NHS
Bedfordshire
Clinical Commissioning Group

Finance and Performance Committee

DRAFT MINUTES

Minutes of the meeting of the Finance and Performance Committee on 25th April 2018, Room 208, Endeavour House, Wrest Park, Silsoe, Beds commencing at 11.30 and concluding at 13.00.

Members Present

Roland Ginn	Lay Member – Finance & Performance (Chair)	**RG**
Sarah Thompson	Accountable Officer	**ST**
Saqhib Ali	Lay Member – Audit and Governance	**SAl**
Malcolm Miller	Acting Chief Finance Officer [Dialled into meeting]	**MM**
Dr William Hollington	GP – Locality Chair of Ivel Valley	**WH**
Alan Streets	Turn-around and Contract Advisor	**AS**
Dr Jonathan Kirkham	GP – Clinical Lead	**JK**
Dr David Howard	GP – Locality Chair of Bedford	**DH**

Others in attendance

Alyson Malciw	PA to Chief Finance Officer (minutes)	**AM**
Charlie Wood	Programme Director of Planned and Unplanned Care, Mental Health and L&D	**CW**
Sally Adams	Programme Director of Out of Hospital Integration	**SA**

Apologies for absence

Jane Meggitt	Director of Governance, Risk and Corporate Affairs	**JM**

No	Item
1.0, 2.0	**Welcome and Apologies** Apologies for absence were noted as recorded above. **The meeting was noted as QUORATE.**
3.0	**Declarations of Interest** There were no declarations in relation to items on the agenda, or noted over and above these on the Conflicts of Interest register.
4.0	**Minutes** Minutes of the meeting held on 28th March 2018 were approved as an accurate record.
5.0	**Action Tracker** The actions were discussed and logged with relevant updates added to the live action tracker. All closed actions will be archived and coded accurately for future reference. FP126 – Delegated Authority for S106 Applications – MM reported that he is to meet with the Local Authorities shortly and will report back to the F & P Committee. The action remains OPEN. FP130 - Circle – CLOSED FP132 – PMS Investment Scheme for 18/19 – Jonathan Bilson to provide a quarterly update on the progress against targets and actual spend – OPEN

	FP135 – Resources – MM reported that an appointment had been made for the Contract Support and will be starting shortly. He reported that the QIPP Planning post had been offered to someone but they had declined, therefore the post is still vacant. FP137 – 2018/2019 QIPP Report – OPEN FP138 – Integrated Performance Report workshop – CLOSED FP139 – Phased QIPP Forecast Outturn 2018/19 – MM to give a report next month – OPEN FP140 – Contract Activity and Finance System – AS gave an update on the mobilisation of Civica – This part is CLOSED **Additional Action fed into FP140 – Update on the mobilisation plan for Civica**. FP141 – Update on Mental Health Financial Implications – CW to liaise with Jonathan Bilson and will provide a short update for the next F&P meeting – OPEN FP142 – Risk Registers – The financial risk of tribunal claims. This was listened to, noted and not put on the Risk Register - CLOSED Putnoe Walk in Centre – Confirmed at the Governing Body subsequently to invest a continued update is required – OPEN FP143 – Briefing Note on Employment Tribunal Claims – CLOSED FP144 – STP Funding Allocations [debate with regard to percentage of funding] – CLOSED
6.0	**Integrated Performance Report – Month 12** CW presented the report. She reported that the template was changing so it will be more succinct, particular areas will have key issues, mitigation and progress update. The information will be consolidated to make it more meaningful. The Chair asked for it to be noted that he was appreciative of the making of the template clearer. ST asked the Committee to note that the NHSE lead for dementia IAPT has requested a conversation with CCG to take place on Friday 27th April 2018. ST added that this paper goes to Quality, Governance Committee and then goes to the Governing Body. DH said that in ICQC they had discussed strategies to improve the dementia diagnosis rate. AS reported that there had been a major incident at the Lister Hospital, a hardware problem had taken their system down, possibly due to software upgrades to routers. This resulted in patients who should have been admitted to the Lister were routed to Addenbrookes to be admitted instead. ST added that this is a matter that needs to be escalated to their lead commissioner at East and North Herts. ST to action this outside of the meeting. ST said that she will be approaching their lead commissioner in terms of compliance of standards contractually for information. **The committee noted the performance report and look forward to further improvements in reporting next month.**
7.0	**Contract Highlight Report** AS said that this report was based on Month 10 and that A&E performance was extremely poor in month 10, there is lack of ability to have capacity to admit patients. This has deteriorated their A&E performance. They did not have enough beds in the hospital for the acuity of the patients coming through A&E. ST reported that this has been escalated to Dr Paul Watson. There were two

	meetings, ST and Stephen Conroy and Dr Watson, and there are action plans now in place. It was a combination of Frail Elderly, Over 85s with high acuity with length of stay of more than seven days. She said that we had looked at the data and know and understand much better what has happened this winter, there was a review and reflection session held with CW's team and the Trust to review and reflect on winter. An A&E Delivery Board has been held resulting in a set of actions that can be usefully used to build on in readiness for next winter. Bedford Hospital A & E – the four hour performance has deteriorated to 81.3% Luton Hospital – Non elective short stay audit has been completed, the outcomes of the audit will be shared with the Trust. Key findings – Out of Hospital commissioning services have a large number of gaps where there is a large percentage of patients capable of being cared for in the community. CW asked if the outcome of the audit had been shared. AS said the three biggest things were DVT, IV in the Community and COPD. The big issue is that we actually commission a Community COPD service from the L&D so it is a question of reviewing that service and questioning if it is £0.5m well spent or is it £0.5m that isn't actually caring for COPD patients in the community. CW asked if it was just the zero length of stay audit for admissions. AS confirmed that it was primarily zero. DH asked how the COPD service at Luton compares in its efficiency with the service at Bedford Hospital. Is the Bedford one more effective at keeping patients out? AS said that he would have to do a comparison. HUC – AS reported that the contract had been signed and that performance had improved. He added that the HUC staffing rota is better in Bedfordshire than it is in Luton. Bedford is far better than Luton. **ACTION: AS to raise the question with HUC regarding performance at Luton**. **The committee noted the Contract Highlight Report**
8.0 **&** **8.1**	**Phased QIPP Actual Outturn 2018/19** **Integrated Finance and QIPP Report – Month 12** Month 12 is the same. We have achieved the £7.2m deficit. Year End has now closed and the External Auditors are in [Grant Thornton]. We have helped secure the position by doing a full and final settlement with Luton & Dunstable which de risks any further movement. In respect of the other major acutes we have taken a fairly prudent approach to any outstanding challenges. With regard to the KPIs, we are ok in terms of all of the cash parameters, running cost parameters. The only ones that are showing red are the ones where it was determined from Month 4/Month 5 where we were overspent. This has been contained. The CFO reported that the second table on Page 1 reflects the number of national year end adjustments, to the £7.2m deficit that we have been reporting throughout, in arriving at the final position we have been required to release a £2.8m national risk reserve, which we are not allowed to commit during the year. The national risk reserve provides a buffer to protect the national position. The CFO reported that the other area in which we benefited from was the Category M drugs rebate. Normally this would flow straight to the CCG's, but NHSE has decided to hold it centrally and penalise the CCG, he added that they have now released it so it flows straight through to the position, so the final reported deficit which will be reported in the accounts will be £3.9m. Within that £3.9m there is a £2.5m cost pressure being driven by a national prescribing issue.

	Page 2 – the table describes the impact of the national prescribing cost pressure, month 12 is £2.5m. If this is stripped out of the adjusted £7.2m there is a £4.7m deficit. There is stability from month 5. He added that if we actually looked at our final reported position of the £3.9m deficit, we stripped out the £2.5m, the final deficit down to the BCCG would be £1.4m, which in the context of a £570m spend is very close to break even. MM said that he had suggested at Directors meeting earlier in the week that he would provide a table of normalised correct adjusted results of when the CCG first went into deficit and what the true position is for adjusting for items in the correct year which will show a far more sensible profile. Debtors have come down over the last couple of months. CSU/Mede £165,000 has now been paid. The £116,000 from Luton CCG is for the IG services which they will pay for. The big one, EPUT, is subject to a dispute escalation which is being worked on at the moment. MM reported that the QIPP was £19.5m at the end of the year, a slight dip at month 12. SA added that the QIPP had dropped by a large amount all of a sudden right at the end of the year; there must have been some warning, or was this just the nature of the plan. MM said that the Sepsis position could not be carried from October, following the then guidance. MM said that we then had received further guidance from NHSE which suggested that we strip out the benefit or disadvantage that should be neutral, so this was dropped out of the equation based on the guidance received. SA said that on a private note that the £19.5m was the largest QIPP the BCCG had ever delivered. ST added that the Directors had looked at the first month QIPP Performance Report and will review on a month by month basis going forward. She further added we need to keep on top of the QIPP and that there had to be a reduction in the corporate spend and we have ended the year under the running cost allowance. ST further added that an intensive vacancy control is undertaken at every Directors weekly meeting. **The Finance and Performance Committee noted the report** **Grant Thornton – Brief for Review of Finance Function** MM reported that Grant Thornton was requested to carry out an external review of the Finance Function at Bedfordshire Clinical Commissioning Group on the effectiveness with regard to both its operation now and in the future. Grant Thornton has advised that they are unable to carry out this review as they are conflicted. Therefore, NHSE have been approached to recommend another Company and to also pay for the review. **ACTION: MM to approach NHSE for a recommendation and also to ensure that NHSE pay for the review.** **The Finance and Performance Committee noted the report**
9.0	**Final Plan for 2018/19** MM presented the full Final Plan pack for 2018/2019, for review and discussion and recommendation to the Governing Body for approval. Page 8 – Contractual status - £371m of signed and agreed contracts within our financial envelope, which is 93% of the total in terms of SLAs. The ones yet to be agreed are EEAST and Bucks; they are soon to be signed. MM reported that the underlying plan is being secured contractually. The plan delivers the target control total surplus of a reduction from £11.4m to £10.0m and is compliant with all national planning guidance.

	It was decided that the Plan will be emailed to DMcN for virtual circulation for approval by the Governing Body members. The Chair requested that a message be sent to the Finance Team to thank them for a clear and commendable document. **ACTION: DMcN to circulate virtually the Plan to Governing Body members.**
10.0	**IT and IG update/NHS Mail2 Update [Jane Meggitt was unable to attend the meeting]** **David McNeil gave the update.** **IG Update** **GDPR** goes live in May 2018. It is not clear what support is being given to GPs to enable them to be compliant. **Laptops** - Roll out is complete. DMcN asked the Committee to clarify if staff should be able to have both a laptop and Ipad. The Committee said that it should be one or the other, not both. This will need to go to Directors for discussion. **Video Conferencing** – NHS Mail2 will enable staff to Skype for up to 5 people. DMcN also reported that HBL have been asked to quote for a video conference system for each room. He reported that this would be at a cost of £5,000 each system. **NHS Mail 2 Update –** The project is on track. All Beds CCG emails will move to NHS Mail on Tuesday 1st May 2018 they will work in parallel for six months. DMcN pointed out that in the instance that people have two NHS Mail accounts, an old one and a new one, they will be given the opportunity to choose which one they wish to use. DMcN also reported that some people are experiencing messages in their in boxes – Your Mail Box is Full – he said that HBLICT have been requested to set the in boxes to the maximum in the first instance and they can be shrunk down to a smaller limit afterwards.
11.0	**Putnoe Walk In Centre Update/UTC Update** SA gave the update. A report had been taken to the Board demonstrating two options for a like to like service at Gilbert Hitchcock House, pending conversation with the OSC. She reported that prior to the OSC meeting ST held a meeting with partners at Putnoe Health Centre who unexpectedly declared an interest that they would like to continue to provide a walk in service from the 1st October 2018 onwards. Hence, when SA and ST went to the OSC meeting they went with potentially two options to have a like for like service, essentially at Putnoe, if that was a solution and secondly at the like for like service at Gilbert Hitchcock House. From the BCCG position there were potentially two solutions and recommended that we get a single solution up and running potentially from Gilbert Hitchcock House from the 1st October 2018, so that the local residents had a like for like service, which would be supplemented by the UTC opening on the 1st October, with extended access in general practice. SA reported that Counsellors debated this option and there were many questions raised and the outcome was that, even though ST had made it very clear, and asked for it to be documented in the minutes, that they wanted us to go to consultation with the public. ST had made it very clear that if we go to consultation with the public the BCCG cannot enter into any other business arrangement with Putnoe Health Centre or Gilbert Hitchcock House for the 1st October 2018. The BCCG came out of the OSC meeting with a position that we would not have any walk in centre services like for like provided from the 1st October 2018 and would have to enter into a consultation process, yet to be determined. At that point the services from the 1st October 2018 will be UTC and extended access. This has changed slightly as SA does not believe that the members of the

	Councillors at OSC clearly understood what they were voting for by going for formal consultation. There have been further meetings and conversations with ST and Councillors and various letters going to and through. ST reported that since the OSC she has stood down the provider. ST had received a letter from the practice, even though they were present at the meeting, and had heard that the BCCG could not continue any business arrangements. The practice then wrote to ST asking for a date to meet with regards to the arrangements from the 1st October 2018. They had clearly not understood, and ST said that the CCG are barred from proceeding. She has equally spoken with Stephen Conroy and has mirrored the same conversation saying that we cannot proceed with Gilbert Hitchock House. ST further reported that the Chair of the OSC had met with her [Councillor Mingay] and the secretary of the Committee and said that he was there at the request of the Mayor and the Chief Executive of Bedford Council and that they had come to realise that they had not understood the consequences of their decision to ask us to go to consultation. They asked if we would consider them asking the BCCG to attend a further meeting at the end of May, for them to consider changing their decision with a view to asking us to maintain the service from the 1st October 2018 and to consult publically after the 1st October 2018. ST listened, and asked them to put in writing what they were asking and ST said to them that we have acted honourably since the meeting and have notified Governing Body members, and have stood down the providers and that we have started work on compiling a consultation document. ST reported that she had recently received an email from Philip Simpkins saying that at the OSC meeting ST had presented information to members that had not previously been provided. I.e. that you don't continue the business discussions, which is the normal good practice for undertaking a consultation, and therefore formally asking, to help members, they would like the BCCG to attend an additional meeting on this matter. They want to broker a solution. [Purdah]. CW added that it is a national mandate to drive the UTC idea as it will standardise all Health Centres, therefore the Walk In Centres will cease to exist. The idea is to build up the 111 and access the GP to book into the UTC. This will minimise waiting times and get a more structural flow. All parties' concerned need to know that it is a finite time period. **It was noted that the Finance and Performance Committee support the position to go to consultation and assurance will be given to the Governing Body.**
12.0	**Risk Registers** **a) Finance –** to be reviewed **b) Contracts –** to be reviewed **c) Information Management and Technology –** to be reviewed **d) Information Governance –** to be reviewed **ACTION: DMcN - All risk registers to be completely reviewed and refreshed for next Finance and Performance Committee.**
13.0	**Any Other Business** ST reported that the Chief Finance Officer interviews had taken place. Malcolm Miller will be Chief Finance Officer for one year. NHSE gave consent to proceed with the appointment of two band 9 Deputies. MM reported that there had been two interim appointments.

	It was reported that NHSE will pay for one of the appointments and that Stephen Makin confirmed that he would be sending the funding through.
14.0	Items to raise to the Governing Body – None recorded
15.0	**Date of Next Meeting: 23rd May 2018**

Signed *(As a true record)* Dated

Roland Ginn - Chairman, Finance and Performance Committee

Audit and Governance Committee

Minutes of the Audit and Governance Committee Meeting
Held on 11 April 2018
Room 208 Endeavour House, Wrest Park, Silsoe, Bedfordshire MK45 4HR

Members Present:

Saqhib Ali	Lay Member – Audit and Governance (Chair)	**SA**
Roland Ginn	Lay Member – Finance and Performance	**RG**

Others in attendance

Malcolm Miller	Acting Chief Finance Officer	**MM**
Janet Young	Governance & Risk Manager	**JY**
Sharon Birdie	Senior Audit Manager	**SB**
Paul Grady	Grant Thornton, External Auditor	**PG**
Parris Williams	Grant Thornton, External Auditors	**PW**

Apologies:

Alison Borrett	Lay Member – Patient and Public Engagement	**AB**
David McNeil	Associate Director of Governance, Risk and Corporate Services	**DMc**
Steve Lake	Director TIAA Internal Auditors	**SL**

1.0 & 2.0	**Welcome and Apologies for absence**	**Action**
	The Chair welcomed all members and attendees to the meeting. Apologies were received from Alison Borrett, Steve Lake and David McNeil.	
3.0	**Declarations of Interest** There were no declarations declared.	
4.0	**Minutes of the Meeting held on 14 February 2018** The minutes of the meeting held on 14 February were confirmed as an accurate reflection of the meeting and were signed by the Chair of the Committee.	
5.0	**Actions from the Meeting Held on 14 June 2017** Updates for all the actions had been received and considered by members. The Committee agreed that they should all be closed.	
6.0	**Internal Audit Plan 2018/19** SB presented the Plan which had been developed from risks identified from the CCG's governing Body Assurance Framework, discussions with senior management and emerging areas within the sector. The draft plan had already	

	been shared with the Interim Chief Finance Officer and the Accountable Officer who were content with its content. 11 Audits are planned over a period of 70 days. Payments to Clinical Leads which was a particular area highlighted by the CCG in 17/18 would be the first audit to be carried out in 18/19. SA raised the point whether the audit plan would sufficiently cover the risk regarding capacity around consultations and putting things out to tender which had realised in the past. SA also questioned whether the CCG now had the right capacity and capability at senior level to mitigate. RG replied that he could assure the committee that the capacity was now in place but some of the posts were still very new. It would be down to this new executive management team to recruit sufficient capacity at lower levels. It was agreed to review this in six months' time. RG was pleased to see that DDPR and Cybercrime were an addition in 2018/19 as these subjects were very important. As there are significant reputation implications as well as financial penalties for non-compliance which could reflect on the CCG, he asked if we should also be getting assurance from NHS England on whether GP Practices were being audited on how data was held and protected. MM replied that the CCG's Head of Information Governance also worked for NHSE through a MOU so it would be easy to gain that assurance. The Head of IG will be asked to provide assurance at a future meeting. SA Enquired whether the Audit Plan would cover any follow-ups on 17/18 audits. SB confirmed that a tracking process in liaison with Janet Young was in place to ensure audit recommendations are completed and TIAA would also be looking at recommended areas of improvement during the audit programme for 18/19. RG enquired whether CIVICA would be part of the QIPP audit. He had heard very good reports about the system and asked MM whether a presentation could come to the Finance & Performance Committee to explain how it worked. MM commented that the system was the same as used by providers and therefore the CCG would now be able to monitor performance of the contract more robustly (which will include QIPP elements) as we will be seeing the same data as the provider. **The Audit & Governance Committee approved the Annual Internal Audit Plan for 2018/19**	
7.0	**Internal Audit Annual Report and Strategy 2017/18** SB presented the 2017/18 Annual Audit Plan which was for 70 days of internal audit coverage in the year. There had been two changes, the addition of a Conflicts of Interest Review (3 additional days) and the cancellation of the proposed QIPP review. The days allocated to the QIPP audit were re-allocated for use of a review of Better Care Fund. All the planned work had been carried out and the reports issues. 9 reviews were carried out in total 4 were assessed as substantial assurance and 5 as reasonable assurance. This had led to the overall Head of Internal Audit Opinion for 2017/18 being "Reasonable Assurance".	

	Action AC001: SA commented that the report showed 73 planned days but should read 70 and SB agreed to amend this oversight. **The Audit & Governance Committee approved the Internal Audit annual Report for 2017/18**	**SB**
8.0	**Final Audit Reports** SB presented two final Audit Reports for the Committee to consider. **(i) Assurance Review of conflicts of Interest** The overall audit objective was to review the continued CCG arrangements in place to ensure compliance with the CCG Conflicts of Interest Policy. The overall opinion was that the CCG had robust procedures in place and awarded substantial assurance. Two routine and 1 operational action points were raised, all of which have subsequently been implemented. **(ii) Assurance Review of Better Care Fund** The rationale of this audit was to consider the arrangements for making contributions to the pooled BCF and for ensuring that the agreed levels of service were provided by the recipient local authorities. Based on the testing carried out, no control weaknesses were identified, hence the assessment of substantial assurance. There were no recommendations made. MM commented that the review had taken some time to complete as he had been unaware that the scope of the audit had been misunderstood by the responsible manager. As soon as this was brought to his attention the correct information was made available to the Auditors. **The Audit & Governance Committee noted the reports.**	
9.0	**External Audit Plan Year Ending 31 March 2018** PG presented the report. The scope of the audit plan was to ascertain a deep business understanding around changes to service delivery including STPs, ICS, primary healthcare and merging Trust; Changes to financial reporting requirements including Group Accounting Manual, submission arrangements and key performance indicators; and key challenges including financial pressures, CCG annual assessment, management team turnover and QIPP. It was the role of external audit to consider the CCG's arrangements for managing and reporting its financial resources as part of their work in reaching their Value for Money conclusion. Significant risks that require special audit consideration as mandated by financial standards are: • *The revenue cycle includes fraudulent transactions*. This presumed risk has been rebutted and our revenue does not primarily involve cash transactions and is principally an allocation from NHS England. • *Management over-ride of controls*. Grant Thornton will gain an understanding of the accounting estimates, judgements applied and decisions made; will obtain a full listing of journal entries, and evaluate the rational for any changes in accounting policies. • *Operating expenses – purchase of secondary healthcare.* GT will gain an understanding of the financial reporting processes used for the purchase of secondary healthcare. The accuracy and occurrence of contract variations as a risk requires special audit consideration. • *Going concern material uncertainty disclosure.* GT are required to obtain sufficient appropriate audit evidence about the appropriateness of management's use of the going concern assumption in the preparation and presentation of the financial statement and to conclude whether there	

	is a material uncertainty about the entity's ability to continue as a going concern. PG went on the explain Grant Thornton's other audit responsibilities that were in addition to their responsibilities under the Code of Practice. SA enquired whether the £4m prior adjustment from last year will be repeated in 18/19. MM advised that assurance will be given that this will not happen. Materiality was discussed and confirmation given that the Audit & Governance Committee would receive reports on any uncorrected omissions or misstatements. The Trivial level for the CCG had been set as £300k. The risks requiring specific audit consideration to deliver value for money were set out in the report:- • Financial position and sustainability. GT will look at the CCG's outturn to review reasons for the expected deviation from its control total. • Delivery of QIPP schemes. GT will reviewing arrangements for monitoring and reporting of savings plans. • Achievement of health outcomes. Used as a balance between spend and health outcomes. SA enquired how far along with the plan GT were. PG replied that the interim work had been completed and early testing work had been completed up to Month 10. They had agreed the requirements for year end and were therefore fully geared up for the accounts coming out on 24 April. SA enquired whether the scope of the audit plan would include a specific audit of the Finance Team. PG confirmed it didn't but could be extended via the VFM route. RG requested that a conversation be held outside of the meeting to ascertain how this could be commissioned. **The Audit & Governance Committee approved the plan**	
10.0	**Internal Audit – Contract Extension** MM explained that TIAA had been appointed as internal auditors on a 2 year contract. MK and Luton CCGs are currently tendering a 2 year contract for internal audit services which Bedfordshire could join or extend their existing contract. In order to avoid both disruption in service and a break in continuity a decision had been made to extend the existing contract with TIAA for a period of two years. This decision was approved by the Governing Body on 7 March 2018. **The decision to extend the existing contract for a further 2 years was noted by the Committee.**	
11.0	**Governing Body Assurance Framework and Corporate Risk Register** JY presented the report. She explained that the previous version of the GBAF had the three lines of defence slightly out of alignment with definitions subsequently explained during the internal audit of the document. This had now been addressed in the version presented. Only two strategic risks remained rated as high – ST1 and ST5. The report set out the mitigating actions that had reduced the residual scoring of risks ST9, ST10, ST13 and ST15. Four risks had been mitigated to their target score and in line with best practice where a risk has been mitigated to its target score then Executives should review	

	whether there is a need for further mitigation to be applied. Risks ST8, ST10, ST11 and ST12 had been taken to the Executive Committee on the 29 March and agreed that further mitigation need not be applied to these risks. JY explained that the risks will remain on the GBAF for monitoring. One risk (ST6) had closed. Failure to identify sudden changes in financial position no longer posed a threat. The corporate risk register was reviewed. It was explained that as the CCG approached year end, risk descriptions had been reviewed and revised. The revisions recorded on the risk register were highlighted in the report. Two new risks had been escalated. SA enquired whether the potential risk of an unlimited fine for a legal case should appear on the CRR. JY was unaware of the risk but MM added that the inclusion of this in the accounts would be classed as business as usual. **The Audit & Governance Committee noted the report.**	
12.0	**Revisions to Risk Management Policy & Framework** JY presented the revisions. She explained that the policy required amendments following the internal audit of the GBAF where a new section required to be added on assurance mapping and an explanation of the "Three lines of defence" model. As a result of the imminent review date of the policy further minor revisions and updates had also been incorporated into this iteration. **The Audit & Governance Committee approved the policy.**	
13.0	**Audit & Governance Committee Annual Report 2017/18** JY presented the draft report and explained that the intention is for the Annual Report to be presented to the May Governing Body meeting but in order to get the wider committees comments on the draft it had to be presented to this meeting with some minor gaps. A completed report will be sent to the Chair of the Committee for final approval. **Action AC002:** SA requested that the clarity around clinical representation at the committee should be mentioned under the ToR section. **The Audit & Governance Committee approved the draft report.**	JY
14.0	**Any Other Business** The Committee were reminded that an Extra Ordinary Audit & Governance Committee will be held on the 24 May to receive the Annual Report and Accounts. **Action AC003:** SA enquired why the Committee had not received the 2018/19 work plan for Local Counter Fraud Specialist and requested that this came to the next meeting along with a report on the work carried out in 2017/18. Regular attendance at the Audit & Governance Committee was also requested to report updates.	TIAA
15.0	**Date of Next Meeting** Wednesday 13 June 2018 13.00 – 15.00 Room 208 Endeavour House, Wrest Park, MK45 4HR	

NHS
Bedfordshire
Clinical Commissioning Group

Minutes of the BCCG Joint Primary Care Co Commissioning Committee - JPCCCC

Thursday 12 April 2018
09.00 to 12.00
Room 208, Endeavour House, Wrest Park, Silsoe

Present:

Name	Initials	Title
Sally Adams (Chair)	**SA**	Director for Out of Hospital, Primary Care
Nicky Wadely	**NW**	Assistant Director of Primary Care
Caroline Goulding	**CG**	Contracts Manager Medical and Pharmacy, NHSE
Tony Medwell	**TM**	Locality Business Manager – Bedford Locality
Miriam Coffie	**MC**	
Dr David Howard	**DH**	Locality Chair – Bedford Locality, BCCG
Dr William Hollington	**WH**	
Dr Peter Graves	**PG**	Chief Executive, Beds and Herts LMC
Martin Fahy	**MF**	Director of Nursing and Quality
Dominic Cox	**DC**	
Linda Hiscott	**LH**	Healthwatch Bedford Borough
Susi Clarke	**SC**	Primary Care Strategic Development Lead
Malcolm Miller	**MM**	Acting Chief Finance Officer
David McNeil	**DMc**	Associate Director of Governance

Apologies:

Name	Initials	Title
Roland Ginn	**RG**	Lay Member Finance and Performance

Agenda Item	PART 1
1	In absence of RG meeting was chaired by SA
2	**Declarations of Interest** GPs DH & WH signalled a CoI in Paper 6 PMS, Part 2 papers CRd and MC for Paper 12 as she is registered at the practice.
3	**Minutes of meeting 15th Feb 2018** WH noted that the minutes implied he had left the meeting but he wasn't in attendance. As no other comments received and the minutes were agreed as correct.
4	**Action Tracker** JCC 070 GPFV delivery Update – LA colleagues to be asked to update at June meeting JCC 073 – on Agenda for meeting today JCC 074 Action was taken and item closed JCC 075 CG & TM gave a brief update on the next steps for TVMC and the issues to be addressed during the caretaking period, particularly finalising a lease which would enable agreement with the landlord to complete cladding required by BBC. Engagement with the patients and local councillors has started on the future shape of services in readiness for the Procurement for a longer term provider. Timeline and proposal for procurement to be included on the agenda for the June meeting

5	**Risk register** The risks on the register were reviewed. Cocom60, resilience of Bedford practices was still shown as a high risk. The mitigating actions were reviewed and it was noted that the Primary Care Working Group was in place with oversight of resilience issues and Enabler/Development workstreams. New risks were added: • GDPR • Extended Access The risk around Clapham Road surgery was closed. **Action: It was agreed that a deep dive on all high and medium risks would be undertaken in 2018/19.**
6	**PMS Reinvestment Scheme** The GP's declared a conflict of interest for this item and left the room. The report had previously been presented at Joint Primary Care Co Commissioning Group without detailed financial information on the cost benefits. NHSE and BCCG have jointly reviewed the cost of the PMS in primary care contracts where they were found to be exceeding the national baseline on GMS contracts. Primary Care funding is being redistributed across General Practices in Bedfordshire in 2018/19 to support the development of a more affordable and sustainable model of care which facilitates integration MDT working and practices working collaboratively in clusters. Practices would therefore be formally asked to sign up. DC asked how this would be monitored at JPCCC? It was conformed that there would be regular updates at the meeting. **Following approval at F&P the Committee ratified the scheme**
7	**Capita/ Primary Care Support England (PCSE)** Primary care support (PCS) services provided by Capita. The contract is due to expire in 2022 and can be extended until 2025. The main aims of the contract were to achieve a national service to standardise work in national PCSE delivery centres; create a new Customer Support Centre to handle telephone and email enquiries and launch a PCSE website. NHS England has been addressing concerns to improve performance of the service. . The Committee had asked that this paper be presented for members to note the functions delivered by PCSE from within the national agreement and better understand lines of communication to support the ongoing improvement of the services. **The Committee received the report for information and agreed to keep the risk on the register**
8	**Extended Access** NHSE has set a mandate for 100% coverage at GP practices by October 2018. This will increase capacity and resilience and reduce wider demand. The report highlighted the work being undertaken by BCCG to deliver extended access and the proposal for a PIN notice to be issued naming our local providers as the most capable.

	The recommended approaches described in the paper, which were Route 1 (US), Route 2 PIN and Route 3 (open) Route 2 had been the preferred option and was being followed. The Committee were asked to ratify the decision to pursue route 2 with the publication of the Prior Information Notice (PIN). **This was ratified with the following caveats:** • Due diligence to ensure a fit with the UTC • Clarity over where the localities were to be positioned.
9	**Financial Planning** The paper was to make the committee aware of the forecast overspend within the CCG GP services budget. The forecast overspend for 2017/18 is c. £1,3m. For 2017/18 this is likely to be c£0.4m. The committee noted the requirement to move to financial balance. Details of proposals to do so would be presented at the next committee. **Action: MM to present an update on proposals to move to financial balance in 2018/19.**
	Items for next agenda • 17/18 complaints report (Mc) • Finance paper update (NHS England) • PMS End of year 17/18 and sign up 18/19
	This resulted in the closure of Part 1 of the agenda

NHS
Bedfordshire
Clinical Commissioning Group

Patient and Public Engagement Committee
DRAFT Minutes of meeting held on 12 April 2018 at Silsoe Village Hall, Silsoe

Present:

Alison Borrett	**AB**	Chair and Lay Member for Patient and Public Engagement
Jane Meggitt	**JMe**	Director of Governance, Risk and Corporate Services (BCCG)
Michelle Summers	**MS**	Head of Communications and Engagement (BCCG)
Anona Hoyle	**AH**	Senior Communications and Engagement Officer (BCCG)
Balraj Singh Rai	**BS**	Deputy Business Manager, Central Bedfordshire Localities (BCCG)
Kevin Parker	**KP**	Deputy Business Manager, Bedford Locality (BCCG)
Ashok Khandelwal	**AK**	Healthwatch Bedford Borough (secondary representative)
Diana Blackmun	**DB**	Healthwatch Central Bedfordshire
Cheryl Green	**CG**	Patient
Dave Simpson	**DS**	Healthwatch Central Bedfordshire
Gary Bellamy	**GB**	Patient
Martin Trinder	**MT**	CEO, Community Voluntary Service (CVS)
Rubina Shaikh	**RS**	Bedfordshire Council of Faiths

Also in attendance:

Ann Nevinson	**AN**	Community Voluntary Service (CVS)
Paul Binfield	**PB**	Head of People Participation, ELFT
Nicola Dowlen	**ND**	Senior Communications and Engagement Manager, BLMK
Ben Brown	**BB**	Public Health Registrar

1	**Welcome and Introduction** AB welcomed everyone to the Patient and Public Engagement Committee (PPEC) meeting and invited everyone to introduce themselves. Ashok Khandelwal advised that he was attending as the Healthwatch Bedford Borough representative and Ann Nevinson advised that she was the nominated substitute for the CVS, so was accompanying MT for her initial meeting. AB also welcomed guest presenters Paul Binfield, Head of People Participation from East London Foundation Trust (ELFT) and Nicola Dowlen, Senior Communications and Engagement Manager for the BLMK Sustainability Transformation Plan (STP).
2	**Apologies** The following apologies were received: Sarah Frisby – SF – Senior Communications and Engagement Manager (BCCG) Jackie Bowry – JB – Communications and Engagement Manager Lisa Wright – LW – Senior Youth Worker - Youth Support Services, Central Bedfordshire Council Hayley Mills – HM – Youth Engagement, Bedford Borough Council Roger Baker – RB – Patient Soniya Dhariwal – SD – Healthwatch Bedford Borough

3	**Declarations of interest** Members of the committee were requested to complete their Declaration of Interest forms and return to AH if they had not already done so. Declarations of interest linked to agenda: - CG declared she was a patient at Putnoe Medical Centre, a member of Putnoe PPG, was self-employed working some hours with ELFT and had links with the Alzheimers Society - AK declared his son worked at Putnoe Medical Centre No further declarations of interest were made by members present. **Members who have not completed a Declaration of Interest Form to do so immediately and send to AH**
4	**Minutes of meeting held on 19 February 2018** The minutes from the meeting were reviewed and agreed as an accurate reflection of the meeting.
5	**Action Tracker** The action tracker was reviewed and all actions had been either partially completed, completed, or covered by items on the agenda. CG suggested to JM that the committee receive training from the Consultation Institute to help explain the basics and relevant legislation regarding consultation and engagement. MT requested that the committee receive final versions of the various plans that they review and provide feedback on at meetings, so they can see how plans have been progressed. AB added that this would support the PPEC with its development. **JM agreed to see whether training could be provided for committee members.** **AH to produce a document tracker, and develop process for plans to be shared with the committee at appropriate intervals.**
6	**Chairs update** Presented by AB AB informed the committee that, Dr Alvin Low, BCCG's Clinical Chair had resigned due to health reasons and that Roland Ginn, Vice Chair of BCCG's Governing Body had taken on the role of Chairperson on an interim basis, until a new Clinical Chair was appointed. Two new directors have joined the CCG, Charlie Wood as Programme Director for Planned and Unplanned Care and Mental Health Commissioning and Sally Adams as Programme Director for Out of Hospital and Primary Care. AB also informed the committee that Dr Paresh Lathia who had been a GP at Clapham Road Surgery, had passed away in March. AB concluded her update reminding the committee that the role of the committee is to provide assurance to the Governing Body, that patients and the pubic have been

	involved in shaping local healthcare services, and that members should remember this function during these meetings.
7	**Mental Health Services and Community Health Services** Presented by Paul Binfield (apologies had been sent in advance from Louise Palmer, Head of Clinical Quality, Cambridgeshire Community Health Services). Paul Binfield introduced himself, explaining that he had been Head of People Participation at ELFT for 10 years. His team is responsible for facilitating the service user, carer and family voice for the various services and contracts ELFT holds. This includes the mental health and learning disability services that ELFT has been providing in Bedfordshire since 2015 and the new Community Health Services which it started providing in partnership with Cambridgeshire Community Services (CCS) on 1 April 2018. Paul explained his team involve service users and carers in various ways and had been doing so for numerous years, so had a very good understanding of what works well and what does not. The methods in which they involve service users and carers include: • Training to sit on interview panels for recruitment and selection of staff • Train the trainer – for example, service users trained staff on how to restrain people with mental health needs in a care setting • Involving service users in quality improvement projects. Service users are involved at all stages of the process from beginning to end • Obtaining regular feedback from service users, that the quality and standard of services are being delivered to the required level • Involving service users and carers in research methodologies ELFT are recruiting a People Engagement Officer to commence a similar range of engagement and involvement opportunities for community health services. Service users and carers have a vast mix of talents, strengths and experiences, so are an asset to the organisation, and the engagement opportunities are empowering and beneficial to the individual. Some of the roles ELFT offer to service users and carers are paid, whilst others are on a volunteer basis. Following the presentation, CCG and RS commented that they had seen how the Trust had positively changed people's lives and how engaged and motivated staff in the organisation were. DB commented that they had received reports from service users that some front-line staff were rude, aggressive and lacked empathy, HWCB had reported this to Paul Rix (Service Director for Bedfordshire Mental Health and Wellbeing Service) who advised it was a training issue that would be looked at. Simon Bailey from Central Bedfordshire's Youth Service had sent in a short video that a group of young people had produced whilst on a residential week. The video featured young people talking about their experiences of local mental health services. The content was extracted from the results of a survey undertaken by Central Bedfordshire's Youth Parliament with 1,200 young people. DB commented that they had heard very similar feedback in the engagement work Healthwatch Central Bedfordshire had conducted with young people. AH informed the group that Simon had shared the report with Anne Murray (Director of Nursing and Quality) and Karlene Allen (Head of Children's, Young people and

	Maternity services), and that they had subsequently invited Simon to meet with them to discuss the report and any opportunity to join the working group. **Whilst encouraged to hear about the various initiatives that ELFT were delivering, members asked PB if they could see ELFTs policies and strategies to provide reassurance that the range of schemes he had spoken about, were formally in place, being practiced and embedded in the work of the organisation.** **PB to forward relevant documents to AH to circulate to members.**
8	**BLMK – STP** Presented by Nicola Dowlen (Sam Holden sent his apologies) Nicola Dowlen introduced herself, explaining that she was the engagement lead for the BLMK STP and would be talking about how her team will be engaging with local people regarding the work of the STP rather than the programme itself. Nicola advised that a meeting had been arranged with the four local Healthwatch organisations to discuss and plan how best to engage with the residents from Bedford Borough, Central Bedfordshire, Luton and Milton Keynes, ensuring that the plans produced for each geographical area were appropriate for the local population. They were working on the collateral for the programmes, content for the website and videos, and would also be planning a number of engagement events. The PPEC agreed to Nicola's request, saying they would be happy to provide feedback on the communication and engagement plans drafted for Bedford Borough and Central Bedfordshire and the videos produced. Members of the PPEC advised that the terminology can be confusing and suggested that all partners adopt the same language when talking about services JM commented the BLMK is a partnership of 16 organisations and that the STP is the vehicle for "knitting" the services provided together, however, as all members have their own plans for delivering services, it's a complex process which requires a change in culture, with the emphasis being on what the person needs. There will be a different story / plan for each local authority area – Bedford Borough, Central Bedfordshire, Luton and Milton Keynes. JM explained that the 3 CCGs had agreed to establish a 'Committees in Common' to make decisions as a group of CCGs together. The purpose will be to agree commissioning decisions that make a positive difference for patients in the region and achieve benefits for the NHS in the long term. The meeting will take place in public on 18 April 2018. **ND to submit the draft Bedford Borough and Central Bedfordshire communications and engagement plans and the videos for review from PPEC**
9	**Extended Access and Urgent Treatment Centre** Update from Michelle Summers MS thanked the committee for their feedback given at the last meeting, and advised that the communications and engagement plan had been updated accordingly.

	MS advised that the CCG had been listening to people's view and as a result a new proposal had been developed. The new proposal was to have a Walk in Service at Gilbert Hitchcock House from 1 October, 2018 as a medium term solution. The proposed medium term solution would: • Offer a 'like for like' Walk in service • Be located at Gilbert Hitchcock House (Bedford Hospital North Wing) • Would operate as a satellite service to the Urgent Treatment Centre (UTC), which will be provided by Bedford Hospital. • The service would maintain the same operational hours as Putnoe Walk in Centre (WiC). • The additional cost to provide the walk in service would be approx. £1million. MS explained the CCG was developing an extensive engagement plan to explain the proposal and test the location of the proposed walk in service with the public. The engagement plan would be shared with the Health Overview and Scrutiny Committees in April to determine whether this was substantial variation to services being delivered and if so, whether the CCG would be required to formally consult. JM explained that there is a national mandate to provide a UTC from October 2018 and that the CCG was not required to provide a Walk-in Centre. Providing both the UTC and WiC would be more than the national standard required. Members of the committee raised a number of issues regarding the proposed model, this included questions regarding affordability, whether GPs had signed-up to the extended hours proposal in the short term, and why the WiC had to change location. Members of the committee made some recommendations regarding some of the language and terminology to use when engaging with the public. • The phrase 'medium term' means different things to different people, it would be better stating a period of time • People do not understand what 'extended access' is, it would need to be explained clearly to enable people to make informed decisions **The committee was pleased to hear that the CCG was talking and listening to stakeholders, and that engagement activity had led to the proposal of providing a Walk-in-Centre at Gilbert Hitchcock House in the medium term.** **MS to incorporate the recommendations into future work and an updated plan shared at the next committee meeting.**
10	**Dementia Diagnosis Communications Plan** Presented by Ben Brown, Public Health Registrar BB shared the Dementia Early Diagnosis Communications plan. Members of the committee suggested having information in GP surgeries and libraries. Following a discussion around dementia diagnosis, BB advised that GPs were being given the information and tools about diagnosis as part of the HEAT sessions (training sessions for GPs) and that there was a 'Transfer of Care' protocol which would support GPs with any additional workload caused from additional diagnosis.

	CG commented that it can sometimes be difficult for someone taking a person with dementia to see a GP, and that practice staff are not always accommodating if the person arrives late for their appointment, recommending that staff be given dementia awareness training and for practices to be dementia friendly. RS asked whether information could be provided in different languages **BB to add the recommendations made by the PPEC to the plan and to start delivering the activities detailed in the plan.**
11	**AOB** RS commented on the number of acronyms that had been used during the meeting, and asked whether a jargon buster could be produced for a future meeting DS sent his apologies for the next meeting **Presenters to be reminded not to use acronyms at meetings and AH to produce a jargon buster.**

Signed **Dated**

Alison Borrett
Lay Member for Patient and Public Engagement

NHS Bedfordshire Clinical Commissioning Group

NHS Luton Clinical Commissioning Group

BEDFORDSHIRE AND LUTON JOINT PRESCRIBING COMMITTEE

Final Draft **v2** notes of the meeting on Wednesday 25th April 2018, Endeavour House (Building 50), Wrest Park, Silsoe, Bedfordshire, MK45 4HS.

Attendees:-

Dr J Fsadni (JF) (Chair)	GP (Retired)
Dr Kate Randall (KR)	GP Representative, BCCG
Dr Lindsay MacKenzie (LM)	GP and BCCG Executive Team Representative (until 3.30pm)
Jacqueline Clayton (JC)	Secretary/Pharmaceutical Adviser, BCCG, working on behalf of Bedfordshire & Luton CCGs
Dr M Chan (MC)	Medical Representative, the Luton and Dunstable Hospital
Fiona Garnett (FG)	Assistant Director and Head of Medicines Optimisation, BCCG
Melanie Whittick (MW)	Pharmacist representative, the Luton and Dunstable Hospital
Tess Dawoud (TD)	Assistant Head of Medicines Optimisation, LCCG
Anne Graeff (AG)	Pharmacist representative, LCCG
Dr O Kwapong (OK)	Medical Representative, Bedford Hospital (from 1.45pm)
Sandra McGroarty (SMcG)	Clinical Pharmacist working on behalf of BCCG and LCCG
Dona Wingfield (DW)	Pharmacist Representative, BCCG
Dr Dayo KuKu (DK)	GP Representative, BCCG
Dr Jenny Wilson (JW)	GP Representative, BCCG
Dr S Mehmood (SM)	GP Representative, LCCG
Dr Hafeez	GP Representative, BCCG
Natasha Patel (NP)	Lead Pharmacist (Bedfordshire and Luton), ELFT (Mental Health)
Gemma McGuigan (GMcG)	Pharmacist Representative, Bedford Hospital
Richard Jones (RJ)	Head of Medicines Optimisation, LCCG
Ann Darvill (AD)	Pharmacist Representative, Cambridgeshire Community Services
Kike Pinheiro (KP)	Pharmacist Representative, ELFT (Community Services)

In attendance: Full meeting: Janice Jones, Pharmacist, NFT; Chirag Shah, Clinical Pharmacist, Greensand Medical Practice (Ampthill) and Leighton Road Surgery, Leighton Buzzard; Chinedu Ogbuefi, Clinical Lead Pharmacist

Luton & Bedfordshire; Sara Burford (SB), Commissioning Manager – Planned Care, BCCG.
For agenda items 5.2 and 5.3 Julia Brown, Specialist Paediatric Diabetes Team, Bedford Hospital and Denise Macey, Specialist Paediatric Diabetes Paediatric Team, the Luton & Dunstable Hospital. **For agenda items 5.2, 5.3, 5.4 and 10.2 (by teleconference) –** Dr A Melvin, Consultant Diabetologist, Bedford Hospital; Dr M Khan, Consultant Diabetologist, Bedford Hospital and Claire Springall, Specialist Diabetes Nurse (adults), Bedford Hospital.

	Agenda item	Action
1	**Welcome and Apologies –** The chair welcomed everyone to the meeting. In particular, a warm welcome back to Gemma McGuigan who has returned from maternity leave. **Apologies for absence received from -** Adrian Spurrell, Dr Nisar (Dr Chan is attending), Natasha Patel, Gerald Zeidman, Dr Joy Mutitika, Celia Shohet, Julie Phillips and Rushnara Begum (Melanie Whittick attending).	
2	**Conflicts of interest declaration** The Committee were reminded that the 6 monthly declarations of interest were now due. TD declared the following potential conflict of interest relating to agenda item 5.1. She participated in 2 advisory boards in the last quarter – Chiesi and Astra Zeneca on respiratory medicines. The first was on inhalers but the second covered NHS priorities and NICE guidance and no inhalers were mentioned. It was noted that the potential conflict of interest applied more to the adult rather than paediatric guidelines. No other conflicts of interest were declared relating to the current meeting agenda by Committee members.	
3	**Minutes of the last meeting (7th March 2018 attached)** The minutes of the meeting were approved for accuracy.	
4	**Matters Arising**	
4.1	**Feedback on miscellaneous actions not included on the agenda.**	
4.1.1	**LMWH in pregnancy (Intermediate Risk) – Shared Care Guideline Update** It was agreed at the March 2018 meeting that the current shared care guideline would be 'rolled over' and would come to the JPC for agreement (virtually if possible). This work is scheduled for the June 2018 meeting and therefore this is an open action.	
4.1.2	**Ketamine Shared Care Guidelines** SMcG had produced a final draft on which she had received comments from Dr Matthews. As there has been a number of amendments since the document was last seen by the JPC, it will be circulated for virtual approval to the Committee prior to publication. The Committee agreed that the guideline (if agreed virtually), could be used prior to formal ratification at the June meeting.	**SMcG**

4.1.3	**Diabetic Meters and Testing Strips Review** Although the recommendations made at the December JPC meeting had been communicated widely (including to Diabetes Specialist Teams, the final bulletin was not yet available as it was awaiting some updates by the author. The LCCG Pharmacy Representatives agreed to prompt the author to undertake this work as the Specialist Diabetes Teams were asking to have copies of the final bulletin.	**Nadine Hall/TD**
4.1.4	**Community Antimicrobial Guidelines – Communication/IT** At the March 2018 meeting, it was agreed that ensuring communication of policies to locum GPs was an ongoing problem that could not be solved by the JPC. LM agreed to contact the IT Bureau to see if they had any solutions and report back to the JPC. LM advised that although the issue had been acknowledged, SystmOne was in the middle of a re-structuring re IT and there was currently no SystmOne IT lead in post. At the last meeting AS had suggested that it may be helpful to invite the SystmOne IT Lead to a future JPC meeting to discuss electronic communication (with GPs) in general. JC had contacted SystmOne and but no response had been received. This was possibly due to the fact that there was no one in this post at present. It was agreed to close both actions at the current time and to revisit when the re-structuring of the IT relating to SystmOne was complete and a new SystmOne IT lead was in post.	**Close Action**
4.1.5	**Opicapone for Parkinson's Disease** The recommendations had been agreed subject to the proposed pathway for the treatment of motor fluctuations (appendix 1 to the bulletin) being taken back to the Trust for re-consideration to bring it into line with the NICE Guideline. In addition, it needed to be tidied up to make clear where brand names and generic names were used. This appendix has now been updated (and the final bulletin published on GPref) as outlined above and therefore this action could be closed.	**Close Action**
4.1.6	**ADHD Shared Care Guidelines (Paediatric)** It was agreed at the last meeting that the final shared care guideline would come to the JPC for review when available. This has not yet been received from ELFT and therefore it is an ongoing action.	**JC**
4.1.7	**Bisphosphonates for Treating Osteoporosis** At the last meeting the following actions relating to the NICE TA were agreed:- • Osteoporosis Guidelines for Primary Care needed to be updated. This was an ongoing action. • FG agreed to check on patient numbers of patients within BCCG prescribed strontium. 12 patients were identified via EPACT and the Medicines Optimisation Team was following up with individual practices, asking for the patients to be reviewed. This action could therefore be closed.	**SMcG** **Close Action**

4.1.8	**EoEPAC Tolvaptan Recommendations** At the March 2018 meeting the JPC endorsed the EoEPAC recommendations for the use of Tolvaptan to treat hyponatraemia resulting from SIADH. These recommendations (in particular, second line use of tolvaptan after demeclocycline) were challenged by one of the Luton & Dunstable Hospital Endocrinologists. The Secretary had advised the Luton & Dunstable Hospital that that the recommendations could be reviewed by EoEPAC if the Endocrinologist wished to make a case. The Committee agreed that there was no further action required by the JPC at the current time.	
5	**Items for consideration**	
5.1	**Paediatric Asthma Guideline (draft 6) for JPC Review** The draft guideline, which has been subject to consultation and discussion within a working group (including clinicians from primary and secondary care) was presented by TD. The following key points were raised:- • The preface is to be written/completed by a GP for a primary care perspective. TD to ask Dr Talati, Paediatric Lead GP, LCCG to undertake this task. • The guideline covers paediatric wheeze and asthma and will be renamed 'Paediatric Wheeze and Asthma Guideline' The working group felt that 'Respiratory Paediatric Guidelines' was an inappropriate title as the guideline did not cover all paediatric respiratory conditions. • It was important to differentiate between the different treatment pathways for the under and over 5s. • In under 5s, clinically it is often acute presentations which over time rarely translate into asthma for some children – therefore management is acute therapy orientated. There is, however, a continuum (which may be referenced in the introduction) hence acute wheeze/asthma is covered first, followed by the chronic condition. • In over 5s the priority is supporting chronic management with some element of acute care, hence the chronic condition is covered first followed by the acute condition (management of acute exacerbations). • Figures 1 and 3 – pharmacological pathways will be reformatted as per the adult guideline. • Section D will be revised following comments received from GPs re treatment of exacerbations and follow-up. • A section relating to transition will be added, incorporating input from secondary care clinicians. • It was confirmed that the NHSE document relating to the treatment of acute wheeze (for under 2's but extended for use in under 5's) was supported by clinicians in the working party. It was agreed, however, that this document needed to be considered alongside the BTS/SIGN guidance, as it may be necessary to also include this information in the	**TD** **TD** **TD** **TD**

	guideline. It was agreed that this would be discussed further at the next meeting of the working group and in the meantime, TD would provide DW and DK with details on how to access the NHSE document. • It was noted that GPs could not carry oxygen (as it would invalidate their car insurance). It was therefore agreed that the text (P6 of the guideline) would be amended to state 'if available' in relation to oxygen as while it was not available on GP home visits, it would be available for use in GP surgeries. • FeNO testing – it was agreed that the guideline needed to clarify the current role of FeNO testing pending local commissioning decisions on its introduction. It was agreed that the wording relating to this which was incorporated in the adult guideline would be replicated in the paediatric guideline. The working party would need to agree whether to include the BTS flow chart as it offered spirometry and peak flow as the main diagnostic tests, until there was more clarity on what FeNO testing would be available in the local Health Economy. • A number of additional comments had been received relating to the draft and it was confirmed that these would be considered by the working group for inclusion in the guideline. **Next Steps** It was agreed that the draft guideline would be revised and considered at a final meeting of the working group and final draft presented for ratification at the June JPC meeting. TD agreed to send the revised draft to the JPC Secretary at the same time it was circulated to the working party for forwarding to JPC members. This would allow JPC members to input any final comments for consideration by the working party. TD also agreed to provide written information alongside the final draft relating to comments received and changes made/not made to the document as this would assist the JPC consider in a more time-efficient manner at the June meeting.	**TD** **TD** **TD** **TD**
5.2	**FreeStyle Libre (Flash Glucose Scanning {FGS}) (Children and Young People) – Recommendations from East of England Priorities Advisory Committee (EoEPAC)** Criteria for funding FreeStyle Libre has been discussed with Diabetologists and Paediatricians across the East of England. The EoEPAC document has been updated to include greater clarity on entry and stopping criteria and cost estimate calculations. Funding for other patient cohorts were considered by the EoEPAC meeting but it were considered a low priority for funding at this time. The JPC was asked to support the PAC recommendations and criteria for use with the exception of recommendations 7 and 8.	

	Recommendation 7 - BCCG and LCCG had asked that the recommendation to restrict prescribing and management to a Consultant led team should not be adopted to allow for more flexible commissioning of this service locally. Recommendation 8 – Further information has been obtained from the EoE Paediatric Diabetes Network and contrary to the information provided at the last EoEPAC, the FreeStyle Libre device does have the ability to calculate bolus doses of insulin and as the currently used paediatric blood glucose testing strips are of a similar cost to the those provided for the FreeStyle Libre device, it is likely that EoEPAC will remove/amend this recommendation at its meeting on 30/4/2018. **See post meeting note below.** The following key points were raised:- • The recommendations/criteria within the guidance needed to be clarified to ensure that it is clear that it applies to children and young people up to the age of 19 years. • Clarification of what happens to patients when they reach 19 years was sought, given that the current agreed criteria for adults and children differed. There were approximately 20 patients a year across the county who transitioned from the paediatric to adult service and who could potentially be started on FreeStyle Libre according to current proposed recommendations. The Secretary advised the meeting that relevant information on this could be found in section 2.9 ('Funding for FreeStyle Libre will be reviewed and stopped at age 19 or on transition to adult services. See PAC document for recommendations on funding FGS in adults with type 1 diabetes') of the document. This was further emphasised in section 2.11 of the guidance where clinicians must agree a contract with the child/patient/carer before commencing treatment and part of that contract was that 'Funding of FreeStyle Libre will be reviewed and stopped at age 19 or on transition to adult services.' Clinicians raised concerns that use of this device would be difficult to withdraw (even though it would be explained that this could happen at the start of using the device) as patients would be leaving school, starting work, going to college etc at this point in their lives. It was agreed that this needed to be explored further and if funding was agreed for patients transitioning to adult services, then the agreed adult criteria would need to be reviewed as inequalities in the system would be created if transitioning patients were funded and adult patient who meet the same criteria were not. The IFR route was not appropriate as this was a cohort of patients. FG advised that a phased approach to the introduction of FreeStyle Libre would enable audit data to be obtained for a small distinct patient group with a view to building a business case for other patient groups.	

- The ability to drive the price of the technology down was raised, however the meeting was advised that this had already been done by the Department of Health and as there was no competition, the current price was unlikely to drop.
- Clarification on recommendation 1 was sought. Could this be applied to Children and Young People where it was highly suspected that they had developed hypoglycaemia unawareness?
  It was agreed that this group would fall into this category provided that they fulfilled the sub criteria (a, b and c)

The JPC agreed to support the EoEPAC recommendations (except for recommendations 7 and 8 as outlined above) and criteria for funding with the clarification that all of the recommendations applied to 'Children and Young People with type 1 diabetes aged 4 up to the age of 19 years'.
The agreed modified recommendations are as outlined below:- **JC**

Flash Glucose Scanning system (FGS) for children and young people with type 1 diabetes age 4 up to the age of 19:

1. *Freestyle Libre® is an innovative device Flash Glucose Scanning system (FGS) that has the potential to improve quality of life for patients and support self-management. However, currently there are significant limitations in available clinical trial data and economic analysis, and routine commissioning for all patients is not recommended.*
2. *PAC supports a managed entry of FGS to allow real world data on use and outcomes to be collected in order to inform future policy.*
3. *FGS is recommended for the patient groups outlined below in line with the criteria and general funding recommendations set out in sections 2 and 3 of this document.*
4. *PAC recommends that funding is initially made available for these patient groups for a time limited period of 1 year. It is recommended that audit data is collected and that funding recommendations are reviewed to include new evidence on cost effectiveness, actual patient numbers and affordability.*
5. *Routine funding for any other indication is currently considered a low priority and is not recommended.*
6. *Funding for patients who are currently self-funding who do not fulfil the criteria is not recommended.*
7. *FGS should be initiated, managed and supplied as agreed by locally commissioned pathways. GP Prescribing is not recommended at the current time.*

<u>Summary of criteria recommended for funding:</u>
All recommendations apply to patients with Type 1 diabetes mellitus only unless otherwise specified (see section 3 for details).

1. *Children and young people up to the age of 19 years who have recently developed hypoglycaemia unawareness (< 3 months onset) [a,b,c].*

a Score >4 on the Clarke hypoglycaemia unawareness questionnaire

b Score ≥4 on the Gold hypoglycaemia unawareness Likert scale
c Evidence of incidentally detected hypo episodes from downloaded blood glucose data/ significant hypoglycaemia lasting >15 minutes confirmed by diagnostic Continuous Glucose Monitoring (CGM) or diagnostic FGS provided by the diabetes specialist team, that occurred during the waking day which the patients were unaware.

2. *Children and young people up to the age of 19 years who have disabling hypoglycaemia [d] without loss of hypo awareness*

d Disabling hypoglycaemia is defined as the repeated and unpredictable hypoglycaemia that results in persistent anxiety about recurrence and is associated with a significant adverse effect on quality of life and is manifested by one or more of the following features:

- *High frequency of blood glucose testing (≥ 8 tests per day)*
- *High frequency of blood glucose testing during night that disturbs sleep*
- *Persistent efforts to maintain high blood glucose levels in excess of the recommended maximum target in order to avoid hypoglycaemic episodes, that adversely affect metabolic control.*

3. *Children and young people up to the age of 19 years where adequate frequency of blood glucose monitoring is unachievable due to diagnosed behavioural or mental health disorders where there are significant concerns about the safety of the individual, and poor metabolic control.*

4. *Children and young people up to the age of 19 years with co-morbidities or who are on treatments which are associated with changes in nutrient intake or insulin sensitivity resulting in marked fluctuations of blood glucose levels that make the diabetes management very challenging. This includes patients with anorexia nervosa, PEG feeding, and children with Cystic-Fibrosis related Diabetes.*

5. *Frequent hospital admissions (>2 per year) with Diabetic Ketoacidosis (DKA) and HbA1c >69 mmol/mol despite intensive clinical intervention.*

6. *Children and young people up to the age of 19 years who meet the current NICE criteria for insulin pump therapy who are on pump pathway, where a successful trial of FGS may avoid the need for insulin pump therapy if clinically appropriate.*

7. *Children and young people up to the age of 19 years with extreme phobia towards finger prick blood test which adversely affect metabolic control defined as:*
    - *Children and young people up to the age of 19 years who have good concordance with insulin treatment but who have significant needle phobia despite psychological/play therapy interventions, and who are BG testing <5 times a day resulting in poor metabolic control (HbA1c > 69 mmol/mol).*

	8. *Children and young people up to the age of 19 years who are unable to achieve the HbA1c target of <58 mmol/mol despite intensive clinical intervention to optimise therapy and persistent (>6 months) intensive blood glucose monitoring (blood glucose tests ≥ 8/ day that is clinically appropriate, on the recommendation of the diabetes specialist team).* Although these documents and recommendations have been produced following discussions with diabetologists and paediatricians throughout the East of England and ratified by the JPC, as with all new developments, they are subject to local CCG discussion and prioritisation against other funding priorities. BCCG has agreed to fund FreeStyle Libre for Children and Young People as outlined above. (Funding agreed by the CCG Clinical Reference and Finance and Performance Groups). Following on from the JPC, LCCG (Medicines Optimisation and Clinical Commissioning Committees) will be reviewing the device in terms of opportunity costs, funding priorities and affordability and a final decision is anticipated at the end of May. The approximate cost impact of fully implementing the Children and Young People recommendations outlined above is between £20,000 to £30,000 for BCCG and between £10,000 and £15,000 for LCCG. It was agreed that further discussions would be required between the CCGs and Diabetes teams relating to the following issues:- • Transitional arrangements from children to adults. In order to do this, there would need to be a review of the currently recommended adult criteria. (See agenda item 5.3). • Implementation of the agreed recommendations. **Post meeting note:** FG had received information on patient numbers (for children and young people) that exceeded (double) the East of England estimates from Bedford Hospital. As a result of this BCCG will need to reconsider the agreement to fund FreeStyle Libre in this patient group.	**FG/RJ And Diabetes Specialist Service**
5.3	**FreeStyle Libre (Adult) (Flash Glucose Scanning {FGS}) – Recommendations from EoEPAC** Criteria for funding FreeStyle Libre has been discussed with Diabetologists and Paediatricians across the East of England. The EoEPAC document has been updated to include greater clarity on entry and stopping criteria and cost estimate calculations. Funding for other patient cohorts were considered by the EoEPAC meeting but it was agreed that more information was need before routine commissioning for these groups could be recommended. EoE PAC will continue to work with EoE clinicians to further develop these recommendations.	

The JPC was asked to support the PAC recommendations and criteria for use with the exception of recommendation 7 (FGS should be managed and supplied by a consultant led specialist Diabetes team. GP prescribing is not recommended). See above under agenda item 5.2 for further details.

The paper was discussed and the following key points were raised:-

- Could patients who did not fulfil agreed criteria be considered via the Individual Funding Request Route (IFR) by the CCGs?
  This is only likely to be possible if the patient fulfils criteria for an IFR, one of which is that the patient is not part of an identified cohort and exceptionality is demonstrated.
- Could IFRs be submitted for patients with complex needs (usually a combination of mental and physical disabilities in care/nursing homes)? The Committee was advised that two separate criteria for funding patients with mental and physical disabilities had been discussed by EoE PAC. The mental health criteria had gone back for further discussion and clarification while it was agreed that for patients who could not self-monitor (e.g. due to physical disabilities) an IFR application would be the appropriate route for consideration. The JPC agreed that complex patients with a combination of mental and physical disabilities (of which there were likely to be very low patient numbers) should be considered via the IFR route.
- There was a request for BCCG to reconsider its current decision not to fund FreeStyle libre in adult patients with particular regard to pregnant patients as outlined in the EoEPAC recommendations as pregnancies associated with diabetes have high maternal and fetal risks, especially if metabolic control is suboptimal. Flash monitoring provides detailed information on glucose trends allowing optimisation of insulin delivery to improve metabolic control to reduce hypoglycaemic events and a reduction in the number of blood glucose tests required to achieve good control. There is more evidence on the benefits of Continuous Glucose Monitoring in pregnancy (CGM) and this is the preferred option, where available, for improved pregnancy outcomes as main endpoint. However, the high cost of CGM means that it is not routinely available to pregnancy patients.

The JPC agreed to support the EoEPAC recommendations (except for recommendation 7 as outlined in the agenda item 5.2 above) and criteria for funding.
The agreed modified recommendations are as outlined below:-

Flash Glucose Scanning system (FGS) for adults with Type 1 diabetes:

- *Freestyle Libre® is an innovative device Flash Glucose Scanning system (FGS) that has the potential to improve quality of life for patients and support self-management. However, currently there are significant limitations in available clinical trial data and economic analysis, and routine commissioning for all patients is therefore not recommended.*
- *PAC supports a managed entry of FGS to allow real world data on use and outcomes to be collected in order to inform future policy.*
- *FGS is recommended for the patient groups outlined below in line with the criteria and general funding recommendations set out in sections 2 and 3 of this document.*
- *Routine funding for any other indication is currently considered a low priority and is not recommended.*
- *Funding for patients who are currently self-funding who do not fulfil the criteria is not recommended.*
- *PAC recommends that funding is initially made available for these patient groups for a time limited period of 1 year. It is recommended that audit data is collected and that funding recommendations are reviewed to include new evidence on cost effectiveness, actual patient numbers and affordability.*
- *FGS should be initiated, managed and supplied as agreed by locally commissioned pathways. GP prescribing is not recommended at the current time.*
- *Due to the high cost of testing strips and unsuitability for patients who are carbohydrate counting, the use of the inbuilt FreeStyle Libre meter for testing blood glucose or ketones is not currently recommended.*

<u>Summary for criteria recommended for funding:</u>

All recommendations apply to patients with Type 1 diabetes mellitus only unless otherwise specified (see section 3 for details).
1.Pregnancy:
1.1 Pre Pregnancy Care (PPC) for women with Type 1 diabetes in a recognised PPC pathway
1.2 Pre Pregnancy Care (PPC) for women with Type 2 diabetes on an intensive insulin regime, in a recognised PPC pathway.
1.3 Pregnancy care for women with Type 1 diabetes
1.4 Pregnancy care for women with preconception Type 2 diabetes on an intensive insulin regimen
2. People with Type 1 diabetes who meet NICE TA151 criteria for Continuous Subcutaneous Insulin Infusion (CSII) and are in a recognised pathway prior to CSII.
3. People with co-morbidities or who are on treatments which are associated with changes in nutrient intake or insulin sensitivity resulting in marked fluctuations of blood glucose levels that make the diabetes management very challenging. This includes patients with anorexia nervosa, PEG feeding, and people with Cystic-Fibrosis related Diabetes.

4. Frequent hospital admissions (>2 per year) with Diabetic Ketoacidosis (DKA) with HbA1c >69 mmol/mol despite intensive clinical intervention.

	Although these documents and recommendations have been produced following discussions with diabetologists and paediatricians throughout the East of England and ratified by the JPC, as with all new developments, they are subject to local CCG discussion and prioritisation against other funding priorities. BCCG is not able to fund the provision of the device to adults at the current time. This decision will be reviewed before the start of the 19/20 financial year. This decision is based on the current financial position of the CCG and affordability and was agreed by the CCG Clinical Reference and Finance and Performance Groups. Following on from the JPC, LCCG (Medicines Optimisation and Clinical Commissioning Committees) will be reviewing the device in terms of opportunity costs, funding priorities and affordability and a final decision is anticipated at the end of May. The approximate cost impact of fully implementing the adult recommendations outlined above is between £48,000 to £88,000 for BCCG and between £24,000 and £42,000 for LCCG. (Actual cost impact is dependent on assumptions on whether 'average cost strips' or 'most cost effective strips' are used in the calculations and also whether VAT is included or excluded. It was agreed that further discussions would be required between BCCG and the Diabetes teams around local patient numbers and costings and the transitioning of patients from the paediatric service and FG stated that she was happy to take this work forward.	**FG/Diabetes Teams**

Post Meeting Note (with respect to agenda items 5.2 and 5.3) : - At the East of England Priorities Advisory Committee meeting on 30th April the following amendments to the FreeStyle Libre Policies were agreed:-

Children and Young People - recommendation 8 has been divided into two recommendations which now state:-

8) The use of FreeStyle Libre blood glucose testing strips using the inbuilt meter should be considered locally.

9) Due to the high cost of testing strips, the use of the inbuilt FreeStyle Libre meter for testing ketones is not currently recommended.

Adults

Recommendation 8 has been amended to read:-

Due to the high cost of testing strips, the use of the inbuilt FreeStyle Libre meter for testing blood glucose or ketones is not currently recommended.

Chairman's action was sought and received to make the amendments to the recommendations as outlined above.

5.4	**Liothyronine Commissioning Position Statement Update** The Committee considered the East of England Priority Advisory Committee (EoEPAC) final draft commissioning statement and recommendations relating to the use of liothyronine. (The Secretary had confirmed that the final draft document had now been ratified by EoEPAC). The EoEPAC document has had extensive	

discussion and consultation with clinicians across the East of England.

The Committee was being asked to ratify the EoEPAC recommendations with the caveat that recommendation 3 could be subject to audit/review by the CCGs and the addition of a recommendation that if liothyronine is prescribed, the least costly preparation should be used. (For Primary Care, advice on this will be provided via Scriptswich/Optimise.)

The JPC discussed the document and the following key points were raised:-

- It was proposed that recommendation 2(b) could possibly be managed via the high cost drug proforma route. No agreement was reached.
- Recommendation 3 was debated at length with concerns raised over whether the drug should be made available at all to this group of patients, and if provided, should this be prescribed by secondary care only, initiated by secondary care and continued by GPs (with or without a formal shared care guideline). No agreement was reached.

The Committee agreed to support the statement and following recommendations with the caveat that there would be local discussion relating to the process to ensure funding of recommendation 2(b) and agreement over who should initiate, who should continue prescribing and the criteria that should be met for initiation and continuation for patients that fall into recommendation (3). **FG/RJ**

The agreed modified recommendations are outlined below:-

1. Levothyroxine monotherapy is the treatment of choice for hypothyroidism. There is no consistent evidence to support the routine use of liothyronine in the management of hypothyroidism, either alone or in combination with levothyroxine.

2. Liothyronine for treatment of hypothyroidism is not recommended for routine funding unless one of the following criteria applies:

    a. Post thyroidectomy thyroid cancer patients. Patients who need to receive radioactive iodine treatment (Radioiodine Remnant Ablation RRA) after their surgery will initially be started on liothyronine due to its shorter half-life and therefore faster onset of action than levothyroxine. These patients will remain on liothyronine until the oncologist is confident that they will not need any more radioactive iodine at which point they are switched over to levothyroxine. Prescribing in these circumstances must remain with the secondary care specialist and GPs should not accept prescribing responsibility for these patients.

    b. In rare cases of levothyroxine induced liver injury, long term liothyronine prescribing may be supported but only after initiation and stabilisation by a secondary care specialist. Arrangements for **individual prior approval**, prescribing and supply should be agreed locally, ensuring that appropriate patient monitoring is in place.

	3. Initiation and prescribing of liothyronine for patients on levothyroxine who continue to suffer with symptoms despite adequate biochemical correction should remain in secondary care under the supervision of an accredited endocrinologist. 4. Funding of unlicensed medicines e.g. Armour Thyroid for the treatment of hypothroidism is not supported. 5. Prescribers in primary care should not initiate or accept clinical responsibility for on-going prescribing of liothyronine for any new patient, including patients who are currently self-funding and obtaining supplies via private prescription or previously prescribed by a secondary care consultant, unless the criteria stated above are met and they have agreed to accept clinical responsibility for prescribing. 6. CCGs should give consideration to providing guidance for GPs to switch existing patients to levothyroxine where clinically appropriate, with support from a consultant NHS endocrinologist where necessary or agree arrangements for appropriate review by a consultant NHS endocrinologist 7. These recommendations will be reviewed in the light of new evidence of clinical and cost effectiveness. 8. If liothyronine is prescribed, the least costly preparation should be used. (For Primary Care, advice on this will be provided via Scriptswich/Optimise.) It was further noted that the statement and recommendations would replace the current JPC bulletin and recommendations.	
5.5	**Dermatology Pathways (BCCG)** BCCG is working with BHT to develop interventions to reduce demand and cost for dermatology. This will include a fully integrated community dermatology service, which is a consultant led service with community clinic locations, utilising dermatology GPSI's and specialist nurses, teledermatology, standardised pathways, primary care education, high cost drug prior approval and advice and guidance in order to administer care closer to home for patients. By developing and implementing these pathways, this would be another step in linking with the agenda for “Care closer to home” With the current model, all activity is being signposted into secondary care. This is not sustainable, nor is it necessary as with a patient treatment plan, patients could be managed by their GP’s in primary care or with more specialist care in the community. Pathways standardise patient care and improve alignment to NICE and best practice. Patients are also referred with the necessary work up to enable and efficient pathway when referred to community and secondary care. Overall, the three pathways for acne, eczema and psoriasis will support GP’s to manage more patients in primary care. The Committee was asked to consider the pathways and the following key points were raised:-	

- The chair had made a number of comments in advance of the meeting and as a result DW has proposed the following changes to the document and these were agreed by the Committee:-

Acne Summary Pathway.

1) 1st line treatment for moderate acne is a little unclear – Could be interpreted as: topical antibacterial/benzoyl peroxide combination OR topical antibacterial/topical retinoid combination OR topical retinoid alone, when in fact the middle of these 3 appears as 3rd line – In relation to this comment this text box has been re-written and '+' and '/' used to clarify the first line treatment option in moderate acne
2) In the bottom right box on use of oral antibiotics, there should be some guidance on min/max duration of treatment rather than simply "limited to the shortest possible period" to ensure clinical and cost effectiveness and minimise risk of early relapse – DW has referred to the antimicrobial guidelines and changed the statement to 'Oral antibiotics should be reviewed after 8 weeks and continued up to a maximum duration of 6 months'.

Atopic Eczema Summary Pathway.

1) Clarithromycin recommended 2nd line for bacterial infection when allergic to penicillin. Should there be an alternative for use in pregnancy, as the last review of the Antimicrobial Guidelines (Nov 2017) had included clarithromycin in the list of drugs not to be used in pregnancy? DW has discussed with Naomi Currie (who recently updated the antimicrobial guideline) and has added a section on antimicrobial use in pregnancy, 1st line is flucloxacillin and 2nd line is erythromycin (if penicillin allergy).

Additional general comments raised at the meeting were:-

- LCCG representatives asked why this pathway and work was being considered by the JPC (equivalent work in LCCG is considered by the LCCG Prescribing Committee) and why the Luton & Dunstable Hospital/LCCG had not been included. SB advised that the Luton & Dunstable Hospital had been invited to participate but had not come back to BCCG and LCCG (Planned Care) had advised that their model of care was different to that of BCCG. The BCCG Prescribing Committee does not have the same remit as the LCCG Prescribing Committee, hence the request for the JPC to consider. While taking up part of the JPC agenda, consideration at JPC does carry the advantage of ensuring that work is shared across the county which may help prevent duplication of work going forward. BCCG was very

	happy for LCCG to use the work and to add a LCCG logo if appropriate. • To add a statement to all pathways that none of the products recommended should be a pharmaceutical special. (This is still an issue for Bedford Hospital. Noted that the Luton & Dunstable Hospital Dermatologists did not recommend the use of pharmaceutical specials). **Acne Pathway** • Could doxycycline be offered as an alternative tetracycline? (DW agreed to check the Community Antimicrobial Guidelines and amend as necessary). • The recommendation to start the patient on a combined oral contraceptive needed to be slightly reworded e.g. Consider starting contraception and use a combined oral contraceptive if not contra-indicated. It also needed to be highlighted (within the chart) that barrier methods of contraception were not considered to provide adequate protection. **Psoriasis Pathway** • The table included in the Atopic Eczema Summary giving further information on steroid cream potency to be included in the Psoriasis Pathway information. • The second and fifth line treatments for 'Trunk & limbs or guttate' seemed to be the same. (DW agreed to clarify the wording). With the above amendments, the pathways were approved by the Committee.	**DW** **DW** **DW** **DW**
5.6	**Anticoagulation in Atrial Fibrillation (AF) - Resources Update** The JPC has two bulletins relating to the use of anticoagulants in AF:- • Bulletin 216 – Anticoagulation in AF (JPC endorsed the East of England Priority Advisory Committee (EoEPAC) bulletin and resources with some additional local recommendations. *http://www.gpref.bedfordshire.nhs.uk/media/156262/advguid_anticoagulationaf_bulletin216_nov16.pdf* • Bulletin 224 – Choice of Non Vitamin K Oral Anticoagulants (NOACs) http://www.gpref.bedfordshire.nhs.uk/media/145603/advguid_choiceofnoac_bulletin224_feb16v3_withprices.pdf Most of resources for GPs included in Bulletin 216 have recently been updated by PrescQIPP and EoEPAC will be retiring their bulletin in favour of the PrescQIPP resources with the exception of the decision aid which is currently under review. In order to facilitate the work that GPs are undertaking with respect to prescribing of anticoagulants, the JPC was asked to ratify the following new PrescQIPP resources. (Agreed):-	

	The JPC supported the following PrescQIPP resources for Anticoagulation in AF:- • Drug Interactions with Non-vitamin K antagonist oral anticoagulants (NOACs) – Patient Information. • Comparison of NOACs. • Prescriber Support – for patients on warfarin with poor control. • AF and Medicines to reduce your risk of stroke – patient information and decision aid. An updated Prescriber Decision Aid Support for Anticoagulants in patients with AF will be considered (possibly virtually) by the JPC when available and then circulated to prescribers. With respect to Bulletin 224 – minor updates to this bulletin have been made to reflect current prescribing patterns, costs and changes to Summary of Product Characteristics. The Committee was asked to support the updated bulletin. (Agreed)	**JC**
5.7	**Guanfacine – consideration of Shared Care** Guanfacine was considered by the East London Foundation Trust (ELFT) Medicines Management Committee in November 2016 where it was agreed that guanfacine was not suitable for shared care. This ELFT recommendation (and supporting bulletin) was discussed and ratified by the JPC in November 2016. ELFT is in the process of updating the Shared Care Guidelines for drugs used in the management of ADHD and has confirmed that as ELFT CAMHS Clinicians have very low usage of guanfacine, there are no plans to include guanfacine in the shared care guideline. As Bedfordshire and Luton Community Paediatricians do have an interest in using this drug and are currently carrying out all prescribing, it was agreed that the need for a locally agreed guanfacine shared care guideline would be reviewed. The place in therapy also needed to be confirmed by the Committee as a new NICE Guideline (Diagnosis and Management of ADHD) has been published – see below for further information. The Committee re-reviewed the ELFT bulletin and the key points that were raised by the JPC with respect to guanfacine when last considered in November 2016. The following key points were noted:- • There are no direct comparative studies with active comparators • There is very limited data on long term use and no further planned studies, despite the EMA requesting these. (This may change in the future) • Co-morbid psychiatric disorders were excluded from trials	

	• The target population in the studies did not include patients for whom stimulants were not suitable, not tolerated and/or ineffective. • Safety concerns were raised, although it was acknowledged that the side-effect profile is no worse than alternative treatments • While the Scottish Medicines Consortium Review confirmed that the drug was cost-effective, the All Wales Medicines Strategy Group did not. Cost impact to the Health Economy would be dependent on patient numbers and final maintenance dose. • Specific additional issues raised which questioned the use of this drug under shared care were the fact that the dose would need re-titration if a patient missed two doses and the interaction with a high fat diet, both of which would be a challenge when dealing with the adolescent patient. In addition, a lot of monitoring was required. • BCCG GPs were already prescribing (around 40 patients). For LCCG GPs the numbers were much lower – only 2 patients. • Pharmacy Representatives from the Community Services advised that re-titration of the drug when doses were missed did not appear to be a problem in practice as the patients/carers were supported and educated to avoid this occurring. It is not clear whether this experience reflects the possibility that re-titration guidance was not being sought when doses had been missed. • Some GP representatives raised concerns around the level of patient monitoring required and that they did not have access to some of these services e.g. paediatric ECG, while other GP representatives noted that they would be happy to provide if there was a clear shared care guideline and the patient was passed to their care after medication was fully stabilised. Pharmacy Community Service representatives indicated that the Community Paediatric Service would be happy to monitor patients if GPs agreed to take over prescribing. While this option could be considered, normally the JPC advised that monitoring and prescribing was undertaken together to ensure safe prescribing as the full responsibility for prescribing rests with the clinician who signs the prescription. • Comments from Dr Yemula indicated that patient numbers were likely to increase as a result of the NICE Guideline. (The reason for this was unclear as the current place in therapy was as recommended in the NICE Guideline). • If the JPC provided a shared care guideline, this advised the Health Economy that shared care was appropriate for the drug and this would increase pressure on GPs to prescribe.	

	• LCCG Pharmacy representatives had already discussed sharing care with the Clinicians at the Edwin Lobo Centre and would be prepared to produce shared care guidelines for local (LCCG) agreement and use. It was noted, however that this could, result in some operational issues as Dunstable GPs also referred to the Edwin Lobo Clinic and therefore a countywide approach would be more desirable. • The latest NICE Guideline indicated that all drugs (including guanfacine) could be subject to shared care with GPs after the patient was stabilised on therapy. The JPC agreed to support the production of a draft Shared Care Guideline for Guanfacine for consideration by the Committee, with a view to making a final decision on whether to proceed to shared care once it was established whether there could be clear demarcation between primary and secondary care responsibilities. The place in therapy for Guanfacine was then considered and it was agreed to support the recommendations included in the recently issued NICE Clinical Guideline (Guideline 87, published March 2018) *'Offer atomoxetine or guanfacine to children aged 5 years and over and young people if:-* • *They cannot tolerate methylphenidate or lisdexamfetamine or* • *Their symptoms have not responded to separate 6-week trials of lisdexamfetamine and methylphenidate, having considered alternative preparations and adequate doses.* *(It is noted that neither atomoxetine, nor guanfacine have a UK marketing authorisation for this indication in children aged 5 years).* *With respect to the treatment of Adult ADHD, NICE states the following with respect to guanfacine:-* • *Do not offer guanfacine without advice from a tertiary ADHD service.* *(It is noted that guanfacine does not have a UK marketing authorisation for this indication).'*	**JC**
6	**NICE Guidance**	
6.1	**NICE Guidance Summary – Published Guidance – from 15 February to 9 April 2018** **The following NICE Technology Appraisal Guidance was noted by the Committee for Implementation:-** **Brodalumab for treating moderate to severe plaque psoriasis, Technology appraisal guidance [TA511] Published date: 21 March 2018.** **https://www.nice.org.uk/guidance/ta511**	

	No significant resource impact is anticipated NICE does not expect this guidance to have a significant impact on resources; that is, it will be less than £5 million per year in England (or £9,100 per 100,000 population). There is also a Confidential Patient Access Scheme Price. The JPC Psoriasis Pathway will need to be updated as a result of this guidance, however as there is another NICE TA in the pipeline for an additional treatment, it is proposed that we update the pathway after both TAs have been published. AG has kindly agreed to update the Psoriasis Pathway.	**AG**
	The following NICE Guidelines (Medicine related and CCG Commissioned) have been published and were noted for information and action by the Committee as appropriate:- **Attention deficit hyperactivity disorder: diagnosis and management** **NICE guideline [NG87] Published date: March 2018.** **https://www.nice.org.uk/guidance/ng87** This guideline covers recognising, diagnosing and managing attention deficit hyperactivity disorder (ADHD) in children, young people and adults. It aims to improve recognition and diagnosis, as well as the quality of care and support for people with ADHD. In April 2018, NICE made clarifications to recommendations *1.5.10, 1.5.12, 1.5.13, 1.7.4, 1.7.7 and 1.8.14* and their rationale and impact sections. **JPC Required Action –** The ADHD Shared Care Guidelines will need to be reviewed as a result of an issue of the guidance. This has been flagged to ELFT who are reviewing the Children's ADHD shared care guidelines. The JPC will review the Adult ADHD Guidelines. Of interest (referring back to discussions at the March 18 JPC meeting) is the following recommendation: '*1.7.29 After titration and dose stabilisation, prescribing and monitoring of ADHD medication should be carried out under Shared Care Protocol arrangements with primary care.* ***[2018]'*** which confirms the JPC opinion/discussions on when GPs should take over prescribing. Community Services representatives are also asked to review their practice against the new Guideline e.g. 'Do not offer clonidine to children without tertiary care ADHD advice. **Heavy menstrual bleeding: assessment and management** **NICE guideline [NG88] Published date: March 2018.** **https://www.nice.org.uk/guidance/ng88** This guideline updates and replaces NICE guideline CG44 (January 2007). NICE has updated the recommendations on investigations for the cause of heavy menstrual bleeding and management of heavy menstrual bleeding in sections 1.3 and 1.5. The references to the use of ulipristal have been removed.	**JC/SMcG** **AD/KP**

	JPC Action: The updated guidance was flagged to the chair of the Beds and Herts Priorities Forum who has acknowledged that this guidance was already under consideration. **Venous thromboembolism in over 16s: reducing the risk of hospital-acquired deep vein thrombosis or pulmonary embolism, NICE guideline [NG89] Published date: March 2018.** https://www.nice.org.uk/guidance/ng89/chapter/Recommendations#interventions-for-pregnant-women-and-women-who-gave-birth-or-had-a-miscarriage-or-termination-of This guideline covers assessing and reducing the risk of venous thromboembolism (VTE or blood clots) and deep vein thrombosis (DVT) in people aged 16 and over in hospital. It aims to help healthcare professionals identify people most at risk and describes interventions that can be used to reduce the risk of VTE. **Recommendations** This guideline includes recommendations on: • assessing the risks of VTE and bleeding • giving information and planning for discharge • prophylaxis for all patients, medical patients and surgical and trauma patients • prophylaxis for pregnant women and women who recently gave birth, had a miscarriage or had a termination of pregnancy **Action required:** This guideline is mainly aimed at secondary care colleagues who will need to review current VTE hospital guidelines. MW advised that this work was already underway at the Luton and Dunstable Hospital. **Otitis media (acute): antimicrobial prescribing** **NICE guideline [NG91] Published date: March 2018.** https://www.nice.org.uk/guidance/ng91 This guideline sets out an antimicrobial prescribing strategy for acute otitis media (ear infection). It aims to limit antibiotic use and reduce antimicrobial resistance. Acute otitis media can be caused by viruses or bacteria. It lasts for about a week, and most children get better in 3 days without antibiotics. Serious complications are rare. **Required JPC Action:** Review of Community Antimicrobial Guidelines. The JPC reviewed and agreed the proposed changes, All electronic versions of the guidelines will be updated. BCCG will need to agree if/what additional update to the 'hard copies' of the guideline will be required and how these will be distributed. Lyme disease, NICE guideline [NG95] Published date: April 2018 https://www.nice.org.uk/guidance/ng95 This guidance was published after the JPC papers were circulated. The Secretary therefore requested direction from the Committee on the following options:-	**Naomi Currie/ SMcG/ FG**

	1. Include detailed information from the NICE Guidance in the Community Antimicrobial Guideline. 2. Signpost from the Community Antimicrobial Guideline e.g. add a statement to the skin and soft tissue section. 'Consider Lyme disease in patients presenting with erythema migrans. Refer to the NICE Guideline on Lyme Disease for advice on diagnosis and management' 3. Do not any reference to Lyme disease in the Community Antimicrobial Guideline. The Committee agreed to support option 2 outlined above. The electronic versions of the Community Antimicrobial Guidance would be updated to reflect this decision. **The following Technology Appraisal Guidance are the commissioning responsibility of NHSE and were noted by the Committee for information:-** Sofosbuvir–velpatasvir–voxilaprevir for treating chronic hepatitis C Technology appraisal guidance [TA507] Published date: 21 February 2018. https://www.nice.org.uk/guidance/ta507 Autologous chondrocyte implantation using chondrosphere for treating symptomatic articular cartilage defects of the knee Technology appraisal guidance [TA508] Published date: 07 March 2018. https://www.nice.org.uk/guidance/ta508 Pertuzumab with trastuzumab and docetaxel for treating HER2-positive breast cancer Technology appraisal guidance [TA509] Published date: 07 March 2018. https://www.nice.org.uk/guidance/ta509 Daratumumab monotherapy for treating relapsed and refractory multiple myeloma Technology appraisal guidance [TA510] Published date: 14 March 2018. https://www.nice.org.uk/guidance/ta510 Tivozanib for treating advanced renal cell carcinoma Technology appraisal guidance [TA512] Published date: 21 March 2018. https://www.nice.org.uk/guidance/ta512	**Naomi Currie/ SMcG**

	Regorafenib for previously treated advanced hepatocellular carcinoma Technology appraisal guidance [TA514] Published date: 21 March 2018. https://www.nice.org.uk/guidance/ta514 Eribulin for treating locally advanced or metastatic breast cancer after 1 chemotherapy regimen Technology appraisal guidance [TA515] Published date: 28 March 2018. https://www.nice.org.uk/guidance/ta515 Cabozantinib for treating medullary thyroid cancer Technology appraisal guidance [TA516] Published date: 28 March 2018. https://www.nice.org.uk/guidance/ta516	
7	**Virtual Recommendations/Documents – for discussion/ratification** There were no documents considered virtually for ratification by the Committee.	
8	**Drug Safety Updates (DSU) – March and April 2018** The MHRA Drug Safety Updates for March and April 2018 were noted by the Committee for information. **March 2018 DSU** https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/686884/DSU-March-18-PDF.pdf Daclizumab (Zinbryta▼): suspension and recall for safety reasons; review patients as soon as possible and start alternative therapy Esmya (ulipristal acetate) for uterine fibroids: do not initiate or re-start treatment; monitor liver function in current and recent users Head lice eradication products: risk of serious burns if treated hair is exposed to open flames or other sources of ignition, eg, cigarettes Confidential prescribing and patient safety reports on key indicators now available free for GPs **April 2018 DSU** https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/701831/DSU-April-2018-PDF.pdf	

	Valproate medicines (Epilim▼, Depakote▼): contraindicated in women and girls of childbearing potential unless conditions of Pregnancy Prevention Programme are met Obeticholic acid (Ocaliva▼): risk of serious liver injury in patients with pre-existing moderate or severe hepatic impairment; reminder to adjust dosing according to liver function monitoring Suspect an adverse reaction? Yellow Card it! The attention of the Committee was particularly drawn to the updated Valproate recommendations outlined above. All relevant NICE Guidance (and associated pathways) had been updated to include the warnings. The MHRA has advised that the Pregnancy Pack Resources are anticipated to be available by the end of next week. Committee members advised that the information has already been included in clinical systems which was causing practical problems as prescribing was being blocked until the Prescriber confirmed that the actions included in the alert had been undertaken including provision of the patient guide which was not currently available.	
9	**Wound Care Formulary Update** There were no formulary updates for consideration.	
10	**East of England Priorities Advisory Committee (PAC) – items for discussion and noting.**	
10 .1	**Draft PAC Minutes - January 2018** The minutes were noted for information.	
10 .2	**Insulin Degludec (Tresiba®)** The Committee was asked to support the EoEPAC recommendations and bulletin noting that there has been extensive consultation with clinicians across the East of England. The updated bulletin and recommendations are very similar to the existing bulletin aside from including the treatment of type 2 diabetes and the option for tertiary centres to use the high strength (200units/ml) insulin. The new recommendation 6 requires that 'arrangements for ongoing provision of the insulin in primary care should be agreed locally' whereas the previous recommendation stated that 'ongoing provision of the insulin may be undertaken in primary care by agreement between the specialist and the patient's GP'. This is for discussion and agreement by the Committee for both strengths of insulin. Comments had been received from local specialists that there was no need for referral to tertiary care for treatment with the high dose product for the treatment of severe insulin resistance. In addition, references to 'Consultant Diabetologist' should be expanded to read 'Specialist Diabetes Service'. Clarification of recommendation 6 was requested with respect to the statement that 'All patients should be managed by the initiating specialist team….'. It was	

confirmed that this related to 'glucose control' rather than full management e.g. GPs should continue to manage other aspects of diabetes care e.g. feet and eye checks. It was reported however that often patients were reluctant to attend GP surgeries for these checks while they were under the care of a specialist diabetes team as they assumed that if these checks were required, the specialist team would care them out.
The Committee agreed that GPs could take over prescribing (of both strengths of insulin) providing that the patient is stabilised as outlined in recommendation 6.

The Specialist Diabetes Teams (paediatric and adult) put forward a request to use Insulin Degludec as a first line treatment for newly diagnosed type 1 diabetic patients for the following reasons:-

- Reflects a change in Diabetic Standards of Care, including patient education and the use of basal bolus insulin.
- Patients are started on insulin glargine and are often switched (due to 'stinging') to insulin levemir. This often has be given twice daily which results in a 'cross over' effect of insulin levels which in turn makes it difficult to decide which dosage to adjust. These patients then end up being switched to insulin degludec. Starting insulin degludec first line would prevent the need to do all of this switching.
- Glargine and degludec were of similar prices. (FG advised that the price of glargine has just been reduced).

Given that EoEPAC recommends no routine commissioning of insulin degludec based on evidence (clinical and cost), the Luton & Dunstable Hospital diabetologists are supportive of the EoEPAC recommendations and the price of insulin glargine has been reduced, the use of insulin degludec first line for newly diagnosed diabetic patients was not supported at the current time. The bulletin and EoEPAC recommendations were endorsed (with the clarifications outlined above):-
The JPC supported the updated East of England Priorities Committee (EoEPAC) bulletin and the following (locally clarified) recommendations:-

Recommendations for use in adults and children

1. Insulin degludec is not recommended for routine use in adults or children with either type 1 or type 2 diabetes.
2. Insulin degludec 100 units/mL may be of benefit to certain patients with type 1 or type 2 diabetes who fulfil the following criteria:

- Patient with significant hypoglycaemia, despite optimal adjustments of lifestyle (eliminating any contributory factors), diet (undertaken structured education e.g. DAFNE), and basal insulin/multiple daily injections and who fulfil the criteria for insulin pump therapy.

	• "Chaotic patient" who may be at significant risk of diabetic ketoacidosis (DKA) or hyperosmolar hyperglycaemic state (HHS) (previously known as hyperosmolar non – ketotic diabetic state or hyper HONK) if daily basal insulin is missed, despite optimal adjustments of lifestyle, and diet and optimising basal insulin/multiple daily injections. • Patients with psychological problems (e.g. eating disorders or patients with intermittent compliance issues with insulin injections), who are not supervised by a daily carer and do not qualify to receive district nurse injections of daily insulin glargine, and who may be at significant risk of DKA or HHS if daily basal insulin is missed. • Patients with a diagnosed allergy to either insulin glargine or insulin detemir. 3. High strength insulin degludec 200 units/ml is <u>not</u> recommended for routine use. It should be considered for patients with severe insulin resistance requiring large daily doses of insulin (≥3units/kg/day), where treatment is initiated by the Specialist Diabetes Service. 4. Approval arrangements for treatment should be agreed locally. Following addition to local formularies, on-going assessment of treatment uptake should be monitored using ePACT data. It is also recommended that the commissioning decision is reviewed annually based on local audit and assessment of outcome data for patients started on insulin degludec to ensure that the treatment is continuing to meet the specific needs of the local population. 5. Insulin degludec should be initiated by the Specialist Diabetes Service only and is <u>NOT</u> suitable for initiation by GPs or other prescribers in primary care unless under the supervision of a specialist. It is recommended that the initial dose titration and monitoring is closely supervised by a specialist team. 6. The glucose control of all patients should be managed by the initiating specialist team for a minimum of 3 months. After this time period, prescribing may be transferred to the GP assuming that the patient's glucose control is stable. (This applies to both strengths of insulin degludec). Patients should be returned to previous treatment if no improvement in overall disease control from baseline is demonstrated. The following actions agreed:- • The Secretary would report back to EoEPAC re the request for first line use by the Bedford Hospital Diabetes Team and seek provisional views from the Committee.	**JC**

	• Further discussions with local diabetologists would be undertaken around the first-line use of insulin degludec in newly diagnosed type 1 patients.	**FG/JC**
11	**Bedfordshire Local Prescribing Committee Minutes** The following meeting minutes were noted for information by the Committee.	
11.1	ELFT Medicines Management Committee Minutes (Mental Health) – January 2018	
11.2	EPUT Community Services Medicines Management Committee minutes – February 2018	
11.3	Minutes of the Bedfordshire and Luton Wound Management Formulary Steering Group – March 2018	
11.4	Minutes of the Cambridgeshire Community Services Medication Safety and Governance Group – March 2018	
12	**Additional Documents for information**	
12.1	**RMOC Documents – Adalimumab Biosimilar** This paper came to the Committee for information but Trusts and CCGs were asked to note actions required e.g. include adalimumab transition as a standing agenda item for local Drugs and Therapeutics Committees.	
13	**Any other Business** The chair requested, that where possible, Committee member comments should be sent to the Secretary in advance of the meeting as this would assist in the smooth running of the meeting and ensure that any questions raised were followed up in advance of the meeting if possible.	**All**
14	**Dates of future 2018 meetings - all at Endeavour House (Building 50), Wrest Park, Silsoe, Bedfordshire, MK45 4HS.** • **Wed 20th June** • **Wed 19th September** • **Wed 28th November**	

NHS
Bedfordshire
Clinical Commissioning Group

Agenda Item: 4.0

Integrated Commissioning and Quality Committee

DRAFT MINUTES

Minutes of the meeting of the Integrated Commissioning and Quality Committee on 25 April 2018 Room 208, Endeavour House, Wrest Park, commencing at 09.00 and concluding at 11.00.

Attendees

Heather Moulder	Registered Nurse lay member (Chair) - *Dialled in*	**HM**
Anne Murray	Director Quality and Nursing	**AM**
David Howard	GP Locality Chair – Bedford Borough	**DH**
Charlie Wood	Programme Director of Commissioning for Planned and Unplanned Care – attended part of meeting	**CW**

Mel Gunstone	Assistant Director of Nursing and Quality	**MG**
Alison Borrett	Patient & Public lay member	**AB**
Carole Davis	Head of Performance	**CD**
Rachel Volpe	Head of Mental Health	**RV**
Karen Chisnall	Quality & Safeguarding Facilitator	**KC**
David McNeil	Assistant Director of Governance Risk and Corporate Services	**DMc**

Apologies for absence

Maria Laffan	Associate Director of Nursing and Quality	**ML**
Ian Brown	Assistant Director of public Health	**IB**
Jane Meggitt	Director of Governance Risk and Corporate Services	**JM**

No	Item
1.0 & 2.0	**Welcome and Apologies** Apologies for absence were noted as recorded above.
3.0	**Declarations of Interest** There were no declarations of interest declared over and above those on the declarations of interest register.
4.0	**Minutes of the meeting held on 28 February 2018** The minutes were discussed and a number of changes were recommended. HM to revise, AM to review and agree.

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5.0	**Action Tracker** The actions were discussed and logged with relevant updates with in the live action tracker. All closed actions will be archived and coded accurately for future reference.
6.0	**Integrated Quality and Performance Report** **Integrated Urgent Care –HUC:** More detail has been provided in the report since the new contract was signed with HUC. There is a synopsis of data including home visits and base visits, and percentages around those. Slight improvement seen but continued poor performance. Information received through contractual routes has improved which will enable increased scrutiny. AM/MF will be attending a meeting in 1 week with HUC Directors, to ensure a continued focus on improvement. HM raised concern that almost 40% of urgent visits are not being achieved within 2 hours. We need to understand how much longer performance is to appreciate impact and therefore clinical risk. We also need to understand what the process is for calling the patient for an update when the 2 hour target is not met, and what the outcome is when 2 hours are exceeded. DH queried the position in relation to the training re-accreditation update, he believes this is only being completed in Biggleswade. Position to be confirmed. **Action ICQC-0067**: AM will follow up with ML. DH shared that a member of staff had made a complaint regarding her son not receiving a call back, and has not received a response from HUC. **Action ICQC-0068**: AM will follow up with MF who is aware of complaint. AM advised that it was felt that HUCs staffing infrastructure had not grown prior to the organisation growing. They have since recruited more local senior staff and have been and this will be one of the points to discuss at the next meeting. An item for the next board meeting should be, what else we can do as a CCG. EEAST are achieving the 10% transfers going directly from HUC. However there are questions over what % of patients may go directly if HUC is not achieving the 2 hour target. Contract now includes expectation of better reporting with analysis of this data. CW reported that the Urgent Treatment Centre (UTC) is due to go live in October and the foundation level is that there is an operational integrated 111 service and support. GP resource is a very limited, and workforce issues are concerning and therefore a multi-disciplinary model is being looked at from a wider clinician's point of view. From a contractual point of view, CCGs need to take a proactive Commissioning approach with clear modelling and flexibility on how to deliver the UTC. AB enquired about patient experience and complaints, and whether there was any intelligence from Healthwatch or ourselves.

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	AM advised there was a question at Governing Body from Health watch in relation to performance for call backs. The ability therefore to continue to analyse the data and where we are with urgent visits, base visits, and call answering is essential ongoing. HM noted how important it is to take GP colleagues with us, and address any concerns raised in relation to service safety. DH queried what was happening with Dunstable cover, as at times there was only doctor covering whole area. **Action ICQC-0069**: AM to follow up with MF. MG noted HUC is Herts Urgent Care, not Hertfordshire Urgent Care. Important to refer to correctly due to legal entity. **52 Weeks:** East and North Herts hospital remains the same in relation to be able to report their performance position due to the implementation of the data system Lorenzo. CD provided an update on the 52 week position. If there is a breach, a clinical harm review is carried out by the Trust. To date there has been no harm identified. Fortnightly meetings continue with NHS England and NHSI. AM confirmed that quality team have linked in with East & North Herts team. DH stated that people have a right to know it's not going well. AM agreed and confirmed we are not assured and therefore this will be escalated to QSG. The Trust won't be able to report until November, with a possibility of extending further. AM confirmed this is a QSG conversation and it will go in the next report for Governing Body. CD update is based predominately on February data, although some March data is included. Data is being transferred to NHS digital portal and there are some data quality issues coming through already. **Diagnostic waits:** Cambridge Community Services have ongoing issue around workforce and have seen a rise in referrals and have 30 breaches in March for audiology. 196 breaches are predicted for May. They are trying to incentivise the staff to stay, recruit and trying to look at it in a different way. **Action ICQC-0070**: CW to explore alternative pathway, potential to subcontract to another provider. L&D continue to recover on diagnostics, and now down to 12 breaches in March in the Endoscopy department.

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Care Programme Approach – ELFT:

The Trust has identified a discrepancy in the national reporting of the Care Programme Approach 7 day follow up. An explanation of why some patients weren't on CPA was given. Some cases were straightforward and therefore CPA not required, or a breach occurred because contact was achieved on day 8 instead of day 7, or moved out of area.

HM queried whether there were any patients that should have had CPA but didn't? and is there a trajectory to recover? A request was made for the report to be explicit on where the breach has occurred, more detail behind it needed?

RV shared that a contract performance notice had been issued to look at the reasons and the notice had been retracted as a full detail report is sent with every breach providing reasons. There is no plan or trajectory in place as not required, assurance received.

Action ICQC-0071: AM requested that RV work with CD to ensure report has additional detail going forward. Also to work with Bernie Harrison so risk to patients is covered.

Referral to Treatment: RTT

RTT, February data showed further deterioration, which was expected with capacity issues associated with winter. Planning shows we are not likely to achieve 92% until month 4 and this has been accepted by NHSE.

The Transfer of dermatology service has had an impact too, more detail can be found on p9 of the report. 52 week report just received and there have been 5 breaches in March, 2 of them we are aware of and will be following up on detail of the others.

A&E shows an improved position for March but still under the trajectory. Plan is to be at 95% currently the position is 88.21%.

Dementia:

Dementia, have just seen March data and this has deteriorated again, 58.86%.

DH enquired if extra finance available if targets met? DH also confirmed that there is no longer a shared care protocol, once the patient is stable, they are discharged back to the GP.

RV gave assurance that the discharge protocol is being looked at.

RV also confirmed that the quality premium is no longer available, so extra finance is not awarded when targets met.

A lot of work is going on around data quality, checks are being completed at GP surgeries to find out if people who have dementia may not have been coded, this started in December. There is also a care home project underway as our data may not be accurate which started very recently. NHSE have provided £14k funding to enable this.

DH confirmed that a proper diagnosis ensures better care can be delivered, encourages

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relatives to get Power of Attorney sorted.

RV continued to provide update on pilot of CANTAB, which is an iPad to assist primary care to diagnose.

CW shared that the future aim is to be able to pull out some of the narrative on all the work, in a succinct way, to demonstrate the focus and the level of work that is going on to improve this position. Trying to be more measured in approach, to track and monitor areas which are more intangible and difficult to measure.

DH queried if ELFT liaise with BHT and L&D when older people are admitted with confusion, do they refer for a memory test directly, instead of going through GPs.

RV shared that ELFT are currently recruiting for a specialist in older people for this role.

When all data quality assurance process driven work is completed, if constitutional targets are still not achieved, then more of the transformational side will be needed.

Action ICQC-0072: CW & AM to start the process for transformational work.

IAPT :–

Predicting end of year position of 14.53%, which is under the standard but a 2% increase on last year. Numerous contract performance notices have been served, a lot of work has gone on but not a lot of movement has been seen. A number of ELFT staff have TUPE to Bedfordshire so we have the lowest vacancy rate we've ever had. ELFT have appointed a new psychology lead who is very dynamic. Emphasis on long term conditions, respiratory, diabetes, pain management and considered ahead of the game and have been asked to present at an NHSE regional event. We were given additional funding last year to meet targets, this year half has been given with the other half to be awarded when achieved.

Stroke :

Discussion on poor snap data results at Bedford and CW & AM to bring back further detail to next meeting on potential solutions in improving care.

Action ICQC-0073: Stroke to be agenda item on next meeting –

CHC:

AM requested update on CHC data issue This should be aligned to funded care report as NHSE cannot change their data. Discussion on where late completions will be recorded, if they are counted in the next month's figures.

Action ICQC-0074: CD will check documentation, it is likely to be a snapshot of data.

Vaccine query:

DH queried pneumococcal vaccine availability, confirmed there has been none in England

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	for last 8 months. When will it be made available again? AM confirmed this is a question for Public Health and this will be raised with them outside of the next meeting.
	Diabetes **Action ICQC-0075**: Diabetes NICE standard to be added to next agenda as not being achieved.
7.0	**Serious Incidents** AM presented the report noting that it provides the number and type of Serious Incidents (SIs) reported in the months of February and March 2018 by our main providers. In total 7 serious incidents were reported in February 2018. These 7 incidents came from the following providers: • Bedford Hospital 1 case (1 x diagnostic incident) • L&D 1 case (1 x sub optimal care deteriorating patient) • ELFT 1 case (1 x case self-inflicted harm) • EEAST 2 cases (1 x delay to treatment, 1 information governance breach) • Other Providers 2 cases (1 sub-optimal care Lister Hospital, 1x IG breach Addenbrookes AM noted that there have been, in total, 10 serious incidents that were reported in March 2018. These 10 incidents came from the following providers • Bedford Hospital 1 case (1 x sub optimal care deteriorating patient) • L&D 2 cases (1 x information governance breach, 1 x diagnostic incident, treatment delay) • ELFT 3 cases (3 x self-inflicted harm) • EEAST 1 cases (1 x Accident/collision (not slips trips, falls)) • EPUT 2 cases (2 x Pressure Ulcers) • Other Providers 1 cases (Maternity incident: baby) Learning from final investigations has been included in the report and where known inquest conclusions and dates provided. The committee focused on the 2 drug cases, in one, a patient did not receive desmopressin medication for 3 days, and then died 3 days later. These have been taken to the SAR subgroup to see if they meet the criteria for serious case reviews. Quality team will keep a focus on drug management generally. Concerns raised with ELFT, national rise in suicide rates. Have seen a spike in Central Beds on children's suicides. ELFT process needs improving, the same mental health issues keep being identified. AM confirmed there is some really good work taking place with CAMHS services. The SPOC IS NOW has reviewed their RAG rating processes and triage is now completed by a clinician, previously completed by an admin person. **Action ICQC-0076**: AM agreed action to seek assurance on key recommendations being completed.

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	DH raised issue with clarity needed on MH services available, and pathways. **Action ICQC-0077**: AM to follow up and gain clarity. AB raised issue with ref 5646, laptop theft. There was a delay of reporting this of 2 weeks. Expectation is of report to be made within 48 hours. **Action**: AM to gain more information on case and reporting delay. **The committee noted the report and thanked KM for the detailed paper.**
8.0	**BHT Radiology Report 1.23.10** Trust had decided to undertake review internally, prior to quality visit being completed with ML & Kay Elliott. Assurance gained from visit. Return visit planned for June. **The committee noted the update.**
9.0	**Safeguarding Adults Annual Report** MG advised that the report is very local authority focused, the activities have remained static and last year was the first full year of having the SAR subgroup. Looking for a Board business Manager to support with board resilience and keeping on top of emerging challenges. **Action ICQC-0078**: MG will send full report to this committee. Concern raised with potential conflict of interest when GPs both own nursing home and are registered as their designated doctors. Suspicion that safeguarding issues may not be raised. MG is aware that some GPs do own nursing homes but as far as is known, they don't have registered patients in them. **Action ICQC-0079**: MG will liaise with contracts team to check for conflict of interest. **The committee noted the report and thanked MG.**
10.0	**CQC Thematic Review of ELFT CAMHS Services – letter?** Very positive report, with Bedford Borough Early Intervention work being exceptional. **The committee noted the letter**
11.0	**Government consultation on Working Together to Safeguard Children (2015) guidance** Key partners for LSCB won't change, can still co-opt in partners. CDOP is moving from Department of Education to Department of Health. New national Child Safeguarding Practice Review Panel. Will follow consultation closely to understand changes. AM has meeting 02/05/18 with chairs of LSCB to define what we want and where the opportunities are. **The committee noted the briefing** It was noted that the new GDPR rules are adding confusion to information sharing

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	guidance. It was advised that named or designated doctors should be consulted if in doubt, and that a GDPR team has been set up in NHSE to support GPs.
12.0	**Risk Register Summary Reports** **a) Commissioning Summary Report** Committee reviewed the report. HM noted that report was last updated 21/03/18 so now a month old. **Action**: AM to follow up on query over perinatal process, to understand where treatment is carried out.
13.0	**Complaints and FOI Report 2017/2018** DMc updated the committee that the Complaints Policy has been updated. 106 complaints were managed during 2017-2018. 57 were CCG complaints and 49 were Provider complaints. DMc confirmed that CCG will take the lead If a number of organisations are involved. **The committee noted the report and thanked DMc.**
14.0	**Sub Group updates** **a) Clinical Reference Group Minutes** Discussed Parity of Esteem item – query over gold/silver models. Confirmed this group does not make funding decisions but can give recommendations. **b) Prescribing Committee Minutes** The Committee did not discuss this report in the meeting, the minutes are taken as read and noted by members of the committee.
15.0	**Any Other Business** No other items of business were discussed.
16.0	**Items to raise to the Governing Body**
17.0	**Date of next meeting** **27 June 2018**
	Following amendments raised at meeting on 27 June, these notes have now been agreed as final.

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