NHS
Aylesbury Vale
Clinical Commissioning Group

NHS
Chiltern
Clinical Commissioning Group

AYLESBURY VALE AND CHILTERN CLINICAL COMMISSIONING GROUPS
GOVERNING BODIES (meetings in common in public)
8 March 2018, 10:30am
Chamber, Chiltern District Council, King George V House, King George V Rd, Amersham HP6 5AW DRAFT

Governing Bodies Members Present:		
Dr Raj Bajwa (Chair)	GP Clinical Chair (Chiltern CCG)	**RB**
Dr Graham Jackson	GP Clinical Chair (Aylesbury Vale CCG)	**GJ**
Robert Majilton	Deputy Chief Officer	**RM**
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**
Dr Robin Woolfson	Secondary Care Specialist Doctor	**RW**
Debbie Richards	Director of Commissioning and Delivery	**DR**
In attendance		
Russell Carpenter	Head of Governance/Board Secretary (minute taker)	**RCa**
Nicola Lester	Director of Transformation	**NL**
Louise Smith	Associate Director Commissioning and Transformation (item 9 only)	**LS**
Dr Christine Campling	Executive Clinical Lead for Planned Care Contracts and Maternity (item 7)	**CC**

1&2.	**Welcome & Apologies**	**Lead**
	RB noted this is the final meeting in public prior to the CCGs merger in effect as of 1 April 2018. Apologies received: • Lou Patten, Accountable Officer (voting member) • Crystal Oldman, Registered Nurse (voting member) • Colin Seaton, Lay Member (voting member) • Lisa Beaumont, Associate Director of Nursing and Quality (in attendance)	
3.	**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.	
4.	**Minutes of the meeting held on 11 January 2018 and Matters Arising**	
	Agreed as an accurate record. Both RB and GJ were shown both as chair. This was a typo – RB was chair.	

5.	**Questions from the public**	
	A preliminary question was raised in relation to MSK performance, suggesting it is currently bad and queried hope to raise this after the agenda item on MSK. RB suggested that the agenda item be carried with an opportunity for the member of the public to raise the question having heard it.	
	Leadership and Governance	
6.	**Accountable Officer's Report and System Working Update**	
	RM noted several matters. 1. The first joint system assurance meeting for Q3 took place in February; it was positive, but as there is no signal regulatory framework we are finding the best way forward. RM thanked Frances Burdock for information co-ordination required. Discussion included development of the ICS, a single regulatory framework, along with develop of quality and clinical leadership frameworks. There remains pressure with urgent care, and we provided an update on community transformation and our financial position. No formal assurance rating is expected. 2. Financial challenges were noted with a further update later on the agenda from PJ, and challenging timescales for operational planning. RM noted hard work from a number of teams to make this happen. Executive Committee has also experienced robust discussions on financial challenges, recovery and ICS development. TD queried whether we have done everything we need to do as far as merger is concerned. RCa replied that we have an interim version of our constitution agreed with NHS England as part of our merger application and conditions. Our merger has otherwise been approved, with some formalities still to complete in terms of signing staff and property transfer orders etc.	
	Assurance and Governance	
7.	**IMSK – update on transitions to lead provider model**	
	CC reported on the current position with the Buckinghamshire Integrated MSK Service and lead provider framework. <u>Concept</u> We had a concept of a prime provider model where one organisation takes budget for the whole of a service. We worked out what our budget would be over 5 years and a mechanism that would incentivise a provider alliance to work in the best interests of patients to produce a seamless service. <u>Delays</u> Unfortunately there have been delays for numerous reasons including shortage in resource for the project delivery group involving Buckinghamshire Healthcare NHS Trust (BHT) and Care UK. Throughout we have aimed to ensure we achieve delivery on the service model we envisaged. Patient benefits will not been seen just yet; e.g. multi-disciplinary team clinics started only 2-3 months ago. Consultants and colleagues from the intermediate care service and physiotherapists are reviewing patient cases, particularly joint replacements hips and knees, to ensure patients get right care first time. <u>Pathways of care</u> We have also delivered pathways of care for GPs so they know what they have to do prior to referral; these have just been launched. We also wanted to ensure consultant care is more uniform with a specific patient pathway. This	

launched last month. We have also started self-referral in one practice, which we will evaluable this over coming months with view to opening out to more in future. There are other measures we wish to launch n-year; e.g. Green Card, which affords patient priority so GPs do not need to continually re-refer when onward care is expected.

Provider alliance

We had an alliance of providers headed up by BHT in conjunction with Care UK who deliver the intermediate care service. They were going to take the budget for the five years. Our concept was that there would be savings achieved by reducing duplication, and so incentivising better ways of working.

Reflections

A new contract with a prime provider was due to take over all administration of contracts between then and alliance providers as of April 2018. However we have reflected that we are in a different system now than we were at the start of the two year process. We are now in an ICS with ourselves and our main hospital provider; it is in our interests to ensure costs to the system are minimised. We concluded a gain share mechanism and formal contract seemed less necessary than before. We were putting costs into the system by asking BHT to manage contracts when we already had CSU managing and therefore prompting duplication of effort.

Proposed change to contracting model

Details continue in development, but in essence this means that:

- Buckinghamshire Healthcare NHS Trust will continue to manage the contract for intermediate care services with Care UK as remains in place.
- The CCG, via South Central and West Commissioning Support Unit (SCWCSU), will continue to manage contracts with the other members of the alliance. This is on the basis that
  1. It reduces risk of duplication of resources otherwise introduced by Buckinghamshire Healthcare NHS Trust to undertake the same work
  2. SCWCSU already have in place the information flows, individuals and scale of operation to ensure this is effective.

Governing Bodies raised no objections to this, however it will need to be ratified by the Executive Committee (ordinarily this process would be reversed)

IFR alternative

GS queried next steps indication of an “IFR alternative” and what this meant. CC replied there has been a lot of concern about IFR (prior approval whereby before certain procedures, intermediate care service been applying for permission to ensure operations to certain thresholds). With the introduction of multi-disciplinary teams (whereby the patient is initially seen by a team), for that to work efficiently we couldn’t expect consultants to fill in IFR referral forms. For those clinicians, we agreed we would amend the process and ensure threshold compliance across all MSK procedures through audit. This is still to be buttoned down but is our direction of travel. Under the revised model, it would be BHT’s responsibility to ensure this compliance.

Self-referral

GS also queried how self-referral would work. CCG replied that a CCG team had visited a London trust with this in place for several years. This was based however on promotion only within GP practices, not more widely, and for physio only. We anticipated GPs would give self-referral form and then send to the provider for various routes including through practices. It’s work in

	progress; the process observed in London had been honed to ensure that all relevant information was captured in the referral and not increase risk of missing something if patient was left to fill it in. <u>Sub-contracting arrangements</u> NL noted the principles for support of commissioning to sub-contractors would create a precedent; given 24/7 primary care contract is also a lead provider model. RM added 24/7 is very defined, whereas MSK has a complexity given Payment by results (PBR) contracts with acute hospitals and impact on financial flows. Progress in wrapping support and expertise in the system to other partners is the best way forward without introducing additional cost. <u>Patient outcomes</u> RM noted contracting is one aspect of the model, but so are improved outcomes and access – what is the journey to achieve outcomes? CC replied this is important – we will only know we have seen improvement if we monitor outcomes. We have developed measurements for patients and staff and these will continue as planned. <u>Patient experience</u> TD queried impact on patients from the delay. CC replied this is the subsequent delay in service rollout. RB noted a principle was to limit patients falling between gaps; how are we monitoring the service in improving this? CC replied we are not currently, though our series of measures will capture this. RM suggested the collaborative board needs some very clear objectives and deliverables for 2018/19 to continue progress and build confidence. <u>Question from the public</u> RB opened the item to the member of the public. The gentleman raised concern about the role of private companies and (words to the effect of) their tactics. CC replied that tendering was an approach, the other choice being collaboration as has been pursued. Tendering is expensive, and in areas where aggressive delivery had fallen down in a number of process with impact on trauma side of orthopaedics. Therefore we collaborated to minimise risk, but even this has not been easy. RB acknowledged the views raised and that they are not unique to our current situation.	
8.	**Finance Report (Month 10)**	
	PJ introduced the item and provided an overview of the current financial position through the Month 10 report. We previously reported a £2.9m deficit at Month 9. We have flagged for some time that this was expected to worsen, with a forecast deficit of £11.7m at Month 10. At M11 this worsened to £19.2m (expected year end position). Key points: 1. In terms of unplanned and unscheduled care, we are overspent by £24.1m. 2. In terms of continuing healthcare, we are overspent by £10.2m. 3. In terms of mental health we are overspent by £2m. Cumulatively this reaches £36m which is our underlying deficit. M10 report shows we have achieved £15m of savings offset against this, so actually outturn would be £19.2m. We have also built in £7.5m for community stock which gives the £11.7m figure. RP noted that the £7.5m figure for community stock remains a net risk which, if not agreed as includable by NHS England, would put our net position at £19.2m.	

	RB noted an increase in prescribing costs and queried likely future pressures. PJ replied this had arisen due to lack of generic drugs leading to more expensive substitutes. This is not unique to us. This is assumed to be non-recurring with short supply of generics expected to be rectified. For some drugs this may continue; the impact is difficult to predict. Although guidance specifies that we should not plan for a continuation, there is intention for NHSE to recognise it if it continued due to the factors beyond our control. GJ noted discussions he is aware of with DH noting that this is a national issue. RM noted points discussed at the Finance Committee: 1. We may need further external scrutiny to ensure accurate forecasts. 2. We need Governing Bodies endorsement that we have sufficient staffing and skills, clinical and managerial, to deliver our ambitions, especially given the previous discussion on MSK and need to ensure sustainable contract management arrangements. RB noted our organisational structure for 2012 when authorised as a CCG was appropriate for the time, whereas the model now, as an emerging Integrated Care System (ICS), is very different and therefore we need to acknowledge that. Challenging work is underway to do this; RM noted a commitment to bring the outcomes of this back to governing body. TD queried the likelihood of further worsening in February and March. PJ replied our year end outturn at this stage is expected to be £11.7m. Early analysis of M11 figures show we remain on track for this, though with £7.5m risk as indicated. The report was noted.	
9.	**Process for Approval of Annual Accounts and Annual Report for the year 2017-18**	
	A paper proposed a request the Governing Body to agree delegated authority to approve the Draft accounts and annual report to the Audit committee at their meeting on the 16 May 2018 and for final approval of any changes post Audit Committee to the Chairs, Chairs of the Audit Committee, Chief Officer and Chief Finance Officer on behalf of the Governing Body. This was agreed. TD noted this was the same arrangement as followed in previous years. RM noted that LP would hopefully be available to sign the annual reports and accounts, but queried whether he could be delegated authority to on her behalf if not. GBs agreed to the request, subject to double checking the scheme of delegation that this delegation is permitted. **Action:** as above PJ added that Gary Heneage would also be in place as Chief Finance Officer by this point. GJ noted that, as Aylesbury Vale CCG chair until 31 March 2018, he would maintain an ongoing responsibility as part of the process until the annual report and accounts are signed off.	
10.	**Quality and Performance Report (Month 10)**	
	LS introduced this item and noted she has been supporting DR, and highlighted a number of current trends. This is December data and represents pour position at the end of Quarter 3, and was therefore submitted to NHS England as part of our assurance process. We don't expect performance to improve greatly in some areas over the next quarter, particularly those related	

to winter resilience.

Cancer

LS noted 6 of the 13 BHT 62 day breaches (for cancer) were for Urology patients – we are working with Thames Valley cancer alliance on this pathway and expect to see improvement. RB queried that some of this relates to patients themselves reaching decisions on their treatment. LS noted this was true, where holidays arise for example, but there are also needs for diagnostic results for example. RB noted urology is difficult since one of the treatments is no treatment. LS added that, where we do see excessive waits, we are undertaking clinical harm reviews.

Referral to Treatment

TD noted reference to there being "*prostate patients who are still to make a decision about having surgery. The CCG has raised concerns regarding the recording method of these patients which is being discussed with OCCG*". What would this relate to? LS replied this falls under Referral To Treatment (RTT) and relates to being able to make an early diagnosis.

KW noted reference to "*There will be a deep dive on Urology, Gynae and Head & Neck at February's performance meeting*" (with Oxford University Hospitals NHS Trust). LS this also relates to RTT. We consistently perform around 90%, but the 92% target evades us. Main areas of underperformance are ophthalmology and trauma. Much Trauma and orthopaedics gets cancelled as a result of winter pressures which results in longer waits. We are managing this.

Over 52 Week Waiters; LS noted four breaches at Oxford University Hospitals Trust. The Trust has requested £1.2m additional funding to rectify this performance and is awaiting a response. Meanwhile gynae long waiters are a recurring problem; a modelling exercise is underway to redefine the pathway and was discussed at the contract meeting this week (and therefore links to the above point about a deep dive).

Diagnostics

We do perform consistency in this area.

A&E and 4 hour waits

This continues as a challenging area. Our system was at top of its escalation rating over last week or so, which has affected ambulance responses. We have high acuity and volume combined with increasing numbers of flu cases. Although this is not unique to us, it is not palatable, and we are seeing continued challenge with handover delays. The ambulance service is also changing a number of targets and categorising, leading to shift in workforce model – which will take until Q3 next to work through all the implications.

LS also noted an internal A&E rapid improvement programme, with a front end GP streaming service. We have also had extra funding to extend hours with general practice over winter; which has worked well where we have been able to source capacity and has performed well.

RMS noted increasing demand in primary care and need for community services to support general practices and offer resilience though primary care transformation to prevent A&E attendances and admissions. LS noted urgent care in general and related demand and capacity had formed part of quarter 3 assurance discussions with NHS England, and how funding may be best be

	used to accelerate improvements. Delayed Transfer of Care LSS noted initiatives which have now gone live, with improvement expected over the next few months. Weekly director level meetings review this, including review of cross border issues. Continuing health care assessments LS noted the percentage of Continuing Health Care assessments completed within 28 days: the national target is 80%, which was not met in Buckinghamshire during Q3, with Aylesbury Vale CCG at 70% and Chiltern CCG at 65%. With a new provider of the administration service in place (Oxford Health NHS Foundation Trust) we do expect further improvement. Dementia LS noted this is a key area for general practice and is included in our primary care development scheme. We expect further improvement in the final quarter, along with an offer of 1:1 support to practices not contributing to our target. Harm reviews RW noted these as undertaken for delayed diagnoses, but asked whether this is also true of people waiting above A&E target, or for diagnostics where there can be significant deterioration in condition. LS replied we do only where we see specific exceptional anomalies. In A&E, we might look at trolley waits for example that reach 12 hours, and those reaching 11.5 hours. Presenting understandable data and trends RB suggested that we could better monitor changing rates of activity between years rather than specific metrics in isolation. RM replied that it can be challenging to find meaningful ways to present complex information, but we can improve through better tracking for example population increases on activity rates for electives and unplanned admissions. RMS continued that we can also better align our system performance monitoring to national trends, especially in areas such as GP triage where variations in numbers can skew the impression those numbers create. KW added we need more analysis of activity growth in primary care, RB suggesting that this has likely trebled over the working lives of member GPs present. NL noted it takes time to train new GPs to contribute to handling growth, and that it does form part of our primary care transformation. We know some GPs planning to retire, and with recruitment is a difficulty nationally, we are looking at how other roles can best support them – pharmacists, paramedics etc. GP triage and streaming GJ queried GP triage and whether data presented related only to one month. The numbers in some cases are small, which can draw more attention to red rated differences in attempted vs accepted attendance rates. RB also noted challenge in interpretation of definition of what “accepted” means; if it refers to whether a paramedic has spoken to a GP, and so it does not relate to transfer of responsibility of care back to GP with patient not conveyed to hospital. GJ noted debate at Aylesbury Vale locality where the definition was concluded to relate to the latter. The report is therefore correct. GJ added anecdotal evidence in relation to streaming where it appears full	

	A&E assessments with diagnostics are being undertaken for more simple presentations, e.g. ear wax. The streaming service needs experienced GPs to minimise this extra unnecessary clinical assessment if it is to work effectively. LS acknowledged this. GJ has also reported knowledge of an NHSE analysis of primary care workload, though noted a concern that the disparate spread of appointment management would make it difficult to complete a conclusive audit. However we can learn locally with our members to review how they manage their appointment systems and work across Buckinghamshire to further analyse primary care activity. This may give us some help in future demand planning. RMS noted report inaccuracies – triage rate charts erroneously include Slough practices under Chiltern CCG; this needs to be rectified. **Action.** <u>CDiff</u> RB queried whether we review why we are consistently exceeding our trajectory. LS replied not at a granular level. RM noted scrutiny on this is through the Quality and Performance Committee. RW added that this relates to community and acute care and important to monitor as there is much learning to be gained through having an effective plan. RB also noted a query on antibiotics prescribing rates in secondary as well as in primary care. <u>Learning Disability Annual Health checks</u> RW queried whether data on compliance would be better presented as a rolling target rather than financial year, as what is important to recognise is whether a health check has taken place within the last 12 months, not what month it took place in. LS agreed to review this. The national target for 2017/18 is 55%. Most health checks may take place in Q4. RB noted we would review this in April. <u>Stroke</u> **Action:** RW queried Thrombolysis; it would be good to see this included. DR noted we have a good service; we have a cardiac stroke receiving unit with nurses and fast track pathways for better outcomes. Part of the national 4 hour stroke target is achieving this and therefore we have a quality difference. <u>Never events</u> LS noted never events being investigated. FHFT reported an incorrect tooth extraction. RW queried whether FHFT had implemented the WHO checklist prior to surgery and whether they had undertaken an audit. LS replied she believed they had, with routes for investigation and action as a consequence. <u>Flu</u> There have been 8 flu outbreaks in care homes in Bucks with 7 requiring provision of prophylaxis. GJ queried if we are achieving this – visiting care homes – given contracting arrangements with pharmacy colleagues. LS replied if depends whether in or out of hours but otherwise seems to be working well, though with a call on CCG medicines management time which may not be the solution next year. Finally, KW commented that the format of the report had been through a number of changes and noted that it was now much improved.	
11.	**Next meeting/AOB**	
	Date and Time of the next meeting: 14 June 2018, Chapel Room, Kings Church, Rain's Road, Amersham HP6 6LX, 10.30am to 12.30pm. RB thanked	

	PJ for his time with us if this turns out to be his last governing body meeting.	

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		