Oxfordshire
Clinical Commissioning Group

MINUTES:

OXFORDSHIRE CLINICAL COMMISSIONING GROUP BOARD MEETING

30 November 2017, 09.00 – 12.45 Spread Eagle Hotel, 16 – 17 Cornmarket Street, Thame, OX9 2BW

	Dr Joe McManners, Clinical Chair
	David Smith, Chief Executive
	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)
	Heidi Devenish, Practice Manager Representative (interim) (non-voting)
	Roger Dickinson, Lay Vice Chair (voting)
	Diane Hedges, Chief Operating Officer (non-voting)
	Gareth Kenworthy, Director of Finance (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)
	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
	Dr Kiren Collison, Deputy West Locality Clinical Director and Clinical Chair Elect
	Julie Dandridge, Deputy Director of Delivery and Localities, Head of Primary Care and Localities – Item 12
	Zoe Kaveney, Project Manager, Planned Care – Item 14
Apologies:	Dr Jonathan Crawshaw, South West Locality Clinical Director (voting)
	Stuart MacFarlane, Practice Manager Representative (substantive) (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	**Chair's Welcome and Announcements** The 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. The Chair advised the Chief Executive would be retiring from OCCG at the end of the year and on behalf of the Board thanked him and expressed very warm wishes to him for the future. The Chair also expressed thanks to the substantive Practice Manager Representative who, following a long period of illness, was resigning from the Board and welcomed the interim Practice Manager Representative who would remain on the Board until a selection process for a substantive had taken place. The Director of Quality read the Patient story and thanked the patient for their consent. The Lay Member (voting) felt lessons could be learnt from the particular case and queried whether there was a lead organisation which would pick up the issues on behalf of the system and share across the system, link to improvements in the system and provide feedback to the system. The Director of Quality advised it would be looked at individually within organisations. She added the 111 service used pathways and undertook end to end reviews and there was a need for the Oxfordshire system to improve. The particular case was being reviewed by Primary Care as a complaint. The Chair observed if the case was being considered on an individual organisation basis then learning for the whole system would not be achieved. He suggested things might improve if the themes were picked up and disseminated across the system and felt OCCG was in a good position to lead this piece of work. The Director of Quality to consider how learning could be shared in a constructive way across the system. The Oxford City Locality Clinical Director (LCD) felt the case illustrated an interesting point of care. People were admitted to hospital as urgent cases and received treatment to stabilise their condition. Previously patients would be kept in hospital for rapid investigation tests but with the focus on getting people out of hospital investigations were now undertaken in a different way. Undertaking a change in one part of the system had a knock on effect elsewhere. The Chair commented complex cases often involved GPs and professionals and feeding back individual pieces did not give a whole picture. He suggested the Quality Committee should consider how this could be addressed. The Director of Quality advised the Assistant Clinical Director Quality was undertaking a piece of work around quality in primary care.	**SW**
2	**Apologies for absence** Apologies were received from the South West Locality Clinical Director, the substantive Practice Manager Representative who had now tendered his resignation from the OCCG Board, the Director of Public Health, and the Oxfordshire County Council (OCC) Director for Adult Services.	
3	**Public Questions** The Chair advised a question had been received via email concerning consultation and engagement on the Locality Plans. The Director of Governance advised the question would be responded to under the Locality Plans item (Item 12) and a written response would be posted on the website within 20 working days of the meeting. The Chair invited questions from the members of the public present but no questions were forthcoming.	
4	**Declarations of Interest** The North LCD advised he had resigned as the OCCG nominated member of the Oxford University Hospitals NHS Foundation Trust (OUHFT) Council of Governors. All GP members of the Board declared an interest under Item 12, Locality Place Based Plans. There were no other declarations of interest over and above those already recorded.	

5	**Minutes of OCCG Board Meeting held on 28 September 2017** The minutes of the meeting held on 28 September 2017 were approved as an accurate record.	
6	**Matters arising from the Action Tracker and Minutes of 28 September 2017** The actions from the Action Tracker and the 28 September 2017 minutes were reviewed and updates provided where these were not covered under items later on the agenda. *Integrated Performance Report:* *Exit Interviews* The Director of Quality advised Oxford Health NHS Foundation Trust (OHFT) undertook exit interviews for the Child and Adolescent Mental Health Service (CAMHS) but the Trust was planning to engage an external company to undertake the exit interviews on their behalf. An update would be provided at a later date. *Board to Board* The Chief Executive had a follow up the conversation and wrote to OUHFT but they were reluctant to hold a Board to Board meeting at that time. The Chief Executive suggested the matter should be picked up by the new OCCG Clinical Chair with the OUHFT Chair. The intention had been to hold two Board to Board meetings a year as it was felt these meetings were beneficial. It was believed it had been a year since the last Board to Board. *Locality Clinical Director Reports:* *System Workforce conference* Work was taking place with OCC and a campaign had been launched to recruit more people whilst another piece of work was taking place through the Transformation Board. Action to be closed with an update provided in a few months' time. The Clinical Chair referred to a letter from the Director of Commissioning Operations NHS England (NHSE) South East concerning the appointment of a workforce lead across the system. The Chief Executive suggested this appointment should be pushed via the Transformation Board as workforce formed part of delivery plans but the need to push for this appointment would require support from all the other organisations in the system. The Oxford City LCD remarked on there being a workforce stream in the Sustainability and Transformation Programme STP which had not yet delivered anything material. He felt OCCG was in the best place to push workforce forward and someone from OCCG should be the lead. *Suspected Cancer Pathway Service (SCAN)* Item on the agenda. The action was closed. *Finance Report:* Item on the agenda. The action was closed. *Better Care Fund (BCF):* The Lay Vice Chair advised attempts had been made to hold a meeting with the OCC Audit Chair but they had been cancelled on two occasions by OCC. The Lay Vice Chair was now escalating the matter to the Leader of the Council for a discussion on how to take the issue forward. The Clinical Chair advised the BCF had been agreed at the last meeting of the Health and Wellbeing Board (HWB) and if it was a matter of governance the issue could be escalated to that body. *Oxfordshire Transformation Programme:* An updated had been provided in the Chief Executive's Report, Paper 17/73. *Oxfordshire Primary Care Commissioning Committee (OPCCC) Minutes – Stress in the System:* The Director of Quality advised a link to the support for GPs highlighted at the 4th Suicide Prevention and Intervention Conference was available on the OCCG website. The action was closed. *Director of Public Health Annual Report X:* The action remained open.	**SW** **CM/SW** **RD** **JMcW**
Overview Reports		
7	**Chief Executive's Report**	

	The Chief Executive introduced Paper 17/73, updating the OCCG Board on topical issues and advised it was the last Board meeting for the Clinical Chair whose term of office finished that day. A process had been followed to appoint a new Clinical Chair and the Clinical Chair Elect had been appointed and would commence in the role on 1 December 2017. **The OCCG Board ratified the appointment of Dr Kiren Collison as the new Clinical Chair for Oxfordshire CCG commencing on 1 December 2017.** The Chief Executive advised discussions continued to have a Chief Executive Officer in place by 1 January 2018. As this was the last Board meeting for the Chief Executive he took the opportunity to thank colleagues commenting he felt a great deal had been achieved together and he would have been unable to do the role without the support of the Clinical Chair and the Board. The Chief Executive thanked the Executive Directors and the Business Manager for their support. The Chief Executive highlighted some of the achievements mentioned in his report stating that he wished to place on record some of the very good initiatives and pieces of work that the Board had undertaken. He commented on the GP Federations work to improve services in primary care and the very exciting developments that had taken place; the positive performance news around cancer waiting times; the significant challenge faced by the system from the issues in A&E advising a series of bids had been made for monies in A&E and winter planning; the system wide review into delayed transfers of care (DTOCs) being undertaken by the Care Quality Commission (CQC) looking at how the system was working together on delivery – the current number was 87 which was still too high but was significant progress; the commencement of work on Phase Two of the transformation programme; the Judicial Review on Phase One which was due to take place in the next week; the letter from NHSE on Quarter 2 which was attached to the report. The Chief Executive thanked the North LCD for his work in undertaking the Deputy Clinical Chair role. The North LCD commented a DTOC number of 87 was a phenomenal achievement. The figure in Oxfordshire had not been that low for many years and the Chief Operating Officer, all those involved in working on the issue and the A&E Delivery Board should be congratulated on the achievement. The Chief Operating Officer felt it was important for people to start believing it was possible to reduce the delays figure. She advised a number of pathway changes had taken place smoothing out areas and making it a better experience for people. The Lay Member PPI queried the expansion of planned care services at the Horton Hospital and the requested business case from OUHFT. The Director of Governance advised there had been an exchange of correspondence and OCCG had been advised more information would be available after the OUHFT November Board meeting. Nothing had been received and a further request for information was made to enable a verbal update to be provided to the OCCG Board. This had not arrived in time for the meeting and would be followed up. The Director of Finance explained a full capital business case took time to develop. The Director of Governance confirmed a capital business case had been requested and whilst this was being produced the Trust was undertaking further work around the transfer of work into the Horton and having discussions about increasing the use of the Ramsay Treatment Centre. The Chair pointed out the Board had been very precise at the time of agreeing the	**DS**

	papers that it was a phased approach. He felt it was disingenuous for anyone to say there was a need to wait for several months before anything happened. The Chief Operating Officer advised as part of the bids for winter work it had been said capacity could be increased through the Ramsay and range of services provided which should give residents more local access and enable a better flow in the system. The Chair stressed the need to follow the implementation through as it was important to maintain the trust of the public. The Lay Member (voting) referred to the assurance letter and the system based approach and assumed the Chief Executive had expressed frustration at the regulator having conversations without involving OCCG. The Chief Executive reported the Regional Director was now a joint appointment for NHS Improvement (NHSI) and NHSE which was a step in the right direction and there was supposed to be further join up for the Quarter 3 meeting. **The OCCG Board noted the Chief Executive's Report.**	
8	**Locality Clinical Director Reports** Paper 17/74 contained the Locality Clinical Director Reports. The South East LCD apologised for the brevity of the report explaining the wrong version had been submitted. He reported the ambulatory model provided two days at Thame Hospital and two days in Marlow. Discussions were taking place around expanding the model to five days a week and to enable more practices to use the service which would allow more patients to have access and be similar to the Henley Rapid Access Care Unit (RACU) model. The Oxford City LCD advised on a review of the number of appointments being delivered in primary care. He pointed out the need to remember general practice delivered a huge number of appointments and contacts in-hours with patients. He felt people should be made aware of these numbers as general practice was the bed rock without which the health service would be in difficulties. The Oxford City LCD commented overflow hubs were a good idea but the Locality wished to provide appointments from practices. The North LCD agreed the number of patient contacts in primary care should be highlighted and commented it was difficult to project how useful overflow hubs and visiting services would be until they were in place. The Lay Member PPI noted in the Oxford City report the development of different skill mix and particularly the role of clinical pharmacists, which was in line with the Five Year Forward View (FYFV), in order to provide more appropriate services and queried whether the difference this might make was being evaluated. She pointed out the aim was better care for patients and to reduce pressure on GPs and suggested patients should be asked for their views as well as taking it up with the Patient Participation Groups (PPGs). The Chair felt patients could also be approached on the Locality Plans and the differences in services. The Lay Member PPI advised research suggested the younger population was happier to use different forms of consultation. It was more difficult with the older population and needed to be introduced in the right way as using different forms of consultation could be more beneficial. The North East LCD advised practices were trialling clinical pharmacist, looking at their roles and undertaking evaluation. A series of engagement events around primary care were taking place. The planned changes would work differently for different people. He observed the system was overwhelmed by doctors seeing the same people when they could be seen elsewhere and it was important patients were seen by the right person.	

	The North LCD advised that clinical pharmacists scored highly on patient satisfaction surveys but more information was needed on where they could add additional clinical benefit and there was a need to consider this. He felt Locality Forums and PPGs should be asked to feedback on the service. In response to queries raised by the Lay Member (voting), the Chief Operating Officer advised there were logistical issues with cross boundary referral in the North of the county pertaining to test results and patient notes. The South East LCD reported referral to the Royal Berkshire NHS Foundation Trust was easy as all the necessary systems were in place and it was actually more of an issue to refer to the John Radcliffe Hospital. The Director of Finance confirmed through patient choice cross border referrals were taking place and there was over performance on out of area contracts. The North LCD observed the North did not use over the border hospitals for laboratory work. He stated it was not difficult to refer patients but the hospitals were unable to access test results or notes. On the question of Sunday appointments, the West LCD thought it was a national requirement to offer Sunday appointments and advised they were used extensively in West Oxfordshire. The Chief Operating Officer advised Sunday slots at the Banbury Health Centre remained empty whereas there continued to be attendance at the Horton Hospital. She stated more work was required around matching capacity with patient attendance. The Oxford City LCD pointed out seven day access was booked in advance whilst the Chief Operating Officer was referring to same day appointments. The Chief Executive suggested this might be a discussion for the Oxfordshire Primary Care Commissioning Committee (OPCCC) as it was about delivering what patients wanted and best value. The Oxford City LCD commented on the interesting data received from practices as it demonstrated an excellent database. Using the data to look at appointments and how services were run there was variation across practices which was partly due to demographics particularly when the cohorts were considered as certain cohorts required more time. The Commissioning Support Unit (CSU) would be rolling out this reporting. **The OCCG Board noted the Locality Clinical Director Reports.**	
Business and Quality of Patient Care		
9	**Finance Report Month 7** The Director of Finance presented Paper 17/75 providing the financial performance of OCCG to 31 October 2017; the risks identified to the financial objectives and the current mitigations. Detailed scrutiny of the full Finance Report had been undertaken at the Finance Committee. The Director of Finance advised OCCG was on plan to deliver year to date and forecast outturn. Overall it was good news but there were still a number of pressures to be managed: the “no cheaper stock obtainable” issue was a significant cost pressure on the prescribing budget of £300-400k a month; the acute activity particularly on the OUHFT contract, the acute spend was the biggest risk to OCCG especially looking forward to next year; there were significant overspends with other neighbouring providers, a deep dive looking at the Buckinghamshire Hospital Trust and the Ramsay Treatment Centre was underway and would be carried out on all other areas of overspend – it was a general increase in both elective and non-elective activity and an ever increasing demand; the new musculoskeletal (MSK) service was now operational and had impacted on referrals to providers, a dip while the service transferred between providers had been expected. A new structure and risk share agreement had been agreed around the pooled budgets. Since the report had been produced a possible significant deterioration	

	in the pooled budget on the CCG side had been identified mainly in continuing care. OCCG had just been notified by OCC and investigation and validation of the numbers was underway. OCCG was looking at any failures in governance and financial controls which would be flagged to the Finance Committee and an internal audit would be undertaken. This was an additional risk and the Director of Finance expected to be able to report back in the next reporting cycle and the issue would be taken back through the Finance Committee. The West Deputy Locality Clinical Director requested some clarity around the primary care budget in order to understand the underspend and receive assurance monies were not being withheld. The Director of Finance explained the prescribing budget counted as primary care and there was the delegated primary care budget in addition to OCCG resources. There had been some slippage in delivery of initiatives. He advised this linked to Item 12 and Paper 17/78 which showed how uncommitted resources would be used and spent on primary care. OCCG was forecasting to fully spend the delegated budget and was anticipating spending the contingency. The Chair pointed out OCCG was required to hold a reserve against emergencies or crises in year but as the year progressed and the risk reduced it was possible to spend the monies held. The Lay Member (voting) advised a lot of time had been spent on finances in the OPCCC and it had only been in the last couple of months that clarity around the risks had been received. He queried whether OCCG was missing some communication to LCDs and members around the use of funds. This would be picked up outside the meeting with the Deputy Director of Delivery and Localities, Head of Primary Care and Localities. **The OCCG Board noted the Finance Report for Month 7 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.**	**GK**
10	**Integrated Performance Report** The Chief Operating Officer introduced Paper 17/76 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 instances of exception. The Chief Operating Officer advised: there were still issues with A&E but these would be picked up through the Winter Plan; there had been good progress around the cancer targets, South Central Ambulance Service although remaining 'red' was of least concern, was still one of the best performing ambulance services and as per the presentation to the September OCCG Board, was moving to a different model; issues continued with the referral to treatment (RTT) numbers and from discussions it was known these linked to long term funding, the results from the additional resourcing from the budget were pleasing but it was not known how these would feed in and it was disappointing to note the Quarter 2 activity had not delivered at the level expected from the Trust; Oxfordshire providers tended to do better than average on the Friends and Family results but OHFT did not match these results and this would be picked up. A 'deep dive' on OHFT would be considered at the Quality Committee. The Chief Operating Officer advised a report had been received from the OUHFT on the rise in 52 week waits but more work was required from the patient experience perspective as there was assurance around any possible patient clinical harm but not on the other areas. A lot of discussion had taken place around understanding the long waiters as well as a good conversation around	**LW/SW**

	strengthening patient audit in this area. A draft RTT report was being prepared which could come to the next OCCG Board meeting and provide further information. The 52 week audit report should also be available in time for that meeting. The Director of Quality advised a 52 week patient experience survey was being undertaken by OUHFT. The outcome would be reported back to the Board once complete. The Chief Executive queried whether a question had been raised around the high level of patients waiting in gynaecology commenting it was unacceptable and queried whether it should go back to the Quality Committee. The Director of Quality advised two specialities were being reviewed and gynaecology was specifically being picked up in the Quality Committee. The Chief Operating Office advised on a number of challenges at the OHFT: an issue had been identified around incorrect reporting in Out of Hours (OOHs) and whilst assurance had been given of reasonable performance, this was not the case. Work was underway internally in the Trust and there was a steady improvement in some key areas. The Chief Operating Officer assured the Board that whilst it was an area of concern it was being addressed. She reported the adult mental health performance standards were reasonably good which was positive. The Lay Member PPI commented that CAMHS continued to be a problem, there was a strong government push on the new targets but there was the continual issue of the skilled workforce in this group and the ability to attract and retain staff. The Chief Operating Officer reported a discussion on the CAMHS service had taken place at the last contract meeting and it had been agreed to detail all of the facts particularly the number of appointments rising in relation to referral rates. The team had been asked to compile, in agreement with the Trust, the number of appointments and referrals in order that they could be understood. This would be followed up in the next contract meeting. The Chair remarked that workforce could be used as an excuse and high performing organisations were able to find ways around these issues. He felt there might be other issues and the concerns should be followed up. The North LCD reported GPs were coming up against barriers when trying to join the OOHs service and because of the issues and problems many did not pursue their applications. The Chief Operating Officer acknowledged there was a question as to whether the forms were processed as quickly as possible but advised OHFT had raised the point that a GP might be on the Performers List but under national requirements for OOHs there was a need to start from basics. The Lay Member PPI stated OOHs was covered at the Quality Committee meetings already and a further detailed report had been received. The Chair advised some frustration had been voiced concerning the contract meetings and their effectiveness and value. He felt there might be a need to do something else. The Director of Quality and Chief Operating Officer would discuss outside of the meeting.	**SW/DH**
	The Oxford City LCD thought the CAHMS problem lay in trying to force a traditional model on doctors and psychologists without the third sector engagement which the current adult service enjoyed. He reported the Head of Response in the mental health adult team was working with the third sector to try and deliver the model. He commented that GPs now had a range of options for jobs which led to workforce challenges. For example the seven day appointment service was attractive to doctors and GP streaming would soon commence which could attract some doctors and as there was only one limited pool getting doctors for OOHs was difficult. He observed OOHs had been seen as the 'jewel in the crown', had been well supported, well run, provided good training, looked after its	

	staff and delivered but it was no longer viewed in this way. The Lay Member (voting) drew attention to the connection between the Performance Report and the Winter Plan update and the impression there had been a significant number of beds closed due to staffing pressures with a number of patients waiting to be discharged. He commented that workforce was continually mentioned as a problem and he did not feel assured going into winter that there were plans to mitigate the lack of workforce in all areas. **The OCCG Board noted the Integrated Performance Report.**	
11	**Urgent Care Winter Update November 2017** The Chief Operating Officer presented Paper 17/77 providing an overview and update of urgent care performance across the Oxfordshire Urgent Care System and described the work underway through the Systemwide Winter Plan to improve efficiency and flow through a safe and responsive urgent care service. A similar paper had been presented to the Oxfordshire Joint Health Overview and Scrutiny Committee (HOSC) on 16 November 2017. The Oxfordshire System Winter 2017-18 Plan was submitted to NHS England (NHSE) on 13 October 2017. The overall plan was rated 'amber' on 26 October 2017 with four areas rated as 'red'. The Chief Operating Officer advised the situation was constantly changing and since writing the report there had been an invitation to bid for further funding. A bid had been made for £4.0m worth of initiatives. There was concern if a series of schemes were put forward whether there would be sufficient workforce. OUHFT had submitted a series of proposals to mitigate staffing issues. A telephone conversation had taken place with the Trust, NHSE and NHS Improvement (NHSI) around the workforce and performance concerns in the OUHFT. The report referred to a visit by NHSE and NHSI to the OUHFT which had identified challenges around work space and the emergency team. A similar paper had been presented to the Joint Health Overview and Scrutiny Committee (HOSC) who had supported the proposal from the A&E Delivery Board to accept the offer of counting type three (minor injuries) alongside A&E for the system. Overall this would improve reported system performance but would not change the patient experience. Identifying people with high care needs was covered in all the Locality Plans and the frailty pathway had been discussed in both a Board Workshop and the CCG Executive. Other workstreams were also building on this. The North LCD advised practices were funded to complete care plans although it had not yet been seen whether effective plans had been produced especially for those at risk of high admission. The Chief Operating Officer reported three virtual wards had been included in the bids to proactively work with primary care to identify that at risk group. This would be tested if the funding was received. The West LCD commented practices were asked to identify patients with frailty this year and to take this further next year when more funding would be available. The scheme was limited in scope this year being a brief assessment and no care planning. The North LCD advised the care plans were well disseminated through OOHs but needed to be distributed further through practices. The Lay Member (non-voting) observed the paper contained a lot of information and ideas and queried how this was disseminated to ensure everyone understood what was required and how to access services; how much could be implemented; how much depended on additional funding; and when linked to the Finance Report, how the risk was reflected and played out in Quarters 3 and 4. He added that he did not feel the Reports provided assurance the targets as reflected in the Finance Report would be met. The Chief Executive advised it linked to Item 13 and the Finance Plan for the next	

	year where there would be a huge financial challenge. OCCG was relatively financially healthy when compared to other CCGs but there were issues with the OUHFT especially around the non-delivery of RTT and A&E. Any new money would be non-recurrent and would cease at the end of March. There was more that could be undertaken around prevention and primary care but no monies for pump priming in the system. The Oxford City LCD advised evidence showed the cohort of people who should be vaccinated against 'flu was children but the Plan focussed on high risk groups and people over 65. He advised only 20% of two to three year olds were being vaccinated in Oxford City and the programme in schools had not started. He thought Public Health should be asked to show what would be avoided if children were vaccinated and felt the vaccination of children should be incentivised as well as ensuring OHFT implemented the schools programme quickly. The Chief Operating Officer advised the schemes contained in the Report would be funded by monies it was assumed would be received. **The OCCG Board noted the Winter Plan and agreed the need for further actions to fully mitigate the risk. The OCCG Board also noted the A&E Delivery Board intention for a system wide approach to the collation of A&E reporting taking type 3 (minor injuries) activity into account.**	
12	**Primary Care Locality Place Based Plans** The Deputy Director of Delivery and Localities, Head of Primary Care and Localities attended for this item and presented Paper 17/78 explaining plans were being developed and LCDs were working in practices and localities to help achieve sustainable primary care in their areas. A number of engagement events had been held or were due to take place for patient and public feedback on the plans. Many cross Oxfordshire themes were emerging such as the frailty plan, care in long term conditions, and same day access. There were workforce challenges in primary care as well as infrastructure and estates but some work could be undertaken digitally to streamline and improve services. Prioritisation work had started to allocate investment from non-recurrent funding from 2017/18 and uncommitted funds from 2018/19 and it was hoped to commence some of the schemes. Draft plans would be published with some of the feedback whilst all the feedback would be taken to the January OPCCC. First versions of these iterative plans would be published at the end of January. The Chair noted the question submitted to the Board and felt there was a need to explain how the public were involved; ideas generated; engagement and involvement as opposed to formal Consultation. The Lay Member (voting) attended the South West event and fed back good questions had been asked; generally the public wished to see plans for the whole system; appeared to be supportive of the proposals; recognised the issues including workforce in both practices and the community; and funding. The North LCD advised the Banbury event had been mostly well received. Concerns centred on skill mix and quality of care. The Deputy Director of Delivery and Localities, Head of Primary Care and Localities advised she had attended four of the five engagement events held to date. There had been good patient engagement with most events having more than 30 people attend; 45 people had attended the Wallingford event. Similar themes were emerging: continuity of care although recognising that not all patients needed continuity; appointment waiting times; communication and how CCGs and practices communicated changes in direction of travel. Communication would be picked up separately from plans and there would be on going engagement. There had been comment that the plans did not contain	

enough on which to comment and once more of the background services, needs assessments and population services were included there would be more for people to consider.

The Lay Member (non-voting) questioned whether OCCG was assured there was a sufficient level of involvement from providers. He felt there was a need for an approach from a system perspective, and that enablers such as workforce, IT and estates were critical to success querying how ready these enabling workstreams were. The Deputy Director of Delivery and Localities, Head of Primary Care and Localities reported early plans had been shared through the Transformation Board with most having been developed through Locality meetings which involved the community and Federations. There was currently a gap around the integration of Social Care and this would be picked up in later versions of the plans. Some investment had been identified to support workforce in the short term, and work was commencing on estates needs with prioritisation of these and IT work to follow at a later stage. There were some plans which would begin to feed into OPCCC.

The Oxford City LCD stated EMIS web should be the common currency for community based health services and should be included in all the plans.

The Lay Member PPI felt there should be measurement in some form. Although items might not be new as they were undertaken elsewhere in the country or Oxfordshire and were being implemented in another practice, these should be tested to ensure they worked. She suggested using Patient Participation Groups (PPGs) to harness patient views and stories on what worked; good and bad. The Lay Member PPI had not seen mention of rural practices in the plans and their specific needs, such as being a dispensing practice. She commented it was often hard to sustain services and there were particular issues for rural practices that needed to be addressed.

On engagement the Director of Quality suggested some thought should be given to the model and how the PPGs could be used to work on co-production more effectively as this would be really beneficial. She advised the Local Authority had employed a group of staff to work on co-production which OCCG might be able to tie in to. The Director of Governance reported ideas for different ways of working were being explored with the Locality Forum Chair (LFC) from the West locality. The Chair remarked that some thought should also be given to engaging the wider audience who could not attend the engagement meetings.

The Chief Executive reminded the Board that a bid for £50.0m had been made for infrastructure and estates but only £2.0m awarded. The £50.0m had not been for future projects but for the priorities list. The lack of funding was a real issue. There was a need for plans to be clear on current and future requirements with proposals around how to obtain funding and what deals could be made to achieve inward capital investment although he cautioned that funding would come with a revenue cost. The Chair advised there were four approved providers for capital investment from industry and queried whether this was being picked up. The Lay Member (voting) suggested working with partners around primary care and particularly the alliance between OHFT and the GP Federations as the OHFT had capital and revenue to support was in the system.

On the workforce challenge the North East LCD commented on the need to make Oxfordshire a place people wanted to come and work. Many people undertook training in Oxfordshire but did not remain in the area. The system could not keep recycling the same pool. There was a need to spread the message that there were good roles for GPs and other professionals in Oxfordshire.

	The Lay Member (non-voting) stressed the need to engage at an early stage with potential financial partners as they would expect some involvement to ensure proposals worked from the perspective of all the stakeholders. The Chief Executive explained there was a revenue cost associated with capital funds which generally worked out at 10% per year. The Oxford City LCD observed that communities wished to have a National Health Service and as this was a better return on investments than current interest rates suggested perhaps approaching communities and queried whether this was possible. The Director of Finance assured the Board investment opportunities were being pursued and a piece of work on the implications of primary care work was underway. Some work on funding routes had been undertaken but crowd funding had not been considered and would be added to the list. The Director of Finance also advised a proposal from LIFT Co, of which the NHS was a shareholder, was being considered as they did not just undertake end to end scoping but built, financed and undertook planning which would include options around funding although with these proposals there would be a need to be mindful of conflicts of interest. The Director of Governance referred to the question received from Keep Our NHS Public (KONP) relating to consultation and formal consultation reminding the Board of the need to be careful with language used. As an organisation OCCG had a duty to involve the public which was by a variety of means. The plans in their current form did not require formal consultation but if any significant service change(s) arose from the plans, then a formal consultation would need to take place. There would be a need for a formal consultation on the changes to the Banbury Health Centre (BHC). The Director of Governance advised a full written response would be uploaded to the website within 20 working days of the meeting. The Chair thanked the Deputy Director of Delivery and Localities, Head of Primary Care and Localities, her team and PA Consulting for taking OCCG a long way forward with the Primary Care Locality Place Based Plans. **The OCCG Board:** • **Noted the progress on the plans** • **Noted the Primary Care Locality Place Based Plans would be published on the OCCG website in draft form at the beginning of December. Final plans would be published in January 2018 following public and patient feedback throughout November and December 2017.**	**CM**
13	**Finance Plan 2018/19** The Director of Finance gave a presentation and reported the financial outlook and challenge for 2018/19 would be very difficult but there were potential solutions although these would mean some difficult choices for the system. The presentation would be uploaded to the OCCG website after the Board meeting. The Director of Finance advised: • The investment in 2018/19 was the lowest real term investment of the Five Year Forward View (FYFV) • The budget statement had allocated £335.0m to the NHS for 2017/18 winter pressures • For 2018/9 the additional £1.6bn would be targeted to certain areas (RTT and emergency care) • Services in Oxfordshire were funded on historic demand adjusted over time for the 'fair shares' formula. Oxfordshire received the correct amount based on the needs formula but that did not take into account OCCG services were under target and Primary Medical Services and Specialised	

Services were over target

- The OCCG allocation was already committed. There was a large gap between the allocation and the commitments
- Savings needed to be achieved before investments could be agreed
- Demand and affordability of demand was a joint problem and was the recommended approach. This needed to be tested with the other organisations
- Current plans would not fit within the affordability of the allocation for Oxfordshire. There would be a need to consider the amount available and actions necessary to deliver plans that fitted within the envelope without burdening any other partner organisation. This would require choices around prioritisation, what should be funded, the impact and the savings that could be achieved
- Reduce activity or improve productivity and efficiency were two possible options
- All decisions would need to be evidence based and fully assessed
- The first cut of the Financial Plan indicated a significant affordability gap for OCCG of up to £30.0m
- The system had made significant progress with the system risk agreement in 2017/18 but there was a need to consider how to improve on the agreement.

The Chief Executive reported the detail had been shared with the OUHFT and OHFT Finance Directors and shared at the CEO Board meeting with the Federations. No one had indicated it was the wrong approach. It was necessary to know how much extra money would be received from NHSE and how much of that money was targeted. It was hoped to have confirmation shortly. Part of the discussions was a need to understand the provider positions. It was known the OUHFT position had deteriorated but there was a need to understand the issues. If the Trust was already in deficit it would not be possible to take costs out of the system. OCCG was also aware OHFT were experiencing some financial pressures and as this was a block contract it was expected they would look to receive further monies. The Chief Executive suggested an early January discussion possibly at the Board Workshop rather than waiting for the Board Meeting at the end of January.

The West Deputy Locality Clinical Director queried whether monies could be used on pathways which would affect A&E rather than being provided directly to OUHFT. It was not known if this was possible although if this was a system approach which achieved the target it might be considered acceptable. The Chief Executive advised it was clear from the national level conversation held on Monday 27 November that if monies were provided to OUHFT they would be expected to deliver the targets. If the targets were not delivered there was the potential the money would be withdrawn. OUHFT would need to be confident that where money was invested outcomes were delivered.

The Chief Operating Officer raised the point that OCC at the Joint Management Group had stated they had not paid any inflation to their providers for years. The Director of Finance agreed there were some areas where this could work but OCCG had national contracts in a national framework which included national prices.

The Oxford City LCD queried the concept that extra money would come into systems through the Sustainability and Transformation Programme (STP) process. The Director of Finance advised this route was still available and discussions were taking place around how prepared OCCG and the system was to access these national pots of money. He added that these funds were a

	solution but would be insufficient to close the gap. The Lay Member (voting) cautioned against losing sight of the money already spent and the opportunities identified as well as ensuring a reasonable rate of return on growth money. **The OCCG Board agreed the approach being taken and that an update should be provided at the December Board Workshop with a fuller discussion being held at the January Board Workshop.** The Oxford City LCD queried whether other organisations agreed the financial position was as described. The Director of Finance advised the presentation had been taken to the CEO Board and although there were no dissenters, neither were there strong views that this was the way forward. With the endorsement of the OCCG Board it would be possible to push from today that OCCG believed this was the way forward and next steps conversations with the system could commence. The Chair felt it might be one way of achieving better system governance.	**GK**
14	**SCAN Pathway Project Update** The Project Manager Planned Care attended for this item and presented Paper 17/80 providing an update on a new project for Oxfordshire. The SCAN Pathway was a new project for Oxfordshire in collaboration with OUHFT, NHSE Thames Valley Cancer Alliance, Nuffield Department of Primary Care Health Sciences, Cancer Research UK and Macmillan Cancer Support via the CRUK ACE Programme. An improvement had been made to the 2 week wait referral process across Oxfordshire with new mandatory forms to ensure 'right slot, first time' appointments but it became clear some patients did not fit specific criteria and the pilot was instigated to improve that pathway. The pilot introduced a new diagnostic pathway for patients with "low-risk but not no-risk" symptoms of cancer. Following GP 'direct access' tests there was a Multi-Disciplinary Centre (MDC) triage system offering the options of further GP management in primary care, further testing in secondary care or movement into the relevant treatment pathway, which should take no more than two weeks. The aim was to improve the patient experience by reducing time from first referral to diagnosis. It was hoped it would also relieve some of the demand on secondary care services. It was hoped there would be fewer overall investigations and patients would see the correct physician first time. Currently referrals from A&E were not being accepted but this might change in the future. A Care Navigator stayed with the patient through the pathway. Currently: • All Oxfordshire GPs had access to the pathway for their patients • The service was scanning 10 – 12 referrals per week and had seen a total of 112 patients (between 15 March and 27 October 2017) • 100% of patients had received a diagnosis within 28 days and only two patients with a cancer diagnosis needed to undergo additional imaging following a CT scan • The cancer conversion rate was 15% which equalled 17 patients • Feedback from GPs who had used the service was positive • There had been very positive feedback from patients who had used the service. The North LCD felt the meeting of the cancer targets since June 2017 should be acknowledged as a major achievement and noted that the SCAN pathway had played a significant part in that change.	

	The Oxford City LCD advised the cancer thresholds had been lowered which was why the 2ww cancer targets were met. **The OCCG Board noted the content of the paper.**	
Governance and Assurance		
15	**Safeguarding Update** The Director of Quality presented Papers 17/81a, the Oxfordshire Safeguarding Adults Board (OASB) Annual Report; 17/81b, the Oxfordshire Safeguarding Children Board (OSCB) Annual Report; and 17/81c, the Oxfordshire Children and Young People's Plan. The Director of Quality advised both the Annual Reports had been presented to the Quality Committee. The Children's Plan was a consultation for the period 2018 – 21. Any comments on the Plan should be passed either to the Director of Quality or directly to the Director for Children's Services at OCC. The Director of Quality advised the West Locality Clinical Director was the Board children's lead and more papers on children's services would be presented to the Board in 2018/19. The Lay Member (voting) queried whether the Annual Reports had been linked back to the Health and Wellbeing Board (HWB) strategy and the Director of Public Health Annual Report in terms of delivery on commitments. The Director of Quality advised there was some on-going work but that it was a good point and she would feedback to the Safeguarding Board. The Director of Quality advised the Annual Reports had been presented to the HWB. **The OCCG Board noted the:** • **Oxfordshire Safeguarding Adults Board Annual Report** • **Oxfordshire Safeguarding Children Board Annual Report** • **Oxfordshire Children and Young People's Plan.**	
16	**Emergency Preparedness Resilience and Response (EPRR) Annual Report** The Director of Governance presented Paper 17/82, the Emergency Planning Report, describing the emergency planning and response activities covering the period from November 2016 to October 2017 and sharing the outcome of the annual self-assessment process against the NHSE Core Standards for EPRR. The Director of Governance would circulate further information to the Lay Members on the requirements of a Lay Member given oversight of the EPRR function in OCCG. She advised the position would be different for OCCG as compared to provider organisations as OCCG was a Category 2 responder. **The OCCG Board:** • **Noted the EPRR Annual Report** • **Agreed to consider a Lay Member to have oversight of the EPRR function in the organisation once further information had been received.**	**CM**
17	**Corporate Governance report** The Director of Governance introduced Paper 17/83 which reported on formal use of the seal and single tender action waivers. It also included details of hospitality and declarations of interest. **The OCCG Board noted the Corporate Governance Report.**	
18	**Strategic Risk Register and Red Operational Risks** The Director of Governance presented Paper 17/84 and advised despite all the actions being taken across the whole system in critical areas, the three Red Strategic Risks and three Extreme/Red Operational Risks remained acute risks. These were systematic problems that the local health economy was struggling to manage and an indication of the stress that the NHS was under. The financial position was being managed in year but the ability to do this next year would be	

	even more challenging and there was a need to decide what level of investment might be required to improve performance.
	
	The OCCG Board noted:
	• **The recent updates to OCCG risks and the three Red Strategic Risks with a rating of 20:**
	  ○ **AF21 – Transformational Change**
	  ○ **AF19 – Demand and Performance Challenges**
	  ○ **AF26 – Delivery of Primary Care Services.**
	• **The review of risk 797, A&E Four Hour Wait, resulting in an increase to a risk score of 20 making it an Extreme/Red Operational Risk.**
	• **The two other Extreme/Red Operational Risks:**
	  ○ **789 – Primary Care Estate**
	  ○ **758 – Delayed Transfers of Care.**	

19	**Oxfordshire Clinical Commissioning Group Sub-Committee Minutes** *Audit Committee* The Lay Vice Chair as Chair of the Audit Committee presented Paper 17/85a, the minutes of the Audit Committee held on 19 October 2017. *Finance Committee* The Lay Member (voting) as Chair of the Finance Committee presented Paper 17/85b, the minutes of the Finance Committee held on 26 September 2017. *Oxfordshire Primary Care Commissioning Committee (OPCCC)* The Lay Member (voting) as Chair of the OPCCC presented Paper 17/85c, the minutes of the OPCCC held on 7 November 2017. He highlighted the issues around Horsefair Surgery acknowledging the work undertaken by the Director of Quality and her team, but advising the OPCCC had requested independent assurance that the action plan was comprehensive and robust. The Terms of Reference (ToR) for the Committee had been amended to remove the reference to the Primary Care Advisory Group as this group had been disbanded. The OCCG Board was asked to ratify the ToR. *Quality Committee* The Lay Member PPI as Chair of the Quality Committee presented Papers 17/85d and 17/85e, the minutes of the Quality Committees held on 31 August and 26 October 2017. The Lay Member PPI advised the Committee undertook a consistent piece of work on maternity services and particularly the stand alone maternity units. The Committee also received a number of pathway reports and it was important when reviewing these reports to look for gaps between services and there was a need to ensure the pathways were fully joined up. Sometimes issues were missed between services and mental health services. The Quality Committee was in a good position to investigate and should be mindful of the way people could fall between the various services. She advised children's issues were picked up through the Children's Board. **The OCCG Board noted the Sub-committee minutes and approved the amended Terms of Reference for the OPCCC.**	
For Information		
	Any Other Business There being no other business the meeting was closed.	
	Date of Next Meeting: Thursday 25 January 2018, 09.00 – 12.45, Jubilee House, 5510 John Smith Drive, Oxford Business Park South, Oxford, OX4 2LH	