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)
13th April 2017

Olympic Room, Aylesbury Vale District Council Offices, Aylesbury

Governing Bodies Members Present:		
Dr Graham Jackson (Chair)	GP Clinical Chair (Aylesbury Vale CCG)	**GJ**
Dr Raj Bajwa	GP Clinical Chair (Chiltern CCG)	**RB**
Louise Patten	Accountable Officer	**LP**
Dr Karen West	Clinical Commissioning Director Integrated Care	**KW**
Robert Majilton	Deputy Accountable Officer, Director of Sustainability and Transformation and Interim Chief Finance Officer	**RM**
Tony Dixon	Lay Member (Deputy Lay Chair, Chiltern CCG)	**TD**
Colin Seaton	Lay Member	**CS**
Crystal Oldman	Registered Nurse	**CO**
Ross Carroll	Lay Member	**RC**
Dr Robin Woolfson	Secondary Care Specialist Doctor	**RW**
Debbie Richards	Director of Commissioning and Delivery (co-opted member)	**DR**
In attendance		
Leigh Franklin	(minute taker)	**LF**
Russell Carpenter	Corporate Governance Lead	**RC**

1&2	**Welcome & Apologies**	**Lead**
	The Chair Dr Graham Jackson (GJ) welcomed the Governing Bodies members and members of the public. **Apologies** • Dr Rebecca Mallard-Smith – Clinical Director Unplanned Community Care • Graham Smith – Lay Member (Chair of Primary Care Commissioning Committee) • Robert Parkes – Deputy Lay Member and Audit Committee Chair, Aylesbury Vale CCG.	
3.	**Declarations of Interest in items on this meeting's agenda**	
	Dr Graham Jackson reminded members of their obligation to declare any Conflict of interest they may have on any agenda items. GJ 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 declarations other than those standing on published registers. There are no existing declarations with materiality for this meeting as there are no commissioning decisions required.	
4.	**Questions from the public**	
	In the East end of High Wycombe there is a doctor shortage with a practice in need, Lynton House. Lynton House has been given some funding for re-fit to ensure its survival in the short term – which was due to take place in January 2017.	

	1. **What is the timescale for the upgrade? (capital funding)** 2. **In light of additional funding, will they re-engage with the public on 5 day service rather than the cut down service as is operating at the moment.** 3. **What are the current number of doctors we can expect to service the two centres (Lynton House and Cressex Health Centre), as in the last week there was an occasion of 1 doctor servicing both practices and three off sick? (resilience in primary care and workforce)** Lou Patten (Accountable Officer) replied: there was some immediate work done to ensure Lynton House could continue to remain open and serve its registered population, some of which is still ongoing. We do have a shortage of GPs locally, particularly partners, which is also a national trend. We recognise the need for a collaborative approach to solving access issues, which for the East of Wycombe has to come from what we do across the town as a whole. We will engage on this as we did for Lynton House, with some plans for engagement by July 2017. Dr Raj Bajwa added: we are working meaningfully with practices in the East end of High Wycombe in terms of future capacity, and in developing community services recognise the need to reflect the needs of patients in the area when we consider future design. **Local residents are looking for a Kingswood or Cressex type health centre to meet their needs in the East end of High Wycombe, not a super centre.** 1. **Can you please confirm that delivery of a new health centre for the East end of High Wycombe will not close existing centres to create a super centre?** 2. **In light of commitment to deliver centres and the land shortages that exist in High Wycombe, where are you planning to put it and have you identified a site before it all available land is taken up by further housing developments?** 3. **What are the timescales for the land purchase and the build?** Lou Patten (Accountable Officer) replied: I can't confirm that delivery of a new health centre for the East end of High Wycombe will not close existing centres. The direction of travel we are seeing nationally is that groups of GP practices are moving towards working together. There are a number of different models where GPs are starting to network to address problems like sickness and recruitment difficulties. But this doesn't necessarily mean that they will all merge. It is worth noting that, as NHS commissioners, we commission the services and not buildings. But we do recognise that premises are challenged in the longer term. So our solution will have to focus on how the network works across and whether there needs to be any new physical building. Dr Graham Jackson (GP Chair, Aylesbury Vale CCG) added: A cluster model approach to primary care is the national direction of travel to ensure collective delivery of a more resilient service to the population, though it does not necessarily mean infrastructure centred on one particular site. Dr Raj Bajwa (GP Chair, Chiltern CCG) added: from a general practice point of view, every change we've seen over the last three or four years has suggested a move towards larger, more sustainable and resilient general practice units (though not super centres) because of the more complex ask with an ageing population and more long term conditions.	

	This debate is separate to the campaign to see the return of A&E to Wycombe General which others are fighting; they want this not to be replaced by super health centres. There are two petitions happening at present and both getting in the region of 2000 signatures. **Is it appropriate to present a petition that asks for a new state of the art health centre for the East End of High Wycombe within the next two years? This would cover Bowerdean, Totteridge, Ryemead and Micklefield which are the areas of deficiency. Funds are available from sale money and S106 money (legal agreements between Local Authorities and developers); with land available from these developments. But we need more focus and urgency from CCGs for quick delivery. The petition has over 500 signatures as required to prompt further debate.** Dr Graham Jackson (GP Chair, Aylesbury Vale CCG): we can accept the petition but not debate it at this meeting, and ensure it is subject to the due governance process. Lou Patten (Accountable Officer) replied: the Primary Care Commissioning Committee holds a meeting in public every quarter, and we will make sure that the work about the assessment of Wycombe, including East Wycombe, will be reported to that meeting and future meetings in public of the Governing Bodies. We therefore accept the petition regardless of the number of signatures as this is recognised as of concern to local people. The timescale for reporting is unclear given baseline work still do in relation to demographic need and where individual practices are in terms of matters such as remaining leases. **A comment rather than question was raised to the Governing Bodies from Patient Participation group member at Rothschild House (Tring), noting with interest the development of Sustainable Transformation Plans (STPs) given location on boundary between Aylesbury Vale and Herts Valleys and therefore two different STP areas.** Lou Patten (Accountable Officer) replied: boundaries are important to us. We have some very significant patient flows, particularly into Buckinghamshire Healthcare NHS Trust, and have to consider that as part of our planning. We have dedicated directors to both Herts Valleys Sustainable Transformation Plan (Debbie Richards) and to the Luton, Milton Keynes and Bedfordshire CCGs (Nicola Lester). We can't commission at scale without a clear understanding of what their plans are. **ACTION 1: In concluding questions from the public on Lynton House and (informal) receipt of petition for a new health centre in East Wycombe, LP agreed to ensure that a fuller list of refurbishment works at Lynton House would be made available in the public domain (i.e. through the Chiltern CCG website)**	

5.	**Minutes of the meeting held on 9th March 2017, Action Log and Matters Arising**	
	5.1 Minutes – 9th March 2017 The minutes were approved with the following changes: 1. RM pointed out titles don't refer to his covering as Interim Chief Finance Officer 2. RM – section 8 (GBAF) should refer to Accountable Care System (ACS) not Accountable Care Organisation (ACO) 3. RB – Dr Rebecca Mallard Smith's title should read as "Clinical Commissioning Director Unplanned Community Care" 4. LP section 6 Accountable Officers report "We will continue to seek organisational change during the coming year" should read "We will work towards an assumed merger for the coming year" 5. LP section 8 Governing Body Assurance Framework: we will be looking at some new ways of nurse leadership, ~~for example~~ Crystal Oldman "is supporting us to do this" rather than "looking at how we deliver nursing in the future." *LP added that with the growing importance of the STP, we would seek a more strategic approach with some shared resources and also as we move into the Accountable Care System (ACS) and we will be looking at some new ways of nurse leadership. Crystal Oldman is supporting us in looking at new models of system nurse leadership alongside Carolyn Morrice at Buckinghamshire Healthcare NHS Trust. KW further indicated that there remains a director responsible for nursing.* *RW replied that this was re-assuring as he was concerned at the loss of professional leadership for nursing at board level; as so much of the CCG's plans are transformational and will require significant development of the workforce. He would be concerned that by sourcing this from outside of the CCG would not allow enough strength and purpose to that role.* *LP further replied that there is good clinical accountability for nursing in the organisation, with clear lines of accountability all the way through to the Governing Bodies. We also separately have nursing leadership, significantly around community and primary care services; it is this that Crystal will be focusing on. This piece of work will be presented to the Governing Bodies for assurance.* **5.2 Action Log –** It was noted that all actions have been updated within the separate action log. **5.3 Matters arising –** None were raised.	

	Leadership Reports	
6.	**Accountable Officers Update**	
	Presented by Lou Patten (LP). **There are no conflicts of interest relating to this paper.** Four brief verbal points were raised: 1. Bucks system transformation continues at pace into the Accountable Care System (ACS) with the Healthy Bucks Leaders group morphing into the ACS Board with NHS Improvement and NHS England to be invited from June onwards. 2. Nurse Leadership Locality nurses – closed consultation report outcomes to be reported next time, though there is a general consensus that this is an existing new era in terms of the role of these individuals in leadership in general practice nursing. 3. Five year forward view (next steps, published 31 March 2017) and urgent and emergency care delivery plan reset – we are working through how these affect operational and STP wide plans; to be monitored through the Executive Committee. 4. Year-end closure for finances – LP publicly thanked the team for their efforts, and noting this has been challenging given ongoing absence of a substantive CFO which RM is filling on an interim basis RC queried in relation to FYFV next steps whether there was anything that jumped out that would impact moving forward. GJ referred to the later agenda item. CO queried succession planning for primary care nurses. LP replied that for GPs there are associate leads who undertake short term additional work to obtain an understanding of how the CCG works and we would intend to continue succession planning through the same method.	
	Assurance and Governance	
7.	**Finance Report (Month 11)**	
	RM provided highlights as follows: • We are on track to meet our planned end of year position circa £200k (1%) along with maintaining £5.8m surplus brought forward. In line with national commitment of £800m contingency we also have set aside a further £6.1m which has not yet been spent. This gives us a carry forward of £12m, but the break up is important so as not to demonstrate that we have £12m unspent. Otherwise this is a massive achievement. • Particularly challenging run to end of the year: 1. Position supported significantly by non-recurrent measures circa £13m release from balance sheets. And £1.5m allocations /expenditure which we not released into position this year but may need to next year. 2. CHC has been an ongoing difficulty in terms of accounting with £1.5m shift on expenditure in last two weeks. This has prompted a need for proactive management of the CHC contract management to improve forecasting and robust assurance process with third sector providers. 3. Contract position – alignment with main contract areas but some not yet closed fixed end deals, with degree of challenge and review in place. We have aimed to out in headline contract position which we would expect to come down from. 4. Allocations – including £1m income from specialist commissioning which hasn't yet been confirmed and so could be at risk.	

	RC highlighted prescribing deterioration and queried what was driving this – e.g. demand/growth. RM replied that there has been general underspend and locally we benchmark extremely well. Normally we'd take a more prudent view and not release all benefit from PPA forecast into position as this does tend to fluctuate. RC also queried the implications of quality premiums moving into programme. RM noted that this was an anomaly linked to running costs and would be better as a programme budget. TD reflected on Audit Committees discussions about performance of the CSU – will we get the accounts completed on time? RM replied that he was more assured and that they have responded to concerns and have shown improvement in comparison with last year. GJ expressed gratitude to the team for delivering the end of year position.	
8.	**Quality and Performance Report (Month 11)**	
	DR introduced this item and drew attention to a number of headlines within the report supplied in relation to cancer, RTT, A&E, ambulance service performance and dementia diagnosis. We have a comprehensive Easter plan with daily situation reports to NHS England, and working closely with Frimley system for South Bucks patients. We have now reset for 2017-18 and will bring further updates in due course. The quarterly NHS England assurance has taken place, with DR/RM asked to convey thanks to teams for evidencing grip and commended for realistic trajectories rather than setting targets that are not achievable. LP noted that if A&E staff work hard enough not to admit and patients are re-directed into primary care, this threatens the historic target. We may choose to challenge NHS England on this as it didn't have much coverage in their urgent and emergency care delivery plan (published this month). DR noted part of achievement is delivered by minor injury level of the service, both at Stoke Mandeville and Wycombe hospitals. If A&E manages more complex cases this puts target at risk, or increase numbers of patients admitted to ambulatory care or short stay wards. We must continue to emphasise these risks to NHS England. KW noted a graph showing the 62 day standard (GP referral to first treatment) which appeared to be falling (circa 90% September 2015 where the graph starts, falling below 85% standard to circa 80% January 2017 where graph ends) and noted concern about this. KW also noted paediatrics and RTT and asked what assurance we have in this eras given current recruitment issues and noting that the safeguarding director has stood down. DR acknowledged recruitment issues though also a high level of confidence that BHT will return to previous performance levels. However, it is recognised that further improvement is not based only on hospital care but a need to look at improvement across paediatrics including community services. We are looking to review a current improvement plan; we recognise issues and those national ambitions aren't sensitive enough.	

There was a lowering of performance in respect of initial healthy assessments for Looked after Children which was down to sickness within the provider and resilience. This was addressed very quickly and dealt with and now returned to positive performance, however the lack of performance in December and January is not acceptable and we are pressing for further performance assurance.

Under the constitutional indicators, KW pointed out that C-section rates were high in the Quality and Performance Report provided for Month 11 (red rated), but that there was no commentary given to describe what actions were being taken to address this. The same applied to the mental health constitutional indicator targets.

ACTION 2: DR agreed to report back on this, whilst noting that a maternity deep dive with NHS England at the May assurance meeting with NHSE and this will be reported back to GBs.

RB queried work on baseline tracking; numbers of people seen out of hours etc. and complexity. DR replied that the provider is collecting it. LP added there is something about the wider system measuring and demonstrating this.

TD drew attention to the following paragraph in relation to Wexham Park Hospital

The current contract to provide support services and 6 months reviews to all stroke survivors across Slough will be ending on the 31st March 2017. The East Berkshire CCG's and the Local Authorities are in the process of reviewing all the service specifications and re-procuring these services across East Berkshire. In order to deliver an equitable service across East Berkshire both health and social have agreed to work together to ensure that there is a collaborative approach to commissioning a single service that will be in place from 1st October 2017. In the interim we will work with the Stroke Association to ensure an equitable interim service for all stroke survivors.

TD commented that this section referred to East Berkshire, but didn't refer to the equivalent for Buckinghamshire. DR assured Governing Bodies that pre and post 6 months support available for stroke recovery is in place from 1 April for Buckinghamshire patients.

ACTION 3: DR agreed however to provide further information and evidence as clarity.

This included clarity on who is working in between with the Stroke Association to ensure equity of service, as RB suggested that it would not be CCGs working with the Stroke Association; rather it would be the providers.

9.	**Five year Forward View – delivery plan update**	
	GJ introduced this item which is the next step in implementation of the Five Year Forward View (FYFV). GJ noted that this was expected by 31 March and was published that day. GJ explained that this document was published half way through the five year forward view (published December 2014) and highlight points in the report. There are no big surprises, but highlights a focus on 4 key areas as would be expected and which we are already focusing on locally – urgent and emergency care, cancer targets, primary care and mental health. GJ reflected on the government budget announcement on £100m investment in A&E; there is a need to consider how this will work and link it to the wider system. GJ reflected that, in his opinion, this was not necessarily about placing a GP at the front door. LP noted that we will map the work we are doing against the Five Year Forward View for the May seminar. GJ added this will also include providers to discuss how we deliver an ACS for Buckinghamshire. CO queried whether there had been a comparison with other areas where nurse practitioners have been used as a front door approach. GJ replied that in the delivery plan it references the Luton model (GP led with primary care centre on site with multi streams and individual staff teams). LP added that there is an STP work stream for urgent and emergency care delivery which looks at what the local health economy will do and added value from STP wide planning. **ACTION 4: Circulation to Governing Bodies members the updated Five Year Forward View document published 31 March 2017 and Urgent and Emergency Care Delivery Plan.**	
10.	**Amendments to terms of reference for Audit Committees meetings in common.**	
	A supporting paper described the following membership and quorum arrangements: *The Committee consists of not less than three members, one of which must be the designated Chair (the lay member from the Governing Body).* *The other members comprise:* • *Practice Member(s)/ Practice Member Representative(s) – a representative appointed from the membership of either CCG in the federation.* • *Remaining Lay Member – who need not be a member of the Governing Body appointed to serve on the Audit Committee.* A quorum shall be two members RM commented that the changes reflect a new mix of membership and number of members required for quorum, which had become an issue in the old	

	constitution. The same arrangements had been discussed and approved by the Audit Committees meetings in common. The proposed amendments were ratified.	
11.	**Amendments to terms of reference for the joint Quality and Performance Committee**	
	The Governing Bodies were asked to ratify **RATIFY** changes to the Terms of Reference for the Quality and Performance Committee and note the lay member vacancy, which is being addressed as part of a wider review of governance arrangements aligned to plans for merger by 1 April 2018. They have already been approved by the committee. The terms of reference were amended following the resignation of Secondary Care Nurse (and Chair) Sheran Oke, and following changes to the Executive Director's portfolios. ***Membership:*** *The Committee does not now have a Secondary Care / Governing Body Nurse. Lisa Beaumont agreed to cover this role in the interim.* *The Committee does not have lay member representation, other than Health Watch, who are non-voting, and who are unable to become voting members (in order to preserve their independence).* ***Chair:*** *Karen West has agreed to become the new Chair, and Debbie Richards will be the Deputy Chair.* ***Voting Members:*** *One lay member (vacancy)* *One Clinical Commissioning Director (Chair)* *Director of Commissioning and Delivery (Deputy Chair)* *Secondary Care Specialist Doctor* *Associate Director of Nursing and Quality* ***Quoracy:*** *Quoracy was agreed as any three of the membership described above to include at least one clinician from the CCGs, and the Committee Chair or Deputy Chair. This has proved a challenge In March, when due to lack of quoracy a virtual meeting had to be held. The committee will endeavour to recruit a new lay member.* DR noted the changes. KW drew specific attention to the absence of a lay member linked to the wider governance arrangements of the CCG. GJ noted the Governing Bodies ratification subject to addressing the ongoing issue on lay membership.	
12.	**CCGs Budget Setting 2017/18**	
	RM introduced the item and noted the budgets presented for 17/18 based on operational plans seen by Governing Bodies last December. They have been seen by the Executive Committee a number of times, with two areas to highlight: 1. Our operational plans have been approved by NHS England with four conditions. a) QIPP incorporates the areas where we need to address spend to ensure appropriate efficiencies; NHSE want to see all our project documentation for more assurance on the level of unidentified QIPP.	

	Given switch to Verto using scoping, mandate and business case documents, we no longer produce Project Initiation Documents (PIDs). We are working with NHSE to enable the information they need. b) A&E and support for the urgent care delivery plan c) Meeting our RTT trajectory (compliant from May 2017). We have been notified of a financial and patient experience risk associated with Oxford University Hospitals and an RTT backlog – this is being worked through by Oxfordshire commissioners. d) Meeting Dementia trajectory. This makes us amber and not seen as high risk in the range of CCGs. 2. There is also a national piece of work across about 100 CCGs around financial recovery and identifying areas of opportunity. Deloitte have also been supporting us as part of an NHSE funded programme to identify further QIPP opportunities, with their final report due. This is also including some national benchmarking on MSK. QIPP next year is circa £25m, £8m currently unidentified. We are also pushing to ensure that all existing projects are on Verto by end of April. We have reported a net risk for next year in the range of 3-4%, though this is not extreme compared to other CCGs reporting 9-10% QIPP (as a proportion of budget). TD queried whether this would be further reported to the Finance Committee; RM replied that it would whilst also reflect the Deloitte report and further improvement in data management which has been difficult this year. RM added that we need clear transparency between the roles of Finance and Audit Committees alongside Governing Bodies and Executive – we need keep the right focus through each on both main contracts and other lines where we don't normally have much focus. This will help us to manage any additional financial risk. Meeting closed 11.58	
	For Information	
13.	**Approved Minutes from sub-committees, sub-groups or steering groups:**	
	Approved Minutes from sub-committees, sub-groups or steering groups: Executive Committee – 23/2/2017 Audit Committee – 1/02/2017	
14.	Date of next meeting (in public): 8 June 2017, Olympic Room, Aylesbury Vale District Council	

Acronyms

A&E	Accident and Emergency	KLOE	Key Lines of Enquiry
ACHT	Adult Community Health Team	LMC	Local Medical Committee
ACO	Accountable Care Organisation	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
AT	Area Team	MCP	Multi-speciality Community Provider
AVCCG	Aylesbury Vale Clinical Commissioning Group	MK	Milton Keynes University Hospital Foundation Trust
BAF	Board Assurance Framework	MCP	Multispecialty Community Provider
BCC	Buckinghamshire County Council	MusIC	Musculoskeletal Integrated Care
BCF	Better Care Fund	NHSE	NHS England
BAF	Board Assurance Framework	NHSi	NHS Improvement
BHT	Buckinghamshire Healthcare Trust	NOAC	New Oral Anticoagulants
BAME	Black and Minority Ethnic	OCCG	Oxfordshire Clinical Commissioning Group
BPPC	Better Payment Practice Code	OOH	Out of Hours
CCCG	Chiltern Clinical Commissioning Group	OUH	Oxfordshire University Hospitals NHS Foundation Trust
CDIF	Clostridium Difficile	OPEL	Operational Pressures Escalation Level
CFO	Chief Finance Officer	PACS	Primary & Acute Care Systems
CHC	Continuing Health Care	PAS	Patient Administration System
CIP	Cost Improvement Programme	PB	Programme Board
COI	Conflict of Interest	PBR	Payment by Results
COPD	Chronic Obstructive Pulmonary Disease	PIRLS	Psychiatric In Reach Liaison Service
CPA	Care Programme Approach	PLCV	Procedures of Limited Clinical Value
CQC	Care Quality Commission	PMS	Personal Medical Services
CQRM	Contract Quality Review Meeting	POD	Point of Delivery
CQUIN	Commissioning Quality & Innovation	POG	Programme Oversight Group
SCWCSU	South Central and West Commissioning Support Unit	PPE	Patient & Public Engagement
CSIB	Children's Services Improvement Board	QIPP	Quality, Innovation, Productivity & Prevention
CSP	Care & Support Planning	QIS	Quality Improvement Scheme
CSR	Comprehensive Spending Review	QOF	Quality & Outcome Framework
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
HASU	Hyper Acute Stroke Unit	TVN	Tissue Viability Nurse
HETV	Health Education Thames Valley	UECN	Urgent Emergency Care Network
HWBB	Health & Wellbeing Board	YTD	Year to Date
ICS	Inhaled Corticosteroids		
ICU	Intensive Care Unit		
IFR	Individual Funding Request		
IG	Information Governance		