NHS
Buckinghamshire
Clinical Commissioning Group

NHS BUCKINGHAMSHIRE CLINICAL COMMISSIONING GROUP
GOVERNING BODY (IN PUBLIC)
14 November 2019, 10:30am
Jubilee Room, Aylesbury Vale District Council, the Gateway, Gatehouse Rd, Aylesbury, HP19 8FF

Members (12)			
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 Rebecca Mallard-Smith	Member GP/Clinical Director Unplanned Community Care	**RMS**	Present
Louise Patten	Accountable Officer	**LP**	Apologies
Robert Parkes	Lay Member / Vice Lay Chair / Chair of Audit Committee	**RP**	Present
Colin Seaton	Lay Member, Patient and Public Involvement	**CS**	Apologies
Graham Smith	Lay Member, Chair of Primary Care Commissioning Committee	**GS**	Apologies
Dr Karen West	Member 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**		
Louise Smith	(Interim) Director of Primary Care and Transformation	**LS**	Present
Also present			
Name	**Title/Organisation**		
Russell Carpenter	Head of Governance/Board Secretary (minutes)	**RC**	Present
Dr Rashmi Sawhney	Clinical Director, Health Inequalities (item 8 only)	**RS**	Present
Simon Kearey	Head of Locality (item 8 only)	**JB**	Present
Dr Juliet Sutton	Clinical Director Children's services (item 8 only)	**JS**	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: ICS Memorandum of Understanding** There are direct conflicts of interest in relation to voting members where any proposal for financial management affects the financial position of individual statutory bodies. However this is irrelevant to this paper as it outlines a set of principles for which there is no specific pecuniary benefit to specific statutory bodies.	
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.**	
	The Governing Body was asked to NOTE in September 2019 approval was sought for Version 1.21, following which a number of further amendments were made to reflect points of feedback given and narrative errors amended to reflect changes as had already been agreed. RC also noted: • Changes in v1.22 and v.1.23 regarding delegated authority to Remuneration Committee for decisions reversed following NHS England advice – now recommendations only • There has also been consideration as to how the Constitution may be changed to reflect change in governance arrangements for the Integrated Commissioning Executive Team (ICET). Any further change w3ill follow at a later date.	
4.	**Review and Approval of Minutes:** **a. Meeting minutes – 12/09/19** **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.	**Matters Arising – escalations/issues from Sub-committee Chairs**	
	None arising.	
6.	**Questions from the public**	
	Question received in advance: *What steps has the CCG undertaken to assess the health burden of Myalgic Encephalomyelitis/ Chronic Fatigue Syndrome in the area, especially given the evidence that 90% are thought to be undiagnosed.* RB confirmed that this sits with the mental health lead, Dr Roberts. Subsequent response agreed as follows. *The diagnosis part of Chronic Fatigue Syndrome is either via rheumatology /musculoskeletal team/pain team. GPs can diagnose too, as it's a clinical diagnosis based on symptoms. After diagnosis, patients can be referred to the Chronic Fatigue Management Service (provided by Buckinghamshire Healthcare NHS Trust) which integrates pain management and*	

	psychological support. GPs or consultants can refer patients to this service. *John Pimm (Consultant Clinical Psychologist – Clinical Lead for Psychological Therapies Pathway – Buckinghamshire, Oxford Health NHS Foundation Trust) has published guidance in the general practice bulletin to highlight the diagnosis and pathway. Its aim is to help GPs to diagnose, talk about and effectively deal with presentations of chronic widespread pain. The working group included a GP, clinical psychologist, rheumatologist, physiotherapist, anaesthetist and pharmacist. The document is based on the latest international evidence based practice guidance.* **NOTE:** The member of the public who asked the question has since made contact with Dr Pimm to discuss further queries in relation to details within the guidance and to discuss what OHFT's service offers for patients with ME/CFS.	
7.	**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 noted the supporting report and described the worthy points within: • Risk 2 (IF alternative care pathways are unable to impact non-elective demand by the end of the financial year) has been increased from 12 to 16 to reflect a continually challenging financial climate and pressure. • Risks 3 and 4 on finance remain highest scoring. Given levels of financial sustainability going forward and until the system financial recovery plan is further developed, these risks have remained red rated. These would be covered later on the agenda under the standing item on finance. • Risk 5 (IF the CCG is unable to maintain effective staffing levels at any time) has been amended and updated to reflect the CCG's current position, handing over to LS as risk owner for further description. LS had reviewed and updated the risk since coming into post as of October 2019, replacing the previous Director of Transformation Nicola Lester. This is linked to the changing architecture for CCG commissioning and future direction of system vs place based. The risk is reasonably low at present, but as we progress towards April 2020, it is thought that the risk may increase. We may ask existing staff to do more whilst future uncertainty also becomes more apparent. It is important for us to retain a strong leadership focus and certainty for our staff. RW noted this as a largely staff side risk, but probed as to where the CCG is capturing the potential impact of future changes on patient experience and the confidence of the public in the CCG. LS replied there is some work we can do to reflect this. RM added some of the impact is otherwise described in the Accountable Officer's report, and that this would again be taken into account when reviewing next year's risks.	

8.	**Clinical Directors Presentation – Tackling health inequalities**	
	Presented by Dr Rashmi Sawhney (supporting slides published on the CCG website), and also accompanied by Simon Kearey and Dr Juliet Sutton). The accompanying slide set is published on the CCG website. https://www.buckinghamshireccg.nhs.uk/wp-content/uploads/2019/02/08.-Inequalities-Presentation-update-6th-Nov-WEBSITE-FINAL.pdf	
Decisions		
9.	**ICS Memorandum of Understanding**	
	Thee Governing Body was asked to: • **APPROVE** the BOB ICS Memorandum of Understanding, which the ICP Partnership Board has recommended to statutory bodies to be approved. • **NOTE** the MoU will be signed by Fiona Wise on behalf of BOB ICS. This it did so. GH noted this has been through ICS leader's group and finance committee in common, setting a framework with receipt of transformation funds linked to it. We have a system wide pack running by April 2020. This is linked directly to the Long Term Plan and signals single CCG and single AO.	
	Leadership and Governance	
10.	**Accountable Officer's Report and System Working Update**	
	RM noted the report as supplied. TD noted importance of place in respect of future CCG architecture. It was also felt that the timescale is ambitious. RM replied there are parallel tasks including development of working at ICS level, integrated commissioning at place, public health and social care linked to new unitary authority, and ongoing ICP development. We shall need to come together as a system to make it work. We have ambitions in LTP to deliver at ICS level, and practical areas including joint commissioning committee across the three where it makes sense to further enhance collaboration. RMS commented on need to mindful of Primary Care Network development and to ensure proper engagement. RP also commented that everything must be done to ensure a patient focus remains, and the CCG should only agree if worth doing so with clear objectives rather than just another re-organisation. TD added we have significant financial challenges, and investment expected will not solve all the issues. We must get our own house in order before further venturing. RB noted we need to capture these themes as part of the process. RM replied we would include this in the engagement, and noted than an ICS oversight group is to be convened with formal representation through the Chair and lay membership. CO added that we can better focus on the patient to identify what difference this will make and how this is evidenced. RM noted that this stage is before a more specific case for change. RB would aim to ensure the timescales when mapped out responds effectively to our concerns. As regards the AO, RB noted LP had been a huge asset with an ambition to strengthen place.	

11.	**Finance Report (Month 6)**	
	GH summarised the position, held forecast as per plan leading to Q2 CSF of £2.5m. There has been £8m over performance in year, fully mitigated. Net risk £5m cont8inued to be reported; whether it will materialise we will know between M8 and M9 to prompo0t review for potential re-forecast. Main risks CHC, acute over-performance/NEL, and matters outside our control (we were told not to plan for Cat M (where manufacture margin increases determined by number of drugs dispensed)/No cheaper stick option NCSO (where there is supply shortage a pharmacist may have to prescribe more expensive option, risk has increased with EU Exit). RB asked if NHS England ask us not to plan for it and it materialises/ GH replied he has put this challenge back to NHS England in no uncertain terms. If we do move off our position, these two matters will become vital. As regards category M, RB noted there will be variance in line with the specific drugs which are affected linked to current levels of prescribing. GH added pressure £10m financial issue per month nationally, circa 1% so almost £1m effect on this year's plan. Year-end issue on balance sheet for CHC - £4m has materialised but mitigated through other balance sheet mitigations. There is a cleat set of actions against all areas to mitigate risk of further pressure – biggest opportunity in CHC. £0.5m investment reserved for 3 and 12 month backlog in quality of assessments. KW noted BHT had additional CCG funds to balance their position in Q2. GH noted this risk share with BHT expected to re-forecast in Q3. RMS queried Length of stay at Wexham; is someone reviewing this? GH replied Nicola Newstone is the lead which much south facing work ongoing. We are analysing population, acuity and time of day with aim to more some of this activity out.	
12.	**ICP transformation funds:** **a. Outstanding 18/19 investments** **b. Commitments 19/20**	
	The Governing Body was asked to **NOTE** the update provided and **APPROVE** the proposed change to delegated authority for management of the ICP transformation funds budget. The updated was **NOTED** and delegated authority **APPROVED**. GH reflected on 18/19 adding that Directors of Finance Group reviewed businesses cases with recommendations back to ICP Partnership Board. There is an element of spend uncommuit5eted, with a process underway to identify final commitments – with a follow up paper next month on remaining business cases and process. As regards 19/20, this is delayed as we have not yet drawn down funds. We have to sign a memorandum of understanding with NHSE which is in progress. We have secured £1.8m for 19/20, most of which has been committed. This will be confirmed at the next meeting. LP queried the proposed delegated authority, in that it defaults to the ICS MD unless there is a conflict. GH confirmed this is the case. GH also noted transparency in that papers are also shared with BHT through Directors of Finance group offering visibility and challenge.	

	RB noted the key challenge as to whether or not a conflict exists and requested assurance as to how due diligence in this regard would be demonstrated. LP replied that ICP Partnership Board would make a decision. RB suggested some of these individuals could be equally conflicted. RM noted this is a fair challenge, and indicated that the ICS MD would also work for the CCG under an honorary contract arrangement. There are sufficient checks and balances in place to manage this.	
13.	**Quality and Performance Report (October 2019 with November exceptions)**	
	KW noted that there has not been a committee meeting held to discuss this report and there are intentions to hold an ICP Quality Committee from November. There is also intention to look at patient pathway stories. RB asked to check that KW is well plugged into this – KW confirmed she was. There were otherwise no other updates other than reviewing what a new RTT pathway for Frimley means to us. KW noted there has been some challenge from Executive Committee in relation to GP referrals for allergy clinics and dermatology – regarding lack of consultant to consultant pathway. RM added it links with wider for dermatology. RB added there have been issues, not entirely of their own making. CHC is an ongoing challenge in respect of additional workforce – this is a difficult job so we need to protect them. GH added that investment is about improving quality. Not just about achieving savings. We are under target in achieving 12 months assessments. RB asked if the right amount of support exists. RM replied we are being proactive rather than being at arm's length which is performance managed. We are holding weekly meetings with service leads. Our team is also in with the team and visible regularly. GH added we are also involving them in BHT training programmes. KW noted concerns raised about learning disabilities health checks – this varies each year with the aim of the clinical director for this looking at outcomes as well as numbers. This is how we encourage people to do them. RB queried that we don't often make a judgement until the end of the year. KW confirmed this was the case. LP added we have to report on LD and autism now. Regarding out of area placement/discharge, our joint director for this is heavily involved. Many are very complex. We are also experiencing positive joint working in relation to safeguarding issues, with the CHC team automatically notified if the county council place someone in a care home. As regards looked after children, it has been difficult to manage sustainable improvement with an urgent meeting to be convened (within two weeks) with the county council to discuss this. LP noted there are various stages to the assessment process and we know where the pinch points were for both in and out of county children. Do we still know this and are we monitoring this? If children are not receiving assessments – is this in or out of county and is there an even split? KW replied it is both, with some specific issues to address out of county. LP added a paediatrician has been appointed to take some responsibility for this. KW replied there are a number of issues in both health and social care.	

	ACTION. **Looked After Children: RM noted this is regularly reviewed at the corporate parenting panel. It was agreed that the Governing Body needs monthly reporting with more detail in the Quality and Performance Report.** KW noted never events at OUH were not Bucks patients. LP raised some queries: 1. Is the principle of the new committee to reduce bureaucracy with one version of the truth? KW replied yes. LP added it was important to support this to enable integrated working. 2. Cancer – there is now a new responsibility to cancer alliances to oversee performance. LP would like the next meeting to consider the shared how that works. There are differences in how data is analysed; cancer performance to the provider compared to the population and which provider they go to. The new committee needs to discuss and provide a steer as to whether it is getting the right assurances from the new managing director at the cancer alliance. 3. We still need to link performance to quality – identify the performance issues and the subsequent link to quality. KW replied that there is a focus when a quality concern is raised, but this goes into the report only if something comes out of that we are really concerned about. The cancer risk has been looked at through cancer assurance meetings and whether changes to pathways are having an impact. RM added he had attended a meeting with our performance and quality leads and Oxfordshire colleagues on how we work together – and proud of our principle for recognising the differences between the two and that they are also not separate. It is always a challenge. 4. Good to hear going through patient experience pathways through organisations. CQC system reviews – which are ongoing – do look at this. Linking this to the CQC framework will help us prepare for the inevitable CQC system review.	**RM/KW**
14.	**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. RC noted that Looked after Children performance (an escalated corporate risk) had also been highlighted under the Quality and Performance Report and currently scores at 16 – no change deemed as necessary. The risk scores for finance remain high as they were reported.	
15-16.	**Approved Minutes and reports as stated on agenda**	
	Minutes provided for information were noted as received. Meeting closed 12:30.	
23.	**Next meeting/AOB**	
	Date and Time of the next meeting (in public): Thursday 12 March 2020, Jubilee Room, Ground Floor, 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