NHS
Oxfordshire
Clinical Commissioning Group

MINUTES:

OXFORDSHIRE CLINICAL COMMISSIONING GROUP GOVERNING BODY

29 January 2015, 09.30 – 12.15 Beacon Centre, Wantage, OX12 9BX

Present:	Dr Joe McManners, Clinical Chair
	David Smith, Chief Executive
	Dr Stephen Attwood, North East Locality Clinical Director
	Dr Julie Anderson, South West Locality Clinical Director
	Dr Andrew Burnett, South East Locality Clinical Director
	Fran Butler, Practice Manager Representative
	Dr Miles Carter, West Locality Clinical Director
	Dr David Chapman, Oxford City Clinical Director
	Roger Dickinson, Lay Vice Chairman
	Diane Hedges, Interim Director of Delivery and Localities
	Gareth Kenworthy, Chief Finance Officer
	Dr Graz Luzzi, External Specialist Consultant
	Dr Jonathan McWilliam, Director of Public Health Oxfordshire
	Catherine Mountford, Director of Governance and Business Process
	Dr Paul Park, North Locality Clinical Director
	Duncan Smith, Lay Member
	Dr Louise Wallace, Lay Member Public and Patient Involvement (PPI)
	Sula Wiltshire, Director of Quality
In attendance:	Lesley Corfield - Minutes
Apologies:	John Jackson, OCCG Director of Strategy and Transformation/OCC Director of Adult Social Services

Item No	Item	Action
1	**Chair's Welcome and Announcements** The Chair welcomed everyone to the meeting and reported Diane Hedges had been appointed to the role of Director of Delivery and Localities and would formally take up the post in February. The Chair also welcomed back the South East Locality Clinical Director and thanked Amar Latif the Deputy Clinical Director for standing in during his absence. The Director of Quality read the Patient story and thanked the patient for their consent.	
2	**Apologies for absence** Apologies were received from the OCCG Director of Strategy and Transformation / OCC Director of Adult Social Services.	
3	**Public Questions**	

	The Clinical Chair invited members of the public to comment or ask questions. He noted that questions from Keep Our NHS Public had been received via the website. The question regarding co-commissioning would be addressed during the meeting whilst responses to the other questions would be put on the website within 21 working days.	
4	**Declarations of Interest** The North Locality Clinical Director, North East Locality Clinical Director, Oxford City Locality Clinical Director, South East Locality Clinical Director, West Locality Clinical Director and the Chair declared an interest in the Proactive Medical Support to Care/Nursing Homes item.	
5	**Minutes of Governing Body Meeting held on 27 November 2014** Subject to amending Item 12 to the effect that children's safeguarding was scrutinised at the Quality and Performance Committee rather than the Oxfordshire Safeguarding Children's Board (OSCB), the minutes of the meeting held on 27 November 2014 were approved as an accurate record.	
6	**Matters arising from the Minutes of 27 November 2014** The actions from the 27 November 2014 minutes were reviewed and updates provided where the item was not covered later on the agenda. *Public Involvement and Engagement* The Interim Director of Delivery and Localities reported on conversations taking place with Locality Fora Chairs and the work around differences between groups and where consistency was required. A table had been produced which could be shared but the Director of Delivery and Localities felt it would be better to report back when the work was concluded and a letter of intent describing the partnership between the Chairs and Oxfordshire Clinical Commissioning Group (OCCG) had been agreed. Public Involvement and Engagement to be a standing item on the agenda for the next and future Governing Body meetings. *Oxford University Hospitals Trust Board (OUHT) Meeting* The Director of Governance and the Associate Lay Member had attended the OUHT Board Meeting and a briefing circulated to the Governing Body. It was advised a rota for attendance at these, and the Oxford Health NHS Foundation Trust Board Meetings, had been set up with a director and lay member to attend each meeting where possible.	**LC**
Overview Reports		
7	**Chief Executive's Report including Locality Clinical Director Reports** The Chief Executive introduced Paper 15/02 updating the Governing Body on topical issues including: • Emergency care pressures which would be discussed further under Item 11, the Quality and Performance Report • The System Leadership Group was in place and involved the chief executives of the major organisations as well as the federations. Feeding into this Group were the System Resilience Group (SRG) which was looking at in year performance and the Transformation Board which would bring all the projects together in order to avoid disjointedness. Stuart Bell, the OHFT Chief Executive, would chair the Transformation Board • The Better Care Fund (BCF) Plan had been signed off by the Health and Wellbeing Board and submitted to NHSE. The result of the National Assessment was awaited but it was anticipated it would be approved • The Prime Minister's Challenge Fund offered £200m for projects in primary care. A bid for just over £4m had been submitted and some excellent innovation had been instigated by practices • A second area for primary care was the Infrastructure Fund. The money was specifically for items such as technology and extensions to practices. The submission date for bids was 16 February • New models of care: planning guidance had identified national funding to support new vanguard sites (now called forerunner). Applications needed to be submitted by 9 February. In addition the planning guidance	

	referenced two new garden cities at Ebbsfleet and Bicester. OCCG was working with GPs in Bicester to help frame a bid for this money. A query was raised around the amount of patient and public involvement in the Prime Minister's Challenge Fund bid and it was advised there had been a reasonable amount of involvement and Healthwatch had been involved in consultation on the bid. A successful bid would result in a huge amount of work and at that point more involvement would be required and the detail would be fleshed out. Some of the work covered by the bid had already commenced. The Chief Executive advised the work would continue whilst awaiting the announcement from the centre. The request from the Director of Public Health for an overview of pressures on A&E and primary care across the system would be picked up under Item 11, the Quality and Performance Report. **The Governing Body noted the Chief Executive's Report.**	
8	**Locality Clinical Director Reports** Paper 15/03 contained the Locality Clinical Director reports. Items from the reports were highlighted and these included: • The opportunity to plan the infrastructure for Bicester (garden city) linked to social care • The demand management education event evaluation, the benefits obtained when consultants attended and the need to engage practices when creating Local Incentive Schemes (LIS) • Emergency Medical Units (EMUs) being a priority within the BCF schemes • Extended opening hours evaluation. An escalation policy was being developed with a cross system approach. Initial thoughts had been shared with the Local Medical Committee (LMC).	
Strategy and Development		
9	**2015/16 Operational Plan Refresh Draft** The Chief Finance Officer presented Paper 15/04 on behalf of the OCCG Director of Strategy and Transformation/OCC Director of Adult Social Services providing a summary of the requirements and timetable for a refresh of the OCCG Operational Plans for 2015/16. A five year overarching plan and strategy with the first two years in detail had been agreed by the Governing Body in July 2014. This exercise was an update of those plans. There had been a number of key changes at local and national level. Locally the system Leadership Group, working with the Health and Wellbeing Board, had agreed work should be undertaken on a single plan for Oxfordshire. The System Resilience Group and Transformation Board would need to be reflected in the plans as a new way of working. In addition the Five Year Forward View and the Monitor consultation of the national tariff for 2015/16 would have a material impact for both commissioners and providers and the operational planning guidance for the NHS was announcing significant changes which would impact CCGs. Commitments and potential calls on the allocation still presented risks for OCCG. A £10.0m shortfall had been identified at this time which would need to be achieved by savings. The one per cent non-recurrent reserve resource would only be available if OCCG could manage the financial position through contract negotiations with providers. This was the first year of change to NHS funding. Further monies were expected in the next year. OCCG was expecting to have all contracts signed by the March Governing Body meeting. This would challenge whether the system was working together.	

	Some anxiety was expressed around the £10.0m savings as the QIPP plans for 2014/15 were only forecast to deliver £4.0m of £15.0m planned. The £10.0m needed to be delivered to enable the necessary transformation to take place. It was suggested OCCG should have a zero tolerance for meeting the 4 hour A&E target and the 18 week target needed to be a priority for the coming year. The Chief Finance Officer advised the £9.4m BCF transfer was an agreement of new funding to support adult social care services. This investment was required otherwise the hospitals would be affected. The savings schemes articulated in the BCF were intended to reduce non-elective admissions. The one per cent surplus was a requirement of the NHS operational planning framework for CCGs and while it could not be used in-year was normally returned the following year as a non-recurrent allocation, although for 2015/16 it was being restricted. **The Governing Body supported the development of a refreshed Operational Plan for 2015/16 as described in the body of Paper 15/04.**	
Business and Quality of Patient Care		
10	**Finance Report 2013/14** The Chief Finance Officer (CFO) introduced Paper 15/05 briefing the Governing Body on the financial performance of the CCG to 31 December 2014, the risks identified to the financial objectives, current mitigations and a most likely, best case and worst case forecast outturn against plan. OCCG was reporting an increased surplus in its forecast outturn due to another in-year allocation from the contribution made to the national risk pool for legacy provisions. £1.5m had been returned with a consequent move for OCCG from breakeven to £1.5m surplus. OCCG would work with NHS England on the effect this change in forecast outturn would have on next year's position. This was good news in-year for OCCG but as a non- recurrent benefit did not improve the recurrent underlying position. Cost pressures were on contracts and the prescribing budget particularly high cost drugs and devices. The Medicines Management Team was investigating the reasons for the over spend which centred on Lucentis and rheumatology drugs. Referrals were meeting thresholds however the Trust was addressing the backlog which would increase usage. OCCG was in negotiation with the Trust to bring the cost pressures down. The QIPP performance target was a stretch and aspirational. OCCG was attempting to deliver real impact this year in order to be in a better position for next year. The QIPP plans had not had the effect hoped for but this did not impact on in-year financial performance. Schemes were being taken forward to address red QIPP schemes and it was still intended to deliver savings but in a reframed way. CQUINs formed part of the overall contract deal made with OUHT as part of a semi-block contract. The process of setting and monitoring targets continued as normal at contract meetings. The agreement for this year effectively substituted for the CQUIN and provided an incentive to the Trust to manage within thresholds. **The Governing Body reviewed the information provided and the assurance received from the Finance and Investment Committee and accepted sufficient assurance existed that OCCG was managing its financial performance and risks effectively, risks identified could be mitigated and was on track to deliver its financial objectives.**	
11	**Quality and Performance Report** The Director of Quality introduced Paper 15/06 updating the Governing Body on quality and performance issues to date. The Report was designed to provide the	

Governing Body with assurance of the processes and controls around quality and performance. It contained analysis of how OCCG and associated organisation were performing. The report was comprehensive but sought to direct members to instance of exception.

The Director of Quality advised the current open contractual levers were: directly bookable services where the query remained open in order to obtain assurance the system was working; outpatient communication; 62 day wait for cancer; and the failure to inform GPs about follow-up on test results which was an issue of particular concern. The Governing Body were made aware OUHT had not responded to OCCG and a remedial action plan had not been agreed within the time extension and as a result fines could be applied. Patients in the south of the county could be referred to the Royal Berkshire Hospital (RBH) and OCCG was currently monitoring three areas of concern: data quality and data management; governance; and finance. A watching brief was in place to ensure there were no patient safety issues. Four 'never events' had occurred at OUHT and OCCG was working with the Trust to understand these events.

The Director of Delivery and Localities explained targets for planned care and urgent care were in the NHS Constitution and in view of concerns raised it had been felt a more detailed conversation on these two topics should take place within discussion of the Quality and Performance Report. More assurance was available in terms of tracking and performance delivery around planned care. There was some small deterioration in parts of planned care but most areas had met their targets. There was growing confidence these targets would be met in the expected timeframe. The numbers for 52 week waiters were visibly reducing. Some information on long waiters at RBH had been received and there was a need to ascertain whether any were Oxfordshire patients. The 62 day cancer target was a particular problem with urology and gastro in particular having a backlog. Oxfordshire was one of the failing areas in the country for cancer targets.

The Director of Delivery and Localities felt it was important to acknowledge there had been an exceptional increase in urgent care activity both locally and nationally. The target for A&E was for 95 per cent of patients to have been seen, treated and admitted or discharged with 4 hours. In Quarter 2 just over 94 per cent was achieved but this fell back to the eighties in Quarter 3. Building work which removed some seats in the Emergency Assessment Unit did have an impact. The quarter to date figure was 78.9 per cent and the year to date 90.6 per cent. There was a complex set of reasons why the Trust was not delivering and Oxfordshire being one of the highest levels of delayed transfers of care (DTOC) had not helped. The OCCG, OUHT and Oxfordshire County Council (OCC) Chief Executives had been requested to attend a meeting with the Secretary of State for Health and were tasked with delivering a 25 per cent reduction within two weeks and a further 25 per cent in the next two weeks (50 per cent reduction over a four week period). This would mean removing 86 patients in one month. There were still challenges in social care particularly in the ability to respond on domiciliary packages, reablement packages, and moving to community hospital beds. The action plan provided by the Emergency Care Intensive Support Team (ECIST) had now been received from the Trust and OCCG would work through the areas requiring management through the contract.

Despite the number of people working on urgent care it still had not been possible to define the reasons for not achieving the A&E 4 hour target or reducing the DTOC numbers. These were managed in other areas of the country which made it more difficult to understand the Oxfordshire situation. OCCG needs to be satisfied the numbers are being counted correctly. For instance, patients who wished to move to a community hospital near their home counted towards the

	DTOC figures but when moved elsewhere to wait for a bed to become available, were counted again. The A&E 4 hour wait target would not be achieved until the DTOC situation was resolved as many of the patients were waiting for a hospital bed. Risk aversion prevented patients being discharged unless certain assessments had been undertaken. The reluctance by clinicians to use the Choice Policy needed to be followed up. **The Governing Body noted the contents of the Quality and Performance Report.**	
12	**Proactive Medical Support to Care/Nursing Homes** The North Locality Clinical Director, North East Locality Clinical Director, Oxford City Locality Clinical Director, South East Locality Clinical Director, West Locality Clinical Director and the Chair declared an interest in this item and would abstain from the decision making process. The South West Locality Clinical Director was not a GP partner and therefore was able to take part in the debate and decision making process. The Vice Chair accepted the meeting chair for this item. The Director of Delivery and Localities presented Paper 15/07 and advised the basis for the proposal was to recognise the range of GPs currently working across different nursing homes and was an attempt to get to a more cohesive structure. It was believed the proposal to invest in medical support to nursing homes would provide savings in terms of reduced admissions. The whole system needed to help nursing homes manage care and admissions. The South West Locality Clinical Director observed there was a huge potential in savings as admissions were not in the best interests of the patient. A weekly GP visit would embed a care plan for each patient and provide crisis planning prior to a crisis occurring. Documented care plans would make staff feel safer and that the responsibility was shared equally. Some practices were already providing this model of care but it could be fragmented within care homes. The Director of Quality supported the direction of travel but felt some safeguards needed to be built in particular in anticipatory case planning. She advised the Mental Capacity Act law had recently changed and stressed the need to ensure clinicians were aware of the changes. Evaluation would also be required as well as independent feedback from the care home. It was advised the preferred model was for one practice to become aligned to a care home and be responsible for 70 per cent of the patients. Choice of GP practice would still apply for patients. The safeguarding issues were recognised and would be included in the service specification. OCCG would work with both the care homes and OCC, who have contracts with care homes, to ensure these were a lever to improve all round quality. Leaflets would be made available to patients, families and carers explaining the benefits of transfer from one GP to another. The Lay Member and Chair of the Finance and Investment Committee advised the Business Case had been through the Finance & Investment Committee who decided the case for investment had been made. It was commented there had been some disquiet in the GP community over the level of payment but it was advised these had been benchmarked and comparators were used. The release of possible savings from A&E attendances was raised. The Chief Finance Officer advised there would not be any cash releasing savings in year adding the challenge for the system was activity and the benefit to urgent care	

	and patient care outweighed savings in this instance. There were some concerns, particularly in Oxford City, where practices had three or four patients in each of the care homes which might result in reluctance by practices to take up the scheme. The proposal did not allow for two practices to join together. A duplication of payment would be avoided by ensuring a practice ended existing arrangements or was not part of one and this would be confirmed by the nursing home. An aligned practice would need systems to ensure a call from a nursing home was acted on in timely fashion in-hours. During out of hours it was felt clear proactive care plans should be in place which would by-pass the system and would go straight to the out of hours GP rather than to the 111 service. **The Governing Body gave approval to proceed and implement subject to the safeguarding concerns raised by the Director and Quality and to consider the suggestion of two practices supporting a care home.** The meeting chair was returned to the Chair.	**DH/JA**
Governance and Assurance		
13	**Primary Care Co-commissioning** The Chief Executive presented Paper 15/08 briefing the Governing Body on the options for co-commissioning primary care medical services. Currently primary care was commissioned by NHS England. The paper only related to GPs and no other areas of primary care. Three options were proposed: • Greater involvement in primary care decision-making • Joint commissioning arrangements • Delegated commissioning arrangements. Option 2 had been recommended. The question of conflict of interest had been raised at a national level and NHS England would be providing training for lay members over the next few months. **The Governing Body agreed to proceed with Option 2 and for NHS England to be informed of the decision.**	
14	**Oxfordshire Clinical Commissioning Group Constitution** The Vice Chair presented Paper 15/09, a revised Constitution for OCCG. All OCCG documentation would be reviewed as it was felt there was a lack of consistency and the involvement of GPs was not clear. In particular there had been a complete review of the Constitution which had been shared with all parties to achieve maximum buy-in. Some new items had been included such as the responsibility of the Chief Executive as the Accountable Officer and a section on joint commissioning. Approval of the document was sought following which it would be submitted to NHS England to review and check compliance with statutory obligations and ensure appropriate enactment of constitution. It was suggested and agreed, the holding of the Executive Directors to account was the responsibility of the Chief Executive not the Finance and Investment Committee. A question was raised around quoracy and operating procedures of locality meetings and the statement that an all practice meeting was quorate if 25 per cent of members were present. It was felt sensible to include items could be raised as a concern but would need to be taken way for further debate. It was noted that the second lay member for the Quality and Performance Committee had not been included. The Vice Chair to amend the document accordingly. **Subject to the amendments above, the Governing Body agreed the revised OCCG Constitution and that it should be submitted to NHS England.**	**RD**

15	**Corporate Governance report** The Director of Governance introduced Paper 15/10 which reported on formal use of the seal and single tender action waivers. It also included details of hospitality and declarations of interest. The Governing Body noted the Chair's Action requested at the January meeting had taken place. The Director of Governance apologised that the changes to the Declarations of Interest for the North Locality Clinical Director had not been made to the document. **The Governing Body noted the Corporate Governance Report.**	**LC**
16	**Assurance Framework and Red Operational Risks** The Director of Governance presented Paper 15/11 which included the Assurance Framework Executive Summary, the Red Operational Risks Executive Summary and Appendix C, the OCCG Assurance Framework Proposed Priorities for 2015/16. The full Assurance Framework and Operational Risk Register had been reviewed by the Integrated Governance and Audit Committee. It was noted that mitigations should be actions not comments on the current position. The Director of Public Health observed a risk around plague, famine, disease, etc, appeared to be missing from the register. It was confirmed the rating of risk 704 had been reviewed but not updated and the rating should be reduced. The Chair requested a check that the Primary Care Board was following up risk ID736. **The Governing Body noted the content of the Assurance Framework, the Red Operational Risk Register and the actions in place to address gaps in controls and assurance. The Governing Body also reviewed the proposed strategic risks for 2015/16 and agreed to accept these as a replacement to the current Assurance Framework.**	**CM**
For Information		
17	**Oxfordshire Clinical Commissioning Group Sub Committee Minutes** The Governing Body noted Paper 15/12 which shared the minutes from the October and November 2014 Finance and Investment Committee meetings, the September 2014 Integrated Governance and Audit Committee meeting and the October 2014 Quality and Performance Committee meeting.	
18	**Oxford University Hospitals NHS Trust Board minutes** The Governing Body noted Paper 15/13 sharing the minutes of the Oxford University Hospitals NHS Trust Board meeting held in November 2014. The Director of Governance and Associate Lay Member had attended the January 2015 meeting and reported there had been a lot of focus on the operational pressures and performance but very little around the challenges. The OUHT non-executive directors had challenged the performance. There was no focus on the contract performance notices but issues with targets were raised. The A&E discussion had been about how other organisations needed to deliver on actions to enable the Trust to deliver the A&E performance. An OUH NED had asked that the Trust identified the actions that the Trust was taking so delivery of these could be reviewed. Achieving the targets without compromising patient safety had been discussed with the Director of Quality.	
19	**Oxford Health NHS Foundation Trust Board minutes** The Governing Body noted Paper 15/14a and 15/14b sharing the minutes of the Oxford Health NHS FT Board meetings held in October and November 2014.	
20	**Older People's Joint Management Group minutes** The Governing Body noted Paper 15/15 sharing the minutes of the Older People's Joint Management Group meeting held in September 2014. The issue of obtaining more up to date minutes was raised and the Director of Governance would discuss the problem with the Vice Chair.	**CM/RD**
21	**Any Other Business** There being no other business the meeting was closed.	

	EXCLUSION OF PUBLIC On recommendation of the Chair, the Governing Body RESOLVED: "that to enable the Governing Body to consider business of a confidential nature, publicity on which would be prejudicial to the public interest, the public be excluded from the meeting in accordance with sections 1(2) and 1(3) of the public bodies (Admission to Meetings) Act 1960"	
22	**Date of Next Meeting: Thursday 26 March 2015, 9.30 – 12.45, John Paul II Centre, Henley House, The Causeway, Bicester, OX26 6AW**	