NHS Aylesbury Vale Clinical Commissioning Group

NHS Chiltern Clinical Commissioning Group

CHILTERN AND AYLESBURY VALE CLINICAL COMMISSIONING GROUPS
GOVERNING BODY (in Public)
8th December 2016
Jubilee Room, The Gateway, Gatehouse Road, Aylesbury, HP19 8FF

Governing Body Members Present
Chair - Dr Raj Bajwa (RB) – GP Clinical Chair (Chiltern CCG)
Dr Graham Jackson (GJ) – GP Clinical Chair (Aylesbury Vale CCG)
Louise Patten (LP) – Accountable Officer
Dr Karen West (KW) – Clinical Director Integrated Care
Robert Parkes (RP) – Lay Member (Deputy Lay Chair, Aylesbury Vale CCG)
Tony Dixon (TD) – Lay Member (Deputy Lay Chair, Chiltern CCG)
Philip Murray (PM) – Chief Finance Officer
Dr Robin Woolfson (RW) – Secondary Care Specialist Doctor
Robert Majilton (RM) – Deputy Accountable Officer and Director of Sustainability and Transformation
Dr Crystal Oldman (CO) – Registered Nurse
Dr Rebecca Mallard-Smith (RMS) – Clinical Director
Lisa Maclean (LM) – Director of Nursing and Quality
Ross Carroll (RC) – Lay Member

Others present (non-voting)
Debbie Richards (DR) – Director of Commissioning and Delivery
Kirstie Neale (KN) Corporate Office Support and PA to Clinical Chair AV & PA to Director of Nursing & Quality (Minute taker) (Aylesbury Vale CCG)
Simon Kearey (SK) – Head of Localities
Dr Rodger Dickson (RD) – Clinical Locality Lead (North)
Dr Charles Todd (CT) – Clinical Associate
Dr Toby Gillman (TG) - Clinical Locality Lead (Central)

Apologies
Colin Seaton (CS) – Lay Member – Patient and Public Engagement
Graham Smith (GS) – Lay Member and Chair of PCCC
Sheran Oke – (SO) – Registered Nurse

Welcome

Introductions

The Chair Dr Raj Bajwa (RB) welcomed the Governing Body members and members of the public

RB advised the Governing Body and members of the public that item 15 Code of Conduct had been deferred; it was felt the draft document needed crossing checking against other relevant policies within the organisation.

Declaration of interests in items on this meeting's agenda

Presented by Dr Raj Bajwa (RB)

Dr Raj Bajwa reminded the Governing Body members of their obligation to declare any Conflict of interest they may have on any agenda items at Governing Body meetings

All conflicts of interests were noted on each agenda item.

Questions from the Public

RB noted that no questions had been submitted in advance of the meeting. No questions were raised from the floor.

Review and Approval of Minutes of previous meetings (RB)

PM commented on the clinical presentations section and made some suggested amendments to the minutes that have been approved.

RB noted under Item 6 Clinical Presentation "*Practices have been incentivised to undertake pulse checks as part of flu clinics* "the word incentivised should be replaced with the word encouraged as no financial payment has been made.

RM proposed to the Governing Body that the presentations included voice overs and be published on the website as this provides an opportunity for them to be reviewed by public and staff at a later date. This was deemed as a good positive form of communication for future presentations of this type.

ACTION: Leigh Franklin to liaise with Communications on any future presentations that come to Governing Body that the voice overs are added.

GJ highlighted that the feedback from the most recent presentation at Governing Body by Raj Thakkar; Clinical Director was well received and enabled a good understanding from Lay members and clinicians.

ACTION: GJ to speak with Raj Thakkar on communicating the voice overs for the presentation from the October Governing Body.

The Governing Body approved the minutes from 13th October 2016, with these amendments.

Action Log (RB)

The Governing Body reviewed the actions and all actions are updated on the action log.

Matters Arising (RB)

No matters arising were noted.

Clinical Presentation

Locality based commissioning and Patient experience

Presented by Simon Kearey (SK), Dr Rodger Dickson (RD), Dr Toby Gillman (TG) and Dr Charles

Todd (CT)

The Clinical Locality Leads presented an update to The Governing Body on the areas of work that are being undertaken in each locality, this included pre-prepared material from the Clinical Locality Leads that were not present at the Governing Body.

The following areas were included in the update:

- The Clinical Locality Leads for each locality and their management support
- An update on the recent locality engagement events
- Areas of synergies between particularly localities, for example Aylesbury Central and Wycombe and also where there were significant boundary issues particularly on acute provision such as Frimley Hospitals for Southern locality and Milton Keynes for the North locality
- The key roles and objectives of the Clinical Locality Leads including member engagement and representing members commissioning interests
- There is a new set of locality profiles provided by Public Health, highlighting the health needs in each locality
- Involvement of the clinical leads in the Executive Committee and development of the Operating Plan
- The Clinical Locality Leads highlighted a number of locality projects including the Over 75's projects, Specialised Paramedics in Primary Care and Dementia Awareness and carers projects.

Multispecialty Community Provider (MCP) update

RD briefed the Governing Body on what a Multispecialty Community Provider (MCP) is and the work currently being done on ENT outpatient project.

A Provider MCP is a new voluntary contract for GP's to work at scale to provide integrated care for a population. Integrating care across Primary and community health services and some aspects of secondary care and built on GP registered lists. In the North locality 5 out of 6 practices are very keen to pursue the MCP model and they would cover a population of around 50,000 - the draft guidance suggests doing this on a population scale of 35,000 – 50,000. Currently an entity is being formed by the partners in the practices to be this provider; a sub group has been formed to pick up various aspects like administration, financial and Governance etc.

RD noted that in the draft guidance on the MCP there are three different versions:

- Vertical MCP (doing all the work)
- Partially Integrated MCP
- Fully Integrated MCP

The North were currently looking at the partially integrated MCP version as this will separate the GMS contract from the MCP and the 5 practices that are involved will stay as 5 separate practices but sharing their work using the MCP model. The state today is to incentivise the management by MCP, funding will be though a captivated budget and there will be a performance based element.

RD noted that potentially all health services that do not need to be delivered though an acute hospital could be within the scope of a MCP.

RD commented that they were looking at how they could take this forward with ENT as an initial project.

The national vanguard pilots have shown that there are other specialities that could be developed in this way, for example dermatology. The ambition is for as much to be done within the community which is more convenient for patients. Meetings have taken place with some hospital consultants and there is support to look at patient care pathways and access closer to home.

Work is being done with secondary care to ensure that the referrals are the best referrals and that they are ready and right, no DNA's, don't refer inappropriately and follow the referral pathways correctly.

RB invited questions:

RC asked whether the main aim was to improve patient experience or is it to reduce inefficiencies or is it both, RD confirmed it is both and came to the conclusion we need to work at scale and the MCP seems to be a logical solution.

RC asked about information the level of financial efficiencies being forecasted over the next year to three years. RD confirmed at present he was unable to tell but will have an answer for the next update on MCP.

TD asked the impact on waiting times and RD confirmed that in the long run they would hope to see them come down and reduce DNA's, referrals and unnecessary follow up's and hopefully this will give a lean and efficient pathway.

LP noted that the evaluation for the MCP has not been seen and was hoping as commissioners this is going to be done and also to see the ideal population and what services do and don't work in them and how the learning is being shared as some practices are thinking of coming together.

LP commented if we do come out of payment of results as we are working towards an ACO next year, how is that going to work and how is the quality of services being measured?

GJ highlighted that there are a number of clinical services that can be delivered at an appropriate scale in each locality.

RW commented that it was exciting what is currently being proposed and asked if, the assumption is that this work is template based, RD confirmed that this is not a 2 week wait form. RW addressed that what works for the patient and what is best for the patient. RW asked is the system flexible enough to bring Primary & Secondary care together. RD commented the idea is to make the patient pathway as efficient as possible.

LP noted that this piece of work is around the MCP is for commissioners to look at and providing input and sharing information to get this right for the future.

Over 75s project

CT discussed in more detail the Over 75s project.

CT noting that funding had been identified around 3 years ago and started in the central locality on three projects based in groups of practices, general practice based, teams led by experienced community nurses and multidisciplinary teams who care for vulnerable over 75s in their homes. Working closely with each patient to help support their care and from a CCG perspective keeping them out of A&E and if they are admitted to hospital that it is a much more focused admission.

CT highlighted that this will relieve the GPs of the work they were formally doing and more time will be given from the nurses (around 2 hours per patient) with a more thorough comprehensive assessment.

CT advised that they hope these projects will go forward as they are part of the CCGs strategy's to provide services and help support them in the community as much as possible.

CT confirmed going forward they would like to see the projects secured and they are being evaluated by Bucks University.

CT also advised on a project called Airedale which is telehealth within care homes. This helps patients who have problems, where the staff in care homes can then communicate with nurses in the central telehealth centre - this is similar to skype and is used in other areas of the country.

RB asked for any further questions.

TD requested that the Governance on conflict of interests would be worked through with the locality teams.

RP commented that even though most of what has been said is in the public domain that there is a balance in ensuring that the public are aware of the schemes taking place in the localities.

GJ noted that the patient requirement is about getting the right care at the right time and appropriately and the service is delivered effectively and that the over 75 projects

Should not stand as a standalone project this should be brought in broadly within the community nursing strategy.

GJ highlighted there had been positive feedback from the Airedale project, this is now live within some practices and this was also reported in the BMJ last week.

LP noted that as some of the projects are coming to an end she believes that an evaluation is going to Executive committee in December 2016.

DR highlighted that the projects are also part of other strategic objectives, for example the Dementia project which Rashmi Sawhney touched upon is actually part of the overall Dementia strategy.

RB advised that it is reasonable for the Governing Body to seek assurance that the CCGs are delivering our locality agenda.

Leadership Reports

Accountable Officer's Update

Presented by Lou Patten (LP)

LP highlighted to the Governing Body the statement on the Mix 96 website from the Labour party; concerns were expressed around NHS cuts in Buckinghamshire.

The health and care plans being developed for Buckinghamshire, as part of the Sustainability and Transformation Plan for this region, do not involve cuts to current NHS funding. In fact, funding to the health services is expected to increase by 12% across this region over the next few years.

But at the same time, costs and demands are rising due to our growing, ageing population - so if we do nothing, our costs across the NHS in Buckinghamshire are projected to outstrip our funding by £107million by 2021.

This plan is about how we can avoid that, by working together to improve the way we meet the health needs of the Bucks population and deliver services to them in a more joined up way with our partner organisations, maximising the budgets available to us.

As we have shared with people who have attended our public information events, much of this can be achieved through existing local plans which we have been discussing with the public and partners across Buckinghamshire for some time. The detailed plan is still being developed with partners across health and social care, and is expected to be published in January. More information was available on:

https://www.chilternccg.nhs.uk/public/your-services/your-health-services/health-and-care-plans-for-buckinghamshire/

LP informed the Governing Body of local and national developments in the context of NHS Aylesbury Vale and NHS Chiltern CCGs and highlighted the following points:

1. Sustainability & Transformation Plans

LP highlighted that colleagues from across Buckinghamshire, Oxfordshire and Berkshire West (BOB) continue to work together on the Sustainability and Transformation Plan (STP) for the footprint. Sessions have taken place and proved very useful in dispelling some of the myths around STP plans and in hearing what patients had to say. The CCGs are still awaiting sign off from NHS England and the full plan is likely to be released in January 2017, subject to NHS England's approval. Many of the draft STP plans across the NHS in England are now in the public domain. The BOB draft plan was recently released into the public domain by a public service partner in one of the local systems.

2. Buckinghamshire System Planning: CCG engagement with the public

LP confirmed that our locality public information events had been held, with the last one taking place on the 7th December 2016 in Buckingham. The events had proven to be highly attended; the CCG is currently in the process of gathering all the frequently asked questions and information, this will then be assembled into a coherent way to be published onto the website.

ACTION: A fuller report will be brought back to the next Governing Body with more detail.

LP advised that the plan is to hold annual events within each locality to ensure everyone has the opportunity to attend and exchange all the local information about their local health services.

3. Networking

LP met with the CEO and Chair of our local Healthwatch in November 2016. Discussions took place around both local and national issues, including the CCGs recent federation, patient engagement responsibilities, the PPG project and the invitation to the CCGs from Bucks County Council inviting us to comment on what Local Healthwatch services in Buckinghamshire should look like.

LP presented at the Combined NHSCC Nurses Forum & Chief Nursing Officer for England commissioners' pre-CNO Summit meeting in London. LP noted that it was helpful to outline the CCG perspective on the future workforce, both locally and nationally and was a good opportunity to dispel some of the media rumours around the workforce proposals in our leaked STP document.

Chair – Verbal Update

Presented by Dr Raj Bajwa (RB)

RB confirmed to the Governing Body that Chiltern CCG has received a positive endorsement by members for delegated responsibility for Primary Care Co-Commissioning. All 32 practices that voted, voted in favour of delegated commissioning.

RB advised the Governing Body that reflection has taken place on the clinical voice of the Executive Committee and it has been recognised that the Clinicians have not been able to spend enough time together to go through clinical issues, and the opportunity to reach clinical consensus and to ensure we are driving our priorities with a single clinical voice. RB noted therefore that the Executive will be arranging the second part of the agenda to include all clinicians and Clinical Directors.

RB advised the Governing Body that there is a meeting being held with the Chairs and Clinical Locality leads to discuss the work that is currently taking place happening within localities and make sure this aligns and best fits with the strategic objectives within the organisations.

RB would like to thank everyone that supported the 7 public meetings that were held in each locality. The issues that were discussed at these meeting were localities, CCG, STP, Community Hubs and local issues and this has helped the CCGs look at the bits that need more focus.

Assurance and Governance

Finance Report (Month 7)

Presented by Philip Murray (PM)

The Governing Body has been asked to note the Conflict of Interest: Lay Member Sheran Oke has an existing declared conflict of interest in respect of the content of this paper. This relates to some coverage of performance of Luton and Dunstable NHS Trust, with whom she is substantively employed as Deputy Chief Nurse. However, the CCGs Governing Bodies are not required to make a commissioning decision and the CCGs are not a lead commissioner for this provider. Therefore this conflict does not affect capacity to participate in discussion as a Lay Member in respect of providers for which the CCGs are leads or associate commissioner given her extensive clinical knowledge and experience.

The purpose of this report is to assure the Governing Body of the financial performance of the federated CCGs and includes both a federated view and view by the individual CCG's to the end of October 2016.

The Highlights of the report are:

Financial Performance: To the end of October 2016 (7 months) the total position is an under spend of £3,481k against an equivalent budgeted surplus.

- The activity position underpinning the October 2016 year to date position relates to September 2016, the national timeframe under PBR guidance states October activity is not due until 12th working day of the following month.
- Under NHSE Planning Guidance, Buckinghamshire CCGs must plan for and aim to achieve a target surplus of 1% - being £5,967k for 2016-17.
- Buckinghamshire CCGs budget and performance includes the 2015-16 carry forward of £5,795k; effectively the CCGs are operating at only break even against their recurrent allocation. This reflects the recurrent pressures on CCG resources and demonstrates the importance of achieving our surplus in year, per NHSE requirements, to ensure it is available to support 2017-18 and avoid potential double jeopardy. If the surplus is not achieved there is no carry forward and a requirement to repay any deficit.
- Once risks and mitigations are taken into consideration the forecast out-turn position ranges from a favourable variance of £16.0m (the 'best case') to an adverse variance of £3.4m (the 'worst case'). The difference between worst case and most likely case (circa £5.9m) is predominantly driven by the potential for underlying performance issues.
- The main drivers for the adverse variance and pressures affecting the position is the result of increases in Non–Elective activity, critical care in the following providers – Buckinghamshire Healthcare Trust, Milton Keynes Foundation Trust, Frimley Health NHS Foundation Trust and increasing referrals and critical care in London Providers.
- Joint and Continuing Care, which includes Funded Nursing Care, continues to be under pressure as a result of increase in activity and cost due to the complexity of packages required.
- To maintain the forecast position the CCG's have utilised £9,126k of non-recurrent mitigations covering the use of contingency, noted below, the use of budget and project slippage and release of balance sheet accruals not required. The position also includes

£4,600k of QIPP stretch target beyond current run-rate.

- The reserves being utilised within the forecast outturn are those that have no specific criteria for use; the 0.5% contingency reserve and the surplus budget. The amount utilised in the year to date position is 7/12 level.
- In conjunction with NHSE guidance the 1% Headroom reserve remains uncommitted in the CCG position.

QIPP: Actual delivery year to date being £5.9m against an equivalent plan of £8.6m (69% achievement).

- QIPP actual savings to date of £5,859k against a plan of £8,553k (69% achievement). When combined with mitigation schemes a year to date saving of £8,685k is achieved (102% achievement). Forecast achievement for the year is £13,449k for the year (73% achievement) and after mitigation added £18,897k (103% achievement).

- The 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.

PM highlighted that the financial position is extremely tight but continued to hold on to the financial position and forecast.

GJ asked whether the CCGs could maintain the run rate as it is, DR highlighted that a number of risks have already been reported with QIPP schemes being off track; she and RM have tasked the QIPP scheme leads to identify mitigating schemes and actions are being sought to reduce the risk.

RM noted that the performance report also highlights risks such as improving the RTT position that could put pressure on the financial position.

PM advised that the report identifies that the underlying driver for the CCGs' current performance, is without exception, across all the main providers, non-elective activity and case mix. He commented that clinical colleagues are looking to identify actions to prevent non-elective admissions and part of this endeavour is to improve the planned care interventions, particularly in the Long Term Conditions area.

DR advised that there are a number of pilot projects in localities such as the Over 75s project, the Locality Integrated teams project, the paramedic project and the Airedale project that are designed to improve community and primary care response, drive down the pressure on the non-electives and deliver QIPP.

RMS noted that to reduce costs with non-elective excess bed day's costs, there is work underway to support the Trust with reducing the number of medically fit discharges patients and to delay

transfers of care.

RMS noted that the CCG values the community care, if there were more social support there would be a lot more than can be done with GPs to prevent admission.

LP asked RMS for more work to be done to understand what conditions or groups are driving the rise in non-electives and whether she had specific areas that the providers would welcome support or intervention from primary care.

ACTION: RMS to liaise with the A&E delivery board on understanding what is going in under non-electives and put some interventions in place to support this.

ACTION: An action plan on non-electives and what is going to be done between now and three months' time, this to be presented by RMS to Executive Committee end of February and Governing Body in March.

DR noted that the Clinical leads who sit on the A&E Delivery Board were asked to take on a thematic review of the non-electives and during the last month there had been clinician visits to the MIIU and to BHT and a report is to be brought back to Decembers A&E Delivery Board on the key themes on what is driving the non-elective activity.

PM highlighted that prescribing had now held its forecast across the CCGs for a number of months and that the CCG has been quite prudent; this was discussed and it was agreed that with this stability it was reasonable to release more of the potential benefit into the QIPP delivery to help the position.

CHC – the additional work undertaken is starting to deliver benefits in terms of recognising overly prudent assumptions and it is expected that this position will start to improve in Month 8 reporting.

Treasury management - cash utilisation is on track, the creditors are generally coming down although there remain a few older creditors although these are subject to challenge. The outstanding debt, discussed at the prior Governing Body, has now been resolved; a paper has been taken through Audit Committee and the position will be verified within the month 8 report.

RM queried the forecast range and the detail within the recovery plan. PM responded that the range should now be narrowing as the forecasting review has been undertaken and this will be reflected within the following month's reporting. PM reminded members that the plan had been to enact recovery style regimes such as balance sheet review; vacancy control and tightening over investment spend which has been happening. He also reminded Governing Body that whilst he had recommended monthly finance committee meetings it had been decided that quarterly would suffice; he had been taking the finance reports to Audit Committee to ensure that they received greater scrutiny.

ACTION: PM was asked to provide an updated recovery plan and also to ensure that the Finance

Committee was established.

RM highlighted that the County Council have proposed cuts which will make a reduction within the Health and Well-being budget and a £800,000 reduction in the public-health budget and asked what effect this will have on the CCGs forward plans. PM noted that conversations will take place with the Council on this and described the issues long term and short term. He highlighted that in terms of prevention the risk was likely to be in future years as desirable interventions would not have taken place, and also that it was counter intuitive and out of line with the STP. Other potential areas of spend review may have immediate and shorter terms impacts e.g. falls services. PM reminded members of the presentation from Raj Thakkar the previous month on the impact of falls upon the system.

LP advised that the CCG needs to understand the Clinical impacts and what they are?

ACTION: PM was asked to discuss the potential impacts with the council and establish whether they had undertaken any impact assessments themselves.

GJ asked had the HRG4+ position been mapped out and gone through Audit Committee, PM stated that nothing had yet gone through audit committee; he reported that considerable work has been done to highlight to NHSE the risk, which across both CCGs is estimated at £2m.

Quality and Performance Report (Month 6)

Presented by Lisa Maclean (LM) and Robert Majilton (RM)

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.

The report seeks to direct members to the following exceptions, noting the actions taken and further work identified:

Cancer performance

RM noted that the cancer performance standards were not achieved in September 2016 and although the October position had improved on a number of the standards, there were still issues around the 62 day standards. Whilst not a constitutional standard the CCG also monitors the 102 day breeches, and there had been a significant increase reported in September (to 10), this has reduced to 9 following validation from BHT. In October there were 4 and the unvalidated number for November was also 4.

RM highlighted that a meeting had taken place with himself, DR and the Chief Operating Officer at BHT. In addition the CCG was

- Ensuring a process of escalation and information sharing is robust
- Declared an internal serious incident
- Review of the provider actions

ACTION: LM confirmed that SI's will be done on each of the breeches and the Governing Body will be assured at a later date that this had been completed.

RTT performance

The **RTT Incomplete target was not met** on a Bucks CCG's basis in September with performance at 91.3% and both CCGs missing the 92% target.

BHT is producing a RTT recovery plan, for RTT recovery by the end of quarter 4. There are particular issues around Ophthalmology and Paediatrics, paediatrics will be addressed by three weekend clinics and Ophthalmology backlog will be cleared of 400 cases by BMI.

Currently the CCG does not have a copy of the formal recovery plan; once this has been received an internal review will take place for assurance.

A & E 4 hour wait

The **A&E 4hr wait target was not met**, except for Frimley Health in September and has not been met YTD by any local provider.

BHT A&E performance for October was 90.1% for all types against NHSE target of 90.6%. Attendances were 10% higher than the expected level of attendances for October 2016.

DR confirmed for November the position is looking worse than reported for October 2016. Week on week there is a gradual deterioration compared to last year.

DR confirmed to the Governing Body the actions that are being taken

- Work around discharge flow
- Work around delayed transfers of care
- Work around lack of social care and what is this driving (Longer Hospital stays) but formal delay of transfers of care have come down from a peak of 19 to 8 and only one of these is Social care
- Prevent patients becoming delayed transfers of care

DR noted that significant progress had been made.

DR brought to the Governing Body's attention that NHSE had produced a national single escalation framework; there is a move away from the familiar terminology to a more detailed terminology. During November the CCG had declared that they are OPAL level 3 which generates a report that goes directly to NHSE.

DR confirmed all the work that is being monitored through the A&E delivery Board.

RM proposed to the Governing Body that, given the current performance issues raised in the report, that the Quality and Performance Committee meetings move from bi-monthly to monthly

for the next 6 months, the Governing Body supported this proposal.

The additional items that where in the report:

Ambulance response times
Stroke – update on the East Berkshire pathway changes
Safeguarding – an enquiry is underway in relation to a respite provider following a recent incident.

No further questions from the Governing Body.

Continuing Healthcare position for Winter – Update

Presented by Lisa Maclean (LM)

The Continuing Healthcare Service (CHC) in Buckinghamshire does not provide an emergency service however the well-being of residents within Buckinghamshire is always paramount.

The purpose of this report is to outline the Buckinghamshire provision for the winter months ahead.

The key points in the paper are:

- Staffing Levels
- Days, hours and location of service
- Service/Management provision
- Christmas Holiday provision
- Brokerage provision

LM assured the Governing Body that CHC is covered for the Christmas period.

Any questions to be sent directly to LM or Fiona McCaul.

Risk Register /Corporate Risk Register /Governing Body Assurance Framework (GBAF)

Presented by Russell Carpenter (RC)

There are no conflicts in relation to this paper.

The Governing Body is asked to:

- **REVIEW** the content of the latest Governing Body Assurance Framework (GBAF)
- **ASSURE** itself over GBAF completeness, validity of scores and appropriateness of mitigating controls, assurances and actions.

The report summarised the risks, their current variance from target and in-month actions.

Overview – The Governing Body Assurance Framework (GBAF) captures those principal risks to the

delivery of 5 strategic aims/goals.

Changes in-month are as follows:

- Risk 13 on performance issues across the system increased from 12 to 16, from moderate to extreme and the reasons and actions were discussed in more detail in the Quality and performance agenda item.
- Risk 7 on patient engagement score reduced from 6 to 4.

PM highlighted the three main extreme risks are: – Risk numbers 9, 10, and 13.

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.
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.
3. Performance issues across the system will adversely affect patients' treatment times (18 weeks etc.) and ultimately the delivery of patient services and planned priorities.

All others are moderate or minor.

PM noted that Risk 3 is around moving services and understanding pathways to move them towards community and integrated care and this helps deliver some of the services that have previously been spoken about.

RC asked about plans for developing the Better Care Fund (BCF); LM commented that the CCGs are working closely with colleagues at BCC on the BCF schemes and how they measure the outcomes. The recently appointed BCF Pooled Budget Manager is developing a revised version that is being discussed at present.

DR explained that the CCGs and BCC had agreed some high level integration milestones for 2016/17 BCF which have now been linked into the Bucks priorities for the STP and the work to be overseen by the Transformation Delivery Group. A specific example is to look at how we could develop integrated health & social care teams rather than the separate services of BCC Rapid Response & Reablement and community health provided by the ACHTs. There are discussions about how to build on the over 75s and Locality Integrated Teams pilots to further these integration ambitions.

Draft Operating Plan

Presented by Robert Majilton (RM)

As the operating plan describes a future model rather than a specific decision(s) it is not expected that there will be specific conflicts of interest.

RM noted that the NHS Operational and Planning Guidance 2017/19 require the CCGs to produce

an Operational Plan. The timetable for this required CCGs to submit a full draft by the 24th November 2016 and a final plan to be submitted on the 23rd December 2016.

RM highlighted to the Governing Body the key areas of the operational plan requirements. The draft report submitted on the 24th November 2016 was circulated to the Governing Body.

Key areas are:

- Delivering Transformation and new models of care including integrated community based services around a cornerstone of sustainable Primary Care.
- Develop a collaborative provider network for local primary, mental health and secondary care.
- Develop care & support planning for Primary Care
- Commission the iMSK service and explore the delivery for a Diabetes pathway.
- EMIS Clinical Services system becomes the software for all primary and community services by April 2018.
- The delivery of the Operational Plan will be clinically led through the Programmes boards, Executive committee and overseen by the Governing Body in common.

The above key areas are the CCGs commissioning intentions and would like to move to system intentions.

RM advised how the CCG would implement the above key areas:

- Further development of the Integrated Commissioning
- Move to outcome based models of care
- Redesign and commissioning of pathways to improve Whole System capacity and flow
- Demonstrable workforce planning
- Build on planning that has already be done
- Deliver a local digital roadmap as an enabler to make some of the change happen

RM noted that the next steps in delivering our operating plan would be:

- Delivering our Primary care strategy
- Integrating the Health & care delivery system
- Continue to deliver our existing Mental health strategy
- continue the system transformation plan

RM advised the Governing Body that the format within the Operational plan is setting out the current picture, our priorities and key actions, what the outcomes and benefits of taking these actions, and the timescales for delivery.

Key themes are around:

- Promoting Self-care and a radical step change in prevention
- Reforming urgent and emergency care
- Continue work on planned health care
- Develop our End of Life Pathways
- Deliver our Local Digital plan
- Deliver our Financial plans
- Deliver our Quality Strategy

RM highlighted the CCGs next steps:

- Triangulate with feedback internally and from NHS England
- Finalise the financial plan, particularly the triangulation of activity and contracts
- Map into programme boards, projects and monitor via programme management

RM asked the Governing Body for approval of the Operating plan and for delegated approval to LP and PM for the final version 23rd December 2016.

CO advised some of the parts that have spoken about today depends on a really good community nursing service, the avoidance of unplanned admissions and the over 75s prevention work, CO noted that it was not really clear in the document where the focus on this was. This may be need a longer conversation on:

1. Do we understand the commissioning intentions
2. Do we understand the activity that will be pushed to the Community Nurses
3. What impact this may have on the Community Nurses and the contract

CO confirmed that currently she is chairing a piece of work with NHSi looking at an improvement resource for the district nursing service, an evidence review has been undertaken and this shows little evidence on the activity and this is worrying that the Operating plan does not include the data which does not help as there is concern on what the Community Nurses currently do now.

RB confirmed he is in agreement and that the Primary and Community is the CCGs number one transformation area.

Safeguarding Annual Report

Presented by Tania Atcheson (TA)

There are no conflicts in relation to this paper.

TA assured the Governing Body that the CCGs are fulling their statutory duties in relation to safeguarding. TA provided the local safeguarding adult and children board's annual reports to demonstrate the CCGs involvement in partnership arrangements.

The Governing Body is asked to:

- Receive the CCG Safeguarding Annual Report for Assurance
- The Safeguarding Board annual reports are for information only

The Safeguarding Annual Report 2015/16 outlines the responsibilities of the CCG, in respect of safeguarding, the actions taken to meet these responsibilities throughout the year and identifies priorities for the coming year.

TA highlighted to the Governing Body that a doctor has now been appointed after 2 years. More robust safeguarding assurance mechanisms have been developed both internally and with provider organisations. The report highlights successes from 2015/16 but recognises the need to

maintain momentum and set priorities for the coming year to build on this.

TD noted that there is a lot of pressure on education to deliver the Prevent strategy and the promotion of British Values and asked what the expectations are from CQC. TA confirmed that Prevent is included in the NHS national contract, CQC will monitor uptake of Prevent training for staff and review provider delivery plans.

LP acknowledged the huge amount of time, effort and work that the safeguarding team have achieved in 2016. This work has been consistently praised and measurable impacts in Primary care have been acknowledged.

Decisions

Code of Conduct

Presented by Nicola Lester (NL)

The paper was deferred as it was felt to be a draft and needed crossing checking against other relevant policies within the organisation.

ACTION: NL was asked to pull to together all relevant policies and cross reference these.

For Information

Approved Minutes from sub-committees, sub-groups or steering groups:

Presented by Dr Raj Bajwa (RB)

The below minutes of meetings reporting to the Governing Body were received for information.

Executive Committee – 27/10/2016

Audit Committee – 28/09/2016

Quality and Performance – 21/09/2016

Primary Care Commissioning Committee – 08/09/2016

Integrated Commissioning Executive Team – 29/09/2016

Meeting closed at 12:30pm.

Date of next meeting:

Thursday 8th December 2016
Aylesbury Vale CCG The Gateway, Aylesbury, HP19 8FF
Time: 10:30am -12:30pm
Room: Jubilee Room

Acronyms

A&E	Accident and Emergency	K	Thousand

ACHT	Adult Community Health Team	KLOE	Key Lines of Enquiry
ACO	Accountable Care Organisation	LMC	Local Medical Committee
AF	Atrial Fibrillation	LPF	Lead Provider Framework
AGM	Annual General Meeting	M	Million
AQP	Any Qualified Provider	MAGs	Multi Agency Groups
AT	Area Team	MCA	Mental Capacity Act
AVCCG	Aylesbury Vale Clinical Commissioning Group	MCP	Multi-speciality Community Provider
BAF	Board Assurance Framework	MK	Milton Keynes Foundation Trust
BCC	Buckinghamshire County Council	MSP	Multispecialty Provider
BCF	Better Care Fund	MusIC	Musculoskeletal Integrated Care
BAF	British Association of Dermatology	NHSE	NHS England
BHT	Buckinghamshire Healthcare Trust	NHSi	NHS Improvement
BME	Black and Minority Ethnic	NOAC	New Oral Anticoagulants
BPPC	Better Payment Practice Code	OCCG	Oxfordshire Clinical Commissioning
C4Q	Commissioning for Quality Committee	OOH	Out of Hours
CCCG	Chiltern Clinical Commissioning Group	ORCP	Operational Resilience & Capacity Planning
CDIF	Clostridium Difficile	OUH	Oxfordshire University Hospitals Trust
CFO	Chief Finance Officer	OPAL	
CHC	Continuing Health Care	PACS	Primary & Acute Care Systems
CIP	Cost Improvement Programme	PAS	Patient Administration System
COI	Conflict of Interest	PB	Programme Board
COPD	Chronic Obstructive Pulmonary Disease	PBR	Payment by Results
CPA	Care Programme Approach	PIRLS	Psychiatric In Reach Liaison Service
CQC	Care Quality Commission	PLCV	Procedures of Limited Clinical Value
CQRM	Contract Quality Review Meeting	PMS	Personal Medical Services
CQUIN	Commissioning Quality & Innovation	POD	Point of Delivery
CSCSU	Central Southern Commissioning Support Unit	POG	Programme Oversight Group
CSIB	Children's Services Improvement Board	PPA	Programme Oversight Group
CSP	Care & Support Planning	PPE	Patient & Public Engagement
CSR	Comprehensive Spending	QIPP	Quality, Innovation,

	Review		Productivity & Prevention
CSU	Commissioning Support Unit	QIS	Quality Improvement Scheme
DES	Directly Enhanced Service	QOF	Quality & Outcome Framework
DGH	District General Hospital	RAG	Red, Amber, Green
DOLS	Deprivation Of Liberty Safeguards	RBH	Royal Berkshire Hospital
DST	Decision Support Tool (CHC)	RCA	Root Cause Analysis
EDS	Equality Delivery System	REACT	Rapid Enhanced Assessment Clinical Team
EOL	End of Life	RRL	Revenue Resource Limit
F&F	Friends and Family	RTT	Referral to Treatment
FHFT	Frimley Health Foundation Trust	SCAS	South Central Ambulance Service
FOT	Forecast Outturn	SCN	Strategic Clinical Network
FPH	Frimley Park Hospitals NHS Foundation Trust	SLA	Service Level Agreement
GB	Governing Body	SLAM	Service Level Agreement Monitoring
GMS	General Medical Services	SRG	Systems Resilience Group
HASU	Hyper Acute Stroke Unit	STP	Sustainability & Transformation Planning
HETV	Health Education Thames Valley	SUS	Secondary Uses Service
HWBB	Health & Wellbeing Board	TDA	Trust Development Authority
ICE	Integrated Clinical Experience	TOR	Terms of Reference
ICS	Inhaled Corticosteroids	TV	Thames Valley
ICU	Intensive Care Unit	TVN	Tissue Viability Nurse
IFR	Individual Funding Request	UECN	Urgent Emergency Care Network
IG	Information Governance	YTD	Year to Date