AYLESBURY VALE AND CHILTERN CLINICAL COMMISSIONING GROUPS
GOVERNING BODIES (meetings in common in public)
11 January 2018, 10:30am
Jubilee Room, Aylesbury Vale District Council Offices, Aylesbury, HP19 8FF

Governing Bodies Members Present:		
Dr Raj Bajwa (Chair)	GP Clinical Chair (Chiltern CCG)	**RB**
Dr Graham Jackson	GP Clinical Chair (Aylesbury Vale CCG)	**GJ**
Lou Patten	Chief Officer	**LP**
Dr Karen West	Clinical Commissioning Director Integrated Care	**KW**
Dr Rebecca Mallard-Smith	Clinical Director Unplanned Community Care	**RMS**
Paul James	Interim Chief Finance Officer	**PJ**
Tony Dixon	Lay Member (Deputy Lay Chair) Chiltern CCG.	**TD**
Robert Parkes	Lay Member (Deputy Lay Chair) Aylesbury Vale CCG.	**RP**
Graham Smith	Lay Member, Chair of Primary care Commissioning Committee	**GS**
Crystal Oldman	Registered Nurse	**CO**
Dr Robin Woolfson	Secondary Care Specialist Doctor	**RW**
In attendance		
Russell Carpenter	Corporate Governance Lead (minute taker)	**RCa**
Nicola Lester	Director of Transformation	**NL**
Lisa Beaumont	Associate Director of Nursing and Quality	**LB**

1.	**Welcome & Apologies**	**Lead**
	The Chair Dr Raj Bajwa (RB) welcomed the Governing Bodies members and members of the public. **Apologies received:** • Ross Carroll, Lay Member • Colin Seaton, Lay Member • Debbie Richards, Director of Commissioning and Delivery • Robert Majilton, Deputy Chief Officer	
2.	**Declarations of Interest in items on this meeting's agenda**	
	The Chair Dr Raj Bajwa (RB) reminded the meeting of obligations to declare any Conflict of interest they may have on any agenda items. RB noted that declarations previously made by members of the Governing Bodies are listed in the CCG's Register of Interests published on the CCG websites with these links provided on the agenda. There were no additional conflicts of interest or mitigations material to items on the agenda with no commissioning decisions scheduled. The meeting was otherwise quorate.	
3.	**Questions from the public**	
	None were received, in advance or on the day.	
4.	**Minutes of the meeting held on 14 December 2017, Action Log and**	

	Matters Arising	
	4.1 Minutes – 14 December 2017 Agreed as an accurate record. Item 10: RM noted discussion at PCCC that transition to bundle across both is a clear recommendation for sustainability rather than variation. (To replace "suitability" as in the previous version. Child and Adult Mental health Services (CAHMS) added to glossary. **4.2 Action Log –** It was noted that all actions have been updated within the separate action log. **4.3 Matters arising –** None were raised.	
5.	**Clinical Directors presentation (including Patient Experience)**	
	Dr Shona Lockie talked through an update on medicines management in Buckinghamshire covering a number of key areas: 1. Deprescribing/reducing variation 2. Care homes 3. Dietetics 4. Improving Clinical outcomes – e.g. reducing stroke, Antibiotics 5. Joint Formulary 6. Responses to national consultations Relates slides are published separately on the CCGs websites. RMS noted an intention that high frailty patients would be referred to the Community Assessment and Treatment Teams (CATS) and multi-disciplinary assessment unit (MuDAS) at Wycombe Hospital. This has taken place with a number of perceptions aligned to the referral, though when discharged back to GPs they have further prescriptions. RMS queried whether clinicians in MUDAS had the mindset for deprescribing, and if so suggested that we need to make sure the deprescribing message is being heard in secondary as well as primary care. SL replied there has been good engagement, though the challenge may be less experienced junior doctors through MuDAS and therefore CATS may appear more effective on this basis. We will continue to emphasise the right messages through both services about deprescribing. RMS also queried increasing daily requests from end of life nurses for signatures to change medications, due to policy change of end of life care homes on no longer accepting syringe drivers with a variable rate of subcutaneous infusion. SL replied that there are a few district nurses who are non-prescribers so they need have doses clearly marked on syringe drivers. SL added that this was a decision that had not gone through or been approved by the Medicines Management, with a recommendation that this be discussed with Dr Malcolm Jones. GJ noted nursing home work for end of life patients has been fantastic, but there have been issues in retaining knowledge and need to address this. SL replied the same applies to staff, and where there are demonstrable issues then the medicines management team can prompt a pharmacist to review their prescribing arrangements. GJ also queried whether Oxford Health are members of the proposed ACS Medicines Optimisation Board. SL replied that	

	they are. KW noted issues with continence pads and whether the team had involvement in this. SL replied Steve Goldensmith (Head of Long Term Conditions, Ill Health Prevention & Supported Self Care) is undertaking work on this, and noted that this is a complex matter. It may be that the allocated budget does not sufficiently represent the level of identified need; stakeholder meetings are planned to review this work. In relation to gender dysphoria and prescribing, we presently have been unable to commission a service for prescribing of gender dysphoria despite extensive enquiries. GS queried the numbers of patients that may be affected. SL replied that there were thought to be around 50 and rising, about one for each practice. We are still investigating opportunities to develop a full service, fund training and reach out to endocrinologists. Few GPs currently feel they have the appropriate skills to prescribe, and as such a specialist service is required. TD queried whether there has been a measure of the reduction in admissions to hospitals through care home work to reduce prescribing. RB replied that care home pharmacists initially employed in fixed term posts had to demonstrate this. It was found to be easily cost effective. RB thanked SL for her efforts since joining the team in 2017. .	
	Leadership and Governance	
6.	Accountable Officer's Report (including update on system working) • Primary Care 24/7 • Mandeville Practice	
	Updates were also provided as follows: System chief executives met before Christmas, with other meetings planned across the year. Strategy can be discussed and links to the STP. Performance on urgent and elective care remains challenging; thanks to all staff involved managing resilience over Christmas. NL noted that, although there has been a Prime Minister that outpatients services should stop to manage winter pressures, this was not the situation locally. RW queried whether this meant local providers held no need to divert resources to support emergency and unplanned activity. LP replied this is explained by most elective care based at Wycombe where there is no A&E rather than Stoke Mandeville. Some acute patients and transferred from Stoke Mandeville to Wycombe, although this as a last resort may affect some elective activity. RW also queried whether cardiology and respiratory outpatient staff had been considered to provide emergency cover through appointment cancellation. LP replied there were not sufficient numbers of appointments that would need to be cancelled so this had not been planned. KW noted that those attending are ill, with acuity and conversation rates, and so the support network to keep people out of A&E is working and so this should be noted. RW noted the increasing conversation rate had also been noted at the Quality and Performance Committee. Primary Care 24/7: At the previous governing bodies meeting on 14 December 2017 we reported having continued a process for 24/7 primary care access through our	

	assurance framework, and that a preferred applicant had been identified and decision taken to contract with the preferred applicant. At that time a standstill period prior to a public announcement was in progress. This ended on 18 December 2017. However, as negotiations continue on Heads of Terms, a public announcement will follow imminently once this subsequent process has completed. Mandeville Procurement: Press statement issued Tuesday 9 January 2018 NHS Aylesbury Vale and NHS Chiltern Clinical Commissioning Groups (CCGs) are pleased to confirm that, following a successful procurement process, they have now awarded a contract to Primary Care Medical Solutions (PCMS) for the provision of primary care services to patients at The Mandeville Practice, Hannon Road, Aylesbury. This contract will start in April 2018. Although there will be some change in those running the practice, the services patients currently receive from The Mandeville Practice will continue. Patients do not need to re-register or do anything differently; services will continue to be provided as usual and will be transferred seamlessly to the new provider on 1 April 2018. GJ noted that offers if support from neighbouring practices were available. LP also noted also having been significantly involved in nurse leadership aligned to development of the accountable care system.	
	Assurance and Governance	
7.	**Finance Report (Month 8)**	
	PJ introduced the item; noting some timing issues with reporting which had led to a verbal update. The Month 8 would be recorded with the papers archive for this meeting for good governance purposes once finalised. The financial recovery plan had been discussed at length with the Finance Committee immediately earlier today. Governing Bodies were asked to note a worsening financial position and subsequent reputational issues. It is now very unlikely our control total will be met even with non-recurring support. The seriousness and difficulty with this situation is wholly recognised, and its causes, with serious action required addressing underlying recurring deficit.	
8.	**Quality and Performance Report (Month 8)**	
	Presented by Lisa Beaumont. Unprecedented pressure was highlighted for emergency and urgent care, both acuity and volume impacting conversion rate. The system has managed, though BHT has missed target. DR presented winter planning at Health and Wellbeing Board in November, rigorously challenged and well received. There is also better system working. A number of bids for additional winter funding have also been successful, directed to acute, primary care and mental health – including domiciliary beds, GP streaming, social work support in the community and BHT escalation capacity. Bucks A&E Delivery Board has established formal escalation with Herts Valleys A&E Delivery Board to address Delayed Transfers of Care (DTOCs), of which currently approximately 40% relate to Herts Local Authority. GS queried flu vaccinations and whether it is the strain we were expecting. RB noted it's a best guess finalised a couple of months before the season starts; July / August. An unexpected strain can mean no coverage. RW asked	

	whether Tamiflu distribution through care homes had proved beneficial. LB replied our flu outbreak plan does include giving antivirals to those who present with symptoms. LP added that we now have a newly qualified prescribing pharmacist that we are keen to keep hold of and who has been seconded to the provider collaborative. A number of other trends from the report provided were highlighted including cancer, GP engagement on dementia /patient referral to the memory clinic. RB noted referral rates across Aylesbury Vale and Chiltern were broadly similar, though there appeared a lower conversation rate for Chiltern with higher numbers of cognitive impairment diagnosis rather than dementia. Although LB felt this accurate, LP challenged that on the basis on one locality having not grasped it. RB acknowledged practice engagement was part of but not the whole issue. LP felt a need to link this to the role of the clinical locality director. OUHFT RTT Backlog: concerns have been raised through NHSE assurance; with plans in place for a meeting to understand the legal implications of clearing the backlog, in conjunction with Oxfordshire CCG. TD queried the timescale to clear the backlog. LP replied the problem is increasing over winter, LB added the backlog was reduced by 600 in December, but had increased again in January. KW noted plans for a clinical review of gynaecology and whether there were issues; LB noted a clinical lead was looking into this. LP noted she would like a clinical review and pipeline review of patient experience. LB noted media coverage of Churchill Hospital (Oxford) and staffing issue; they are not alone. The trust is looking at all options to ensure safe staffing levels with recruitment of specialist nurses a particular challenge. There are currently open safeguarding adults concerns within a Nursing Home after a coroner's report last year. GS queried specifics. LB replied neglect and safeguarding concerns. Our 4 CHC funded patients had been offered alternative care home placements but their families had refused. LP queried if they were aware of the full accusations. LB replied she had written a letter drafted with the CQC to patients and their next of kin. The care home management are keeping the patients families informed, and the four CHC funded patients / their families have been given a point of contact in the CHC nursing team. CQC undertook an inspection in December and issued a Notice of Decision (NOD), setting out immediate actions and restrictions. Final report due in January. GS queried future litigation and whether it was a CCG risk. LP replied we have a commissioning responsibility and whilst working in partnership with CQC, have offered alternative care home placements. Yes we have a risk. NL queried whether the accusations related to our residents. LB replied the current investigation does involve one of our residents. Several staff have been suspended; we have been assured there is a good manager in place, although a draft report from CQC from follow up inspection in December is not good. We will continue to work closely with CQC and BCC until service improves. The care home is also prevented from admitting new patients, and requires explicit permission form the CQC before readmitting any residents that have attended A & E. Stroke: NHSE will be commissioning a thrombolectomy service from OUH from later this month (treatment within an hour of attendance) and will be available	

	to Buckinghamshire patients. LP queried where this service is based whether patients would go to Milton Keynes as they provide cross cover. LB replied OUH at present, but there are plans, with appropriate staff training, to roll it out to Bucks. LB has also discussed with Dr Raj Thakkar this week options to reconvene the cardiovascular assurance group to help provide assurance. **Action: LP queried Milton Keynes provision for stroke and whether we are clear where rehab is located. Some units provide stroke care and rehab, others repatriate for rehab to local hospitals. Action to clarify for the next report.** LP continued – DTOCs seem to be improving – levels reported here are September 2017, are they going massively up? LB replied we are ensuring those medically fit for discharge are being moved as quickly as possible. KW noted work to utilise a third party to assist self funders and reduce delays; this should come into place this month. **Action: RTT incompletes – October data shows Milton Keynes 85.7% for Chiltern and 91.9% for Aylesbury Vale. Can we check these figures are the right way around? Action to clarify.** **Action: RB: 62 day screening standard for cancer with performance given as 83.3%. Aylesbury Vale's is given as 50% with Chilterns as 100%. Is this correct? LP agreed an action to check these figures are accurate.** **Action: GJ re: annual LD health checks. GJ suggested it would be useful to have a chart showing checks within the last 12 months (rolling). This will overcome the challenge of more checks taking place in Q4/March when they are otherwise due.** RB noted we should also instigate a communications exercise now to flag checks due within Quarter 4. LP concluded: we are now seeing GP triage numbers in the report and next month would expect to see further improvement with the urgent and emergency care transformation money specifically directed towards this, especially the low GP triage rate. The report states: "*The low GP triage accepted rate can be interpreted that patients are conveyed to an emergency department".* GJ noted there is debate about what "accepted" means – whether a practice accepts (or does not accept) a call from SCAS, or means the call gets through but the transfer of care is not accepted. LP confirmed this was GP triage accepted call, given busyness of GPs. RB suggested therefore "accepted" was not the right wording. **Action: revised and clarified wording on GP triage acceptance rate.** KW queried where primary care development and primary care quality fits in terms of uptake as there is a mixture of indicators. It was agreed to include this. LP noted a primary care resilience dashboard in Oxfordshire had also been developed which could also be adapted. RB noted we should have assurance on the primary care development scheme at the meeting in the first quarter of next year to see if we are on track.	

	TD raised a query on CHC; percentage of Continuing Health Care assessments completed within 28 days of checklist being accepted. He queried whether this is co-ordinated with what the finance report is telling us. PJ noted he would need to check which of these are relating to Arden and GEM and which relate to the new regime. With the figures presented relating to Q1 and Q2, they will relate to Arden and GEM led assessments (transition to Oxford Health in Q3 from 1 December 2017). KW pointed out that there is no connection with spend on CHC; this relates to assessment (before packages of care are agreed). LP noted this is a national "must do" as some CCGs were not acting as quick in order to save money. TD queried the correlation. PJ replied this shows a sluggishness in completing assessments which has led to backlog which is now impacting our cost profile. LP continued; this makes clear a reason why we have sought to change provider.	
9.	**Communications and Engagement Quarterly update (community services)**	
	NL introduced the item noting these updates circulate quarterly on basis that this is a statutory duty, and this year NHSE have introduced a new related indicator to the Improvement and Assessment Framework (IAF) with a desktop review. RW noted that communication with hard to reach groups was not hugely reflected and queried our actions. NL replied that the report provides a snapshot and that LP had visited a number over of 65s clubs, women's institutes, Age UK and parish councils in recent months. We will not return where attendance has been low and therefore not an effective use of resources. A U3A event in Wendover later this month is expected several hundred. We have not had invitations to harder to reach groups and are looking therefore to expand our offer. BHT is also running a number of roadshows that we will also attend so we can collectively demonstrate good public engagement. CO queried whether these large group events were an opportunity to offer the flu vaccination. All member GPs reflected this was value; GJ noted we should consider as part of 18/19 flu plan (though with mitigations to prevent more than one vaccination). GJ added a point about some care home work to ensure all appropriate patients for the vaccination had been covered. RMS noted previous messaging through screens in general practice receptions and that this route for messaging had little coverage. NL replied that this was a key part of the Live Well Stay Well campaign over winter; with flu vaccinations advertised on GP screens. RB queried whether other approaches to population based healthcare had been considered. NL replied that this has, though screens have focused on more personalised messaging on 15 minute cycles. GJ noted plans for a new website and whether this would be a system website. NL replied a CCG website would be embedded within a system website. CO suggested these reports should include a summary of learning and future actions to be taken. NL agreed and noted this was feedback we had also received through the desktop review and we would be addressing it going forward. We do not have a "you said, we did" section on the website and this forms part of our plans.	

10.	Next meeting/AOB	
	The next meeting in public on 8 March will take place in the chamber at Chiltern District Council. The next meeting, a seminar, will take place in Aylesbury (Jubilee Room) on 8 Feb. As regards future venues as a single CCG, LP suggested the church in Amersham used for stakeholder engagement events in autumn 2017, whilst CO suggested Bucks New University in Wycombe. RCa will follow up options. **There was no AOB.** **Meeting ended at 12:15**	

Acronyms

A&E	Accident and Emergency	IFR	Individual Funding Request
ACHT	Adult Community Health Team	IG	Information Governance
ACO	Accountable Care Organisation	KLOE	Key Lines of Enquiry
ACS	Accountable Care System	LMC	Local Medical Committee
ADSD	Attention Deficit Hyperactivity Disorder	LPF	Lead Provider Framework
AF	Atrial Fibrillation	M	Million
AGM	Annual General Meeting	MAGs	Multi Agency Groups
AQP	Any Qualified Provider	MCA	Mental Capacity Act
ASD	Autism Spectrum Disorder	MCP	Multi-speciality Community Provider
AT	Area Team	MK	Milton Keynes University Hospital Foundation Trust
AVCCG	Aylesbury Vale Clinical Commissioning Group	MCP	Multispecialty Community Provider
BAF	Board Assurance Framework	MusIC	Musculoskeletal Integrated Care
BCC	Buckinghamshire County Council	NHSE	NHS England
BCF	Better Care Fund	NHSi	NHS Improvement
BAF	Board Assurance Framework	NOAC	New Oral Anticoagulants
BHT	Buckinghamshire Healthcare Trust	OCCG	Oxfordshire Clinical Commissioning Group
BAME	Black and Minority Ethnic	OOH	Out of Hours
BPPC	Better Payment Practice Code	OUH	Oxfordshire University Hospitals NHS Foundation Trust
CAMHS	Child and Adult Mental Health Services	OPEL	Operational Pressures Escalation Level
CCCG	Chiltern Clinical Commissioning Group	PACS	Primary & Acute Care Systems
CDIF	Clostridium Difficile	PAS	Patient Administration System
CFO	Chief Finance Officer	PB	Programme Board

CHC	Continuing Health Care	PBR	Payment by Results
CIP	Cost Improvement Programme	PIRLS	Psychiatric In Reach Liaison Service
COI	Conflict of Interest	PLCV	Procedures of Limited Clinical Value
COPD	Chronic Obstructive Pulmonary Disease	PMS	Personal Medical Services
CPA	Care Programme Approach	POD	Point of Delivery
CQC	Care Quality Commission	POG	Programme Oversight Group
CQRM	Contract Quality Review Meeting	PPE	Patient & Public Engagement
CQUIN	Commissioning Quality & Innovation	QIPP	Quality, Innovation, Productivity & Prevention
SCWCSU	South Central and West Commissioning Support Unit	QIS	Quality Improvement Scheme
CSIB	Children's Services Improvement Board	QOF	Quality & Outcome Framework
CSP	Care & Support Planning	QNI	Queens Nursing Institute
CSR	Comprehensive Spending Review	PCCC	Primary Care Commissioning Committee
CSU	Commissioning Support Unit	RAG	Red, Amber, Green
K	Thousand	RBH	Royal Berkshire Hospital
DES	Directly Enhanced Service	RCA	Root Cause Analysis
DGH	District General Hospital	REACT	Rapid Enhanced Assessment Clinical Team
DOLS	Deprivation Of Liberty Safeguards	RRL	Revenue Resource Limit
DST	Decision Support Tool (CHC)	RTT	Referral to Treatment
EDS	Equality Delivery System	SCAS	South Central Ambulance Service
EOL	End of Life	SCN	Strategic Clinical Network
F&F	Friends and Family	SLA	Service Level Agreement
FHFT	Frimley Health Foundation Trust	SLAM	Service Level Agreement Monitoring
FOT	Forecast Outturn	STP	Sustainability & Transformation Plan
FPH	Frimley Park Hospitals NHS Foundation Trust	SUS	Secondary Uses Service
GB	Governing Bodies	TOR	Terms of Reference
GMS	General Medical Services	TV	Thames Valley
HASC	Health and Adult Social Care Select Committee	TVN	Tissue Viability Nurse
HASU	Hyper Acute Stroke Unit	TVPC	Thames Valley Priorities Committee
HETV	Health Education Thames Valley	UECN	Urgent Emergency Care Network
HWBB	Health & Wellbeing Board	YTD	Year to Date
ICS	Integrated Care System		
ICU	Intensive Care Unit		