NHS
Buckinghamshire
Clinical Commissioning Group

Executive Committee Meeting
Minutes

Thursday 24th October 2019 – 13:00 – 16:40
Chair: Gary Heneage, Chief Finance Officer

Executive Committee Voting Members:

Louise Patten	LP	Chief Officer	Apologies Received
Robert Majilton	RM	Deputy Chief Officer	Apologies Received
Gary Heneage	GH	Chief Finance Officer (Chair)	**Present**
Louise Smith	LS	Director of Primary Care & Transformation (Interim)	**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	Apologies Received
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 Manager	**Present**
Dr Raj Thakkar	RT	Clinical Director – Planned Care	**Present** (to 15.30)
Dr Stuart Logan	SL	Clinical Director – LTC	Apologies Received
Dr Rebecca Mallard Smith	RMS	Clinical Director – Unplanned Community Care	**Present** (from 14.30)
Other Attendees			
Dr Raj Bajwa	RB	Clinical Chair	**Present**
Russell Carpenter	RC	Board Secretary / Head of Governance	**Present**
Jane Butterworth	JB	Associate Director Medicines Management	**Present** *(items*
Frances Burdock	FB	Associate Director Contracts and Performance	**Present** *(Item 10 only)*
Minute Taker			
Sarah Edwards	SE	EA to Chief Officer & Deputy Chief Officer	**Present**

No	Agenda Item	Discussion
1.	**Welcome & Apologies**	Louise Patten, Robert Majilton, Dr Malcolm Jones, Dr Stuart Logan, Dr Dal Sahota
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** |	
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Accountable Officer or Deputy AO or Chief Finance Officer	✓
One other Management Director (if only one of the above present, i.e. 2 out of 4 management directors)	✓
Four Clinical Directors	✓	 Various items identified within items 7, 8 & 9 as described within the papers, but none of the conflicts require clinicians present to leave the room and are able to form part of quorate decisions. ShL raised the issue of where conflicts in relation to workload implications in primary care are raised in relation to member GPs, whereas other members of CCG staff may also have a direct conflict which is not mentioned. RC replied that authors should engage with him at the earliest possible opportunity if there is some perceived ambiguity as to whether conflicts of interest exist as direct or indirect, and to determine their materiality to decisions. RS stated that we should be aware that every person in the room has a conflict whether it is financial, clinical or in relation to workload and we need to keep this in mind.
3.	**Long Term Plan 5 Year Strategy- Buckinghamshire, Oxfordshire & Berkshire West (BOB ICS) submission**	<u>Long Term Plan 5 Year Strategy</u> RC provided a brief summary of the LTP BOB submission and reminded those present that work stream priorities had also been considered at the previous meeting. The paper presented at this meeting collates all feedback received from members and has been returned to the ICS team who have subsequently produced an updated iteration of the document. Committee was reminded that the Accountable Officer and CCG Chair have delegated authority from Governing Body to approve the final technical submission by 1 November. It agreed that the attached papers, provided yesterday but not circulated to the Committee in advance given the time limitations, would be circulated to all members and also to SMT as an action from this afternoon's meeting. Additional feedback/comments are welcome by 09.00 on Wednesday 30th. **Action 160: LTP papers to be circulated to the Committee and SMT – any additional feedback/comments to be submitted to RC/SE by 09.00 on Wednesday 30th October**. LS asked if this paper has also gone to management leads so they can respond if necessary in the absence of clinicians who may be on half term leave. GH confirmed the paper would also be circulated to SMT.
	Draft Commissioning Intentions	The Committee reviewed the revised draft commissioning intentions pack. A page by page review was held and the following comments noted: *Context for System Commissioning Intentions slide* Q. ***Bullet point 3 – "what is a partnership activity" and how wider scope does this have?*** RB stated that Fiona Wise has asked to meet with the three Chairs to discuss this further, as this is a material question due to differences across the three BOB organisations. This question will also be posed to Governing Body. Traditionally there were commissioners and providers and then they co-joined, but to what extent are the roles and responsibilities of

commissioners given up to providers in each area. GH reflected that we are at different stages possibly because our ICPs are also at different stages in development. KW felt most areas within quality have been good, but some areas delegated to providers have been challenging, however areas overseen by the County Council from a commissioning approach have been good. RS suggested it would be worth looking at past intelligence what was done well, what was done badly and learn from those lessons.

RB stated the ICS recognise that any future merger will be determined by the three CCGs through membership voting. The membership was made aware of the potential at a recent Protected Learning Time (PLT) and offered no specific opinion at this stage. The LMC is also engaged in the process, which in time their opinion may colour that of the wider membership. It is important we are close to what our members feel on this and a vote would be in jeopardy if we are not informed.

Out of Hospital Services slide
No comments other than it has previously been suggested that the use of "out of hospital" is not the right term to use and could be replaced with "Community".

LS asked how we support Primary Care Networks to accelerate their development. RB replied one of the Chairs in BOB has had sight of the new Primary Care service specifications and was not happy as they were not what they were expecting. This has been recognised by clinicians advising DoH and the view is that this is going to be contentious.

Planned Care slide
ShL observed that medicines optimisation is under planned care.

Urgent & Emergency Care slide
Needs to steer clear of specific targets but there is something about the crisis response and 2 day re-ablement which are new targets and there are timelines to some of this. Do we want to wait for the National Programme or push some of this out earlier?

If community is working well there is something about BHT working with community to pull out patients. RT commented that a palliative care consultant at Buckinghamshire Healthcare NHS Trust (BHT) is looking to have approved a business case to increase the number of end of life consultants (currently 1.5 across the county). Frailty and end of life needs to be included with the clinicians being community based. GH reported that a funding stream for end of life has come through. LS felt it was important to tie this into work being done around care homes and dementia.

A reference to children is missing from both the Urgent care and Planned care slides. GH commented that the specifications will provide more specific targets for delivery.

Mental Health, Children and Young People (CYP) slide
There is no content about children / young people (CYP) contained in this slide. It should be included somewhere, in the least should be removed from the Mental Health slide and slide renamed as "All Age Mental Health".

		Much is being delivered for children and young people mental health; the slide needs to be more broad spectrum to include Learning Disabilities, improving physical wellbeing and being supported in the community rather than being admitted to hospital. Mental Health standard – our intention is to improve access for all ages to ensure people are seen in the right place at the right time by improving crisis services and access to mental health services – the financial focus is featured rather than clinical quality focus IAPT runs through mental health and needs services behind it, but not sure if this sits in MH? Link to low level psychology support and move it to community. Every Long Term Condition should be signposted to IAPT. The "why" and the "how" are missing what we want to achieve or how we get there is missing as well as the "why we need to do this". RS felt this needs to be highlighted in portfolios, not just added as a broad descriptor. MH is seen as comparator to physical health – clinical phrasing is required. **Action 161: RB asked clinicians to provide any further comments to Robert Majilton ahead of the finalisation of slides.** *Cancer slide* This slide could be strengthened as it is light on detail and aligned with the Long Term Plan. Money from the Cancer Alliance is available to look at inequality incentive scheme. **Action 162: RT agreed to provide additional specifics.** *Universal Personalised Care slide* There were no additional comments other than CYP to run as a thread through all slides. *Enabling system integration.* Not entirely sure we are ready to promote the Local Health & Care Record (LHCRE). RB suggested adding a line on the objective to narrow the local health inequality gap. Last bullet point (slide 2); our basis is to use evidence based interventions and this needs to be added to slide.
4.	**Tackling health inequalities: dry run for GB 14/11/2019**	RS ran through a presentation on Tackling Health Inequalities highlighting that the presentation still needs input from medicines management and maternity. Suggestions for amendments to the slides were: • Title of presentation to be changed to *Addressing Health Inequalities;* • Moving "What are Health Inequalities?" slide to top of the presentation and then re-arranging context slide; • Limiting the use of acronyms as this presentation will go on the public website; • Explain measure of deprivation used and define which quintile is being measured; • Re-arrange PCN & GP Practice slide in order area of deprivation – highest to lowest; • Add how much longer babies born in individual wards are expected to

		live; • Add a death rate chart; • Change the word “richest” in Key Facts for Buckinghamshire slide to “least deprived” . • Add percentages; • Change “higher and lower” to “more and less” • Add illustrative examples • Scale graph up (Gap for 5+ slide) • Equity & equality slide – could consider removing this • LTP slide remove acronym and address typos • Patient stories – fill in the gaps around support; • Presentation to last for 20 minutes with 20 minutes for discussion; • Portfolio health inequalities slides to be amended and tightened up; • Additional pictures to be included and a reduction in text on each slide; • Reduce slide pack to circa 20 slides; • Link to financial sustainability to be included; • Needs to join up with Commissioning Intentions; • Offer Portfolio leads the opportunity to present their own slides. GH commented that this is a good piece of work but needs to reference numbers and where the numbers are from by including a reference and year.
5.	**Review and approval of minutes**	Minutes of the meeting held on 26th September 2019 were approved as an accurate record of the meeting**,** subject to the amendments below: • Page 11 Q&P – bullet point 4 should read: KW advised that the quality team are liaising with TVPC planning to look at a pathway approach. • Page 3, line 5 – typo “wether” change to “whether”. Update on Gluten Free Consultation – feedback to-date has been supportive of the CCGs suggestion to remove gluten free foods on prescription for all apart from a limited group of patients. Update on Actions: Action 136 – remain open – not yet had feedback from LP. RT stated routine cardiology referrals to London continue – this has been discussed at the Elective Care Board and has been discussed with the quality team but not sure where in system it is now. RT will pick this up with EB. SR added patient choice is routinely quoted back for MH referrals. Does patient choice apply to tertiary referrals? More clinical scrutiny is required. Action 138 - action closed. Action 143 – GH updated that there are financial implications on bed days at Frimley – circa 71 days but not yet quantified and needs further work to understand the driver. This is a financial challenge but re-opening beds may not be the solution – action open Action 148: action to be closed as consultation started. **New Action: 163 EIA to be circulated.** Action 150 – Consultant connect agreement ended in Sept. Free extension to April next year. Looking at system requirement going forwards for that service – action closed

		Action 151 – To be updated at next meeting – action open Action 152 – see action 150 – action closed Action 153 – action closed Action 154 – MSK risk on corporate risk register – RT risk isn't as high as currently but risk has reduced following review may go to November Executive COmmittee for moderation if score is 12 or above, then if moderated at 15 and above will go to GB through the GBAF in January. **New Action: 164 RT/RC & NF to talk through by 7th November** Action 155 – Outline risk described but not yet shared – RT to pick up with DS action open Action 156 – RC to circulate draft Action 157 – Change item name on action log to CCG Architecture Group and close action Action 158 – TVPC policies to be clinically review and ratified – decision still to be taken on where this will be done in future whilst meanwhile decisions on policy adoption were routed through the Executive Committee – discussion followed and options around a meaningful forum discussed. GH suggested an analysis would be useful on the number of policies this would likely entail and a comparison with workload over the previous 6-9 months – **Action 165: RB/GH to take this offline to review with support from RC/GR.** Action 159 – on agenda for this meeting – action closed
6.	**Accountable Officer's Report**	The report was taken as read by the Committee and the following areas highlighted: • Daily EU exit escalation and winter reporting is under way. • There was a brief mention in the recent Queen's speech on legislative reform in order to deliver the Long Term Plan.
7.	**Thames Valley Priorities Committee – Recommendations for adoption October 2019**	The CCG Executive Committee was asked to **APPROVE** the policy recommendations listed below. • TVPC23 Trigger Finger CCG Policy adoption Update v1.0 • TVPC94 Restless Leg Syndrome CCG policy adoption v1.0 • TVPC95 Chalazia CCG Policy adoption v1.0 TVPC23 Trigger finger In order to align with NHSE's policy we have had to tweak our policy and some of our criteria has been made looser and some tighter to match national policy. However there will be no significant change in numbers going into service. **Decision: The Executive Committee agreed to adopt the revised policy TVPC23.** TVPC94 Restless Leg syndrome Good policy, but when it gets to point of using dopamine agonist we refer to Buckinghamshire Healthcare NHS Trust. The revised TVPC policy matches what we do already, except that it goes further and recommends that GPs instigate drug treatment. The Formulary Committee will still be required to agree the change in traffic light position. However this should lead to reduction in referrals. Having this clear pathway shouldn't make any difference to patients and will prevent some of the referrals. RT said that hospitals should be pushing patients back to primary care. It was suggested the pathway needs to be re-

		visted. **Decision: The Executive Committee agreed to adopt the revised policy TVPC94.** TVPC95 Chalazia The TVPC policy matches the NHSE policy and as we didn't have an individual policy on this before this puts a specific policy in place – referrals are mapped out in the policy. Add work to these criteria and refuse any patient who doesn't meet criteria. **Decision: The Executive Committee agreed to adopt the revised policy TVPC95.** Workshop due to be held to look at policies over past 12 months. JB reported to date she has only had ideas from ShL and SG which are quite broad. Podiatry and prescribing of insoles suggested for review.
8.	**Hydroxychlorine: MHRA guidance**	The Executive Committee was asked to: • **AGREE** to an additional £40k funding to ensure screening of high risk patients this year. • **APPROVE** a scoping exercise to look at longer term solutions to screening provision in collaboration with Berkshire West and Oxfordshire. JB reported that the £40k spend on this drug falls under delegated authority of the CFO, but the item has been escalated to the Executive Committee given the clinical risks involved in not investing in screening. There is risk around retinopathy baseline screening and ongoing annual screening for some patients. The Local Medical Committee (LMC) wrote to Bucks and Oxfordshire to confirm prescribing guidelines and a holding statement has been sent out. In addition we have spoken to rheumatologists. All new patients who are likely to be on the medication for more than 5 years will have an ophthalmological baseline assessment, and the current cohort who are being treated and are at increased risk of ocular toxicity are being reviewed as they come up for their annual check by the specialist in secondary care There is capacity for referrals for new patients starting on hydroxychloroquine, but existing patients who need screening this year will be an additional piece of work and additional resources will be required to facilitate it. SR asked if the diabetic retinopathy service can be used. ShL replied she didn't think this was the same type of screening. Otherwise there was unanimous support for this investment. Recommendations agreed were to: • Review shared care principles; • Check whether the diabetic retinopathy service can be used to provide the service; • Ensure patients are not being sent to multiple appointments. **Decision: The Executive Committee agreed the additional £40k spend and approved the scoping exercise requested.**

9.	**The future of complex care management**	The Executive Committee was asked to **NOTE** the main benefits of the services which have been: • The impact on A&E activity which whilst still seen to continue to rise is at a statistically significant slower rate to the rest of the CCG; • Impact on GP time with fewer consultations as a consequence of the interventions; • Improvement in general staff satisfaction and resilience in primary care; • Fewer consultations in less acute environments for the patients and a positive effect on satisfaction. Given its direct and material conflict of interest in this matter as a commissioning decision, the CCG Executive Committee is asked to **NOTE** the preferred recommendation (option 2) to map existing services to the PCN DES as already accepted by the paper author but offer any **CLINICAL OPINION** it may have in relation to the recommendation and the evaluation and principles of funding that sit behind it. The recommended option to map the existing provision against the Primary Care Network DES is to address inequality and delivery across the PCNs. However there may be a commissioning gap that arises as a result of the mapping exercise. Depending on what this looks like, what value it has and how we procure it some members may become conflicted. The CCG Executive Committee is also asked to **DELEGATE** to the Interim Director of Primary Care and Transformation and Chief Finance Officer to undertake the required mapping exercise between existing specification and PCN DES. The future of complex care management was previously known as “Over 75s” one of the main findings is about the focus on the co-morbid population. LS provided a high level overview of the paper which set out a description of the service does now and what was originally set out for it to do and gave an overview of the logic model. Comorbidity data will be reviewed in the future where patients have 2-4, 5+ and 7 plus long term conditions. When looking at A&E activity all of these projects demonstrated slower growth in A&E activity than other CCG activity. When looking at the variation in the data, Poplar Grove has a compliment within their team which enables them to look after right category of patient. Whereas the Weston Grove model doesn’t show such a marked change. ShL asked if variable A&E attendances were noticed because different practices were using their teams in different ways LS replied yes, but if we were to do some more analysis we may get a different view. The Committee discussed the recommendations and findings and the following comments/questions were raised: Q: Is the anticipatory care DES going to be funded. A: This is not confirmed as yet but it is anticipated that funding is not going to be available. Q: Where is new money going to come from to fund the services? A: It is not definitely coming but services are already in place provide elements of the anticipatory care DES. If funding does come through nationally then all practices would get the same funding but current funding would be removed.

		But if no funding comes through nationally the current pot of money will require topping up and will need to be looked at. Q: Paper needs to be made clearer as it pays be very little attention towards getting equity. A: Timescales cannot be attached until the roadmap comes out. Q: Paper should come back once we know what the anticipatory care DES contains? A. This won't be known until February 2020. RMS said that if the anticipatory care DES comes up with additional funding then the model can be evolved and rolled out to everyone and rolled back funding could be used to support PCNs who haven't started this service. If there is no money then this becomes a material discussion. Q: Option 2 needs to be made clearer; we can transform how we look after budget and money but needs imagination to show how we make this happen. A: Numbers have not yet been seen, but we need to ensure equal access to these services across Buckinghamshire as currently service is inequitable. The paper needs to show what the plan is if funding available through anticipatory care DES i.e. "These are options" and if no funding available then "these are the options". RC said assuming there is no funding then any commissioning decision will be taken by us taking into account any conflicts of interest – signal to Primary Care Commissioning Committee for decision in March 2020, with necessity for warm up in December 2019 so there is an understanding of the decision likely required. Q: There is no timescale included about when we hope to achieve equity A: The 1st April is when implementation would happen but this will a proper timescale developing. **Decision: The Executive Committee agreed that delegated authority to do mapping is with LS/GH but needs to takes account of the "ifs and when scenarios" on whether the anticipatory DES comes with funding. The commissioning decision on the future of the service will be taken to the March Primary Care Commissioning Committee for a decision on future funding.** Over 75s funding will continue for the remainder of this financial year recognising that there will be a challenge when informing the individuals concerned whether their contracts will be extended. An interim arrangement may need to be put in place for first quarter of 20/21. **Action 166: LS/GH/RM to look at this offline**. RC suggested taking this issue to PCCC in December to provide them with information in advance of the March PCCC decision. **Action 167: An update to come to the December Committee meeting to feedback from the LMC meeting due to take place on 22nd November.**
10.	**CAMHS & Transformation**	a. Contract Extension JW summarised the paper. The CAMHS contract is currently valued at £7.1m, 77% of this is funded by the CCG remainder comes from the Local Authority The contract started in October 2015 and finishes in October 2020. An allowable extension has been through Local Authority governance routes and recommended by the Integrated Commissioning Executive Team (ICET). JS and SR confirmed they had been cited on the contract and neither felt that it

		wasn't a good idea, and it would be sensible to extend at this point due to the new Unitary Council due to be established from April 2020. RC noted that, had this been a new contract award, it would have been escalated to Governing Body for decision. Rather it is to be extended under delegated authority to the CCG Executive Committee. **Decision: The Executive Committee approved the two year contract extension to October 2022. In 12 months' time there will be a need to review it again for the future and may need to be recommissioned.** b. Local Transformation Plan (presented for information) This is a Nationally mandated document that requires a yearly refresh. The document had a large refresh (re-write last year) and feedback was positive. All data has been updated, new priorities included, including a "you said we did approach", improved areas included around needs analysis as this was highlighted as lacking last year. BOB ICP and LTP are also included. Elements also added around under-represented groups which will be the focus. Positive feedback has been received from NHSE. The document will be published on 31st October. We have taken on board outcomes of previous NSPCC reports and ensured we have appropriately targeted the plan to address their findings. JS commented that this was a good piece of work c. All Age Mental Health (presented for information) Three separate strategy documents around mental health and the local transformation plan have all consolidated into one document. Workshops and conferences were held with carers and staff. The document has been through ICET and is due to go for cabinet member decision in December. Comments around prevention and suicide prevention to be incorporated by Public Health.
11.	**Finance Report (Month 6)**	Month 6 position reported on plan at end of M6 and we have hit our CSF target. A Net risk of £5m remains relating to CHC, Acute pressures and Category M/NCSO drugs. During Q3 (M8) will need to do a detailed forecast (and will have a better idea if we can hold the position). Finance Committee in common met on 4th October and confirmed position in relation to PSF/CSF.
12.	**Transformation Funds: Commitments 18/19 and 19/20**	The Executive Committee was asked to: **(a) NOTE** the update provided on 18/19 spending of transformation funds **(b) NOTE** proposed commitments for 19/20 GH stated the paper clearly documents use of transformation funds with Committee members asked to raise any additional questions directly with GH. There is a balance of £1.377m remaining from 2018/19; the only business case we have received so far is on respiratory and opthomology. We are awaiting a business case relating to OD. The balance of 2018/19 funding will be retained for funding of future business cases. RC added that a similar paper will report to Governing Body on 14 November ShL reported that BCCG is 9th in the country for the lowest spend on by demographics for prescribing and we should be proud of this. .
13.	**Milton Keynes University Hospital: quality & performance assurance report**	RD reported on overspending on acute activity at Milton Keynes University Hospital, which breaks down as 3.1% through A&E and 11% for non-electives. A lot of this is out of hours and we don't have any BHT data to compare. There has been a drift over last 15 years of patients going to MK but there should be a corresponding change at BHT.

		Non electives compared favourably to other PCNs. One issue with the Out of Hours provider with FedBucks and it had been noticed that Buckingham Out of Hours clinic was not being manned however this has was re-started but has gone back to being unmanned. The issue has now been escalated to Nicola Newstone who is due to meet with FedBucks. LS suggested highlighting this to provider collaborative in general. **Action 168: RD to raise this with Medicas PCN director.**
14.	**Quality & Performance (September 2019) with October verbal exceptions**	FB joined the meeting and gave the following highlights: • 31 day cancer breaches (skin and breast) mainly due to capacity and medical staff resources, A new clinician started in September. • 62 day screening tertiary delays for diagnostics. Concern as we were losing sight of them. • Increase awareness around nationally increased volumes of referrals, capacity available in all areas remains constant. • DTOCs – monitoring bed days but there is still a concern that whilst this has improved we need to extend monitoring to compare with our peers and to be able to see the wider picture. • Issue with Frimley DTOCs where they have opened up another ward to hold patients. Frimley have formally requested a timeline for the re-opening of Chartridge from BHT. Further work is required to review the flow of patients. • Quality premium for Q4 in Q2 performance hasn't improved – report to include a comparison for 18/19.
15.	**Policy compliance assessment/dash board**	Provided for assurance – there were no comments or questions.
16.	**Approved minutes (for information)**	The minutes enclosed with the papers were noted by the Committee.
17.	**Buckinghamshire ICP Winter Plan (for information)**	The Buckinghamshire ICP Winter Plan was noted by the Committee.
18.	**NHS Buckinghamshire CCG Financial Trajectories Letter (for information)**	The CCG Financial Trajectories Letter was noted by the Committee.

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Minutes

Thursday 28th November 2019 – 13:00 – 16:00
Chair: Robert Majilton, Deputy Chief Officer

Executive Committee Voting Members:

Louise Patten	LP	Accountable Officer	Apologies Received
Robert Majilton	RM	Deputy Accountable Officer (Chair)	**Present**
Gary Heneage	GH	Chief Finance Officer	**Present**
Louise Smith	LS	Director of Primary Care & Transformation (Interim)	**Present**
Dr Karen West	KW	Clinical Director – Quality and Integration	**Present**
Dr Juliet Sutton	JS	Clinical Director – Children's	**Present**
Dr Rashmi Sawhney	RS	Clinical Director - Wycombe	Apologies Received
Dr Dal Sahota	DS	Clinical Director – Urgent Care	Apologies Received
Dr Sian Roberts	SR	Clinical Director - Mental Health & Learning Disabilities	**Present**
Dr Rodger Dickson	RD	Clinical Director	Apologies Received
Dr Shona Lockie	ShL	Clinical Director – Medicines Manager	**Present** (until 3.30)
Dr Raj Thakkar	RT	Clinical Director – Planned Care	Apologies Received
Dr Stuart Logan	SL	Clinical Director – LTC	Apologies Received
Other Attendees			
Dr Raj Bajwa	RB	Clinical Chair	Apologies Received
Russell Carpenter	RC	Board Secretary / Head of Governance	**Present**
Dr Rebecca Mallard Smith	RMS	Clinical Director – Unplanned Community Care	Apologies Received
Jane Butterworth	JB	Associate Director Medicines Management	**Present** *(items 8 & 9 only)*
Frances Burdock	FB	Associate Director Contracts and Performance	**Present** *(Item 11 only)*
Ian Cave	IC	Head of Community Models of Care	**Present (***Item 7 only)*
Minute Taker			
Sarah Edwards	SE	EA to Chief Officer & Deputy Chief Officer	**Present**

No	Agenda Item	Discussion
1.	**Welcome & Apologies**	Apologies as indicated above. **Quorum** Accountable Officer or Deputy AO or Chief Finance Officer ✓ One other Management Director (if only one of the above present, i.e. 2 out of 4 management directors) ✓ Four Clinical Directors ✓ With the number of apologies received, quorum was checked, and it was agreed the meeting was quorate to proceed and for decisions.

2.	**Declarations of Conflicts 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. **Item 8: Thames Valley Priorities Committee: Recommendations for adoption November 2019** **TVPC22 Tonsillectomy- The policy refers to the referral criteria. A potential increase to workload for GP's may be anticipated due to proposed variations to thresholds for GP referral for subsequent treatment. However this direct conflict is deemed immaterial to a decision to adopt, on the basis that otherwise the CCG Executive Committee would be unable to discharge its function. There is no known financial benefit to be achieved from policy adoption and therefore no further action is required.** **TVPC96 Anti-VEGFs for the management of sight-threatening rare eye conditions - there are no perceived conflicts in relation to voting GP's. No further action required.** **TVPC42 policy withdrawal verteporfin PDT - No further mitigations identified or required given policy for approval is a direct replacement for a previous version.**
3.	**Review and approval of minutes (24/10/2019)**	The minutes of the meeting held on 24/10/2019 were approved as an accurate record of the meeting. Actions: Action 136: London activity – Cardiology - SE to chase LP for a response – **action open.** Action 143: Financial implications in regard to the closure of Chartridge Ward - Data shows that admissions/referrals of Wexham patients in Amersham beds have not decreased since the closure of Chartridge and therefore it is fair to assume the increase is due to activity and not capacity. We have seen a decrease in DToCs and the hope is that this will continue. GH confirmed he is not prepared to open negotiations with Frimley in relation to blended rates. ShL said we need to address the transfer of patients who are taken to Frimley instead of Stoke Mandeville – a recent case where a patient was taken from Chesham to Frimley who then had to be transferred to Stoke. GH said handover delays may be the reason why ambulances are being directed to Frimley where they have faster drop off times. SCAS have confirmed they undertake intelligence conveyancing and we will need to review what SCAS are being told about where to drop patients. GH suggested a deep dive on the Chesham to Frimley transfer**. New Action 169 : ShL to raise with DS to look at decision making of ambulance crews and what are the pathways around the border issues.** Action 151: Q&P management of discharge of spinal patients - RC advised that a meeting has been set for this week – **action open** Action 155: CRR DVT - DS/FB are managing this between them – it is still to

be determined whether the risk is to be added to register. FB reported that this is an operational issue rather than a contractual issue. DS has agreed to putting something in the service contract and DS/NN will also pick up through the appropriate channels – **action closed**
Action 162: Draft Commissioning Intentions - RT has provided an update on the cancer slide – **action closed**
Action 165: TVPC Analysis – a paper was submitted at this meeting which provided an analysis on the number of policies reviewed by the Committee and a comparison with workload over the previous 6-9 months. JB/RB have been provided with a process to review which entails setting up meetings every few months to review TVPC policies – **action closed**
Action 166: Over 75's funding - LS advised that we are fairly certain there will not be additional funds, but due to Purdah this has not yet been formally notified. As a CCG we will need to provide some clarity around what we are going to do for primary care services. – **action open**
Action 167: see above feedback
Action 168: Closure of Buckingham OOH clinic – RD raised as an AOB at November's PCN meeting and will be raised as a main item at their December meeting. RC to speak to NN and get written assurance that the weekend clinics are being delivered – **action open**

Matters Arising:
3a. CCG Constitution interpretation: process to appoint an Accountable Officer

RB (not present) had asked that an interpretation of the CCG Constitution in relation to the process for the recruitment and appointment of a single Accountable Officer be circulated to Executive Committee for comments. The proposed recruitment of a single Accountable Officer for Buckinghamshire, Oxfordshire and Berkshire West CCGs is currently expected between January and March 2020. A selection will be made by the CCG Governing Body with recommendation to NHS England who will appoint.

This process is specified within the current CCG Constitution and is unchanged from when the CCG came into effect in 2013. It is also deemed as allowing appointment across more than one CCG as there is no statement to preclude it.

However, it is stated elsewhere within the Constitution that this process is subject to a membership vote. In March 2019, the voting membership of the CCG was asked to approve a version of the Constitution which included this process for recruitment and appointment within standing orders. It could be argued that by doing so, the membership has already approved the unchanged process and therefore no separate decision is required.

Although the Clinical Chair of the CCG reserves a right for "Final authority on interpretation of the CCG's constitution and supporting appendices", which is also specified within the scheme of reservation and delegation, he deemed that Governing Body and Executive Committee should both endorse this interpretation. Governing Body has already done so at its meeting on 14/11/19.

Executive Committee did likewise, but with request that there be a clear

		communication to the membership as to the intent and rationale for this interpretation with a right to reply should member practices wish to, and if necessary arrange a subsequent vote. **Action 170: Membership communication regarding interpretation of CCG Constitution as to approval of the process to recruit and appoint a single accountable officer across the three CCGs in BOB.**
4.	**Corporate Risk Register**	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. • **NOTE** risk escalations for integrated commissioning **a. Corporate Risk Register Reports November 2019** RC updated the Committee on the seven existing risks and highlighted there were two new risks which were new and therefore required moderation. EXISTING RISKS AT OR ABOVE ESCALATION THRESHOLD FOR CORPORATE RISK SCORE (12+) 1. Looked after Children – nothing further to add in regard to this risk and the risk should remain scored at 16. Latest position documented within the Quality and Performance Report. 2. Buckinghamshire Transforming Care Partnership (TCP) Cost Pressures – GH advised this relates to SPECOM patients and the funding from NHSE is rarely enough to cover the size of the package required. It was agreed the risk remains at 16. RC noted commentary under reasoning for current score "*UPDATE ongoing correspondence with NHS England on this matter*" and queried the next steps. GH replied we are awaiting correspondence from NHS England to confirm the availability of capital funding. The risk will be updated to reflect this. The risk is otherwise unchanged. RM provided an update following ICET around Autism and LD and advised that there is are additional expectations for CCGs to undertake 6 weekly reviews on all LD patient within a patient setting. We intend to go back as an ICS with some queries around this expectation. The requirements and expectations are increasing and we have some very expensive packages of care on the horizon. 3. NEL – remains at 16. 4. MSK – moderated down to a 12 at Corporate Risk level, so will continue to report on this register but not escalate to Governing Body. 5. DOLs, gender identify, EU exit, A&E – all remain unchanged. 6. GP referral management: activity reduction – risk deemed as now closed given referrals are down year on year. To be replaced with risk on C2C referrals. 7. **Action 171: Replace GP referral risk on Corporate Risk**

		Register with replacement on C2C referrals. This will appear in the next quarterly Corporate Risk Register Report in February 2020 – GH/RC. NEW RISKS AT OR ABOVE ESCALATION THRESHOLD FOR CORPORATE RISK SCORE (12+) - FOR MODERATION 8. **New Risk** Cat M Drugs – GH said this is an in-year pressure and should be moderated at 16. The mitigation on this is to seek funding from NHSE. 9. **New Risk** Provider capacity and resource – LS gave some brief background detail around the risk and confirmed this will require additional capacity with new place based roles and the Committee agreed this needs to be moderated at a 16. This is on the basis of a worsening financial position as documented in the Corporate Risk Register report, and therefore the score has increased from baseline despite controls and assurances in place. Place based roles are being introduced and will need some time to bed-in to demonstrate they are effective – the risk will be further reviewed once this has taken place. **b. Integrated Commissioning Risk Register Report.** These are documented on a separate report in line with the agreed escalation process reported previously. This report has not circulated to the Integrated Commissioning Executive Team (ICET), though has been updated from the version which circulated to the ICET in July. The report to ICET also included all other integrated commissioning risks which fell below the escalation threshold of 12. This document was provided for information and was noted by the Committee. RM confirmed that ICET risks should report to ICET before escalation to the Executive Committee, although at this month's meeting there had not been a report. **Action 172: RM to ensure that ICET has the integrated commissioning risk register report as a continually standing item.**
5.	**Accountable Officer's Report**	Update on Long Term Plan RM advised that due to Purdah there will be no publication of LTP submissions. However the final version of the BOB ICS submission will be circulated to the Committee for reference. Future CCG Architecture An engagement document has been circulated to staff and the feedback opportunity closes on 01/12. The CCG Architecture oversight group are due to meet on 10th December. The timetable set out in AO report will be followed. CCG formal response to CCG architecture engagement document. Governing Body discussed the engagement document and a formal response has been compiled by the CCG. RB asked that the Committee see the draft response. RC read the formal response out to those present. This will be updated to include Executive Committee feedback, summarised as:

		1. We retain a clear commitment to place based commissioning in order to maintain the local clinical voice. 2. If a merger and a single CCG Constitution were to result from this process, then we would need to continue to ensure appropriate place based governance to ensure the requirements of the Long Term Plan remain achievable and deliverable. AO statement RM highlighted the recent resignation statement from LP and the Committee acknowledged that she will be a great loss to the CCG. Accommodation GH provided an update on accommodation – we have received Heads of Terms for office space at County Hall (30 desks on the Mezzanine floor). We will be moving out during week commencing 6th January. We are still negotiating access to room hire and will have access to rooms for a period of minimum 4 hours per day. We are also looking at all our main meetings for an interim solution until March. Post April we should be able to secure more space at County Hall.
6.	**Terms of Reference**	The Executive Committee was asked to: (a) **APPROVE** updated terms of reference which reflect staffing, role and organisational changes (b) **1. RATIFY** its sub-committees terms of reference approved by each of the committees. **2. NOTE** terms of reference for CHC Exception Panel are elsewhere on this agenda. **3. NOTE** amendments to reporting lines given approved change in accountability for the Integrated Commissioning Executive Team (ICET). a. Executive Committee terms of reference RC has further updated the ToRs and incorporated additional comments raised at the meeting today around job titles and membership. All remaining clinical directors are now formal voting members. **Decision: The Executive Committee approved all changes to the document.** b. Assurance from / Ratification of sub-committees Ratification of ToRs for sub-committees of the Executive Committee; Equality, Diversity and Inequalities Steering Group and Staff Partner Forum. **Action 173: Staff Partnership Forums ToRs - Change job title of management representative from Director of Transformation to Deputy Accountable Officer. RC.** **Decision: With the above amendment the Executive Committee ratified the ToRs for the sub-committees.**

7.	**Continuing Healthcare**	The Executive Committee is asked to **REVIEW**, **APPROVE** and **RATIFY** the refreshed CHC Equity and Choice Policy and the CHC Exceptions Panel terms of reference. a. CHC Equity & Choice policy & Terms of Reference for the Exception Panel IC provided an overview of the existing policy and advised that the policy has been strengthened to include children's continuing care. Placements with the Integrated Placement team have also been incorporated into the policy. There were no further questions. **Decision: The Executive Committee reviewed, approved and ratified the changes to the CHC Equity & Choice Policy and Exception Panel Terms of Reference.**
8.	**Thames Valley Priorities Committee**	The Executive Committee are asked to **APPROVE** the policy recommendations listed below: JB joined the meeting to present three TVPC recommendations. TVPC22 – Tonsillectomy – policy updated to bring this in line with NHSE advice. The main change is moving from needing five previous infections to seven before tonsillectomy is approved. JB reported that BHT does not think this will make much difference to the flow of these patients. **Decision: The Executive Committee approved the revised version of TVPC22** TVPC96 Anti-VEGF agents for the management of sight threatening rare eye conditions involving neo-vascularisation This is a new policy for a small group of patients where Anti-VEGF makes a small difference. The conditions are being treated via IFR but this will remove the need for IFR and channel the use of the cheaper drugs. **Decision: The Executive Committee approved the revised version of TVPC96. The CFO agreed the cost implications for the CCG as specified in the supporting paper.** TVPC42 Verteporfin and PDT This policy has been withdrawn as many of the patients are now treated with Anti-VEGF. **Decision: The Executive Committee approved the withdrawal of TVPC42.** **Action 174: The Committee requested that TVPC22 is added to the bulletin. JB will also inform the Clinical Effectiveness Team of the decisions around the all policies presented at this meeting.**
9.	**Buckinghamshire Medicines Optimisation Update**	The Executive Committee was asked to **NOTE** the update provided, and it did so. JB presented the paper and advised there is now a joint strategy with some joint posts agreed. The Governance process is in place although there is still a lack of clarity as to where this is reports into. The Band 7 Pharmacist Clinical Supervisor post required to complete the team has just been uploaded to NHS Jobs. FedBucks are providing the hosted employment of

		the PCN pharmacists working in the practice and this is a leadership role to help support the PCNS with the mentoring, clinical supervision and creation of a network. Seven national pilots were held last year but we are still waiting for the framework and toolkit. Once received this will help support us in taking system leadership roles forward. A suggestion has also been made that we look for some external support and a call is due to be held with the Regional Pharmacist Steve Brown in the next week to explore this suggestion. SR asked if Oxford Health were part of this arrangement? JB replied we haven't yet bottomed out what is going to be done at ICP or ICS level. The Medicines Optimisation team is being built and formatted to work across the system as a single team. RM highlighted that we need some independent support to look at the options at what will happen at ICS level and what will happen at ICP level and then bring this back through CCG governance. There is a concern that Primary Care is being swallowed up and we need to make sure we have equal voice and leadership with a system-wide medicines optimisation approach to build on benefits and good working we have as a system but not lose what we have had as individual organisations.
10.	**Finance report (M7)**	GH described and noted the following points: • The FOT remains at £2k underspend against an in year planned deficit of £15m before accounting for any CSF opportunity. • M7 year to date position shows a £18k underspend against plan. • The CCG anticipates further allocations throughout the year relating to CSF of £10m, reducing the in-year deficit from £15m to £5m – this is not included in the current forecasts. • NHSE have agreed this net in-year deficit of £5m can be added to the historic deficit position. • The CCG met the criteria for gaining CSF at the end of Qtr 1 and Qtr 2 and has received an allocation of £1m in July 2019 and £2.5m in October. • It still remains difficult to determine an exact forecast position based on the six periods of acute activity which includes high levels of un-coded activity and some provider plans (mainly Frimley) are still being worked through in SLAM to reflect the contract agreements. • Key drivers of the in-year pressures are: Category M drugs/NCSO/Prescribing pressures, Acute overperformance and CHC. • The CCG continues to explore avenues to generate savings and to ensure that the CCG maximises its opportunities to deliver against its targets. • There remains at net risk of £5.0m. • The CCG will undertake a full reforecast ahead of M9.

11.	**Q&P (October 19) with November verbal exceptions**	FB joined the meeting and provided the following highlights from the November Q&P report: Cancer – includes the 5/6 conversion rate of patients requiring cancer treatment in line with national trend. A lot of drive but no capacity BHT still experiencing the juggling of capacity against increasing demand along with a number of staffing issues – whilst these have now been resolved we are still waiting to see improved performance. BHT internal performance call – un-validated achievement for October is indicating that on the 31 day treatment / 31 day subsequent treatment and 62 day screening they have made an improvement. The 60 day urgent referral remains static. There is still data validation to do but this is looking promising for October. Diagnostics meeting target on DMO1 there is a backlog of review patients which is not reflected on the DMO1 until they breach the 6 week wait. BHT have a business plan to address this. A&E performance is low – extremely busy across the system and moving further into winter further deterioration may occur. Winter plan has been overseen and has been assured by the A&E Delivery Board any additional actions should be considered. A&E performance – winter plan in place but experiencing unprecedented growth and not assured plan will manage the increased growth. There is an unprecedented demand for children's A&E. Improvement in DToCs. Frimley DToCs reduced from 139 to 44. It was identified that same number of patients would have been admitted to Chartridge and additional patients waiting at Frimley are due to the increase in demand. Waiting lists for community hospitals has reduced from 10 – 6. No update on LACs as DW wants to report the view of the local parenting panel and this will be included in the December report. Endoscopy issues that need addressing. LS asked if the situation with children needed something specific in the winter plan? JS replied there is no contingency in place and children have to be seen and many are admitted for observation. SR reported that a couple of people have recently been sent down the longer iron deficiency pathway rather than referred via the two week wait and have subsequently been diagnosed with cancer. KW reported we have asked for a revised trajectory for LD health checks but this has not come back yet. RM said we see a report that says we have done some good stuff but we are not seeing the action plan and the impact on performance. However we are not getting a sense that we are looking at X and agreeing Y.

NHS
Buckinghamshire
Clinical Commissioning Group

Executive Committee Meeting
Minutes

Thursday 19th December 2019 – 13:00 – 14:45
Chair: Robert Majilton, Deputy Chief Officer

Executive Committee Voting Members:

Louise Patten	LP	Accountable Officer	**Present** *(from 14.00)*
Robert Majilton	RM	Deputy Accountable Officer (Chair)	**Present**
Gary Heneage	GH	Chief Finance Officer	**Present**
Louise Smith	LS	Director of Primary Care & Transformation (Interim)	**Present**
Dr Karen West	KW	Clinical Director – Quality and Integration	Apologies Received
Dr Juliet Sutton	JS	Clinical Director – Children's	**Present**
Dr Rashmi Sawhney	RS	Clinical Director – Health Inequalities and The Primary Care Network DES	Apologies Received
Dr Dal Sahota	DS	Clinical Director – Unplanned Acute Care	Apologies Received
Dr Sian Roberts	SR	Clinical Director – Mental Health & Learning Disabilities	**Present**
Dr Rodger Dickson	RD	Clinical Director – non-portfolio	Apologies Received
Dr Shona Lockie	ShL	Clinical Director – Medicines Management	Apologies Received
Dr Raj Thakkar	RT	Clinical Director – Planned Care	**Present**
Dr Stuart Logan	SL	Clinical Director – Long Term Conditions	**Present**
Other Attendees			
Dr Raj Bajwa	RB	Clinical Chair	**Present** (from 13.15)
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** *(item 5)*
Frances Burdock	FB	Associate Director Contracts and Performance	**Present** *(Item 8)*
Minute Taker			
Sarah Edwards	SE	EA to Chief Officer & Deputy Chief Officer	**Present**

No	Agenda Item	Discussion
1.	**Welcome & Apologies**	Apologies received as indicated above
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/

		Thames Valley Priorities Committee – earwax removal There is a potential conflict of interest identified for GPs in relation to member GPs with voting rights, as partners in primary care practices, which are in turn members of a GP Federation. Any decision to adopt this policy may pre-empt a subsequent commissioning decision for a service incorporating one or more elements of earwax intervention, any one or more of which primary care member GP practices and/or Federations could apply for within a procurement process. It is determined that the potential conflict is not material to a decision to adopt the policy itself since any perceived and subsequent gap in provision is subject to separate discussion and decision, with clinical involvement facilitated through non-conflicted GPs. However, for avoidance of doubt, a quorate membership of Executive Committee agreed a delegated authority to named individuals i.e. 2 non-conflicted GPs, Head of Planned Care, Head of Governance and Deputy Chief Officer) to separately review the decision to adopt the policy. It is intended to do the same for this subsequent decision to adopt the policy. Additional declarations RMS appointed as Buckinghamshire Director for LMC starting in April – this was deemed to not affect quorum for the above decision on this agenda. No further action required. It was noted that, from January 2020, Dr Rodger Dickson will be Clinical Director of North Bucks Primary Care Network and therefore cease to be an Executive Committee member. Dr Dickson was not present and therefore did not make the declaration personally, and therefore this is immaterial to items on the agenda. No further action required. **Quorum** Accountable Officer or Deputy AO or Chief Finance Officer ✓ One other Management Director (if only one of the above present, i.e. 2 out of 4 management directors) ✓ Four Clinical Directors ✓
3.	**Review and approval of minutes (24/10/2019)**	The minutes of the meeting held on 28/11/2019 were approved as an accurate record of the meeting. Actions: Action 136: London activity – Cardiology - DH in conversation with NF and FB to identify the size of the issue and suggest actions. RT has also had a meeting with FB and Optum analysis has shown there is a case mix which includes devices and MRI cases. Following conversation with BHT it was identified that MRI capacity was an issue but there are plans to get a new MRI scanner. Feedback is due from Oxford to determine whether some of these issues are SPECOM or not. Some of the referrals to Imperial may also be due to consultants who work at Imperial. There is now an on-going piece of work underway to unpick the various issues – **action open** Action 151: A meeting has taken place between Tammy Nossiter (TN), ASC, spinal unit, and CCG (meeting was led by Frances Woodroffe). It was agreed that TN would have oversight of the spinal patients to ensure discharge planning starts early on in patient's journey, not when they are medically fit. Spinal case managers now feed into medically fit meetings that TN leads on daily basis at 10.30am – **action closed**

Action 166: Over 75's funding – LS advised that there was no real update available as yet. A meeting has been held and the date reviewed and there will be a need to review further with individual practices. This item will come back again at February Executive Committee meeting - **action open**
Action 167: As above – **action open**
Action 168: NN provided the following update by email: "I have met with Fed Bucks to discuss and can confirm that they are providing a service on Saturday and Sunday in line with contractual requirements. Two hours of their time is spent at base (Buckingham Hospital). The difficulty Fed Bucks reported is that they are requested to perform duties like clerking in patients during this 2 hour period and this will mean there aren't appointments available for patients to be booked into as they have to block them to do this. After the two hours they do visits. I am picking up whether we can manage this better to ensure appointments are available". - **action open**
Action 169: Handover delays: **action open**
Action 170: CCG Constitution interpretation process to appoint an Accountable Officer: This communication has been circulated in the GP Bulletin on 5th December - **action closed**
Action 171: Corporate Risk Register – to be finalised next week and reported back at January meeting – **action open**
Action 172: Integrated Commissioning Risk Register – RM to update after the next ICET meeting – **action open**
Action 173: ToRs – RC has amended the job titles in the SPF ToRs. **action closed**
Action 174: TVPC Policies – JB confirmed that TVPC 22 tonsillectomy is still to be added to a Bulletin but this will be done in the New Year and the Clinical Effectiveness team have been informed - **action closed**

GH raised a previous action around how TVPC policies are to be managed is to be picked up with RB for the decision. RB said this has been raised at Clinical & Care Forum but no agreement was reached.

It was discussed there is a need to decide how policies are reviewed for clinical input prior to Executive Committee approval, as we move to taking these recommendations through a single governance process across the three CCGs.

JB explained that our current process is to:

- Send out a request for any ideas of policies that need to be reviewed;
- A Consultation paper sent is then to the BHT Medical Director (TK) and RB and if there is an obvious CCG clinician who may be able to input they also receive paper;
- Comments are sent back to Clinical Effectiveness team;
- Ratification is then sent to BHT (TK and AM), RB and any relevant CCG clinician.

RT felt that the current process was not fit for purpose and that each policy needs a robust discussion and not just be reviewed individually by email. GH suggested diarising meetings for groups of clinicians to review policies which may be cancelled if there are no policies to review. There are existing meetings in place through which this could be achieved.
Action: 175 JB agreed to attend established Clinician's meetings and to update the flowchart for ratification at a future Executive Committee meeting.

4.	**Accountable Officer's Report**	**CCG Architecture update** The CCG architecture oversight Group met 10th December to discuss key matters from the engagement document. Over 200 responses were received across the three areas, detailed engagement document not yet circulated. Themes emerged around how to ensure local accountability linked to the AO structure, openness and transparency with the recruitment process, scale and geography of AO/ICS Lead – how is this linked to the local work verses the scale of the role. A CCG Governing Body meeting is due to be held on 9th January and members will receive a pack which will include the full engagement report, description of purpose and vision of the AO and set up the next steps towards a single management team. An invitation to join this meeting may be extend to Executive Committee Members and RM agreed to pick this up with LP/RB. Joint Committees of CCGs – the following have already been discussed/agreed: Primary Care Transformation Group, with involvement from Primary Care Networks Specialist Commissioning Planning Board – not yet delegated approval or formal governance, specialist commission will progress this; Joint Committee to enact certain elements of CCG business – this is under discussion after agreement to establish this came out of the Architecture Oversight group but we still need to work through the agreed delegated decisions and when things may need to come back to the CCGs for ratification. Single ICS control total for 20/21. Important that there is transparency as this is a county level allocation however there are no plans to move money in 20/21 between systems. GH updated the Committee on three things currently in progress: • As a BOB/ICS we are the second worst in terms of distance from our control total gap of £77m • Benchmarking exercise has been sent out to each acute trust/CCG and we need to see where we benchmark and provide a robust response; • Bucks ICP Case for Change – through Partnership Board in January. The paper presented to the Committee also provided an update and described progress in the following areas: • Health & Wellbeing Board • Service Design & Engagement Framework There no further comments questions in relation to these by Committee members present.
5.	**Thames Valley Priorities Committee Recommendations for adoption – December 2019 - Earwax**	The Executive Committee was asked to: 1. **NOTE** intention to adopt the current Thames Valley wide TVPC 88 policy on Earwax which NHS Oxfordshire CCG are also adopting (Appendix A) with no equality impacts identified (appendix B) 2. **DELEGATE** authority for formality of decision to adopt the policy to named individuals i.e. 2 non-conflicted GPs, Head of Planned Care, Head of Governance, Chief Finance Officer and Deputy Chief Officer, to mitigate conflicts of interest. Adoption of the policy includes the following recommendations: • Self-care should be the approach for most patients with patients directed to NHS choices or community pharmacy by General Practice for

additional advice on this.
- Due to financial constraints there can be no additional primary/community care service commissioned
- Practices will determine the appropriate response for patients as per the policy with referral to secondary care only for those patients as outlined in the policy

Berkshire West CCG and Oxfordshire have already agreed to adopt the policy as is presented, however Oxfordshire CCG has done so with the proviso that they are not putting in any further investment in primary care or community care services. They do have a small investment in an oral toilet service which can be accessed through ENT in secondary care.

JB confirmed she has spoken to the SCWCSU Clinical Effectiveness Team on this matter. As all the other commissioners were happy with the policy and the team could not identify any improvements in the wording, it was felt unlikely a further meeting would result in any changes.

As Oxfordshire have now ratified it with the caveat of no additional funding include commissioning the middle Tier 2 service, the recommendation is that we do the same. The new audiology contract will allow some access but not provide open access If we don't adopt the current, policy we won't have a clear criteria for referral to ENT in secondary care.

Discussion followed on the criteria outlined for self-care and that is used to determine the eligibility in Primary Care and the differences between ear syringing and irrigation.

SR questioned if you have a hearing aid or require a review then would that would qualify for primary care or ear wax removal? People may say they have tried all the self-care options and they meet the criteria and are we commissioning primary or community care to do this – the policy says it "may be available" but not that it "is available".

Decision: The Executive Committee members present confirmed that they:

- **NOTED their endorsement for intent to adopt the policy as is stands in line with Berkshire West and Oxfordshire CCGs having already done so.**
- **ENDORSED intent for clear messaging on self-care should be the approach for most patients with patients directed to NHS choices or community pharmacy by General Practice for additional advice on this, and also messaging on the circumstances where a patient meets criteria for referral to ENT.**
- **Recognised that a Tier 2 service may form part of future audiology procurement.**
- **DELEGATED authority for formality of decision to adopt the policy to named individuals i.e. 2 non-conflicted GPs, Head of Planned Care, Head of Governance, Chief Finance Officer and Deputy Chief Officer, to mitigate conflicts of interest.**

		Further discussion took place on those patients who do meet the ENT referral criteria but cannot get the service. The Executive Committee asked for LMC feedback if the policy is adopted with a statement produced on what we do locally that we fall back on locally. Communication needs to be produced on the use of Millbarn's current service, and a conversation held with our community providers to confirm they are not commissioned to do any micro-suction for any group that does not meet the criteria. SR asked for clarification on how this affects the elderly and those with dementia, as this wasn't currently covered by the Equality Impact Assessment provided. The Executive Committee members present discussed and endorsed that it was better to have the policy in place with the caveat on how this will be locally interpreted and managed. **Action 176: The Planned Care team to have conversations with providers currently delivering ear wax services about communicating with the rest of Primary Care.** **Action 177: JB to feedback to Clinical Effectiveness team that dementia is not referenced in Equality Impact Assessment provided.**
6.	**Optimise RX: member engagement**	JB delivered a presentation on Optimise Rx and explained that this is an alternative decision support tool for GPs. Following conversation with other colleagues across BOB and it was agreed collectively that any decision about implementing a new tool should be across the BOB and Optimise Rx looked like a better tool than Script Switch. JB commented that a financial arrangement has been negotiated. The benefits of Optimise Rx is that it will be easier for us to manage as Optimise Rx will do a lot of the work for us and we can then switch things on and off easily. Because the tool integrates records it will only give pop ups relevant to each particular patient. In addition if produced quite good reports that can be fed into to other pieces of work in relation to adherence to guidance. Further details in relation to the contract and information governance are described in accompanying slides. The following questions were raised: • Is the application only licensed to clinicians or open to other staff – Script switch cannot be used by receptionists so they cannot order repeat prescriptions? • Does it work on the EMIS clinical and community services platform and EMIS anywhere? • Will Out of Hours be able to use the system? • Clarification around the transition for use across a practice. **Action 178: JB to feedback answers to questions in relation to Optimise RX.** RC confirmed that because OptimiseRx is on a SBS shared business services framework we are not required to go out to formal tender. **The Executive Committee** • **RECEIVED for information a briefing on OptimiseRX and endorsed the approach as was described to replace Script switch.** • **NOTED corporate governance actions as indicated within the**

		supporting paper
7.	**Finance Report (M8)**	GH provided a brief update and confirmed that despite significant pressures this year we have managed to hold the position to year end. JS expressed her disappointment that transformation monies have been absorbed into the bottom line and the work that has gone into the Children's Hubs may not be able to go on if there isn't small amount of money for the Hub Co-Co-ordinators. GH agreed to discuss this offline. **Action 179:** Discuss offline funding for children's hub business case given potential funding for 19/20 has since been subsumed from transformation monies into the CCG bottom line.
8.	**Quality & Performance (November 2091) with December verbal exceptions**	G:\AVCCG CCCG SCWCSU\Governance Meetings\Executive Committee\2019-2020\2019 12 19\08. November QP Report FINAL.PDF FB joined the meeting to provide highlights for the Committee: the November report was tabled following highlights provided at the previous meeting. December highlights include: • Cancer target (31 days) was achieved – this is an improvement from September: • RTT slight deterioration from last month – 2 x 52 week breaches which were at OUH and UCLH. Both patients have now been treated. We are working closely with all providers to manage the 52 weeks. The impact if not maintained will be a number of breaches should elective activity be ceased as happened last year (a predicted 66 breaches if this does happen). • Diagnostics are achieving targets but capacity remains tight. National issues remain around MRI capacity. Project to review in radiology. RT repeated the update he provided under Action 151. LP said we need to chase the MRI scanner especially in relation to the cancer waits. • **Action 180:** LP asked for a clear, joint, review of the cancer performance specifically at the OUH and harm given concerns over performance – DW/FB to consider the approach for this and agree with counterparts in Oxfordshire so we can report the process and timescales for this back to Exec and give LP an update. • GP referrals – slightly increased from September – main focus is to look at other referrals – the main pressure is into Frimley and a further update will be available next month. RT reported a huge number of cardiology referrals going into Frimley. A virtual border clinic is being developed. • 4-hour targets were not achieved at BHT, MK and OUH. Assurance has been received from NN that winter plan is being reviewed by A&E Delivery Board. Weekly CEO meetings are in place to review and provide assurance. JS said there are safeguarding concerns with issues around equipment for ventilation with no capacity in any neighboring hospitals. Paediatric activity this winter has been one of the highest ever seen. Flu vaccine uptake is not good in Buckinghamshire due to shortage of vaccines. A lot of Paediatric cases are in the under 1's

		however conversations are happening across the system around this. • The Business case for PDU needs to be supported, LP agreed to chase this up. • Flu – FedBucks are putting on an extra clinic this weekend. Uptake in care homes has been good. RB said immunization of Primary Care staff is low with practice managers having to make a lot of phone calls to try and work out the guidance on indemnity. This is a major risk as a lot of Primary Care staff are not immunized this year. The message form Simon Stephens at a recent NHS Leadership event was "Staff are as important as patients" and this needs to be relayed to Primary Care staff. Discussion followed around the pressures currently being experienced by Primary Care with vaccination of staff. The Executive Committee made the following recommendations: - A Board-wide understanding of what this means followed by a statement. - SB to provide the latest flu survey position and to pick this up with the public health team. • SCAS times struggling to achieve targets – vacancies and high sickness absence. Handover delays have increased. The increase is a year on year comparison. • BHT stopped their neurophysiology service a few years ago and all patients have been referred to OUH. OUH will be ceasing seeing routine referrals from the 19th January. OUH are going to write to Dan Gibbs and Neil MacDonald (NM) to voice their disappointment that BHT haven't responded to their request to re-provide the service LP said this needs to be escalated to the SRO of the work-stream (NM). • The December Quality & Performance report has been transformed into an ICP report.

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Clinical Commissioning Group

Executive Committee Meeting
Minutes

Thursday 23 January 2020 – 13:00 – 16:15
Chair: Robert Majilton, Deputy Chief Officer

Executive Committee Voting Members:

Louise Patten	LP	Accountable Officer	Apologies Received
Robert Majilton	RM	Deputy Accountable Officer (Chair)	**Present**
Gary Heneage	GH	Chief Finance Officer	**Present**
Louise Smith	LS	Director of Primary Care & Transformation (Interim)	**Present**
Dr Karen West	KW	Clinical Director – Quality and Integration	**Present**
Dr Juliet Sutton	JS	Clinical Director – Children's	Apologies Received
Dr Rashmi Sawhney	RS	Clinical Director – Health Inequalities and The Primary Care Network DES	Apologies Received
Dr Dal Sahota	DS	Clinical Director – Unplanned Acute Care	**Present**
Dr Sian Roberts	SR	Clinical Director – Mental Health & Learning Disabilities	Apologies Received
Dr Shona Lockie	ShL	Clinical Director – Medicines Management	**Present**
Dr Raj Thakkar	RT	Clinical Director – Planned Care	Apologies Received
Dr Stuart Logan	SL	Clinical Director – Long Term Conditions	**Present** (until 3.00pm)
Dr Raj Bajwa	RB	Clinical Chair	Apologies Received
Dr Rebecca Mallard Smith	RMS	Clinical Director – Unplanned Community Care	**Present**
Other Attendees			
Russell Carpenter	RC	Board Secretary / Head of Governance	**Present**
David Williams	DW	Director of Strategy, Buckinghamshire Healthcare NHS Trust	Present (for item 9)
Minute Taker			
Sarah Edwards	SE	EA to Chief Officer & Deputy Chief Officer	**Present**

No	Agenda Item	Discussion
1.	**Welcome & Apologies**	Apologies received as indicated above
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

any noted within the meeting papers.

Quorum

Accountable Officer or Deputy AO or Chief Finance Officer	✓
One other Management Director (if only one of the above present, i.e. 2 out of 4 management directors)	✓
Four Clinical Directors	✓

The meeting was quorate.

Item 4: Shared accountable officer and design principles for a single management team (for noting and discussion)

Executive Committee membership includes executive directors, the current CCG accountable officer and clinical leads. Any current executive director member who meets the eligibility criteria could apply for the role of shared accountable officer when advertised.

The current holder of the role of accountable officer in Buckinghamshire has already resigned with a leaving date of 31 March 2020.

There is also a direct conflict of interest for any current executive director whose role will be affected by a decision now or in the future to introduce a single management team.

There is also a direct conflict of interest for any individual whose mandatory role will be affected now or in the future through introduction of a single management team.

There is also a direct conflict of interest for the Clinical Director for Quality and Integrated Care on the basis of potential implications for the quality assurance and patient safety portfolio currently held.

However these conflicts are deemed immaterial to the item on this agenda as it is for information only, with committee asked to note the reports provided. No further action required.

This agenda item also supersedes discussions and decisions on these matters already taken by the Governing Body on 9 January 2020.

The same conflicts of interest and resulting mitigations were described and published separately on the CCG website, with committee also asked to read these minutes.

<u>Decisions:</u>

- Item 6: Thames Valley Priorities Committee: Recommendations for adoption January 2020 – none expected therefore no conflicts of interest to mitigate
- Item 7: no conflicts of interest identified

3.	**Review and approval of minutes (19/12/2019)**	The minutes of the previous meeting were approved as an accurate record. Action Log updates: Action 136: London Activity Cardiology: This is still on-going. FB and RT will meet with Buckinghamshire Healthcare Trust (BHT) next week to investigate the high number of referrals from BHT into London cardiology. A further update will be provided at the February Committee meeting – action open Action 166: Over 75s Funding: Item to return to the February meeting Action 167: Over 75s Funding: as above Action 168: MK Q&P: GH agreed to pick this up with FB – action open Action 169: Handover Delays: DS reported that there has been action around this and an audit is taking place at Frimley which will look at conveyancing. They have been asked specifically to look at patients under haematology/oncology with chronic needs who should go back to original hospital and VK has also been made aware of this level. Action closed Action 171: Corporate Risk Register – C2C referrals – scored below threshold – not on corporate Risk Register for moderation. If the risk score changes it may escalate – action closed. Action 172: Integrated Commissioning Risk Register Report: ICET is due to be held next week RM to feedback at the February Committee meeting on whether ICET will have it's own risk register – action open Action 175: Senior Clinicians Forum (SET) - RB/JB are still to discuss this – action open Action 176: Feedback from JB to be provided at a future meeting – action open Action 177: TVPC: Recommendations for adoption (Earwax): JB to feedback – action open Action 178: Optimise Rx – member engagement: AH confirmed that messages are only seen by those given prescribing rights. The transition will not be noticeable to the practices as it will not appear vastly different at the user end. The build will take place over Feb – March to be ready for switch on April 1st. We will continue to communicate through forums and newsletters again in March. Answers to additional questions will be circulated with the minutes – action closed Action 180: Q&P: Two additional papers were included in the pack for this meeting – action closed Matters Arising Assurance paper to OCCG on OUH 52 week clinical harm reviews process (section 3) The Committee are asked to note that as part of a recent NHS improvement investigation OUHFT has been asked to describe its plans to assess potential harm to patients waiting 52 weeks for treatment. The paper presented is the OUHFT process for harm review which will be put in place for three months and thereafter evaluated. This will be discussed further at QRM. Item 03b: OUH Clinical Harm review report – December 2019 Item 03c: The Committee noted the report – there were no additional questions. **Matters arising 03d. New Corporate Risk for moderation by the Committee** A new corporate risk in relation to leadership capacity across Buckinghamshire and Oxfordshire CCGs linked to the resignation of the incumbent accountable officer has been added to the register. There were no further questions around the risk description or moderation as described. RC said if the risk moderated at 16 it would be reportable to Governing Body. The Committee agreed to moderate the

		risk at 16 on the basis that this is above the escalation threshold to Governing Body which was deemed as requiring assurance on this risk. RC confirmed that the moderated risk would appear in the next iteration of the Corporate Risk Register reporting to the Executive Committee on 27 February 2020.
4.	**Shared accountable officer and design principles for a single management team**	The Executive Committee was provided with (for information only) and **noted**: a. A copy of the CCG architecture engagement feedback report including stakeholder mitigations, engagement activities and a draft Job Description for a shared accountable officer across Buckinghamshire, Oxfordshire and Berkshire West CCGs. This was circulated separately to Executive Committee members on the 8 January 2019. This report went to the Governing Body meeting on the 9 January. b. Feedback on the decisions made at that Governing Body meeting (09/01/20) c. An opportunity for the Executive Committee to ensure collective understanding of the next steps and, noting the requirement for intensive communications as a result of the Governing Body decisions over the next few weeks and months on describing how place will work and its accountability to members and local authority colleagues, support the development of the associated work. RM explained the rationale for the papers why they were presented at this meeting. Our Governing Body (GB) agreed to commence the process of appointing a shared accountable officer for the three CCGs. This has still to go through the Oxfordshire CCG GB next Tuesday but has already been approved by the Berkshire West GB. RB has previously reflected that there are some areas where primary and secondary care interface (e.g. Frimley) but it does not feel like we have that space in Bucks yet and this does appear to be a gap. RM asked clinicians to give some thought as to how this gap can be closed. KW asked if Berkshire West agreed the design principles as well as the shared AO. RC replied that Berkshire West had approved both.
5.	**Accountable Officer's Report**	RM provided the following highlights from the report: Buckinghamshire ICP: A number of presentations and slide sets developed over December and included in the papers for this meeting were circulated to the ICP Partnership Board. System Meetings: The final HASC meeting before hand over to Unitary Authority will be held on 7th February and is expected to cover: • BOB ICS – feedback on the recent engagement document regarding the future of CCG commissioning and next steps; • Prevention and Early Intervention – addressing inequalities and social isolation; • Developing Health & Social Care in the Community – development and alignment of PCNs and Community Boards # as well as an update on future proposals for the development of GP provision across the county; • An update on the temporary closure of Chartridge Ward;

		• Delivering Health & Social Care in the Hospital – BHT's performance and key priorities/challenges, partnership working of health and social care (DTOC, short term intervention service and Reablement), mental health services • A retrospective review of work of the HASC over the past 12-18 months and a discussion about future work for the new Buckinghamshire Council. Ageing well Accelerator: The CCG along with colleagues across the BOB ICS have submitted a bid to become and Accelerator site linked to Ageing Well elements of the Long Term Plan. Winter: It was recognised that the system has been under significant pressure with BHT consistently at Opel Level 4. DS reported that things are slowly getting better. A real effort with non-weight bearing beds and step down beds has been put in place. Wycombe Hospital has been used for the first time for overnight medical patients this Winter. There have been 44 open escalation beds this year. In December there was 1000 more attendances than in previous the previous December, however admissions via A&E have reduced. Caroline Capell, the new Winter Director joins the system on 27th January. Meds Optimisation update: RM and TK have held conversations with the regional pharmacist and we are due to receive some guidance around joint plans for medicines optimisation at ICS level and integrated budgets. We need to check how the Medicines Optimisation Board (MOB) fits into governance with the ICP. ShL reported a concern with recent MOB's being cancelled when the system is on Opel 4. RM agreed there is still some work to do to understand how Medicines Optimisation Board works and where it fits into the ICP.
6.	**Thames Valley Priorities Committee – Recommendations for adoption January 2020**	There are no TVPC items to report this month.
7.	**ICS MOU acute collaboration**	The Executive Committee was asked to **APPROVE** the terms of the memorandum of understanding (MOU) for acute collaboration prior to signature on behalf of the CCG by the Accountable Officer. The attached MOU was also provided to the BOB ICS System Leadership Group on 7 November 2019 which recommended to statutory bodies for approval. GH explained that the MOU needs to be signed in order for us to get the transformation monies and work through the risk share across the ICS. System governance and risk arrangements are in place. RC asked how confident are we that this is about collaboration across the acute trusts? GH replied this is the biggest opportunity for clinical variation across BOB from a system perspective with

		how we take costs out of system. SL highlighted that handover delays are usually caused by Wycombe refusing to accept patient who then usually end up going to Wexham. If a patient has any other co-morbidity, ambulance crews are deterred from going to Wycombe. Discussion was held on capacity and handover delays in Cardiology and it was noted that the issues with non-acceptance of patients at Wycombe needs to be addressed. **Decision: The Executive Committee approved the terms of the memorandum of understanding prior to signature.**
8.	**CCG & ICP Operating Plan**	GH provided the following update: 20/21 - no planning guidance received as yet. There was a National meeting of all Directors of Finance across NHSE/I and at this meeting it was advised that the first submission will be 5th March with the final submission due on 29th April. • Where we are as an ICS – everyone is aware that plans were submitted in November for the Long Term Plan and at ICS level we had a gap to control total of £73m. All CEOs agreed ways of closing gap across the ICS. • Gap to be closed by a further £43m reducing to £30m. High levels schemes of how this may be achieved were discussed, and we are yet to receive confirmation from the regulator as to whether a £30m gap is deemed acceptable. • We are not in the top ten and therefore not subject to intense scrutiny. Every ICS has to re-submit their plans on 10th January. There are various options as to how money may put into individual organisations, and it was agreed to be parked in organisations based on their distance from break even. B • Buckinghamshire has an allocation of £16m of the £43m. Of this, £5m is allocated to the CCG with £11m allocated to BHT. Whilst this is an improvement in the CCGs position, it creates an enormous risk. • A workshop is due to take place tomorrow with all CEOs and Directors of Finance to debate these provisional allocations further. Our proposal from a CCG perspective is as follows: • Control total for next year of £14.2m deficit and in our LTP submission we would plan for a £15m deficit and we will miss our control total by £800k. • We will submit a compliant plan by 5th March for a £14.2m deficit with a £16m QIPP challenge, of which £4.5m is currently unidentified and once we risk assess our existing schemes this will push this number up with a significant risk across ICP. • The final risk is whatever else comes out of the £43m, and this needs to be worked through over the next few weeks. ShL asked what we are doing to identify further mitigations. GH replied a significant amount has energy has been given to identifying efficiencies within continuing healthcare, and we are looking at planned and emergency care. There has been a clear request from the ICP to demonstrate how we will manage this from a CCG perspective. The extended invitation for the Finance Committee

		meeting next week is to be stood down as the planning guidance has not yet been received.
9.	**Strategic Case for Change**	David Williams, Director of Strategy, BHT joined the meeting and delivered a presentation on the ICP Strategic Case for Change (for information/assurance): The following comments / questions were raised: • DS highlighted the issue of access for patients to same day emergency care treatment and this may need to en enabled by digital. DW said this will need a big piece of urgent care re-design. • ShL said we need to be thinking strongly about transport and access for patients and deliver new opportunities and patients in part of the County miss out on accessing services due to the lack of transport options. LS said the challenge will be looking at assumptions we use. Vulnerable patients may also miss out on using digital options. RM reflected that this was an important point and created opportunities for doing thing differently. • Integrated care pathways - a good opportunity through the Ageing well pilot due to be announced next week. £9m has been allocated in anticipatory care work and the money will be accelerated into next year and the year after. • Challenges remain around mental health and primary care - is this going to make a difference in primary care? Is there something additional that will come out of this? Public Health, secondary care clinicians, following up smokers will it make a difference? • Public Health colleagues have been challenged to come up with the evidence that makes a case. • SL said we need to start at the bottom and work up, go into communities and drive change upwards • A survey of parents identified that 20% of primary school aged children would be classified as mental health patients if they were adults. • The urgent care challenge is for a pattern on emergency care services in Buckinghamshire. We need a new vision for hospital services in the county • Consolidate rehab, internal thoughts are by pulling together we may create efficiencies and become a leading national service to attract high quality staff. • Diagnostics, pathology, radiology and pharmacy - huge efficiencies to be gained if we partner with other trusts. • Outpatients - a 30% reduction in outpatients with more investment in digital services to reduce attendance. • Digital Transformation – e-prescribing, the scale of IT investment has to deliver changes in behaviours. • Estates – acute and community sites are they in the right places? Where is the best place to have these hubs? • There will be a big health conversation as we go into the next financial year starting in April and a financial recovery with a 5 year plan that

		links/communicates with regulator. • At the recent Board to Board the presentation enabled useful discussion and was more positive than initially thought.
10.	**Developing place based integrated commissioning - update**	This document was provided to the Committee for information. RM gave an overview of document and there were no additional questions from Committee members.
10ii & 10iii	**Journey to integrated services & delegated budgets – Mental health, Learning Disability & Autism – the development of Provider Collaboratives** **and** **Buckinghamshire Long Term Plan Analysis: All Age Mental Health**	These documents were provided to the Committee for information. RM highlighted mental health and delegated budgets for mental health and explained the document contains background info on what is in the LTP, development of mental health provider collaboratives and what this could look like, LTP Mental Health priorities, progress and challenges. Development of delegated budgets around S117 and to have an agreed way of working in terms of the profile via the Mental Health Delivery Board and link to clinical priorities and outcomes. KW commented that a Hertfordshire partnership would be good. We need to have providers who are willing to work with us as a system, ShL said we are missing part of population who we are not giving support to people with mental health issues linked with drug abuse and these patients are bouncing in and out of A&E. Local intelligence needs to come to population health delivery board. GH said there is a challenge across the system and there is a question of this area should get £4m. The way we are addressing this is that anything that goes into this must have a return on investment.
10iv.	**Community Integration Partnership**	This document was provided to the Committee for information. LS explained that this presentation came out of a piece of work following the evaluation of community integration by People2 and provided an overview of the journey to integrated services. **Challenges** • Varied progress by group of practices and community partners in integrating • Lack of capacity to develop above BAU Persistent 'tricky' issues that are never resolved such as single system wide templates and process e.g. access to records/ACPs, trusted assessor. **Opportunities** • NHSE clearly articulated LTP ambition and implementation expectations • Alignment with BCC Better Lives Strategy • Nationally mandated community and PCN contractual changes • Earmarked community investment • Ageing well focus including urgent community response accelerator site • Success of telehealth solutions. This presentation is going to HASC 7th and we are expecting the question on why

		these things are not in place. RMS felt that it was probably because the DES is unlikely to last. Commissioners need to consider responsibility for the whole population if a PCN doesn't want to sign up to something, we may have to talk to other PCNs or providers who can support these new pieces of work. RM said conversations need to be held with PCNs regarding coverage and overlap to avoid stretching staff time and PCNs need to think about building up relationships and communication and to try and find ways of covering items on Community Boards between them.
11.	**Finance report (M9)**	GH provided an overview of the M9 finance report and confirmed we are still expecting to meet the outturn forecast this year.
12:	**Quality & Performance (December 19) with January verbal exceptions**	The Executive Committee noted the December Q&P report – there were no additional questions. KW gave a verbal update on January the Q&P report. Cancer 31-day surgery is below target; 62-day GP screening – ongoing issues with diagnostic provision and tertiary centre capacity. New MRI scanner at BHT will be operational by April TVCA workstreams 2 week wait has gone off target - one area due to breast cancer but also maternity leave sickness and staffing vacancies. There is a plan to get this back on track. RTT continued falling performance reflects regional and national figures, works going on at OUH theatres and a rota of work has to go through. The ability to do the list has decreased, increasing pressure within RTT but they are looking at alternative providers to try and keep on track. Pathway transformation, an ophthalmology paper is due in March looking at new pathway, MSK, paper due in February. Diagnostics we are targets but on-going issues to achieve gastroscopy, colonoscopy etc. GP referrals are reduced, pressures from other sources and an increasing number of referrals going to Frimley. Cardiovascular numbers are going up. Triage pathways are being reviewed. Cardiology triage pathways, cardiology advice and guidance, quicker than triage. The suggestion is to shut down ERS advice and guidance and just make GPs go through the triage route, but the quality of this route is not good and bounces back to GP. This will create a risk of out of county bookings increasing. Cardiac pathway review to be undertaken along with bounce back of HF referrals.. KW agreed to feedback to RT. SR had a question about 52 week breaches - how do we know there is no harm (the report says little no harm on reviewing those on the breach list).Sometimes the harm comes AFTER the procedure or event. I.e. delay in hip replacement, causes significant mobility deterioration/falls, lack of independence, fractures, and ultimately then may need earlier transition to Care Home. This may not be apparent at the time they are reviewed. KW replied this goes back to our pathway approach.

		A&E breached across system, particularly bad winter, whole hospital and whole ICP have worked together to balance demand. On-going issues with staff at BHT GP streaming service. Buckinghamshire is currently 5th in the region. Audit of how many patients that have gone through same day emergency care and have been pushed back to primary care. Out of hospital discharge methods, haven't landed certain pathways and need to move to it in escalation and to get proactive. DToC was raised this month, but the recent trend has been to rise and fall monthly. A new Winter Director is starting at the end of January. SCAS – GPs not fully educated on understanding the new categories and this adds to the pressure. On-going issues with vacancy and sickness rates. Need to look at time crews are spending with patients before setting off. CHC improving performance on 28 day target however less than 15% of full NHS CHC assessments in an acute setting are currently being met Dementia – there are coding issues and the message needs to get out to primary care – KW to feedback to SR. Looked after children - Issues with flow and data sharing.
13.	**Q2 workforce report**	The Executive Committee noted the Q2 workforce report which was provided for information.
14.	**HR policies update**	There were no HR policies for review this month.
15.	**Approved Minutes**	The Committee noted the approved minutes.

Finance Committee Meeting – Minutes

Wednesday 30th October 2019, 09.15 – 11.00am
Bevan Meeting Room, Buckinghamshire CCG Offices, Aylesbury, HP19 8FF

Finance Committee Voting Members:

Tony Dixon	TD	Lay Member and Finance Committee Chair (Chair)	**Present**
Robert Parkes	RP	Lay Member and Audit Committee Chair	**Present**
Graham Smith	GS	Lay Member and Primary Care Commissioning Committee Chair	**Present –** dialled in
Gary Heneage	GH	Chief Finance Officer	**Present**
Alan Cadman	AC	Deputy Chief Finance Officer	**Present**
Kate Holmes	KH	Deputy Chief Finance Officer	**Present**
Robert Majilton	RM	Deputy Chief Officer	Apologies Received
Louise Patten	LP	Chief Officer	**Present** - dialled in for agenda item 7 10.20am
Russell Carpenter	RC	Board Secretary / Head of Governance	**Present**
Minute Taker			
Dawn Riddell	DRi	EA to Chief Finance Officer	**Present**
In attendance			
Helen Delaitre	HD	Associate Director of Primary Care	**Present** – agenda item 7 only

1.	**Introduction, Apologies & Quoracy**	
	TD welcomed the committee members to the meeting. Apologies were received from: • Robert Majilton, Deputy Chief Officer 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 25th September 2019**	
	The minutes were approved as an accurate record.	
4.	**Action & Decision Logs**	
	The action log was updated as discussed.	

5.	M06 Update & Financial Recovery Plan	
	GH ran through the Financial Recovery plan and M06 update, the Finance Committee are requested to **NOTE** the position**:** The main points/discussion were: • The position at M06 is to plan as agreed at the Finance Committee in Common meeting. • CSF funding has been received for Q2 of £2.5m, total to date equating to £3.5m. • There is an over performance of £8m in year which has been fully mitigated. • Net risks continue to be reported at £5m. There will be a full reforecast during M8 when there is a greater understanding of the winter pressure position. It will be challenging to hold the position but this is still the intention for the remainder of the year. • Formal letters have been exchanged with Buckinghamshire Healthcare Trust to confirm the £4.5m risk share would be repayable to Buckinghamshire CCG in Q3. TD enquired when we could expect the funding back. GH explained that if we requested the funds back too early then Buckinghamshire Healthcare Trust may have to draw loans. GH went on to say that he would ensure the cashflow is maximised across the system. Other areas to note: • Buckinghamshire Healthcare Trust would formally reforecast in M7 and the risk share amount would be included in these figures. • There were 2 commissioning challenges that arose from the Anne Eden meeting held approximately 6 weeks ago. The CCG was asked if any further savings could be identified within Prescribing and CHC. – Prescribing: the benchmarking for 2019/20 has been relooked at for the first 4 months of 2019/20. Buckinghamshire CCG is ranked 9th in country which is the best outside of London. There is £780k difference between Buckinghamshire CCG and Richmond who are ranked 1st. The CCG are currently in conversation with Optum who are a company that send pharmacists into GP practices on a 'no win no fee' basis to identify savings by switching drugs. There is an opportunity to save between £500k – £750K. - CHC: To improve the in-year performance a team of 12 will be in place from 4/5th November to start clearing the 3 and 12 month reviews with a view to complete these by March 2020. Work has started on the trajectories for BAU; a call will take place on Friday 1st November 2019 to agree these. The KPI's are improving, in the first 6 months of 2019/20 there has been a reduction of 9 patients on CHC & FastTrack. TD asked if clearing the 3 & 12 month review backlog would be at the detriment to Bucks County Council by increasing their costs. GH explained that this had been raised at the last CHC Transformation board by the County Council. GH had responded that Buckinghamshire were currently paying £18m to much a year compared to peers and this would be rightsizing the issue. There would be a template completed for each review which confirms if the patient was moved into FNC, not eligible or moving into social care. This would be shared with the County Council on a regular basis for total transparency. TD asked how the Finance Committee would gain visibility of this work. It was agreed that the KPI table from the CHC Transformation board papers be bought back to future meetings. **Action:** KPI table from CHC Transformation Board to be bought back to Finance Committee	**AC**

for Assurance.

Incorrect posting of journal
AC advised the committee that during M5 a debit journal had been processed incorrectly. This has been exaggerated by processing the journal the wrong way and the use of incorrect balance sheet codes. This was not bought to CCG's attention by the CSU and was highlighted by NHSI querying the large debit amount showing in the accounts.

The error occurred due to the final balance sheet not being checked by the CSU. The CCG previously reviewed the balance sheet 2 weeks after month end. The process has now been changed to review on WD5.

GH explained that he has been requested the in-housing of CSU finance for approximately 7 months and submitted a business case to NHS England, to date they have not been able to sign this off. GH intends to request a meeting with NHS England once the CHC work has been completed to advise that due to the combination of the incorrect journal posting and CHC the CCG will in-house the CSU Finance team and would hope to gain NHS England's support to do so. As Chief Finance Officer of the CCG GH felt that the in-housing could not be delayed any further due to the significant material issues created by the CSU.

The Finance Committee **AGREED** to endorse the proposal for the need to in-house the CSU Finance team for the need of the business.

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

No items discussed.

7. Full Business Cases

HD provided the Finance Committee with the background for the 3 business cases needing approval to be submitted to NHS England. The Berryfields business case wasn't ready in time for this committee.The main points / discussion were:

- There are 3 business cases across 2 sources of capital funding which date back 3 years.
- In 2016 a couple of GP practices applied independently for estates technology transformation funding with the support of Chiltern CCG and Aylesbury Vale CCG (at that time).
- In 2017 a bid was entered for further Primary Care transformation funding via the STP. This was successful and received an allocation of £8.8m in December 2017.
- ETTF funding has to be utilised and paid by March 2021, due to the tight deadline NHS England are working with Capsticks and the developers to put forward a proposal for a direct agreement to be bought in to allow the flow through of the funding in Tranches. This would mitigate the risk of not completing the schemes by the existing ETTF deadline.

Berryfields and Meadowcroft

- This is a new build case; it has been processed through the outlined business case stage, approval given from the CCG via the Primary Care Commission Committee and Governing Body Oct/Dec 2018 and NHS England approval subsequently.
- Planning consent has been granted and the land acquired.
- Practices are currently located in portakabins.
- Berryfields and Meadowcroft practices are planning to merge.
- There have been numerous challenges and meetings held with the developer and district valuer to agree a settlement both were happy with. This figure was agreed on

25th October 2019.
- The full business case is not ready; a virtual sign off will be required by the NED's next week to give approval. It was decided that GH would provide a summary to issue via email for sign off.

Action: GH to produce a summary of Berryfields business case and issue to NED's for virtual sign off. **GH**

Threeways (GS left the call at 10:30am and provided email confirmation of approval for all 3 Business Cases to be submitted to NHS England**)**

- £0.5m investment to create 6 additional clinical rooms and a reception area on 1st floor.
- No planning consent required.
- No change on the rentable value of the practice due to the changes being internal.
- This has moved from Capital to ETTF monies.
- This is a positive move for the south of the county as services such as Out of Hours can be put in place to help the flow on the south border into Frimley.

TD asked what would persuade patients to attend the surgery in Stoke Poges as opposed to Wexham. HD responded that the surgery would be appointment based with no 4 hour wait to be seen. There is free parking and patients would have to drive past the surgery to reach Wexham meaning less distance to travel.

- There will be opportunity to look at how the additional clinical rooms can provide more services for the network during working hours to repatriate the activity currently going to Wexham.

LP enquired if the internal business case for the practice was dependent on income from the Out Of Hours service. HD confirmed it was not.

GH explained that there were risks; these include the costs being more than initially budgeted for. To mitigate this risk there is an underwriting from Assura (the owner of the building) that they will absorb that risk up to £100,000.00. Post completion of the work there will be a 25 year lease. HD confirmed that the lease had already been signed by the practice.

TD asked how happy we were with costs. HD commented that the District Valuer had provided a value for money report which had confirmed value for money.

LP expressed her full support for this business case.

The Finance Committee were asked to formally **APPROVE** the business case to be submitted to NHS England.

The Finance committee **APPROVED** this.

Beaconsfield

- This is a new build case; it has previously been through the outlined business case stage, approval given from the CCG via the Primary Care Commission Committee and Governing Body Oct/Dec 2018 and NHS England approval subsequently.
- Planning consent has not been granted, this is expected to be agreed at the planning committee on 11th December 2019.
- £3.4m ETTF funding.

- There will be abatement on the rent due to the ETTF monies invested. This will result in a reduction on the rentable value.
- In terms of the revenue impact, the final business case is approximately £25k less than the outlined business case. The Finance committee were asked to note that this offsets a £25k pressure on the Berryfields business case (FBC vs OBC).
- The size of practice and rentable value will incur a pressure on the Primary Care budget of approximately £134k per annum. The Primary Care reserves in the budget will be utilised for this to provide a fit for purpose practice for future growth of the population.
- The District Valuer report confirms value for money.
  The developer has provided a letter to stating they will cover the risk of any capital overspend.
- A 25 year lease has been signed by the practice.
- Heads of Terms has been signed.

RP enquired if there were concerns regarding the planning consent being granted. HD explained that objections had been raised and the developer is putting forward a case to mitigate and will be holding a public event to lobby support.

LP asked if the additional income from the CCG related to the business rates. GH confirmed that the calculation on the rateable value was incorrect in the outline business case. The rateable value on the premises is approximately £77k. The revenue difference is due to the increase in size of the space and rent as per the District Valuer.

The Finance Committee were asked to formally **APPROVE** the business case to be submitted to NHS England.

The Finance committee **APPROVED** this.

8. Commissioning Intentions

KH spoke through the revised pack issued prior to the meeting, the main points/discussion were:

- The commissioning intentions are a link between the National approach and 'must do's' and how to filter these down to a local level for primary care and community.
- 2021 will be a transitional year.
- As there is a challenging financial environment, the CCG cannot continue to do things the way we have previously.
- The development of PCN's will occur and there will be a need to establish how these link into the primary community care through planned and urgent care.

TD enquired what this meant and how would we establish this. KH explained that this would be part of the development of the PCN's and the appetite for them to take these up and where would be most appropriate for the areas to sit.

- The commissioning intentions went to the Executive Committee on 24th October 2019 and are out for comment by clinical leads. These will go to Governing Body on 14th November 2019 for approval.

TD asked how community care would be integrated from Buckinghamshire Healthcare Trust. KH responded that this links into the local plan to decouple the community contract from Buckinghamshire Healthcare Trust. GH confirmed there had been an informal conversation with Buckinghamshire Healthcare Trust re this. The outcomes and specifications for the community contract need to be clear.

9.	**Long Term Plan**	
	1st November submission KH ran through the slide pack of the 1st November Long Term Plan submission. The main points/discussion held were: • The submission does not meet the trajectories. The in year ICP gap to control total in 2020/21 is £19.6m. Cumulative ICP gap to control total over 5 years is £86m (£4m relating to CCG and £82m Buckinghamshire Healthcare Trust). • Activity levels broadly align over the 5 years both within the ICP and out of system providers. • Workforce assumptions aligned across the ICP and in line with BOB. • Capital assumptions in line with BOB. GH highlighted that the ICP gap for next year is £19.6m compared to the control total whereas the gap across the ICS is in the region of £65m. This will be an extreme challenge across the BOB ICS to close. Fiona Wise and Gareth Kenworthy have asked for an organisational recovery plan, a place recovery plan and an ICS recovery plan to address this. GH commented that our BOB ICS is one of the most challenged in the country. TD enquired if we knew why this was. GH responded that from a Buckinghamshire system point of view we knew. In previous years CCG's had used non-recurrent funding to balance the position and this is no longer available, Oxfordshire CCG is now encountering this within their position. The regime around the new Financial Resilience Funding (FRF) has not helped providers within the patch. TD asked who was controlling BOB. GH explained that there are 2 main groups consisting of all the Financial Directors of the organisations in 1 and all the Commissioning Operational Director in another. There is also an Independent Chair. RP enquired if there was independent governance. GH commented that the governance would lie with the individual Chief Executives of organisations but they are not a decision making body as they represent their individual organisations. Decisions would be taken at CCG level. Key changes from the draft submission The Finance Committee were asked to **APPROVE** the below listed changes to the submission: • An overall improvement in the Bucks ICP LTP position of £8.8m. • Broken down over the 5 year period as: – CCG QIPP to 1.6% of £1.5m (Years 3-5) – this was previously 1.5% – Buckinghamshire Healthcare Trust CIP to 1.6% of £4.0m (Years 2-5) - this was previously 1.5% – Remove historic deficit of £3.3m for CCG as LTP shows in-year trajectories only. The Finance Committee **APPROVED** the changes to the submission. • The CCG is currently showing a gap of £0.8m in 2020/21 compared to the	

trajectories. The CCG will aim to close this gap for the detailed operational plan (although cognisant of the gap/impact across the ICP)
- Submission of the LTP will go to Governing Body on 14th November 2019 for Assurance.

2020/21 Plan

KH ran through the 2020/21 plan slide pack, the main points/discussion were:

- The slides relate to the 1st year of the Long Term Plan.
- Meetings will be held with budget managers during November to review and agree plans with ongoing monthly meetings until finalised.
- The plan will be brought back to Finance Committee during November and December for transparency.
- No guidance has been issued but there is an assumption that the NHS England submission of the operational plan will be required in January 2020.

RP asked that the Governing Body be made aware of the steps the Finance Committee would be taking on their behalf in relation to the Operational plan for 2020/21.

Action: KH to take the governance process followed for the operational plan by Finance Committee to Governing Body as part of the Long Term Plan. **KH**

- The contracting round is expected to take place between January and March 2020.
- Plan vs Control totals – for 2020/21 the CCG control total is £14.2m deficit, the plan has been submitted as £15m deficit currently showing £0.8m gap to control total.

TD raised concerns over the Buckinghamshire Healthcare Trust deficit and asked what they were currently doing to hit their control totals. KH responded that the CCG are linked into Buckinghamshire Healthcare Trust's planning timetables and attend weekly meetings.

Key requirements in 2020/21 from a local perspective to achieve the plan:

- De-couple the community contract from the Buckinghamshire Healthcare Trust acute contract.
- Limit investment in acute contracts to enable investment in Primary and Community.
- Take costs out of Continuing Healthcare (addressing benchmarking).
- Reduction in running costs by 20%.
- Delegate budgets where able to.
- System to agree Mental Health investment (how, where prioritised).
- Integrate primary and secondary prescribing budgets.
- Set realistic but stretching QIPP targets.
- Note – budgets may change once the efficiency targets have been worked up.
- The CCG will be looking to find the further £0.8m during the 20/21 planning round to enable a compliant plan to be submitted if possible.

TD asked whose key requirements these were. GH confirmed that these were the local financial strategy/'must do's' to arrive at a compliant plan. TD asked if the Finance team would require approval from the Finance Committee and Governing Body for these requirements. GH explained that it would be beneficial to split out the 'must do's linked to the Long Term Plan. RP commented that these were also key risks as if not achieved a compliant plan would not be met. TD asked that the key requirements be split out into strategic and operational.

Action: KH to add slide to the pack splitting out the key requirements. **KH**

	TD asked what 'integrate Primary and secondary prescribing budgets' meant. GH responded that work is happening to integrate the 2 teams. There would be one team covering both the CCG and Buckinghamshire Healthcare Trust. The consolidation of the CCG's prescribing budget and Buckinghamshire Healthcare Trust's secondary care budget is being worked through currently with issues to overcome. TD commented that by doing this would it mean losing control of the prescribing budget. GH explained that pulling the budgets together should see economies of scale. A paper is being worked on that will state the governance, control, oversight and assurance that will need to be put in place to facilitate this. I&E summary • There is a 2020/21 in year £15m deficit. This assumes in year requirement to breakeven and historical debt of £3.3m (2018/19) and £5m (19/20) is not paid back. • QIPP requirement of 2.31% (£17.6m) included, a paper is being worked up to see how we can achieve the savings. • All national requirements have been included in the plan except the £0.8m gap to required control total. GH explained to the Finance Committee that every year the Acute contract is negotiated with Buckinghamshire Healthcare Trust with an assumption that they will receive circ. 3% increase in monies and activity equating to circa. £7m-£8m. The conversation being held currently is that this will not go to Buckinghamshire Healthcare Trust; they will receive the price increase of 1.1% only with the remaining growth money being invested in Primary and Community Care. This will be a significant change to prior years and will provoke challenging conversations over the coming months. TD asked if there were any changes to how the Financial Resilience Funding is achieved. GH confirmed that no guidance had been issued but there is an assumption that this would not change i.e. would be paid quarterly on achievement of financial position. GH went on to say that is his view it would be very unlikely that control totals would change as has happened in previous years. GH highlighted to the Finance Committee that there had been a request from the regulator at the Assurance meeting on Monday to provide a clear paper from both organisations that set out what the run rate was doing, why has the position deteriorated or has it stabilised and what is the likely out turn process. The CCG is currently working on this and will state there is a risk for the CCG of between £0m-5m and is too early to say if that will been seen in the position between now and year end. As stated previously, a full reforecast will be undertaken at M8. The Finance Committee **APPROVED** the Long Term Plan.	
10.	**Any Other Business**	
	<u>Terms of Reference</u> RC asked the Finance committee to **NOTE** that the Terms of Reference had been updated to remove the Director of Commissioning and Delivery from the membership list. The Finance Committee **APPROVED** this change. <u>CHC Provider uplift requests</u> GH informed the Finance Committee that he had received 4 requests from CHC providers in nursing homes requesting uplifts to their fees. Over previous years no uplifts have been granted. The council hold a panel each year to review the requests with the next one being	

	14th November 2019. GH asked if the NED's would like to hold a similar panel to discuss the 4 requests or would they be happy to provide delegated authority to CFO to make the decisions. RP enquired if this could be done jointly with the Council for consistency. GH said this was unlikely given we are separate statutory organisations. TD asked what the consequence would be of not approving the uplifts. GH explained that during the planning period one uplift had been granted due to the provider being at financial risk if it didn't receive the uplift. One provider from the 4 requests has asked for an escalation per the terms of the standard NHS contract which means they must meet with a Governing Body member. The other 3 providers do not at this time appear to be at Financial risk if the uplift is not granted. GH emphasised that the CCG is in deficit and itself is challenged with a QIPP target of over 3% so it was unlikely uplifts would be granted due to affordability. Both RP and TD were in agreement that the CCG would wait to see the outcome of the Council's panel before making a decision. <u>Risk Register Assurance</u> KH noted that the work plan had stated the risk register be bought to the September 2019 Finance committee meeting for Assurance but this was omitted from the agenda. As this is a quarterly action the Finance Committee were asked if they would be happy to pick this up in December. The Finance Committee were happy to pick up the risk register in the December meeting only.	
11.	**Date & Time of Next Meeting** Wednesday 27th November 2019, Bevan Room, BCCG Offices, 08.30am –09.45am	
12.	**For information** The reports below were noted by the Committee. • Work plan review - rag rated • Use of Transformation Monies • Financial Improvement Trajectories • Protocol for moving off plan • S75 Dashboard M06	

Finance Committee Meeting – Minutes

Wednesday 27th November 2019, 08.30 – 09.30am
Bevan Meeting Room, Buckinghamshire CCG Offices, Aylesbury, HP19 8FF

Finance Committee Voting Members:

Tony Dixon	TD	Lay Member and Finance Committee Chair (Chair)	**Present**
Robert Parkes	RP	Lay Member and Audit Committee Chair	**Present**
Graham Smith	GS	Lay Member and Primary Care Commissioning Committee Chair	**Present**
Gary Heneage	GH	Chief Finance Officer	**Present**
Alan Cadman	AC	Deputy Chief Finance Officer	**Present**
Kate Holmes	KH	Deputy Chief Finance Officer	**Present**
Robert Majilton	RM	Deputy Chief Officer	**Present**
Louise Patten	LP	Chief Officer	Apologies Received
Russell Carpenter	RC	Board Secretary / Head of Governance	Apologies Received
Minute Taker			
Dawn Riddell	DRi	EA to Chief Finance Officer	**Present**
In attendance			
Barry Jenkins	BJ	Director of Finance, Bucks Healthcare Trust	Apologies Received

1.	**Introduction, Apologies & Quoracy**	
	TD welcomed the committee members to the meeting. Apologies were received from: • Lou Patten, Chief Officer • Russell Carpenter, Board Secretary/ Head of Governance • Barry Jenkins, Director of Finance (BHT) 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. The log was reviewed.	
3.	**Review & Approval of Minutes for 30th October 2019**	
	The minutes were approved as an accurate record.	
4.	**Action & Decision Logs**	

	The action log was updated as discussed.	
5.	**M07 Update & Financial Recovery Plan**	
	GH ran through the Financial Recovery plan and M07 update and gave apologies for the late presentation issued yesterday, the Finance Committee are requested to **NOTE** the position**:** The main points/discussion were: • The position has been held to plan at M7, the only main movement is Frimley where the risk has materialised. • Prescribing – there has been a national issue due to Lloyds Pharmacy not submitting their prescribing returns for 2 months due to the price increase on 1st August. This meant that the activity for June and July were not submitted until Aug and the impact on year to date was approximately £700k. This has impacted the forecast by £1.2m and is an extra pressure which cannot be mitigated. GH gave apologies for the lateness of presentation on the Buckinghamshire CCG Quarter 3 Reforecast slide pack issued, the pack was reviewed and the main points/discussion were: • There is new protocol issued by NHS England/I for reforecasting positions. This now requires sign off from Accountable Officer, Clinical Chair, Chief Finance Officer, Audit Chair and , System STP lead or financial lead. RP had questioned why the Audit Chair would need to provide sign off prior to the meeting. GH explained that the Audit chair sign off would be to ensure the process had been adequately followed rather than signing off the movement. • Due to the governance process there would not be enough time to complete this at M9, the reforecast would need to be formally reported on WD6 but results would not be available until WD4 or 5. Because of this the governance will be completed at M8 and the M9 position will be estimated. • A recovery plan will need to be produced which clearly identifies the drivers of the deterioration and what is being done to mitigate. There is a robust audit trail of the £10m over performance and in year mitigations identified throughout the year. • The System position will be discussed at the Finance Committee in Common meeting on 6th January 2020. STP sign off will also be required. **Action:** Sign off for Quarter 3 reforecast required from Governing Body before M9. • GH flagged the £4m-£5m risk is likely to materialise. In preparation for the December Finance committee meeting GH will calculate a figure that the forecast is likely to move out by for the remainder of the year. GH will brief NHS England throughout the process and will issue a formal paper to them. TD asked how delegation from board would be obtained as there is not a Governing Body meeting in December. RP responded that a virtual meeting on 4th December is scheduled where this could be discussed. GH confirmed he would also need to brief the Clinical Chair. <u>Forecast Out Turn</u> • The CCG's position is likely to move between £4-5m at M9. A net risk of £5m has been reported consistently throughout the year. • The areas that have attributed to the movement are: - Category M drug £0.9m and prescribing pressure of £1.1m. These areas were not planned for at the planning stage as advised by NHS England.	**GH**

RP commented that this must be a national pressure. GH confirmed it is. AC mentioned that a monthly return was submitted to NHS England which highlighted this pressure.

- Independent Sector over performance due to freedom of choice for patients £1.5m
- Community Equipment £0.5m

- The position can only be moved once.
- The impact will be a deficit of circa £18.8m to carry forward for 2020/21 (£10.5m further deficit to carry forward on top of planned 2019/20 £5m and £3.3m 17/18 to carry forward). This is based on a £4m movement in the 19/20 in year position.

RP asked if permission needed to be sought from the Joint Finance Committee with regard to the reforecast at the end of Q3. GH explained that permission was not required but there would need to be a decision around the 2 organisations moving off plan and what would be the best way to maximise PSF/CSF.

GH explained that his recommendation would be the following mechanism: due to the Trust underperforming against the contract, £4m-£5m could be clawed back by the CCG to allow the £6.5m CSF to be achieved from Quarters 3+4. RP asked if this was in our authority to insist the Trust do this if they refused the recommendation. GS commented that as the statutory body could we not insist.

GH explained that in the Acute block contract there is no claw back clause for underperformance.

GH also added that there is no risk to the CCG for the £4.5m risk share the Trust received as it had been confirmed in a formal letter from BHT's DoF. GS enquired if the block contract was absolute and GH confirmed it was.

TD enquired if the underperformance was likely to continue for the rest of year. KH responded the areas underperforming are drugs and elective. The trust has asked their division for a recovery plan to recover the position for elective. This may not be the best decision for the system as the elective work will need to be paid for elsewhere in the system (OUH & Frimley). If the position is recovered, it will increase the Trusts baseline for 2020/21. GH also commented that we are heading into winter and elective surgeries may have to be cancelled depending on the pressures.

RM stated that the principle of the joint Finance Committee was always to maximise PSF/CSF between the 2 organisations. If PSF is no longer available then obtaining CSF must be the option. There may be some challenging conversations ahead.

<u>Next steps</u>

- Review Forecast following M8 reporting and update at December finance committee (including sensitivity analysis of Best, Worst, Most Likely)
- Update recovery plan
- Ensure new governance process followed
- Recommendation for "system position" at Finance Committee in Common on 6th January 2020

GH stated that he would hold an extraordinary Finance committee if any other significant pressures arose beyond the £4m-£5m.

GS asked if NHS England not being happy with movements of more that £5m would provide any leverage to negotiate. GH responded that he would need to have a conversation with

	NHS England regarding this. RP asked if the Trusts equivalent of the Governing Body where aware of their position. GH confirmed that BJ has flagged this to the Trust's Finance Committee and has been transparent of the risk throughout the year. The regulators have asked for an audit trail of year on year movement and why the movement has occurred but GH has not seen this to date. There is a formal board meeting taking place on 9th December to discuss Forecast Out Turn. GH asked that it be noted that he believed that he would have reached year end holding the position but given the pressures outlined it has not been possible.	
6.	**Discretionary Spend over £50k for approval and STW where applicable**	
	No items discussed.	
7.	**2020/21 QIPP Efficiency Plan**	
	KH ran through the draft 2020/21 QIPP Efficiency Plan with the Finance Committee, the main points / discussion were: • The CCG have currently submitted a noncompliant plan to NHS England due to £0.8m gap to its £15m control total. • The paper looks at what can be done to achieve a compliant plan for 2020/21 • The proposed QIPP targets are listed under QIPP (operational savings) and System (structural and strategic savings) ensuring no savings are counted twice. <u>QIPP targets</u> • Acute saving from IFR/POLCE £1m. GH explained that as discussed previously at Finance Committee, there is a need to approach the acute contract differently. As the contract has underperformed this year it will need to be right sized firstly for 2020/21. For elective only the price increases will be applied and for non-elective the national guidance will be followed in relation to using the blended tariff rate. This should ring fence circ. £5m that will come out of Acute and into Primary Care and Community investment. TD asked what was meant by Primary Care Community. GH responded this would mean moving money out of hospitals and into community care to provide an environment to treat patients. TD commented that the Community Care would still be under the Trusts control, what enthusiasm is there from the Trust to look at this system wide. RM replied that he believed there was enthusiasm from the system to look at community based care. There is a need to look at the pot of commissioner services outside of the national primary care contract and align as a system. • There are no QIPP for community, Mental Health or Delegated Co commissioning. • Other Primary Care - £3.2m planned by removing improved access money (£6 per head) as it has been assumed that this funding would come from central sources as in previous years. GS enquired if this should be classed as a QIPP saving and when would the CCG find out if this was sourced centrally. KH responded that the CCG were still pushing for a decision but the decision was not made until late this year. TD asked what assurance there was that the £6 per head had been spent appropriately. KH confirmed that there is monitoring of this. The	

	Senior Management Team had identified that this may be an area for internal audit to look at for 2020/21 on 26th November 2019. **Action:** Decision to be made around whether the Improved Access funding requires an internal audit or review of contract monitoring. TD asked how PCNs fit into this. Could the PCN's monitor how the funding is used? KH confirmed that they do work in a locality basis for Improved Access currently. • Running costs of £2.3m equates to the 20% reduction. • CHC looking for £3.4m by holding growth flat. This is ambitious. • Meds Optimisation - Looking for 2.5% savings by holding growth flat. There have been the pressures around NCSO and Category M drugs that have arisen and will need to be discussed with budget managers. RM commented that the CCG's current QIPP this year in Meds Management makes Buckinghamshire CCG the top performing CCG outside of London and holding flat for another year may not be appropriate. • There is still £4m currently unidentified and there are very limited opportunities for savings in other areas. This is extremely challenging. TD commented that there were no savings assumed from system strategies. GH confirmed this as these were still being worked through and there was still a lot of work to be completed. TD commented that as the business cases are only just being worked through any savings next year would be unlikely. RM asked how we could work collectively with other CCG's to find savings. GH replied that there is a Director of Finance group across the BOB ICS who are currently carrying out a piece of work which asks each organisation what they have done to maximise their positions. The BOB ICS are looking at opportunities across system on areas such as clinical variation. RP enquired if there was work happening to look at the potential merger of all organisations. GH responded that there is a merger group and the CSU are completing a piece of work BOB wide looking at opportunities.	**KH**
8.	**Continuing Health Care Update**	
	AC provided an update on the prior year accrual issue that the Finance Committee were briefed on at the September meeting (25th), the main points/discussion were: • A vast amount of work and reconciliation has been undertaken in 2019/20 by a specialist CHC accountant to provide assurance that - that transactions are reconciled to the Broadcare system, both ledger and cash - that Broadcare has the correct forecasts and thus correct accruals - any non CHC transactions posted to the CHC cost centres are accounted for correctly in the correct cost centres • The peer review requested by the Finance Committee was arranged and took place on 4th November 2019. This was carried out by Debbie Fraser, Deputy Director of Finance, Berkshire East CCG. • The CCG received recommendations from the review which are being implemented. • The Current financial value is £4.3m with £4.5m mitigations identified.	

	GH stated that the peer review was useful and recommendations were sensible. TD asked if NHS England had been informed. GH confirmed he had flagged this issue to them on a regulatory call 2 weeks ago but no formal response had been received to date. GH confirmed that he still needed to issue a formal letter to the CSU.	
9.	**Any Other Business**	
	KH asked the Finance Committee if they would like to attend a social gathering with the CSU Finance Team after the Finance Committee on 18th December 2019. The members agreed this would be a good idea. **Action:** KH to confirm if the CSU team are available to meet after the December Finance Committee meeting,	**KH**
10.	**Date & Time of Next Meeting** Tuesday 17th December 2019, Nightingale Room, BCCG Offices, 10.30am –12.00pm	
11.	**For information** The reports below were noted by the Committee. • Work plan review - rag rated	

Finance Committee Meeting – Minutes

Wednesday 17th December 2019, 10.30 – 12.00pm
Bevan Meeting Room, Buckinghamshire CCG Offices, Aylesbury, HP19 8FF

Finance Committee Voting Members:

Tony Dixon	TD	Lay Member and Finance Committee Chair (Chair)	**Present**
Robert Parkes	RP	Lay Member and Audit Committee Chair	**Present**
Graham Smith	GS	Lay Member and Primary Care Commissioning Committee Chair	Apologies Received
Gary Heneage	GH	Chief Finance Officer	**Present**
Alan Cadman	AC	Deputy Chief Finance Officer	**Present**
Kate Holmes	KH	Deputy Chief Finance Officer	Apologies Received
Robert Majilton	RM	Deputy Chief Officer	**Present**
Louise Patten	LP	Chief Officer	Apologies Received
Russell Carpenter	RC	Board Secretary / Head of Governance	**Present**
Minute Taker			
Dawn Riddell	DRi	EA to Chief Finance Officer	**Present**
In attendance			
Barry Jenkins	BJ	Director of Finance, Bucks Healthcare Trust	Apologies Received

1.	**Introduction, Apologies & Quoracy**	
	TD welcomed the committee members to the meeting. Apologies were received from: • Barry Jenkins, Director of Finance (BHT) • Kate Holmes, Deputy Chief Finance Officer • Graham Smith, Lay Member • Lou Patten, Accountable Officer 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. The log was reviewed.	
3.	**Review & Approval of Minutes for 27th November 2019**	
	The minutes were approved as an accurate record subject to the changes discussed.	
4.	**Action & Decision Logs**	
	The action log was updated as discussed.	

5.	**Finances**	
	Quarter 3 Reforecast GH ran through the Quarter 3 reforecast, the main points/discussion were: • The CCG have reported a net risk of £5m since the beginning of the year which has now materialised. Mitigations are in place for £1.3m with £3.7m still to be identified. • A conversation has been held between GH and NHS England. Support of £2.0m is available if the CCG are able to hold the position to year end. The CCG has found further mitigations of £0.7m, so this leaves a gap of £1.0m. • There are currently £1m mitigations to be identified, the 2 options to mitigate are: 1) The Trust absorbs the £1.0m deficit. This option would deteriorate the system position further. 2) The balance of 2018/19 transformation monies will be used to support the position. Lou Patten and Neil MacDonald are both fully supportive of this option. TD asked how much the Trust was expected to move from plan. GH stated there would be a Board meeting held tomorrow (Wednesday 18th December) where this would be discussed and GH would be informed on Thursday but the figure is expected to be in the region of a £20m movement. GH went onto say: • If the CCG utilises transformation monies of £1m the CSF for quarters 3 & 4 will be received which amounts to £6.5m. This will also reduce the bought forward deficit amount that would need to be repaid (if the CCG moved its position). TD enquired what would happen if the risk could not be mitigated. GH explained that growth has been built into the final quarter for both CHC and Acute (£1.5m) which should enable the plan to be held. RP enquired what the position of Frimley was. GH responded there is over performance of £2.3m which is already in the forecast. There are on-going discussions being held which may improve this figure by using a blended rate. There is still a risk due to a further 4 months of reporting. RM asked if Frimley would agree to a year end deal that would help to crystallise the year end position. GH commented that year end deals could potentially happen across numerous Acutes. If the Forecast Out Turn is included in the year end it gives the CCG the opportunity to de-risk the position. • There are challenges expected at Finance Committee in Common meeting on 6th January 2020. GH stated that it would not be practical for the CCG to absorb the Trusts deficit. The recommendation will be for the CCG to stay on plan until year end. • The next steps will be for GH to meet with Steve Gooch, NHS England on Friday to review and agree the process. GH asked Finance Committee for formal support for the CCG to remain on plan until year end using Transformation monies from 2018/19 to mitigate the risk. The Finance Committee **APPROVED** the request for formal support. Running Costs AC ran through the running costs paper, the main points/discussion were: RP enquired if the 20% savings needing to be achieved by April 2020 related to actual or	

planned figures. AC responded that the context to make 20% savings came from the planning guidance from NHS England. In reality the figure is 12%, the original figure was calculated on 2017/18 allocations and there has been various inflation regrowth since that point. The savings need to be made against this year's allocation to next year's allocation which equates to a figure £1.3m lower.

RP asked if there was any merit received from the savings made from the Aylesbury Vale and Chiltern CCG merger. GH stated that the majority of savings already made were due to the merger. There are historic savings as the CCG has not spent the full allocations and had approximately £1m underspend on running costs. Staff have not been replaced when they have left the CCG and targeted work has been completed to reduce costs.

TD enquired how much more reduction could occur. GH explained that for non-staff perspective there is not much more that can be reduced. From a staff related perspective colleagues have left and not been replaced which may become a risk. There is £4.2m spent on the CSU which has not been factored in, there are no savings taken from 'In-housing' due to there being a stranded cost associated which would offset any savings in year one. TD asked if the CCG would still need to pay NHS England even though the work had been bought in house. RM explained that this would be a one off cost; the time taken to repay the stranded costs would be case specific. The CSU cost equates to 40% of the total running costs and this area would be the one to focus on as there are limited opportunities in other areas.

- Any associated change for agenda costs would need to be funded.
- The pension contribution has increased from 14.38% to 20.68% from 1st April 2019 and has been funded by NHS England for 2019/20. For 2020/21 it is expected that the CCG would need to fund this.
- Savings of £1.8m need to be identified.

RP enquired what the big headlines were in the 'non pay' amount. AC confirmed that £4m related to the CSU.

- The CSU contract has been reduced this year on the basis that there would be reductions from the 'in housing' process but these have not materialised to date due to delays in signing off the business cases.
- Savings have been identified in the following areas; Pay saving of £1.6m and Non pay savings of £309k. There will be £281k Transformation costs (ICP shared resources) to add back in which will give an anticipated total savings of £1.69m creating a shortfall of £181k.

RM commented that the Planned Care Programme role should be included in the Transformation figure. GH responded that this would need to be moved from Programme costs into Transformation.

GH explained that the 20% running cost is an actual allocation reduction that has to be met. The paper shows cash savings (staff not being replaced when they have left the organisation) and non-cash savings (moving staff from running costs into programme spend). RP highlighted that the cash savings are resources that are not being replaced by the CCG and this in turn implies a risk.

TD asked if there was a programme in place to manage running costs throughout 2021.RM commented that the Finance Team had done a great job mapping a figure, historically running costs have not posed a problem but these will be extremely tight and challenging next year. The key points would be a regular review, there is already a shared management structure with Oxford CCG which has not been reflected in the paper as money has not been

transferred to date.TD asked if the shared management structure was up and running. RM responded that it was in specific areas such as Quality. The CCG need to be prepared for the shared AO and how that works out throughout the year. As the ICS becomes the vehicle to deliver and expects the CCG to work as commissioners to the ICS there will be a need to look at shared posts and how these are funded. There may be BAU requirements that have been understated currently and gaps arising that need to be filled; there will be limited flexibility within the running costs next year to cover these. Conversations will need to be had with ICP system partners as to how they will provide support.

RM commented that the current paper to him did not support a narrative to suggest that a merger for running costs is required at ICS level.

RP asked that the paper clearly show what savings have been made but what has been lost as a result of the saving i.e. resource. RM suggested that an external narrative be added to the paper that sets out the risks from the savings and the gaps emerging.

RP enquired if the Trust has to reduce their running costs by 20%. GH answered that they did not. RM explained that an expectation for Trusts to reduce was set but as running costs are effectively built into their prices it wasn't as explicit. GH commented that he was having challenging system conversation relating to back office. The CCG have already reduced their costs by a substantial amount and this would need to be reflected when looking at the system as a whole. The Trust have suggested that there are system wide savings e.g. from payroll, however GH highlighted the CCG spend £5k per year on Payroll and no savings would be found here.

GH explained that the HR function was reviewed to become one function but an executive decision was made to keep the function due to the challenges ahead with potential mergers and the ICP/ICS emerging.

RM flagged that work was taking place with the local authority on how to integrate commissioning, there had been an ask as to what resources would be provided with the response that commissioning resources are limited. RM also highlighted that the in-housing business case approval for the CSU is becoming more difficult within the ICS. RP commented that he believed this would become more difficult over time and there appeared to be an inflexibility at other CCG's compared to Bucks in making decisions. This creates a risk of being at the lowest common denominator across the patch which will be by definition the most expensive denominator.

- There are opportunities to close the £81k gap within budgets and moving staff into Programme costs. If the funding for the pension increase is received this will cover the gap.

RP highlighted the training budget of only £10k and enquired if this was for the whole of the CCG. GH responded it was as this reflected the amount requested by staff via their personal development plans this year. There are free training courses available and centrally funded courses provided. There are also Financial credits available for non-financial staff to use.

TD asked if there was an option to acquire more space from the local council to vacate Amersham hospital and reduce the £100k spend. GH explained that the estate strategy for the next 12-18 months would need to be reviewed and this taken into account.

The Finance Committee were asked for formal approval of this paper.

The Finance Committee formally **AGREED** the running costs paper.

	RP asked if any formal approval was required from him for the governance of the Forecast Out Turn process. GH confirmed that a signature would be required. RP responded that in his capacity as Audit Chair his electronic signature could be used.	
6.	**Discretionary Spend over £50k for approval and STW where applicable**	
	No items discussed.	
7.	**Accommodation Update – Albert House**	
	GH ran through the Accommodation update regarding Albert House, the main points / discussion were: • A consultation to move staff from The Gateway offices in Aylesbury to Albert House in High Wycombe was undertaken. The decision was made not to undertake the move to Albert House following the consultation feedback. • Albert House currently has 76 staff working there with costs of £220k per annum. Not all of the 76 staff are supporting the CCG. • There is an opportunity to exercise the break clause on 16 July 2020. • Property Services whom hold the lease have asked the CCG for their view with regard to exercising the break clause. • The Chief Finance Officer has delegated authority from the CEO to exercise the break clause but would like formal support from the Finance Committee to recommend this approach. RM enquired who held the lease for Albert House. GH confirmed that the CSU hold a sub-lease from Property Services. The CCG have it as part of their contract with the CSU to pay this amount. RM asked if NHS England were asking what the CCG's intentions were in order for them to make plans and look at the longer term estates strategy. RM stated that the CCG would not intend to pay for a 3rd commissioning base in one county and the CSU would need to remove the price from the contract if they intended to stay at the location or look at redeployment options. AC enquired what would happen with Oxford Health staff. RM explained that partners would need to work through the options for their staff once the intentions had been made clear. TD asked where the staff would go. GH explained this would be part of the options appraisal carried out by Property Services to determine this. TD commented that this may cause a risk. GH stated that some staff would be in-housed and there are properties in one public estate available. RM responded that he believed there was 2 pieces of work that were required: 1) What the ICS footprint for commissioning looks like. 2) In Buckinghamshire the One Public Estate team need to map out the function and accommodation required. TD asked there that would be a backup plan if this work had not been completed in the required timescales. **Action:** GH to inform Oxford Health and the CSU of the CCG's intentions to action the break clause on 16 July 2020. **Action:** GH to formally signal the intention to Property Services that the CCG will not require the premises going forward.	

8.	**Risk register Quarterly Update**	

RC provided a quarterly update on the Risk Register. The Finance Committee were asked to **NOTE** discussion at Governing Body 14 November 2019 on current GBAF finance risks and action agreed.

1. **NOTE** current GBAF risks on Finance (appendix a)
2. **NOTE** Corporate Risk Register risks associated with Finance (appendix b)
3. **DISCUSS** any further controls, assurances or actions deemed as required to manage/mitigate these risks

The main points/discussion were:

- Risk 2 Better Health in Bucks – Frimley over performance – there is potential to negotiate a year end deal as a further control to mitigate risk.
- Risk 3 Sustainability within Buckinghamshire - QiPP – there is the potential for national funding for Cat M/NCSO drugs mitigating this risk.
- Risk 4 Sustainability within Buckinghamshire – Other Acute organisation - there is potential to negotiate a year end deal to mitigate risk, specifically in relation to Milton Keynes University Hospital and Luton and Dunstable University Hospital. The “leading to” consequence of a section 30 audit letter will no longer be relevant if year-end figures fall within budget/agreed parameters.
- The Finance Committee agreed that the corporate risk scores identified would otherwise remain the same.

The above risks have also been discussed in detail elsewhere on the agenda in relation to finances, estimated outturns and running costs.

RC reminded Committee of the finding from last year’s CCG risk management audit:

Although our review of the GBAF was generally positive, we identified four out of the total of seven risks where, although the current risk was scored as above the acceptable level for the risk, there were no gaps in controls or assurances recorded. In a further instance, a gap in control had been identified, but no actions were recorded to address this. This may create a risk that weaknesses in the risk management environment are not addressed, leading to an increased likelihood of unmitigated risks materialising.

A specific action was subsequently agreed to further review and update this for the finance risks, specifically prior to the next GBAF reporting to Governing Body in January 2020.

Action: AC/RC to review the GBAF risks and add detail where required.

As regards corporate risk register escalations, the main points/discussion were:

4. All Corporate Risk escalations appeared on an iteration of the register that was reviewed at the Executive Committee on 28th Nov 2019.
5. The TCP cost pressure risk was amended to show there has been ongoing dialog with NHS England and the CCG are awaiting confirmation from NHS

	England to confirm the availability of funding. AC confirmed that the match funding had been received to mitigate and the risk no longer exists. **Action:** RC to close the risk in Verto Transforming Care Partnership 6. There was no change to the Non-Elective or CHC risks. 7. The main risk from Category M/NSCO drugs risk has been fully mitigated and the corporate risk score agreed to be reduced to 12 as a result. This means it will no longer appear on the register of corporate risks escalated to the Governing Body in January 2020.	
9.	**Any Other Business**	
	RC asked if there were any agenda items for the Finance Committee in Common meeting on 6th January 2020. GH asked that the CHC Business case be included in the appendices for information only. RM asked that the Financial Recovery Plan and Case for Change paper from Barry Jenkins be included.	
10.	**Date & Time of Next Meeting** Wednesday 29th January 2020, Conference Room 2, AVDC Offices, The Gateway, Aylesbury, HP19 8FF @ 08.30am –09.30am	
11.	**For information** The reports below were noted by the Committee. • Work plan review - rag rated	

Finance Committee Meeting – Minutes

Wednesday 29th January 2020, 10.00 – 12.00pm
Conference Room 2, AVDC Offices, Aylesbury, HP19 8FF

Finance Committee Voting Members:

Tony Dixon	TD	Lay Member and Finance Committee Chair (Chair)	**Present**
Robert Parkes	RP	Lay Member and Audit Committee Chair	**Present**
Graham Smith	GS	Lay Member and Primary Care Commissioning Committee Chair	Apologies Received
Gary Heneage	GH	Chief Finance Officer	**Present**
Alan Cadman	AC	Deputy Chief Finance Officer	**Present**
Kate Holmes	KH	Deputy Chief Finance Officer	**Present**
Robert Majilton	RM	Deputy Chief Officer	**Present**
Louise Patten	LP	Chief Officer	Present for item 5. Closing ICS gap only
Russell Carpenter	RC	Board Secretary / Head of Governance	Apologies Received
Minute Taker			
Dawn Riddell	DRi	EA to Chief Finance Officer	**Present**
In attendance			
Barry Jenkins	BJ	Director of Finance, Bucks Healthcare Trust	Apologies Received

1.	**Introduction, Apologies & Quoracy**	
	TD welcomed the committee members to the meeting. Apologies were received from: • Barry Jenkins, Director of Finance (BHT) • Graham Smith, Lay Member 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 17th December 2019**	
	The minutes were approved as an accurate record.	
4.	**Action & Decision Logs**	
	The action log was updated as discussed.	
5.	**Finances**	

2019/20 by Exception

GH ran through the Finances for 2019/20 by exception, the main points/discussion were:

- The position at year end is expected to be met but will be challenging.

RP enquired if there had been any continuity discussed regarding the Wuhan Flu. GH responded that preparation is under way and Public Health had issued guidance to both Ambulance and Acute trusts but he was not aware of any CCG requirements currently..

- The M9 activity would be available early next week. There could be impact on the Independent Sector due to the slow down within planned care at Acute trusts. Continuing Health Care is still the biggest concern with pressures within the budget. The full year effect of the savings will not materialise until next year due to the timings of the reviews.

KH shared with the Finance Committee that she had an extremely positive meeting with Frimley on 28th January stating that DTOC has reduced to a more reasonable level.

- GH confirmed that written confirmation had been received from NHSE for the £2m funding. The allocation is expected to be received in M10. The signed MOU has been received for the Transformation monies, the risk for £1.8m is now limited, although we have yet to see it in our allocation.

Action: AC to contact GK re when the transformation monies would be released into 2019/20. **AC**

2020/21 - Operation Plan Submission.

KH provided an update with regard to the Operation plan submission, the main points/ discussion were:

- The submission date has been changed to 5th March 2020 as planning guidance has not been received.
- The plan has been produced with the expectation of hitting the £14.2m deficit plan. The LTP submission was a deficit of £15m.
- The draft will be bought back for review at the next Finance Committee on 26th Feb for submission on 5th March 2020. The draft would go to Governing Body for review in March for the final submission on 29th April 2020.
- Financial Recovery Funding (FRF) has been confirmed at 50% which is linked to organisational delivery and ICS delivery. If the CCG hits the plan of £14.2m ,£7m will be received but the balance of £7m will be dependent on the ICS hitting its plan. If the ICS plan does not hit the plan there will be an additional £7m risk.

The Finance Committee have been asked to **APPROVE** an operational plan submission on 5th March 2020 which shows:

- £14.2m deficit (compliant plan aligned with control total)
- Additional ICS led agreed schemes (following 24th January workshop) provided there is sufficient detail and robustness and these are incremental to the CCGs existing schemes.

Key System Challenges

- 2019/20 FOT changes and impact on starting point for 2020/21.
- Underlying system deficit and expectation growth monies will support this.
- Winter pressures and impact across the system.
- ICS expectations on Control Total and process to manage this.
- Unidentified QiPP of £4.2m which is likely to increase to £6.7m when risk assessed.
- The ICS scheme for Clinical Variation that has been identified to reduce the gap

already has £3.5m against QIPP. Unless this delivers above this amount the impact will not be incremental. The ICS schemes have not been worked up to this level currently and there needs to be caution that savings are not double counted in the figures.

Action: KH to document the assumptions in Operational Plan to avoid double counting. **KH**

RM requested that common descriptions/categories were identified to be used across organisations to reduce the risk of double counting. RM also asked that the level of ask(financial, performance improvement or transformational delivery) be quantified and where in the Bucks system this would sit with regard to resource as soon as possible to allow alignment across the system.

GH responded that last year an 'Expenditure review/Invest to save summit' was held with all of the Senior Management Team which explored each line of the budget to see what could be stopped and what could be invested for significant change to reduce activity. GH asked that this take place again this year within the next 2 weeks.

TD enquired when the single management team would be adopted. RM responded that his current understanding was that an Interim Accountable Officer would be in place by 1st March 2020 and the structure would be reviewed after the appointment

- Income & Expenditure – although there are significant risks within Continuing Health Care, the spend has held over the year and has reduced year on year.
- The plan assumes that the historic debt from 2018/19 (£3.3m) and 2019/20 (£5m) totalling £8.3m is not repaid.

Action: KH to review the Mental Health and Acute figures within the Income and Expenditure table re 2019/20. **KH**

- Growth monies – the figure is £29.7m for 2020/21, the majority of the amount is allocated to mandatory areas and minimum growth in other areas.

GH informed the Finance Committee that BHT had requested a detailed schedule of growth from the CCG. GH will provide this once the planning guidance has been received, digested and the risk attached to the plan calculated. RP asked why Bucks HealthCare would require this level of information. RM commented that for transparency the data should be shared but by all organisations. RM believed that by 2021 there would be a shared Control Total for all 9 organisations in the ICS and the providers would need to understand the wider risks of the organisations to understand how these could be controlled. In Buckinghamshire total transparency would be required around the Primary and Community and Mental Health and Autism budgets to support the delivery of the integration of Primary and Community Care.

TD enquired what the justification of the 5.7% growth within Continuing Healthcare was. KH responded that the figure from the Long Term Plan was based on historic growth and inflation targets. GH added that the monetary value equated to £4.2m growth with an equivalent QIPP amount to achieve flat cash.

- The activity assumptions may change as the process evolves.
- QIPP – the Medicine Management Optimisation target has been stretched to £2.0m where £1.6m has been identified.

Action: KH to change SRO for planned care to Diane Hedges **KH**
Action: KH to review SRO for Urgent Care. **KH**
Action: KH to recognise the £2m risk for Mental Health within the plan (difference between **KH**

funding envelope to meet the MHIS and the LTP requirements).
Action: KH to change the SRO for Continuing Health Care to Robert Majilton. **KH**

RP highlighted the key message arising from the plan was that the gap was unlikely to be closed, going forward the financial risks would need to be highlighted when the plan was submitted. GH highlighted that during the contracting round 2019/20 a substantial amount of QIPP was taken out and savings made, it is highly unlikely that this will be achievable for 2020/21.

The Finance Committee agreed that a circa 5 page presentation would be prepared to be presented at Governing Body in March, this would highlight the Operational Plan headlines and the associated risks.

Action: KH to produce a circa 5 page presentation for the Governing Body meeting in March which shows the risks and headlines on the 2020/21 plan. **KH**

GH informed the Finance Committee that the Finance Directors had agreed to produce a table documenting ICS risks by CCG and provider. GH would be adding Mental Health and Financial Recovery Funding to this table for Buckinghamshire CCG.

- The contract deadline remains as 27th March 2020.

Action: KH to look to have the BHT and Frimley contracts approved by 12th March 2020. **KH**

<u>Planning Guidance</u>

The planning guidance has not been received to date.

<u>ICS - closing the Gap</u>

LP dialled in to the meeting and provided the following update to the Finance Committee:

- The pre-Christmas submission of the Long Term plan had been pushed back due to there not being enough stretch across the ICS to close the gap.

- The ICS took an oversight of the whole system and highlighted opportunities to close the £73m gap by £43m leaving a £30m gap. All Chief Executives across the system signed up to this agreement.

- When the plan was resubmitted in January it was realised that there was no opportunity to describe the £43m as a system challenge. This was due to the ICS not existing as a statutory function. The Chief Executives and Accountable Officers were aware that the additional stretch for the individual organisations had not been through the appropriate boards for governance but for administrative purposes the £43m had to be divided up and absorbed by the individual organisations (based on each organisations distance from break even). The risk would be removed and become a System risk after the submission with the assumption that any remaining risk would be allocated in a fair way.

- Lou Patten and Neil MacDonald have sent letters to NHS England stating that as individual organisations they would not accept the additional risk amounts into their organisations positions.

- The Bucks ICP LTP submission for 20/21 improved by £16m on the 10 January 2020 (CCG £5m and BHT £11m). This is effectively a further risk in the system.

- A call between Fiona Wise and the Chief Finance Officer of NHS England on 28th January has resulted in a further £10m savings being required across the BOB system to close the gap. There was a suggestion from NHS England that Buckinghamshire should not be expected to absorb any further risk.

- The workshop held on 24th January agreed that Buckinghamshire would commit to key areas focusing on how much of the £43m gap could be closed. It was felt that the statement around Buckinghamshire not absorbing any further risk had been made as work had been completed and credibility tested of the plan. The next step would be to test some credible schemes, ensure all work completed is sound and not accept any more risk that is comfortable to do so.

- Fiona Wise has been asked to respond back to NHS England explaining the work will be completed but it would be highly unlikely that the £43m gap will be closed with a further £10m on top.

GH explained that there were numerous risks at ICS level at M9, these were:

- Significant movement in some organisations positions in 2019/20.
- Unidentified QIPP/CIPPs – £6.7m currently for the CCG.
- System gap – contractual misalignments. The main gap is CCG & BHT equating to £5-10m.
- The CCG's share of the £43/£53m system gap.

A discussion was held, the main points/discussion were:

- TD commented that this appears to be unachievable and how as a system would we would identify credible schemes to close the gap. GH responded that benchmarking has been completed at both ICS and local level. This suggested at CCG level there was a £22m opportunity, this is currently being reviewed and £11m has already been included in the plan. This is from a commissioner lens which suggests less activity taking place to make the savings. The challenge as a system is how to take costs out. The opportunities for the remaining £11m need to be reviewed and the CCG need to demonstrate to NHS England that all avenues have been explored to close the gap at ICS level.

- The 3 biggest opportunities identified at ICS level were:
  - Elective clinical variation – GH has agreed to support this work stream. It will look at the clinical variation within BOB and outside of BOB.
  - Agency Staff – looking at the Acute sector setting upper limit when bringing agency staff in.
  - Non value adding activities.

- RP enquired if the ask to close the gap by a £53m was a way to drive the merger of the 3 CCGs. LP responded that the merger would not save this level of money. As a system there needs to be bigger thinking to make the savings. E.g. there are currently 3 Mental Health providers, would it be an option to merge these. To make these significant savings in a short time period the referral management systems will need to be reviewed. GH explained the context that there are 10 ICS that are significantly off plan with the BOB ICS being number 11. The total sum of the 10 is £700m and savings need to be found to get the figures as near to plan as possible.

- TD commented that the clinical variation savings may not allow clinicians to give patients the care required. GH responded that this would strengthen the thresholds for the procedures taking place therefore reducing the activity. RM commented that

there is evidence based policies currently for procedures taking place but audits have shown that there are procedures taking place that do not meet the clinical thresholds. GH stated that money should not be taken out of the BOB Acutes to increase their deficit, there is significant spend outside of the BOB ICS which can be utilised.

- RP highlighted that the identifiable QIPP/CIPPs still need to be achieved.

- The next steps over the coming weeks are to work through the ICS level agreed work streams to understand the opportunities and values attached. These will need to be calculated at ICS, place and organisational level. The organisations will need to take the opportunities through their Boards. A system discussion will need to happen after this to decide how the inherent gap in the system is managed.

- The CCG's current inherent risk from the £43m is £5m. On top of this, there is £6.7m for unidentified QIPP and £10m gap due to contractual misalignments.

- RP commented that the only solution appears to be reducing patient care significantly. TD responded that he agrees that the work needs to be completed but there are demands from the regulator that we know we cannot meet.

- GH & LP to relay the Finance Committees comments back to the Governing Body with regard to the risk and assurances required around the pooled risk. TD asked that his concern around the damage to patient care versus savings financially was also noted. LP confirmed that Simon Stevens had been very clear that patient care should not deteriorate.

- RP was concerned that clinical variation would be seen as a deterioration of service. LP explained that Buckinghamshire has a healthier and wealthier population than most and the activity for procedures should reflect this, currently the activity level is over or on par with national average. In terms of fairness this process would sit better with clinicians and patients as it is more equitable.

  RP explained that would feel more comfortable if changing the level of service had been clinician led rather than financially led. LP replied that work was already underway to review some of the procedures as thresholds were not being met and this would be clinically driven. This would also highlight opportunities to reduce the current clinical variation that exists between ICS's.

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

No items discussed.

7. Any Other Business

GH informed the Finance Committee that a STW for Fed Bucks was due to come to the meeting but had been delayed. Fed Bucks carry out work across the ICP currently and the STW would be to extend the Extended Access contract for 2020/21 equating to £3.3m.

The Finance committee requested finance due diligence be undertaken before the contract is extended by a further 12 months.

GH would like to appoint an external audit firm to carry out the due diligence. The expected cost is £10k-15k. The finance committee supported this.

	TD asked if the extension was to the same company and if the procurement rules were being adhered to. There was also a question as to whether the contract should be extended for a further year. GH explained that normally the money would flow through to the PCN's but as they are not statutory bodies NHS England have stated that the money cannot go to individual practices which is why the money would flow via Fed bucks. The due diligence work would provide an audit trail and highlight any further controls that could be put in place with Fed Bucks to limit the risk to the CCG. Finance Committee **APPROVED** delegated authority to the Chief Finance Officer to spend £10/15k on the due diligence work.	
8.	**Date & Time of Next Meeting** Wednesday 29th January 2020, Conference Room 2, AVDC Offices, The Gateway, Aylesbury, HP19 8FF @ 08.30am –09.30am	
9.	**For information** The reports below were noted by the Committee. • Work plan review - rag rated • S75 19/20 Dashboard	

NHS
Buckinghamshire
Clinical Commissioning Group

Audit Committee Meeting - Minutes

Wednesday 27th November 2019, 10.00 – 12.00am
Bevan Meeting Room, Buckinghamshire CCG Offices, Aylesbury, HP19 8FF

Audit Committee Voting Members:

Robert Parkes	RP	Lay Member and Audit Committee Chair (Chair)	**Present**
Tony Dixon	TD	Lay Member and Finance Committee Chair	**Present**
Graham Smith	GS	Lay Member & Primary Care Commissioning Committee Chair	**Present**
Standing Invites			
Gary Heneage	GH	Chief Finance Officer	**Present**
Alan Cadman	AC	Deputy Chief Finance Officer	**Present**
Kate Holmes	KH	Deputy Chief Finance Officer	Apologies Received
Robert Majilton	RM	Deputy Chief Officer (Chair)	**Present**
Louise Patten	LP	Chief Officer	Apologies Received
Russell Carpenter	RC	Board Secretary / Head of Governance	**Present** – dialled in (items 1 – 9 &12)
Liz Wright	LW	RSM Risk Assurance Services (Internal Audit)	Apologies Received
Louise Davies	LD	RSM Risk Assurance Services (Internal Audit)	**Present**
Gareth Robins	GR	Counter Fraud Manager, TIAA	**Present**
Janet Dawson	JD	Ernst & Young, External Auditors	Apologies Received
Adrian Balmer	AB	Ernst & Young, External Auditors	**Present**
Sean	S	RSM Risk Assurance Services (Internal Audit)	**Present**
Minute Taker			
Dawn Riddell	DRi	EA to Chief Finance Officer	**Present**

1&2	**Introductions & Apologies**	
	Apologies received • Lou Patten, Accountable Officer • Kate Holmes, Deputy Chief Finance Officer • Liz Wright, RSM Risk Assurance Services (Internal Audit) • Janet Dawson, Ernst & Young, External Auditors With at least two voting members present the committee was quorate.	
3.	**Declarations of Interest in items on this meeting's agenda / Attendance Register**	
	RP reminded members of their obligation to declare any Conflict of interest they may have with any agenda items at Audit Committee meetings in common. No existing declarations were deemed to have materiality to items on the agenda.	
4.	**Review and Approval of Minutes of previous meetings**	
	The minutes dated 25 September 2019 were reviewed and agreed as a true record of the meeting with the amendments discussed.	
5.	**Action and Decision Logs / Matters arising**	
	All actions were reviewed and the log updated accordingly.	
6.	**Losses & Special Payments**	

	None to report.	
7.	**Single Tender Waivers**	
	The Audit Committee were asked to **NOTE** the following Single Tender Waivers: • MIG - this is for the annual renewal of the system used to allow real-time view of GP data within Out of Hours and other agreed organisations. • Optum – this organisation is used for the contract management of London providers. There is a collaborative agreement with 12 other organisations. This contract costs the CCG approximately £150k a year. The contact is coming up for renewal; a 12 month extension has been agreed whilst procurement takes place. • Helen and Douglas House Hospice – provider of residential children's hospice care within reasonable travelling distance for the residents of Buckinghamshire. This has been wholly funded by charitable donations in previous years. Buckinghamshire CCG has decided to award a new 2 year contract to part fund the services with charitable funds to cover the remainder. The cost from 2018 to 2020 totals £136,800.00. Audit Committee **NOTED** this.	
8.	**Update from Finance Committee**	
	GH provided the Audit committee with an update from the Finance Committee. The main areas discussed were: • In year over performance – there has been £10m over performance in year which has been fully mitigated through reserves and contingency. The 3 main areas driving this are Acute, Continuing Health Care, and Prescribing. • There has been a national issue with delays in submitting pharmacy claims from Lloyds Pharmacy, due to this issue the CCG are unlikely to hold the Forecast out Turn. • The £5m net risks that have been consistently flagged throughout the year are now likely to materialise. • A full reforecast will take place during month 8, ahead of the formal submission in M9, there is a very stringent protocol to follow for changing forecast movements around governance, a recovery plan and system sign off. An estimate for Month 9 will need to be completed. • CHC – GH briefed the Finance Committee on 25th September 2019 on an emerging issue from 2018/19 where the CSU had under accrued the year end position for CHC by £4m-£5m. NHS England and the CSU were briefed. Since May an external CHC accounting expert has been undertaking reconciliation work. The Finance committee asked that a peer review be completed; this was undertaken by the Deputy Director of Finance for Berkshire East. The outcome was reviewed at Finance Committee on 27th November. It was agreed that the peer review was useful and the recommendations for the CCG will be implemented. The final amount for the under accrual was £4.2m, there is a small risk in this amount but manageable and within the threshold. This has been fully mitigated in the position therefore no risk to Income and Expenditure. The CCG have committed to complete monthly cash reconciliations between the Broadcare database, I & e and management accounts. There is a CHC internal audit scheduled for the end of January 2020.	
9.	**Internal Audit Update**	
	LW provided the Audit Committee with an update regarding the Internal Audit Progress report, the main points were: • 4 final reports have been issued since the last meeting; they are Individual	

	Funding Requests (IFR), Committee Effectiveness, Financial planning and contract management. These were all awarded substantial assurance. • There are no reports currently in draft awaiting review by the CCG. • The ICP Governance work has been pushed to 2020/21. • The following audits are still to take place: - CHC – 24th January 2020 - S117 - to be returned to internal audit by the end of week. - Key Financial Controls – to be returned to internal audit in the next few weeks. - Risk Management and Assurance Framework – early January 2020 - Data security tool kit - 25th Feb 2020 - Follow up of actions – early March 2020 • GH informed the Audit Committee that LD had attended the Senior Management Team meeting at Buckinghamshire CCG on 26th November 2019 to discuss areas for which focus should be given for the internal audit plan 2021. This proved a useful exercise.	
10.	**External Audit Update**	
	AB provided a verbal update, the main points were: • External audit intend to bring the plan to the January meeting. • NAO code of practice – there is a refocus on value for money. This will be a stringent and rigorous piece of work. There are 3 key issues that have been highlighted which the revised value for money criteria will cover which are: - Financial Sustainability - Governance - Improving economy, efficiency and effectiveness. • NAO property services review – This is the 1st formal review and has highlighted huge losses. AC enquired when a planning timetable would be available. AB responded that resource has been booked for the week after next to complete this piece of work. AB also informed the Audit Committee that Friday 22nd May 2020 would be the date External audit would aim to sign off the accounts. RP enquired if it would be the same team as 2018/19 that would be completing the audit. AB confirmed it would.	
11.	**Counter Fraud Update**	
	GR provided an update on the Progress report, the main points were: <u>Fraud awareness week</u> • An email was sent out to all staff with a web link and newsletter to promote Fraud Awareness week. Online training for new starters is still being undertaken. <u>Prevent & Deter</u> • Mandate fraud is still a risk. TIAA have linked in with SBS and the CCG to look at controls. • Fraudsters are also posing as Executives and asking for bank account details to be changed on ESR. GS commented that substantial custodial sentences were handed down for fraud by the courts, could this be highlighted to staff as a deterrent. GR replied that any convictions where custodial sentences are given are published via the newsletter. <u>Hold to account</u> • Alleged Health Care travel cost claims – all the information has now been	

	received and shared with the Chief Finance Officer (GH). It was agreed that in the first instance a letter would be sent to the individual requesting full repayment of the claims. • Alleged Misappropriation of a Personal Health Budget (PHB) – this was reported due to carer's salaries for one month not being paid totalling £26,000.00. The representative has not responded to any calls or requests for contact to provide reconciliation information for the PBH. A statement is currently being compiled for the police and financial investigator. GS asked why the police had not been informed with regard to the salaries not being paid. GR responded that the police would require the statement as evidence and this would be handed over to the police once compiled. TD asked if there was an issue with the care provided for this PHB. GR confirmed that there had been no issues with the care provided just with the reconciliation of how the PHB had been spent. The management of the PHB has been transferred to a 3rd party. GS enquired if NHS email accounts where more vulnerable than other email accounts.GR commented that he didn't believe so, the controls are in place, the vulnerability is with the individuals. GH asked the Audit Committee to formally thank GR for all his hard work and the raising of awareness around fraud within the CCG as this would be his last Audit Committee.	
12.	**Corporate Governance Assurance Update**	
	RC asked the Audit Committee is asked to: a) **NOTE** Integrated Risk Management Framework – Framework update& bi-annual register review • **NOTE** risk reporting arrangements and the Integrated Risk Management Framework are both unchanged from when this item was last reported. The current framework for formal review by CCG committees is included for information (Appendix 13a1) • **REVIEW** the content of the latest Corporate Risk Register (CRR) which was reviewed by the CCG Executive Committee on 26 September 2019 and updated post the meeting (Appendix 13a2) – assure itself over CRR completeness, validity of scores and appropriateness of mitigating controls, assurances and actions. Review evidence of discussion through subsequent minutes (Appendix 13a3). **REVIEW** the content of a randomly selected risk register from a Sub-Committee within the last 3 months, with discussion evidence through minutes (Appendix 13a4). For this report, the Primary Commissioning Committee has been chosen with minutes evidence provided (Appendix 13a5). • **NOTE** minutes from Governing Body as evidence of review of the Governing Body assurance framework (Appendix 13a6). • **NOTE** risk management audit is scheduled for January 2020, with this report to form part of evidence. The Audit Committee **NOTED** this. b) **NOTE** Conflict of Interest Exception report and informal audit findings (13b) The main points/ discussion were: • Conflicts of Interest were not on the formal internal audit programme for 2019/20. An informal internal audit has been completed and 95% of Conflicts of Interest declarations are now in date.	

	The Audit Committee **NOTED** this. c) **NOTE** assurance provided by the report from the CCG Data Protection Officer (13c) The main points/ discussion were: • The deadline for EU exit has been pushed back to 31st January 2020, RC has sought assurance from the suppliers of the database infrastructure for both CHC and IFR that there would be no issues due to loss of flows to the system and that their servers are hosted in UK. • A specification is being drafted to work on a joint mini procurement with Oxfordshire CCG for a DPO. Oxfordshire are leading on this and expect to have an update for the next Finance Committee meeting in December.	
13.	**Any Other Business**	
	None discussed.	
14.	<u>Date and time of next meeting</u> Wednesday 29th January 2020, 10.00-12.00pm, room TBC	
15/16.	**For Info**	
	The reports were noted for information.	