NHS
Oxfordshire
Clinical Commissioning Group

MINUTES:

OXFORDSHIRE CLINICAL COMMISSIONING GROUP BOARD MEETING

29 November 2016, 09.00 – 12.45 High Street Methodist Church, 40 High Street, Witney, OX28 6HG

	Dr Joe McManners, Clinical Chair
	David Smith, Chief Executive
	Dr Julie Anderson, South West Locality Clinical Director (voting) [from 09.40]
	Dr Stephen Attwood, North East Locality Clinical Director (voting) [from 09.20]
	Dr Andrew Burnett, 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)
	Roger Dickinson, Lay Vice Chair (voting)
	Diane Hedges, Chief Operating Officer (non-voting)
	Kate Terroni, OCC Director for Adult Services (non-voting) [until 12.15]
	Gareth Kenworthy, Director of Finance (voting)
	Dr Jonathan McWilliam, Director of Public Health Oxfordshire (non-voting) [absent between 12.15 and 12.45]
	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)
	Tony Summersgill, Deputy Director of Quality for Sula Wiltshire
	Dr Louise Wallace, Lay Member Public and Patient Involvement (PPI) (voting)
In attendance:	Lesley Corfield - Minutes
	Professor Sian Griffiths, Chairman, Health Inequalities Commission for item 12
Apologies:	Stuart MacFarlane, Practice Manager Representative (non-voting)
	Duncan Smith, Lay Member (voting)
	Sula Wiltshire, Director of Quality and Lead Nurse (voting)

Item No	Item	Action
1	**Chair's Welcome and Announcements** The Chair welcomed everyone to the meeting and welcomed Kate Terroni as the new Director for Adult Services and a permanent member of the OCCG Board. The Deputy Director of Quality read the Patient story and thanked the patient for their consent.	

	The Chair 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.	
2	**Apologies for absence** Apologies were received from the Practice Manager Representative, the Lay Member (voting) and the Director of Quality & Lead Nurse.	
3	**Public Questions** The Chair advised 40 questions had been received via the website. Due to the large number it would not be possible to answer the questions during the Board Meeting and written responses would be uploaded to the website within 20 working days of the meeting. The Chair invited questions from members of the public. Nine questions were asked and where appropriate would be answered during the meeting with a full response uploaded to the website within 20 working days. As an exception and due to the OCCG Board meeting being held in Witney, the Chair then invited the Chair Person of the Deer Park Medical Centre Patient Participation Group (PPG) to present their petition and to address the OCCG Board. The Chair Person of the PPG advised there was in addition an online petition which would be forwarded. The Chair advised Deer Park Medical Centre was not a substantial item for the OCCG Board but as Deer Park was mentioned in the paper to Item 11, General Practice in Oxfordshire; Board members would try to pick up some of the items raised at that time.	
4	**Declarations of Interest** There were no declarations of interest over and above those already recorded. All GP members of the Board had an interest in Item 11; as this paper was for noting all Board members could participate in the discussion.	
5	**Minutes of OCCG Board Meeting held on 29 September and 25 August 2016** The minutes of the meetings held on 29 September and 25 August 2016 were approved as an accurate record.	
6	**Matters arising from the Minutes of 29 September 2016** The actions from the 29 September 2016 minutes were reviewed and updates provided where these were not covered under items later on the agenda. *End of Life Coordination Centre* The South West Locality Clinical Director advised a bid had been submitted to Macmillan and a decision as to whether funding would be available was awaited. *Scheme of Delegation* The Director of Governance advised the Scheme of Delegation had been considered at the Audit Committee and a section was included in the Chief Executive's report. *Strategic and Operational Risks* The Oxford City Locality Clinical Director observed no actions had been attributed to the Risk item and thought a plan around how risks would be raised had been agreed. To be picked up under Item 19. *Science Vale Group* The South West Locality Clinical Director advised the Science Vale Group had been incorporated into the Oxfordshire Primary Care Commissioning Committee (OPCCC) although it also continued to exist virtually and there were on-going discussions around new services.	**JA**
Overview Reports		
7	**Chief Executive's Report** The Chief Executive introduced Paper 16/74 updating the OCCG Board on topical issues including performance against national targets, Quarter 2 Improvement and Assessment Framework meeting and Sustainability and Transformation Plans.	

The Report also included an item on the Scheme of Delegation and Reservation, Conflict of Interest Policy and Bribery Policy. The Audit Committee had reviewed proposed changes to the Scheme of Reservation and Delegation which were aimed at minimising ambiguity and bringing together rules for commissioning and contracting for primary care services, health care services and non-health care services. Following the publication of statutory guidance from NHS England in June 2016, the Conflict of Interest Policy has been updated to ensure compliance with the new requirements. The new Policy also includes a provision with respect to the publication of individual declarations of gifts or hospitality and a register has now been published. The revised Counter Fraud, Bribery and Corruption Policy had been updated to maintain compliance with the NHS Protect guidance and unnecessary information had been removed. The Audit Committee recommended and endorsed adoption of all three amended documents.

The Chief Executive explained there were 44 sustainability and transformation plan (STP) footprints and OCCG was part of the Buckinghamshire and Berkshire West (BOB) footprint. A draft plan had been submitted to NHS England (NHSE) at the end of October. Feedback had been received and a shortened version would be published over the next few weeks. The BOB plan had not been formally published but it had been released by Reading Borough Council on their website. The STPs were to address three gaps: inequalities; quality of services; and finances and across the whole footprint there was a need to save £405.0m. The STP would produce plans across the three areas. The Oxfordshire Transformation Plan would address areas within Oxfordshire where it was believed services needed to change locally.

The current discussions taking place with Oxford University Hospitals NHS Foundation Trust (OUHFT), Oxford Health NHS Foundation Trust (OHFT) and the GP Federations were at a very early stage. By 23 December 2016 OCCG needed to have signed contracts for the next financial year. Previously these contracts had not been signed until March or April but CCGs were under direction from NHSE to sign before Christmas otherwise an arbitration process would be undertaken. Due to the active discussions with the trusts it was not possible to go into the detail of the contracts at this stage but it would be possible to vary the contracts at a later date. It was not possible to hold up the placing of NHS contracts until after the consultation, which would be undertaken in two stages, as the contracts needed to be in place to ensure services for patients were secured. At this point contracts would be agreed on the current service models. It was anticipated there would be changes and the contracts would include clauses to allow them to be varied within year.

Responding to whether monies received for transformation would need to be passed through the BOB the Chief Executive advised for some services, such as some of the cancer services, it was felt Oxfordshire was too small a base and it would make sense to plan on a larger area. Over time it was considered monies could be channelled through the footprint but statutorily it would be OCCG who would decide how these monies would be spent. In future there might be a need to review the governance through the BOB together with the question of prioritisation as different areas would have different priorities. The Chief Executive, Director of Finance and Chief Operating Officer were leading the process but it was important for the Board to be sighted on the work being undertaken and there was a need to create time for the Board to review. The timing would be quite tight to agree the contracts before 23 December and it was likely to only be in the days before that the Board could be sighted.

The North East Locality Clinical Director expressed concern around portraying the current potential changes in service delivery as being like an American health maintenance organisation (HMO) model stating that currently the clinical

	interactions with secondary care were very 'monetised' and that OCCG was looking to work in a more integrated way between primary and secondary care. Citing diabetes as an example he reported on the working to provide an integrated way to deploy resources which was a different concept to the American style HMO. It was a more clinical model with clinical pathways being established first with the financial model being developed later to support these. This was integrated care using resources differently and was not about cuts. Clinicians felt this was how services should work. The North Locality Clinical Director commented the HMO was a standard model whereas the accountable care organisation (ACO) was a new model and the aim should be sharing financial risk in the system. **The OCCG Board noted the Chief Executive's Report and approved the Scheme of Delegation and the Conflict of Interest and Bribery Policies.**	
8	**Locality Clinical Director Reports** Paper 16/75 contained the Locality Clinical Director Reports. The North Locality Clinical Director apologised that there was an error in the fourth paragraph of his report (the word 'were' to be removed from the eighth line). The North Locality Clinical Director referred to the question raised around OCCG being out of step with the views of GPs in the north of the county. He commented there had been a great deal in the press around the views of the GPs and particularly on the issue of the Horton maternity services. The North Oxfordshire Locality Group (NOLG) was a group of north locality practices who met monthly to discuss issues. The NOLG was disappointed at what had happened at the Horton but it had been known for a while that the service was fragile and this had been discussed. The GPs were very engaged and understood the reasoning. A letter was sent to the Banbury Guardian but it was signed by a minority of GPs in Oxfordshire and many were not GPs in the north of the county. The West Locality Clinical Director advised serious consideration had been given by the three remaining practices in Witney and the other Practices in the Locality to offering services from the Deer Park site but unfortunately this was not possible as there were insufficient GPs to offer services due to problems with recruitment. **The OCCG Board noted the Locality Clinical Director Reports.**	
Strategy and Development		
9	**Oxfordshire Transformation Programme Update** The Chief Operating Officer presented Paper 16/76 setting out the three core areas to demonstrate the case and seek approval for formal public consultation. The paper provided the latest segments of work undertaken within the Oxfordshire Transformation Programme which would form part of the pre-consultation business case (PCBC). The Case for Change document laid out why there was a need to make changes. Demand for services was increasing as the population increased and lived longer. The current workforce model was not sustainable and there were significant gaps across all professions in recruiting and maintaining staff in the NHS and social care. There were a number of areas where the quality of services needed improvement and an inconsistent level of service standards. Rather than treating people once they became ill, more resources should be provided for prevention work. Much of the system infrastructure and buildings were inadequate and inequalities existed across the population. When all these factors were added together the amount of money available was not sufficient to address all the needs which necessitated the need for transformation and changes to services. The Transformation Plan was still subject to approval from NHSE but assuming	

this was given the first part of consultation would be in January and the second part would take place after the Council local elections.

The Chief Operating Officer advised the action required by the Board was set out on page two of the front sheet. The consultation was subject to clearance from the Clinical Senate for the clinical proposals and NHSE. The Board were being asked for approval to move to a public consultation subject to review of the PCBC in part two of the meeting. At the moment the public consultation would be around one set of services and not the entire transformation proposals. No decisions had been made or were implied. Some preferred options, which it was believed were the best way to deliver services eg stroke services, were proposed as well as changing to different models.

The Scope document set out the proposed method in terms of the phased approach for formal consultation with the public but OCCG was the statutory body charged with undertaking the consultation. Those services where there was the greatest risk due to work force or where changes were already in place would be included in the first phase of the consultation.

The obstetric cover for the county needed careful consideration and this would include the maternity led units (MLUs) in both Chipping Norton and the Horton. The obstetrics change at the Horton was predominantly around whether the unit could be safely staffed. The Chipping Norton MLU was an excellent unit but more than twice the tariff was spent on each birth. As a result the obstetric issues were due to safety in one area and resources in another. The issues across the county were not straightforward

There were many services in the community (first aid unit (FAU), minor injuries unit (MIU) and the new GP access services) which had grown in isolation and there was a need to consider how these services could be brought together. There was a need for a two phased approach as the breadth of community services, the strengthening of primary care services, the interface, the bed base in support, and the level of engagement required meant OCCG was not at a point where this could be taken in the first phase. The proposal was to consult on the securing of patient services and formalising those areas where changes had been implemented on a temporary basis.

Points of discussion included:

- One problem of a two phased approach was the very reason for questions from the audience; the scale of the problem across the system could not be grasped. Producing one section rather than the whole could lead to the potential for people to believe continuing existing services would not cost a great deal more whereas if they had the full picture the need for change would be understood. A two phased consultation would make transformation more difficult
- It was difficult to articulate the case for change in stroke services when only considering the acute stroke services. The rehabilitation pathway was the major part of the service. Although the difficulties were understood, it did not make a lot of sense to split the consultation into two parts
- The points were well made but it was clear the second part of the consultation needed to look at the community hospitals, bed based services and different models of care. Significantly more time to consider and look at the models was required as ultimately this had to be about what happened to a patient in a particular area and what was best for them. Those models needed to be developed. Although not perfect the two phased approach was supported as it was necessary to have sensible realistic models that worked for people. Time to work these up was

required

- A move to a two phased approach was a real cause of concern. Only became aware of the sentiment raised by the MPs last night whilst was aware of the GPs concern and the letter from 45 GPs. Accepted these were not all NOLG GPs but the feeling was around the use of the Horton hospital. Patients do not consider which county they are in when they become ill; they just go to where services are available. Remain unconvinced about the two phased approach particularly around how services would interdigitate. The approach was strongly objected to
- It would not be possible to consult on everything in January which would mean deferring the whole consultation until May. Believe it is better to undertake the consultation in two stages. If being serious about consulting and listening to public needs OCCG should be clear around the purpose and it not being just about local services. The public were asking to have a say and be listened to and this would be easier in two stages
- Delaying the consultation until May would result in real risks around stroke management. It would raise the question of whether clinicians would wish to wait another six months during which patients would not be receiving the best services. Significant disappointment had also been expressed that the process was not moving faster to enable the whole consultation to begin in January. Discussion had taken place at the Health Overview and Scrutiny Committee (HOSC) meeting on 17 November and HOSC had taken a unanimous view for the consultation to be in two phases. Absolute clarity could not be given on when decisions would be taken because it was dependent on the responses to the consultation. However, there might be discrete areas where a decision could be taken following the phase one consultation and prior to completing the phase two consultation.
- HOSC discussed the consultation a number of times and were keen for the proposed changes to be known without further delay. Although some reluctance was expressed it was felt the consultation should be undertaken in two parts.

The Director of Public Health clarified that he and the Director for Adult Services were officers of Oxfordshire County Council (OCC). They were non-voting members of the OCCG Board to work with the CCG to join up health, social care and public health. It did not imply assent or support by councillors or the county council to the proposals. OCC would be a consultee.

The Chief Operating Officer advised NHSE would rely heavily on feedback from the Clinical Senate which was expected that week. Support for the clinical models from the Senate would be required before looking at workforce assumptions, finances and sustainability. There was a suite of key lines of enquiry around the PCBC which were being reviewed and a session would take place with NHSE on Monday 5 December with a view to expecting to hear mid-December if the move to consultation on phase one was supported.

The Chair advised the Case for Change included information on the financial pressures and service changes required due to funding received not being sufficient to meet the need and it was in this context OCCG was undertaking transformation.

The OCCG Board:

- **With an objection from the Lay Member PPI, approved the proposed Case for Change and public Consultation Scope**
- **Approved the proposed Consultation Plan**
- **Noted the remainder of the PCBC sign off would be undertaken in the**

	Part II session of the Board meeting • **Agreed, subject to NHSE approval, the launch of a public consultation in early January for 12 weeks** • **Agreed delegation of the finalisation of the public consultation document to the Chief Executive** • **Noted no decisions on substantial service changes would be made until consultation had ended and the proposal were reviewed in the light of the consultation responses.**	
10	**Operational Planning** The Director of Governance presented Paper 16/77, a first draft of the Operational Plan submitted to NHSE on 24 November 2016. The Final Operational Plan would be submitted on 23 December 2016. The Operational Plan reflected the commitments outlined in the BOB STP, the commissioning intentions agreed for 2017/18 – 2018/19 and the Oxfordshire Transformation programme. The same framework had been used as in the previous year and an attempt made to keep the document shorter by referring to other documentation in an appendix. The Operational Plan connected with the transformation work but at present contracts would need to be based on current service delivery. The Director of Finance made the link between the Case for Change, Operational Plan and savings plan by referring to the summary of the draft financial plan and key financial assumptions on page 25 of the document. OCCG had been notified of the allocation growth for the coming years; £14.6m in both 2017/18 and 2018/19. This represented 2 per cent uplift on OCCG resources and was the minimum level of growth for CCGs nationally. Demographic growth was expected at 0.8 per cent but there was also growth in other areas and demand was hugely in excess of the pure demographic change. A&E had increased year on year by 4 per cent and referrals by 5.5 per cent. If this continued there would be a clear affordability gap going forward. The net QIPP savings was basically the gap in savings the CCG needed to find and to balance books this was £20.0m. The South East Locality Director commented non-demographic growth was also a factor. There had been improvements in clinical practice resulting in better care for patients but more referrals to hospital: deaths were prevented but the cost of treatment increased. The Director of Governance would ensure the Health Inequalities Commission recommendations were included. The Lay Vice Chair reported on behalf of the Lay Member (voting) that the Finance Committee had debated the Operational Plan at its last meeting. A major concern had been around the QIPP and whether it could be delivered. Past experience showed only a small fraction of the savings were achieved. Even if schemes commenced quickly most of the benefit would not be realised until later years rather than in year. The Finance Committee felt more work needed to be undertaken to mitigate any shortfall in the QIPP. The Director of Finance agreed with the Finance Committee observation acknowledging the high risk in terms of plan delivery. He added this highlighted the impact of any delay in implementing plans and the direct financial impact. The Chief Executive commented on the outcomes from the Right Care work advising top quality practice could remove cost from the system as well as preventative work and implementing changes quickly. There was a need to close the financial gap and a later paper on the agenda around the savings taskforce would highlight the challenge. **The OCCG Board:**	**CM**

	• **Approved the OCCG priorities for 2017/18 – 2018/19** • **Noted the progress on the development of the 2017/18 – 2018/19 Operational Plan** • **Endorsed the approach taken to develop the Operational Plan** • **Agreed delegated authority to the Chief Executive and Executive Directors to sign off the final Operational Plan for submission on 23 December 2016.**	
11	**General Practice in Oxfordshire** The Chief Operating Officer presented Paper 16/78 highlighting the high performance of General Practice in Oxfordshire whilst recognising the pressures faced. The Paper detailed actions taken and looked at the background, vision, programme of work and outlined the development of a new model for sustainable primary care. The Chief Operating Officer commented on the need for the OCCG Board to set the strategic tone for general practice. To assist with assurance the cycle of meetings for the Oxfordshire Clinical Commissioning Committee (OPCCC) had been changed to enable papers to the OPCCC to be brought to the Board. The Paper laid out the strategic direction whilst being aware primary care was the corner stone for delivery of services and the foundation stone which was becoming very fragile, it moved on to the practicalities and mentioned the loss of practices and clarity around providing services. The Paper did not go into any great depth around a solution but laid out the direction of travel. More detail would be obtained through the Locality meetings in December which would firm up the strategic direction. OCCG had gone out in good faith to reprocure a service at Deer Park Medical Centre and a great deal had been learnt through the process. There had only been one bidder who had not met the specification even though the contract had been funded 13 per cent more than a GMS practice. It had been a hard decision to make and it was difficult for patients but small practices were a challenge. It was agreed the specification for the reprocurement at Deer Park would be uploaded to the OCCG website. The bid could not be released as OCCG was bound by procurement law. It could only be released if the bidder gave permission to do so. The Oxford City Locality Clinical Director suggested the discussion was slightly premature as the Paper had not yet been taken through the Localities. He believed the new model of vision for primary care had omitted the quality of primary care and this should be included before the Paper was reviewed in December. He also felt the risk issue had not been addressed particularly the very clear risks around primary care collapsing. He noted the issue had been discussed in the OPCCC minutes but felt a paper should be brought to the Board as 13 per cent above APMS had been paid for Deer Park and if GMS practices collapsed a minimum 13 per cent premium would be required for primary care. Figures around how this risk would be addressed were required. The GP Access Fund (GPAF) brought in £6.00 a head but this only provided the seven day working, which was already available in out of hours, rather than addressing the issues of the sustainability of primary care. A paper that seriously addressed the problems in primary care and how primary care was funded was required. The North Locality Clinical Director observed OCCG had bid successfully for the GPAF which a number of other counties did not have. The GP access hubs had been very helpful and the primary care visiting service was very good. He agreed the Paper did not provide a robust solution on how to fix General Practice but it did try to address the significant issues.	**DH**

	The South East Locality Clinical Director stated clearly there was a massive difficulty in general practice which was not as a result of the CCG but had arisen over several years. The issues could not be fixed immediately. OCCG was trying to do its best to improve facilities across Oxfordshire but 'shuffling the pack' might make stable practices unstable. There was also a need for caution as some of the proposals could dis-incentivise working in General Practice. Localities would require different solutions: what would work in the south east would not work in Oxford City; but the fixing of one area must not destabilise another. The North Locality Clinical Director felt General Practice was idiosyncratic. Although nothing should be done to destabilise primary care he felt some areas of the county would be happy to 'shuffle the deck' and it might be possible to try out ideas that had worked in other areas of the country to provide better, more sustainable primary care and a better work/life balance. The Lay Vice Chair advised the OPCCC generally agreed with the points raised and was aware of the issues and risks to GP practices falling over. The concern was around support and whether it might be possible to have within OCCG a rapid response group which could assist in sorting out mechanisms within practices to help resolve issues and work through problems, perhaps with some additional external support. There was a very hard working team in OCCG but it needed more capacity. The Chair commented primary care was one of the biggest risks for OCCG with some areas hitting crisis point. There was a need to consider a response and how this should be taken forward. There was an OPCCC meeting in early January and the Chair suggested the Committee should have an action plan looking at the longer term and that the action plan should also be brought to the January OCCG Board. OPCCC would need to be mindful of conflicts of interest and the OCCG Board would have overall strategic responsibility and risk management. There was also a need for the right level of GP and patient involvement over the next few months. The Chair requested an update at the next OCCG Board. The Chief Executive felt the OPCCC meeting should address the risks specifically as well as considering the resource issue; level of funding, how much primary care required, the areas of spend; and stressed the need for a conclusive discussion. **The OCCG Board noted the paper and work programme.**	**DH**
12	**Health Inequalities Commission Report** The Chair introduced Paper 16/79, the Health Inequalities Commission Headline Report, and invited Professor Sian Griffiths, Chair of the Health Inequalities Commission, to the table. The Chair explained the Oxfordshire Health and Wellbeing Board (HWB) had commissioned a report on health inequalities and Professor Griffiths had been appointed as an independent chair. Professor Griffiths advised reducing inequalities was not an option but a requirement for the CCG and should be considered in every aspect of work; in the longer term addressing inequalities when planning services could result in savings. The Commission had held public consultation sessions around the county and evidence had been taken from local authorities, health, acute, general practice and lay members. The objectives were to raise the profile of inequalities, to inform strategic planning and for people to use the report. The Commission had a set of five common principles to address health inequalities: • The profound influence and impact of poverty on health needs to be widely recognised and systematically addressed • Commitment to prevention needs to be reflected in policies, resources and	

prioritisation
- Resource re-allocation would be needed to reduce inequalities
- Statutory and voluntary agencies needed to be better co-ordinated to work effectively in partnership organisations using the Health in All Policies approach
- Data collection and utilisation needed to be improved for effective monitoring of health inequalities.

The cross cutting themes were:
- Access
- Housing and Homelessness
- Physical and Social Health and Wellbeing
- Mental Health
- Issues Relating to Rural Communities

The Headline report ended with the Kings Fund analysis around the economic impact of investment in the social determinants of health (Appendix 1).

Professor Griffiths thanked the commissioners, Alison Thorpe and the Director of Public Health and his team for all the help provided in producing the report.

The Lay Member PPI felt it was a good, thorough and far reaching report but expressed surprise it did not contain anything on breast feeding. Professor Griffiths advised the data available did not indicate breast feeding rates had varied, it had not been an issue which stood out nor was it a social gradient. The report had been based on the evidence available. The Lay Member PPI suggested data could be collected by practice which might indicate social gradients. In addition there were services which collected data on breast milk feeding and she felt more could be undertaken in this area.

The Oxford City Locality Clinical Director reported being very aware of inequalities as across Oxford city there was an eight year longevity difference from one side to another. Services such as language line and drug and alcohol use varied greatly but the funding was the same for each and consideration should be given to funding streams. He felt it was an excellent report and suggested there was a lot the CCG could do if it was serious about addressing these issues.

The Director of Finance noted the comment in the narrative on page 21 of the report which linked to recommendation 37 and 39 and advised OCCG received the lowest allocation per head of population. As a consequence the relative spend could be expected. In addition other areas, such a prescribing, were also benchmarked very low when compared to other parts of the country.

Professor Griffiths remarked on the need to push for greater intervention commenting OCC could drive prevention in the secondary care sector and any contact with a patient could be a preventive intervention as evidence showed doctors were still the best method for dispersing information. The Commission had tried to make the report as evidence based as possible and would have liked more information on acute services but it had not been possible to obtain the evidence or data. This had been the same situation with black and ethnic minorities where engagement on the Commission and representation at evidence sessions had not been as broad as would have been wished.

The Medical Specialist Adviser commented an advantage of an English based accountable care organisation could be the ability to work together to improve services and benefit patients. Commitment would be necessary as it was not possible to turn processes around quickly and some areas might need a 10 – 15

year investment.

The Director of Public Health advised the report had been well received at the HWB meeting. The shift to prevention was sensible but would take time and had long financial horizons. OCCG would need to make difficult decisions and perhaps find some monies for prevention to supplement OCC otherwise the prevention work would be under threat. The resource allocation was the issue and monies would have to come from other areas. He queried how much prevention and inequalities were included in contracts and whether it might be possible to tighten up this area. The Director of Public Health thought the actions required of the OCCG Board were a little soft and felt there should be a commitment to bring a specific report back to the Board in six months' time.

The Chair remarked on the agreement for work around prevention and inequalities and the need to think to the future and the longer term. Health inequalities and prevention were both on the agenda for the Board Workshop in December to consider an action plan and work to be undertaken. The Director of Public Health would be attending to talk about commissioning for prevention. The Chair endorsed the action to bring an action plan back to the HWB and agreed the OCCG Board should commit to bringing an action plan back in six months if not before. Key to bringing something back would be ownership by leaders around the table and the Chair felt there should be some clinical leadership from OCCG.

The Chief Executive echoed the comments but was less positive about the ability to implement as these were really difficult issues which would be hard to resolve. In order to address inequalities there was a need to move resources and OCCG was not very good at tackling this hard issue. Many of the recommendations were around how the statutory organisations worked together on the inequalities agenda. The Chief Executive expressed some concern the whole system had the necessary level of joined up responsibility across system. He felt the challenge would be how the organisations worked together and unless this could be resolved the health inequalities agenda would not be delivered.

The Oxford City Locality Clinical Director observed there were some actions which could be undertaken fairly easily. The money released from the change from personal medical services contracts was supposed to be used to address inequalities. There were many elements within social prescription which could be co-ordinated, better and more integrated.

The OCC Director for Adult Services advised a small example of current joint working was under the Health Improvement Board on homelessness where there was a joint commissioning strategy.

Professor Griffiths advised the full report contained examples of initiatives in the county and admitted it was a challenge to do things differently. She raised the question as to whether large employers were doing their part in the community commenting public debate was essential together with understanding much of the work could be undertaken in the community.

The Director of Public Health acknowledged the point regarding working with others but stressed this should not be used as an excuse for individual organisations to shelter in the partnership. Communication was important and if the issues were difficult and could not be addressed or the resource allocation could not be changed, it would be important to communicate the fact. The Director of Public Health felt if the work was not brought back to the OCCG Board it would not work at the HWB either.

The Chair observed there were many things which could be undertaken but some

	would take time and effort. There were some priorities which OCCG should commit to even though they would not be easy. The Chair stated a report must be brought back to a Board meeting and the Board should commit to looking at all areas, to having a response and to be specific on those areas where nothing could be done. Professor Griffiths advised the overarching group being formed by the Director of Public Health would be reporting back to the HWB. She felt it would be good if the momentum and engagement with all organisations could be maintained. The problems would get worse and Oxfordshire needed to ensure it could cope. The Economic Unit within NHSE had produced some documentation around health inequalities. The official launch of the Health Inequalities Commission Report would take place at Rose Hill Community Centre on 1 December 2016. **The OCCG Board noted the Health Inequalities Commission Report and would consider the recommendations at the Board Workshop on 13 December 2016. A follow up report outlining how OCCG would take this forward would be presented to the Board in May/July 2017.**	**JMcW**
Business and Quality of Patient Care		
13	**Finance Report Month 7** The Director of Finance presented Paper 16/80 providing the financial performance of OCCG to 31 October; 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 Director of Finance reported OCCG was on track to deliver its financial plan, the risks remained as previously and the Month 7 reported position, identified risks and mitigations and progress against the Financial Recovery Plan (FRP) had been reviewed by the Finance Committee at its November 2016 meeting. **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.**	
14	**Financial Recovery Plan (FRP) including Savings Taskforce Update** The Director of Finance introduced Paper 16/81 explaining the document was 'work in progress' and would remain so given the context of the financial challenge. The Board was asked to discuss and agree the themes and approach. The Director of Finance advised the Paper linked with other papers on the savings challenge. The minimum savings required had been identified as £20.0m although this figure would change as OCCG went through the contract negotiations with the main providers. Savings opportunities of £17.0m had been identified. There was a range of benchmarked areas identified for savings which were of a higher risk. Some of the schemes included in the £17.0m were more developed than others. If these were risk assessed the figure would decrease. There was now a need to transform the opportunities into hard deliverables. The first group identified were the transactional savings which were based on benchmarking to comparable organisations and included such items as savings through the Activity Planning Assumptions (APA) process; other commissioning budget reductions; savings related to compliance with Clinical Commissioning (Lavender) Statements; reviewing existing thresholds in Lavender Statements; and reductions in OCCG running costs. The other themes for savings were Right Care; prescribing; procurement; decommissioning; and improved engagement in primary care and secondary care	

	to reduce activity. The South West Locality Clinical Director remarked it was known some increased activity was due to a desire to improve quality but this was not necessarily best for patients and services could be improved by doing less although there would be a need to be able to justify this assertion. There was also a need to learn to work at speed and radically change methods of operation if OCCG hoped to address even a part of the deficit; to become more comfortable talking to the public at an earlier stage as the longer it was left the more the distrust arose; and conversations should start with the public and member practices to gather information and garner ideas around other possible actions that could be undertaken should the OCCG proposals not be accepted. The Chief Operating Officer thought there would be a need to bring forward some engagement timelines relating to waiting lists in the Integrated Performance Report. Some of those waiting lists were areas being put forward as potentially less valuable whereas the providers required more money to address the issues. The Director of Governance queried when engagement with HOSC would commence and the need to be more specific around the engagement taking place over the next month. The Lay Member (non-voting) stressed the need to make the connection with the contract round and the agreement of contracts in December as the Finance Committee had been comfortable with the approach and themes but there was a lack of assurance on the ability to contribute to savings. This would lead to reliance on the contract negotiations to make up the difference. Until the outcome of the negotiations was known, the Finance Committee was unable to provide more assurance around the plan. The Director of Finance reported there were two options: to undertake contract negotiations and resolve as much as possible through those negotiations whilst trying to cap the contract and transfer some financial risk; if this was unsuccessful there would be a need to further extend the transactional savings which would be counter strategic but OCCG would have no option if it held the financial risk. The Chief Executive commented that he was not surprised at the Finance Committee view point and in many ways this did not differ from the position in previous years. He cautioned the Board not to become fixated on the £20.0m figure as this was not the limit of the savings required. At the end of the contract negotiations the savings figure was likely to have increased. The contract negotiations would not close the financial gap. Changes around sensitive areas would be required and those areas where consultation would be required would delay the process. Any significant change in service delivery would need discussion with HOSC and to come back to the Board which from a timing perspective could be difficult. The South West Locality Clinical Director believed if OCCG could demonstrate to HOSC more consultation with GPs and members had been undertaken, the process might proceed more smoothly. **The OCCG Board agreed the direction of travel and proposals.**	
15	**Integrated Performance Report** The Chief Operating Officer introduced Paper 16/82 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. The Chief Operating Officer reported A&E was red rated but a joined up improvement plan had been received and was attached as an appendix to the Paper. An impact had been seen from improved management of the minors' pathway by the Trust and better diagnosis of the workings of the A&E department had resulted in considerable improvement. NHSE and NHS Improvement (NHSI) were concerned with performance but a summit around the emergency department and planned care referral to treatment (RTT) had gone well. OCCG had committed to providing support for some of the backlog work. The Chief Operating Officer advised on the need to update the Chief Executive's Report as an updated plan had been received and it was not anticipated the RTT target would be achieved until March 2017. Although this was disappointing it was a much better plan. Recovery of the cancer target was expected in January 2017. Also attached as an appendix to the Report was a paper on ambulance response times. South Central Ambulance Service (SCAS) was the highest performer in the country but the specifics showed SCAS performed well in Red 2 whilst there were issues with Red 1. Responding to a query the Chief Operating Officer advised there were increases in the A&E figures for the John Radcliffe, Horton and South Northampton but they were not a large outlier. The Chief Operating Officer reported there had been improvements in diagnostics and challenging conversations around OUHFT not meeting their targets were continuing. In the short term the trust was seeing more outpatients who did not require ongoing procedures. This raised the question as to whether this would cause a problem in the next year. The Medical Specialist Adviser observed this would cause problems with RTT and that it could take up to a year to get the RTT numbers back on track. The Chief Operating Officer advised discussions were still taking place around the models and there was a need to resolve situations more quickly between OCCG and the hospitals. The Deputy Director of Quality advised there were still issues with outpatient communication and the trust had not achieved any real improvement over the last six months. A deep dive had been undertaken and a new plan was expected at the December Quality Review Meeting (QRM). **The OCCG Board noted the Integrated Performance Report.**	
Governance and Assurance		
16	**Safeguarding Update including Oxfordshire Safeguarding Adults Board (OSAB) Annual Report and Oxfordshire Safeguarding Children Board (OSCB) Annual Report** The Deputy Director of Quality presented Paper 16/83 updating the OCCG Board on safeguarding issues and the Annual Reports for the Oxfordshire Safeguarding Adults (OSAB) and Oxfordshire Safeguarding Children Boards (OSCB). The Lay Member PPI reported the Quality Committee had received the OSAB and OSCB Annual Reports and there were a number of good indicators of progress. The Quality Committee felt the OCCG Board should be aware of and see the Reports. The Quality Committee commended both Reports to the Board. The Deputy Director of Quality believed it was a good example of joint working. The Oxford City Locality Clinical Director was pleased to note a fuller OSAB Annual Report than previous years. **The OCCG Board noted the Safeguarding Update Report, the Oxfordshire Safeguarding Adults Board Annual Report and the Oxfordshire**	

	Safeguarding Children's Board Annual Report.	
17	**Emergency Preparedness Resilience and Response (EPRR) Annual Report** The Director of Governance presented Paper 16/84, an update and Annual Report on EPRR for the period from November 2015 to October 2016. The Paper also shared the Improvement Plan which had been developed following the annual self-assessment process against the NHSE Core Stands for EPRR. A discussion around responsibility for primary care had been held with NHSE and this would be reflected in the Annual Report next year as well as considering what this meant in terms of responsibilities and capacity. **The OCCG Board noted the Emergency Preparedness Resilience and Response Annual Report and Improvement Plan.**	
18	**Corporate Governance report** The Director of Governance introduced Paper 16/85 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.**	
19	**Strategic Risk Register and Red Operational Risks** The Director of Governance presented Paper 16/86 advising it was the standard report and she would pick up the earlier challenge around how the report was used and whether risks were being adequately reflected. She explained Strategic Risks were those which would completely hinder the ability of the organisation to deliver against its strategic objectives whilst Operational Risks were more focused on individual issues and she would consider whether these were reflected properly. She felt the organisation was better at identifying risks but needed to improve the mitigations and more work would be undertaken around addressing this. This still required some thought and there was a need to ensure papers showed connection to and how risks were being addressed. The agenda for the meeting showed the risks were being picked up but this was not reflected in the papers and there was a need to make those connections. The Medical Specialist Adviser had expected there would be a separate risk around the service for Deer Park patients from March 2017 and queried whether this was being addressed. The Director of Governance advised the Board did not receive the full Operational Risk Register, which was reviewed in other areas, but there was a specific risk on the Operational Risk Register presented to the OPCCC. The Chief Operating Office assured the Board the list was being dispersed and OCCG was working with the practices in West Oxfordshire. There were enhanced services in place and a comprehensive range of resources. The Director of Governance suggested two options to ensure Risks were being properly reflected. Either the risk item could be brought forward on the agenda or extra boxes could be included in the Board paper front sheet for completion. **The OCCG Board:** • **Noted the content of the Strategic Risk Register and the Red Operational Risk Register** • **Approved the new strategic risk AF26, Delivery of Primary Care Services** • **Noted the increase in Strategic Risk AF19, Demand and Performance Challenges, from 16 to 20** • **Noted that Strategic Risk AF21, Transformational Change, remained an Extreme risk** • **Noted that Operational Risk 731, Urgent Theatre Cancellations, had increased in rating from 8 to 16 and was now a High risk** • **Noted that two Operational Risks 735, OUH Test Results, and 769,**	**CM**

	Primary Care Capacity, remained Extreme risks.	
20	**Oxfordshire Clinical Commissioning Group Sub-Committee Minutes** *Audit Committee* The Lay Vice Chair as Chair of the Audit Committee presented Paper 16/87a, the minutes of the Audit Committee held on 20 October 2016. *Finance Committee* The Lay Vice Chair presented Paper 16/87b, the minutes of the Finance Committee held on 20 September 2016 and advised a meeting had taken place last week but the minutes were not yet available to circulate. *Oxfordshire Primary Care Commissioning Committee (OPCCC)* The Lay Vice Chair presented Paper 16/87c, the minutes of the OPCCC meeting held on 6 October 2016. The Chief Operating Officer undertook to check the rise in A&E attendance mentioned in the minutes. *Quality Committee* The Lay Member PPI as Chair of the Quality Committee presented Paper 16/87d, the minutes of the Quality Committee held on 27 October 2016 and highlighted the red risk concerning discharge summaries advising this had been an on-going issue and there was a continuing need to address. The Deputy Director of Quality advised the trust had accepted there were issues around having consistent and sustainable processes but OCCG was hopeful there would be some changes this time. **The OCCG Board noted the Sub-committee minutes.**	**DH**
Papers for Ratification		
21	**CCG Executive Terms of Reference** Director of Governance presented Paper 16/88 advising minor changes had been made to the CCG Executive Terms of Reference. The Lay Vice Chair observed the remit did not include work around the BOB STP or the joint commissioning Section 75. **Subject to including reference to the BOB STP and joint commissioning Section 75 in the remit of the CCG Executive, the amended Terms of Reference were approved.**	**CM**
For Information		
22	**Any Other Business** There being no other business the meeting was closed.	
23	**Date of Next Meeting: Thursday 26 January 2017, 09.00 – 12.45, Jubilee House, 5510 John Smith Drive, Oxford, OX4 2LH**	