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)
12 October 2017, 10.30am
Memorial Lounge, Union Baptist Church, Easton Street, High Wycombe

Governing Bodies Members Present:		
Dr Graham Jackson (Chair)	GP Clinical Chair (Aylesbury Vale CCG)	**GJ**
Dr Raj Bajwa (Chair)	GP Clinical Chair (Chiltern CCG)	**RB**
Dr Karen West	Clinical Commissioning Director Integrated Care	**KW**
Dr Rebecca Mallard-Smith	Clinical Director Unplanned Community Care	**RMS**
Robert Majilton	Deputy Chief Officer	**RM**
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**
Colin Seaton	Lay Member (Patient and Public Involvement)	**CS**
Dr Robin Woolfson	Secondary Care Specialist Doctor	**RW**
Debbie Richards	Director of Commissioning and Delivery	**DR**
In attendance		
Russell Carpenter	Corporate Governance Lead (minute taker)	**RCa**
Dr Sian Roberts	Clinical Director – Mental Health and LD (item 5 only)	**SR**
Alex Britton	Senior Talkback Manager, Talkback Bucks (item 5 only)	**AB**
Kim Parfitt	Communications Team, Buckinghamshire County Council (item 9 only)	**KP**

1.	**Welcome & Apologies**	**Lead**
	The Chair Dr Graham Jackson (GJ) welcomed the Governing Bodies members and members of the public. **Apologies received:** • Louise Patten, Chief Officer • Crystal Oldman, Registered Nurse • Ross Carroll, Lay Member • Nicola Lester, Director of Transformation	
2.	**Declarations of Interest in items on this meeting's agenda**	
	The Chair Dr Graham Jackson (GJ) reminded the meeting of obligations 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. RCa noted that in relation to any decisions which would require member GPs not to participate in discussion and decision we would not be quorate given absence of LP. However there were decisions required with this mitigation on the agenda.	

3.	**Questions from the public**	
	There were no questions received in advance of the meeting or on the day.	
4.	**Minutes of the meeting held on 14 September 2017, Action Log and Matters Arising**	
	5.1 Minutes – 14 September 2017 RW – Page 6, reference to "conversation rates" should read "conversion rates" RMS – queried accuracy of the point she had made. "*To enable good practice access, these should be offered before day 7".* Because appointments can be self-booked on ERS, some patients are choosing later appointments, and therefore good practice would be even more difficult to maintain. GJ emphasised that for a two week wait it is good practice to be seen within 7 days rather than wait until the end of the two weeks which is more likely to breach. We may see a drift which is patient driven depending on when they choose to book their appointments. The final minutes will be amended to reflect this. **5.2 Action Log –** It was noted that all actions have been updated within the separate action log and proposed closure. This was agreed. **5.3 Matters arising –** None were raised.	
5.	**Clinical Directors presentation (including Patient Experience)**	
	The meeting was attended by: • Dr Sian Roberts, Clinical Director – Mental Health and LD • Aylesbury Vale and Chiltern CCGs Alex Britton, Senior Talkback Manager, Talkback Bucks Who talked through a presentation on learning disabilities including annual health checks, locality health check rates (highest figure 66% for Aylesbury Vale North during 2015/2016), action planning and paper roll displays with feedback from patients on how they felt treated by primary care in relation to access to annual health checks. Alex Britton described 11 barriers: 1. Communication 2. Reception staff 3. Waiting times 4. Support 5. Lack of understanding regarding general health 6. Fear 7. Mental health 8. Lack of flexibility and reasonable adjustments 9. Unwelcoming surroundings 10. Difficulty in making an appointment 11. Lack of continuity and regular staff SR noted that it is powerful to hear real patient feedback. GJ commented that a lot of the barriers described are felt by members of the wider population in relation to access to primary care. In relation to locality health check rates, GJ asked SR what work is being undertaken to engage practices to improve their health check rates. SR replied that this was ongoing, and to support practices to make "reasonable adjustments" to improve the experience. GJ asked whether lower penetration practices were positive to the engagement. SR replied that there are challenges with	

	capacity though there is experience of practices wanting to improve using a local Buckinghamshire "toolkit". GJ noted practices are funded to do this above their contracted work. DR noted that service user engagement forms a core part of the transforming care programme, with this just one element. DR noted her thanks for the presentation. RM queried whether there were means to do this differently, i.e., not necessarily in a single one hour appointment, given our accountable care focus towards population health management. SR replied that this wasn't limited to single on hour appointments, and that in some cases practices are visiting their patients who are resident in care homes. RM suggested that a virtual health check would be useful to which a number of clinicians would contribute. SR replied that development of integrated teams would help in furthering this approach. RM also asked if the name could change if it isn't achieving what we want. AB replied that different people are calling it different things and it is confusing. PJ queried actions in Buckinghamshire to embed the lessons of the feedback, especially given the links with increasing non-elective admissions. RM replied that our work on population health management would further explore this in focusing interventions at certain target groups, and noted that this has been discussed by the ACS Partnership Board. GJ added that there are a number of vulnerable groups whose needs are to be understood. SR noted that other measures are also underway, for example an increasing number of practices are becoming dementia friendly. RB queried whether primary care is the best place for health checks, as the system moves towards accountable care. SR replied that this is a role for primary care; about three quarters of patients should be using their GP but only about a quarter are currently doing so, and issues with familiarity are recognised. A wider team undertaking checks through the ACS model would be hugely beneficial. RB also queried the evidence base that proves benefit to patient outcomes. SR replied that Public Health have looked at this, and there is useful additional evidence from Manchester. GJ thanked SR and AB for attending; the link **Action: Circulate link to Healthwatch report on learning disabilities/accessing annual health checks for people with a learning disability to governing bodies (as part of reading list)**	**RCa**
	Assurance and Governance	
6.	**Finance Report (Month 5)**	
	PJ introduced the item; the target for year end is £125,000 surplus. We have identified risks which are described in the report. We have reported to NHSE an expected £5.3m deficit, A recovery plan is in place which has revised that figure to £2.9m deficit although this still has significant risk. Key variances are shown in table 1 (forecast outturn) TD observed that we are now in Month 7 and queried the current status. PJ replied that we moved to a forecast deficit of £2.9m in Month 6. We are facing significant risks as figures reviewed earlier this week by the Finance Committee show a worsening position. However Month 6 figures have not	

	yet been finalised. Month 7 is anticipated to show improvement now that we started a CHC recovery plan. DR informed Governing Bodies that formal Oxford Health NHS Foundation Trust board approval has been obtained for a step-in contract, which means that from 1 December the service previously provided by Arden and GEM CSU formally transfers. The new provider already provides this same service in Oxfordshire. To support the transition, the Oxford Health team is in receipt of new referrals as of Monday this week to help mitigate mobilisation risks. We are nationally benchmarked as an outlier in terms of numbers of CHC cases, with a lot of work ongoing to maintain appropriate outcomes. PJ added this should impact on our financial position if we get it right. TD queried the number of backlog cases; DR did not have the detail to hand but would action. DR noted that a detailed review had taken place. We need to prioritise new service users and carers to ensure we offer appropriate quality. **Action: Advise Tony Dixon on CHC backlog measures (of which there are several) given ongoing challenges and figures not available to hand. Newly approved patients noted as subject to review at 3/12 months - figure of 150 mentioned in passing but detail TBC** PJ added that all cases should be reviewed and 3 and 12 months, and annual review for long standing cases. There is an outstanding issue in terms of carrying out these reviews and timeliness; there is 2 months between now and formal start of the step-in contract. RM queried if there was assurance from the Finance Committee on the status of the recovery plan. PJ replied that we are in a challenging position and that Finance Committee was fully informed of that. RM added that there is learning from past experience that we should ensure if taken into account. RP replied that the Finance Committee does explore beneath the surface. RMS highlighted the percentage variances for commissioned provider trusts (as proportion forecast spend), especially out of county. RMS queried whether people are really choosing to visit trusts out of county or SCAS conveyance. PJ replied that we need to focus on this; some is muted as possibly out of hours if Care UK is closing its service which results in more A&E conveyances. **Action: Further focus on % variance at out of county hospitals; whether current trends reported in Table 5 are based on patient choice or SCAS conveyance. PJ/DR to provide further explanation based on work of Alec Thomas brought into CCG Finance Team.** DR added that there has been a significant deep dive into non-elective activity by practice, day of week, hour of day, age group, conveyance and high intensity usage. This high level summary is now being acted on. A systematised approach to analyse this intelligence is in progress. KW noted concern with the financial risks and whether the system has grip as opposed to only the CCG. PJ replied that some ACS wide financial	**DR** **PJ/DR (Alec Thomas)**

	reporting is in development and now executive teams from the CCG and Buckinghamshire Healthcare NHS Trust are now meeting together to address these issues. RB queried the lag time between our analysis and localities acting upon it to have in-year effect, and that this is a risk. PJ replied that some transformation would need to be recurring to have benefit, with non-recurring savings having a greater impact this year. We do need clarity on priorities. DR added that we have bid for transformation money for a GP cluster high intensity user project and have been awarded circa £0.5m to support this. This will help accelerate what we are already doing in primary care and community transformation. RB challenged whether GP clusters are ready to add what we are already doing. KW took this on-board. DR concluded that we have also been taking on board learning from elsewhere. The Finance Report was noted.	
	Leadership Reports	
6.	**Accountable Officers Update (including update on system working**	
	Presented by Robert Majilton (verbal update). We continue to make excellent progress in the development of our Buckinghamshire Accountable Care System. LP is today at a meeting of the national leaders. A number of national work streams are also underway that we are supporting; control totals and payment mechanisms, population health management and new care models (GP clustering and integrated teams). Population Health Management is absolutely a priority. We have also heard experience from Canterbury in New Zealand; change is a much as social movement as it is a list of discreet projects and programmes. We also need to be aware of capacity and capability in the system to move forward at our desired pace. The national **Memorandum of Understanding** (MOU) between NHSE, NHSI and the ACS has now been signed. A lot of work has also taken place on processes and principles for use of transformation funding. GJ queried if this can now be shared with governing bodies. RM replied that this has circulated with the September papers for the meeting in public. In terms of **communications and engagement**: • The national primary care team is visiting us next week, along with national visit on 3 November. • A Buckinghamshire Health and Social Care integration “big tent” summit is scheduled to take place on 16 November 2017 in Amersham. Professor Jonathan Benger, National Clinical Director for Urgent Care at NHS England has also visited Wycombe. DR provided highlights of the visit on 22 September; he visited the Cardiac and stroke screening unit, Dr. Piers Clifford talked him through the benefits to patients and the new look multidisciplinary assessment service (MuDAS), both in Wycombe Hospital and in the wider community through community hub pilots. It was a positive and encouraging visit; we were commended on our abilities to manage patients out of A&E and focus on community prevention. RB queried if there were plans to communicate the success of the visit. DR replied that the local MP has already done this.	

	RM noted that the Quarter 2 NHS England assurance visit has taken place this week; we have a new regional team and so this was opportunity for them to understand the picture in Buckinghamshire. Our financial and A&E challenges were recognized during a largely positive meeting. RM concluded in stating that we are continuing a process for 24/7 primary care access procurement; with a number of applications under review through gateway assessments. GJ added that future clinical leadership remained in development; a number of leaders had met this week to re-start this discussion.	
	Assurance and Governance	
8.	**Quality and Performance Report (Month 5)**	
	DR introduced this item. <u>Cancer and A&E</u> There are a range of ongoing performance challenges; with key areas focused on with NHS England assurance including cancer and A&E (there has been a deep dive of A&E and winter planning, with a sub-group of A&E delivery board stress testing the winter plan). There is expectation to push ourselves to full compliance with cancer following improvement demonstrated to date. We are also looking for proactive support from the Thames Valley alliance to make improvements to pathways. RM added that we are being proactive as a system through the alliance to review the whole pathway given it as a good area for prevention lead work, system Buckinghamshire and localities. NHSE are helping facilitate looking at what each other is doing as a future template. RM also added that members should be under no illusion as to the challenge to meet the A&E target this year; the level of scrutiny and concerns are clear and high on the agenda. GS noted anecdotal evidence about levels of treatment and whether the target is a misnomer. RB replied that he understood the context of the question, and that we needed to better understand the measure of actual outcomes. DR replied that there is a daily and weekly breach review at BHT with our quality team also reviewing long waits and undertaking quality visits. DR acknowledged that the A&E target is a crude measure, but it is a measure none the less. The least sick are also the ones waiting longer than 4 hours. GS queried how this was known; DR replied it was through individual patient analysis of breaches. <u>Continuing Healthcare</u> CCGs are now required to report on 2 CHC metrics: • Percentage of Continuing Health Care assessments completed within 28 days: the national target is 80%, which was not met in Buckinghamshire during Q1, with AVCCG at 43% and Chiltern at CCG 50%. • Less than 15% of full NHS Continuing Health Care assessments to take place in an acute hospital setting by March 2018 Oxford Health has reported 3 serious incidents involving deaths of patients in the community during August 2017: they each occurred in June, July and	

	August. RP asked for clarification as to what was meant by "serious incident" in this context – DR replied that in this case it is because they were unexpected. RM queried the CHC element of the report. He suggested the content on the percentage of Continuing Health Care assessments completed within 28 days was confusing. The national target is 80%. Compliance against this target was not felt to be clear – whereas a separate table refers to different indicator showing a national target for 15% or less of Continuing Healthcare Assessments to take place in an Acute Hospital setting by March 2018. **Action: Minutes to clarify difference.** In Quarter 1 2017/2018 the national 80% target for % of Continuing Health Care assessments completed within 28 days (in all settings) was not met, with AVCCG at 43% and Chiltern CCG at 60%. During Q2 the position deteriorated further to 40% Chiltern and 22% Aylesbury Vale. We expect the situation to improve significantly in Q3 as Oxford Health have taken over the management of all new CHC referrals on 9th October. Meanwhile a separate indicator shows compliance with a national target (on a trajectory) to ensure that no more than 15% of these assessments take place in an acute hospital setting (with 15% to be achieved by March 2018). At the end of quarter 2, against a target trajectory at that point in time of 49%, both Aylesbury Vale and Chiltern were compliant at 31% and 30% respectively. We are expecting both to be compliant by March. <u>Delayed Transfers of Care</u> RM noted DTOC rates (delayed transfers of care) and asked for clarity as to why these may occur. DR replied that this may relate to health or social care reasons. Buckinghamshire Healthcare NHS Trust, there is a low number of adult social care attributed delays (less than 5%) For those patients which are Buckinghamshire patients, they delay is frequently attributable to waits for specialist community beds or complex domiciliary care, especially where it is self-funded. Joint work continues with BHT and Buckinghamshire County Council to manage self-funded patients, including discharge support for carers and families at weekends. There is also a lot of winter focused work on minimising delayed transfers for Hertfordshire patients at Buckinghamshire Healthcare NHS Trust, and Buckinghamshire patients at other neighbouring trusts (e.g. Frimley). <u>Ambulance performance</u> GS raised queries in relation to ambulance response times; Thames Valley as a whole meeting target but Buckinghamshire not doing so. It is difficult to see why there is a difference. DR replied that some improvement has been demonstrated, but agreed an action to provide a further update. DR also noted that the ARP (Ambulance Response Programme) is now in progress with some further assurances being requested on how that will work in practice. KW noted that GP streaming was now in place at Buckinghamshire Healthcare NHS Trust which, in providing supportive triage, would assist in freeing up ambulances earlier. DR added that data analysis shows high intensity users and address these issues. GJ continued that we need to	**RCa**

	better understand the relationship between A&E data and what local GPs are saying in relation to patient behaviour, with a focus on general practice to own the issue and themselves understand the data analysis. DR concluded by stating that Dr Dal Sahota are working closely on ongoing data analysis, noting that South Central Ambulance Service have reported to the Executive Committee on the success of GP streaming elsewhere. **Action: report to include more detail on actions being taken on ambulance response times to reflect Buckinghamshire position (falling performance)** <u>Electronic Referral Service</u> TD noted practice level usage of ERS – data to June 2017 showing numerous yellow RAG ratings with very few green. TD queried whether this meant the system is not working properly. GJ noted it does not reflect this; RB noted a change in process which is taking a while to embed, to which added that this is a new technology being developed. DR noted this was also a reporting addition and an area of priority. It is now a national requirement to move to the full use of the NHS e-Referral Service (eRS) for all consultant led first outpatient referrals. RW raised a query about publishing ERS data (from the programme) on numbers of referrals refused by secondary care. **Action: DR agreed to take this action to ensure this is reported.**	**DR** **DR**
9.	**Communications and Engagement Quarterly update (community services)**	
	KP introduced the item (for information), emphasising a focus on integrated and joined campaigns working closely together with the county council. The winter pressures campaign is a good example of this; managed through a health and social care communications group meeting every two months. In relation to accountable care, a conference took place with some 300 system staff in July 2017. Notably after the event, almost 70% said they would feel confident about explaining the ACS to colleagues, family and friends, whereas before the event 56% said they knew nothing at all. A stakeholder newsletter is also due to circulate imminently. Your Community, Your Care Roadshows; several have taken place with more to come over the next few months; tailored to groups to address local needs. RM noted that there is a challenge in targeting all the right channels; KP replied that the communications group would be undertaking a task to map all partners available channels, especially free channels (newsletters etc.), in order to target messages appropriately. **Action: CS requested that an addition to the report is a summary of events and activities to tackle health inequalities as this wasn't currently included.** The supplied report was **NOTED**.	**NL/KP**
	For Information/Ratification/Reading List	
13.	**For Information/Reading List**	
	All Approved Minutes provided within papers were noted.	

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
ACS	Accountable Care System	M	Million
AF	Atrial Fibrillation	MAGs	Multi Agency Groups
AGM	Annual General Meeting	MCA	Mental Capacity Act
AQP	Any Qualified Provider	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
CCCG	Chiltern Clinical Commissioning Group	OPEL	Operational Pressures Escalation Level
CDIF	Clostridium Difficile	PACS	Primary & Acute Care Systems
CFO	Chief Finance Officer	PAS	Patient Administration System
CHC	Continuing Health Care	PB	Programme Board
CIP	Cost Improvement Programme	PBR	Payment by Results
COI	Conflict of Interest	PIRLS	Psychiatric In Reach Liaison Service
COPD	Chronic Obstructive Pulmonary Disease	PLCV	Procedures of Limited Clinical Value
CPA	Care Programme Approach	PMS	Personal Medical Services
CQC	Care Quality Commission	POD	Point of Delivery
CQRM	Contract Quality Review Meeting	POG	Programme Oversight Group
CQUIN	Commissioning Quality & Innovation	PPE	Patient & Public Engagement
SCWCSU	South Central and West Commissioning Support Unit	QIPP	Quality, Innovation, Productivity & Prevention
CSIB	Children's Services Improvement Board	QIS	Quality Improvement Scheme
CSP	Care & Support Planning	QOF	Quality & Outcome Framework
CSR	Comprehensive Spending Review	RAG	Red, Amber, Green
CSU	Commissioning Support Unit	RBH	Royal Berkshire Hospital
K	Thousand	RCA	Root Cause Analysis
DES	Directly Enhanced Service	REACT	Rapid Enhanced Assessment

			Clinical Team
DGH	District General Hospital	RRL	Revenue Resource Limit
DOLS	Deprivation Of Liberty Safeguards	RTT	Referral to Treatment
DST	Decision Support Tool (CHC)	SCAS	South Central Ambulance Service
EDS	Equality Delivery System	SCN	Strategic Clinical Network
EOL	End of Life	SLA	Service Level Agreement
F&F	Friends and Family	SLAM	Service Level Agreement Monitoring
FHFT	Frimley Health Foundation Trust	STP	Sustainability & Transformation Plan
FOT	Forecast Outturn	SUS	Secondary Uses Service
FPH	Frimley Park Hospitals NHS Foundation Trust	TOR	Terms of Reference
GB	Governing Bodies	TV	Thames Valley
GMS	General Medical Services	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	Inhaled Corticosteroids		
ICU	Intensive Care Unit		
IFR	Individual Funding Request		
IG	Information Governance		