NHS
Buckinghamshire
Clinical Commissioning Group

NHS BUCKINGHAMSHIRE CLINICAL COMMISSIONING GROUP
GOVERNING BODY (IN PUBLIC)
13 September 2018, 10:30am
The Misbourne Practice, Church Lane, Chalfont St Peter SL9 9RR

Members (14)			
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**	Apologies
Crystal Oldman	Registered Nurse	**CO**	Present
Robert Majilton	Deputy Accountable Officer	**RM**	Present
Dr Rebecca Mallard-Smith	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**	Apologies
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
David Williams	Associate Director of Quality and Safeguarding	**DW**	Apologies
Hannah Mills	Director of Contracts, Performance and Assurance	**HM**	Apologies
Additional people or experts called to attend meetings on case-by-case basis to inform discussions.			
Name	**Title/Organisation**		
Gary Passaway	Head of Urgent Care (item 5 only)	**GPa**	Present
Dr Dal Sahota	Clinical Commissioning Director- Unplanned Acute Care	**DS**	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/ Material conflicts and mitigations noted as follows: 1. Primary Care Improved Access – award of contract Funding for Primary Care Improved Access has been provided by NHS England, with an allocation to the CCG baseline of £3 per head of weighted population for 18/19. This has then been awarded as a contract, notified by PIN, to FedBucks (a Buckinghamshire's GP provider company) as the contracted lead provider on behalf of the Buckinghamshire provider collaborative in order to facilitate implementation in line with the deadline of 1st October 2018. FedBucks are in turn contracting with each of the member practices. GPs who are partners in practices which are in turn population based shareholders of FedBucks have a direct material conflict of interest where also holding roles as CCG GP Clinical Directors, voting member GPs on the Governing Body, and the CCG Clinical Chair. In relation to this meeting where the above conflict applies, they 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. There is no further mitigation required in relation to financial information as this is not detailed within the supporting paper, it is not commercially sensitive and was nationally published. The CCG Clinical Chair will hand over the chair of the meeting to his Lay Vice Chair for the duration of this item.	
2a.	**Amendments to the CCG Constitution** **CCG Scheme of Reservation and Delegation**	
	The Governing Body is asked to APPROVE a revised CCG Scheme of Reservation and Delegation as contained within the CCG Constitution. This was approved.	
3.	**Review and Approval of Minutes:** **a. Meeting minutes – 13/09/18** **b. Action Log/Matters Arising**	
	First page: Helen Delaitre (HD) to be added to list of additional people or experts called to attend meetings on case-by-case basis to inform discussions. **9. Integrated Care System: delegated authority for spending transformation funds 2018/19** *GJ noted this helpful; new future funding will come to ICS through the system and not statutory organisations, likewise for primary care through primary care networks and not to individual practices.* LP indicated this was not accurate; end of sentence to be removed.	

	12. Quality and Performance Report (Month 1) *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.* LP asked if this would be addressed later on the agenda. IC confirmed it would be. RC will also add to the action log.	
4.	**Questions from the public**	
	None received in advance or on the day	
Decisions		
5.	**Winter / Urgent Care** a) Winter planning b) Non-elective Demand Management / Discharge To Assess decision c) Emergency Preparedness, Resilience and Response (EPRR) 2018/19 assurance process assessment against core standards	
	a) Winter planning – a supporting presentation was given by GPa. The meeting was opened to questions on the winter planning presentation. RP commented that the plan is comprehensive, but there may be competition for resources if too wide. GPa replied that key priorities have been identified which the A&E Delivery Board is accountable for clarifying and managing. The aim is about reducing length of stay in hospital to free up capacity. DS added that our clinical priority is also clear to focus on flu and respiratory. As regards Frimley, we are aware that attending patients are more likely to be admitted and tend to stay longer, so we also have a priority to investigate why some patients with the same co-morbidities are admitted and stay longer than when compared to Buckinghamshire Healthcare NHS Trust. KW queried how the plan specifically addresses workforce issues. DS replied that our partner trusts are aware of the Alamac system to manage urgent care activity trends and provide a future predictive model. It also helps identify expected seasonal surges. But we also recognise the difficulties in recruitment for GP locums. We are encouraged that GP streaming is benefiting patients, and this is expected to further benefit us now that the process is embedded. LP noted two specific points on workforce; there is need for clear modelling of workforce needs in hospital, given their knowledge of busy times for non-elective demand, and therefore where elective capacity may need reducing to compensate. The A&E Delivery Board needs to be seeing this evidence, and be assured that providers can effectively move their resources to manage non-elective demand. CO queried whether flu vaccinations are offered to care home staff, and whether there is a process to monitor care home bed occupancy. GPa replied there is a system wide dashboard in development for this. IC added a system is about to be piloted where we would have all live time capacity data on a dashboard, so it's available to our procurement teams for example. DS also	

	noted public health have offered all came home staff a flu vaccinations on site. CO queried if the community teams were aware of this. DS was unsure, but would liaise with a new public health consultant who is working out a way to target those community staff given recognition that they frequently move around between care homes and other locations across the county. **ACTION.** CS referred to schools asthma education and that three were targeted; how was it decided that to target? DS replied that bus hire had to be within budget for a 5 day week only. The service was offered to 10 schools with intent for half a day at each. 5 initially replied, but others subsequently dropped out as the week coincided with 11 plus exams. However, we also managed to take it to an adult learning difficulty and autism event, which meant benefit to a cohort which would not ordinarily access this type of service. We also ensured county consistency with this pilot with one school each in Beaconsfield, Princes Risborough and Wendover. RB further queried that the service was targeted at greatest areas of need and inequalities. DS replied it did include Aylesbury and High Wycombe central wards, though some schools in more affluent areas also asked for the offer. The aim is that effective education at ages 13-14 will carry through into adult life RW queried effectiveness of referral pathways from A&E back to community alternatives, especially affected by the times of day they are available. GP replied GP streaming is key to this, though with further work to ensure effective positive re-direction is in place, including through services such as 111. Data tells us that 50-60 patients day are being positively re-directed through GP streaming. LP requested for next Governing Body meeting an update for information on the winter plan after it has been discussed by the A&E Delivery Board. Further inclusions in the winter plan suggested for next week's A&E Delivery Board were: 1. Formal evaluation of last winter including measurable outcomes of what did and didn't work, and how that has affected this year's plan 2. Presentation included no measurements or timescales, and no real link to what the problem was, i.e. top ten clinical diagnoses analysis; where originating from and time of day, and therefore how approaches and actions within the presentation address the findings. 3. System analysis for forecasting bed need; this needs link to a currency of bed days – we know how many beds we have in hospitals and care homes; we need to know how many bed days each project will offer up to the system to benefit patients. LP added that the presentation given clearly needs to go through HASC and the external bodies and be a little more public facing. RB added that there is also need to understand impact on urgent care demand from MuDAS, CATS, GP streaming, GP triage, MIIU and 111 in keeping patients out of hospital. What is the impact of 111 in relation to access to pharmacies, GPs and A&E? What is the quality of service? LP replied that the A&E Delivery Board would need to address the detail in relation to the query. DS added that MuDAS may not be used as effectively as it might, one of the reasons for that relates to referral pathways, the success of which is depended	**DR**

	on clinical engagement both in primary and secondary care. We have a forum to discuss this, though some clinicians have interpreted this the creation of an ICS urgent care board which we need further work to address. RM mentioned that the presentation had a mixture of measures we have had in place in previous years with evidence to suggest where there are capacity gaps and how these are to be addressed. Super stranded patients on mental health pathways who often experience long delays need also to be addressed. But we must not neglect the wider impact on capacity from improvements needed in cancer and managing related waiting lists. GPa and DS were thanked for their participation, with the winter plan endorsed by the Governing Body. b) Non-elective Demand Management / Discharge To Assess decision D2A is primarily about patients having their needs assessed in their usual place of residence, a care home, or own home, or a place of residence close to their own home as soon as they are medically optimised and deemed safe by a consultant to leave hospital. This takes place in tandem with assessment. IC noted a paper had been provided to governing body members, but it did not now reflect the current situation and so was withdrawn. Governing Body was asked to support: 1. CFO committing up to £500,000 in 2018-19 to commission D2A 2. Prioritise Frimley facing capacity and expansion of the Enhanced Recovery at Home model. 3. CFO and Director of Commissioning and Delivery to identify an agreed model for a permanent, year round, sustainable solution. IC noted CFO has authority already for £500,000 but due to Financial Recovery Plan this has been brought to Governing Body to seek assurance that this approach is agreed. IC noted a national objective to better utilise resources, especially during winter. This year the local authority is providing more funding into domiciliary care than last year which has led to better preparedness, and increased care home funding in terms of hour being delivered. We also recognise a workforce challenge, especially in the south of the county, in order to ensure the capacity we need. Frimley last year introduced an enhanced recovery service in Hampshire which they are offering to Buckinghamshire, so we are seeking agreement to fund this. We are also seeking flexibility to fund measures we know are effective; we have good opportunities and need some flexibility for how we deliver. GH added options being explored to fund this, including monies from NHSE circa £1m to invest. ICS partnership board agreed £0.5m from ICS transformation funds would be ring fenced for this. The other 50% to be funded by ICS partners, but if not forthcoming by the CCG alone as a crucial part of winter planning. Without this would experience a tough winter and increase patient safety risks. CO noted workforce challenges and whether staff would move from acute to community. IC replied that this would be a principle, though some organisations such as Frimley Health NHS Foundation Trust have better resilience where they pay London/fringe weightings which aren't applicable in Buckinghamshire. IC added that our contract with Frimley is PBR; our investment would pay for itself in reducing overall lengths of stay. CO further queried where the people resource would come from to treat stranded patients	

	(i.e. those awaiting discharge). RM replied the intent is for a model of care delivered throughout the year and being able to respond to surges with effective planning; not just focusing on winter planning. IC added that there is already care home capacity available through building programmes, if we can put capacity into it. As regards nursing capacity, this is more challenging. LP noted the evaluation, activity and clinical, will be a major factor, and there are some valuable precedents elsewhere with therapy and nursing led units to enable different elements of the workforce to support this. CO also recognised the recruitment challenge. IC noted purchase of demand and capacity modelling which will support what LP has described. LP continued that early discharge to assess has led elsewhere to less dependency with lower need supporting packages. It was also made clear that this is to be delivered by Frimley Health NHS Foundation Trust – this is new in Frimley North and is a change in direction, though this has already been done in Frimley South for some years. RMS queried if D2A period has been defined. IC replied these are standards CHC; the time period for this is six weeks. KW added that this will help reduce the cost of supporting CHC packages. RB queried return on investment if this is successful. GH replied the current objective is impact on system performance, particularly the A&E target. GH felt A&E performance would be improved. **GB Supported the recommendations 1 – 3 in the paper** c) Emergency Preparedness, Resilience and Response (EPRR) 2018/19 assurance process assessment against core standards The Governing Body was asked to: a) NOTE the progress of the Emergency Preparedness, Resilience and Response EPRR) process and assurance on compliance. This report reaffirms the process followed by NHS Buckinghamshire CCG in undertaking the EPRR self-assessment and subsequent approval by NHS England. This year the CCG has completed a self-assessment against the core standards and have rated itself as substantially compliant. There is a further process completion required to review, approve and ratify through the CCG Executive Committee on 27 September 2018 a suite of documents which support the assessment against the NHS Core Standards for EPRR a. Major Incident Framework/Incident Response Plan b. CCG Business Continuity Plan and c. Surge and Escalation Plan b) DELEGATE AUTHORITY to the CCG Executive Committee to undertake the above, in order to discharge approval requirements within core standards. c) NOTE further requirements for reporting to Governing Body within the core standards and additional assurances provided. RC noted the CCG Business Continuity Plan as broad as it covers all directorates, which may not always be affected by a major incident (whereas the Urgent Care Team would be directly impacted). GP added that there had been a forensic analysis of compliance, with confirmation that confirm and challenge with Buckinghamshire Healthcare NHS Trust would be taking place on 14 September, followed by confirm and challenge with NHS England on 27 September. Substantial compliance is expected through both.	

	NL drew attention to “Duty to risk assess – recording and reporting through the Corporate Risk Register” and suggested that CCG business continuity and EPRR were different and therefore should be reflected in separate risks. **ACTION RC** took an action to develop a separate EPRR risk. NL also felt our reasoning for current score should read as “We don’t provide front line services and so our risk is low” rather than “The risk to major interruption is generally low because the CCG is not CQC registered and does not therefore provide frontline services” as currently stated. LP echoed these points.	**RC**
6.	**Primary Care update including Resilience** **a) Primary Care Improved Access – award of contract** **b) Update on Chiltern House Medical Centre and engagement plan for Wycombe**	
	a) RB handed over the Chair role to RP given material conflict for GPs present. A full paper was reviewed at the Primary Care Commissioning Committee on 6 September 2018 in public. This has been a short timescale given original live date of April 23019 moved forward to October 2018. There remain some teething issues to address; in only one locality of seven across the county. A line by line review has also taken place at the project steering group which has involved NHS England. Governing Body was requested to: • Review summary progress report on mobilising Improved Access to General Practice. Full paper reviewed at Primary Care Commissioning Committee (PCCC) on 6th September 2018. • Receive verbal update on progress to-date in terms of service readiness and comments from PCCC regarding this scheme. • Note details of contract to be awarded. • Approve contract signature. NL noted a typo in the conflicts of interest section: The route to procurement for this contract was as Phase 2 of a procurement 24/7 service. It was therefore not subject to a separate formal external tender, rather a 30 day Prior Information Notice (PIN) as required with EU regulations. There were no challenges to this, leading to signing of heads of terms with FedBucks. LP noted we have a formal framework for procurement previously agreed at Governing Body, with requires active collaboration with local providers to ensure true integration and value for patients. This is an APMS contract with one provider within our provider alliance. We must recognise that if FedBucks were to leave the provider collaborate then this would put us in a difficult position. NL clarified that the contract is to be awarded to the provider collaborative with FedBucks as the lead provider. LP asked for this to be amended to be really clear. **ACTION** CO queried patient involvement expected. NL replied there will be a local version of an NHSE communications plan. Part of the contract is very clear on promotion is part of what is required alongside delivery by the contract holder. Because of short mobilisation time, we expect a soft launch on 1 October. RW	**NL**

	asked if A&E can divert patients. NL replied 111 can book on the day, but this is not for urgent referrals, rather it is aimed at planned care. Requests above of Governing Body were agreed. b) Chiltern House Medical Centre Practice – update This practice had dissolved its partnership without notice on 9 July 2018. We put in place an emergency decision to contract for up to 12 months with Primary Care Management Services (PCMS), which is proving effective to date. In the meantime, we had to negotiate lease extensions as there were no leaseholders working at the practice. At Temple End, this has gone well with an extension agreed with the new provider. However, at Dragon Cottage, the lease was due to expire on 29 September 2018. Early indications suggested this would be extended, but the landlord changed their mind and we were asked to give vacant possession on 29 September 2018. To allow for repairs/refurbishment we had to vacate by 7 September 2018. However a large scale communications campaign was undertaken explaining the position; to date we have had a few enquiries. We will now undertake a stakeholder participation exercise for up to 12 weeks to help us make a future decision, and we have published an expression of interest to take over on Contracts Finder. LP suggested the cover sheet does not describe the patient involvement that has already taken place, especially PPG groups. LP commended the team for their early interventions. As regards Temple End, LP noted the list size is quite small and, if there were no willing provider, we may have to disperse the list. Is there a liability with us on the extended lease? NL replied there is three months' notice. The update was noted for assurance.	
7.	**Integrated Care System: memorandum of understanding with NHS England**	
	RM introduced the MOU with NHS England for the Integrated Care System. This is an update as we had a similar document last year. It has been through the ICS Partnership Board and sets out high level priorities and national must do's required of every system. Discussion across ICS partners is that, in addition to the MOU, will be a covering letter declaring our sign up and commitment to deliver our operational plan. We also have transformation funds to support it. Comments received: 1. RP – there is reference to quarter 2, but it not clear whether this is calendar year or financial year. 2. CO – Primary Care Networks referred to don't yet exist. NL clarified we refer to them as "clusters". 3. LP noted until this is signed we don't get transformation funds. Also helpful would be the version control. RB queried whether a version earlier in the process would have been helpful. LP replied the model had come from NHS England, and the Partnership Board would then flag any risks to it being signed. A lot has been discussed at	

	Partnership Board and Executive Leadership Group, so LP was able to provide this assurance as CCG lead. The MOU was duly approved and ratified.	
	Leadership and Governance	
8.	**Accountable Officer's Report and System Working Update**	
	RM talked through a number of points within the report provided. The report was received for assurance. RM specifically noted that the development of ICS Programme Boards has been undertaken in order to really focus on in-year delivery. RB queried if we had thanked staff for their participation at AGM; LP replied we had and those involved had a full day in lieu.	
9.	**Finance Report (Month 4)**	
	GH provided a finance update; circa £9m risks which will crystallise into FOT at Month 5. These have been fully mitigated, but we only have £3.5m contingency remaining. This is uncomfortable at only Month 5. We already know our pressures; Frimley Non-elective, QIPP shortfall, Section 117. Since we reported last month we have additional emerging risks discussed at Finance Committee earlier in the week, for example Category M drugs (national pressure £15m a month, £1.1m for the financial year for us). We have also undertaken sensitivity analysis on numbers; we think there will be further pressures on acute. We need to find further QIPP schemes. GH had instigated extension to discretionary spend; this means any uncommitted spend will be further scrutinised to assist in holding the position. We remain committed to meet our year-end forecast. We missed our Q1 Commissioner Suitability Fund (CSF) and BHT their Provider Sustainability Fund (PSF), we expect to hit CSF in Q2 and therefore recoup Q1 money. This is circa £5.5m which is much needed. RB queried GH's optimism in recouping this. At Month 5 we are showing a break even position, which we also expect at Month 6. We have looked at everything we can to ensure this. GH added that, at system level, there has been much challenge through system assurance and we need to do better on our forecast outturn. This is a system not organisational problem; we need to improve performance and finances this year by taking costs out. There will be a prioritisation exercise to look at further schemes. LP queried who is looking at the analysis of what went wrong last year and lessons learned; it is the ICS Executive Leadership Group? GH that it is; supported by joint quarterly forecasting to maximise PSF and CSF. We have missed the A&E target at end of Q2 which means we miss PSF, but we should achieve CSF. LP suggested if we were a larger ICS (like Manchester) we would have greater movement of our system control. LP noted this was important for the Governing Body to understand. RP provided some additional assurance to Governing Body that Finance Committee are putting GH under scrutiny in relation to the position, and monitoring at some depth each step. It is also vital that individuals set measurable objectives. We already know much more about this year than we did at the corresponding stage last year. We must ensure a balance between reflecting on what has already been achieved against what we still need to do to ensure we achieve a break even position. We must be harder and faster in the targets that we set. RB suggested to the brief to those who come to	

	describe their portfolios is just that. We need to know what is making a difference. GH concluded that A&E and non-elective is also an ongoing challenge at BHT – areas that should not still be open are staffed by locums which is increasing cost, and there is a high vacancy rate with pressure on locum and agency staff. We also have a challenge with Cost Improvement Plan (CIP) delivery and maintenance costs across the estate. All these issues we are tackling across the system. LP noted that Milton Keynes Hospital, although a smaller contract, also over performs. GH replied that we have a value circa £9m – it is not showing massive variance as yet. As regards Frimley, there had been an aim to sign a block contract, but it is disappointing to note that this will not now happen. However any activity above a capped value of £52.3m we will pay only a 50% marginal rate tariff, with Frimley paying for the other 50% of the tariff. We are also discussing a number of contract challenges, including short stay admissions of less than one hour. .	
10.	**Discretionary Spend Approvals Report (Month 4)**	
	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. RP queried whether the report has benefit to the Governing Body. CS queried whether it was mandatory. RC replied that it is for transparency that we are following a process and evidencing rigour. CS suggested there must be a balance. GH noted there has been a previous discussion about transparency and upwards assurance where Executive Committee had taken any decisions on behalf of the Governing Body. RB added that there had also been the same point in relation to discussion at SMT. KW felt it was important to have it here for information. NL felt the detail was better at Executive Committee given inclusion of values of contracts. RB noted some content also relates to Executive Committee members. RM added it also circulates to Finance Committee and this would be better for detail with some inclusion within the Finance Report. LP concluded that GB needed assurance that there is a list and type, no need for the additional description column. RB noted wanting involvement in discussions about clinical roles. It was concluded it would come to GB for information in appendices with no identifiable details.	
11.	**Quality and Performance Report (Month 5)**	
	KW introduced and described elements of the report – cancer, A&E, and Referral to Treatment (RTT), Delayed Transfers of Care (DTOC), mixed sex breaches, IAPT, learning disabilities, safeguarding, and dementia screening. RB suggested this was an example of aiming to manage too many priorities; naturally work is undertaken to meet national priorities but over time there may be less focus. LP replied we shouldn't lose sight as it is one of many indicators of CCG effectiveness. RW noted reference under 4 hour A&E waits to "Focus on acuity and admissions – 11.83% increase from July 2017 to July 2018". Is this an increase in acuity or increase in the number of people? RM replied there is a general theme on the right type of information; type 1 A&E attendances are generally down, but it remains important to continue understanding the link through to admissions. Sometimes we may have broad statements which don't link	

	context. RB continued this would evidence a reduction in acuity, so perhaps acuity is the wrong term to appear here. It should refer to reduction in type 1/volume. RW also referred to previous data reported on diagnostics; this is an interesting metric which was not included in this report. KW replied that it can get long when including so much information. RB queried we have considered diagnostics as a means of reducing in-year spend; we may be spending on excess tests. LP noted emphasised diagnostics in relation to cancer targets – KW confirmed these had been included. General diagnostics primary care and hospitals, were not. KW would feed this back. KW also referred to the first ICS Quality Committee having taken place earlier this week; we are looking at having a couple of focus areas at next meeting in November – learning from end of life deaths and winter planning. LP noted difficulties with the report, for example safeguarding was a long list of things we are doing so wasn't clear why this was included. It confused some of the serious incident monitoring with some of the wider work. She also felt it couldn't be mapped to the safeguarding board; given our new statutory responsibilities this needs to be looked at for both children's and adults. There was some ambiguity about some of the bullet points and link to quality – how are we assured? This needs some further clarity, particularly around cancer. LP also queried status of aiming to agree a dashboard across Oxfordshire and Buckinghamshire with links to quality. The CSU helps monitor this and some of the providers; so this would be helpful. KW replied that this is being discussed. LP requested that we aim for end of Quarter 3; and push back to CSU to ensure it is done. LP added that there were figures around GP triage and GP streaming, but not broken down by locality or practice. We seem to have lost this; we just see GP referrals. KW queried this level of detail at Governing Body. LP replied that when it came it was a graph, and DR made link that it seemed to affect behaviours. It definitely should be reported by locality which also should be reported to localities themselves. Part of our responsibility to the system is not just assuring ourselves that BHT have discharged their responsibilities, but that member practices do what they should. RB suggested this was partly a description of the locality dashboard and how well each locality is discharging the functions it is expected to – referrals, acute care, diagnostics, prescribing, 8-8 improved access etc. RB queried where this would be done; NL replied NHSE are developing it (a dashboard). LP added there remains some wider system performance resilience of primary care providers; RM continued stating this had also been discussed at ICS Partnership Board in relation to an ICS dashboard which should also focus at locality level on A&E, cancer and RTT. RMS added that the dashboard needs to include 8-8 etc.	
12-14	**Approved minutes, Bucks CCG Workforce report (Q1) and Healthwatch Bucks Annual Report 2017-18**	
	These were noted (refer to agenda for details). Reports provided for information were noted as received. Meeting closed 12:45	
15.	**Next meeting/AOB**	
	Date and Time of the next meeting: 11 October 2018	

	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		