NHS
Buckinghamshire
Clinical Commissioning Group

NHS BUCKINGHAMSHIRE CLINICAL COMMISSIONING GROUP
GOVERNING BODY (IN PUBLIC)
11 June 2020, 10:30am-12:15pm
Microsoft Teams

Members (13)			
Name	**Title/Organisation**		
Dr Raj Bajwa (Chair)	GP Clinical Chair	**RB**	Present
Dr Karen West	Member GP/Clinical Director Quality and Integration	**KW**	Present
Dr Rashmi Sawhney	Clinical Director – Health Inequalities and The Primary Care Network DES	**RS**	Present
Dr Dal Sahota	Clinical Director – Unplanned Acute Care	**DS**	Present
Robert Parkes	Lay Member / Vice Lay Chair / Chair of Audit Committee	**RP**	Present
Tony Dixon	Lay Member / Chair of Finance Committee	**TD**	Present
Graham Smith	Lay Member, Chair of Primary Care Commissioning Committee	**GS**	Present
Currently vacant	Lay Member, Patient and Public Involvement		
Dr James Kent	Accountable Officer	**JK**	Apologies
Robert Majilton	Deputy Accountable Officer	**RM**	Present
Gary Heneage	Chief Finance Officer	**GH**	Present
Dr Crystal Oldman	Registered Nurse	**CO**	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
Julie Hoare	Managing Director, Buckinghamshire ICP	**JH**	Present
Dr Raj Thakkar	Clinical Director, Planned Care	**RT**	Present
Dr R Mallard-Smith	Medical Director, Local Medical Committee (LMC)	**RMS**	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 The meeting was noted as quorate with the above present, with only the Accountable Officer having given apologies. Dr Rashmi Sawhney will join the meeting part way through.	

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. **Item 8: A supplementary network service enhancement to the Care Homes specification within the 2020/21 Primary Care Network Directed Enhanced Service (DES)** Member GPs who are also CCG Clinical Directors and partners in their practices are directly conflicted given their practice partner status and therefore subsequent status as (a) Recipient providers in the signature of Primary Care Network Direct Enhanced Service (DES) contracts and (b) Recipient providers of "*supplementary network service*" in signing up to the national DES specification (c) Recipient providers for Locally Commissioned Services for which funding is expected to be re-purposed to fund a supplementary network service enhancement to the Care Homes specification. For clarity within the minutes, member GPs present confirmed the following direct conflicts of interest: • Dr Raj Bajwa – partner in a practice (Little Chalfont surgery) already signed up to the national DES at time of discussion • Dr Rashmi Sawhney – partner in a practice (Riverside Surgery) already signed up to the national DES at time of discussion • Dr Dal Sahota – not a partner, but a GP working in a practice (Hall Practice) already signed up to the national DES at time of discussion. • Dr Karen West – partner in a practice (Haddenham Medical Centre) already signed up to the national DES at time of discussion. Governing Body 11/06/2020 Member GPs have voting rights and so the direct conflict of interest is material. Member GPs are free to remain in the meeting of the Governing Body, and can participate in discussion on the clinical elements and outcomes. This will be at the discretion of the Lay Vice Chair who will lead the item given the direct and material conflict of interest for the CCG Chair. RP confirmed they would remain participant but not form part of voting quorum. Members were also asked to **REVIEW** their declaration of conflicts of interest (stated in the register at appendix 1) and provide any new or updated signed declarations as required using the form at appendix 2. These have been provided separately to the Corporate Governance Manager. **Item 09c: CCG Statutory and other appointments** Named individuals included within the schedule are voting members of the Governing Body; however this decision is an assurance to note appointment to the role and does not relate to decision to appoint or discharge of duties within the remit of the appointment. Therefore no further action necessary.	
3.	**Review and Approval of Minutes:** **a. Meeting minutes – 12/03/2020** **b. Action Log**	
	The minutes were agreed as a true and accurate record with some amendments from RM: • RM clarified this had been re-negotiated nationally ~~but did not get LMC support.~~	

	• Page 16 – ICS not OCS • Page 16 – remove “long” from sentence on pathways • Page 17 – Contribute not contrite • Page 20 - Dr Dal Sahota was trying to get support from practices to prescribe antivirals – we didn’t feel this was a safe thing to be doing and is not specified in national guidance – sentence removed as erroneous. Updates to the action log are described on the action log.	
4.	**Questions from the public**	
	The Local Medical Committee (LMC) of Buckinghamshire wishes to express concern that the CCG proposes to create a “DES+” service, local to Buckinghamshire, which will only be available to practices who have opted into the national PCN DES, and that the practices who have opted out of the PCN DES (nearly 20% of Buckinghamshire’s population) would be excluded from being commissioned to deliver this service. *The NHS Long Term Plan indicates an intention for services to increasingly be delivered at network level but this must not be conflated with the DES, which is an optional enhanced service, nor should it be misinterpreted that a practice may only work at network level if it is participating in the DES. The LMC is concerned these two distinct items (the DES and PCNs) are being conflated.* *As with all local enhanced services, such a service must be available to all patients. Therefore, if such a service is commissioned, the CCG will be required to deliver it to the patient populations of those practices who have opted out of the PCN DES. Failure to commission to all patients would also create a two-tier system with significant health inequalities across the county.* *Furthermore, were such opted out practices to be excluded from being commissioned such a “DES+” local service, then this would also create significant health inequalities in Buckinghamshire, for the following reasons:* • *Practices know their patients better than any third-party provider* • *Patients would likely have further to travel* • *Separate providers looking after separate services erodes continuity of care* • *The above-mentioned factors are further exacerbated in complex, vulnerable and deprived populations* *In summary, the LMC wishes to ask the Governing Body for assurance that any such “DES+” local incentive service be offered to all practices in Buckinghamshire, regardless of whether practices have opted into our out of the national PCN DES, in order to prevent the health inequalities mentioned above*. Note: The CCG states on its website ask that questions are provided no less than 24 hours before the meeting, with this question received after that point. Therefore it was agreed that a written response would be provided as soon as reasonable after the meeting. **Response from Louise Smith, CCG Interim Director of Primary Care and Transformation (lead director, on behalf of the Governing Body)**	

	The CCG is proposing to develop a "*supplementary network service*" for care home provision as it is now termed, rather than as DES+ (this terminology has been changed on the instruction of NHS England). LMC can be assured that this service will be provided to 100% of the care home population of Buckinghamshire, which means care home patients registered with practices not signed up to the national Directed Enhanced Service (DES) will not miss out on the service this offers. The CCG has also already committed to the roll out of the Immedicare telehealth platform to all 152 care homes and supported living homes in the county. As stated it is intended that this will be commissioned via a "supplementary network service", as such it would be commissioned from a Primary Care Network which is signed up to the National DES specification. The commissioning of the Direct Enhanced Services associated with networks is directed by NHS England and therefore the CCG Governing Body cannot divert from this process. The CCG Governing Body has agreed to the development of the supplementary network service*. It will be co-produced in conjunction with Primary Care Networks, other providers, care homes and local authority colleagues to ensure services are fit for purpose and can be delivered across the care home population in the county. Although the CCG acknowledges the reasons highlighted as potentially leading to health inequalities, as stated the intention is to commission this across the county. *Allowing for appropriate mitigations of material conflicts of interest as permitted by the CCG Constitution, where GPs with voting rights have a pecuniary interest.	
5.	**Risk Management** **a) Governing Body Assurance Framework** **b) Corporate Risk Register escalations (including COVID-19 related escalated risks) 15+** **Members reminded to consider during meeting any points for consideration for recap (item 13).**	
	The Governing Body was asked to NOTE as ASSURANCE and COMMENT on a) The Governing Body Assurance Framework (GBAF) and its controls/assurances as detailed. b) Corporate Risk Register escalations (15+) from the CCG Executive Committee and its controls/assurances as detailed. RC described the updates and changes to the GBAF since it was last reported in public in March 2020. 1. Risks reviewed and updated to reflect 2020/2021 financial targets (e.g. £20.5m target in 2020/2021; CCG QIPP £16.1m + additional £4.4m re ICS schemes) 2. Controls and assurances updated to reflect 2020-2021 risk set, including plans for community transformation and implementation of the Primary Care Network Directed Enhanced Service. 3. Current risk scores match initial baselines at this early point in the financial year and when the final financial impact of the COVID-19	

	pandemic is largely unknown. 4. Acknowledgement that full re-forecasts are to follow: o Impact of block contract arrangements if extended to financial year-end o Non-delivery of QIPP savings given costs arising from COVID-19 o Impact of missed ICP/ICS savings targets 5. Risk 5, specifically on optimum staffing levels, now reflects the risk of 20%, 30%, 50% loss of staff due to COVID-19 – a trend which has not yet materialised for us. 6. The GBAF also cross references where appropriate to separate detailed risks on the Corporate Risk Register and COVID-19 risk register, with those risks above the escalation threshold of 15 included as paper 05b. GH noted that he would provide further detail on the financial position under the relevant agenda item. RW challenged on the status of risks in relation to late presentation to both primary and secondary care given fear of COVID-19 infection (with elective work) and whether the CCG had an appropriate handle on the level of risk. RC replied that a risk in relation to this matter has been identified and forms part of a separate COVID-19 risk register, though its current score did not meet the threshold for escalation to the Corporate Risk Register escalation report on the Governing Body agenda. During the meeting RC checked and confirmed it has a risk score of 12. **Action: risk owner/s to be asked to review this risk and deem whether to increase the score above threshold for escalation (15) and therefore include in future reports to the Governing Body.** RW noted we need to be ahead of the curve on this. RC added that the clinical harms group also has a role in overseeing this risk. KW added we are tracking moderate and severe risk, with BHT prioritising based on clinical risk. RB asked RW whether he would deem the risk to fall above threshold. RW felt this was of enough of a risk to be escalated upwards. LS supported this, and this links to the recovery plan and potential for harms. RB noted opportunity to discuss on the restoration and recovery plan item.	**RC/risk owners**
6.	**Accountable Officers Report**	
	RM presented this item and invited questions from the Governing Body – there were no follow up questions on the Accountable Officers report.	
7.	**COVID-19 – restoration and recovery** **Second phase of NHS response to COVID-19: the local recovery and restoration plan**	
	JH and RT led the item with time for discussion and questions. We are at early stages of recovery response. We have identified a number of key aspects of change: • Access to service and delivery of services – face to face vs non face to face given areas of greater risk of infection. Lockdown and personal impacts on the public and their families. Infection control and use of PPE will affect service delivery.	

	• Where services halted and impact plus delay in presentation. Plus economic impact and wider determinants of health plus impact on deprivation and BAME population. There are principles behind recovery as set out by second phase letter from Simon Stevens. The local approach to this covered by slide presentation. Recovery framework: Established by Buckinghamshire Council covering the broader determinants of health – links to economy, business sector and wider health economy. Involves cross representation with the county. RT described the vision and principles for moving forward – ICS vs place. Our new service model of excellence to be of high quality, outcome driven, and resilient to further surges. This necessitates workforce resilience to ensure we can continue to deliver. As a minimum we aim to reach pre-COVID activity levels, but also provide better and faster outcomes. We are seeking innovation and transformation, whilst breaking down barriers between providers. Media coverage has addressed growing waiting lists; part of our work includes backlog analysis, the clinical harms group supporting this and recognised for its value by CQC. But how do we risk stratify patients needing to be prioritised? (Rhetorical). There are ethical considerations to this to ensure we have an appropriate process which is aligned to region. **Dr Rashmi Sawhney joined the meeting.** One of the key issues is to ensure inequalities are not unnecessarily widened. Delivery has to be resilient to future crisis, whatever that may be. Real time technology is a communications enabler which offers a far better patient experience, and avoidance of unnecessary paperwork and referral burden. A virtual ward approach – this is our community rather than a segregation of providers. We expect the long term plan to change and will need to react to this. We have a principle for learning which also offers better outcomes, focusing on needs of the population. Finally, this involves the whole county from beginning to end of life – addressing both geography and deprivation. This aligns to the ICP case for change. <u>Questions</u> • RW noted this is exciting. RW challenged on the transition process. At Royal Free a considerable number of patients are refusing to attend for elective surgery– there has to be local ownership of the communications process to provide re-assurance about safety of engaging with secondary care. RT replied this is a national challenge; many people invited to attend despite re-assurances but remain concerned. It is recognised as a challenge; national team may be looking at communications which is a critical pillar. JH added the ICP Partnership Board has also discussed this, with the Director of Public Health part of the discussion. • KW echoed the plea for communication and clarity to primary care on recovery roadmap and same communications to the public – we lose them when told different things. RT agreed; this is a leadership and inclusive in co-production, including patients. • CO referred to mention of inequalities and that these do not worsen. What examples can be given? Plus “community by default” approach and whether HEE are involved to support workforce development. RT replied they are not at present (good suggestion), but recognised it is essential to have leadership and prompt cultural change in order to	

	ensure success of the strategy. As regards inequalities, an example is 40% of cardiovascular deaths occur in three of the most deprived areas. Much work ongoing to understand what drives this – access, speaking of English, housebound restrictions etc. We are aiming to identify patients with irregular heartbeats and housebound and so at increased risk of stroke. There are national toolkits to support this – including mental health linked to cardiovascular risk. LS noted there is an ICP/place workforce group and we are developing training academy/hubs, and at BOB level we have a community and primary care transformation group that has a workforce development component. HEE involved at this level. This probably needs strengthening. **Action: LS/CO to pick this up in their discussions about community transformation** • TD noted virtual ward is positive, but given some groups have less access to technology, how inclusive can this be without patients? RT replied there are times when the patient doesn't need to be in the room, e.g. cancer MDT or with other professionals. In terms of patients in the room but no access, we are looking at developing virtual clinics where patients come to surgery to link with hospital specialists if they have no access to technology at home. We know we need to be agile to respond to patient needs. • RB noted lower spend on patient transport which could be invested in technology to help housebound patients and has real potential. RT replied resource needs to follow care, and we recognise patient transport isn't the greatest experience and so this is a great innovative idea. RM added technology (c 80% of the Buckinghamshire population own a smart phone / device) is perhaps higher than we think, and we have the highest level of video conference primary care consultations across BOB. We need to really understand the opportunity. We have also rolled out immedicare into care homes. RT replied this is about personalised care. RB asked whether we know about the 20% of patients who aren't using technology. RT replied we need to investigate this and make it sophisticated. RT concluded saying this is a critical opportunity to transform delivery – resource allocation cannot be underestimated. At this point, RB welcomed Dr Rashmi Sawhney to Governing Body as first meeting following appointment, leading inequalities and care home work.	**LS/CO**
Decisions		
8.	**A supplementary network service enhancement to the Care Homes specification within the 2020/21 Primary Care Network Directed Enhanced Service (DES)**	
	The Governing Body was asked to approve the creation of a supplementary network service for care homes within the 2020/21 Primary Care Network Directed Enhanced Service (DES) Given the direct and material conflicts of interest as identified above, **RB handed over the chair of the meeting to RP.** RP again confirmed GPs are directly and materially conflicted. Member GPs are free to remain in the meeting of the Governing Body as it is in public, and can participate in	

	discussion on the clinical elements and outcomes. But they will not count towards final decision. RP handed over to LS to describe the paper. LS stated that the paper had previously been recommended by AO and CFO in context of PCN engagement to the Primary Care Commissioning Committee (PCCC), which in turn recommended it to Governing Body for approval. NHS England standing invitees at PCCC had endorsed the paper, but with request that it is referred to as a "supplementary network service" rather than DES+. LS stated that Governing Body has previously been informed of uptake of the National DES (an optional agreement which encouraged practices to form as networks). Last year all practices signed with 12 networks resulting, this year reduced to this year 41/48 singing up. This includes one practice pulled off from its PCN to operate separately, plus one whole network which has chosen not to opt in. It is recognised that practices are finding challenging the requirements for care homes given the complexity of provision across the system and needs of residents. However the CCG deemed that this area needed additional investment hence its proposal described within the paper above and beyond the national specification. LS clearly stated the paper does not set out how service will run, but how it will be developed through co-production with practices, networks and providers in order to maximise both resources and outcomes. LS confirmed the overall investment involved: Re-purposing existing Locally Commissioned Service to be de-commissioned - £413k in 2019/2020, national DES specification funding £270k plus further investment to bring total investment circa £1.2m - £1m (£0.4m Ex-LCS and £0.6m O75) + £0.2m from the national DES. The CCG has already committed to the roll out of Immedicare to all 152 care homes and supported living homes in Bucks (total investment of £899,881). This is a telehealth platform which practices / PCNs and community providers can use. The meeting was opened to questions from members. TD asked how the CCG would resource the service to cover the practices that have opted out of the national DES specification. LS replied it is the CCG's responsibility to ensure equality of access to care, and so we must re-commission that service from an alternative provider. It is those neighbouring practices signed up to the national DES and the networks of which they are members that would have first opportunity to be commissioned. We had a good discussion at BOB level about need to keep practices engaged and recognise their value. RM emphasised this service will be offered to the whole population of Buckinghamshire, which means care home patients registered with practices not signed up to the national Directed Enhanced Service (DES) will not miss out on the service this offers. CO 1. How are we going to evaluate and how know it is successful 2. If we identify those care homes with nursing, it might be helpful to invest so these nurses became prescribers. Will we be able to pick this up and invest in it?	

	LS replied: 1. At present this service offer hasn't been worked up any more than what is on the paper. We know we have a population with a number of needs and there are a number of tools that can enable better quality of care. We are keen to make this less about process and more about outcomes – identifying frail elderly patients, advanced care planning, increasing value of MDTs. **Defining outcome measures, using Queens Nursing Institute (QNI) care homes network as a benchmark – to be further discussed** As regards workforce, this is an area recognised on BOB community and primary care transformation call yesterday. There is a small budget for development so this does need to be included. RM stated his support; support to the care home sector has been and continues to form an important part of COVID-19 recovery. Really support this as there is a strong indication of our commitment to vulnerable parts of our population combined with opportunity for co-production. **The Governing Body approved the creation of a supplementary network service for care homes within the 2020/21 Primary Care Network Directed Enhanced Service (DES)** *Quorate vote count of 7 members excluding GPs: RP Lay Vice Chair, RM Deputy Accountable Officer, RW Secondary Care Doctor, CO Registered Nurse, TD/GS Two Lay Members, GH (CFO) One other management director.* **RP handed back to RB to chair the meeting.**	**LS/CO**
9.	**Corporate Governance:** **a) CCG Corporate Objectives 2020/2021** **b) Annual Review of Terms of Reference and SORDs** **c) Statutory appointments 2020/2021**	
	a) Governing Body was asked to: • **APPROVE corporate objectives for 2020/2021 recommended by the CCG Executive Committee.** • **NOTE these remain separate CCG objectives for now –a single set across the three CCGs in BOB may emerge in time.** RP commented that given previous discussion, the objective on COVID-19 to move further up. RM commented that, given the COVID-19 pandemic and suspension of normal financial regime, whether a system FRP and financial recovery objective is still relevant. GH replied this is in suspension. GH suggested "work towards financial sustainability" as possible alternative wording. **Action: revise wording for objective on financial sustainability** **b) The Governing Body was asked to:** • **RATIFY its sub-committees terms of reference approved by each of the committees.** • **NOTE as regards the Governing Body itself; it does not have separate terms of reference as these are wholly incorporated into the CCG Constitution.** • **NOTE Constitution appendices to be updated where relevant**	**GH**

	(Audit Committee, Primary Care Commissioning Committee and Remuneration Committee) RB noted the paper incorrectly referred to the Accountable Officer as Lou Patten; this is now James Kent. RC noted the error and stated that a number of sets of terms of reference remained subject to annual review as stated within the paper. Terms of Reference were ratified as were present, and also noted matters as stated above. **c) The Governing Body was asked to NOTE CCG Statutory and other appointments for 2020/2021.** There are a number of key statutory roles required of a CCG detailed in the supporting paper, which simply lists these roles and names of appointees, published for openness and transparency on the CCG website. This document was ratified.	
	Assurance and Governance	
10.	**Finance Update** **a) 2019/2020 audit update** **b) 2020/2021 progress**	
	2019/2020: GH reminded members the CCG received £15 of Commissioner Sustainability Fund (CSF) in 2019/20, therefore ended the year with surplus £63k – subject to ongoing audit. Final submission 25 June, to be signed off by James Kent. 2020/21: the operational planning process suspended – no formal requirement to report Month 1. Interim arrangements – 01/04/2020-30/07/2020 – new allocations with block contracts with NHS providers. There will be difference between allocations and actual expenditure. If these are minimal the national team will top this up on a monthly basis in arrears. We are expecting top up on Month 2. We would expect monthly break even. Await further guidance from August to the end of financial year – block expected to continue – contract round unlikely. Similar regime as now anticipated. No expectation to deliver QIPP this year. CO asked about difference between actual and block contract expenditure – what percentage permissible. GH replied the allocations were based on Month 11, with Month 12 estimated plus 2.8% growth. Original allocations included 4.5% growth. We are expecting top ups circa £3m per month. On top of that, we are told to claim COVID-19 related costs separately. This should give us in-year break even. Reports will come to Governing Body.	
11.	**Quality and Performance Report (May 2020 with June exceptions, any matter not covered under Corporate Risk Register COVID-19)**	
	KW introduced the item, and FB joined the meeting. FB noted the report remains in summary format as per NHSE reporting directive. The update provided was largely based on April contemporaneous data. • Cancer 2 week waits improvement of 0.2%; maintaining progress in right direction. • 2 week breast saw big increase 15.5% in April – 31 day surgery actually small decline, and so has 62 day urgent GP referrals. • We know one locum has started – but staff shortages remain at about	

	25%, especially within urology. • Telephone appointments increased; patients prioritised to attend hospital, but anecdotal evidence suggests patient declining for fear of COVID-19. • Development of hot and cold sites – pathways being maintained to encourage primary care referrals. • Diagnostics remains challenging; endoscopy staffing low (unable to get further update) • A&E – slight increase from April to May – 89.4% in May (BHT. It is showing signs of improvement. Main areas to cover clinical harm; numbers between April and may increase of 470 patients of which patients with significant harm increased by 129, moderate to mid risk 344. This is worrying. • Largest increase in harm seen in ophthalmology (55), plastics (50), trauma and orthopaedics (25) – these are not insignificant numbers. RB queried the baseline for moderate harms on which the numbers increase is based. FB replied she didn't get the split of data between moderate and mild, only total figures. FB will query the detail. KW clarified this is a risk analysis, not actual harm. GS noted a study a UCL study excepting 20% more cancer deaths over the next year. Is this right and whether it is this, or COVID-19 deaths, expected to be higher. RT replied – clinicians on the ground have been concerned and hence their involvement in restoration and recovery. There is a significant number not presented, but not yet quantified, and likely to present later. We don't yet have the data. 2WW rates have dropped significantly – patients do have fear of COVID-19. The number is likely to be significant. These late presentations will take time to filter, includes GP referrals or emergency crisis. Mortality 50% higher than those who present early. The UCL paper is reasonably accurate but exact number difficult to determine at this stage. RW noted we must take care not to drown the data. Patients who are delayed – those who have had pathway delayed vs presentation. The latter is greater high risk. Those with pathway delay will also influence their outcome. We need to be able to monitor both of these trends without them being affected by those areas which are clinically inconsequential. RB asked if we can stratify the harms we record. RW replied this is what we need to do, with cancer of high priority. RB added that cardiovascular also is important. KW replied it can be stratified, dependent on how the data is analysed. RT added his interest in harms analysed by deprivation, and also presented to inform change where specific and appropriate action. Data is showing out of hospital cardiac arrests up 400%; with those surviving have significant morbidity. RM stated this is population health management in action. GS queried impact on mental health and suicide. KW replied there are fewer presentations but with higher acuity. We haven't seen an increase in suicides. RB thanked the quality team for their endeavours to improve the quality of information provided. KW added it is challenging to get the right data to achieve proper outcomes. RB replied we should build this into recovery. RT acknowledged this despite its difficulties.	

12.	**Matters Arising – escalations/issues from Sub-committee Chairs**	
	No matters were arising.	
13.	**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 other than what has already been discussed. RB noted need to include implications of COVID-19 – the existing risks are suitably high.	
Information		
14-18.	**Approved Minutes and reports as stated on agenda**	
	Papers provided for information as described on the agenda. RB noted that on previous occasions, one or other would have been discussed in more detail but are provided today for information given pressure on the agenda. RB opened to queries, particularly in relation to the annual reports. 16 – Communications and engagement RC noted previous recognition to ensure the Governing Body heard the patient voice, a patient has story been included in this report. 15a – safeguarding annual report 2018/19 TD noted the amount of time documented as being taken to undertake multi-agency reviews. KW replied that part of this is authoring and getting correct outcomes required. RM noted this is historic report – not all are still outstanding currently having been completed in between. 15b – Data Security and Protection / Information Governance (incorporating Caldicott Guardian, Senior Information Risk Owner and Data Protection Officer) Governing Body was asked to: • **ACCEPT** this annual report and the assurance it offers • Continue to **SUPPORT** the role of Data Security and Protection / Information Governance and appointments of Caldicott Guardian, Data Protection Officer and Senior Information Risk Owner (SIRO) This it did so.	
19.	**Next meeting/AOB**	
	Date and Time of the next meeting (in public): Thursday 10 September 2020, TBC dependent on lockdown arrangements in place.	

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