Buckinghamshire
Clinical Commissioning Group

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

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**	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**	Present
Colin Seaton	Lay Member, Patient and Public Involvement	**CS**	Apologies
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**	Present
Minute taker			
Name	**Title/Organisation**		
Russell Carpenter	Head of Governance/Board Secretary	**RC**	Present

1	**Welcome & Apologies**	**Lead**
	The Chair Dr Raj Bajwa (RB) welcomed the Governing Body members to the meeting in public. Apologies noted as above.	
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/ There was only one decision, to ratify the Conflicts of Interest Policy, for which there were no material conflicts and therefore no action required.	

3.	**Review and Approval of Minutes: a. Meeting minutes – 11/10/18, b. Action Log/Matters Arising**	
	In relation to the presentation on communications and engagement given at the last meeting; RB suggested it was difficult to distinguish quoted comments, specifically "*GPs do not communicate with their patient base other than on a one-to-one basis*". This was not the committee view. LP added it was difficult to understand this was part of the presentation. It was agreed to amend. GJ noted RMS should also be referred to as a Member GP. In relation to the direct award scheme update on as flu antiviral prophylaxis (for care home residents and staff), RB confirmed he was not conflicted on basis of his practice having no care home patients. LP added this should also be at the beginning. There were no actions that had remained open.	
4.	**CCG Constitution amendments**	
	Governing Body was asked to APPROVE/ADOPT proposed amendments to the CCG Constitution. A supporting paper described a number of amendments. There may be further amendments associated with roles and responsibilities of clinical members and change to committee structures associated with ongoing development of the Integrated care System (ICS) LP raised a query in relation to an earlier amendment: *The nomination and election process, for the Chair, will be supported by the LMC (Local Medical Committee) irrespective of the number of candidates.* RC noted this related to a comment by Dr Paul Roblin that the previous iteration has suggested LMC would support the process (Returning Officer) only if there were more than one candidate. The Constitution was amended to clarify that LMC would support however many candidates were nominated. GJ noted that the recent election had been undertaken with Dr Roblin not in post as Chief Executive of LMC as he had already left. RC added this wasn't the case at the time the Constitution amendment had been agreed by the Governing Body. LP clarified LMC had agreed the process for election including Returning Officer. Wording subsequently to be amended as: *The nomination and election process, for the Chair, will be agreed by the Chief Executive of the LMC (Local Medical Committee), including appointment of Returning Officer, irrespective of the number of candidates.* GJ queried if there had been any feedback from member practices. RC confirmed an interim Constitution had been adopted in April 2018. RC confirmed intent to do this only once with any other amendments linked to changes in the clinical model and ongoing development of the ICS. However, through the election nomination process, members were given opportunity to comment on changes to the wording stated in relation to the election process (Appendix E Standing Orders, section 2.3.6, page 53). However we received no comments back from our member practices. GJ suggested, although he had no concerns, we should be proactive as these papers were in public. TD queried when any revised version may be expected. RC replied that, come what may, this would be before the end of the financial year as we would need an updated version to come into effect for 1 April 2019. RB agreed this would not be an unreasonable timescale.	
5.	**Questions from the public**	
	None received in advance or on the day	

6.	**Governing Body Assurance Framework**	
	Governing Body was asked to **RECEIVE FOR ASSURANCE** the Governing Body Assurance Framework (GBAF) and Corporate Risk Register escalations (15+), whilst also discussing and commenting on control and assurances detailed. RC noted detailed work to review and revise the framework including controls, assurances and actions to be taken to mitigate risk. RC challenged members to discuss whether the evidence presented gives robust assurances and if there are further controls or assurances we should be applying. TD noted that GBAF risk 1 (The CCG is unable to deliver its commitments within the ICS memorandum of understanding and related operating plan) was an outlier with current risk score of 16 versus acceptable score of 8. TD queried how we would deal with this. NL left the meeting.RM agreed, on reflection, that it was scored too high and would be reviewed.	
Decisions		
7.	**Conflicts of Interest Policy – annual review**	
	The Governing Body was asked to **RATIFY** an updated conflicts of interest policy to reflect (a) ongoing development of the Buckinghamshire Integrated Care System (b) review of policy breach reporting and investigation arrangements. Amendments to the policy were ratified. **RP observed that there was a conflicts of interest guardian for the CCG but that there was not an equivalent for the ICS. LP replied this would a good point and would consider it. ACTION**	**LP**
	Leadership and Governance	
8.	**Accountable Officer's Report and System Working Update**	
	RM noted updates provided within the report, particularly on primary care, Director of Public health Report and Brexit. LP noted it has been great to see the turnaround with the Mandeville practice and their improvement in CQC rating. **RB noted that all 50 member practices in Buckinghamshire are CQC rated as good or outstanding. CO queried whether this was the same elsewhere, and is amazing and should be shared. CO has also been meeting with primary care lead nurses to discuss learning which needs to be promulgated. RB replied he wasn't sure that we are. Many times at Governing Body we reflect that we frequently problem solve rather than celebrate success. LP felt this was an opportunity and the communications team would ensure coverage in the bulletin and on the website. We should also get this out in Q4 so we can include it as part of Q4 assurance; on quality in primary care and link to networks.** GJ suggested there was a need to be able to identify ahead where a practice may not come up against the standard, how they are best supported to do so in improving quality, and embedding learning. RB replied the quality team has an engagement plan on this due to start in the new year. KW noted this as challenging so as to be a two-way conversation and not to be viewed as a CCG led assessment. RB added many outcomes are rooted in primary care delivery. There is more work to do to learn from Mandeville and Chiltern House (those practices which	**LP**

	went into special measures). GS also emphasised the extraordinary job facilitated by the primary care team on engaging practices and level of detail, to which RB noted that delegated commissioning had been an unqualified success. DR added in relation to item 5 regarding CAHMS transformation plan. Colleagues were previously briefed that the previous plan had been reviewed by NSPCC who had undertaken a word analysis and criticised our plan. They have subsequently helped design this revised plan. We are confident that this now covers their expectations. TD declared an interest in chairing a college in Berkshire, with students from Buckinghamshire, with an increasing number requiring support amid an increasing number of organisations. TD queried what success of the plan would look like. DR replied we had a helpful deep dive with NHS England as part of assurance, which will be inserted into the next Q&P report. As regards access, the CCG has invested into the MH standard this year and now ahead of trajectory on young people's access to CAMHS, specifically wait times and prevalence. Nationally we are shown as only 6% due to a data glitch when the CCGs merged. This is now resolved. We have also worked jointly with the Local Authority on a bid for wave 1 trail blazer status, which if successful we would receive additional money over two years to improve school support with focus on areas of greatest need. We should know the outcome in January 2019. CO noted recent headlines on mental health workers and whether this is known. DR replied there is recognition that there are workforce shortages; where funding bids are successful we are looking to providers for most creative use from our workforce. Our integrated joint commissioners are also commissioning joint health, social care and public health work. As regards the Berryfields outline business case reported, the Governing Body was assured on the process followed and scrutiny provided and ratified the decision of the Primary Care Commissioning Committee on approving the business case, subject to final approval by the Finance Committee.	
Governance and Assurance		
9.	**Planning Framework – process and timescales** • **18/19 financial position update** • **19/20 Planning Update**	
	KH introduced the item and talked through a presentation (published on the CCG website). LP queried whether we would address the Frimley overspend position. GH replied we are working on a proposal. This is a high risk plan; we have talking about significant savings, and we already benchmark well. We are now looking at upper centile (best in class) to see where we can achieve further efficiencies. We will need to reduce contract values. TD noted this doesn't necessarily reduce expenditure. TD queried how we would make sure expenditure falls with value. GH replied this is back to system decision making. LP added we must signal clear intent to do this. TD observed this will be more difficult to achieve with Frimley. GH replied we have a payment by results arrangement, though we need their help to understand cost per activity.	

	RB added that organisations need also to facilitate structural change and how we ensure this. GH replied if we changed how some services were delivered, there would be mutual benefits to finances and outcomes, e.g. outpatients. DR also added her confidence in providers in collaborative working to sustain performance of specialities with an STP led approach. RB further noted potential workload impact in primary care a need for understanding in advance, e.g. outpatients, and consistency of referrals emerging from primary care. LP added we have an underlying deficit with some brave steps needed. We should we well below national average and not on average. Where we do have sight of check and challenge now the Planned Care Programme Board no longer exists? GH replied we would have discussion direct through Executive to Executive team discussions with Buckinghamshire Healthcare NHS Trust, focusing on system opportunities with operational lead work plans. RP noted reference to hard decisions in future. We cannot leave this for maximum effect next year. KH replied these are being worked through. GH added there is a long list which will be revised to a short list with detailed business plans on implementation. We will need to consider system impact, not for single organisations. GJ queried whether public consultation would be required and whether we are discussing impact with neighbouring areas. GH replied the analysis of the long list is based on quality and financial impacts, and need for consultation. Some are being reviewed at STP level. GJ added we should be realistic about affordability and not be afraid of consultation. TD queried how we would deal with public expectation of substantial investment. LP replied we have to clearly communicate our plan and allocations. This is a difficult issue. GJ added we need a consistent generic narrative for the system about joint working, focus on outcomes and value for money. RB stated what might have been the message 4 years ago is different now, and is there a plan to review ICS communications. LP confirmed there is. **Action: RP asked for a communications strategy rather than piecemeal approach. RM added that last time we had a communications update, we discussed we needed a forward plan which we assuming they are working on. LP noted it needs to be wrapped around the plan, ICS, Q4 assurance, population health and primary care. LP took as an action.** Delegated authority was requested from Governing Body for January submission to NHS England to the Chief Finance Officer. This was agreed.	**LP**
10.	**Finance Report (Month 7) including** • **ICS transformation funds report** • **Risks and Mitigations** • **Discretionary spend**	
	YTD £84k favourable FOT. We still expect to meet year end position, but with risk. We have had to utilise contingency with £5m of risk. We continue to experience over performance, particularly on Section 117 patients and continuing healthcare. There is also a move on the pooled budget from 46%/54% split to a 50/50 arrangement. An internal audit of this is being carried out to ensure it is a correct split. RB queried cost pressure. GH replied a significant £500-600k per annum.	

	Non-elective at Frimley remains high, with significant increase in zero length of stay, depth of coding and average price for a non-elective admission. We need to address directly as part of 19/20 planning round and contract discussions. <u>Winter funding</u> We were expecting winter funding to be received in 2018/19. This has subsequently been allocated to the county council who are receiving £1.67m winter funding and it was expected that this would be shared and support a contribution to the system discharge to access model. Earlier in the year the CCG invested £1m at risk in discharge to assess. This was agreed at system level, with expectation from NHS England that some of this money is to come from winter money. Whilst there is ongoing validation of what the money will be spent on with further scrutiny, it has become clear that the plan does not include the expected contribution to the discharge to access capacity and is expected to be used to cover other packages of care costs funded by Buckinghamshire County Council. The Governing Body expressed disappointment in this position and noted that there therefore remains £0.5m unmitigated risk in our position. RP queried if there was a means of appeal. LP replied NHS England and Improvement are constantly asking whether we are sighted on their plans. The council are stating they are spending it on what they should be, but that it is already used and therefore not available for anything else. We have set our reasons for sharing with us, and the county council have set out their reasons for ring fencing and their financial challenge. RB queried learning. GH replied hopefully in future years, winter funding would come via CCGs. TD queried to whom the county council must report their plans. GH/LP replied this is the Department of Health and Social Care. GH asked whether there was a feel for how much of the winter funding we would like to have had, and going forward there is an issue about money invested through a system partner and how the system owns it until the legal framework changes. GH replied we made a system decision to invest, with £0.5m from NHS England and £0.5m gap, so we would have expected at least £0.5m. The bigger question is how we obtain assistance for recurrent investment. RB queried official recourse where investment is committed to but then a partner does not follow through. GH replied the CCG receives £1.8m for transformation funds in 18/19; there has been significant scrutiny and challenge with system agreement to spend, with visibility where this is spent. LP added the implementation board and partnership board have debated with some difficulty. We need some MOU commitment that investment is into a single budget, though it may not be achievable as elected members of the council would find it difficult. We would need to explore options.	
11.	**Quality and Performance Report (Month 7)**	
	DR updated members on a couple of areas not within the report. The winter plan (in the pack for information) has been well received by HASC and the health and Wellbeing Board. We have had to submit assurances and will be on a national call talking through details of workforce plans and winter coverage. Our winter director is Frances Woodruffe – we may invite to future governing	

	Body to give her reflections. Although new to Buckinghamshire, given her experience she can hit the ground running and a fresh approach. We had a national call last week with Chief Executive of BHT and RM on behalf of LP, national director for urgent care and regional NHSE director Anne Eden to discuss high level assurances of key constitutional standards and winter plans. There is recognition we have comprehensive plans despite not meeting some standards and Q3 is on track for an improvement compared to the equivalent position in 17/18. RTT we are not achieving standard, but we have agreed with BHT that in Q4 we will undertake a waiting list initiative for 985 cataract procedures January to march. This means we are confident our waiting list will end the year no greater than at the start. The facility is a vanguard standalone unit, so we are confident in ability to deliver. RB queried if there is a financial cost to this. GH replied we previously reported this and it is in the position. £1m from NHSE, half into RTT and the other half into discharge to assess. Our 62 day target for cancer remains fragile for us and BHT; they did achieve in August and September, but October likely to show further challenge. We are working closely with partners to manage this and recover. We are still flagging as not having achieved dementia diagnosis. As a system we have improved as a system from 64.95% to 65.1%. But we are the only CCG in Thames Valley not to be meeting the standard. Our lead Dr Sian Roberts has analysis further opportunities, with a campaign this year to achieve additional 145 diagnoses by year end. We are grateful for her leadership. LP asked if this will be reported to CCG Executive Committee as it is important to get on top of this. DR replied yes, with a target by practice and care home. We also have longer waits in the south of the county for memory clinic assessments. DR confirmed Dr Roberts was also just about to circulate diagnosis numbers for each surgery to them. **RB suggested local awards for care homes should include a standard screening for dementia. Whatever members can do to facilitate that change and achieve sustainable performance would be helpful. DR replied she was unclear on the specific numbers but would provide feedback. ACTION.**	**DR**
12.	**Governing Body Assurance Framework – recap**	
	RC noted having changed the agenda to review the GBAF at the beginning and end of the meeting, in order to determine if there is any need for further changes. LP felt there was no need to this time. GJ suggested it would be useful if all members were to consider this during the meeting. RC noted this would be recurring so we would prompt consideration of new risks or changes after each agenda item.	
13/14.	**Buckinghamshire ICS Winter Plan 2018-19 Approved Minutes as stated on agenda.**	
	Reports provided for information were noted as received. Meeting closed 11:45.	

15.	**Next meeting/AOB**	
	Date and Time of the next meeting: 10 January 2019 Jubilee Room, Aylesbury Vale District Council, the Gateway, Gatehouse Rd, Aylesbury, HP19 8FF	

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		