Health & Adult Social Care Select Committee minutes

Minutes of the meeting of the Health & Adult Social Care Select Committee held on Thursday 5 November 2020 in , commencing at 10.00 am and concluding at 1.24 pm.

Members present

K Ahmed, Z Ahmed, A Bacon, P Birchley, M Bradford, M Collins, G Hollis, S Jenkins, J MacBean, G Powell, B Roberts, A Turner, L Walsh, J Wassell and Zoe McIntosh

Others in attendance

Mrs E Wheaton and A Macpherson

Apologies

L Wood

Agenda Item

1 Apologies for absence/changes in membership

The Chairman welcomed everyone to the meeting. Apologies were received from Mr L Wood and Mr D Williams (Mr D Leveson attended in place of Mr D Williams). The Chairman advised that Ms Zoe McIntosh, the new Chief Executive Officer, Healthwatch Bucks, had replaced Mr Miguel Souto on the Committee. The Chairman thanked Mr Souto for his contribution and stated she was looking forward to working with Ms McIntosh.

2 Declarations of interest

Mr A Turner declared an interest as he was a trustee of an independent adult day care provider charity.

3 Minutes

The minutes of the last meeting were reviewed; the Chairman advised that the responses to the additional questions on the Mental Health topic and Primary Care Network item were being prepared and letters would be circulated to the partners; if any additional questions were raised they would be added to future meeting minutes.

Ms P Birchley referred to item 6, point 14, which stated "*A 24/7 mental health helpline had been established to divert the pressure from 111 and A&E. Whilst this offering had been established quickly, it was deemed unsustainable so the Trust was*

working with commissioners to find a solution." Ms Birchley asked whether a solution had been found. Julia Wassell reported that the mental health helpline was advertised as being available 24 hours a day, seven days a week, and should be used as the main point of contact. The Chairman acknowledged J Wassell's comment and stated she would contact the Oxford Health NHS Foundation Trust for formal confirmation.

ACTION: The Chairman

Ms Birchley highlighted that the sentence on page 9, "*It was acknowledged that there would be an unprecedented demand on flu jabs this year. As yet, there were no real plans on how to resource this and deliver it in a Covid safe way*"; had been superseded by other comments later in the minutes. The Chairman explained that the point reflected what was said at that point in the meeting. The Chairman added that she had attended the last Health and Wellbeing Board meeting and raised questions on the winter plan; follow up work would be carried out on flu vaccinations and the winter plan.

RESOLVED: The minutes of the meeting held on 10 September 2020 were AGREED as an accurate record.

4 Public Questions

There were no public questions submitted for this meeting. However, an email had been received past the submission deadline; the Chairman advised that a response had been sent to the member of the public advising them to watch the meeting and if the resident still had outstanding questions after the meeting today, the Chairman encouraged the resident to put them forward in time for the January meeting.

5 Chairman's update

The Chairman updated Committee Members on the following issues:

A response had been provided on Buckinghamshire Healthcare NHS Trust's Annual Quality Account 2019/20; the Chairman thanked the committee members involved and stated she was looking forward to seeing the quality account published.

6 Proposed closure of New Chapel Surgery, Long Crendon

The Chairman advised that on 20 August 2020, the Clinical Commissioning Group (CCG) Comms team had circulated an email on behalf of Unity Health (the health providers of five GP surgeries in Buckinghamshire and Oxfordshire) to key stakeholders with a consultation paper for patients on the proposed closure of New Chapel Surgery in Long Crendon. The public consultation would finish on 23 November 2020 and there was a Primary Care Commissioning Committee meeting on 3 December 2020 where it was proposed that the potential closure would be discussed.

The Chairman welcomed Ms L Munro-Faure, Managing Partner, Unity Health; Dr S Logan, Clinical Partner, Unity Health and Dr A Furlonger, Clinical Partner, Unity Health.

Dr Furlonger explained that Unity Health served 22,000 patients across five sites and was a training practice, training future GPs. Unity Health had formed in Oct 2017 through the merger of Trinity Health and Wellington House practices. Wellington House had covered Princes Risborough and Chinnor; Trinity Health had covered Long Crendon, Brill and Thame. The Long Crendon practice served 3,490 patients of which 2,350 lived in Long Crendon and the remainder travelled from the surrounding villages. The existing premises in Long Crendon were unfit for purpose; it was an old chapel which was inadequate in terms of space and the clinical rooms did not meet modern regulations. Training for GPs and healthcare professionals had ceased in this site due to lack of space. It was a dispensary practice but was on the road with no parking, drop off or safe disabled access. There were drainage problems at the site and there was no outside space to expand further; also the age of the building did not lend itself to modification. Other options had been explored and a number of redevelopment/new premises applications had been submitted which had not been successful in obtaining approval for the funding of a new site. It had also been a struggle to recruit and retain GPs and other healthcare professionals as they were reluctant to work in isolation in the old building. After a great deal of consideration, Unity Health had started the consultation process about the possible closure Unity Health prepared a paper for the Select Committee in which it put forward 4 options. The paper made clear this was not a formal options appraisal but a presentation of the position to date. The preferred option was option four (*Register all patients with Brill surgery but continue to provide some services from another facility in Long Crendon to address some of the patient concerns identified through the consultation process and the difficulties in accessing services in rural communities*). Unity Health had held discussions with a village action group and the CCG and proposed continued provision of services from new premises which could be a collaboration in a community building using land provided to the parish council by the developer for this purpose as part of the Section 106 money.

Ms J Newman, Head of Primary Care, Clinical Commissioning Group, added that she had read the paper prepared by Unity Health and that she would support Option 4.

The Chairman welcomed Ms F Cayley, Chairman of the Local Action Group (LAG) and Ms F Momen, a member of the LAG. Ms Cayley reported that the LAG, with support from a large number of residents in Long Crendon and the surrounding villages, had formed as a result of the consultation on the closure of the surgery. Long Crendon had had its own health service for years and had put up with the building as there was no alternative; however, the prospect of losing it altogether had emphasised the value to the community. The LAG was willing to look at all the options in order to keep the asset in the community. Residents wanted the dispensing service, GP appointments, the nursing service and other healthcare services in a fit for purpose building. Travel to Brill was difficult; Thame was easier to access via public transport; but it was unknown if it had the capacity to cope with an influx of extra people accessing services. The LAG had received good engagement with Unity Health and the CCG and had come up with a viable option.

Ms Momen advised the LAG had sought local views on concerns and what they

wanted to see as a minimum. The LAG understood that it had to fit in with the national plan and Buckinghamshire Healthcare NHS Trust (BHT) plans. The NHS five year plan was to move healthcare out of hospitals and be closer to home. The LAG had looked at the Buckinghamshire Integrated Care System Operational Plan and found that emphasis was on prevention; for residents to help themselves more; local support in the community to support people for longer at home; care integrated locally to provide better support closer to home; patients being seen in the most appropriate setting; services located where they are needed which provided care in a timely manner and support for people with long-term conditions. The LAG did not believe the aims could be fulfilled by having healthcare centres a distance away. Covid had emphasised the risk of spreading disease and residents recognised that Zoom calls would play a part but also wanted face to face access to a doctor. There was concern that vulnerable people would slip through the net; preventative care was essential. People needed local access to physios, nurses, counsellors and GPs and the LAG believed there was an opportunity for a new kind of multi-purpose healthcare centre, including a meeting space and a drop-in area for ongoing preventative care, which was flexible with secure IT. The centre would be a very valuable building for the future and the Section 106 money would provide a massive start with the funding.

Ms Cayley outlined the next steps. The LAG had looked at the policy documents; however, a lot of the information was not directed towards rural communities, particularly the NHS Greener Plan; the Group felt this should be looked into at a higher level to see how rural areas could be best served. Option 4 was the option they supported and would need a clear commitment from all parties to that plan. The land had been granted by the Section 106 agreement; there was already a made up access road and utility services. A local architect had offered his services and the parish council would provide £10,000 towards the initial fees for drawing up plans. The issue was the time pressure as the Section 106 agreement expired in December 2021 so work on a new facility would need to commence by then. Ms Cayley stressed the importance of commitment and working together to look at the funding options; the Group hoped the CCG would fully commit to the plan and welcomed the support of the Select Committee and local councillors.

The Chairman advised that the Select Committee had a duty to be involved in this substantial service change.

During the discussion, Members asked the following questions:

- A member of the committee commented that the data behind the options was sparse and that he would like to see an in-depth options appraisal to enable a definitive outcome.
- The LAG were commended for their work and all parties were urged to look into funding options in greater depth as there were companies who specialised in assisting with sourcing funding.
- Option 4 was clearly the option the local community favoured; Mr A Turner agreed to discuss the option further with the LAG.

ACTION: Mr A Turner/Ms F Cayley/Ms F Momem to discuss Option 4

- Following a query from the Chairman on when the document had been prepared; Ms Munro-Faure stated the document had been prepared for the Select Committee and pulled together the discussions which had taken place; it was not a formal options appraisal. The Chairman added that she had only seen a two page document which Unity Health had sent out to patients and it would have been logical to have provided an options appraisal as the first step.
- Ms Newman explained that the CCG would make a decision on the proposal. The timescale/process was for the practice to gather the evidence, including the results from the public consultation, which the CCG would consider at its Primary Care Commissioning Committee on 3 December 2020. However, Ms Newman stated the date was not 'set in stone' and maybe a different proposal should be considered. Ms Newman added that the CCG was excited about the possibility of developing a community hub and would play their part in the General Practice element of it. The Chairman stated that this was positive to hear but still expressed concern regarding the possibility of the proposal being discussed at the meeting in December 2020.
- There were a number of organisations/groups involved but it was not clear who was going to take it forward. The CCG had said they were willing to work with Option 4 and provide some funding even though the population was less than 10,000 if the right proposal came up. Members asked how the £1.4 million would be raised for a new facility. Ms Newman provided some clarity on the funding issue and stated that the CCG did not hold capital. The capital for health projects came from NHS England; it had not happened in the last two years, and due to the recent investment related to Covid-19, it was unlikely to have capital available in the next couple of years. The CCG could provide the rental revenue which would come from NHS England to support the practice. The revenue could be put into a new facility; if the revenue increased due to an increased footprint or improved facility it would change the revenue as a consequence. A population of 10,000 was not set in stone but was part of the CCG strategy as it looked at the context of Buckinghamshire as a whole and the developments that needed prioritising; Aylesbury was a prime example as 20,000-30,000 houses were being built. However, in terms of providing a solution for a rural community this could be a leader in a model for the future.
- In response to being asked who was responsible for producing an Equality Impact Assessment (EIA) and an options appraisal Ms Newman confirmed that the CCG and the practice would be responsible and were preparing an Equality Impact Assessment which would be presented to the Health Inequalities Group in November. Ms Newman stated that due to the work of the LAG and the views/information received; the proposal had evolved in a positive way. Unity Health and the CCG had changed their view of the future of the Long Crendon practice.
- A member of the committee commented that Thame Town Council had refused a planning application to extend a surgery and asked how this would impact on the planned closure of Long Crendon surgery. If planning

permission was granted, how would the Thame surgery cope with new patients during a new build in Long Crendon. Dr Furlonger explained that Unity Health shared a site in Thame with the Rycote Practice and had been looking to redevelop as a joint venture using a developer. There was limited space at Thame which was why they were attempting to accommodate patients at Brill and projects were being worked on being mindful that it was a five site practice. It was acknowledged that it was a challenge to accommodate the growing population across the practice area. There was a mix; properties were often owned by a company who leased to the practice. Some were owned properties which were not suitable and jumping that divide from ownership to finding a developer who would build a new facility was difficult. For smaller practices the capital cost versus the revenue costs was hard to balance and would be a challenge in terms of obtaining funding for Option 4.

- In response to whether analysis had been carried out on the patient base and their access needs and the impact of moving patients to another surgery, Ms Munro-Faure stated that Unity Health ran a triage first system. There was a lot that could be done over the telephone, and during covid there had been a conversion rate of 20-30% of appointments being held face to face to over the telephone/video call. Unity Health was considering Option 4 and how to provide services in Long Crendon to solve the access problem, including a dispensing service. Dr Logan added that there was a paramedic service which could assess housebound people. The Chairman reiterated her concern over the lack and quality of information which had been provided as well as the reach of the consultation; Dr Logan commented that the consultation had been planned and carried out in consultation with the BCC communications team. Dr Logan clarified that the only option available at the time of publicising the consultation was to close the surgery; the other options arose after Unity Health discovered that the CCG would support a community venture.
- Assurance was requested that vulnerable, elderly residents, those on low incomes, possibly without digital technology and reliant on public transport, would not be left without a surgery in Long Crendon if New Chapel surgery closed and it was not viable to develop a new facility. Ms Newman was unable to provide a guarantee but stated that if it was proposed that New Chapel surgery closed and a new facility be built then the Primary Care Committee would have to consider the timing of the closure of the current surgery. The Chairman advised that she had made enquiries as to whether the Section 106 deadline could be extended. Ms Cayley commented that the surgery was still operating as a dispensing service. A member of the Select Committee emphasised that this was an opportunity to 'think outside the box' to accommodate the greater healthcare requirements of the rural community and provide a return on investment. The Chairman stated that the Select Committee had been looking at the community hub pilots in Marlow and Thame and the concept of developing care closer to home. Option 4 involved the use of digital appointments, limited face to face appointments and a dispensary; if Thame could not expand there was an

opportunity for a discussion on what could be offered for the surrounding area which could make a bigger building more viable. Dr Logan confirmed it was the direction of travel but would be based around the primary care networks (PCNs).

- In response to a question on who owned the premises of the New Chapel Surgery and whether there was capital in the building which could be put into a new build; it was confirmed that the Unity Health partners owned the building but it was mortgaged up to the capital value. Option 4 would help with the recruitment and retention issue since clinicians would be based in Brill with sessions held in Long Crendon. Healthcare professionals wanted to be able to work as team.
- A Member asked whether there were other potential healthcare services which might be interested in joining together with Unity Health to provide services from a community location – for example, dentists, physiotherapists.
- Dr Furlonger explained that historically GPs would invest into a partnership; however, at the moment, GPs were not being asked to make a large capital investment in a business and it was a big challenge; all the options needed to be explored and considered.
- Ms Cayley stated that all the points raised today had been discussed by the LAG but emphasised that someone needed to take the lead and felt this should be Unity Health with support from the local action group. Ms Cayley encouraged commitment and support from the CCG and stressed that it would be helpful to take away the threat of closure of the surgery as it was adding to the stress and difficulty in the process. All parties needed to focus on finding a sustainable solution/ and look at all the different requirements that a community healthcare facility could provide. Once the Covid-19 restrictions were over, Ms Cayley hoped the surgery would be able to provide the services it did before and to remain open as an interim solution until the new building was in place. The LAG had done their best to find an alternative solution and requested that the possibility of the closure of New Chapel Surgery be removed. The Chairman stated that the decision would be made by Unity Health. Ms Munro-Faure advised that there was a strong steer from the CCG that they would not support a standalone GP facility; it would need to be something more innovative with community involvement.

The Chairman summarised that she and Ms Wheaton, Committee and Governance Advisor, would prepare a draft response to the consultation on behalf of the Committee which would be circulated to the committee members for comment. The Chairman summarised the key areas of concern:

- The consultation process and the brevity of the information that was put out in the public domain as part of the briefing consultation paper.
- The lack of data provided and the lack of options appraisals as part of the consultation
- The over-reliance on online channels to promote the consultation. There were concerns that the majority of users of the surgery were not aware of the consultation until the LAG was set up.

- The unrealistic timeframe between the end of the consultation on 23 November and the Primary Care Commissioning Meeting on 3 December.
- More work was required by Unity Health and the CCG in exploring the other options, particularly the building of a new community facility.

The Chairman thanked everyone for their participation.

7 County-wide engagement exercise

The Chairman welcomed Mr D Leveson, Deputy Director of Strategy, Buckinghamshire Healthcare NHS Trust (BHT). Mr Leveson explained that he and Mr D Williams had been leading on the engagement process during which an online survey had been held from 24 August to 19 October 2020. There were four themes in the survey; reducing health inequalities, community services, keeping people safe and digital appointments. Phase 2 of the engagement process was underway and would run during November and December; a social research company had been employed to run 12 in-depth focus groups and 20 in-depth one-to-one interviews to target hard to reach groups e.g. carers, young people, those living in deprived areas and the Black, Asian and Minority Ethnic (BAME) community; these would be completed by the end of 2020.

Approximately 2,800 responses had been received; the average age of respondent was 61 and the majority were white with over 70% being white women. Initial analysis had shown that there were over 20,000 pieces of free text to be coded and themed.

Mr Leveson highlighted a few key points from the survey data:

- More than 50% of respondents felt they were healthy or very healthy.
- Of those who responded saying they were not healthy; a number were receptive to making lifestyle changes, particularly in obesity.
- 80% of respondents had had a phone or video appointment in the last three years and were generally satisfied with the appointment. The majority were happy to continue with a digital appointment in the future but the number declined with increased age. The biggest concern over online consultations was when people needed a physical examination; it needed to be clear that a face to face appointment would be available when required.
- When asked about planned care e.g. ophthalmology, and what was most important to people, the following points were made:
  - Receiving a diagnosis and being treated as quickly as possible.
  - Being treated locally; people were willing to travel if being seen at a centre of excellence resulted in quicker treatment but it was important to consider the frequency of need and the age of the person.
- People were generally receptive of dialling 111 or visiting a pharmacy but there was a slight reticence over clinical credibility; particularly by those with a long term condition or older people.
- Community services – the response rate for those with experience of a

community hospital bed was low; however, there could be detail in the free text. When asked about rehabilitation and recovery and whether they would prefer to recover at home or in a hospital bed; it depended on the circumstance; the security of a hospital bed was appealing for older people.

During the discussion, Members asked the following questions:

- The Chairman queried the timing of this piece of work as people were accessing services differently during the pandemic. Mr Leveson stated that the use of digital appointments and NHS 111 had been planned before the pandemic but Covid-19 had accelerated the changes. The pandemic had forced BHT to think slightly differently about how to reach people.
- The Chairman stressed it was an online survey and that huge swathes of the community were not comfortable with digital technology and had not seen the survey. The Chairman commented that her local Patient Participation Group (PPG) had not been contacted by the Primary Care Network (PCN) for over a year and were not aware of the survey and queried whether 2,500 was a good number of responses.
- A Member asked whether the results of the survey would be subject to independent review and scrutiny. In response, Mr Leveson advised that a report would be prepared on the first phase of the engagement and would be open to scrutiny. Mr Leveson agreed that a large number of the population struggled with digital technology and they would take the opportunity to engage with areas of the population not historically reached.
- A member of the committee asked for a breakdown of the age of respondents Mr Leveson stated he would provide a full breakdown to the Committee & Governance adviser for circulation to the committee members.

  ACTION: Mr Leveson to provide a breakdown of the ages of respondents for circulation
- Concern was raised over the difficulty of measuring health inequality during the pandemic, particularly in terms of access to IT to conduct online consultations. Mr Leveson stressed that when people needed to be seen in person they would be given a face-to-face appointment and when a person was in a life threatening situation they would be seen in the right setting. The important message was that the video appointments worked but were not right for everyone and every condition.
- A committee member highlighted that people who were suspicious of authority would not take part in a consultation. Engagement with travellers, working mothers or the LGBT community could be done but would take time and money and reassurance would be needed on how the data would be used. The digital revolution could cause a breakdown in society; healthcare benefitted from being face to face.
- A Member asked whether there was the budget to support the initiatives that might come to light following the engagement, particularly in light of the financial strains due to the pandemic. Mr Leveson added that the costs of running the survey had been afforded by the Integrated Care Partnership and stressed that investment in engagement was important. Part of his job was

to develop the strategy for the next five to 10 years and it would need to be sustainable. Prevention, keeping people at home and health inequalities were fundamental for the sustainability of the system as a whole and would be a challenge for everyone.

It was agreed that the Chairman would put any further questions to Mr Williams and Mr Leveson on any areas of concern. The Chairman explained that this item will be discussed in more detail at the January Select Committee meeting when the results of the survey would have been analysed and the further engagement exercises undertaken.

RESOLVED: The Committee NOTED the contents of a report to the Health and Well-Being Board and RECEIVED a verbal update on how the community engagement exercise was progressing.

8 Pharmacy services

The Chairman welcomed Ms J Butterworth, Buckinghamshire CCG; Mr M Patel, Chief Officer, Local Pharmaceutical Committee (LPC) and Mr K Patel, Local Pharmacist and owner of a number of local pharmacists.

The Chairman declared an interest in having known Mr Kalpesh Patel for several years as he was the Chairman of the local Rotary group and an owner of numerous pharmacies.

Ms Butterworth, Associate Director for Medicines Optimisation, advised that the report had provided a brief overview of where the pharmacy workforce sat in the system and stressed that they were all working together more closely than ever under a single governance structure.

During the discussion, Members asked the following questions:

- The Chairman highlighted that report referred to additional roles being recruited to support the Primary Care Networks (PCNs) and asked how recruitment was going and what would happen to the funding if the posts were not filled. Ms Butterworth explained that the approval for use of the funding had been delayed due to the pandemic but the process had been accelerated and funding would be taken from this year and next year's pot. The number of clinical pharmacists and technicians increased each year. Recruitment was still going ahead. Funding was for a mid-point between a junior and senior post but if a senior pharmacist was needed the PCNs needed to provide additional funding which was an issue for some PCNs. Last year there had been anunderspend and this had been utilised creatively; it had also been used to fund a PCN lead pharmacist two days a week to provide support to pharmacies.
- A member of the committee asked what the take up was for electronic repeat prescriptions and how were the people being handled who were not computer literate. Ms Butterworth did not know the exact figure but

thought it was approximately 15%. Ms Butterworth explained that patients could not be put on an Electronic Repeat Dispensing (ERD) service unless their medication was stable and there were a large number of patients waiting for monitoring results which had been delayed by Covid-19. For those patients who could not be put on ERD they relied on patient access to make things easier using technology but surgeries were trying to move away from prescriptions being posted through the letter box. However, there was a difference between electronic prescriptions, which was very high, and ERD where six to 12 months' worth of prescriptions were loaded onto the spine at one time and then the community pharmacies could pull them down as appropriate.

- A member of the committee stated he was conscious of the crucial role of staff in the pharmacies during the pandemic and asked if they had received all the support they needed i.e. had the insurance issue of preventing deployment staff on an emergency basis been resolved? Pharmacists were not paid for the delivery of prescriptions – could the gap be plugged? Pharmacists had to source their own Personal Protective Equipment (PPE) – could this be funded? Ms Butterworth confirmed that the insurance issue had been resolved; pharmacies were being paid for the delivery of medicines for end of life drugs but in general there was no payment for delivery; this service was being stood back up for shielded patients. It was also confirmed that pharmacists now had access to PPE.

Mr M Patel confirmed that delivery of medicines had re-started for vulnerable patients and been extended to two other vulnerable groups. Pharmacists were signing on to the national supply of PPE. The staff deployment insurance issue had been resolved very late and Ms Butterworth added that there had not been any requests for a community pharmacy to help out.

Mr M Patel highlighted that the report explained what the LPC was and how it worked with the local stakeholders to ensure pharmaceutical services were provided. The report explained what had happened during the pandemic, the services offered and the challenges ahead.

The Chairman asked for feedback from Mr K Patel on the practicalities of running a pharmacy during the pandemic. At this point, K Patel declared a past interest as a previous chair of the LPC.

K Patel advised it was his 'worst nightmare' to run a business ensuring his staff and the public were safe and provide the medicines required. A system had been put in place whereby electronic prescriptions could be diverted to another group if the scenario arose where all the staff in one branch became ill. There were now three dispensing robots which could be used overnight if needed. K Patel commended all the staff who had known nothing about the virus at the beginning of the pandemic.

Pharmacies had moved their counter to the doorway to prevent people entering the premises. There had been issues with the lack of PPE but he had been fortunate to

source PPE from India and China until it was provided by NHS England. Volunteers were prepared to cover other branches when staff were ill or self-isolating. There had been an increase in demand, particularly in repeat prescriptions, and staff worked over the weekend to process the orders; a recent increase had just been seen due to the latest lockdown. Prescriptions were delivered to patients by volunteers and the scheme had recently re-started.

Approximately 200 deliveries a day were carried out in the Chesham area alone and the majority had been continued as the pandemic continues/. It was possible to manage demand but not stock shortages. There had been a huge extra investment in pharmacies; the government had made an advance payment but would claw it back at a later date. The health economy needed to be better prepared going forward and the system needed a review to address the problems.

The first drug which was in short supply was paracetamol; K Patel had six months' supply but when he managed to source new stock in small quantities they were very expensive so he had to dispense from larger packs to manage the supply problem. Other products such as sanitising spray and thermometers were also very expensive during the start of the pandemic.

During the discussion, Members asked the following questions:

- The Chairman asked how the Government had helped pharmacies to access supply. K Patel stated that he had not been able to wait to ask for help; he had to take action before the systems were operational e.g. sourcing PPE. No one had predicted the virus and the extent of the effect on the whole economy and it would have been unrealistic to expect NHS England to supply PPE when they were struggling to supply the hospitals. M Patel added that he had worked closely with the PSNC (the negotiating committee for pharmacies) who negotiated the medicine supply, pricing etc. The LPCs fed back what happened locally and the PSNC carried out the negotiation. M Patel stated he would like to engage with the MPs in the area to lobby as he was concerned about the mental health and wellbeing of pharmacists. The Chairman agreed mental health was a key issue right across healthcare.
- In response to whether anything could be done to prepare for 1 January 2021; K Patel stated that the industry had been asked to have a six week supply, but questioned whether six weeks was enough. He kept a three week supply of drugs in his pharmacy but keeping a six month supply would cost too much. He had the choice of losing half his staff due to the stress after 1 January or to build up his stock so there was less stress in the system Guidance was needed on what to do after 1 January because leaving it too late would mean pharmacies would not be able to procure from alternative sources as drugs had to have quality assurance. Ms Butterworth added that the six weeks supply was in addition to what the wholesalers already had in stock. Ms Butterworth also stated she understood the concerns on the ground but assured that the Department of Health was looking at the issue; the team had been increased and were working to manage drug shortages.

A shortage protocol had also been introduced to allow substitutes. M Patel added that there was a tracker system which was communicated to the practices.

- The Chairman asked how much involvement the pharmacists had with the Health and Wellbeing Board (HWB) which consisted of a number of health partners. M Patel advised that they were not members of the HWB and were only involved during the Pharmaceutical Strategic Needs Assessment (PSNA) which was carried out every four years but had been postponed to April 2021 due to the pandemic. The Chairman agreed to contact the Chairman of the Health & Wellbeing Board.

  ACTION: Chairman to write to the Chairman of the Health & Wellbeing Board

- It was noted that there would be a soft launch on 1 November 2020 where GPs could refer patients to the community pharmacy as a first port of call for self-care and minor aliments; it was a six month national roll out which would be deployed by the PCNs. M Patel stated that councillor and MP support would be required and that patient education needed to be improved.

Julia Wassell stated the pharmacists had been heroic during the pandemic; the Chairman agreed and asked for the Committee's thanks to be put on record.

The Chairman thanked J Butterworth, M Patel and K Patel for their input.

9 Buckinghamshire, Oxfordshire and West Berkshire Integrated Care System - joint health scrutiny committee

Mr N Graham, Service Director, Legal and Democratic Services, stated that there was a statutory requirement to set up a Joint Health Scrutiny Committee for the five authorities in the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System (BOB ICS). The draft Terms of Reference (TofR) were attached to the report. Work had been carried out on defining the work of the scrutiny committee; Mr Graham emphasised that there was no wish to take away the scrutiny arrangements of each authority but there were certain things the ICS had been carrying out at a strategic level which it would be helpful for all authorities affected to come together and work on. The existing local scrutiny committees had the power to refer decisions to the Secretary of State and this would also apply to the Joint Health Scrutiny Committee. The size of the committee was still under discussion. The draft TofR set out the practical arrangements and would need to be ratified by Full Council. The next Full Council meeting was on 9 December 2020 and it was proposed that if the Select Committee agreed to the content of the draft TofR, that delegated power be given to the Chairman for final sign-off. If the content was significantly changed the draft TofR would be brought back to the Select Committee and ratified at a future Full Council meeting.

The Chairman thanked Mr Graham and Ms Wheaton for their work on the setting up of the Buckinghamshire, Oxfordshire and West Berkshire Integrated Care System - joint health scrutiny committee.

RESOLVED:

- **Members of the Health and Adult Social Care Select Committee DISCUSSED the progress made to date in setting up a joint health scrutiny committee for the BOB ICS which will aid continued negotiations.**
- **Members APPROVED the draft terms of reference and AGREED to delegate the final sign-off of the terms of reference for the joint health scrutiny committee to the Chairman of the Health & Adult Social Care Select Committee.**

Members APPROVED that the final terms of reference will be discussed and ratified at Full Council.

10 Work programme

Committee Members discussed the draft work programme and agreed the following items for the January meeting:

- Hospital discharge to assess Buckinghamshire Integrated Care Partnership (ICP)
- The Winter Plan and an assessment of Covid-19.

Access to GP surgeries during the second lockdown.

11 Director for Public Health Annual Report

It was agreed that an email would be circulated requesting comments on the Director of Public Health Annual Report (DPHAR) which would be fed back to the Director of Public Health and Councillor Gareth Williams, Cabinet Member for Communities and Public Health.

ACTION: L Wheaton to circulate and email requesting feedback on the DPHAR

12 Date of next meeting

Thursday 7 January 2021 at 10am.