NHS
Oxfordshire
Clinical Commissioning Group

MINUTES:

OXFORDSHIRE CLINICAL COMMISSIONING GROUP BOARD MEETING

30 March 2017, 09.00 – 12.45 John Paul II Centre, Henley House, The Causeway, Bicester, OX26 6AW

	Roger Dickinson, Lay Vice Chair (voting) – Meeting Chair
	David Smith, Chief Executive (voting)
	Dr Andrew Burnett, South East Locality Clinical Director (voting)
	Dr Miles Carter, West Locality Clinical Director (voting)
	Dr David Chapman, Oxford City Clinical Director (voting)
	Mike Delaney, Lay Member (non-voting)
	Dr Shelley Hayles, North Deputy Locality Clinical Director (voting) [for Paul Park]
	Diane Hedges, Chief Operating Officer (non-voting)
	Gareth Kenworthy, Director of Finance (voting)
	Dr Will O'Gorman, North East Deputy Locality Clinical Director (voting) [for Stephen Attwood]
	Dr Guy Rooney, Medical Specialist Adviser (voting)
	Duncan Smith, Lay Member (voting)
	Kate Terroni, OCC Director for Adult Services (non-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
	Sarah Breton, Lead Commissioner (Children and Maternity)
	Lucy Butler, Director Children's Services Oxfordshire County Council
	Julie Dandridge, Deputy Director of Delivery and Localities, Head of Primary Care and Localities
	Chris Wardley, Patient Advisory Group for Primary Care Chair
Apologies:	Dr Joe McManners, Clinical Chair (voting)
	Dr Julie Anderson, South West Locality Clinical Director (voting)
	Dr Stephen Attwood, North East Locality Clinical Director (voting)
	Stuart MacFarlane, Practice Manager Representative (non-voting)
	Dr Jonathan McWilliam, Director of Public Health Oxfordshire (non-voting)
	Catherine Mountford, Director of Governance and Business Process (non-voting)
	Dr Paul Park, North Locality Clinical Director (voting)

Item No	Item	Action

1	**Chair's Welcome and Announcements** The Lay Vice Chair welcomed everyone to the meeting and reminded those present the OCCG Board was a meeting in public and not a public meeting. He advised the public would have the opportunity to ask questions under Item 3 of the agenda. The Director of Quality read the Patient story and thanked the patient for their consent.	
2	**Apologies for absence** Apologies were received from the Clinical Chair, the South West Locality Clinical Director, the North East Locality Clinical Director, the Practice Manager Representative, the Director of Governance, the Director of Public Health and the North Locality Clinical Director.	
3	**Public Questions** The Chair advised eight questions had been received via the website and as the majority did not relate to OCCG Board papers responses would be posted on the website within 20 working days. Those relating to agenda items would be answered as much as possible during the relevant item. The Chair invited questions from members of the public. A question was raised around GP estate in Faringdon and, given the housing expansion in the area, measures to be taken to address capacity issues. The Chief Operating Officer advised the Deputy Director of Delivery and Localities Head of Primary Care and Localities would be attending later in the meeting to present Paper 17/21 and she would be able to provide more detail on actions being undertaken. The Chief Operating Officer reported bids had been made for estates support but only a very small proportion of the bids submitted had been received. At this point OCCG did not have a solution for many schemes and there was a need to consider alternative ways to support practices. The issue was common to many practices where the submitted bid had been unsuccessful and other solutions would involve revenue; an item which would be discussed later in the meeting.	
4	**Declarations of Interest** There were no declarations of interest over and above those already recorded or pertinent to agenda items.	
5	**Minutes of OCCG Board Meeting held on 26 January 2017** The minutes of the meeting held on 26 January 2017 were approved as an accurate record.	
6	**Matters arising from the Minutes of 26 January 2017 and Action Tracker** The Lay Vice Chair explained an Action Tracker had been produced to ensure all actions were recorded and the Board updated on progress and completion. The Action Tracker presented included all actions during 2016 where a final update had not been recorded in the Board minutes and the actions from the 26 January 2017 meeting. Future Action Trackers would only include open actions and those closed at the preceding meeting. **The OCCG Board noted the content of the Action Tracker.**	
Overview Reports		
7	**Chief Executive's Report** The Chief Executive introduced Paper 17/18 updating the OCCG Board on topical issues including the request to approve and endorse adoption of the amended Prime Financial Policies and Standing Orders. The Chief Executive highlighted: • The official opening of Townlands Memorial Hospital in Henley commenting on the increased activity with a doubling of the number of out-patients seen, more diagnostics being undertaken and a fully open and	

	operating Rapid Access Care Unit (RACU). The Chief Executive observed there were some really good models of staff providing out reach into the community. Following the long discussions around the future of the Hospital and the consultation it was really pleasing to see the facility working so well • The awarding of a contract to Oxford Health NHS Foundation Trust (OHFT) for the provision of Integrated Child and Adolescent Mental Health Services (CAMHS) was noted. The Lay Vice Chair advised he chaired a stakeholder group in Townlands with public and provider participation. During the past nine months there had been a move from a position of concern at public meetings against reducing bed numbers and facilities delivered to a situation where the RACU had been fully open since January 2017 and a pleasing change in response from the public and local press. The Lay Member (voting) as Chair of the Finance Committee confirmed the Finance Committee had supported awarding the contract for CAMHS services to OHFT. The West Locality Clinical Director referred to the GP Access Fund (GPAF) item in the Report advising the scheme was up and running in the West. The scheme had made a difference and patients were very happy with the service. He considered it to be a good investment which had been managed really well and was working for patients. **The OCCG Board noted the Chief Executive's Report and endorsed the adoption of the amended Prime Financial Policies and Standing Orders.**	
8	**Locality Clinical Director Reports** Paper 17/19 contained the Locality Clinical Director (LCD) Reports. The Lay Member (non-voting) felt it was very positive to see such a wide range of development taking place in localities despite the pressure practices were under. He noted comments on the long term lack of progress around integrated locality teams and queried the cause as there appeared to be some suggestion this was largely about the sharing of information and communication. He was concerned as this was critical to the success of transformation schemes. The LCDs responded: • The South East and South West had come together to progress. The Deputy South East LCD was leading the group. It had taken a while to combine the different groups and individuals. There was now a clearer view with leadership from the Deputy South East LCD and confidence there would be progress. There was an appetite from all organisations to move the situation forward. Townlands Hospital had been a good example and the localities were learning from this experience • There was less optimism in Oxford City. Meetings had been held on a regular basis with a number of organisations. Good discussions were held and repeated every month but affecting change had been enormously difficult. The greatest problems were with the community services. There was a lot of silo working rather than integration. This was partly due to a lack of workforce in particular the chronic problem with District Nurses in the City. It was a very challenging situation which had been slightly confused by discussions entered into between OHFT and the Federations. There was every possibility that this might help the situation eventually but it was not obvious at the moment how this might be achieved. All plans had been shared and although there had been more enthusiasm it would be necessary to wait and see how the situation progressed • It was a big issue at NOLG and being unclear on process was a problem	

	for GPs. They were happy to integrate but were not sure with whom. The general feeling was practices required better relationships with District Nurses. There was also concern around communication and not just in the community but also from the community into hospitals. There was a need for IT systems to work together. The Director for Adult Services observed locality team working was essential. She suggested some focus on areas of good practice in order to be able to understand the 'blockers' in other areas. She agreed there was a need to share information and to have IT systems working together. The Director of Adult Services offered to have discussion around areas for particular focus outside of the Board meeting and to bring a report back to the Board. The Chief Operating Officer agreed on the need for some focus and to look at IT systems working together as this had been a matter for discussion for quite a while. It was agreed the Chief Operating Officer and Director for Adult Services would bring a report to the next Board meeting and look at actions to take forward. The Lay Member (voting) observed IT had been mentioned a couple times in the LCD Reports and transparency around IT plans had been discussed in the Finance Committee. He queried whether it would be possible for an OCCG Board Workshop to receive a presentation on the IT road map and whether a risk assessment had been undertaken around change in the system. The Lay Member (voting) raised two further issues: intimidation of health staff in Banbury which had been raised in the North LCD report which he felt should be noted and he queried whether there was support in place for these staff; and the fact OCCG on behalf of practices had not fared well in the bids to the centre and he questioned whether OCCG had the central resource or skill base to support people when making bids. He added that if the lack of award was due to the bid not being good enough rather than monies not being available, it should be addressed. The Lay Member voting had also wished to enquire from the North East LCD what a 5km safe health route was. The Lay Vice Chair reported safety of staff had arisen at a couple of the consultation meetings. He felt it was a worrying trend that staff were feeling threatened. At a couple of consultation meetings it had been decided to hire some security. Members of the public had raised questions around why security was needed and why OCCG was spending tax payers' money on it. The Chief Executive advised there had been some issues around the survey undertaken in the town centre of Banbury which were being followed up as the researchers had felt intimidated when engaging with members of the public. Staffs were aware of the general issues and OCCG was supporting staff to enable them to feel able to speak out. The Board noted the difficulty for staff and patients attending public meetings being able to say they felt the proposals were a good idea. OCCG needed to ensure people felt able and supported to make their views known. The Lay Vice Chair observed at the public meetings where it had been possible to use round tables it had been much better and people had felt more able to speak. The Chief Operating Officer wished to ensure members noted the extensive discussions held at the North Oxfordshire Locality Group (NOLG) around critical care and stroke. She stressed the importance for people to be aware that detailed conversations had been held and that GPs had concerns around some elements particularly as OCCG was being challenged as to whether it had support from GPs. The Deputy North LCD felt it was a fair summary adding she could not stress enough how several practices in the North were struggling to survive and these issues were in addition to business as usual. The comments and issues being raised around the Horton were not new and was part of the work of all GPs in the north as most patients were referred to the Horton. GPs were aware of the	**DH/KT** **CM/PP/ GK**

	health issues and understood the financial constraints. The Deputy North LCD advised there was a small group who had strong feelings and were very vocal but there was a large body of GPs who understood there had to be change and were holding discussions. She added the north GPs were quite a cohesive group and had worked together as a body. She felt it was very good that they came together in the Locality meetings and discussed issues and advised the GPs did understand the financial situation. The Lay Vice Chair was concerned at the lack of success in bidding for funds from the centre. The biggest example was capital expenditure for primary care where an application for £50.0m had been made and £2.0m awarded. Although a common problem for all CCGs it was not helpful for OCCG when there was such a tight hold on the public purse from the centre as this had a severe impact on the ability to extend and improve the offering in Oxfordshire. The Chief Executive reported it was not the quality of the bids and there had been some really good worked up bids from practices. It was the capital available which was in short supply. The issue for OCCG was that in a number of locations there was a need to find some capital. Conversations had commenced with council colleagues around consideration of the totality in Oxfordshire and how to obtain inward investment. OCCG could not rely on the centre and needed to find other ways to fund the investment required. There were considerable issues in primary care around staffing and premises. **The OCCG Board noted the Locality Clinical Director Reports.**	
Strategy and Development		
9	**Oxfordshire Transformation Programme Update** The Chief Operating Officer presented Paper 17/20 providing a short update on the Oxfordshire Transformation Programme explaining more information in relation to Phase 1 would be provided at the next meeting in May. A number of engagement events had been held in addition to the public consultations events and these included meetings with voluntary groups. The Chief Operating Office advised the Board members had been very involved and had attended many of the meetings both as panel members and as part of the audience. The Board had listened and heard the comments made and participated in the conversations at the round table facilitated sessions. The Chief Operating Officer expressed her gratitude to all those who had been involved particularly the Lay Members. OCCG had worked together with OUHFT and this had been one of the best examples of partnership with the Trust and was a good sign of how the two organisations could work together in the future. There was undoubtedly a level of anxiety around change and the clear issues were transport, travel times, community services and where services would be delivered as a result of bed closures. Since the last Board meeting the Secretary of State had issued additional tests to be met before any bed closure could take place. OCCG was reviewing how these tests applied to areas already undertaken but there was confidence evidence could be provided. The particular challenge was ensuring the services were in place as the beds were closed. Through the realignment of beds resources had been used to start other services: hospital at home; discharge liaison hub; and additional community beds. OCCG had good evidence to meet the request by the Secretary of State that alternative services should be in place before any beds were closed. The delayed transfer of care (DTOC) patients would continue to be a challenge but OCCG had clear evidence of the support services in place. There were plans to strengthen governance arrangements for the team and the paper detailed how the governance structure would be set up following a more pro	

forma type process.

The Chief Operating Officer advised one of the questions to the Board ahead of the meeting had concerned who would carry out the community hospitals review. This piece of work would be part of the community services stream led by OCCG but undertaken by the whole system.

As part of Phase 2 a 'long list' of all possible combinations of service delivery was being developed. The paper indicated the Board would start to see this work from May. There would be public engagement in this work. Parking at both the John Radcliffe and Horton Hospitals had been raised as a challenge and the transformation team was taking this forward with the Trust. Public engagement meetings had been held out of county although there had been comment that more should have been undertaken but there had also been engagement with practices and county councils. The Chief Operating Officer was a member of the Community Partnership Network which covered the whole of the north area including southern parts of neighbouring counties. There was some learning for OCCG from this experience about ensuring engagement and feedback.

The Lay Member PPI felt it was very positive OCCG had begun to engage on cross border communication commenting people did not understand the need for cross border engagement and it was very important. She noted in the report from the North LCD there had been reference to a lack of operational integration causing difficulty in achieving even simple things. The Lay Member PPI suggested these could have been anticipated and as the obstetric unit had now been shut for some months, the on-going operational issues were a concern. OCCG should have been mindful of the strategic and operational issues which should have been anticipated and planned for. The Lay Member PPI hoped there would be lessons learnt from Phase 1 that could be taken forward into Phase 2 where the issues would be much bigger. It was not just cross border issues that would affect how people accessed services. With regard to the 'long listing' process, it would be helpful to have more clarity on the various engagement with the public and the information which would be released into the public domain.

During Phase 1 the Thames Valley Clinical Senate had been very important in providing assurance. It would be useful if the evidence for the Clinical Senate could be made available as early as possible because people wished to engage with the evidence and OCCG needed to be sure it was transparent with the evidence for the short list.

Other points of discussion included:

- The need for transparency around the 'long list' to provide confidence all reasonable options had been considered. There was a need for full information with nothing concealed to enable people to be confident in the process. The 'long list' would be the product of evidence and common sense which should be apparent to the Board and the public
- Phase 1 had been driven by inevitable challenges. For Phase 2 there would be a whole range of options and the methodology would be to start with the clinical standards which would be in the public domain
- Reduction in DTOC numbers was dependant on the Homes Assessment Reablement Team (HART) working well and social services being in place. Oxford City represented a large population of 220,000 patients who were unable to get a bed in the hospital on their doorstep but instead were being admitted to Wallingford, Chipping Norton, etc
- The Board would need to consider the Joint Strategic Needs Assessment (JSNA). The JSNA mentioned Cherwell on a number of occasions in terms of deprivation but an obstetric service would not cure these issues.

Many factors would drive service change but for the obstetric service it was clear staffing was the issue

- OCCG was one of the largest CCGs and had diverse areas of challenge which should be remembered during discussions
- OCCG was some way from achieving clarity around the sort of model it would be able to implement at a locality level. The Board should consider whether this was a risk and if it was, how it should be mitigated. The 'long list' and 'short list' process was compromised by not being transformational enough due to being unsighted around what was possible at locality level. It was an issue of sequencing which needed to be managed
- A number of issues had been raised by residents in Thame and Brackley around organisational boundaries and organisations not working effectively together for the population. Picking up these issues should be addressed as part of Phase 2. Phase 1 had been mainly driven by quality, safety and workforce issues. Phase 2 would be different and OCCG needed to be upfront about the financial challenge otherwise the confidence of the population would be lost. There was a need to be assured plans would be financially viable as OCCG came out of the Phase 2 consultation. Going forward if resource were being moved to localities and Integrated Locality Teams there would need to be planning targets or options by locality for the resource available
- Phase1 had primarily looked at urgent issues. Phase 2 would have a much more holistic objective and, therefore, be more difficult to manage. There would need to be more involvement with the County Council and debate with the public. A number of points had been made around financial sustainability and having clear targets. There would be a lot of pressure on the management team to drive this forward. In order to ensure the Board had a good grasp over all aspects and be able to comment on proposals, there would be a need to address and debate more in forthcoming workshops.

The Chief Executive agreed the need to fully inform the Board and reminded members that OCCG was still consulting on Phase 1 as this did not close until 9 April 2017. The public consultation events had finished but comments could still be received. No decisions had yet been made and would not be until a future meeting. Phase 1 had focussed more on quality and safety of services whilst Phase 2 would be more around discussing financial sustainably and doing the best within the resources available. It would be necessary to make choices around what services were provided where. The focus would need to be on the services provided rather than the buildings. It was acknowledged this would be difficult for members of the public but OCCG had a responsibility for sustainability and mange within the finances available. It was important OCCG worked with Oxfordshire County Council (OCC) and the Clinical Chair had written to the Leader to ask if OCC would work with OCCG as a partner in Phase 2.

The comments made around the options and transparency were acknowledged and would be considered but the Chief Executive warned that the work would be available as a freedom of information request and consequently some caution might be necessary as OCCG would not wish any rumours to start. It was important to do some work up first before being more open with the options. It was clear there were boundary issues, which was why discussions had commenced with CCGs to the north of the county but there would be a need to undertake such engagement on all boundaries to Oxfordshire. The Chief Executive pointed out that a lot of the comments around service change and the negativity received was due to the effect on hospital sites but 90% of the OCCG contact was within primary care which only received about 10% of the funding.

	There was a need to address this point. The Primary Care Framework started to address the shift which was required. This would be a difficult area and it would be necessary to make choices. The South East LCD advised primary care used to receive 11% of the funding but the current figure was now 8.5%. The Lay Vice Chair commented this would be the biggest issue for OCCG and the Oxfordshire community over the next few months. He reiterated the need for close scrutiny and monitoring by the Board and need to consider the process in place going forward. **The OCCG Board noted the content of the paper.**	
10	**Primary Care Framework** The Deputy Director of Delivery and Localities, Head of Primary Care and Localities joined the meeting for this item and the Lay Vice Chair advised the Patient Advisory Group (PAG) for Primary Care Chair would be invited to the table to make a comment. The Deputy Director of Delivery and Localities, Head of Primary Care and Localities explained the aim of the Framework was to set the strategic direction for Primary Care in Oxfordshire over the next five years and beyond. It aimed to provide a framework on which local groups of GPs could build in order to achieve a sustainable Primary Care that could meet the needs of patients and the public into the future. A stable Primary Care was important to the whole transformation project. The Framework had been shared with GP colleagues and input had been received from the PAG(s). It was hoped the Framework could be used to move forward and transform Primary Care. The aim was to use the Framework within localities with input from other stakeholders to develop locality place based plans. The PAG for Primary Care Chair advised he was proud of the PAG contribution to the workstream stating this was an opportunity for proper involvement and co-production from Patient Participation Groups (PPGs). It was also an opportunity to promote the PPGs. Although many patients would not see major change it was important for patients to be seen to be involved through the localities and providing input and not being presented with a solution. The focus should be on promoting services and making the best use of services and not solving the problems experienced by OCCG in delivering services. It was about communication and key would be how the results were communicated. The PAG for Primary Care Chair advised he had been invited to attend the next meeting of the Oxford PPG and he would be happy to attend other PPG meetings. The Lay Member PPI advised she had been kept up to date on progress of the Framework by the PAG for Primary Care Chair and colleagues and fully supported the comments he had made. She felt co-production needed to be part of OCCG culture. There were real opportunities at each level of the Framework and patients were very interested in what happened in their local GP practice. It was important OCCG listened to the needs of patients and did not import a city approach into a rural practice. There was a need to ensure solutions worked for patients on the ground and for staff within practices. The Lay Member (voting) reported the Oxfordshire Primary Care Commissioning Committee (OPCCC) had reviewed the Framework on three occasions and had been interested in the feedback which had helped develop the paper. OPCCC endorsed the Framework subject to a number of small changes. It was felt the Framework was important for planning and investment purposes. If OCCG was serious about localities and integrated community services he needed to reiterate concerns around the financial budget for long term planning but he looked forward to seeing the Framework implemented.	

The Oxford City LCD observed the public facing document concerned development of primary care services to enable people to be kept at home. The appendices provided an ideal model. The Oxford City LCD felt the Framework should not apply to just general practice as he felt neighbourhoods could be substituted for general practice in the paper. General practice was facing a crisis in funding and work force. It was very explicit in the paper that although there may be a general practice surgery in a patient's vicinity they may not see a GP but another practitioner. It was fundamental that patients should have input but also essential changing roles were understood and that another practitioner could be the most appropriate person. The Oxford City LCD believed there should be mapping of the needs for Oxfordshire in order to comprehend how monies should flow. Addressing health inequalities included healthcare and the need for more GPs. Oxford City had many areas of inequalities and it was necessary to consider how to get GPs in the right places and that resources flowed in the right direction to address health inequalities and access. There were some hard targets in the Framework such as obtaining an appointment within 7 days. The public felt this was reasonable but to deliver this would be difficult in some areas particularly Banbury and Oxford City. If the OCCG Board signed up to the Framework there was a need to understand there might be a need for resource.

The Director of Quality suggested an area which had not received much discussion was the fact in future people would need to be more reliant on themselves and their family and this required greater understanding of the prevention agenda. There was a need to consider how the public was engaged and ownership and drive within the localities. The Lay Vice Chair concurred prevention should be the first step and expressed concern not enough time and resource was allocated to this area. He felt there should be engagement with colleagues and the County Council to take this agenda forward.

The Director of Finance believed the Framework to be excellent but wished to underline the challenge around investment and resource. He drew attention to the diagram on page 18 reminding the Board of previous conversations around the left shift of resources observing the Board was aware resources were nearly all committed on current services. The challenge was in the allocation being taken up on growth; about choices being not just investment but potential disinvestment; and the need to move money from hospital services into primary care.

The Lay Member (non-voting) congratulated the team on production of the document and raised the need to consider the support localities would require to take this forward. It would not be a trivial task to change the Framework into a workable plan. Key to success would be getting the right process and involvement from stakeholders. System wide technology support needed to be considered and understood with assurance provided to the Board around how this would be enabled. With the question of capital investment and the estate being a big part of the transformation piece there was a need to commence work around the options for other investment as soon as possible and not wait until the amount required was understood. There was a need to create a market to attract potential new investment providers and for work to be undertaken on a process to enable those potential investors to feel comfortable and have confidence prior to reaching the investment stage.

The South East LCD acknowledged the paper accepted the need for local variation but felt certain areas needed to be strengthened as individual general practices were small businesses and to sign up to the Framework it would need to make business sense and there would be a need to facilitate the extra services. Practices would engage with the public and their patients and would need to be able to carry them with the plans. Continuity was also important as continuity of

	care led to fewer admissions. Many of the challenges concerned funding and many individual practices were being crippled by long term leases and issues with their buildings. It would not be easy to coalesce practices into larger groups. GPs were motivated by a desire to look after their communities and it was necessary to allow them to do so. The Chief Operating Officer pointed out the need to acknowledge the guidance received around primary care streaming in Emergency Departments which required a GP on the front door from 8.00am until 9.00pm. Given the challenge with recruitment this would require some innovative thinking. Conversations had begun but the Board needed to recognise this was a significant dynamic. The Deputy Director of Delivery and Localities, Head of Primary Care and Localities noted the comments around: • The Framework allowed for different models of working • The need for patient engagement • Prevention was very important and this work needed to start at an early stage • Discussions would take place at PAG around methods for engaging patients at an earlier point • The targets were hard but there was a need to aspire practices to move primary care and general practice forward • There were key pieces of work to be undertaken across the county such as estate and IT but areas could be embarked on at locality level and these needed to be owned by those on the ground. The Director of Finance referred back to the diagram on page 18 pointing out the further the move to the left the less money was being spent with very little available for prevention. He queried how the Framework and the integration of prevention fitted with the recent Health Inequalities Commission report commenting on the need to ensure this work came through. The Lay Vice Chair observed a major issue was the need to understand how progress would be measured and monitored. The Lay Vice Chair congratulated the Deputy Director of Delivery and Localities, Head of Primary Care and Localities and her team for putting forward a solid document. **The OCCG Board approved the Primary Care Framework.**	
Business and Quality of Patient Care		
11	**Finance Report Month 11** The Director of Finance presented Paper 17/22 providing the financial performance of OCCG to 28 February 2017; the risks identified to the financial objectives and the current mitigations; and a most likely, best case and worst case forecast outturn against plan. The Director of Finance reported OCCG was on target to delivery its financial plan. There were three key areas he wished to draw the attention of the Board to: *Surplus* At Month 11 OCCG was on target to deliver its surplus but on instruction from NHS England (NHSE) had been holding a 1% non-recurrent reserve. National guidance now issued gave formal instruction from NHSE that the reserve would be released to CCGs and as a result the surplus would increase from £12.9m to £21.1m as £8.2m would be released to the bottom line in Month 12. This national direction would apply to all CCGs. The release of the surplus would be to offset overspend in providers and support the national overspend. The possibility of the release had been signalled and conversations held in relation to how this should be presented particularly in terms of the transformation work and financial drivers	

when OCCG is suddenly reporting a surplus in excess of £20.0m. This directive meant OCCG would report a higher surplus but the money would be utilised to support the national position and would not be returnable to CCGs in the next financial year.

Headroom

The Director of Finance referred the Board to the table on page 4 of the Report and the headroom risk. A discussion had been held at the Finance Committee where it was noted the best and worst case scenarios had been overstated due to the mechanics of how the presentation and table worked. The Director of Finance assured the Board the range of scenarios was much smaller and OCCG would meet its surplus. How the reserves could be applied in 2017/18 would be considered as the year end was concluded.

Provider Performance

The Director of Finance advised there was deterioration in the Oxford University Hospitals NHS Foundation Trust (OUHFT) forecast outturn position. OUHFT was reporting a £3.8m over-performance at Month 10 which was a minor improvement but in the 2017/18 agreed contractual arrangements the forecast had been based on a £2.3m overspend. The increase put additional pressure on the contracts and risk sharing agreement.

The Chief Executive felt there was a need to have on record that half way through the year there had been major financial issues around funded nursing care and financial pressures but OCCG had managed to keep its budgets in balance. OCCG should be congratulated on this achievement especially as a number of CCGs had run into deficit. The 1% non-recurrent reserve was an issue but national policy prevented OCCG from being able to spend the money.

The OCCG Board noted the Finance Report for Month 11 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.

Financial Plan

The Director of Finance advised he needed to brief the Board on an emerging material risk to deliverability of the Financial Plan for 2017/18. The Director of Finance referred the Board to the discussion at the last meeting commencing on page 9 of the minutes and the paragraph at the bottom of the page setting out the outcome of the contract negotiations, the risk pool arrangements in place to share the risk and the proposals to mitigate the risk. The Financial Plan had been submitted in December and approved although two further updates and resubmissions had been made. The Financial Plan would not be changed but there was a key risk as a result of a review of performance against national referral to treatment (RTT) standards in OUHFT.

OUHFT had identified a material cost pressure. Modelling and information had been shared by the Trust in draft form. The approach and modelling had not yet been validated by OCCG and the modelling undertaken by the Trust was a worst case scenario. The value of the potential investment to rectify CCG performance was in the region of £34.0m. This figure was split between the amount needed to address the backlog and the investment required to address the ongoing run rate (one third, two thirds). The recurrent run rate was the greatest risk to OCCG. If the 2017/18 agreement held OCCG had mitigated some of the risk through the risk share agreement and would incur a 40% cost. NHS Improvement (NHSI) was working with the Trust. This work was not yet complete and the figures were, therefore, provisional. The regulators were planning to put a key stakeholder meeting in place before the end of April. The Director of Finance advised the Board would be updated as the situation progressed.

The Lay Member (voting) advised the Director of Finance had brought the issue to the Finance Committee. The Committee were not assured the revised plan was deliverable given the risk. The Committee recognised the figures were provisional but the Lay Members were concerned and wanted answers on a number of matters. It was not known if this was a major governance failing by the Trust or whether the Trust had not been open with OCCG in the contract round. The Committee wished to know: when had the issue come to light; when had the investigation started as OCCG had not been party to this and might have been the last organisation to know of the level of risk which raised a query around the level of communication with OCCG; and there was a real need for the Board to feel assured OCCG was party to the work and plans. The Committee was concerned as for a couple of years there had been a lack of transparency around elective work and it had been clear the Trust was struggling to find the data. It was not a surprise there was a problem but the amount was significant and far in excess of anything that might have been expected given £4.5m was the figure in the Financial Plan. A sum of £25.0m had been voiced as the need to sustain the RTT going forward. Going forward OCCG needed to be involved in the plans. There would be an increased level of activity in electives going forward. From a Lay Member perspective pressure to increase the QIPP targets should be resisted. To deliver the Plan OCCG would need to delivery £10.0m of savings in terms of the risk pool and given the track record on delivery QIPP savings this would be a challenge. Before this risk had been highlighted the Finance Committee had felt OCCG was in a good place in terms of partnership working which historically had been a block to delivering QIPP savings.

The Oxford City Locality Clinical Director expressed concern, as OHFT had 20% of the risk share they might argue this cost had not been raised at the time of the contract negotiations and agreement of the risk share, they would not risk share on this item which would lead to the OCCG position being even worse.

The Lay Member (non-voting) commented there was a risk to the risk sharing agreement and the possibility the agreement could unwind. He reiterated the point made by the Lay Member (voting) around the importance for OCCG to have an opportunity to understand the situation, data, modelling and to be involved in the decisions to be taken around how the situation would be addressed. Modelling was complex with a wide range of variables in the models which could involve quite heroic assumptions being made to drive the model and one or two key issues could make major differences. This reinforced the need to be assured and to understand how the numbers were arrived at before being able to start actions to mitigate the risk.

The Chief Executive observed the RTT had not been achieved since July 2016 from which it could be reasonably deduced money would be required to resolve the situation. When the agreements were discussed a figure had been assumed and the risk share agreed on that set of assumptions. The elective activity in those assumptions was around £3.6m consequently the increase was not credible. A meeting was due to take place that afternoon with the OUHFT Chief Executive, the OCCG Chief Executive, Clinical Chair and Chief Operating Officer to go through the issue and understand how the model had been pulled together. OCCG had been informed on 29 March that NHSI would be calling a system meeting to discuss the way forward. NHSE was expecting OCCG to submit later in the day trajectories for RTT but it was not possible to do this at this stage. This would cause issues with the OCCG regulator. The Chief Executive felt it was important the system did not abandon the excellent work undertaken getting the risk share in place as this would result in a return to disagreements around activity data. He stressed the importance of meetings with the Trust and the need to see what information could be obtained from the regulator. If the figure was of the order suggested, OCCG would not be able to find the finance and it would mean

	reviewing all the financial plans. The Chief Executive suspected OCCG and the regulator would have differing methods for achieving the target. It was not known whether the Trust Board was aware of the situation and, if it was, at what point they had been informed. OCCG was pressing the OUHFT Chief Executive to explain the situation. The Director of Quality advised OCCG was also pressuring OUHFT to assess the clinical risk to patients. A paper had been provided but there had not been an opportunity for review. The paper would be shared with the Quality Committee. A request had been made to be kept appraised of the risk. The South East Locality Clinical Director queried whether any assurance had been provided that capacity to clear the backlog was available should OCCG be able to produce £34.0m. He questioned if the situation had arisen due to a failure of monitoring; who policed the regulator. The Medical Specialist Adviser pointed out if patients awaiting a first appointment had not been seen there would be another group of people who were not yet recorded and it would be helpful to know how many patients this applied to. The Oxford City Locality Clinical Director suggested the situation should be treated as a separate entity to the risk share agreement and the 40% should be put away before consideration was given to tackling the balance. The Lay Vice Chair brought the discussion to an end and advised a brief closed session of the Board would be held at the end of the meeting to explore the matter further.	
12	**Integrated Performance Report** The Chief Operating Officer introduced Paper 17/23 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 queried whether comparative data should be included in the report particularly when discussing the constitutional standards as across England systems were experiencing the same strain particularly bearing in mind the ambulance response times were all red but in fact Oxfordshire was the best in the whole country. Likewise feedback around the A&E 4 hour wait categorisation placed the ambulance trust in the third category which was not the most alarming. The Royal Berkshire Hospital had also been quite challenged on the 4 hour wait. The Chief Operating Officer advised OCCG was not complacent about the performance but felt the comparative data provided some context to the red areas. There was some evidence the A&E performance position was stabilising. One of the key issues for the A&E Delivery Board was workforce capacity in A&E and further information around the planned capacity to meet demand, particularly in the late afternoon early evening, had been sought. Delayed transfers of care (DTOC) were a factor but the performance in A&E varied on a day to day basis which colleagues in OUHFT were investigating. Consideration had been given to matching staffing to demand and the requirement for primary care streaming would add another strand to the staffing issue. A trajectory for A&E would be submitted of 90% each month rising to 95% at the end of March 2018. OCCG would have preferred to be in a better position but this was the same trajectory as OUHFT would submit. The Trust had agreed to there being a series of triggers and conditions on their performance and the organisations were working to agree	

	these as well as the agreed figures which would sit under the trajectory. For RTT it was disappointing the 62 day cancer target had still not been met. OCCG was submitting that this would be met by April 2017. The North Deputy Locality Clinical Director advised OUHFT had approved the plan to define the diagnostic stage but workforce loss had been a big issue and the reason the target had not been met. A delay had occurred in 2 week wait (2ww) as patients had not been informed they needed to attend a 2ww appointment which had caused a knock on effect. Agreement had now been reach on the trajectory in relation to discharge summaries. The Director of Quality advised it had been a challenge to agree a trajectory but 95% by June for discharge letters and 90% for test results and out-patient letters had been agreed. Again this was not the figure OCCG would have liked to agree and the Trust would be pushed to go further. The Lay Member (voting) pointed out the loss to OCCG of the Quality Premium as a result of the Trust not meeting the constitution measures. He felt it would be interesting to know the true cost of poor performance. **The OCCG Board noted the Integrated Performance Report.**	
13	**Children's Trust Board Update** The Director Children's Services Oxfordshire County Council and Lead Commissioner (Children and Maternity) attended for this item. The Director Children's Services provided an overview of the Children's Trust Board and talked the OCCG Board through the presentation, Paper 17/24. The Director Children's Services advised Oxfordshire was doing well with a number of services and prevention work but there was a need for more co-ordination. She observed Social Services were not as good as health at pathway work and there was a need for this to improve and ensure services were coordinated. There had been a dramatic increase in the numbers of looked after children (LAC) and in those being placed out of county. Some of the drivers around these out of county placements would be explored. An analysis would be carried out of the research undertaken and the Children's Trust Board would work with partners on a new vision and constructive way of working. Views and ideas around working together would be welcomed. The Director of Quality advised there was partnership working on the safeguarding agenda but there was a need to ensure interface and escalation to the relevant body. The Safeguarding Report, Paper 17/25, echoed many of the comments from the Director Children's Services around LAC. There was a need to build on prevention work and consider whether all the interventions were having an effect and, if they were, how these could be used further to improve services. The Chief Operating Officer agreed there was more work that could be done around how the organisations engaged. She felt it might be possible to use the new arrival to post of the Director of Children's Services for a stocktake to consider what was in place, the way resources were spent and whether OCCG and OCC were being ambitious enough for the children of Oxfordshire. The recently released Joint Strategic Needs Assessment (JSNA) contained some stark messages about health spend if the services for children were not right at the front end. This was demonstrated by the increase in use of the Child and Adolescent Mental Health Service (CAMHS). The Director Children's Services explained the cuts had been made to the universal service and not targeted at certain areas and the need to preserve the prevention element targeted at those children who were most vulnerable had	

	been recognised. OCC was unable to afford the retention of all services but had retained the early preventative work. The service had a strong contingent of health visitors and school nurses and recognised the need to mesh all the services in the best possible way. The Children's Trust Board provided influence and was a strategic force for moving plans forward. Its function was to bring partners together to work through the areas on which it should be concentrating. The Lay Member (non-voting) suggested the Children's Trust Board could link with the CCG through the children's workstream mentioned in Paper 17/20 which would allow all their knowledge and experience to be available to the group. The Chief Executive pointed out the Lead Commissioner (Children and Maternity) was a joint appointment between OCCG and OCC providing linkage between the two organisations. The OCCG Clinical Lead for children's services was Dr Matthew Gaw who was also Vice Chair of the Children's Trust Board. It was agreed the Director Children's Services should discuss with the Chief Operating Officer a greater connection and relationship with the Children's Trust Board and how the OCCG Board should receive further updates. The Lead Commissioner (Children and Maternity) advised the Children's and Young People Plan had been presented to the OCCG Board in 2014. The Plan was refreshed annually but had not been brought back to the OCCG Board since its initial presentation. She felt this could be a vehicle for further linkage. **The OCCG Board noted the work of the Children's Trust Board.**	**DH/LB**
14	**Safeguarding Update** The Director of Quality presented Paper 17/25 updating the OCCG Board on safeguarding issues advising there was a similar challenge in adult safeguarding as had been described under Item 13 as there had been a 30% increase in referrals and further enquiries were being undertaken. A piece of work around how the Local Authority reported back to GPs for both children and adults was underway and led by one of OCCG's Named GPs for Safeguarding. The OCC Director for Adult Services advised the safeguarding team was providing support across the county. The low transfer rate from referral to investigation was interesting. A number of referrals were being received from the Ambulance Trust regarding the state of a person's home. There was also the question of where a person did not take their medicine as to whether it was a safeguarding issue or the way the person chose to live. The Director of Quality advised an increase in safeguarding referrals from the OUHFT Emergency Department and the Trust was undertaking an audit to ascertain what was happening. Work undertaken was beginning to show dividends in primary care safeguarding. There was more to do in terms of support but there was good engagement and a safeguarding lead in each practice. Deprivation of Liberty Standards (DoLS) had created a substantial piece of work and there was a need to analyse the Law Society review of the DoLS process which was anticipated by the end of March 2017. The OCC Director for Adult Services reported the DoLS had been extended to care homes and there was a possibility it would also be applied to self-funders. As a consequence the remit could be getting larger rather than smaller. The Lay Member (non-voting) advised a summary report containing a large amount of data had been presented to the last Quality Committee meeting. He had been surprised and alarmed by the referral numbers in both vulnerable adults and children. The numbers were driven by many different circumstances and	

	although some might not be safeguarding issue he felt more analysis and insight could be gained from the circumstances behind the issues and particularly whether issues upstream were giving rise to genuine safeguarding concerns. He would have expected referrals to be the exception but the numbers were significant which caused concern. The OCC Director for Adult Services advised a referral could be five missed medications in a year. All referrals needed to be followed up but the high number did not mean 1000s of people were being abused each year. The Deputy North East Locality Clinical Director observed when something was publicised it made people more aware and there was usually a corresponding increase in referrals. People being more aware and hence an increase in referrals was good even if the referrals included a number of people with minor issues. The Oxford City Locality Clinical Director expressed concerns around communication with social workers. Currently the only form of contact was via a central bureau. A considerable amount of time was spent trying to reach a social worker. It was necessary to improve the flow of information. The Director of Quality advised the OCC Director Children's Services had been invited to attend the next Quality Committee to discuss the referral process and how it could be improved. The Oxford City Locality Clinical Director reported it was a good service; the difficulty was making contact through the central bureau. **The OCCG Board noted the Safeguarding Activity Update Report.**	
Governance and Assurance		
15	**Corporate Governance report** The Director of Finance introduced Paper 17/26 which reported on formal use of the seal and single tender action waivers. It also included details of hospitality and declarations of interest. The Director of Finance advised the procurement referred to in the single tender action waivers had commenced and would be reviewed by the Finance Committee. **The OCCG Board noted the Corporate Governance Report.**	
16	**Strategic Risk Register and Red Operational Risks** The Director of Finance presented Paper 27 drawing attention to actions for the Board. The Medical Specialist Adviser felt the financial, operational and strategic risk around the RTT situation should be considered in the Risk Register. The Director of Finance concurred and advised the management would review and reflect the risk in the next iteration of the Report. The Lay Vice Chair advised the Audit Committee had felt it was unclear under risk AF26 how the extra monies to Localities would ameliorate the risk and had requested more information. **The OCCG Board:** • **Noted the content of the Strategic Risk Register and the Red Operational Risk Register** • **Noted that AF19, Demand and Performance Challenges, remained an extreme risk** • **Noted that AF26, Delivery of Primary Care Services, remained an extreme risk** • **Noted that one Operational Risk 769, Primary Care Capacity, remained an extreme risk** • **Noted that Operational Risk 792, Legal Challenges Around Service**	**GK**

	Change, had increased from 123 to 20 making it an extreme risk • **Noted that risk 735, Oxford University Hospitals NHS Foundation Trust Test Results, rating had reduced from 20 to 16 reducing it from an extreme risk to a high risk. The reduction in score reflected the remedial action plan which was now in place and an agreed trajectory to reach 90% by June 2017.**	
17	**Oxfordshire Clinical Commissioning Group Sub-Committee Minutes** *Audit Committee* The Lay Vice Chair as Chair of the Audit Committee presented Paper 17/28a, the minutes of the Audit Committee held on 23 February 2017. The Lay Vice Chair advised the timetable for the Year End, Annual Report and Accounts had been considered specifically whether the Finance team, Governance team, Commissioning Support Unit (CSU), and Internal and External Audit were working closely together to ensure an efficient and accurate outcome. The Risk Registers had been reviewed. During the review of the Standing Orders and Key Financial Policies the Audit Committee had felt there was a need for greater understanding of the OCC nomination process to panels and the OCCG Board's ratification of such nominations: how much OCCG had a steer and say in getting the right people on board. The Audit Committee noted the two OCC representatives on the OCCG Board and had requested the specification for the Director of Public Health as one of the representatives be sought. Aside from this the Committee recommended adoption of the revised Orders and Policies. The Committee also reviewed the Budgetary Controls and felt there should be stronger wording around the procedures for managing and monitoring the budgeting for capital expenditure, virements, delegated funds and Pooled Budgets. *Oxfordshire Primary Care Commissioning Committee (OPCCC)* The Lay Member (voting) as Chair of the OPCCC presented Paper 17/28b, the minutes of the OPCCC held on 28 February 2017. *Quality Committee* The Lay Member PPI as Chair of the Quality Committee presented Paper 17/28c, the minutes of the Quality Committee held on 23 February 2017. The Lay Member PPI highlighted the clinical effectiveness report on therapeutic pathway for sexual abuse and exploitation as an important piece of work. She stated the importance of a clear pathway to appropriate services observing the front end of the map around how people accessed relevant services was unclear. It was also important for Oxfordshire local services to market the sexual assault referral centre which was not based within the county. This required further work and the Oxford City Locality Director had pointed out at the meeting the need to consider the inclusion of men in the pathway who had been the victims of sexual exploitation and assault. The Lay Member PPI advised work was in progress and expressed the hope social services colleagues would have input. The Lay Member PPI reported close scrutiny of on-going monitoring of the interim maternity arrangements at the Horton. The Quality Committee was not aware of any major incidents and there had been no births to mothers whilst in transit. The numbers of births at the Horton were small which made it difficult to gain assurance against benchmarking with other units. At the moment the Horton was within the bounds expected for clinical effectiveness around the way the service was running but it was operating on the margin and OCCG needed to keep on top of what was happening. A smaller number of patients were going through the maternity led unit (MLU) than had been projected by the Trust. The Trust had reduced the number from 500 to 250 a year and the actual numbers were less than this figure. The Lay Member PPI believed patients had a perception of the service they would receive. It had been expected the consultant cover would improve to meet the new standards for delivery suites but this had not happened. The Committee was pleased that, as far as could be ascertained, the unit was operating safely but felt the situation should continue to be monitored closely and work should be undertaken around the perception of how the service was	

	operating. The Director of Quality advised the number of maternity attendances was in line with national expectations which might not have been reflected adequately in the paper; OCCG linked closely with the Trust including around any incidents; and sickness and maternity leave had caused a delay in the consultant cover and it was hoped the situation would be addressed rapidly. **The OCCG Board noted the Sub-committee minutes.**	
For Information		
18	**Any Other Business** The Lay Vice Chair advised it was the final Board meeting for two members and expressed regret at their departure and the loss of invaluable skills. The South West LCD was on annual leave and not present at the meeting. She had been with OCCG since May 2014 and as well as the LCD role had also been the clinical lead for dementia and stroke and undertaken a number of pieces of work for OCCG. The Lay Vice Chair wished to record a note of thanks to the South West LCD. The second member was the South East LCD who had been with OCCG from the start in April 2013. He had been a stalwart in everything OCCG had tried to do. The Lay Vice Chair noted his calm demeanour and way of influencing people. He had worked particularly hard with the Townlands Hospital project in getting the message across and keeping people focussed on the issue. The formal opening had taken place on 28 March and the success of the project and the change in view and positive response from patients, public and the press had largely been due to efforts made by the South East LCD. He was not only retiring from the OCCG Board but as a GP and as the LCD, however, OCCG was engaging him in transformation activities where he would be leading the clinical stream. On behalf of the OCCG Board the Lay Vice Chair thanked the South East LCD for his efforts on behalf of the OCCG Board. The South East LCD thanked the Lay Vice Chair for his generous words and thoughts He felt working with OCCG had been a great part of his career and he had enjoyed representing the local GPs. He observed all the GP Board member got on well together and all believed passionately in the wellbeing of their patients and he would encourage everyone to keep on in the same vein but to also continue with what they believed in as the results at Townlands Hospital had shown. There being no other business the meeting was closed.	
	Date of Next Meeting: Thursday 25 May 2017, 09.00 – 12.45, Jubilee House, 5510 John Smith Drive, Oxford Business Park South, Oxford, OX4 2LH	