NHS
Buckinghamshire
Clinical Commissioning Group

NHS BUCKINGHAMSHIRE CLINICAL COMMISSIONING GROUP
GOVERNING BODY (IN PUBLIC)
12 March 2020, 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**	Apologies
Gary Heneage	Chief Finance Officer	**GH**	Present
Crystal Oldman	Registered Nurse	**CO**	Apologies
Robert Majilton	Deputy Accountable Officer	**RM**	Present
Dr Rebecca Mallard-Smith	Member GP/Clinical Director Unplanned Community Care	**RMS**	Present
Louise Patten	Accountable Officer	**LP**	Present
Robert Parkes	Lay Member / Vice Lay Chair / Chair of Audit Committee	**RP**	Present
Colin Seaton	Lay Member, Patient and Public Involvement	**CS**	Apologies
Graham Smith	Lay Member, Chair of Primary Care Commissioning Committee	**GS**	Present
Dr Karen West	Member GP/Clinical Director Quality and Integration	**KW**	Present
Dr Robin Woolfson	Secondary Care Specialist Doctor	**RW**	Apologies
Standing invitees (non-voting, subject to continual review):			
Name	**Title/Organisation**		
Louise Smith	(Interim) Director of Primary Care and Transformation	**LS**	Apologies
Also present			
Name	**Title/Organisation**		
Russell Carpenter	Head of Governance/Board Secretary (minutes)	**RC**	Present
Sarah Creighton	Lead Dietetic Prescribing Advisor	**SC**	Present (item 8 only)
Julie Hoare	Managing Director, Buckinghamshire Integrated Care Partnership	**JH**	Present (item12 only)

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 However the meeting was noted as **NOT** quorate. CCG Constitution	

	Appendix E Standing Orders: "*Whether any vote for any member sought in advance where there are issues of quorum will count will be at the discretion of the remaining voting members*". The remaining members agreed that decisions obtained from members in advance have been recorded and will be counted to carry decisions as indicated on the agenda. These details will be recorded under each agenda item. RB noted this as the final meeting for RMS and LP; on behalf of the Governing Body and organisations RB thanked them for their contributions and wished them well.	
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 8: Gluten free food – decision to only prescribe gluten free bread, bread mixes and flour mixes to people who meet indicated exception criteria.** Member GPs where partners in practices which are dispensing practices are identified as having a direct conflict of interest as they could be perceived to lose income from this decision. Member GPs with voting rights on Governing Body are not partners from dispensing practices: • Dr Raj Bajwa from Little Chalfont Surgery • Dr Karen West from Haddenham Medical Centre • Dr Rebecca Mallard-Smith from John Hampden Surgery. No further action is therefore deemed necessary. **Item 9b: Draft submission CCG/ICP Plan 2020/21 and delegated authority** Member GPs as voting members of Governing Body and where partners in practices may be perceived to benefit from elements of agreed plans where related to primary care funding. However this is not deemed material to decision required from this paper given no conflict in a governance decision to delegate authority to a sub-committee where this conflict ceases to exist. No further action required.	
3.	**Proposed changes to the CCG Constitution (from 1 April 2020)**	
	The Governing Body was asked to: 1. **NOTE** receipt of letter from NHS England confirming their approval previous Governing Body approved amendments to the CCG Constitution, v1.25 dated November 2020 (**Appendix A**). 2. **APPROVE** further editorial changes versions 1.26 through 1.28 (**Appendix B**) 3. **NOTE** at present the CCG Constitution is not wholly aligned to the national template, but that this is not a mandated requirement. The Constitution is otherwise deemed to be legally compliant resulting from NHS England approval. Through collaborative working with Oxfordshire and Berkshire West CCGs there is expected to be	

	further Constitution review and alignment over coming months. CCG Constitution Appendix E Standing Orders: *Whether any vote for any member sought in advance where there are issues of quorum will count will be at the discretion of the remaining voting members.* Remaining voting members agreed to count for quorum decision purposes votes from members cast in advance: specifically Tony Dixon (Lay Member), Dr Robin Woolfson (secondary care doctor) and Dr Crystal Oldman (Registered Nurse) to approve constitution changes as described within the supporting paper. RB noted the letter from NHS England approving the previous set of changes. RC noted this is likely to continue to be iterative over the coming months, including as and when the CCGs federate and therefore line up consistency in format and content. However ours does meet the minimum requirements of the national model. RB noted the CCGs are widely different. RC replied we would need to allow for this. RC stated that there is debate about what falls within material or immaterial changes; the current set of changes relates to those authorities already held by Governing for onwards delegation and therefore deemed "immaterial" and not requiring membership approval. Editorial changes were **APPROVED** and differences from model constitution **NOTED.**	
4.	**Review and Approval of Minutes:** **a. Meeting minutes – 14/11/2019** **b. Action Log/Matters Arising**	
	The minutes were agreed as a true and accurate record. Updates to the action log are described on the log.	
5.	**Matters Arising – escalations/issues from Sub-committee Chairs**	
	None arising.	
6.	**Questions from the public**	
	None received in advance	
7.	**Governing Body Assurance Framework (GBAF)**	
	The 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 provided a summary of updates: • Risks 2, 3 and 4 on finance remain highest scoring because have been subject to reduced scores. • The CCG Finance Committee discussed its risks (GBAF 2, 3, 4) when it met in February 2020. There was confidence that the CCG's 19/20 plan would be met with agreement reach to re-focus our GBAF risks for 2020/2021. Accordingly current scores for all three risks are reduced to 8 (likelihood reduced from 4 to 2, but impact remains the same) and therefore meet their acceptable	

score.

- A number of risks have been also been reviewed updated to take into account feedback from the last risk management internal audit since the GBAF was last reported in public in November 2019.

The GBAF was noted.

RP queried if there is a risk on resources. RC replied there is – risk 5 – *The CCG is unable to maintain its optimum staffing levels at any time*

There is a separate risk in relation to the role of the AO and is on the escalation report in public. This was moderated at Executive at 16 in order to be reported in public. It was discussed whether risk 5 was high enough. RM noted we are planning for 20%, 30% and 50% staff reduction linked to COVID-19.

RC added that COVID-19 does not appear in GBAF risks, but does appear in a corporate risk relating to non-elective activity. However this same risk has been updated to include the CCG's business continuity arrangements. Staffing impact was felt as needing to be included on the GBAF. Risk 5 score also to be increased, not only because of COVID-19.

<u>Corporate Risk Register escalations</u>
RC noted coverage of COVID-19 and CCG business continuity arrangements which covers much more detail, a review of which will be formally approved by Executive Committee 26/03/2020 although already in action.

KW also queried 111 resilience efforts; GH replied that additional funding nationally was supporting 111. RM added NHS Digital has circulated a message that patient support should not just be telephoned based. We have already had a request from 111 to stand down Protected Learning Time in order to support the system.

GH added an incident control centre is also being established at Jubilee House for resilience with two tier director on call rota, normal activity and COVID19 specific. RMS stated that there is not as much pressure on acute at present, but primary care is still seeing flu and its complications. Normal winter pressure cannot be ignored.

RB supported this. A while back there was focus on a specific set of symptoms, but this is changing and making it more difficult to clinically diagnose which will be a big challenge. We are still in time of year where respiratory illness is still common. GH added BHT have been on OPEL4 recently which is not COVID-19 related; once we have pressure of COVID-19 on top will create capacity challenges which we need to recognise.

Decisions		
8.	**Gluten free food – decision to only prescribe gluten free bread, bread mixes and flour mixes to people who meet indicated exception criteria.**	
	SC joined the meeting The Governing Body was asked to: 1. **APPROVE** recommendation from the CCG Executive Committee to only prescribe gluten free bread, bread mixes and flour mixes to people who meet the indicated exception criteria. 2. **APPROVE** exception criteria "dietary neglect" and GPs will use their clinical judgement to apply this exception criteria 3. **NOTE** the process for applying the policy and exception criteria will be part of the implementation of the decision. The meeting today was previously noted as **NOT** quorate to take decision. CCG Constitution Appendix E Standing Orders: *Whether any vote for any member sought in advance where there are issues of quorum will count will be at the discretion of the remaining voting members.* Remaining voting members agreed to count for quorum decision purposes votes from members cast in advance: specifically Tony Dixon (Lay Member), Dr Robin Woolfson (secondary care doctor) and Dr Crystal Oldman (Registered Nurse) to approve recommendation and exception criteria as stated. RB noted the paper, developed by the CCG Medicines Management Team, had been subject to robust discussion at two Executive Committee meetings, and has very broad clinical support. Remaining Governing Body members* therefore confirmed as **APPROVED** the recommendation and exception criteria and **NOTED** related process, with Governing Body quorum requirements having been met. *i.e. GP Clinical Chair, Accountable Officer, two clinicians Member GP/Clinical Director Unplanned Community Care and Member GP/Clinical Director Quality and Integration/Caldicott Guardian, one lay member and one other management director (both deputy accountable officer and Chief Finance Officer). **SC left the meeting**	
9.	**Financial Governance:** **a) Process for Approval of Annual Accounts and Annual Report** **b) Draft submission CCG/ICP Plan 2020/21 and delegated authority**	
	Financial Governance: a) Process for Approval of Annual Accounts and Annual Report The Governing Body was asked to **AGREE** delegated authority to approve the Draft accounts and annual report to the Audit Committee at their meeting on the 14 May 2020 and for final approval of any changes post	

	Audit Committee to the Chairs, Chairs of the Audit Committee, Chief Officer and Chief Finance Officer on behalf of the Governing Body. GH noted this was no different to previous years. We have discussed 30 September and the annual report. We need to be cognisant this timetable may change depending on what happens nationally and all CCGs submitted annual accounts on time. **b) Draft submission CCG/ICP Plan 2020/21 and delegated authority** The Governing Body was asked to **DELEGATE** authority to the CCG Finance Committee to approve the version of the 2020/21 CCG/ICP Plan (and associated budgets) by 29 April 2020. First submission was in March, this is no different to previous years. RW has raised in advance a question; does the Audit committee not have a similar role in this? RP replied in reality they are the same people. GH added audit committee will want to know that the process has happened. The meeting today was previously noted as **NOT** quorate to take these decisions. CCG Constitution Appendix E Standing Orders: *Whether any vote for any member sought in advance where there are issues of quorum will count will be at the discretion of the remaining voting members.* Remaining voting members agreed to count for quorum decision purposes votes from members cast in advance: specifically Tony Dixon (Lay Member), Dr Robin Woolfson (secondary care doctor) and Dr Crystal Oldman (Registered Nurse) to approve delegations requested. Remaining Governing Body members* therefore confirmed as **APPROVED** the above delegations requested. *i.e. GP Clinical Chair, Accountable Officer, two clinicians Member GP/Clinical Director Unplanned Community Care and Member GP/Clinical Director Quality and Integration/Caldicott Guardian, one lay member and one other management director (both deputy accountable officer and Chief Finance Officer).	
10.	**Corporate Governance:** **a) Annual Review of Terms of Reference and scheme of reservation and delegation – PCCC** **b) CCG Code of Conduct**	
	a) <u>Annual Review of Terms of Reference and scheme of reservation and delegation – PCCC</u> **b) <u>CCG Code of Conduct</u>** The meeting today was previously noted as **NOT** quorate to take decision. CCG Constitution Appendix E Standing Orders: *Whether any vote for any member sought in advance where there are issues of quorum will count will be at the discretion of the remaining voting members.*	

	Remaining voting members agreed to count for quorum decision purposes votes from members cast in advance: specifically Tony Dixon (Lay Member), Dr Robin Woolfson (secondary care doctor) and Dr Crystal Oldman (Registered Nurse) to ratify terms of reference and scheme of delegation for the primary care commissioning committee (PCCC) and code of conduct previously approved by the audit committee. RC described the ratification of terms of reference and scheme of reservation and delegation required in the absence of GS. Remaining Governing Body members* therefore confirmed as **RATIFIED** the terms of reference and scheme of reservation and delegation and code of conduct previously approved by the audit committee. *i.e. GP Clinical Chair, Accountable Officer, two clinicians Member GP/Clinical Director Unplanned Community Care and Member GP/Clinical Director Quality and Integration/Caldicott Guardian, one lay member and one other management director (both deputy accountable officer and Chief Finance Officer). RC noted an amendment to the scheme of delegation in relation to oversight of funding deployment for primary care networks, depending on sign up to the national DES. RMS noted LMC national conference had rejected it leading to further discussions by the BMA. RM clarified this had been re-negotiated nationally. RB queried this leads to a risk for us. RC replied a separate risk on this had been developed and forms part of the CCG Corporate Risk Register, to be moderated by the CCG Executive Committee. RB added LMC may make a statement on this locally for us. RMS felt they had already done so. This will likely remain an ongoing issue for some time in relation to the specificity of the requirement. RC noted that this oversight had been further delegated to the community transformation board. RB queried if it could do this (i.e. double delegation). RC replied this does not fall within the boundaries of the delegated functions within the delegation agreement and so there is not an issue.	
	Leadership and Governance	
11.	**Accountable Officer's Report and System Working Update**	
	RM noted the report as supplied. On 27 February 2020, the CCG Executive Committee approved under delegated authority pharmaceutical joint working frameworks/agreements for cholesterol lowering drugs, cumulatively amounting to £50k through 2020/21 (maximum £25k per pharmaceutical company supplier). This is alongside receipt of a grant agreement. **Action: RB queried how we allow for exit strategy – do we build it into baseline costs?** LP thanked the Governing Body for its support over the years. We need to include a good news story. RB stated his agreement we need to get better on reflecting patient experience.	**RM**

Assurance and Governance		
12.	**Integrated Care Partnership – plans for 2020/21**	
	JH joined the meeting. JH and talked through an accompanying slide set. The narrative below focus on the questions arising from the presentation. RB queried the fit of planned care into the ICP and that we are comfortable there is enough planned care function at place and where the planned care lead fits, e.g. respiratory pathway. JH replied it is definitely one of the work streams; LP the aim was to create place where work is done once and distributed. Majority of planned care is at ICS level in harvesting data, but with implementation at place through ICP/CCG MD role having responsibility. Clinical roles likely much more across ICS pathways. This part to the structure needs further thinking. JH added there is a named individual for the place based work we do. Respiratory pathway is included in community services to make sure it's joined in. There is always a danger community based work group becomes enormous, clinicians in work stream need then to link to other work streams. RMS noted 12 community boards are not yet in place. JH replied these are being formed, with discussions ongoing to discuss strengthen links with the ICP Partnership Board. RM noted population health management is developing and queried the middle tier between PCN 30-50k populations and 500,000k population at ICS level. JH replied this debate continues to evolve. KW asked how PCN representatives at ICP Partnership were identified; JH replied this was chosen by them with work ongoing to replicate this through the ICP shared executive group. RB also noted there is an ageing well accelerator as an opportunity for system investment. RM queried PHM oversight now as we get closer to go live; there is a need for triangulation with work on the ground which needs to be link back to what the ICS framework might design. JH replied there remains ongoing workforce challenges and how best we recruit, and developing opportunities around being able to take leadership and change training into geographical areas, shadowing and mentoring to share information and strengthen working with practice nurses and practice managers. RP asked how this will be achieved through bottom up rather than top down. JH replied there will always be a mixture; with effort to raise people's awareness of opportunities. As that increase we shall see ideas and initiatives being driven at local level. RB asked how in 12 months' time we can how demonstrate how all that work has made a difference to the population. JH replied work streams will need to be clear on what they are targeting and its impact, as well as feedback how it feels to work and live.	

	LS is also contacting the King's Fund to help evaluate impact. RB said Governing Body would expect a report back at some point. <u>Financial challenges</u> GH noted £43m system control total deficit submitted on 10 January 2020; subsequent meeting with CEO's and Finance Directors discussed likely push from national team to increase this to £53m. We have probably spent longer on apportioning than delivery. PWC have identified 4 main schemes; demand management, estates, workforce and corporate back office. Based on benchmarking to date and where savings fall, they have got to £30.5m number. Balance £22.5m then apportioned pro-rota. Adjustments for RBH and Oxford Health excluding Buckinghamshire. For Buckinghamshire ICP this means extra £11m CIP/QIPP. This is a holding position, numbers may change with full detail of £30.5m and how other schemes may deliver 22.5. There is a lot of risk which has to be managed collectively across the system. RP asked whether the estimated £30.5m is yet fully detailed. GH replied at this stage it is based on benchmarking the model hospital and right care but needs further analysis. Broadly split £2m for demand management (to be defined, e.g. POLCE, IFR), £1m back office (premise to save 25% of CSU costs), with the rest as pro-rota element. We need to have a plan to deliver over coming periods. RM noted we are moving to an ICS control total and so there is opportunity to maximise these numbers, and operationalise how we translate this into contracts to support delivery. RB queried at what point COVID-19 is expected to impact these finances GH replied we shall deal with this whenever we need to deal with it. It will be difficult. RM added it may also be the impetus for transformation that has been previously hard to land, e.g. digital transformation. GH summarised other key points: • 11th nationally in prescribing rates • CHC on track • Mental Health we can't change given Mental Health investment standard • Not targeted delegated commissioning for savings. • Only place left within budget is elective care. Have to support non-elective to take activity out of acute. • Long term plan challenges, RTT, 92% bed occupancy and financial challenge don't match. • At any one time medically fit patients in BHT – getting these out frees up beds and gets us closer to 92% bed occupancy. • Massive ask to deliver on top of significantly risky CIPS and QIPPs with their gaps (£11m gap, it is high risk, linked to long term plan) RM commented when we had feedback from CCG engagement, there was a narrative on finances. Is it correct to say Buckinghamshire would contribute 4m towards balancing ICS position? How does unitary and social care play into the finances?	

	GH replied Buckinghamshire is delivering more. RM added the financial narrative is very important. There has been a perception that the other CCGs were supporting Buckinghamshire CCG position, but now it is the other way around. JH added the Buckinghamshire Council (unitary) CEO has taken over as ICP lead; very much for the integrated approach. Real opportunity for greater partnership. We need to know this delivers into something. GH concluded that our plans contain significant risk – Executive Committee and Governing Body must own it (it is not just a finance plan). Will need significant support in making some tough decisions over the next few months. **JH left the meeting**	
13.	**System Finances** **a. update on 19-20 and proposals for 20-21** **b. Finance Report (Month 11)**	
	GH stated we will hit plan in 2019/2020. As regards 2020/2021, we have to land contracts. There will be significant risk in the position. This support by the Buckinghamshire pound group to prioritise system monies on investment and system support for financial recovery. Deficit plan submitted and massive QIPP target. Some net risk will close off as we negotiate contracts. There is also a risk to achieving FRF £14.1m (7 of that related to CCG position, the other ICS finances). We will do what we can. KW queried advice and guidance into Frimley contract. GH replied it will go into all contracts and linked to reduction in face to face. **Action: RB asked if we can identify money to support Frimley interface. GH has signed this off. RB said this has not filtered through. Take this offline.**	**RB/GH**
14.	**Quality and Performance Report (February 2020 with March exceptions)**	
	KW introduced the item; this is the most up to date report as it is dated March and therefore no reportable exceptions. KW described a number of issues in turn: <u>Cancer</u> • Although performance is falling, there is a recovery plan • 222 breaches sit 9 days over, now 23 breaches over two weeks. • This is not acceptable, and this is being challenged with weekly escalation calls and pathway harm reviews with BHT. National issue with shortage of radiologists, and potential for harm. • RB stated that Governing Body recognises the concerns and is seeking assurance that the right actions are being taken to 1) Review local constraints in ensuring the effectiveness of the national pathway 2) communicate to primary care around ensuring they follow national guidance 3) mitigate the risks to patients	

	Referral to Treatment (RTT) • We are not meeting trajectory, but this is national issue driven by non-electives. • GH stated for elective value we need a minimum level of activity to mitigate this going to the independent sector. • RB asked if we have a policy to refer elsewhere if BHT cancels elective surgery and patients adopt consumerist behaviour. RM replied that this would need to be clear in communications to primary care. Hospital receiving referral still remains responsibility for outsourcing. We may reach a situation where this is not isolated and so needs to be flagged nationally through NHS England/Improvement. Diagnostics We stopped outsourcing additional backlog clearance so it is building back up again. Same issue as with cancer with national shortage of radiologists. RM queried how we are prioritising the human resource we have. KW replied we are looking at this. **Action: RB asked if there has been an evaluation of the impact of direct access endoscopies. It is fundamental to a pathway. This was taken as an action.** GP referrals • If anything these are decreasing. There is also ongoing analysis of Milton Keynes referral data. • C2C's are still an issue, but not as big an issue as some of the intermediate pathways. Large numbers seem to going from ophthalmology, optometry, gynaecology and orthopaedics • RMS commented that a patient could be referred through intermediate service or MS. The referral makes clear what joint or gynaecology complaint is the problem. The patient then sees someone, only to be told it is not the right consultant and is referred on, despite the referral being clear on the clinical need. This wastes patient's time. • RB commented this is about the effectiveness of pathways, which is a massive part of what an ICP should be doing. A&E and GP streaming • There has been a reduction in A&E pressures, with much good work in the system and numbers dropped in attendances potential (lull before the storm given nervousness about COVID-19 impact). • GP streaming is an ongoing concern; when people in streaming it works well, but there is a struggle to fill rotas evenings and weekend. RB suggested this is affected by market forces. • RM asked whether OOH and GP streaming services are being linked given their competition for staffing. KW replied BHT is now linking OOH capacity with more cross working. • RB queried steps to formally bring the contracts together. RM replied GP streaming is part of the acute contract. KW said this is ongoing. Delayed Transfers of Care (DTOC) • Improving performance; real notable improvement at Frimley, monitored daily and meeting with BHT and social care partners	**KW**

every morning, process in place.
- Ongoing improvement in process and discussion between partners.

South Central Ambulance Service (SCAS)/111
- Higher demand than planned forecast only going to worsen.
- Ongoing increase in handover delays.
- Risk of COVID-19 on performance measures; GH commented the online 111 algorithm is quite good. RMS primary care should make use of it.
- RB suggested general practice could be better at adapting to rapidly changing guidance, so this is a benefit of electronic tools.
- RMS commented it is inevitable that practices continue to use 111 in triage.

Continuing Healthcare (CHC)
- Improved performance for assessments within 28 days (target 80%), increasing steadily. GH noted 79% in February,
- KW added a downside is a large number of in acute hospitals, with out of hospital pathway in progress to clear backlog.
- RB queried patient outcome. RM replied we are much more in line with conversion rate and peer review.
- GH added there is the review of backlog now going on to June 2020, and making sure there is not a new backlog developing. We are reporting on both. There is a savings opportunity where peer to peer review leads to increased conversions.

Dementia/health checks
- RB asked when we receive February data for annual health checks. Practices often use March to complete these and QOF.
- KW replied Dr Sian Roberts (clinical lead for mental health and learning disabilities) is more concerned about quality of health checks rather than simply meeting the target. We can show we have an action plan in place for general improvement even if the target were not met.
- RMS added there is also an LD part to PCN development.
- RM added there are a number of things that we would be reliant on in March which may not happen and need to consider how we approach that. Governing Body noted this; there may need to be some pragmatic discretionary decisions.

COVID-19
- Likely increase in case numbers anticipated.
- RM noted the CCG has been required this week to commission a home check-in service for those who are mild unwell and self-isolating. RMS added this involves daily calls but is not a service that GPs can refer into.
- RB queried what if non-COVID-19 illness. RMS replied this is being discussed on primary care daily calls.

RB noted “Broader Quality oversight” as an exception description – says n/a. What does this mean? It was agreed to take this out if there is nothing to report.

15.	**Workforce Race Equality Standards – progress review**	
	The Governing Body was asked to: • **NOTE** progress made in the updated WRES action plan for Q4. • **NOTE** the Executive Committee will support the Staff Partnership Forum to adopt the action plan • **NOTE** that it is planned to hold a Governing Body development session to review progress in Q1 of 2020/21 The above it **NOTED** as indicated. RM added this is being activity reviewed by the Staff Partner Forum, and development of staff diversity champions and development of unconscious bias training.	
16.	**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. The risk scores for finance remain high as they were reported. There were no further changes proposed.	
17-20.	**Approved Minutes and reports as stated on agenda**	
	Minutes provided for information were noted as received. Meeting closed 12:30.	
21.	**Next meeting/AOB**	
	Date and Time of the next meeting (in public): Thursday 11 June 2020, venue TBC	

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