Finance Committee Meeting – Minutes

Wednesday 26 September 2018, 08:30-09:30am
Bevan Meeting Room, Buckinghamshire CCG Offices, Aylesbury, HP19 8FF

Chair: **Tony Dixon**

Present:

Members

Tony Dixon	TD	Lay Member and Finance Committee Chair (Chair)
Robert Parkes	RP	Audit Committee Chair & lay Member, Buckinghamshire CCG
Gary Heneage	GH	Chief Finance Officer, Buckinghamshire CCG
Alan Cadman	AC	Deputy Chief Finance Officer, Buckinghamshire CCG
Kate Holmes	KH	Deputy Chief Finance Officer, Buckinghamshire CCG
Debbie Richards	DR	Director of Commissioning and Delivery
Graham Smith	GS	Lay Member, Buckinghamshire CCG

In attendance

Russell Carpenter	RC	Head of Governance & Board Secretary, Buckinghamshire CCG (minutes)

1.	**Introduction, Apologies & Quoracy**	
	TD welcomed the committee members to the meeting. Apologies were received from: • Robert Majilton • Dawn Riddell The meeting was declared quorate.	
2.	**Declarations of Interest**	
	The Chair reminded committee members of their obligation to declare any interest they may have on any issues arising at committee meetings which might conflict with the business of the Buckinghamshire Clinical Commissioning group. No declarations were received. No existing declarations were deemed to have materiality to items on the agenda. All published CCG registers of declarations of conflicts of interest can be found on the Buckinghamshire CCG website: https://www.buckinghamshireccg.nhs.uk/public/about-us/how-we-make-decisions/business-conduct/conflicts-of-interest-policy/ There were no conflicts with materiality to items on the agenda.	
3.	**Review & approve Minutes of previous meeting**	
	The minutes for the Finance meeting held on 10 September 2018 were reviewed and approved as a true reflection of the meeting.	
4.	**Action and decision Logs**	
	The Action Log was reviewed and updated accordingly.	

5.	Month 5 Update	
	GH provided the committee with the Month 5 update. KH joined the meeting by phone. GH talked through an accompanying slide pack. This is the first month estimate of risks are greater than mitigations; partly a consequence of loading risks with sensitivity analysis. Circa £9m have now moved from risks into forecast outturn, but contingency in full is still available. This felt a prudent view. GH noted expected capitalisation of community stock circa £1.0m is factored into the FOT. RP queried reaction from auditors. GH replied initial conversation suggests relative support. GH highlighted Category M drugs as a £15m per month pressure across the country, in Bucks 1% = 150k per month = £1.1 for the financial year. We had a windfall last year, but this will change the other way this year and will materialise into cost pressure. In terms of sensitivity analysis, we have looked at M4 SLAM data to calculate a forecast outturn, however we have also taken into account what happened last year when, by this point in the year, we had spent circa 40% of acute estimate costs. Were that to happen again, we would have a further risk of £2m on acute activity spend. AC added that this allows for seasonal trends. TD queried the pressures, which showed that Frimley is the majority of overspend in acute. GH replied the Frimley Trust is in financial recovery. But because of 50% marginal rate tariff, we have a £2m financial benefit. But in relation to S117, we have a £100k pressure if current demand for placements continues (circa 2 additional per month). A further £2.6m is anticipated on continuing care for the same reasons. This will all be included in risks at M6 onwards and updated monthly. TD enquired how the Oxford Health NHS Foundation Trust was performing. GH replied in terms of CHC that an initial QIPP of £7.2m has been fully delivered, plus additional £3m. AC added that there has been a drop in conversion rate (i.e. applications which met criteria and packages subsequently agreed), from 60% or so down to less than 30% (slightly above national levels of 23%), these savings are starting to be offset by increases in patient activity. AC added that this rigour has been extended to December 2018, to achieve further anticipated £1-1.5m saving. However a reduction in cases through R.I.P is being counteracted by an increase in fast track. If this continues we could have impact elsewhere which nets to a smaller rate of saving. DR added that the whole legacy caseload would be reviewed by December 2018, along with addition of an Oxford Health assessor in BHT is making a difference to quality and patient experience. There is an impact on the local authority which they are challenging us on. GH noted there are also a handful of appeals at present. As regards discharge to assess, it is hoped NHSE will fund the pressure of £1m, if not half is to come from transformation funds as a system priority. The other half to come from the CCG (delegated authority has already been agreed by the Governing Body to the CFO for this purpose). As regards prescribing, we have budgeted growth and 5.5% and seeing current growth at 3.8%; this gives a potential mitigation of 1.7%. GH concluded that there are significant risks for which we are working on mitigations which we are carefully managing. Overall we still anticipate a balanced position and therefore still	

	forecasting to hit plan, with strong governance and controls in place. TD requested assurances that we would not anticipate the same financial impacts as last year with increased activity. GH outlined a forward view forecast as assurance; on a monthly basis, line by line of contracts, we monitor year to date total and forward forecast, counteracted separately by all our mitigations so we don't double count run rates. We are also reviewing all forward commitments for opportunity to hold any investments and defer them into next year. Further pressures could arise on acute during winter, but this may be offset by cancellation of elective procedures. GH also went onto say we also explain run-rate differences in terms of FOT. TD further asked how much of BHT's deficit position would likely flow through to the CCG. GH replied this would be very little as we have a block contract, however the system will be in deficit which as an ICS we are required to address as a system. DR added there are some issues which may drive some of their position which is not easily fixable, such as workforce gaps. Their statutory obligation, and ours, is to provide safe care to patients. As a result they may have running costs higher than budget where, for example, they are short of substantive A&E consultants and reliant on locums. GH added there is work for the trust to do to improve efficiencies to place them in the top quartile which they are not at present. GS queried timing of assurances on the efficiencies they will deliver. GH replied the challenge as the ICS is £7m off plan year to date and £8m most likely outturn didn't look realistic. There is a lot more to do before Month 6 is reported. GH also emphasised importance of appointment of a winter director to support the system. TD queried how excess bed days are counter balanced by social care and whether this covers the south of the county (Frimley facing). GH replied they have further invested in domiciliary care. DR added that they have indicated an increase in hours between last winter and this, from the Better Care Fund, so this gives us some confidence, and will be applied to the south of the county. We are also working closely in integrated discharge to improve efficiency. GH note the biggest difference between Frimley and Bucks is that we should see a reduction in excess bed days through the implementation of the discharge to assess scheme and therefore charges should reduce at Frimley. GS noted a review of referral patterns for the independent sector and what opportunity there as for efficiencies. GH replied that use of these providers is based on patient choice. KH added that a series of discussions have taken place with localities to describe the winter plan and management of non-elective activity. DR asked that we note that whatever we report at the end of Month 6 will give us the benefit of the Commissioner Sustainability Fund (CSF). RP concluded that we are in a much more transparent position than we were 12 months ago.	
6.	**Finance Committee 2018/19 Work plan**	
	KH introduced the item. The aim is to describe the needs of Finance Committee reporting linked to deliverables of the CCG business. We will use the same template for future years. TD noted there was a missing date for a December meeting – this needs to be rectified.	

	Action: confirmed date for December meeting It was also agreed that we would include the same item for information each month as our reminder of where we are. Actions: 1. RC noted reference to Section 75 dashboard review for September 2018 which was not on the agenda. KH replied it was meant to be aligned to October. 2. GH also suggested colour coding; green for items completed and red not completed. 3. RC also to cross reference to GB work plan GH added that there is also monthly STP reporting that Committee will need to receive on a monthly basis. TD noted "Strategic Approach; Decision – Review proposal" with question over November indicating timing. GH noted this as action 2 on the log re: medicines optimization deferred to April 2019. KH noted this links to when the guidance comes out. It was agreed to be clear what this is. **Action**: "Strategic Approach; Decision – Review proposal"; clarity as to what this refers to for the next iteration of the work plan.	KH/DR KH
7.	**Governing Body Assurance Framework – risk review**	
	The Committee was asked to: 1. **NOTE** findings from RSM financial governance review in relation to the role of the Governing Body Assurance Framework (GBAF) and Corporate Risk Register. 2. **DISCUSS** and **COMMENT** on existing GBAF risks aligned to the Committee (Appendix 3), taking into account the following: • Do we really understand what they mean? • Can they really provide assurance if we don't understand them? • Do the supporting descriptions (specifically controls, assurances and actions to be taken to mitigate gaps) effectively describe our mitigations and contingencies to manage down these risks? • How would existing risks read if they were re-defined using IF, THEN, LEADING TO best practice model. RC noted this as a means to address findings from the recent RSM financial governance review. This work will feed in to the next seminar in November. TD noted five risks related to the Finance Committee. GH noted we are expecting a QIPP audit which will report in due course. RP noted it was important to ensure that the risks described, in their entirety, are understood. Second to that is how they are presented. In terms of an environment where resources are priority, it is better to focus on the first part rather than the second. There was a feeling that we have much higher pressing priorities than the semantics of how risks might be defined and description of related controls and assurances. RC took an action to redefine the existing risks as 2/3 using the IF, THEN, LEADING TO model for the next meeting DR suggested whether each of these risks should also have a clinical lead which they do not at present. It was acknowledged that, in time, they should – given a statutory obligation to achieve financial balance.	
8.	**Any other Business**	
	RC noted that a procurement flowchart is in development. RC noted a previous action that	

	required a flowchart to describe to our staff the process to determine needs for procurement/quotes etc. when buying clinical or non-clinical services. It is designed as a step by step process, including financial thresholds. GS noted that, up to a certain thresholds, the CCG could purchase goods and services without ever going to procurement. RC replied that this was true; though for us very little would fall below it (e.g. stationery) which we carry out on a repeat re-order basis. The flowchart also specifically refers to use of single tender waivers. RP suggested re-wording for non-healthcare up to £5k whole life: No formal requirement for external procurement process. TD queried intention. RC replied it would circulate to all staff. Members felt that Audit Committee should approve it. GH was keen to circulate. At Audit Committee, agree to delegate to the Chair the final version. AC also noted a keenness to move to more electronic Purchase Ordering. There is a user guide on how we use the electronic ordering system. DR also noted it would be beneficial for the final version to circulate to SMT in order for staff to seek any points of final clarification. It will then be announced through next team brief. The meeting closed at 09:33.	
9.	**Next Meeting Date:**	
	Wednesday 31st October 2018, Bevan Room, AV CCG Offices, 09.30am –10.30am	

Finance Committee Meeting – Minutes

Wednesday 31st October 2018, 10:00-11:00am
Bevan Meeting Room, Buckinghamshire CCG Offices, Aylesbury, HP19 8FF

Chair: **Tony Dixon**

Present:

Members

Tony Dixon	TD	Lay Member and Finance Committee Chair (Chair)
Gary Heneage	GH	Chief Finance Officer, Buckinghamshire CCG
Alan Cadman	AC	Deputy Chief Finance Officer, Buckinghamshire CCG
Robert Majilton	RM	Deputy Chief Officer, Buckinghamshire CCG
Debbie Richards	DR	Director of Commissioning and Delivery
Graham Smith	GS	Lay Member, Buckinghamshire CCG

In attendance

Russell Carpenter	RC	Head of Governance & Board Secretary, Buckinghamshire CCG
Dawn Riddell	DR	PA to Chief Finance Officer (minutes)

1.	**Introduction, Apologies & Quoracy**	
	TD welcomed the committee members to the meeting. Apologies were received from: • Robert Parkes • Kate Holmes The meeting was declared quorate.	
2.	**Declarations of Interest**	
	The Chair reminded committee members of their obligation to declare any interest they may have on any issues arising at committee meetings which might conflict with the business of the Buckinghamshire Clinical Commissioning group. No declarations were received. No existing declarations were deemed to have materiality to items on the agenda. All published CCG registers of declarations of conflicts of interest can be found on the Buckinghamshire CCG website: https://www.buckinghamshireccg.nhs.uk/public/about-us/how-we-make-decisions/business-conduct/conflicts-of-interest-policy/ There were no conflicts with materiality to items on the agenda.	
3.	**Review & approve Minutes of previous meeting**	
	The minutes for the Finance meeting held on 26 September 2018 were reviewed and approved as a true reflection of the meeting.	
4.	**Action and decision Logs**	
	The Action Log was reviewed and updated accordingly.	
5.	**Month 6 Update (Including Discretionary spend summary report & ICS position)**	

GH provided the committee with the Month 6 update and talked through an accompanying slide pack. The main points/discussion were:

- YTD is £71k better than budget, still currently on forecast to hit £15.5m deficit plan.
- NHSE have confirmed that the CCG will receive £5.5m of CSF funding in M7 as on plan.
- Forecast Outturn position held, the main variances due to:
  - Frimley NEL
  - increase in pressure in the Independent Sector of £0.6m,
  - London of £0.5m due to high cost patients.
  - Mental Health relating to S117 placements £1.8m

  In terms of CHC – assumes to deliver further savings of £1.6m from 2nd cohort but some risk around eligibility. Oxford Health (CHC provider) has delivered £1.1m of £1.6m as at 22nd October 2018.
- Ongoing review of prescribing run rate due to No Cheaper Stock Option pressures. Community pharmacy has reported a benefit across the country of £10m per month from November which the CCG are approx. 1% of this amount. The difficulty is calculating the outturn on prescribing, work is being undertaken with the CSU to understand what the outturn may be. This could be a potential risk.
- Risks

  – A further £6.6m on top of the reported known £9m that has already gone into the FOT. There is £3.4m contingency still in full.

GH informed the committee that there is a current backlog of patients on the cataract waiting list and proposed £0.5m funding is allocated to clear the back log. The funding would be ring-fenced for ophthalmology and would not be impacted by any winter pressures encountered. The Finance Committee gave their support to make the decision which would be transacted under a contract variation which GH already has delegated authority to approve in the Scheme of Delegation.

Action: GH to circulate a 1 page document on the £0.5m funding for the cataracts back log. **GH**

The following assumptions have been made with regards to mitigations:

- Prescribing continues at current growth levels (3.9% not 5.5%) £0.7m
- CHC savings of £1.6m for 2nd cohort
- Further savings of £0.5m are found to offset Primary Care pressures; GP pay award has been confirmed at 2%, funding has only received for 1%.
- Community stock adjustment of £1.0m is included.
- - Where the YTD has been extrapolated and is showing a potential pressure of FOT this has been included as a pressure/risk.

DR joined meeting (10.18am)

- What are we doing to mitigate risks
  - Block contract with Bucks Healthcare Trust
  - Frimley contract has been discussed and the figures for the outturn are broadly agreed and fixed.
  - Weekly CHC meetings occurring.
  - Discharge 2 Assess funding decision received.
  - Reviewed all committed spend for the remainder of the year.
  - Independent Sector referrals are being reviewed.

TD asked what the status was with BMI Healthcare overspend (independent hospital provider) GH responded that work had been conducted to look at the waiting lists.

GH went on to explain that the CCG has undertaken a Best, Worst and Most Likely outturn.

- Worst case scenario is deterioration in outturn by a further £3.4m. The data needs to be refreshed for M7 as running costs, community stock, CHC and D2A amounts can be removed as risks. This would reduce the figure to approximately £2m.

TD asked what the impact on the £15.5m deficit plan would be if the worst case scenario was reached. GH explained that this would probably need to be declared at M9 with the possibility of losing the last quarter CSF funding.

GH informed the committee that a system plan was being looked at for 2019/20.The initial organisational gap for QIPP is circ. £26m. This year has seen benefits of £9.5m from CHC and £ 8-10m from non-recurrent savings this financial year. It doesn't look feasible to get a breakeven plan next year (when factoring in the benefit of CSF and the non-recurrent items) and therefore it is likely to be a deficit plan similar to the 18/19 planned number.

TD asked if there were any indications as to what our allocations would be next year. GH responded that the planning round will be difficult due to changes to this year's tariffs e.g. the Provider Sustainability Fund (PSF) will go into the A&E and Non Elective Tariff meaning the funding will flow through to Bucks HealthCare Trust automatically. The allocations will not be received until December and the plan will already have been drawn up. A 2nd iteration of the plan will have to be produced with the must do's from the tariffs included. From a system position we look at the Buckinghamshire £'s available to us and divvy it up ignoring the tariffs/changes until late December when received. The assumption for the core allocation growth is 2.31%.

RM highlighted a need to capture what has been achieved this year by the staff and system. £30m+ savings have been found and this is due to the huge efforts of everyone involved. A Comms of some sort needs to be issued before the planning begins for next year. RM also mentioned that zero based budgeting may be the approach taken when planning for 2019/20. DR supported this strategy and felt that best practice could be used to highlight the system amounts that should be used to set the budgets.

TD mentioned that he was alarmed that the allocations may flow straight into A&E, what happens to cost improvement plans that are currently in place for Bucks Healthcare Trust if this occurs? How do we collectively keep this on track? GH responded that part of the role this year is to due diligence on CIPs and Qipps collectively; there should also be a system target on system savings. The plans for this year should be developed as a system first and by organisation as the second phase. The challenge as a system will be approximately £50m gap for next year. RM asked if doing something bold such as keeping the growth aside to fund transformational saving schemes would be a better approach and would help to change the mind-set. TD replied that this would be dependent on the 'must do's' required such as Mental Health.

DR explained that Frimley continues to be a risk of over performing for winter. To provide assurance DR has established close working relationships with the COO at Frimley, a South Facing Bucks project is coming online, winter monies have been given ensuring the CCG as closer this winter than last. TD enquired if Frimley were in Financial recovery? GH confirmed

	that they are and they will want to maximise income. RM enquired when the additional commission post would start. DR responded that this post starts in December and the Clinician post is being interviewed end of this week/beginning of next.	
6.	**Discretionary Spend over £50k for approval and STW (if applicable)**	
	AC ran through the Discretionary spend over £50k applications. • Continence Service – this has been approved at a Senior Management Team meeting. It is an investment to save and will be reviewed again in 6 months. The committee **APPROVED** this spend.	
7.	**Financial Policies and Procedure revision**	
	The Finance procedures and policies were issued to the committee prior to the meeting for review. Feedback has been received from various members. Frances Burdock from the contracts team has been asked to review all the policies to ensure they are consistent in format and language and make the required amendments. The Finance Committee where asked give GH delegated authority to approve the policies subject to comments received being incorporated. This was **APPROVED**.	
8.	**Governing Body Assurance Framework – risk review**	
	RC provide an update, the main points were: • Exercise completed to rewrite the existing risks in the IF, THEN, LEADING TO model and link them to the strategic and corporate objectives for 2019/20. • There are 2 main Finance lead risks are: - The QIPP programme is unable to deliver its end of year cost reduction estimates. - Providers exceed activity run rate projections incorporated into block or PBR contracts at end of the financial year. • There are a total of 7 BAF risks. GH reminded the committee that this is not the final version and Executive Committee had asked that a Clinical lead be appointed to the financial risks. The decision as to who this should be needed to be made but the Clinical Chair was suggested. GH asked that a reference be added stating that the 1st audit of the QIPP had provided 'reasonable assurance' and that a Task & Finish Group had been formed by the PMO function to complete the set of actions taken from the audit. The date of completion is still to be confirmed. • The 2 Financial risks have been added to the existing BAF format. The process of adding controls, assurances and actions has been started as this was a key point from the Financial Governance review. RC asked the committee if the information included on the risk register at high level was adequate or if further information was required. DR commented that action plans/documents monitored through other committees could be referenced in the GBAF with the lead being held accountable to Governing Body.	

	The Committee agreed the 2 financial risks and noted the GBAF would be discussed at the meeting on 8th November 2018. The committee also agreed that the controls, assurances, gaps and actions are fit for purpose at high level but a monthly reporting cycle needs to be developed.	
9.	**Any other Business**	
	December Meeting – a date has been proposed for Wednesday 19th December from 10-11am. This was agreed. **Winter monies** – A letter has been received stating that £1.67m funding has flowed through to Buckinghamshire County Council to be utilised for health and engage CEO's in the system. The general view of the CCG is that some of the funding received by the council should be used to fund D2A. The CCG have lobbied Bucks County Council for some of the funding. GS enquired what BCC plans are for the funding. This is currently unknown as the plans are yet to be shared. The finance committee were concerned to note that there had been no satisfactory engagement in the development of the plan for the spending of the monies received for winter pressures. This is to be referred to Governing Body on Thursday 8th November 2018. **Oxford CCG** - Rodger Dickinson from Oxford CCG has contacted TD to arrange a meeting to discuss integration across sites. A meeting with TD, RP and RD to be arranged. TD asked RM for an update regarding joint working with Oxford CCG and the permanent Chief Finance Officer role at Buckinghamshire CCG. Due to a conflict of interest GH left the meeting @12.05pm. RM explained that working with Oxfordshire has been looked at on the basis that things can be done on a larger scale where it makes sense to do so and creates efficiencies. Increasing this will need to look at what the STP can do especially as resource is now flowing through to the STP. NHSE/I are going through a regional re-structure currently and it is likely that there will be direct encouragement for the CCG to complete its strategic commissioning on a large scale such as STP level. This will mean Oxford and Buckinghamshire working together at STP level. TD asked if there is any proposed legislation that could change this. RM responded none that he was aware of in the proposed timescale. Commissioners can currently do a lot with regard to joint committees in terms of the current legislation. There may be changes to secondary legislation to allow the integration work to happen. **CCG Chief Finance Officer role**– an advert had been put out for a permanent Chief Finance Officer role within the CCG. The recruitment process has been pulled on the basis that an opportunity has been identified to appoint a Chief Finance Officer for the system (Bucks HealthCare Trust & CCG) due to the Chief Finance Officer from Bucks HealthCare Trust leaving. RM confirmed that as a statutory organisation there would always be a Chief Finance Officer on our board. There are examples where the Trust Chief Finance Officer is also the CCG Chief Finance Officer.	

10.	**Next Meeting Date:**	
	Wednesday 28th November 2018, Bevan Room, AV CCG Offices, 08.30am –09.30am	
11.	**For Information**	
	GH confirmed that the Financial plan would be bought back to the committee at the end of November 2018. The 1st draft has been requested for 14th January 2019, aiming for the plan to be written by end of November/beginning of December but this will be pre planning guidance. The 2nd iteration of the plan will need to be revised for 14th January 2019. GH informed the committee that a set of planning slides depicting how we do this as a system have been prepared to go to the ICS board on Monday 5th November 2018.	

NHS
Buckinghamshire
Clinical Commissioning Group

Executive Committee Meeting
Minutes

Thursday 27 September 2018 – 13:30pm – 17.00pm
Chair: Robert Majilton

Executive Committee Voting Members:

Louise Patten	LP	Accountable Officer (Chair)	Apologies Received
Robert Majilton	RM	Deputy Accountable Officer (Deputy Chair)	**Present**
Gary Heneage	GH	Chief Finance Officer	**Present**
Nicola Lester	NL	Director of Transformation	**Present**
Hannah Mills	HM	Director of Performance, Assurance & Contracts	Apologies Received
Debbie Richards	DR	Director of Commissioning & Delivery	**Present**
David Williams	DW	Associate Director, Quality	**Present**
Dr Karen West	KW	Clinical Director - Integration	**Present**
Dr Malcolm Jones	MJ	Clinical Director – Locality Lead – South	Left at 4pm
Dr Toby Gillman	TG	Clinical Director – Locality Lead - Central	**Present**
Dr Juliet Sutton	JS	Clinical Director – Children's	**Present**
Dr Rashmi Sawhney	RS	Clinical Director – Locality Lead - Wycombe	**Present**
Dr Dal Sahota	DS	Clinical Director – Urgent Care	Apologies Received
Dr Sian Roberts	SR	Clinical Director - Mental Health & Learning Disabilities	**Present**
Other Attendees			
Dr Stephen Burr	SB	Clinical Director – Locality Lead	Apologies Received
Dr Raj Thakkar	RT	Clinical Director – Planned Care	Apologies Received
Dr Rodger Dickson	RD	Clinical Director – Locality Lead	**Present**
Dr Shona Lockie	ShL	Clinical Director Medicines Management	Apologies Received
Dr Peter Newman	PN	Clinical Director – Locality Lead	Apologies Received
Dr Raj Bajwa	RB	Clinical GP Chair	Apologies Received
Gary Passaway	GP	Head of Urgent Care	**Present**
Russell Carpenter	RC	Board Secretary/ Head of Governance	**Present**
Frances Burdock	FB	Associate Director of Contracts & Performance	Apologies Received
Dr Stuart Logan	SL	Clinical Director Long Term Conditions	Apologies Received
Ian Cave	IC	Head of Commissioning Community services	**Present**
Neil Flint	NF	Head of Commissioning Planned Care	**Present**
Graham Jackson	GJ	Member GP	**Present**
Asela Ali	AA	Quality & Patient Safety Manager	Item 4 only
Minute Taker			
Gemma Richardson	GR	Corporate Governance Manager	**Present**

No	Agenda Item	Discussion
1.	**Welcome & Apologies**	Louise Patten, Dr Stuart Logan, Dr Dal Sahota, Dr Raj Thakkar, Dr Stephen Burr, Sarah Edwards

2.	**Declarations of Interest**	The Chair reminded committee members of their obligation to declare any interest they may have on any issues arising at committee meetings which might conflict with the business of Buckinghamshire CCG, the standing declarations were as noted in the Declarations of interest register. https://www.buckinghamshireccg.nhs.uk/public/about-us/how-we-make-decisions/registers-of-interests/ There were no additional declarations of interest from today's meeting. **Quorum** Accountable Officer or Deputy AO or Chief Financial Officer ✓ Two other Management Directors ✓ Four Clinical Directors ✓ With the above members present, the meeting was noted as quorate in line with the terms of reference. Potential conflicts of interest in relation to item 9 were noted regarding Re-procurement of Audiology. There are member GPs as voting members and standing invitees of the Committee who are partners in their practices which are in turn population based shareholders in FedBucks, a GP provider company. In isolation or in partnership with others, this company could apply for this contract during the subsequent procurement. The same conflict applies to Dr Raj Thakkar, CCG Clinical Director for Planned Care and partner GP at Pound House Surgery. This and any other conflicts will be addressed as part of the procurement process. As regards subsequent contract award post procurement, given the material conflict identified, future decision on award will be escalated to the CCG Governing Body. Therefore discussion in this meeting would focus on the clinical elements of the specification and no potentially conflicted members were permitted to remain and participate.
3.	**Guest Speaker topic:** **Bucks : Challenges & Opportunities**	RSh delivered presentation on Buckinghamshire Challenges and Opportunities, **Action: Presentation circulated to members.**
4.	**Quality Service, improvement & Re-design (QISR)**	Asela Ali, Quality & Patient Safety Manager NHS Improvement Quality Service Improvement redesign programme is a National programme which has been running since 2015, delivered by NHSI across the country. Emphasis has been on Trusts but has since spread across the whole patient pathway. In 2017 the *Building Capacity and Capability for Improvement* document was published- focusing on quality improvement, the concepts, tools and methodology enabling a targeted approach to quality improvement training. Following review by the PMO offices in relation to current and planned projects, and have developed a targeted plan for QSIR training across ICS partners and the STP footprint. • QSIR training has been designed by the NHS for the NHS and partners • Training is interactive and incorporates the knowledge and expertise in the room, for a broader spectrum of viewpoints. • Tools are also drawn from industry as well as healthcare with an overall health and welfare focus and are on the online cahoots platform.

		• Experienced based co-design is encouraged • QSIR has a wide cross section of teaching associates and cohorts from across the ICS, making QSIR unique for the ACT Academy. • Funding is provided by NHS Health Education England until the end of 2019. • Has garnered a high profile and has been involved in been involved in the NHSI marketing strategy for executive bodies, and will soon be involved in the ACT Academies marketing strategy. **Questions and Comments** MJ observed that the quality improvement methodology is similar to NHSIQ. AA advised that within NHSI there are a few teams such as, the ACT Academy and a team focuses purely on demand and capacity and delivering the training Nationally. QSIR also delivers demand and capacity day training but has developed this further to give local live examples rather than provide the NHSi slides, which may prove more beneficial for use within GP practices. DW advised that links had been made with the Oxford AHSN and Oxford Health's improvement activity, and therefore the QSIR approach has been to understand the group activity and methodologies being used from an ICS point of view. RM felt that the flexibility of the methodology works well along with the ethos and focus of encouragement and building upon achievable change. **Action: AA to return answer to the query from RM; "What's the one thing you could do for us, and what's the one thing we could do for you?"** *DW left the meeting*
5.	**Review & Approval of Minutes & Action log updates**	Minutes of the meeting held on 23 August; the following amendments were requested; Item 6. Urgent & Emergency Care additional resource to manage Non-Elective Demand; *RS said her area was one of highest users of Airedale and one of the highest hospital admissions and asked if Airedale was doing the job it should be doing? A particular example was one care home in RS's area had an issue which may need further analysis.* Item 8. Priorities for Locality Meetings over the next 3 months; *JS suggested using urgent care dashboards and locality focus. Given that localities were told they could set their own meeting agendas, JS felt that this posed a reputational issue.* Item 8. Priorities for Locality Meetings over the next 3 months; *RS challenged the first slide and stated that although localities agenda had reflected what was asked for by the CCG and what had been asked for in the CCG work plans, advised further clarity is required for what is considered commissioning and what is considered providing.* Item 13. Programme Board reports- top three headlines and escalations Joint Care subheading to be amended to *JCDB Update.* As an update to the group regarding ongoing funding, RM reported that the Trailblazer site bid has now been submitted. DR added that she had raised the significant opportunity and potential risks regarding Mental Health bids to NHS England. **Update on actions:** Action 95: FedBucks/CCG Joint Board. Significant discussions regarding the mobilisation of the 8:8- **action closed.** Action 96: Programme Board Localities-Population Health Management- **action open**

		Action 108: ICS Development- DR reported that this has been raised but will pick up again. RM requested the correct version is cascaded and JS stressed that Children's care is set separately- **action open.** Action: 109 Urgent & Emergency Care- With regard to Discharge to Assess, this item was approved at Governing Body. Delegated authority to GH was agreed- **action closed.** Action: 110 End of Life Planning in care homes- DR reported a proposal had been developed- **action closed.** *RD entered the meeting*
6.	**Chief Officer's Report / System Working & Planning & Programme Update**	RM opened up the meeting for questions on the report; In response to a query regarding standing down of programme boards DR advised Karen Jackson-SRO for Integrated Programme Board is working with management leads for existing Boards to map against current and future transitional arrangements. Until the mapping process is complete, operation of boards remain business as usual. The Executive Committee was asked to consider one area of priority for discussion at the October Clinical Care Senate. RM drew attention to the list on page 5 of the report and requested the group to nominate one, or any additional priority for clinical focus to put forward. **Decision:** The Executive Committee agreed the following topics could be put forward: • Clinical support to care homes (linked to EOL plans) • House bound elderly patients **Action: A proposal is to come back for discussion at Executive Committee regarding potential delegation of areas of process commissioning to system-wide clinical groups.** DR to liaise with Jane Butterworth in order to map the current, the transitional, changes made, and options for the future. DR was mindful of the transparency and stated the CCG would need to be clear with regard to delegation of clinical or financial responsibility.
7.	**Winter / Urgent care Update**	a) EPRR Assurance DR attended the Assurance Confirm and Challenge meeting with NHSE as Accountable Emergency Officer prior to Executive Committee, and summarised the report along with informal feedback from the NHSE meeting; The CCG had reported full compliance against 41 of the 43 EPRR core standards, and reported partial compliance on 2 of the 43 standards. The CCG had provided plans for achieving compliance and mitigations against the element of non-compliance, which were accepted by NHSE. *Informal feedback:* NHS England were assured the CCG had been through a robust and thorough process of self-assessment, and had described the CCG's approach as critical and honest and were assured that good processes are in place for assurance to Buckinghamshire Healthcare NHS Trust. Once formal feedback is received this will be reported through to Governing Body. The following polices were recommended to the Executive Committee as having undergone a robust process of review and update, aligning against NHSE national guidance; b) CCG Business Continuity Plan c) Surge and Escalation Plan **Decision: The Committee ratified the process of assurance and approved the revised policies.**
8.	**Sickness Absence**	The Committee is asked to ratify the Sickness Absence Policy based on the assurance that the policy had been reviewed by HR and is recommended from the Staff Partnership

	Policy	Forum. NL advised the policy is revised every three years and is updated to align with National law and now includes; • CCG's membership of the Mindful Employer Network • Mental health issues have parity with physical health issues • A full Equality Impact Assessment. **Decision: The Committee ratified the update policy.** **Action: RC to develop proposal regarding management and assurance process for policies submitted to Executive Committee**. *NF joined the meeting*
9.	**Re-procurement of Audiology**	The Executive Committee was asked to: 1. NOTE that current AQP contracts are ending with no option to extend, therefore we are required to introduce a new service with resulting procurement. 2. NOTE that part of the forthcoming procurement process will include options for contractual model and payment mechanism. 3. AGREE recommendation to include ear wax removal in the procurement specification, a non-commercial version attached for COMMENT on the clinical elements. NF summarised the paper. The Chair recommended the group focus on clinical conversation and collective input regarding proposed specification and clinical pathway. RM advised the process by which the CCG secure services and construct contracts would be discussed outside of the meeting given **Questions and Comments** Q: What method is being considered for ear wax removal? NF advised the method is micro-suction. Q: Are all providers required to provide domiciliary care as the elderly are more housebound? NF advised there has to be a mandate that domiciliary care is still available; however there will not be a stipulation that a provider has to be the one to deliver the service. Providers can sub-contract out to another. Q; Service specification section 3.4 Any acceptance and exclusion criteria thresholds *"People with learning disabilities and some requiring domiciliary care may require special test facilities and techniques. It should be the responsibility of the referring clinician and provider to manage between them the appropriateness of referral/treatment according to a person's needs and not automatically exclude them from this service because they have a degree of learning disability or require domiciliary care."* RS asked how the referring clinician would know whether or not the AQP provider could provide this service. NF advised that this is still an area within the service specification which is being worked on. Q; Why is the GP required to do the written referral for someone in a care home, as opposed to a care home manager or relative? NF advised we have to be mindful where some providers may not have capability to do this, but suggested this is something which could be built further into the specification. Q; Will the use of micro-suction be an extra cost to the System in addition to the current audiology service or will this be bolted in? NF advised this service is to be bolted in KW stated that volumes will be higher than expected if self-referral is made too easy. NF advised that criteria has been built into the specification where by a provider would have to accept responsibility for the self-referral in the first instance DR raised a query regarding age applicability and drew attention to section 6

		Recommendation; "The Executive is asked to note the proposals for commissioning Audiology (Hearing Loss in the over 55's) set out above and comment." Where elsewhere the papers refer to the registered population? JS clarified that if a patient is under 55 years old and has hearing loss, they must be referred to ENT. **The Executive Committee:** 1. **NOTED** that current AQP contracts are ending with no option to extend, therefore we are required to introduce a new service with resulting procurement. 2. **NOTED** that part of the forthcoming procurement process will include options for contractual model and payment mechanism. 3. Concluded that it was not appropriate to further comment on a recommendation to include ear wax removal in the procurement specification given the potential conflict of interest highlighted, but provided input on clinical elements, requesting further work to the specification of the overall audiology clinical pathway. The committee are in support of an integrated model of service provision.
10.	**TVPC – policy check**	RC advised that previously the Executive Committee had delegated **Approval** of Thames Valley Priorities Committee recommendations to the Right Care Programme Board. As the RCPB is now disbanded, the Executive Committee is asked to **Approve and Ratify** policy recommendations from Thames Valley Priorities Committee (TVPC), on this occasion. The Executive Committee was not assured that the appropriate level of localized discussion and clinical review had been undertaken prior to submission to the meeting. **Action: A virtual clinical review of the recommendations to be coordinated by RT and NF and RCPB clinicians, to provide comment/endorsement of changes, to the Executive Committee. Following which the Committee will virtually Approve and Ratify the changes.** *Comfort break* *DW left the room: Confidential section presented*
11.	**Member Engagement Action Plan / 360 degree survey**	The Executive Committee is asked to **discuss**; 1) 360 degree survey report for 2018 2) CCG Action Plan RD presented updates and feedback following review with locality leads, on the results of the 2018 360 degree survey (commissioned by NHS England). RD reported the 2018 survey questions were different from the surveys run in the previous two years. 56% of practices had responded to the survey, along with Health Watch and 1 of the 3 provider organisations invited to reply. The areas of positive feedback pulled through are; • BCCG were thought to be an effective organisation and system leader • There was confidence in the CCG • There was confidence in the CCG leadership, which is well liked. • High value for money and good quality RD advised that the arear of poorest feedback is with regard to influence of members on CCG plans and priorities. Feedback shows localities would like to have an influence on commissioning decisions. An option is to ensure the information that portfolio leads have, is sighted at locality meetings, to allow debate on priorities. Feedback on the CCG Action plan; In order to have well informed localities the following are required; • Better information, relevant to localities (on finance, performance, quality) in order for the right decisions to be made. • Scrutiny of commissioning plans at Executive Committee, for locality leads.

		Questions and Comments: RS stated that Chiltern CCG used to take the draft commissioning intentions to localities for input and help with prioritisation. Being sited on commissioning intentions proved useful and there was a clearer sense of what patient needs were. A two way conversation is important and taking feedback to modify commissioning intentions, to not risk a lack of confidence in the structure if members do not feel listened to. GH highlighted a number of actions are proposed for September and October- what is the next step? RD advised that a number of options are being looked at which would tie this together, such as quality and performance reports. SR stated that Executive Committee need to be amenable and should be acting on the feedback received. Due to financial recovery the committee should be mindful that we may not be able to satisfy all of our members and there should be consideration as to how committee members might mitigate and manage expectations after feedback. RS advised positive engagement is key to members feeling valued and supported. RM recognised that, unlike previous years, clinical teams and the locality team have picked up this, and have taken actions forward or have had positive discussion regarding how information is best reported to localities. The next challenge is to work out how we are to continue to engage with members as a membership organisation, whilst benefitting from working at scale within an ICS, and how CCG would engagement reflects our aims at system level. **Action: RD and SK to submit a summary of the report in time for the next Governing Body meeting.** *DW joined the meeting*
12.	**Flu update / Pandemic Flu Plan**	DW provided a verbal update; Flu outbreaks and Pandemic planning; we have been through a process regarding how this will be managed, and the document which will describes the management is currently in final stages of agreement, with a view to share for final discussion in readiness for circulation in October. The CCG Pandemic Flu plan has been updated with NHS England operating framework guidance. Conversations with Oxfordshire CCG have commenced with regard to how these are aligned across Buckinghamshire and Oxfordshire. Seasonal flu vaccinations; A follow-up exercise was undertaken a few weeks ago with practices in understanding where there have not been orders submitted. Two practices have been identified where there may be possible vaccination supply issues. Guidance is currently awaited from NHS England with regards to the potential to transfer patients to alternative practices to obtain their jabs in instances where we know there are supply issues. The team is exploring ways in which we can receive real-time information on uptake and usage, how this could be shared proactively. Tops tips have been shared, such as liaison with the communications team to enable the better promotion of public health massages. This has been shared with PALS, Health Watch and MASK so they are aware of how this is being managed. Any further updates would be shared going forward. SR put forward a query raise by Public Health, regarding whether or not we capture and hold flu uptake for primary care? And advised that this is an important key area that needs to be considered for tracking resilience. **DW will take back and pick up with the team.** *DW left the meeting*

13.	**GBAF**	The Executive Committee is asked to: **1) NOTE** findings from RSM financial governance review in relation to the role of the Governing Body Assurance Framework (GBAF) and Corporate Risk Register. **2) DISCUSS** and **COMMENT** on existing GBAF risks aligned to the Executive Committee(Appendix 3), taking into account the following: •Do we really understand what they mean? •Can they really provide assurance if we don't understand them? •Do the supporting descriptions (specifically controls, assurances and actions to be taken to mitigate gaps) Aligned to the roles and responsibilities of the Executive Committee, RC requested the committee review the risks and definitions of the risks it owns-. Appendix 1 extracts and highlights the executive committee risks on the GBAF (risk numbers; 1, 3 12 and 14). **Discussion and Comment;** DR challenged risk number 14 as disruption to the CCG's service continuity and organisational delivery would not impact patient care, as were are not a provider or CQC registered. As commissioners, the CCG would look for assurances around there the ability of providers to ensure business continuity. RS stated that payment to providers, and provider staff would be affected if the CCG did have adverse disruption to its business continuity. RM advised that payment to providers and staff would be the priorities in our business continuity plan. The question is whether or not this is a strategic risk or a business continuity corporate risk? **Decision: The Committee agreed risk 14 should be incorporated into the corporate risk around business continuity.** RS queried how Executive Committee could mitigate risk number 1. RM advised this risk seemed to be a system risk. DR was mindful that if there is a system risk, it still needs to be owned by a statutory organisation as the system is not accountable as a statutory organisation. RS felt the committee has no influence on risk 1 and therefore could not mitigate against it. RS suggested ownership is at Governing Body level. KW asked how the corporate risk register linked into GBAF. RC advised they sit side by side. The GBAF currently does not follow the IF,THEN, LEADING TO model- whereas the corporate risk register works on the escalation and de-escalation basis from Executive Committee where risks are only reported upward to the Governing Body where they hit the threshold of 15 or above, and those would be reported alongside the GBAF. RM summarised the four corporate objectives; Transformation and commission services under the FYFV, Finance, Performance, and Transition of the system. **Recommendation: The Executive Committee recommended, as an organisation we describe, under the IF, THEN, LEADING TO model review the strategic commissioning risks around deliverance of the 4 corporate objectives- which the Executive Committee would own the mitigation.** **Action: RC to complete and bring back to the next Executive Committee meeting and then submit to Governing Body.**

14.	**Localities – top three headlines & escalations**	Wycombe RS reported Kate Holmes attended the last locality meeting and went through the financial headlines. RS did a presentation on planned care- "winter is coming" which provided options regarding what is available and access links- to use as an aide memoir. RS advised she is working on a planned care for the coming locality meeting and awaits information from NF to complete. RS mentioned Script Switch data was shown at the most recent meeting – as we are now receiving this data more regularly is there an opportunity to support practices to increase the usage of this in year as there appears to be a high potential for savings and variation across the county. Amersham & Chesham (RS on behalf of SB) • Members felt extension of MUDAS would be helpful. • SB to liaise with and invite clinical lead Dr. Hassan from BHT to discuss MUDAS and CATS pathway and expectations, particularly due to lack of proximity of some services and feedback regarding others. • Amersham has asked for support of CCG Exec team and nomination of CCG management representative to attend subsequent locality meeting and monitor feedback being given to the trust. • PCDS dashboard to be reviewed with particular focus on specifications o aimed at reducing GI bleeds, heart failure, medicines optimisation, o COPD rescue pack and flu vaccinations – all measures that if were adopted sooner rather than later could help avoid admissions in these realms • Request the Exec nominate the appropriate CCG clinician/management lead who would be monitoring secondary care data to provide feedback on PCDS and if it is making a difference. GH advised the CCG is working on a provisional project for prescribing. There is more work to be done by the CSU, but the hope is for this to go out to practices and localities. RS asked if some headlines could be provided for inclusion in the upcoming locality meeting. RD reported there is an issue regarding manager's engagement within BHT surrounding software/IT and Rio. Improved access has been underway since April Constituent members are complaining about the quality of discharge summaries. Liaison with Rob Hicks is being organised to work through issues. *RD left the meeting.*
15.	**Q&P (Month 6)**	DR provided the highlights from the Quality and Performance report (Month 6): • In July RTT did not meet the National standard of 92% but met the 90.4% Local trajectory agreed with NHSE • 19 breaches of 52 week waits- Majority under OUH who advise they have an improvement plan, being monitored nationally and locally. • In July Cancer 62 day standard achieved 77.2% against the 85% standard (98 of 127 patients seen in time) remaining a concern. A recovery plan is in place and recovery expected to show from October. The new ICS Board ACE will be seeking further assurances as we are not achieving this quality standard. • A&E 4 hour wait; September looks to be an improved month as BHT is currently on track to achieve 90% for September provided there are no more than 27

		breaches over the coming weekend. Indicative of an improved level of understanding and operational ownership at BHT. • Improvements are being seen with regard to GP Triage, which is aggregated up to SCAS • Significant reduction in handover delays DR outlined current priorities: • Now out to advert for a Winter Director. • Focusing on the Winter Plan. • ICS Transformation money: Procurement process undertaken for a strategic partner to focus on capacity and demand across the system. McKinsey has been awarded the contract. • Non Elective areas of Focus; - NHS 111 remains off track with only 78% of calls answered within 60 seconds, achieved against the 95% standard. Extra funding provided toward clinical support for the Christmas period. - Impact of NHS online triage and assessment is not yet tracked in the report. There is hope this will pick up traction in the coming months as the volume of service users using NHS 111 is higher than expected. • Reducing length of stay; NHS England are supporting an ongoing piece of work, revising internal systems under BHT in order to improve discharge from moment of arrival. • Workforce Risks; Gaps in workforce for GP triage and A&E consultants • DR reported that August ERS coverage shows significant improvement and is up to 92%. **Questions and Feedback** JS reported BHT Paediatrics' have appointed to three of the four consultant posts advertised, and will be starting in the new year. The fourth position is to be re-advertised. A respiratory Nurse Practitioner is also appointed along with a Specialist Nurse, specialising in children's constipation. Q: Is there any evidence that SCAS has is meeting a less than 8 minute response time to GP practices for children and for adults when the practice calls? **DR advised this was happening but would need to feedback to the meeting.** KW reported that following submission of the previous quality and performance report to Governing Body; there was a request for data to drill down to locality level and to include more primary care based information. SR stated that it is unclear if ambulances are able to access My Care Record when out of base and on the road? **Action: RM requested that the Digital Transformation presentation be submitted to Executive Committee.**
16.	**Financial Management**	a) 18/19 Plan (update) Key messages • The CCG has moved the previous reported risks of £8.7m into the FOT position and are fully mitigated. At month 5 £4.6m has materialised leaving a contingency of £3.5m with 7 months remaining. Although the position is balanced, it will prove difficult to hold until the year end. • Pressures continue- Frimley section 117 placements, QIPP under delivery and starting to see pressures in the independent sector, particularly BMI. • Expected to land the Quarter 2 Commissioner Sustainability Fund (CSF) of

		£5.5m. • Sensitivity analysis undertaken over the last weeks August as the first month where Net risks are showing at 400k. • CCG continues to explore avenues to mitigate risk to ensure that the CCGs maximise it opportunities and deliver against its targets. • System Financial position; BHT's position deteriorated by circa. £2m between month 4 and 5, and BHT now show a variance position of £7m at month 5. GH working with Director of Finance at BHT to ascertain the ICS OT position. **Questions and Comment** Q: Regarding NEL patients going to Frimley is there a System pressure which may be applied for SCAS to send Wycombe patients to BHT? **Action: GH and DR to review data and feedback.**
b)	**Approved Minutes (for information)**	The following minutes were noted by the Committee: a) A&E Delivery Board (21.08.18)
c)	**Close & Date of Next Meeting**	25th October 2018 @ 1.00pm – 5.00pm - Bevan and Nightingale Rooms, Second Floor, Aylesbury Vale District Council, the Gateway, Gatehouse Road, Aylesbury, HP19 8FF **AOB:** NL notified the committee that the CCG Chief Finance Officer role is to be appointed substantively, and an advert will be posted onto the NHS Jobs website the on 28th September.

NHS
Buckinghamshire
Clinical Commissioning Group

Executive Committee Meeting
Minutes

Thursday 25 October 2018 – 14:00pm – 16:50pm
Chair: Gary Heneage, Chief Finance Officer

Executive Committee Voting Members:

Louise Patten	LP	Accountable Officer (Chair)	**Present** (*from 14.00 – 14.40 only*)
Robert Majilton	RM	Deputy Accountable Officer (Deputy Chair)	Apologies Received
Gary Heneage	GH	Chief Finance Officer	**Present**
Nicola Lester	NL	Director of Transformation	**Present**
Hannah Mills	HM	Director of Performance, Assurance & Contracts	Apologies Received
Debbie Richards	DR	Director of Commissioning & Delivery	**Present**
David Williams	DW	Associate Director, Quality	**Present** (*for item 10 only*)
Dr Karen West	KW	Clinical Director - Integration	**Present**
Dr Malcolm Jones	MJ	Clinical Director – Locality Lead – South	Apologies Received
Dr Toby Gillman	TG	Clinical Director – Locality Lead - Central	Apologies Received
Dr Juliet Sutton	JS	Clinical Director – Children's	**Present**
Dr Rashmi Sawhney	RS	Clinical Director – Locality Lead - Wycombe	Apologies Received
Dr Dal Sahota	DS	Clinical Director – Urgent Care	Apologies Received
Dr Sian Roberts	SR	Clinical Director - Mental Health & Learning Disabilities	**Present**
Other Attendees			
Dr Stephen Burr	SB	Clinical Director – Locality Lead	**Present**
Dr Raj Thakkar	RT	Clinical Director – Planned Care	**Present until 15.30 (***co-opted as a Voting Member for this meeting*)
Dr Rodger Dickson	RD	Clinical Director – Locality Lead	Apologies Received
Dr Shona Lockie	ShL	Clinical Director Medicines Management	**Present**
Dr Peter Newman	PN	Clinical Director – Locality Lead	Present
Dr Raj Bajwa	RB	Clinical GP Chair	**Present**
Russell Carpenter	RC	Board Secretary/ Head of Governance	**Present**
Frances Burdock	FB	Associate Director of Contracts & Performance	**Present** *(for item 10 only)*
Dr Stuart Logan	SL	Clinical Director Long Term Conditions	Apologies Received
James Limehouse	JL	Senior CHC Commissioning Manager	**Present (***for item 7 only)*
Ian Cave	IC	Head of New Models of Care	**Present** *(for item 7 only)*
Simon Kearey	SK	Head of Localities	**Present**
Minute Taker			
Sarah Edwards	SE	EA to Chief Officer & Deputy Chief Officer	**Present**

No	Agenda Item	Discussion
1.	**Welcome & Apologies**	Dr Stuart Logan, Dr Dal Sahota, Dr Malcolm Jones, Dr Rodger Dixon, Dr Tony Gillman, Dr Stephen Burr, Dr Rashmi Sawhney, Robert Majilton, Hannah Mills,

		LP informed the Committee that Dr R Bajwa had been duly voted back in for a three-year term as Clinical Chair and thanked the candidates for their impeccable behaviour during the process. LP extended commiserations to Dr Karen West.
2.	**Declarations of Interest**	The Chair reminded committee members of their obligation to declare any interest they may have on any issues arising at committee meetings which might conflict with the business of Buckinghamshire CCG, the standing declarations were as noted in the Declarations of interest register. https://www.buckinghamshireccg.nhs.uk/public/about-us/how-we-make-decisions/registers-of-interests/ There were no additional declarations of interest from today's meeting. **Quorum** Accountable Officer or Deputy AO or Chief Financial Officer ✓ Two other Management Directors ✓ Four Clinical Directors ✓ With the above members present, and the co-opting of Dr R Thakkar the meeting was noted as quorate in line with the terms of reference.
3.	**Review & Approval of Minutes & Action log updates**	Minutes of the meeting held on 26 September 2018: the following amendments were requested: Page 6 Item 7 should read EPRR Assurance not EPRR major incident and as "accountable emergency officer" to be added. To note that once formal feedback is received this will be reported through to Governing Body. Page 9: Item 12 – typo – "Public House" should read "Public Health" AOB update: The CFO role advertising has been put on hold due to the resignation of the BHT Director of Finance and the potential to go out for a system Director of Finance. RC noted thanks to Gemma Richardson for standing in as minute taker for this meeting. **Update on actions:** Action 108 Children's services at the Task & Finish Group. This has been raised once with Karen Jackson and revised Governance arrangements for the ICS to be picked up with her again, also been raised with Louise Watson at a recent SRO meeting. Action 110 – action closed Action 112 QiSR – feedback at next meeting – action open Action 113 Chief Officer's report – TVPC item on agenda, delegation of policy procedure type work to be informed by Item 7 - to come back next month – action open Action 114 Sickness Absence Policy – deferred to November agenda – action open Action 115 TVPC policy check – on agenda Item 7 Action 116 Member engagement action plan – Updated provided at last GB - action closed Action 118 Q&P report – deferred to November agenda – action open Action 119 Financial Management – Picked up as part of overall clinical work with SCAS on ambulance conveyancing. Reductions seen on Cat 3 and Cat 4 with on-going clinical audit. SCAS paramedic OT pilot due to launch next week. Wycombe work needs mapping to be completed.
4.	**Chief Officer's Report /**	The Executive Committee are asked to note the following updates: Approach to Planning 19/20 & 5 year plan (19/20 – 20/24)

	System Working & Planning & Programme Update	We have received a joint letter from NHSE/I. The main points are: • We are expected to deliver a 1 year operational plan for 19/20 (by Summer 2019 expectation of a 5 year system plan) • 5 year allocations due by end December with planning guidance mid December. • General view lots of changes in terms of tariffs. Blended approach to A&E tariffs with fixed elements and variable elements. Benchmark for activity levels and anything above or below will be variable element. Re-admissions no longer in place, MRET to be removed. Key is Boards and Governing Bodies need oversight of the development of plan. DR asked about shifting activity out in to A&E GP streaming, this is adding pressure and will blended pricing help with system conversations. GH replied there is a move away from PBR and move to cost recovery. Early indicators are we will continue with some sort of block with BHT and a block type contract Frimley as part of the ICS. RB asked if the 5 year allocation means we will know what we are getting for 5 years or does it mean we have flexibility within the 5-year budget? GH advised we will know what money is over the next 5-years and this will aid long term planning and enablement commitment to more than just one year projects. DR queried that we are around 10-13% less in allocation, will 5 year funding build in expected population growth? GH said we are circ 4% distance from target and in previous years less than 5% is deemed acceptable, although in terms of the plans areas for review are market force factors and population growth based on ONS statistics should have a positive impact. A large proportion of PSF is expected to move into Tariff. Cost of the BHT contract could go up by c£12m to reflect the PSF. Key dates are different this year with an early submission due on 14th January 2019. Draft of plan needs to be ready early December signed off by Finance Committee and Executive Committee however this will be pre the planning guidance. A further iteration will need to be done once planning guidance comes out. Final submission due by end April. LP advised this needs to be co-ordinated through the STP. Consistency must be seen between Bucks and Oxford and aligned with Berkshire West. DR asked about the ICS operating plans and whether this needs to be influenced to ensure they align across the STP. The one year plan feeds into ICS plan and then consolidates with the STP. NL asked how will this work if other areas don't wish to align. LP advised there is already alignment between Frimley and Berkshire West and we need to create some alignment between Oxford & Bucks. ICS Group update – main headlines: • Feedback from 11th September Assurance meeting; • Winter planning – *see Item 12;* • Development of the Buckinghamshire Integrated Care System. Buckinghamshire, Oxfordshire & Berkshire West (BOB) STP • £11.5m on digital health & care received from NHS England for 12 prioritised projects; • £7.5m of capital has gone into the Frimley system and beyond to fund digital records for access beyond STP.
5.	**Protected Learning Time (PLTs) for Financial year 19/20**	The Executive Committee are asked to: 1. **Approve** the recommendation that CCG PLT sessions should continue in 2019/20 2. **Agree** the scheduling of the PLT dates for 19/20 in line with the CCGs corporate business (that is noting Wednesdays and Thursdays are CCG clinical days)

		3. **Agree** the CCG will continue to lead on 4 sessions per year; noting the financial cost of venue and catering costs (see paper). The CCG has committed to rotating the venue round the County to ensure equality of access. SK summarised the PLT paper: • PLT increasingly successful (155 attended last event). • Great variety and engagement with agenda items • Engaging far closer with BHT in terms of pathway items and well supported nurse led sessions and focused items for practice managers and GPs • Networking opportunity for colleagues • Further discussions on who leads etc KW felt uncomfortable with the "notional" cost included in the paper. DR said SCAS and 111 state that PLT increase their call level and patients complain that they cannot get appointments. RB felt that we need to reflect on why a paper came to the Committee without being seen by the Clinical Chair who is also a member of the PLT steering group. NL commented that papers come to Exec for discussion, however RB felt that if paper was a co-production with a clinical input it would be easier to make a decision. The Chair agreed that paper needs to return next month once it has had further clinical input. SR explained that providers value PLT as a way to engage with GPs. RT said that whilst PLT enables networking and encourages communication is there a mechanism where we can have a nominal clinician on call to enable a degree of access to primary care? RB agreed that this lends a need for a more considered discussion. GH reiterated that a discussion outside of this meeting was needed seeking views of clinicians and the paper to return next month. • A lack of senior management presence at PLT has also been noticed. NL said we need to face the question that some areas (including London) have no protected learning time at all. **Decision: The Committee agreed that the paper should return to the November Committee after a conversation takes place outside this meeting, incorporating clinicians, to review the proposals and to come with a recommendation.**
6.	**Executive Committee delegation arrangements – Thames Valley Priorities Committee**	The Executive Committee are asked to: **1. APPROVE and RATIFY the proposed amended** process for consulting on, approving and ratifying adoption of Thames Valley Priorities Committee recommendations, including appropriate clinical consultation. **2. AGREE** recommendation that these arrangements are reviewed in six months to report back to the CCG Executive Committee. KW explained the process on how policies go through the ratification process. The change suggested going forwards would be for the process to go through the Clinical Care Senate before going to TVPC for evidenced based discussion – it should then come back around to a Clinical Executive for final decision. RC suggested in theory we should keep discussion to a minimum at this Committee as it will have gone through a round of discussions involving the Senate. SL asked for it to be noted that papers were not circulated to Dr Campling and were not individually coming to her. DR said she will ask JB to formally note this. **Decision: The Committee approved the revised process.**
7.	**CHC Equity & Choice Policy**	The Executive Committee are asked to:

	CHC Exception Panel Terms of Reference	R**eview**, **Approve** and **Ratify** the Refreshed CHC Equity and Choice Policy and CHC Exceptions Panel Terms of reference, the former, which was supported by the CHC Development Forum and the latter by the members of the CHC Exceptions Panel: JL provided an overview of the need for refreshed Equity & Choice policy due to change in new CHC provider which has been subject to full consultation with all stakeholders and has had full judicial review. Policy has been reviewed by Healthwatch, Bucks County Council and Carers Bucks and their feedback is factored into the refreshed policy. Further amendments may be made next year due to CHC and BCC brokerage functions being merged. ToRs for CHC Exception Panel are aligned to the policy and the CCG scheme of delegation to ensure decisions made are clinically led. RC confirmed both documents have been checked for consistency and aligned with other policies. • KW identified a risk in relation to the number of Exception Panel meetings as there is no GP Deputy • DR recommended that it was a clinician that sits on this group as it informs clinical financial decisions. • A line needs to be added to the ToRs to ensure that a nominated deputy can sit in on Exception Panels. **Decision: The Committee ratified the refreshed policy with the above amendments.** *15:30 RT left the meeting after this item and at this point the committee was no longer quorate but no further decisions were due to be taken.*

8.	**GBAF**	The Executive are asked to: **DISCUSS** and **COMMENT** on newly defined GBAF risks aligned to the Executive Committee, taking account of discussion points described. RC requested that taking each existing risk and examples in the paper to give some thought as to how we might merge some existing risks to be better defined? Do Executive Committee members think the way in which we have reframed these risks fit what our we think our current risks are as a CCG? Are they linked back to 5-year strategic objectives and corporate objectives agreed by Governing Body? More work is required to focus on controls and assurances and gaps and the actions required to rectify gaps. Existing Governing Body assurance framework uses the word "on-going" to describe actions required. • NL said the first risk "the CCG fails to align it's priorities and plans to whole system ……" puts an emphasis on the plan which is not what it is there for. Plan misleading to health – if then leading to – is the refined version of risk – does this make sense and help us better control our risks. RB asked where is this looked at? RC replied Governing Body and needs to be reframed on the Governing Body agenda to allow more time for this work. The recent RSM financial review highlighted that this conversation is not happening at Governing Body. • Risk 2 – is there a word missing "reduce motivations for remaining CCG…" the word "staff" is missing Further develop controls assurances on GBAF template to ensure it meets controls assurances, looking specifically in relation to risks aligned to the Executive Committee. Volunteers from this Committee are requested. The exercise needs to be dynamic and add value and not treated as a tick box. DR suggested that risk owners should sit down with colleagues and review their risks. **Action 119: DR/RC meet with clinicians to review the following risks:** • BMS / KW - 5YFV/transformation work • StL - Pathways • DR/RB - Capacity across commissioned services • KW - Quality • Clinical Lead to be added to Finance risks – to be discussed at Finance Committee
9.	**Localities : top three headlines and escalations** (standing item)	• Improved access went live at start of October – a few issues remaining. Some localities not receiving as much cover of patients as others and more work required. Good meeting around derivation of locality dashboard around key priorities. Locality dashboard will go through a process and will be delivered by 9th Nov. SB said a feedback loop has been developed from an SMT aspect and shared with CLLs. It was felt it was silly to have two separate meetings and the opportunity for a once a month opportunity to get everyone in same room. **Action 120: Joint clinical lead/SMT monthly meeting proposed.** • Meeting held last week convened by Jane McVea and Louise Smith and has a clear plan for work to be carried out by CCG staff over the next 5 months. There is uncertainty as to what process this went through as it has not been to the Executive Committee or Governing Body. DR said this should be worked up through the Integrated Transformation board in the ICS. NL has seen the presentation as it was delivered but was not involved in work to put together. The CCG is not required to sign off ICS work as they have been given the mandate to develop localities.

		• There is an ask for localities to deliver primary care networks and new models of care and they are slowly forming teams within localities, Central are quite far ahead but other localities are still at starting blocks. NL advised that as far as she is aware the document has not gone through any form of governance. • SB advised funding is available but it is not known where this funding is or what it can be used for. A working group to be formed to get locality funding fully agreed. The "ask" is to deliver by end of March and work needs to be started. • RB commented that BSMs and clinicians need a clear steer on this if they are to implement networks effectively. • Content of presentation contains a lot of work that has been seen by this Committee and the visibility could be down to lack of communication and presentation style. We need to get behind this, deal with the imperfections and build from the learning. NL summarised that the key is identifying the clinical leadership. • **Action 121: GH agreed to bring a paper to this Committee each month to provide visibility on how the ICS transformation monies are being spent. GH will also brief RB separately.** • SR asked about the role of this Committee in regard to the Joint Care Delivery Board (JCDB) is still carrying on but seems to be in limbo and clarity is required. It is evident we have an integrated Executive team that oversees but need to be clear about the role of ICET. DR confirmed that agreement was reached at ICET this morning that the JCDB should continue in its current form and report into ICET and this will strengthen governance. RB queried whether the CCG Executive had a view on what locality leadership needs in order to deliver the CCG statutory objectives? It was concluded that it was important to understand ICS expectations of future models for delivery in order to answer this question. **Action 122: Jane McVea's presentation on Locality Implementation of the Care Model to come to the next Executive Committee to update where we are with this.**
10.	**Quality & Performance (month 6)**	DW & FB joined the meeting to give an update on Quality & Performance: • Cancer monitored on a weekly basis – BHT a lot of work has gone in • 64 day screening decline this month due to complex patients • Clinical harm reviews are being carried out for patients waiting. Complex cases may involve multiple pathways, diagnostics and challenges around when patients need to go to other centres for diagnostics. • Some delays identified around choice have been resolved in London and a visit is planned to that Trust to look at how this was achieved. • We are well sited on quality issues from a BHT point of view but more challenging with the tertiary centres. • Tertiary referrals are reported weekly to-date with 25 waiting at Oxford out of 35 total. Basingstoke, Harefield, Mount Vernon and UCLH. Able to access information but also a concern that we are not always getting the detail requested. • RTT remains a struggle for most providers. BHT are working to improve. Conversation at meeting was about taking more of a view on waiting lists and validation. RTT will probably slip in October to 87%. Essential to get an accurate waiting list rather than just asking patients to come in and then deciding a procedure is not needed or patient decides they don't want it. • A&E waiting times, hard to meet, Oxford below NHSE average. OUH A&E have formerly appointed a Winter Director. This is a senior system post working with a winter team. Social Care, CCG, community & acute teams are all working together on site at the John Radcliffe to try and improve system support for the overall target.

- Winter officially starts on 1st November. NHSE and NHSI have set up their winter operating model. Winter Operating Look Forward (WOLF) calls will be held every Thursday chaired by Anne Eden. The 8 most challenged systems in the South will have deep dives (4 per fortnight), Oxford is one of these systems. Our Winter Director is yet to be appointed but we will be called if we go below 85% or have 12 hour breaches.
- BHT only marginally missed their RTT and A&E trajectories.
- 4-hour waits uptake of GP streaming is going well but there are staffing issues with rotas which does impact on availability of service. RB asked how proactive are they in filling the rotas? DR agreed to take this question away and more assurance about routine rigor of all rotas has been requested.
- Recording of information of type 3 attendances and quality premium of 18/19 measured on type 1 attendances. Data quality issues being addressed with CSU.
- Paeds GP streaming is a lot harder due to level of expertise required, however numbers of children coming through are relatively low.
- SCAS targets have improved apart from CAT1 mean – a lot of work is being done to reduce conveyances. Detailed SCAS operating plan in place with Incident control rooms up and running, extra staff have been recruited for winter and reliance is on Cat 3/Cat 4 dispersal to places other than A&E. Private ambulances have been hired for peak periods.
- DToC – a huge amount of work being undertaken and because DToCs are one of the KPIs for Better Care Fund scrutiny as a joint exec on a monthly basis. Beginning to see improvements over last three months. Wexham accounts for 25% on non-elective activity we need to do more work.
- Directors meet every Friday to try and unblock, winter mental health calls and same in place for Frimley.
- Council funding for social care for winter. BCC £1.67m. Plans to be agreed and to support winter and reduction of DToCs. This funding non recurrent. CCG had not had sight of plan to be able to contribute.
- DR working with Alamac on what analysis from daily reports looks like to see how many DTOC relate to social care assessment. We would like D2A to receive some funding out of this allocation.
- The biggest risk to winter plan is reducing length of stay and this Committee will look to support in spirit of excess bed days, support for enhanced recovery at home and discharge. There is a lack of clear progress on D2A and an update has been requested. DR to send reply for minutes paper agreed and signed off by directors at end of September and is currently with Communications team to be finessed.
- Care home beds – currently 14 potentially increasing to 19 and an additional 59 hours of home care per day agreed. Independent brokerage for self-funders and support for Frimley on a phased rollout . Risk continues to be medical cover for the care home beds. Proposal for two care homes in the North, 2 in South and 10 in Aylesbury. DR said these are not additional beds as if they didn't have D2A people in they would still have someone in. A&EDB have asked three clinicians to come up with and recommend a solution.
- DW advised that there are currently 5 wards with norovirus at Stoke (26 symptomatic patients and 7 staff affected). BHT are managing it with their command and control structure. Communications around risk have been sent out. Post evaluation briefing to be done once things settle down. A briefing will be sent out tomorrow to CCG Executives. Our Infection Control lead is working

		closely with BHT Infection Control Lead.
11.	**Finance report (month 6)**	The Executive Committee were appraised of the financial position of the CCG at the end of September 2018. The following areas were noted: • At month 6 year to date £71k better than budget and we received our CSF for quarters 1 and 2. • NHSE are managing the performance of the CCG on the in-year deficit of £15.5m. • The reported forecast position reflects pressures developing in London, BHT (due to drugs) and Frimley (due to increased NEL activity) and other providers. • A £21.4m QIPP target was submitted to NHSE on 30th April, the CCG is forecasting 92% on the QIPP delivery before the application of mitigations. • Additional avenues to generate savings are being explored. • MH relating to Section 117 placements – DR reported a paper came to ICET which describes where we are as a system with 117s and gave real transparency. ICET cannot agree split (46/54) but welcomed paper and transparency. Paper should go to Governing Body but first come to Executive Committee for review as it puts us at additional risk. • CHC assumes delivery of a further £1.6m from 2nd cohort. • Weekly monitoring of CHC • Frimley discussions on-going but outturn broadly agreed with the Trust. • Most likely case is we will hit plan and we will get to in-year break even • Worst case is £3.4m off plan if CHC eligibility increases and the effect of Winter on activity levels. • Emerging risk on Transforming Care patients SR to pick up with the Commissioning team and provide detail where patients are. DR suggested a face to face.
12.	**Winter Plan**	*This item was covered under item 4* DR explained a huge amount of work has been undertaken to further develop a winter plan for the ICS. Final signed off operating winter plans received for each provider and they are the best received to-date. The BHT plan has a huge amount of granular clinical engagement with clear actions around how each of the services are going to work to support winter. This has been aggregated up and the draft pack is to be finalised and circulated to colleagues. Format is through a narrative which will have language that any Director can use to present within their own organisations and externally and for internal use details behind the plan. The most critical message is if we don't get on top of our length of stay at BHT and Wexham we will still have a difficult winter. A lot of pressure is being put on the ICS and system to get on top of the whole discharge message about home first and reducing avoidable waits and making the best use of the range of community alternatives. LP asked DR to map the DtAs when wards are closed do the DtAs go down as well? GH asked how widely has been communicated across BHT to "the floor" DR replied her understanding is being communicated and NHSI are on site for 6 weeks helping them get back to basics. An Executive Director has been allocated to every single ward in the hospital as a visible presence, A&EDB partners are happy to be part of this and provide support. Honorary contrasts are being offered to any clinician who wishes to support BHT. The winter plan includes Bucks CC, Primary Care resilience, Fedbucks, SCAS and

		is taking an ICS approach. RT suggested it would be helpful if A&E doctors called GPs before admitting patients as the GP may be able to prevent admission. There have also been delays in discharging patients due to waits for drugs. DR confirmed that a piece of work is on-going with the Enablement Team to see if they can change how the dosette ? box works. GP interface - all analysis shows 50% of patients GP heralded and admitted only stay less than a day – those arriving later in day are more likely to be admitted and kept in overnight. Thinking needs to be done about access to immediate investigation so patients can be discharged home . DR said this could be a topic for the clinical senate. RT suggested a session at the next PLT for secondary/primary care doctors. Having a care plan visible to the A&E doctor may make a difference. Nursing home patients have care plans but ambulance staff don't always refer to these and there is no feedback loop on care plans. Care plans are also not always accessed by clinicians in A&E and better use should be made of Airedale. SB asked if there were any plans to extend the opening hours of MUDAS, CATS? DR confirmed that MUDAS hours have been slightly extended but as CATS is still relatively low numbers but we can go back on this. It is designed to help with Consultant connect and the silver phone interface which should help reduce admissions. CATS is not accessible to the majority of population and we need to look at getting the CATs team into other areas such as Amersham hospital as it is underused but has a great amount of professional knowledge available. DR felt that as a system we need a conversation clinician to clinician and to involve Dr Tina Kenny and those running/overseeing the service. **Action 123**: **A Joint Clinical Review of winter actions via a deep dive to be arranged with invitations to clinicians from BHT and Primary Care to see what we can do together ahead of Winter to reduce admissions** – **DR/DS to arrange** Key managerial people on board to be agreed. NL said electronic sharing of care plans seems to be the missing element and a mechanism needs to be put in place for the sharing of care plans. Areas for unblocking need to be looked at over the next few weeks are. • Consultant connect is about to go live and needs to be used. • Lack of transport is contributing to underuse of CATS. As a county we benchmark as a high spender on transport. • Dr Hassan attending locality meeting in December to discuss lack of attendance at CATs. • Discussion with clinical colleagues to look at plans that could make a difference for Winter.
a)	**Approved Minutes (for information)**	The following minutes were noted by the Committee: a) Joint Commissioning Delivery Board (16.08.18)
b)	**Close & Date of Next Meeting**	22nd November 2018 @ 1.00pm – 5.00pm - Bevan and Nightingale Rooms, Second Floor, Aylesbury Vale District Council, the Gateway, Gatehouse Road, Aylesbury, HP19 8FF **AOB:** • RC reminded members of the Executive Committee to review their conflict of

		interest declarations by end of October • HS2 should be coming to next Committee meeting – please submit questions to RC ahead of November Governing Body.

NHS
Buckinghamshire
Clinical Commissioning Group

Quality & Performance Committee

Meeting Notes

Thursday 20th September 2018, 09:00 – 11:30

Bevan Meeting Room, Buckinghamshire Clinical Commissioning Group, Aylesbury Vale District Council, the Gateway, Gatehouse Road, Aylesbury, HP19 8FF

Present		**Role**	
Dr Karen West (Chair)	KW	Clinical Director for Integration	
David Williams	DW	Associate Director for Quality and Safeguarding [dial in]	
Dr Robin Woolfson	RW	Secondary Care Doctor [dial in]	
In attendance			
Gilly Attree	GA	Designated Nurse for Safeguarding Children and Looked After Children	
Frances Burdock	FB	Associate Director of Contracts and Performance [dial in]	
Niamh Whittome	NW	Head of Quality and Patient Safety	
Thalia Jervis	TJ	Chief Executive Healthwatch Bucks	
Russell Carpenter	RC	Head of Governance / Board Secretary	(up to item 6)
Jessica Newman	JN	Senior Primary Care Manager	(item 9)
Asela Ali	AA	Quality and Patient Safety Manager	(item 9)
James Limehouse	JL	Senior CHC Commissioning Manager	(item 10)
Georgina McMasters	GM	Patient Representative	(item 11)
Julia Simpkins	JS	Quality Support Assistant (Minutes)	

1. Chairs Welcome

KW welcomed committee members and attendees.

2. Apologies for absence

Apologies received from:

1. Debbie Richards – Director of Commissioning and Delivery
2. Barbara Poole – Healthwatch Bucks
3. Jane Butterworth – Associate Director of Medicines Management and Long Term Conditions

3. Declarations of Interest

Chair, Dr Karen West (KW) reminded the Quality and Performance committee members of their obligation to declare any conflict of interest they may have on any agenda items. KW noted that declarations previously made by members of the Quality and Performance committee are listed in the CCGs Register of Interests published on the CCG websites with these links provided on the agenda.

No additional declarations were made.

4. Minutes of the last meeting – 19th July 2018

The minutes of the last meeting held on 19th July 2018 were reviewed as an accurate account of the meeting.

5. Action Log – 2018/19

The action log was updated separately.

GA joined the meeting.

6. Risk Register

The Committee discussed the GBAF risks; in order to effectively feedback to the next Governing Body seminar, the three risks will be reviewed outside the meeting with proposals provided before 8th November 2018.

Action 2018/17: KW, DR, DW, FB and RW to review the quality and performance risks and feedback proposals to RC before November Governing Body seminar.

Committee members scrutinised the corporate register, reviewing the following risks:

A&E – the risk rating score will remain the same. BHT will be auditing stages of the pathway to understand the impact of long waits.

SCAS – Committee members agreed to close the Q&P risk; a new risk will be developed and scrutinised through the Ambulance Response Programme.

DoLS – There is a proposal to take an ICS approach.

Mazars – five cases remain (not a resourced work stream).

Ofsted – A monitoring meeting is due December 2018.

TJ challenged Committee members and asked whether the risk rating of achieving the Cancer 62 day wait, RTT and A&E 4 hour wait constitutional standards should be reviewed to reflect discussion at the Q1and Q2 NHSE system assurance meeting which highlighted these areas in order to mature into a live Integrated Care System (ICS).

RTT – FB to review risk and upgrade. Discussion undertaken during item 7 – Quality and Performance Report – June 2018.

Cancer – FB to review risk and upgrade. Discussion undertaken during item 7 – Quality and Performance Report – June 2018.

Action 2018/18: FB to review RTT and Cancer risks reflecting discussion from the Q1 and Q2 NHSE assurance visit.

The CCG Audit Committee randomly selected the Quality and Performance Committee to review the risk register and minutes from July 2018.

RC left the meeting.

7. Quality and Performance Report – June 2018

FB introduced the new formatted report. Feedback from GB concluded that the report would benefit from performance data disclosed by locality, to include GP triage, referrals and A&E attendances; primary care quality assurance and safeguarding reporting will also be reviewed.

RTT – The CCG and Trust have jointly submitted an assurance report to NHS England and are awaiting feedback. Top pressure areas are Trauma and Orthopaedics (T&O) at BHT and Urology and Gynaecology at OUH. To avoid long waits, patients are opting to attend independent providers

whereby the CCG has noted over performing contract values for T&O services. Weekly monitoring of RTT is undertaken at the APMG.

To mitigate long waits, additional capacity is being sourced at the Horton to undertake general gynaecology procedures. Capacity alerts are displayed on eRS to highlight limited resourced areas.

The Committee discussed the extent of complaints at BHT in relation to RTT challenges, however, as TJ explained, the receipt of a complaint should not be indicative of patient experience. If an opportunity to survey patients to understand their experience at points within the pathway, it would be advantageous. Measuring physical harm, as pointed out by RW, should also be considered.

Action 2018/19: FB To liaise with BHT and establish what data/information is available to look at patient experience & harm risks in relation to RTT challenges

The CCG need to be mindful that patient choice could be an attributing factor of long waiters, BHT are in discussions with an external provider (Kingston) that have managed patient choice well.

Cancer – BHT have implemented more proactive processes, improvements in performance indicators and meeting constitutional standards should be declared next month.

ENT has reported inappropriate referrals; specific details will be referred through to localities.

Performance indicators of A&E attendances are not being achieved, the CCG are monitoring through the Urgent Care Board.

Healthwatch has recently completed a project to understand patient awareness of 111 and MIU, early findings indicate 111 awareness is good; patients are less knowledgeable of MIU services. Understanding patient perception within A&E would provide a rich source of information to understand areas of focus to deliver public education.

The ICS Care Model Lead is currently liaising with Frimley to discuss GP streaming challenges.

Oxford University Hospitals are not achieving stroke performance indicators, DW has raised with OCCG.

Complaints performance at Heatherwood and Wexham needs focus to improve standards.

AA and JN joined the meeting.

8. Safeguarding and Looked After Children

A Serious Case Review recommendation has been presented to the Safeguarding Board in relation to three unrelated individuals which will be undertaken as a themed case review. The Safeguarding Board are querying the ToR for a second SCR.

Looked After Children have declared some improvements and breaches are reducing in number. Regular meetings between the Trust and Social Care are being conducted, supported by the CCG to ensure processes are clear for all parties.

The Child Protection Information Service is an area of concern; implementation is mandatory by 1st October, however, this process is not fully implemented in A&E, Maternity, and emergency eye and dental services. Monitoring will continue through the Clinical Quality Review Meetings.

9. Primary Care Assurance

The Quality and Performance Committee requested AA, JN and the Head of Locality Delivery to devise a format that will specifically monitor primary care quality and performance, to include referrals, access, A&E and prescribing, identified by locality and incorporate to the Primary Care Quality Improvement and Assurance framework.

JL joined the meeting.

Action 2018/20: AA, JN and Head of Locality Delivery to propose a format for monitoring quality and performance by GP Practice and Locality level. KW to present proposal at the next Governing Body, in addition, schedule an update at the next Q&P Committee.

AA and JN left the meeting.

10. Continuing Healthcare Assurance

JL presented the Continuing Healthcare assurance item and highlighted performance trajectories as submitted to NHS England; the improvement plan was circulated to Committee members with the minutes. Unfortunately, performance has declined and trajectories have not been met for all indicators; the CCG have escalated at CHC monitoring meetings.

Data analysis from the IT system is currently ineffective which the CHC team are finding challenging.

As of August, 43 appeals had been declared, 11 have exceeded 6 months. Healthwatch would welcome information of resolution rates.

Action 2018/21: DW to discuss further with JL outside the meeting to implement a plan.

JL left the meeting.

11. Patient Experience Feedback

GM joined the meeting.

DW invited GM to the Quality and Performance Committee to share her patient story, detailing her cancer journey to date explaining areas of poor practice, the good experience she has encountered and where improvements are needed.

GM developed a set of questions (circulated with the minutes) following her experiences which the Trust has adopted for their quality assurance processes. DW has discussed with Lead Commissioners in Berkshire East, Berkshire West and Oxfordshire for a quality assurance exercise.

GM left the meeting.

12. Decision Log

No decisions made.

13. Any new risks identified by the Committee

No new risks identified by the Committee.

14. Next meeting

Thursday 22nd November, 09:00-11:30.

15. Additional attachments for information

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16. Agenda items for the next meeting

2017/18 Safeguarding Annual Report
2018/19 Q1 & Q2 PALS and Complaints Report
IFR deep dive
2017/18 IFR Annual Report
DToC deep dive

Primary Care Quality Report
Modern Slavery
Learning from Deaths Review

Buckinghamshire Integrated Care System Partnership Board
Date/Time: Tuesday 14 August 2018, 3.00pm-5.00pm
Venue: COMT Boardroom, County Hall, Aylesbury

Members:			
Name	**Title/Organisation**		
Lou Patten (Chair)	Chief Officer, Buckinghamshire CCG	**LP**	Present
Rachael Shimmin	Chief Executive, Buckinghamshire County Council	**RM**	Present
Robert Majilton	Deputy Chief Officer, Buckinghamshire CCG	**RMJ**	Present
Neil MacDonald	Interim Chief Executive, Buckinghamshire Healthcare NHS Trust	**NM**	Present
Stuart Bell	Chief Executive, Oxford Health NHS Foundation Trust	**SB**	Present
Will Hancock	Chief Executive, South Central Ambulance Service	**WH**	Apologies
Laks Khangura	Chief Executive Officer, FedBucks	**LK**	Apologies
Standing invitees (non-voting, subject to continual review):			
Name	**Title/Organisation**		
Louise Watson	Managing Director, Integrated Care System	**LW**	Present
Jane O'Grady	Director of Public Health, Buckinghamshire County Council	**JOG**	Present
Gill Quinton	Interim Exec Dir – Communities, Health & Adult Social Care, BCC	**GQ**	Present
Gary Heneage	Chief Finance Officer, NHS Buckinghamshire CCG	**GH**	Apologies
Additional people or experts called to attend meetings on case-by-case basis to inform discussions.			
Name	**Title/Organisation**		
David Williams	Director of Strategy, Buckinghamshire Healthcare NHS Trust	**DW**	Present
Dr Graham Jackson	Member GP, ICS	**GJ**	Not Present
Kim Parfitt	ICS Communications Led, Buckinghamshire County Council	**KP**	Not Present
Sophie Payne	Head of Customer Experience and Communications, BCC	**SP**	Not Present
Lee Jones	Director of Communications, Bucks Healthcare NHS Trust	**LJ**	Not Present
Volker Kellerman	Director of Sales Operations & Development, SCAS	**VK**	Not Present
Nicola Lester	Director of Transformation, NHS Buckinghamshire CCG	**NL**	Not Present
Daniel Leveson	Deputy Director of Strategy, Buckinghamshire Healthcare NHS Trust	**DL**	Not Present
Fiona Wise	STP Executive Lead	**FW**	Present
Karen Gill	Business Development Director	**KG**	Present
Joanne Baschnonga	Head of Communications, Insight and Business Improvement, Buckinghamshire CC	**JB**	Present
Minute taker			
Name	**Title/Organisation**		
Lisa Kewish-Collins	Executive Assistant, Buckinghamshire ICS	**LKC**	Present

Comment [LW1]: Don't think Robert is a member – he should be inattendance. Change the initials so that they are not the same a Rachael

Comment [LW2]: Have new title now

Comment [LW3]: Should be a standing invitee

Comment [LW4]: Now left the trust

Comment [LW5]: Should be a standing invitee

Item	Subject	**Action**
1.	**Introduction and apologies**: as above	
2.	**Declaration of interest** No further or material declarations of interest were declared other than those already included in published register.	
3.	**Minutes from meeting on 12 June 2018**	

Item	Subject	Action
	Pg 1; RM noted that Robert Majilton and Rachel Shimmin are both listed as "RM" which needs to be amended. Minutes were otherwise approved as an accurate record. GQ wanted to pick up on a matter arising from the update on the Community Model [page 3], regarding spending a day with the hospital team. GQ updated the mem~~e~~bers on a meeting between GQ, NMcD and LP where they had agreed to prioritise some areas, one of which was to ~~he P~~prioritise Tier 2 adult t~~T~~ransformation. As a consequence of the meeting NM and GQ have arranged an event in September with the joint teams, to launch the vision and scope of that particular aspect and launch the 2B models~~. This is a large piece of work, noted for the for the minutes~~. LW added that as SRO of the Integrated Care portfolio, Karen Jackson was leading on this as a significant priority for the programme board this year. ~~as part of the ongoing work by Karen Jackson, this [work] is encompassed in her Intergarted Care portfolio and to contextualise this as a significant elemnt of the integrated care priority for this year.~~ RS asked that it be recoreded that the discussion in relation to concrete actions relating to transformational work that would improve outcomes for people, had taken place. **Action Log:** **76: Independent Review of Finances-Action closed** GH referred to the Governance paper that will be circulated to the members, where there are 21 recommendations in the paper and an action plan to address those within the next 3 months. **Action: GH to circulate Financial Governance paper.~~iece and circulate to the members~~** **96: Issues log - Action closed** It was receommended that the issues would be initially raised at Executive level and if unresolved, would be escalated to the Partnership Board.	LKC GH
4.	**Managing Director's Monthly report** LW asked the members whether they had any specific question relating to the report, on the assumption it had been read in advance. Chair (LP) asked LW to address what she considered were key aspects of the report. LW to drew members attention to the progress of the Operating model and the SRO agreement (pg3). LW ~~was very please to~~ confirmed that four directors from across the system will take on SROs roles for four pillars of the ICS Programme. They are already working on developing their portfolios, working through the current work~~ing~~ prioritises and looking at the ~~to a 2B~~future priorities.~~y.~~ As an example, LW met with Karen Jackson regarding Integrated Care; who is keen to deliver a 3 year plan for integrated care across the system. Questions GQ as a Sponsor would like to have a closer link to the Programme Delivery Group, as it is essential for a sponsor to have a broad understanding of what is being undertaken in the portfolio they are sponsoring. GQ asked for a better understanding of the Programme Delivery Group. LW replied that the Portfolio Delivery Group was dicussed today (14th August) in the	

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	task and finish group, and there were currently two views. The first view is that there is a need for this group, operationally to ensure ~~a~~ cohesion across the system and ensure that no board is sit~~t~~ing in isolation ~~iscolation~~ of each other. The second view is that it is not necessary and should revert to Executive Leadership group to reduce buracracy. The current position is for SROs to have a collective discussion, as they would be the most impacted by the decision to have, or not have a PDG. They will bring a proposal next week. SROs have also been asked, with support, to decide membership of the Portfolio Delivery Group ~~GQ feels disconnected as a sponsor, but admitted this could be due to annual leave. She would like more input, LW and GQ agreed to take this discussion offline.~~ GQ asked for more information around the n~~N~~ational s~~S~~upport offer in relation to Population Health Management [detailsed in Para 3.1], and how to access this. LW explained this is an emergent support offer. NHS England are working with PWC and Optum to create a bespoke offer on fully supporting~~ed~~ implementation on population health management in an integrated care system. This is an intensive 20 week programme which will take people through the identification [in relation to tools required and needed] the risk str~~estr~~atification and the ability to run an economic model for the system that would support it in terms of health and care anaylsis. Further on this would also enable us, with support from PWC and Optum, to help cost future provision. ~~XXXXX.~~ The offer is not currently fully formed~~there~~, it is embryonic. The next step is a meeting with the Director of Operations~~portunity~~, Matthew Swindells and to assess what this will look like in practise. LW spoke to NHS England and there are two schools of thought; one is that it will be a bespoke offer to a system and the second is that it will be a co-hort related offer, that all first wave ICSs would be invited to take part in. **Action: LW to circulate the deck to the Partnership Board members for review.** Comments RS asked why would it would be bespoke, rather than national if it is essesntially a methodology for benefit for change. It would be wastful of resource to be bespoke if there are the same general issues at play nationally. LW explained it would be bepoke in terms of the team supporting us and the unique current status that Buckinghamshire ICS is in, in terms of its maturity, but the methodology would be national. LP flagged that they have had a south regional presentation on population health management. It was clear from this that different areas had progressed with different elements, for example Frimley is very different to Oxford. LP asked whether this will this pull together all the streams. LW acknowledged that yes this would support it adapting it for local circumstances.~~, this is one school of thought, in that the algorythmn focus is national. However, the bespoke element is that from the generic information, Buckinghamshire will then focus on different elements that are relevant to that as a locality, than for example Blackpool.~~ RMJ raised that although not connected to population health management, we are internally looking at delivery, linking with oxford for commonality of programmes. There is a key link to population health and integrated care transformation. The links across these programmes have to be discussed but this is also in the context of the delivery board. SB was concerned that population health is a solution in search of a problem. He would like to, cluster by cluster, identify what as a system we think is going to happen if we do nothing compared to what will be achieved by various	

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	interventions. Essentially a comparitiveson analysis. He would hope this report would identify the problem. ~~LW flagged this is not the solution and the definition of the *problem* sits in various areas, aprt of which is in the capacity and demand piece for transformation funds.~~ DW noted that Shakiba gave a very detailed presentation on population health that was a good anaylsis of where we are, cluster by cluster. However, SB asked whether this told us what and where the issue was which it did not. FW identified that there haves~~s~~ been issues with data from CSU and the Population Health Steering group. As soon as we have the data from September we can look at that. FW flagged that we need to see the support offer and learn from other places. The team that will be brought in with the National Offer, can do actuarial analysis and forward thinking. Until recently the public health haven not been abe to access information The Chair (LP) acknowledges a good challenge from SB. **ACTION: LW will circulate the presentation on population health from Shakiba.** **ACTION: GQ will take Shakiba's report and work with Jane O'Grady to do more work around identidying the issues. GQ will bring this back to the meeting [September 11th].** NM agreed this [the MD Report] was a very helpful summary to receive. Linking back to GQ's point and the operata~~a~~ing model, he asked how to determine the short, medium and long term deliverables. His second question was how to map clinical leadership to match support to these programmes. Finally, he asked when we start to transition people into these roles, how we can help give clarity of messages to staff to ensure they are equipt in the future. RMJ added ~~to~~ to NM's question on delivery and flagged that as a system we must make sure we are stopping the things that the new working is replacing and who is a~~u~~ctioning that. This has to be done to ensure that the transformation progresses and that staff are not trying to service the old and the new model. LP agreed and reiterated that the comms was very important and asked for timing on rolling out comms across the system. LW responded that there was a comms item for discussion at this Board and so can address issues there. LW responded to NMcD's question over short, medium and long term goals. SROs will work with the programme delivery boards to develop those goals to come here [Partnership Board] for consideration. The dashboard will be developed in tandem with this but will also need to evolve, its still organisationally focussed. Regarding strategic thinking, LW has spoken to a number of Partnership Board members regarding the need for a session from the partnership board to talk about what we look like in 2-3 years time. She confirmed that we need a ~~a~~ further strategic thinking session to understand the ICS's future. In relation to RMJ's point about stopping some workstreams where they are no longer needed, this is one of the major challenges for~~of~~ the SROs. The SRO's are tasked with reviewing existing infrastructure and ~~the exiting,~~ stopping things where they are not needed, ~~reviewing and~~ creating new areas of support where necessary. She confirmed that all the task and finish group had ~~and~~ signed up to stopping things where reasonable to do so~~they can~~. LP asked who is doing the mapping. LW explained that the SROs are mapping this, and that they determine what sits in their portfolios, with the support of the	**LW** **GQ**

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	PMO. **Action: The members a~~r~~g<u>r</u>eed to a strategy session and that this needs to happen at the next Board [September 11th] with a follow up session afterwards.** **Action: Jane O'Grady agreed to be an SRO <u>for population health and</u> needs to understand the scope. Jane to meet with Louise Watson.**	**ALL** **LW/JO'G**
5.	**Buckinghamshire ICS 2018/19 MoU** <u>Context</u> Partnership Board Members received a draft MoU at the last meeting. This has changed to the final draft that is now before the members. LW has put together a detailed front pager that explains the differences. The changes are a mixture of changes from the n~~N~~ational element and changes made at the request of the Partnership. The added complexity to the MoU, is that in the context of the national definition of an ICS, we [Buckinghamshire ICS] would be seen as an ICP rather than an ICS, however in 18/19 we are an ICS as we have an MoU. LP noted the ICS, ICP distinction was very confusing. . FW discussed the difference between Buckinghamshire and Berkshire West ICS's and that Berkshire have a lot of self assurance a<u>t</u>~~s~~ a local level. The STP ~~is~~ then <u>holds</u> more of an assurance role. She flagged that this MoU looked similar to that of the Berkshire West MoU. GQ thought that this MoU had changed a lot and that there were significant asks in there, for example health and care frameworks. RM<u>J</u> noted that some of these are national requirement that every health system has signed up to and consequentially Bucks would be expected to aim to deliver upon. LW gave more context to the document and laid out that pg5 and 6, are those that we a<u>g</u>reed we can achieve, and that the FYFV in the annex 1 (pg14 onwards) are national must do's. Annex 1 are national requirement<u>s</u> that every health system has to sign up to. SB raised the issue of signing something [Annex 1], with the understanding that not only would one sign something thinking that they would not meet certain requirements, but that in some instance<u>s</u> a decision has <u>been</u> taken to actively not deliver certain requirements as this would not be financially achieveable. In some cases actively not participating to achieve certain targets was at the request of NHS England in the first instance. GQ also asked what the consequences would be if we did not sign, or if we signed and then failed to deliver on the terms. LW confirmed that in not signing~~-~~ the MoU, the system would not be recognised as an ICS and in turn would not receive the transformation funding related to the MoU, which is £1.8m plus additional funds. GH added that there are three bids approved against the £1.8m would need a risk share agreement between the parties if this funding was withdrawn<u>.</u> RS asked whether in agree~~d~~ing to be a system are they worse off given they would have received certain funds as independent organisations but this was waived to receive System funding. This point was raised in the past and the Chair confirmed they had been assured they would not be at a loss in agreeing to be a system. RM<u>J</u> thought it helpful to go through the MoU, and check the national targets against the Buckinghamshire targets; and to check trajectory against those targets,	

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	before signing the MoU. There are some targets for example A&E trajectory, we have signed up to hit a target but may not achieve. LW flagged that this list of commitments [Annex 1] was the same as last month, and that they have checked with each member to confirm that the national numbers fit within the FYFV operating plan.~~as an operational factor.~~ SB noted we can recognise this, but if we are saying we are~~a~~ committing to delivering, we are not going to deliver on them. He asked whether we can caveat the MoU. LP asked whether there could be a piece of work regarding the risk of each of the areas, in relation to delivery. LW responded that yes, this work has already been done. Risk against delivery is laid out in section 2 (pg2) and states the guidance. [Read the guidance] This sets priorities and the deliverables~~ies~~. LW agreed we need to clarify that we are signinig up to the committ~~t~~men~~e~~t set out in the FYFV, which is what we have to do as a system. LW reflected that the MoU was presented a month ago with limited feedback and flagged that what we are discussing had not changed. The debate around Annex 1 has not changed since last Board. ~~LW will be more overt in the risk of papers presenting.~~ LW is happy to move forward with whatever is ~~as~~ recommended by the partnership Board members and flagged the need to take account of the risk in terms of doing that. We are clear there are two things at risk here, one is organisation reputations ~~resentations~~, if we fail to deliver and the second is the risk of depletion of funds if the MoU is not signed, NM suggested we would sign up to the principles but have caveats to bring to the attention of NHS En~~b~~g~~a~~land. He said we should ~~he would~~ ex~~a~~plain~~in~~ we have an emergent delivery model which we are looking to deliver, and this is the progress we have made to date. In our governance we have been clear on the risks etc. NM emphasised that each member needs to assist with this as they will need to take it through each of their Boards. LP asked the members how do we take this forward and that there should ~~e~~be a uniform system approach. The timing of having this through Governing Bodies and Boards is September. GQ flagged that she cannot get though until 1st October at earliest and BHT would be the 29th Septem~~b~~er. LW asked if the CCG would be happy for her to use the PMO co-ordination function ~~in terms of caveats against each of the areas of perfrmacnce that are areas for concern.~~ RMJ was concerned with the level of skill required for this but it was noted that this will be an administrative task to identify the risks. FW has a risk register that flags the areas for concern wh~~i~~ich~~i~~ she will share. **ACTION: FW to send the risk register onto RW and LW** NM confirmed that this is not necessarily a detailed piece of work, it can be quick and generic. The Chair agreed the principles to sign off today, **The members commit to help craft the language of the caveats and the MoU so that everyone is comfortable. SB noted that the critical issue is to identify the areas where we have actively taken action not to deliver on certain aspects of the MoU.** **Action: RMJ/ LW agree to take this offline and agree the process. Need comments back to the Group, and then take a consistent set of text for each**	**FW** **ALL** **RM/ LW**

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	partner to have approved through their statutory bodies.	
6.	**Buckinghamshire ICS Month 3 Financial Report** GH took the members through the paper. CCG has a plan of £15.5m defecit, and the plan is to break even. In terms of the Trust they have £12m of PSF plus £2m defecit so including PSF have a £10m surplus~~face~~ target. RS asked to clarify that in the NHS a provider~~d~~ is essentially rewarded for having a defecit, if it isn't getting worse. GH explained that PSF is broadly backended, and that if you miss a quarter it can be recouped if you hit your year end target. In terms of the trust 30% is on A&E (performance based) and 70% is on finance. As a system ~~S a system~~ we are £6.5m off plan ~~but the majority of this is not hitting the XXX~~, however this it can potentially be made ~~make this~~ up in Q2 by using mitigations. In terms of BHT ~~the trusy~~ they are £4.5m off, so the challenge as a systems is to work on a 3 month rolling quarterly forecast ~~rolling xx for~~for PSF and CFS. SB questioned what needs to be done to make up the gap. GH explained how the CCG has been on FRP since middle of last year, and that going forward there needs to be a true System FRP. BHT are now doing an FRP too and the CCG and BHT are joining~~g~~ schemes in relation to meds optimistaion and non electives, to close the financial gap. NM indicated the system has significant challenges in terms of demand, and beds open they did not expect to have. He flagged there are issues with specialised services. ~~and some issues around sick programme~~. BHT are meeting with the regulator next week. GH described how pg6 sets out the gross risks as a system and what our current mitigations are. This is a significant ~~huge~~ challenge (£6m off plan) in 6months. LP questioned the performance in Q2, and whether targests would be achieved. NM~~GH~~ responded that regarding the Q2 A&E target, this is extremely likey to be missed unless they hit 98% every day. In terms of PSF, there is a meeting tomorrow morning. RM asked how we can translate this data so we understand what can be done that is tangi~~e~~able, to make a difference financially. For example reduce referrals. How can the system support this work so that there are improvements. This has to be a system effort in order to make a £16m difference. SB referred to pg5 and the saving schemes and asked whether the numbers are realistic. GH confirmed this is a realist forecast for the CCG. RS asked where partners can help to claw some savings back and whether there is a range of actions that would make a difference. NM said how the Trust position is that non elective is an issue and they would have to halt these in the near future he continued that there will be a need to make a decision on constitutional standards, and a collective decision on recurrent asset disposals. NM confirmed that all the data is readily available through the non elective programme board. If this is not permiating, then there needs a review of the membership and how information flows. He made clear it was predominantely a health issue. NM questioned whether it was several small reductions that will make a big result or whether a few smaller decisions that would make a greater impact, he explained	

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	we are not yet in a position to understand which is better. SB asked what would relieve ive the cost more than anything. NM mentioned how estate management and , non elective challenges werewas a major issues and there are two wards of patients that need not be there. The group asked how to assist and why patients were on said wards. SB continued that this relates to the issue of what is the question in the first place. We need to understand the problem rather than being distracted with the process. LP, asked whether the Partners had done enough at ground levelr, as this does lead to results and what more can be done. GQ said that with access to the data, her team would be able to assist in identifying some issues and providing some solutions. The group discussed how the A&E delivery Board is where the data currently comes in. The A&E Delivery Board need to escalate the issues, and the partners need to support the work being done here. Jane O Grady said the CCG used to have a dashboard that said how many A&E admittances an hospital has had used and how many admittances are allowed. This would be helpful to understand the issue. GQ disdcussed that the CQC sent the data thate explores this. It demonstratesoates that Bucks has a disproportionate rate of admissions. RM flagged that there is already a lot of data there but referring back to SB's point, there needs to be clarity in terms of how to translate the dashboards into something easy for a cluster or practicse to understand and take clear action on. GQ agreed there was data there but that her teams did not have access to it, and if they could she believes they could make a difference. LP reitetated that if GQ's team had the data, they would be in a position to identify the issue and from there find a means of a solution. **Action: GQ asked for a small group to look at the data and work on solutions** The Chair asked for the FedBucks perspective from Karen Gill. Karen explained they attend the delivery board (A&E) from GP perspective but they need to understand where we are as a system. The dashboard should go to the GPs and reception staff, because frontline staff can make a differencet. LW dicussed how there was a non elective FRPB Group that is already driving this, and stated there are already Bucks CC members on this, so the issue is not that partners are not represented but that the information is not flowing to the right people. RM said that alongside the right information, there needs to be instruction of what to do with it or actions that should be taken. **The Board committed to commissioning a piece of work by the A&E Delivery Board to provide their primary intervetions that they will consider will improve attddendance figures.** **The Board also agreed to feed this conversation back to Debbie Richards**	**GQ** **ALL** **LW**

Item	Subject	Action
7.	**Buckinghamshire ICS Strategic Risk and Assurance Framework July 2018** Item for information and not discussed. LW to circulate to the Partners and feedback to be sent back to LW by email.	**LW**
8.	ICS Comms and Engagement Way Forward JB took the members through the presentation, which was well received. The presentation flagged that the Comms piece had good relationships and enthusiasm but a lack of capacity to commit to ICS. The paper looked at the short, medium and long term aims and the options relating to each one. Questions NB asked whether the comms piece was going to be used to support the transformation or whether this was for the public. JB responded that this is for ICS comms, but there is another element of comms that will support transformation for the public. RS commented on the issues of the county footprint and noted she would like a conversation about that, which is a bigger piece of work. RS is keen to explore a joint arrangement and would like to open that up for other partners to join in should they wish. The Board agreed the recommendations in the paper and agreed that the work in terms of scoping was good idea. KG asked whether comms could support getting the key message from the A&E delivery board out to the partnership, as well as the public. **JB and KG agreed to take this offline.**	**JB/ KG**
9.	**ICS Assessment: 11 September 9.30am** LW agreed to circulate this for comment LW asked the Partners to prioritise attendance at this meeting, which is for "go-live" status. If Chief Executives are not available, they are asked to nominate a Deputy	**LW**
	ICS Clinical and Care Leadership Update Carry this item over to September.	**LKC**
	ICS Minutes These were provided for information.	
	Items for Next Agenda Partnership Board Member Key messages: - Concern around non-electives - Need to support A&E delivery Board to deliver key messages **Additional** **Action: NM agreed to arrange an extra-ordinary meeting regarding BHT for**	**NM**

Item	Subject	Action
	the Partnership Board members	
	AOB - Launch of Health System Led Investment in Provider Digitisation - BOB STP (FW) Partners to put together their prioritiesse, also that there is a comprehensive list. FW asked to add this to the agenda next month. This will be addressed threough the STP. After the 21st August, FW will be in a position to prodive the partnership board members with more guidance, and agree a consistent system approach. - Update on the Chairs / chief exec session (DW) – agreed to have 3 focuses: 1) Case studies 2) report from LW 3) and strategic topic - Alignment of Boards (DW) Whether we get Non exec and Board members together. DW asked whether itti would be a good opportunity to get the Boards together. General consensus from the group to action this. - Market position statement (GQ) Looking for representation from the health system to this meeting. Suggested to ask Pauline Scully	
	Date and time of the next meeting: 11 September 2018, COMT Boardroom, County Hall	

NHS
Buckinghamshire
Clinical Commissioning Group

BUCKINGHAMSHIRE CLINICAL COMMISSIONING GROUP
AUDIT COMMITTEE
26 September 2018

Bevan Meeting Room, Aylesbury Vale CCG, Aylesbury

Voting Members Present
Robert Parkes (RP), Audit Committee Chair and Lay Member, Buckinghamshire CCG
Tony Dixon (TD), Finance Committee Chair and Lay Member, Buckinghamshire CCG
Graham Smith (GS) Lay Member Buckinghamshire CCG

Others present (non-voting)
Gary Heneage (GH), Chief Finance Officer, Buckinghamshire CCG
Alan Cadman (AC), Deputy Chief Finance Officer, Buckinghamshire CCG
Russell Carpenter (RC), Head of Governance/Board Secretary, Buckinghamshire CCG (Minutes)
Liz Wright (LW), RSM Risk Assurance Services (Internal Audit)
Maria Grindley (MG), Ernst and Young (External Audit)

1&2	**Introductions & Apologies**	
	Apologies received • Kate Holmes (KH), Deputy Chief Finance Officer, Buckinghamshire CCG • Dawn Riddell (DRi), PA Interim Chief Finance Officer (Minutes) • Gareth Robins (GR), Counter Fraud Manager, TIAA (Counter Fraud) • Lou Patten, (LP), Accountable Officer With two voting members present the committee was quorate.	
3.	**Declarations of Interest in items on this meeting's agenda / Attendance Register**	
	RP reminded members of their obligation to declare any Conflict of interest they may have with any agenda items at Audit Committee meetings in common. No existing declarations were deemed to have materiality to items on the agenda – this meeting takes no commissioning decisions.	
4.	**Review and Approval of Minutes of previous meetings**	
	The minutes dated 25 July 2018 were reviewed and agreed as a true record.	
5.	**Action and Decision Logs / Matters arising**	
	All actions were reviewed and the log updated accordingly. **Action: GH to follow up on the Procurement policy and produce a 1 page process flow for distribution to staff.** Meeting held brief discussion of procurement flowchart for benefits of auditors. Delegated authority requested from Audit Committee to Chair and CFO to finalise. Internal Auditor asked to clarify if any process change - RC replied that only change related to minimising, if not eliminating, single tender waivers due to challenge risk. It was also noted, in relation to seeking quotations, the Procurement Team emphasised that we needed only to demonstrate attempts to seek them, not necessarily actually obtaining them.	

	Internal Audit also asked if the same limits would apply to STP funding. GH replied that it would, though RC noted an exception would be where we are purchasing from an agreed framework and therefore do not need to instigate a separate procurement process. GH added that another exception would relate to use of transformation funds for specific purposes through specific named organisations such as Buckinghamshire Healthcare NHS Trust to assist with, for example, demand and capacity modelling. Amendments discussed and subsequently included were: 1. Re-wording for non-healthcare up to £5k whole life: No formal requirement for **external** procurement **process**. 2. Clarification of definitions for "healthcare" and non-healthcare" 3. Insertion (at Robert Majilton's request) of reference to the Procurement Framework approved and ratified by Governing Bodies in common in July 2017. 4. Some minor re-wording in relation to use of single tender waivers 5. Reference added "All procurement should be accompanied by a Purchase Order". 6. SMT request – reference to "VAT is also not re-claimable on non-health contracts (unless special conditions apply)" under non-healthcare section. Final Chair approval was completed 9 October 2018, with the flowchart circulated to staff 12 October 2018. The Senior Management Team (who would use the process and help socialise the flowchart with CCG staff) were engaged at their weekly meeting on 2 October 2018. **RC to check the list of public organisations exempt from GDPR fines regime.** Paul Antony (CSU Information Governance) confirmed that there is no such list, and all organisations are deemed liable. Size of potential will be based on extent of breach. Members noted that the scope if potential fines are significant. RC noted emphasis of size of fine relating to size of turnover, which if we deem we do not have does this mean we are exempt. However, for belt and braces, we should deem that cumulative income equates to a definition of turnover, and therefore act and discharge our responsibilities as if fines could be levied. RC noted appropriate steps are being taken to keep risk down to a minimum.	
6.	**Losses & Special Payments**	
	AC noted this as new agenda item, having reviewed our policies and procedures. AC confirmed there were none to report – contractual compensation or payments for major assets. GS queried whether special payments for employment termination would also come through this route. GH replied if outside contractual arrangements there is a clear process through NHS England. There was uncertainty if there was a payment through this route if it would be reported to Audit Committee and/or agreed through remuneration only. It was noted that Audit was for information, not decision.	**GH**
7.	**Single Tender Waivers** • **Direct Healthcare**	
	Relates to a CHC patient who was in receipt of bariatric equipment in a nursing home. Details provided in application. STW was noted. RP noted high cost circa £14,000 for six weeks. AC replied there are complications with these patients which lead to high costs.	

8.	**Update from Finance Committee**	
	GH provided the Audit committee with an update from the Finance committee. In terms of a summary of the meeting: • Risks and mitigations still in balance • M5 ytd £89k favourable (before mitigations £4.6m adverse) • FOT moved £8.7m adverse to reflect risks but offset by mitigations as previously reported (so balanced position) • Contingency held in full at £3.5m • It is getting tougher. Effectively, risks have now moved into the FOT position…. • Frimley mainly NEL – FOT moved by £2.8m, a deterioration of £0.2m from previous month – continued NEL increased activity and price • S117/LD/IECS – FOT movement £1.9m – increased number of S117 patients/cost and transfer from Spec Comm • QIPP activity (not in contracts) £2.0m Finance Committee also discussed risks outside £9m transferred into FOT. This is first month forecast expenditure is exceeding mitigations, with circa £400k net risk. Much sensitivity analysis has been undertaken, so this is worst case rather than truly reflective. We are also assuming we will be successful in completing a £1m community stock adjustment. As an ICS, we are £7m off plan to date with FOT £8m off plan. Much work to review this with BHT ahead of M6 reporting. RP stated that Finance Committee met immediately prior to this and discussed this to some considerable depth. GH also noted, as regards Provider Sustainability Funding (PSF), BHT is unlikely to receive any – as they are off target on the finances and the funding is binary (whether A&E target met or not which represents 30%). As regards Commissioner Sustainability Funding (CSF), given we are £89k above plan, CSF of £4.1m has been recognised. But it is not included in the numbers yet as it is paid quarterly. We are confident we will achieve by end of M6. Finance Committee has also discussed the forward forecast. There is risk, but GH is confident of meeting requirements for £15.5m CSF. MG queried whether the Trust has a grip on its position. GH replied that between M4 and M5, the Trust position deteriorated by £2m. Their challenges relate to vacancies (50% consultant vacancy rate in A&E and 18% nursing vacancy rate across the Trust), CIP shortfall and PSF shortfall. This means numerous locums and agency staff. They cannot immediately change this, though a Financial recovery Plan is in place which has been subject to much challenge. A first board to board will also be taking place later today with challenge around the finance position. GH also expects a peer to peer review of each other's forecasting and a line by line review of assumptions. This will be completed ahead of Month 6. We recognise that we need to work as a system to mitigate the pressures. MG noted that there was only so much within control and challenged what the CCG is doing to manage the situation. GH replied there is little more to do between us in terms of financial support as we have a block contract. But we need to drive out the activity to enable costs to be reduced across the system.	
9.	**Internal Audit Progress report and Benchmarking report**	
	<u>Progress Report</u> LW reviewed the Internal Audit Progress report, the main points were:	

	• No further reports issued since the last meeting due to meeting timings. • Primary Care co-commissioning currently out as a draft report – broadly good governance found, but some issues in relation to contract management. • CHC – debrief pending • QIPP Delivery started last week. LW referred to proposed changes to internal audit plan: • Governance review proposed with BHT on ICS – NHSE are undertaking that review themselves. This was noted as sensible • Financial Budgetary and controls – timed for February 2019. • Patient Experience – not felt to be area of high risk and therefore agreed to divert budget to Mental Health Act and S117 agreements. Internal Audit previously gave assurance that current processes are effective. RC commented on merits of an Information Governance audit and whether there is opportunity to use budget for GDPR compliance. RC took action to discuss with Louise Davies, whether we alternate two years, and/or focus on cyber security. AC queried which audits are mandatory. LW replied financial controls, risk management and governance, but otherwise everything else is based on a risk based approach. RC noted that there is need to ensure good governance on managing conflicts of interest in an integrated care system as opposed to a CCG in isolation. LW replied management of conflicts of interest in previous years was a mandatory requirement, but this hasn't been specified for this year as yet. GS asked for clarification on headline findings on primary care co-commissioning. LW replied that the report was still in draft, but that front end contract management was strong but ongoing performance management was less so. There is a noted capacity issue. GH noted the function had transferred from NHSE with no additional resource, so we will need to take recommendations and discuss how we will address them. Pressures on primary care were recognised, as was there being no easy legal solution to the issue. <u>Benchmarking Report</u> Now the organisation is a single CCG, data has been amalgamated into one. For 17/18, there was one report which gave a more critical opinion but otherwise broadly in line with previous year. So this is positive assurance. RC queried what issues were emerging in the "no assurance" category; LW replied that this was largely QIPP related. GH noted much effort in tightening governance processes on QIPP within the last six months, though this may not be reflected in the financial position. RP suggested that we provide this report at the same time as our financial outcome to evidence that we have done everything we possibly can to manage our position.	**RC**
10.	**External Audit Progress Update**	
	MG provided an update. The previous year has now completed with start to 18/19 planning through September and October. The plan will be presented to the next committee. MG also noted that Janet Wilson will be taking over the Partner role. Discussion has also taken place in respect of the engagement letter now that the CCGs have merged, and opportunity for efficiencies with the fee. Some areas of efficiency have already been undertaken, for example audit committees in common and joint audits. However, we have dropped overall joint fee by £10k though it is a bit of guess at this stage. It is set for one year and review after one year. We may need to undertake as much transactional testing. We are also dealing with only one CSU, though one set of statements also has some efficiency. TD thanked MG for her	

	experience and assistance given this was her last meeting.	
10.	**Conflicts of Interest**	
	The Audit Committee was asked to: Conflicts of Interest: • **NOTE** that the register of breaches numbers 1 in the financial year to date (having been reset at 1 April 2018). • **NOTE** quarterly self-assessment report for Quarter 2 2018-19 which includes above breach (Appendix A) • **APPROVE** proposed amendments to CCG Conflicts of Interest policy to reflect emerging ICS governance arrangements (Appendix B) • **APPROVE** proposed amendments to CCG Conflicts of Interest policy to reflect review of policy breach reporting and investigation arrangements. RC noted that there was opportunity to agree the wording for the breach reported within the report provided, and RC also noted creation of ICS Programme Boards which supersede those previously accountable to the CCG Executive Committee. RP noted having been involved in the investigation reported and that the wording was fit for purpose. RP also commented an amendment to policy is also proposed in relation to the involvement of line managers in investigations. HR advice had been sought which stated that circumstances may vary. RP was concerned that a line manager may aim to influence an outcome, either how the investigator works or how the investigated individual receives the results. New policy wording is proposed as stated in the supporting paper: *Depending on the nature of the alleged breach of policy, with a judgement to be reached by the investigator/s, an employee or contractor's line manager, in respect of the role being performed for or on behalf of the CCG, may be involved in the investigation. As a matter of course, line manager/s will also be provided with a copy of the findings and recommendations after they have been shared with the individual or individuals subject to investigation.* The exception is if it were the line manager that had prompted the original investigation. The investigation concerned and reported was deemed at a sufficiently high level. RC noted that NHSE will become aware of the investigation on submission of the quarterly report. TD queried what NHS England does with it. RC replied that it is currently unclear what they do. RP added that it other contexts they have not provided advice or help when asked for it. Post meeting note: NHS England region have reviewed the breach report and asked for further clarification of actions. RC also noted that the section on ICS's had been further amended to remove referral to the word "committee" in an ICS context, as legally no ICS group or board can be referred to as a "committee" legislatively. GS queried how we can have clear oversight of potential oversight in an Integrated Care System. RC replied that the phrase "collective decision making" is being widely used, but there are constraints to this within the existing legislative framework. As a CCG, what we can do is delegate to our staff who acts for us in an ICS context who becomes members of the various ICS boards. GS asked if it was then our responsibility to ensure no conflicts. RC replied that, for practical purposes, this would fall to the Chair of a meeting, which may not be a CCG staff member. Though they would be required to act within the requirements of the terms of reference. RC noted that he can ensure that the CCG's named individuals	

	have appropriate delegated authority, but cannot do so for the other statutory bodies as they need to manage that internally. He also cannot be present at every meeting to ensure that the process (to default to CCG policy and register management) is being undertaken effectively. Points were noted and amendments approved. RC also noted inclusion of a checklist for identifying, managing and mitigating conflicts of interest for use by all CCG staff, especially those who support meetings. There was discussion about the right mind set needed to manage the process effectively.	
12.	**Community Stock Paper**	
	The paper provided was for information, AC introduced it. This paper describes the rationale for treating part of the Community Equipment stock as loan stock within the CCG Statement of Financial Position for the year ending 31st March 2019 to a value of c£1m. The position has been reviewed, and benchmarking other CCGs where proposals have been accepted by NHSE, we have reviewed work from last year to bring estimate value down from £4m to £1m. We have removed some categories; reviewed return rates across all categories, acuity etc. and proposed four main categories as described within the paper (£1,059k). RP asked if there had been an audit of the proposal. AC replied this has been undertaken with figures proposed last year but not repeated. Auditors were asked if they were comfortable with the rationale. RP noted that the Finance Committee has asked the Finance Team and GH to have this settled by Month 6 so we are clear whether we are proceeding. MG noted that external audit had been heavily involved last year and challenged various elements and what would be acceptable. E&Y will now obtain the related working papers to review the figures. Though in principle they believe it to be robust given level of review last year. AC added that as soon as updated figures are available they will also be included.	
13.	**Integrated Risk Management Framework - framework update and bi-annual register review**	
	The Audit Committee was asked to: • **NOTE** risk reporting arrangements and the Integrated Risk Management Framework has changed since last reported; to include a risk appetite statement (Appendix A) • **APPROVE** risk appetite statement as described in Appendix A. • **REVIEW** the content of the latest Corporate Risk Register (CRR) which was reviewed by the Executive Committee on 23 August (Appendix B) – assure itself over CRR completeness, validity of scores and appropriateness of mitigating controls, assurances and actions. Review evidence of discussion through subsequent minutes. • **REVIEW** the content of a randomly selected risk register from a Board/Committee within the last 3 months, with discussion evidence through minutes. On this occasion, this relates to the July 2018 quality and performance committee. The risk appetite statement included within the paper was based on Bedfordshire CCG given their earlier financial challenges. GS challenged whether there was need for a “high” risk appetite. The meeting discussed what this might mean, entrepreneurial for example, or experimental drug use. LW can provide some alternative definitions. There was discussion as to whether this should be described as “extreme” and that this, or “high” could be used against us, so we must have	**RC**

	caution in how we use it. RC noted this defines a list of categories, it does not specific what our risk appetite actually is, which the statement should also refer to **ACTION: RC will include an amendment on moderate/high risk appetite and clarification that this does not specifically indicate our risk appetite.** RC noted iterations of the Corporate Risk Register and Risk Register from the Quality and Performance Committee. RC also noted a finding within the RSM financial governance review in relation to the Governing Body Assurance Framework (GBAF), with a separate piece of work underway to review these risks in line with best practice. GS queried if we might miss something if we reduce our number of risks. RC confirmed the review would be difficulty diligent to ensure appropriate coverage. LW noted it would also be at a strategic level, and any more than 6-8 could be argued as not clearly aligned to strategy.	
14.	**Memorandum of Understanding between system partners and NHSE**	
	The Audit Committee was asked to: 1. **NOTE** approval and ratification in public at Governing Body 13 September 2018 of a Memorandum of understanding for 2018/19 between partner organisations in the integrated care system, NHS England and NHS Improvement. 2. **NOTE** all ICS partner organisations are being asked to approve and ratify the same document throughout September 2018. 3. **NOTE** delegation to the Accountable Officer as collective CCG signatory to the MOU on behalf of all system leaders/ICS partner organisations (to accompany the signatures of Matthew Swindells on behalf of NHS England and Ben Dyson on behalf of NHS Improvement) once the above has completed. This was duly completed.	
15.	**RSM Governance Recommendations Update (Internal audit action plan)**	
	GH introduced and reminded members of its 24 recommendations. We set our own deadlines with aim for completion within first three months. There are 9 actions on financial reporting, with increase in detail and scrutiny undertaken through Finance Committee. GH noted R08 relates to deep dive into GBAF which is, as noted earlier, underway. GH commented that principle related to level of scrutiny – we have been consistent and Governing Body are clear about the financial position and implications if we do not meet our forecast outturn plan. We are otherwise broadly on track – 80% or so actions completed. RSM will be reviewing in January. RP asked to clarify if we were required. GH replied that we were strongly advised. BHT has been subject to a similar review. There is opportunity for joint learning.	
16.-18.	**Any Other Business / Standing Items**	
	There was no AOB. Data Protection Officer: Information Governance and GDPR compliance Update was received for information.	
19.	<u>Date and time of next meeting</u> Wednesday 28th November 2018, Trust Room 3, Amersham Hospital, 10am -12pm **ACTION: Request to change meeting location from Amersham to Aylesbury (if possible) given parking difficulties. The cumulative parking cost would, in GH view, justify a one off cost for a room to be hired downstairs in Aylesbury if necessary.**	**RC /DRi**

NHS
Buckinghamshire
Clinical Commissioning Group

Paper A

Primary Care Commissioning Committee
Thursday 6th September 2018 – 3pm – 5pm
Olympic Room, Aylesbury Vale DC, Ground Floor, The Gateway, Gatehouse Road, Aylesbury, Buckinghamshire. HP19 8FF

Voting Members:

Graham Smith	(GS)	Lay Member, PCCC Chair, CCG
Louise Patten	(LP)	CCG Accountable Officer.
Gary Heneage	(GH)	Chief Financial Officer, CCG
Nicola Lester	(NL)	Director of Transformation, CCG
David Williams	(DW)	Associate Director of Quality and Safeguarding

In Attendance:

Helen Delaitre	(HD)	Associate Director of Primary Care, CCG
Kate Holmes	(KH)	Deputy Chief Financial Officer, CCG
Jessica Newman	(JN)	Senior Primary Care Manager, CCG
Vicki Parker	(VP)	Business Support Manager, CCG
Alan Overton	(AO)	Finance Analyst, NHSE
Paul Rowley	(PR)	Estates Advisor, for CCG
Karen West	(KW)	Clinical Director Integration, CCG
Rebecca Mallard-Smith	(RMS)	Clinical Commissioning Director, CCG
Nick Spence	(NS)	Assistant Head Of Primary Care, NHS England
Thalia Jervis	(TJ)	CEO, Healthwatch Bucks
Simon Kearey	(SK)	Head of Localities, CCG
Stephen Burr	(SB)	Locality Director Amersham & Chesham, CCG
Raj Bajwa	(RB)	Clinical Chair, CCG
Wendy Newton	(WN)	Primary Care Manager, CCG
Sue Barber	(SB)	Infection Control Lead, Quality Team, CCG
Dawn Bing-Lowe	(DBL)	Executive Administrator, CCG (Minutes)

Members of the Public

Peter Newman	(PN)	Public Member

Apologies:

Matt Mayer	(MM)	LMC
Robert Majilton	(RM)	Deputy Chief Officer, CCG
Niamh Whittome	(NW)	Deputy Head of Quality, CCG
Jane O'Grady	(JOG)	Buckinghamshire County Council
Colin Seaton	(CS)	Lay Member, CCG
Alan Cadman	(AC)	Deputy Chief Finance Officer, CCG

No.	Item	Action
1	**Welcome & Introductions.** Primary Care Commissioning Committee (PCCC) members were welcomed to the meeting. The Meeting was declared quorate. **Apologies:** Apologies were received from MM, RM, NW, JOG, CS and AC.	

2	**Declarations of Interest.** The Chair reminded members of their obligation to declare any interest they may have, on any issues arising at the PCCC meeting, which might conflict with the business of NHS Buckinghamshire Clinical Commissioning Group. Declarations declared by members are listed in the CCG's Register of Interests. The Register is available on the CCG websites through the following link: https://www.buckinghamshireccg.nhs.uk/public/about-us/how-we-make-decisions/registers-of-interests/	
3	**Questions From Members of the Public.** There were no questions raised from members of the public.	
4	**Minutes from the meeting held on 7th June 2018 and the Extraordinary Meeting held on 19th July 2018.** Minutes were agreed as a true and accurate record of the previous meeting. **Decision: Approved**	
5	**Review of the Conflicts of Interest Register** Members were asked to review the Conflicts of Interest Register as part of an annual review process and advise Gemma Richardson (gemma.richardson14@nhs.net) of any amendments. Conflict of Interest Policy: https://www.buckinghamshireccg.nhs.uk/wp-content/uploads/2015/03/2016-09-28-Conflicts-of-Interest-Policy-ANNUAL-REVIEW-SEPTEMBER-2017-clean-MERGER-UPDATE.pdf **ACTION:** All members to review the Conflict of Interest register and advice Gemma Richardson of any amendments.	All
6	**Head of Primary Care Report.** Highlights of the report were: • The Buckinghamshire Primary Care Team is working with the Oxfordshire Primary Care Team to share experience, knowledge and capacity. • The Special Allocation Service (SAS) started on 1st July 2018. The first contract review meeting has taken place and the service is bedding down, with four patients registered. • The first formal contract review meeting has taken place at The Mandeville Practice. Further negotiations to be undertaken to agree the sub-lease. CQC are expected to reinspect the practice in October 2018. • Pound House Surgery and Hawthornden Surgery formally merged on 9 July 2018 to become The Bourne End and Wooburn Green Health Centre. • The first phase of the Bucks 24/7 service went live in April 2018. The timescale for the second phase of the service (Improved Access to General Practice) had been accelerated by NHS England to commence from 1 October 2018. • RSM have undertaken an internal audit into the CCGs primary care commissioning process. Recommendations include undertaking a programme of annual contract review meetings with member practices. • The BOB STP has been awarded GP Retention Scheme funding to develop a GP Workforce Support Programme. The Programme will support GPs	

	throughout their career focusing on newly qualified GPs and retiring GPs. Funding will also contribute to the establishment of a Locum Chambers. • The CCG is implementing Sensely's Ask NHS on-line consultation service. Patients can access the service online and it includes a symptoms checker which enables patients to speak to a clinician or book an appointment via the online app. Twelve practices have expressed an interested in trialling this service. • The CCG "Time for Care" PLT session held on 10 July 2018 was well attended with expressions of interest received from practices to take part in the various elements of the Time for Care Programme. The Primary Care Team will work with NHS England's Sustainable Improvement Team to enable practices to access support from this programme. • The Primary Care Team has been involved in several primary care estates schemes over the last three months. Of note is the preparation of an outline business case for STP Wave 2 funding which is due to be submitted to NHS England before the end of December 2018. .	
7	**Primary Care Risk Register.** The Primary Care Risk Register is reviewed monthly by the Primary Care Operational Group (PCOG) with any risks that are scored 12 or above post mitigating actions to be escalated to the PCCC. Three risks on the register are currently scored at 12 post mitigating actions: • **Stability of General Practice** this risk is scored at 12 post mitigation following the cessation of the GMS contract at Chiltern House Medical Centre, the award of the temporary APMS contract and the requirement for a full engagement exercise to be undertaken to determine future plans for the practice. • **Improved Access** – timeframes for delivery of the improved access service were accelerated by NHS England from April 2019 to October 2018. • **Quality in Primary Care** – one practice in Buckinghamshire remains in CQC Special Measures. The practice is due to be re-inspected in October 2018. PCCC raised concerns that the delay in practices signing the required data sharing agreements for Improved Access may hinder the launch of the scheme on 1 October 2018. Some practices are requesting assurance from NHS England and the CCG that they are protected from associated risks before they will agree to sign the data sharing agreements. SK agreed to facilitate a weekly SMT escalation call to ensure that the plans remain on track.	**SK**
8	**Finance Report (M4).** PCCC received an update on the Primary Care Commissioning budget for 2018/19. There is a current underspend of £24,000, the primary care budget remains under review.	
9	**Quality Report.** DW presented the quarterly Quality Report. This quarter the Quality Team have focused on GP clinical concerns / themes raised with Oxford Health Foundation Trust (OHFT). The Quality team have met with OHFT for a clinical review meeting and were satisfied that the actions were appropriate and proportionate. The report also highlighted the General Practice Patient Survey (GPPS) position for practices based on their results and the need for the CCG to consider how we process	

	this information to move forward. The Buckinghamshire and Oxfordshire Quality Teams are aligning and have considered a shared draft Quality Assurance (QA) framework for Primary Care. It has been decided to retain a Bucks specific QA framework that is equivalent but not identical to that of the Oxfordshire CCG. This includes a work plan of reporting throughout the year to ensure that information is relevant and live for the PCCC, which is currently being considered. PCCC thanked the Quality Team for their report and oversight of potential quality concerns.	
10	**Delegated Responsibilities for Primary Care Commissioning Delegation Agreement.** On 25 May 2018, GDPR came into effect, and therefore the PCCC delegation agreement which had previously been signed by NHS Buckinghamshire CCG, requires a variation to ensure compliance, which itself takes effect as of 21 August 2018. The national variation to the primary care delegation agreement has already been signed by Paul Baumann on behalf of NHS England and has been reviewed by the CCG Head of Governance. **Decision:** PCCC agreed to delegate to the Accountable Officer or Deputy Accountable Officer the signing of the national variation to the Primary Care Delegation Agreement by 21 September 2018.	**LP / RM**
11	**Chiltern House Medical Centre: Proposals for Participation Exercise.** NHS Buckinghamshire CCG was notified on 9 July 2018 that one of the partners at Chiltern House Medical Centre (CHMC) was immediately dissolving the partnership which held the contract for provision of primary medical services. NHS Regulations governing GMS contracts require that the contract ceases at the same time as the dissolution. In August 2018, the owner of Dragon Cottage Surgery requested vacant possession of the premises at the end of the agreed lease term which is 29 September 2018. In order to allow for the required repairs to the property to take place within the landlord's stipulated timeframe, the branch surgery will close on 7 September 2018. Letters have been sent to all patients registered at Dragon Cottage advising them of the forthcoming closure and some patients have already chosen to register with alternative practices, this has created some disruption and concern with those practices. Following discussions with affected practices the CCG has negotiated an interim payment for practices willing to register the CHMC patients of £17.50 per patient. Practices who decide not to register patients from CHMC will need to apply to the CCG to close their practice list. On-going discussions with representatives from neighbouring practices regarding the long term solution for the practice have commenced and practices will be invited to propose a local solution. The CCG has committed to carrying out a robust options appraisal and undertake a patient and stakeholder participation exercise to gather views about the best solution for the future care of patients registered at CHMC. The Customer and Communications Team at Buckinghamshire County Council will provide media and communications support. Accordingly, the team have drawn up a communications plan for this patient participation exercise and results will be included in an options appraisal to be considered at the December 2018 meeting of the PCCC.	

	PCCC requested for the communication plan to include ensuring that the Health and Scrutiny Committee (HASC) were fully sighted on plans and that the engagement exercise should include all potential stakeholders. **Decision**: PCCC approved the communications plan for the patient and stakeholder communication and engagement exercise which will form part of the option appraisal around the future provision of services for patients registered at Chiltern House Medical Centre.	**HD**
12	**Berryfields Medical Centre: Request for Additional Portakabin.** Berryfields Medical Centre has contacted the CCG to request financial assistant to install an additional portakabin. Additional space is necessary to meet the needs of this increasing population with further clinical and non-medical staffing facilities required. Additional space would allow the practice to continue in their temporary accommodation for a further 3 years which is when it is anticipated that the permanent premises solution will be completed. NHS England has agreed to allocate minor improvement grant (MIG) funding for the additional unit. NHS England will cover £10,496 and the practice has confirmed they will cover the remaining £5,407. The cost implication for the CCG will be the weekly rent reimbursement of £125.80 + VAT. The rent reimbursement is funded from within the CCGs delegated budget. **Decision**: Approved.	
13	**Care Homes Antiviral Flu Prophylaxis: Locally Commissioned Service (LCS).** During the flu season, GPs are allowed to prescribe antivirals on FP10s both for treatment of patients and as a prophylactic for those that do not have symptoms. Public Health England is keen to ensure that antivirals are issued to all exposed patients where flu outbreaks occur in residential settings with vulnerable patients, such as care homes. Last year, this service was delivered centrally by the CCG. This year it is recommended that the CCG commission a locally commissioned service for Buckinghamshire GP surgeries, which will be in line with Oxfordshire CCG's approach. PCCC were reassured that for the practices, this is not expected to be an onerous task. A guidance sheet is available to advise practices on the prescriptions they will be required to issue. The care homes will cover the administration which the costs reflect. The GP Out of Hours service will cover weekends and bank holidays. **Decision**: Approved.	
14	**Locally Commissioned Services and The Primary Care Development Scheme (PCDS) 2019/20: Verbal Update.** NHS Buckinghamshire is reviewing its Locally Commissioned Services for 2019/20 with NHS Oxfordshire CCG. Service specifications for each CCG have been shared and it was noted that the services commissioned by each CCG were broadly comparable. There will be a number of options available to the CCG regarding how they approach commissioning services in the future e.g. through primary care networks. A paper will be presented to the PCCC outlining proposals. The PCDS has been successfully running for two years with 100% sign up by member practices in both years. Nationally, there is an emerging picture of a potential new version of the Quality and Outcomes Framework (QOF) being released. This could	

	result in NHS England wanting all CCGs to align to a newly developed QOF scheme rather than offering local alternatives such as the PCDS. The CCG is awaiting further clarification however, in the meantime the CCG is starting to consider the PCDS for 2019/20. PCCC requested that a robust evaluation of the PCDS is undertaken.	**SK**
15	**Beaconsfield Primary Care Centre: Outline Business Case for New Build.** Millbarn Medical Centre and the Simpson Centre are GP practices that are both located in Beaconsfield. In 2015, they started work looking at options to move from their existing sites and co-locate onto a new site. The scheme was awarded Estates and Technology Transformation Funding (ETTF) in 2016 subject to NHS England approval. Subsequently, a Project Initiation Document (PID) was submitted and approved by the PCCC in September 2017, subject to outline business case (OBC) confirming affordability. Since then, designs have been worked up to produce a final building design. These have been submitted to the District Valuer and a resulting OBC has now been drawn up. Land has also been acquired from the Town Council to allow this new build to go ahead. The practices and their developer are now seeking approval from the CCG to submit their OBC to NHS England before end October 2018. The Premises Sub Group reviewed the OBC on 17th August 2018 and approved the business case in principle. PCCC noted that the rent proposed by the District Valuer offers the CCG value for money. However, indicative incremental costs of the business rates are prohibitive for the CCG due to limited available funding. The recommendation from PCCC is that the scheme should be approved, subject to further clarification/mitigation on business rates. Action: GH and PR to review indicative business rates and check methodology applied.	**GH/PR**
16	**Improving Access to General Practice: Progress Report.** In line with the national commitment to deliver seven day services, NHS Buckinghamshire CCG is required to commission improved access to general practice by October 2018. Improving Access to General Practice has been commissioned as Phase 2 of 24/7 Primary Care model of care. A Prior Information Notice (PIN) was posted in the Official Journal of the European Union (OJEU) for 30 days by the CSU Procurement Team stating the CCG's intention to award this contract to FedBucks Limited, as a member of the wider Buckinghamshire provider collaborative. The 30 day period finished on 9th July without challenge and therefore the award of contract went ahead and Heads of Terms were drawn up and signed by both parties. The service model is a combination of services provided by localities and FedBucks at the weekend. The contract has the ability to be extended for a further 3 years. It was noted that communication with patients and practices will be essential through the implementation period and beyond.	

17	**General Practice Forward View (GPFV) Action Plan: Deep Dive – Workforce, Training and Development.** The Primary Care Team has committed to undertake a quarterly deep dive into the individual workstreams of the Buckinghamshire GPFV plan. This month the PCCC is asked to note an update on the Workforce Training and Development workstreams. • STP Workforce Leads have highlighted a BOB STP wide workforce audit will be undertaken in 2018 across the BOB STP. Following release of the results of the audit, the CCG will be in a much better position to understand what is needed to address any shortfall and to investigate how new ways of working and new roles within primary care can support this. • Bucks Training Hub (CEPN) continues to work with practices, local universities and Health Education England (HEE) to increase the number of training practices and trainee placements within Buckinghamshire. The aim is to offer additional training placements for GPs, practice nurses, clinical pharmacists, paramedics and other clinical roles. • In June the CCG submitted a proposal to NHS England, which was supported by the BOB STP, for GP retention funding to develop an STP wide GP Workforce Support Programme. This bid has now been approved. The Programme aims to support the GP workforce (both independent and employed in general practice) to maintain and improve local GP services for the Buckinghamshire population. A key component of the programme will be to establish and embed a Locum Chambers. • The CCG in collaboration with Bucks Training Hub and HEE intends to undertake a comprehensive training needs analysis for the Buckinghamshire primary care workforce. Discussions are still in the early stages however the aim is to develop a programme of training opportunities for clinical and non-clinical staff which could be made available to staff throughout 2018/19. • On 10 July 2018 the NHS England Sustainable Improvement Team facilitated a CCG-wide Time for Care Showcase Event during a CCG led Protected Learning Time (PLT) session. The afternoon was held at Missenden Abbey and was well attended by both clinical and non-clinical staff working at member practices. The event presented the case for change in general practice and introduced the 10 High Impact Actions, their impact and the evidence about using them to stabilise and transform care. There was a focus on how the CCG, NHS England, the Federations and practices can work together in the delivery of an 8-8 service and how developing Quality Improvement initiatives can contribute to releasing the full potential of teams and individuals. • The CCG has successfully launched a Care Navigation Training programme. The first tranche of training has seen 60 practice staff (covering 24 practices) trained across the county. The training which is delivered by the National Association of Primary Care (NAPC) provides a solid, practical grounding in the skills required to successfully engage with and signpost people across the health and care system. Feedback received from trainees and Practice Managers has been positive with practices implementing the learning. A second wave of training is due to commence on 12 September 2018. • On 1 May 2018 the CCG hosted a Practice Managers Away Day. The day was well attended and feedback positive. Practice Managers have shown their enthusiasm for another Away Day which the CCG hopes to host in the autumn. Practice Managers have taken the opportunity to share with the CCG their preferred topics and this event will be co-produced with Practice Managers to	

	ensure that the day meets all expectations.	
18	**Any Other Business.** There was no other business raised.	
19	**Date of the next meeting.** Thursday 6th December 2018. 3pm – 5pm – Venue The Gateway, Aylesbury.	

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Action Log:

Date Action Raised	Action Description	Responsibility / Owner	Status	Progress Details / Comments
05/04/2018	**Extended Hours DES** Primary care Team to conduct an analysis of sign-up and hours provided under the Extended Hours DES	Wendy Newton	Open	Audit completed, further work is being undertaken to discuss discrepancies with individual practices to ensure that all practices are compliant with the specification of the Extended Hours DES.
05/07/2018	**Audit of Practice Opening Hours** Following concerns raised by CQC re access to primary medical services in the Central Aylesbury Locality. The Primary Care Team will undertake an audit.	Jessica Newman	Open	The CCG has undertaken an audit of practice opening hours based on individual practice website content. CCG to hold further discussions with outlying practices to ensure compliance with the core contractual hours.
06/09/2018	**Improved Access** SK to facilitate a SMT weekly escalation call to ensure that the plans remain on track.	Simon Kearey	Closed	Improved Access was successfully launched in Buckinghamshire on 1 October 2018
06/09/2018	**Variation to Delegation Agreement** Accountable Officer or Deputy Accountable Officer to sign the national variation to the primary care delegation agreement by 21 September 2018.	Lou Patten / Robert Majilton	Closed	Variation to delegation agreement signed and sent to NHS England
06/09/2018	**CHMC Communication and Engagement Exercise** PCCC requested for the communication plan to include ensuring that the Health and Scrutiny Committee (HASC) were fully sighted on plans and that the engagement exercise should include all potential stakeholders.	Helen Delaitre	Closed	CHMC engagement exercise completed on 26/11/2018. Options appraisal including the outcome of the engagement exercise to be presented to PCCC on 06/12/2018.
06/09/18	**Primary Care Development Scheme** PCCC requested that a robust evaluation of the PCDS is undertaken	Simon Kearey	Open	CCG undertaking preparatory work on both LCS and PCDS schemes to be presented to future PCCC

06/09/18	**Beaconsfield New Build OBC** Review indicative business rates and check methodology.	Gary Heneage Paul Rowley	Closed	GH has contacted GL Hearn regarding rateable values for all non-domestic properties which we now understand is subject to a multiplier. The multiplier - also known as the Uniform Business Rate (UBR) - is then used by the local authority to calculate what percentage of the rateable value of a property has to be paid as business rates. For 2018/19 this is 49.3pence in the pound. This means in cash terms that rates payable for the Beaconsfield new build would be between £73k to £77k which is much more in line with CCG expectations.
04/10/2018	**GP Retention Scheme** STP wide bid to develop a GP Workforce Support programme.	Stephen Burr / Wendy Newton	Closed	GP Workforce Support Programme plan to be developed and approved by BOB STP. Action closed by regular updates to be presented to PCOG / PCCC.

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Abbreviations and Acronyms Glossary

A&E	Accident and Emergency	DST	Decision Support Tool (CHC)
ACHT	Adult Community Health Team	EDS	Equality Delivery System
AF	Atrial Fibrillation	EOL	End of Life
AGM	Annual General Meeting	ETTF	Estates and Technology Transformation Fund
APMS	Alternative Provider Medical Services Contract	FFT	Friends and Family Test
AO	Accountable Officer	FHFT	Frimley Health Foundation Trust
AQP	Any Qualified Provider	FOT	Forecast Outturn
AT	Area Team	GB	Governing Body
BAF	Board Assurance Framework	GMS	General Medical Services
BCC	Buckinghamshire County Council	GP	General Practitioner
BCF	Better Care Fund	GPFV	General Practice Forward View
BAF	British Association of Dermatology	GPIR	General Practitioner International Recruitment
BCCG	Buckinghamshire Clinical Commissioning Group	GPRF	General Practice Retention Funding
BHT	Buckinghamshire Healthcare Trust	GPRP	General Practice Resilience Programme
BOB	Buckinghamshire, Oxfordshire & Berkshire West	HASU	Hyper Acute Stroke Unit
BME	Black and Minority Ethnic	HEE	Health Education England
BPPC	Better Payment Practice Code	HETV	Health Education Thames Valley
CCG	Clinical Commissioning Group	HWBB	Health & Wellbeing Board
C4Q	Commissioning for Quality Committee	ICE	Integrated Clinical Experience
CDIF	Clostridium Difficile	ICS	Integrated Care System
CEPN	Community Education Provider Network	ICU	Intensive Care Unit
CFO	Chief Finance Officer	IFR	Individual Funding Request
CHC	Continuing Health Care	IG	Information Governance
CIP	Cost Improvement Programme	K	Thousand
COI	Conflict of Interest	KLOE	Key Lines of Enquiry
COPD	Chronic Obstructive Pulmonary Disease	LMC	Local Medical Committee
CPA	Care Programme Approach	LPF	Lead Provider Framework
CQC	Care Quality Commission	M	Million
CQRM	Contract Quality Review Meeting	MAGs	Multi Agency Groups
CQUIN	Commissioning Quality & Innovation	MCA	Mental Capacity Act
SCWCSU	South Central West Commissioning Support Unit	MCP	Multi-speciality Community Provider
CSIB	Children's Services Improvement Board	MIG	Minor Improvement Grant
CSP	Care & Support Planning	MK	Milton Keynes
CSR	Comprehensive Spending	MusIC	Musculoskeletal Integrated CareReview
CSU	Commissioning Support Unit	SCN	Strategic Clinical Network
DES	Directly Enhanced Service	SLA	Service Level Agreement

DOLS	Deprivation Of Liberty Safeguards	SLAM	Service Level Agreement Monitoring
NOAC	New Oral Anticoagulants	SRG	Systems Resilience Group
OBC	Outline Business Case	STP	Sustainability & Transformation Partnership
OCCG	Oxfordshire Clinical Commissioning Group	SUS	Secondary Uses Service
OJEU	Official Journal of the European Union	NAPC	National Association of Primary Care
OOH	Out of Hours	NHSE	NHS England
ORCP	Operational Resilience & Capacity Planning	NHSi	NHS Improvement
OUHT	Oxfordshire University Hospitals Trust	TDA	Trust Development Authority
PACS	Primary & Acute Care Systems	TOR	Terms of Reference
PAS	Patient Administration System	TV	Thames Valley
PB	Programme Board	TVN	Tissue Viability Nurse
PBR	Payment by Results	UECN	Urgent Emergency Care Network
PGP	Productive General Practice	VuPS	Vulnerable Practice Scheme
PID	Project Initiation Document	YTD	Year to Date
PIN	Prior Information Notice	5YFV	5 Year Forward View
PIRLS	Psychiatric In Reach Liaison Service		
PLCV	Procedures of Limited Clinical Value		
PLT	Protected Learning Time		
PMS	Personal Medical Services		
PCCC	Primary Care Commissioning Committee		
PCDS	Primary Care Development Scheme		
PCOG	Primary Care Operational Group		
POD	Point of Delivery		
POG	Programme Oversight Group		
PPE	Patient & Public Engagement		
PPG	Patient Participation Group		
QIPP	Quality, Innovation, Productivity & Prevention		
QIS	Quality Improvement Scheme		
QOF	Quality & Outcome Framework		
RAG	Red, Amber, Green		
RBH	Royal Berkshire Hospital		
RCA	Root Cause Analysis		
REACT	Rapid Enhanced Assessment Clinical Team		
RRL	Revenue Resource Limit		
RTT	Referral to Treatment		
SAS	Special Avocation Service		
SCAS	South Central Ambulance Service		