NHS
Buckinghamshire
Clinical Commissioning Group

NHS BUCKINGHAMSHIRE CLINICAL COMMISSIONING GROUP
GOVERNING BODY (IN PUBLIC)
10 January 2019, 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**	Apologies
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/Accountable Emergency Officer	**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/Caldicott Guardian	**KW**	Present
Dr Robin Woolfson	Secondary Care Specialist Doctor	**RW**	Apologies
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
In attendance			
Name	**Title/Organisation**		
Dr Stuart Logan	Clinical Director Long Term Conditions	**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/ **Item 6** Primary Care Investments: a) Primary Care Development Scheme 19-20 b) Locally Commissioned Services 19-20 **Member GPs materially conflicted where partners in practices that financially benefit. Will remain present as meeting held in public but do not participate in discussion or decision.** It is on this same basis that the financial detail described has not been withheld prior to decisions on both investments 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 these items. . Both the Registered Nurse and Secondary Care Doctor are absent from the meeting, one of whom would ordinarily be required to ensure quorum (as one of two clinicians for quorum). Likewise one of the Accountable Officer, Chief Finance Officer or Deputy Accountable Officer would be required for quorum. To ensure a quorum for decision, the Accountable Officer as a registered nurse is counted as one of two clinicians required. The second clinician for quorum is the Director of Transformation, also a registered nurse, through enacting a CCG Constitution clause "The Director of Transformation will be co-opted as an additional voting member only in circumstances of conflict of interest material to member GPs/Chair which requires them not to count for quorum purposes."	
3.	**Review and Approval of Minutes:** **a. Meeting minutes – 13/12/18** **b. Action Log/Matters Arising**	
	DR commented as follows: • Page 6 Accountable Officer's 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.* • Page 8 Winter funding; *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.* • Page 9 Quality and performance (RTT); this means we are confident our waiting list will end the year no greater than at the start. The minutes were otherwise approved. Actions are updated separately in the log.	

4.	**Questions from the public**	
	RC confirmed none received in advance or tabled on the day.	
5.	**Governing Body Assurance Framework (GBAF)**	
	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. RB noted this item had come up the agenda following previous discussions so that Governing Body is fully energised when it is reviewed. RB also noted members are reminded to consider as the meeting progresses through the agenda any points for consideration for the recap (item 13). <u>ICS Memorandum of Understanding and operating plan</u> RC noted challenge previously in relation to the score for risk 1 regarding MOU for the ICS "IF the CCG is unable to deliver its commitments within the ICS memorandum of understanding and related operating plan". This has since reduced to 12 on the basis that an appropriate governance framework is in place for the ICS reflective of it not having a legal status in its own right and the CCG Governing Body assured on its delivery (including copies of Partnership Board minutes for information). This was the only major change, with owners having reviewed in between. We are clear on our main risks, especially finance, which will be discussed further elsewhere on the agenda. <u>EU Exit</u> RC highlighted a risk identified and assurances provided within the report on the possibility for a no deal EU Exit and local impact. Our current risk is scored at 12 and so does not technically meet criteria for escalation (GBAF details risks at 15 and above), but members can be assured we do have a risk especially in relation to stockpiling in primary care. Materials previously circulated by the Department of Health and Social Care have been circulated to primary care practices in partial mitigation of this risk. RP queried if was any sign of movement from staff from the NHS affected by EU Exit. DR replied that there is in place a system EU Exit planning group; with Natalie Fox (Chief Operating Officer at Buckinghamshire Healthcare NHS Trust) as the nominated ICS lead for this with constituent partners of the ICS all members of the group which meets fortnightly. The CCG is not anticipating any specific workforce threats. We are discussing with primary care on their impacts, with provider trusts looking at this in some detail. Where support from HR can be given to people to remain in post, this is being offered. We are not anticipating any further CCG issues that those we are not already aware of. GS queried, following the successful motion to prevent a no deal scenario ahead of further vote on the Prime Minister's plan, would that mean the current risk would need to increase. RC replied the risk as currently defined would be eliminated if a no deal scenario was legislatively prevented, however that does not mean impact is eliminated and so the risk would need to be re-defined accordingly. Once we know the outcome of the subsequent vote on the Prime Minister's plan the risk would be reviewed, and if the score changed and it met GBAF threshold it would escalate. DR pointed out all providers are undertaking detailed work on supply chain including equipment contract. We are supporting this rather than leading the process.	

Looked After Children health assessments

TD raised concern in relation to the escalated corporate risk on Looked After Children (LAC) assessments. Current compliance 50% with 81 outstanding review health assessments for Looked After Children (as at 9 November 2018). This breaches statutory timescales of 100%. DR replied that she shared this concern; such were these that at the end of last year she now co-ordinates two weekly system escalation calls. There have been improvements. In relation to health summaries, we have now confirmed that all children who left care in 2018 have received a health summary, and later today we will receive a trajectory for the 2016 and 2017 backlog.

In terms of the initial health assessments, October 2018 was a challenging month. We have actions in place for both in and out of county. We are continuing to work really hard to ensure that, even if the 20 day target for initial assessment is not met, we are doing everything we can to achieve on days 21 and 22 given recognition of complexities associated with this process. We are working to avoid every avoidable breach.

In terms of the reviews, our next step is a trajectory to ensure compliance. Our provider is taking this very seriously and has introduced additional administrative and clinical resource in place to address this. The Local Authority has reviewed its systems and processes to ensure better communication between the two organisations in order to minimise any delays in the process.

TD noted this has been picked up in a previous inspection report. DR went one stage further and noted a series of Ofsted monitoring visits which takes place. The next visit is anticipated to take place in February 2019. There is system commitment to ensure that during December 2018 and January 2019 this will have focus to ensure assurances can be given when inspection takes place.

Transforming Care Partnership

LP transforming care partnership risk is currently scoring above the escalation threshold. LP noted baselines of 16 and post mitigation scores also of 16. It is difficult to understand this if mitigations are expected to bring risk score down. This looks as if we haven't got any interventions in place and she didn't feel this was correct. If we removed all the controls we are pursuing, performance would be much worse. The risk score after mitigation isn't looking at what has already been delivered. RC replied this is all dependent on the views of the risk owners on the impact they think controls and assurances in place are having; it is within their discretion.

Accident and Emergency 95% target

DR replied, in terms of A&E 95% target, DR agreed we have comprehensive performance management planning in place. We have not met 95% target or Q3 trajectory, but we have made progress since last year and can review this risk. As regards transforming care partnership, this is much harder. We continue to escalate to NHS England that this is an unmitigated risk for us in terms of our financial exposure to very high cost packages. GH stated he is refusing to match fund until NHSE confirms capital.

LP noted she understood this, but the risk currently reads as if there are no mitigations. GH replied there should be a transfer of allocation from NHS England to the CCG, which is why it continues to be high risk. DR noted we

	have control in terms of oversight of all named individuals, where they are and future expectations. But we are significantly disadvantaged in terms of resource as we have no beds to close to transfer funds from elsewhere. TD queried if we obtained funding the risk would be eliminated. GH replied in theory yes. LP added it is unlikely it would ever fully be eliminated but the score would reduce below threshold. RB that discussing this item higher on the agenda is effective.	
Decisions		
6.	**Primary Care Investments:** **a) Primary Care Development Scheme 19-20** **b) Locally Commissioned Services 19-20**	
	RB handed over chairing of the meeting to RP. RP invited SK to describe the paper provided to the Governing Body. **(a) Approval of Recommendations for Primary Care Development Scheme (PCDS) 2019/20** The Governing Body is asked to agree the following recommendations for the PCDS (as described in the attached paper) Recommendations 1. Update the scheme elements with new specifications reflecting changes. 2. Update and simplify templates for the scheme and update the dashboard to reflect new elements and requirements. 3. Recommend for the PCDS that no further financial investment made until existing funding justified through review of outcomes. SK introduced the item; discussions with clinicians have been ongoing since May 2018 to inform 19/20 plans. It is also clear that CCG's nationally have been waiting for further guidance from NHS England on the Quality and Outcomes Framework (QOF) before taking local commissioning decisions. It is now expected to review this at end of 19/20 in line review of the GP contract. It is expected in 19/20 therefore to proceed with a third year of the current scheme. It is delivering on many areas linked to patient outcomes, especially heart failure, Atrial Fibrillation (AF) where the CCG is leading nationally, and diabetes care and support planning. There is further work to do on end of life care and links with secondary care on advanced care planning. The CCG is seeking longer term outcomes for long term conditions and self-care initiatives, which are known to feature in the NHS ten year plan. We are also developing primary care networks, so this scheme is a key part of this. The scheme is also being re-written to help the patient as a whole rather than in piecemeal. Prescribing elements of the scheme have also been tweaked; LMC have positively endorsed this. SL was permitted to speak (directly conflicted as a partner in a practice that would benefit from the scheme), highlighting that the aims seek to minimise hospital admissions, especially for more frail patients, through ensuring adequate care plans are in place. He stated a need to focus on risk stratification – both the top 10-15% of patients who are co-morbid with numerous long term conditions, and the base of the pyramid where patients do	

	not have long term conditions with the aim to prevent them being diagnosed in future. We are aiming for good, holistic care which involves relatives and good outcomes. LP noted support in principle and its contribution to the long term plan. LP noted paper states "*Recommend for the PCDS that no further financial investment made until existing funding justified through review of outcomes".* LP sought to confirm that this was beyond what is currently being requested as this was not clear in the paper circulated. SK replied that historically there is a budget which combines QOF (which moves as population and achievement increases) and a CCG investment element. The recommendation indicates no further investment from the CCG above that already budgeted for. RM noted that existing funding needed to be linked to outcomes (as the recommendation states) and believed that this has not yet taken place. SK confirmed it. LP asked that the recommendation be extended to "outcomes or evaluation", as we always struggle with outcomes. LP also asked that in circumstances such as this, where clinicians are unable to participate in elements of scheme development due to conflicts of interest, we need absolute clarity on what the clinical involvement has been. LP asked to hear from SL that there has been sensible clinical involvement, despite conflicts of interest (SL directly conflicted as a partner in a practice that would benefit from the scheme). SL replied that regular meetings have taken place. **RC raised on behalf of Dr. Robin Woolfson (not present) who had asked for clarity as to how progress was going to be monitored and reported to the GB throughout the year. SK replied that there is a comprehensive monitoring regime for the existing scheme, including monthly emails to all practices and monthly meetings with locality and portfolio clinicians. RM suggested we look at how this is incorporated into the quality and performance report. ACTION.** **Decision:** The proposed recommendations were agreed. **(b) Locally Commissioned Services 19-20 (previously known as Direct Awards)** NL set the context; the CCG on an annual basis commissions practices to participate voluntarily in improvement schemes/enhanced services which are in addition to the core GMS contract. These were previously known as Direct Awards. SK described the national context in that all CCGs to some extent invest in local services that are above core GMS contract. Locally the CCG compares well with its neighbours, with close partnership with Oxfordshire to align specifications, with two services added that Oxfordshire had previously introduced, namely health checks for patients with serious mental illness (SMI) and prophylaxis for care home staff in the event of a flu outbreak. In year a dashboard had been developed to give all practices visibility of delivery, with aim now to automate this process so practice administration for their quarterly claims is seamless. This has been a key element in discussions with practice managers. RP asked if this scheme commissioned as one service or a number of	**RM (SK)**

	services. SK replied the whole list is 10 services; in Aylesbury 6 are bundled and contracted as one service for option of sign up (100% of practice have signed up), for the rest they are individual. When the CCG requests and sends out information each March, practices are asked to indicate which they are prepared to deliver. The aim is for as high sign up as possible as these are services people should be getting. Some practices will judge they don't have capacity or capability. For some areas, these services are not being automatically delivered by their local practice. It is hoped to change this as primary care networks develop further and deliver these to cover patients not part of individual practice catchments so all patients have access. This is why the recommendations are as they are. Networks are not yet mature to offer this; this is expected to be in place in the next year. Meanwhile the scheme continues with the existing Aylesbury bundle and Chiltern individual based on activity. The scheme will be subject to ongoing monitoring as primary care networks develop. TD noted estimated spend on the scheme exceeds the allocated budget, and asked what assurances are in pace to no further overspend if further practices sign up to services. SK replied the scheme is monitored closely to balance demand and capacity and that budget can be exceeded. LP added that this cannot happen. GH agreed; we budget QOF at 100% delivery but we are often slightly under budget which largely mitigates overspend on enhanced services. We need a fixed budget given the financial position. We know from the beginning of the year the rate of take up with payment based on activity. RP raised concern that patients across the county have different levels of service and whether this is fair. SK replied to some extent they will still get the service, but may be through another local practice rather than their own. LP noted that the CCG has a responsibility to ensure equitable access. As part of ongoing evaluation, LP requested an assessment of equality impact in different communities as patients do have choice of GP practice. RP added if we are running different schemes through different practices that increases administration, and one of our drivers is to cut back on this encourage as many practices to drive to higher standard so we get more consistency. LP noted this as a clear message from Governing Body. LP noted clearly the paper doesn't reflect PCN networks description in the long term plan. CCGs have a responsibility to understand what the ten year plan means and share that work with providers, so there is that work still to be done locally. LP further queried the difference between options 1 and 2 indicated within the paper as the disadvantages of both options appear to be the same. SK replied that option 1 bundles all the services, with option 2 retaining bundling 6 services for Aylesbury Vale practices and expending this to also cover Chiltern practices. LP noted that the table does not describe member practice push back as a disadvantage; we have to accept why this is a sensitive subject and we must take time to do this properly. SK added if you ask Chiltern practices about the bundle approach, their feedback is they prefer the current position. LP noted there is divided opinion which is not detailed in the disadvantages. There are sensitives, which mean	

	more time is needed to ensure equitable access for specific communities and equitable contracting. The concern around the 10 year plan is that it is moving us away from principle of items of service and bundling at practice level to payment at primary care network level, which reduces costs for individual practices. SK replied that during 19/20 there would be thorough review to determine if this is the right package, with delivery at practice, network level or in hubs will be considered. **Recommendation 1** – Current list of LCS services continues into 2019/20. TD suggested this may mean the scheme may change part way through the year – is this sensible? LP suggested this should "*continues for 19/20*". SK replied that 19/20 will be a year of change. Expectation is this scheme will be in place for full 19/20. What is offered to practices will include the word change. LP added, if anything, the contract may change but the list of services would remain the same. TD requested certainty. SK confirmed that at the moment, there were no more services expected to be added. **Recommendation 2 –** Existing specifications are consolidated into the current specification used by (former) Chiltern practices. LP referred to the recommendation. LP suggested the paper not clear on whether this is because it reflects best practice, if the proposal is consistent with best practice and links to academia/NICE guidance. It's not a concern which prevents a decision, but still needs explanation. SK replied that because Chiltern practices have delivery based on individual services, all detailed specifications were reviewed last year. Aylesbury Vale specifications which indicate the bundling approach were less detailed and specific. They don't fundamentally differ; rather the Chiltern specifications are better laid out. LP asked if there were administrative implications, SK confirmed there were not. <u>Care Home Prophylaxis for Flu.</u> DR noted, although we know people need a community based solution in 19/20, we need to evaluate success of the current winter scheme and ensure learning is built into subsequent schemes. What we commissioned this year may not be the same for next winter. LP asked whether this eventuality was described within the paper provided. DR replied that it was not described and is therefore why DR had pointed it out. The evaluation of this year's scheme will need to be linked to what is commissioned in future, but either way this is not expected to form part of Locally Commissioned Services. <u>Conclusions</u> RM recognised this is a holding position, and enhanced services are specifically mentioned in the long term plan as migrating to network level. So we must be clear about what capability, analysis and capacity we need to work through with practices/networks. It is tricky and sensitive. RM recommends that PCCC/PCOG have a detailed delivery plan to monitor and what co-production looks like, and how we provide skillset to support internal resource to deliver it. NL responded our main priority in 19/20 has to be to get networks established and so skills and capacity will be subsumed by this as a priority. RM acknowledged that we can't do everything at once, but if we are doing this we have to be clear how it will be delivered. SK acknowledged a need for a robust mechanism. RM emphasised that we need a clear plan with timescales and milestones and to be monitoring it to ensure delivery through PCCC. LP noted	

	networks will be held responsible for uniform coverage and addressing inequality. **Decision:** The proposed recommendations were agreed (with request that evaluation include equality impact assessment). RP handed back the Chair of the meeting to RB.	
	Leadership and Governance	
7.	**Accountable Officer's Report and System Working Update**	
	RM stated operational planning guidance was released 21/12/18, and the long term plan had launched on the previous Monday. It contains many elements we have already been doing a system, with emphasis on commissioners working at scale with the STP. There are a number of areas we are waiting further detail. <u>Thames Valley and Surrey Local Health and Care Record Exemplars (LCHRE)</u> RM noted an update in the report provided. The matter was discussed at ICS Partnership Board last Tuesday; there is some additional assurance work required through Balvinder Heran before LP signs the partnership agreement. The recommendation (for delegated authority to LP to sign the Partnership agreement) still stands. And a recognition that the CCG signs on behalf of the system and therefore any costs is a call on system control total whatever the funding mechanism. **Decision**: this was agreed. Brexit RM noted previous discussion on this matter (under Governing Body Assurance Framework). RM asked Governing Body to note the CCG lead on Brexit is DR (as Accountable Emergency Officer). This was **NOTED**. LP added further comment to the report, In relation to ICS development, we are looking carefully at the form and function of the Clinical Senate; LP will be writing to organisations to request that it does meet on a regular day of the month, preferably Thursday, so that it can take commissioning work from the CCG. ICS Managing Director interviews will take place in a couple of weeks' time, so LP hopes to report back on progress at the next meeting. CEO interviews for Buckinghamshire Healthcare NHS Trust are expected at the end of the month. RB commented that holding senate meetings on days which makes best use of clinical resources is essential. <u>Brexit/medicines</u> GS suggested it would appear odd the idea that patients may not have access to medicines with a no deal scenario, and queried (a) the CCG's mitigations for risks in relation to administration and data sharing and (b) the risk of scaremongering which could lead to bad decisions. DR replied that a Brexit planning group meets fortnightly, with DR as the CCG SRO. The Brexit planning group is represented by directors of constituent organisations, with regional and national input through NHS England representation. In relation to nationally published guidance, we are using existing systems and processes for Emergency Preparedness, Resilience and Response (EPRR) and business continuity. Where business continuity plans are in place, providers and commissioners are revisiting those plans and will again in light of	

	further guidance. Workforce issues are particularly concerning to providers who have contingencies to address any workforce risks. The Local Authority is working with the independent sector where it is harder to obtain situational reports. The CCG is also in discussion with primary care commissioning colleagues to understand the impact. We also have a system medicines optimisation board, of which clinical members are clear on their contingencies. Through NHS England they are liaising with community pharmacists and through the CCG to communicate with general practices. As system we have responsibility to provide public re-assurances not to stockpile; this behaviour could generate overreaction. Nationally demand is being tracked through the NHS supply chain; they know where every drug and medical device has come from, and we are supporting clear messages on this. GJ suggested that members of the public stockpiling is difficult as it's not in public control, rather it is prescribers control. DR replied that we are re-assuring the public that they don't need to ask for extra medication. LP added that this also relates to over the counter medications. RB concluded that this was another reason not to support third party ordering.	
Governance and Assurance		
8.	**Planning Framework – process and timescales** • **18/19 financial position update** • **19/20 Planning Update**	
	GH noted that 18/19 Month 8 is 32k favourable to plan. Expect to receive Q3 CSF in full, still forecast to hit year end plan but there is risk circa £5m. This is fully mitigated at this stage, but biggest risk is continuing healthcare and pressure on acute (Frimley and London providers). Attention will soon shift to year-end audit, and we anticipate take Audit Committee through the plan. As regards 19/20, we are still waiting for further balance of planning guidance, still unconfirmed on the control total and we still don't have our allocations. Expecting some of that imminently, but we are unable to release first iteration of 19/20 plan without this. Given our financial challenges for next year, it is highly likely contract values will be reducing in 19/20. TD noted this as a difficult message and queried how we communicate it, especially with the general public. GH replied there is a clear need to communicate, internally, across the ICS and the public – as regards what is affordable for the Buckinghamshire pound once we understand our allocations. RB added that there is a dichotomy with national messages that the NHS is investing more. TD added it is one thing reducing contract value, another thing keeping an organisation to that. With Buckinghamshire Healthcare NHS Trust we could expect a block contract, but how will this work with other organisations? GH replied we will need to work together to do things differently and reduce costs. We have got good examples about what we can stop, especially elective activity, and we will need to send a clear message to the system. LP concluded that clinicians will also need to understand this message.	

9.	**Finance Report (Month 8) including** • **ICS transformation funds report** • **Risks and Mitigations** • **Discretionary spend**	
	Covered under above item.	
10.	**Quality and Performance Report (Month 8)**	
	DR apologies for the paper pack not having a report due to timing; it was not ready for the executive committee to be assured before it circulated to Governing Body. We do now have a report to be reviewed by the Quality and Performance Committee before release into the public domain. DR noted at the previous meeting we presented the winter plan, and reported on progress. The STP performance for December shows BHT performance for A&E did achieve 90%, and was best in STP and better than Frimley. Also borne by also best performance in bed day delays. Through Governing Body there has been concern about us needing to ensure we would get improved grip on reducing long LOS and driving out bed days. We have also been reducing ambulance handover delays. As regards this year to date, we have been improving capability for system forecasting demand and capacity across all elements of the system. In large part predicted pressure for the first two weeks of January has transpired. It came three days earlier, Friday 4 January rather than Monday 7 January. Further pressure this week is within expected levels with staff working hard to mitigate. We are maintaining OPEL3. CS queried why Friday 4 January was a pinch point. DR replied we are looking at this in terms of clinical presentation and trends to see what more we can learn. GS asked if next year it can be ensured members see data earlier. DR replied yes, on this occasion there was a timing issue. RMS suggested the pinch point is more closely related to where new year falls and that patients will wait until after when general practice becomes very busy. GJ added this this can also be affected by when the first day of the new school term also falls. GS further queried if Buckinghamshire is above average when compared nationally, and whether NHS England will be eliminating the 95% 4 hour target. DR replied we are in the middle of the pack and so we are not flagging as a challenged system. As regards the target, indications are we are not likely to see the target go, but there is national piece of work to ensure standards remain clinically appropriate. RM added that the model of care can move beyond what the original target was created for. . RB thanked all the people who worked on the winter plan. DR concluded that our new winter director has also brought in additional resilience with virtual system operations team on site at BHT, and they are having look forward meetings, managing multi-agency discharge beds and providing system challenges to improve discharge and drive out delays.	
11.	**Inequalities Advisory Group (IAG): Update**	
	CS talked Governing Body members through a supporting presentation published on the CCG website. https://www.buckinghamshireccg.nhs.uk/wp-content/uploads/2018/05/11.-IAG-presentation-CS.pdf	

	Data comes from public health, with clinicians attending to address specific priorities. Membership is based on the county's community diversity. The group discusses strategies to address inequalities and engage communities with broad scope of ethnicity and culture with CCG messages on its behalf (e.g. winter pressures and what communities can do to help themselves). CS stressed independence of the group in both health and political terms. The benefits of a large membership outweigh the size of the group. CS noted CCG support to the group, facilitating clinical engagement and leadership in ensuring appropriate attendance. Their work is somewhat guided by this and the CCG's priorities. CS noted having previously presented to the NHS Clinical Commissioners Lay Members Network about aims, from which a small amount of funding was provided by NHS England. Although is there is no further funding, the group is focused on its objectives with members willing to provide venues for meetings at no cost. As regards governance, the group is accountable to the engagement steering group on its objectives but with desire to be accountable and report to the CCG Executive Committee. In its next phase, CS thinks over the next six months the group will expand and allow greater reach, which needs continued support of the CCG. TD queried the amount of funding received. CS replied £2.5k. LP noted the great work of the group as a critical friend, which is the right way forward. Representation would always be difficult, but it looks representative. LP also welcomed links to public health especially with increased collaboration on population health management. LP noted a balance is needed between strategic and operational work (in a school for example). As regards funding, we need to work as a system to embed as all organisations have equality duties. The group could be a single entity for the system, linking to corporate social responsibility (CSR) activity and lottery funding. LP indicated looking at this as ICS lead. GS queried whether the success of the Chiltern house survey was entirely down to the group. CS replied not entirely, although a couple of group members are patients with group able to facilitate clarity on the long term plan and prevent unnecessary disquiet on an issue where public feeling can otherwise quickly become toxic. NL noted in terms of current and future accountability and reporting, the group currently reports through the engagement steering group, which feeds into the quarterly communications and engagement update reported to the Governing Body. The "getting Buckinghamshire involved" quarterly steering group met for the first time a few weeks ago, which in future will be its natural place. It is a system group chaired by Healthwatch with third party providers and community groups invited to be involved. They have yet to set their purpose with the first meeting more about introductions. LP queried whether reporting would be more effective to the Health and Wellbeing Board. NL replied the ICS would likely need its own engagement group of some sort. RB thanked CS for his role in this initiative, with a feeling that this is different to some other meeting with head teacher's ability to reach	

	into families an aspect we can use better to address inequality gaps and financial challenges. Earlier on the agenda, we didn't challenge how primary care investments (direct awards, primary care development scheme) would address the inequality gap. We should reflect on this and ensure this is part of our core challenge of business cases. Moving forward, RB expects to step aside with Dr Rashmi Sawnhey (Clinical Locality Director for Wycombe) expected to take a greater role	
12.	**Communications and Engagement Update**	
	NL introduced the Q3 report and noted CS had previously referred to the survey of Chiltern House Medical Centre in which 1,124 members of the public took part to share views about the future of the practice. Overwhelmingly they wanted us to consider procurement for a new provider. That decision has subsequently been taken. This process had been supported by the Inequalities Advisory Group who handed out surveys at schools and mosques. A significant amount of work supporting it was also undertaken by the practice Patient Participation group (PPG). NL also noted the Equality and Diversity Annual Report is in its final stages before publication, seen by the Engagement Steering Group yesterday. Regards out of Hours provision in the south of the county, the survey referred to in the report was stated as closing on 25 January. And up until 2 December, the public was invited to comment on the CCG operational plan for last year to inform the plan we are now writing. We have also revised our engagement strategy to be published on our website. And a strategy for engagement was published alongside the town year plan this week, so patients and the public can understand it. We are working through what this means for Buckinghamshire. LP noted it useful to see all in one place.	
13.	**Governing Body Assurance Framework – recap**	
	There were no further comments.	
14/15.	**Approved Minutes and reports as stated on agenda**	
	Minutes provided for information were noted as received. Meeting closed 11:45.	
16.	**Next meeting/AOB**	
	Date and Time of the next meeting: 14 March 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		