NHS
Buckinghamshire
Clinical Commissioning Group

NHS BUCKINGHAMSHIRE CLINICAL COMMISSIONING GROUP
GOVERNING BODY (IN PUBLIC)
10 September 2020, 11:00am-12:15pm
Microsoft Teams

Members (13)			
Name	**Title/Organisation**	**Initials**	**Attendance**
Dr Raj Bajwa (Chair)	GP Clinical Chair	**RB**	Present
Dr Karen West	Member GP/Clinical Director Quality and Integration	**KW**	Apologies
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**	Present
Robert Majilton	Deputy Accountable Officer	**RM**	Present
Gary Heneage	Chief Finance Officer	**GH**	Present
Dr Crystal Oldman	Registered Nurse	**CO**	Apologies
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
Caroline Capell	Director of Urgent and Emergency Care Covid-19 Campaign Chief of Staff (item 4 only)	**CC**	Present
Neil Flint	Head of Planned Care (item 4 only)	**NF**	Present
Frances Burdock	Associate Director of Contracts & Performance (item 12 only)	**FB**	Present
David Williams	Deputy Director of Quality (item 12 only)	**DW**	Present

Standing Agenda Items		
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.	
2.	**a. Declarations of Interest in items on this meeting's agenda** **b. Gifts and hospitality received**	
	The Chair Dr Raj Bajwa (RB) reminded the meeting of obligations to declare any Conflict of interest they may have on any agenda items. **<u>Item 3: Care Homes Supplementary Network Service (SNS)</u>** RC referred to the description of conflicts of interest for this item given within the supporting paper: *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 also* *(b) recipient providers for Locally Commissioned Services for which funding is expected to be re-purposed to fund a supplementary network service (SNS)* *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 as it is being held in public, 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.* *The Supplementary Network Service and resulting specification has been worked up and co-produced in conjunction with PCNs, providers (Buckinghamshire Council social care, Buckinghamshire Healthcare NHS Trust community teams), care homes and patients to* • *Utilise the service and professional expertise and strengths of each.* • *Ensure services are fit for purpose and can be delivered.* *Given the direct and material conflicts of interest, this refers to the clinical elements of the scheme and specification rather than the financial details. CCG Clinical Director Dr Rashmi Sawhney as the lead for the specification is also directly conflicted as a practice partner and therefore beneficiary. This was immaterial at PCCC as a standing invitee, and through the process of development, as this is the purpose of her role as Clinical Director for implementation of the PCN DES. Dr Sawhney shall remain present and participate as appropriate. However for avoidance of doubt and for a quorate decision, Dr Sawhney shall not be included in voting quorum to reach required decision.* For clarity within the minutes, member GPs present have the following direct conflicts of interest: • Dr Raj Bajwa – partner in a practice (Little Chalfont surgery) signed up to the national DES • Dr Rashmi Sawhney – partner in a practice (Riverside Surgery) already signed up to the national DES • Dr Dal Sahota – not a partner, but a GP working in a practice (Hall Practice) already signed up to the national DES • Dr Karen West – partner in a practice (Haddenham Medical Centre) already signed up to the national DES.	

	RP deemed that conflicted members were to remain present. RC further clarified points not stated in the supporting paper that: • It is deemed appropriate that Dr Sawhney present the item as a GP Lead despite the material conflict, given part of role and this is as took place at the Primary Care Commissioning Committee on 3 September 2020. • That all other GPs will count towards voting quorum, which means the Governing Body is unable to meet its ordinary constituted quorum. • For further avoidance of doubt, the CCG shall invoke its constitution clause (6.7.2, composition of Governing Body) whereby: *The Director of Transformation will be co-opted as an additional voting member only in circumstances of conflict of interest material to member GPs/Chair which requires them not to count for quorum purposes.* Accordingly decision required is deemed to have two clinicians given LS's clinical registration.	
3.	**Care Homes Supplementary Network Service (SNS) specification**	
	RS introduced the item, stating the proposal replaces a Locally Commissioning Service and is outcomes based. The PCN DES sets out various process steps practices must undertake to support care homes but not outcomes. There are smart outcomes – benchmarking BOB outcomes regarding attendances, admissions avoidance. Numbers reduction is based on counterparts to offer good quality service. This complements other care homes work, and proposes to join this up and support excellent care and system working and financial efficiencies working with community teams. There is a £1m investment combining LCS funding and previous service offers. This aims to ensure all patients benefit. We've looked at equity rather than equality, with a chart showing number of beds. It is bed based and divided on that basis rather than by 12 (as the number of networks). It has been high trust interactive co-production over 6-8 weeks with PCNs and ICP partners, with feedback from care homes themselves. Funding is agreed; RS noted conflict of interest and so not involved in this element. There are transition issues including IT with steps being taken to resolve these. Recruitment to some roles may be challenge. We have a vision for the frail patient – pro-active care, re-active care and reablement. Patients may be in care homes or in their own home. Over time we can roll this out to support frail elderly in their homes to offer joined up care. RW noted this as important work. RW linked this to a later paper on winter planning and that there is a relationship with move of patients into care homes through hospital discharge planning. This will be intensive – is primary care able to manage the demands? RS replied this is difficult to answer. We are trying to support primary care in best way possible – good outcomes are key. We are also working with relevant physicians to develop integrated pathways. If each partner understands their responsibilities and we deliver as a team it will be easier, but more difficult if we continue to work in silos.	

	JK noted it may be helpful to be clear/provide guidance on how much of the work is directly on general practices vs. how much picked up by increase in pharmacists and other workers in primary care. We are putting additional workforce in. Also, in outcomes, we should be clear what an increase in 10% means, plus overlap between a reduction by 10% of admissions from falls and 10% reduction of overall admissions. We need to ensure if these are separate or combined. RS agreed percentages can be vague and need absolute numbers. With baseline data these will be finalised. All falls are reported to social care, so they have a list. Every fall doesn't result in admission, but we would want to measure both. This is why they are separated out. The full impact of workforce probably in year 3 and 4. Different PCNs are currently at different levels of maturity – some networks have senior pharmacists whereas others more junior or still advertising where let go due to training issues etc. One pharmacist for circa 400 patients at a junior level won't be able to deliver quality of fare that we want. When this has matured we will need to review, perhaps every year, to see what we need to change/enhance. TD commented we need to ensure value for money, and whether possible to have regular reports back to Governing Body to show progress. RS acknowledged this. DS noted comparison across BOB – we must factor in regarding length of stay there is a difference in community bed capacity – are we comparing apples with pears? As regards coding, are we coding falls in the same way. Is one coding syncope and not calling it a fall? RS will feed this back. If 10% is a false number, then 5% would be an improvement – it can't all be coding. LS noted that RS and her team have done a great job in a short amount of time. This is our first cross organisational co-production and is a model for the future. One of the other areas in pipeline is diagnostic hubs. They aren't easy and we don't always know who is contributing most to the outcomes, but this is a first step to synergy and alignment. This is transitional until April 2021 and PCNs have to do a lot of work; these are organisations not used to working collectively. This is why we have OD work alongside. The maturity matrix is important, and we will move to a place where outcomes are delivered from April 2021 with payments aligned to reflect achievement and we may also align incentive to the other organisations involved. RM noted support and discussion at PCCC; really encourage co-production to continue beyond specification sign off and contract issue, with the ethos of this to pout care homes at the heart of it and simplifying support they need. There are other measures bringing this principle together including ageing well. RP concluded the item. **Decision: a quorate Governing Body agreed the specification as provided and circulated to members.** RB noted 100% sign up to PCN DES and thanked those involved in this process to encourage co-production.	

4.	**COVID-19 – restoration and recovery** **a. Third phase of NHS response to COVID-19: the local recovery and restoration plan** **b. Winter and flu planning 2020/2021**	
	(a) NF provided a verbal update on COVID-19 restoration and recovery. NF provided highlights; progress focused on phase 3. NHSE asked for assurance and production of information to understand this and drive national recovery and capacity ambition. By end of September 90% of electives at same levels this time last year, and 100% by end of October. There are challenges – ways of working, re-distribution of teams etc. Across the system we are preparing templates and returns with trajectories against last year's numbers and current capacity. A draft has now received feedback on trajectories and worked with providers to understand what difficulties providers have. There are outcomes and financial elements, plus narrative describing action plans to evidence substance behind meeting trajectories. We have an action tracker for phase 3 broken down into components and updated daily by partners. We are on track to submit with final draft in the ICS by 21 September with local sign off in the next week. We are ensuring we are consistent across the ICS. From first draft feedback there are areas to update – specifically action timescales. We are at about 45% complete of actions specified with evidence. Some things have been completed but further evidence needed. One week ago there was sonly one action not started. NHSE targets are difficult – we have a backlog, and we have challenges from providers in patients returning. We are looking at pathway opportunities and with independent sector to allow patients to make the best choices. RP noted targets and queried confidence in achievement. NF replied providers will be nervous; some areas we are on track to reach full capacity but there are other areas of struggle. We need providers to be open with us in order to facilitate any changes needed to reach them. JK noted this is stretching with need for additional capacity to reduce waiting lists. There are efficiencies, but this needs management and clinical time, plus routing activity through independent sector. There are moves to increase workforce sessions to clear backlogs. We may become compliant, but then some levels have additional cost but we don't have the financial envelope in which to operate. TD queried sign off process. NF replied ICP recovery board, and sign off by Chief Executives including providers. Also submits through ICS with several iterations, likely virtual. RM added this is planning and response, and we are making sure there is a constant flow and iterative update of the information – which includes us and Trust Board. Clinical harms and inequalities work has also been positive to ensure response is driven by clinical risk factors. We are also overseeing community work. This is an opportunity focus and drive forward historic difficulties – e.g. diagnostic hubs. There are many interface conversations with a big ask of clinicians and system staff to restore, deliver and transform. It is an ongoing process.	

	NF concluded that we are gathering information from across BOB to have a clear picture of what is happening and feed this into our plans. (b) The Governing Body was asked to • **APPROVE** the Winter plan for 2020/2021 • Have **ASSURANCE** of the steps being taken by the system over winter 2020/2021 CC provided a summary and talked through a slide presentation, with a programme of work as part of the plan to anticipate and not react. CC emphasised that Think 111 is not about using 111 for an appointment in ED. There will be a clinical assessment and signposted to the most appropriate place, with an ED appointment if available. A programme of work is in place for fever and bronchiolitis. Over 1000 flu vaccinations now taken place. RW queried the 111 and booking into fixed appointments "if there is capacity" – what is the mechanism for debate between provider and need to facilitate slots. CC replied the 111 pathway recommends a route. We are attempting to move away from this to direct support – either booked direct into a slot or recommended to attend A&E. There will be a comprehensive communications and engagement plan. RB added the number of fixed appointments will influence patient behaviour to phone 111 next time they think they need A&E – is there scope to over provide for a while to promote this behaviour. CC replied first three weeks one appointment slot per hour, open and simple, and then increase capacity as needed over winter. Demand via 111 currently relevantly low, but will increase as people recognise this is the pathway. DS added we have primary and secondary care engagement for this. There is also patient participation in the working group to reflect their feedback. This may be the opportunity to have this working effectively. RM queried how the plan will be measured and what is the level of confidence in relation to system performance. CC replied this is part of a wider programme – each work stream has their own metrics reported to UEC and recovery and renewal boards. Think 111 has 56 metrics. Each element of the action plan will be monitored. RM also asked if there was any further support required for the hospital discharge programme being implemented. CC replied there is a "get me home" work stream supporting discharge modelling, with 6 high impact actions specifically related to discharge – and project plan for this with a system partners group working through the actions. It is challenging. There are specific metrics on discharge, length of stay and medically fit. **Decision: Governing Body agreed the plan supplied and circulated.**	
5.	**Review and Approval of Minutes:** **a. Meeting minutes – 11/06/2020** **b. Action Log**	
	The minutes were agreed as a true and accurate record with an amendment from RW regarding COVID-19 restoration and recovery: *At Royal Free 90% of patients are refusing to attend for elective surgery* becomes *At Royal Free a considerable number of patients are refusing to attend for elective surgery.*	

6.	**Matters Arising – escalations/issues from Sub-committee Chairs**	
	None arising	
7.	**Questions from the public**	
	Question stated from Diana Bowerman, on the committee for the newly formed action group to keep open Long Crendon surgery (Aylesbury Vale). *Why, when government wants 6,000 more GPS and 50million more appointments, is the CCG considering the proposed closure of the only GP surgery in Long Crendon yet unsupportive of building a surgery in the village fit for purpose when the site has already been given.* Notes: • The CCG states on its website ask that questions are provided no less than 24 hours before the meeting, with this question received on the day. Therefore it was agreed that a written response would be provided as soon as reasonable after the meeting. This is documented separately. • Robert Parkes, Lay Vice Chair and Chair of Audit Committee, declared a conflict of interest as a patient at this surgery. This was immaterial given no further discussion about the question at the time. **Response:** NHS Buckinghamshire Clinical Commissioning Group is responsible for the commissioning of primary medical services to meet the needs of its entire county wide population. Where seeking to invest in additional service provision it must take into consideration the differing health needs of the populations it serves, existing service provision and the requirement to reduce inequalities across the county. Each General Practice has a contract to deliver services to their registered list of patients. As part of this contract they are responsible for arranging suitable premises from which it can deliver these services. A decision to close or relocate a surgery will therefore originate from the practice. When a practice takes such a decision, it must apply to the CCG's Primary Care Commissioning Committee (PCCC) for approval. Part of the application process requires that patients, public and local stakeholders are consulted on the proposed change (which is currently in progress with regards to Long Crendon). The PCCC then decides whether or not to approve the application, taking into account feedback from the consultation and a range of wider considerations, such as the health and social care needs of the affected area in the context of wider county requirements and service provision. In terms of investment, although the CCG is responsible for reimbursing practice rent in accordance with the Premises Costs Directions, it is not responsible for developing them and indeed, does not hold any capital funding to do so. That said, the CCG does have a role to play in setting estate strategy and ensuring value for money and upholds the following principles in line with the local and national transformation agenda: • The CCG supports the development of modern, fit for purpose premises that are accessible to local populations.	

	• The CCG will work with practices to make sure they remain resilient and sustainable for the future. This means it would only wish to support the development of new practices or premises which cater for populations of at least 10,000, for example. If a proposal for the development of smaller premises were to be made by a practice, it would be considered. But cost and long-term sustainability would be key factors in any decision. • Where possible, the CCG will promote the consolidation of services onto fewer sites. This maximises the use of existing infrastructure and promotes joint working between healthcare services and professionals.	
8.	**Risk Management** **a) Governing Body Assurance Framework** **b) Corporate Risk Register escalations (including COVID-19 related escalated risks) 15+** **c) COVID-19 Corporate Risk Register escalations (15+) from the CCG Executive Committee and its controls/assurances as detailed** **Members reminded to consider during meeting any points for consideration for recap (item 14).**	
	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. c) COVID-19 Corporate Risk Register escalations (15+) from the CCG Executive Committee and its controls/assurances as detailed. RC described the highlights of updates and changes to the GBAF since it was last reported in public in June 2020. • GBAF Risk 5 (The CCG is unable to maintain its optimum staffing levels at any time) has been updated to reflect the CCG's current staffing position. • *Key operational vacancies/upcoming vacancies. Requirement to balance substantive appoints vs recognition of entering a period of organisational change, plus balance of work to support ICP plus statutory duties. Possibility that future operational demands will require further appointment of staff through winter/whilst pandemic ongoing. Gap - the permanent CFO has tendered a resignation and we will follow up with the interim arrangements in due course.* • It is clear that we shall need to recruit in some manner to this role to fulfil our statutory duty. • As regards corporate risks, escalated risks relate to: o Prescribing growth o Re-imbursement of COVID-19 costs by NHS England (separate to risk on control, documentation and reporting) o Allocation methodology for phase 3 financial regime. o Finance and Executive committees have both discussed these risks and agreed the scores given which prompt escalation. **Updates provided and the supporting GBAF report were NOTED.**	

9.	**Accountable Officers Report**	
	JK noted having covered much of the content of the report under other items and during the preceding AGM (i.e. our priorities managing COVID-19, getting all our services back to pre-COVID levels best we can, preparing for winter in terms of resilience and flu, addressing inequalities, and increasing focus on the workforce). More details are also provided within the report circulated to members. JK spoke specifically to items 4 (BOB Systems Leaders Group – SLG) and 5 (BOB Single Management Team) within the report. SLG held in August focused on restoration and recovery and the BOB single management team as described, and discussed changes in CCG commissioning architecture resulting from his role having been introduced, and how we now involve system partners in developing the shape of future CCG commissioning architecture. An "in common" Governing Body workshop is taking place on 17 September to discuss process and confirm collective direction.	
Decisions		
10.	**Corporate Governance:** **a) Gifts, Hospitality and Sponsorship Policy** **b) Annual Review of Terms of Reference and SORDs – Executive Committee, Finance Committee, Quality and Performance Committee** **c) COVID-19 governance accountability and statutory duties (1) Decision Log,(2) COVID-19 costs return to NHS England** d) **Changes to the CCG Constitution**	
	The Governing Body was asked to: 1. **RATIFY** the CCG Gifts and Hospitality Policy 2. **NOTE** gifts, hospitality and sponsorship effectiveness reviews as described 3. **NOTE** that this policy will soon be superseded by a Buckinghamshire, Oxfordshire and Berkshire West (BOB) CCGs wide policy on standards of business conduct incorporating conflicts of interest, gifts, hospitality and sponsorship. This it did. (b) The Governing Body was asked to: 1. **RATIFY** its committee's terms of reference approved by each of the committees. 2. **NOTE** as regards the Governing Body itself; it does not have separate terms of reference as these are wholly incorporated into the CCG Constitution. 3. **NOTE** Constitution appendices to be updated where relevant (Audit Committee, Primary Care Commissioning Committee and Remuneration Committee). This it did. (c) The Governing Body was asked to **NOTE** as **ASSURANCE**: a) COVID-19 Decision Log as at 10 September 2020 (which excludes any decisions previously recorded and reported to Governing Body on 11 June 2020).	

	b) submission of "reasonable costs" related to COVID-19 for the months April 2020 to July 2020 This it did. (d1) The Governing Body was asked to approve changes to the CCG Constitution as described in the supporting paper. RM asked that the delegation cited for packages over £5000 per week include him. This was agreed. (d2) The Governing Body was asked to receive changes for INFORMATION only. This it did.	
	Assurance and Governance	
11.	**Finance Update**	
	GH recapped the current financial regime, in that the CCG had received an allocation for the first 4 months, which was subsequently extended to months 5 and 6 under a block contract regime with main providers. Further top ups have been retrospective. The aim is to break even monthly for all non-COVID expenditure. At month 5 the CCG has received 4 top ups to Month 3, agreed through the monthly assurance process with NHS England. The CCG is submitting monthly returns with all reasonable costs reimbursed through a robust governance process. Post month 6 a separate financial regime is anticipated with prospective top ups. The ICS is likely to get a control total for months 7-12 for non-COVID-19 related expenditure, plus an expected COVID-19 allocation at ICS level for months 7-12. Identified within this are three main risks: • Non-COVID-19 expenditure – months 1-6 expenditure greater than allocation – this will continue unless the system control total is amended • COVID-19 allocation – and whether existing commitments cover it. • Hospital discharge programme – yet to understand what this allocation may be. The CCG is working through this closely with NHS England and will further report back to Governing Body when the positon becomes clearer. There were no further questions on this matter.	
12.	**Quality and Performance Report (August 2020 with September exceptions, any matter not covered under Corporate Risk Register COVID-19)**	
	FB joined the meeting. There were no questions on the report circulated. FB noted: • Key areas remaining challenging were RTT, diagnostics, cancer and A&E waiting times. A&E waiting times are being reviewed. Task and Finish groups have now been established, with FB now more involved in diagnostic and endoscopy groups complying with adapt and adopt national model. • RW noted in RTT data line which states "RTT incomplete within 18 weeks" it should say "RTT complete % within 18 weeks". This needs to be corrected as it appears in public. • On cancer, BHT in July did not achieve one target (31 day performance	

	but all others improving. • 3 targets currently under performing in un-validated data – 31 day first, 31 day subsequent surgery and 62 day. This is August data, but there is time for this to be reviewed and achieved. • Activity is unstable, affected by available capacity, resources and choice where patients are not overly keen to attend hospital environment due to COVID-19 fears. • RB commented there is evidence that patients are choosing to attend Frimley A&E rather than BHT as it develops community relationships. Do we know the implications? FB replied the view from the Trust is that it is much more accessible and has better waiting times. There is little we can do. RB noted this was true based on patient preference. But we need to be sighted that this is a pattern of behaviour. CC noted this has been raised at A&E delivery board and will pick it up. • DS – VTE – stated this needs some narrative to clarify the national target (p115 of pack) DW joined the meeting. • DW noted target relates to adherence to prophylaxis. **Action – VTE target detail to be added to the indicator.**	**DW/Rob Hicks**
13.	**Primary Care Rebate Schemes**	
	RC stated that the report provided was for information.	
14.	**Governing Body Assurance Framework – recap**	
	This final recap agenda item provides the Governing Body an opportunity to consider any points for consideration for change or addition to the Governing Body Assurance Framework (GBAF) following discussion of the rest of the agenda. There were no further amendments other than what has already been discussed.	
Information		
15-17.	**Approved Minutes and reports as stated on agenda**	
	Papers provided for information as described on the agenda: 15. Annual External Audit Letter 16. Safeguarding Adults Board – papers and minutes 17. Healthwatch Bucks annual report	
18.	**Next meeting/AOB**	
	Date and Time of the next meeting (in public): Thursday 12 November 2020, TBC dependent on social distancing arrangements in place at the time.	

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