NHS
Cambridgeshire and Peterborough
Clinical Commissioning Group

CCG REPORT COVER SHEET

Meeting Title:	**Governing Body in Public**						**Date: 11 May 2021**	
Report Title:	**Integrated Performance & Assurance Committee (IPAC) Overview Report**						**Agenda Item: 4.2**	
Chief Officer:	Sharon Fox, Director of Governance							
Committee Chair	Dr Jane Collyer, GP Member and IPAC Chair							
Report Author:	Simon Barlow, Corporate Governance Manager							
Document Status:	Final							
Report Summary:	This Report provides a summary overview of the last meeting of the Integrated Performance & Assurance Committee held on 27 April 2021.							
Report Purpose:	**For Assurance**	**x**	**For Decision**		**For Approval**	**x**	**For Recommendation**	
Recommendation:	The Governing Body is asked to: • Note the contents of the Overview Report and endorse the work of the Committee. • Note the approved minutes of the meetings held on 23 February 2021 (Appendix A) and 30 March 2021 (Appendix B). • Note the latest clinical policies and position statements approved by the Clinical Policies Forum and IPAC (Appendices C – I).							
Link to Corporate Objectives: 2020/22	**Ensure everyone has the opportunity to improve their health and well-being**							√
	Level-up health and care provision to ensure our communities in areas of high deprivation and need get the resources needed to minimise inequalities							√
	Focus time and resources on areas where people receive most of their health and care services, the community							√
	Facilitate organisations to join forces at 'place' and offer 'patient first' well-co-ordinated efficient services to those who need them.							√
	Deliver our statutory financial commitments as best as possible							√
CAF (Strategic Risk) Reference	**Description of Risk** *Pertinent risks include the following*							**Current Risk Score**
CAF 03	There is a risk that the system will fail to achieve the expected 2021/22 cost base and planned deficit (as submitted to Regulators in January 2020) which will lead to non-delivery of the LTP trajectory.							20 (R)
CAF 08	There is a risk that the transition from the CCG to the Integrated Care System will lead to loss of focus on business as usual and the delivery of the CCG's statutory functions							12 (A)
CAF 12	There is a risk of serious impact to patients as a result of a failure in quality, safety and patient experience in the services that the CCG commissions as a result of the covid pandemic and recovery requirements							20 (R)
Impact Assessments	**Equality**							N/a – overview report
	Health Inequalities							
	Health Impact							
	Data Privacy							
	Sustainability							
	Quality							
Financial Impact	Not applicable - overview report							
Chief Officer/ SRO Sign Off:	Sharon Fox, Director of Governance							
Chief Finance Officer Sign Off: (if required)	N/A							
Legal implications	Nil							
Conflicts of Interest	Any Conflicts of Interest will be raised in line with the CCG's Conflicts of Interest Policy							
Report history:	Prepared for Governing Body following each IPAC meeting							
Next steps	GB to review/discuss							

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MEETING: **GOVERNING BODY IN PUBLIC**

AGENDA ITEM: **4.2** **SECTION:** **OPERATIONS**

DATE: **11 MAY 2021**

TITLE: **INTEGRATED PERFORMANCE & ASSURANCE COMMITTEE OVERVIEW REPORT**

FROM: **DR JANE COLLYER, GP MEMBER & CHAIR OF COMMITTEE**

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1 ISSUE

1.1 This report provides a summary overview of the last meeting of the Integrated Performance and Assurance Committee (IPAC) held on 27 April 2021.

1.2 IPAC provides scrutiny of delivery and assurance processes for quality, finance, performance, and contract management including activity. The Committee is also responsible for Operational Risk Management.

1.3 The approved minutes of the meetings held on 23 April and 30 March 2021 are attached as **Appendices A and B**

2 KEY POINTS

2.1. A summary of the main matters considered by the Committee at its April meeting is set out below:

- ***Integrated Performance Report (IPR) –*** IPAC received and discussed the April 2021 IPR. Specific areas highlighted included:
  - COVID-19 case rates were continuing to reduce across the CCG area. There had been a slight fluctuation in cases in Peterborough and Fenland in recent weeks due to increased levels of testing.
  - As time of reporting there were 29 COVID-19 patient in our hospital beds compared to a peak of 619 in January 2021.
  - Waiting lists in the Hospital Trusts remained a significant concern, although latest reporting indicated that 52+ week waiters was coming down.
  - Numbers of GP referrals had increased but remained lower than at the equivalent time in 2019/20.
  - Outpatient activity levels were rapidly increasing, particularly at NWAFT, but were still below pre-COVID-19 numbers.
  - There had previously been a reported downward trend in virtual activity levels at NWAFT, but over recent weeks an increase had been seen in first outpatients and follow-up appointments.
  - A very gradual improvement in diagnostics performance was reported
  - Improvements in urgent care performance at NWAFT reported in recent weeks which had been driven by plans put in place to bridge staffing gaps. Both Hinchingbrooke Hospital (95.5%) and

Peterborough City Hospital (92%) Emergency Departments had made positive progress in their daily performance in recent weeks.
- Overall Emergency Department admissions although increasing remained below pre-COVID-19 levels. Ambulance arrivals was however now above l pre-COVID-19 levels. A spike in NHS 111 activity was also reported.
- IPAC asked for additional data around Advice and Guidance use to be included in future reporting.
- In terms of Quality, it was highlighted that across all provider Trusts' staffing gaps and fatigue was a significant risk and had a major influence on the patient safety metrics.
- Maternity remained a specific area of concern at NWAFT. IPAC agreed to invite the new Director of Midwifery to its May meeting to discuss the latest position.
- The numbers of Serious Incidents reported by CPFT was an identified area of concern. The Quality Team was working with the Trust to gain a better understanding of the reasons for this.
- IPAC was encouraged to note that there had not be a COVID-19 outbreak within our care homes for a fortnight. Vaccination levels for residents in homes was over 90% but further work was needed to improve vaccination take-up by staff in certain homes.
- In terms of finance, it was reported that as at Month 12 the CCG was reporting a surplus of £138k and subject to Audit would report a break-even position for 2020/21. The system as a whole was also reporting a break-even position. The CCG's underlying financial position (Exit deficit) of £97m remained a significant concern.

IPAC also received initial 2021/22 H1 (months 1 – 6) activity forecast data plus an update on the financial allocations that had been issued by NHSE/I for the first half of the year and the progress that was being made towards developing a System Financial Plan for this period.

The latest version of the IPR appears elsewhere on this agenda for the Governing Body's consideration (Agenda item 4.1 refers)

- **Skin Cancer Tele Dermatology Service**

  IPAC approved a recommendation to proceed with implementation of a Tele-dermatology pilot in primary care that will improve patient outcomes for faster diagnosis of skin cancers. The Service is designed to ensure that patients with a skin lesion are seen in the correct clinical pathway and aims to maximize numbers of patients with skin cancer seen within the required national cancer target timescales. It is anticipated it will help to reduce the volume of GP referrals through the 2week pathway for benign (non-cancers), help improve cancer wait times, and improve GP education and skills on recognition of skin lesions and improve clinical pathways. Primary Care clinicians who currently do 2ww referrals (GPs and ANP) will also be trained to do dermoscopy.

  The presented paper addressed a number of questions that had been raised by the CCG's Medical Director. These concerned Medicines and Healthcare products Regulatory Agency (MHRA) product classification; Skin Analytics (SA) data sharing; inequalities; quality assurance and financial risks. There remained an issue concerning the classification of DERM AI as a Class 1 or

Class 2 device. That being the case it was confirmed the pilot would proceed on the following basis:

- Switch off the Telederm Artificial Intelligence (AI) function and implement the service with intermediate referral triage for skin lesions diagnostic unsurity and where Primary care is unsure whether a 2ww referral or a routine referral is warranted. This pathway will reduce the volume of 2ww referrals for non-cancerous skin lesion and help to reduce the burden of demand on 2ww pathways as requested by both CUHFT and NWAFT.
- Once the outcome of the MHRA Classification was established a further report will be brought to IPAC around the future 'switch-on' of the AI functionality.

In supporting implementation IPAC asked for further information on patient consent arrangements and selection of the participating practices.

- **Eating Disorder Services Update**

A paper was presented which provided an overview of the Eating Disorder Exemplar Project progress for the past 12 months, impacts of COVID-19 and the implications of the Report to Prevent Future Deaths.

The Committee was disappointed to learn that implementation of the Eating Disorder Exemplar Project, initially funded by NHS England and approved by the Governing Body in November 2019, had been detrimentally impacted by COVID-19 due increase in referrals, acuity and the need to pause transformation work to focus on managing demand, restoration and recovery. As a result the formal launch of the new service has been delayed until October 2021. Given the delay the CCG and Cambridgeshire and Peterborough NHS Foundation Trust (CPFT) Medical Directors and quality leads will meet to discuss any issues and provide support to this workstream. In addition, IPAC supported the recommendation that the Eating Disorder Summit be reconvened to ensure progress is made in this priority area.

IPAC has asked that it receive a further update in October 2021.

- **Escalation from Harm Free Cell on Learning Disability**

The Harm Reduction and Review Cell was set up in January 2021 to review the potential and actual harm that patients were experiencing across the system. Although its focus was on potential COVID-19 related harm, it was recognised that a lot of the harm had been exacerbated by COVID-19 as opposed to being directly due to the disease. Following a presentation by the Learning Disability Team the Cell agreed to submit its first escalation report to IPAC to highlight risks in three specific areas where the existing mitigations were not considered to be strong enough. The areas identified related to Annual Health Checks, Avoidable Deaths and Social Circumstances.

IPAC expressed its concern around the issues reported. The need to involve System Leaders in subsequent discussions and also to formally write on behalf of the CCG to escalate our concerns was supported.

- **ICS Population Health Management (PHM) Development Programme Wave 3 Pilot**

  Population Health Management (PHM) is an emerging technique for local health and care partnerships to use data to design new models of proactive care and deliver improvements in health and wellbeing which make best use of the collective resources. It uses historical and current data to understand what factors are driving poor outcomes in different population groups. PHM is already supported by the Governing Body and System Leaders. IPAC received an update on the programme together with details of the PHM Development Programme.

  The System Transformation team in NHS/EI has offered all systems the opportunity to participate in the PHM Development Programme which aims to build capacity and capability by working with all tiers of the system to transform service delivery around key population groups. The programme – run through a blend of NHSE/I teams, external SME and transformation partners - is intended to support and enhance local efforts in the ongoing response and recovery and build on local governance rather than add to an already stretched workload of frontline teams. IPAC noted and supported key progress points as follows:
  - The Health Inequalities Board was helping to choose the Place to focus the project on. Clinical, Medical Director Executive and Non-Executive input into decision making would be sought.
  - Work was taking place with the Local Medical Committee to seek expressions of interest from Primary Care Networks from across the system.
  - In terms of creating a linked dataset meetings held with Optum, NHSE/I and local data and information governance leads to discuss requirements. The System IG Group was supporting with Data Sharing and Processing agreements as well as Data Protection Impact Assessments.
  - Due consideration to be given how to utilise most effectively the £50k that NHSE/I was making available to support the project.

  IPAC was fully supportive of the programme and agreed the paper would be submitted to ICS System Leaders for further discussion and decision. The importance of ensuring the right level of resource to manage the project was identified as key.

- **Shared Care Record Procurement Update**

  Simon Stevens', Chief Executive of the NHS in England, letter in July 2020 mandated that all Integrated Care Systems/STPs were to have a Shared Care Record (ShCR) solution with a Minimal Viable Solution (MVS 1.0) in place by September 2021. In response, ShCR MVS 1.0 was now a core priority for Cambridgeshire and Peterborough (C&P) as agreed by System Leaders. IPAC received a progress report on the Shared Care Records Programme and associated procurement process. In light on ongoing contract negotiations this paper will be presented to the Governing Body in Private for decision.

- **Clinical Policies Forum and Exceptional/IFR Cases Report**

  The recommendations of the Clinical Policies Forum were approved by IPAC. This included approval of the following clinical policies and position

statements, in line with its delegated authority. These are listed below for noting by the Governing Body **(attached as appendices C – I)**

- Dupuytren's Contracture Surgical Threshold Policy - Appendix C
- Open or Upright MRI Lower Clinical Priority Policy – Appendix D
- Referral for Bariatric Surgery Surgical Threshold Policy – Appendix E
- Lower Gastrointestinal Endoscopy (Colonoscopy or Sigmoidoscopy) – Appendix F
- Circumcision Surgical Threshold Policy – Appendix G
- Cosmetic/Aesthetic Surgery Lower Clinical Priority Policy – Appendix H
- Chalazion Surgical Threshold Policy – Appendix I

- **CCG Assurance Framework & Risk Register**

  Version 1 of the 2021/22 Corporate Assurance Framework and Risk Register (CAF) was received and noted IPAC welcomed the new format now adopted and which sought to make the CAF more accessible and easier to monitor.

  The current version of the CAF is presented elsewhere on this agenda for Governing Body consideration (Agenda item 2.7 refers)

3. OTHER MATTERS

3.1 IPAC Meeting held 30 March 2021

Age Learning Disability and Autism 3-Year Commissioning Intentions and Funding Expenditure Plan 2021-22

IPAC received a paper and an accompanying presentation that outlined the local allocation and the 3-year funding expenditure plan aligned to the Long Term Plan (LTP) commitments based upon outcomes of the local community mapping exercise. The plan had been developed to be a sustainable 3-year plan integrated into the NHSE planning process and which provided full coverage of the patient pathway including a personalised approach to care.

IPAC recommended the following recommendations for Governing Body approval:

- Commit to the delivery of the Long Term Plan Commitments as outlined in the Funding Expenditure Plan;
- Approve the 3-year expenditure plan where investment has been identified until Financial Year 2023/24; and
- Support the five key priorities outlined in the report and referenced above.

The full report on this matter is included elsewhere on the agenda for Governing Body discussion and approval (Agenda item 3.2 refers)

3.2 In addition to the above, IPAC received and considered the following items at its March meeting:

- IPR - March 2021
- Year End update
- Financial Plan 2021/22 Update
- Mass Vaccinations Update
- Complex Cases 28 Day Backlog Proposal
- Latest CCG Assurance Framework and Risk Register

The approved minutes of this meeting are attached as Appendix B for information.

4 RECOMMENDATION

4.1 The Governing Body is asked to:

- Note the contents of the Overview Report and endorse the work of the Committee.
- Note the approved minutes of the meetings held on 23 February 2021 (Appendix A) and 30 March 2021 (Appendix B).
- Note the latest clinical policies and position statements approved by the Clinical Policies Forum and IPAC (Appendices C – I)

Simon Barlow,
Corporate Governance Manager
6 May 2021

Attachments

Appendix A	Minutes of the meeting held on 23 February 2021
Appendix B	Minutes of the meeting held on 30 March 2021
Appendix C – I	Approved Clinical Policies.

Meeting: **Integrated Performance & Assurance Committee**
Date: **23 February 2021 at 1PM**
Venue: **VIRTUAL MEETING – TEAMS**

MINUTES

Present:
Dr Jane Collyer (Chair)
Stephen Mitcham – Lay Member
Dr Sri Pai – GP Member
Dr Adnan Tariq – GP Member
Carol Anderson – Chief Nurse
Dr Katherine Rowe – Secondary Care Doctor
Louis Kamfer – Chief Finance Officer
Jessica Bawden – Director of Primary Care
Sharon Fox -Director of Governance
Jane Webster – Director of Commissioning
Jan Thomas -Accountable Officer (part – Minute 6.3)
Dr Gary Howsam – Clinical Chair

In attendance:
Laura Hill – Lay Member
Alison Clarke – Dir. of Intensive Supp. & System Lead Dir. for C&P, NHSE/I
Sandie Smith – Healthwatch
Chris Gillings – Associate Director Business Analytics
Sarah Hannay – Acting Deputy Chief Finance Officer
Mandy Staples – Deputy Chief Nurse
John Clayton - Senior ICT Service Development Manager (Minutes 6.1)
Dr Gysbert Fourie - GP Clinical Lead (Minute 6.3)
Rob Murphy - North Alliance Programme Director (Minute 6.3)
Tonia Keates - Senior Programme Manager – Planned Care (Minute 6.3)
Kelly Broad - Deputy Chief Pharmacist (Minute 6.6)
Lyndsay Codd - Head of Service Complex Cases Team (Minute 6.7)
Simon Barlow – Corporate Governance Manager

1. Welcome, Introductions and Apologies for Absence

Apologies for absence were received from Dr Mark Brookes, Dr Fiona Head and Sue Graham,

2. Declarations of Interest

Agenda Item 2.1 – *Provision of Ardens for all C&P Practices* – The GP Chair and all other GP Members declared an interest in this item. Refer to minute 6.1 for details.
Agenda Item 2.3: *IVF Services* - Dr Gysbert Fourie declared an interest in this item. Refer to minute 6.3 for details.

3. Notification of Any Other Business

Position update on accuRX system. This was discussed under minute 6.1.

4. Minutes of Last meeting.

The Minutes of the meeting held on 26 January 2021 were accepted as an accurate record.

5. Action Log and Matters Arising

The action log was updated and appended to the minutes.

6. Operational & Other Matters

6.1 Provision of Ardens for all C&P GP Practices

All GP Members of the Committee declared an interest in this item and did not participate in the decision, although this did not preclude them from participating in the discussion. The Lay Member Deputy Chair, Stephen Mitcham took the chair for this item.

John Clayton, Senior ICT Service Development Manager was in attendance for this item.

IPAC was informed that Ardens was a Clinical Decision Support Tool (templates and reports) for GP practices which used either SystmOne or EMIS Web GP clinical systems. Standard clinical templates offer users access to national and localised best practice guidance to support coding of clinical data into the GP clinical record. This improved quality of the data recorded within the GP clinical record and could be an aid to provision of evidence based care. It was also capable of being used to provide anonymous reporting to support performance and quality monitoring including across Primary Care Networks and the CCG as well as within the GP practice. Feedback received from a number of practices and Primary Care Clinical directors was that Ardens was beneficial for patient care as well as for practice ways of working. As a result a proposal had been put forward to purchase and implement a CCG wide contract for the provision of Ardens to all GP Practices, a large number of whom (50 out of 85) were already using the system.

IPAC (excluding GP members) **approved** the recommendation to support all remaining 35 practices to implement Ardens as soon as possible under a free trial basis to provide standardised support to COVID vaccination cohort identification, management and associated data recording and to then proceed with the purchase of Ardens and Ardens Manager. IPAC (excluding GP members) **approved** for 2021/22 but also asked that managers explore the potential for a longer term contract to be put in place. Should a longer

term arrangement be procured it was confirmed this would need to be reported through the Governing Body, with funding coming from the GP IT budget. IPAC also highlighted the need to make appropriate provision for training to support practices and help them to understand the benefits it could provide and to use the system to its full potential.

It was noted that procurement would be progressed through a Framework but would require a waiver to Standing Orders to be completed and agreed given the uniqueness of the product.

In response to a query raised by Dr Adnan Tariq, the Committee was informed that future paper would be presented to the Chief Officer Team, and potentially IPAC, concerning the current contract and future funding arrangements for the accuRx system in light of national plans to introduce a new video consultation and communications framework in August /September of this year. **ACTION: Louis Kamfer (John Clayton)**

Dr Jane Collyer returned to the Chair at the conclusion of this item.

6.2 Peterborough UTC & OOHs Relocation to PCH Site Update

IPAC received an update on the relocation of the Peterborough Urgent Treatment Centre (UTC) & Out of Hours services (OOHs) from the City Care Centre (CCC) to the Peterborough City Hospital (PCH), which was a key element of the Urgent and Emergency Care (UEC) Collaborative Delivery Plan.

It was reported that the COVID Pandemic and associated lockdowns had caused the programme to be delayed. This had primarily been due to an issue with supply chains involved in the provision of new modular units; contractors unable to work on site because of COVID restrictions; and winter pressures. To mitigate this the Chief Officer Team had recently approved an extension to the existing contract with Lincolnshire Community Health Service (LCHS) until 1st July 2021. As a result, a new 'Go Live' date of 30 June 2021 had been set with a revised critical path plan developed to enable this date to be met. It was noted the revised timeframe would be reliant on a number of elements, which included North West Anglia NHS Foundation Trust's (NWFT) Full Business Case (FBC) being approved by its Board; successful recruitment to a number of identified vacancies; and securing satisfactory solutions to a number of Information Management and Technology issues that concerned the use of different clinical systems. In terms of the vacancy rate refenced in the received paper of 10 Whole Time Equivalents (WTE) it was confirmed that the latest figure was considerably lower at 5.72 WTE.

Sandie Smith, Healthwatch observed that in view of public disagreement and dissatisfaction which had been raised in some quarters regarding the move she welcomed this delay as it would provide the CCG with additional opportunity to further explain and promote the benefits associated with co-locating services. It was noted that a specific area of concern raised was the ongoing issue of parking on the hospital site.

IPAC **noted** the reasons and assurances given behind the revised date of the transfer & go live of the relocation of the Peterborough UTC & OOHs services from the City Care Centre to the PCH site until 30th June 2021.

6.3 IVF Services

Rob Murphy, North Alliance Programme Director, Dr Gysbert Fourie - GP Clinical Lead and Tonia Keates, Senior Programme Manager were in attendance for this item.

Dr Gysbert Fourie declared an interest as his wife was an IVF Specialist who worked in private practice in London. Dr Gysbert was in the meeting to support presentation of the paper and was not part of the decision-making process.

The Committee received a further draft paper that explored options concerning the possibility of re-instating IVF services, following its suspension in September 2017. The paper provided supporting information around numbers (and types) of IVF cycles plus the financial impact and other related impacts should a decision to re-instate services be ultimately made.

Following general discussion, IPAC asked that additional information and clarification be provided in a number of areas - including the reasons for re-instatement; associated impacts; and financial assumptions, in advance of any recommendations being brought to a future meeting of the Governing Body for its consideration and decision. The Committee recognised that should any subsequent decision be made by Governing Body to re-instate IVF services, the associated policy would then need to be revised and relevant contractual arrangements be determined.

6.4 CCG Assurance Framework & Risk Register

The latest version of the Corporate Assurance Framework and Risk Register was received and discussed.

It was noted that a number of substantive changes had been made to the CAF since the previous version was presented at the January 2021 meeting. The changes included:

- Increased risk score from 20 (Red) to 25 (Red) for CAF05 - *Failure of Care Homes to be able to respond and manage resident care needs during the Pandemic and the Increasing expectation from NHSE/I on the responsibilities for care homes to sit with CCGs* – to reflect the increase in Covid outbreaks at home;
- Increased risk score from 12 (Amber) to 20 (Red) for CAF 06 - *Failure to deliver the Covid-19 Recovery and Restoration Plan* to reflect the impact of Wave 3 of the pandemic and also the delivery of the mass vaccination delivery programme had had on this work.

- A de-escalation of CAF 08 - *Risk to maintaining robust CCG Governance Arrangements* – had been proposed due to the target risk score having been reached and the fact risk would continue to be monitored as part of the Governance Directorate's risk register.
- Proposed de-escalation of CAF 17 - *Failure to adequately prepare for End of Transition (EU Exit) on 31.12.2020* - due to this no longer being viewed as a major risk post passing of the exit deadline.

The Committee was also informed that a new risk – CAF 20 - *Potential failure to safeguard people or use appropriate assessment of capacity in services the CCG Commissions* had been added to the CAF on the request of the Chief Nurse, who considered the risk to have been heightened due to the impact of the Covid 19 Pandemic on workforce resilience (both frontline and safeguarding staff) and the increased complexity of safeguarding cases.

IPAC **noted** the latest version of the CAF which would presented to the Governing Body in Public on 2 March 2021. IPAC also **supported** the recommendation to de-escalate the two risks referenced in the report (CAF 08 and CAF 17) from the CAF to the Governance Directorate Risk Register, where they would continue to be reviewed and monitored at a directorate level.

6.5 IG, BI & ICT Steering Group Overview

IPAC considered a short overview of the work of the IG, BI & ICT Steering Group. Although the last meeting of the Group on 28 January had been cancelled, the Committee received a number of documents which related to the My Care Record (MCR) which provided health and care professionals with electronic access to records by participating organisations, for endorsement.

IPAC **noted** the latest overview of the work of the Steering Group and **endorsed** the following documents.

- MCR Information Sharing Agreement
- MCR ISA GP Addendum
- MCR DPIA
- MCR Fair processing Agreement
- MCR Audit Procedure

IPAC also received and **endorsed** the Steering Group's Terms of Reference which had undergone their annual review.

6.6 C&P Joint Prescribing Group Recommendations

Kelly Broad, Deputy Chief Pharmacist was in attendance for this item.

IPAC received and approved the recommendations of the Cambridgeshire and Peterborough Joint Prescribing Group (JPG) arising from its meetings held between October 2020 and February 2021. The recommendations in full can be found at **Appendix A** to these minutes.

The Chair queried how updates to the Shared Care Guidelines / Prescribing Support Guidance was communicated to primary Care. IPAC was informed that this was done through a variety of ways which included circulation of the Prescribing Newsletter; updating templates with Shared Care Guidelines within SystmOne; and also via the updated Formulary.

The Chair was pleased to note that relevant costings had been included within the presented report as had previously been requested.

Under this item, Carol Anderson, Chief Nurse wished to place on record the excellent work that the Medicines Management Team had, and continued to

do, around the Mass Vaccinations Delivery Programme. These sentiments were endorsed by the Committee.

6.7 Complex Cases Team Service Update

Lyndsay Codd, Head of Service Complex Cases Team was in attendance for this item.

The Committee received a comprehensive service update on the Complex Cases Team and progress made in relation to performance, recovery work and staffing positions for the previous three-months.

It was reported that COVID-19 had had a significant impact on the performance, delivery and finances of the Complex Cases Team which was seeing a higher volume and acuity of patients being referred for assessment. Since 1 September 2020, the Team had returned to some business-as-usual functions, as well as managing the recovery of services suspended during COVID-19. However, the impact of Continuing Healthcare Nurses being redeployed to support the mass vaccination programme continued to have an impact on the normal functions undertaken by the Complex Cases Team.

IPAC was pleased to note the positive recruitment campaign that had been carried out during the pandemic, and that staff vacancies within the Team were now significantly reduced.

It was noted that there was a direction from NHSE for all deferred assessments to be completed by 31 March 2021. A trajectory had been developed which detailed the number of assessments to be completed on a weekly basis to achieve this target. For the latest period reported to NHSE on 31st January 2021, the Team remained on track to meet the trajectory, with 163 outstanding deferred assessments remaining, from the original starting point of 510 outstanding cases.

IPAC **noted** latest service update and acknowledged the positive progress that had been made by the Complex Cases Team in the last quarter, particularly given the significant pressures the service continued to face.

7. Integrated Performance, Delivery & Transformation

7.1 Integrated Performance Report (IPR) – February 2021

The Committee received and discussed the February 2021 Integrated Performance Report (IPR). The latest version included sections on Covid-19; performance metrics; activity and trends; quality, safety and patient experience; mental health, population health and inequalities, finance, and HR data. Specific points raised and discussed by the Committee were briefly noted as follows:

- Positive cases of COVID were down in Cambridgeshire to around 100 cases per day. A similar decrease was being seen in Peterborough, but the overall number of cases remained high. position in Peterborough had been exacerbated by an outbreak at the prison.
- As expected acute activity performance was rated red against the majority of national standards, although some ‘bounce-back’ was being reported in some areas.
- A decrease in referrals was reported for January 2021 which was aligned to the national lockdown.

- At the request of the Committee first outpatient attendances virtual activity data was now included broken down to speciality level and which demonstrated there were noticeable variances between specialities.
- Although it was recognised that the number of Covid patients would remain high a question was raised around Critical Care bed occupancy and the current patient mix within the respective Trusts and whether there were any marked differences between them. It was noted that this was an area which would need to be explored outside of the meeting. **ACTION: Chris Gillings to raise with Sue Graham.**
- The marked difference in activity levels between NWAFT and CUHFT was noted. IPAC asked that relevant activity at private hospitals (e.g. Fitzwilliam Hospital and the Spire) be overlayed with acute trust activity data to provide a more complete picture. **ACTION: Chris Gillings**
- Some concern was raised concerning the accuracy of primary care data included within the IPR, which in many cases did not align with GP Member experience 'on the ground'. It was explained the data used was subject to a number of variables which made reporting locally comparable data problematic. To reflect this a future 'health warning' concerning the nature of the Primary Care data presented would be included within this section of the IPR until addressed. **ACTION: Chris Gillings**
- An improvement in diagnostics performance was reported across all of the Trusts, but it remained below 'ordinary' levels.

- In terms of cancer, two-week (2ww) waits had remained relatively constant over the last month at both NWAFT and CUHFT – although a slight decrease in 2ww activity had been seen in the last week. Activity around Cancer Patient Treatment Lists (PTLs) and 62-Day Cancer PTLs backlogs and treatment activity continued to fluctuate. IPAC was reassured to learn that the CCG was now meeting with Trusts on a weekly basis and working closely with the Cancer Alliance to review all data in detail and identify and seek to address any anomalies or issues that were impacting on activity and/or performance.
- IPAC was informed that in regard to Mental Health information discussions were being held with CPFT to ensure that all required data was reported to the CCG in a timely way.
- A number of significant quality issues and concerns were reported to the Committee by the Chief Nurse. It was noted that these would be raised and discussed in greater detail at the Governing Body (Part 2 meeting).
- IPAC was pleased to note the Queen Elizabeth Hospital NHS Trust (QEH) was responding well to the Care Quality Commission recommendations and had been rated as 'good for care' in a number of areas. The Section 31 previously applied to the Trust's maternity service had also now been lifted.
- The Committee was disappointed to learn that a further two Never Events had been reported, one at CUHFT and the other at NWAFT.
- The reported increase in pressure ulcers was also seen as a specific of the stress and pressures the system was currently facing and was likely to be directly linked to the reduced numbers of nursing staff.
- In terms of finance, at Month 10 the CCG was reporting a year to date £4.5m favourable variance against the planned deficit of £15.4m and had therefore revised the end of year forecast to a £7m favourable variance against a deficit plan of 23.1m.

- The CCG's underlying financial position remained an area of considerable concern, with the planned 2020/21 deficit of £54m having significantly increased to £97m 2020/21 Exit (recurrent). This was mainly as a result of the non-delivery of QIPP due to the focus on COVID; higher than anticipated provider block contract costs; and other cost pressures. The CCG was working with its partners to assess the overall system deficit position which would then be reported to the Region.

IPAC **noted** Integrated Performance Report for February 2021.

8. Committee Effectiveness

8.1 Reflections on Meeting

Although a this had been a particularly long meeting with a full agenda, Members considered all items had been appropriately discussed and dealt with. The Committee also congratulated Dr Jane Collyer for her effective chairing of the meeting.

9. Date of Next Meeting

Tuesday, 30 March 2021 at 1PM

Simon Barlow
Corporate Governance Manager
March 2021

Appendix 1

The Integrated Performance & Assurance Committee (23.02.21) approved the following recommendations of the Cambridgeshire & Peterborough Joint Prescribing Group (These were reported to the Governing Body in Public on 02.03.21)

Medication / Medical Device	Impact	Comments
Urinary Continence Products Formulary	Cost neutral	Members supported the extension of the current formulary to allow product choices to become embedded. Formulary choices remain cost effective.
Stoma Accessories Formulary	Cost saving	Members supported the system stoma accessories formulary. The products have been chosen based on clinical efficacy, patient tolerability, and cost. Members also noted that the system guidance provided advice to Primary Care on prescribing quantities and items which should not be prescribed or should be deprescribed going forwards. Items within the formulary have been classified as Green (suitable for prescribing in primary care) and Amber (items which should only be prescribed under the direction of a stoma care specialist – normally for a limited time duration).
Fidaxomicin	Based on a decrease in recurrence of CDI potential cost saving of £66,140 per annum and improved patient outcomes.	Members noted the recommendations of the system wide antimicrobial stewardship group supporting the position that for patients with a high risk of C.Diff. infection (CDI) recurrence (RCDI) fidaxomicin should be considered 1st line (FCDI) on the advice of a microbiologist. Recurrence rates for high-risk patients for fidaxomicin (15%) vs. current treatment vancomycin (28%) leading to a reduction in RCDI tariff costs per annum.
Potassium chloride oral formulations – removal of Slow K from the formulary (except for paediatric patients receiving chemo)	Slow K® is now unlicensed and subject to varying price costs (not listed in Part VIIIb of the Drug Tariff. Sando K® is the formulation with the lowest system accusation cost currently (comparable per mmol of potassium)	Members supported the recommendation that Sando K® effervescent tablets should be the formulary choice of oral potassium chloride as this is currently the formulation with the lowest accusation cost across the system. Members noted that Slow K® was now unlicensed but due to its palatability should be reserved for paediatric patients receiving chemo only (hospital only)
Olanzapine dispersible medications (formulary choice)	Cost saving: Orodispersible sugar free tablets range: £7.59 - £18.93 per month Orodispersible tablets range: £29.73 - £79.55 per month Oral lyophilisilates range: £48.07 - £174.79 per month	Members supported the recommendation that where a dispersible formulation of olanzapine is required this should be prescribed as 'orodispersible sugar free'. Members noted the difference in price between dispersible formulations and agreed that all patients should be reviewed and switched to the recommended formulations, where clinically acceptable and there was no risk of destabilisation for example due to table appearance. There is no evidence to suggest that one formulation is clinically better in relation to pharmacokinetics to pharmacodynamic properties and impact on patient outcomes.
Subcutaneous infliximab	Cost saving on activity. Use of infliximab SC will increase drug costs (PbR excluded) but total costs will be offset by a reduction in the activity costs associated with IV administration. Annual cost saving (collective) for existing patients: £218,660	Members supported the recommendation that subcutaneous infliximab should be made available to all new patients requiring infliximab (aligned to its license) and existing patients who are stable and would like to switch. Members noted that subcutaneous infliximab had dropped in price over the last 6 months but remained at a higher cost than intravenous infliximab based solely on drug costs. Members supported that as the evidence was comparable between both formulations and there was a drive to move patients away from the hospital setting, subcutaneous

Medication / Medical Device	Impact	Comments
	Annual cost saving (collective) for predicted new patients: £252,528.	infliximab should be supported, and the additional drug costs would be offset against the saving from activity related to intravenous administration.
Subcutaneous vedolizumab	Cost saving on activity. (Drugs cost are comparable for both formulations per patient per annum (PbR excluded) Annual cost saving (collective) for existing patients: £506,250 Annual cost saving (collective) for predicted new patients: £286,875.	Members supported the recommendation that subcutaneous vedolizumab should be made available to all new patients requiring vedolizumab (aligned to its license) and existing patients who are stable and would like to switch. Members noted that subcutaneous vedolizumab was comparable in price to intravenous vedolizumab and that as both formulations had shown to be comparable in relation to evidence and patient outcomes, subcutaneous vedolizumab should be supported as this would release activity associated with intravenous administration. This would also support patients locally by moving care out of the hospital setting into the patient's home.
Intravitreal Steroid Implant Dexamethasone (Ozurdex®) in Phakic patients with Diabetic Macular Oedema	Cost neutral when comparing drug costs and activity collectively to other commissioned anti-VEGF treatments (ranibizumab or aflibercept).	Members supported the recommendation that Ozurdex® should be considered a 1st line treatment where a patient is contraindicated to other NICE approved treatments (for example, significant cardiovascular risk or stroke risk, or for pregnant or breastfeeding women). Members also supported the recommendation that Ozurdex® should be considered a 2nd line treatment where there is no significant effectiveness and response of the diabetic macular oedema to the previous use of anti-VEGF agents (ranibizumab or aflibercept) and is more than 400microns, or central diabetic macular oedema which is less than 400microns which is refractory to other available treatments used and is associated with started vision (BCVA) decline because of this reason. Members noted that this indication had not been reviewed by NICE and was not currently on their workplan. Members agreed that if NICE were to review in the future and their recommendation was more restrictive or negative then CPJPG would review with the recommendation to align with NICE.

- **Shared Care Guidelines (SCG) / Prescribing Support Guidance Approved**
  - Trientine for the treatment of Wilson's disease (SCG between tertiary and secondary care) - *NEW*
  - Bosentan for digital ulcers in systemic sclerosis (update)
  - Melatonin Prescribing Support (paediatrics) – replaces current SCG
  - Stiripentol (update)
  - Humulin R U500 (update)
  - Triptorelin for precocious puberty (update)
  - Thiopurine treatment for paediatric gastroenterology and hepatology patients (update)
  - Penicillamine for Wilson's disease (update)
  - Penicillamine for Rheumatoid Arthritis (SCG withdrawn as no prescribing for this indication)
  - Azathioprine for inflammatory conditions (update)
  - Methotrexate (update)

The shared care approval process has been updated to ensure that associate CCGs are consulted and are able to comment on the clinical content of shared care guidelines.

- **NICE Technology Appraisals**. (CCG commissioned)
  All NICE Technology Appraisals will be commissioned 90 days' post publication, and prescribing will be reviewed 6 months' post implementation by CPJPG. Where a medicine included in the NICE TA is excluded from tariff a Group Prior Approval will be made available to providers.

Drug & Indication	NICE TA	Publication date	Excluded from tariff	Financial Impact	Comments
Galcanezumab for Chronic Migraine or Episodic Migraine in Adults	659	18/11/2020	Yes	NICE advises that reducing the frequency of chronic migraine attacks is likely to reduce the burden on healthcare providers which will offset the increased	Members supported the recommendation of 'HOSPITAL ONLY'

				cost associated with this treatment, making it comparable to other PbR excluded migraine treatments (including reduction in activity costs)	
Upadacitinib for severe rheumatoid arthritis	665	09/12/2020	Yes	NICE advise that they do not expect this guidance to have a significant impact on resources as this is a further treatment option and is available at a similar price to current treatment options.	Members supported the recommendation of 'HOSPITAL ONLY'
Liraglutide for managing overweight and obesity	664	09/12/2020	No	In tariff treatment. NICE advises under TA criteria that this should be prescribed within secondary care due to PAS price	Members supported the recommendation of 'HOSPITAL ONLY'
Brolucizumab for wet age-related macular degeneration	672	03/02/2021	Yes	Brolucizumab requires fewer injections per year and fewer monitoring appointments which can free up capacity in providers. However, this needs to be balanced against potential for biosimilars of existing treatment options becoming available.	30-day implementation required as per NICE TA. Members supported the recommendation of 'HOSPITAL ONLY'

- **Other Items for Noting:**
    - **End of Life Care Medicine Administration Chart (update) –** Chart has been updated based on feedback from Community Nurses and GPs. Changes included revision of wording relating to calculating maximum doses.
    - **Antimicrobial guideline update:** Guideline updated in line with NICE and PHE updates. This has been agreed through the system Antimicrobial Stewardship Group.
    - **Deprescribing Algorithms: Members agreed to endorse PrescQIPP deprescribing algorithms for:**
        - Allopurinol and Febuxostat (Gout)
        - Antidepressants
        - Antipsychotics in patients with dementia
        - Non-steroidal anti-inflammatory drugs
        - Benzodiazepines
        - Drugs of dependence – opioids
    - **Primary thromboprophylaxis policy for haematology and oncology patients** – Trust will supply full treatment course and notify Primary Care.
    - **Lipid Management for Primary and Secondary Prevention of CVD and Statin Intolerance Pathway**: Members supported the two documents developed by NHS England and the accelerated access collaborative.
    - **Dose escalations for intravenous infliximab and intravenous vedolizumab**: Members supported the recommendation that dose escalations should be considered short-term where a patient has had a subtherapeutic response to standard dose. This recommendation is in line with other CCGs across the East of England.
    - **Continuous Glucose Monitoring during pregnancy for women with Type 1 diabetes:** Members noted the commissioning decision from NHS England, as part of their long-term plan, to support the use of CGM (as defined in the framework) for Type 1 pregnant ladies for up to 12 months (C&P system guidance on the availability of CGM to be updated to include this recommendation).
    - **Freestyle Libre - additional NHSE categories**: Members noted a new patient cohort has been added to the NHS England list of those patients eligible for Freestyle Libre on the NHS, specifically any patient with Type 1 diabetes and on the GP learning disability register. Additional funding has been made available to the CCG**.**

- **Anticoagulant management of cancer and associated thrombosis** (update)**:** Members supported the updated policy which included a change of anticoagulant from edoxaban to rivaroxaban. Low molecular weight heparin will also remain a treatment option where a DOAC is contraindicated.

- **PHE and NICE statement on Vitamin D including free supplementation**: Members noted the updated PHE advice on vitamin D supplementation for all. Members noted that the availability of free supplements directly from PHE for those who are considered high risk (i.e. care home residents and those shielding). For others, the recommendation to purchase over the counter remains.

- **COVID-19 treatment, vaccination, and vaccine guidance**: Members supported the national guidance and updates relating to NHSE commissioned COVID-19 treatments and the vaccination programme. Members noted three vaccines had now been approved within the UK and agreed that these should be added to the system formulary as they become available with relevant links to key pharmaceutical documentation.
  Members also supported the recommendation relating to the prescribing of tranexamic acid for patients with inherited bleeding disorders requiring COVID-19 vaccinations on the recommendation of local haematologists *(Specialist advice)*

- **New Insulin Pumps and CGM prescribing Guidance (closed loop systems):** Members supported the use of several insulin pumps and CGM devices which are available under the Thames Valley Framework (available to all stakeholders within C&P) including the use of the Cam APS FX app which is licensed for children and in pregnancy unlike other commercial hybrid closed loop systems.
  Members noted that hybrid closed loop systems would only be supported for those patients who met both insulin pump and CGM commissioning criteria.

Appendix B

NHS
Cambridgeshire and Peterborough
Clinical Commissioning Group

Meeting: **Integrated Performance & Assurance Committee**
Date: **30 March 2021 at 1PM**
Venue: **VIRTUAL MEETING – TEAMS**

MINUTES

Present:
Dr Jane Collyer (Chair)
Stephen Mitcham – Lay Member
Dr Sri Pai – GP Member
Dr Adnan Tariq – GP Member
Karen Handscomb – Deputy Chief Nurse (attending for Carol Anderson)
Kit Connick – Director of Strategy and Planning
Louis Kamfer – Chief Finance Officer
Sharon Fox -Director of Governance
Jan Thomas -Accountable Officer
Dr Gary Howsam – Clinical Chair

In attendance:
Laura Hill – Lay Member
Lynne Brown – (Attending for Alison Clarke, NHSE/I)
Sandie Smith – Healthwatch
Jeremy Lane – Associate Director Business Intelligence
Marek Zamborsky – SRO for MH and LD Services (Minute 7.1)
Mandy Staples – Deputy Chief Nurse (Minute 7.3)
Cathy Barresi – Operational Manager, Complex Cases Team (Minute 7.3)
Simon Barlow – Corporate Governance Manager

1. Welcome, Introductions and Apologies for Absence

Apologies for absence were received from Dr Mark Brookes, Dr Sri Pai, Dr Katherine Rowe, Dr Fiona Head Sue Graham, Carol Anderson, Jess Bawden, Jane Webster and Sarah Learney

2. Declarations of Interest

There were no declarations of interest raised.

3. Notification of Any Other Business

There were no additional items of business identified.

4. Minutes of Last meeting.

The Minutes of the meeting held on 23 February 2021 were accepted as an accurate record.

5. Action Log and Matters Arising

The action log was updated and appended to the minutes.

6. Integrated Performance, Delivery and Transformation

6.1 Integrated Performance Report – March 2021

The Committee received and discussed the March 2021 Integrated Performance Report (IPR) which included sections on Covid-19; performance metrics; activity and trends; quality, safety and patient experience; mental health, population health and inequalities, finance, and HR data. New elements included in the March report were Independent Sector Provider activity data and reporting on the new Sentinel Indicators. Headline points raised and discussed by the Committee were briefly noted as follows:

- In terms of COVID it was reported that in line with the national picture a levelling off of new cases had been seen from the start of March 2021 and were continuing to reduce, although rates for Peterborough and parts of Fenland still remained in the top twenty nationally. An increase in school age cases had been seen, although this had been anticipated due to the increase in testing. The potential impact following the return to schools and initial lessening of lockdown restrictions would not be reflected in the data for another ten days or so.
- The number of COVID patients in the Acute Trusts was also slowly reducing. As at 16 March 2021 97 patients were being treated in our hospitals. IPAC was verbally informed this figure was now 74 as at today's date.
- The accuracy of the data around virtual activity, which indicated a falling trend since January 2021 was questioned. The expectation was that this type of activity would be increasing. In particular, it was highlighted that contrary to all the other Trusts Papworth was reporting an increase in its virtual activity. IPAC requested that this issue be further explored to establish if any data was missing or not being reported correctly. The observation was also made that due consideration needed to be given to how virtual activity was categorised e.g. telephone calls etc. The Business Intelligence Team to further explore and reflect in future reporting. **ACTION: Jeremy Lane**.
- In terms of outpatient virtual activity Dr Gary Howsam commented that there appeared to be disparity between different providers with NWAFT appearing to be some way behind CUHFT. Haematology and Dermatology were identified as particular examples.
- Concerns were raised around significant waiting lists which had built-up in the Trusts as a result of the ongoing pandemic, In particular the figure for patients waiting over 52 weeks across the system was unprecedented and emphasised the long term recovery planning that would be required. Jan Thomas, Accountable Officer advised that due priority and focus was being given to this issue. It was noted that Graham Wilde, Director of System Deliver had recently joined the organisation and working with Sue Graham, Director of Contracts and Performance and Jane Webster, Director of Commissioning, would lead on this work.
- Sandie Smith, Healthwatch commented that in terms of the waiting list build up, realistic communications with patients and public on this matter,

both in terms of the extent of the problem and the length of recovery process required, would be very important.

- The Chair raised a particular issue concerning particularly long waits for Lower GIs being reported at North West Anglia NHS Foundation Trust (NWAFT) and queried if any plan was in place to address this. **ACTION: Jeremy Lane** to raise with **Sue Graham.**
- A very gradual improvement in performance was being seen on a week by week basis for diagnostics.
- An increase in Mental Health Referrals across adults and children was being reported.
- The cancer 2-week waits was highlighted as an area of concern with an 11% increase on the previous months report.
- Staff absences at Trusts had steadily rose with the introduction of the last lockdown in November, although it was reported that numbers were now beginning to fall.
- It was noted the IPR now included Independent Sector Provider (ISP) activity for the whole of the system and that this was currently reporting an increase in activity. It was noted the CCG had very little access to historical ISP data so it was not possible to report on any trends at this stage. Work was ongoing to develop this dataset with a view to showing pre-COVID data at a future point.
- Jan Thomas, Accountable Officer highlighted that reported GP referral rates were lower than anticipated and that this was another key area which needed to be explored in greater detail to fully understand the reasons for this. The observation was also made that there had been little change in consultant to consultant referral rates and was an area that should be raised with the Trusts.
- IPAC noted that Sentinel Indicators had been included in the IPR for the first time. This set of indicators had been developed by the Health Intelligence and Insight Team within the CCG for the purpose of monitoring whether health inequalities were present and any trends over time. Forty three indicators had so far been identified which covered health needs; risk factors; mental health, community, secondary, and primary care services, workforce and outcomes. Data for nineteen of these indicators were currently available and included in the report. Work on the other indicators was ongoing and these would be reflected in subsequent reporting. A need to provide additional context around the indicators was identified and Jeremy Lane advised he would discuss this with the Health Intelligence and Insight Team to ensure the correct metrics were being used.
- IPAC noted the Urgent Care Flow Map which had been included in the pack and which sought to capture in visual form the existing flow across the system. Dr Gary Howsam commented this was helpful and posed the question as to whether improvements could be made to managing patient flow more effectively if current processes were structured differently.
- Sandie Smith, Healthwatch raised a query around ultrasound provision at Nuffield Hospital, and whether the additional capacity referenced at CUH was linked with that provided at PoW, Ely. **ACTION BI Team/Sue Graham to check.**
- Discussion was held around the Harm Reduction and Review Tactical Operational Cell, which worked collaboratively with Trusts and providers around the restoration and recovery of services and which ensured quality and patient safety was given due focus. Consideration was given about what would be an effective route for reporting any relevant issue to IPAC

but avoided potential for duplication. Process to be discussed off-line with the Chair. **ACTION: Karen Handscomb/Chair.**

- In terms of quality it was noted the first meeting of the quality surveillance group was held on 17 March 2021.
- There continued to be a high level of concern around maternity services at NWAFT and risks have been escalated to CCG Governing Body. These include the level of midwife to mother ratio and gaps in staffing in key areas including safeguarding and risk.
- CPFT were reporting high numbers of suicides. It was noted Public Health England would be looking at this in April.
- Infection Protection and Control visits to NWAFT had been carried out during March. Positive progress was being made.
- Jan Thomas, Accountable Officer advised she had attended a de-briefing with the Regional Chief Midwife, Director of Nursing which provided an overview and analysis on the RAG status of the actions in the Ockenden Maternity Services Assessment completed by Trust in the Cambridge and Peterborough LMNS. IPAC was pleased to note the report on Cambridgeshire and Peterborough's progress was one of the most positive in the East of England Region. Executive summary to be circulated to IPAC for information post meeting. **ACTION: Jan Thomas (Simon Barlow).**
- In terms of care homes and the relatively low vaccination take up rates by staff, Stephen Mitchell questioned if there was anything the CCG could do to address this. Karen Handscomb, Deputy Chief Nurse advised members of the quality team visited care homes to offer support and provide challenge where required. However, the CCG was limited in what it could do around this matter as it concerned personal choice. It was understood all staff undertook lateral flow testing and monitoring of this should provide some assurance and transparency.
- Some concern was raised around the higher than normal level of falls and pressure ulcers being reported by Trusts. This increase was in part associated with an increase in the movement of patients in hospitals, mainly as a result of the pandemic. It was noted an increase in falls and pressure ulcers was a general indicator for the current strain that Trusts were presently working under.

IPAC **noted the** Integrated Performance Report for February 2021.

6.2 Year End Update

Louis Kamfer Chief Finance Officer reported that NHSE/I had recently advised that not just healthcare systems but all individual organisations would now be required to achieve a breakeven position at year end. Initial work had improved the CCG's deficit position from the £16.1m originally reported at M11 to £12.6m. Further actions would need to be progressed as the CCG sought to meet this requirement.

Under this item IPAC received a paper that set out the System 2020/21 financial position and summarised the proposed approach to managing the systems year end position which revolved around a revised distribution of covid and growth allocations. This was subject to further discussion and agreement with individual partners. It was also highlighted that the final forecast position for the System would be dependent upon confirmation of the income support to be received from NHSE regarding Lost Income. Following

discussion, IPAC **approved** the proposed approach as set out in the received paper subject to the other income being agreed by NHSE and **supported** its submission to the Financial Performance and Planning Group (FPPG) for sign-off. A position update would be given at the next meeting.

7.3 Financial Plan 2021/22

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Louis Kamfer, Chief Finance Officer advised that national planning guidance around 2020/21 had only very recently been received, with the significant focus being placed on recovery and ability for systems to obtain additional monies to support their recovery. The Finance Team and system colleagues were currently working though the guidance and a report on the latest position would be prepared for the April 2021 Committee.

7.3 Mass Vaccinations Update

Jan Thomas, Accountable officer provided a verbal update to confirm delivery of the vaccination programme was continuing to progress well. There were concerns around the increasing stock levels of 'green tops' (Short shelf-life vaccines) and the potential for wastage if not used. Work was also progressing on the 'pop-up' clinics which would provide easier access to different groups. IPAC was pleased to note that in all current cohorts, including the over 50s, coverage was above 75% and take up of the vaccination remained good. It was recognised that the coming Easter weekend and subsequent weeks would be an important period in respect of the programme's delivery.

IPAC welcomed the effort and thanked all those concerned for the good progress being made, recognising that significant work still remained.

7. Operational and Other Matters

7.1 All Age Learning Disability and Autism 3-Year Commissioning Intentions and Funding Expenditure Plan 2021-22

Marek Zamborsky, SRO for MH and LD Services, was in attendance for this item.

IPAC received a paper and an accompanying presentation that outlined the local allocation and the 3-year funding expenditure plan aligned to the Long Term Plan (LTP) commitments based upon outcomes of the local community mapping exercise. The plan had been developed to be a sustainable 3-year plan integrated into the NHSE planning process and which provided full coverage of the patient pathway including a personalised approach to care.

It was noted that a mapping exercise to measure Cambridge and Peterborough's progress against the original model service specifications had identified five clear priorities within the investment of the LTP, these related:

- LeDeR (Learning Disability Mortality Review Programme) with a focus on completing reviews as per performance indicators and embedding system wide learning from those reviews.
- Crisis care – All age 7-day specialist crisis care for LD and ASD including adjustments to existing mental health services within this remit.
- Autism – All age post diagnostic system off across health and social care in addition to enhancements to the diagnostic commissioned service

- Children and Young People (CYP) keyworkers – All CYP with a learning disability, autism or both on the Dynamic Support Register to have a designated keyworker, including those who face multiple vulnerabilities such as looked after and adopted children, and children and young people in transition between services.
- Adult LD Community Forensic Service – Inclusion of the forensic provider collaborative led by Hertfordshire for our region and adjustments to our existing LD ASD community forensic offer.

IPAC was advised that all proposed investments set out in the report would be funded within the anticipated Learning Disability allocations or available CCG Mental Health Investment Standard (MHIS) budget as follows:

2021/22	£1,273,172
2022/23	£1,158,812
2023/24	£1,755,310

It was highlighted that the NHSE/I anticipated allocation was based on indicative budgets and commitments would therefore be withheld until the allocations had been received. In addition, in light of any financial impact resulting from lack of confirmation of a finding settlements beyond 2023/24 the priorities would be reviewed in line with NHSE/I guidance.

It was recognised that due to a national shortage in suitably trained and skilled staff recruiting to the roles identified in the plan would constitute a risk. Local and national recruitment strategies, together with other alternative means to secure required staffing, would be explored.

Sandie Smith, Healthwatch in welcoming the plan sought assurance that the CCG and Local Authorities were both fully linked into the all-age autism strategy. Marek Zamborsky confirmed this was the case.

Following discussion on this report IPAC **recommended** that the Governing Body:

- Commit to the delivery of the Long Term Plan Commitments as outlined in the Funding Expenditure Plan;
- Approve the 3-year expenditure plan where investment has been identified until Financial Year 2023/24; and
- Support the five key priorities outlined in the report and referenced above.

7.2 CCG Assurance Framework and Risk Register

The latest version of the CCG Assurance Framework and Risk Register was received and discussed.

IPAC was informed that the annual Internal Audit review of the Risk Management Framework, which was undertaken on an annual basis, had provided the CCG with Reasonable Assurance with a number of low priority actions recommended. These would be taken forward by the Governance Team working alongside the Chief Officer Team and directorate risk coordinators.

It was noted work to prepare the 2021/22 CAF in the new format that had previously been shared with the Committee was being progressed. Following discussion with Internal Audit, efforts would be taken to further enhance reporting and for the new format to include further detail on the presentation of

the risks to relevant Committees, refining the narrative in the summary report, including more clarity around First, Second and Third Assurance, and a 12 month trend analysis.

In terms of specific risks, the observation was made that the risk score for CAF 10 - *The possible serious impact of any failure in quality, safety and patient experience in the services that the CCG* commissions *in acute care, community, integrated and mental health care* - may need to be reviewed and increased in light of the reported quality concerns and issues. This would be done as part of the overall review of the CAF for 2021/22.

IPAC **noted** the latest version of the CCG Assurance Framework and Risk Register.

7.3 Complex Cases 28 Day Backlog Proposal

Mandy Staples, Deputy Chief Nurse and Cathy Barresi, Operational Manager, Complex Cases Team joined the meeting for this item.

A paper was received that provided an overview of the 28 day backlog (Covid Wave 2), how it arose and possible solutions to address this issue. IPAC was informed that the impact of postponing NHS Continuing Healthcare Framework principles during the second wave of COVID had resulted in a backlog of NHS Continuing Healthcare cases where patients had failed to have their assessment within the 28-day time frame. Based on the latest projections there were now 260 assessments to be undertaken to ensure patients were receiving the right care and that the CCG was fulfilling its Responsible Commissioner duties from day 29. A specific area for urgency around this concerned the fact that it was not known if all patients that had been referred for assessment were currently receiving appropriate care.

The options considered were to progress with the assessments in house; retain agency nurses to complete; outsource the activity to an outside organisation; or do nothing. The preferred option was to outsource to the independent provider, CHS Healthcare, to do the backlog assessments at an estimated cost of £467k for a period of 5-months. This recommendation took in to account all assessments would be completed by 31 August 2021, there would be no backlog of assessments, the financial trajectory and oversight would be clear, patients would be in a clinically appropriate commissioned service where deemed eligible and that the full NHS Continuing Healthcare statutory process would be fully recommenced. It was noted that given the urgent need to commence this work authorisation to dispense with competitive tendering or Standing Financial Instructions requirements in relation to the award would be sought should the proposal be approved.

IPAC acknowledged there was a need to adopt an alternative and targeted way to clear the backlog and recognised that outsourcing the work would free-up the current workforce to focus on new referrals, reviews and other statutory functions from the start of the new financial year. The observation was made that the options appraisal which had accompanied the presented report did not include a financial breakdown for all of the options put forward. It was therefore requested that this be addressed and a fully populated version be circulated to IPAC members post meeting for information. **ACTION: Mandy Staples.** A need to further assess and confirm the rationale around the

procurement process and waiver to standing orders process being proposed was also highlighted. **ACTION: Mandy Staples/Mark Balaam**

Jan Thomas, Accountable Officer made the observation that in the longer term serious consideration would need to be given by the System on how to reduce the high numbers of referrals, which had a proportionally low conversion rate, that continued to be made, and which in some cases only served to unreasonably raise expectations.

Subject to relevant assurance checks being made around the procurement arrangements IPAC approved the utilisation of an independent provider (CHS Healthcare) to carry out the backlog of assessments.

8. Committee Effectiveness

8.1 Reflections on Meeting

The Committee welcomed the reduced size of agenda which enabled more in-depth discussion to be held around the respective items.

9. Date of Next Meeting

Tuesday, 27 April 2021 at 1PM

Simon Barlow
Corporate Governance Manager
April 2021