, Oxford University Health, Luton and Dunstable and London over performance.
- Mental Health of £454k relating to the 50:50 spilt with the local authority.
- Community of £578k relating to continence and equipment overspend.
- Prescribing of £1,614k mainly relating to Cat M drug pressures of £1m.
- CHC of £1,577k relating to in year pressures for package size increases.

Mitigation

The following have been used to mitigate the risks:

- The full contingency of £3.6m.
- £1.8m of transformation funding allocated.
- Upside from the quality premium of £427k.
- Reserves left in position.
- Charge Exempt Overseas visitors – currently not confirmed but expected to be upside when received later on in the year.

TD enquired what £1.8m should have been used for. GH confirmed the money was for

transformation, it has been used mainly to fund the Integrated Care Programme (ICP) Managing Director and associated team (£0.6m), investment into CHC transformation work (£0.5m) and the work undertaken on financial recovery (£0.2m).

RP asked if GH was aware of any impact from Brexit for prescriptions. LP responded that there are management prescriptions at regional and national level, some places are stock piling. The short life shelf life drugs will pose the biggest issue and market demand is likely to increase the cost of these drugs. Due to this there is a potential for NCSO drugs to increase.

Year To Date (YTD) Extrapolation

- YTD variance at M5 is adverse by £5.6m which includes the £2.5m risk share with BHT. The net variance in £3.1m.
- The £3.1m is extrapolated for 12 months to £7.5m, the Cat M pressure will hit in the 2nd half of the year and has to be included to give us a figure of £8.4m. The forecast shows £8.6m. This suggests that if the pressures YTD continue at the same level for the remainder of the year then the forecast looks accurate.

Risks

- All risks have been reviewed and re-categorised at M5.
- The biggest risk movement is within Acute over performance, specifically against Frimley of £2-3m for M4 to M5 activity reporting. This looks likely to materialise but there are £3m mitigations identified to cover. If further risks arise such as increased activity over the winter period there will not be any further mitigation to hold the position.
- The most material risks remain as Frimley, CHC in year pressures and activity increase on PBR contracts over the winter period.

Finance Committee **AGREED** to hold the forecast at M6 and continue to report net risks of £5m.

6. Discretionary Spend over £50k for approval and STW where applicable

No items discussed.

7. Long Term Financial Model – Approval for submission

System Recovery Plan

GH talked the Finance Committee through the System Recovery Plan (SRP) slide pack received prior to the meeting, the main points/discussion held were:

- Each organisation was required to pull together a Financial Recovery Plan. A joint System Recovery Plan was also required by our regulators with a 1st draft being produced by 27th September 2019. The document is a working document at a point in time.
- The driver of the deficit work identified a gap across the Buckinghamshire system of £60m which would build year on year if not addressed.
- For 2019/20 the CCG starts the year with a £5m deficit and BHT as a breakeven plan. There was CSF/PSF support amounting to £28m. This provides a control total of £33m (without system support). With the CCG risk (£5m), BHT risk (£23m) and MRET (£4m) added back results in a starting point of £57m deficit (which is broadly in line with the drivers of the deficit work at £60m).
- The plan uses this figure and calculates recurrent projections for the next 4 years.

The year 4 figure has been calculated at £44m deficit which would be the recurrent system efficiencies required to break even.

- Trajectories (control totals) have been received as part of the 5 year Long Term Plan (LTP). Over the 5 year period the control totals for Buckinghamshire ICP are £95m deficit.
- The CCG would be expected to break even in 2023/24.
- The trajectories do not factor in the underlying 2019/20 underlying deficit and risk.
- Based on the first submission of the LTP, the gap to Control total is circa £100m for the Bucks ICP.

TD enquired what the £12m for 2020/21 system unfunded pressures related to. GH confirmed that this was due to the ICT/backlog maintenance at BHT.

Strategic priorities to close gap

There have been 5 strategic priorities identified to close the gap, and GH talked through each of them::

1. Digital transformation – this would require significant capital investment

TD asked what capital would be available as part of the LTP. GH responded that the 20% reduction in in-year capital had been reversed; and money has been allocated to 20 schemes. RM added that there is 5 years revenue but no confirmation of capital funding to date. LP commented that where the savings came from were not shown, if the system becomes more efficient then activity will be enhanced. GH explained that business cases would be reviewed for the strategic priorities to identify what the ROI and savings would be. RM commented that to make savings there would be a need to describe and cost the system requirement within the allocations and how this could be enabled. This would drive the digital, estates, workforce strategies.

2. Strategic Assets - estates
3. Non clinical services – effectively back office
4. Service Optimisation
5. Integrated care pathways

- The final submission of the LTP is due to NHSE/I by 15th November 2019.
- The business cases are hoping to be completed by the end of the financial year, investment is likely to be required to support the business cases. The proposal will be to use funding from the transformation monies.

RM commented that with the triangulation, the need for capital and prioritising resources of staff would become an ICS role. When the plan is submitted the process would need to involve the other 2 systems, are we aware how this would happen.

GH commented that he had spoken with the Buckinghamshire, Oxon and Berkshire Financial Directors and the general consensus was that a SRP would be required at BOB ICS level. There is a need to socialise across groups wider than financial directors once specific numbers are available.

Long Term Plan – Approval for submission

GH provided an update on the Long Term Financial Model, the main points/discussion held were:

- The plan is a point in time.
- Triangulation issues – there are differences in assumptions in activity between the

	CCG and BHT and triangulation was required on income and expenditure with providers. • There is an enormous amount of work required for the next submission. The Finance Committee were asked **APPROVE** the draft Long Term Plan for submission on 27th September 2019. The Finance Committee **APPROVED** this.	
8.	**Any Other Business**	
	No items discussed.	
9.	**Date & Time of Next Meeting** Wednesday 30th October 2019, Bevan Room, BCCG Offices, 09.30am – 11.00am	
10.	**For information** The reports below were noted by the Committee. • Work plan review - rag rated	