NHS
Buckinghamshire
Clinical Commissioning Group

NHS BUCKINGHAMSHIRE CLINICAL COMMISSIONING GROUP
GOVERNING BODY (IN PUBLIC)
12 April 2018, 10:30am
Jubilee Room, Aylesbury Vale District Council, the Gateway, Gatehouse Road, Aylesbury, HP19 8FF DRAFT

Governing Body Members Present:		
Dr Raj Bajwa (Chair)	GP Clinical Chair (Chiltern CCG)	**RB**
Dr Karen West	Clinical Commissioning Director Integrated Care	**KW**
Dr Rebecca Mallard-Smith	Clinical Director Unplanned Community Care	**RMS**
Lou Patten	Chief Officer	**LP**
Gary Heneage	Chief Finance Officer	**GH**
Tony Dixon	Lay Member	**TD**
Robert Parkes	Lay Member	**RP**
Graham Smith	Lay Member, Chair of Primary Care Commissioning Committee	**GS**
Crystal Oldman	Registered Nurse	**CO**
Dr Robin Woolfson	Secondary Care Specialist Doctor	**RW**
In attendance		
Russell Carpenter	Head of Governance/Board Secretary (minute taker)	**RC**
Nicola Lester	Director of Transformation	**NL**
Paul James	Finance Interim	**PJ**

1&2.	**Welcome & Apologies**	**Lead**
	RB noted this is the first meeting in public following the CCGs merger in effect as of 1 April 2018. Apologies received: • Dr Graham Jackson, Member GP • Debbie Richards, Director of Commissioning and Delivery • Robert Majilton, Deputy Chief Officer	
3.	**Declarations of Interest in items on this meeting's agenda**	
	The Chair Dr Raj Bajwa (RB) reminded the meeting of obligations to declare any Conflict of interest they may have on any agenda items. RB noted that declarations previously made by members of the Governing Bodies are listed in the CCG's Register of Interests published on the CCG websites with these links provided on the agenda. RC confirmed there were no commissioning decisions on the agenda for which there were material conflicts of interest, and therefore no further action required. The meeting was otherwise quorate in line with the requirements of an interim constitution (see below).	
3a.	**Formal adoption of CCG constitution**	
	RC confirmed that members are already aware that to call the meeting, a version of an interim constitution was circulated with a request for support under the old CCGs governing bodies in common quorum.	

	This interim version of our constitution was agreed with NHS England as part of our merger application and conditions. It reflects in full the amendments previously discussed and endorsed through a number of discussions. It also reflects proposed amendments that have been made following initial discussions with LMC, with further LMC engagement essential and planned, which is why this can only be an interim arrangement. Robert Majilton as Deputy Chief Officer had requested that this be circulated The interim constitution will then be subject to further revision and adoption at a later date on the back of the clinical leadership work which is ongoing, and also the important subsequent engagement with our membership including LMC. NL noted a challenge in that quorum required only one manager to be present and there should be an additional manager present. RC reminded members of quorum as is stated in the interim: • Clinical GP Chair (or Lay Vice Chair) • Accountable Officer or Deputy Accountable Officer or Chief Finance Officer • Two clinicians (one of which must be a Registered Nurse or specialist hospital doctor) • Two Lay Members TD felt we could incorporate this request in any subsequent revision. RC added that a revised version in June was currently anticipated. The interim was otherwise duly adopted.	
3b.	**Conflicts of interest assurances** **1. Formal annual update** **2. Management arrangements – Interim CEO of Bucks Healthcare NHS Trust and Chair of FedBucks, GP Federation**	
	1. RC asked members to inform him of any amendments to registers to ensure what is published on websites is accurate and up to date. 2. RB noted a paper had been circulated, as had also been circulated to the last meeting in public of the board of Buckinghamshire Healthcare NHS Trust (BHT) This provided assurance on the matter, though if any members had further concerns they were asked by RB to communicate them to RC by email. RP stated that this was the end of the matter. KW queried whether we needed equivalent assurances from FedBucks. RB replied we had approached BHT as our contract is through them on behalf of the provider collaborative, and so it is a matter for them to address.	
4.	**Review and Approval of Minutes:** **a. Meeting minutes – 08/03/2018** **b. Action Log/Matters Arising** **c. Forward Work Plan**	
	a. Quality and Performance Report *GJ has also noted an NHSE analysis of primary care workload, though noted a concern that the disparate spread of appointment management would make it difficult to complete a conclusive audit.* LP stated we had not noted that; he was reporting on an analysis he had seen. Amended to read: *reported knowledge of.* 1) CO also noted she had been referred to twice under attendees and apologies – she had sent apologies.	

	2) Action log updated separately/there were no matters arising. 3) RC indicated the work plan had accidentally included only the Executive Committee and not the Governing Body. An update will be provided in June. RC also asked members to notify him of any areas of interest to include in the plan.	
5.	**Questions from the public**	
	There were no questions received, either in advance or on the day.	
	Leadership and Governance	
6.	**Accountable Officer's Report and System Working Update**	
	LP introduced the item, with most work on our financial position and year end. We are reviewing the size of the challenge – LP gave her thanks to all staff under pressure to achieve this. There is a resilience challenge with some directors unavailable at present, with those remaining under additional pressure. RB added his thanks to those directors for their resilience. LP also welcomed GH as newly appointed interim Chief Finance Officer. In turn LP thanked PJ for his help and support. As regards the Integrated Care System, Louise Watson is setting our baseline in terms of future management and resourcing of system projects. Development of an interim operating model continues, though some areas will require financial recovery in order to deliver. TD queried the governance with statutory bodies responsible. LP replied that it is up to statutory bodies what is delegated to the ICS, likewise our other committees. These arrangements remain unchanged. RB added there are further co-aligned work streams looking at clinical leadership and roles and responsibilities within the CCG. LP suggested that at the next seminar (10 May) there would be a conversation about the emerging model. RB queried the role of GB in reviewing outputs; do we approve them or are they for information. LP replied we have agreed to develop an integrated way of working. The CCG needs to make sure it does its part. GS queried whether this is the other way around. LP replied she holds the CCG to account on basis of having committed to an ICS, whilst LP holds Louise Watson to account to ensure she delivers on our behalf. RB suggested GB would also hold her to account. LP replied these updates come through ICS Partnership Board. RP added that there is a point about traceability with GB ultimately carrying responsibility, and therefore it needs an appropriate opportunity to review progress. LP continued that we have delegated responsibility for the ICS to the Partnership Board; we can receive reports and have her regularly attend. How else we monitor is for further discussion. RB added that no one individual should be above governance arrangements and accountability for each organisation. LP agreed this was true, but added that we have delegated responsibility to avoid Louise Watson having to regularly attend every statutory body. RP added some independent governance would be useful. RB asked that enough time was allowed for this (at the seminar).	

	Decisions	
7.	**Statutory appointments:** **a. Caldicott Guardian, Senior Information Risk Officer (SIRO) and Data Protection Officer (DPO)** **b. Caldicott Guardian Framework arrangements**	
	The Governing Body was asked to: • **NOTE** and **RATIFY** appointments of Caldicott Guardian, Senior Information Risk Officer (SIRO) and Data Protection Officer (DPO). • **RATIFY** a framework for delegation of Caldicott Guardian related tasks to allow for flexibility during periods of annual leave etc. KW noted points from the supporting paper – Caldicott Guardian and SIRO appointments are unchanged. In line with the General Data Protection Regulations (GDPR) into effect as of 25 May 2018, the CCG is required to appoint a Data Protection Officer (DPO). This should ideally be a separate appointment to the Caldicott Guardian. On a temporary basis, the CCG has appointed its Head of Governance/Board Secretary to the role, who is not also Caldicott Guardian or SIRO. GS queried whether RC was conflicted. RC referred to EU Guidelines which state the "*DPO cannot hold a position within the organisation that leads him or her to determine the purposes and the means of the processing of personal data"*. Whereas KW does arguably do this given her dual role as a GP Clinical Director, RC replied that he is not directly involved but does have a role in quality assuring the use of data through oversight of privacy impact assessments. LP added this this is managed. However this is not expected to be long term whilst discussions continue with a view to a single Integrated Care System appointment, most likely through Buckinghamshire Healthcare NHS Trust, though this is by no means certain at this stage. KW added that, given she did not work full time, a framework for delegation has been worked up for periods of annual leave etc. David Williams is now in support for this. RC confirmed this has already been through the Quality and Performance Committee. Both were duly ratified.	
8.	**Freedom to Speak Up – appointment of guardian**	
	DW stated what Governing Body was asked to do: 1. APPROVE and RATIFY appointment of Debbie Richards as replacement Freedom to Speak up Guardian (FTSU) for the CCG. RC confirmed this is to support RW also previously appointed to the role. The appointment was ratified.	
9.	**Operational and Financial Plan for 2018/19; Lessons learned and actions taken**	
	GH introduced the item with reference to LP having already alluded to our financial challenge and Financial Recovery Plan (FRP). The second submission for 18/19 is due to submit to NHS England by 30 April; this will be taken through the Executive and Finance Committees prior to this. Executive and Governing Body have talked through the challenge at length as well as the benefit of numerous related QIPP schemes.	

	As regards 17/18, at Month 11 we continue to report a £19.2m yearend deficit. There has been no material movement since Month 10, apart from treatment of community stock originally a risk but is now not in our position. We are confident this is where CCG will land. In terms of main reasons for movement, these are consistent with previous months, namely: over performance on contracts, continuing healthcare pressures and joint care/mental health – Section 117 and learning disabilities. KW stated that our planning must allow for sustainable measures and not just short term aims. GH replied we are required to report to NHS England a one year plan, though we have extended to two years to address this and address our recurrent issue. LP noted this signals a very different way of working; we also said we would get the transformation agenda moving so it would deliver. There is now an expectation to deliver, but it won't happen without our staff to help develop busy GP community providers to support it. RMS asked that we have financial and contractual support for community services, and that they need further supported to deliver transformation. GH replied that resourcing is something we are continuing to discuss. RB requested assurances on: 1. Progress to date on arriving at system control total 2. Risk share with Frimley GH replied: 1. First iteration of the plan had this at a £16.7m deficit – £16.2m CCG and £0.5m BHT. At this stage the plan remains the same with further work on QIPP schemes – too early to say where this will land. 2. Discussions are ongoing with further report in due course.	
Assurance and Governance		
10.	**Finance Report (Month 11)**	
	No separate discussion, position covered under item 9.	
11.	**Quality and Performance Report (Month 10)**	
	DW introduced the item and noted paper as taken. DW highlighted an opportunity to identify areas for deep dive focus in the coming year to shape discussions with providers at contract meetings and at Quality and Performance Committee. RB queried which areas DW would recommend. DW replied that cancer requires a different focus, with plan to look at a number of areas; particularly choice in 104 day breaches and the urology pathway. GS referred to breast cancer performance (Maximum 14 day – Breast Symptoms; 93% target was not achieved in January at joint CCG level with performance of 92.4%, Aylesbury Vale CCG missed the target with performance of 85.25%. Of 8 breaches; 6 occurred at BHT (3 Patient Choice and 3 Admin Error) and 2 at Milton Keynes University Hospital). These are low numbers. DW replied that patient choice can be influenced – for example timeliness of an appointment. We will be looking into this. LP replied we use targets as a	

	scanner to assess quality issue. Some indicate need for more work whilst others highlight there is not a lot more we can do. If we had admin issues more than 2 months running, this could indicate a quality issue that we would need to investigate further. LP asked we make sure the Thames Valley quality surveillance group is sighted with its feedback reported into the Quality and Performance Committee. DW noted that at the last meeting there had been a discussion about community services. KW noted gynaecology recovery plan under Referral to Treatment (RTT) and queried Delayed Transfers of Care (DTOC) rates for patients discharged from Frimley. LP replied there is a DTOC challenge with all our external providers locally. This is an area that needs focus in next quality report. RW noted concern with an increasing trend of breach above 1% target for diagnostics – these are discreet services not part of unplanned care pathway. DW replied that this is an area of focus. RW interested to know if this is a demand or supply problem. DW felt it likely to be a combination of both. RW further queried completion of serious incident reports by provider trusts and assurance on action plans, especially never events. DW replied there are several aspects; at point of reporting there is discussion about immediate mitigation. It's variable as to how quickly incidents are reported; in some cases we have extended deadlines to ensure greater involvement of families. We seek assurance on implementation of action plans. Some are simple changes, whereas others can lead to detailed pathway changes. NL suggested a deep dive include the move of quality into an ICS; mental health and maternity to be added in addition to cancer as already mentioned. LP brought up ambulance conveyance by GP practice. We did ask for this monthly; to be fed back to Frances Burdock. Regarding 52 week waits for Referral to Treatment; GH noted this is clearly an issue, with part of operating plan to reduce this by 50%. LP replied work is being done to reduce this; OUH is a significant challenge and this may swing further out. At STP level, work has been commissioned to look at system capacity and see where activity can be better distributed to share capacity. RMS highlighted A&E performance in February. DW replied that there is a review of performance due to report and some of that will be reported back. RB also suggested we deep dive areas of greatest financial impact on the CCG.	
12.	**GBAF and risk management update (including risk of resource and capacity for a successful accountable care system)**	
	Governing Body was asked to: 1. **REVIEW** the content of the latest Governing Body Assurance Framework (GBAF) 2. **ASSURE** itself over GBAF completeness, validity of scores and appropriateness of mitigating controls, assurances and actions. 3. **NOTE** updates and escalations to our most extreme risks. RC noted circulation with the papers of an assurance report. It does reflect our current risks, especially financial which have been discussed at length in previous meetings and again today. It has also been updated to reflect quality	

	issues just discussed, for example 104 day breaches and urology. RC is confident of good quality and it will be kept under review. RP suggested an additional risk related to human resources within the CCG. **Action.** RC noted an update of the Corporate Risk Register is scheduled to report to the Executive Committee on its quarterly cycle in May.	
13.	**Communications and Engagement Quarterly update (community services)**	
	NL introduced this item **FOR INFORMATION;** a paper to outline communications and engagement activity. NL highlighted this reflects winter months where there has been significant pressure. We have also had two new contracts go live, as well as the CCG merger. The work of the ICS will also continue to dominate communications and engagement with circa 20,000 staff across the system (and public). We have held workshops to explain proposed system changes – over 600 people engaged. BHT has also been engaging on its own circa 600 people. We have had 3 events aimed at health and care professional to engage the clinical voice; GPs, consultants and social care staff. RB added that this also had a strong nursing presence. An inequalities advisory group on 28 March. A grant has been received to engage the more cultural diverse parts of our population. LP queried if the group would be visiting community groups. CS replied the aim is to involve wider representation to look at tackling health inequalities, complementing existing roadshows. It will look at the best ways to achieve this. LP queried whether the group was being supported by the county council on demographics data. CS replied that there was a link; we will be reporting an update to NHSCC by 24 April. GH noted this is a great piece of work. NL added a presentation from Public Health does drill down into disease areas. GS queried cultural and financial issues involved. CS replied there are lots of socio economics issues with diets etc.; we have aim to spread positive messages. LP added analysis needs also to look at who is attending A&E to appropriately target communications. RB concluded the group will help achieve this. CO queried the work of the group at system level. CS replied this will be the direction of travel. Claire Gourlay added that this does link in to the wider work plan. CO also queried involvement from community nursing. CS replied not as yet, but it would be considered as part of evolution of the group alongside schools which are already involved.	
14.	**Approved minutes**	
	These were noted (refer to agenda for details)	
14.	**Next meeting/AOB**	
	Date and Time of the next meeting: 14 June 2018, Jubilee Room, Aylesbury Vale District Council, the Gateway, Gatehouse Road, Aylesbury, HP19 8FF, 10.30am to 12.30pm. However this may change to 21st June due to a clash with NHS Confederation and ensuring quorum. This remains in progress. The meeting ended at 11:30.	

Acronyms

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

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		