AYLESBURY VALE AND CHILTERN CLINICAL COMMISSIONING GROUPS
GOVERNING BODIES (meetings in common in public)
8 June 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	Chief Officer	**LP**
Dr Karen West	Clinical Commissioning Director Integrated Care	**KW**
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**
Colin Seaton	Lay Member (Patient and Public Involvement)	**CS**
Graham Smith	Lay Member (Chair of Primary Care Commissioning Committee)	**GS**
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**
Dr Dal Sahota	Clinical Commissioning Director, Unplanned and Urgent Care	**DS**

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 • Ross Carroll – Lay Member	
3.	**Declarations of Interest in items on this meeting's agenda**	
	Dr Graham Jackson reminded the Governing Bodies 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**	
	There were no questions received in advance of the meeting. There were no questions raised from the floor.	

5.	**Minutes of the meeting held on 13 April 2017, Action Log and Matters Arising**	
	5.1 Minutes – 13 April 2017 Proposed amendments to the minutes from 9 March 2017 including in the minutes for 13 April were approved (with final version of 9 March 2017 minutes updated). • Item 4, questions from the public regarding a petition on a new health centre for East Wycombe "I can't confirm that confirm" to be amended. • Item 7, finance report "We are on track to meet our planned end of year position circa £200k (1%) along with maintaining £5.8m". Reference to millions missing. GJ noted we must be careful to avoid these omissions. 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. In relation to stroke, DR confirmed a county wide stroke service is now in place with Buckinghamshire Healthcare Trust sub-contracting post stroke rehabilitation to the Stroke Association. **5.3 Matters arising –** None were raised.	
6.	**Clinical Directors presentation (including Patient Experience)**	
	Urgent Care (includes winter planning) Presented by Dr Dal Sahota (DS); an outline of her clinical portfolio. A copy of the presentation and audio recording is otherwise published separately on the CCG websites. GJ noted that the presentation was useful and illuminating**.** DR noted that a number of community beds had been re-purposed to avoid lengthy stays, influenced by studies which have concluded just 10 days in hospital leads to the equivalent of 10 years ageing in muscles for people over 80. Community hub pilots in Marlow and Thame previously reported are a part this approach to reduce A&E reliance and improve patient outcomes. We now have a geriatrician on site working with community nurses taking calls from GPs and community nurses to divert these often elderly and vulnerable patients from going into hospital. GJ added that this is a strong message. RB asked how best we monitor the quality of service patients receive whilst in hospital. DS noted that the fit between urgent care and quality teams was a challenge, but both shared a good standard of quantitative and qualitative data. Anecdotal member practice feedback was also vital, though it was recognised there is a need to work better with quality to ensure this is integrated. To achieve this, the quality team is best represented at the A&E Delivery Board. Provider site visits have also been undertaken to engage front line staff on what else could help improve quality. DR noted this also included an unannounced Friday night visit to A&E at Stoke Mandeville. GS queried why it is assumed that excess bed days contribute to muscle ageing. DS replied that excess bed days does limit use of muscles and increase likelihood of wasting, and increased risk of other conditions such as chest infection. There is also however a challenge with delayed transfer of care with a need to improve turnaround so patients who are medically fit are not unnecessarily occupying beds. RB noted that as we improve in this average	

	length of stay would likely increase as those occupying beds would likely be sicker. GJ commented that GS is picking out an issue about data accuracy, to which DS added that it's important to understand what happens to individual patients. GS also queried reference to a £35m increase in budget but the service stays the same – why is this the case? DS replied that it relates to the tariffs paid for activity which have increased for the same conditions. RM noted that this is a national policy. RW queried merits of streaming in A&E not just as the front door, but referring direct to specialists such as chest, fractures etc. DS replied that this is an area for development that we are keen to work further on. DS noted that Frimley has a Medical Consultant who does exactly this with an action for further discussion at A&E Delivery Board. GJ thanked DS for her presentation. **Action 1 - Publish Urgent Care presentation on website**	**LP (RCa)**
	Leadership Reports	
7.	**Accountable Officers Update**	
	Presented by Lou Patten (LP). **There are no conflicts of interest relating to this paper.** LP provided a verbal update on a number of issues. 1. Annual Report and Accounts – these have now been signed off and will be published on CCG websites post purdah**. (Action 2)** 2. Accountable Care System – plans are progressing well, Healthy Bucks Leaders is morphing into a partnership board to meet w/c 12 June to discuss membership and governance. Buckinghamshire County Council is leading communications activity in engaging patients in the wider process, whilst we await confirmation on whether our Expression of Interest for the first wave has been successful. 3. Urgent and Emergency Care Delivery Plan – 7 must do domains at STP level – we have documented key deliverables required at scale which will involve patient engagement as we move forward. Feedback to us is that our plan is best in region. 4. Thames Valley Priorities Committee (TVPC) that decides on funding of certain procedures with lay chair along with GP, ethics, professor of law and public health representation – LP is leading Accountable Officer at present (on a yearly cycle). Governance arrangements are proving effective. GJ is also a member of TVPC. GJ commented it would be useful to have more reflections on the effectiveness by GP clinical leads to attend as observers on a rota basis. 5. LP opened second system conference on exploitation organised by CCGs and Buckinghamshire County Council. 6. Visited Marlow community hubs, meeting staff, with silver line phone connecting to GPs working well and is becoming a popular community asset. 7. LP has met with CO and Carolyn Morrice, Chief Nurse at BHT, with a plan for developing a single nurse leadership approach the Accountable Care System.	**LP (RCa)**

	Assurance and Governance	
8.	**Finance Report (Month 1)**	
	PJ introduced this verbal item for Month 1 given integrity of early data. PJ noted a £127,000 planned surplus for 2017/18, which is small and challenging given pressures in acute contracts and continuing healthcare, and work on our QIPP programme to address gaps in our financial position. A more detailed update will follow next month. Audit Chairs both confirmed they were content with this update. DR added that there have been discussions about how best to identify risks given PJ is new in post and these will continue. GJ asked to note for the minutes his thanks to RM for holding the role of CFO on an interim basis before PJ joined the organisation.	
9.	**Quality and Performance Report (Month 1)**	
	DR highlighted key points from the report, but also informed members of dementia diagnosis figures for April 2017 not contained within the report. In April Aylesbury Vale achieved 71.2% which is now best in Thames Valley, whereas Chiltern CCG achieved 65.3% and therefore fifth in Thames Valley. If the CCGs had merged for April 2017, a combined average would have been 67.4%. There has been great success in Wycombe with Asian communities led Dr Rashmi Sawhney, increasing the rate from 60% in March 2016 to 70% in April 2017. RB noted this showed the importance of localities in galvanising a community. RM asked whether we were capturing this to showcase how outcomes can be achieved. RB replied that he will ensure Dr Sawhney documents this experience. TD queried the localities which still needed improvement. DR replied Southern and Wooburn Green, with this still being monitored at practice level. Some practices are below 50%, so there is more work to do. LP referred to mention in the report of Referral to Treatment (RTT), in that this is also an issue for OUHFT and Oxfordshire CCG. The numbers and financials are proportionately much higher there and consequently the interest from NHSI and NHSE is substantial. LP asked for any further headlines and where this is being monitored. DR replied that work has been undertaken on this; it looked like that there could be a financial risk with a request for further financial validation. It has also been raised on our NHS England assurance call. More detail will be provided next month. **Action 3: Referral to Treatment (RTT). Additional assurance requested on RTT performance related to Oxford University Hospitals NHS Foundation Trust.** TD queried our level of assurance on the national Prevent strategy in light of recent news events. DR replied it is part of quality schedules in contracts to ensure a prevent strategy is in place, training and escalation routes. LP added this is also monitored through safeguarding boards. **Action 4: Prevent – next report to include statistics on number of people trained and how the strategy is working in practice in light of recent news events.** **Action 5: Prevent – at request of Tony Dixon, include this evidence (above action) in the minutes of this meeting.** Post meeting note addressing this action: Prevent Training is reported quarterly and is included as part of the quarterly Safeguarding update within this report.	**DR**

	Next update due July 2017. TD drew attention to reference to Seeley's House and continuing healthcare reviews, with a request for more information on what this matter related to. DR replied that this is a respite care service previously provided by Bucks Care, a trading arm of the county council. It had an inadequate CQC rating hence inclusion in the report. This service has been in-housed with a rapid action improvement plan which the quality team has supported. They are now formally registered but yet to be re-inspected. They are now also taking back adult social care funded clients, though more complex health clients funded by CHC are not yet returning until further improvements have been made.	
10.	**Reflections – 360 degree survey**	
	RB introduced some reflections from the survey circulated in February 2017. He highlighted four key questions; What does it say? Is it accurate? How does it compare historically? What do we do next? The previous survey suggested further work was needed on engagement, though this survey suggests this is still the case. The survey does also include the county council and health watch, though members make up the core. 85% Chiltern response, 89% Aylesbury Vale response, often from a named practice individual. There are 27 parameters; Chiltern has improved in 10; Improvement has been seen in working relationship with CCG, understanding what we are doing, skills and experience and system leadership. But it has worsened in 17, though it is recognised the membership is challenging. There are lots of comments; which is evidence of engagement, but the critical element is useful to keep us focused. There also themes we need to respond to. Chiltern is below national benchmarks, as is Aylesbury Vale. We will discuss and share with members, though sometimes views of responding individuals aren't always wholly shared with the wider membership which is further point to reflect on. There are themes and comments which suggest the CCG has been distant since Federation in July 2016, which we need to explore further, and may relate to issues such as the location of governing body meetings and AGM. CO queried whether there were any specific comments on how to improve. RB replied there was a theme which emphasised how busy general practice is at the coalface and that some of this time would need to be released to facilitate effective engagement. We can also been seen as a mouthpiece of national policy with a loss of local focus. To address this we should really sell the local vision and demonstrate that action can produce results. GJ added that this is not a survey for which we can influence the design, and some comments can sway the overall findings. LP added that even if we changed the input, we are looking at a whole cultural change. Some areas have also refused to use it. Maybe we have to better engage with clusters and localities. RB queried if we could circulate to all members rather than named individuals, to which NL replied this was difficult because of how the survey is set up by IPSOS Mori. RM added that we need also manage system wide engagement linked to development of the ACS, given different organisations with different surveys.	

	DR noted an interesting disconnect with NHSE assurance where both chairs were congratulated on the level of clinical engagement. RB concluded that there is likely more resentment when members feel they are being made to fit a national picture rather than reflect what is happening locally. It was also agreed to include these reports as a future seminar agenda item to provide further feedback on progress.	
11.	**Accountable Care System– feedback from seminar & next steps**	
	GJ noted discussions with partners (SCAS, FedBucks, county council, Healthwatch, Buckinghamshire Health Trust - BHT) at the previous seminar on 11 May for which governing bodies members were present. The tables were mixed with discussion about direction for the Accountable Care System. Notes have been pulled together as a starting point. LP is chair of the emerging ACS Board; the national process has an element of permissiveness about building what is right locally, which is all dependent on relationship which locally is strong and positive. In terms of clinical input, we must not lose sight of this. GJ noted that at the seminar this was broadly CCG and GP led, which GJ had fed back to BHT's Chief Executive (though the Medical Director and Chief Nurse had attended). Accessing a broader pool including consultants will be important going forward. A process is also in development to bring together clinical leaders and creative a collective voice that feeds into ACS senior management process. Some issues emerged about training and data sharing. This is a journey with a focus and likely date to meet with the national director to obtain further national guidance to support our plans. RM emphasised it was important to capture the notes of the seminar. We are also re-branding the Transformation Delivery Group which will be leading implementation. There is an important role for sharing knowledge and embedding staff who can work system wide if transition is to be successful. CO queried the involvement of higher education and further education to support evolution. GJ replied that Health Education England have workforce planning on their agenda. LP added that there has to be some thinking about academic rigour – and to start to list areas where we may need financial support. There is wider work at STP which is also working on this supported by the Academic Health Science Network (AHSN) alongside local workforce planning.	
12.	**Governing Body Assurance Framework**	
	Governing Bodies meetings in common were asked to: 1. **REVIEW** the content of the Governing Body Assurance Framework. 2. **ASSURE** itself over GBAF completeness, validity of scores and appropriateness of mitigating controls, assurances and actions. RM highlighted changes in the last quarter: 1. Risk 1 (The CCG fails to align its priorities and plans with the Buckinghamshire health and care system) has reduced to 9 (from 12), this reflects the continued work to strength our whole system approach and embed the working as an Accountable Care System increases the alignment of prioritisation and delivery of system plans. 2. Risk 10 (Over-performance at providers; increased system demand that	

	may lead to capacity shortages/be unaffordable - CCG targets may not be met.) has reduced to 16 (from 20), this reflects that both CCGs are under target but within 5% materiality threshold after 16/17 settlement. However QIPP ask higher than 16/17 and remains challenging. RM noted this would be continued to be reviewed through the year as we understand our financial position. TDG has also discussed a system risk workshop and address our collective understanding of risk as opposed to just individual organisation.	
	For Information/Ratification/Reading List	
13.	**Policies and procedures: Whistleblowing Policy/Freedom to Speak Up Guardian**	
	Governing Bodies were asked to ratify a number of policies and parts of policies All documents have already been approved by responsible committees. a) Whistleblowing Policy – Freedom to Speak Up flowchart for primary care escalation – ratification for amendment to Whistleblowing Policy on escalation of whistleblowing concerns originating in primary care. b) Whistleblowing Policy – confirm appointment of replacement guardian in place of former Director of Quality. **A) WHISTLEBLOWING POLICY – FREEDOM TO SPEAK UP FLOWCHART FOR PRIMARY CARE ESCALATION** This was ratified by Governing Bodies meetings in common, but confirm whether this is guidance or mandatory and if a CQC requirement before circulating to member practices, to include in their whistleblowing policies (which guidance requires to be in place by September 2017). **(Action 7).** We need to be careful with how we promote this in a supportive way, especially if not mandatory. **B) FREEDOM TO SPEAK UP GUARDIAN – APPOINTMENT; Action for Governing Bodies: CONFIRM APPOINTMENT of replacement guardian in place of former Director of Quality.** RP queried, in relation to recommendation to appoint Lisa Beaumont (Associate Director of Quality and Nursing), parameters on whether the appointee was of sufficient seniority, well-known enough and respected enough. GJ replied that we would need to test that. NL emphasised that this request related to our internal guardian, RW is also still in place. RCa added that status of the CCG as a "prescribed organisation" which remains subject to decision by the Department of Health would also affect the number of concerns it may receive. LP suggested a case study, from NHS England, so that this could be properly worked through. **Action 8: b) Confirm appointment of Freedom to Speak Up Guardian; Case study: how the appointed FTSU Guardians would react to a reported whistleblowing concern (a) from a member of CCG staff, (b) from a primary care member practice, in order to test the whistleblowing policy.**	**GJ/RB (RCa)**
14.	**Approved Minutes from sub-committees, sub-groups or steering groups:**	
	Approved Minutes from sub-committees, sub-groups or steering groups: a) Executive Committee – 27/04/17 b) Primary Care Commissioning Committee – 02/03/17	
	Date of next meeting (in public): 8 July 2017, Olympic Room, Aylesbury Vale District Council. TD will chair as GJ and RB have both given apologies.	

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		