NHS
Bedfordshire
Clinical Commissioning Group

Governing Body Meeting

held in public – Part 1

AGENDA

Date: Thursday 16 January 2020

Time: 14.00 – 16.30pm

Venue: Lockyer Suite, Rufus Centre, Steppingley Road, Flitwick MK45 1AH

No	Time	Item		Lead	Enc
1.		Welcome and Introductions		Clinical Chair	Verbal
2.		Apologies for absence	To receive and note	Clinical Chair	Verbal
3.		Declarations of Interest	To receive and note any declarations of interests in relation to the agenda	Clinical Chair	Verbal
4.		Minutes of the Meeting held on 21 November 2019	To receive for approval as an accurate record	Clinical Chair	√
5.		Action Tracker	To receive and note progress on agreed actions	Clinical Chair	√
6.		Report of the Joint Accountable Officer	For information	Accountable Officer	Verbal
STRATEGY AND COMMISSIONING					
7.		Operations Plan		Chief Operating Officer	To follow
CLINICAL QUALITY, PATIENT SAFETY AND PERFORMANCE					
8.		Integrated Performance and Quality Report	For information and to receive assurance	Chief Operating Officer / Chief Nurse	√
9.		Special Education Needs and Disabilities update (SEND)	For assurance	Chief Nurse	√
FINANCE					
10.		Finance Report as at 30th November 2019 (Month 8)	For discussion	Chief Finance Officer	√
GOVERNANCE AND CORPORATE AFFAIRS					
11.		One Team Programme Briefing	For information	Director of System Commissioning	To follow

COMMITTEE REPORTS AND UPDATES					
12.		Assurance Update from Committee Chairs: a) Finance & Performance Committee b) Primary Care Commissioning Committee c) Minutes from Bedfordshire and Luton Joint Prescribing Committee (JPC)	To gain assurance from the Committees on business transacted.	Chairs of the Committee	√
		Any Other Business Items notified to the Chair in advance of the meeting		Clinical Chair	
13.		**Questions from the Public** Questions from the public relating to items discussed within the agenda *Members of the public are encouraged to submit questions in writing relating to the agenda 3 days before the meeting.*			
14.		**Date of next meeting** 19 March 2020 14.00 – 16.30 Venue - TBA			

Resolution to exclude members of the press and public

The Governing Body of the Clinical Commissioning Group resolves that representatives of the press, and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity of which would be prejudicial to the public interest, in accordance with the Public Bodies (Admissions to Meetings) Act 1960.

NHS
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Clinical Commissioning Group

Agenda Item: 4

Governing Body *held in public*	***Report*** Date of Meeting: 16 January 2020

Report Title	Draft Minutes of Governing Body Meeting Held on 21 November 2019.		
Report Author	**Presented By**	**Responsible Director**	
Janet Young	N/A	Chair	
Purpose for presenting report	For review and approval		
Action Required:	For approval		
Approval Route:	Reviewed by the Chair and then the Governing Body		
Further Assurance:	N/A		

Which Strategic Objectives does this report provide evidence for?	**Please Tick √**
We will commission high quality, safe and sustainable models of care that deliver effective clinical outcomes and patient experience using evidence based decisions and best practice	
We will ensure that there is a financially sustainable and affordable healthcare system in Bedfordshire.	
We will lead, engage and operate as an effective place based and STP wide system partner to achieve greater integration of care delivery.	
We will support local people and stakeholders to have an influence on services we commission to ensure our decisions are informed and shaped by local views and insights.	
We will operate and manage our Governing Body to the highest standards of accountability and transparency.	√

Implications/Assessments	**Yes**	**No**	**N/A**
Have any financial implications been signed off by the Chief Finance Officer?			√
Have any quality implications been signed off by the Director of Nursing & Quality?			√
Have any privacy implications been signed off by the Head of Information Governance?			√
Have any conflicts of interest implications been signed off by the Corporate Office?			√
Have any public engagement implications been signed off by the Head of Communications & Engagement?			√
Has an Equality Impact Assessment been carried out?			√

Key Risks	None Identified
Executive Summary	Draft Governing Body Minutes for approval

Minutes of the Governing Body Meeting

Held on 21 November 2019
Room S1 Kings House, 245 Ampthill Road, Bedford, MK42 9AZ

Members Present:

Heather Moulder	Clinical Chair	**HM**
Saqhib Ali	Lay Member – Audit and Governance	**SA**
Sally England	Lay Member – Finance and Performance	**SE**
Alison Borrett	Lay Member – Public and Patient Engagement	**AB**
Patricia Davies	Joint Accountable Officer	**PD**
Anne Murray	Chief Nurse	**AM**
Mike Thompson	Chief Operating Officer	**MT**
Chris Ford	Chief Finance Officer	**CF**
Dr Linus Onah	Member Practice Governing Body Representative	**LO**
Dr Roshan Jayalath	Member Practice Governing Body Representative	**RJ**
Muriel Scott	Director of Public Health	**MS**

Others in attendance:

Geraint Davies	Director of System Commissioning	**GD**
Janet Young	Governance & Risk Manager (Minutes)	**JY**
Teresa McDonald	Looked After Children Designated Nurse (part meeting)	**TM**
Emma Hunt-Smith	Assistant Director Unplanned Care Commissioning (part meeting)	**EHS**

Apologies:

Sarah Whiteman	Medical Director	**SW**
Dr Chris Longstaff	Member Practice Governing Body Representative	**CL**
Dr Sanjay Sharma	Member Practice Governing Body Representative	**SS**
Diane Blackmun	Healthwatch Central Bedfordshire	**DB**
Jane Meggitt	Director of Partnership Engagements and Communications	**JM**

1.0 & 2.0	**Welcome and Apologies for absence** The Chair welcomed all members and attendees to the meeting. Apologies were received and noted as above.	**Action**
3.0	**Declarations of Interest** There were no declarations declared. The Governing Body's register of interest had been circulated following the recent annual update and was noted.	
4.0	**Minutes from Governing Body meeting held on 19 September 2019** The minutes were agreed as an accurate record.	

DRAFT

5.0	**Action Tracker** **GB01 19/20 – The Winter Plan** On agenda for this meeting**. Action closed.** **GB05 19/20 – Response to Working Together 2018 Safeguarding Guidance** AM confirmed that an update on safeguarding arrangements would be brought to the January Governing Body meeting **GB18 19/20 – End of Life & Palliative Care Strategy Patient Leaflet** Communications Team confirmed they were engaging with Healthwatch to progress with the production of the patient leaflet. AB suggested that the production should be owned by the Patient & Public Engagement Committee and it was agreed that the action would come off the Governing Body action tracker and transfer to PPEC. **Action closed.** **GB19 19/20 Staff Survey Results - Reporting of Physical Violence.** MY confirmed that a message had gone out to all staff encouraging them to report any physical violence incidents using the Incident Reporting Policy. **Action closed**. **GB20 19/20 Ambulance Response Times.** Part of Winter Plan Progress Report on agenda. **Action closed**	
6.0	**Report of the Joint Accountable Officer** Patricia Davies reported the following:- The move for Luton & Dunstable Hospital Trust to acquire Bedford Hospital Trust was on track to be completed by 1 April 2020. Q1 and Q2 had shown financial pressures mostly as a result of increase in action against plan centred on non-elective care. A significant piece of work is being undertaken to understand the root cause. Activity is only up by 3% but costs are showing an increase of 10-12%. The CCG is working with the whole system to understand the position and has a strong financial recovery plan in place to mitigate. As previously reported, the CCG has engaged with the OAKS Group to look across the Bedfordshire system at patient flows and admissions of patients. This work has been completed and an action plan in place. The work has highlighted lessons to be learnt across the whole system on how we manage patient flow. The CCG's Winter Plan has been submitted to NHS England and the initial feedback has been positive.	
7.0	**Asylum Seeking Children in Custody** Teresa McDonald, LAC Designated Nurse, attended the meeting to inform the Governing Body of the work recently undertaken with asylum seeking children going through Home Office procedures. A working group had invited two children who had been through the experience to their meeting to understand how they could be supported. When entering the country the children are arrested and put into custody. Their finger prints are taken; they are showered and given new clothes; they have a medical examination and then invariably put in a cell on their own not knowing their future. This is a very frightening	

	experience. A social worker will then visit the child, if they are under 16 they are placed in a foster home, if over 16 they move to semi-independent living. The working group wanted to help give support to these children whilst in custody. They firstly engaged with the police to give the feedback from the children on their experiences whilst under arrest, which received a sympathetic and understanding response. Secondly, money was secured from NHSE to produce a poster showing (in pictures as many would not speak English) what would happen to the child whilst in police custody and most importantly showing that there is an exit from this frightening experience either to a foster home or semi-independent living. The two children the group had been engaging with - who were now in foster care - were shown the poster and confirmed it would help the experience of these young and vulnerable children. The Governing Body congratulated the LAC Team on this valuable piece of work.	
8.0	**Winter Plan Progress Report** MT introduced the report. It was covering an update on Winter preparation and planning and a report on ambulance response times in answer to the concerns raised at the last Governing Body. The paper also gave assurance that the Putnoe Walk-in Centre contract has been extended to September 2020 whilst the NHSE primary care access review is taking place. **Winter preparation and planning**. This is a year round process not just during the winter season looking at capacity. Table A in the report demonstrated the schemes in place outside of acute settings to reduce demand and/or increase capacity as well as those scheme in place within the acute setting. At the current time the gap in capacity is a 33 bed equivalent. Last year this figure was 80 bed equivalent. The Governing Body was assured that a comprehensive winter plan had been developed being monitored by the A&E Delivery Board. It was further assured that demand is not up and currently remains relatively flat. The competence and planning required was to be able to deal with variation rather than demand. SE enquired whether any additional funding was required. MT responded that there was none, other than spot purchasing additional bed capacity when required in times of extreme pressure. SE enquired how was the CCG managing the flow into mental health beds. MT responded that the MH work stream was looking into this. Out of area placements have been zero for some time due to the ongoing transformation in services. The general flow is good and is always considered as part of the winter resilience work. EHS added that the CCG was also linking with 111 on mental health beds as part of the new LTP. She was asked if a HALO was part of the Winter Plan. She confirmed it was not. This post used to receive funding from NHSE to fund this post but confirmed that BHT are looking to recruit somebody else to manage patient flow in A&E. MS advised the Governing Body that Public Health had set up and Imms & Vaccs Group to ensure the right flow of information is going out to the various cohorts of patients regarding the importance of flu vaccines.	

	PD pointed out that it was a huge testament to the work of primary care colleagues that patients were being appropriately managed in the community and wanted to raise recognition of this work and offer her thanks on behalf of the CCG. **Ambulance Response Times.** MT acknowledge that the performance around ambulance response times was a concern and the CCG was addressing these concerns through the Ambulance Commissioning Consortium. BCCG are one of 19 CCGs in the Consortium and close monitoring was taking place at quality review meetings, sub groups and EEAST's fortnightly strategic, performance and capacity meetings. The Governing Body could take assurance that Bedfordshire CCG is consistently one of the top four best performing CCGs within the consortium and is the top performing CCGs for hospital handovers. The report set out the steps that EEAST are undertaking to bring performance to national standards. In addition, EEAST have seven strategic winter actions that they are working on. EHS also highlighted the clinical audit undertaken at BHT A&E department which gave focus to Health Care Professionals ambulance conveyances. The audit had identified inconsistencies between the approaches taken by health care professionals referring into the hospital for same day urgent/emergency care and the CCG is working the LMC and A&E Consultants to launch something simpler. A separate Task and Finish Group has been set up for this purpose. In addition, this Group would be looking at "hear to treat" call triaging to ensure ambulances are despatched appropriately. EHS added that GPs are being encouraged when calling for an ambulance to leave their mobile numbers for paramedics on the road to contact them if necessary. LO raised the issue that ambulances were not intentionally being used inappropriately by HCPs as patients were not always able to take public transport to hospital due to mobility or affordability. AM enquired if there had been any further developments with the 24/7 Clinical Advisory Service (CAS) and whether any multi-disciplinary help was required. EHS replied that there was lots of development work going on and the report highlighted the current data. The main difficulty is currently the retention of clinicians. **The Governing Body were assured regarding the CCG's winter preparation and planning. The Governing Body also noted the work to improve performance against national standards for ambulance response times.**	
9.0	**Integrated Quality, Safety and Performance Report** MT explained that due to the timing of meetings and the desire for the Governing Body to receive as up-to-date information as possible, the Month 6 report being presented was **draft** as it had not yet been through the appropriate governance processes. **Cancer**. In September there was an improvement in the 62 day standard for first treatment following a GP referral although this was still below the 85% requirement. The biggest challenge at BHT continues to be histopathology reporting which is having a significant impact on the diagnostic pathway. In	

	addition the breast service had a further period of instability due to staff sickness. HM requested further assurance (? 'deep dive') from the Cancer Board as the Governing Body is not seeing any real change in position. PD commented that she also expects to see improvements when the L&D and BHT merge. GD reported that he had asked for a recovery plan to be pulled together by the new Lead at BHT. AM assured the Governing Body that clinical harm reviews were undertaken on any patient not treated within 62 days. LO mentioned that GPs need to ensure patients know they have a right to be seen at a hospital of their choosing under "patient choice" giving them greater control of their care. **Action: GB21 19/20 Report from Cancer Board to be received at future Governing Body meeting.** In addition to cancer, AM highlighted from the report that dementia diagnosis rates were continuing to improve (63.26%) and were nudging towards the national standard of 66.7%. Latest SHMI data was showing that BHT is now back within the expected range. There had been a slight rise in C-Diff cases but no thematic links had been identified. There had been one Never Event reported which was a wrong site surgery incident (wrong tooth extraction) at East & North Herts. **The Governing Body noted the report.**	**MT**
10.0	**Month 6 Financial Report** CF presented the report. The month 6 financial return showed a net £6.7m negative variance to date. £2.5m of the £6.7m is driven by the profiling in of the stretch target of £5.0m and £1.5m of the contract affordability gap with BHT and L&D (a joint responsibility). The £6.7m variance is primarily driven by acute services overspend. Scrutiny has ascertained that this is down to cost pressures as opposed to unplanned increases in activity. The CCG recognise that there is a need to make further savings of £14.3m by year end. Forecasts are prudent and the CCG is acting robustly in terms of cost control processes. The Financial Recovery Plan (FRP) is beginning to bite and the financial position is starting to improve but still on deficit to plan. The FRP lists potential opportunities for £7.5m savings which are being validated. SA congratulated the work of the QIPP programme and acknowledged it was doing well. CF mentioned that the CCGs financial performance is one of the best across the Eastern Region but NHSE requires the CCG to achieve an in-year £11.1m surplus which is our challenge. **The Governing Body noted the report and the inherent risk to delivery of the CCG's control total**	
11.0	**EPRR Core Standards Report** MT advised the Governing Body that the CCG had undertaken the formal Core Standards review for Emergency Preparedness, Resilience and Response and	

	Business Continuity for this year. The CCG assessed itself as being fully compliant against the standards and have received confirmation from NHSE that they have endorsed this assessment. The Governing Body recognised the CCG has a strong EPRR Team which is hugely important and was assured the CCG was in a strong position to step forward and respond to any emergency. AM commented that the Executives have individually been trained in responding to incidents and put forward the suggestion that as the Executive Team is relatively new, it may be helpful to receive training as a collective Group. This was supported by the Governing Body. **Action: GB22 19/20 MT to take forward with Mark Meekins.**	**MT**
12.0	**Assurance Reports** Assurance reports from the following Committees were taken as read by the Chair Finance & Performance Committee Integrated Commissioning & Quality Committee Primary Care Commissioning Committee Patient & Public Engagement Committee Minutes from Joint Prescribing Committee SA wished to highlight on behalf of the Audit Committee that an audit of Primary Care Delegated Commissioning had received limited assurance; the external auditor's contract had been extended for 24 months; and the provision of internal audit provision across the three CCGs was being looked into.	
13.0	**Any Other Business** There was no other business	
14.0	**Questions from the Public.** Questions from the public relating to items discussed within the agenda were invited by the Chair. Paula Grayson representing Bedfordshire & Luton Fair Play advised the Governing Body that GPs requesting patients to be transported to hospital should make use of Volunteer organisations who are willing to convey patients. In particular Stotfold has an emergency response available. Paula Grayson also asked for clarity on the primary care audit that had received limited assurance. MT explained the audit picked up on the procurement of a single practice during the NHSE handover of commissioning responsibilities. It was not around the procurement of primary care as a total service. He also gave assurance that all the recommendations within the audit had been addressed.	
	Meeting Closed 14.30pm	

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Agenda Item: 5

Governing Body *held in public*	***Report*** Date of Meeting: 16 January 2020

Report Title	Action Tracker		
Report Author	**Presented By**	**Responsible Director**	
Various, as stated on the tracker	Chair	Various, as stated on the tracker	
Purpose for presenting report	For discussion		
Action Required:	For discussion		
Approval Route:	Updated at Governing Body Meetings		
Further Assurance:	N/A		

Which Strategic Objectives does this report provide evidence for?	**Please Tick √**
We will commission high quality, safe and sustainable models of care that deliver effective clinical outcomes and patient experience using evidence based decisions and best practice	
We will ensure that there is a financially sustainable and affordable healthcare system in Bedfordshire.	
We will lead, engage and operate as an effective place based and STP wide system partner to achieve greater integration of care delivery.	
We will support local people and stakeholders to have an influence on services we commission to ensure our decisions are informed and shaped by local views and insights.	
We will operate and manage our Governing Body to the highest standards of accountability and transparency.	√

Implications/Assessments	**Yes**	**No**	**N/A**
Have any financial implications been signed off by the Chief Finance Officer?	[please tick if appropriate]		√
Have any quality implications been signed off by the Director of Nursing & Quality?			√
Have any privacy implications been signed off by the Head of Information Governance?			√
Have any conflicts of interest implications been signed off by the Corporate Office?			√
Have any public engagement implications been signed off by the Head of Communications & Engagement?			√
Has an Equality Impact Assessment been carried out?			√

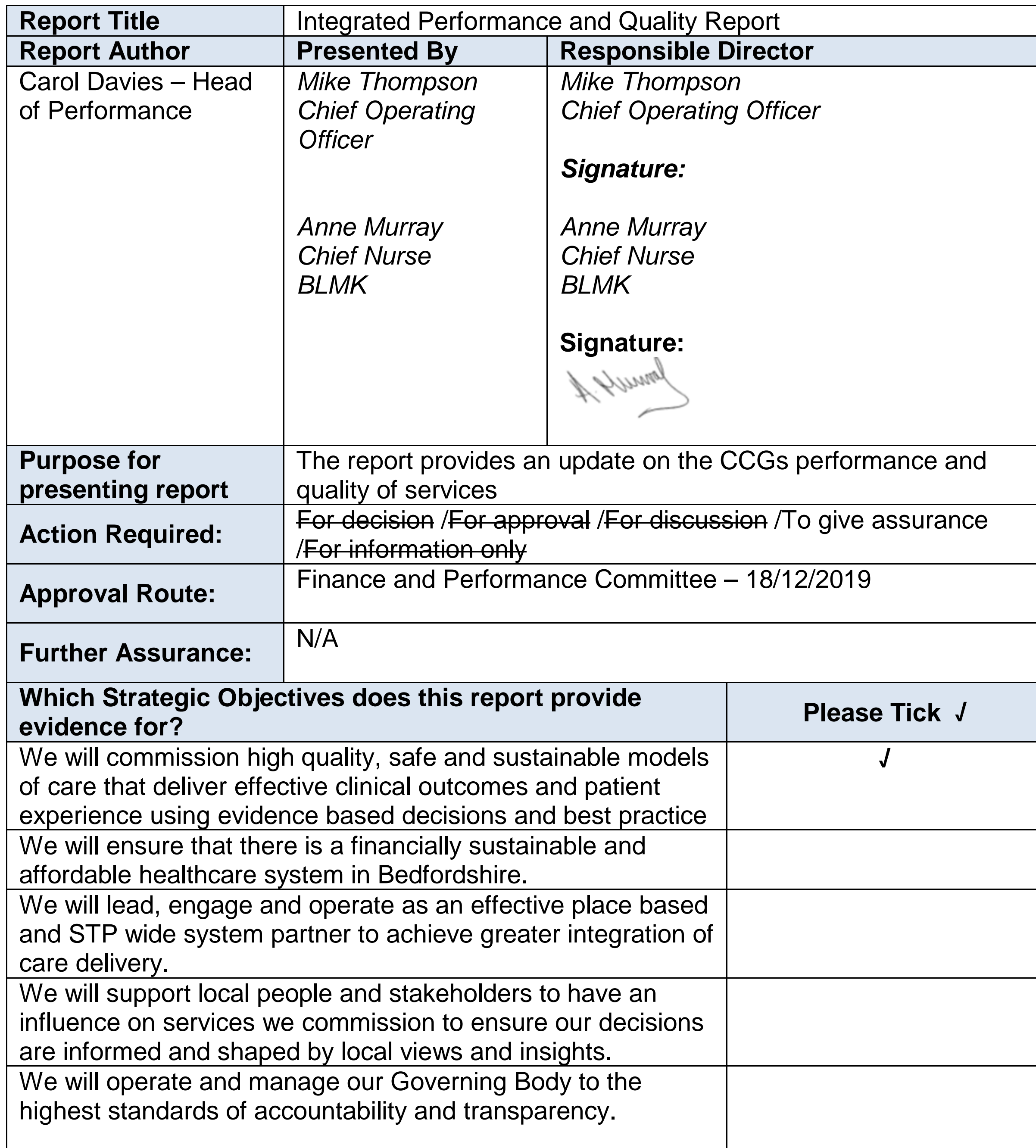
Key Risks	None identified
Executive Summary	N/A

BCCG Governing Body Action Tracker 2019/2020. Part 1.

Meeting Date/ Ref Number	Action	Update	Nominated Lead	Target Completion Date	Completion Date
16.05.19 **GB04**	**Response to Working Together 2018, Safeguarding Guidance** AM to bring an update regarding the Safeguarding arrangements post September 2019 to assess position and key priorities.	21.11.19. Agreed verbal update to come to January meeting.	Anne Murray	16.01.20	
21.11.19 **GB21**	**Cancer 62 Day standard continuous breach** Assurance Report from Cancer Board to be received at future Governing Body meeting.	07.01.2020. Cancer Assurance paper/ recovery plan will be discussed Executive Management Committee on 09.01.20 as a first stage before going to Governing Body in March 20. At the 16.01.20 meeting a verbal update can be given to the GB as part of the performance report regarding next steps.	Mike Thompson	16.01.20	
21.11.19 **GB22**	**EPRR Joint Training for Executive Team** AM commented that the Executives have individually been trained in responding to incidents and put forward the suggestion that as the Executive Team is relatively new, it may be helpful to receive training as a collective Group.		Mike Thompson	16.01.20	

Bedfordshire Clinical Commissioning Group

Agenda Item: 8



Governing Body *held in public*	**Report** Date of Meeting: 16th January 2020

Report Title	Integrated Performance and Quality Report	
Report Author	**Presented By**	**Responsible Director**
Carol Davies – Head of Performance	*Mike Thompson* *Chief Operating Officer* *Anne Murray* *Chief Nurse* *BLMK*	*Mike Thompson* *Chief Operating Officer* ***Signature:*** *Anne Murray* *Chief Nurse* *BLMK* **Signature:**
Purpose for presenting report	The report provides an update on the CCGs performance and quality of services	
Action Required:	~~For decision~~ /~~For approval~~ /~~For discussion~~ /To give assurance /~~For information only~~	
Approval Route:	Finance and Performance Committee – 18/12/2019	
Further Assurance:	N/A	

Which Strategic Objectives does this report provide evidence for?	**Please Tick √**
We will commission high quality, safe and sustainable models of care that deliver effective clinical outcomes and patient experience using evidence based decisions and best practice	√
We will ensure that there is a financially sustainable and affordable healthcare system in Bedfordshire.	
We will lead, engage and operate as an effective place based and STP wide system partner to achieve greater integration of care delivery.	
We will support local people and stakeholders to have an influence on services we commission to ensure our decisions are informed and shaped by local views and insights.	
We will operate and manage our Governing Body to the highest standards of accountability and transparency.	

Implications/Assessments	**Yes**	**No**	**N/A**

Have any financial implications been signed off by the Chief Finance Officer?			√
Have any quality implications been signed off by the Director of Nursing & Quality?	√		
Have any privacy implications been signed off by the Head of Information Governance?			√
Have any conflicts of interest implications been signed off by the Corporate Office?			√
Have any public engagement implications been signed off by the Head of Communications & Engagement?			√
Has an Equality Impact Assessment been carried out?			√

Key Risks	Issues for discussion identified within the report and discussed at the relevant committees.
Executive Summary	The Integrated Performance and Quality report (IPQR) has been populated with the latest nationally published data which is predominantly Month 7 (October). The report provides an update on the CCGs performance and quality of services and links to the strategic objectives identified above.

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Integrated Performance & Quality Report

Month 7 October 2019

for Governing Body

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NHS Bedfordshire Clinical Commissioning Group

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Key Issues

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Issue	Mitigation
Cancer In October there was a deterioration in the 62-day standard for 1st treatment following a GP referral, and this remains the main area of concern. Performance against the 31-day subsequent treatment - surgery standard fell below the 94% threshold with 5 breaches at Bedford Hospital due to capacity issues in the skin pathway. Overall, 5 of the 8 cancer standard indicators were achieved.	Performance against the 62-day standard continues to be a challenge with diagnostic capacity and delays at tertiary treatment centres the main issues. Bedford Hospital is developing a comprehensive action plan to address the operational challenges and define key actions against the main components of the cancer pathway: • Outpatients – increase capacity in order to offer first outpatient appointment earlier • Biopsies/endoscopies – increase capacity to reduce waiting times • Diagnostic pathways – introduce/improve Straight to Test pathways in Colorectal, Urology and Upper GI • Histopathology – increase capacity and improve administration process to enable samples to be processed quickly • Radiology – improve turnaround times for appointments and results
18 Weeks RTT The waiting list continues to rise with 31,078 people waiting for treatment at the end of October. The number of people waiting more than 18 weeks also increased by 147 on September to 3,692. Preliminary data for November shows a further increase in the waiting list to 31,129 with the number of people waiting more than 18 weeks increasing by 246 to 3,938.	At Bedford Hospital, specialty level action plans have been developed in T&O, Dermatology and Gynaecology. The plans aim to increase capacity in these specialties and are monitored through the monthly Access and Performance Board which is attended by the CCG.
52+ Week Waits There was one 52+ week breach in October at UCLH on the gynaecology pathway. A further breach has been identified for November at Oxford University Hospital on the plastic surgery pathway.	The breach at UCLH was due to ongoing capacity constraints within a highly specialist service and the patient was treated in November. The breach at Oxford was due to a number of delays at the start of the pathway and capacity issues. The patient was treated in early December.

Key Issues

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Issue	Mitigation
Diagnostics Tests within 6 Weeks Performance against the Diagnostic Waits standard underachieved again in October although there was an improvement on the September position. This was primarily due to 25 breaches at Cambridge Community Services (CCS), all in paediatric audiology, and 35 breaches at Bedford Hospital (BHT) mostly due capacity issues in Audiology. Preliminary data for November shows a recovery of the standard for the CCG with a reduction in breaches at CCS to 16.	CCS had expected to recover in October, this was then extended to mid November and latest position is showing recovery in January. This is due for discussion at the next Contract Review Meeting. BHT highlighted audiology as an area of risk due to staffing issues and the Trust is in the process of recruiting to an additional post in the department. Trust wide the indicator was achieved.
Integrated Urgent Care (IUC) Service – Luton and Bedfordshire Average call answering times improved again in October. Calls directed to 999 for ambulance dispatch and calls directed to A&E also both improved. Abandoned calls showed an improving position but is still higher than the 5% threshold at 7.69%	Further recruitment is underway to increase the current staffing cohort with two additional courses scheduled before Christmas.
Ambulance Response Times There was an improvement in mean response times for Category 1T calls (where patients were transported in an emergency vehicle to a hospital or other place of care), however performance against the Category 1 and 2 standards deteriorated. There was a significant improvement in the Heart & Treat rate in October although this remains below the national threshold.	The CCG continues to work closely with EEAST to improve performance for ambulance response times and the Hear & Treat rate.

Key Issues

NHS
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Issue	Mitigation
Urgent and Emergency Care In October the CCG achieved 90.66% against the constitutional standard of 95% of patients discharged, admitted or transferred within 4 hours of arrival at A&E, which is a worsening positon compared to September. A&E type 1 attendance activity is over plan and higher than this time last year. Non Elective Admissions 1+ are also over plan and remain higher than this time last year.	A clinical assessment report was presented to the Bedford Hospital A&E Delivery Board in November with recommended actions. A task and finish group will be set up in the New Year to oversee completion of these actions. Transformation and efficiency schemes supporting the safe and effective management of demand and capacity at the Trust are monitored at a fortnightly Demand and Capacity Steering Group, which is a sub group of the A&E Delivery Board. A deep dive is underway to understand the increased demand at Luton & Dunstable which will be aligned to GP practices.
CPA – 7 day follow up In Q2 there were 15 breaches of the 7 day follow up standard reported nationally, all of which were at ELFT. The Trust have confirmed that 6 of the breaches were patients discharged on CPA.	Performance against the CPA 7-day follow up standard has been raised with ELFT at Contract Review Meetings and they agree it is a serious concern and have Quality focussed on it. ELFT have agreed to provide additional assurance and oversight in Q3 and Q4 under CQUIN and formalising the contractual approach will be reviewed once this has been received.

Key Issues

NHS Bedfordshire Clinical Commissioning Group

Issue	Mitigation
Dementia Diagnosis The dementia diagnosis rate in Bedfordshire increased to 63.7% in October however this is below the revised recovery trajectory. The latest data for November shows a deterioration to 63.6%.	A number of projects aimed at increasing the dementia diagnosis rate are due to end in December which could have an impact on achievement of the 66.7% standard.
Serious Incidents and Never Events In October there were 17 serious incidents none of which have been defined as a Never Event.	All SIs are accompanied with detailed learning/action plans which the CCG monitors on a regular basis.
Infection Control There were 3 cases of C-Diff in October giving 51 year to date of which 27 were acute trust apportioned. The CCG is now 17 cases above the year to date threshold. There were 8 care homes in Luton and Bedfordshire affected with symptoms of Norovirus in November.	All infection control cases are reviewed by the relevant providers. Care home outbreaks are managed by Public Health England.
Safeguarding Currently there are two Serious Case Reviews (SCRs) in progress, one related to a case of neglect, and one the death of a baby.	The SCR reports for both cases are expected to be available for publication in early 2020.

NHS Constitutional Pledges

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Performance Against NHS Constitutional Pledges and Additional Quality Indicators

KPI Code	BCCG Indicator Level	Plan	Oct '18	Nov '18	Dec '18	Jan '19	Feb '19	Mar '19	Apr '19	May '19	Jun '19	Jul '19	Aug '19	Sep '19	Oct '19	2019/20 YTD	Trend
E.B.6	Cancer 2 week waits following urgent GP referral for suspected cancer	93%	94.98%	96.03%	96.20%	94.77%	96.05%	95.23%	86.41%	92.26%	85.37%	88.05%	93.67%	93.25%	94.28%	90.43%	*↑
E.B.7	Cancer 2 week waits - Breast Symptomatic where cancer not initially suspected	93%	93.10%	93.27%	96.34%	90.70%	92.11%	96.74%	61.54%	86.59%	51.35%	78.85%	93.83%	88.89%	93.62%	79.43%	*↑
E.B.8	Cancer 31 day - 1st definitive treatment from diagnosis	96%	97.25%	96.77%	97.58%	96.65%	98.50%	98.56%	97.83%	96.72%	94.84%	99.09%	98.05%	98.40%	97.16%	97.51%	*↓
E.B.9	Cancer 31 day - Subsequent treatment for cancer - Surgery	94%	81.82%	89.66%	97.14%	82.86%	86.96%	94.87%	85.37%	94.12%	89.19%	100.00%	96.88%	96.97%	88.00%	92.86%	*↓
E.B.10	Cancer 31 day - Subsequent treatment for cancer - Drugs	98%	100.00%	100.00%	97.67%	100.00%	100.00%	100.00%	97.50%	98.11%	100.00%	100.00%	100.00%	100.00%	100.00%	99.45%	*↔
E.B.11	Cancer 31 day - Subsequent treatment - Radiotherapy	94%	93.33%	97.67%	98.78%	97.30%	98.81%	98.63%	98.46%	93.98%	96.30%	97.17%	98.70%	96.00%	100.00%	97.13%	*↑
E.B.12	Cancer 62 days - 1st treatment following an urgent GP referral	85%	81.31%	82.31%	75.23%	67.48%	75.44%	76.85%	83.33%	74.32%	77.00%	72.66%	72.55%	74.11%	74.07%	75.19%	*↓
E.B.13	Cancer 62 days - 1st treatment following referral from Screening Service	90%	92.86%	96.97%	85.71%	86.67%	76.47%	100.00%	91.67%	94.12%	88.89%	85.71%	95.00%	76.92%	88.24%	89.22%	*↑
E.B.15	Mean Ambulance Category 1 calls response time (minutes) - BCCG Patients	7:00	7:09	7:23	6:28	6:52	7:05	06:49	7:07	6:58	7:27	7:52	7:09	7:26	7:44	07:24	↓
E.B.15.ii	Mean Ambulance Category 2 calls response time (minutes) - BCCG Patients	18:00	27:18	25:09	22:40	26:50	25:05	26:30	27:39	26:42	25:09	27:19	21:42	23:33	24:37	25:16	↓
E.B.16	90th Centile Ambulance Category 3 calls response time (minutes) - BCCG Patients	120:00	162:18	136:45	144:37	166:10	166:12	178:37	186:54	173:52	184:15	226:57	98:17	163:51	159:25	169:30	↑
E.B.16	90th Centile Ambulance Category 4 calls reponse time (minutes) - BCCG Patients	180:00	209:48	158:06	152:39	137:02	132:45	192:10	164:27	169:52	194:48	196:46	140:49	157:30	115:04	159:03	↑
E.B.S.3	CPA follow up within 7 days of discharge from psychiatric in-patient care	95%			93.80%			90.74%			92.46%			93.70%		93.06%	↑
E.B.3	18 week Referral to Treatment - Incomplete pathway	92%	90.62%	91.22%	90.50%	90.24%	90.44%	90.84%	90.70%	90.12%	89.98%	89.47%	88.78%	88.49%	88.12%	89.36%	↓
E.B.S.4.iii	52 week referral for incomplete pathways	0	3	1	2	0	1	1	0	1	1	0	2	2	1	7	↑
E.B.4	Diagnostic tests - % of patients waiting 6 wks or more	<1%	1.19%	1.17%	1.56%	1.23%	0.55%	0.78%	0.97%	0.97%	0.97%	1.08%	2.68%	2.06%	1.12%	1.41%	↑
E.B.5	A&E 4 hour wait (7 Providers)	95%	92.74%	92.92%	93.57%	90.90%	88.86%	88.10%	87.11%	88.34%	90.18%	89.53%	91.66%	92.45%	90.66%	89.99%	↓
E.B.S.1	Mixed-sex accommodation breaches	0	17	30	8	11	14	11	30	26	21	4	21	29	31	162	↓
E.B.S.2	Cancelled operations on or after day of admission and not offered another date within 28 days	0			6			6			5			3		8	↑

- A&E 4 hour wait for BCCG is produced using a mapping across multiple providers where they see more than 1% of the CCGs patients. On 22nd May 2019 fourteen trusts, including Luton and Dunstable Hospital and Cambridge University Hospitals NHS Trusts, began field testing new emergency care performance standards and as a result these providers are not required to report against the 4 hour wait target. The data shown reflects the impact of the field testing from May 19 onwards and is based on 6 providers and assumes 100% achievement at Cambridge and Luton & Dunstable Trusts in line with national guidance.
- Data is ragged Green if an indicator has been achieved or over-achieved, Amber if it has under-achieved within the agreed tolerance of the achievement level and Red if it has under-achieved over the agreed threshold.
- Trend arrows reflect the latest data compared to the previous month/quarter.

* Due to constraints within the national reporting timetable the Cancer monthly activity reflects validated data up to March 2019; April onwards shows the latest un-validated position.

National Standards & Quality Indicators

NHS Bedfordshire Clinical Commissioning Group

Performance Against NHS Constitutional Pledges and Additional Quality Indicators																	
KPI Code	BCCG Indicator Level	Plan	Oct '18	Nov '18	Dec '18	Jan '19	Feb '19	Mar '19	Apr '19	May '19	Jun '19	Jul '19	Aug '19	Sep '19	Oct '19	2019/20 YTD	Trend
E.B.S.5	Trolley waits in A&E over 12 hours	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	↔
E.B.S.6	Urgent Operations cancelled for a second time	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	↔
E.A.3	IAPT - access rate	11.25%	1.71%	1.74%	1.22%	1.82%	1.6%	1.58%	1.69%	1.77%	1.59%	1.81%	1.60%	1.66%	1.86%	11.97%	↑
E.A.S.2	IAPT - people who completed treatment and are moving to recovery	50%	52.10%	51.82%	50.21%	50.47%	52.96%	53.27%	50.00%	51.56%	49.25%	51.22%	55.88%	52.05%	51.03%	51.36%	↓
E.H.1_A1	% people referred to IAPT programme treated within 6 weeks of referral	75%	98.94%	100.00%	99.71%	98.73%	99.70%	98.61%	100.00%	97.26%	96.67%	97.33%	97.62%	97.62%	98.63%	97.96%	↑
E.H.1_A2	% people referred to IAPT programme treated within 18 weeks of referral	95%	99.69%	99.73%	100.00%	100.00%	100.00%	99.70%	98.61%	100.00%	98.63%	98.89%	98.67%	98.81%	99.73%	99.04%	↑
E.H.4	Psychosis treated with a NICE approved care package within two weeks of referral (from October 2019 changed to 3 month rolliing to align to new national data release)	56%	83.33%	90.91%	60.00%	80.00%	71.43%	75.00%	66.67%	92.31%	71.43%	81.82%	87.50%	66.67%	75.00%	80.77%	↓
E.A.S.1	Estimated diagnosis rate for people with dementia - Primary Care	66.7%	58.92%	59.47%	59.41%	58.98%	59.19%	59.70%	59.81%	60.30%	61.27%	62.61%	62.64%	63.26%	63.70%	63.70%	↑
E.A.S.4	Number of MRSA incidents	0	1	2	1		0	0	0	0	0	2	0	0	0	2	↔
E.A.S.5	Number of C-Difficile incidents	54	7	2	0	6	4	5	8	8	8	14	4	6	3	51	↑

- Data is ragged Green if an indicator has been achieved or over-achieved, Amber if it has under-achieved within the agreed tolerance of the achievement level and Red if it has under-achieved over the agreed threshold.
- Trend arrows reflect the latest data compared to the previous month/quarter.
- IAPT data for 2018/19 reflects local activity due to errors in the national data caused through an unsuccessful upload of May activity which impacted on the whole year. For in year reporting 2019/20 activity will reflect local data which will be validated following the release of the monthly national activity due to a significant lag in national reporting.

Planned Care - Cancer

Bedfordshire
Clinical Commissioning Group

Measure	Period	Target	Latest Data	Trend	YTD
2 Week Wait - Urgent GP Referral	M7 2019/20	93.00%	94.28%	↑	90.43%
2 Week Wait - Breast Symptomatic	M7 2019/20	93.00%	93.62%	↑	79.43%
31 Day subsequent treatment - Surgery	M7 2019/20	94.00%	88.00%	↓	92.86%
62 Day First Treatment - GP Referral	M7 2019/20	85.00%	74.07%	↓	75.19%
62 Day First Treatment - Screening Service	M7 2019/20	90.00%	88.24%	↑	89.22%

Issue	Mitigation
In October 5 of the 8 cancer standard indicators were achieved. The main area of concern continues to be achievement of the 62 day standard for 1st treatment following a GP Referral. This indicator has underachieved since 2018/19 and the October position is a deterioration compared to September, with 108 patients treated and 28 breaches. Performance against the standard for 2 week wait breast symptomatic improved in October as expected.	**62 Day 1st Treatment from a GP Referral** Performance against this standard for Bedfordshire patients continues to be a challenge at a number of providers – Bedford Hospital (BHT), Cambridge University Hospitals and East and North Hertfordshire Trust. Common themes are diagnostic capacity (including pathology and radiology) and delays to treatment pathways outside of the hospitals' control, for example PET (positron emission tomography) scans at Mount Vernon Cancer Centre. BHT is developing a comprehensive action plan to address the operational challenges and define key actions against the main components of the cancer pathway: • Outpatients – increase capacity in order to offer first outpatient appointment earlier • Biopsies/endoscopies – increase capacity in order to reduce waiting times • Diagnostic pathways – introduce/improve Straight to Test pathways in Colorectal, Urology and Upper GI • Histopathology – increase capacity and improve administration process to enable samples to be processed quickly • Radiology – improve turnaround times for appointments and reporting of results
31-Day Subsequent Treatment – Surgery In October the standard was underachieved, with 50 patients treated and 6 breaches. 5 of the breaches were at Bedford Hospital and all were due to capacity issues.	The biggest pressure on this pathway is skin (dermatology/plastics). BHT has an action plan around the whole Dermatology service which is intended to address the capacity issues. The Trust have recruited 2 new consultants who will start in the New Year and have agreed outsourcing work to another provider to also address capacity issues.

Planned Care - Referral to Treatment Incomplete Pathway

NHS
Bedfordshire
Clinical Commissioning Group

Measure	Period	Target	Latest Data	Trend	YTD
18 Week Waits	M7 2019/20	92.00%	88.12%	↓	89.36%
Waiting Lists	M7 2019/20	26874	31078	↓	31078

Issue

Treatment Function	Total Waiting List	18+ Weeks	26+ Weeks	39+ Weeks
Trauma & Orthopaedics	2534	674	340	40
Other	6302	623	177	17
Dermatology	2778	578	157	15
Ophthalmology	3876	305	55	6

Performance against the 18 Week RTT standard continues to be underachieved with a further deterioration in October. At the end of October there were 3,692 patients waiting over 18 weeks which is an increase of 147 compared to September. The table above shows the total waiting list for the top 4 specialties and a breakdown to show those still waiting at 26+ weeks and 39+ weeks.

For the CCG total waiting list the following 4 specialties have the highest number of 18 week breaches:

- Trauma & Orthopaedics (T&O) – 674 breaches (18.3%) the majority of which are BHT (451), L&D (59) and MKUH (43).
- Other – 623 breaches (16.9%) the majority of which are BHT (179), ENH (101) and L&D (95).
- Dermatology – 578 breaches (15.7%), 526 at BHT.
- Ophthalmology – 305 breaches (8.3%), 112 at L&D and 102 at BHT.

Mitigation

Monitoring of the RTT position continues internally and the CCG is working with local acute providers to identify recovery actions through the monthly contracting process. There is a focus for all providers to ensure they are continuing RTT recovery best practice through robust validation of waiting lists. The CCG continues to attend the BHT Access and Performance Board on a monthly basis where RTT issues are discussed. Speciality level action plans have been developed in T&O, Dermatology and Gynaecology.

- **T&O** - plan includes increasing capacity by February through outsourcing and changes to consultant job plans. The Trust has extended conversations regarding outsourcing to a wider network of Trusts and have agreed to do some focused work on paediatric long waits.
- **Dermatology** - plan includes use of GPs with special interests to support minor surgery work, increasing capacity by utilising Telederm and recruiting additional consultants. Since the launch of the Telederm service in October, 74 patients have been seen and 28% of referrals were returned to primary care. Remaining referrals converted to minor surgery, face-to-face or onward referral to plastic surgery. There has been a decrease in paediatric waiting times.
- **Gynaecology** - plan includes increasing capacity and continued waiting list validation. The CCG and Trust service managers have agreed to implement a number of recommendations from the NHSE Elective Care handbook.

Planned Care - Referral to Treatment 52+ Week Breach

NHS Bedfordshire Clinical Commissioning Group

Measure	Period	Target	Latest Data	Trend	YTD
52 Week Waits	M7 2019/20	0	1	↑	7

Issue	Mitigation
There was one 52+ week breaches in October at UCLH on the gynaecology pathway. The CCG has a total of 7 breaches reported nationally to date however as previously reported East and North Hertfordshire Trust has confirmed that the 52+ week wait reported in June was not a genuine breach. This is an improvement on the same period last year, where 26 breaches had been reported up to month 7. The CCG is aware of a further 52+ week breach in November at Oxford University Hospitals (OUH) on the Plastic Surgery pathway.	The CCG has a process in place to monitor and follow up long waiters to ensure steps are being taken to avoid a 52+ week breach. The patient at UCLH is under the care of the lead consultant within a highly specialist service with ongoing capacity constraints. The Trust has put in place actions to reduce long waits within the service, however was unable to prevent the breach and the patient was treated in November. UCLH have provided the CCG with their escalation process for potential 52+ weeks breaches. The breach in November at OUH was due to a number of clinic and patient cancellations resulting in a prolonged wait at the start of the pathway. The patient was treated in early December.

Planned Care - Diagnostic Waits

Bedfordshire
Clinical Commissioning Group

Measure	Period	Target	Latest Data	Trend	YTD
Diagnostics	M7 2019/20	1.00%	1.12%	↑	1.41%

Issue	Mitigation
Diagnostic Tests within 6 Weeks Performance against the Diagnostic Waits standard underachieved for the fourth month in a row in October, although there was an improvement on the September position. There were 8,664 patients on the diagnostic tests pathway with 97 breaching the 6 week threshold, which was 10 breaches over the tolerance for achievement of the national standard. • 25 at Cambridge Community Services (CCS), all in audiology (paediatric). • 35 at Bedford Hospital (BHT) – 20 in Audiology, 14 of which were due to capacity reasons and 6 patient choice; 5 in cystoscopy, 4 in MRI, 3 in echocardiography; 2 in gastroscopy, 1 in colonoscopy.	The CCG is working with local acute providers to identify recovery actions. CCS have provided a copy of their recovery plan for paediatric audiology and have confirmed that the high level of breaches in July and August were due to a combination of an increase in referrals at the end of the school summer term and staff shortages. CCS had expected to recover in October, this was then extended to mid November and latest position is showing recovery in January. This is due for discussion at the next Contract Review Meeting. At BHT, audiology was highlighted as an area of risk in the exception report due to staffing. A post to support the department has been advertised but has not yet been recruited to. The MRI breaches relate to Paediatric patients who need anaesthetics input. The Trust have put measures in place to ensure regular anaesthetic cover is in place. Improvements should be seen from mid November

Urgent and Emergency Care

Bedfordshire
Clinical Commissioning Group

Urgent & Emergency Care Dashboard (NHS Bedfordshire CCG and Bedford Hospital NHS Trust)

Managing Urgent Demand

Luton & Bedfordshire IUC Service
Herts Urgent Care

Integrated Urgent Care Service - Average Call Answering Time (seconds) (60)

Oct-19	69	YTD	74
↑			
Ranking			32/38

Integrated Urgent Care Service - % calls abandoned (5%)

Oct-19	7.67%	YTD	8.54%
↑			
Ranking			29/38

Integrated Urgent Care Service - % calls assessed by a clinician (≥50%)

Oct-19	78.15%	YTD	73.39%
↓			
Ranking			4/34

NHS 111 Dispositions - % calls directed to 999 for ambulance dispatch (≤10%)

Oct-19	11.56%	YTD	11.10%
↑			
Ranking			5/38

NHS 111 Dispositions - % calls directed to ED (≤10%)

Oct-19	9.50%	YTD	9.85%
↑			
Ranking			19/38

GP Extended Access Utilisation Rate (75%)

Oct-19	79.87%	YTD	78.16%
↑			

Ambulance Services

EEAST - NHS Bedfordshire CCG Patients

Ambulance Response Times - Category 1 (mean) (7 minutes)

Oct-19	7:44	YTD	7:24
↓			
Ranking	6/19	Ranking is within EEAST Consortium	

Ambulance Response Times - Category 1T (mean) (7 minutes)

Oct-19	12:27	YTD	13:01
↑			
Ranking	11/19	Ranking is within EEAST Consortium	

Ambulance Response Times - Category 2 (mean) (18 minutes)

Oct-19	24:37	YTD	25:16
↓			
Ranking	3/19	Ranking is within EEAST Consortium	

Clinical Models for Ambulance Services - Hear and Treat (7%)

Oct-19	6.43%	YTD	6.55%
↑			
Ranking	8/19	Ranking is within EEAST Consortium	

Clinical Models for Ambulance Services - See and Treat (35.5%)

Oct-19	32.61%	YTD	33.84%
↓			
Ranking	16/19	Ranking is within EEAST Consortium	

Ambulance - Arrival to Handover % within 15 minutes (100%) - EEAST into Bedford Hospital NHS Trust

Oct-19	66.07%	YTD	65.86%
↓			

Ambulance - Arrival to Handover > 30 minutes (0) - EEAST into Bedford Hospital NHS Trust

Oct-19	38	YTD	323
↓			

Ambulance - Arrival to Handover > 60 minutes (0) - EEAST into Bedford Hospital NHS Trust

Oct-19	4	YTD	52
↓			

A&E Front Door

Bedford Hospital Trustwide
(unless otherwise stated)

A&E Attendances - Type 1

Oct-19	6,398	YTD	44,860
↓			

Arrow shows improving position if type 1 attendances is lower than previous period

A&E Attendances - Type 3 (UTC Streamed from A&E) (918)

Oct-19	1,075	YTD	6,842
↑			

Arrow shows improving position if type 3 attendances is higher than previous period

UTC Attendances - Direct Booking via NHS 111

Oct-19	636	YTD	4,292
↑			

Arrow shows improving position if UTC attendances is higher than previous period

Walk In Centre Attendances Putnoe Medical Centre

Oct-19	1,711	YTD	11,968
↑			

Arrow shows improving position if attendances is higher than previous period

% of Patients who spent 4 hours or less in A&E (95%) Bedford Hospital main site only

Oct-19	87.11%	YTD	85.39%
↓			
	22/120		

% of Patients who spent 4 hours or less in A&E (95%) Bedford Hospital footprint (includes Putnoe)

Oct-19	89.51%	YTD	88.13%
↓			
Ranking	20/120		

Number of patients spending >12 hours from decision to admit to admission

Oct-19	0	YTD	0
↔			

Number of patients attending A&E arriving by Ambulance

Oct-19	1,518	YTD	10,233
↓			

Arrow shows improving position if arrivals by ambulance is lower than previous period

% of patients seen by a clinical decision maker within the first 60 minutes upon arrival

Oct-19	95.00%	YTD	95.92%
↓			
Ranking	1/16	Ranking is within East of England Region	

In Hospital

Bedford Hospital Trustwide
(unless otherwise stated)

Total Emergency Admissions via A&E

Oct-19	2,148	YTD	14,457
↓			

Arrow shows improving position if admissions is lower than previous period

Conversion Rate - A&E Attendance to Emergency Admission

Oct-19	28.74%	YTD	27.96%
↓			
Ranking	114/137		

Non Elective Admissions 0 Length of Stay (NHS Bedfordshire CCG - all providers)

Oct-19	1,468	YTD	10,068
↓			

Ragging is against the 2019/20 operating plan

Non Elective Admissions 1+ Length of Stay (NHS Bedfordshire CCG - all providers)

Oct-19	3,236	YTD	21,147
↓			

Ragging is against the 2019/20 operating plan

Patients in hospital for 7+ days Daily Average and Proportion

Oct-19	166	YTD	169
↑	45.38%		46.65%
Ranking	12/16	Ranking is within East of England Region	

Patients in hospital for 21+ days Daily Average and Proportion

Oct-19	51	YTD	53
↑	13.89%		14.65%
Ranking	11/16	Ranking is within East of England Region	

Delayed Transfers of Care (≤3.5%)

Oct-19	3.18%	YTD	3.56%
↓			

Bed Occupancy Including Contingency Beds (<92%)

Oct-19	95.97%	YTD	95.10%
↓			

Bed Occupancy Excluding Contingency Beds (<92%)

Oct-19	99.88%	YTD	98.65%
↓			

Out of Hospital

Bedford Hospital Trustwide
(unless otherwise stated)

Total Discharges

Oct-19	5,997	YTD	38,988
↑			

Arrow shows improving position if total discharges is higher than previous period

Monday to Friday Discharges - Total and Daily Average

Oct-19	5,084	YTD	32,673
↑	221		212

Arrow shows improving position if average discharges is higher than previous period

Weekend Discharges - Total and Daily Average

Oct-19	913	YTD	6,315
↑	114		105

Arrow shows improving position if average discharges is higher than previous period

% of All Discharges before midday (30%)

Oct-19	12.57%	YTD	13.51%
↓			

EEAST NEPT - % Pts collected within 90 mins of booked ready time following a minimum 1 hour notice (95%)

Oct-19	72.64%	YTD	78.60%
↓			

ELFT Community Beds - Average Length of Stay (4 community houses)

Oct-19	27	YTD	23
↑			

Local Council Care Homes - A&E Attendances Bedford Borough and Central Bedfordshire

Oct-19	210	YTD	1,624
↑			

Local Council Care Homes - Non-Elective Admissions Bedford Borough and Central Bedfordshire

Oct-19	182	YTD	1,283
↓			

Key

- National Data via NHS Statistics
- Sourced via regional UEC Dashboard
- Local data by CCG
- Highest performing quartile
- Mid quartile range
- Lowest performing quartile

Urgent and Emergency Care

Bedfordshire
Clinical Commissioning Group

Issue	Mitigation
Integrated Urgent Care Service – Luton and Bedfordshire The average call answering time, abandoned calls and calls directed to 999 for ambulance dispatch all improved in October but did not achieve against the national thresholds.	Further recruitment is underway to increase the current staffing cohort with two additional training courses for new members of staff scheduled before Christmas.
Ambulance Services - East of England Ambulance Service 3 of the 4 ambulance response times indicators underachieved in October. Category 1, which includes first response vehicles, and Category 2 saw a slight deterioration compared to September, Category 1T, which only includes emergency transport vehicles, saw an improvement. Healthcare Professional response times against the 3 and 4 hour standards have improved from the previous month and are both within the national thresholds. The Hear &Treat rate remained below the national target however there has been a significant improvement on the previous month however See & Treat performance has deteriorated.	The CCG continues to work with EEAST to understand issues that impact the C1 and C2 performance and to monitor the plans that are in place to improve performance. The CCG also continues to work with EEAST to understand issues that impact on the Hear & Treat rate. See & Treat performance is monitored through the ambulance sub group. EEAST implemented the new Health Care Professional (HCP) and Inter Facility Transfers framework at the beginning of October which means the HCP 1hr and 2hr data will be captured in the same way as Category 1 and Category 2 response times. EEAST have advised that this data will be separated out for monitoring purposes.

Urgent and Emergency Care

NHS
Bedfordshire
Clinical Commissioning Group

<table>
<tr><th>Issue</th><th>Mitigation</th></tr>
<tr><td>A&E 4 hr Waits
In October the CCG achieved 90.66% against the constitutional target of 95% of patients discharged, admitted or transferred within four hours of arrival. This is a worsening position.

There were 11,267 type 1 attendances, with 78,449 year to date. Compared to this time last year type 1 A&E Attendances have increased by 0.21%</td><td>• Following an external review by the Oak Group a business case for a pilot on 4 wards is awaiting BHT input.
• Actions from the clinical review and in-depth clinical audit have been agreed and will be implemented via the A&E Delivery Board.
• Commitment has been given by system partners to transformation and efficiency schemes to support the safe and effective management of demand and capacity through Winter. Fortnightly meeting of the demand and capacity group are in place to monitor delivery against plan.</td></tr>
<tr><td>Non Elective Admissions 1+ Length of Stay
In October there were 3,236 admissions with 21,147 year to date which is over plan by 4.61%. Compared to this time last year 1+ LoS admissions have increased by 6.33%.</td><td rowspan="3">• Successful recruitment of an Integrated Discharge Manager to support greater fluidity and co-ordination of services enabling smoother transition from hospital to step down care. Start date of January 2020.
• Daily review of plans for all medically optimised patients continues and daily reviews of delayed transfers of care are in place.
• Long stay meetings have been implemented to review all patients with a length of stay over 21 days. These meetings have also now been extended to include patients with a length of stay greater than 14 days.
• Further development of the acute frailty pathway is underway.
• System partners commitment given to additional capacity to support the discharge of patients and/or reduction in avoidable admission to hospital.
• Demand and capacity groups are closely monitoring the agreed KPIs through fortnightly meetings.</td></tr>
<tr><td>Patients in hospital for 21+ days
In October there was an average of 53 patients per day at Bedford Hospital (13.89% of total patients). The number of patients in hospital for 7+ days averaged 166 (45.38%).</td></tr>
<tr><td>Bed Occupancy – Bedford Hospital
In October bed occupancy was 96.06% (including contingency beds) against a threshold of 92%.</td></tr>
</table>

Mental Health

Bedfordshire
Clinical Commissioning Group

Measure	Period	Target	Latest Data	Trend	YTD
CPA - 7 day Follow-Up	Q2 2019/20	95.00%	93.70%	↑	93.06%
Dementia Diagnosis Rate	M7 2019/20	66.70%	63.70%	↑	63.70%

Issue	Mitigation
Care Programme Approach (CPA) – 7 day follow up In Q2 there were 15 breaches of the 7 day follow up standard reported nationally, all of which were at ELFT, giving an achievement of 93.70% against the threshold of 95%. ELFT continue to report nationally on all patients followed up after an inpatient stay rather than just those discharged on CPA. Patients will only be discharged on CPA if they have more complex mental health needs. Of the 15 breaches, 6 were patients discharged on CPA.	ELFT continue to provide details on all breaches including where patients have been successfully followed up after the 7 day threshold, or have disengaged with the service. The provider has confirmed that there has been no incidents or safeguarding concerns due to the delay to follow up. ELFT have provided an action plan to achieve compliance against the current 7 day target which is monitored at monthly contract meetings.
Dementia Diagnosis At the end of October 2019 there were 3,402 people aged 65+ with a diagnosis of dementia giving an improving position of 63.7%. Latest data for November shows a slight decrease in the diagnosis rate to 63.6%. The main issues are: • A number of projects aimed at increasing the dementia diagnosis rate are due to end in December and this could have a potential impact on achievement of the 66.7% standard. • Lack of referrals from the South Beds area • Lack of diagnosing outside the memory clinic	The dementia board continues to monitor the recovery action plan and trajectory. Support for practices is continuing and plans are in place to move from three memory services to one by April 2020 in order to streamline processes, ensure timely referrals to post diagnostic services and give patients a choice as to where they would like to be seen. A proposal to incentivise GPs from April 2020 to diagnose has been submitted to primary care as part of next year's Personal Medical Services scheme. Within the Memory Assessment Service, a clinical director has been appointed to oversee diagnosis in memory clinics, a new operational lead is in place and dementia nurses continue to undertake diagnosis. A consultant psychiatrist continues to work within Bedford Hospital to aid diagnosis of dementia in secondary care.

Quality & Safety

Bedfordshire
Clinical Commissioning Group

Measure	Period	Target	Latest Data	Trend	YTD
Serious Incidents	M7 2019/20	0	17	↓	66
Never Events	M7 2019/20	0	0	↑	3
Cancelled Ops	Q2 2019/20	0	3	↑	8
Mixed Sex Accommodation	M7 2019/20	0	31	↓	162
Infection Control					
MRSA	M7 2019/20	0	0	↔	2
C-Difficile	M7 2019/20	54	3	↑	51
VTE					
Bedford Hospital					
VTE Risk Assessments	M7 2019/20	95.00%	97.60%	↓	97.47%
Luton & Dunstable Hospital					
VTE Risk Assessments	M7 2019/20	95.00%	99.00%	↑	99.14%

Issue	Mitigation
Serious Incidents & Never Events In October there were 17 serious incidents reported none of which have been defined as a Never Event. Of the 17, 4 were in mental health services, 1 in community services and 12 in acute services. Year to date there have been 66 serious incidents reported, 3 of which have been defined as Never Events.	All SIs are accompanied with detailed learning/action plans which the CCG monitors on a regular basis.

Quality & Safety

NHS Bedfordshire Clinical Commissioning Group

Issue	Mitigation
Cancelled Operations not rebooked within 28 days In Q2 the CCG has received confirmation that there were 3 Bedfordshire patients who have had an elective operation cancelled on or after the day of admission and not rebooked within 28 days, 2 of which were at Bedford Hospital and 1 at Milton Keynes University Hospital.	Through the contract monitoring process, the CCG contacts providers to request the reason for each breach and confirmation that all cancelled operations have been rebooked. All patients have now been treated.
Mixed Sex Accommodation In October there were 31 mixed sex accommodation breaches for Bedfordshire patients, 30 of which were at Bedford Hospital and 1 at Oxford University Hospitals (OUH). There have been 162 breaches to date of which 149 were at Bedford Hospital.	The CCG continue to request a root cause analysis from providers for all MSA breaches to understand the reasons for the breach and to obtain assurance around patient privacy and dignity. Bedford Hospital has reported that all of the Mixed Sex Accommodation breaches to date have occurred in the critical care unit and are 'unjustified' in line with national reporting guidance. The Trust has confirmed that patients' privacy and dignity was maintained at all times. The CCG has received a copy of OUH's privacy and dignity policy.

Quality & Safety

NHS Bedfordshire Clinical Commissioning Group

Issue	Mitigation
Infection Control **C-diff -** In October 2019 there were a total of 3 cases of C-diff for the CCG. This gives a total of 51 cases year to date which is 17 above the year to date ceiling. 2 of the cases were acute apportioned and 1 case was non-acute. Of the acute cases 1 was at Luton & Dunstable and 1 at Cambridge University Hospitals. Of 25 reported cases at the Luton & Dunstable Hospital trust-wide, 1 case has been removed as it has been reclassified by Public Health England. **MRSA** – there were no cases of MRSA in October, giving a total of 2 cases year to date for the CCG. **Norovirus –** there were 8 care homes affected with symptoms of norovirus in November across Luton and Bedfordshire. In December there have also been 2 homes affected to date. No organism has been identified in any case.	**C-Diff -** All cases are under review by the relevant providers. The Infection Prevention & Control team at L&D has reviewed each case and carried out an epidemiological review of all cases processed through their laboratory. There is no evidence of any links between cases. 8 cases apportioned to the Trust have been successfully appealed and the Trust is currently carrying out root cause analyses on a further 4 cases. Clostridioides difficile Infection Reports (Patients Aged 2 and Over) **Norovirus** – Care home outbreaks are managed by Public Health England.

Quality & Safety

NHS
Bedfordshire
Clinical Commissioning Group

Issue	Mitigation
Safeguarding Currently there are two Serious Case Reviews (SCRs) in progress. One Domestic Homicide Review has been completed within Central Bedfordshire and the final report pending sign off by the Home Office before publication, it is likely to be 3-6 months before it is published. There are two Safeguarding Adult Reviews ongoing in Bedfordshire. The first involves an independent author and panel, and a SAR workshop was completed in November with a further workshop scheduled for January. The second is being managed by the chair of the local Safeguarding Adult Board and an initial SAR workshop was held in early December.	The SCR reports for both cases are expected to be available for publication in early 2020. Learning from reviews will be shared once reports have been completed and published. Clear action plans where identified, will be put in place for the services involved.

Acute Providers

Bedfordshire
Clinical Commissioning Group

Bedford Hospital and Luton & Dunstable Hospital

Performance against NHS Constitutional Pledges & other quality indicators				Bedford Hospital						Luton & Dunstable					
				BCCG Patients			Trust Wide			BCCG Patients			Trust Wide		
KPI Code	Indicator	Plan	Reporting Period	Latest Data	YTD*	Trend	Latest Data	YTD*	Trend	Latest Data	YTD*	Trend	Latest Data	YTD*	Trend
E.B.6	Cancer 2 week waits following urgent GP referral for suspected cancer	93%	Oct-19	93.82%	87.93%	↑	93.91%	87.91%	↑	94.72%	93.60%	↔	94.27%	93.87%	↓
E.B.7	Cancer 2 week waits - Breast Symptomatic where cancer not initially suspected	93%	Oct-19	91.67%	65.00%	↑	93.33%	65.71%	↑	92.31%	89.64%	↑	94.92%	92.94%	↑
E.B.8	Cancer 31 day - 1st definitive treatment from diagnosis	96%	Oct-19	97.20%	97.49%	↓	97.22%	97.52%	↓	100.00%	100.00%	↔	100.00%	100.00%	↔
E.B.9	Cancer 31 day - Subsequent treatment for cancer - Surgery	94%	Oct-19	80.00%	89.76%	↓	80.00%	89.15%	↓	100.00%	100.00%	↔	100.00%	100.00%	↔
E.B.10	Cancer 31 day - Subsequent treatment for cancer - Drugs	98%	Oct-19	100.00%	98.39%	↔	100.00%	98.39%	↔	100.00%	100.00%	↔	100.00%	100.00%	↔
E.B.11	Cancer 31 day - Subsequent treatment - Radiotherapy	94%	Oct-19	100.00%	100.00%		100.00%	100.00%		NP	100.00%		NP	100.00%	
E.B.12	Cancer 62 days - 1st treatment following an urgent GP referral	85%	Oct-19	N/A	N/A		73.17%	72.19%	↑	N/A	N/A		86.33%	86.42%	↑
E.B.13	Cancer 62 days - 1st treatment following referral from Screening Service	90%	Oct-19	N/A	N/A		62.50%	75.00%	↑	N/A	N/A		96.30%	97.23%	↓
E.B.3	18 week Referral to Treatment - Incomplete pathway	92%	Oct-19	87.58%	88.50%	↓	87.47%	88.15%	↑	91.68%	92.30%	↑	90.00%	90.59%	↑
E.B.S.4.iii	52 week Referral for incomplete pathways	0	Oct-19	0	0	↔	0	0	↔	0	0	↔	0	0	↔
E.B.4	Diagnostic tests - % of patients waiting 6 wks or more	1%	Oct-19	0.76%	0.76%	↑	0.75%	0.76%	↑	0.61%	0.66%	↓	0.63%	0.68%	↑
E.B.5	A&E total time in department - less than 4 hours (Trust Wide)	95%	Oct-19	N/A	N/A		87.11%	85.39%	↓	N/A	N/A		N/A	N/A	↔
E.B.S.1	Mixed-sex accommodation breaches	0	Oct-19	30	149	↓	36	164	↓	0	0	↔	0	2	↔
E.B.S.2	Cancelled operations on or after day of admission and not offered another date within 28 days	0	Q2 19/20	2	5	↑	2	5	↑	0	1	↑	0	1	↑
E.B.S.6	Urgent Operations cancelled for a second time	0	Oct-19	0	0	↔	0	0	↔	0	0	↔	0	0	↔

Acute Providers

Bedfordshire
Clinical Commissioning Group

East & North Herts and Milton Keynes Hospital

KPI Code	Indicator	Plan	Reporting Period	East & North Herts – BCCG Patients – Latest Data	East & North Herts – BCCG Patients – YTD*	East & North Herts – BCCG Patients – Trend	East & North Herts – Trust Wide – Latest Data	East & North Herts – Trust Wide – YTD*	East & North Herts – Trust Wide – Trend	Milton Keynes – BCCG Patients – Latest Data	Milton Keynes – BCCG Patients – YTD*	Milton Keynes – BCCG Patients – Trend	Milton Keynes – Trust Wide – Latest Data	Milton Keynes – Trust Wide – YTD*	Milton Keynes – Trust Wide – Trend
E.B.6	Cancer 2 week waits following urgent GP referral for suspected cancer	93%	Oct-19	99.31%	95.84%	↑	98.50%	96.42%	↑	92.52%	93.53%	↑	93.13%	94.16%	↓
E.B.7	Cancer 2 week waits - Breast Symptomatic where cancer not initially suspected	93%	Oct-19	100.00%	96.61%	↑	95.37%	92.30%	↓	100.00%	95.16%	↔	99.17%	97.76%	↓
E.B.8	Cancer 31 day - 1st definitive treatment from diagnosis	96%	Oct-19	95.24%	92.11%	↓	96.88%	95.33%	↑	87.50%	96.83%	↓	97.22%	97.87%	↓
E.B.9	Cancer 31 day - Subsequent treatment for cancer - Surgery	94%	Oct-19	50.00%	70.59%	↓	65.52%	81.13%	↓	100.00%	100.00%		100.00%	98.73%	↔
E.B.10	Cancer 31 day - Subsequent treatment for cancer - Drugs	98%	Oct-19	100.00%	100.00%	↔	99.48%	98.95%	↑	100.00%	100.00%	↔	100.00%	99.08%	↔
E.B.11	Cancer 31 day - Subsequent treatment - Radiotherapy	94%	Oct-19	100.00%	98.77%	↔	98.25%	97.60%	↑	100.00%	80.00%	↔	100.00%	93.98%	↔
E.B.12	Cancer 62 days - 1st treatment following an urgent GP referral	85%	Oct-19	N/A	N/A		81.14%	76.42%	↑	N/A	N/A		86.32%	82.04%	↑
E.B.13	Cancer 62 days - 1st treatment following referral from Screening Service	90%	Oct-19	N/A	N/A		100.00%	79.87%	↑	N/A	N/A		92.59%	91.21%	↓
E.B.3	18 week Referral to Treatment - Incomplete pathway	92%	Oct-19	85.32%	87.49%	↓	83.52%	85.06%	↓	83.47%	89.18%	↓	85.70%	88.03%	↓
E.B.S.4.iii	52 week Referral for incomplete pathways	0	Oct-19	0	5	↑	16	104	↑	0	0	↔	0	3	↑
E.B.4	Diagnostic tests - % of patients waiting 6 wks or more	1%	Oct-19	0.00%	0.69%	↔	0.20%	0.68%	↑	8.26%	4.13%	↑	2.19%	1.04%	↓
E.B.5	A&E total time in department - less than 4 hours (Trust Wide)	95%	Oct-19	N/A	N/A		84.97%	83.60%	↓	N/A	N/A		85.83%	90.89%	↓
E.B.S.1	Mixed-sex accommodation breaches	0	Oct-19	0	0	↔	0	0	↔	0	0	↔	0	0	↔
E.B.S.2	Cancelled operations on or after day of admission and not offered another date within 28 days	0	Q2 19/20	0	0	↔	6	13	↑	1	1	↓	11	22	↔
E.B.S.6	Urgent Operations cancelled for a second time	0	Oct-19	0	0	↔	0	0	↔	0	0	↔	0	0	↔

Performance against NHS Constitutional Pledges & other quality indicators

Community and Mental Health

NHS
Bedfordshire
Clinical Commissioning Group

ELFT Mental Health

Operational Standards	Threshold 2019/20	Qtr. 1	Qtr. 2	Oct	Nov	Dec	Qtr. 3	Year to Date
Care Programme Approach (CPA): The percentage of Service Users under adult mental illness specialties on CPA who were followed up within 7 days of discharge from psychiatric in-patient care.	95%	93.90%	92.74%	94.57%			94.57%	93.53%
Early Intervention in Psychosis programmes: the percentage of Service Users experiencing a first episode of psychosis who commenced a NICE-concordant package of care within two weeks of referral (All ages)	56%	80.00%	81.82%	77.78%			77.78%	80.36%
Patients on CPA who have had a formal review within the last 12 months	95%	95.58%	95.45%	95.03%			95.03%	95.03%
% of placed out of area patients with a named coordinator	100%	100.00%	100.00%	100.00%			100.00%	100.00%
SPOA Emergency referrals received and attended to within 24 hours	100%	100.00%	100.00%	100.00%			100.00%	100.00%
% of CYP ED cases that start treatment within 4 weeks of referral	95%	87.50%	100.00%		Quarterly			93.55%
% of CYP urgent ED cases that start treatment within 7 days of referral	95%	100.00%	100.00%		Quarterly			100.00%
% discharge summaries following inpatient/daycase care and A&E attendance issued to general practice within 24 hours	100%	70.16%	73.14%		Quarterly			71.58%
% of clinic letters following outpatient attendance issued to general practice within 7 calendar days	100%	53.30%	52.42%		Quarterly			52.86%

ELFT Community Services

Operational Standards	Threshold 2019/20	Qtr. 1	Qtr 2	Oct	Nov	Dec	Qtr 3	YTD
Percentage of Service Users on incomplete RTT pathways (yet to start treatment) waiting no more than 18 weeks from Referral (only Community Paediatrics)	92%	99.49%	92.55%	84.00%			84.00%	94.60%
Percentage of Service Users on incomplete RTT pathways (yet to start treatment) waiting no more than 18 weeks from Referral (non-consultant)	92%	98.37%	96.54%	95.74%			95.74%	97.23%
Percentage of stroke survivors who are supported by a rehabilitation team (6-8 weeks)	100%	100.00%	100.00%	100.00%			100.00%	100.00%
Percentage of letters sent to the GP following children and young people Speech and Language first (new) clinic attendance within 7 ordinary days	100%	98.79%	98.51%	94.05%			94.05%	97.94%
Percentage of discharge letters sent to the GP following children and young people Speech and Language final clinic attendance within 7 ordinary days.	100%	98.21%	96.47%	100.00%			100.00%	97.54%
Percentage of carers identified and offered a referral for a carers assessment	90%	95.33%	98.46%	100.00%			100.00%	96.92%
Percentage of people whose ESD treatment programme started within 1 working day of discharge from hospital	95%	97.06%	96.77%	95.24%			95.24%	96.69%
Percentage of children in and out of area receiving an initial health review within 20 working days of becoming	95%	82.50%	90.70%	90.00%			90.00%	87.10%
Percentage of children placed in and out of area receiving a review health assessment within 40 days from receipt of referral.	95%	90.72%	87.41%	93.94%			93.94%	89.43%
Evidence that all young people leaving care receive a relevant health passport	100%	100.00%	100.00%	100.00%			100.00%	100.00%
Percentage of children receiving a children's wheelchair within 18 weeks	100%	100.00%	94.74%	100.00%			100.00%	98.41%
Percentage of children and young people on the caseload receiving an epilepsy management plan in the community	95%	93.80%	99.03%	100.00%			100.00%	97.30%

Areas of escalation to contract meetings – discharge letters and LAC health reviews.

Definitions

NHS
Bedfordshire
Clinical Commissioning Group

Ambulance - Cat 1 - Immediately life threatening conditions emergency response within an average time of 7 minutes.
Ambulance - Cat 2 – Emergency calls average response time of 18 minutes.
Ambulance - Cat 3 – Urgent calls – 9 out of 10 responses within 120 minutes.
Ambulance - Cat 4 – Less Urgent calls – 9 out of 10 responses within 180 minutes.

CPA follow up within 7 days of discharge from psychiatric in-patient care - people under adult mental illness specialties on CPA followed up (face to face contact or by phone discussion) within 7 days of discharge from psychiatric in-patient care.

Dementia Diagnosis – Diagnosis rate for people aged 65 and over, with a diagnosis of dementia recorded in primary care, expressed as a percentage of the estimated prevalence based on GP registered populations.

18 Weeks Referral to Treatment – Incomplete pathway - Patients on a non-urgent consultant led pathway setting a maximum time of 18 weeks from the point of referral up to the start of any treatment necessary where it is clinically appropriate. Incomplete pathways are those where patients are still waiting for treatment.

Diagnostics – Access to 15 key diagnostic tests within 6 weeks.

Cancer 2 Week Wait Following Urgent GP Referral For *Suspected* Cancer – Patients seen within two weeks of an urgent GP referral for suspected cancer

Cancer 2 Week Wait for Breast Symptoms where cancer was *not initially suspected* – Patients seen within two weeks of an urgent referral for breast symptoms where cancer was not initially suspected

Cancer 31 day first treatment following a cancer diagnosis – Patients that receive first definitive treatment within 31 days of receiving a diagnosis for all cancers.

Cancer 31 subsequent cancer treatments – Surgery – Patients that receive subsequent treatment of surgery within a maximum waiting time of 31 days.

Cancer 31 subsequent cancer treatments – Anti cancer drug regimens – Patients that receive subsequent/adjuvant treatment of anti-cancer drug regimen within a maximum waiting time of 31 days.

Cancer 31 subsequent cancer treatments – radiotherapy – Patients that receive subsequent/adjuvant radiotherapy treatment within a maximum waiting time of 31 days including patients with recurrent cancer.

Cancer 62 day first treatment following an urgent GP referral – Patients who receive first definitive treatment for all cancers within 62 days following an urgent GP referral.

Cancer 62 day first treatment following referral from an NHS cancer screening service – Patients who receive first definitive treatment for all cancers within 62 days following referral from an NHS cancer screening service.

52+ Week RTT waits - The number of incomplete Referral to Treatment (RTT) pathways (patients yet to start treatment) of 52 weeks or more.

A&E waiting times – total time in the A&E department - Percentage of patients who spent 4 hours or less in A&E.

Mixed-sex accommodation breaches - The total occurrences of unjustified mixing in relation to sleeping accommodation.

Cancelled operations on or after day of admission and not offered another date within 28 days - Number of patients not treated within 28 days of last minute elective cancellation.

Trolley waits in A&E over 12 hours - Total number of patients who have waited over 12 hours in A&E from decision to admit to admission

Urgent Operations cancelled for a second time – The number of Urgent Operations Cancelled for the 2nd or more time

Psychosis treated with a NICE approved care package within two weeks of referral - People experiencing first episode psychosis or ARMS (at risk mental state) that wait 2 weeks or less to start a NICE recommended package of care.

IAPT Access Rate - Proportion of people that enter treatment against the level of need in the general population

IAPT - people who completed treatment and are moving to recovery – Proportion of people who complete treatment who are moving to recovery.

IAPT waiting times - People that wait 6 weeks or less from referral to entering a course of IAPT treatment and people that wait 18 weeks or less from referral to entering a course of IAPT treatment.

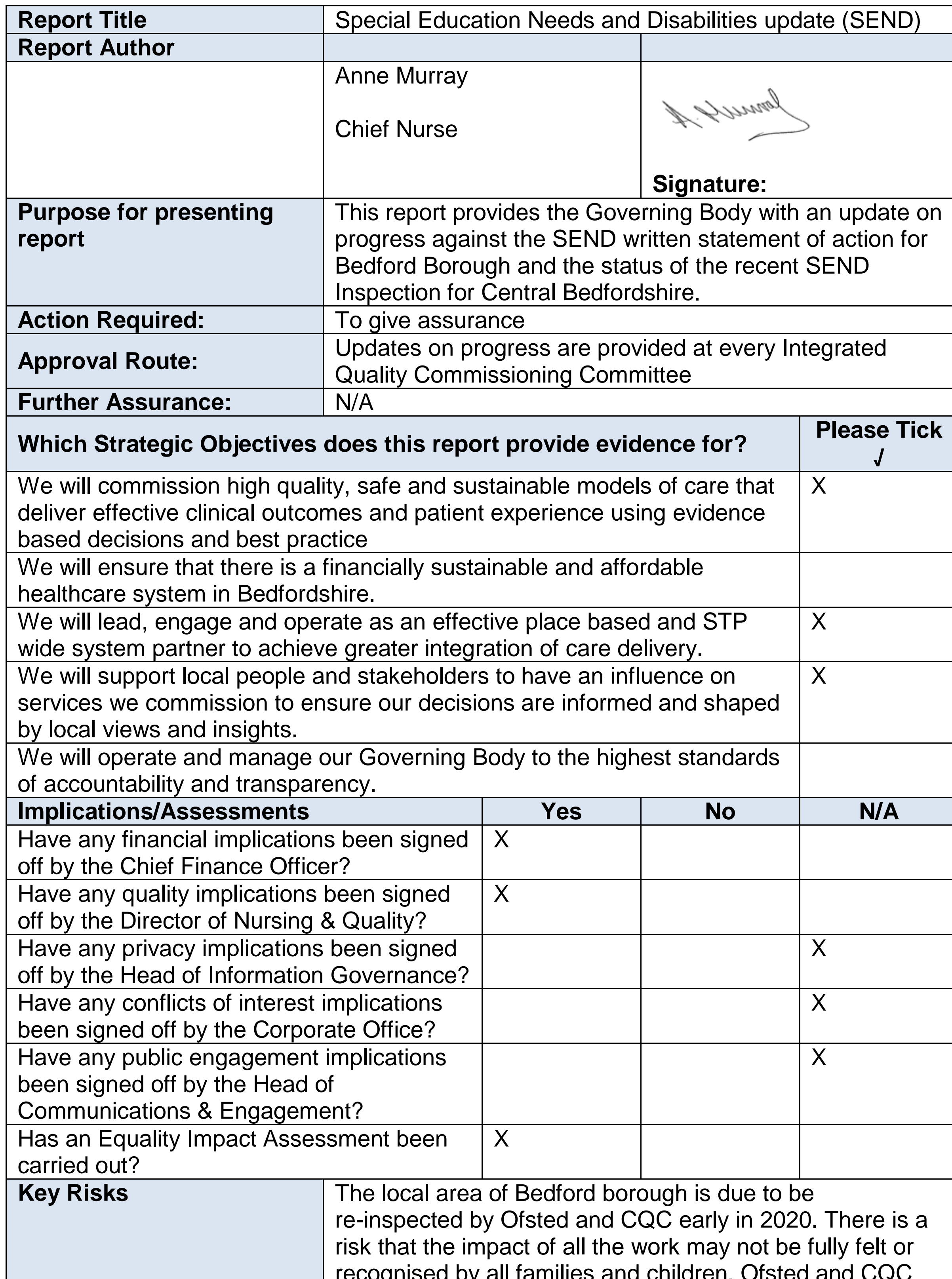
Improve access rate to Children and Young People's (CYM) Mental Health Services (CYPMH) - Number of individual CYM under 18 receiving treatment by NHS funded community services as a proportion of those with a diagnosable mental health condition.

Waiting times for Urgent and Routine Referrals to Children and Young People Eating Disorder Services - Proportion of CYP with an Eating Disorder (urgent cases) that wait one week or less from referral to start of NICE-approved treatment and proportion of CYP with an Eating Disorder (routine cases) that wait 4 weeks or less from referral to start of NICE-approved treatment.

NHS Bedfordshire
Clinical Commissioning Group

Agenda Item: 9

Governing Body *held in public*	***Report*** Date of Meeting:



Report Title	Special Education Needs and Disabilities update (SEND)		
Report Author			
	Anne Murray Chief Nurse	**Signature:**	
Purpose for presenting report	This report provides the Governing Body with an update on progress against the SEND written statement of action for Bedford Borough and the status of the recent SEND Inspection for Central Bedfordshire.		
Action Required:	To give assurance		
Approval Route:	Updates on progress are provided at every Integrated Quality Commissioning Committee		
Further Assurance:	N/A		

Which Strategic Objectives does this report provide evidence for?	**Please Tick √**
We will commission high quality, safe and sustainable models of care that deliver effective clinical outcomes and patient experience using evidence based decisions and best practice	X
We will ensure that there is a financially sustainable and affordable healthcare system in Bedfordshire.	
We will lead, engage and operate as an effective place based and STP wide system partner to achieve greater integration of care delivery.	X
We will support local people and stakeholders to have an influence on services we commission to ensure our decisions are informed and shaped by local views and insights.	X
We will operate and manage our Governing Body to the highest standards of accountability and transparency.	

Implications/Assessments	**Yes**	**No**	**N/A**
Have any financial implications been signed off by the Chief Finance Officer?	X		
Have any quality implications been signed off by the Director of Nursing & Quality?	X		
Have any privacy implications been signed off by the Head of Information Governance?			X
Have any conflicts of interest implications been signed off by the Corporate Office?			X
Have any public engagement implications been signed off by the Head of Communications & Engagement?			X
Has an Equality Impact Assessment been carried out?	X		

Key Risks	The local area of Bedford borough is due to be re-inspected by Ofsted and CQC early in 2020. There is a risk that the impact of all the work may not be fully felt or recognised by all families and children. Ofsted and CQC

	may not be assured that significant progress has been made against the 5 areas identified in the Written statement of action that was agreed June 2018.
Executive Summary	The local area of Bedford Borough was inspected by Ofsted and the Care Quality Commission February 2018 to judge the effectiveness of the area in implementing the special educational needs and disability (SEND) reforms as set out in the Children and Families Act 2014. The lead Inspector determined that Bedford Borough Council and Bedfordshire Clinical Commissioning Group were required to jointly submit a Written Statement of Action because of significant areas of weakness in the local area's practice. Central Bedfordshire Council has now had their SEND inspection. The letter with the outcome is awaited. The Governing Body will be informed of the position once the final letter is received and accuracy confirmed. The purpose of this paper is to update the Governing Body on progress against the Written Statement of action for the local area of Bedford Borough Council.

Background

The local area of Bedford Borough was inspected by Ofsted and the Care Quality Commission February 2018 to judge the effectiveness of the area in implementing the special educational needs and disability (SEND) reforms as set out in the Children and Families Act 2014.

The lead Inspector determined that Bedford Borough Council and Bedfordshire Clinical Commissioning Group were required to jointly submit a Written Statement of Action because of significant areas of weakness in the local area's practice.

The Governing Body has previously received details of the weaknesses and the actions within the Written Statement of action. The Integrated Quality and Commissioning Committee has received monthly updates on progress.

NHSE and DfE have monitored and advised on progress during the past year since the inspection. The last oversight meeting was December 5th.

The purpose of this paper is to provide a position statement in relation to the imminent re-inspection of Bedford Borough local area.

The Written statement of action identified 5 areas of weakness:

Section 1
There are no coordinated priorities, strategies or accountabilities between the services to ensure that joint commissioning is undertaken effectively:

- A Joint Commissioning Strategy for SEND has been co-produced with Bedford Parent Carer Forum. An outcomes framework has been incorporated into the strategy.

- The JSNA SEND chapter has been refreshed with data from education, health and social care. This will enable us to forecast and understand demand and capacity challenges and the associated risks. Modelling suggest another 2500 SEND children in Bedford Borough by 2030.
- A co production charter has been created and signed by schools and health providers.
- Engagement with parents, carers and providers has been supported by a range of different activities, including workshops, surveys and regular attendance at parent coffee mornings.
- A key area that needed a new model of service was access to speech and language therapy services (SALT). Bedford Borough and Bedfordshire Clinical Commissioning group agreed immediate funding to manage a case load of children that were on waiting lists with immediate effect.
- A new model of delivery has also been agreed which works with schools and recognises the therapy services within Health services at the specialist end of the delivery model.
- 209 assessments were undertaken between July and November 2019.
- A similar approach has been developed for sensory occupational therapy.
- Joint commissioning posts have also been agreed and funding for the parent carer forum in recognition of the parents as key partners in line with the coproduction charter.

Section2
BCCG had only recently undertaken self-evaluation, at the time of the inspection there was no robust action plan to deliver improved outcomes for Children and Young people:

- Chief Nurse identified as Executive lead with additional executive ownership.
- A review of the Designated Clinical Officer role was undertaken and extra capacity identified.
- A health summit was held to ensure system wide engagement and learning.
- Weekly health transformation calls set up with monthly face to face provider meetings. This has ensured that the 6 week turnaround for all educational health care plan requests are met within timescale. Rising from 2% in Q4 18/19 to 99% in Q3 19/20
- Data flow is now improved from provider services. Referral to treatment (RTT) data shows good performance: Children's Adolescent Mental Health (CAMHS) 3.9 weeks, Paediatricans, Occupational Therapy 8 weeks, SALT 12.4 weeks, Paediatricians 13.8 weeks.
- Greater engagement with primary care leads ensuring local offer available on GP websites.
- Creation of self-evaluation toolkit for provider teams, in order to raise awareness and ensure that strategy and actions are meaningful to frontline staff.

Section 3
Leaders have not ensured that the local offer provides clear, comprehensive, accessible and up to date information about the available provision and how to access it. Leaders are not responsive to local needs and aspirations by involving children and young people, their families, and service providers within its development and review:

- Bedford Borough commissioned and external web designer to improve functionality
- A full time development officer was appointed.
- All providers briefed to ensure all are aware that all services need to be published and updated on the websites. Information needs to be accurate and updated regularly.
- The new site has been tested by parent's cares and young people.
- Local offer promoted on every GP practice waiting room.
- Local offer now promoted by local business including Tesco's and Mc Donalds.
- CAMHS service also promotes offer through User podcast.

Section 4
Leaders have not ensured collectively that Educational Health Care (EHC) plans identify the range of needs for children and young people beyond the diagnosis or a multi-agency approach to meeting needs effectively, including the subsequent signposting around personal budgets.

- A bespoke EHCP Outcomes training package has been co- produced and delivered across education, health and social care and parent carer forum. Training has now been delivered to 250 frontline practitioners.
- Designated Clinical Officer (DCO) delivered training to all CAMHS services.
- Multiagency audits take place to monitor quality of EHCPs. 70% of EHCP audited rate good or outstanding between September and November.
- EHCP co-ordinator role developed by Community Health Services.
- 63% increase in personal budgets in Bedford Borough.
- BCCG has more personal Health budgets than National average.

Section 5
There are weaknesses in the provision across the borough for young people who have emerging SEND, and more complex needs such as autistic spectrum disorder to live successful olives where they participate positively and transition into adulthood.

- The numbers of young adults with SEND supported into employment has increased since the time if the inspection.
- The numbers of young adults being supported to live independently has increased by 25%
- 44% decrease in SEN support leavers who were NEET in 2017 to 2018
- CAMHS Schools and Early help programme was externally evaluated and this found that "as a result of this project there has been increased access to assessment and intervention for children and young people with mental health difficulties" Referral from secondary schools have reduced into the single point of entry. Teachers and frontline practitioners have increased access to advice and guidance from mental health.

Ongoing Risks

Despite the work that has been completed and the strength that has developed within the partnership to continue to progress the agreed actions, this programme of work still has significant risks. Mainly due to capacity within services and rising demands on services as identified in the JSNA. New models of delivery will help to mitigate this risk with clearer understanding of universal and targeted offers.

Feedback has been received from families and frontline staff about the positive impact that is now being felt through this work programme. The focus within the partnership must continue in order to keep improving outcomes.

Recommendation

The Governing Body is asked to note the highlights of the work that has been completed in partnership with Bedford Borough Council and Bedford Parent Carer Forum. The monitoring of the action plan has been undertaken by the Send Improvement Board chaired by the Education portfolio holder. A positive oversight meeting was held with NHSE and DfE in December.

The Governing Body will be informed of the position following the re-inspection of Bedford Borough and following the publication of the Central Bedfordshire Council Inspection.

NHS
Bedfordshire
Clinical Commissioning Group

Agenda Item: 10

Governing Body *held in public*	***Report*** Date of Meeting: 16th January 2020

<table>
<tr><td>Report Title</td><td colspan="3">Finance Report as at 30th November 2019 (Month 8)</td></tr>
<tr><td>Report Author</td><td>Presented By</td><td colspan="2">Responsible Director</td></tr>
<tr><td>Malcolm Miller,
Deputy Chief Finance Officer</td><td>Chris Ford
Chief Finance Officer</td><td colspan="2">Chris Ford

Signature:</td></tr>
<tr><td>Purpose for presenting report</td><td colspan="3">The report provides the Committee with a routine monthly update on the financial position of the CCG.</td></tr>
<tr><td>Action Required:</td><td colspan="3">1. To note and discuss the financial position at month 8 and that whilst the CCG is currently reporting to achieve the 2019/20 financial plan as agreed with NHSE, there is significant inherent risk to delivering that position. This is reflected in the financial scenarios set out in the report
2. To note the summary of Key Performance Indicators at the beginning of the finance report which provides a quick overview of financial performance.</td></tr>
<tr><td>Approval Route:</td><td colspan="3">Recommendation from the Finance and Performance Committee to the Governing Body</td></tr>
<tr><td>Further Assurance:</td><td colspan="3">N/A</td></tr>
<tr><td colspan="3">Which Strategic Objectives does this report provide evidence for?</td><td>Please Tick √</td></tr>
<tr><td colspan="3">We will commission high quality, safe and sustainable models of care that deliver effective clinical outcomes and patient experience using evidence based decisions and best practice</td><td></td></tr>
<tr><td colspan="3">We will ensure that there is a financially sustainable and affordable healthcare system in Bedfordshire.</td><td>✓</td></tr>
<tr><td colspan="3">We will lead, engage and operate as an effective place based and STP wide system partner to achieve greater integration of care delivery.</td><td></td></tr>
<tr><td colspan="3">We will support local people and stakeholders to have an influence on services we commission to ensure our decisions are informed and shaped by local views and insights.</td><td></td></tr>
<tr><td colspan="3">We will operate and manage our Governing Body to the highest standards of accountability and transparency.</td><td>✓</td></tr>
<tr><td>Implications/Assessments</td><td>Yes</td><td>No</td><td>N/A</td></tr>
<tr><td>Have any financial implications been signed off by the Chief Finance Officer?</td><td>✓</td><td></td><td></td></tr>
<tr><td>Have any quality implications been signed off by the Director of Nursing & Quality?</td><td></td><td></td><td></td></tr>
<tr><td>Have any privacy implications been signed off by the Head of Information Governance?</td><td></td><td></td><td></td></tr>
<tr><td>Have any conflicts of interest implications been signed off by the Corporate Office?</td><td></td><td></td><td></td></tr>
</table>

Have any public engagement implications been signed off by the Head of Communications & Engagement?			
Has an Equality Impact Assessment been carried out?			

Key Risks	As at month 8: • The latest data from acute providers demonstrates that activity and price pressures are continuing month on month to the level and extent that poses a significant risk to the CCG financial position going forward. • Acute services forecast shows an £19.3m overspend (up by £1.3m from month 7) after having anticipated securing £5m of the £9m as yet unidentified savings plans (£4m system affordability and £5m ICS stretch target). • Other service areas are forecasting a net £1.2m surplus position, continuing healthcare offsetting pressures in mental health, community and other areas. • The CCG set aside £3.1m contingency to manage risks as they materialise which has been fully released into the forecast position. • The forecast also anticipates further support of £3.6m through slippage on investments and prior year benefits. • Consequently, the CCG needs to identify an additional £10.9m of savings in the remaining four months to year end to achieve its planned surplus. • The CCG has initiated a financial recovery programme to identify and delivery the additional savings. Currently potential opportunities totalling £7.6 have been proposed leaving £3.3m as yet unidentified. A significant proportion of the identified opportunities relate to the contract affordability gap and securing challenges to reduce acute sector charges. • Overall, the CCG has assessed a net £11m risk against achieving its control total which, if materialised, would result in the CCG breaking even in-year. • The CCG is actively seeking support from the local health system and NHSE in achieving its financial target and contributing towards achieving the ICS overall target. • Achieving its target would enable the CCG to have its historical debt frozen which would be a significant benefit towards 2020/21 planning.
Executive Summary	The 2019/20 financial plan agreed with NHS England (NHSE) requires the CCG to achieve an in-year £11.1m surplus. Acute sector data in particular is fuelling a significant pressure which has put the financial control total at considerable risk. Other service areas overall are forecasting

	a small surplus. Contingency and other benefits bring the net position to as shown. Month 8 financial return to NHSE shows a net £6.4m negative variance year to date (a £1m in year surplus year to date) which is then recovered as the year progresses. It should be noted that £3.3m of this £6.4m adverse variance to plan is driven by the profiling in of the stretch target of £5.0m (a system responsibility to deliver) and £1.5m of the contract affordability gap with Bedford Hospital and Luton & Dunstable Hospital (a joint responsibility to deliver). The CCG is indicating reaching its planned forecast control total having recognised the need to make a further £10.9m of savings by year end. NHSE has requested that the CCG prepares a financial recovery plan (FRP) and internal mechanisms have been established to prepare, deliver and monitor against the FRP. The latest FRP plan has listed potential opportunities for a further £7.6m savings as yet not reflected in the forecast. These are being validated and pursued. A significant proportion of this relates to acute sector reductions (activity and cost challenges) and includes the joint delivery of the £4m contract affordability gap. In response to the level of risk in delivering the £11.1m surplus and the potential benefit resulting in the freezing of debt repayment (£32m over 5 years) the CCG has secured additional non-recurrent funding from other NHS organisations. NHS England is fully aware of the position and we believe that this funding is from other CCG's. It should be noted that this non-recurrent funding is repayable.

NHS
Bedfordshire
Clinical Commissioning Group

Finance Report: November 2019 (Month 8)

FINANCE

Summary of Key Performance Indicators

Indicator	Year to Date Month 8				Forecast Outturn			
	Target £'000	Actual £'000	Variance £'000	RAG Rating	Target £'000	Forecast £'000	Variance £'000	RAG Rating
Running costs do not exceed allocation					9,908	9,855	53	
Total expenditure does not exceed total allocation					685,082	673,982	11,100	
Running costs spend within plan	6,531	6,667	(136)		9,844	9,855	(11)	
Programme spend within plan	442,010	448,270	(6,260)		664,055	663,934	121	
Actual In-Year Surplus/(Deficit)	7,400	1,004	(6,396)		11,100	11,100	0	
Risk adjusted In-Year Surplus/(Deficit)					11,100	100	(11,000)	
QiPP delivery (Gross)	18,787	17,758	(1,029)		30,259	24,812	(5,447)	
Better Payment Practice Code (Value)	95.0%	98.0%	3.0%		95.0%	97.0%	2.0%	
Better Payment Practice Code (Number)	95.0%	97.0%	2.0%		95.0%	97.0%	2.0%	
Cash drawdown does not exceed maximum cash drawdown	449,125	448,082	1,043		673,687	673,687	0	

1.0 Key messages

The annual plan agreed with NHSE is to achieve an in-year surplus position of £11.1m which comprises a 1% annual surplus (£6.1m as per NHSE business rules) together with a further £5m stretch target. The additional £5m savings target was notified in May 2019 and whilst this is an Integrated Care System (ICS) requirement, the £5m is reflected in Bedfordshire CCG's control total. Plans are still being developed to ensure that the £5m is secured and delivered across all ICS partner organisations.

At month 8, the CCG is reporting a £1m in-year surplus (£6.4m behind plan and a £0.3m adverse movement from last month). However, the CCG has indicated achieving its year-end control total after assuming:

- Securing £5m of the £9m system affordability and ICS stretch target gap
- Delivering current identified QiPP schemes
- Identifying a further £11m savings via financial recovery planning

The £6.4m year-to date variance is primarily driven by £11.9m acute services overspend (a £1.8m deterioration from last month) and includes £1.5m slippage on system affordability savings. As mentioned above, it should also be noted that the plan includes a proportion of the £5m stretch target (£3.3m) which is a system responsibility to deliver. The table below illustrates more accurately the underlying performance of the CCG.

Month 8	YTD			FOT		
	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000
BCCG Control Total	4,067	1,004	(3,063)	6,100	6,100	0
System Stretch Target	3,333	0	(3,333)	5,000	5,000	0
Total Plan as reported	**7,400**	**1,004**	**(6,396)**	**11,100**	**11,100**	**0**

Pressures also exist in mental health and community services (combined £1.7m overspend - £100k in-month deterioration). The combined year to date position is offset by continuing health care, primary care, release of contingency together with slippage on investments and prior year benefits. Securing the stretch £5m ICS saving requirement is not forecast to be delivered until later in the year (March 2020) given the late notification and need to establish clear plans across ICS partners.

Year to date the CCG is reporting a variance against the top 6 acute providers of £11.1m (a further £1.8m deterioration on previous month) of which £9m is against Non Elective PODs. There is a year to date overspend across planned care (Electives, day cases and outpatients) of £4.9m. These are offset by anticipated contract challenges of £1.6m and underspends on excluded drugs and devices.

The underlying forecast for the top 6 acute providers based on month 7 data is an over spend of £19.9m. This is brought down to £16.6m when adjusted for anticipated contract challenges and QIPP savings not in the year to date run-rate.

In response to the level of risk in delivering the £11.1m surplus and the potential benefit resulting in the freezing of debt repayment (£32m over 5 years) the CCG has secured additional non-recurrent funding from other NHS organisations. NHS England is fully aware of the position and we believe that this funding is from other CCG's. It should be noted that this non-recurrent funding is repayable.

The cash and debtor positions are not giving any cause for concern at present.

2.0 Month 8 year to date

Summary ytd positions are shown at Appendix 1a.

The key year to date positions are;

2.1 Acute

Analysis of Variance	£'000 (Over) /Under
2.1 Acute Services	
Bedford Hospital	(5,637)
Luton & Dunstable	(3,807)
East & North Herts Trust	(875)
Milton Keynes Hospital	(1,367)
Other Acute NHS Providers	557

Cambridge University Hospitals FT	316
System Affordability Gap	(1,479)
Others	344
Total	**(11,948)**

The overall year to date position on Acute has worsened by £1.8m since the previous month's report and shows a £11.9m overspend The run-rate has increased since month 7 for Bedford Hospital, Luton & Dunstable Hospital and Milton Keynes Hospital, the run-rate has reduced slightly since month 7 for the other 3 "top 6 acute trusts". There is very little change outside the top 6 acute trusts.

The blended tariff threshold has been exceed at all trusts where it applies. Both Bedford and the Luton and Dunstable have exceeded the 0.5% payable at a 20% marginal rate and any over performance above 0.5% is therefore being paid for at full tariff.

2.1 Other Non-Acute Areas

Analysis of variance - Other areas	£'000 (Over) /Under
Mental Health	(998)
Community Health	(741)
Continuing Healthcare	2,090
Delegated Primary Care	512
Primary Care	(581)
Other program services	(173)
Running Cost Allowance	(137)
Total	**(28)**

As set out above, non-acute areas overall are showing a net breakeven position against an overall £205m spend to month 8.

- Mental Health – overspend compared to last month increased by £99k in month, primarily reflecting a further month of the on-going S.117 monthly overspend offset by an in-month improvement on CAMH services. It is anticipated that the S.117 will stabilised in the coming months and reduce following the introduction of a financial recovery initiative which is focussing on 3 areas:
    - Placing a time limit on when Local Authorities can raise old claims
    - Moving to a 50:50 share of costs pre-review as opposed to 100% healthcare
    - Review all existing cases (which has not been carried out for several years)
- Community Health Services: in total is similar to last month (£9k in month movement) and reflects the increased activity/financial pressure on acquired brain injury (£545k overspend) and community beds (£377k overspend). Small underspend on the ELFT community contract along with Community Equipment and out of hospital services nets the overall position to £741k overspend on £29m budget.
- Continuing Healthcare – improved it's under spend by a further £218k in month based on current activity and reducing provision for anticipated costs.

- Delegated Primary Care – underspend increased by a net £303k in month after reflecting slippage accumulated in the past three months across recruitment to Primary Care Network Additional Roles.
- Primary Care: deteriorated by £773k to £581k overspend across £51m ytd budget. National published monthly profile amended that rebased position ytd. CCG has reflected the revised profile. No cheaper stock option pressure totals £1.3m.
- Other Programme Costs: reduced Individual Funding requests and CSU costs improved position by £92k.
- Running cost allowance: Whilst slippage on CCG vacancies continues, additional unexpected Executive Team costs has pushed ytd to an overspend.

3.0 Forecast Outturn variances

A more detailed breakout of the forecast position by service area is set out in appendix 2a with an expectation that, overall, the outturn planned position will be achieved having identified and secured a further £10.9m of savings. The key in month movements are set out below;

3.1 Acute

Forecast positions	£'000 (Over) /Under
4.1 Acute Services	
Bedford Hospital Trust	(8,512)
Luton & Dunstable FT	(5,668)
East & North Herts Trust	(1,241)
Milton Keynes Hospital	(2,033)
Other top 6	948
MSK Circle	84
Other Acute NHS providers	836
Other acute	239
System Affordability gap	(4,070)
QiPP Enabling Investments	73
Total	**(19,343)**

The forecast for Acute Services based on month 7 data has deteriorated by £1.3m. This is due to the following factors:

- Increase in run-rate at ICS acute providers resulting in a forecast increase of £1.3m across the three. This main driver of this is non elective activity.
- This is offset by a small reduction in run-rate for East & North Herts Trust, Cambridge and Buckinghamshire trusts resulting in a reduction to the forecast of £0.1m across the three.
- A small increase out of area provider forecast of £0.1m

As in month 7 the forecast for the top 6 acute trusts is based on the following methodology and assumptions:

- Extrapolate year to date SLAM data based on calendar days, working days or 12ths depending on POD.
- An adjustment has been made to the above calculation in 2019/20 which takes two days from both August and December and move them to March, this will mitigate against the potential impact of winter on the forecast position.
- An adjustment is made for risk adjusted QIPP not in the year to date run-rate, at month 8 this was £0.7m.

The main driver continues to be non-elective over-performance of £14.3m across the top 6 acute providers. There are also significant overspends on outpatients £5.7m, day cases £1.7m, other services £1.5m and A&E £0.8m.

Year to date performance on other NHS providers has been extrapolated to month 12. Some of these contracts can be quite volatile so there is a risk that current trends may not continue for the remainder of the year.

3.3 Other Areas

Analysis of variance - Other areas	**£'000 (Over) /Under**
Mental Health	(323)
Community Health	(1,201)
Continuing Healthcare	3,113
Delegated Primary Care	595
Primary Care	(401)
Other program services	32
Running Cost Allowance	(11)
Total	**1,804**

Non-acute areas are collectively forecast at £1.8m surplus against an overall £311m budget allocation. This represents an improvement of £200k on last month's forecast position.

- Mental Health – forecast overspend improved from month 7 by £155k reflecting anticipated benefits from reviewing s.117 costs and the improved month 8 Child and Adolescent services flowing through the year-end position.
- Community Health Services: similar position to last month and reflects current monthly run-rate to year end.
- Continuing Healthcare – a small deterioration (£164k) in anticipation of increased activity over winter months.
- Delegated Primary Care – similar position to last month. Some pressures emerging (e.g. back dated rent reviews, seniority payments) offset by slippage on PMS re-investment schemes and Primary Care Networks' staffing.
- Primary Care: Prescribing forecast reflects the revised national profiling but provides a forecast similar to previous versions. The national cost pressure for no-cheaper drug stock option currently estimated at £2.0m.
- Other Programme Costs: forecast position improved by £243k due to reduced month 8 Individual Funding Requests and reduced CSU costs continuing to year-end.

- Running cost allowance: Now showing a marginal forecast overspend reflecting the pressure is emerging around the Executive Team and unbudgeted costs committed for consultancy and agency support towards CCG merger and operating in shadow for from 2020/21.

4.0 Financial Recovery Plan

In response to the challenges facing the CCG a Financial Recovery Plan has been developed to mitigate the financial impact. As reported at month 8 the CCG has identified a gap of £10.9m to achieving its planned surplus of £11.1m i.e. effectively forecasting a break-even position.

As at month 8 the Financial Recovery plan had identified scope for savings amounting to £18.2m of which £10.6m has already been played into the financial position. The remaining £7.6m of potential saving initiatives are at varying stages of development prior to being embedded into the financial position. These potential savings initiatives have been risk assessed and form the basis for the range of likely year end forecast outturns as illustrated in the table below.

Risk Assessed Outcome (at Month 8)	**Best £'000**	**Most Likely £'000**	**Worst £'000**
Planned Surplus	11,100	11,100	11,100
Financial gap at Month 8	(10,886)	(10,886)	(10,886)
Unmitigated Forecast Outturn	**214**	**214**	**214**
Realisation of additional FRP savings at Month 8	5,597	3,518	645
Forecast Outturn	**5,811**	**3,732**	**859**
Variance to Plan	**(5,075)**	**(7,154)**	**(10,027)**

The above assumes that the Stretch Target of £5.0m is achieved throughout.

The Financial Recover Plan is discussed in more detail under Agenda Item 8.0.

5.0 Debtors

	2018/19	**2019/20**			
	Month 8 £	**Month 7 £**	**Month 8 £**	**No.**	**% (Value)**
30 days or less	1,540,711	2,547,569	2,531,158	67	39%
31 to 60 days	3,088	2,131,771	51,668	10	1%
61 to 90 days	9,212	31,766	2,015,456	13	31%
91 to 120 days	424,137	384,622	13,064	5	0%
121 days or more	400,555	1,603,620	1,805,320	52	28%
Total	**2,377,703**	**6,699,348**	**6,416,667**	**147**	**100.0%**

The debtors' position is materially greater than last year even having allowed for the Q2 invoices being raised in month 7. At present, circa £3m is outstanding from Circle and payment is delayed whilst the CCG and Circle finalise the 2018/19 profit share figure. Negotiations with Circle are in-hand.

Aged debtors > 121 days have increased from last month as a result of further Circle invoices now becoming outstanding for greater than 121 days. NHS England's outstanding account is still awaiting the appropriate NHSE manager to approve for payment. This and Other Aged debts continue to be pursued.

6.0 QiPP 2019/20

The Committee's attention is drawn to the separate agenda item on QiPP 2019/20 month 8 position and forecast. QiPP reporting includes the further £9m affordability gap and ICS stretch target. The current position is summarised below.

	Year to Date			Forecast		
	Plan £000	Actual £000	Variance £000	Plan £000	Forecast £000	Variance £000
Original Schemes	17,308	17,758	450	26,189	24,812	(1,377)
Affordability Gap	1,479	0	(1,479)	4,070	0	(4,070)
Stretch	0	0	0	5,000	5,000	0
	18,787	17,758	(1,029)	35,259	29,812	(5,447)

The overall forecast is a £450k improvement on the previous month. Whilst CCG schemes are marginally ahead of plan at month 8, risks in the remaining months indicate that CCG QiPP is forecast to deliver 95% of its annual plan. Given plans have yet to be developed and approved to address the £4m affordability gap, QiPP reporting reflects this as nil achieved and is a contributing factor to the £10.9 additional savings to be found by year end. The financial forecast currently assumes that the ICS Stretch £5m will be secured. QIPP scheme implementation is reviewed by the QIPP control group and the Financial Recovery Board.

7.0 Underlying Position

The table below sets out the underlying position for the CCG. This adjusts the forecast surplus for the year for non-recurring items. In order to test the robustness of the CCG's underlying position it has been based on the forecast outturn position, a surplus of £11.1m. After making these adjustments the CCG is delivering a deficit on a recurrent basis.

Underlying Position: 30th November 2019 (Month 8)

Description	£'000
Forecast Surplus 2019/20	**11,100**
Adjustments:	
Prior year items	(2,806)
Adjustment to reflect non recurrent mitigations in financial recovery plan under development.	(15,886)
Other non-recurrent expenditure	200
Non Recurrent Allocations	251
Underlying Financial Position	**(7,141)**

Based on the forecast outturn position, the CCG's underlying position is a deficit of £7.1m. This has increased in month 8 due to the release of non-recurrent benefits to offset growth in acute expenditure.

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NHS Bedfordshire Clinical Commissioning Group

Appendix 1a

Summary of YTD financial position at 30th November 2019 (Month 8)

	Current Month - November			Previous Month - October			Movement - (in month position)		
	Budget YTD	Actual YTD	Variance YTD	Budget YTD	Actual YTD	Variance YTD	Budget YTD	Actual YTD	Variance YTD
Income	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Recurrent Resource Allocation	(404,284)	(404,284)	0	(353,654)	(353,654)	0	(50,629)	(50,629)	0
Running Cost Allowance	(6,693)	(6,693)	0	(5,889)	(5,889)	0	(804)	(804)	0
Delegated Primary Care Allocation	(42,598)	(42,598)	0	(37,453)	(37,453)	0	(5,145)	(5,145)	0
Deficit brought forward	28,327	28,327	0	24,786	24,786	0	3,541	3,541	0
Others	(2,367)	(2,367)	0	(1,869)	(1,869)	0	(498)	(498)	0
Total Income	**(427,615)**	**(427,615)**	**0**	**(374,080)**	**(374,080)**	**0**	**(53,535)**	**(53,535)**	**0**
Expenditure - CCG Program Allocation									
Acute Services	240,305	252,253	(11,948)	210,219	220,339	(10,121)	30,086	31,914	(1,828)
Mental Health Services	40,447	41,445	(998)	35,364	36,263	(899)	5,083	5,182	(99)
Community Health Services	28,929	29,670	(741)	25,310	26,042	(732)	3,619	3,629	(9)
Continuing Care Services	24,351	22,261	2,090	21,293	19,422	1,871	3,058	2,839	218
Primary Care Services	51,062	51,642	(581)	44,680	44,487	193	6,382	7,155	(773)
Other Program Services	13,149	13,321	(173)	11,432	11,697	(265)	1,716	1,624	92
TOTAL EXPENDITURE BEFORE APPLICATION OF RESERVES	**398,243**	**410,593**	**(12,350)**	**348,297**	**358,250**	**(9,953)**	**49,945**	**52,343**	**(2,398)**
Reserves									
Contingency Reserve	2,055	0	2,055	1,798	0	1,798	257	0	257
Investment Reserves (Held until PID Approved)	1,319	0	1,319	1,220	0	1,220	99	0	99
Allocations held in reserves	(374)	0	(374)	(529)	0	(529)	155	0	155
Prior Year	0	(2,579)	2,579	0	(1,071)	1,071	0	(1,508)	1,508
Sub Total	3,000	(2,579)	5,579	2,489	(1,071)	3,560	511	(1,508)	2,019
TOTAL PROGRAMME EXPENDITURE AFTER APPLICATION OF RESERVES	**401,242**	**408,014**	**(6,772)**	**350,787**	**357,179**	**(6,392)**	**50,456**	**50,835**	**(379)**
Delegated Primary Care Budget	40,768	40,256	512	35,852	35,643	209	4,916	4,613	303
Running Costs	6,531	6,667	(137)	5,752	5,704	48	779	964	(185)
SURPLUS/(DEFICIT)	**(20,927)**	**(27,323)**	**(6,396)**	**(18,311)**	**(24,446)**	**(6,135)**	**(2,616)**	**(2,877)**	**(261)**
IN YEAR SURPLUS/(DEFICIT)	**7,400**	**1,004**	**(6,396)**	**6,475**	**340**	**(6,135)**	**925**	**664**	**(261)**

Appendix 2a

Summary Forecast Position at 30th November 2019 (Month 8)

	Current Month - November			Previous Month - October			Movement - (in month position)		
Income	Annual Budget £'000	Forecast Outturn £'000	Variance YTD £'000	Annual Budget £'000	Forecast Outturn £'000	Variance YTD £'000	Annual Budget £'000	Actual YTD £'000	Variance YTD £'000
Recurrent Resource Allocation	(607,438)	(607,438)	0	(607,521)	(607,521)	0	83	83	0
Running Cost Allowance	(9,908)	(9,908)	0	(9,908)	(9,908)	0	0	0	0
Delegated Primary Care Allocation	(63,541)	(63,541)	0	(63,541)	(63,541)	0	0	0	0
Deficit brought forward	42,490	42,490	0	42,490	42,490	0	0	0	0
Others	(4,112)	(4,112)	0	(4,112)	(4,112)	0	0	0	0
Total Income	**(642,509)**	**(642,509)**	**0**	**(642,592)**	**(642,592)**	**0**	**83**	**83**	**0**
Expenditure - CCG Program Allocation									
Acute Services	355,407	374,751	(19,343)	355,407	373,479	(18,071)	0	1,272	(1,272)
Mental Health Services	60,781	61,105	(323)	60,781	61,260	(479)	0	(155)	155
Community Health Services	43,297	44,498	(1,201)	43,297	44,524	(1,227)	0	(26)	26
Continuing Care Services	36,581	33,468	3,113	36,581	33,304	3,277	0	164	(164)
Primary Care Services	76,590	76,991	(401)	76,590	76,914	(323)	0	78	(78)
Other Program Services	20,014	19,982	32	19,759	19,970	(211)	255	12	243
TOTAL EXPENDITURE BEFORE APPLICATION OF RESERVES	**592,672**	**610,795**	**(18,123)**	**592,417**	**609,450**	**(17,034)**	**255**	**1,345**	**(1,090)**
Reserves									
Contingency Reserve	3,083	0	3,083	3,083	0	3,083	0	0	0
Investment Reserves (Held until PID Approved)	2,947	1,593	1,354	2,947	1,611	1,336	0	(18)	18
Allocations held in reserves	1,813	2,401	(588)	2,151	2,536	(385)	(338)	(135)	(203)
Prior Year	0	(2,806)	2,806	0	(1,354)	1,354	0	(1,452)	1,452
Sub Total	7,842	1,188	6,654	8,180	2,793	5,387	(338)	(1,605)	1,267
TOTAL PROGRAMME EXPENDITURE AFTER APPLICATION OF RESERVES	**600,514**	**611,983**	**(11,469)**	**600,597**	**612,243**	**(11,646)**	**(83)**	**(260)**	**177**
Delegated Primary Care Budget	63,541	62,946	595	63,541	63,051	490	0	(105)	105
Running Costs	9,844	9,855	(11)	9,844	9,789	55	0	66	(66)
Financial Recovery Plan to be developed	0	(10,886)	10,886	0	(11,101)	11,101	0	215	(215)
SURPLUS/(DEFICIT)	**(31,390)**	**(31,390)**	**(0)**	**(31,390)**	**(31,390)**	**1**	**(0)**	**1**	**(1)**
IN YEAR SURPLUS/(DEFICIT)	**11,100**	**11,100**	**(0)**	**11,100**	**11,100**	**1**	**(0)**	**1**	**(1)**

NHS
Bedfordshire
Clinical Commissioning Group

Agenda Item: 12a

Sub-Committee Report

This Report is to assure the Governing Body that the committee has formally met in accordance with their terms of reference and to advise Governing Body members of the business transacted at the most recent meeting.

The Governing Body is asked to note the business discussed and to raise any questions in relation to the same.

Title of Sub-Committee	**Finance and Performance Committee**
Date Meeting Held	27th November 2019
Chaired By	Sally England, Lay Member Finance and Performance
Aligned Executive Director	Chris Ford, Joint Chief Finance Officer
Quoracy	The meeting was not quorate as there were not GP members present due to unforeseen circumstances.
Conflicts of Interest declared	None in addition to those already declared.
Key Decisions Made	No decisions made.
Items requiring approval by the Governing Body	No items require approval from the Governing Body.
Delegated decisions requiring ratification by the Governing Body	No delegated decisions required ratification from the Governing Body.
Policies Ratified for noting by the Governing Body	No ratified policies require noting by the Governing Body.
Risks identified during the meeting	See narrative below.
Financial implications identified during the meeting	See narrative below.

Key points to note from December 2019 meeting are as follows:

- **Financial position and financial recovery**

  The Committee noted the financial position reported at month 8 as a £1m surplus (£6.4m behind plan). The Committee also noted the forecast scenarios presented with the most likely year end position of a £3.7m surplus, £7.4m behind plan and the continued work to find ways to improve this position via the Financial Recovery plan. The Committee welcomed the regional discussions which were on-going to seek improvement in the year end forecast and the continued challenge to the Acute position.

  The Committee discussed and noted the initial submission of the CCG's Long Term financial plan and the requirement to deliver a 0.5% surplus and a £33m efficiency requirement and requested a further update on the operational plan at the February 2020 Finance and Performance Committee.

- **IT update**

  The Committee welcomed the update on the IT and noted the progress being made in delivering IT solutions to PCN's and that IG was working well across BLMK CCG's following recent changes.

- **Continuing Healthcare (CHC)**

  It was noted that there was duplication in reporting on Continuing Healthcare at ICQC and F&P. Given the financial position of CHC it was agreed that until there was a specific request for a paper at F&P, reporting would continue to ICQC.

Agenda Item 12b

Sub-Committee Report

This Report is to assure the Governing Body that the committee has formally met in accordance with their terms of reference and to advise Governing Body members of the business transacted at the most recent meeting.

The Governing Body is asked to note the business discussed and to raise any questions in relation to the same.

Title of Sub-Committee	Primary Care Commissioning Committee
Date Meeting Held	11th December 2019
Chaired By	Alison Borrett
Aligned Executive Director	Mike Thompson
Quoracy	Quorate
Conflicts of Interest declared	No declarations of interest declared from members in the first part of this meeting.
Key items discussed and decisions made	• Item 8b - West Mid Beds Wound Care - The Chair recommended that the Committee could not make a final decision at this stage with further discussions taking place about inclusion in the PMS scheme to the next meeting to ensure equity across BCCG. • Item 13 - Ivel Valley Medical Centre – List closure agreed for 3 months from November 2019. • Item 15 – Highlight Report Primary Care Dashboard – following discussion re development of the PC dashboard, CCG will continue working with LMC. • Item 16 - Sub-Contracting plan for approval – The Committee are happy to approve Leighton Road Surgery.
Items requiring approval by the Governing Body	None
Delegated decisions requiring ratification by the Governing Body	None
Policies Ratified for noting by the Governing Body	None
Risks identified during the meeting	The two Primary Care Commissioning risks relate to Bedford Borough and Central Bedfordshire will be escalated as high high (red red).

Financial implications identified during the meeting	None

Agenda Item: 12c

Governing Body *held in public*	***Report*** Date of Meeting: 16th January 2020

Report Title	Bedfordshire and Luton Joint Prescribing Committee (JPC) – 18th September 2019 Meeting Notes	
Report Author	**Presented By**	**Responsible Director**
Jacqueline Clayton, Assistant Head of Medicines Optimisation, BCCG and Professional Secretary to the JPC	*N/A*	Dr Sarah Whiteman **Signature:**
Purpose for presenting report	The JPC Notes are presented to the Governing Body for Assurance Purposes only as the JPC has delegated authority to make and issue recommendations on behalf of the CCG.	
Action Required:	To give assurance	
Approval Route:	Approved by the Bedfordshire and Luton Joint Prescribing Committee at its meeting on 4th December 2019.	
Further Assurance:	No	

Which Strategic Objectives does this report provide evidence for?	**Please Tick √**
We will commission high quality, safe and sustainable models of care that deliver effective clinical outcomes and patient experience using evidence based decisions and best practice	√
We will ensure that there is a financially sustainable and affordable healthcare system in Bedfordshire.	√
We will lead, engage and operate as an effective place based and STP wide system partner to achieve greater integration of care delivery.	√
We will support local people and stakeholders to have an influence on services we commission to ensure our decisions are informed and shaped by local views and insights.	
We will operate and manage our Governing Body to the highest standards of accountability and transparency.	

Implications/Assessments	**Yes**	**No**	**N/A**
Have any financial implications been signed off by the Chief Finance Officer?			√ - all budgetary implications agreed with Budget Holder (Fiona Garnett, Assistant Director and Head of Medicines Optimisations) aside from NICE Technology

			Appraisal Guidance (Mandatory Direction to Fund and all relevant Budget holders advised).
Have any quality implications been signed off by the Director of Nursing & Quality?			√
Have any privacy implications been signed off by the Head of Information Governance?			√
Have any conflicts of interest implications been signed off by the Corporate Office?			√
Have any public engagement implications been signed off by the Head of Communications & Engagement?			√
Has an Equality Impact Assessment been carried out?	√ All relevant agenda items have been assessed and recorded in the meeting notes. Full Assessment not required (Confirmed by BCCG Equality and Diversity Lead)		

Key Risks	None anticipated
Executive Summary	The Bedfordshire and Luton Joint Prescribing Committee Meeting Notes come to the Governing Body for Assurance Purposes only.

BEDFORDSHIRE AND LUTON JOINT PRESCRIBING COMMITTEE

Notes of the meeting on Wednesday 18th September 2019, Endeavour House (Building 50), Wrest Park, Silsoe, Bedfordshire, MK45 4HR.

Attendees:-

Dr J Fsadni (JF)	GP (Retired) Committee Chairman
Jacqueline Clayton (JC)	Secretary/Pharmaceutical Adviser, Bedfordshire CCG (BCCG), working on behalf of BCCG & Luton CCG (LCCG)
Dona Wingfield (DW)	Pharmacist Representative, BCCG
Matt Davies (MD)	Assistant Head of Medicines Optimisation, BCCG. (Deputising for the Head of Medicines Optimisation)
Sandra McGroarty (SMcG)	Pharmaceutical Advisor, BCCG (working JPC work streams)
Dr Kate Randall (KR)	GP Representative, BCCG
Dr Jenny Wilson (JW)	GP Representative, BCCG
Dr Lindsay MacKenzie (LMacK)	Executive Team Member, BCCG
Dr Joy Muttika (JM)	Medical Representative, Keech Hospice
Victoria White	Head of Clinical Service, St John's Hospice
Anne Graeff	Pharmacist Representative, LCCG
Richard Jones (RJ)	Head of Medicines Optimisation, LCCG
Dr Marian Chan (MC)	Medical Representative, the Luton and Dunstable University Hospital NHS Foundation Trust (LDUH)
Gemma McGuigan (GMcG)	Pharmacist Representative, Bedford Hospital NHS Trust (BHT)
Julie Phillips (JP)	Pharmacist Representative, the Luton and Dunstable University Hospital NHS Foundation Trust (LDUH)
Chined Ogbuefi (CO)	Pharmacist Representative, East London Foundation Trust (ELFT)
Russell Foulsham (RS)	Pharmacist Representative, Cambridgeshire Community Services (CCS)

In attendance (full meeting as observer) – Courtenay Pearson, Care Home Pharmacist, BCCG.
For agenda item 5.2 – Dr S Wijayasiri, Consultant Physician and Dr S Bhaktal**,** Specialist Registrar, the Luton & Dunstable Hospital; **For agenda items 5.4 and 5.5 –** (By teleconference) Dr Bagmane, Consultant in Respiratory Medicine, BHT

NHS

	AGENDA Item	Action
1	**Welcome and Apologies** – The chair welcomed everyone to the meeting. The meeting was advised that Dr Chan is now the 'official' L & D Medical Representative with Dr Nisar acting as her deputy. **Apologies for absence were received from -** Dr Nisar (Dr Chan attending as deputy); Adrian Spurrell; Fiona Garnett (FG) (Matt Davies deputising); Rushnara Begum; Tess Dawoud; Dr Dhatta, Dr Kwapong; Melanie Whittick; Dr Sarkar; Gerald Ziedman and Janice Jones.	
2	**Conflicts of interest declaration** No conflicts of interest were declared relating to the current meeting agenda by Committee members.	
3	**Minutes of the last meeting (19th June 2019)** The minutes of the meeting were approved for accuracy.	
4	**Matters Arising - Feedback on miscellaneous actions not included on the agenda.**	
4.1	**SystmOne Template to support guanfacine monitoring in line with the shared care guideline** It was agreed that this action could be closed as the work has been largely superseded by the introduction of the Arden Templates.	**Close Action**
4.2	**Public Health Representative to the Committee** RJ had identified a potential Public Health representative – Samantha Chepkin who should be in a position to attend from the December 2019 meeting.	**Close Action**
4.3	**Antimicrobial Guidelines Update** A section on WHO ACCESS WATCH and RESERVE list has been added to the introduction pages of the guidelines and going forward, as part of the JPC antimicrobial update work stream it was agreed that the JPC works with the microbiology teams at both Bedford and Luton & Dunstable Hospitals to create a localised list and include this as an appendix to the guidelines – Naomi Currie will pick this up in October 2019 as full engagement with microbiology specialist teams is required and this is outside the scope of JPC – more an ongoing work stream – ongoing action.	**JC to report back**
4.4	**Anticoagulants in Atrial Fibrillation Resources - Drug Interactions with NOACs.** To be replaced by updated EoEPAC document. The Secretary reported at the February 2019 meeting that during the Q and A process, there had been some queries raised and these were in the process of being reviewed by the authors. The Committee agreed that the final EoEPAC document could be circulated for virtual approval when it became available and then published as a replacement document, as outlined above, on GPref. This was an ongoing action as the final PAC Document had not yet been published.	**SMcG**

4.5	**Antibiotic Prophylaxis to prevent exacerbations for Non-Cystic Fibrosis Bronchiectasis – Focus on the use of Inhaled/Nebulised Tobramycin and Inhaled/Nebulised Colistimethate sodium -** The committee agreed to support use in line with criteria to be developed in conjunction with the Specialists and there would be no funding until the criteria were agreed and proformas set up. It was agreed that the proformas and pathways would be developed as a result of the commissioning policy approval. AG advised the meeting that draft criteria were being drawn up in conjunction with the L & D Department of Paediatrics and that similar work needed to be undertaken between LCCG and the Adult Respiratory Clinicians. This was an ongoing action.	**AG to report back**
4.6	**Apomorphine Shared Care Guideline** Following the update to the Shared Care Guideline at the June 2019 JPC meeting, the ELFT Community Services Pharmacist had agreed to take forward the action to investigate the use of Homecare, working with the CCGs as necessary. KP has educated the Specialist Parkinson's Disease Nurses on Homecare and is currently looking into generating a Business Case to support the use of Homecare as an alternative to shared care guideline.	**KP**
4.7	**Alemtuzumab SCG Update by Cambridgeshire Joint Prescribing Committee** The Cambridgeshire Joint Prescribing Group had discussed the update to the SCG at their July 2019 meeting. A final version of the document had been requested and was awaited and would be brought to the Committee when available.	**JC**
4.8	**Blood Glucose Testing Strips (BGTS) – proposed change from the formulary position to commissioning position – New Patients** Discussions were still ongoing between the CCGs and Specialist Teams. This is therefore an ongoing action and no changes to the current Formulary Position/JPC BGTS document can be made.	**RJ/FG**
5	**Items for consideration**	
5.1	**GLP1 Shared Care Guideline Update** At the June 2019 meeting, changes to the Formulary choices of GLP-1 receptor agonist were agreed. The Shared Care Guideline has been updated to reflect these changes, a fact sheet for Semaglutide added and general updating of the factsheets for the other drugs undertaken. No changes had been made the shared care guideline clinical responsibilities or the initiation/continuation criteria. The only response received from the Diabetes Specialist Teams was from Julie Pledger, Specialist Diabetes Nurse	

	who advised that she had no further comments on the documents. RJ advised that the LCCG Specialist Diabetes Pharmacists in Primary Care were now initiating these drugs. It was agreed that the Shared Care Guideline would be amended (if necessary) to ensure that this group of staff were included. Aside from this minor amendment, the updated Shared Care Guideline was approved. **Equality and Diversity Impact Assessment -** N/A – the shared care guideline's purpose is to support prescribing of medicines that have been previously assessed by the Committee. **(BCCG E & D Lead agrees)**	**JC**
5.2	**Safinamide for Parkinson's Disease** The Luton & Dunstable Hospital had requested the addition of safinamide for the treatment of Parkinson's disease (in accordance with the marketing authorisation for safinamide (Safinamide is indicated for the treatment of adult patients with idiopathic Parkinson's disease {PD} as add-on therapy to a stable dose of Levodopa {L-dopa} alone or in combination with other PD medicinal products in mid-to late-stage fluctuating patients. and NICE Clinical Guideline 71 – Parkinson's Disease in Adults) to be added the Joint Bedfordshire and Luton Formulary. A review outlining the key evidence of efficacy, safety and cost for safinamide (mainly based on NICE Evidence Summary – Parkinson's disease with motor fluctuations: safinamide, published 21 February 2019) was discussed by the Committee and the following key points highlighted:- • The summary of product characteristics (SPC) states that safinamide (Xadago: Profile Pharma) is a highly selective and reversible MAO-B inhibitor. This differs from rasagiline and selegiline which are selective and irreversible MAO-B inhibitors (European Public Assessment Report [EPAR]: Xadago). Several other mechanisms of action of safinamide have been identified by in-vitro data, including sodium channel inhibition and reducing excessive glutamate release. However, the extent to which the non-dopaminergic effects contribute to the overall clinical effect of safinamide has not been established. The EPAR for safinamide states that no clinical effects that might be related to these mechanisms were clearly evident in clinical trials. • The NICE evidence summary discusses 3 randomised controlled trials (RCTs) in people with Parkinson's disease of at least 3 years duration, who were taking a stable dose of levodopa and were experiencing motor fluctuations. Most people	

	in the studies were also taking other Parkinson's disease medicines, most commonly a dopamine agonist. There is limited data on the use of safinamide as a first choice add-on treatment to levodopa. • The main clinical benefits of safinamide at 24 weeks were an increase in 'on time' without troublesome dyskinesia (involuntary movements) of approximately 30 to 60 minutes daily, and a similar reduction in 'off time', compared with placebo. This effect was still observed at a 2-year follow-up. • Dyskinesia was the most commonly reported adverse effect, but was usually mild and associated with an increase in on time. Contraindications and cautions for use are similar to those of other MAO-B inhibitors. There is a potential risk of retinal degeneration in people with, or a previous history of, retinal disease with safinamide. • Safinamide is the third MAO-B inhibitor licensed in the UK as add-on treatment to levodopa in people with Parkinson's disease who are experiencing motor fluctuations. It is more expensive than other MAO-B inhibitors. • There are no head-to-head studies comparing the efficacy and safety of safinamide with other active treatments, including other MAO-B inhibitors. • The NICE guideline on Parkinson's disease makes recommendations on the place in therapy of adjuvant treatments. The choice of treatment will depend on the person's clinical and lifestyle characteristics, and their preferences, after an informed discussion about the benefits and risks of treatment. • In addition to the Consultant requesting the addition of the drug to the Formulary, the request was supported by the Parkinson's Disease Specialist Nurses as a second line treatment in patients who unable to tolerate rasagiline or selegiline. • Other Formulary decisions:- ○ CUFT had recently approved use as 'Add on therapy for motor fluctuations in idiopathic	

	Parkinson's Disease where existing oral agents have failed or are contra-indicated'. ◦ The Regional joint formulary committee (North Central London; NCL, request from UCL, which has a large Parkinson's Disease Unit) – reviewed Safinamide when it was licensed in 2017 and did not approve it. ◦ North Essex CCG – Approved – Specialist initiation, GP to continue. ◦ Hertfordshire CCGs; Thurrock CCG; Milton Keynes CCG; Bucks Healthcare NHS Trust – Not requested or reviewed. • With respect to drug interactions - The SPC for Safinamide states that 'concomitant use of Safinamide with fluoxetine or fluvoxamine should be avoided, or if concomitant treatment is necessary, these medicinal products should be used at low doses. A washout period corresponding to 5 half lives of the SSRI used previously should be considered prior to initiating treatment safinamide.' The eBNF entries relating to selegiline/rasagiline/safinamide with respect to the interactions with fluoxetine and fluvoxamine are the same. • Parkinson's disease is associated with orthostatic hypotension. As per NICE guidelines regarding treatment of Parkinson's disease, if pharmacological treatment of orthostatic hypotension in Parkinson's disease is required, first-line therapy is midodrine, with fludrocortisone second-line. Sympathomimetics, such as midodrine, are contraindicated for use with rasagiline/selegiline, while may be used in combination with safinamide with caution. However, the eBNF interaction information relating to the safinamide/midodrine interaction states the following 'Safinamide is predicted to increase the risk of a hypertensive crisis when given with midodrine. Manufacturer advises avoid. Severity of interaction: Severe; Evidence for interaction: Anecdotal'. • Selegiline is contraindicated for use in association with levodopa in patients with concomitant severe cardiovascular disease, arterial hypertension, hyperthyroidism, phaeochromocytoma, prostatic adenoma with the appearance of residual urine, tachycardia, arrhythmias, severe angina pectoris and thyrotoxicosis, while rasagiline and safinamide have no specific caution or contra-indication in these patient groups.	

	• Rasagiline is not on the Joint Formulary but feedback from clinicians is that is in use locally and has been for some time. • Potential Equality and Diversity impact (positive or negative) – see below. Dr Wijayasiri indicated that safinamide may have the following advantages:- • Daily dosing. • More useful for motor control and 'on-effect' may enable the dose of levodopa to be reduced. • Better than existing alternatives on impulse control. • Less expensive than Rotigotine patches. • It may reduce the incidence of falls and fractures. • Useful second line option in patients who fail on selegiline or as per the CUFT position outlined above. • Could also be used (in patients) where apomorphine is unavailable. The Committee decided not to support the Formulary application for safinamide. The main concerns were the lack of head to head trials with appropriate comparators, safety issues (e.g. retinopathy) and cost/cost-effectiveness. Dr Wijayasira was advised that the JPC would be happy to re-review/revisit the decision in the light of any new significant evidence/clinical audits from centres using the medicine. The Committee also agreed the following:- • A short medicines review on rasagiline would be prepared and circulated for virtual approval. This was considered an acceptable approach as the medicine was already established in therapy. • Dispersible Selegiline (for patients who cannot swallow) could be considered for addition to the Formulary by the L and D DTC for Formulary addition as it is an additional formulation of an existing Formulary drug and there is very low usage. **Equality and Diversity Impact Assessment -** As Safinamide is used for the treatment of Parkinson's Disease and Parkinson's Disease is a protected characteristic under Equality and Diversity legislation, a negative or positive decision could potentially impact on this patient group in a disproportionate manner to the general population. **(BCCG E and D Lead agrees).** Raised at meeting that approval could negatively impact on this patient group if they developed the symptoms of retinopathy etc.	**RN** **JP**

5.3	**Dementia Shared Care/Transfer of Care Guideline Update** The shared care guideline had been extended as agreed by the JPC at the April 2019 meeting, to include Lewy Body Dementia (LBD), Parkinson's Disease Dementia and Vascular Dementia in line with NICE Guidance. In addition LCCG had been consulted and it has been agreed that the document would be a joint Bedfordshire and Luton Document. The document had been shared with stakeholders, including a teleconference and ELFT Medicines Management Committee. The ELFT Medicines Management Committee were supportive of the draft document, provided that the LCCG commissioning position with respect to ELFT would be included (see below for more details). The main discussion points during the consultation phase were:- • GPs performing ECGs – it was discussed that while ELFT accept referrals for the vast majority of patients without an ECG, there may be instances (for a small number of patients) where an ECG is required. It was recognised that it can be difficult to undertake and interpret ECGs in primary care, hence the reason that this had not been included previously in the SCG as a primary care responsibility. During the teleconference, it was suggested that in the rare instances that a patient requires an ECG, the individual cases would be discussed between the ELFT Clinician and GP to reach an agreement. The JPC agreed to include undertaking an ECG as a GP responsibility for the rare instances that this was necessary where it was possible for the GP to facilitate. Where it was not possible for the GP to undertake the ECG, the responsibility would remain with the Specialist Service. Interpretation of the ECG would remain a Specialist responsibility. The SCG to be updated to include this information in both the GP and Specialist responsibilities sections. • The SCG reflects the current BCCG Commissioning Position with ELFT and is therefore subject to change depending on the outcome of discussions between ELFT and LCCG. RJ agreed to advise on the LCCG commissioning position (likely changes were around different recall time intervals, not to the clinical details) and the Committee agreed that the SCG could be updated to reflect this without returning to the Committee for approval.	**CP** **RJ/CP**

	• Noted that a sentence on P10 was incomplete – to be amended. With the above amendments (and inclusion of LCCG Commissioning position), the revised Shared Care Guideline was approved. **Equality and Diversity Impact Assessment -** No equality impact predicted. This document brings the shared care guideline into line with national guidance and current practice.	**CP**
5.4	**COPD inhaler review including proposed incorporation in the COPD Guidelines.** The guidelines have been reviewed and updated following the update of the NICE COPD Guideline to include triple therapy. The Committee was asked to note that the proposals included in this agenda item and agenda item 5.5 were consulted on with local Respiratory Specialists and other relevant and interested stakeholders prior to the meeting. **ICS Review Protocol** DW advised the Committee that this protocol, formerly called 'ICS Step-down Protocol' had been updated following the publication of the updated NICE Guidance, to include recommendations on triple therapy. The protocol had been renamed to reflect the fact that it may be necessary to 'step-up' and 'step-down' treatment. It has been updated at step 2 to include information on Smoking Cessation and consideration of physical and mental conditions which may impact on symptom control. In the 'Continue ICS therapy' box (step 3), the criteria for triple therapy has been included. The NICE conversion chart for equivalent steroid doses has been included but following the meeting, DW/MD had agreed to produce a conversion chart based on local Formulary choices and spacer combinations. This was to ensure that if patients were transferred from one inhaler to another, the steroid dose would be equivalent. A review date has been added for triple therapy use and also criteria for switching back to ICS/LABA. (The NICE Guidance states that patients in this group who don't respond with 3 months should be switched back to dual therapy – this recommendation was also supported by the local clinicians). A minor amendment relating to Fostair® dosing had been added to the flowchart. The Committee supported the revisions to the protocol. **COPD/ACO Guidelines** The section on triple therapy in the COPD/ACO Guidelines has been updated (P15 treatment algorithm) to include	**DW/MD**

	reference to the NICE Guidance and addition of Trelegy®- for confirmation (see below). NICE recommends 30mg of prednisolone daily for 5 days for prevention of exacerbations. DW advised that during the consultation, local respiratory experts had advised that they preferred to remain with current historic practice – 40 mg of prednisolone daily for 5 days. The Committee discussed this proposed deviation from NICE Guidance. It was noted that 40mg of prednisolone daily for 5 days was in line with BTS guidance. While there was a suggestion that dosage and duration of therapy should be left to the discretion of the clinician, it was agreed that as 'prepacks' of medication were produced, the guidelines needed to provide a set dose and duration of therapy. After some discussion, it was agreed that the local guidelines would reflect the NICE guidance with respect to dosage (30mg daily) but would allow flexibility in duration (5-7 days) as clinicians often reviewed patients at the 5 day point to decide whether or not they needed to continue.	
	With the above agreed amendments (and some minor formatting changes), the proposed update the COPD/ACO Guidelines were approved.	**DW**
	Trust Pharmacy representatives to action the change in prednisolone pre-packs required for 'out of hours' use.	**JP/MW/GMcG**
	New Medicines Review Bedford Hospital had received an application to include the Ellipta® range of inhalers to the Formulary. This included the following inhalers:- • Umeclidinium bromide (Incruse®Ellipta®) - **LAMA** • Umeclidinium bromide/vilanterol (Anora®Ellipta®) – **LAMA/LABA** • Fluticasone/vilanterol (Relvar®Ellipta® powder for inhalation) – **ICS/LABA** • Fluticasone/umeclidinium/vilanterol (Trelegy®92 microgram/55 microgam/22 microgram)- **ICS/LAMA/LABA (Triple therapy)** GMcG had produced reviews on all of the proposed new inhalers, updating the information to include the new clinical (and other) evidence (including changes to packaging to make the formulations safer to use) that had become available since the JPC had last considered (some of) this range of inhalers. The Committee was also presented with current (BLMK) usage data and costs to help inform changes to Formulary choices/ positioning. It was noted that Milton Keynes had recently approved addition of the Ellipta® range to their Formulary. The Committee was asked to discuss the following:-	

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	1) Whether to add the Ellipta® range of inhalers to the Formulary. 2) If added, where these should be positioned in relation to current treatment options? (Proposals were to include Incruse®Ellipta®as a first choice LAMA option; Anoro®Ellipta® as a second choice LAMA/LAMA option; Relvar®Ellipta® as a first choice ICS/LABA option; and Trelegy®92 microgram/55 microgram/22 microgram inhalation powder as first choice ICS/LABA/LAMA. 3) Which, if any, of current inhaler options could be removed from the Formulary. (GP representatives had previously advised {and it was confirmed that this was still the case}, that they wished to have relatively restricted range of products made available). The following discussion points were noted by the Committee:- • The teleconference supported the addition of the Ellipta® range. • This offered a range of inhalers with once daily administration. It was noted that while some patients preferred once daily administration, there was a cohort of patients who liked the reassurance provided by twice daily administration. It was noted, however, that there were enough formulary options to accommodate this patient choice. • Dr Bagmane advised that once daily dosing provided better FEV1 and symptom control than twice daily in patients with COPD. • With respect to LAMA choice. Tiotropium was first choice and the Braltus® inhaler needed to remain available as it was the most cost-effective in Primary Care and was included in CCG QIPP. Second line choices – feedback was divided – the BCCG respiratory lead GP proposed in advance of the meeting that Seebri®Breezhaler® was moved to joint first line (as glycopyrronium is a constituent of Trimbow®), while other views (borne out by usage and cost data) were that the inhaler that should be removed. • With respect to the LAMA/LABA combination inhaler, it was noted that despite the lack of use of Seebri®Breezhaler®as monotherapy, there was a reasonably high usage of the corresponding dual inhaler (Ultibro®Breezhaler®), but also high usage of the Duaklir®Genuair®. This may reflect the fact that the only (current) formulary choice of LABA/LAMA is Ultibro®Breezhaler® and while	

	clinicians may be happy to start patients on a twice daily LAMA, when a LAMA/LABA is prescribed, they move to a once daily preparation. There is also high usage of Duaklir®Genuair®, the only twice daily LABA/LAMA on the formulary but this may reflect the fact that this product was first to become available and usage of the once daily preparation (which became available later) has caught up. • The cost of Incruse®Ellipta® vs Seebri®Breezhaler® was the same as was the price of Ultibro®Breezhaler® vs Anora®Ellipta®. All were once daily preparations. • Milton Keynes formulary had the same range of inhalers on their formulary (except that they did not specify first and second line options), but had elected to add the Ellipta® range of inhalers without proposing the removal of any of the current options. • Dr Bagmane advised that he had received some patient feedback that Braltus® had not had the same clinical effect as Spiriva®. It was noted that while Spiriva® remained available on the formulary, it should be reserved (on the grounds of cost-effectiveness) for patients who did not respond to Braltus®. The Committee agreed to support the following:- • Addition of the Ellipta® range of inhalers (all once daily preparations). Placing in therapy as outlined below: • Umeclidinium bromide (Incruse®Ellipta®) for COPD – (LAMA) - 2nd choice option • Umeclidinium/vilanterol (Anora®Ellipta®) for COPD – (LAMA/LABA) – 2nd choice option • Fluticasone/vilanterol (Relvar®Ellipta® powder for inhalation) FOR COPD – (ICS/LABA) – 1st choice option • Agreed that the triple therapy option - Trelegy® would be a joint first line option (for COPD) alongside Trimbow® as it was similarly priced, but offered patient choice of device. • Removal of the Seebri®Breezhaler® and Ultibro®Breezhaler® (both once daily preparations) for new initiations. Patients currently on this treatment could continue to receive them. • This means that the formulary balance remains with respect to the availability of once and twice daily preparations.	

	• LABA/ICS combinations – all current options to remain available (with caveat that asthma patients should have a twice daily dosing preparation, except for the patient group outlined in agenda item 5.5), (It was raised at the meeting that all combinations would remain on the formulary as each device was different and catered for our current patient population and were all cost effective. Data on usage was therefore not required. The COPD Guidelines and Formulary to be updated to reflect the above decisions. DW agreed to advise the BCCG Respiratory Lead GP (who was unable to attend the meeting) of the JPC decision. The Committee thanked DW and GMcG for their hard work in producing the information for consideration and organisation of the teleconference. **Post meeting note**: DW discussed the committee decision with the BCCG Respiratory GP lead. The BCCG Respiratory GP lead supported the addition of the Ellipta range to the formulary. There was a concern raised that there is a genuine clinical and practical need for the Ultibro® breezhaler® (glycopyrronium based LAMA) to remain as a formulary choice as NICE guidance and the local ICS protocol supports use of triple therapy for patients with ICS+LABA. A 3 month trial of triple therapy would be the addition of a LAMA before consideration of a single therapy triple inhaler. The LAMA contained in Trimbow® is glycopyrronium. Therefore the option to trial the LAMA contained in Trimbow (glycopyrronium – Ultibro) is warranted. The BCCG Respiratory GP lead proposed that both inhaler therapies remained on the formulary for review in 12 months. Inclusion of these products for an additional year/ long term would be consistent with the range endorsed by MKCCG and promotion of an ICS standardised and consistent approach to patient choice of inhaler treatment options. The option to consider deprioritising Ultibro® Breezhaler® and Seebri® Breezhaler® (moving both inhaler therapies to third line, for review over the next 12 months) was also explored. Additional feedback was obtained from others. As a result of this, DW/JC discussed with the meeting chair and received chairman's action to retain the products on Formulary until the December meeting to enable a short further discussion under matters arising. **Equality and Diversity Impact Assessment -** The guidance for COPD is for adults and the condition affects	**DW/RN** **DW** **DW**

	adults only and the treatment to manage the condition are all licensed for adults. Th e national guidance has been issued by NICE, to assess the impact of the NICE recommendations on management locally we have actively engaged with the local respiratory teams as part of the consultation process. Alongside the update to guidance we have also reviewed our inhaler choices with regards to triple therapy inhalers. **(BCCG E & D Lead – no issue regarding EQIA).**	
5.5	**Fluticasone/vilanterol (Relvar®Ellipta®) for Asthma** GMcG had produced a review for consideration by the Committee. It was noted that we do not currently have a once daily preparation on the formulary for asthma. Relvar®Ellipta® is currently being used for this indication as GOSH recommend its use in difficult to control teenage patients who have been admitted to ITU as a result of loss of control of asthmatic symptoms. This is the patient group that Dr Adler (Consultant Paediatrician, the Luton & Dunstable Hospital) has requested Relvar® addition to the Formulary for the asthma indication. The Committee agreed to add Fluticasone / Vilanterol (Revlar®Ellipta®) to the formulary within its licensed indication for the following - • as an option for the treatment of asthma in young people who have 'difficult to control' asthma and who are under the care of a Specialist outreach team / tertiary centre. Asthma guidelines and formulary to be updated to reflect the above decision. **Equality and Diversity Impact Assessment – BCCG E and D Lead** – I think that this is quite a local decision. Technically of course if the consultant wants this and the decision is no, then patients are impacted. I don't have enough information to quantify the impact. **Author's response** - Thank you for forwarding the comments from E and D about the Relvar® review for asthma. If the committee chose not to approve it would then not be denying anyone treatment which is the key. We currently have other ICS/LABA combination inhalers on the formulary for prescribing in asthma. Equality and diversity is one aspect that the prescribing committee will take in to account when reviewing an application for a new drug to be added on to the formulary, in addition we will review the clinical evidence for the new drug together with	 **DW/RN**

	cost-effectiveness and safety information to enable us to come to a decision. In this situation as there are other ICS/LABA inhalers and there is no clear evidence to show that clinically Relvar® is significantly more effective than those options currently available I do not believe there will be a negative impact on patients if the committee were to reject the application. **BCCG E & D Lead -** Thank you, it is good to know other alternatives are available.	
5.6	**Inflammatory Bowel Disease Biologic Treatment Pathways** The biological treatment options for Inflammatory Bowel Disease had expanded greatly and as a result of this, it was agreed that production of pathways (similar to those for rheumatology and dermatology) would improve clarity for both providers and commissioners when considering high cost drug requests. Treatment pathways for Crohn's Disease (based on NICE and East of England Priorities Advisory Committee information) and Ulcerative Colitis (based on NICE Guidance) had been prepared in consultation with gastroenterologists from the Luton & Dunstable Hospital with input from the Bedford Hospital Gastroenterology teams and had been agreed. The Specialist teams had requested the inclusion of dose escalation within the Ulcerative Colitis Pathway and first line use of vedolizumab and been advised that these service developments would require the submission of a business case for consideration. The Committee supported the pathways as presented and thanked DW and AG and the Bedford Hospital and Luton & Dunstable Hospital Gastroenterology teams for their hard work in producing the pathways. **Equality and Diversity Impact Assessment -** Both pathways developed are in line with NICE recommendations and local policy ensures that patients have access to dose escalation which is a licensed indication for certain biologics for certain indications (infliximab and adalimumab). The pathways developed are for adults – patients 18 years if age and older – CCGs are the responsible commissioners for this indication. Children and adolescent use NHSE is the responsible commissioner and use for this cohort falls outside the commissioning and pathway scope for the CCGs. The pathways form part of the collective guidance with regards to the management of inflammatory bowel disease – the shared care guideline for	

	drugs used prior to biologics has been updated alongside the monitoring advice. The biologic treatment pathways are for use by the Trust specialist teams (no GP prescribing) as they are high cost specialist drugs not suitable for prescribing in primary care.	
5.7	**Inflammatory Bowel Disease SCGs (Update)** Full consideration of this item was deferred to the December 2019 as some late comments from the Specialists at the Luton & Dunstable Hospital had raised some issues that could require rewriting some parts of the document. The Committee were asked to comment on two main issues to be taken into consideration as part of the re-write:- 1) Separating GP monitoring and prescribing responsibilities. The Committee were largely in agreement that from a GP perspective, it was safer for the GP to undertake both monitoring and prescribing together. This was contrary to the views of the Luton & Dunstable Hospital Gastroenterologists. 2) Given that the Trusts were due to merge, would it be better to put the Bedford Hospital and Luton & Dunstable Hospital Shared Care Guidelines back to one document (they had been separated to aid clarity)? The Committee felt that as it was likely to be more than 18 months before the merger was complete (at which time these guidelines, and others, would need to be reviewed), the documents could remain separate and therefore the 'rewrite' would only be potentially needed for the Luton & Dunstable Hospital document. The Committee agreed, that a working group needed to be set up to revise the Luton & Dunstable Hospital part of the SCG. MC, AG, SMcG, JP and KR agreed to work with the Gastroenterology team at the Luton & Dunstable Hospital. (Also LCCG Gastroenterology Lead GP Hetal Telati- AG to provide email contact details – action completed). SMcG to set up working group, arrange meeting and provide an updated document to the December 2019 JPC meeting. **Equality and Diversity Impact Assessment -** Both azathioprine and mercaptopurine are accepted treatment options for IBD. (**BCCG E and D Lead -** Existing SCGs which have been updated but no change to the drugs being prescribed – no EQIA required).	**SMcG**
5.8	**Items which should not be routinely prescribed** NHSE/NHS Improvement has just published an update (June 2019) to this guidance (first published in November	

	2017). https://www.england.nhs.uk/wp-content/uploads/2019/08/items-which-should-not-routinely-be-prescribed-in-primary-care-v2.1.pdf The guidance is aimed at Clinical Commissioning Groups to support them to fulfil their duties around appropriate use of their resources. CCGs are therefore expected to take account of the guidance in formulating local policies. The Committee considered a paper which provided a summary of the June 2019 updates to the guidance with proposed required actions for JPC implementation only. It was noted that BCCG and LCCG Medicines Optimisation Teams were taking additional actions as appropriate. Two major areas of prescribing were considered:- **Bath and shower preparations for dry and pruritic skin conditions** The national recommendations were:- • Advise CCGs that prescribers in primary care should not initiate bath and shower preparations for any new patient. • Advise CCGs to support prescribers in deprescribing bath and shower preparations in this category and substitute with "leave-on" emollients and, where appropriate, to ensure the availability of relevant services to facilitate this change. The Committee was asked to consider the proposed options:- 1) Remove products from the Joint Formulary. “Leave-on” emollients to be used instead. OR 2) Retain products on the formulary for Hospital use only. Patients to be advised that these products will be ‘self-care’ (no GP prescribing) only in Primary Care. GPs will substitute “leave on” emollients, if appropriate. The limited feedback from the consultation (paediatrics and dermatology specialists) indicated that specialists were generally supportive of option 1. The Committee discussed the options and the following key points were raised:- • Hospital pharmacy representatives advised that while they could ‘block’ prescriptions at discharge (if option 2 is supported), many of these prescriptions were either generated via the FP10 (HP) route, or indeed via a GP letter requesting that GPs initiate treatment. • Evidence is lacking that these products worked – hence the national guidance.	

The Committee agreed to support option 1 above i.e. remove Bath and shower preparations for dry and pruritic skin conditions products from the Joint Formulary. "Leave-on" emollients to be used instead.
Additional agreed actions:-

- Add patient information leaflet (contained in the national document) to NetFormulary.
- Hospital Pharmacy colleagues to monitor FP10 (HP) prescribing with respect to these products.

Needles for Pre-Filled and Reusable Insulin Pens

The national recommendations were:-

- Advise CCGs that prescribers in primary care should not initiate insulin pen needles that cost >£5 per 100 needles for any diabetes patient.
- Advise CCGs to support prescribers in deprescribing insulin pen needles that cost >£5 per 100 needles and, where appropriate ensure the availability of relevant services to facilitate this change.

The specialist diabetology teams consulted on the following:-

1) Review of the Formulary to remove insulin pen needles that cost > £5 per 100 needles (all <£5 per 100 needles to be made available).**The specialist diabetology teams were supportive of this approach.**
2) Needle length – should needles of 8mm and 12mm length be excluded from the Formulary for safety reasons? (Needles of 4, 5 and 6mm length to be the Formulary choices). **The specialist diabetology teams were supportive of this approach.**
3) Safety Needles – Do the Specialist teams recommend use of these needles to anyone other than health care professionals? The CCGs are seeing a growing number of family members requesting and using safety needles. Would it be reasonable to switch these patients back to 'normal' needles? If safety needles are required – can we add the most cost-effective choice (GlucoRx) to the Formulary. **Feedback from the Specialist Diabetology Teams was that there was a small restricted group of patients that required safety needles i.e. patients who were unable to inject their own insulin and relied on carers to undertake this task e.g. young children at school**

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	where teaching staff injected them with insulin. The Luton & Dunstable Hospital Diabetes team had trialled the GlucoRx safety needle but found that it was unacceptable from a quality perspective. They and the Bedford Hospital diabetes team preferred using the Autoshield safety needle – the most expensive of the three safety needles currently available on the market. The Committee discussed the paper and the above feedback from the specialist Diabetes teams. • RF advised that the Luton & Dunstable Hospital Specialist Diabetes Teams often asked for safety needles to be prescribed when District Nurses administered insulin to patients. It was noted that the organisation administering insulin to these patients (in this case CCS) were responsible for purchasing the safety needles and that it was inappropriate for GPs to undertake prescribing in this situation. JC agreed to reiterate this to both Bedford Hospital and the Luton & Dunstable Hospital specialist Diabetes teams. RF agreed to follow up re Governance within CCS. The Committee agreed to support the following:- 1) To remove insulin pen needles that cost > £5 per 100 needles (all <£5 per 100 needles to be made available). 2) Needles of 4, 5 and 6mm length **only** to be the Formulary choices. 3) Safety Needles to be made available by GP prescription **only** for patients who cannot self-inject and require a carer (not a healthcare professional) to administer the insulin. (This information to be specified within NetFormulary). It was further agreed that the Specialist Diabetes Teams would be contacted to ask if they could trial the second most cost-effective safety needle. **Equality and Diversity Impact Assessment -** There may be an impact on patients (including children) with diabetes and long term skin conditions, however, as these recommendations have been produced nationally, following extensive consultation with members of the public, patients and their representative groups, NHS staff, various Royal Colleges and the pharmaceutical industry, there should be no need for further local consultation/assessment. Indeed, one of the objectives of	**JC** **RF** **RN** **RN** **RN** **JC**

	producing this guidance nationally was to reduce duplication and postcode prescribing. **BCCG E and D Lead –** It is clear that this is nationally driven. My only question is what option is there for managing exceptions. I don't see the value in doing an EQIA on a national decision which has already been subject to consideration. What I would like to see is the way someone whose individual circumstances does need one of these would be helped. I think this means that an assurance of that and an explanation needs to be included in the document. **JPC Secretary response:-** Formularies cover 80 to 90% of prescribing. If there is a genuine need identified for an exceptional case, prescribers can prescribe outside of the Formulary. This information will be added to the document. **Post meeting-** the following information was received from the **LCCG E and D Lead:-** If there is a potential negative impact on children (age), an impact assessment is required to highlight what the impact is, what is proposed and what (if any) mitigation is available. **JPC Secretary response –** There will be an impact (to all patients) who are currently receiving prescriptions for bath and shower preparations for dry and pruritic skin conditions, in that these will no longer be prescribed. National guidance is however that 'leave on' emollients are the preferred clinical treatment option and these may still be prescribed. **Post meeting note:-** The paper contained the following information with respect to **amiodarone prescribing**:- National Recommendations:- • Advise CCGs that prescribers should not initiate amiodarone in primary care for any new patient. • Advise CCGs that if, in exceptional circumstances, there is a clinical need for amiodarone to be prescribed, this should be undertaken in a cooperation arrangement with a multi-disciplinary team and/or other healthcare professional. Proposed Actions JPC Actions:- • Recommendations outlined above are supported. • Develop formal shared care guidelines with cardiologists, if appropriate, after the results of the BCCG audit of use and monitoring is complete and has been reported and change formulary status of tablets to amber with shared care. Following the JPC meeting, the BCCG Medicines Optimisation Team advised that the results of the audit indicated that a formal shared care guideline needed to be	**JC** **MD**

	developed. This work would be undertaken and presented to a future JPC meeting for consideration.	
5.9	**Melatonin – Choice of Preparation** A number of new melatonin preparations have been licensed in the last few months which necessitated a review of current recommendations on the choice of melatonin preparation. The paper was discussed (focussing on Slenyto®) and the following key points raised:- • Slenyto® is a licensed preparation manufactured by the same pharmaceutical company that makes Circadin®. • Slenyto® is much more expensive that Circadin®. • The Scottish Medicines Consortium (SMC) has recently 'not recommended' the use of Slenyto® stating that 'The submitting company's justification of the treatment's cost in relation to its health benefits was not sufficient and in addition the company did not present a sufficiently robust clinical and economic analysis to gain acceptance by SMC.' The license holder has indicated their intention to resubmit. • For existing patients, the decision to switch a patient would need to be made on a 'case by case' basis acknowledging that changing medication in this patient group could be challenging. • For new patients Slenyto® could be considered as a joint first line treatment option alongside Circadin®. This was likely to be the stance of ELFT. (A Slenyto® review was being prepared with an update the melatonin shared care guideline). • Should the use of melatonin now be reconsidered as the licensed product costs shift in the direction of not being cost-effective, given the evidence base? In summary, the Committee was not convinced by the cost-effectiveness of Slenyto® but was aware of medico/legal issues and needed further consideration of the risks associated with not approving versus the costs to the Health Economy of not approving it. The Committee therefore agreed to defer the decision and to seek a legal opinion and a commissioning position. **Equality and Diversity Impact Assessment -** These formulations are for use in children and adolescents in accordance with the current approved shared care guideline. Provision is made for patients with disabilities e.g. swallowing difficulties within the recommendations and a range of options offered. (**BCCG E and D Lead -** I think	**RJ**

	that this is regarded as a technical change and therefore no EQIA required).	
6	**NICE Guidance**	
6.1	**NICE Guidance Summary – Published Guidance – from 6th June – 4th September 2019 inclusive** **The following NICE Technology Appraisal Guidance (CCG Commissioned) have been published:-** **Fluocinolone acetonide intravitreal implant for treating recurrent non-infectious uvetitis, Technology appraisal guidance [TA590] Published date: 31 July 2019** **https://www.nice.org.uk/guidance/ta590** **No significant resource impact is anticipated** NICE does not expect this guidance to have a significant impact on resources; that is, the resource impact of implementing the recommendations will be less than £5 million per year in England (or £9,000 per 100,000 population). This is because the technology is a further treatment option and the overall cost of treatment will be similar. **JPC Action – Added to Joint Formulary; Update Ophthalmology Pathway** **Risankizumab for treating moderate to severe plaque psoriasis, Technology appraisal guidance [TA596] Published date: 21 August 2019,** **https://www.nice.org.uk/guidance/ta596** **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 £9,000 per 100,000 population). This is because the technology is a further treatment option and is available at a similar price. Risankizumab has a discount that is commercial in confidence. For enquiries about the patient access scheme please contact pricing@abbvie.com. **JPC Action – added to Formulary and Severe Psoriasis Pathway. (NB – 30 day implementation)** **Dapagliflozin with insulin for treating type 1 diabetes Technology appraisal guidance [TA597] Published date: 28 August 2019.** **https://www.nice.org.uk/guidance/ta597** It is estimated that the total cost of implementing the guidance (at the end of a 5 year period) will be **£27,000 for BCCG and £12,000 for LCCG.** **JPC Action – NICE link added to the Formulary.**	 **JC**

	Sodium zirconium cyclosilicate for treating hyperkalaemia **Technology appraisal guidance [TA599] Published date: 04 September 2019** **https://www.nice.org.uk/guidance/ta599** NICE Estimate that this drug will be used to treat 1,630 people nationally in 2019/20 rising to 8,170 by 2023/24. **JPC Action – added to the Formulary. The Committee agreed to retain the current 'red' Formulary traffic light status.** **Post meeting note:-** The PAS price is now available. The total impact/100,000 population of implementing the guidance is £20,243. The impact has been expressed in this way as the drug is not payment by results excluded and therefore the cost of implementing fall to each Provider Trust. **The following NICE Guidelines (Medicine related and CCG Commissioned) have been published/updated and were noted for information and action as appropriate:-**	

	Hypertension in pregnancy: diagnosis and management, NICE guideline [NG133] Published date: June 2019 https://www.nice.org.uk/guidance/ng133 This guideline covers diagnosing and managing hypertension (high blood pressure), including pre-eclampsia, during pregnancy, labour and birth. It also includes advice for women with hypertension who wish to conceive and women who have had a pregnancy complicated by hypertension. It aims to improve care during pregnancy, labour and birth for women and their babies. Depression in children and young people: identification and management, NICE guideline [NG134] Published date: June 2019 https://www.nice.org.uk/guidance/ng134 This guideline covers identifying and managing depression in children and young people aged 5 to 18 years. Based on the stepped-care model, it aims to improve recognition and assessment and promote effective treatments for mild and moderate to severe depression. Urinary incontinence and pelvic organ prolapse in women: management, NICE guideline [NG123] Published date: April 2019 Last updated: June 2019. https://www.nice.org.uk/guidance/ng123 In June 2019, we withdrew recommendations 1.8.21 and 1.8.22 on the use of synthetic polypropylene or biological mesh insertion for women with recurrent anterior vaginal wall prolapse. We have replaced them with a link to the NICE interventional procedures guidance on transvaginal mesh repair of anterior or posterior vaginal wall prolapse. For further details see update information. Long-acting reversible contraception Clinical guideline [CG30] Published date: October 2005 Last updated: July 2019 https://www.nice.org.uk/guidance/cg30 This guideline covers long-acting reversible contraception. It aims to increase the use of long-action reversible contraception by improving the information given to women about their contraceptive choices. In March 2019 we revised our decision on how to implement the recommendations of our October 2017 review. Although no new evidence was identified, we noted significant changes in how we commission and provide contraceptive services in England. We have removed the recommendations in this guideline that no longer fit with current practice. There are also many new LARC products now available. See our long-acting reversible	

	contraception: implementation resource summary for links to the latest information. Chronic obstructive pulmonary disease in over 16s: diagnosis and management, NICE guideline [NG115] Published date: December 2018 Last updated: July 2019, https://www.nice.org.uk/guidance/ng115 This guideline covers diagnosing and managing chronic obstructive pulmonary disease or COPD (which includes emphysema and chronic bronchitis) in people aged 16 and older. It aims to help people with COPD to receive a diagnosis earlier so that they can benefit from treatments to reduce symptoms, improve quality of life and keep them healthy for longer. In July 2019, NICE reviewed the evidence and made new recommendations on: • inhaled triple therapy for stable COPD • systemic corticosteroids for managing exacerbations **JPC Action – review of Bedfordshire and Luton COPD Guideline – agenda item 5.3** Motor neurone disease: assessment and management, NICE guideline [NG42] Published date: February 2016 Last updated: July 2019 https://www.nice.org.uk/guidance/ng42 This guideline covers assessing and managing motor neurone disease (MND). It aims to improve care from the time of diagnosis, and covers information and support, organisation of care, managing symptoms and preparing for end of life care. **MHRA advice on gabapentin:** In July 2019 we added a footnote to this guideline to reflect a change in the law relating to gabapentin. As of 1 April 2019, because of a risk of abuse and dependence gabapentin is controlled under the Misuse of Drugs Act 1971 as a class C substance and is scheduled under the Misuse of Drugs Regulations 2001 as schedule 3. Neuropathic pain in adults: pharmacological management in non-specialist settings, Clinical guideline [CG173] Published date: November 2013 Last updated: July 2019. https://www.nice.org.uk/guidance/cg173 This guideline covers managing neuropathic pain (nerve pain) with pharmacological treatments (drugs) in adults in non-specialist settings. It aims to improve quality of life for people with conditions such as neuralgia, shingles and diabetic neuropathy by reducing pain and promoting increased participation in all aspects of daily living. The	

	guideline sets out how drug treatments for neuropathic pain differ from traditional pain management. **MHRA advice on pregabalin and gabapentin:** In July 2019 NICE updated footnotes in this guideline to reflect a change in the law relating to pregabalin and gabapentin. As of 1 April 2019, because of a risk of abuse and dependence pregabalin and gabapentin are controlled under the Misuse of Drugs Act 1971 as class C substances and scheduled under the Misuse of Drugs Regulations 2001 as schedule 3. Multiple sclerosis in adults: management, Clinical guideline [CG186] Published date: October 2014 Last updated: July 2019 https://www.nice.org.uk/guidance/cg186 In July 2019, NICE updated a footnote in this guideline to reflect a change in the law relating to gabapentin. As of 1 April 2019, because of a risk of abuse and dependence gabapentin is controlled under the Misuse of Drugs Act 1971 as a class C substance and scheduled under the Misuse of Drugs Regulations 2001 as schedule 3. Generalised anxiety disorder and panic disorder in adults: management, Clinical guideline [CG113] Published date: January 2011 Last updated: July 2019. https://www.nice.org.uk/guidance/cg113 In July 2019, NICE updated footnotes and tables in this guideline to reflect a change in the law relating to pregabalin and gabapentin. As of 1 April 2019, because of a risk of abuse and dependence pregabalin and gabapentin are controlled under the Misuse of Drugs Act 1971 as class C substances and scheduled under the Misuse of Drugs Regulations 2001 as schedule 3. Venous thromboembolism in over 16s: reducing the risk of hospital-acquired deep vein thrombosis or pulmonary embolism NICE guideline [NG89] Published date: March 2018 Last updated: August 2019, https://www.nice.org.uk/guidance/ng89 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. In August 2019, we amended our recommendation on mechanical VTE prophylaxis for people with spinal injury to clarify when anti-embolism stockings can be used.	

	Hypertension in adults: diagnosis and management, NICE guideline [NG136] Published date: August 2019. https://www.nice.org.uk/guidance/ng136 This guideline covers identifying and treating primary hypertension (high blood pressure) in people aged 18 and over, including people with type 2 diabetes. It aims to reduce the risk of cardiovascular problems such as heart attacks and strokes by helping healthcare professionals to diagnose hypertension accurately and treat it effectively. NICE has also produced a guideline on hypertension in pregnancy. **Recommendations** This guideline includes new and updated recommendations on: • diagnosing hypertension • starting antihypertensive drug treatment • monitoring treatment and blood pressure targets • choosing antihypertensive drug treatment (treatment steps 1 to 4) • who to refer for same-day specialist review It also includes unchanged recommendations on: • measuring blood pressure • assessing cardiovascular risk and target organ damage • lifestyle interventions See 2 page visual summary of diagnosis and treatment of hypertension:- https://www.nice.org.uk/guidance/ng136/resources/visual-summary-pdf-6899919517 Key Messages:- 1) Diagnosing hypertension a. CV risk assessment – lower risk patients now have treatment options b. Clarification of blood pressure monitoring 2) Starting antihypertensive drug treatment a. Patient decision aid to help discussions and decisions b. Monotherapy as initial option for all 3) Monitoring treatment and blood pressure targets a. Emphasis on maintaining blood pressure below target 4) Choosing antihypertensive drug treatment (treatment steps 1 to 4) a. Minor changes in drug options 5) Who to refer for same-day specialist review. Type 2 diabetes in adults: management, NICE guideline [NG28] Published date: December 2015 Last updated: August 2019. https://www.nice.org.uk/guidance/ng28	

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	This guideline covers the care and management of type 2 diabetes in adults (aged 18 and over). It focuses on patient education, dietary advice, managing cardiovascular risk, managing blood glucose levels, and identifying and managing long-term complications. In August 2019, the recommendations on blood pressure management were updated and replaced by recommendations in the NICE guideline on hypertension in adults (see update information for further details). **The following Diagnostics guidance has been published:** **Therapeutic monitoring of TNF-alpha inhibitors in rheumatoid arthritis, Diagnostics guidance [DG36]** **Published date: July 2019** https://www.nice.org.uk/guidance/dg36 Recommendations:- 1.1 Enzyme-linked immunosorbent assay (ELISA) tests for therapeutic monitoring of tumour necrosis factor (TNF)-alpha inhibitors (drug serum levels and antidrug antibodies) show promise but there is currently insufficient evidence to recommend their routine adoption in rheumatoid arthritis. The ELISA tests covered by this guidance are Promonitor, IDKmonitor, LISA-TRACKER, RIDASCREEN, MabTrack, and tests used by Sanquin Diagnostic Services. 1.2 Laboratories currently using ELISA tests for therapeutic monitoring of TNF-alpha inhibitors in rheumatoid arthritis should do so as part of research and further data collection (see section 5.22). 1.3 Further research is recommended on the clinical effectiveness of using ELISA tests for therapeutic monitoring of TNF-alpha inhibitors in rheumatoid arthritis (see sections 5.23, and 6.1 and 6.2). **Local rheumatologists have confirmed that they do not currently undertake therapeutic drug monitoring for TNF alpha inhibitors and therefore their practice is in line with the NICE Diagnostic Guidance outlined above.** **The following NICE TA's are the commissioning responsibility of NHSE and are listed for information only.** Ocrelizumab for treating primary progressive multiple sclerosis, Technology appraisal guidance [TA585] Published date: 12 June 2019 https://www.nice.org.uk/guidance/ta585 - **Recommended (Added to Formulary)**	

	Lenalidomide plus dexamethasone for multiple myeloma after 1 treatment with bortezomib, Technology appraisal guidance [TA586] Published date: 26 June 2019. https://www.nice.org.uk/guidance/ta586 - **Recommended (Added to Formulary)** Lenalidomide plus dexamethasone for previously untreated multiple myeloma, Technology appraisal guidance [TA587] Published date: 26 June 2019. https://www.nice.org.uk/guidance/ta587 - **Recommended (Added to Formulary)** Lenalidomide for treating myelodysplastic syndromes associated with an isolated deletion 5q cytogenetic abnormality Technology appraisal guidance [TA322] Published date: 24 September 2014 Last updated: 26 June 2019. https://www.nice.org.uk/guidance/ta322 - **June 2019:** Sections 1 and 2 updated to include a new commercial arrangement. Standard text in implementation section updated**. - Recommended (Added to Formulary)** Lenalidomide for the treatment of multiple myeloma in people who have received at least 2 prior therapies Technology appraisal guidance [TA171] Published date: 18 June 2009 Last updated: 26 June 2019. https://www.nice.org.uk/guidance/ta171 **June 2019:** Sections 1 and 2 updated to include a new commercial arrangement. Standard text in implementation section updated**.- Recommended (Added to Formulary)** Nusinersen for treating spinal muscular atrophy, Technology appraisal guidance [TA588], Published date: 24 July 2019 https://www.nice.org.uk/guidance/ta588 - **Recommended (Not added to Formulary as neither the L&D nor BHT are on the NHSE list for provision of this highly specialised service)** Blinatumomab for treating acute lymphoblastic leukaemia in remission with minimal residual disease activity Technology appraisal guidance [TA589] Published date: 24 July 2019, https://www.nice.org.uk/guidance/ta589 - **Recommended (Added to Formulary)** Letermovir for preventing cytomegalovirus disease after a stem cell transplant, Technology appraisal guidance [TA591] Published date: 31 July 2019, https://www.nice.org.uk/guidance/ta591 - **Recommended (Added to Formulary)**	

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	Cemiplimab for treating metastatic or locally advanced cutaneous squamous cell carcinoma Technology appraisal guidance [TA592] Published date: 07 August 2019, https://www.nice.org.uk/guidance/ta592 - **Recommended - Cancer Drugs Fund (Added to the Formulary)** Ribociclib with fulvestrant for treating hormone receptor-positive, HER2-negative, advanced breast cancer Technology appraisal guidance [TA593] Published date: 14 August 2019**,** **https://www.nice.org.uk/guidance/ta593/chapter/1-Recommendations - Cancer Drugs Fund (Added to Formulary)** Brentuximab vedotin for untreated advanced Hodgkin lymphoma (terminated appraisal) Technology appraisal [TA594] Published date: 14 August 2019, https://www.nice.org.uk/guidance/ta594 - **Terminated Appraisal - treated as negative appraisal – not added to the Formulary.** Dacomitinib for untreated EGFR mutation-positive non-small-cell lung cancer, Technology appraisal guidance [TA595] Published date: 14 August 2019, https://www.nice.org.uk/guidance/ta595 - **Recommended - Added to Formulary** Patisiran for treating hereditary transthyretin amyloidosis, **Highly specialised technologies guidance** [HST10] Published date: 14 August 2019, https://www.nice.org.uk/guidance/hst10/chapter/1-Recommendations - **Recommended - Not added to Formulary as unlikely to be used locally as the treatment of amyloidosis is a highly specialised service.** Olaparib for maintenance treatment of BRCA mutation-positive advanced ovarian, fallopian tube or peritoneal cancer after response to first-line platinum-based chemotherapy. https://www.nice.org.uk/guidance/ta598 - **Recommended - Cancer Drugs Fund – Added to Formulary.**	
6.2	**NICE Guidance Summary – Anticipated Guidance – September – December 2019.** The Committee noted this paper for information.	
7	**Virtual Recommendations/Documents – for discussion/ratification:-**	

NHS

7.1	**Drug Monitoring for Aminosalicylates in IBS in Primary Care (Update)** The Committee had supported this paper with the exception of one comment. The Luton & Dunstable Hospital Clinicians had asked that Full Blood Count (FBC) be added to the mesalazine monitoring. JF had asked, during the Consultation whether the GP action with respect to mesalazine should therefore mirror that of sulphasalazine. Advice on this had been requested several times from the Specialist Gastroenterology teams but no response had been received. The Committee agreed that the Drug Monitoring Fact sheet should be updated to include this information and with this amendment the revised fact sheet was approved. **Equality and Diversity Impact Assessment -** Not completed or required as by definition, only non-controversial items are submitted to the Committee for virtual approval.	**RN**
7.2	**Lanthanum and Sevelamer SCGs** These shared care guidelines are produced by the renal unit and East and North Herts Trust and ratified for use locally by the JPC. The updated versions of the documents were ratified by the Committee. **Equality and Diversity Impact Assessment -** Not completed or required as by definition, only non-controversial items are submitted to the Committee for virtual approval.	
8	**Drug Safety Updates – June, July, August 2019 and HRT paper.** The following Drug Safety Updates came to the Committee for information. **June 2019** https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/810191/June-2019-DSU-PDF.pdf • Direct-acting oral anticoagulants (DOACs): increased risk of recurrent thrombotic events in patients with antiphospholipid syndrome • GLP-1 receptor agonists: reports of diabetic ketoacidosis when concomitant insulin was rapidly reduced or discontinued • Lartruvo▼ (olaratumab): withdrawal of the EU marketing authorisation due to lack of efficacy • Oral retinoid medicines▼: revised and simplified pregnancy prevention educational materials for healthcare professionals and women	

NHS

	July 2019 DSU https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/818083/July-2019-PDF.pdf • Febuxostat (Adenuric): increased risk of cardiovascular death and all-cause mortality in clinical trial in patients with a history of major cardiovascular disease **comment:** message added to Scriptswitch • Tocilizumab (RoActemra): rare risk of serious liver injury including cases requiring transplantation • Rivaroxaban (Xarelto▼): reminder that 15 mg and 20 mg tablets should be taken with food **comment:** message added to Scriptswitch **August 2019 DSU** https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/826120/Aug-2019-PDF.pdf • Daratumumab (Darzalex▼): risk of reactivation of hepatitis B virus • Naltrexone/bupropion (Mysimba▼): risk of adverse reactions that could affect ability to drive • Carfilzomib (Kyprolis▼): reminder of risk of potentially fatal cardiac events **MHRA Drug Safety Update** **Article published 30 August 2019, in advance of the next issue of Drug Safety Update** **Hormone replacement therapy (HRT): further information on the known increased risk of breast cancer with HRT and its persistence after stopping** New data have confirmed that the risk of breast cancer is increased during use of all types of HRT, except vaginal estrogens, and have also shown that an excess risk of breast cancer persists for longer after stopping HRT than previously thought. Prescribers of HRT should discuss the updated total risk with women using HRT at their next routine appointment. https://www.gov.uk/drug-safety-update/hormone-replacement-therapy-hrt-further-information-on-the-known-increased-risk-of-breast-cancer-with-hrt-and-its-persistence-after-stopping The Committee was also advised that organisations who issue Safety Alerts were now going through an accreditation programme to ensure consistency of provision of information.	

9	**Formulary Update** The following information came to the Committee for information and/or ratification:- **DTC decisions noted for information** **Letrozole:** approved for off label use in polycystic ovary syndrome at L and D hospital DTC in July 2019 – **Hospital only** **Trometamol (THAM):** retrospective addition at L and D hospital DTC in July 2019, kept in emergency drug room for metabolic acidosis in paediatrics under the advice of a tertiary centre – **Hospital only** **Cetraxel Plus ® (ciprofloxacin and fluocinolone acetonide):** for treatment of otitis externa and otitis media approved by Bedford Hospital DTC – **Hospital only** **Items agreed virtually by the Formulary Group** **Biktarvy® (Bictegravir-emtricitabine-tenofovir alafenamide (B/F/TAF))** - for treating Human immunodeficiency virus-1 (HIV-1) in adults. Commissioned by NHSE **Other items:-** • Testosterone – **products have been added to the formulary in line with gender dysphoria SCG and status changed to amber** • Lanreotide – **RAG status amended to amber** • GLP1s – **formulary updated - Exenetide twice daily (Byetta) and Lixisenatide non-formulary. Semaglutide added to formulary as second choice product.** • Rasagaline- Formulary Submission to JPC - **Proposal is that an agreement in principle from JPC, an application will follow if proposal accepted. (see agenda item 5.2 for more information)** **For information** • Sun creams – **updated prescribing criteria added (to note)** • Degaralix – **changed to Amber done (for note)** Menopur – **to add the multidose formulation**. JP confimed that this was approved at L&D September DTC meeting.	

	Olaratumab – Marketing Authorisation withdrawn. **To be made non formulary with a note to cover historic prescribing** **No formulary additions or amendments to note from the BCCG or LCCG Prescribing Committees.** **Proposal to JPC – Formulary Subgroup – formally reporting in to the JPC** JC proposed that the Joint Formulary Working Group was made a formal subgroup of the JPC to ensure appropriate Governance for the group. The Committee supported this and it was agreed that Formal Terms of Reference would be developed for the Formulary Working Group and that the JPC Terms of Reference would be updated if necessary.	**RN/JC**
10	**East of England Priorities Advisory Committee (PAC) – items for noting.**	3.50 pm
10.1	**Draft PAC Minutes - May 2019** The Committee noted the minutes for information.	
10.2	**Doxylamine succinate and pyridoxine for nausea and vomiting in pregnancy.** The Committee ratified the EoEPAC Bulletin and recommendations and agreed that product and link to EoEPAC bulletin would be added to the Joint Formulary as a 'Non-Formulary' item. Although no interest had been expressed by local clinicians during the consultation period, GMcG advised that there may now be some interest as ondansetron was now no longer recommended in the first trimester of pregnancy. It was agreed that the Committee would await a Formulary request as it was noted that the trial evidence base for the product was not for the severe form (hyperemesis) of nausea and vomiting in pregnancy. **Equality and Diversity Impact Assessment - BCCG E and D -** Only coming for ratification and therefore it is difficult to make meaningful considerations. It comes back to the question – will this negatively impact on patients? **JPC Secretary response -** There are alternative treatments available which have been used for many years and there was no clinician interest during multiple consultations.(But see above – JPC to re-review if requested)	**SMcG/RN**
11	**Bedfordshire Local Prescribing Committee Minutes for information**	
11.1	**Minutes from the Luton and Dunstable Hospital DTC meeting – June 2019**	

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11.2	**Minutes of the Bedford Hospital DTC meeting – July 2019**	
11.3	**ELFT Medicines Management Committee Minutes (Mental Health) – March 2019**	
11.4	**Minutes of Circle/MSK MMC Meeting – April 2019**	
11.5	**Minutes of the Bedfordshire and Luton Wound Management Formulary Steering Group – July 2019**	
11.6	**Minutes of the Cambridgeshire Community Services Medication Safety and Governance Group March and May 2019**	
12	**Additional Documents for information/approval**	
12.1	**RMOC Liothyronine Bulletin Update – for decision**. The Secretary advised the Committee that there had been a minor update to the RMOC bulletin, in that it was no longer advised that GPs 'de-prescribed' liothyronine without support from Specialist Teams and was seeking the views of the Committee on whether the current JPC recommendations (based on EoEPAC recommendations) should be amended to reflect this. The new RMOC Guidance states that 'The withdrawal or adjustment of liothyronine should only be undertaken by, or with the oversight of, an NHS consultant endocrinologist. Where General Practitioners (GPs) are involved in such treatment changes, this should be with NHS consultant endocrinologist support. This advice applies to both liothyronine monotherapy and combination therapy with levothyroxine.' GP representatives advised that in practice they were withdrawing liothyronine without specialist input. It was therefore agreed that the liothyronine recommendations should remain unchanged. RJ reiterated LCCG position – no GP prescribing and repatriation of patients. It was noted that some of the historical patients were from private sector not current NHS services **Equality and Diversity Impact Assessment -** Not assessed – very minor update to recommendations for consideration.	
12.2	**RMOC Update** The Committee was asked to note for information, the following documents that have been issued by RMOCs since the papers for the June JPC meeting were circulated:- Regional Medicines Optimisation Committee Newsletter Issue 5 2019 Rarely Used and Urgent Medicines List	

	This position statement and user guide have been approved by RMOC (London). The position statement includes a list of Rarely Used and Urgent Medicines. The list indicates which medicines should be stocked locally, and which could be obtained via other methods when the need arises. There is a "How To" guide to support pharmacy staff to access Rx-info's Define system in order to identify which local Trusts have recently issued medicines included in this list. RMOC briefing on adalimumab - July 2019 Biosimilar versions of the original biological medicine adalim Humira®) have been introduced in the NHS as part of a forr agreement dated 1 December 2018, after the patent for Hu October 2018. This briefing provides important details for o implementation of best value adalimumab products. Regional Medicines Optimisation Committee Newsletter Issue 6 2019	
13	**Any other Business** • **Change in venue for 2020 JPC Meetings** The 2020 JPC meetings would be held in room 130 in Enterprise House (next building to Endeavour House).	
14	**Dates of future 2019 meetings - all at Endeavour House (Building 50), Wrest Park, Silsoe, Bedfordshire, MK45 4HS.** • **Wednesday 4th December 2019** **Confirmed 2020 JPC Meeting Dates, to be held at Enterprise House (Room 130), Wrest Park, Silsoe, Bedfordshire, MK45 4HS:-** • **Wednesday 26th February 2020** • **Wednesday 29th April 2020** • **Wednesday 1st July 2020** • **Wednesday 23rd September 2020** • **Wednesday 2nd December 2020**	

Please inform Jacqueline Clayton of any apologies on 01525 624382 or email Jacqueline.clayton@nhs.net
Circulation: JPC Members, BCCG Medicines Optimisation Team (not JPC members)

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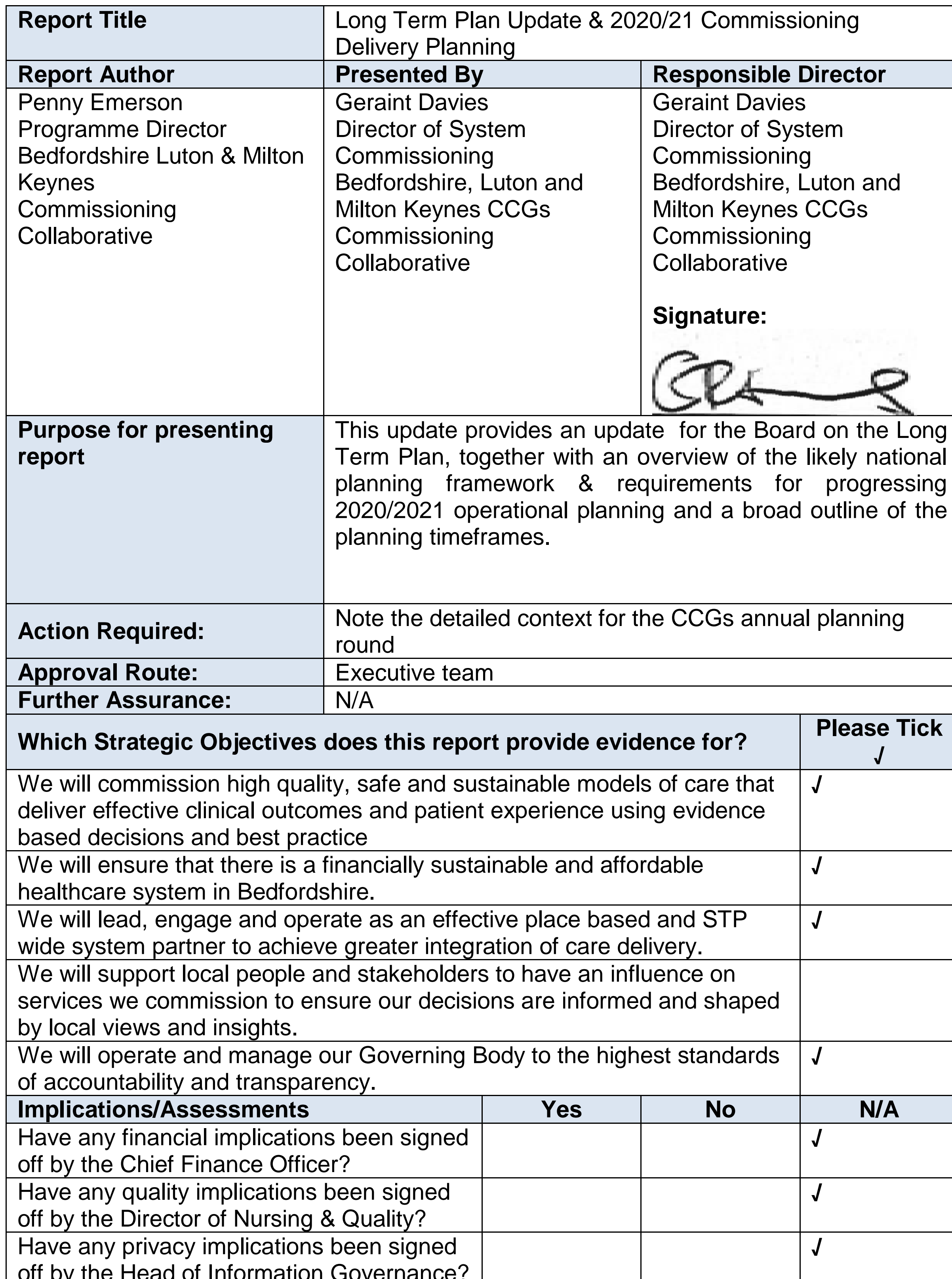
NHS
Bedfordshire
Clinical Commissioning Group

Agenda Item:7

Governing Body *held in public*	***Report*** Date of Meeting: 16/1/20



Report Title	Long Term Plan Update & 2020/21 Commissioning Delivery Planning	
Report Author	**Presented By**	**Responsible Director**
Penny Emerson Programme Director Bedfordshire Luton & Milton Keynes Commissioning Collaborative	Geraint Davies Director of System Commissioning Bedfordshire, Luton and Milton Keynes CCGs Commissioning Collaborative	Geraint Davies Director of System Commissioning Bedfordshire, Luton and Milton Keynes CCGs Commissioning Collaborative **Signature:**
Purpose for presenting report	This update provides an update for the Board on the Long Term Plan, together with an overview of the likely national planning framework & requirements for progressing 2020/2021 operational planning and a broad outline of the planning timeframes.	
Action Required:	Note the detailed context for the CCGs annual planning round	
Approval Route:	Executive team	
Further Assurance:	N/A	

Which Strategic Objectives does this report provide evidence for?	**Please Tick √**
We will commission high quality, safe and sustainable models of care that deliver effective clinical outcomes and patient experience using evidence based decisions and best practice	√
We will ensure that there is a financially sustainable and affordable healthcare system in Bedfordshire.	√
We will lead, engage and operate as an effective place based and STP wide system partner to achieve greater integration of care delivery.	√
We will support local people and stakeholders to have an influence on services we commission to ensure our decisions are informed and shaped by local views and insights.	
We will operate and manage our Governing Body to the highest standards of accountability and transparency.	√

Implications/Assessments	**Yes**	**No**	**N/A**
Have any financial implications been signed off by the Chief Finance Officer?			√
Have any quality implications been signed off by the Director of Nursing & Quality?			√
Have any privacy implications been signed off by the Head of Information Governance?			√

Have any conflicts of interest implications been signed off by the Corporate Office?			√
Have any public engagement implications been signed off by the Head of Communications & Engagement?			√
Has an Equality Impact Assessment been carried out?			√
Key Risks	Risks to the delivery of our plan will be reflected in the GBAF for 2021		
Executive Summary	This is a summary paper		

1.0 Background

Across the Integrated Care System (ICS) we have developed a Long Term Plan (LTP) for Wellbeing and Health for Milton Keynes, Luton, Central Bedfordshire and Bedford Borough (BLMK) spanning a 5 year period. This was submitted to NHS England at the end of November 2019. An Executive Summary of the final BLMK LTP response has also been developed. Both will be issued soon, following final sign off by NHS England.

This year has been a foundation year, laying the groundwork for the implementation of the Long Term Plan as a whole from April 2020 onwards. Work has now commenced on detailed planning for commissioning and delivery that will specifically take place during 2020/2021 in line with both national requirements and the BLMK LTP.

This update provides a summary for the Board, likely national planning framework & requirements for progressing 2020/2021 operational planning and a broad outline of the planning timeframes.

2.0 Introduction

The NHS Long Term Plan sets out the direction of travel for the NHS over the next five to ten years. All STPs/ICSs have submitted a final response to NHS England at the end of November including:

- A Strategy Delivery Plan (narrative, plus trajectories for delivery in some areas)
- Supporting technical appendices including detailed template returns for workforce, finance and activity.

This was collaboratively developed to provide a focus for partnership working for the next five years. In part it explains how we will implement the proposals in the NHS Long Term Plan, but it goes beyond that to consider the wider action that is needed to improve wellbeing and health. It links closely with the four Health and Wellbeing Board strategies, and their constituent priorities. The plan is of a high level and has been designed to make it accessible for the public, patients and staff through production of an Executive Summary (Appendix A). Feedback from the public, patients and service users on the Long Term Plan (following a number of engagement events held during April – August) has also been used to inform its development.

In line with the NHS national annual operational planning timeframes, work has recently commenced to develop and agree (in further detail) local commissioning delivery plans for the forthcoming year, ensuring that they are reflected appropriately in service contracts.

3.0 National Planning Parameters for 2020/2021

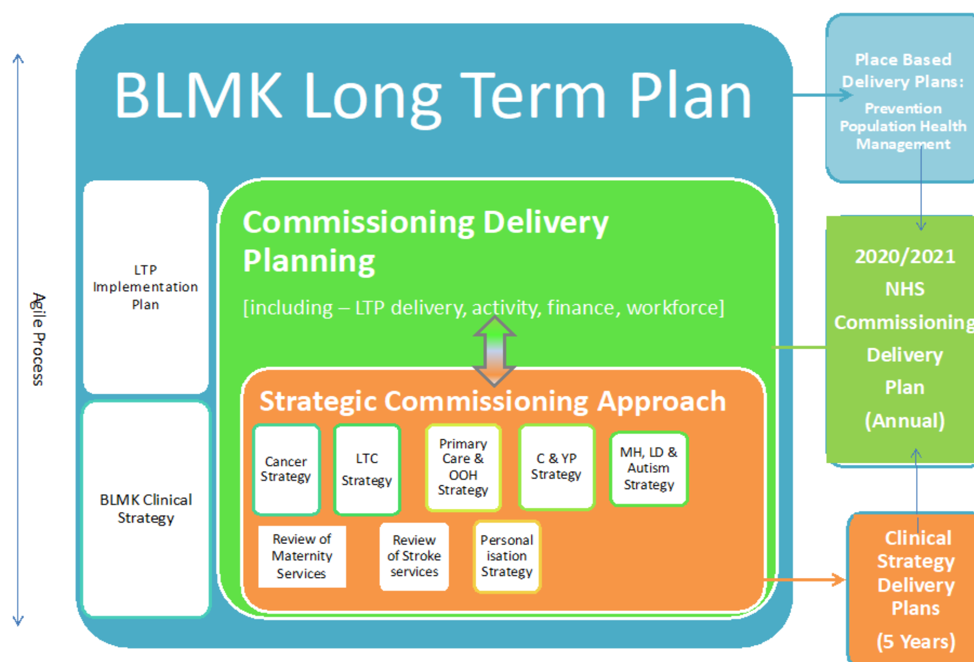
Detailed guidance, to assist systems and organisations in preparing for 2020/21 operational planning and contracting, is expected to be published by NHSE w/c 13th January. As with previous years, it is likely that plans will need to reflect the following elements:-

- Delivery requirements for 2020/2021 that reflect LTP commitments and local commissioning priorities
- Organisational activity & financial plans for 2020/2021 that reflect LTP system planning
- Productivity, Efficiency & Performance assumptions that reflect LTP system planning
- Workforce planning
- Data & Technology planning

4.0 Developing our Commissioning Delivery Plan

4.1 Context

2019/20 has been a foundation year for BLMK, seeing progress in the development of our Integrated Care System (ICS), the development of Primary Care Networks (PCNs) and the identification of two Integrated Care Provider (ICP) footprints. 2020/21 will see further collaborative transformation as the local NHS architecture responds to the commitments laid out in the Long Term Plan. These changes lay the groundwork for the implementation of the Long Term Plan, the collective vehicle of which will be a range of local aligned strategies and plans as illustrated in the diagram below:



Going forward, it is important that the different elements of our wider system planning (as shown above) fit together cohesively, and that there is clarity of leadership for them.

4.2 Commissioning Delivery Plan for 2020/2021

Whilst the overarching Long Term Plan has set out the strategic direction for the system across key priority areas, more detail is now required to outline service delivery, key outcome measures and system efficiencies at a commissioning level. This detail will form the basis of our Commissioning Delivery Plan for 2020/21, and will encompass the implementation plans for each of the key service areas referenced and articulated in the LTP response.

We are expecting that NHS annual planning guidance will be issued on 13th January 2020 and that this will set out the explicit requirements for development and inclusion of our CCG plan for 2020/2021. Importantly, the plan will need to align to the commitments already set out in the LTP, Place Based Plans, individual Clinical Service Strategies and ultimately The Clinical Strategy and it's delivery plans (when these are ready).

4.3 Planning Timeframes

A national planning timetable is likely to be included in the technical guidance, to be published shortly. However, timeframes for the production of organisational level and STP/ICS system level operational plans are likely to reflect the following outline:-

National Guidance & Supporting Technical Information published.	w/c 13th January
Organisations & STP/ICS systems submit draft Operational Plans.	Mid-February
Organisations & STP/ICS systems submit draft Operational Plans.	28th February
Contract agreed and signed with providers	End of March

4.4 System Intentions & Priorities

Whilst our overarching BLMK Long Term Plan has set out the strategic direction for the system across key priority areas, more detail is now required to outline service delivery, key outcome measures and system efficiencies at a commissioning level. This detail will form the basis of operational planning and the development of a CCG Commissioning Delivery Plan for 2020/21 and will summarise key service and transformation priorities that will be delivered next year. As well as reflecting commitments outlined in our BLMK LTP response, commissioning plans for next year should also reflect local priorities.

As part of the early work being undertaken to support the development of an Integrated Care Partnership (ICP) across Bedfordshire, and to engender closer working between providers and commissioners, the CCG has initiated a number of bilateral and joint conversations between the CCG and providers to formulate efficiency savings and quality improvements that are aligned across Bedfordshire.

4.5 Financial Context

The funding settlement for Bedfordshire CCG amounts to an additional£124.5m to 2023/4. This equates to on average 4.6% increase per annum to the core programme budget and

5.7% per annum for delegated primary care. In addition to this the BLMK system will be in receipt of targeted transformation funds for mental health, primary care, cancer and long term conditions (£10m in 2019-20 rising to £30m by 2023-24) of which Bedfordshire will receive a share.

NHS England have set the financial trajectories (previously called control totals) for each ICS system for the next four years. Systems will be measured on their overall delivery as well as that of individual organisations. For BLMK this encompasses the 3 CCG's of Bedfordshire, Milton Keynes and Luton, as well as the hospital providers (Bedford Hospital, Milton Keynes University Hospital and Luton & Dunstable) and 50% of Cambridge Community Services. Each organisation has been set a trajectory including a 0.5% stretch target to contribute to a Regional contingency reserve.

For Luton & Milton Keynes CCGs the trajectory requires delivery of a 0.5% surplus each year. For Bedfordshire CCG the trajectory includes an element of historic debt recovery as well, which is being challenged by the BLMK ICS and plans have been submitted excluding the delivery of this additional target. For Bedford Hospital and Milton Keynes University Hospital, who have previously held deficit trajectories, the requirements are for a modest improvement year on year, with a contribution from the national Financial Recovery Fund (FRF) required to offset remaining deficits. The system trajectory will not reach an overall surplus position before FRF until 2023/24.

Financial plans have been developed to meet the NHS England performance requirements of the long term plan (including the mental health investment standard) , together with the local pressures from population growth. Taking all of these planning requirements into account the delivery of the financial trajectory over the next four years will be challenging, particularly in the next year 2020/21. Bedfordshire CCG has a £123m efficiency challenge across the period, with £33m (4.7% of allocation) in year one. Bedford hospital has a further £4.8m efficiency challenge (before impact of the CCG target)(2% of revenue) in year one.

Efficiency plans are under joint development as part of the contract negotiations with Bedford Hospital and Luton and Dunstable University Hospital, along with East London Foundation Trust.. There is a focus on delivery of real cash releasing savings across the local system rather than cost shifting between organisations. High level areas of focus have been identified, but further work is required as part of the next steps for operational planning to develop the more detailed delivery plans within each area and the degree of risk share between organisations.

5.0 Recommendation

The Board is asked to note the detailed context for the CCGs annual planning round as set out within the paper.

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Appendix A – BLMK LTP Response – Executive Summary

BLMK LTP SUMMARY 251119.pdf

WORK IN PROGRESS

Living longer in good health

Bedfordshire, Luton and Milton Keynes Longer Term Plan (2019 – 2024) for improving health and care

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Introduction

What's this about?

The organisations responsible for health and care in Bedford Borough, Central Bedfordshire, Luton and Milton Keynes are working together to develop a plan for the next five years, responding to the NHS Long Term Plan[1] that was published in January 2019. At the heart of the plan is making sure that you get the care you need, when you need it.

Our ambition - why we've written this plan and what it means for you and your family

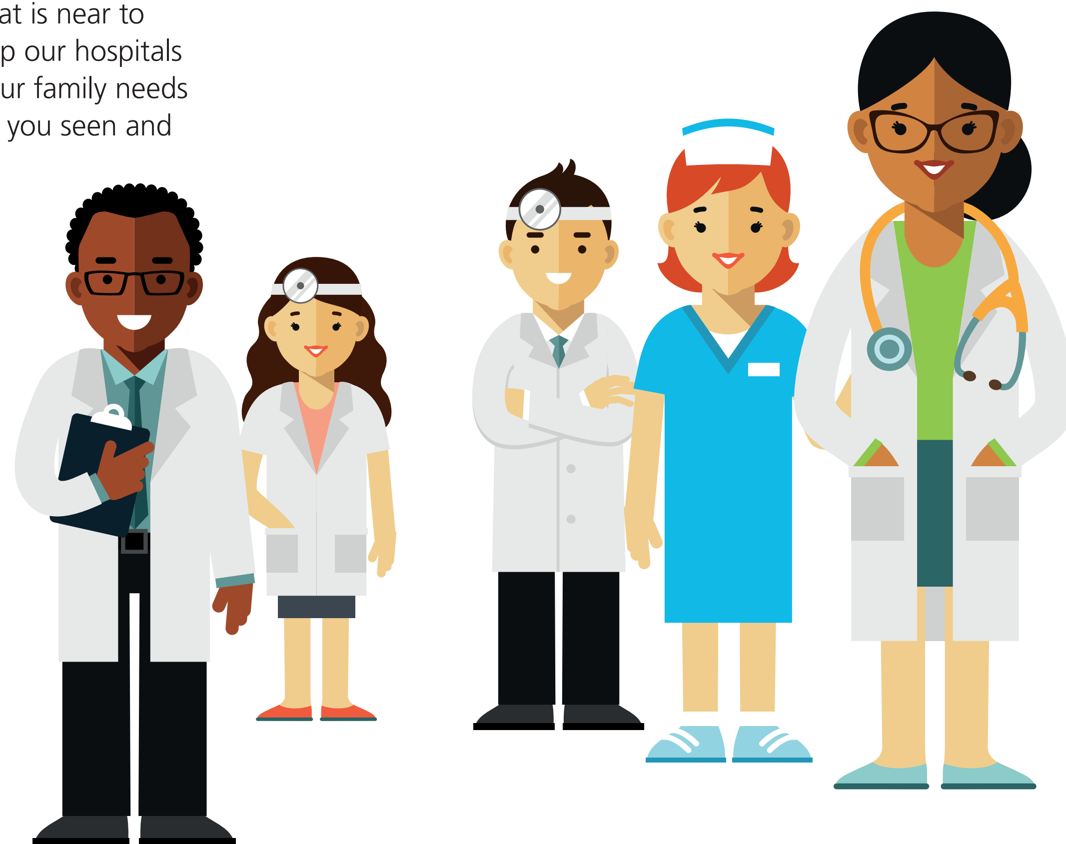
The purpose of our plan is to improve our services so that it's easier for you to manage your own care as much as possible. When you do need us, we want to make sure that you can get an appointment quickly, with the best person to help you in a place that is near to where you live. This will also help our hospitals work better, so that if you or your family needs specialist treatment, we can get you seen and treated without delay.

[1] www.longtermplan.nhs.uk

Making the best use of our skills and resources

Since 2016 hospitals, clinical commissioning groups, GPs, community and mental health trusts, ambulance trusts and local councils in Bedfordshire, Luton and Milton Keynes have been working more closely together. This means we can contribute better to the overall health and care needs of the people we serve and get the most out of the skills and resources we have available.

We share a common purpose – we want people to live longer in good health. When people need care, we want them to get the very best available. To do this we need to look after our staff, recruiting and retaining the highest quality people. And we have a duty to spend public money wisely on services that will make the biggest difference to local people.



Living longer in good health

Bedfordshire, Luton and Milton Keynes Longer Term Plan

Our priorities for the future are very much in line with those set out in the NHS Long Term Plan. We've talked to colleagues to understand and learn from them about what is working well. But most importantly, we've talked to you, local people, to find out what matters most.

One of the biggest changes we're making is to create teams of health and care professionals who will work with GP practices and with community and mental health services, social care workers and volunteers to provide more tailored services in your area.

We want to work with communities to help people stay healthy and well

Factors such as good jobs and housing affect our physical and mental health, so while we need to look at how we can continue to improve local health services, we can't do this alone. This is why the NHS, your local councils and other organisations are working more closely together than ever, to really make a difference.

We know that local people want local services, and so local health and care providers are planning to work together to break down barriers and make it simpler for you when you are in need of help.

These are ambitious plans and we're excited about the positive improvements we'll be making for you and your family. Over the next five years we will continue to work with you to shape our future together.

What you have told us is important to you and your family

During the course of this year we have listened to local people, supported by local Healthwatch[2], to get a better idea of what's important to you and what you think we could do better.

We know that people want to keep local services and to access healthcare when they need it. Here are some common themes we've heard:

1. **You want to access local services, like GP services and hospital referrals, quicker.** People would like to get appointments sooner, with 80% of people we surveyed saying improved access to GP services was the most important thing.
2. **Improving mental health services for both children and young people and adults should be a priority.** People of all ages should be able to get the help and support they need quickly and easily.
3. **You would like more support and information to help you lead a healthier life.** Our communities want to be healthier, but need support to tackle things like obesity and diabetes.
4. **New technology provides an opportunity to improve people's care. You would like us to make the most of this opportunity.** By investing in technology we can help people access services online and reduce the pressure on our services.
5. **Our staff are excellent, but stretched. Therefore, we must recruit more people to work in health and care.** To provide high quality, compassionate and person-centred care we need to recruit new people to work in the health and care sector, as well as do more to retain our existing workforce.
6. **You don't want to have to repeatedly tell your story to different health and care staff.** You want your care to be better coordinated across the different staff group, organisations and services and for us to use technology to help us do this.
7. **When people are diagnosed with cancer, they want to feel confident they can access better information and support.** People recognise that treatment and care after diagnosis works well but they would like to see improved information to help them make informed choices throughout their diagnosis and treatment.

[2] https://www.healthwatch.co.uk/report/2019-09-04/what-people-have-told-us-about-health-and-social-care-april-june-2019

We have been out and about asking local people what their future NHS looks like and what would help them to stay as healthy and well as possible. Here are some of the things you told us:

"We want mental health services to be accessible to ALL"

"I want access to healthcare professionals at times convenient to me"

"More information and support to improve our diet and cooking skills"

"More screening for older people"

"Better use of social prescriptions"

"Good education to enable me to understand how to look after myself"

"Ability to access services online via apps and Skype"

"More integration between health services and social worker teams, hospitals and charities"

"More care in the community provided by people who care"

The big issues we currently face as a local health and care system

The NHS has for some time been challenged by a number of big issues. These are slightly different depending on where you are in the country. Across our region we are working hard with partners to face these big issues head on.

Almost one million people live in Bedford Borough, Central Bedfordshire, Luton and Milton Keynes, one of the fastest growing areas in the country. The characteristics of these different places affect what local people need from their health and social care services.

With a 20 year gap in life expectancy and healthy life expectancy, more people will mean more care will need to be provided. Without action now, keeping people healthy and happy in the future will be much, much harder.

Some specific challenges we have are:

We have a growing population. Our population could increase by nearly 90% by 2050. This would include an 80% increase in the number of children and young people, a 70% increase in the working age population and nearly 150% increase in the population aged over 65. We need to make sure we have the right health and care services in place to support this.

More people are living with long term health conditions, such as diabetes and arthritis that cannot be cured but can be effectively managed. The quality of healthcare that people receive and their general health and wellbeing varies.

We have considerable health inequalities. A baby girl born in Central Bedfordshire today can expect to live for 84.4 years, over 6 years longer than a baby boy born in Luton (78.3 years).

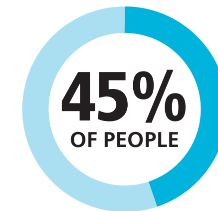
The number of people seeking treatment at our A&E departments continues to rise and this places pressure on ambulance and hospital providers. Our plans are aimed at supporting people to seek appropriate treatment and only attending A&E departments when really necessary.

We could be doing better on circulatory and respiratory diseases. Coronary heart disease admission rates are higher than nationally in our area. Hospital admissions for asthma in under 19s are high in Milton Keynes. Admissions for cardio-pulmonary disease are high everywhere except Luton.

We are also facing workforce shortages and significant financial pressures. We can't continue to provide both the high quality and wide range of services we do today without making changes; to work smarter and more efficiently to get better value for every pound of taxpayers' money.

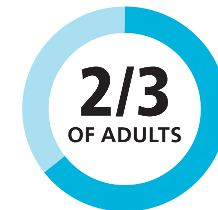
We need to make sure we can meet these challenges head on and that is why we have put together this plan, which shows what we will change over the next five years and what difference it will make to you and your family.

People are living on average as much as 20 years in poor health (the gap between healthy life expectancy and life expectancy).



Only 45% of people using social care in BLMK feel they have as much social contact as they would like.

In the most deprived areas of Luton and Bedford Borough, two thirds of children are living in poverty.



Two thirds of adults in BLMK are overweight or obese.

Almost 1 million people live in Bedfordshire, Luton and Milton Keynes

4 local councils

3 acute hospital trusts‡

3 clinical commissioning groups*

3 community health providers

2 mental health providers

2 ambulance trusts

102 GP Practices

22 Primary Care Networks (PCNs)

‡ Bedford Hospital and Luton & Dunstable Hospital will become Bedfordshire Hospitals Foundation Trust in April 2020
* The 3 CCGs will create a single, new CCG in April 2021

Our goals – what we want to achieve

We recognise that getting the fundamentals right will help us successfully deliver the rest of our five year plan. There's lots of things we can do, but we think these are four of the most important:

1. **Making sure that every person in Bedfordshire, Luton and Milton Keynes lives as healthy a life as possible, for as long as possible:** People living in some parts of our area currently suffer significantly poorer health than others and on average, tend to die younger. We have to do something about this.
2. **Making sure we're there for you when you need us most:** Sometimes people can't get the right appointments quickly, or they have to wait too long to see a specialist. And then they have to tell their story over and over again. We have to make our services work better together.
3. **Making sure that Bedfordshire, Luton and Milton Keynes is the best health and care system to work in:** In order to look after you, we need to look after our people. If we can help them to work better together and feel more supported, they'll be better able to give you consistently high standards of compassionate care.
4. **Making the most of our funding:** The NHS Long Term Plan provides future investment into local services which, for our area, means we have an extra £234 million over the period of the plan, including an allowance for inflation. By achieving our six changes (see next section), we will be making the best use of public money and ensuring as much money as possible goes into patient care.

Our top six changes for helping you live longer in good health

As you'd expect, our plan is extensive. There are lots of things we need to do differently to make a positive change to the health and care services you and your family can access. The biggest of these are set out here. They are our top six changes and they're aligned to the promises set out in the NHS Long Term Plan.

1. Creating opportunities for you to see a range of staff in your community, offering you more coordinated and personal care
2. Improving the way our hospitals work so you get faster treatment in an emergency and don't wait too long for an operation or other hospital care
3. Giving you better information and support to help you stay well and manage illness sooner
4. Giving you choice and control over the way your care is planned and delivered
5. Making sure the right people are there to support you
6. Getting the most out of technology

1 Creating opportunities for you to see a range of staff in your community, offering you more coordinated and personal care

Our GPs, nurses, social workers, mental health workers and other staff need to work together, in teams, in the community to better meet your needs. This means you will be able to see the right person, when and where you need to and your care will be better organised to meet your individual needs.

Many of you have told us that you'd prefer to be cared for at home as much as possible, near to your family and friends, rather than having to be in hospital or residential care. In order to make this happen we need to spend more money on your local GP and community health services. In the last year or so, many of our GP practices have provided evening and weekend appointments so that working families can see a GP at a time to suit them. Over the next four years we'll be continuing this investment and introducing some new approaches.

Since July, we've created 22 teams of different health and care staff across BLMK who are now working more effectively together to meet your health and care needs. These teams are called Primary Care Networks (or PCNs). They are led by local GPs and include Nurses, Physiotherapists, Mental Health Workers, Pharmacists, Social Workers and others. There are lots of advantages to working in this way, one of which is that you don't have to repeat your story time and time again and our teams of staff are quicker at gathering the information they need from you and others to organise your care. As these teams have only been in place for a short period of time, you might not be aware of these changes in your own GP practice. **Over the coming years we plan to further develop these PCNs and the staff who work in them.**

Here are some examples of the changes you can expect to see in your local PCN:

From 2020 you'll be able to see a **clinical pharmacist**, who will use their specialist knowledge of medicines to assess and treat you as needed. There will be staff who can provide you or your family with mental health and wellbeing support when needed. There will also be **social prescribers**, whose job it is to connect people, especially the more frail and vulnerable, with non medical support, day centres, charities or community groups to improve wellbeing and help tackle loneliness or social isolation.

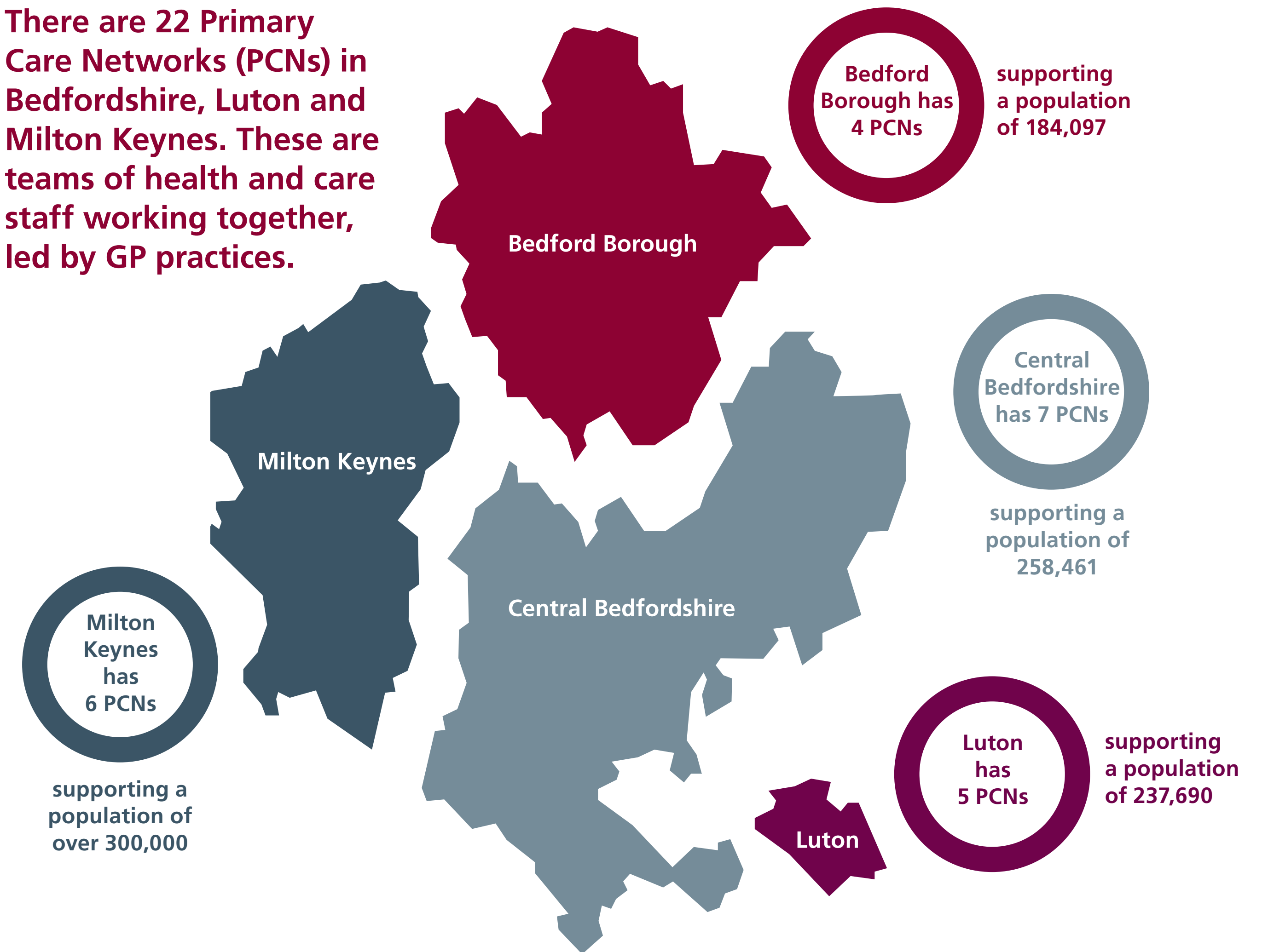
Further support in PCNs will continue and from 2021 this will include **physiotherapists who have completed extra orthopaedic training** to enable them to support you and your family with injuries or illnesses involving muscles, bones or joints. In some instances, you'll be able to self-refer to see these staff and in others, you might be directed by key staff. You'll see new staff, such as **Physician Associates**, who are trained to do some of the work of your GP and some of the work of the Practice Nurse, like examining you, interpreting your test results and diagnosing what's wrong.

By March 2022 we'll introduce the **Advanced Paramedic Practitioner,** who will be there to support 'same day clinics' for minor illness and injury, assessing and treating you as required, as well as carrying out health check reviews and home visits on behalf of your GP.

Living longer in good health

Bedfordshire, Luton and Milton Keynes Longer Term Plan

There are 22 Primary Care Networks (PCNs) in Bedfordshire, Luton and Milton Keynes. These are teams of health and care staff working together, led by GP practices.



You will also see the introduction of some new ways of working to get you the support and help you need quicker.

About half of our GP practices already offer online consultations and this will become more widely available during 2020. The opportunity to talk to a GP via a telephone appointment will also continue and expand. We are testing video consultations in some of our practices, so you can talk to a GP 'live' from home, without having to come to the surgery. This will become more widely available during 2020. And for some patients with particular Long Term Conditions we'll be testing group sessions in the practice to help manage diabetes, high blood pressure and similar conditions, as well as ensuring these patients always see a GP and are offered longer appointments.

We are planning to introduce an urgent service for people who need crisis support at home, so we can prevent them from being admitted to hospital, unless it's necessary. This will mean that by 2022 if you or your family are clinically judged to need urgent care from our community services, we'll see you at home within two hours. If you then need further services to help you return to daily life, we'll provide this within two days.

And for people who live in Care homes, there'll be extra support to help them manage what is often a wider range of health needs, meaning faster and more effective help from a range of staff according to need. This support will be available to all BLMK care homes by 2021.

2 Improving the way our hospitals work so you get faster treatment in an emergency and don't wait too long for an operation or other hospital care

At the moment when people can't see their GP when they want to, they sometimes go to A&E. This means that our hospitals slow down and planned operations can sometimes get cancelled while we deal with more emergencies. We need to reduce the pressure our hospitals are under and that's why we're investing in more opportunities for you to see the right health staff in the community. This will help our hospitals work faster and better and ensure you get the treatment you need more quickly and conveniently. Here are some of the things we have started and will be rolling out:

Making sure that everyone across BLMK gets the same access to the NHS 111 service. We want to make sure that, where appropriate, you can access our Clinical Advisory Service or CAS for short. This is a telephone service run by GPs, Clinical Advisors, Nurses, Paramedics, and Pharmacists which allows you to talk directly to a healthcare professional from the comfort of your own home. If necessary, you will be booked directly into an appointment with your own GP surgery.

We're currently working to extend this service more widely in care homes, so that staff there can speak with a clinician at any time, day or night. We want to ensure that this service is available to all care homes across BLMK. We believe this will help support care home residents better, so they're don't have to go to hospital unless necessary.

We will improve the way you are managed when you arrive in A&E. You will be greeted by a healthcare professional who can quickly decide which one of our urgent services is best for you, whether this is one of our Urgent Treatment Centres, Urgent GP Clinics or Same Day Emergency Care services or whether you'll need to be seen in A&E. This will ensure you get the treatment you need, in the quickest and most appropriate way. We also plan to improve the availability of emergency ambulance services across our area, ensuring delays are minimised. We'll make sure that when you don't need to go to hospital, you can be treated at home or where the emergency has occurred.

We'll also ensure you get the latest up to date information about where and when you can access Urgent and Emergency Care services. This will help everyone to use urgent and emergency services more effectively, so that our hospitals can continue to treat you and your family quickly in an emergency and routine operations and procedures aren't cancelled unnecessarily. Soon we will extend our Same Day Emergency Care service, enabling you or your family to be treated on the same day, without the need for admission to hospital.

We want to make sure you don't wait any longer than necessary for an operation. We recognise that waiting for an operation for too long can have a negative impact on your health and wellbeing. When this happens it impacts the rest of our service as more people end up needing extra support while they're waiting, like prescriptions for pain relief, time off work and sometimes even having to go to A&E for emergency treatment.

We're increasing the amount of planned operations we do, year on year, so that we can reduce the long waiting lists and speed up the time it takes for you to get your operation (currently a maximum of 18 weeks from when your GP first sent you for a specialist opinion). As well as this, we're improving the way we keep you up to date with information about how long you'll have to wait, so that when your GP refers you, you'll know straight away how long it's going to be before your operation.

We understand that waiting for treatment is difficult for everyone. None more so that those diagnosed with cancer and to this end we want to ensure that everyone in our region receives the best possible care in the unfortunate event of a cancer diagnosis. This includes ensuring consistency across primary care so that everyone with an urgent two week cancer referral is seen by a cancer specialist within this timeframe.

Living longer in good health

Bedfordshire, Luton and Milton Keynes Longer Term Plan

3 Giving you better information and support to help you stay well and manage illness sooner

In future we need to do more to reach out to people who we know are likely to be at greater risk of becoming ill, or those whose health might deteriorate to the point where they need hospital care.

We want to help you reduce your risk of developing avoidable health conditions by enabling you to make healthy choices where possible e.g. by stopping smoking, being active or staying a healthy weight. However we recognise that your health is influenced by many things such as where you live and work, so support will be tailored to your needs and help you make the best possible choices. Public services don't have all of the answers so we will work with communities to help you and your family stay well and healthy e.g. to reduce social isolation and loneliness.

As well as this, we want to ensure that anyone at risk of developing health conditions, is identified and supported as early as possible. We have a lot of information available to us. By using this data better, we'll be able to spot people who might not realise they have conditions like High Blood Pressure, Diabetes or Stroke, so that together we can support you to manage your health. You can help us by taking up any offer of screening or immunisations.

Modern technology provides us with new ways to provide this kind of proactive care such as helping you to monitor your own health and share information with those supporting you.

As a result, we expect you will have greater confidence in managing your own health and there will be less variation in treatment and outcomes for people with conditions such as cardiovascular disease, respiratory disease and cancer.

We also anticipate that fewer people will need to attend or be admitted to hospital as they will be skilled at looking after themselves when appropriate. This reduces pressure on our system, so that care can be provided for those who need it most.

4 Giving you choice and control over the way your care is planned and delivered

You've told us that you think you'd benefit from care that is built around your individual needs and that you'd like support to build the knowledge, skills and confidence to manage your health conditions and improve the way you live. We want to help support this, so we've developed a range of measures that will give you more choice and control over your health and care needs.

The first of these is a process to give you support from your clinician to take decisions, choose tests and treatment options based on evidence and your personal preferences. We will build on this **'shared decision making'**, initially focusing on people with Chronic Obstructive Pulmonary Disease but extending this to include people with mental health and learning disabilities and those with long term conditions such as cancer, diabetes and stroke. We will also use this approach for people with frailty and those at the end of their life.

Other support includes questionnaires that help us understand your level of knowledge and confidence about your long term condition. This helps us support you in developing your own capability to manage your health and care, giving you tailored information and support you can act on. This is known as a **Patient Activation Measure or PAM** for short. Linked to this we are using more and more **social prescribing**, which is when we refer you to a range of local non-clinical services to help improve your health and wellbeing.

Personal Health Budgets are an amount of money to support your health and wellbeing and are available to adults who are receiving NHS funded long term health and personal care outside hospital. We've now made these available for wheelchair users and will be expanding this to more people across our area. These approaches are collectively called a **Comprehensive Model of Personalised Care.**

5 Making sure the right people are there to support you

Demand for health and care services is growing, largely as a result of there being more people in our area and that generally we are living longer. To properly meet this growing demand we recognise we need to do things differently in the way that we recruit, train and retain our people. This includes improving the working lives of staff, so that people feel more supported at work and better able to balance the challenges of their working lives with those they may face at home.

In order for our staff to continue to offer compassionate, responsive and understanding care and to develop a more joined-up, personalised approach, we need to value and invest in our staff through the delivery of a workforce plan that enables health and care staff to work as teams around local communities.

We will require not just continued growth in our workforce, but also a shift in our thinking and the way in which we train and compose our teams in health and care settings. We do need 'more', but we also need 'different'.

Different will mean there will be much stronger links between integrated health and care teams within Primary Care Networks. There will be new roles and existing staff will increasingly develop skills that support joined up approaches. We will release staff time to care as technology and scientific innovation transforms care pathways.

Here are some of the key things we've already started to do:

Growing our own people; by engaging better with local schools and colleges to attract young people as they consider careers and at recruitment fairs and local initiatives for those seeking a change of career. We want to make sure there are opportunities across a broad range of levels, so anyone who wants to join us has the chance to do so. We are offering job guarantees following successful completion of local training programmes.

Addressing our workforce shortages; we have challenges across many of our health and social care roles and our initiatives to recruit, train and retain staff are targeted at all health and care staff. We are taking a specific focus on key areas, including addressing nursing shortages, with current vacancy rates averaging at 14%. We will attract more nurses through nurse cadet schemes and creating ambassadors for nursing within local schools. We are also increasing the number of clinical placements available for students. With GP vacancies at 10-12% we are also supporting new GPs with coaching, mentoring and training opportunities and more varied job roles.

Supporting and developing our staff; we are focusing on making our organisations the best place to work through offering flexible ways of working, more opportunities for training and development and staff health and wellbeing services. We are also attracting those who have left health and care jobs to return and recruiting, where we can, from overseas. We are developing rewarding roles that enable staff to develop more integrated care skills and rotate across services. This includes rotational health and social care apprenticeships, paramedic rotations across ambulance and GP services, specialist children's nurses working across hospital and community services and cancer care teams offering mobile lung checks and working alongside GP and community teams. We will also support our staff with the skills to work with evolving technologies, which enable teams to share information and work more effectively to support care needs.

We are developing a range of new roles including:

- Physician Associates, who are trained to support our doctors. As well as carrying out some patient examinations, they are able to interpret test results and diagnose illnesses.
- Nurse apprenticeships and nurse associate roles are two new ways of getting into nursing, working with registered nurses and healthcare support workers to care for a wide range of patients in different settings. Our numbers of nurse associates in training will increase to 91 within 2020 and we are also growing support roles within maternity and within mental health services, such as Peer Support Workers.
- Advanced care practitioners are existing professionals from a range of traditional backgrounds such as pharmacists, nurses paramedics or occupational therapists, who undertake further education so that they have more skills to support local communities.

All these new roles, together with a greater focus on training and development, will mean our people are even better equipped to support patients, in some instances freeing up other professionals like GPs, to concentrate on those with more complex health needs.

Improving our culture and leadership by creating a more supportive environment for our people. This will include the introduction of a new 'Leading Beyond Boundaries' programme to strengthen and support healthy, inclusive and compassionate leadership at all levels. As part of our shared learning, we have already started to create opportunities for our clinicians to meet and discuss key issues. We will evolve this over time to create clinical networks bringing together local clinicians to shape future working, based on their own experience and industry best practice.

Looking after our people better, using our staff in the right way to make the most of their skills and expertise will ultimately help us give you the best possible treatment in whatever setting you may need our care and support.

6 Getting the most out of technology

Our lives are all now heavily influenced by advances in technology and innovation and in health and care we know that there are constantly new ways in which we can support you, your families and our own people to improve the services we provide. In the next five years there will be new and exciting changes in IT, but in the meantime we want to harness the best of today's technology to improve the way we communicate between our hospitals and GP practices, the information we share and the speed with which we can respond to your needs.

Importantly, we want to ensure you are involved in your personalised health care plan, adding in details of how you prefer to be treated and monitoring your own conditions and alerting your doctor or community nurse if there's a problem. We also want to make sure that the treatment we're providing is consistent, has worked to make you better, and is good value for money.

Some of our other priorities include:

- **Hospital based health care staff being able to write in your notes**, so your GP or other community health professional can see relevant details about your care and treatment.
- **In an emergency, all healthcare staff being able to see an extract from your GP record**, so they can make faster and more accurate clinical decisions.
- **We're currently testing remote monitoring of high-risk residents in care homes,** so we can act quicker when there's a problem.

We're already setting up systems so you can get advice from your GP practice via an online consultation and we've recently introduced a new app for outpatients at Milton Keynes University Hospital. This allows you to view and amend your appointments and access other information. We will be looking to expand this offer across our other hospitals. In Luton a pilot with care homes is testing the adoption of a remote monitoring app for the most vulnerable patients to identify and treat health issues earlier, thereby reducing unnecessary admissions to the Emergency department. Early indications suggest this has reduced attendances at A&E in this area by 17%.

All these innovations will help us to support you and your family, creating a single digital care record for all health and care organisations, so that you don't need to tell your story time and time again and we can provide you with more joined up care.

Improving Care for Major Health Conditions

As well as the big changes we've set out above, we're also taking action to improve care for major health conditions, such as cancer, diabetes, stroke and mental health, and for people at key stages of their life. These include:

- **Improving uptake for bowel, breast and cervical screening programmes** to reduce the number of people diagnosed with cancer at a late stage. This will improve survival rates and provide faster cancer diagnosis, with most people receiving a definitive diagnosis that will confirm or rule out cancer, within 28 days of referral.
- **Establishing three new mental health support teams** to work in schools and colleges. They'll support children and young people who may be experiencing mental health issues to get the right support, so that they can stay in education.
- **Expanding mental health services** to provide earlier intervention and support for mothers from pre-conception to 24 months after birth, and further support for their partners, to prevent problems escalating into a crisis situation.
- **Taking a proactive approach to identify people with high blood pressure** and provide supported self-management to control this. This will mean a better experience, reduced risk of heart failure and stroke, and fewer unnecessary visits to hospital.
- **Introducing multi-disciplinary respiratory hubs** to identify and manage complex respiratory disease closer to home, and improve outcomes. This will include improved quality of diagnostic tests, increased uptake of vaccinations (influenza and pneumonia) and increased uptake of Pulmonary Rehabilitation.
- **Developing stroke services** so there is consistent access to high performing stroke units and rehabilitation, so people have the best chance of long-term recovery with the possibility of living independently.
- **Providing universal access to structured education,** both face-to-face and digital, to help people with Type 2 Diabetes manage their condition, according to their individual needs and preferences, which means they are likely to have fewer complications, and need fewer visits to their GP or hospital.
- **Ensuring health, care and therapeutic services work better together** and have the capacity to meet the needs of children and young people with special educational needs.

How will we pay for this?

Under the NHS Long Term Plan published in January 2019, the NHS will receive increased funding of £20.5 billion per year by the end of five years. Under this deal, funding for our local area is increasing by between 3.2% and 4.4% per year over the period of the Long Term Plan which is greatly welcomed.

This will enable us to invest in the priority areas identified in the NHS Long Term plan (local GP and community services, mental health and cancer) as well as target funding towards local needs.

The increased funding will enable us to deliver services better and smarter by investing in technology, prevention, earlier intervention and treatment.

What happens next?

Some changes will take longer to implement, particularly those that address long-standing health inequalities across our area.

This plan is designed to be live and agile, helping us to drive continual improvement. We recognise we won't get everything right first time – but we will ensure that we test and learn from different approaches elsewhere and challenge our understanding of what we can do here.

We have a responsibility to work together to respond to the challenges we face so that by 2024 people's health and wellbeing in our area is better, our health and care services are better, and we get better value for money.

As we have used your feedback to help guide and develop our plans, we want to continue to involve you as we develop more detailed plans to help us achieve what we have set out in this Longer Term Plan.

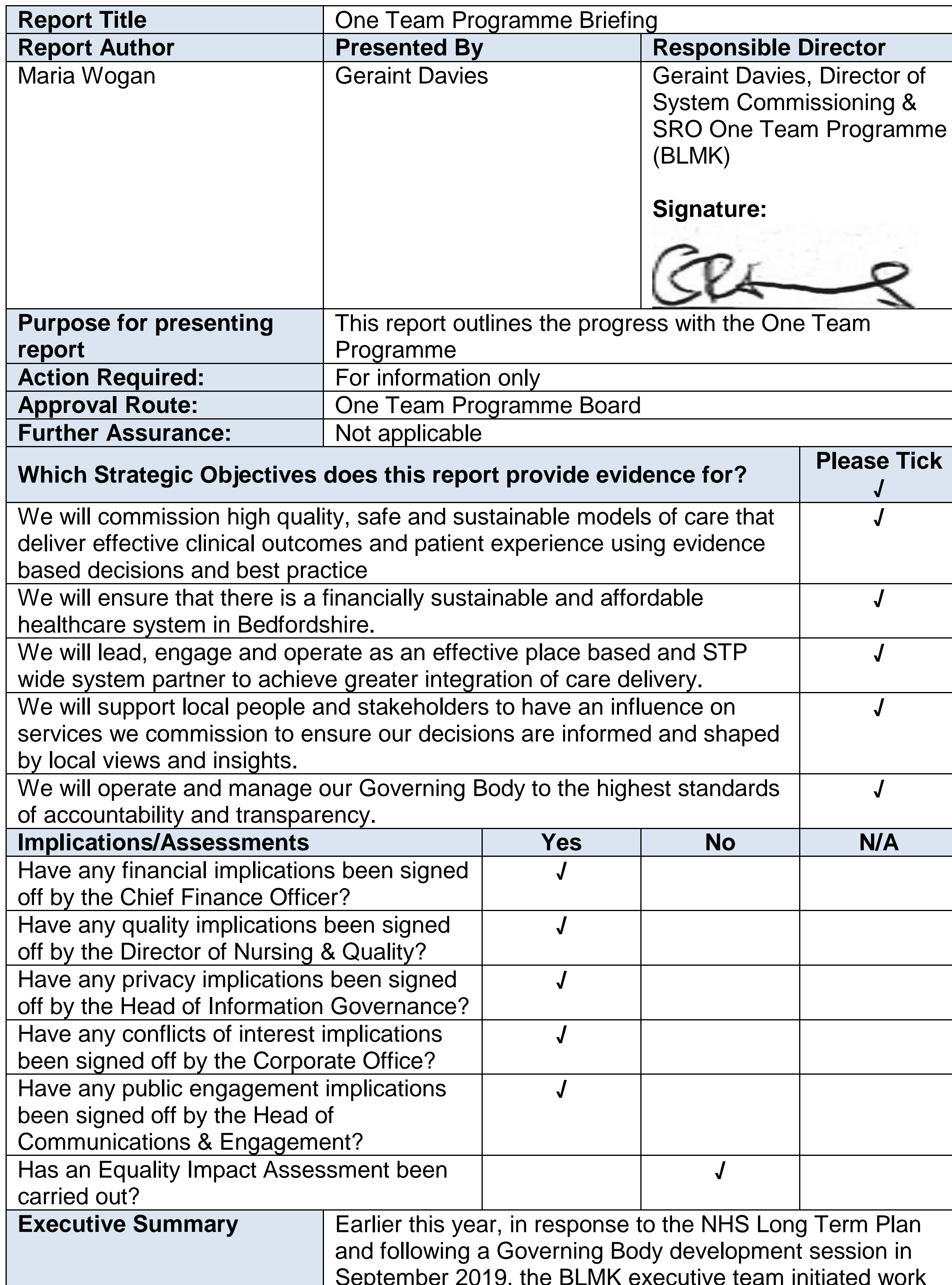
You can find out more about our plans for the future by watching this short animation: Together we can grow a healthier future for everyone.
If you have any feedback please share with the Healthwatch in the council area you live.

BLMK
Integrated Care System

NHS Bedfordshire
Clinical Commissioning Group

Agenda Item: 11

Governing Body *held in public*	***Report*** Date of Meeting: 16 January 2020



Report Title	One Team Programme Briefing	
Report Author	**Presented By**	**Responsible Director**
Maria Wogan	Geraint Davies	Geraint Davies, Director of System Commissioning & SRO One Team Programme (BLMK) **Signature:**
Purpose for presenting report	This report outlines the progress with the One Team Programme	
Action Required:	For information only	
Approval Route:	One Team Programme Board	
Further Assurance:	Not applicable	

Which Strategic Objectives does this report provide evidence for?	**Please Tick ✓**
We will commission high quality, safe and sustainable models of care that deliver effective clinical outcomes and patient experience using evidence based decisions and best practice	✓
We will ensure that there is a financially sustainable and affordable healthcare system in Bedfordshire.	✓
We will lead, engage and operate as an effective place based and STP wide system partner to achieve greater integration of care delivery.	✓
We will support local people and stakeholders to have an influence on services we commission to ensure our decisions are informed and shaped by local views and insights.	✓
We will operate and manage our Governing Body to the highest standards of accountability and transparency.	✓

Implications/Assessments	**Yes**	**No**	**N/A**
Have any financial implications been signed off by the Chief Finance Officer?	✓		
Have any quality implications been signed off by the Director of Nursing & Quality?	✓		
Have any privacy implications been signed off by the Head of Information Governance?	✓		
Have any conflicts of interest implications been signed off by the Corporate Office?	✓		
Have any public engagement implications been signed off by the Head of Communications & Engagement?	✓		
Has an Equality Impact Assessment been carried out?		✓	

Executive Summary	Earlier this year, in response to the NHS Long Term Plan and following a Governing Body development session in September 2019, the BLMK executive team initiated work

	to take the three BLMK CCGs on a journey towards the disestablishment of the existing CCGs and the creation of one single new CCG for Bedfordshire, Luton and Milton Keynes by April 2021. To that end, in November BLMK Governing Bodies approved the development of a Programme Plan, Programme Board and establish a dedicated team to deliver the programme. This Paper summarises the progress that has been made since November 2019. **Recommendations:** The Governing Body is asked to note progress with the One Team Programme.

Subject: **One Team Programme Briefing**

Meeting: **BLMK Governing Bodies (Part 1)**

Date of Meeting: **January 2020**

Report of: **Geraint Davies, Director of System Commissioning & SRO One Team Programme (BLMK)**

Is this document Commercially Sensitive	N
Has this proposal been approved by Finance	NA

1. Background

In November 2019 the BLMK CCGs' Governing Bodies gave approval for the BLMK executive team to develop the One Team Programme, which is the vehicle to deliver the three CCGs' ambition to:

- Create a new single CCG for Bedfordshire, Luton and Milton Keynes (and disestablishing the existing three CCGs);
- Establish the new CCG as a strategic commissioner as part of the BLMK Integrated Care System; and
- Support the development of two Integrated Care Partnerships in Bedfordshire and Milton Keynes within the BLMK Integrated Care System.

A dedicated team and Programme Board have been established, and the Programme Plan has been developed. This paper summarises the progress that has been made since November in setting up the Programme to realise our ambitions.

2. The One Team Programme Resources

Dedicated resources have been identified to lead the One Team Programme who will work closely alongside Governing Body members, the CCG membership, staff at all levels in the three CCGs and other senior stakeholders in BLMK ICS partner organisations. Russell Foster has been engaged on a three month interim basis (mid Nov- mid Feb) to provide the additional capacity and expertise needed to establish the programme, its governance arrangements and to develop the detailed programme plan. The dedicated team members are being supported by a number of senior level work stream leads who are all specialists in their own areas such as Governance,

Communications & Engagement, Organisational Development, HR Finance and IT. The full work stream list and resources is shown in **Appendix 1.**

Working relationships have been established with our NHS E/I regional assurance colleagues, one of whom is a member of the One Team Programme Board, and the other provides day to day operational/technical support including arranging liaison with subject matter experts from other similar CCG Programme Teams.

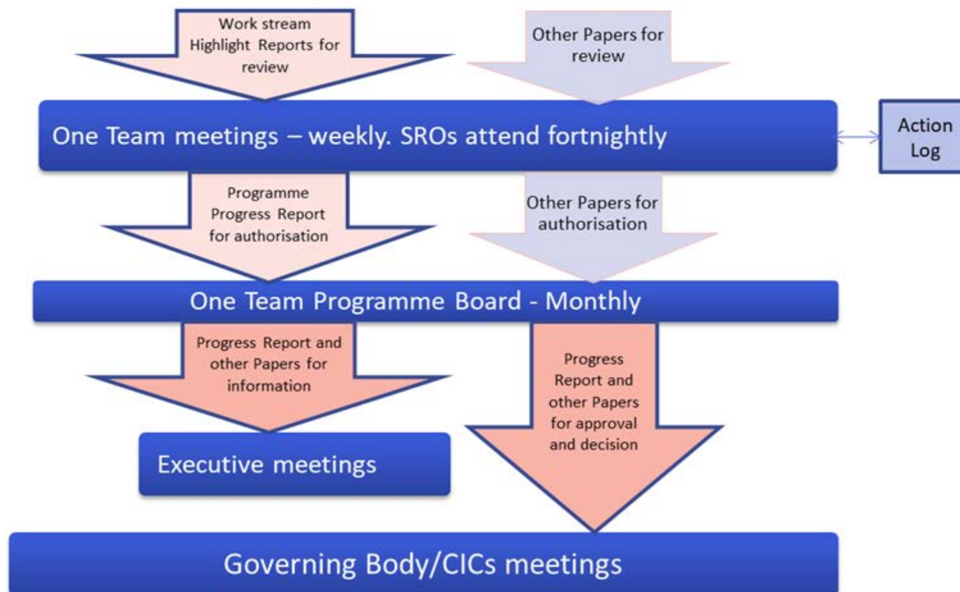
3. The One Team Programme Board

The One Team Programme Board will report to the three Governing Bodies and will comprise the following membership:

- One Lay Member from each CCG (one of which has been appointed as Chair of the Programme Board) (3 Lay members in total)
- One GP Member from each CCG (3 GP members in total)
- The SROs for the One Team Programme: Richard Alsop and Geraint Davies
- The Director of Partnerships, Communications and Engagement: Jane Meggitt
- The Chief Nurse: Anne Murray
- An NHS E/I Regional representative

Governance, reporting templates and reporting cycles have been fully integrated with our established CCG governance processes – see **Table 1.**

Table 1 - One Team Programme Reporting Cycle



4. The One Team Programme Plan Summary

A detailed Programme Plan has been drafted using the template from the Kent & Medway CCGs Programme which had been previously validated and assured by NHS England. The draft Programme Plan was reviewed with our Regional regulator before being submitted to our One Team Programme Board.

The Plan sets out the key tasks deliverables and milestones within each work stream. A more detailed Gantt chart has been developed to manage the programme activity and delivery against the Gantt chart will be overseen by the Programme Board. The Plan will be continually updated and shared with Governing Bodies on a regular basis to support the GB's tracking of progress.

There are three phases to the One Team Programme:

Phase 1: September 19 – March 20: *Defining our story*
Phase 2: April 20 – September 20: *Working Together as One Team – Winning Hearts and Minds*
Phase 3: October 20 – April 21: *Fit for the Future – Creation of New Organisation*

5. Next Steps

From January 2020 the Programme Team will focus on three key areas:

- Creating and socialising our Case for Change and Communications and Engagement Strategy (up to end of Phase 1).

- Ensuring our senior management structure and governance is fit for purpose for moving into shadow form by 1st April (beginning of Phase 2).

- Drafting and approving the documents required for our application to become One BLMK CCG (end of Phase 2).

Appendix 1 - One Team Programme work streams, core membership and responsibilities

Role Title	Responsibilities	Resource
Programme Leadership	Reporting to SRO with responsibility for management of entire programme, including stakeholder management	**Maria Wogan / Alison Joyner**
Programme Delivery Manager	Main focus on delivering TOM and organisational structure and supporting AD to deliver other work streams	**Sandra Vanreyk**
Comms & Engagement	To deliver all comms and engagement requirements for single CCG	**Ruth Adams**
Governance	To delivery all governance requirements for single CCG	**Michael Wuestefeld-Gray**
Organisational Development	To manage the OD work stream	**Karen Rhodes**
Human Resources	To provide client-side management of AGEM team supporting delivery of HR workstream	**Emma Richards**
PMO Support	Programme planning and reporting function	**Joyce Baskerville**
Target Operating Model Design Lead	To design the TOM & new organisational structure from the "Do Share Buy" outputs	**Maria Wogan**
Finance workstream	To develop the and deliver all finance requirements of single CCG	**Wendy Rowlands**
Digital Strategy	To deliver the single ICT workstream	**Mark Peedle**
Quality & Nursing	To ensure CCG statutory standards for Quality & safeguarding are maintained	**Maria Laffan**
Primary Care Commissioning	To manage the processes required to implement new Primary Care operational delivery arrangements and ensure smooth transition to end state Primary Care commissioning	**Alexia Stenning**
Estates & Property	Develop and implement plans for new BLMK CCG corporate estate	**Stephen Makin**
BI, Contracting & Performance Management	Determine BI contract information and resource requirements, SOPs and corporate performance reporting to match future functions	**Stephen Makin**