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)
14 September 2017
Council Chamber, Chiltern District Council, King George V House, King George V Rd, Amersham HP6 5AW

Governing Bodies Members Present:		
Dr Raj Bajwa (Chair)	GP Clinical Chair (Chiltern CCG)	**RB**
Dr Graham Jackson	GP Clinical Chair (Aylesbury Vale CCG)	**GJ**
Louise Patten	Chief Officer	**LP**
Dr Karen West	Clinical Commissioning Director Integrated Care	**KW**
Dr Rebecca Mallard-Smith	Clinical Director Unplanned Community Care	**RMS**
Robert Majilton	Deputy Chief Officer	**RM**
Paul James	Interim Chief Finance Officer	**PJ**
Robert Parkes	Lay Member (Deputy Lay Chair) Aylesbury Vale CCG.	**RP**
Graham Smith	Lay Member (Chair of Primary Care Commissioning Committee)	**GS**
Ross Carroll	Lay Member	**RC**
Colin Seaton	Lay Member (Patient and Public Involvement)	**CS**
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**

1&2	**Welcome & Apologies**	**Lead**
	The Chair Dr Raj Bajwa (RB) welcomed the Governing Bodies members and members of the public. **Apologies** • Tony Dixon, Lay Member (Deputy Lay Chair, Chiltern CCG) • Nicola Lester, Director of Transformation	
3.	**Declarations of Interest in items on this meeting's agenda**	
	The Chair Dr Raj Bajwa (RB) reminded the meeting of obligations to declare any Conflict of interest they may have on any agenda items. RB 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 was one declaration 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: process of election to clinical chair.	There is a Conflict of Interest for the two current Clinical Chairs (financial) and a potential conflict for other GP Governing Body members as they may wish to apply (financial). The Chair of the meeting will therefore pass to the Lay Chair and the GPs will be asked to leave the room.

There are no material conflicts of interest in relation to the decision required to agree a suite of governance documents for the accountable care system. The meeting was quorate to conduct its business.

Quorum requirement	Main meeting	Merger update (election)
Chair from either group (or deputy lay Chair)	RB	RP
Accountable Officer or Chief Finance Officer	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) RMS, GJ, KW	LP (as a registered nurse) RW (Secondary Care Doctor) CO (Registered Nurse)
Two lay members	RC, CS, GS	RC, CS, GS,

4. Questions from the public

There were no questions received in advance of the meeting or on the day.

5. Minutes of the meeting held on 13 July 2017, Action Log and Matters Arising

5.1 Minutes – 13 July 2017
Page 11, agenda item 12: Procurement Approach: Community Services Programme Board projects - framework for procurement. "*RM queried whether capability assessment 1 could cover legal form that allows potential provider to ~~up~~hold risk*". 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.

Regarding action: Stroke: ensure inclusion of stroke commentary from next report as this was noted as missing. DR noted that she was not satisfied with the level of assurance on this matter and therefore the action was re-opened.

5.3 Matters arising – None were raised.

Leadership Reports

6. Accountable Officers Update (including update on system working

Presented by Lou Patten (LP). **There are no conflicts of interest relating to this paper.** LP outlined a summary of her report, with updates to the original report and challenges during the item as follows:

Buckinghamshire Accountable Care System: LP noted the MOU is currently going through constituent body boards for approval and ratification. RC queried capacity and capability across the system to make the ACS a reality and what this looks like in terms of system roles and whether we would anticipate external consultancy. RM replied that the Population Health Management strand of our approach has a steering group involving external help from NHS England to help us move forward. Another workshop at the

	end of August helped to review what we already have in the system; we have existing population data which we need to review how we share it between organisations. LP added that the ACS Partnership Board had supported this week the expectation that population health management would be clearly linked to a value based approach to commissioning. Links to additional information and resources will be included on the reading list. GJ suggested this be a separate circulation. CCG Merger: our application was noted as excellent and highly commended as an exemplar, but a letter received from Rachel Pearce does now state that the whole process will go to NHSE England's national commissioning committee on 25 October rather than 27 September as originally indicated. This has implications for our plans and therefore enquiries to re-adjust the timing back to September will be made and governing bodies updated. GJ queried the extent of additional evidence the letter had also requested. LP replied that this would be straightforward to rectify and included a letter of support from Frimley Health; but that this was not the reason for the change in timescale, rather it related to the timings of NHS England's committees. 24/7 Primary care Access: RM queried if we are going to capture the learning of the new framework applied to this work. LP replied that we would and ensures it reported to the Executive Committee and in turn governing bodies.	
	Assurance and Governance	
7.	**Finance Report (Month 3)**	
	PJ noted focus on year-end forecasting, with potential for a significant deficit if no action were taken. However a £9.1m Financial Recovery Plan is in place which is currently showing a forecast £2.5m deficit at year end. We anticipate further improvement on the recovery plan to hit our break even requirement. The main reasons for forecast deficit is due to: 1. Higher levels of acute activity compared to forecasts and expectations (broken down in report by contract, Table 5 – Acute expenditure by contract). This table shows an outturn variance of 2% for Buckinghamshire Healthcare Trust, compared to 7% for Frimley Health. We have further analysed available data to establish that the majority of variance relates to non-elective activity, which has in turn led to a deep dive to develop heat maps around emerging problems and increases in A&E attendances. We are also working on solutions. 2. CHC – with focus aligned to planned transition of this service to Oxford Health who we expect to adopt a different approach. PJ added he would expect to revise forecasts in Month 6 aligned to the equivalent NHSE England process. LP noted it was useful to see the contract comparison table (Table 5) to allow more understanding. LP observed we have few practice populations facing Luton and Dunstable, and that critical care can be expensive. **Action: Further insight into Luton and Dunstable NHS Trust to report to Executive Committee re: effect of GP streaming in place and how that could benefit Buckinghamshire (as it has been in place at L&D a lot longer)** KW queried how primary care transformation and developing an ACS will contribute to our position. PJ replied that we should get close to our target	**DR**

	through non-recurring support with an underlying recurring deficit. Transformation change will affect our recurring position going forward; therefore we will need to demonstrate a sustainable ACS next year. Some measures this year will have full year effect next year and therefore contribute to future sustainability. LP noted we have to hold programme boards to account to ensure we deliver on our ambitions. GJ observed that Table 5 referred to "74% with issues in elective" in relation to Luton and Dunstable and that historically we have focused less on Luton and Dunstable and Berkshire contracts. We also invest in intermediate services in Buckinghamshire which should help mitigate over activity in areas cited in Table 5 (Ophthalmology etc.) RB noted that there is a choice agenda for elective care and how this influences rates of activity given variance in trust reputation. LP replied that choice is absolutely paramount; what we have to reflect in our contracts is intelligence on where we anticipate our patients choose to go. In regards to non-elective, there are significant flows from the south locality to Frimley. DR noted that there is now a monthly contracts oversight meeting supported by a CSU integrated provider report through explains granular detail. It focuses on recommendations for actions, both CSU and CCCG, which we also using to brief the "heads of" team for further action through programme boards and localities. The CSU are under no illusion we need to drive down over-performance and risk. LP drew attention to non-elective surges that can be experienced; RMS queried whether the issue related to an increase in numbers or an increase in cost of each episode. DR replied that a non-elective deep dive had taken place with Quarter 1 modelling undertaken to understand year on year trends for the last three years. This has shown A&E attendances have increased across all providers. Practice heat maps have also helped prompt discussions over activity management. RMS queried visibility of the urgent care dashboard and making sure this is reported to localities. DR replied that Dr Dal Shota will be undertaking further locality engagement work along these lines. CO noted the reports of increased A&E attendances and asked if there was a correlation between expected increased based on ageing populations and actual increases. DR replied that this has been mapped by practice and weighted population, with some having increased by up to 20%. The urgent care team is continuing to monitor this. RW queried conversion rates between attendance and admittance and whether the threshold for admittance has changed. DR replied that this is looked at; two stand out areas we continue to manage and mitigate are: 1. At Frimley our conversion rate is greater for the Buckinghamshire population than non-bucks admitted to Wexham Park; suggestive that they may be less aware and confident than community alternatives and prompt us to accelerate our integrated team approach 2. When we have seen Q&A performance under pressure, we have seen an increase in conversion especially during out of hours – which is what we have been seeing at Buckinghamshire Healthcare NHS Trust.	

	Action: Page 28: Table 5 – Acute expenditure by contract – request to link commentaries provided to work now being led by localities in response to the financial variances the table raises, and include percentage variances. (Localities through the executive need to respond to this)	**DR**
8.	**Quality and Performance Report (Month 4)**	
	DR introduced this item. There are a range of ongoing performance challenges, and since written we have continued to identify and respond to challenges. <u>Cancer Two week waits</u> DR specifically highlighted cancer as a priority area and discussed through NHS England assurance. In the next report it is anticipated to give a greater distinction between CCG and provider performance. For two week waits, this is in large part driven by patient choice, but when looking at detail of appointment offers the majority were offered at days 9-12. To enable good practice access, these should be offered before day 7, and therefore specific work is underway to address this variance. RMS noted that, because appointments can be self-booked on ERS, some patients are choosing later appointments, and therefore good practice would be even more difficult to maintain. For a two week wait it is good practice to be seen within 7 days rather than wait until the end of the two weeks which is more likely to breach. We may see a drift which is patient driven depending on when they choose to book their appointments. DR also highlighted 62 day waits where, although Buckinghamshire Healthcare NHS Trust (BHT) is rated green, 8/15 breaches related to BHT. DR noted this was a complex picture; BHT themselves rating green for this indicator. GJ queried whether BHT could help facilitate other providers to improve their performance (and achieve green ratings). RM replied that we should look to the cancer alliance to provide leadership; cancer is a pan-system matter and not just Buckinghamshire. RW pointed out that some patients don't realise that they are on a timed pathway for cancer. DR replied that the Executive Committee had recently discussed the very same point with an action for Dr Christine Campling to ensure inclusion of an article in the member Bulletin to remind colleagues about best practice with 2ww referrals. RW noted the levels of scrutiny in this area, and felt that we may not wish to upset patients through over emphasising that a referral falls within a 2WW pathway. RB added that this is a sensitive issue given many referrals do turn out not to be confirmed diagnosis of cancer. GJ replied to this in stating that, for his practice, he and his partners are open and transparent about the pathway. LP concluded the item in stating that Executive Committee would need ongoing assurance about levels of patient awareness of about 2WW pathways. <u>Referral to Treatment (RTT)</u> DR also reflected on the contents of the report in relation to Referral to Treatment (RTT) and Oxford University Hospital backlog. LP emphasised that	

	some areas, especially vascular work, is being protected from falling within backlog. DR added that they are prioritising in clinical order rather than performance order. GJ queried our confidence that procedures of low clinical value are not causing us an RTT backlog issue. DR replied that we are watching this and undertaking peer to peer quality to help manage demand. LP asked if we have a seen a McKinsey report on OUH. DR replied that we should receive it in due course; highlights will be reported next time. <u>A&E</u> In relation to A&E, DR reported we continue to see significant challenges. The A&E Delivery Board has a presentation on challenges from the COO at BHT in August; they have also developed a recovery plan involving specialist support from NHSI who are now on site one day a week progressing improvement actions. August performance is expected to average 88%; the difficulty has centred not on system pressure as is often the cause, rather it related to effectiveness of co-ordination of patient movement within the department. The least sick waited the longest, many of which were discharged home, which is re-assuring. BHT has also reported significant vacancies often compounded in summer with staff not taking on additional shifts. DR reported that, whilst the meeting has been in progress, the daily 95% target has been met. **Action: Quality and Performance dashboard noted as shorter than on previous occasions – Q&P Committee asked to review format and improve quality** DR noted the Quality and Performance Committee is meeting every two months and that this is on the agenda for the next meeting. RM asked timeframe for redevelopment of the report; DR replied that this would be November, though already includes a number of areas previously highlighted as missing, e.g. learning disability health checks. RM raised two additional points about South Central Ambulance Service (SCAS). He noted that the report did not include new national performance standards, and that there are references for a remedial action plan for 111 and whether remedial actions were closed off or continued with change of supplier into the new contract (as of 4 September 2017). DR replied that there had been a timing issue, the new framework has launched between meetings and will therefore feature next time. In relation to 111, we have now included an indicator set, and in the first week of the new service we achieved target for calls answered in less than 60 seconds. There is close monitoring of all new elements as the contract is mobilised. KW noted challenge around quorum with Q&P committee. **Action: Function of Q&P Committee; recent quorum challenge given departure of lay member chair and registered nurse. Review of lay member commitments required (in light of merger)**	**DR** **LP**

9.	**Emergency Preparedness, Resilience and Response (EPRR) 2017/18 assurance process assessment against core standards and annual work plan.**	
	Governing Bodies meetings in common were asked to: 1. **NOTE** the progress of the Emergency Preparedness, Resilience and Response process and assurance on compliance. NHS Organisations are required to undertake an annual self-assessment of its state of preparedness in being able to respond to emergencies. This is done through an assessment of the extent of compliance with the NHS Core Standards for EPRR. Governing Bodies are presented a draft. Last year we were confirmed as substantial, and at this point we are partially compliant based on needing up ratify updates to our Major Incident Framework. We expect to be substantial by the end of October 2017. The AEO for the CCGs will also be attending an Assurance Confirm & Challenge Meeting with NHSE. Separate confirm and challenge meetings have also taken place with providers as we are required to do, the results of which were noted as: 1. Buckinghamshire Healthcare Trust (BHT) has been assessed to be 'Substantial', with no major areas for concern. 2. Care UK has been assessed as 'Substantial', with no major areas for concern. LP queried, in current absence of a substantial rating, if an emergency were to occur before the end of October that sufficient resilience would be in place. DR replied that appropriate plans are already in place, though they were being updated to reflect current requirements. EPRR progress was duly **NOTED.** The requested delegation was **AGREED.**	
10.	**Governing Body Assurance Framework (and Note November seminar deep dive)**	
	Governing Bodies meetings in common was asked to are asked to: 1. **REVIEW** the content of the latest Governing Body Assurance Framework (GBAF) 2. **ASSURE** itself over GBAF completeness, validity of scores and appropriateness of mitigating controls, assurances and actions. **Overview** – The Governing Body Assurance Framework (GBAF) captures those principal risks to the delivery of the 5 strategic aims/goals. RM noted the attached report was received for information. Of the 14 identified principle risks, 4 remain extreme (15+) – Risks 9, 10, 11 and 13. We can see the rationale for that given the length and detail of earlier discussions. LP noted that there would also be a further deep dive at the November seminar.	
	For Decision	
11.	**Merger update: final application to NHS England.**	
	All Member GPs left the room. The meeting remained quorate. RP took over as chair. The Governing Bodies were asked to:	

1. **APPROVE** the Clinical Chair role time commitment at 5 sessions per week.
2. **NOMINATE** members for the competency panel
3. **AGREE** that Dr Paul Roblin (CMO for the Local Medicines Committee) is appointed the Returning Officer.

LP introduced the item to state that at present we have 10 sessions per week with two chairs, to be reduced to 5 sessions. RP opened the meeting to questions from members. CO queried whether a reduction to 5 sessions with one chair was doable. LP replied that CCG benchmarking showed this was about right, given average of 4 sessions per week. We not planning to reduce the number of clinicians overall. CO noted surprise at locums being eligible for nomination. LP replied that they have to be on the performers list, and that this is stated within agreed CCG constitutions.

CO noted inclusion of the new appointment to clinical chair on a one year contract. LP replied that this is currently a challenge with all our clinicians; there is a tenure and as an officer it is a non-employment status, but there is also an employment status and they are incongruent. The next process will be to identify any suitable alternative employment.

The planned 12 month short term tenure is also important given wider system changes and potential impact on wider leadership. This step allows us to be seen as flexible in acknowledging fast moving change in the development of an accountable care system. The job description will also be different in having an enabling focus. There is also a list of statutory responsibilities. LP asked for delegation for approval by at least two lay members and a lay clinician.

RP noted reference to an “Extra-ordinary Governing Body meeting for assurance on election process and confirmation of Clinical Chair”. LP noted that the dates may change based on NHS England’s committee timings, with a delegation to adjust agreed.

LP noted a need to report to the outcome before it goes public. RM agreed this, but that as an extraordinary governing body may not be the best description. LP noted a need to give assurance and that assurance on the election process (through a telephone conference) may be a better description.

The competency panel would be set up only if there are candidates other than the current two chairs. RM queried external representation; LP replied NHS England would take part. RM suggested possibly a non-conflicted chair from another area, LP agreed this principle. RC also agreed to join the panel from the governing body, but had only certain availability.

Dr Paul Roblin had previously acted as returning officer in Aylesbury Vale. Only LP would have the right other than Dr Roblin to see the results if needed, which gives members assurances that CCG staff would not otherwise see the votes. There was a question as to whether Dr Roblin was conflicted given one of the existing chairs is treasurer of the LMC. This was discussed and agreed not an issue; he is also overseeing an election in Oxfordshire. Competency panel members were suggested as RC, CO, RW and RP. A delegated group for review the job description CO agreed to take part, along with CS, RC and RW.

12.	**Accountable Care System**	
	The Governing Bodies were asked to: 1. **APPROVE** and **RATIFY** a) Memorandum of understanding between partner organisations in the accountable care system and NHS England. b) A draft system compact agreement, which describes the practical operational arrangements between partner organisations in the accountable care system c) Terms of reference for the Accountable Care System (ACS) Partnership Board which is accountable to the governing bodies/boards of partners. 2. **NOTE** information and assurance provided on the management of Bucks ACS transformation funding. 3. **AGREE** delegation to the CCG Chief Officer and CCG Corporate Governance Lead to make any additional minor amendments to the system compact agreement alongside partner organisations. 4. **AGREE** delegation to Chief Executives or equivalent as signatories to the system compact agreement and memorandum of understanding as required. 5. **NOTE** that whereas all partners are signatories to the system compact agreement, the Memorandum of Understanding with NHS England requires the signature of a single individual on behalf of Buckinghamshire system leaders, along with a signature on behalf of NHS England and NHS Improvement. This is Lou Patten as nominated Lead for the Buckinghamshire ACS. The memorandum of understanding (MOU) does not have legal force but it does describe what we need to achieve in 2017/18 and the way we agree to help each other to make the fastest possible progress. Some initial concerns were raised in relation funding; we are expecting to get our fair share of available funding rather than apply, and it is not ring-fenced to particular areas. We have £2m of new money coming in, but it is only available if all partners approve the MOU. We also have governance arrangements in place which we are reporting to NHS England and NHS Improvement. We also asked the finance group to look at some issues and that levels of risk overall are manageable with an appropriate level of confidence. PJ added that he and Buckinghamshire Healthcare NHS Trust, along with Buckinghamshire County Council, had worked closely together on this and that we are heading in the right direction. There is also further work to do on the detail of financial governance reporting through the ACS Executive Group. There is some uncertainty remaining over future funding, although that is not unique to us and therefore not a major issue at this stage. CO observed that the MOU was very hospital focused and doesn't specifically refer to the nursing workforce in primary care and should highlight upfront offering better care closer to home. LP replied that governing bodies are best to gain assurance through the Partnership Board arrangements on how nursing leadership is being addressed. The key is to identify and monitor local priorities once the MOU itself has been agreed. CO was assured that there is local flexibility. RMS drew attention to the "provider alliance" and where primary care fits in terms of accountability. LP replied that this is through the GP Federation (i.e. FedBucks) on behalf of all practices, including unaligned and members of Medicas. RM suggested the diagram needed some more work; the executive	

	group and provider alliance are separate, and further emphasise the clinical leadership model. RMS also queried understanding of accountability within the federation itself. RB noted that the diagram provided (in compact agreement and partnership board terms of reference on accountabilities and decision making) describes the relationship between the ACS and FedBucks, though what is less well defined is the relationship between FedBucks and its member practices. LP added that this clarity has been requested from FedBucks through the Partnership Board. **Action: Accountability arrangements within GP Federation; relationship between FedBucks and its practices (noted as requested through ACS Partnership Board) but also taken here is an action.** PJ queried the accountability for the Directors of Finance Group, whether Partnership Board or ACS Executive Group. LP replied that it would ordinarily be the ACS Executive Group, though there have been some matters, e.g. MOU issues, reporting directly to the Partnership Board. DR noted that the MOU is very health focused and that social care, although referenced, could appear not to form a core part of the ACS. DR suggested that LP comment on local priorities to ensure social care transformation is appropriately incorporated. LP replied the MOU serves 8 very different systems with varying levels of engagement and different organisational arrangements. The level of integration is varied. Therefore the MOU is a broad brush document that focuses on the system control issues, with local arrangements describing the various relevant layers and detail. PJ added that some of our providers also work in other geographies, though our geography and that of BHT are closely aligned which then explains our joint role at the centre of the system for Buckinghamshire. **Transformation funding arrangements: this is in development, next meeting run through some examples of how this might work** All requests of the governing body following this discussion were agreed and /or noted as described above.	**LP** **LP**
	For Information/Ratification/Reading List	
13.	**For Information/Reading List**	
	All Approved Minutes provided within papers were noted.	

Acronyms

A&E	Accident and Emergency	KLOE	Key Lines of Enquiry
ACHT	Adult Community Health Team	LMC	Local Medical Committee
ACO	Accountable Care Organisation	LPF	Lead Provider Framework
ACS	Accountable Care System	M	Million
AF	Atrial Fibrillation	MAGs	Multi Agency Groups
AGM	Annual General Meeting	MCA	Mental Capacity Act
AQP	Any Qualified Provider	MCP	Multi-speciality Community Provider
AT	Area Team	MK	Milton Keynes University Hospital Foundation Trust
AVCCG	Aylesbury Vale Clinical Commissioning Group	MCP	Multispecialty Community Provider
BAF	Board Assurance Framework	MusIC	Musculoskeletal Integrated Care
BCC	Buckinghamshire County Council	NHSE	NHS England
BCF	Better Care Fund	NHSi	NHS Improvement
BAF	Board Assurance Framework	NOAC	New Oral Anticoagulants
BHT	Buckinghamshire Healthcare Trust	OCCG	Oxfordshire Clinical Commissioning Group
BAME	Black and Minority Ethnic	OOH	Out of Hours
BPPC	Better Payment Practice Code	OUH	Oxfordshire University Hospitals NHS Foundation Trust
CCCG	Chiltern Clinical Commissioning Group	OPEL	Operational Pressures Escalation Level
CDIF	Clostridium Difficile	PACS	Primary & Acute Care Systems
CFO	Chief Finance Officer	PAS	Patient Administration System
CHC	Continuing Health Care	PB	Programme Board
CIP	Cost Improvement Programme	PBR	Payment by Results
COI	Conflict of Interest	PIRLS	Psychiatric In Reach Liaison Service
COPD	Chronic Obstructive Pulmonary Disease	PLCV	Procedures of Limited Clinical Value
CPA	Care Programme Approach	PMS	Personal Medical Services
CQC	Care Quality Commission	POD	Point of Delivery
CQRM	Contract Quality Review Meeting	POG	Programme Oversight Group
CQUIN	Commissioning Quality & Innovation	PPE	Patient & Public Engagement
SCWCSU	South Central and West Commissioning Support Unit	QIPP	Quality, Innovation, Productivity & Prevention
CSIB	Children's Services Improvement Board	QIS	Quality Improvement Scheme
CSP	Care & Support Planning	QOF	Quality & Outcome Framework
CSR	Comprehensive Spending Review	RAG	Red, Amber, Green
CSU	Commissioning Support Unit	RBH	Royal Berkshire Hospital
K	Thousand	RCA	Root Cause Analysis
DES	Directly Enhanced Service	REACT	Rapid Enhanced Assessment

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