NHS
Buckinghamshire
Clinical Commissioning Group

**NHS BUCKINGHAMSHIRE CLINICAL COMMISSIONING GROUP**
**GOVERNING BODY (IN PUBLIC)**
**11 October 2018, 10:30am**
**Jubilee Room, Aylesbury Vale District Council, the Gateway, Gatehouse Rd, Aylesbury, HP19 8FF**

| **Members (14)** | | | |
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| **Name** | **Title/Organisation** | | |
| **Dr Raj Bajwa (Chair)** | GP Clinical Chair | **RB** | Present |
| Tony Dixon | Lay Member / Chair of Finance Committee | **TD** | Apologies |
| Gary Heneage | Chief Finance Officer | **GH** | Present |
| Dr Graham Jackson | Member GP and Clinical lead ICS | **GJ** | Present |
| Crystal Oldman | Registered Nurse | **CO** | Present |
| Robert Majilton | Deputy Accountable Officer | **RM** | Present |
| Dr Rebecca Mallard-Smith | Member GP/Clinical Director Unplanned Community Care | **RMS** | Present |
| Louise Patten | Accountable Officer | **LP** | Present |
| Robert Parkes | Lay Member / Vice Lay Chair / Chair of Audit Committee | **RP** | Present |
| Debbie Richards | Director of Commissioning and Delivery | **DR** | Apologies |
| Colin Seaton | Lay Member, Patient and Public Involvement | **CS** | Present |
| Graham Smith | Lay Member, Chair of Primary Care Commissioning Committee | **GS** | Present |
| Dr Karen West | Member GP/Clinical Director Integrated Care | **KW** | Present |
| Dr Robin Woolfson | Secondary Care Specialist Doctor | **RW** | Present |
| **Standing invitees (non-voting, subject to continual review):** | | | |
| **Name** | **Title/Organisation** | | |
| Nicola Lester | Director of Transformation | **NL** | Apologies |
| **Additional people or experts called to attend meetings on case-by-case basis to inform discussions.** | | | |
| **Name** | **Title/Organisation** | | |
| Paul Henry | Chair CCG Engagement Steering Group (Item 6 only) | **PH** | Present |
| Kim Parfitt | Kim Parfitt, Communications, Bucks County Council (item 6 only) | **KP** | Present |
| Dr Rodger Dickson | Clinical Locality Lead, Aylesbury Vale North (item 6 only) | **RD** | Present |
| Simon Kearey | Head of Localities (item 6 only) | **SK** | Present |
| **Minute taker** | | | |
| **Name** | **Title/Organisation** | | |
| Russell Carpenter | Head of Governance/Board Secretary | **RC** | Present |

| **1** | **Welcome & Apologies** | **Lead** |
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| | The Chair Dr Raj Bajwa (RB) welcomed the Governing Body members to the meeting in public. Apologies noted as above. | |

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| **2.** | **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 website. https://www.buckinghamshireccg.nhs.uk/public/about-us/how-we-make-decisions/registers-of-interests/<br><br>There was only one decision on the agenda, to ratify Executive Committee terms of reference, for which there were no material conflicts and therefore no action required. As regards an update provided within the AO report in relation to the direct award scheme update on as flu antiviral prophylaxis (for care home residents and staff).<br><br>There is a material conflict of interest for GPs where they are partners in practices which have as registered patients care home residents. The direct award scheme pays GPs to provide the antiviral prophylaxis to care home residents and staff in the event of a flu outbreak.<br><br>An expedited decision had previously been taken by the Lay Vice Chair on basis of interpretation that this applied to RB as Chair. However this was incorrect as RB confirmed that this did not apply to him as his practice does not have any care home residents. No further action was required in any case with an expedited decision having already been taken by the Lay Vice Chair in August 2018 in order to mitigate any further delay in rollout. | |
| **3.** | **Review and Approval of Minutes:**<br>**a. Meeting minutes – 13/09/18**<br>**b. Action Log/Matters Arising** | |
| | Minutes were agreed. Updates to actions are provided on the separate log. | |
| **4.** | **Questions from the public** | |
| | None received in advance or on the day | |
| **Decisions** | | |
| **5.** | **Executive Committee terms of reference update** | |
| | The Governing Body was asked to **RATIFY** updated terms of reference for the Executive Committee, currently one of its sub-committees. This it did. LP queried whether in doing so affected the number of clinician's vs managers' membership. It was confirmed that the number of clinicians had increased with Dr Karen West, Clinical Director for Integrated Care replacing David Williams, Associate Director for Quality and Safeguarding. | |
| **Clinical Directors Presentation** | | |
| **6.** | **Communications and engagement - role and work of the steering group**<br>**6a: Communications and Engagement Update including 360 degree report** | |
| | The presentation is published on the website. At the end, PH made a specific point in relation to the impact of GDPR on practices, and that for his surgery a database had been developed of patient email addresses. However this can be collected by the Practice Participation Group (PPG), not by the practice, with the practice maintaining that it cannot give authority without consent. | |

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| | PH commented that, in his view, GPs do not communicate with their patient base other than on a one-to-one basis when specific individual health-related issues need addressing and are, sadly, totally unable to communicate health prevention related messages. There is much confusion and fear about the new GDPR rules, with some practices being advised that they can write to patients by email with invitation to PPG organised events. There is no clear guidance, with ability to effective communications dependent on being able to engage with patients.<br><br>RB acknowledged that we can do more to engage patients, but we have recognised, as has NL in particular, the role of patient engagement. CO queried learning from other PPG's and use of regional and national networks. PH replied that there is a national network of patient participation groups, which is especially useful during start-up phase in providing useful material. However we have also engaged Healthwatch level to help manage our objectives locally. There is no regional presence. RW asked PH about how the PPG engages with patients on the different ways healthcare is delivered across services to prevent short-sightedness and silo working; getting patients to have a view of the big picture and the pressures on the delivery of health.<br><br>PH replied there are a small number of champions at various levels, GPs who are huge proponents of their purpose. What we have been less effective in in addressing GP base as a whole; a 20 minute slot has been requested at PLT for three years but unable to get on the agenda. At all levels within the primary care sector, we want to make communities aware of the advantages, which are significant. We facilitate many tasks practices would not otherwise be able to do.<br><br>The role of the PPG is to inform; general practices tend not to communicate with their patient base unless the patient comes to them. PPGs can take the first communication layer and manage for practices. We use messaging, posters and letters to address health matters.<br><br>The next level is feedback based, gather feedback on practice or service provision. We also manage the practice annual survey – GPs only involved if want specific questions answered. We analyse some 1500-2000 responses and produce a feedback report. The third layer is involvement; where we ask for volunteers to participate in projects where volunteers may be needed. This alone justifies having a PPG.<br><br>KW emphasised that there is also a role for GPs in promoting the use of the PPG. This year the engagement steering group has discussed flu vaccination and the different types, promulgated through PPGs so they can explain this to their patients. There is a two way element.<br><br>LP noted the role of local PPGs not having taken on an assurance role which is helpful, and we acknowledge a need to support success. The legislation is clear on consent, which means we have to be creative with communications and intelligent ways to segment the population.<br><br>PH suggested we could include on registration forms a disclaimer for engaging on matters which concern health; a message seems to be circulating that even this is not permitted and so is potentially misleading. GS noted that penalties are large and legislation untested, so there is high risk. PH replied we need clarity on the risk. GS replied that this is unlikely as the issue is beyond the NHS. How can we address our patients about their health if we can't talk to | |

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| | them? RB closed the item at this point.<br><br>KP provided an update on the communications and engagement report (circulated with papers). RB introduced Dr Rodger Dickson to provide feedback on the member practice 360 degree survey (circulated with papers). The CCG Executive Committee was previously informed that there were also some identified areas for improvement:<br><br>1. Commissioning and decommissioning involvement<br>2. GP view that CCG will deliver high quality value for money services – finance should be a standing item at localities<br>3. Acting on feedback in regards quality of services – through a monthly quality report at localities<br>4. Influence of members on CCG plans and priorities – forward plan agendas for localities to cover key decision making<br>5. Patient and Public influence on commissioning decisions – through sharing best practice on engagement through localities. We also need to ensure appropriate scrutiny of plans by locality leads, especially with the emergence of the integrated care system.<br><br>LP challenged "scrutiny of plans by locality leads" and countered that clinical locality leads needed to be involved, but not all clinical locality leads are members of the Executive Committee. LP queried what this would look like if clinical locality leads were reporting this as feeling good. RD felt that there was a general lack of engagement with them all; it has been more difficult as a bigger CCG.<br><br>RM commended the clear summation provided, with some powerful principles that can feed into system thinking around how localities develop in the future. RB noted that the larger our footprint becomes, the more important it is to systematically embed the power of localities.<br><br>CO queried whether it was known why those practices who didn't respond hadn't done so. SK replied that we are not provided that information. LP added that, nationally, the response was good and there has been a general decrease. Most years it is questioned as to whether it is a useful tool, which locally it has been.<br><br>RM noted a lot of communications and engagement activity reported. RM queried how we ensure a forward plan for activity is included. KP endorsed this. RB noted Executive Committee needed also to reflect on communication with localities. RM would pick this up with the Executive Committee. CS also added that the report did not include any summary on addressing health inequalities, especially in hard to reach groups. KP welcomed a contribution. | |
| | **Leadership and Governance** | |
| **7.** | **Accountable Officer's Report and System Working Update** | |
| | RM talked to the report provided in the circulated papers. RM referred to an expedited decision for a direct award scheme for flu antiviral prophylaxis (for care home residents and staff). Although the paragraph in the paper correctly referred to this as flu antiviral prophylaxis (for care home residents and staff), the title erroneously stated flu vaccination.<br><br>In relation to the primary care business case cited in the report, GH added that there will likely be much NHS England scrutiny of the business case. The | |

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| | Governing Body otherwise confirmed that is was assured on the process that had been followed and ratified the decision of the Primary Care Commissioning Committee on approving the business case.<br><br>LP added a few extra points. She had attended the national cancer alliance conference during the previous week; cancer performance is still disappointing with the conference an opportunity to discuss. We had a successful board to board with BHT; there was much energy and willingness to explore further openness, transparency and collaborative working. We are also working on winter plans including recruitment of a winter director, with an escalation process to chief executives to facilitate fast decision making, whilst LP has also undertaken the role of A&E Delivery Board Chair. | |
| **Assurance and Governance** | | |
| **8.** | **Finance Report (Month 5)** | |
| | GH introduced his report. £89k better than plan YTD – we have moved risks we have reported consistently into the forecast outturn at Month 5, which we have fully mitigated. The FOT is still on plan; the pressures seen from the start of the year are still occurring – Frimley non-elective, S117 placement and QIPP delivery.<br><br>Our risks are changing as we progress through the year - £5-£6m – we are holding these in full as we are holding our contingency in full. We are also seeing further CHC pressures emerge. It remains tight with continued emphasis on system savings over winter. | |
| **9.** | **Quality and Performance Report (Month 5)** | |
| | KW introduced the report and provided a summary of key points from the report. KW acknowledged that feedback on content provided previously has not yet made its way into report allowing for a known time lag. However the next iteration is expected to include changes proposed.<br><br>KW specifically noted using of funding provided to further expand implementation of prevent training. In relation to Looked After Children (LAC), KW noted the service in Bucks continues to struggle to provide timely review health assessments.<br><br>In relation to Learning Disabilities Annual Health Checks, GJ noted that previously there had been discussion about reporting a rolling 12 month graph on target compliance, and raised concern whether these would be completed by year end (through a Q4 push) if demand on primary care for other areas were to increase over winter.<br><br>In relation to ambulance GP triage, the figures are broken down into attempted and accepted. GJ queried understanding of the figures, specifically 416 “GP triage attempted”. KW clarified this figure relates only to those where it was deemed necessary to make contact with the GP where the patient could be treated without conveyance. So this figure is 100% of those SCAS think should be picked up by GPs. KW added it is known there is discrepancy between rates north and south of the county that is continuing to be monitored.<br><br>GS raised concern about Looked after Children and undertaking of timely health assessments. KW replied that our safeguarding children lead is also our | |

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| | lead for Looked after Children. So we are focused on this area, though there are known issues with recruitment. Our compliance with initial checks are good; though our bigger issue is with the review check and given a lot of our Looked after Children are not resident within the county.<br><br>It is becoming increasingly challenging to ensure other authorities are undertaking these checks for our patients residing elsewhere, as they can be focused on meeting their own statutory requirements. We are concerned and have escalated.<br><br>RB queried how we benchmark to highlight whether we have a particular issue or whether this is a high risk group generally. LP replied this is difficult; a good safeguarding team would likely find more. Governing Body needs assurance that those we've found, or think we've found, are we doing enough to manage that and are there enough staff to deliver the social care and health care support they need.<br><br>Legislation has changed; we have equal authority with police and local authority that we didn't have before. LP asked that members see safeguarding action points and minutes (adults and children's) at this meeting (for information) as it is such a fundamental part of our responsibility. This was agreed by lay members.<br><br>GS raised concern about culture concerning compliance with statutory guidelines and targets; we have to assess what we have to do in working together to safeguard children. Does this take too much time? LP asked whether the question was spending too much time on its own self-improvement and compliance with targets. GS recognised this has to be done, but we may be sucked into too much process, e.g. review of job description for named nurse.<br><br>LP replied that the Looked after Children pathway has been completely reviewed, with learning embedded as there is much co-ordination between health and social care. And particularly this has been important locally given previous Ofsted report findings which have created many actions and external ongoing scrutiny. We have to take some assurance from this. RB noted this has also been subject to regular review and discussion through the Health and Wellbeing Board.<br><br>LP commended the traffic light system to link performance with quality to ensure patients stay safe. However, there has to be more work on cancer performance by tumour group; collectively with the STP, cancer alliance and CCG executive we must be emphasise that this is not good enough. RB added that where we don't meet statutory targets, GB might want assurance about harm or absence of harm experienced by the population.<br><br>KW replied that this is facilitated through the Quality and Performance Committee; every 104 day waiter is subject to full pathway check. However, the committee has challenged whether this is enough and looking at different points of the patient journey, with the last meeting hearing a powerful patient story about someone travelling through a pathway.<br><br>LP indicated 52 week waits are unacceptable – with clear line to other providers there must be no more by year end (BHT noted as not having any). We need further assurance on patient harm in gynaecology at OUH. There is also the means of dissemination at localities – they have to understand their | |

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| | performance at locality level, and this needs to feature in future reports. RB asked that is it is targeted and proportionate. | |
| **10-11** | **Winter / Urgent Care - Winter planning update**<br>**Approved minutes** | |
| | These were noted (refer to agenda for details). Reports provided for information were noted as received. Meeting closed 11:50 | |
| **15.** | **Next meeting/AOB** | |
| | Date and Time of the next meeting: 13 December 2018<br>Jubilee Room, Aylesbury Vale District Council, the Gateway, Gatehouse Rd, Aylesbury, HP19 8FF | |

**Acronyms**

| | | | |
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| A&E | Accident and Emergency | IFR | Individual Funding Request |
| ACHT | Adult Community Health Team | IG | Information Governance |
| ACO | Accountable Care Organisation | KLOE | Key Lines of Enquiry |
| ACS | Accountable Care System | LMC | Local Medical Committee |
| ADSD | Attention Deficit Hyperactivity Disorder | 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 |
| ASD | Autism Spectrum Disorder | 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 |
| CAMHS | Child and Adult Mental Health Services | OPEL | Operational Pressures Escalation Level |
| CCCG | Chiltern Clinical Commissioning Group | PACS | Primary & Acute Care Systems |
| CDIF | Clostridium Difficile | PAS | Patient Administration System |
| CFO | Chief Finance Officer | PB | Programme Board |
| CHC | Continuing Health Care | PBR | Payment by Results |
| CIP | Cost Improvement Programme | PIRLS | Psychiatric In Reach Liaison Service |
| COI | Conflict of Interest | PLCV | Procedures of Limited Clinical Value |
| COPD | Chronic Obstructive Pulmonary Disease | PMS | Personal Medical Services |
| CPA | Care Programme Approach | POD | Point of Delivery |
| CQC | Care Quality Commission | POG | Programme Oversight Group |
| CQRM | Contract Quality Review Meeting | PPE | Patient & Public Engagement |
| CQUIN | Commissioning Quality & Innovation | QIPP | Quality, Innovation, Productivity & Prevention |
| SCWCSU | South Central and West Commissioning Support Unit | QIS | Quality Improvement Scheme |

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| CSIB | Children's Services Improvement Board | QOF | Quality & Outcome Framework |
| CSP | Care & Support Planning | QNI | Queens Nursing Institute |
| CSR | Comprehensive Spending Review | PCCC | Primary Care Commissioning Committee |
| 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 |
| HASC | Health and Adult Social Care Select Committee | 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 | Integrated Care System | | |
| ICU | Intensive Care Unit | | |