NHS
Buckinghamshire
Clinical Commissioning Group

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

Members (14)			
Name	**Title/Organisation**		
Dr Raj Bajwa (Chair)	GP Clinical Chair	**RB**	Present
Tony Dixon	Lay Member / Chair of Finance Committee	**TD**	Present
Gary Heneage	Chief Finance Officer	**GH**	Apologies
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	Clinical Director Unplanned Community Care	**RMS**	Apologies
Louise Patten	Accountable Officer	**LP**	Apologies
Robert Parkes	Lay Member / Vice Lay Chair / Chair of Audit Committee	**RP**	Present
Debbie Richards	Director of Commissioning and Delivery	**DR**	Present
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**	Apologies
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
David Williams	Associate Director of Quality and Safeguarding	**DW**	Present
Hannah Mills	Director of Contracts, Performance and Assurance	**HM**	Present
Additional people or experts called to attend meetings on case-by-case basis to inform discussions.			
Name	**Title/Organisation**		
Alan Cadman	Deputy Chief Finance Officer	**AC**	Present
Kim Parfitt	Assistant Head of Communications, Buckinghamshire County Council (item 5)	**KP**	Present
Helen Delaitre	Associate Director of Primary Care (item 5)	**HD**	Present
Maxine Foster	Older Adults Mental Health & Dementia Commissioning Manager (item 7 only)	**MF**	Present
Minute taker			
Name	**Title/Organisation**		
Russell Carpenter	Head of Governance/Board Secretary	**RC**	Present

1&2.	**Welcome & Apologies**	**Lead**
	The Chair Dr Raj Bajwa (RB) welcomed the Governing Body members to the meeting in public. Apologies noted as above.	
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 website. https://www.buckinghamshireccg.nhs.uk/public/about-us/how-we-make-decisions/registers-of-interests/ Material conflicts and mitigations noted as follows: 1. Serious Mental Illness (SMI) and physical health Direct Award Member GPs present whose practices would ultimately benefit financially from the scheme described are formal voting members and therefore are suggested to remove themselves from discussion and decision in relation to this item. They are free to remain present in the meeting given it is taking place in public. It is on this same basis that the financial detail described has not been withheld prior to a decision as it is already in the public domain. The Clinical Chair will hand over the chair of the meeting to his lay deputy for the duration of this item. Member GPs recognised the conflict and action required. 2. Integrated Care System: delegated authority for spending transformation funds 2018/19 Member GPs are materially conflicted given their status as partners in their practices which in turn have population based shareholdings in FedBucks. For quorum purposes they are not counted towards decision to approve the plan. They are permitted to remain in the room as this is a meeting in public. Mitigations will be enacted as described at relevant times during the meeting.	
2a.	**Amendments to the CCG Constitution**	
	RC noted this remains an interim version until we confirm any further changes to form and function linked to development of the Integrated Care System. RM commented that it would be useful for the structure chart included to give some flexibility for the CCG Executive Committee to agree how it discharges its functions without having to formally change the Constitution if these arrangements were to change. RB made the same point in relation to the number of locality meetings detailed. DR noted that a CHC Exception Panel should also be accountable to the CCG Executive Committee rather than a Programme Board as described within the version circulated. The Panel is part of our CHC Equity and Choice arrangements hence the inclusion. RC noted in reply a number of amendments already based on comments from	

	members in advance, and clarified which of the committees detailed were formal statutory requirements (Governing Body, Audit Committee, remuneration Committee and Primary Care Commissioning Committee). A virtual follow up approval was agreed. GJ noted that a revised Constitution template was also being published by NHS England. RC added this was expected to be shorter and anticipated by the end of July 2018. GJ added we are looking to the future, sharing our quality function with Oxfordshire, with further need to ensure we remain compliant with statutory responsibilities.	
3.	**Review and Approval of Minutes:** **a. Meeting minutes – 12/07/2018** **b. Action Log/Matters Arising**	
	The minutes were approved as an accurate record. 1. RM: section 6; Shadow to full ICS: status: "We will continue in shadow form for 2018/19" should read as "We will continue work to achieve full ICS status in-year". 2. DR commented; In terms of RTT, it is of note we did not achieve 92% at yearend – rather 90.~~0~~89% 3. BHT has launched a new ~~prudent~~ improvement programme internally "care fully" programme that we are participating.	
4.	**Questions from the public**	
	There were no questions received, either in advance or on the day.	
5.	**Clinical Directors presentation**	
	This item was noted as deferred due to the late notice unavailability of Dr Karen West due to illness. 5a: Communications and Engagement Update (Kim Parfitt, Communications, Bucks County Council) KP described the report provided, including communications development within the Integrated Care System. KP also noted a patient survey on Primary Care Improved Access with 1018 responses in three weeks. RB queried findings. KP replied the data is being analysed by rural north and urban south with a final report to follow. Themes to date noted access within 20 minutes of home, a pharmacist open nearby and plentiful parking. Bus routes seem a lower need, whereas with weekend hours most have requested Saturday mornings. They also wanted to see nurse appointments and blood tests. We are making sure we provide feedback on outcomes and next steps. DR thanked KP and the team for their work with such a responsive team, and we have enjoyed the support of planning for and reacting to campaigns. RB supported this on behalf of Governing Body.	

	Leadership and Governance	
6.	**Accountable Officer's Report and System Working Update**	
	RM provided updates. The ICS core team and plan is continuing to evolve with discussions held on how teams within existing statutory organisations are best re-prioritised to support our transformation endeavours. This is to support our ambition for full ICS status with a task and finish group established across the system with DR and GH supporting it. We are looking at where CCG people have roles and relationships within the system that can drive forward out key transformation areas. We are also working our difference between system and place based commissioning, along with joint commissioning that also be split between placed and strategic county level commissioning. Bucks and Oxfordshire Directors are also now regularly meeting together. RB queried the difference between shadow and full. RM replied it is part of a journey in terms of system maturity and effectively permission to continue. DR added that, like with the creation of CCG's, there are eight thematic areas and maturity index within a framework. We must assure our operating and transformation plans make this better for the people of Buckinghamshire. The process will demonstrate maturity and plans are in place. Full ICS will also give us greater autonomy over our system. RB queried how many other systems have gone through this. DR replied this is a new process. GJ added that there is some confusion about our status and that we are not yet a full ICS – this is a continuing process. CO queried the legal status and if there is opportunity to discuss where other ICS' are and where the governing body will likely change. GJ replied that there are ongoing discussions about legislative change; there is appetite for secondary legislation, rather than primary legislation (i.e. abolishing CCGs) which is unlikely. DR added each organisation remains sovereign with statutory obligations. We are being assured as system partners. GJ also asked for a note in the minutes that a change to the Secretary of State was announced this week, which may affect future changes to policy. <u>ICS Partnership Board</u> Finances remain challenging; with work continuing to develop integrated financial reporting so ICS partners can better share challenges that together contribute towards meeting a system control total in 2018/19. It is known to be a challenging year and a key feature of our system work including developing our reporting. We also recognise the areas of performances and activity affecting our financial position. Transformation funds are elsewhere on the agenda. We are also reviewing our Memorandum of Understanding with NHSE as part of our ongoing development. RB queried how NHSI fit. RM replied we have a joint NHSE/NHSI director – NHSE hold the transformation funds delegated down to our ICS. We also have a joint AGM coming up with Buckinghamshire Healthcare NHS Trust. We have also had events linked to NHS 70, including a staff afternoon reflecting on lengths of service, reasons for joining and ongoing values.	

	Decisions	
7.	**Serious Mental Illness (SMI) and physical health Direct Award**	
	HD and MF joined the meeting RB again noted conflict of interest for him and GJ and handed over to RP. RP asked for further note that the meeting remained quorate. DR noted delegation for approving new direct awards – this is on a pilot basis. Mental health is a national priority, with this pilot to increase physical health checks. There are inequalities in health outcomes. We are also measured against a mental health investment standard. We propose to use some funds to support this pilot. HD continued that a direct award is deemed to be the most effective means to deliver health checks. CO queried the alternative. HD replied there could be a number of routes; any qualified provider, existing acute or mental health provider (outlined as options in the supporting paper). For expediency a direct award was deemed to be most effective. CO noted this could be undertaken by a nurse. TD clarified the target as 60% - what happens to the other 40%. HD replied the tiered approach described would achieve 100%. TD queried reason for 60%; HD replied it is a national scheme. RP queried why this is specialised treatment. HD replied that many practices already do this, to which GS added that they are paid for it. MF further added that they are a hard to reach group and are therefore a priority area. GS noted lower life expectancy for this cohort. RP replied that they would be a natural target for a GP looking after their population. DR replied there is recognition of more work involved to seek these individuals and encourage attendance, which may also require additional follow up time. RW noted gap analysis with some known given receipt of counselling or medication, but there may be others not registered and so below the surface. How are these identified? HD replied that we don't have that data and it would be difficult to identify. These would not be the only providers; patients may still be covered by other providers, where patients are referred to Oxford Health for example. This is designed to achieve maximum coverage. TD queried how we'd know success. HD replied we would use EMIS enterprise to analyse by practice. MF added we would report this monthly to NHSE. HD added Primary Care Operational Group suggested the cohort may also be entitled to a physical health check provided by public health and need to prevent accessing three checks in any one year. CS noted harder to reach group are so for a reason; this provides an ideal opportunity to do something different and has his support. CO it is often services, rather than people, who are hard to reach. RM noted additional checks are a helpful addition. We also need ambition for target interventions which is the premise of population health management, as this does. HD replied that as a pilot we are testing theory to inform our future direction. As regards likely reception by member practices, MF has attended a meeting of the Local Medical Committee (LMC), and Dr Sian Roberts as clinical leads has had further discussions. This has indicated that this is the right things to do,	

	and taken LMC comments into consideration in relation to the payable tariff. HM queried the cohort is established actuals rather than estimate of population. HD queried this was the case. The Governing Body was asked to: • **APPROVE** and **RATIFY** the attached service specification for issue as a pilot scheme. • **DELEGATE AUTHORITY** to the Director of Commissioning and Delivery and Director of Transformation to make appropriate amendments to the specification to reflect additional patient and public engagement. This was agreed. RB resumed Chair of the meeting.	
8.	**Corporate Objectives 2018/19**	
	RC noted, in absence of NL, a revised set of corporate objectives linked to financial recovery and CCG merger, with related engagement as necessary. Governing Body was asked to approve the objectives described. RM noted that a version at Executive Committee had agreed to highlight a number of words not reflected in the version circulated to Governing Body. RM asked that members supported these additional changes. This was agreed. RP asked if these objectives would appear at the AGM. RM confirmed this would be the case. TD noted we had set ourselves objectives and asked the clarification as to how we would measure them. RM replied we would achieve this through also monitoring our operating plan. TD referred to its supporting appendix which described our targets. RM concluded this would be reported. RB asked if we formally review objectives. RM replied this would be through annual report, amongst other means. Objectives proposed were approved and ratified.	
9.	**Integrated Care System: delegated authority for spending transformation funds 2018/19**	
	RM introduced the item and described key points of governance described within a supporting slide set which have already been discussed endorsed by the ICS Partnership Board. The Directors Finance Group has also been involved in the process. The CCG retains the funding through its accounts; we delegate to Louise Watson as ICS Managing Director, a system role and independent from statutory bodies. The delegation is then linked to delivery of the ICS Operating Plan which Governing Body has seen previously. Specific reference was made to slide 3 (Governance Process for Transformation Funds). RM noted what these funds cannot be used for and also emphasised that the criteria for spend should be based on the following plus other criteria that should be added by discussion with the ICS team. 1. That it delivers against one of the key transformation ICS priorities as defined within the system's agreed ICS operating plan for 18/19. 2. That it supports the development of the ICS operating model as agreed by the ICS Partnership Board. 3. That it supports the development of the ICS community care concept.	

	4. That is supports our achievement of ICS live status. TD asked to clarify the funding would not be used to meet a shortfall in any organisations budget at any point in the year. RM confirmed this as an agreed principle. TD further asked what happens if some form of BAU supporting transformation came into the transformation plan because of identified need for it. RM replied this would be subject to review through our ICS governance arrangements to determine as a system if it is material. RM continued to indicate that this is designed to be transparent, with recognition at ICS Partnership Board that GH has worked hard to ensure appropriate transparency. More and more capitated transformation budget would, in future, be allocated to the ICS based on system maturity. GJ noted this helpful; new future funding will come to ICS through the system and not statutory organisations. There is desire to invest in systems rather than organisations. It is critical to be clear where transformation funds should not be used and hold partners to account accordingly. RB noted our usefulness as an assurance body will be dependent on the information we get. Measures of funding use needs to describe where money is being spent and how its use has been evaluated. CO reflected a recent meeting which discussed wound care and how transformation money would support it. That level of visibility would be helpful. The Governing Body agreed the process. RM added that a joint ICT director had also been appointed between CCG and Buckinghamshire County Council – she will also have a role in the transformation process.	
Assurance and Governance		
10.	**Finance Report (Month 3)**	
	AC noted some points had already been discussed in June and reflected in minutes. We are currently projecting in-year deficit of £15.5m. There is some uncertainty as to accuracy of current data as we have only for Month 1 to date. At present are forecasting break-even, with £2.2m estimated cost pressure for yearend in 4 main areas: 1. Acute activity 1.9m forecast pressure at Frimley 2. Acute activity 0.6m at BHT (drugs and devices), 3. Increased activity in hips and knees through third parties 4. £1.4m cost pressure in continuing care. Numerous projects are underway to help reduce non-elective demand; 3.9% above activity plan. Bio-similars is a further opportunity with potential savings circa £1m. We are also reviewing third sector referral patterns and whether current overspend is truly a reflection of patient choice. AC referred to risks and mitigations; 2.9m net risk with contingency and reserves. Net position £1.3m at Month 2. AC also referred to the Non ISFE workbook submitted for M2 incorporated a manual adjustment of £583k as a result of the CSU not processing a journal. A process has been adopted so that this error will not occur in the future.	

	TD queried whether the same level of demand was happening at BHT compared to increase at Frimley. AC replied the activity rate above trajectory was 3.9% at Frimley, and 3.4% at BHT. We need to reduce activity to manage impact on both finances and performance. TD asked how this would be done. HM noted ongoing work with Frimley colleagues to ensure rigour in contract management and appropriate charging for activity, along with audit of ambulance service conveyance rates and influences on decisions to admit. There are also plans to roll out care home models to ensure appropriate repatriation of patients. But there remains pressure in-year and in future years. DR highlighted her role as system recovery plan Senior Responsible Officer for non-elective. This is massively complex; the cost to us from increases in activity at Frimley is circa 20%. Clinically, patients at Wexham Park are more likely to be admitted, so we are wanted to allocate a clinical audit allowing a system GP to analyse clinical variation. Admission is also likely to result in a longer wait for a re-ablement package, so we are working to look at market availability for alternative options. With a range of actions in place, we are still seeing high levels of demand, including 111, the urgent treatment centre in Wycombe and A&E. We are seeing more appropriate use at BHT of alternative pathways, contributed to by use of GP streaming with over 7% of activity going through that route. TD reported his concern at use of two thirds of planned contingency so early in the financial year. AC replied we need to ensure initiatives deliver this year.	
11.	**Discretionary Spend Approvals Report (Month 3)**	
	The Governing Body was asked to **NOTE** assurance report provided on CCG discretionary spending. This was noted as a contribution to our transparency in reporting our financial position.	
12.	**Quality and Performance Report (Month 1)**	
	DM and HM introduced the item and outlined an approach to further developing the report provided. This has been based on feedback from a number of stakeholders on the information provided and user friendliness. We are using a new concise and punchy template highlighting situation, background, assessment, recommendation and recovery. The template also allows joining up of conversations, quality vs performance. HM added that the report circulated is Month 1 in the old format, with new format from Month 2 onwards on which feedback would be welcome. There are a few areas to note: cancer, RTT and A&E continue to challenging constitutionally, though cancer is looking more favourable for Month 2. We do need to focus on asymptomatic two week breast, knowing there may be seasonal influencing factors which we expect to improve from June onwards. We have seen a few mixed sex breaches; working to ensure actions in train. We have a variance of 1 for Month 1 on our C Diff trajectory. DR highlight improvement in ambulance performance linked to the ambulance response programme (ARP). Bucks were previously an outlier with a specific plan. There are now fewer red ratings with much improvement, working with	

	both local hospital trusts to reduce handover delays, promoting GP triage, and joint audits to reduce category 3 and 4 conveyances to emergency departments. In terms of ED performance, July has been a challenging month for 111 calls and A&E activity. Meeting the 4 hour target is difficulty – spikes in volume rather than acuity, and gaps in BHT's medical rota. RM noted improvement in performance for cancer 62 days, but was concerned with reference to "Due to the delay in reporting (2 months in arrears) this will be reported in November 2018". RM queried whether there was means of assurance available before that. DR replied that we attend weekly meetings with visibility of management of each pathway to achieve this. As regards CHC indicators, RM stated it is disappointing to see low rates of assessment completions, and that it would be better to have rolling figures rather than year to date. As regards "Current performance is not achieving the required standard and has been adversely impacted by no longer being able to access "discharge to assess" beds in care homes which enabled patients to move out of hospital while receiving rehabilitation", RM was unclear of the link between these points. DR replied for both measures we have an improvement plan. We were also placing during winter using monies to place people into discharge to assess beds, but we no longer have access to this capacity. RB noted further reference to "Buckinghamshire County Council to lead a system D2A Business As Usual model proposal to ensure opportunities within the Better Care Fund (BCF) are maximised". RB queried the time lag and risk without a process. DR replied D2A has a number of models; we have used short term winter monies for pilots. This year a significant sum is directed through the Better Care Fund, and to use health monies to offer D2A rather than a CCG short term fix. This work is ongoing during July/August to ensure this is in place for the Autumn. DW noted having reviewed the action plan, reported to NHSE, who understand the detail. We monitor this with the provider direct and supportive discussion with NHSE. RM asked that we look at forward Q&P agenda to review this where we will have more time for assurance.	
13.	**Approved minutes and Annual Audit Letter**	
	These were noted (refer to agenda for details). AC referred to the annual audit letter circulated with the papers.	
14.	**Next meeting/AOB**	
	Date and Time of the next meeting: 13 September 2018, The Misbourne Practice, Church Lane, Chalfont St Peter SL9 9RR	

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		