



**MINUTES:**

**OXFORDSHIRE CLINICAL COMMISSIONING GROUP BOARD MEETING**

**27 July 2017, 09.00 – 11.45 Sudbury House Hotel, London Road, Faringdon, SN7 8AA**

	Roger Dickinson, Lay Vice Chair (voting) – Meeting Chair
	David Smith, Chief Executive (voting)
	Dr Stephen Attwood, North East Locality Clinical Director (voting)
	Dr Ed Capo-Bianco, South East Locality Clinical Director (voting)
	Dr Miles Carter, West Locality Clinical Director (voting)
	Dr David Chapman, Oxford City Locality Clinical Director (voting)
	Mike Delaney, Lay Member (non-voting)
	Diane Hedges, Chief Operating Officer (non-voting)
	Catherine Mountford, Director of Governance and Business Process (non-voting)
	Dr Paul Park, North Locality Clinical Director (voting)
	Dr Guy Rooney, Medical Specialist Adviser (voting)
	Jenny Simpson, Deputy Director of Finance (voting) [for Gareth Kenworthy]
	Duncan Smith, Lay Member (voting)
	Dr Louise Wallace, Lay Member Public and Patient Involvement (PPI) (voting)
	Sula Wiltshire, Director of Quality and Lead Nurse (voting)
In attendance:	Lesley Corfield - Minutes
Apologies:	Dr Joe McManners, Clinical Chair
	Dr Jonathan Crawshaw, South West Locality Clinical Director (voting)
	Gareth Kenworthy, Director of Finance (voting)
	Stuart MacFarlane, Practice Manager Representative (non-voting)
	Dr Jonathan McWilliam, Director of Public Health Oxfordshire (non-voting)
	Kate Terroni, OCC Director for Adult Services (non-voting)

Item No	Item	Action
1	<p><b>Chair's Welcome and Announcements</b></p> <p>The Lay Vice Chair welcomed everyone to the meeting and reminded those present the OCCG Board was a meeting in public and not a public meeting. He advised the public would have the opportunity to ask questions under Item 3 of the agenda.</p> <p>The Director of Quality read the Patient story and thanked the patient for their consent.</p>	
2	<p><b>Apologies for absence</b></p> <p>Apologies were received from the South West Locality Clinical Director, the Director of Finance, the Practice Manager Representative, the Clinical Chair, the</p>	

	Director of Public Health and the OCC Director for Adult Services.	
<b>3</b>	<p><b>Public Questions</b></p> <p>The Chair advised questions had been received via the website covering Deer Park, the Sustainability and Transformation Plan (STP) and the public consultation and these would be responded to with written answers posted on the website within 20 working days. The question relating to funding for NHS Estate would be picked up at the appropriate point in the meeting. The Chair invited questions from members of the public but none were forthcoming.</p>	
<b>4</b>	<p><b>Declarations of Interest</b></p> <p>There were no declarations of interest pertaining to papers presented or over and above those already recorded.</p>	
<b>5</b>	<p><b>Minutes of Extraordinary OCCG Board Meeting held on 20 June 2017</b></p> <p>The minutes of the meeting held on 20 June 2017 were approved as an accurate record subject to an amendment on page 8 that the pilot for the Early Discharge Service (EDS) had been undertaken in the city and north east rather than the north and north east.</p>	
<b>6</b>	<p><b>Matters arising from the Minutes of 20 June 2017</b></p> <p>The actions from the 20 June 2017 minutes were reviewed and updates provided where these were not covered under items later on the agenda.</p> <p>It was noted a workforce paper had not been brought to the meeting. The Director of Quality advised primary care workforce would be picked up through the Oxfordshire Primary Care Commissioning Committee (OPCCC) whilst the broader workforce piece of work would be considered by the Board through a Board Workshop discussion. The Director of Governance would ensure the workforce piece was included in the Board Workshop agenda.</p>	<b>CM</b>
<b>Overview Reports</b>		
<b>7</b>	<p><b>Chief Executive's Report</b></p> <p>The Chief Executive introduced Paper 17/46, his report updating the OCCG Board on topical issues including Performance Against National Targets, the Improvement and Assessment Framework, the Oxfordshire Transformation Programme, the transfer of the Learning Disability Service and the process to appoint a Clinical Chair and Chief Executive for OCCG. The Chief Executive highlighted:</p> <ul style="list-style-type: none"> <li>• The national outcomes of the Quarter 4 reviews were complete and OCCG had been assessed as good. The Quarter 1 meeting had taken place on 26 July 2017. OCCG had self-assessed as good but this was subject to a national process.</li> <li>• The transfer of the Learning Disability (LD) Service had taken time to complete but it had been important to ensure it was implemented correctly. This was an important move forward for the service.</li> <li>• The reappointment of the Lay Member (non-voting) for a further four year term.</li> <li>• The process for the appointment of a new Clinical Chair and Chief Executive Officer.</li> </ul> <p>The Oxford City Locality Clinical Director advised transfer of the contract for LD services was the beginning of the next piece of work. The contract had been transferred in its existing form and OCCG with Oxford Health NHS Foundation Trust (OHFT) would now begin to work on transforming the services. There had been good engagement from Oxford Health NHS Foundation Trust (OHFT). The Oxford City Locality Clinical Director felt there were some learning points from the process which had focussed on the individual service users and the provider organisations.</p> <p>The Director of Quality concurred advising a review of the transfer would be undertaken as well as some further work. The first 100 days were really</p>	

important to ensure the service was embedded in OHFT, the OHFT Board was sighted on the service and it became part of their work. She observed it was everyone's responsibility to look after a group of vulnerable people and this had not always been undertaken quite as it should.

The Director of Quality advised it had been difficult for the families and carers during a period of uncertainty around the transfer but they were now pleased and were part of the contractual process. The families and carers also met OHFT with OCCG and were able to ask questions. The Oxford City Locality Clinical Director commented on how powerful it had been to have the carers in the room.

The Director of Governance suggested this was another piece of important learning for OCCG observing users and carers had made important contributions in the negotiations for the mental health services outcomes based contract. The Director of Quality made a plea to involve those who used services and felt more co-production in services would be good. The Director of Quality confirmed the service would be monitored via the Quality Committee.

The Lay Vice Chair welcomed the Lay Member (non-voting) to a second term.

The Lay Vice Chair advised the recruitment process for the Clinical Chair and Chief Executive Officer lay with the Board and formal delegation to the Remuneration Committee to organise and run the recruitment process was required with the Board making the final decision.

**The OCCG Board noted the Chief Executive's Report and delegated authority to the Remuneration Committee to run the process to appoint a Clinical Chair and Chief Executive Officer.**

**8 Locality Clinical Director Reports**

Paper 17/47 contained the Locality Clinical Director Reports.

The North East Locality Clinical Director advised recruitment remained a challenge. Work was underway with the council and voluntary groups on the Bicester Healthy New Town (BHNT) project and some real outcomes were beginning to be seen. The Director of Quality felt the prevention work and the Health Routes were excellent and accessible for everyone. The North East Locality Clinical Director acknowledged the secondment of Rosie Rowe to the BHNT project commenting her hard work was a key to the success. The Director of Quality suggested it was an initiative that should be adopted in other areas.

The Oxford City Locality Clinical Director reported on workforce issues and the improvement in quality of care for the Oxford Refugee health initiative through the use of students and other groups of people whilst they were undergoing their training. It was an opportunity to provide help through use of this resource. It was reported the Oxford University Hospitals NHS Foundation Trust (OUHFT) Chief Executive would be chairing a workforce meeting around the unregistered workforce to develop a whole system plan for this known area of challenge and potential competing mitigating actions.

The Chief Operating Officer referred to the question posed around primary care estate and reference to 'alternative private provision of estate which OCCG could support through revenue costs'. As national funding was not available OCCG was considering all options including developers with Section 106 funding. A policy had been agreed at the Oxfordshire Primary Care Commissioning Committee (OPCCC) around health expectations per number of units ([here](#)). The contribution for healthcare could be provided by a Section 106

or from developers but other options were also being explored. Conversations had been held with all councils and good relationships were being built. There was a very comprehensive list of all discussions and plans were being submitted to OCCG and responded to. There was a need to make a case for demand for core primary care services which could be applied to particular developments. A proper estate strategy particularly for primary care had been discussed at OPCCC. The Board should remember that only £2.0m had been received from the bids for £50.0m.

The North East Locality Clinical Director advised different models were being considered as well as multiuse buildings. There were imaginative ways of working such as sharing buildings with councils. The Lay Vice Chair observed the larger developers now generally approached OCCG around use for new premises before submitting proposals to councils. The North East Locality Clinical Director commented there was a challenge as developers could hold old fashioned attitudes leading to the opening of a new GP service which did not fit the more centralised and modern model.

The South East Locality Clinical Director reported on the positive cross locality working for the dermatology service. He reported a couple of practices had signed up to the National Institute for Health Research (NIHR) and attempts were being made to get other practices on board. The Lay Member PPI hoped the Patient Participation Groups (PPG) might help to support the initiative as it was an opportunity for them to be involved as participants as well as the Patient and Public Involvement (PPI) as respondents. It helped to raise the level of the service and the Lay Member PPI hoped other localities would follow suit. She felt this was something the Quality Committee could look at as part of the Quality Committee remit was to look at research, including innovation.

The Lay Member PPI requested future reports from the South East and South West should include a section on the PPG forum role. The South East Locality Clinical Director advised he had met with the PPG in the last week but it was too late to include in the report.

The West Locality Clinical Director advised subsequent to writing the report a large property developer had made contact and the west locality would be engaging as it was in the interests of both to ensure a good proposal before submission to the council. It was noted any bids should consider the new models of care and be based on emerging locality plans. The locality plans were awaited for OPCCC to start developing strategies for workforce, estates, IT, etc.

The Chief Executive advised the Independent Reconfiguration Panel (IRP) report on the closure of Deer Park Medical Centre had been received and was available on the government website ([here](#)). The report cited actions the Board needed to undertake and work was in train; this would be overseen by OPCCC. The Director of Quality advised the report had been shared at the west locality meeting.

**The OCCG Board noted the Locality Clinical Director Reports.**

ECB/JC

**Business and Quality of Patient Care**

**9 Finance Report Month 3**

The Deputy Director of Finance presented Paper 17/48 providing the financial performance of OCCG to 30 June 2017; the risks identified to the financial objectives and the current mitigations; and a most likely, best case and worst case forecast outturn against plan.

The Deputy Director of Finance advised Month 3 OCCG was reporting to be on plan in accordance with the new NHSE guidelines. This meant OCCG would

break even in year and would be able to carry forward the reserves into 2018/19. Page 6 of the report flagged the risk position for OCCG with the net risk currently being £4.9m. Page 5 provided an update on the external risk agreement for the whole system but excluded the Quarter 3 and Quarter 4 referral to treatment (RTT) work. Work continued on mitigations to counter any further increases in activity and to offset the RTT activity. The forecast was for these mitigations to achieve around £5.0m.

Other emerging risks included: the Ramsey Treatment Centre had a potential significant overspend but this forecast was based on only two months information, a deep dive was underway to fully understand the impact; the any qualified provider (AQP) podiatry, work was being undertaken to understand and mitigate; A&E streaming which was not yet reflected in the risk table but was a national directive and evidence indicated this would increase OCCG costs.

The Oxford City Locality Clinical Director pointed out GP streaming would take GP workforce from the front line which could not be reflected in the risk costs. The Lay Member (voting) advised the risk had been recognised and discussed in the Finance Committee and OPCCC. The Finance Committee had requested a further report from a commissioning perspective around A&E streaming which would include a full risk analysis which could be fed into future reports.

The Chief Executive cautioned that although the report covered the first quarter, only data from the first two months was available. The Board needed to take care around making judgements as it was still early days. It was important to have traction on the list of savings schemes. By the September meeting four months of data would be available and would provide a more accurate position.

The Medical Specialist Adviser raised concerns around follow-up appointments explaining if there were issues seeing newly referred patients it could create problems for follow-ups. This could create both quality and financial issues. He felt it would be useful to receive some further information at the September meeting.

The Oxford City Locality Clinical Director felt in trying to balance finance and workforce there could be an impact on quality in primary care particularly around access to GPs. The Chief Operating Officer observed quality was a broad item. Reference was being made particularly to one element; access to GPs. It was really good that more and more could be undertaken for more patients but reduction in quality was only one element. The North Locality Clinical Director stated from a GP view, GPs would see less access to their patients but the quality to patients when they were seen would be as high as ever. It was noted there had been a significant increase in the number of booked appointments across the county.

The Lay Member (voting) had hoped the Primary Care Framework together with work in the localities around providing services at scale would have helped to start managing the pressures on primary care. In the Phase 2 transformation work it was hoped to see a shift of resources from secondary to primary care. He felt it would be useful to have a discussion adding in a national survey some areas in Oxfordshire were coming out ahead of national averages and there were a lot of concerns about primary care. It was agreed to hold a Board Workshop discussion.

It was commented that there was a need to manage expectations. The drive to maintain quality and access against increased demand and complexity with barely any increase in finances was difficult.

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	<p>The North East Locality Clinical Director felt different models of care and innovation should be considered although general practice was at tipping point and unless the service was stabilised there was a danger of reaching a point from where there would be no solution. It was a challenge to persuade colleagues and younger doctors that primary care was somewhere they would be valued and have a worthwhile job. It would be necessary to make an argument for primary care. There were also many innovations in secondary care services which should not be lost but there was a need to invest in primary care otherwise no one new would join general practice.</p> <p>The Lay Vice Chair stated primary care was the bedrock of the whole system. There was a need to obtain maximum efficiency for the money spent. It made sense through transformation to put more money in primary care and OPCCC was very aware of this need.</p> <p>The Chief Executive commented the Board was moving off the agenda and stressed the need to take the subject away for discussion at a workshop.</p> <p>Scrutiny of unnecessary activity at the Ramsey Treatment Centre was questioned. The Chief Operating Officer advised there was a consistent process for NHS or non-NHS providers around obtaining authorisation. Audit work had been completed with private providers but it had taken time to persuade NHS providers that they also needed to go through the process. Testing was being undertaken equitably across the system.</p> <p><b>The OCCG Board noted the Finance Report for Month 3 and considered sufficient assurance existed that OCCG was managing its financial performance and risks effectively, that it could mitigate any risks identified and that it was on track to deliver its financial objectives.</b></p>	
10	<p><b>Integrated Performance Report (IPR) including Referral to Treatment (RTT) Plan</b></p> <p>The Chief Operating Officer introduced Paper 17/49 updating the OCCG Board on quality and performance issues to date. The Integrated Performance Report was designed to give assurance of the processes and controls around quality and performance. It contained analysis of how OCCG and associated organisations were performing. The report was comprehensive but sought to direct members to instance of exception.</p> <p>The Chief Operating Officer advised there were challenges with the 4 hour target but the OUHFT Chief Executive was now the Chair of the A&amp;E Delivery Board which would ensure there was focus from all parties, he was keen to be clear about priorities and a workforce plan around unregistered staff had been put in place. A lot of work was underway around streamlining care pathways which might be challenging due to the patterns of work across providers. More A&amp;E consultants had been recruited but recent sickness in nursing staff had caused issues. It was helpful to have the OUHFT Chief Executive leading the A&amp;E Delivery Board as the OUHFT had been assessed as one of the poorer performing A&amp;Es in the country. Cancer targets continued to be a challenge in gynaecology and gastroenterology and OCCG was working closely with the Trust. The tender for diagnostics services should be completed by the end of October which would help with gastroenterology targets. There had been a challenge from NHS England (NHSE) and NHS Improvement (NHSI) to understand the progress of individual patients on the cancer pathway and OCCG was looking at this with the Trust.</p> <p>The Chief Executive was involved in leadership of the RTT work via the Referral to Treatment Oversight Group chaired by the NHSI Executive Regional Managing Director (South) and attended by all the Oxfordshire Chief Executive</p>	

Officers. All parties were working towards a plan for Quarter 3 and Quarter 4.

The Chief Operating Officer reported the Ambulance Service was implementing the new national programme to ensure more time was allowed to decide the ambulance response required and the category of the incident. The new system was supposed to help the balance of decision making and priority and be less about the 8 minute target. OCCG would monitor how the new system worked.

Points of discussion included:

- The Chief Operating Officer to check the 31 day subsequent treatment (surgery) figures for the OUHFT and recirculate
- The NHSE dashboard for social care showed Oxfordshire to be doing well for length of elective stay and badly for delayed transfers of care (DTCs) although no areas were doing well in both indicators. The Joint Management Group had raised a question around whether OUHFT clinicians were optimistic about length of stays. The Chief Operating Officer referred the Board to Paper 17/55 on the pooled budgets and the summary table
- Questioned whether there was a realistic expectation of reducing the 169 DTOC figure. The Chief Operating Office advised a revised trajectory had been submitted. NHSE had asked for 99 but the trajectory submitted had been 120 by the end of October. The trajectory would go to a national process for approval. NHSE had been requested to approve the 120 figure as this had been agreed by the system. There had been workforce and turnover issues with the HART service but the turnover element had now flattened and it was hoped this would impact on growth of face to face care provision. Choice and other aspects were also issues. There was reasonable confidence the 120 figure would be achieved. OCCG was working through a workforce event with OCC to establish what would be achieved. The situation was not helped by there being more jobs in Oxfordshire than people to fill them
- There was a need to consider how to develop and improve the IPR, which was an important report, possibly by expanding the range of areas covered but also including dynamic elements. A period of more detail in the report should be considered when it was known major changes would occur. The report was still some way from being a system wide integrated performance report and there was a question around how primary care was managed with a separate committee and performance being reported separately. The report should also contain information on care homes and home care
- The Quality Committee had discussed services provided by OHFT and the fact the gaps between targets and performance were bigger than those within the acute. The trend lines were moving in the wrong direction and a deep dive would be undertaken. This work would be reported at board level in due course
- Compliance around prior approval was difficult to measure although it was hoped the electronic system would help once it was available. An audit had just been completed and the results would be checked.

The Director of Quality advised infection control continued to be a focus and whilst Oxfordshire remained below the limit for Clostridium Difficile, managing infections remained a priority for the system. Outpatient clinical communication remained a focus. Data for the end of July was now available and the trajectories of 90% and 95% had not been reached. This was being picked up with the Trust. It was also on the agenda within the Trust but there was a need to understand which individuals were not being consistent with performance and the impact this had on the system. Discharge summaries were being reviewed

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	<p>and beginning to look more streamlined. One of the Oxford City Deputy Locality Clinical Directors had been working with the Trust to ensure the information received was succinct and appropriate.</p> <p>Points of discussion included:</p> <ul style="list-style-type: none"> <li>• The Director of Quality would be writing to the OUHFT Medical Director for verification of the clinical communication figures and to establish next steps. To hold further discussion if improvements and new targets were not met had been included in the Performance Notice. One to one conversations with clinicians to change behaviour were required. The Trust had stated outpatient communication was not measured anywhere else in the country. The Director of Quality would investigate what information from other parts of the country could be obtained</li> <li>• The OHFT figures were not very informative as no comparisons were given. The Chief Operating Officer advised obtaining benchmarking information against community services was difficult but a year on year comparison within the Trust could be possible. She reported a number of people were undertaking some detailed work and last year's performance would be compared with previous years. There was a specific benchmarking report on District Nurses which indicated there were some areas where improvement could be made</li> <li>• There appeared to be worrying trends around the Children and Adults Mental Health Service (CAMHS) and a suggestion in the report that the situation may become worse. The Director of Quality advised discussions were taking place that week. Issues were attracting workforce and an increase in demand. The Trust was working hard to ensure patient safety. The new service was due to commence in September and it was hoped this would improve the situation.</li> </ul> <p>The Chief Executive advised a meeting took place on 26 July 2017 with the two regulators and he would be writing to the OUHFT Chief Executive to follow up on a number of issues including A&amp;E, DTOC and RTT. The Chief Executive suggested writing to the OUHFT Chair to request a Board to Board meeting as there had been a number of discussions over the years with the same process and no improvement. NHSI had issued an enforcement notice to OUHFT. If a Board to Board meeting were to take place a proper agenda would be required and issues raised at the OCCG Board would need to be raised at that meeting. The Board members agreed a Board to Board should be arranged in September.</p> <p>Given the complexities of the system and getting everyone to work together the Lay Member (voting) wondered whether there was an opportunity to undertake an analysis of the system and to organise a meeting of all organisation Boards to review. The Chief Executive stated there would be a need for discussion with OCC and OHFT but there was a need to start the conversation with OUHFT.</p> <p><b>The OCCG Board noted the Integrated Performance Report and that a Board to Board meeting would be organised with Oxford University Hospitals NHS Foundation Trust.</b></p>	<p>SW</p> <p>LC</p>
<b>Governance and Assurance</b>		
<p>11</p>	<p><b>Mazars Mortality Review</b></p> <p>The Director of Quality presented Paper 17/50 updating the OCCG Board on the two stage review of deaths of people with a learning disability within Oxfordshire's commissioning responsibility. The paper set out the findings of the retrospective review.</p> <p>The Director of Quality advised it had not been possible to obtain the exact cohort from Mazars and a set of Terms of Reference had been developed. The</p>	

	<p>Oxfordshire Family Support Network (OFSN) had been involved in order to inform people a review was taking place and enable them to make contact if they wished. It had been enormously helpful having OFSN involved.</p> <p>The list used was of those people known to the local authority. Some had been cared for by the Ridgeway Partnership, some had social care support, and some used Southern Health services. The review had tried to obtain as many death certificates as possible as it was difficult to know whether or not a death had been expected. There had been a need to obtain sufficient information to be assured a review could be properly undertaken. Of the cases considered, 40 people were deemed to warrant further investigation. Over a two day period users, carers, the local authority, provider trusts, GPs and Southern Health among others undertook an appreciative enquiry where cases were allocated and reviewed comprehensively. Obtaining clinical records had proved difficult, particularly for primary care due to change from the Thames Valley Primary Care Agency to Primary Care Services England. The Learning Disability Service now sat with OHFT who had a robust approach to people who died within the service. The Oxfordshire Adults Safeguarding Board (OASB) had also formed a sub-committee to monitor these instances.</p> <p>The Director of Quality expressed her gratitude to the families and OFSN for their support.</p> <p>The Director of Quality reported the work would be taken through the Transformation Care Partnership where learning would be picked up and work was already underway in primary care involving the Oxford City Locality Clinical Director in his role as clinical lead for learning disabilities to ensure review templates were used and reviewed properly when people came into the service. Monitoring would be picked up through the Quality Committee and the report would be presented to the OASB.</p> <p>The Lay Member PPI was pleased to note acute liaison had not been identified as lacking in Oxfordshire. The fact this had consistently been identified as excellent was very commendable.</p> <p>The Chief Operating Officer commented on the statements around commissioning not picking up quality issues and felt this should be add to the recommendations in the pooled budget mix.</p> <p>The Oxford City Locality Clinical Director observed the issues raised had been issues for a long time which should be a learning point for all concerned. It had been a tragic event which had brought the situation to the fore but workers individually within Southern Health were trying to do a good job. Research showed it was a system failing and that individuals had been working to a high quality. There were a number of vulnerable areas and there was a need to skill up to deal with the issues.</p> <p>The Board iterated the congratulations given by the Director of Governance to the Director of Quality and the quality team on a very good and comprehensive piece of work.</p> <p><b>The OCCG Board noted the contents of the Mortality Review.</b></p>	
12	<p><b>Oxfordshire CCG 360<sup>®</sup> Stakeholder Survey 2017</b></p> <p>The Director of Governance introduced Paper 17/51 providing an overview of the main messages from the Oxfordshire CCG 360<sup>°</sup> survey undertaken in January and February 2017. The full report had been included as an appendix to the paper.</p>	

The Director of Governance reported the survey had been disappointing with a significant decrease in results. Further work had been undertaken in addition to work with the North East Locality Clinical Director around the questions for localities and how OCCG needed to improve in working with them. OCC officers had also provided a wider view as the response within the national survey had been one person's view against a set of questions. Primary care felt OCCG was not doing enough in terms of support when they were in difficulties although the constraints on OCCG were acknowledged. It was a balance between trying to do the best for the whole county against the individual. There was also a need to improve "you said, we did". There had been discussion about the website and a request to consider the way localities operated. There had been a lot of detail from OCC officers generally providing support and endorsement for OCCG's engagement and leadership. The last page of the paper provided a summary of the last year, what had changed and the next steps.

Points of discussion included:

- A key action was to agree locality plans. Although it would not be possible to deliver everything a debate could be undertaken to agree the elements to be taken forward and the direction of travel
- North Oxfordshire practices had expressed negative views in the survey but when directly asked felt OCCG was doing a good job. There was discontent around national issues, the Horton Hospital and the primary care situation in Banbury and there had been no other avenue by which to express these views
- The result was not a surprise as it was generally felt monies were all going to secondary care. Oxfordshire was the lowest funded system in the country and the results reflected not having money available for primary care. A check-in point with localities in a few months' time was suggested to establish whether OCCG had undertaken pieces of work and that they had addressed the issues raised
- Locality Clinical Directors had raised issues from the localities but perhaps were not as good at feeding back and ensuring localities were aware of what was happening. Localities might feel listened to but that nothing was being done. The Primary Care team had undertaken a lot of work in difficult circumstances. OCCG needed to be held to account but should also explain work undertaken by people within OCCG and how hard they had fought on behalf of the localities
- An incredible amount of detail was included in the report but it was also difficult to draw conclusions. In every case the metric had gone down and this highlighted a serious issue. It should be investigated in the further analysis whether there were a relatively small number of issues behind the results and, if so, a plan formed to address them. The Director of Governance advised this had been the prime purpose of going back to the localities and this reinforced the main issues were support to primary care, clarity of feedback and whether OCCG was appropriately holding the main providers to account
- OCCG did not always have Local Medical Committee buy-in to the issues. The Chief Operating Officer advised a more constructive relationship with the LMC had recently been developed. The Chief Executive suggested picking this up with the Clinical Chair. He reported regular meetings had previously been held with the LMC and there was a need for OCCG to be more specific around when LMC should be included. The Chief Operating Officer was pleased the Board recognised the importance of the LMC and advised engagement and support had improved. She added the LMC Chairman had supported OCCG around the prescribing incentive scheme
- It was questioned whether there had been responses from people within

	<p>practices. The Director of Governance advised the survey had been sent to people identified as the commissioning GP lead who attended the Locality meetings. Whether they had sought input from within the practice was unknown</p> <ul style="list-style-type: none"> <li>• It was queried whether the Locality Clinical Director Reports Board paper was circulated within the localities as it would provide a means of communication.</li> </ul> <p><b>The OCCG Board noted the outcome of the Oxfordshire CCG 360° stakeholder survey 2017 and endorsed the proposed next steps.</b></p>	
13	<p><b>Corporate Governance Report</b></p> <p>The Director of Governance introduced Paper 17/52 which reported on formal use of the seal and single tender action waivers. It also included details of hospitality and declarations of interest.</p> <p><b>The OCCG Board noted the Corporate Governance Report.</b></p>	
14	<p><b>Strategic Risk Register and Red Operational Risks</b></p> <p>The Director of Governance presented Paper 17/53 explaining the paper provided an at-a-glance view of the current status of all risks on the Strategic Risk Register and Extreme/Red risks (risk grading <math>\geq 20</math>) on the Operational Risk Register.</p> <p><b>The OCCG Board reviewed and noted the recent updates to OCCG risks:</b></p> <ul style="list-style-type: none"> <li>• <b>AF19 Demand and Performance challenge updated its Summary of current mitigation and continued to be a Red Strategic risk with a risk rating of 20</b></li> <li>• <b>AF26 Delivery of Primary Care Services continued to be a Red Strategic risk with a risk rating of 20</b></li> <li>• <b>AF25 Achievement of business Rules – The directors had discussed the risk at the Directors Risk Review meeting and agreed to continue with the current risk rating of 16</b></li> <li>• <b>The two Extreme/Red Operational Risks:</b> <ul style="list-style-type: none"> <li>○ <b>789 Primary Care Estate updated its Summary of current mitigation and continued with a risk rating of 20</b></li> <li>○ <b>758 Delayed Transfers of Care (DTC) continued with a risk rating of 20 but was likely to change post the Care Quality Commission inspection</b></li> </ul> </li> <li>• <b>A summary of all the live risks was presented in Appendix 1.</b></li> </ul>	
15	<p><b>Oxfordshire Clinical Commissioning Group Sub-Committee Minutes</b></p> <p><i>Audit Committee</i></p> <p>The Lay Vice Chair as Chair of the Audit Committee presented Paper 17/54a, the minutes of the Audit Committee meetings held on 23 May and 22 June 2017. The Lay Vice Chair reported the audit process had been undertaken smoothly this year, an unqualified conclusion on the statements had been received and the audit had not revealed any weaknesses or inappropriate misstatements relating to the risk areas identified but some issues around journals and payroll authorisation were raised.</p> <p><i>Finance Committee</i></p> <p>The Lay Member (voting) as Chair of the Finance Committee presented Paper 17/54b, the minutes of the Finance Committee held on 22 June 2017. The Lay Member (voting) hoped the summary provided information on areas covered by the Committee and assurance. The Quality and Performance Dashboard had been received at the OPCCC but they had not yet received the performance information. The Lay Member (voting) felt it would be helpful to have an update at the Board Workshop on the working of the system group around system risk mitigation and savings.</p> <p><i>Quality Committee</i></p>	

The Lay Member PPI as Chair of the Quality Committee presented Paper 17/54c, the minutes of the Quality Committee held on 29 June 2017 but advised the minutes were not agreed and would be amended. She advised the Committee had spent time looking at the Mazars report; the Individual Funding Requests and Prior Approval report showed an increasing workload in this area; an update on children's services had shown agency communication issues had led to a breakdown in care through the different services and OCC had agreed four 'obsessions'; patient safety and experience had been scrutinised; maternity services were being monitored specifically around the new midwife led unit (MLU) at the Horton Hospital. The report had specifically commented on the continuing issue of consultant cover in the maternity unit which remained below target and was of great concern. This issue needed to be resolved. A report had been received on transfers from the four MLUs in Oxfordshire looking at rates and times and actions officers need to take.

**The OCCG Board noted the Sub-committee minutes.**

### For Information

#### 16 Improved Better Care Fund and the Pooled Budgets

The Chief Operating Officer presented for information Paper 17/55 setting out the joint OCCG – Oxfordshire County Council (OCC) proposals in respect of Oxfordshire's Improved Better Care Fund allocation which had been presented to the Oxfordshire Health and Wellbeing Board on 13 July 2017. A further paper setting out the plans for the Pooled Budgets including the wider Better Care Fund would be presented to the OCCG Board in September following its review at the Finance Committee meeting held on 25 July 2017.

The Lay Member (voting) welcomed the funding. He advised the Finance Committee had been asked to approve the Section 75 Agreement. Subject to agreement between management around risk share and confirmation contributions were in line with the budget, the Finance Committee had agreed the Section 75 Agreement.

The Lay Member (voting) recognised further work around linking performance metrics to proposals and objectives of the fund was required and expected this would become available over the rest of the financial year. He advised the Finance Committee had not seen the governance proposals for approving the Better Care Fund (BCF). As Chair of the Finance Committee the Lay Member (voting) reported the Committee had struggled for a couple years over the management of the funds and linkage between spending and outcomes. Additional assurance, particular from OCC on outcome of funds, had been requested. The Finance Committee also had concerns around budget, plans, activity and monitoring against the additional plan. The Chief Operating Officer reported the team were developing a dashboard with OCC and the first version had been presented that week with the Quarter 1 data. The dashboard required further work but it was good to have the information available and to be able to monitor and review spend.

The Lay Member (voting) felt the challenge was that the work of the OCCG Board Committees was not recognised in the governance section and it needed to be acknowledged or recognised and the Board should delegate to the Committees to undertake monitoring as part of the governance. Given the issues and challenges there should be a statement that both the Quality and Finance Committees should undertake scrutiny of the performance of the fund and the statement could be made available to the Joint Health Overview and Scrutiny Committee (HOSC) who had overall lead for the BCF.

The Director of Governance commented that her reading of the paper was that OCCG would use its governance scrutiny in a way applicable to OCCG and

	<p>would decide to use Board Committees for this. The Lay Member (voting) felt the statements would provide more traction and recognition of the Committees might provide the opportunity to develop the dashboard further.</p> <p>The Chief Executive felt there should be linkage with the OCC Audit Committee and suggested a conversation between the Audit Chairs. He felt there was a need for single governance of oversight. The Chief Executive observed OCCG and OCC shared external auditors and obtaining their advice might be helpful.</p> <p><b>The OCCG Board noted the paper presented to and approved by the Oxfordshire Health and Wellbeing Board on 13 July 2017.</b></p>	<b>RD</b>
<b>17</b>	<p><b>Any Other Business</b> There being no other business the meeting was closed.</p>	
<b>18</b>	<p><b>Date of Next Meeting:</b> <b>Thursday 10 August 2017, 09.30 – 11.30, Oxford Examination Schools, 75 – 81 The High Street, Oxford, OX1 4BG. Extraordinary Board meeting to make decisions on the transformation consultation.</b></p> <p><b>Thursday 28 September 2017, Board Meeting 14.00 – 17.00, Jubilee House, 5510 John Smith Drive, Oxford Business Park South, Oxford, OX4 2LH</b></p> <p><b>Thursday 28 September 2017, Annual Public Meeting 18.00 – 19.30, Jubilee House, 5510 John Smith Drive, Oxford Business Park South, Oxford, OX4 2LH</b></p>	