AYLESBURY VALE AND CHILTERN CLINICAL COMMISSIONING GROUPS
GOVERNING BODIES (meetings in common in public)
13 July 2017
Jubilee Room, Aylesbury Vale District Council Offices, Aylesbury

Governing Bodies Members Present:		
Tony Dixon (Chair)	Lay Member (Deputy Lay Chair, Chiltern CCG)	**GJ**
Louise Patten	Chief Officer	**LP**
Dr Karen West	Clinical 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**
Robert Parkes	Lay Member (Deputy Lay Chair) Aylesbury Vale CCG.	**RP**
Colin Seaton	Lay Member (Patient and Public Involvement)	**CS**
Graham Smith	Lay Member (Chair of Primary Care Commissioning Committee)	**GS**
Ross Carroll	Lay Member	
Crystal Oldman	Registered Nurse	**CO**
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**
Nicola Lester	Director of Transformation	**NL**

1&2	**Welcome & Apologies**	**Lead**
	The Chair Tony Dixon (TD) welcomed the Governing Bodies members and members of the public. **Apologies** • Dr Graham Jackson, GP Clinical Chair (Aylesbury Vale CCG) • Dr Raj Bajwa, GP Clinical Chair (Chiltern CCG)	
3.	**Declarations of Interest in items on this meeting's agenda**	
	Chair Tony Dixon (TD) reminded the Governing Bodies members of their obligation to declare any Conflict of interest they may have on any agenda items. TD 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 were a number of declarations noted with relevance to items on the agenda and subsequent action required:	

Declarations of interest from today's meeting

ITEM	CONFLICTS OF INTEREST AND ACTION
Agenda Item 11: Merger update: final application to NHS England.	GPs who are members of the Governing Bodies could nominate themselves for election to the post of CCG chair when nominations open formally at the date in October as is specified within this paper. Accordingly it has been proposed and agreed with the lay chair of the meeting in advance (deputising for the clinical GP chair in his absence) that member GPs of the Governing Bodies are suggested to remain but refrain from participating in the discussion and decision required in relation to this item. This is to mitigate risk of conflict of interest which would need to be declared should an individual be considering a future nomination. The remaining voting members excluding all GPs will be quorate to make the decision as is requested of them. In order to further mitigate risk of prejudice in relation to the required election process, it has been considered whether to restrict circulation of the timescale details contained within this supporting paper. As this is a meeting in public for which papers are widely available through CCG websites, it is concluded and agreed with the deputy lay chair that this would be impractical and unnecessary. Dr Karen West specifically noted her conflict of interest in respect of this item.
Agenda Item 12, Assurance Framework for implementation of a Provider Collaborative approach to complex commissioning	This item is presented to agree a standard framework which could be applied to a number of re-commissioning exercises. GP Members present do have a potential conflict of interest as partners/shareholders in practices that are operators (or within a group thereof) of services commissioned by the clinical commissioning groups, some of which may be subject to re-commissioning. There is no specific service or pathway being discussed at this time and so there are no conflicts of interest for any of the Governing Body Members for this decision to agree the generic framework and agree requested delegation to a sub-group to apply and approve the use of the framework for two forthcoming procurements signalled in the paper. In delegating to a Sub-Group application of the Assurance Framework of the two service areas signalled in the paper, there is a potential conflict of interest for GP Members who may be involved in any Provider Collaboratives that express an interest. The Sub-Group will not contain any conflicted GPs. When the two worked up frameworks come back to Governing Bodies for ratification, conflicted member GPs will be excluded from that decision.

Agenda Item 15: Verto Approvals Framework – Project Management Office	Approval of business case may require upwards escalation to a higher committee if material conflicts of interest are identified by chair of committee asked to make decision through agenda planning and cross reference to conflicts of interest register and through liaison with the Corporate Governance Lead. The business case executive summary box must also refer to any material conflicts of interest. This may also be identified in advance of this planning process and escalated automatically upon agreement between the SRO and lead director responsible for the business case. In relation to this specific paper, it requires a recommendation on governance process. Accordingly all voting members of the Executive Committee can participate in recommendation of approval to the Governing Bodies meetings in common the mechanics of approvals, where ordinarily they may have a conflict as described above.	

The meeting was quorate to conduct its business.

Quorum requirement	**Main meeting**	**Items 11 and 12**
Chair from either group (or deputy lay Chair)	TD	TD
Accountable Officer or Chief Finance Officer	PJ/LP	PJ
3 clinicians (1 of which must be a registered nurse or specialist hospital doctor and one must be a GP). Where GPs are conflicted in the decision, the meeting will be quorate with 3 clinicians and no GP.	RW (Secondary Care Doctor) CO (Registered Nurse) BMS, KW	LP RW (Secondary Care Doctor) CO (Registered Nurse)
Two lay members	RC, CS, GS, RP	RC, CS, GS, RP

4. Questions from the public

There were no questions received in advance of the meeting.
There were no questions raised from the floor.

Receipt of a petition

LP noted on 12 July 2017 having received a petition of some 1705 from Councillor Julia Wassell collected between November 2016 and May 2017 from Mr and Mrs Hawkes. It is a petition to provide a new heath centre for East Wycombe.

Members may recall us also having received a petition on 13 April 2017 from a prospective councillor which asked for a new state of the art health centre for the East End of High Wycombe within the next two years. At the time we also accepted that petition and there will likely be some overlap. We are accepting the petition but are not debating it at this meeting, though are confident that the number of signatures does prompt debate at a future Primary Care Commissioning Committee meeting, and these take place in public every quarter.

	LP asked GS as chair of the Primary Care Commissioning Committee to accept to a request to review an outline plan for our strategy toward this at the meeting to be held in December 2017, which will in due course be reported back to Governing Bodies. This was acknowledged.	
5.	**Minutes of the meeting held on 8 June 2017, Action Log and Matters Arising**	
	5.1 Minutes – 8 June 2017 Proposed amendments to the minutes from 8 June 2017. Minor amendments: role of Robert Majilton to be amended to "Deputy Chief Officer" rather than "Deputy Accountable Officer". The minutes were otherwise approved. **5.2 Action Log –** It was noted that all actions have been updated within the separate action log and proposed closure. This was agreed. Open action: Referral to Treatment (RTT). Additional assurance requested on RTT performance related to Oxford University Hospitals NHS Foundation Trust. RCa noted this could be closed if appropriate assurances were felt to have been provided. DR noted this matter had been further discussed with NHS England. Of 1650 patients currently on the waiting list, there are 170 residents of Buckinghamshire waiting more than 18 weeks for treatment. We need to further understand when these patients will be booked given a booking strategy where the longest waiters and those considered urgent are scheduled first rather than Buckinghamshire or Oxfordshire patients. We are also working hard to be party to a discounted rate that Oxfordshire CCG had agreed with OUH. This is still to be concluded but the provider is minded to offer this to us; NHS England to offer us support to ensure we have greater visibility. LP noted that this will be picked up through Quality and Performance Reports; action subsequently closed. Open action: Case study: how the appointed FTSU Guardians would react to a reported whistleblowing concern. RCa noted a meeting would take place directly after the meeting of the Governing Bodies to review a number of possible scenarios that could arise. **5.3 Matters arising –** None were raised.	
	Leadership Reports	
7.	**Accountable Officers Update**	
	Presented by Lou Patten (LP). **There are no conflicts of interest relating to this paper.** LP outlined a summary of her report, with points and challenges during the item as follows: <u>CCG Assurance Process:</u> RP noted having attended the Q4 assurance meeting and Buckinghamshire's exemplar to the rest of the country. <u>Maternity Deep Dive:</u> RMS queried reasons behind the increase in premature births. LP replied that Buckinghamshire as a whole is not an outlier. DR added that comparisons against england average for specific areas and high risk groups do show outlying areas across the county; older mothers, young mothers, smokers and obese people who are at greater risk. Some activities	

	have been targeted at these groups. Organisational Development: Oxfordshire Clinical Commissioning Group has announced that its clinical chair, Dr Joe McManners, has decided not to seek re-election to the post in February 2018 and will be standing down. At the same time, chief executive David Smith has announced his intention to retire from his role at the end of December 2017. We wait to see plans to ensure robust leadership. KW queried whether there are appropriate replacements to step in and whether this would prompt greater involvement with Oxfordshire going forward. GS also queried whether there was a reason why two individuals were stepping down at the same time. LP replied that she could not give a specific answer in respect of the timing but noted these things happen. There is a trend to look at Accountable Officers looking at larger scale and this may also form part of future plans. NHS England and NHS Improvement: With effect from 1st September 2017, Anne Eden will assume the joint responsibilities of both the Regional Director for NHS England and the Executive Regional Managing Director for NHS Improvement for the NHS in the South East. CO queried whether there was a conflict of interest if she was still a local resident. LP confirmed that she is and would take this into account.	
	Assurance and Governance	
7.	**Accountable Care System – update**	
	A slide pack was provided within the supporting papers. LP noted a staff session of circa 230 people from local providers, commissioners and county council had taken place 10 July. The slide pack had also been provided to localities and to the board meeting of FedBucks, the local GP provider company which represents 87% of Buckinghamshire practices. At the end of presentations LP took questions. CS left the meeting due to illness (the meeting remained quorate). RW queried the organisational development investment to ensure people throughout organisations are embracing expected change. LP replied that it is a massive challenge; this journey has begun with a series of workshops but there is more to do in especially in respect of population health management. RP queried whether the level of workload is appropriately resourced. LP replied there is a capacity issue across a number of organisations, but with talent across the system we need to assess gaps and plan to fill from the system to develop a cohesive team to support this work. TD queried whether additional funding available as an ACS would support this. LP confirmed that it would, but would need to be agreed as a system. GS noted the ambition and queried merits of a Memorandum of Understanding. LP replied that our contracting relationship with NHS England is not legally binding. RM added that their expertise would also help our journey where it is not available within our system. There is also a compact agreement across core partners, without legal involvement at this stage, to aim to capture collaborative working arrangements and engagement. This may change over time, though the legal framework remains separate statutory organisations.	

8.	**Finance Report (Month 2)**	
	PJ introduced this item for Month 2 with a number of key messages: No major change in finances with expected change in reporting format from Month 4. The forecast risks and mitigations reported for M2 are in line with the plan submission and show a net risk of £5,457k. As at the end of May 2017, the CCGs are reporting an in year forecast surplus of £125k, and in year, year to date surplus of £21k, as per the plan. Key actions remain ongoing in relation to CHC, contract management and discretionary spend/QIPP. The remainder of the report was noted as detail had been discussed in the previous confidential meeting.	
9.	**Quality and Performance Report (Month 1)**	
	DR introduced this item with a high level summary from the supporting report. As requested by the last Governing Body an update on the PREVENT initiative in Buckinghamshire was also provided in the accompanying report. RM queried the extent to which a new model for 111 (to launch September 2017) would improve core performance. DR replied that additional assurance is being sought to give public confidence that calls will be responded to when the new service launches, and they will be ramping up staff deployment to ensure 24 hour coverage. Stroke: RM noted there was no commentary. DR acknowledged this and indicated this should have been highlighted as an exception. DR noted that there is a cardiac stroke unit in Wycombe and that the national target is more about ensuring patients are not in an A&E before onwards referral to a stroke unit ward. Although some patients are waiting more than 4 hours to be admitted to a ward, DR noted we are assured they are in receipt of bespoke specialist support in a recovery area rather than an A&E bed. **Action 1: Stroke: ensure inclusion of stroke commentary from next report as this was noted as missing.** **Action 2: NHS 111 – add as routine to the report – need to understand whether the new service model will improve performance** RM also queried whether primary care development as part of a wider set of indicators would also be captured in the report going forward. DR replied that there are a number of areas to be included in the next report. Governing Bodies to be focused on electronic referrals and areas from within the Five Year Forward View such as mental health. Quality and Performance Committee to oversee this. LP noted the Executive Committee had received a presentation from SCAS on GP triage (i.e. contact with GP prior to clinical decision to leave at home and not transport if unnecessary) with reflection on significant improvement in Milton Keynes and how Aylesbury Vale GPs were lowest in Thames Valley and Chiltern about average. LP asked that this is brought back through the report to measure improvement. DR agreed to do this. **Action 3: GP triage: ensure that future performance review includes updates on SCAS GP triage project, current developments with which were reported to the last Executive Committee.**	**DR** **DR** **DR**

10.	**Better Care Fund Update**	
	The Governing Bodies in common were asked: • **NOTE** the approach to developing the Integration and Better Care Fund Plan for 2017/19 • **ENDORSE/APPROVE** the draft plan including outline budget proposal. • **NOTE** additional funding offered by spring budget 2017 (£3.489m 17/18) and spending limitation which is included within tan overall budget of circa £34m. • **DELEGATE** CCG approval and submission of the final plan to the Director of Commissioning and Delivery and Chief Officer • **ENDORSE** next steps for the final overall approval of the plan and budget by the Health and Wellbeing Board. • **NOTE** the monitoring arrangements described. DR presented the item on behalf of both the CCGs and Buckinghamshire County Council (BCC) as Jane Bowie Director of Joint Commissioning, Health and Adult Social Care was unable to attend due to council cabinet taking place at the same time. DR introduced a draft plan for 2017/18, with a number of elements likely familiar given it is based on previous submissions. Guidance had been expected for December 2016. DR described progress to date and financial implications as were described in the report provided within the papers. PJ queried whether changes to the plan, especially in relation to financial implications, are included as part of the delegation. This was asked to inform if Governing Bodies were approving the financial values as final, or whether the delegation may involve changes to the financial values. DR replied that the proposed value of £34,464,366, which is important to note that in very large part this is not new money, has largely been incorporated into contracts. However endorsement to discharge new money is requested, to allow the Local Authority to start to take action in developing the domiciliary care market in advance of winter. Further work required under delegation up to submission relates to the specific actions required to ensure performance targets are met – no further change is required to the allocations. LP added that this is being discussed by cabinet today, though no further change is anticipated. It was agreed that the Interim Chief Finance Officer would also be included in the delegated authority. RM suggested that the plan should also show the trend in terms of where previous funding has been invested, and queried whether the financial value for new money (£3.489m in 2017/18) would be broken down into tangible schemes in order to monitor impact. LP replied that technically this money is to be used to manage DTOCs (as opposed to a wider portfolio of schemes) with a key set of metrics in place to help understand social care spend. Any material change in the outline budget would be reported to Governing Bodies. RM queried whether the plan for assistive technology reports to the Integrated Commissioning Executive Team. DR replied that this sits within the integrated community equipment service and acknowledged a need for much for focused outcome reporting from this service.	

	Action 4: Review and update of acronyms in draft plan as some were not clear what they meant. RMS drew attention page 95 "carer's breaks" and should read "carer's support". This will be corrected. Otherwise Governing Bodies agreed/noted as asked.	**DR**
	For Decision	
11.	**Merger update: final application to NHS England.**	
	The Governing Bodies were asked to: 1. **AGREE** indicative changes to the CCGs' constitutions to facilitate full merger and completion of required application by 31 July. 2. **DELEGATE** responsibility for further minor amendments between now and 1 April 2018 to the Chief Officer and Corporate Governance Lead (Governing Bodies further if any additional major amendments arise). Any major amendments would be reported back to Governing Bodies. 3. **NOTE** an updated case for change document anticipated to be submitted with a completed application. 4. Be **ASSURED** that a comprehensive evidence gathering process has been exercised to ensure a completed application to NHE England to merge has the best possible chance of approval. 5. **NOTE** revised merger timescale. 6. **NOTE** anticipated timescale as part of the ongoing merger process for voting in a single chair of the CCG from 1 April 2018. 7. Receive for **INFORMATION** the current election procedure described within CCG constitutions. As noted at the start of the meeting, member GPs of the Governing Bodies are suggested to remain but refrain from participating in the discussion and decision required in relation to this item. **RMS and KW remained in the room.** <u>Background:</u> CCGs separate Governing Bodies had previously taken decisions in May 2016 to "merge in all but name", sharing back office functions through a federation arrangement that came into effect in July 2016. We are now in final stages in making an application to NHS England. We have also met with NHS England to make sure our application is appropriate. <u>Timescales:</u> Appendices provided two timescales aligned to merger, which RCa clarified as related to general timescales including any further amendments required to constitutions, plus also a timescale for planned election of a single clinical chair. The item was opened to comment by the chair. RM pointed out that the timescale for election of a single chair included reference to: "Winner announced to member practices subject to full governing body confirmation of winner". RM queried the paper on why the GB would have an opportunity to veto the result which had been decided by our membership and whether winner was the most appropriate term. It was agreed that this was not correct; rather Governing Bodies would be asked to note the result. LP made clear the LMC would be asked to discharge the role of returning officer with only LMC returning officer and Accountable Officer knowing the spread of votes. It was also acknowledged that a clear process for communication of the election results would be required. It was also noted	

	that at the meeting in public in September, Governing Bodies would also agree the competency interview process and formally appoint a competency assessment panel. Governing Bodies otherwise agreed/delegated/were assured as indicated above.	
12.	**Procurement Approach: Community Services Programme Board projects - framework for procurement**	
	The paper, prepared by SCWCSU Procurement Team, sets out the structure for delivering outcomes based commissioning using a provider collaborative approach – a non-competitive approach to procurement to give providers opportunity to better target resources. The Provider Collaborative will have to work across traditional service/organisational boundaries to deliver the range of pathways. Governing Body was recommended to approve the process described in the framework. Furthermore, Governing Body was asked that a delegated sub-group of the Governing Body may apply and approve the use of the framework for two forthcoming re-commissioning areas (at pace): 24/7 Primary Care and Integrated Community Teams. NL introduced the item and described the steps involved: Stage 1: Identifying the Provider Collaborative, Stage 2: Capability Assessment. Agreement of financial envelopes and contract would follow these stages. This must also be compliant with NHS England's Integrated Support & Assurance Process (November 2016) with a checklist included to ensure that this is the case. 24/7 Primary Care is on a timescale given the existing contract expires in March 2018 and therefore there is a need to move quickly. NHS England has been informed of our re-procurement plans. The template provided would be completed for each of the procurement as is required. NL clarified that two sub-groups would be formed, one for each procurement. RC queried what the outcomes would be and how they would be defined, more specific to diseases or high level population based. NL replied they would be in four key areas: population health, quality of life (with patient input), quality and experience of care and system efficiencies. RM queried whether capability assessment 1 could cover legal form that allows potential provider to hold risk, and include CQC registration. RM queried where assessment of previous quality history is included. NL replied quality and history are in capability assessment 2, but agreed risk holding entity should be agreed in capability assessment 1. RW queried how negotiation with GP practices works given they are independent providers. FedBucks and Medicas will be part of the two upcoming procurements, so engaging them will be a matter of course. We would still expect to work through these other organisations for other procurements as well. CO queried application to community services and difference between the existing contract and a contract which is outcomes based. Some outcomes for community are so interdependent on others, and how this will be taken into account in a contracted template. NL replied that both upcoming	

	procurements would have the same set of outcomes. **Action 5: Assurance provided to governing bodies that the framework has been completed for 24/7 primary care access and the blank template published on CCG websites.**	**NL**
	For Information/Ratification/Reading List	
13.	**Policies and procedures:** **a) Hospitality, Gifts and Sponsorship Policy** **b) Code of Conduct**	
	Governing Bodies were asked to ratify a number of policies and parts of policies. All documents have already been approved by responsible committees. (a) Hospitality, Gifts and Sponsorship Policy, (b) Code of Conduct. There were no additional queries from members. Policies requested were ratified, subject to action 7. **Action 6: Spell check Hospitality, Gifts and Sponsorship Policy before publishing on CCG websites.**	**RCa**
14.	**Organisational Development and Corporate Affairs: Annual Report.**	
	This report was presented information and received. **Action 7: Review publication scheme re: FOI. Publishing FOI requests may reduce future workload.**	
15.	**Verto Approvals Framework – Project Management Office**	
	The Governing Bodies were asked to: • **NOTE** an attached approvals framework for mandate and businesses cases through committees and Verto. This was noted.	
16.	**Approved Minutes from sub-committees, sub-groups or steering groups:**	
	Executive Committee – 25/05/2017 – received for information.	
17.	**Reading List**	
	The reading list was acknowledged.	
18.	**Approved Minutes from sub-committees, sub-groups or steering groups:**	
	Date of next meeting (in public): 14 September 2017, 10:00am-12:00pmCouncil Chamber, Ground Floor, Chiltern District Council Offices, Amersham HP6 5AW.	

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		