Agenda Item: 4

Minutes

Buckinghamshire CCG Governing Body – in public
12/11/2020. 10:30-12:30
Microsoft Teams
The MS Teams video of this meeting is also published on the CCG website.

Members			
Name	**Role and Organisation**	**Initials**	**Attendance**
Dr Raj Bajwa	**GP Clinical Chair (Chair)**	**RB**	Present
Tony Dixon	Lay Member / Chair of Finance Committee	**TD**	Present
Kate Holmes	Interim Chief Finance Officer	**KH**	Present
James Kent	Chief (Accountable) Officer	**RM**	Present
Robert Majilton	Deputy Chief (Accountable) Officer	**JK**	Present
Crystal Oldman	Registered Nurse	**CO**	Present
Robert Parkes	Lay Member / Vice Lay Chair / Chair of Audit Committee	**RP**	Apologies
Dr Dal Sahota	Clinical Director – Urgent and Emergency Care	**DS**	Present
Dr Rashmi Sawhney	Clinical Director – Health Inequalities and The Primary Care Network DES	**RS**	Present
Graham Smith	Lay Member, Chair of Primary Care Committee	**GS**	Present
Dr Karen West	Member GP/Clinical Director Quality and Integration/Caldicott Guardian	**KW**	Present
Dr Robin Woolfson	Secondary Care Specialist Doctor	**RW**	Present
Others: (Standing Invitees or In attendance)			
Frances Burdock	Associate Director of Contracts and Performance	**FB**	Present (item 10b)
Caroline Capell	Director of Urgent and Emergency Care	**CC**	Present (for item 9)
Russell Carpenter	Board Secretary/Head of Governance	**RC**	Present
Neil Flint	Head of Commissioning for Planned Care / Restoration and Recovery Lead	**NF**	Present (item 10a)
Catherine Mountford	Director of Governance, Director of Governance Oxfordshire and Accountable Emergency Officer	**CM**	Present (item 13)
Bashak Onal	System Resilience Manager	**BO**	Present (item 13)
Louise Smith	Interim Director of Primary Care and Transformation / Senior Responsible Officer Covid-19 Vaccination Programme	**LS**	Apologies

Standing Agenda Items		
1	**Welcome and introductions** The Chair welcomed everyone to the meeting.	
2	**Apologies for Absence** Noted as above. The running order to change allowing JK to leave by 11am.	
3	**Declaration of Interest** The Chair reminded members of their obligation to declare any interest they may have on any issue arising at Governing Body meetings that might conflict with the business of Buckinghamshire CCG. The following update was received at the meeting: **Item 14: PCN and Additional Roles Reimbursement Scheme (ARRS) update**. Member GPs who are also CCG Clinical Directors and partners in their practices are directly conflicted given their practice partner status and therefore subsequent status as (a) Partners in practices which are members of Primary Care Networks (PCNs) (b) Recipient providers in the signature of Primary Care Network Direct Enhanced Service (DES) contracts (c) Recipient financial beneficiaries of funding made available to PCNs through a new Additional Roles Reimbursement Scheme (ARRS) to recruit up to five specific roles, over the next five years. (d) Recipient providers for a supplementary network service (SNS) introduced to support primary care locally to achieve better quality care outcomes for care homes residents. However this is deemed to be immaterial to the agenda item. This is on the basis that Governing Body is not being asked to approve the PCN workforce plans or the associated ARRS funding allocations. No further action required. CCG Clinical Director Dr Rashmi Sawhney as the lead for the Primary Care Network DES is also directly conflicted as a practice partner and therefore beneficiary. This is also immaterial as there is no decision required. **Declaration of Gifts & Hospitality** The Chair reminded those present of their obligation. None were declared.	
4	**Minutes of the Meetings held on** 10/09/2020 These were agreed as a true record of that meeting, subject to (from RM): • Section 4 final paragraph: CC (not CCG) commenting on there being a "get me home" work stream which supports discharge modelling. • Section 9 first paragraph: JK (not KJ) noted having covered much of the report content under other items and during the preceding AGM	
5	**Action Log/Matters arising:** as described on the separate log.	
6	**Accountable Officer's and Deputy Accountable Officer's Report** The winter plan is now amber-green rated following further feedback from NHS England. We continue to work through with NHS England allowable overruns to the £37.8m forecast overspend against envelope.	

	We are working with partners including LMC on use of EMIS records to assess patient encounters and impact on primary care workload. A system session was held yesterday to consider early actions on *Happier, Healthier Lives: A shared plan for Buckinghamshire.* This is to reports back to the Health and Wellbeing Board on 10 December. GS observed under primary care that face to Face interventions were at 49% and asked whether patients are being missed. JK referred to work as described with Healthwatch as a check and balance, with reporting timescales to be confirmed. We are also making sure there is a selection of channels available to minimise this. Many video consultations have now returned to telephone. RB emphasised we don't want to neglect the most vulnerable. In response to a question about patient feedback on impact, RM highlighted this was addressed through an ICP engagement process just closed. **<u>Action:</u> Results are being collated and summarised, to circulate to members for further information.** NF added we are working to further capture patient outcomes with Buckinghamshire Healthcare NHS Trust. TD questioned the risk in relation to new contracts for planned care intermediate services as described (section 6 within report supplied). NF advised there is a risk of challenge in lieu of procurement, especially those contracts above EU procurement threshold (i.e. £663, 540 whole life). However this is deemed to be low given the circumstances. These are established services with a plan in place for re-commissioning. We have liaised with SCWCSU procurement specialists to inform this conclusion. The Governing Body received and **<u>NOTED</u>** the report.	**RM**
	Operational Performance	
8	**COVID-19 Wave 2 preparation: approach to incident management** The ICC is led by Volker Kellerman on secondment from SCAS. 3-500 enquires a day through ICC during the first wave – this is an intensive set of processes. At system level we have four cells: • Capacity, Planning and Escalation – making sure we are aware when running out of PPE and key supplies, reviewing NHS capacity especially critical care with mutual aid in support, and regional escalation if required. • COVID19 Vaccine Program – headed up by Louise Smith • Communications – internal and external Twice weekly place based calls include chief executives to discuss mutual aid issues. It is a greater challenge given pending winter aligned to triple aim of winter, COVID and restoration/recovery. We remain cognisant of impact on front line staff. RW noted potential of social distancing on flu rates, and asked how flexible triple aim is to ensure we don't have an over emphasis of resource into reactive response. JK advised we are clear on difference in approach for the second wave. There is pressure to maintain planned care and urgent care. We have learned with good tracking mechanisms for this.	

	There are also robust processes for green sites and use of independent sector for planned care. But we don't know what may run out, so a capacity escalation cell involves Chief Operating Officers to make appropriate judgements. There will also be a lean on primary care for vaccine deployment which will affect screening and activity planning. RW added diagnostic waits (6 weeks) frequently come up in quality and performance reports. This was a lead in to reduced cancer activity during the first wave. RW is keen to be assured that there is a focus on this and that the impact on cancer pathways is being measured. JK reiterated cancer has been falling again since June with diagnostic capacity constraints. **<u>Action:</u> we are improving performance with waiting times falling, but will double check and feed back to RW.** Two weeks waits have been challenging over the last month with rising referrals. RB noted broader impact on patients, with need to maintain focus on "clinical harms" as during the first wave. GS questioned whether we know more about the virus now. JK explained that once people are in hospital, our ability to treat in intensive care is much greater. There are lower numbers and greater use of CPAP which has led to lower death rates. But we are in a different place to the North West, and it is difficult to know how social distancing and lockdown has impacted. We did expect higher numbers of admissions. RB added the areas most affected now were less so during the first wave and vice versa, with social behaviours potentially affecting this. The Governing Body received and **<u>NOTED</u>** the report. **JK left the meeting at 11am, the meeting remained quorate.**	**JK**
	Risk Management and Assurance	
7	**Risk Management and Assurance** **a. Governing Body Assurance Framework (GBAF)** **b. Corporate Risk Register Escalations – BAU** **c. Corporate Risk Register Escalations – COVID-19** RC referred to the standing agenda item on Finance for further evidence of these risks specifically (including prescribing growth and phase 3 allocations). The GPIT capital risk was unchanged with funding position not yet confirmed, and asked RM/KH to provide an update on gap in shortfall in in-year funding. RM confirmed that a Project Initiation Document (PID) has been approved, but as yet no additional funding has been received. The Governing Body received and **<u>NOTED</u>** as **ASSURANCE** a slide set as focusing attention on key risk highlights (BAU and COVID-19).	
	Operational Performance	
9	**Winter Planning / Flu** TD noted at that Finance Committee has discussed discharge of COVID-19 patients to care homes and availability of designated facilities to address this. CC reported we are looking at options for positive patients but otherwise medically fit patients to be discharged, but only with negative result. There are	

	staffing and safety issues to consider. RB added there had been productive ICP discussions about this. GS queried flu incidence likely to fall. CC advised the R rate of Flu is circa 5, compared to lower for COVID-19, so face masks etc. will be helpful. There has been a reduction, but whether that is COVID measures or the weather it is difficult to know. RB added 2% of normal figures through data from 1500 sentinel practices. There have been fewer patients reporting. DS reported we will learn from the southern hemisphere which had fewer numbers, but whether public behaviour will impact on this we are not sure. Vaccination update also increased in some groups, e.g. pregnant women whom Buckinghamshire Healthcare NHS Trust is more proactively vaccinating, and an increase on the previous rate for this group. KW added flu cases had decreased, which is perhaps not surprising perhaps given current social distancing measures. The Governing Body received and **NOTED** as **ASSSURANCE** the update provided.	
10	**Restoration and Recovery** **a. Phase 3** NF ran through the report supplied, which has circulated to a number of boards. The video of the item in full is published on the CCG website. The report contains summary slides and system progress against phase 3 requirements. There is confidence that aims will be delivered. Some asks are at ICS or NHSE level, e.g. community pharmacy, where this is little we can do even though forms part of our plan. We aim to include social care activity. • **Primary Care** – challenges to restore services and establish PCNs at the pace originally planned. RS commented referrals have dropped due to fear, people are now presenting so referrals have increased again. PCNs are busy – advantage of digital has meant more time available for multi-morbidity patients. Practices are encouraging patients to make contact by phone or digitally. RB added data shows more activity compared to January 2020. • **Elective Care** – rated amber – largely due to diagnostics – we are improving. Ophthalmology and TNO have been under high demand due to high demand and numbers of 52 week waits. We are 5% away from plan. • **Community Care** – amber status – starting to get through backlog. Flood at rookside clinic in Aylesbury has affected podiatry services. • **Mental Health** – amber status – increased demand has been met. Risk status relates to health checks where we have set a lower local target as the national target is not expected to be met. Overall demand is increasing. Uptake of virtual appointments has increased, but some are reverting to face to face. IAPT continues to see much virtual activity. A 24/7 line remains in place for mental health crisis. • **Infrastructure** – with a large programme including estates through to HR. HR highest risk given staff off whether related to symptoms, isolation or carer duties. There are fewer complaints likely due to Buckinghamshire Healthcare NHS Trust's patient letters about	

	delayed appointments. KP queried whether reference to an amber rating for communications relates to Buckinghamshire Healthcare NHS Trust or system as a whole? NF advised it is a collective as a whole. There have been previous queries around joining up with challenges remaining. KP asked how this is articulated so the team is ware there is a challenge. NF reported there is a fortnightly recovery group including communications colleagues and with actions to engage with relevant leads. There is much work captured within this pack to share knowledge across the system. RB asked for KP to be linked into this work. • **Inequalities** – making sure through every work stream we are identifying any work to address this. Each work stream asked to identify any gaps. Steve Goldensmith now supporting RS to work on inequalities. RS added a key piece of work with PHM action learning sets to work with three Primary Care Networks who have analysed deprivation data with actions arising: Cygnet looking at people with severe mental illness (SMI) and deprivation, Mid Chilterns looking at heart failure, and ARC looking at social deprivation of people with sever co-morbidities. As an ICS a bid had been submitted for cardiovascular with deprivation, which will start fairly soon. **<u>Action:</u> RB suggested the gambling section be re-phrased given circulation of reports in the public domain.** • **Performance** (1) Actions being updated, 60% of activity overall relates to Buckinghamshire Healthcare NHS Trust with overall CCG position expected to report within the next month. (2) We are seeing activity closer to trajectories, especially day cases. 70% compared to last year, and 75% this month coming closer to trajectory. (3) Outpatients 83% compared to last year, resulting from mixture of case mix and we are analysing this. (4) 52 weeks - orthopaedics we have commissioned IS working with Horton to do more activity, and ophthalmology over 200 cataract procedures within last two weeks to recover this service, prioritised on length of wait. • **Risk of harm** for delayed patients also monitored. Patient choice is still factoring in to people choosing not to go to places further away, e.g. up to Banbury or down to Reading. • Ongoing work to join up **primary and secondary interfaces.** • **Reporting arrangements** will continue to evolve. RB asked that a broad base of clinicians is engaged before any guidance documents are released to primary care. NF advised the Recovery Board (including Dr Raj Thakkar) had also highlighted this. DS referred to outstanding actions, specifically “Publish BAME senior management plan – in progress”. Can some narrative be included? With a matter such as this to be outstanding at this point is a reputational issue. Is “in progress” a default status? NF indicated there is a commentary in a document which sits alongside this. But there is always room to add further detail. This pack was based on three weeks ago with an update to be published next week.	**NF/Steve Goldensmith**

	RB noted the eternal challenge of overview vs. level of detail for assurance. The presentation was an excellent. Thanks to colleagues for the amount of work involved through the recovery board and supporting work streams. This provides a level of granularity which is important sustain once the pandemic has ended. NF also acknowledged the collective effort. **b. October 2020 Quality and Performance Report** 1. Diagnostics – capacity challenges currently experienced linked to Buckinghamshire Healthcare NHS Trust. Main areas of risk where numbers increasing, in total plus both under and over 6 weeks in Non-Obstetric Ultrasound, echocardiogram, MRI, CT, gastroscopy and colonoscopy. FB also provides project management for the task and finish group. It agreed looking at image sharing, sharing DNAS, reviewing Richard report and plans to achieve zero 6 week breaches by end of March. Early stages at present. 2. RTT – September figures under 18 waits lower than April, 18-40 weeks increased as well as 52 and 52+ week waits. 3. Query received from a GP on referrals from private consultants referring in – increasing number seen privately and transferring with jumping of waiting list. This was discussed with Andrew Maclaren noting that patients can enter 2 week pathways but require retrospective referral. In other specialities private consultants will need to refer to triage otherwise there will be a referral back to GP. This is not intended to increase GP workload but ensure fairness and equality in meeting trajectories. 4. RB noted clear criteria for this with few barriers – then why is this necessary if referral is already acceptance to Trust?. Retrospective referral doesn't add to pathway or patient care. FB advised this was for the completeness of the record on Trust PAS. **<u>Action:</u> RB suggested this may not be good use of primary care clinician time with an action agreed to take offline, liaising with Raj Thakkar. FB did not want to have patients unnecessarily delayed.** 5. Areas of rural Oxfordshire which are reliant on heating oil, which will impact on care if there is a shortage. 6. Workforce within social care with expected shortage given reliance on EU workers. 7. Medicines and EU exit – FB asked for any issues to be escalated to her. RB invited queries or areas of particular significance. 1. GS asked whether water shortage was realistic. FB noted this has been taken up as a national issue. 2. RM highlighted LD and SMI health checks with work to do to meet expectations given COVID impact. KW stated work is going on to improve health checks and quality, with SMI closely following behind through Primary Care Networks. 3. RM suggested CHC information does not reflect discussions at CHC Transformation Board. The CHC assessment process has re-started – 250 deferred assessments during suspension with recovery plan trajectory to mid-February 2021 to work through this. There were no hospital assessments during September. Some other targets will take time to re-balance. 4. RC noted a Public and Health Service Ombudsman (PHSO) report	**NF**

	with recommendations for CCGs on learning and training for nurse assessment staff. **<u>Action:</u> To review (for local learning) the PHSO report published last week on CHC. Includes recommendations for CCGs on ensuring appropriate training and learning opportunities for staff applying the criteria. These appear on the executive summary and on pages 22/23 of the full report.** The Governing Body received and **<u>NOTED</u>** the report and updates provided.	**KW/David Williams**
11	**Finance Update / Month 6 Finance Report** Changes to the financial regime had been reported previously – with an allocation for months 1-6 and reimbursement including hospital discharge programme up to the end of September. This also relies on national block arrangements. All our claims up to including Month 5 have been reimbursed. Top ups into month 8, but otherwise break even months 1-6. There is a control total for months 7-12, with additional allocations for COVID and recovery spending. Plans were submitted in October as referred to by JK. CCG £6.3m deficit plan – relates to different views nationally for prescribing and CHC whereby actual costs are higher than allocations. We are discussing this with NHS England. £6.2m BAU also assumes £3.6m for COVID spend and this remains within allocation, plus hospital discharge schemes (pre and post 31 August) will continue to be reimbursed centrally. Further update on this next month. Risks are as highlighted on the risk management item. Although we remain within allocation the second wave is not planned for. There is a resultant cost pressure with £0.5m risk. There is £150k expenditure this week relating to COVID and primary care. There is no indicative allocation for the hospital discharge programme. We are expecting this to follow. RB invited any comments from TD as Chair of the Finance Committee. TD noted careful monitoring at Finance Committee with the team working hard. RM added Governing Body needs to know implications for future years – cost base and spend will shift significantly given out response to the pandemic. This will be taken into account with 2021-2022 planning. KH advised future planning will report through Finance Committee. So will joint work with colleagues from Buckinghamshire Healthcare NHS trust and Oxford Health NHS Foundation Trust on managing the impact on the mental health investment standard. The Governing Body received and **<u>NOTED</u>** the report.	
	Decisions	
12	**Corporate Governance and Constitution** **a. Annual Review of Terms of Reference – Quality and Performance Committee** **b. COVID-19 governance accountability and statutory duties (1) Decision Log,(2) COVID-19 costs return to NHS England** **c. Changes to the CCG Constitution – delegated authorities**	

	a. The Governing Body **RATIFIED** the terms of reference for the Quality and Performance Committee following completion of annual review. RC noted reporting for other committees earlier in the year, with challenges in convening Q&P due to pandemic challenges. b. The Governing Body **NOTED** as **ASSURANCE**: • COVID-19 Decision Log as at 12 November 2020 (which excludes any decisions previously recorded and reported to Governing Body on 11 June 2020 and 10 September 2020). • submission of "reasonable costs" related to COVID-19 for the months August 2020 and September 2020 RC described this as a standing item, recapping previous HSJ coverage earlier in the year and the risk of legal challenge of CCGs. The decision log is reported for completeness, relating at this time to Integrated Commissioning and includes only those arising subsequent to previous reporting in September. The "reasonable costs" description is no different than what KH has already reported under the Finance item. (c) The Governing Body **APPROVED** constitution changes as described within and **RATIFIED** terms of reference for the integrated commissioning executive team (ICET) which were approved at its meeting on 1 October 2020. RC clarified the delegations to ICET. RM reflected that the authorities were supported, but ICET didn't actually meet for the first few months of the pandemic. **Action: RM to reflect on how best to report discussions at ICET, e.g. mental health, learning disabilities etc., so that Governing Body is appropriately assured. RB noted this is a good principle to ensure link back to Governing Body.** RC noted other technical changes, tricky when detailed but otherwise owned by Governing Body. RB noted Governing Body remains supportive of such arrangements and changes.	
	Governance and Assurance	
13	**Emergency Preparedness, Resilience and Response (EPRR) annual assurance report 2020** CM introduced herself as Accountable Emergency Officer. During the year a combined on call rota across Buckinghamshire and Oxfordshire has been introduced and thanked directors for adapting to this. We have tested our pandemic response, with resultant learning having informed the report. BO described the in-year challenges. This is year has been light touch whilst providing evidence of completing previous actions. We have only one areas remaining for compliance, overall substantially compliant. The remaining governance action will be picked in collaborative work across the CCGs. NHS England content with evidence provided of preparedness for winter, with note of urgent and emergency care work streams working across the geographical footprint. Provider assurance was also sought, with Buckinghamshire Healthcare NHS Trust now fully compliant. RM added the pandemic has	

	brought into sharp focus what EPRR is; prioritising work into cells during what is a challenging time. The Governing Body: 1. **NOTED** the submission to NHS England by 31st October 2020 of • The CCG's Emergency Preparedness, Resilience and Response (EPRR) self-assessment with rating of substantial compliance and assurance on compliance (attachments a/b) • CCG action plan (attachment C) 2. **NOTED** this report meets a requirement to ensure the overall assurance rating is reported to the Governing Body at a meeting in public. 3. **NOTED** outcomes of internal audit related to EPRR	
	Primary Care and Primary Care Networks (PCNs)	
14	**PCN and Additional Roles Reimbursement Scheme (ARRS) update.** RB confirmed his conflict of interest as indicated at the beginning of the meeting. RM thanked Wendy Newton in the primary care team for her supporting work. The scheme is predicted to utilise nearly £4m of resource through to March 2021. Indicative plans up to 2023/2024 have also been submitted. There were 19 posts in 2019/2020, whereas 184 are planned in this financial year, with 107 in 2021/22, 58 in 2022/2023 and 81 in 2023/2024. This is a significant amount of recruitment in a short amount of time. Estates and IT required along with training and recruitment are recurring themes. We can bring back plans for fulfilment of roles. RB highlighted this as a key vehicle to sustain primary care in the future, and the model which articles the long term plan. There is evidence our system is not as joined up as it needs to be. Wendy Newton has been essential to produce workforce reports and conduct important ground work to make this successful. Jessica Newsman and RB have discussed how to utilise this. **DECISION: We are meeting Rebecca Tyrell from the Training Hub to ask that Wendy have a seat at the Training Hub board. RB asked Governing Body to support this. There were no other objections to this and so it was AGREED**. TD queried how these roles would be recruited to. RB emphasised this is the single biggest risk. RM added we must not think of this as one off, with over 800 WTEs during the next four years. It is an expanded workforce.RS added PCNs have moved forward, but there is differing maturity. Notable successes include: (1) Launch of care homes supplementary network service (SNS) (2) Re-alignment of care homes to PCNs – practices are understanding closer working and more patient centred delivery. (3) Population Health Management action learning sets have been positive – learning from others to see how to analyse specific population needs. The new challenge for Networks is the COVID DES; to deliver at speed the	

	vaccinations. The CCG is responding to feedback and are meeting fortnightly through the SNS team but also addressing other issues. DS added that there is a commitment to recruit to ARRS scheme roles. KW reported there is much variation remaining including training and learning between PCNs. Governing Body **NOTED** (as information) progress to date with regards to the PCN Workforce Plans as outlined.	
	AOB & For Information	
15	**Questions in advance** RC confirmed none received in advance.	
16	**Questions from the floor** None tabled. RC noted the response to the question about Long Crendon surgery is documented in the previous minutes.	
17	**Communications and Engagement Report Q1-Q2 2020/2021** Highlights: (1) The domination of the pandemic, jointly with much use of council channels and Martin Tett's newsletter (down to once/twice a week currently). We are sustaining 3 times a week briefings to primary care. (2) A health and care service engagement has been undertaken – with a phase one survey with analysis due back on that shortly. Phase 2 involves a workshop, with focus groups to be arranged to ensure we are effectively reaching our populations (BAME, groups more affected by use of digital services) (3) Winter preparations, with an insert in Your Buckinghamshire newsletter covering this. (4) Help Us Help You campaign. KP thanked all communications colleagues for their endeavours. RB noted Governing Body's thanks for the team at the Council supporting the CCG. RM echoed this – further information through primary care bulletins is really valued. RM also noted clinical colleagues who took part in earlier webinars and public facing activities to support various sectors in their response. Governing Body received and **NOTED** the report for information.	
18	**Learning Disabilities Mortality review (LEDER) annual report 2019/2020.** This update forms part of the work to progress Learning Disability Mortality Reviews and the forward looking view for Learning Disability Mortality Reviews (LeDeR) and the subsequent arrangements to be developed in Buckinghamshire. RB emphasised the importance of this report. KW added that a safeguarding investigation has also taken place as a result of a LeDeR review, the outcomes of which will be reported back. RB felt it would be useful to communicate back to practices over the next few weeks to make sure they cover as many patients as possible. RM assured members this programme remains a priority and useful to see outcomes in the recommendations from the reviews. The Governing Body received and **NOTED** progress to date, work programme and timescales.	
	Date of Next Meeting: 11 March 2021, PM	
	Meeting Closed: 12:30	