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)
9th March 2017
Council Chamber, Chiltern District Council, King George V House King George V Road, Amersham HP6 5AW

Governing Bodies Members Present:		
Dr Raj Bajwa - GP Chair (Chiltern CCG)	GP Clinical Chair – Chiltern CCG	**RB**
Louise Patten	Accountable Officer	**LP**
Dr Graham Jackson	GP Clinical Chair (Aylesbury Vale CCG)	**GJ**
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**
Dr Rebecca Mallard-Smith	Clinical Commissioning Director Unplanned Community Care	**RMS**
Tony Dixon	Lay Member (Deputy Lay Chair, Chiltern CCG)	**TD**
Robert Parkes	Lay Member (Deputy Lay Chair, Aylesbury Vale CCG)	**RP**
Graham Smith	Lay Member (Chair of Primary Care Commissioning Committee)	**GS**
Dr Robin Woolfson	Secondary Care Specialist Doctor	**RW**
Ross Carroll (RC)	Lay Member	**RC**
Others present (non-voting)		
Debbie Richards	Director of Commissioning and Delivery (co-opted member)	**DR**
Kate Holmes	Deputy Chief Finance Officer	**KH**
Nicola Lester	Director of Transformation	**NL**
Louise Smith	Associate Director Commissioning and Locality Delivery – Item 13	**LS**
Leigh Franklin	Executive Assistant and Office Manager (minute taker)	**LF**
Karen Kilshaw	Personal Assistant (Visuals)	**KK**

1&2	**Welcome & Apologies**	**Lead**
	The Chair Dr Raj Bajwa (RB) welcomed the Governing Bodies members and members of the public. **Apologies** Crystal Oldman – Registered Nurse Colin Seaton – Lay Member (Patient and Public Engagement)	
3.	**Declarations of Interest**	
	Dr Raj Bajwa reminded the Governing Bodies members of their obligation to declare any Conflict of interest they may have on any agenda items at Governing Bodies meetings in common. Declarations previously made by members of the Governing Bodies are listed in the CCG's Register of Interests published on the CCG websites and available for review at the meeting.	

Declarations of interest from today's meeting

ITEM	CONFLICTS OF INTEREST AND ACTION
8. Process for Approval of Annual Accounts and Annual Report for the year 2016-17	As this a process decision, all voting members can participate in decision to delegate authority to approve the Draft accounts and annual report to the Audit Committees. RB to remain as chair.
11. Primary Care delegated commissioning – Chiltern CCG	This paper is for information and to note that the delegation agreement has been signed. No other conflicts of interest action is required as there is no commissioning decision requested. RB to remain as chair.
12. Scheme of Reservation and Delegation (Primary Care Commissioning Committee, Quality and Performance Committee)	Member GPs are not conflicted as there is no financial benefit, and can therefore take part as voting members in the decision to delegate. As this is a process decision, member GPs will not be required to leave the room. No other conflicts of interest action is required as there is no commissioning decision requested. However, for the avoidance of doubt, the chair of the meeting will change to TD as Lay Member and Deputy Chair for Chiltern CCG (agreed in advance).
13. Primary Care Improvement Scheme (following recommendation from Primary Care Commissioning Committee)	The Primary Care Improvement Scheme has a conflict of interest for the CCG clinicians as it relates to primary care development and an associated payment scheme. Although the paper has been owned by the management team it has involved development with the clinicians due to the clinical content and this has been considered essential. Clinicians have not however been involved in the discussions and conclusions reached regarding financing. The paper was previously discussed at the Primary Care Committee (2nd March 17) and is for sign off including financial commitment. The conflicted Clinicians will remain in the room for discussion at the governing bodies meetings in common, but will refrain from participation in the final decision to approve the financial commitment for the scheme. Given the above, TD will remain as chair of the meeting. Conflict of Interest was noted from RB/GJ/KW/RMS.
14. General Practice Resilience Programme (following recommendation from Primary Care Commissioning Committee)	Conflict of interest arises if a member of the Governing Bodies from a member practice has or will in the future be selected for support using the Vulnerable Practice Scheme or General Practice Resilience Programme funding. However, it should be noted that no practice will directly receive funding from either of these routes. Member GPs are not conflicted as there is no financial benefit. As this is a process decision, they can take part as voting members in delegating to the Primary Care Operational Group the mechanics of programme investment (of which member GPs are not voting members). However, for the avoidance of doubt, the chair of the meeting will remain as TD. Conflict of

	Interest was noted from RB/GJ/KW/RMS.	

Quorum requirement	Main meeting	Items 8, 11	Item 12, 13	Item 14
Chair from either group (or deputy lay Chair)	RB	RB	TD	TD
Accountable Officer or Chief Finance Officer	LP	LP	RM	LP
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 GJ KW DR	RW GJ KW DR	RW LP DR	RW GJ KW RB
Two lay members	RP TD GS RC	RP TD GS RC	RP RC	RP RC

4	**Questions from the public**	
	None were received, in advance or from the floor	
5.	**Minutes of the meeting held on 12th January 2017, Action Log and Matters Arising**	
	3.1 Minutes – 12 January. The minutes were approved unchanged. **3.2 Action Log –** It was noted that all actions have been updated within the action log. In relation to an action on management of non-elective admissions, the CSU is looking at top 5 presentations in terms of value: Pneumonia, UTIs, Falls, Acute Kidney Infection (AKI) and Sepsis. Further update to GB as part of Urgent Care clinical director's presentation in June 2017. **3.3 Matters arising –** None were raised.	
5.	**Questions from the public**	
	RB noted that no questions had been submitted in advance of the meeting. No questions were raised from the floor.	
	Leadership Reports	
6.	**Accountable Officers Update**	
	Presented by Lou Patten (LP). **There are no conflicts of interest relating to this paper.** LP informed Governing Bodies of local and national developments in the context of NHS Aylesbury Vale and NHS Chiltern CCGs. LP discussed the following: **Buckinghamshire System Transformation** Work continues at pace with our local system transformation programme. We are currently developing a new role for our General Practice Nurse Leaders as we recognise they have a key role in this transformation. At the time of writing we are about to consult on the new proposals. **Sustainability & Transformation Plans (STP)**	

	LP attended a special Health and Social Care Select Committee (HASC) meeting to update on the STP and our local NHS plans supported by Dr Graham Jackson and Neil Dardis, Chief Executive of Buckinghamshire Healthcare Trust. This was well attended with some challenging questions. It can be viewed here: https://buckscc.public-i.tv/core/portal/webcast_interactive/271795 **Organisational Development - Merger** NHSE met to understand whether they could facilitate merger of our two organisations for April 2017, given the tight timescale and the amount of work required, outside of our control, they have recommended that we wait until April 2018. We will work towards an assumed merger for the coming year. **Referrals Audit - update** Further to the Governing Bodies recent decision (based on a recommendation by the Executive Committee), a clinical audit of referrals into secondary care during the period January-April 2017 is being set up across our providers. A report on this will come back to the Governing Bodies in June. RC asked what issues and challenges had been raised by the HASC on the STP presentation. LP advised that there is a growing understanding that there are no proposed significant changes around restructuring in Buckinghamshire and the plans focus around our local plan for patients. There was challenge around the funding and gaps in working at scale through the STP, and how this may affect members of the public and the overall approach to health management. TD commented that at a recent national audit chairs forum, the members had discussed guidance for audit committee chairs in STP areas on how they may best achieve assurance on delivery. As there is currently no specific guidance from NHS England, audit committee chairs in the STP area expected to meet to discuss how they might achieve their needs for assurance. LP further advised that the STP will look at further refresh of finances, with a proposal to take that work to a future audit committee with a discussion at the end of April. GJ reiterated that the joint presentation as a collective system at the HASC was a positive step forward, and was well received with good debate between Health commissioners and social care colleagues. KW asked that as we would now have to wait until April 2018 for merger could we clarify that we would continue with proposals to combine some of our working practices. LP confirmed that we would continue to ensure we used this next year to transition and continue with the significant work achieved so far. RB reiterated that we would look to continue to stream line the two organisations. RP suggested a master plan of next 12 months looking at milestones to achieve merger that could be shared with members of the public.	
	Assurance and Governance	
7.	**Finance Report (Month 10)**	
	Presented by Kate Holmes (KH). The purpose of this report is to Assure the Governing Bodies of the financial performance of the federated CCGs, in both summary federated view and by individual CCG to the end of January 2017. The supporting paper related to Month 10 (January) but there was also additional briefing on Month 11 February.	

KH provided highlights as follows:

1. Financial Performance: To the end of January 2017 (10 months) the total position is an under spend of £4,140k. The CCG's reduced the forecast outturn by £1m; from achieving the 1% planned surplus of £5,967k down to £4,967k. Furthermore the CCG's have reported a net, risk assessed, opportunity of £0.3m to NHSE.
2. The forecast position deteriorated by c£2m in relation to two high cost critical care episodes at Guys & St Thomas Hospital in London. We are continuing to work to ensure that we aware of these episodes earlier in the future. There is also further deterioration in the Frimley position and reducing Prescribing underspend.
3. The CCGs continues to refresh its financial recovery plan, previously presented to NHSE and internal Committees, to ensure expenditure remains within planned levels through further expenditure controls and reviewing forecasts to identify mitigating opportunities. This will continue to be iterated to ensure that the CCG maximises it opportunities to deliver against its targets.
4. Across Buckinghamshire CCGs there is a year to date under spend of £4,140k (AVCCG £1,616k and Chiltern CCG £2,524k) against a budgeted under spend of £4,973k. The position has been achieved by the utilisation of Non-Recurrent mitigations of £10,994k and Contingency of £3,128k released into the position to cover the crystallisation of some of the risks and the additional in month pressure.
5. KH also advised that the QIPP: actual delivery year to date being £11,298k against an equivalent plan of £13,785k (82% achievement), before mitigations. The year to date QIPP performance is considered below target and is rated amber. Forecast achievement is also below target at 83%, before mitigations, and also rated amber.
6. To hold the CCG position QIPP is required to deliver an additional £2,000k above ytd run rate; mitigations identified through the summer and autumn balance sheet and forecast reviews enable us to cover this stretch.
7. Buckinghamshire CCGs have instigated a deep dive into the QIPP schemes to gain assurance in the robustness and deliverability of the schemes, look for in year mitigation and to build up a pipeline of schemes that can be used to replace underperforming schemes or used for future years.
8. KH also bought the Governing Bodies attention to a material error in the report, unfortunately the wrong SLAM figures had been attached, all other figures and reporting were correct.

RW asked what proportion of the provider payments are in dispute. KH reported that all providers are paid on a monthly contractual basis, so cash flow is not affected, but we do have a system of data challenges with our Providers. KH advised that the whole CCG had been working hard to ensure correct levels of challenge have been taking place.

The QIPP clinics have been held regularly to support us in reducing spend, and the Verto project management system is now embedded into the organisation to help ensure good control of all projects in place.

	DR further replied that alongside the data challenges with Providers, we also have an amount of activity coded by providers with high levels of un-coded activity. DR advised that they have formally written to the Provider to express concern at the level of un-coded activity, and have requested a recovery plan. This does add risk to our forecast, but we are working to mitigate this. RM added that, in terms of the scale of financial recovery, a number of large elements have been landed, although the financial position remains susceptible to further movement. We are dependent on end of year reporting to determine our final position which has not yet completed. Whereas in previous years we would have agreed our close out position at the end of year with our providers, this is not the case for any provider this year, with a number of financial settlements still to be reached. TD queried whether, in terms of the end of the year close, we are anticipating any further demands for payment from providers for activity we are not currently sighted on. KH responded that we have worked closely with providers and feel that our forecast outcome is robust as it can be, although recognising that we still have an overall net risk. RM also advised that part of our financial recovery plan was to become an early adopter of the national QIPP support programme. We have been accepted on this and from next week there will be some external support to add further value to the process. TD also asked about Continuing Healthcare (CHC) and the possibilities of large scale overspend, with a request for a report to the audit committees on any overspends anticipated. RM replied that there is a CHC recovery plan with specific issues and that it would be beneficial to take to the Audit Committee and to carry out a deep dive. RC asked about the iMSK new service to develop Musculoskeletal project and to understand the slippage in the new project and the possible financial implications. RM acknowledged that there is slippage, but that had been mitigated against for this financial year but there would be a risk into next year if this continued. Work is being undertaken and the Programme Board will be considering the final business case to be bought to Governing Bodies at a future date. The Governing Bodies noted the Financial Report for Month 10	
8.	**Process for Approval of Annual Accounts and Annual Report for the year 2016-17**	
	The Governing Bodies were asked to agree delegated authority to approve the Draft accounts and annual report to the Audit committee at their meeting on the 16 May 2017 and for final approval of any changes post Audit Committee to the Chairs, Chairs of the Audit Committee, Chief Officer and Chief Finance Officer on behalf of the Governing Bodies. Under the CCG's Scheme of Reservation & Delegation approval of the annual report and accounts is delegated to the audit committee. Under the audit committee terms of reference the audit committee will review the annual report and financial statements before submission to the	

	Governing Bodies. The National Annual Reporting guidance requires Governing Bodies to approve the final Annual Report and Accounts. This paper clarifies the process for approval of the annual accounts and report to be submitted by 12.00 on the 31 May 2017. Due to the deadline for the submission of the draft accounts and annual report to the Department of Health (31 May 2017) and its proximity to the date by which the preparation and audit of these documents will be completed, it is proposed that the Governing Bodies agree to delegate authority to approve the final accounts and annual report to the Audit Committee at their meeting on the 16 May 2017. Given the tight timetable for auditing the accounts there may be a requirement for adjustments post review by the Audit Committee. It is proposed that any such changes be approved by the Chairs, Chairs of the Audit Committee, Chief Officer and Chief Finance Officer on behalf of the Governing Bodies taking advice from the Auditors and other members of the Audit Committee. Such approval may be made virtually. There are specific Certificates and Statements which are required to be signed by the Chief Officer (as Accountable Officer) and Chief Finance Officer. The Annual Report and Accounts are then published on the CCG website and presented to an Annual General Meeting to take place in September 2017. Key dates 1. The draft annual report and accounts, the ISFE consistency statement & supporting data collection templates and Head of Internal Audit Opinion to be submitted by Wednesday 26 April 2017 2. The Full Audited and signed Annual Report & accounts, approved by the Governing Bodies, ISFE consistency statement & supporting data collection templates and External audit completion report to be submitted by Wednesday 31 May 2017 3. The annual report and accounts in full on the public website by Friday 9 June 2017. 4. A public meeting will be held by 30th September 2017 at which the annual report and account are presented. RP asked that the minutes clarify that there will be two sets of accounts one for Aylesbury Vale CCG and one for Chiltern CCG. The Governing Bodies approved the recommendations as requested.	
8.	**Governing Bodies Assurance Framework (GBAF)**	
	Presented by Robert Majilton (RM). The Governing Bodies were asked to note that the previous iteration of the Governing Bodies Assurance Framework was circulated to the Executive Committee on 23 February 2017. The Executive Committee discussed the revised approach to risk and will undertake a deep dive review of the Corporate Risk Register every quarter; the same timescale for which the Governing Bodies review the GBAF. RM advised the following changes : 1. Risk 1 (The CCG fails to align its priorities and plans with the	

Buckinghamshire health and care system) has increased to 12 (from 9), this reflects the risk around delivery of the iMSK transformation programme escalated from the Executive Committee at their meeting on the 23 February and that delivering changes in this pathway are currently delayed.
2. Risk 12 (internal capacity and capability) has increased to 12 (from 6), related to departures of substantive Chief Finance Officer and Director of Nursing and Quality.

Against a maximum risk score of 350 (14 risks, each of which has a maximum score of 25), we have assessed our current level at 162 (46%) against a target of 86 (24.5%). Of the 14 identified principle risks, 4 are now extreme (15+) – Risks 9, 10, 11 and 13.

The following extreme measures are:-
1. Poor management of the QIPP programme, cost pressures and in-year changes to CCG allocations may create an increased requirement for QIPP or reductions in spending plans (Risk 9)
2. Over-performance at providers; increased demand in the system may lead to capacity shortages/be unaffordable - and therefore CCG targets may not be met (Risk 10)
3. The wider health and care system's financial challenges may adversely affect the CCGs' performance (Risk 11)
4. Performance issues across the system will adversely affect patients' treatment times (18 weeks etc.) and ultimately the delivery of patient services and planned priorities (Risk 13).

All others are moderate or minor.

RW also asked about Risk 1 and the iMSK project and what the level of concern related to. RM said that the delay in this specific project but also the risk to transformational programmes and the approach and to ensure learning from this project within the health and social care system as a whole.

RC asked specifically about Risk 12 and addressing of vacant senior positions and the recruitment gap. RM advised that the CCGs are looking to recruit an interim Chief Finance Officer and until that point RM will be covering the position with the help of the two existing Deputies. He also advised that it has been decided to not replace the Director of Nursing and Quality position, the other Directors in the organisation having taken on added responsibilities to absorb that work.

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.	
9.	**Quality and Performance Report (Month 10)**	
	Presented by Debbie Richards (DR). DR noted the purpose of this report is to provide assurance and highlight quality and performance exceptions, together with actions to address the issues and risks identified. DR reported on the Cancer targets; two of the eight national targets were not met in December; the 31 day (94%) target for standard treatment was narrowly missed in Aylesbury Vale by one patient. The 62 day standard target was missed by 16 patients and below the 85% standard target. We work closely with the Provider to understand the reasons why and to ensure there has been no resultant harm to patients. We now have support from the national intensive support team (IST), an improvement team which helps providers and commissioners to work better together in managing patient pathways. DR also reported on the RTT (Referral to Treatment within 18 weeks) the incomplete target was not met in December with performance at 90.3%, with both CCGs missing the 92% target. Buckinghamshire Healthcare NHS Trust has initiated a RTT recovery plan which is monitored each week, with an expectation to return to compliance with standard by the end of March 2017. Contributory factors include non- elective pressures such as the use of the day bed unit for escalation beds. DR updated on the A&E performance – Buckinghamshire Healthcare NHS Trust delivered a performance of 86.9% for all types in January, against the 4 hour standard of 95%. This is a 7.1% adverse variance to plan of 94%. Total attendances in the month were 11,328 a reduction from the previous month of 470 patients. Performance has started to improve and in February reached over 90%. We are now at Operational Pressure Escalation Level (OPEL) 1 having spent a lot of the last few months in an out of OPEL 3. NHSE have congratulated the whole system on the efforts made. A lot of work with is also taking place with Wexham Park/North Frimley and we are attending their A&E delivery board. We are also working to reduce the numbers of South bucks patients waiting for discharge who are medically fit but experienced delays on discharge to community placements. DR has also been asked by the Regional Chair assurance and delivery at NHSE to co-host an improvement workshop with North West London on A&E Delivery so that we can share our learning and work. DR report that the Ambulance response time targets were not met in December SCAS continue to report on their Remedial Action Plan at regional level and their local action for Bucks at a more local level. The CCGs continue to work very closely with SCAS. Work continues with Buckinghamshire Healthcare NHS Trust to	

	address the handover delays that have a direct impact on SCAS performance. DR finally reported that there were three MRSA cases provisional assigned in December. RW queried delayed transfer of care (DTOC) and the difficulties for Providers with the process of moving people out of secondary care and current delays. DR advised that we are currently focussing on DTOC in Buckinghamshire Healthcare NHS Trust and Frimley /Wexham Park, and noted that the HASC (Health and Social Care Committee) had recently led a review on DTOC and will be publishing their findings in two weeks' time. This review will be circulated to the A&E Delivery Board. We do currently have a low level of DTOC but are running higher than this time last year and are seeing a deteriorating trend. To mitigate this problem we are holding anonymised weekly calls, where Associate Directors will review pathways and escalate any blocks and escalate to DR any significant issues. The reasons for DTOC are well understood and tend to be social care placement in the community, some domiciliary care or Continuing Healthcare or social care that my need complex packages of care that cannot be met by the independent sector. There can also be system shortage in Elderly Mental Illness (EMI) capacity in nursing homes and small groups of self-funders where families need to find places. TD asked about the Buckinghamshire Healthcare NHS Trust CQC report on safety between Stoke and Wycombe, what the specific issues that were identified, and if the Governing Bodies could do anything to contribute to improving these issues. DR responded that this report was fully published in September 2016 and the quality improvement plan was fully reviewed and reported through the Quality and Performance Committee meeting. Although the headline report cited the Trust requirements improvement, 21 of 35 indicators were rated as good. RM acknowledged discussion held by the Quality and Performance Committee, noting that it is important to recognise that this wasn't a full review or full re-inspection report, and did not reflect progress made since it was published. RB asked to clarity whether CQC was expected to re-visit. DR replied that they are monitoring the plan and can opt to re-inspect at any time. RC asked whether the social care funding announced in the government budget (£2bn extra funding over the next three years) would be ring fenced. DR advised that her understanding was that it might not be. LP said that we will ensure the Governing Bodies had clarification.	
10.	**Primary Care delegated commissioning – Chiltern CCG**	
	Presented by Graham Smith (GS), chair of the primary care commissioning committee (PCCC). GS advised the Governing Bodies that Chiltern CCG had requested delegated responsibilities for the commissioning of primary medical services from 1st April 2017. This gives CCGs more control over general practice and is part of a wider strategy to support the development of place-based commissioning and a key enabler for the development of new care models. In preparation for full delegation of primary care responsibilities, the CCG has taken the following steps:	

	• It carried out a full consultation with member practices between July and September 2016, culminating in a vote for delegation by 33 out of 34 Chiltern Practices in October 2016. • The Governing Bodies noted progress and approved the CCG's proposal to make an application to NHS England in October 2016. • Application agreed by Deputy Chair of the CCG and Lay Chair of the Audit Committee. • Application signed by CCG's Accountable Officer and submitted to NHS England Regional Team in November 2016. • Application approved by NHS England in January 2017 and draft Delegation Agreement issued. • Delegation Agreement signed by CCG's Accountable Officer and submitted to NHS England by 1st March 2017. RMS asked if there were plans for a level of communication to practices to explain CCG responsibility and NHS England responsibility (and in respect of commissioning versus contracting function). It was agreed that this would be helpful (and working with LMC to ensure communication is seamless). LP will ensure this is undertaken. GJ noted that the GMS contract is not something we will be interfering with or changing at CCG level. The commissioning function coming together across Bucks allows us to manage bigger pieces of work and therefore a single primary care function makes sense. We can't assume practices understand what this function is.	LP
	For Decision	
11.	**Scheme of Reservation and Delegation (Primary Care Commissioning Committee, Quality and Performance Committee)**	
	As this agenda item relates to primary care, RB asked TD (Deputy Chair – Chiltern) to take over as chair as was agreed prior to the meeting. However RB remained in the room. This item was presented by Lou Patten (LP). The Governing Bodies through meetings in common were asked to: (1) REVIEW, APPROVE and RATIFY attached draft operational schemes of reservation and delegation for Quality and Performance and Primary Care Commissioning Committee. (2) NOTE that this request is based on a recommendation from the Audit Committee as an assurance that the committee have reviewed a draft and concluded delegations as appropriate, subject to amendments described. Whereas the draft presented to the Audit Committee limited a £50k threshold for a specific number of decisions (.e.g. premises improvement grants and capital developments), it was discussed and recommended by the Audit Committees meetings in common that approval is limited to £50k for all decisions listed and delegated – to include direct awards/primary care improvement schemes. Any decision above the threshold would need to be escalated to the Governing Bodies with a recommendation from the Primary Care Commissioning Committee. This will also apply irrespective of the number of contracts or awards underneath. This allows for delegation so that the Governing Bodies are not stifled, but also recognising that some decisions may need to be escalated.	

	Decision: The Governing Bodies ratified the proposed limits recommended: (1) Approval is limited to £50k for all decisions listed and delegated to the primary care commissioning committee. (2) Draft was amended to read that PCCC can "Advise on or approve matters relating to primary care contracting within agreed levels, specifically in relation to commissioning Quality Outcomes Framework (QOF - subject to allowances within NHS England's legal framework). In addition however, LP asked that with the approval of delegated commissioning to Chiltern CCG, the limits would need to be further reviewed. LP therefore recommended that that Governing Bodies accept the above decision, with the with the Primary Care Commissioning Committee to review when holding the first meeting post delegated commissioning coming into effect, with a further review by the Audit Committee before an additional recommendation to the Governing Bodies to approve and ratify. TD queried the timescale for further Audit Committee review. LP replied that the first primary care commissioning committee meeting post delegation and therefore including both CCGs would take place in June, and therefore at the earliest it will be July 2017. This was acknowledged and agreed.	
12.	**Primary Care Improvement Scheme (following recommendation from Primary Care Commissioning Committee)**	
	TD remained as chair of the meeting (Deputy Chair – Chiltern) The Primary Care Improvement Scheme has a conflict of interest for the CCG clinicians as it relates to primary care development and an associated payment scheme. Although the paper has been owned by the management team it has involved development with the clinicians due to the clinical content and this has been considered essential. Clinicians have not however been involved in the discussions and conclusions reached regarding financing. The paper has previously been discussed at Primary Care Committee (2nd March 17) and is coming to Governing Bodies for sign off including financial commitment. The interests of all clinicians in the organisation are recorded on the CCGs register of interests. The Conflict of Interest was specifically noted from RB/GJ/KW/RMS. For the avoidance of doubt, member GPs in the room felt that they should not take part in the discussion. GJ also emphasised that clinician discussion has taken place the previous week in public at the Primary Care Commissioning Committee but had not included financial elements. RB/GJ/KW/RMS left the room. TD advised that the Governing Bodies remained quorate, with LP taking on the clinical nurse role. LS joined the meeting, and advised the Governing Bodies that the purpose of the supporting paper was to provide the Governing Bodies with details of the primary care development scheme. Whilst it is acknowledged that there may be further refinement to the clinical expectations as a result of on-going clinical engagement the principles of the scheme stand firm and are not expected to change. The paper suggests that a development model is progressed, designed to enable primary care to transition to new models of care in line with the 5 year	

forward view whilst maintaining clinical quality of services. This model is built on the following
1. Foundation - A robust and reactive infrastructure from which to deliver, to include clustering of general practice and standardisation of practice
2. Delivery - structured, evidenced based delivery vehicles which have demonstrated improved clinical outcomes in those areas that are considered a priority to Buckinghamshire because of the health needs of the local population
3. Outcomes – Improved population based outcomes

This model will be supported by a multiyear development scheme which builds on these three areas. The core principles behind the scheme are:

- Encompasses the Quality and Outcomes Framework (QOF) and the current Quality Improvement Schemes (QIS)
- Reduces inappropriate workload, that does not add clinical value
- Is built on evidence based care
- Is responsive to the population health needs of localities and adds value to patient care
- Does not disadvantage practices that take up the proposed scheme
- Aligns to national, STP and CCG strategies

It is proposed that practices will receive a one off payment which will support achievement of the foundation stage. This will be considered a gateway because without the fundamentals within the foundation stage practices will not be able to deliver the services in the 'Care Delivery' stage and work at scale as part of a new model of care. It is also proposed that the Care Delivery stage may involve changes to the Quality Outcome Framework (QOF) expectations for 17/18. Finally as part of the 'care delivery alternative' it is proposed that alternative evidenced based outcomes are delivered. This stage will require further work up by the CCG but proposed outcomes would apply to any provider and or a MCP/PACs.

The total budget requested is £1.5m. This will cover the practice support to transition to this way of working as well as the infrastructure within the CCG to provide support, training and technical solutions such as templates and protocols. The Governing Bodies were asked to approve the principles, direction and financial envelope available to the scheme. LP advised that the aim is to try and influence the Practices to work with us and this is a real opportunity to work together to gain improvements.

RM clarified the investment that this is a quality improvement scheme that both CCGs have supported in the past and it uses non-recurrent funding on schemes that could move into recurrent funding, these could be multi-year outcomes. TD asked whether the additional £200k could be accommodated in next year's budget plans. RM said that this has been accounted for and can be accommodated.

RW said that this was a great model and looked to reduce variations in care and very important, although didn't entirely understand the funding parts but recognised that this was to ensure delivery.

RC asked if there was a danger that if practices don't have partial payment they may be discouraged rather than encouraged to do the work. LS advised that this was recognised and that some have practices have further to go than others, it will be challenging going forward but we will have clear markers and

having carried out something similar before we hope to encourage most practices into new ways of working and want to encourage them to work differently and make the scheme attractive.

RM said that it is recognised that some Practices may find the scheme more difficult but would encourage clustering of practices and need to ensure support to the practices.

Decision: The Governing Bodies approved the principles, direction and financial envelope available to the scheme.

14 General Practice Resilience Programme (following recommendation from Primary Care Commissioning Committee)

The Chairmanship of the meeting remained with TD (Deputy Chair – Chiltern). However member GPs RB/GJ/KW/RMS returned to the room.

GS updated the Governing Bodies on three elements of funded support on offer from NHS England and the steps taken by the CCGs to identify how the funding should be utilised within primary care. The three elements are Vulnerable Practice Scheme (VPS), funding to provide training for receptionists and clerical staff and the General Practice Resilience Programme (GPRP).

In July 2016, CCGs were allocated £35,000 non-recurrent funding each, specifically for practices identified as vulnerable. Work has been ongoing throughout the year to identify, support and work with practices that fit the original criteria as set out by NHS England in the scheme guidance.

So that this funding could be accessed in a consistent, transparent manner, the CCGs drew up a policy based on the NHS England guidance. The aim of the scheme was to assess and treat the causes of vulnerability, securing practice improvement and build longer term resilience rather than deliver short term quick fixes. The types of support included:

- Diagnostic services so improvements can be identified and understood
- Specialist advice and guidance e.g. HR, management, finance, IT
- Coaching, supervision or mentorship
- Practice management capacity and support.

The Primary Care Operational Group has reviewed spend against the Vulnerable Practice Scheme on a monthly basis and funding has now been fully committed. NHS England is committed to investing £40m in the General Practice Resilience Programme (GPRP) until 2018/19. The funds available to NHS Aylesbury Vale and NHS Chiltern CCGs based on capitation share as follows:

	Aylesbury Vale CCG Allocation £'s	Chiltern CCG Allocation £'s	Buckinghamshire CCGs Total £'s
2016/17	44,000	70,000	114,000
2017/18	22,000	35,000	57,000
2018/19	22,000	35,000	57,000

NHS England has identified the following menu of support for which the GPRP funding should be used at a local level to address specific issues:

	• Diagnostic services to quickly identify areas for improvement support • Coaching / supervision / mentorship as appropriate to identify needs • Practice management capacity support • Rapid intervention and management support for practices at risk of closure • Coordinated support to help practices struggling with workforce issues • Change management and improvement support to individual practices or groups of practices. LP noted we should ensure that they include Locality working and ensure that the General Practice nurses are included as a fundamental part of our transformation. In terms of management turnaround team support package a good idea to ensure rapid turnaround, there is still support available from NHSE and we should be sure to work with that capacity as well. RM said that this was not a huge amount of money within our new commissioning responsibilities and should be used through the Primary Care Commissioning Committee. **Decision**: Governing Bodies agreed to:- • Note the update from the Primary Care Commissioning Committee to Governing Bodies on schemes related to building primary care resilience. • Note the use of Vulnerable Practice Scheme funding, previously approved by the Primary Care Commissioning Committee. • Be assured that plans to spend primary care resilience funding in 2016/17 are in line with CCG-approved policies, stated commissioning intentions and have been subject to our financial policies. • Note that this funding does not form part of our discretionary spend (as the funding is ring-fenced for specific uses) and that final approval will be in line with our Scheme of Delegation. Given the CCG is in financial recovery, this will be two of either the Chief Officer, Deputy Chief Officer or Chief Finance Officer to give final approval.	
	For Information	
12.	**Approved Minutes from sub-committees, sub-groups or steering groups:**	
	Approved Minutes from sub-committees, sub-groups or steering groups: a) Executive Committee – 22/12/2016 b) Executive Committee – 26/01/2017 c) Primary Care Commissioning Committee – 02/12/2016 d) Quality and Performance Committee – 26/01/2017 e) Health and Wellbeing Board – 15 December 2017	
	Date of next meeting (in public):	
	Thursday 13 April 2017, 10:30am – 12:30pm; Jubilee Room, The Gatehouse, 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		