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)
12th January 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 Karen West	Clinical Commissioning Director Integrated Care	**KW**
Philip Murray	Chief Finance Officer	**PM**
Robert Majilton	Deputy Accountable Officer and Director of Sustainability and Transformation	**RM**
Dr Crystal Oldman	Registered Nurse	**CO**
Dr Rebecca Mallard-Smith	Clinical Commissioning Director Unplanned Community	**RMS**
Tony Dixon	Lay Member (Deputy Lay Chair, Chiltern CCG)	**TD**
Colin Seaton	Lay Member (Patient and Public Engagement)	**CS**
Graham Smith	Lay Member (Chair of Primary Care Commissioning Committee)	**GS**
Dr Robin Woolfson	Secondary Care Specialist Doctor	**RW**
Others present (non-voting)		
Debbie Richards	Director of Commissioning and Delivery (co-opted member)	**DR**
Jane Butterworth	Associate Director - Medicines Management and Long Term Conditions (in attendance for item 12 only)	**JB**
Kirstie Neale	Corporate Office Support and PA to Clinical Chair AV & PA to Director of Nursing & Quality (Minute taker)	**KN**
Russell Carpenter	Corporate Governance Lead	**RC**

1.	**Welcome & Apologies**	**Lead**
	The Chair Dr Raj Bajwa (RB) welcomed the Governing Bodies members and members of the public. **Apologies** Ross Carroll (RC) – Lay Member Robert Parkes (RP) – Lay Member (Deputy Lay Chair, Aylesbury Vale CCG) Dr Graham Jackson (GJ) – GP Clinical Chair (Aylesbury Vale CCG) Sheran Oke – (SO) – Registered Nurse Lisa Maclean (LM) – Director of Nursing and Quality	
2.	**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
RB, RMS and KW confirmed that they are conflicted (financial direct) (already recorded on the register) under agenda item - Proposed Extension to the current Direct Award for Insulin.

This is a decision which relates to potential payments to primary care practices. The three GPs are all partners in their practices and therefore shareholders. It was agreed that they would remain in the room for this item but not participate in the decision. It was also agreed that TD as deputy chair would take the role of chair from RB for this item.

RB and TD both declared direct financial conflicts of interest in relation to item 11 on a proposal for the two CCGs to merge. In relation to the two Clinical Chairs, the proposal to merge presents conflicts of interest as it could affect the future clinical leadership and therefore potential personal financial loss. In relation to the two Audit Committee Lay Chairs, a merger would reduce the Audit Committee requirements and therefore potential personal financial loss.

It had been agreed prior to the meeting that the Chair of this part of the Governing Bodies meeting will be passed to Graham Smith, Lay Member and Chair of the Primary Care Commissioning Committee who is not conflicted. It had also been agreed prior to the meeting that the conflicted members would leave the room in respect of specific discussion on clinical and audit chair arrangements.

Quorum requirement	**Majority of meeting**	**Decision on CCG merger**	**Decision on Direct Award extension**
Chair from either group (or deputy lay Chair)	RB	GS	GS
Accountable Officer or Chief Finance Officer	LP PM	PM	PM
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.	CO RW RMS KW	RW RMS KW	CO RW LP
Two lay members	GS, CS, TD	CS, CO	CS, TD

3. Minutes of the meeting held on 8th December 2016, Action Log and Matters Arising

3.1 Minutes - RB advised the Governing Bodies that RM submitted a number of changes directly to KN and these changes and suggestions will be made after the meeting. The Governing Bodies agreed for these changes to be made.

3.2 Action Log – It was noted that all actions have been updated within the action log. Of 10 actions open, 6 were agreed to be closed with remaining 4 to remain open.

3.3 Matters arising – None were raised.

4.	**Questions from the public**	
	RB noted that no questions had been submitted in advance of the meeting. No questions were raised from the floor.	
	Clinical Presentation	
5.	**Update on Mental Health, Learning Disabilities and Dementia**	
	Presented by Dr Sian Roberts (SR); an outline of her clinical portfolio. A copy of the presentation and audio recording is otherwise published separately on the CCG websites. • Mental Health key themes • What is being done locally for all ages – Child and Adolescent Mental Health Services (CAMHS), Acute Mental Health Teams (AMHT), Perinatal & Improving Access to Psychological Therapies (IAPT) • Mental Health Urgent Care Pathway • Increasing Access to Psychological therapies (IAPT) – Key points were given • Parity of Esteem (i.e. focused effort of resources on improving clinical services and health outcomes) • Child and Adolescent Mental Health Services (CAMHS) Transformation plan funds • Learning Disabilities – Transforming Care Plan • Transfer of inpatient learning disability beds from Southern Health to Hertfordshire Partnership NHS Foundation Trust. • Annual Health Check Target - By 2020 , national target will be 75% of patients on LD Register to have had an annual health check • Dementia – reducing variation and current projects RW noted that for patients with diagnosed mental health issues who are also diabetic, it can sometimes be difficult for them to effectively utilise community based diabetes services. He therefore queried how this was expected to work locally. Dr Roberts commented that mental health patients that have diabetes are screened at annual health check for any issues that may arise. Specifically in relation to helping patients who are diabetic who may experience mental health or anxiety issues, the Live Well Stay Well Single Point of Access (SPA) also offers a holistic way of using emotional wellbeing practitioners to help manage diabetes rather than sole reliance on drug based interventions including insulin. This also extends to signposting to opportunities for increasing exercise and stopping smoking. Dr Roberts also commented that, for mental health patients who may have undiagnosed diabetes, Oxford Health are now screening patients for their blood sugars to ensure other underlying chronic conditions are not missed which could be exacerbated by their mental health condition. LP reflected that Buckinghamshire Healthcare NHS Trust A&E had also, during a period of recent pressure, experienced a mental health patient who was a known diabetic who had a general and relatively minor medical issue yet had still been conveyed to A&E. So it was recognised that pathways of care could benefit from further improvement. CO queried annual health checks for patients with learning disabilities, and a tough challenge to reach a target for ensuring 75% of these patients has had	

	one (a national target by 2020). SR replied that the reason for being below target (Chiltern CCG 31%, Aylesbury Vale 39%) were multi-factorial, with a renewed effort on communication on why it is important to both patients and carers – though recognising there are challenges in reaching these patients. **Patient Experience Story** Dr Roberts's introduced a patient who would like to share with the Governing Bodies her patient experience in relation to LGBT issues and services. (Link to be inserted once edited and published) Some suggested actions that she feels the Governing Bodies should take into consideration included (1) events for LGBT awareness week and inclusion in school PHSE and form classes (2) trained staff on LGBT issues, (3) help and support for parents (4) continued supporting vital work of Child and Adolescent mental health Services (CAMHS) and gender identity clinics. RB asked the Governing Bodies and members of the public if there were any questions. LP thanked the patient on sharing her story and added that a number of the points highlighted could be taken forward by the Governing Bodies with others across the system as a whole, especially around LGBT awareness.	
	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: **1. Buckinghamshire System Planning** LP noted that the Operational Plan was finalised. Positive feedback was received from NHS England in terms of its clarity and alignment with the STP footprint. Workstreams have been mapped into the Programme Boards for the work to start. Since submission, the team have worked hard to ensure that all work streams are mapped into Programme Boards and projects within the programme management framework. **2. Buckinghamshire System Planning: CCG engagement with the public** LP highlighted all public events have been completed; both CCGs websites have been updated with fully functional signposting, e.g. STP summary. **3. Organisational Development** The Executive Committee have reviewed the programme board framework in order to seek assurance that the correct prioritisation and focussed capacity on the right areas of transformation work is in place. It was agreed that a programme will be created that is dedicated to the transformation of primary and community sustainability, which will include some system wide initiatives such as integrated multi-disciplinary teams. Progress in respect of this will be further reported next time. **4. Staff** The CCGs Chief Finance Officer, Philip Murray will be leaving us in February 2017 as he has been successful in his application for a CFO post in a Mental	

	Health Trust. An interim arrangement for the CFO post will be put in place until the permanent position has been filled. LP also noted that the organisation will also need to be mindful of how the post going forward will fit into the development of the Sustainable Transformation Plan (STP).	
	Assurance and Governance	
7.	**Finance Report (Month 8)**	
	Presented by Philip Murray (PM). 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 November 2016. The supporting paper related to Month 8 (November), but there was also additional briefing on Month 9 (December). PM provided highlights as follows: **1. Year to Date:** Across Buckinghamshire CCGs there is a year to date under spend of £3,978k (AVCCG £1,546k and Chiltern CCG £2,432k) against an equivalent budgeted surplus. This has been supported by the continued holding of prescribing performance, with additional savings having been released into the position. 2. **QIPP:** To hold the CCG position QIPP is required to deliver an additional £3,700k above ytd run rate. This has reduced from previous months (£4,600k) as some schemes, e.g. prescribing, are showing real savings. PM noted that Governing Bodies had previously asked for assurance that this would be delivered. Through QIPP workshops and additional financial recovery work we could expect to cover this. In relation to contracts, Buckinghamshire Healthcare NHS Trust and Oxford Health particularly, they remain broadly on track. A focus continues on non-elective admission and delayed discharge rates for patients at Milton Keynes University Hospital NHS Foundation Trust. 3. **Financial Recovery Plan:** The CCGs continues to apply a financial recovery plan to ensure expenditure remains within planned levels and the CCGs fulfil their statutory duties by year end. Measures include: vacancy control system for all permanent and temporary staff ; continual review all budget lines to identify opportunity for slippage; review all planned investments; undertake a balance sheet review; QIPP review to identify the underlying gap and opportunity. 4. **Treasury management**: total cash draw down to date is 66.3% of current year cash allocation compared to a budget of 66.6% (at this point in the financial year). PM noted therefore that Governing Bodies can be assured that cash is not being spent faster than it should be. 5. **Debt management:** Buckinghamshire CCGs have 12 outstanding invoices totalling £2,085k, of which 7 invoices (£1,678k) are not yet due. Debts that are over 90 days show no movement and the invoice for £330k from 2015-16 owed by Buckinghamshire County Council has now been cancelled. A further invoice reported as outstanding (greater than 90 days and a value of £64,000), but has now been paid and contributes to position (albeit small). RM noted an adverse variance for CHC Assessment & Support relating to payments made to Arden and GEM CSU for the risk share agreement on savings achieved on the price of care packages plus the costs of supporting personal health budgets. RM queried whether this risk share agreement had been reviewed given the current financial position. PM confirmed that there was a contractual clause from two years ago which required that organisation to review long standing and high cost placements	

	that they had inherited, in order to determine if they should still be placed, and if so to reduce underlying costs. Although savings have been realised, there has also been an increased rate of referral which has subsequently contributed to use of risk share funds.	
	Month 9 position PM briefed the Governing Bodies on the financial Performance of Month 9. PM noted that a number of forecasts have swung significantly with a total impact which, when allowing for planned surplus, leaves a net risk of circa £3m if all existing identified risk were to materialise. Main areas of movement relate to additional CHC cases, increased activity through a wheelchair and continence service and outpatient activity through NHS Frimley Health Foundation Trust (though this has led to increased costs for all commissioners). NHS England has been briefed, with a further review of all forecasts (including contracts) and development of a financial recovery plan (as is required by NHS England as a result of reported net risk and "requires improvement" performance rating from January 2017). TD queried whether the set aside 1% headroom (in line with treasury rules) could now be utilised given the position. PM confirmed that this had been asked of NHS England but was not permitted. Further funds had also been set aside over two years to support the transformation agenda at Wexham Park when previously under special measures. It was intended to be derived from 1% headroom, but then could not be given treasury rules, and an equivalent QIPP saving hasn't yet been identified to account for it. Further, a £1m lodgement with NHS England from Chiltern CCG in 2015/16 which was expected to be returned has also not been honoured because of tightened treasury rules. LP added that this was not guaranteed. LP commented that there would be a significant amount of work required and the Audit Committee chairs would continue to be assured on financial recovery plans, as would the Finance Committee. **ACTION:** RM noted that it is important to have a communication cascade to everyone to confirm what the CCGS are doing in light of our financial position.	LP
8.	**Governing Bodies Assurance Framework (GBAF)**	
	Presented by Philip Murray (PM). This report is presented for information only and there were no changes to these risks scores in month. Any changes that have been made to the report are highlighted in Red. PM highlighted the three main extreme risks 9, 10 and 13 which are around delivery, financial control and performance. PM highlighted the main updates on controls and actions for risk 7 which is around patient engagement, and 8 and 10 around performance and financial controls. PM advised the Governing Bodies that the finance committee is meeting on 30th January 2017 to further discuss the financial position. LP referred to the covering summary page that shows all the CCGs strategic risks and scores, noting that risk 11 (the wider health and care system's financial challenges may adversely affect the CCGs' performance) was scored	

	at 6 whereas related risks 8 (robustness of financial controls – score 8) and 10 (Over-performance at providers – red rated 16) were higher. LP suggested all should be scored higher at 16 and above (i.e. red). PM suggested that this would not necessarily be the case in relation to risk 8 given strength of existing controls, although this does not mean the positon would not change and the risk score increase. LP suggested this risk would need to be reviewed in light of the change to financial position reported earlier. Risks 11 and 12 (on staff capacity and capability) would also need to be reviewed given PM's departure by the end of February. TD acknowledged this and noted that in relation to over-performance of providers there were not specifically any additional controls that could be introduced to manage this risk down further. LP also suggested the A&E Delivery Board should be asked to review risk 14 (If service continuity and organisational delivery is disrupted by unexpected adverse events or capacity to deliver, this will severely impact on patient care). **ACTION:** Review risk 8 (robustness of financial controls) in light of change to financial position (net risk circa £3m) **ACTION:** A&E Delivery Board to review risk 14 on the GBAF.	PM DR
9.	**Quality and Performance Report (Month 8)**	
	Presented by Robert Majilton (RM). RM 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. RM highlighted that the RTT position still continues to be challenging. An action within the performance report was around a recovery plan and this has been received from BHT. This provides plans and specific actions at speciality level and this is currently subject to internal review for assurance. Support from NHSE has also been secured to ensure that the recovery plan is suitably robust. Governing Bodies members noted that this has now been received RB noted that there is a statutory responsibility to deliver on RTT targets, whilst also achieving financial balance, and how this should best be managed. RM replied that this was true and challenging, with some additional funding secured specifically to support achievement of RTT alongside additional measures to ensure that the quality of referrals are appropriate. DR provided an update to the Governing Bodies on current A&E performance, which has been subject to much local and national coverage. The A&E 4hr wait target was not met and has not been met YTD by any local provider, reflecting overall and ongoing system pressures. The Governing Bodies noted that the winter plan has been assured rated green by NHS England. Although the Christmas and New Year period was challenging and the A&E target was not achieved, an amber rating was maintained on the NHS England Operational Pressures Escalation Level (OPEL) Framework – mostly level 2 (starting to show signs of pressure) and at times level 3 (experiencing major pressure). However, BHT escalated to level 4 at the end of last week (pressure in the local health and social care system continues to escalate leaving organisations unable to deliver comprehensive care). Although community capacity remained available, as a system the rating subsequently increased to OPEL4 and was	

	therefore reported to NHS England. RM (as director on call) spent a whole day on site as part of gold command to support the emerging situation, including engaging support from adult social care in purchasing packages off their framework, and work with continuing healthcare. The rating was later deescalated with BHT now working through to recovery. However pressures continue with yesterday 65 admissions compared to an average 45, with general trends of a 14% winter increase in emergency department admissions and 30% increase in ambulance conveyances compared to the same period last year. The A&E Delivery Board continues with oversight of these issues locally, working closely with the equivalent boards for Oxfordshire and Frimley. DR added that in relation to continuing healthcare, there remain challenges in matching demand for packages with capacity, especially elderly mental health with challenges in recruiting appropriate staff. RB further noted that Dr Dal Sahota and RMS were also present in A&E at the same time as RM. RMS commented that the pressure had been well managed.	
10.	**Proposal to Merge the two CCGs**	
	RB asked GS to take over as chair as agreed at the start of the meeting, who then asked LP to introduce the item. Presented by Lou Patten (LP) The Governing Bodies were asked to consider the benefits and risks of the potential merger of NHS Aylesbury Vale and NHS Chiltern CCGs, and whether merger would meet the five factors consistent with the 2006 Act and the Regulations, as well as meeting the further six factors for merger, which NHS England considers are relevant to one or more of the matters set out in section 14C (2) of the NHS Act 2016. LP noted that on 1st July 2016 the two CCGs formally federated. The Executive Committee has already considered this proposal and recommends to the Governing Bodies that merger is applied for to commence April 2017. In May 2016 the CCGs' memberships ratified a decision to "merge in all but name", though at the time, there was no formal NHS England procedure that enabled merger. This has since changed and therefore promoting this decision. LP explained the key points of the merger proposal and why it will benefit the CCGs becoming one organisation. As the Governing Bodies are aware there is one Executive meeting, Senior Management meeting and 7 localities which will lead to one constitution rather than being separate. Going forward what the CCGs would benefit from is having one set of finances, one annual report etc. Under the new federation, both CCGs retained their strong clinical leadership with a robust Executive Committee and Programme approach to clinical commissioning business. This will continue unchanged through merger. The Executive Committee discussed at length the options for future Clinical Chair leadership of the merged organisation, given the current situation where there are two. It was understood that currently the two Clinical Chairs are in a position of high trust and respected leadership with their specific CCG Member	

	Practices. Given a challenging agenda for transformation in the next two years, the Executive Committee noted that significant clinical leadership will be required to achieve the scale and pace of the transformation within Primary and Community services. It was agreed that in the light of this, both Chairs should retain a Co-Chair responsibility for half of their time, with the remaining time spent on helping achieve deliverable outcomes within transformation plans. This will be in place for one year only, with a review in 6 months' time by the Executive Committee. Risks: • The setup of a single entity ledger will require investment in time – year-end entries will need to be transferred from existing ledgers. There is a risk of error/omission in this process. • Providers will have to realign databases to a new single CCG entity – this is assessed as low risk. Both CCGs share their CSU support and are currently procuring jointly their future support services through the lead provider framework. It is anticipated that the merger would significantly reduce duplicity of services with a reduced price next year. LP noted in regards to the 5 legal factors that will need to be achieved will consist of: • Coterminosity with local authorities • Clinically-led: the new CCG should demonstrate that it will remain a clinically-led organisation, and that members of the new CCG will participate in decision-making in the new CCG. • Financial management: NHS England will consider whether the new CCG will have financial arrangements and controls for proper stewardship and accountability for public funds. • Arrangements with other CCGs: the new CCG will have appropriate arrangements with others, for example lead commissioning arrangements. • Commissioning support: NHS England can take into account whether the new CCG has good arrangements for commissioning support services. LP confirmed that section 3 on the paper covers the six factors that NHS England state that have to be a requirement in order to compete the merger there are: • Strategic purpose: to provide a more logical footprint for delivery of the local STP. • Prior progress: the relevant CCGs must have already demonstrated progress in systematically implementing shared functions; and there is evidence of a willingness to work together. • Leadership support: the merger proposal enjoys the support of the STP leadership and the support of constituent CCG governing bodies • Future-proofed: the merger proposal provides the right footprint for oversight of likely local multispecialty community providers (MCPs) and primary and acute care systems (PACS) • Ability to engage with local communities: we would want assurance that the move to a larger geographical footprint is not at the expense of the new CCG's ability to engage with GPs and local communities at locality	

level.

- Optimising use of administrative resources: the merger should show how 20% in ongoing running costs will be released to supporting local system transformation, including how the changes are commissioned.

It is anticipated to reduce to one audit committee and further refine membership of the Governing Bodies. RB noted that he believes he should leave the room for the Governing Bodies to have discussions around chair arrangements if they wish. TD stated the same in respect of his role as Audit Chair for Chiltern CCG.

RB and TD left the meeting.

GS queried the criteria for review of the chair's roles at 6 months. LP advised the commissioning landscape is potentially due to change within the next couple of years, seeing an increase in responsibilities for STPs and the larger scale of commissioning. A strong local voice for localities will however remain important, with chairs having an important role in ensuring this.

It is anticipated that within 6 months there will be a better indication of the direction of travel at STP level and therefore the position can be reviewed at this point in relation to expected management efficiencies. It is expected that the Executive Committee will work through this.

RB re-joined the meeting.

RW queried the size of the CCG once merged with the national trend. LP replied that the merged CCG would enter the top third, but would still not be larger than Oxfordshire CCG. PM added that the county and district councils are also reviewing their alignments with a view to potentially becoming unitary authorities – district level or county wide, although that would not specifically affect this decision. LP confirmed that they have all been made aware of the intention for the CCGs to merge.

RM asked the Governing Bodies to note that there will also be some reconfiguration of performance data to report (including to NHS England) once only. A new name would also come into effect, and going forward as commissioning arrangements change around development of Accountable Care Organisations (ACO) more joint commissioning with local authorities will emerge. Current CCG staff would need to be supported through this process over the next 18 months and more.

CO queried:

1. Whether the current financial position was an issue that could prevent merger. LP replied that it was not specifically a stated criterion, and merger would create further financial efficiencies (as already described) in relation to a number of performance targets.
2. Is the footprint of both CCGs the same as Bucks PCT, RM confirmed that this is not the same one practice in Thame had previously transferred to Oxfordshire and likewise several practices in South Bucks (Taplow) had transferred from Slough CCG. CO replied that this is helpful to see that the CCGs were not going back to where they were before as Bucks Primary Care Trust (PCT).

GS noted that merger would lead to one system for invoices, coding structure,

	contract management and all transactions and suppliers paid once where services were previously duplicated. However, he queried there was a risk that as transition takes place duplicate invoices could still be paid. PM assured members that appropriate systems and process were in place to mitigate down this risk of duplicate payments as much as possible. The quorate membership in the room agreed that this was right course of action and an application to merge be completed. ***GS handed back the Chair role to RB.***	
11.	**Proposed Extension to the current Direct Award for Insulin**	
	Presented by Jane Butterworth (JB). ***TD re-joined the meeting and took over as chair. RB asked TD to take over as chair as agreed at the start of the meeting; TD then asked JB to introduce the item.*** JB presented to the Governing Bodies a paper on an application to make a small adjustment to a direct award to practices for insulin. This is a new injectable treatment and moves initiation from secondary to primary care. This is a temporary solution until this forms part of a new primary care diabetes pathway. A recommended tariff of £38 per patient per year has been calculated with a potential cost of £2,749 for the year. This proposal is recommended as it is less likely to adversely impact the prescribing or planned care budget. LP added that this would improve patient experience as it is an offer through primary rather than secondary care. There is additional benefit in terms of reduced outpatient appointments at an average cost per patient of £100 (where some may have up to three outpatient appointments). PM felt that, although it would not affect the decision today, there needed to be a complete understanding of what looks like given earlier discussion about the financial position. JB agreed to undertake a calculation, but suggested it would come to less than £10k. **ACTION:** JB to provide PM with a calculation of the potential figures, JB confirmed this will be less than £10,000. RW queried whether member's role was to consider the financial decision or the clinical governance and probity of the intervention. TD gave way to RB to reply, stating that the clinical case has already been made and agreed externally to the CCG. LP also noted that implementation will be audited to ensure benefit is realised. The quorate membership agreed the extension requested.	
	For Information	
12.	**Approved Minutes from sub-committees, sub-groups or steering groups:**	
	The below minutes of meetings reporting to the Governing Bodies were received for information. Executive Committee – 27/10/2016 Integrated Commissioning Executive Team – 29/09/2016 **Meeting closed at 16:00pm.**	
	Date of next meeting (in public):	
	Thursday 9th March 2017 Council Chambers, Chiltern CCG Time: 10:30am -12:30pm, Room: Council Chambers	

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		