NHS
Buckinghamshire
Clinical Commissioning Group

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

Members (14)			
Name	**Title/Organisation**		
Dr Raj Bajwa (Chair)	GP Clinical Chair	**RB**	Present
Tony Dixon	Lay Member / Chair of Finance Committee	**TD**	Apologies
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**	Apologies
Louise Patten	Accountable Officer	**LP**	Present
Robert Parkes	Lay Member / Vice Lay Chair / Chair of Audit Committee	**RP**	Present
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	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**		
Nicola Lester	Director of Transformation	**NL**	Present
Also present			
Name	**Title/Organisation**		
Russell Carpenter	Head of Governance/Board Secretary (minutes)	**RC**	Present
Bashak Onal	System Resilience Manager (item 9 onloy)	**BO**	Present
Jane Butterworth	Associate Director Medicines Management (item 10 only)	**JB**	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 10: 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. **Item 11: Long Term Plan 5 Year Strategy – Buckinghamshire, Oxfordshire and Berkshire West (BOB) Integrated Care System (ICS) submission and delegated authorities for oversight.** All voting members would have a direct conflict of interest where aims and objectives of the strategy may, in time, affect those organisations financially (including member GP practices where voting members are partners). However this is otherwise irrelevant and therefore immaterial to this paper because the Governing Body has the above pre-existing authority which links directly to the intent of the paper. No further action is therefore necessary in respect of this paper. **Item 12: Update on ICP transformation funds (under delegated authority); Governance Process for Transformation Funds – 19/20** Member GPs as voting members of the Governing Body have a direct conflict of interest given their status as partners in their practices which in turn have population based shareholdings in FedBucks. This is a GP provider company, which forms part of the provider collaborative, and may benefit financially from deployment of transformation funds. The same applies to member practices in relation to their membership of Primary Care Networks which may also benefit financially from transformation funds deployment (although the Networks are not legal entities). This direct conflict is deemed immaterial to a decision to delegate authority given this is proactive in order to mitigate future risk **Item 13: Corporate Governance Update** Named individuals are conflicted in respect of appointment to their own role. Quorum count has sufficient flexibility to take this into account. No further action necessary. Deputy Accountable Officer Robert Majilton is only named individual to whom conflict applies. As the Accountable Officer is present, the "one other management director" required for quorum is the Chief	

	Finance Officer, and therefore the Deputy Accountable Officer is not counted for quorum to his own appointment as Executive Lead for Health and Safety and Freedom to Speak Up Guardian.	
2a.	**Conflicts of interest assurances: annual declarations review and update**	
	RC reminded members of their action required to review (and if necessary update) their declarations of interest on the CCG website and update accordingly as part of annual review.	
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 summarised a supporting paper; that there are some technical amendments to the Constitution to reflect organisational and staffing changes. RC noted an additional paper later on the agenda to confirm changes to statutory appointments arising from collaborative arrangements with Oxfordshire CCG. RC did not describe the entirety of the supporting paper, but noted in relation to organisational structure that Localities had been removed to be replaced by Primary Care Networks. RC noted feedback from Dr Rebecca Mallard Smith (who has given apologies for today's meeting) about how continuity of communication with localities and the clinical voice is ensured. RC stated that the governing body or a member practice retains a right to convene a council of members meeting to discuss any particular issues as it deems necessary. RB added that a part of the query also related to maintaining an ongoing dialogue, which has been important in maintaining relationships. This is something that we do need to pay attention to; whether and how we use the Primary Care Networks as the vehicle is something that we haven't quite addressed yet. KW agreed that it is important that we keep the dialogue going, with much work still to do with our Primary Care Networks in relation to quality and performance etc. RB queried where healthy member relationship management would be addressed. LP replied Primary Care Networks were very grateful for the opportunity to develop, but we do retain the right to re-convene a locality meeting if we had a major commissioning decision that is expected to substantially affect member practices. For now it was felt that it was empirical in how comfortable they felt about level of communication on commissioning decisions. It is also envisaged that local commissioning decisions will be made through delegated authority to place, so member practices will retain an active role in making those decisions. RC added that, meanwhile, the supporting paper described proposed equity in delegated authority for more flexibility, in that existing authorities delegated to the Deputy Accountable Officer and Chief Finance Officer would be extended to Oxfordshire counterparts in order to be equitable. All other amendments relate to authorities already delegated to the Governing Body and therefore no membership approval is deemed necessary. RP requested suggested a language check be undertaken given various	

	references to Chief Officer and Accountable Officer, whilst LP often introduces herself as the Chief Executive. RC acknowledged this. ACTION. **The Governing Body was asked to APPROVE Version 1.21 (September 2019) with amendments as described prior to request for NHS England approval. This it did so.**	
4.	**Review and Approval of Minutes:** **a. Meeting minutes – 12/06/19** **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**	
	NL confirmed receipt of a series of questions in advance in relation to outcomes for community services. Governing Body agreed that confirm ed responses would be inserted into the minutes as evidenced below. Some time ago (2017/18?) a group of patients spend a considerable length of time developing a set of patient outcomes for community services. These outcomes were consulted on & only 4 responses were made, most of which contained suggestions for improvements to the draft version. In spring of this year I asked about the status of the draft and was told it was going through the governance process. Could you please inform us of the current status of the outcomes framework? The outcomes framework, originally conceived as a piece of work to support the commissioning of community services, was submitted to the Integrated Care Programme Board in January 2019 for a view on whether it would be of value to the Integrated Care System (now Integrated Care Partnership) to enable assessment of system outcomes and this was supported. The framework is developed to the point of having identified indicators for its outcomes, but work is still required to find sources of evidence and data to baseline and assess the indicators. This work will be undertaken if the framework and approach to using community representatives to lead and assess the outcomes is adopted by the Integrated Care Partnership once the new governance arrangements are in place and primary care networks are better established. Could you tell us what changes were made following the consultation? All feedback provided by respondents was carefully considered by the working group and whilst the philosophy and approach was not changed, some changes were made to the statements. It should be noted however that these statements are not final – they are currently written in a very technical style and need to be re-written for wider accessibility. Could you please tell us how the outcomes will be measured? Indicators have been developed and many sources of data and evidences have been identified. No baseline assessment has been undertaken or mechanism developed to capture data/information on an ongoing basis. Could you please tell us how the outcomes framework will be used? The	

	ambition is that the framework will be used by a panel of community representatives to hold the system to account. Using local knowledge and subject matter experts from community groups, areas for investigation will be identified by the panel and the framework used to structure key lines of enquiry.	
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 that one risk had reduced in score; Risk 7 (IF The CCG is unable to deliver the requirements stipulated within the Five Year Forward View for New Models of Care, Primary Care and Mental Health) has been reduced from 12 to 9 now that Primary Care Networks have been established to support delivery. RC noted that financial risks also remain high scoring. GH confirmed that the risk scores remain reflective of the discussions to be held on the substantive finance item later on the agenda. RB noted the GBAF would be further reviewed at the end of the meeting.	
8.	**Clinical Directors Presentation – Winter Planning**	
	Frances Woodruffe and Dr Dal Sahota talked through a supporting presentation, noting submission of the plan to NHSE by end of September. Dr Dal Sahota noted the role of winter director was also making a difference, and referred to a winter wash-up event that had taken place to share reflections involving some 50 members including neighbouring counties. RP queried whether measures to reduce attendances and NEL admissions for adults and children were one stream or separate streams. FW replied one stream to benefit both, but within the plan there is a detailed plan for paediatrics as this is known as an area of risk. DS added that consultant capacity has been increased leading to access to Hot Clinics. Fragility service also to be increased from 3 days a week to 5 days a week, which is a great step as this is a very valuable service. RB queried why this is not in place all year round. DS replied there is a desire for this, to which FW added this is in place in many other areas and a commissioning decision to be considered for next year. LP queried if we are measuring the number of bed day equivalents expected to deliver in the system as a real evaluation. DS replied we had evaluation last year which would be repeated and ensure inclusion of the right parameters. FW added that there is clear methodologies to monitor patients who are waiting for interventions in order to manage down the gap between admission and discharge in order to identify priorities that will improve flows. LP requested clarity as to meaning of “Non weight bearing -15 beds”. FW replied at any one time, there are 15 patients who are non-weight bearing, one third out of area. GH noted the extra funding that would be required and queried the strength of the case. DS replied that a pilot in Reading three years ago had been inspirational, with physiotherapy involvement preventing re-occurrence. RM suggested this needs to go back to the A&E delivery board. FW confirmed	

	there is a case with estimate costings already calculated. **ACTION: Frailty service falls vehicle - commissioning decision to be considered for next year to increase from 5 day a week winter service to all year around - with recommendation from the A&E Delivery Board.** DS added that we are also working closely with Oxfordshire to ensure we enact the OPEL framework at the right points in time, taking actions earlier to mitigate risk of OPEL4. FW noted we can be reactive to this. We must also ensure the welfare of our staff. DS added this should be on the agenda for PCN development. RM queried whether managing staff wellbeing was being extended beyond ED as there are numerous other staff under pressure during winter. FW replied each organisation will have their own resilience plan during Winter; ED is one area where we see and feel most pressure. There is a recognised gap between some providers and primary care. DS noted that there is an opportunity given development of PCNs. RM suggested there are some key measures such as checklists (before going home) that will help patients. KW noted other Trusts use signs in relation to staff wellbeing. FW added this will be further discussed at A&E Delivery Board. GH queried the 3 biggest things that will happen over next couple of months to release operational pressure on BHT as we have been in OPEL3 for a considerable length of time. FW replied this includes plans to move the medical take which currently flows through ED; anyone who is GP expected will default to A&E rather a medical receiving unit/ambulatory care. Whilst health and social care discharge teams are also already together, they will be formally in place together from beginning of November including unified joint assessment paper. DS added many surgical specialities already function outside A&E. The aim is to ensure patients do not go to A&E unless they clinically require A&E care. In relation to workforce, KW noted that through the Q&P report we frequently note that South Central Ambulance Service (SCAS) has issues with workforce and sickness. FW replied we have been assured that there is a wellbeing strategy, but can further investigate this through the A&E Delivery Board. LP added ambulance workforce is most challenging in respect of staff well-being. CO queried community services; if people coming to A&E shouldn't be there. Are we assured there is sufficient staffing in community services (i.e. district nursing) over the winter. DS replied we have to consider 111 and its role in telephone advice, with a national review about staffing capacity. Our population is using 111 which will be further strengthened this year. As regards primary care resilience, the role is understood as is that of flu planning. As regards district nursing capacity, FW replied we do need more assurance on this, with a plan we have already received flagging workforce as a risk. RB queried how we can address cultural challenges where A&E staff treat patients as episodes with subsequently follow on pushed back to primary care. DS replied that we would be able to streamline where we take out the	

	bureaucracy and put the patient back at the centre of what we do. This is a point of discussion at our next joint urgent care group. RW questioned how we best manage flow into ED. FW replied that BHT is one of six trusts nationally have flagged as having significant growth, with an NHSI/E deep dive looking at the reasons including type 3 non-urgent. The GP streaming service at Stoke Mandeville has also been well-received and reflects the population growth in the area. We have seen on social media that patients and proactively advertising the service. KP added that is also a degree of self-policing evident to ensure services are used appropriately. DS added that GP streaming is providing a good clinical service, but it is too easily accessible. It is hoped with time how we may change our offer at the Stoke Mandeville site – there is a national criterion for a UTC does. RW queried whether this is new business or re-diversion. We may create a different kind of capacity in primary care. DS replied that there is need to work with primary care networks to address this. LP noted a real case for consistency of approach in terms of triage both in primary care and in a UTC – PCNs give us the opportunity. Other areas have major inconsistencies in managing on the day appointments. Ideally minor illness goes through 111, only injuries to walk in. RB noted change in public behaviour has a cumulative effect on the system. RB noted his practice is encouraging more responsible use of available services and asked about marketing to sell this message across our communities. KP replied we promote 111 and pharmacists every winter, but there is a fine line and it can be hard to get right. We need to look at why people are going to A&E. But we are effective at doing communications with nothing. Funding is an issue if we are really to address prevention. NL noted the tipping point on a number of August weekends (when on call) was no rostered GPs for the streaming service. FW noted there is disparity in pay rates between BHT streaming GPs and out of hours GPs. We need to be more intelligent about this. GH added BHT have had 6% growth year on year which is not sustainable given existing capacity constraints. RW suggested it's difficult to stop this, so should primary care be changing its offer? GH indicated part of the growth is the success of GP streaming. LP added people choose the easiest route when we open up capacity. DS added that if there is a consistent message at every contact point, as has been emphasised in paediatrics, then it helps in ensuring better behaviours overall. KW added that there is also a changing role for pharmacy. FW noted that there is a plan for a community pharmacist in BHT as part of the streaming service. gave thanks for the rich and informative discussion held. KW also endorsed this.	
Decisions		
9.	**Emergency Preparedness, Resilience and Response (EPRR) 2019/20 assurance**	
	Bashak Onal (System Resilience Manager) joined the meeting and briefly described the accompanying report, noting the requirement for annual assurance reporting and difference in questions given category 2 role.	

	The Governing Body was asked to: 1. **NOTE** the progress of the Emergency Preparedness, Resilience and Response EPRR) process and assurance on compliance. This report reaffirms the process followed by NHS Buckinghamshire CCG in undertaking the EPRR self-assessment and subsequent approval by NHS England. 2. **APPROVE** the CCG's completed a self-assessment against the core standards and rating of <u>substantially compliant.</u> 3. **NOTE** approval by the CCG Executive Committee a suite of supporting documents which support the assessment against the NHS Core Standards for EPRR i. Major Incident Framework/Incident Response Plan ii. CCG Business Continuity Plan and iii. Surge and Escalation Plan 4. **RATIFY** the above suite of documents. 5. **NOTE** further requirements for reporting to Governing Body within the core standards and additional assurances provided 6. **NOTE** that Catherine Mountford has succeeded the Director of Commissioning and Delivery as Accountable Emergency Officer (AEO). The Governing Body did as described above. BO described the rationale for a "substantially compliant" rather than "fully compliant" rating, with the following areas deemed to have single criteria as partially complaint: • The presence of a non-executive board member, or a suitable alternative to support AEO in their role. • Availability of loggists during a major incident – the CCG does not have its own resource so this service would be available from other ICS partners during a whole system incident. • Data Protection and Security Toolkit – South Central West Commissioning Support Unit (SCWCSU) is awaiting for the reassessment reports and certificates which are expected in September 2019. The CSU Cyber Security team provided confirmation that the assessment last year and reassessment this year was carried out by an external accredited organisation. We have provided our evidence to NHS England, which Catherine Mountford has approved as Accountable Emergency Officer. We do not anticipate our compliance rating to change. We have also assured BHT's compliance, with a couple of areas identified for improvement for which they have an action plan in place.	
10.	**Gluten free food – decision to instigate a public consultation**	
	The Governing Body was asked to **APPROVE** instigation of public consultation on proposal to discontinue providing gluten free foods on prescription for adults and children. JB noted an existing limit on the number of products available within this area. RB noted previous discussions about this matter and that there is now a further opportunity prior to a final decision. RW queried peer review in relation to this and whether this is now a common theme. JB replied that it	

	is; locally all CCGs either limit the offer or does not prescribe at all (Berkshire West), the letter reflected nationally. Herts Valleys does not prescribe aside from a few exceptions. Oxfordshire still prescribes but has limited quantities. GS queried whether there has been any legal impact. JB replied that, following enquiry, it been identified that there have been no judicial reviews. RB noted the paper covers other clinical areas where special diets are required which is not a responsibility for the NHS to prescribe. The Governing Body **APPROVED** the decision.	
11.	**Long Term Plan 5 Year Strategy – Buckinghamshire, Oxfordshire and Berkshire West (BOB) Integrated Care System (ICS) submission and delegated authorities for oversight.**	
	RM noted the paper more akin to deadlines and governance than the plan itself, with numerous work streams and statutory organisations involved which is complex. Clinical Directors may also be involved directly in a work stream and/or circulate details as and when we receive them – so we can be assured that input has been effective and inclusive. RM emphasised that what is not reported in the paper is discussion through the Health and Wellbeing Board and agreed that we will circulate virtually the documents and are attempting to arrange a follow up session a week before the final deadline for submission to ensure oversight. RP acknowledged the various delegations make good sense. The Governing Body was asked to: 1. Delegate oversight of incorporation of our Board discussion and organisation's comments into the final document to the CCG Executive Committee that meets on ***26 September 2019*** (a pre-existing diary commitment). • Governing Body members will be sent the papers and will have an open invitation to contribute accordingly; • This also offers an opportunity for other CCG Clinical Directors who are not otherwise members of the Governing Body to contribute. 2. Delegate oversight of the final submission draft to the CCG Executive Committee on ***24 October 2019*** (a pre-existing diary commitment). • This falls before the final submission date of 1 November 2019 to NHS England. • Governing Body members will be sent the papers and will have an open invitation to contribute accordingly • This also offers an opportunity for other CCG Clinical Directors who are not otherwise members of the Governing Body to contribute. 3. Delegate approval of the full draft submission to Louise Patten as Accountable Officer and Dr Raj Bajwa as Clinical Chair, taking into account discussion to be held at subsequent CCG Executive Committee meetings. The Accountable Officer and Clinical Chair would have one week from the date of the Executive Committee to the deadline for final submission.	

	These delegations were agreed.	
12.	**Update on ICP transformation funds (under delegated authority): Governance Process for Transformation Funds – 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.	**Corporate Governance Update:** **a) Executive Committee Terms of Reference** **b) Remuneration Committee Terms of Reference** **c) Statutory appointments 19/20** **d) Conflicts of Interest Policy** **e) Gifts and Hospitality Policy (including sponsorship)** **f) Freedom to Speak Up Policy**	
	The Governing Body was asked to: a) **RATIFY** interim terms of reference for the CCG Executive Committee b) **RATIFY** amended terms of reference for the CCG Remuneration Committee c) **APPROVE AND RATIFY** amendments to statutory appointments 2019-20 d) **RATIFY** the CCG Conflicts of Interest Policy e) **RATIFY** Gifts and Hospitality Policy (including sponsorship) f) **APPROVE AND RATIFY** Freedom to Speak Up Policy. Approvals and ratifications were confirmed as described. RM added there is	

	a policy principle given direction of travel that we don't review policies for the sake of it because they have come up for review. We would facilitate reviews and further extend existing policies unless there are major amendments required due to some change in legislation for example. This is also consistent to our current schemes of delegation to named groups.	
14.	**Dissolution of the Engagement Steering Group**	
	The Governing Body was asked to **AGREE** a decision to dissolve the CCG's Engagement Steering Group and transfer its roles and responsibilities to the ICP's Getting Bucks Involved Group. NL noted reviews of workload and identification of overlap, and given expectation that the new group will meet monthly rather than bi-monthly as was the frequency of the predecessor, NL felt confident that the new group would be able to deliver. LP queried if the new proposed group would also be used by the Health and Wellbeing Board though its implementation system wide. NL confirmed this was the intention. RP asked whether this had been discussed with CS. NL replied he has been given the opportunity to contribute. The proposal was **AGREED**.	
15.	**Workforce Race Equality Standards**	
	The Governing Body was asked to: • **NOTE** that the CCG's data was submitted to NHSE in August • **APPROVE** the WRES Action Plan (Appendix 15a) • **NOTE** the Executive Committee will support the Staff Partnership Forum to adopt the action plan • Request a development session to review progress in Q4 of 2019/20 The above points were **NOTED/APPROVED** RW queried recruitment – at Royal Free every panel must have an individual from a BME background, and if a person who is BME is interviewed but not successful then the Chair has to write to the CEO to explain why. RB queried the reason for this. RW replied it was an acknowledgement of the local demography and that more people from within the BME community were employed towards the lower end of the organisation rather than upper end. NL noted the CCG has some limitations given its headcount. GH added we have also had a headcount freeze. NL added that we have sought to ensure recruitment decisions mitigate against unconscious bias through appropriate training. GS queried what this means. NL replied it means making clear that use of language could offend. But we have been good at growing our own staff, including apprentices, who have worked their way up. We need to achieve the same with BME colleagues. RM added that we need an affirmative commitment from Governing Body on the principles behind this, not solely that we are doing this as an expected requirement. RB agreed this is a valid point. LP echoed – we have to proactively manage the balance and review this in Q4. CO added that the more proactive the CCG is to do this, the better. RB noted this was a beneficial discussion and that Governing Body should not be afraid to discuss these matters. RB spoke, as the only BME person	

	present, in stating there is a subtlety due to cultural connection and means of interaction which can be difficult to address. GS wondered whether more division is created by naming a specific group as BME. CO replied this came up at a national nursing advisory group as recognised that experience can be different to perception. NL added that staff had been asked if they would like to nominate BME champions, but felt that this is not the only issue so diversity champions have been developed instead. RB queried who will pick this up – Ojalae Jenkins would be facilitating.	
	Leadership and Governance	
16.	**Accountable Officer's Report and System Working Update**	
	RM highlighted population health management as an exciting national programme to accelerate this area, particularly linked to development of Primary Care Networks and improving patient outcomes. Berkshire West has been in wave 1, with all ICSs now part of the programme. RB noted discussion at primary care transformation board – that there is both PCN and Thames Valley levels, with risk of operation separately. They need to be joined up. RM replied they are joined up with perhaps a need to refine the language. This is a programme within an overall approach as an enabler that will answer some of these questions and cover such matters as information governance. Relevant leads across the ICS will come together to develop it.	
Governance and Assurance		
17.	**Finance Report (Month 4)**	
	GH described year to date variance of £24k with forecast as per plan, but underlying challenges remain – CHC pressure, acute over performance, independent sector and Milton Keynes. We will facilitate a specific piece of work on Milton Keynes activity. Plus pressure within continence and equipment budget. We have held position, but we know a £5k risk has increased to £6m at month 5 as a result of category M pressure (less than 1% of spend circa £730m). It will be difficult to hold position and the risk will likely materialise. Effects include missing our CSF (£10m available, back end phased, which will inform when we move risk into position). Risks relate to category M drugs – this came out post planning, a national issue £10m a month nationally – circa £1m locally this financial year. We are managing both acute over performance and CHC, with a task and finish group addressing the latter. We have a strong relationship with BHT. RM queried support we can give to BHT to re-focus activity into community services. GH replied that we need Governing Body support to limit investment into acute and pump prime community. RB replied that this has been a plea for a long time. LP added we find this challenging for non-elective, which is a whole system challenge. We need to be clear, to balance our books, we need to review planned care activity and clinical thresholds. We should be 10% below national averages given numbers of self-funders. RB added we are more likely to release efficiencies through how BHT is managing their pathways. GH emphasised that this is not just about BHT as this is only 60% of acute spend.	

	This was supported by Governing Body.	
18.	**Quality and Performance Report (July 2019 with August 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:	**RM/KW**

	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.	
19.	**Communications and Engagement Update**	
	The supporting report was provided for information.	
20.	**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 finance risk scores will remain unchanged. RB asked GH for his opinion. RP indicated nothing had changed. Scores for risk 2 (12), 3 (16) and 4 (16) were agreed to remain the same.	
21-22.	**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.	
23.	**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