NHS
Buckinghamshire
Clinical Commissioning Group

NHS BUCKINGHAMSHIRE CLINICAL COMMISSIONING GROUP
GOVERNING BODY (IN PUBLIC)
13 June 2019, 10:30am
Bevan/Nightingale Rooms, Aylesbury Vale District Council, the Gateway, Gatehouse Rd, Aylesbury, HP19 8FF

Members (14)			
Name	**Title/Organisation**		
Dr Raj Bajwa (Chair)	GP Clinical Chair	**RB**	Present
Tony Dixon	Lay Member / Chair of Finance Committee	**TD**	Present
Gary Heneage	Chief Finance Officer	**GH**	Present
Crystal Oldman	Registered Nurse	**CO**	Present
Robert Majilton	Deputy Accountable Officer	**RM**	Present
Dr R Mallard-Smith	Member GP/Clinical Director Unplanned Community Care	**RMS**	Apologies
Louise Patten	Accountable Officer	**LP**	Present
Robert Parkes	Lay Member / Vice Lay Chair / Chair of Audit Committee	**RP**	Apologies
Debbie Richards	Director of Commissioning and Delivery/Accountable Emergency Officer	**DR**	Apologies
Colin Seaton	Lay Member, Patient and Public Involvement	**CS**	Not present
Graham Smith	Lay Member, Chair of Primary Care Commissioning Committee	**GS**	Present
Dr Karen West	GP/Clinical Director Integrated Care/Caldicott Guardian	**KW**	Present
Dr Robin Woolfson	Secondary Care Specialist Doctor	**RW**	Present
Standing invitees (non-voting, subject to continual review):			
Name	**Title/Organisation**		
Nicola Lester	Director of Transformation	**NL**	Present
Other attendees			
Name	**Title/Organisation**		
Russell Carpenter	Head of Governance/Board Secretary (minutes)	**RC**	Present
Helen Ellis	Locality Practice Nurse (Item 7 only)	**HE**	Present
Simon Kearey	Head of Localities (Item 7 only)	**SK**	Present
Frances Burdock	Associate Director of Contracts & Performance (item 13)	**FB**	Present

1	**Welcome & Apologies**	**Lead**
	The Chair Dr Raj Bajwa (RB) welcomed the Governing Body members to the meeting in public. Apologies noted as above. The meeting was otherwise quorate to make decisions with the following mix of members: • Clinical GP Chair (or Lay Vice Chair) • Accountable Officer/Deputy Accountable Officer/Chief Finance Officer • Two clinicians (one of which must be a Registered Nurse or specialist hospital doctor) • Two Lay Members • One other management director	

2.	**Declarations of Interest in items on this meeting's agenda**	
	The Chair Dr Raj Bajwa (RB) reminded the meeting of obligations to declare any Conflict of interest they may have on any agenda items. RB noted that declarations previously made by members of the Governing Bodies are listed in the CCG's Register of Interests published on the CCG website. https://www.buckinghamshireccg.nhs.uk/public/about-us/how-we-make-decisions/registers-of-interests/ **Item 9: Gluten free consultation** Member GPs where partners in practices which are dispensing practices have a direct conflict of interest as they could be perceived to lose income from any decision post public consultation. However this is irrelevant and therefore immaterial to this paper because: 1. The three member GPs as voting members of Governing Body are not partners in dispensing practices – Dr Raj Bajwa from Little Chalfont Surgery, Dr Karen West from Haddenham Medical Centre and Dr Rebecca Mallard-Smith from John Hampden Surgery. 2. This paper relates to proceeding with consultation in line with requirements of the CCG Constitution to facilitate consultation, not any subsequent decision post consultation. No further action is therefore necessary in respect of this paper. **ACTION 1: RC reminded members of actions to review their declarations of interest on the CCG website and update accordingly as part of annual review.** Gemma Richardson (Corporate Governance Manager) is updating the master register to make it easier to navigate, especially for sub-committee copies of registers. LP asked whether this is being done through default – i.e. no reply means it is up to date. RC replied if it important that everyone provides an update which is date and time stamped as evidence for auditors. We are also reviewing to ensure references to old organisations are removed from the registers, e.g. CV Health. As regards member practices, our declarations relate to only individuals involved in CCG commissioning business. For localities this is relevant. LP asked if member practices have been asked whether any other team members have conflicts of interest? RC replied this happened a long time back but not recently. **ACTION 2: LP asked to take this up outside as this would link to PCN involvement. We need to tidy this up.** RC also noted assurance on how conflicts of interest at Governing Body during the year as good audit evidence.	**All** **RC**
3.	**Proposed changes to the CCG Constitution (from 1 April 2019) Recap aligned to LMC and locality engagement prior to formal virtual vote of member practices to adopt changes.**	
	RC re-capped progress described within the paper. RC highlighted need for delegated authority from the membership regarding "not material" amendments – to LP/Governing Body. The paper describes definitions for this and "material" which would require member adoption.	

	LP thought governing body delegation for non-material changes was already best practice. RC replied the membership may assume this. LP replied this may seem odd to the Membership. RC replied the need to complete a process to confirm that we are not assuming. RB felt we should not assume. LP suggested we do this when we look at the annual report and request this at the time. RC agreed to do this on the next annual report cycle. GS commented this is semantics. RC added that when the Membership adopted in April, the distinction between material and non-material was not included. This is now included given paragraph in revised model constitution: *The Accountable Officer may periodically propose amendments to the Constitution which shall be considered and approved by the Governing Body unless:* • *Changes are thought to have a material impact* • *Changes are proposed to the reserved powers of the members;* • *At least half (50%) of all the Governing Body Members [CCGs should consider and adapt this to fit local circumstances] formally request that the amendments be put before the Membership for approval.* RB queried the issue we are trying to fix – do we anticipate lots of non-material changes? RC replied there are some proposed amendments. LP commented these were material rather than non-material. GH suggested we need to be pragmatic. RB suggested we inform practices through the bulletin. RC agreed to follow this process. RM commented A to H on material were valid, whereas I and J on a case by case basis. This was agreed. TD suggested there may be changes above which impact. RC replied we would need to then consider whether this was material or immaterial. RB commented of a change above us affects the Constitution, it is material by definition. We will sweep up all changes in one go. RC will tweak timescale to fit this. Proposed change to composition to be deferred to fit in with this timescale – LP asked why this needed to happen now. RC replied this is to ensure the Constitution is up to date. LP suggested we transact this in September alongside other changes to governance as a result of the changing landscape. We will also review other amendments at that point.	
4.	**Review and Approval of Minutes:** **a. Meeting minutes – 14/03/19** **b. Action Log/Matters Arising**	
	DR provided some comments; a final set of minutes was completed accordingly. Updates to actions otherwise included on the log.	
5.	**Questions from the public**	
	RC confirmed none received in advance or on the day.	

6.	**Governing Body Assurance Framework (GBAF)**	
	Governing Body was asked to **RECEIVE FOR ASSURANCE** the Governing Body Assurance Framework (GBAF) and Corporate Risk Register escalations (15+), whilst also discussing and commenting on control and assurances detailed. RC summarised the updates as documented within the supporting paper, with discussion focussed on risks 3 and 4 as they were highest scoring at 16. TD noted the work GH had undertaken to mitigate the risks as described and queried red rating and whether these could be downgraded. GH replied that given levels of financial sustainability going forward and until there has been consensus on the system financial recovery plan, these risks will remain red rated. Remaining members of the Governing Body agreed. It is too early to tell level of impact come year end. Scores for these and all other risks remain unchanged.	
7.	**Clinical Directors Presentation - Locality Practice Nurses**	
	The supporting presentation is published on the CCG website. Questions were asked: LP asked about early nurse involvement with Primary Care Networks development. HE replied nurses had attended a recent PLT where PCN's were described. HE is finding they are not being included given legal considerations. HE also sits on Bucks Integrated Teams for southern locality. LP asked if there was one wish, what would it be? HE replied being more supportive of nurses – training, managing skills. SK added we have mapped lead GPs for each PCN with network managers. We would like a nurse lead for each PCN at some stage. GS noted need for primary care nursing and queried whether new entrants would be at disadvantage in not having experience outside primary care, and can this be tackled. HE replied that experience through training still means you are a nurse – it is not such as issue to go straight into practice these days. In the past this wasn't done (when more a route for child care reasons). RB challenged GS whether the same would be asked of a hospital nurse. GS replied probably not. CO noted this speaks volumes of understanding (not critical of GS). CO noted the QNI sees where if a new GP, it is known they have had ten years' experience of training, but for a nurse new or after 10 years all that is known is that they have had three years of training. There is no requirement to complete a career education pathway which a huge barrier to practice nursing. GP colleagues may be aware student nurses placed in general practice have £74 a week tariff in London, whereas a medical student on pre-registration programme attracts £655 per week. It's no surprise this affects take up leading to older nurses. TD asked how many nurses we are short of, and there used to be a bursary process. HE replied number of nurses has dropped since bursaries. Average age of nursing has also increased from 18 in 1981 when HE began, now 29. As regards county shortage, there is no precise number as	

	it keeps changing. CO noted 40,000 across England. And just over the London border means recruitment issues (loss of London weighting). A summary of other debate between members: • General practice nursing does give the broadest exposure to a range of issues and so is a good place to learn those skills. • There are also training places, but it is up to general practices to pay for courses. Bucks training hub are looking for funding opportunities. • Cardiology and surgical ward experience does necessarily benefit as these are different skills sets, hence the benefit of specific training courses leading to building up specialist skills through other experience. But there is no linked infrastructure for training and career progress. RM queried early learning from development of Bucks Integrated Teams and other pathways we could be looking at that could offer community based learning. HE replied there have been discussions with PCN nurse lead development an opportunity. RB noted different nursing roles may not liaise well. HE replied there is opportunity to improve understanding of each other's roles to avoid patient being stuck in the middle. RB asked how this is delivered. SK replied PLT has expanded its nursing element to help bridge relationships. CO noted there is opportunity to be "Bucks nurse" and learn from each other. CO asked if there is an opportunity for nurses in the PCN ACD role. HE replied yes, and two practice nurses are ACD's elsewhere. CO noted this is now 5. None applied locally. CO asked whether there is attendance at university employment fairs. HE replied Shelley Wagstaff does attend these. GS reflected "Your county needs you" type approach can also be beneficial. **ACTION: RB suggested a presentation on inequalities at a future meeting. Members agreed with this to be scheduled.**	
Decisions		
8.	**Financial and Corporate Governance:** **a) Buckinghamshire CCG 2019/20 Final Budget Plan** **b) ICS Operating Plan 2019-20** **(included Finance Month 1)**	
	The Governing Body was asked to: 1. **NOTE** and **APPROVE** the 19/20 CCG Financial Plan and associated budgets as submitted on 15/5/19. 2. **NOTE** and **APPROVE** the 19/20 CCG Operational Plan as submitted on 11/4/19 updated for finance submission made on 15/5/19. GH noted full details on the website and described highlights. Deficit position moved out to £15m from £10m though opportunity for sustainability funding remains. £5m overspend agreed with NHSE. We also began year with £5m net risks which remain in position. We are working through mitigations. There is an error in total expenditure: stated as £747.8m. Should be £746.8m. RM commented that the visuals were helpful and it is positive for the first time to see that delegated commissioning, community and mental	

	health and don't have QIPP allocated against them. This comes from greater transparency. If these are now protected budgets, how do we ensure best value from them? (Directed at the meeting, not the CFO). GS noted the mental health budget has also increase. GH confirmed this was circa 6%. RB added over 5 years there will be redress. GH added we have a planning gap, but we have protected these budgets. TD noted the challenge now to deliver. The Financial plan was approved. Operational Plan – submission previously to NHSE on 4 April. Only difference is finances. RM added that these are always a point in time. This year more than ever we have needed flexibility, and it is comprehensive. The key will be drawing out actual delivery The Operational plan was approved. <u>Month 1</u> Acute activity is one month in arrears and prescribing data 2 months in arrears, which makes Month 1 reporting difficult. We broadly accrued the plan to budget. We do have remaining risk – it is more difficult this to have risk visibility. CHC run rate is most challenging areas and accurate forecast, plus acute over performance including independent sector. Contracting and efficiencies are more integrated this year to improve ownership. Finance Committee "in common" needs to work through FRP and risk share agreement with BHT for Q1.	
9.	**Gluten free consultation**	
	The Governing Body was asked to APPROVE instigation of public consultation on proposed termination of prescribing gluten free food. The CCG currently allows only for gluten free bread and mixes to be prescribed at NHS expense in line with national NHS England guidance. AH noted other CCGs have taken decisions to end gluten free prescribing in entirety, which is non-compliant with current NHS England guidance. https://www.england.nhs.uk/publication/prescribing-gluten-free-foods-in-primary-care-guidance-for-ccgs/ RW queried decisions elsewhere. AH noted other areas had recognised cost reductions and increased variety in equivalent foods available, and therefore availability through prescribing was a lessor issue for many people, which has helped other areas make their decisions (as described within an accompanying paper). RW also asked whether other areas had also considered exceptions, safeguarding issues. AH confirmed they had done. RW suggested that average costs of items, e.g. a loaf of gluten free bread, costs on average as part of consultation evidence. **ACTION.** KW queried opportunity at STP level. AH relied this has been considered, but in some cases those CCGs already taken their own decisions to terminate prescribing gluten free and/or with variable exceptions (as described in the accompanying paper). KW also asked whether this has been discussed by Thames Valley Priorities Committee and if there is an active policy. AH did not know and would ask Jane Butterworth (Associate Director of Medicines Management). **ACTION**.	

	LP continued to indicate that we must have STP consistency, and although we may have asked other areas and it is not the right time frame, this will significantly affect whether we proceed. There needs to be a mechanism for escalation; if we are not together we should re-consider. We need a really tight process to mitigate risk of judicial review (against the CCG as a statutory body in respect of the consultation, not necessarily a decision to terminate prescribing) in an area with further risk of postcode lottery. RB queried Frimley ICS position. AH replied they are the same as us currently (maximum of bread and mixes only); GS queried if the CCG would be challenged and whether postcode lottery would apply and where any legal challenge could land, and who would bear the costs. LP replied there are two elements; a judicial review of the CCG as a statutory organisation, the other the unfairness of what we are aiming for, to NHS England pushed back to the CCG to undertake the resulting work, with potential considerable time implications for both opportunity costed against any savings opportunity and legal costs which are potentially eye watering, with the CCG facing the legal costs rather than individual, even if a review were to rule in its favour. It is similar to the IVF issue. AH noted savings circa £111k and therefore there is consideration of benefit. RB added NHS England has guidance on what a population might expect – our policy proposal is not consistent and whether they have a view LP replied that the view is the risk is to be locally managed. Whilst locally there is no risk pooling on this matter across CCCs. RB asked if there was a discussion needed with NHSE on affordability. LP replied it is up to us to assess risk and poling it would be a safer option. GH noted we have been asked previously to consider what falls within the remit of “difficult decisions”; these have been all considered. Apart from risk of challenge, this is an area that is a more straightforward/least risky de-commissioning decision compared to many others. We have a financial gap that we have to seek steps to close. LP queried how this links to the planning framework, there was not a string clinical case for change – we have previously excelled in consultation to ensure this is represented. There is a small reference to resources – LP asked for more detail on management time/opportunity cost in facilitating consultation. We also need to consider a basket of options for consultation. RB asked GH whether there were others to consider. GH confirmed there were none from the options considered. AH added that a pharmacist will be working with practices to review this and identify affected patients within current resource. RB noted savings would be recurrent. AH noted consultation will include all relevant stakeholders. TD queried the safety net for patients and whether there are exceptions. AH replied this would be managed through Individual Funding Requests. TD asked how much of that is part of the £111k savings estimate. RB suggested it would be a small proportion. TD also asked if there is an equalities argument; more woman than men currently prescribed. AH replied that we did not have the cohort of data to distinguish. RB queried how a Thames Valley position on policy could be reached if currently CCGs are in different places and therefore it could not be applied and whether there are any other examples of this occurring. LP replied this is about management of risk for us to understand; there are no examples to	

	benchmark against. TVPC set policy as we have to adopt it, so this may happen in some cases. RM added the statement would the same, but there may be some local variation. RB noted this is not specifically clinical and therefore stating the case is a challenge. LP noted the priorities committee did look as instances of celiac vs prescriptions. RM also noted it was circulated to the clinical and care forum. AH added we can look at other CCGs and their clinical cases for change. The Governing Body did not at this stage approve Consultation. It endorsed pre-Consultation, with request for assurances/evidence on 1. Inclusion of further detail on clinical case for change, management time/opportunity cost in facilitating consultation, risk assessment on judicial review benchmarked against experience elsewhere, and average item costs to patient were prescribing to terminate post consultation. 2. Clinical engagement/sounding through the CCG Executive Committee. This should have taken place first, though was affected by timing of Governing Body given its Constitutional requirement to approve initiating consultation (it does not meet again in public until September 2019). LP noted that the overall risk is at this board; we need to refine our processes around clinical priorities.	
10.	**Corporate Governance Update:** **a) Corporate Objectives 2019/20** **b) Annual Review of Terms of Reference and SORDs** **c) Statutory appointments 19/20**	
	The Governing Body was asked to: **APPROVE AND RATIFY** CCG Corporate Objectives for 2019/20. These were approved and ratified. Governing Body is asked to: **RATIFY** its sub-committees terms of reference approved by each of the committees. These were ratified, the exception being the Executive Committee as its annual review has yet to take place (arranged for 27 June, to be ratified by Governing Body 12 September 2019). Primary Care Commissioning Committee had previously been ratified in March 2019. RC noted that this will form part of annual audit later in the Summer. The Governing Body also **NOTED** as regards the Governing Body itself; it does not have separate terms of reference as these are wholly incorporated into the CCG Constitution. The Governing Body was asked to: **APPROVE** CCG Statutory and other appointments for 2019/20. RC indicated this is a useful aid memoir for all members as to appointees to statutory and other posts. This was approved by the Governing Body members. CO noted that this was a really helpful document.	

	Leadership and Governance	
11.	**Accountable Officer's Report and System Working Update**	
	The report was taken as read. Work on commissioning development due to finish in next 3 to 4 weeks and will come back to Governing Body for final sign off. Regarding EU exit, RB noted practices are seeing medicines shortages and this is impacting prescribing budgets. There was debate as to why (GS) and LP replied this needs to be understood and picked up as part of on-going planning. **ACTION: Update on EU Exit preparation required.** Consultation on East Berkshire GP Out of Hours (GP OOHs): NL noted decision was at PCCC. LP asked that this section be extracted as it could be lost within AO report. **ACTION.** Looked After Children designated doctor: Whether this changes through ICP new ways of working TBC. We will look to delate the whole of the mental health budget to OHFT. RB asked if we contribute to salary of the MD post. LP confirmed that we do not. TD queried reporting arrangements for the post. LP replied there is a partnership board for mental health that looks at all spend and includes service users and the public. They will undertake check and challenge and report back. It is anticipated that this will also involve lay membership. TD asked if our mental health staff will continue to report to the CCG through delegating the budget. LP replied the staff are already jointly commissioned with BCC. This is work in progress, it depends on who the successful appointee is. Interviews are next Tuesday. They will need to come back and set vision.	**RC**
Governance and Assurance		
12.	**Finance Report (Month 1)**	
	Covered under above item (8).	
13.	**Quality and Performance Report (End of year 18-19)**	
	FB talked to this report, noting the year-end report. There were improvements in most targets though some still underachieving. Details were as described within the report. Delayed Transfers of Care: TD probed the total number of transfers within the year, the report states an increase of 25 with total 1690. Is this not an area where we could make significant savings? FB replied there are two weekly ward rounds led by the Director of Urgent Care. There are measures, but due to high numbers of patients, there has not been as much of a reduction as we would have liked. RB asked whether there were specific reasons why BHT had struggled with this more than other acute providers. FB replied other providers don't have as high numbers at BHT. Members would like some more detail on this. **ACTION.** CO quoted national statistics; 26% because of trying to find a care home. Do we use the capacity tracker within Bucks? (Free from NHSE/digital	**FB**

	platform). RM replied we have a local equivalent. CO asked if this had made a difference? More detail on impact on DTOC. RB replied we need to understand if this is a real opportunity. GH added that the affect is excess bed days so there is a QIPP element. TD commented this is a real area for the ICS (ICP) to focus on – what is the cost per bed per day. FB added bed day rate will be dependent on factors – we can calculate an average bed day cost. RM suggested that we need something back from A&E Delivery Board on their portfolio. GP referrals: overall there has been a reduction but pressure remains in cardiology, gastroenterology and urology. RM commented that the use of ERS at year-end – have we applied rule for not paying for activity processed through ERS (14%)? FB replied this is a national data source which we are challenging – our team believe it is higher. RM suggested we should be challenging PBR providers that we are not willing to pay. **GH agreed to take this as an action** – some assurance as to whether we are applying the national rules. Mental health OOA placements increasing but difficult to control. E.g. Slough patient to be placed by OHFT then became a Bucks patient. GS queried whether this works both ways over the course of the year? FB replied it probably does but was not aware of any patients to whom it applies. We are seeing a lot of pressure.	
14.	**Annual Reports:** **a) Safeguarding 2017/18 (includes child protection and Looked After Children)** **b) Caldicott Guardian** **c) Senior Information Risk Owner**	
	These reports were **NOTED** as for assurance. RC noted the safeguarding report has already been to the Quality and Performance Committee. RC noted inclusion in the Caldicott Guardian job description a reference to producing an annual report. KW added that this is a snapshot. KW suggested the Caldicott Guardian and SIRO reports be combined going forward highlighting key points. **This was agreed** as continuing to meet statutory obligations. RM gave thanks to RC for the work in data flow mapping for the Data Security and Protection Toolkit. RC added that there remains further work regarding establishing legality for a number of different flows and this was ongoing within the context of the overall framework. GS queried whether it is likely a CCG or any other commissioning body could incur a fine from the ICO. RC replied that this has cropped up before, noting that the definition concerns “annual global turnover” which the CCG would argue it does not have. However it is uncertain and there is, as yet, no legal precedent. It is also very difficult to discharge some statutory responsibilities without a number of flows.	
15.	**Governing Body Effectiveness Review – summary of results**	
	The Governing Body was asked to: **1. NOTE** purpose, plan and next steps for Sub-Committee	

	effectiveness reviews and self-assessments (Appendix A) 2. **NOTE** summary findings and actions arising from its effectiveness review in February 2019 (Appendix B). RC noted actions are aligned to questions reviewed in the last seminar (with RAG rating); with an update on progress expected at the next meeting. At the next seminar in July will be another follow up discussion post sub-committee evaluation and feedback to frame expectations for those sub-committees for the remainder of the financial year. RC noted we make provision in the Constitution for a council of members, and lay members meeting with the Chair either side of Audit Committee meetings. RB noted 2/5 lay member appraisals are still to complete. Action 6: TD noted wording "*limit confidential agenda item on Finance to only the key messages"*. (Board Secretary)." To be amended as "*Preserve a robust and spontaneous discussion in the Governing Body in public on finances*. (Board Secretary)."	
16.	**Communications and Engagement Update**	
	The report was **noted**. NL added that the report does not reflect a national self-assessment. RB queried how well we are perceived to do this by stakeholders. NL replied the 360 gives a snapshot (Feb/March), predominantly aimed at member practices -33/50 replied this year. Also includes about 7 stakeholders –we had a poor response rate with 50/50 split of perception between responders.	
17.	**Governing Body Assurance Framework – recap**	
	This final recap agenda item provides the Governing Body an opportunity to consider any points for consideration for change or addition to the Governing Body Assurance Framework (GBAF) following discussion of the rest of the agenda. There were no further amendments.	
18-21.	**Approved Minutes and reports as stated on agenda**	
	Minutes provided for information were noted as received. Meeting closed 12:30. RC reminded Governing Body that it is anticipated winter planning for this year will form the Clinical Directors agenda item in September 2019.	
16.	**Next meeting/AOB**	
	Date and Time of the next meeting (in public): Thursday 12 September, Jubilee Room, Aylesbury Vale District Council, the Gateway, Gatehouse Rd, Aylesbury, HP19 8FF	

Acronyms

A&E	Accident and Emergency	IFR	Individual Funding Request
ACHT	Adult Community Health Team	IG	Information Governance
ACO	Accountable Care Organisation	ICS	Integrated Care System
ADSD	Attention Deficit Hyperactivity Disorder	KLOE	Key Lines of Enquiry
AF	Atrial Fibrillation	LMC	Local Medical Committee
AGM	Annual General Meeting	LPF	Lead Provider Framework
AQP	Any Qualified Provider	M	Million
ASD	Autism Spectrum Disorder	MAGs	Multi Agency Groups
AT	Area Team	MCA	Mental Capacity Act
AVCCG	Aylesbury Vale Clinical Commissioning Group	MCP	Multi-speciality Community Provider
BAF	Board Assurance Framework	MK	Milton Keynes University Hospital Foundation Trust
BCC	Buckinghamshire County Council	MCP	Multispecialty Community Provider
BCF	Better Care Fund	MusIC	Musculoskeletal Integrated Care
BAF	Board Assurance Framework	NHSE	NHS England
BHT	Buckinghamshire Healthcare Trust	NHSi	NHS Improvement
BAME	Black and Minority Ethnic	NOAC	New Oral Anticoagulants
BPPC	Better Payment Practice Code	OCCG	Oxfordshire Clinical Commissioning Group
CAMHS	Child and Adult Mental Health Services	OOH	Out of Hours
CCCG	Chiltern Clinical Commissioning Group	OUH	Oxfordshire University Hospitals NHS Foundation Trust
CDIF	Clostridium Difficile	OPEL	Operational Pressures Escalation Level
CFO	Chief Finance Officer	PACS	Primary & Acute Care Systems
CHC	Continuing Health Care	PAS	Patient Administration System
CIP	Cost Improvement Programme	PB	Programme Board
COI	Conflict of Interest	PBR	Payment by Results
COPD	Chronic Obstructive Pulmonary Disease	PIRLS	Psychiatric In Reach Liaison Service
CPA	Care Programme Approach	PLCV	Procedures of Limited Clinical Value
CQC	Care Quality Commission	PMS	Personal Medical Services
CQRM	Contract Quality Review Meeting	POD	Point of Delivery
CQUIN	Commissioning Quality & Innovation	POG	Programme Oversight Group
SCWCSU	South Central and West Commissioning Support Unit	PPE	Patient & Public Engagement
CSIB	Children's Services Improvement Board	QIPP	Quality, Innovation, Productivity & Prevention
CSP	Care & Support Planning	QIS	Quality Improvement Scheme
CSR	Comprehensive Spending Review	QOF	Quality & Outcome Framework

CSU	Commissioning Support Unit	QNI	Queens Nursing Institute
K	Thousand	PCCC	Primary Care Commissioning Committee
DES	Directly Enhanced Service	RAG	Red, Amber, Green
DGH	District General Hospital	RBH	Royal Berkshire Hospital
DOLS	Deprivation Of Liberty Safeguards	RCA	Root Cause Analysis
DST	Decision Support Tool (CHC)	REACT	Rapid Enhanced Assessment Clinical Team
EDS	Equality Delivery System	RRL	Revenue Resource Limit
EOL	End of Life	RTT	Referral to Treatment
F&F	Friends and Family	SCAS	South Central Ambulance Service
FHFT	Frimley Health Foundation Trust	SCN	Strategic Clinical Network
FOT	Forecast Outturn	SLA	Service Level Agreement
FPH	Frimley Park Hospitals NHS Foundation Trust	SLAM	Service Level Agreement Monitoring
GB	Governing Bodies	STP	Sustainability & Transformation Partnership
GMS	General Medical Services	SUS	Secondary Uses Service
HASC	Health and Adult Social Care Select Committee	TOR	Terms of Reference
HASU	Hyper Acute Stroke Unit	TV	Thames Valley
HETV	Health Education Thames Valley	TVN	Tissue Viability Nurse
HWBB	Health & Wellbeing Board	TVPC	Thames Valley Priorities Committee
ICS	Integrated Care System	UECN	Urgent Emergency Care Network
ICU	Intensive Care Unit	YTD	Year to Date
ADSD	Attention Deficit Hyperactivity Disorder	KLOE	Key Lines of Enquiry