NHS
Oxfordshire
Clinical Commissioning Group

MINUTES:

OXFORDSHIRE CLINICAL COMMISSIONING GROUP BOARD MEETING

25 January 2018, 09.00 – 12.45 Jubilee House, 5510 John Smith Drive, Oxford Business Park South, Cowley, Oxford, OX4 2LH

	Dr Kiren Collison, Clinical Chair (voting)
	Louise Patten, Chief Executive (voting)
	Dr Stephen Attwood, North East Locality Clinical Director (voting)
	Dr Ed Capo-Bianco, South East Locality Clinical Director (voting)
	Dr David Chapman, Oxford City Locality Clinical Director (voting)
	Dr Jonathan Crawshaw, South West Locality Clinical Director (voting)
	Heidi Devenish, Practice Manager Representative (non-voting)
	Roger Dickinson, Lay Vice Chair (voting)
	Diane Hedges, Chief Operating Officer (non-voting)
	Gareth Kenworthy, Director of Finance (voting)
	Dr Jonathan McWilliam, Director of Public Health Oxfordshire (non-voting) [until 10.30]
	Catherine Mountford, Director of Governance and Business Process (non-voting)
	Dr Paul Park, North Locality Clinical Director (voting)
	Duncan Smith, Lay Member (voting)
	Kate Terroni, OCC Director for Adult Services (non-voting) [until 11.20]
	Dr Louise Wallace, Lay Member Public and Patient Involvement (PPI) (voting)
	Sula Wiltshire, Director of Quality and Lead Nurse (voting)
In attendance:	Lesley Corfield - Minutes
Apologies:	Dr Miles Carter, West Locality Clinical Director (voting)
	Mike Delaney, Lay Member (non-voting)
	Dr Guy Rooney, Medical Specialist Adviser (voting)

Item No	Item	Action
1	**Chair's Welcome and Announcements** The Chair welcomed everyone to the meeting and reminded those present the OCCG Board was a meeting in public and not a public meeting. She advised the public would have the opportunity to ask questions under Item 3 of the agenda. The Chair welcomed Louise Patten as interim Chief Executive of Oxfordshire CCG. The Director of Quality read the Patient story and thanked the patient for their consent.	
2	**Apologies for absence**	

	Apologies were received from the West Locality Clinical Director, the Lay Member (non-voting) and the Medical Specialist Adviser.	
3	**Public Questions** The Chair invited questions from members of the public but none were forthcoming. The Chair advised several questions had been received via the website and where appropriate these would be picked up under items on the agenda and full written responses posted on the website within 20 working days. The Chair read out questions relating to support to GP practices in Banbury. The Chief Operating Officer advised on a range of support being provided to practices in Banbury and wished to assure the person who had sent in the question that OCCG was sighted on the challenges in Banbury. Additional resources to support hub appointments and provide practice support had been identified. Other areas were also being considered including maintenance of GP services in Banbury Health Centre (BHC). The CCG was taking the situation seriously and was providing human and financial resources to support and the practices were working closely together. The North Locality Clinical Director reported the practices had been working effectively together for the last two years. He apologised to patients who had to wait longer for appointments which was a symptom of the increased activity not only in Banbury but across the county. He stressed the need to tackle the issue of people being directed to general practice as their first port of call when there were other options open to them. The Chair précised the questions concerning the Horton and advised these would be addressed as the Board went through the papers as well as written responses being provided on the website within the normal timeframe.	
4	**Declarations of Interest** There were no declarations of interest over and above those already recorded.	
5	**Minutes of OCCG Board Meeting held on 30 November 2017** The minutes of the meeting held on 30 November 2017 were approved as an accurate record subject to checking the comment attributed to the West Locality Clinical Director concerning Sunday appointments in Item 8, Locality Clinical Director Reports, and an amendment to the final paragraph of Item 14, SCAN Pathway Project Update, that the lowering of the cancer thresholds had resulted in the conversion rate being lower across the whole pathway and as a consequence more people were being seen and hence the 2ww cancer targets being met. The Lay Member PPI observed that an action under the Chief Executive's report to follow up a response from the Oxford University Hospitals NHS Foundation Trust (OUHFT) for a business case on the expansion of planned care services at the Horton Hospital had not been included in the Action Tracker and requested an update. The Chief Operating Office advised opportunities around the Ramsey Centre for planned care provision were being considered. These discussions were concluding and it was expected to be able to report an increase in the number of operations that would take place there. Information was still awaited on the capital for the OUHFT proposal and it took time to produce a business case. The Lay Member PPI was concerned the business case had not been produced reminding the Board that a letter had been received from the OUHFT Chief Executive stating they were working on the timetable and the Board needed to be assured of the robustness. She pointed out a long time had passed since the August Extraordinary Board Meeting where the decision had been made and the Board was not seeing any development of an area of services which were not contentious. A large number of people had commented that this was good news in terms of out-patient appointments and the diagnostics for out-patients which would be possible and be of benefit to the area as well as helping with the	

	congestion at the Oxford sites. The Lay Member PPI remained frustrated that nothing had progressed and requested the Chief Executive asked the provider to deliver a business plan. The Director of Governance shared the frustration of the Lay Member PPI and advised the issue had been followed up in November. She explained that whilst the Phase One consultation had been subject to challenge under the Judicial Review, the Trust had not put in a lot of time and energy as organisations were advised not to do anything which would incur a great deal of expenditure. In addition if the legal challenge had gone against OCCG all the decisions made might have been quashed. Although the Judge had found against the claimants, the situation remained whilst the interested party sought permission to appeal. The Chief Executive advised the OUHFT would be asked to undertake some background work in order to ensure momentum would not be lost. The Lay Member PPI stated the background work should already have been completed and by now at least an outline business case should have been available. The North Locality Clinical Director (LCD) commented these were difficult times for the NHS with operations being cancelled. He did not believe there had been proportionally more at the Horton but would like some assurance that this was not the case. He added that as a GP he had noticed that more clinics were taking place at the Horton but he would like to see an even greater number.	**LP** **DH**
6	**Matters arising from the Action Tracker and Minutes of 30 November 2017** The actions from the Action Tracker and 30 November 2017 minutes were reviewed and updates provided where these were not covered under items later on the agenda.	
Strategy and Development		
7	**Health Inequalities Commission Implementation Plan** The Director of Public Health presented Paper 18/03 providing a comprehensive overview of progress against each of the 60 recommendations in the Oxfordshire Health Inequalities Commission report which had been presented to the Health and Wellbeing Board (HWB) and OCCG Board in November 2016. The Director of Public Health stated health inequalities were core to all organisations. The Health Inequalities Commission had been an independent commission chaired by Professor Sian Griffiths. The Commission took a fresh view on health inequalities across Oxfordshire. Although the Director of Public Health majored on health inequalities in his Annual Reports, he felt it had been good to have a fresh look. The Commission produced 60 recommendations which were all aimed at different organisations. This was a large number to address in one go. As a result some were implemented at once but an Implementation Group had been formed to take the other recommendations forward. The OCCG Clinical Chair had agreed to pick up Chair of the Group from Dr Joe McManners, the previous OCCG Clinical Chair. Some of the recommendations had not yet been managed as they required further consideration. The report had been taken to the Health and Wellbeing Board (HWB) in November consequently it was already out of date as actions had been progressed. The Director of Public Health felt there was value in raising the subject of health inequalities again at the OCCG Board and rather than dwelling on the detail advised he would value hearing a general discussion about health inequalities and how OCCG planned to take this area of work forward. The Director of Public Health confirmed oversight sat with the HWB, who had originally commissioned the work, and the HWB had already received three reports. The Director of Quality queried how confident the Director of Health was that the	

health inequalities work coupled with his Annual Reports would make changes and when he expected to see health inequality issues addressed. The Director of Public Health advised this was not a topic that ended but was one where the character changed as time changed. For instance the aging population was leading to new challenges. He felt it was more a question of how organisations remained fleet of foot to tackle the challenges that arose. The health inequalities indicators showed Oxfordshire to be less than nationally and the Director of Public Health judged they were gradually reducing. The Director of Quality commented on the need to ensure learning disabilities were included in the health inequalities work.

The Oxford City LCD raised the issue of the difference in mortality rates across Oxford City which had not closed and was significant. He queried whether consideration should be given to how the money flowed and whether need was truly being addressed. He also wondered if the Locality Plans looked at need and whether the money followed. The Oxford City LCD was pleased to see the focus on loneliness and commented that communities no longer worked as communities. There was a need to build this up and organisations should not be complacent.

The Lay Member PPI commented on the perinatal mental health recommendation advising this was a significant inequality issue with a number of particular women being at risk. She felt there was a need to link this issue to safeguarding as some mothers had issues with addiction, as well as other issues, which could affect the baby. OxPuP had recently pioneered a perinatal mental health pathway for women with safeguarding issues. The pathway had a good effect and had produced some good evidence using an intervention from Australia. This initiative had not been included in any of the reports which came through the Quality Committee. On query it had been advised that the initiative was no longer active or part of a pathway. The Lay Member PPI felt this was a shame as where interventions appeared to have worked organisations should learn from them and see where they could be integrated into commissioning. She felt OCCG should ensure services were joined up for those with significant mental health problems which would be transferred to the next generation if care was not set up properly. The Chair advised a bid had been submitted to address perinatal mental health.

The Chief Executive observed some of the descriptions were intervention focused rather than looking at desired outcomes and the recommendation might trigger some outcomes which would be better for patients. She also felt there was a need to ensure the role of the monitoring group was not as a tick box but changed outcomes. How inequalities were addressed should always be the main issue.

The Director of Finance commented the cover paper stated there were no financial implications but it was clear there would be some resource requirements and this was at a time when the system was in the most constrained financial situation. The Director of Public Health felt this could either be tackled by a separate budget for health inequalities or re-profiling and reprioritising within the resources already available.

The Lay Member (voting) had felt overwhelmed by the number of recommendations and welcomed the split into three areas expecting those in section three to be longer term. On reading the report he had realised some areas were a real priority but the response in the next steps was very disjointed considering the recommendation had been about working together. He wondered whether all the public bodies were signed up to the Health Inequalities Commission Report and whether it was a priority and if there was a real commitment to deliver. He queried the timescales commenting there was a need for measurable outcomes and methods of measuring. The Lay Member (voting)

also queried how embedded the inequalities work was and whether it was included in the transformation work or Locality Plans. He felt there was a need for the inequalities work to be considered seriously rather than monitoring as a separate programme and be seen very visibly as part of plans for the next few years. The Director of Public Health advised the recommendations were not all implementable in the form they had been given. Agency sign-up was easier through the HWB and quite a number of items were day to day work for the Council and District Councils. Negotiation and discussion was required as a multiagency did not exist through which to take the work forward. There had been Locality engagement with some of the District Councils around social prescribing as well as much better join up around housing and homelessness. The Director of Public Health felt these were green shoots but not the solid bedrock of working as a single organisation.

The Chief Operating Officer reported Locality Plans were firmly behind social prescribing and resources from OCCG were available to support this work. Cherwell District Council and OCCG had also made a joint social prescribing bid. The Chief Operating Officer had been surprised from reading the Locality Plans, this paper and the BOB Health Inequalities report that some of the wards were featuring as the worst for deprivation across the footprint. She queried if enough emphasis was being given to drugs, alcohol and homelessness. The Director of Public Health advised this was being strengthened and good input was being obtained through the OCC Director for Adult Services and her team. This work would require intra-agency working. There was now a forum but the more this area could be kept on the agenda and the more effort the OCCG Board could oversee and put in the better it would be. The Oxford City LCD observed these were secondary events and queried where was the emphasis on stopping people becoming homeless or addicted to alcohol. He commented the Children's Centres had focussed on areas of deprivation but there had been a big cut in Children Centres over the county. The idea of the Centres was to undertake some preventative work. The Oxford City LCD queried whether Public Health sat in the right place observing that drugs and alcohol, home visiting, and school nurses were not under OCCG but were areas in which the CCG should be engaged. The Director of Public Health stated there was a need to persuade everyone that they were all doing Public Health. He felt where Public Health people sat was not important; it was how all organisations engaged with preventative work, focussed on and took forward health inequalities and how seriously the agenda was taken by each organisation.

The North East LCD felt in trying to address health inequalities, particularly outcomes, there was a need to have a thriving primary care. He commented it was not a coincidence that difficulties and challenges were seen in areas of deprivation. The strength of the system was that patients came to primary care when they were frightened and or did not understand situations and it could be possible to get the best outcome out of the system. If core primary care did not work well there would be challenges in addressing health inequalities.

The Chair felt it was an excellent report bringing out all the themes. She commented on the recommendation concerning the harder to reach population who did not always present to primary care and reaching out to them. She presumed there was a lot of work behind scenes and the report contained a snap shot. She queried whether the Board would receive updates. The Director of Public Health advised it was very much a joint effort and was in everyone's hands. He stated it was a question of how much emphasis and priority the Board put on these issues in its papers.

The OCCG Board noted the progress made with the Health Inequalities Commission Implementation Plan.

Overview Reports		
8	**Chief Executive's Report** The Chief Executive introduced Paper 18/04 updating the OCCG Board on topical issues. The Chief Executive advised this was her first Board meeting. Her responsibility had started on 1 January 2018 and she was maintaining oversight in Buckinghamshire as well. Due to overlaps and previous co-working she knew many of the people in Oxfordshire and thus the transition had not been as strange as it could have been. The Chief Executive explained her first 30 days were being spent learning, getting out and about, understanding how things worked and taking views. Her report described a lot of travel but it was important to see people in the context that they worked or where services were provided. She expected to be able to say more around this and how to take forward at the next Board meeting. The Chief Executive reported the judgement from the Judicial Review had been published. The claimants had decided not to appeal but the interested party were considering doing so. The Chief Executive was unsure if they had submitted the relevant papers. The referral by the Oxfordshire Joint Health Overview and Scrutiny Committee (JHSOC) to the Secretary of State of the decision to permanently close the maternity unit at the Horton Hospital and create a midwife led unit had been referred to the Independent Reconfiguration Panel. The Chief Executive explained the regulators held quarterly meetings to ensure organisations were doing the right thing for their population and patients. There had been a move for both regulators to meet with the providers and commissioners for them to report on their local system. High level attendance was expected and a slide pack was being prepared. A further update would be brought to the next meeting. **The OCCG Board noted the Chief Executive's Report.**	
9	**Locality Clinical Director (LCD) Reports** Paper 18/05 contained the Locality Clinical Director Reports. The Lay Member (voting) noted a number of reports mentioned the improvement the new musculoskeletal (MSK) service pathway had made in reducing the waiting list and acknowledged the work of the Chief Operating Officer and her team. Nursing homes were also mentioned in a number of reports and had been discussed at the Oxfordshire Primary Care Commissioning Committee (OPCCC). The OPCCC was considering undertaking a 'deep dive' around nursing home cover at a non-public meeting. He wondered if this was an opportunity for the LCDs to comment on the content of the 'deep dive'. With regard to the virtual wards, he queried whether there was a service model, clear guidance on how they should work and information on how the risks were managed on the ground. The North LCD advised there were currently discussions on a new classification of nursing homes. He added that not mentioned in his report was that since October 2017 all the care homes in the North bar one were covered but not all the practices had signed up to the care home scheme. The South West LCD advised more work needed to be undertaken on future planning of care home numbers and locations which would be critical to making the system work over the next 10 years. Restricting the number of beds had ramifications for the system and more work around care home provision would be required. There were 30 planning applications for new care homes in Oxfordshire at the moment. An enhanced service was in place to provide more proactive care and covered around half of the care homes in Oxfordshire. Work was underway to increase this number but the figure would never be 100% as there were other arrangements for providing cover. To date none of the care homes in Abingdon	

had been covered but local practices had agreed they would take the care homes under the enhanced service. The Specialist Gerontology service existed in a patchy way but would become a key part of the frailty pathway.

The Chief Executive commented the enhanced service was on top of normal primary care services and pointed out that 30 care homes was the equivalent of a hospital. She stated the registered nurse population should be recognised as they provided a lot of care and expertise which ought to be shared.

The OCC Director for Adult Services advised a single approach to community care home beds had been discussed but there was a patchwork of help to support services and this needed to be targeted around quality. She felt any deep dive should involve commissioners and clinicians and should look at how support could be provided going forward.

The Oxford City LCD suggested care homes should also be engaged in any 'deep dive' as it was an OCCG duty to strengthen quality. In the Care Quality Commission (CQC) reports a number of care homes were rated 'red' whilst a number were doing well. The OCC Director for Adult Services advised a higher number of care homes were 'good' and 'outstanding' in Oxfordshire than other areas of the country. Conversations were taking place around whether outstanding groups of providers should be brought together to share best practice. At a recent JHOSC meeting a registered manager of a home had demonstrated good practice in a care home that specialised in dementia care.

The Chief Operating Officer felt it was good news to hear the potential to increase coverage of the Banbury and Oxford City care homes as these are OCCG's greatest area of need. She added she was concerned that the current scheme did not provide proactive medical cover 24/7 nor had linkage to the frailty pathway and there was a need to ensure this was all joined up.

The Oxford City LCD felt there was a need to consider Extra Care Housing which was a problem that was not being addressed. It was a good initiative but was currently not working well as inhabitants had indicated they were lonely and this was due to the initiative not working as a community. The North LCD observed assisted living was beginning to shade more into residential and supported care. The frailty pathway ought to concentrate on care of the elderly in the population as they were a source of high admissions and did not receive the care they should.

The South West LCD advised most nursing home patients received good and responsive care at the weekend through the OOHs and the GP OOHs service. Most patients had a care plan in place which removed some of the uncertainty when a GP visited a patient they had never seen before. The South East LCD observed patients who moved into extra living were high demand and there was a requirement to ensure contact was retained. He thought it could perhaps be suggested that some of the high demand care could be part of the service to enable GPs to attend. He advised there were some quality issues as patients were discharged to extra living as it was believed these were care homes.

The Chair reminded the Board it had been agreed to take the frailty pathway forward as one of OCCG's priorities. A workshop to discuss the issues was due to take place in February with clinicians from all organisations. The virtual wards linked into the frailty pathway and all Locality Plans contained some aspects of this and there was a need to ensure these were all brought together.

The South West LCD advised it was actually Wallingford not Wantage that was piloting the virtual ward.

	The OCCG Board noted the Locality Clinical Director Reports.	
10	Paper 18/06 was withdrawn	
Business and Quality of Patient Care		
11	**Finance Report Month 9** The Director of Finance presented Paper 18/07 providing the financial performance of OCCG to 31 December 2017; the risks identified to the financial objectives and the current mitigations. Detailed scrutiny of the full Finance Report would be undertaken at the Finance Committee. The Director of Finance informed the Board assurance would normally be taken from the Finance Committee but it had been necessary to reschedule the meeting from Tuesday 23 January and it would now take place immediately following the Board meeting. OCCG was forecasting to deliver against the business rules targets and financial target to breakeven although there were significant underlying issues and concerns. A £7.0m overspend pressure was being reported in the acute position which was being managed through the contingency reserves. The pressure was from the main acute providers in Oxfordshire but some of the pressure was from neighbouring acute providers. The neighbouring acute provider pressure might reflect patient choice but could also be due to the referral pressures at OUHFT. The over performance was in both elective and non-elective activity. The risk agreement in place with OUHFT and OHFT reflected the position and whilst there was a significant overspend the Director of Finance still recommended that this was the right approach in terms of moving forward. The position on the pooled budgets was a significant and escalating concern particularly the overspend in the Better Care Fund (BCF) on Continuing Health Care (CHC) in care homes. The overspend was estimated to be in the order of £4.0m. This was a material concern for OCCG and OCC as part of the risk share components. This would be considered further in the Finance Committee. Looking forward to the next year if this was a recurrent pressure it would be a first call on finances. A reduction in waiting times for assessments had caused an increase in placements funded which was good from a patient perspective but did have a financial impact. People were also living longer which meant the case load was growing. The CCG Executive had received a paper on the overall prescribing care budget and the national pressure of No Cheaper Stock Obtainable (NCSO). In Oxfordshire the pressure was in the region of £3-4.0m. It was only due to the good work in practices in identifying savings that the figure was not greater. This needed to be borne in mind and managed as OCCG approached year end. There was mixed news in Section 3 of the report around the savings programme. There was some good news in those programmes owned and controlled by OCCG where a slight over-delivery on savings targets was forecast. Significant under-delivery was forecast around those schemes in the system risk mitigation which required system sign up to deliver. It was reported nationally that the delivery of savings started with good relationships and the right level of system engagement. OCCG had encouraged and built on this, putting in a lot of effort and holding weekly meetings and this needed to be taken forward to delivery. The Director of Finance believed the top schemes in each area needed to be identified and driven through. There had been positive discussions around risk share with the Trusts for the next year's contracts despite the pressures in the system risk which were not as originally anticipated. There was a willingness to sign up to some form of risk share in the next year.	

	The Director of Finance advised the £20.0m surplus was effectively carried forward. The plan had been not to add to the surplus this year which led to forecasting a breakeven position. However, there were a couple of national issues which needed to be managed as in Month 12, OCCG might be asked to release the surplus which would lead to a change in the forecast year end position. The Director of Finance stated OCCG had to work within the approach set nationally by NHSE England (NHSE) and in planning for 2018/19 some of the problems around perception were recognised and the team was looking for ways to address this. The Oxford City LCD had received a letter around the increase in referrals to Reading due to Healthshare offering choice to patients who opted to avoid the waiting list in Oxford. He commented that the risk share agreement had been signed last year prior to the referral to treatment (RTT) situation arising. He queried whether there would be a more nuanced risk share for 2018/19 allowing for more predictable items to be carried more fairly. The Director of Finance advised the agreement reached last December had held even though it had been under strain during the year. There was a lot of learning from the form and nature of the agreement which could be built on and brought forward in the negotiations. The Lay Member (voting) observed if the main provider delivered the RTT there would be insufficient financial headroom to manage the risk. This would need to be addressed should RTT delivery improve. The Director of Finance advised OUHFT had struggled to find the capacity to deliver the RTT however it was recognised they were moving forward and there was a need to have an RTT medium term plan. The Director of Finance directed the Board to the NHSE Board paper which clearly recognised the settlement in the budget statement did not meet the 'ask' in the NHS and there would be difficult choices. **The OCCG Board noted the Finance Report for Month 9 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.**	
12	**Integrated Performance Report** The Chief Operating Officer introduced Paper 18/08 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 advised the key issue was readiness for winter and A&E performance. A&E was running at 83% but Christmas and the January period had been managed. There were still concerns whether 'flu would continue to cause problems. A substantial number of patients had been managed through the system but more work was needed. A huge amount of support was being received from other agencies. NHS Improvement (NHSI) was reviewing whether the flows and systems through OUHFT were as good as they could be. Hunter Healthcare was supporting the Trust by reviewing the 'stranded' and 'super stranded' patients. An initiative would commence in the next week around the short stay ward and ensuring it was short stay and patients were turned around in a timely manner. This was a challenge for all partners. The Board should note there was a huge amount of different and new work taking place with external eyes supporting the system to address the A&E situation. There was some optimism around RTT but agreement on the resources was required before the work could be taken forward further. Agreement had been	

reached with the Ramsey which would provide OUHFT with a bit of space and would not be affected by any pressures in emergency care.

There continued to be good performance around the cancer targets although there was continued concern over the volatility of the 62 day target. Mixed sex wards were taken seriously but due to the considerable pressures the system was asked to consider and there had been some instances of wards being mixed sex.

The ambulance service appeared to be performing well against the new response standards but there were some questions around whether the new system was delaying the actual time of the patient arrival in the emergency department. The OCCG was exploring if there had been any unintended consequence of implementing Ambulance Response Programme (ARP).

In relation to ambulance handover South Central Ambulance Service had been complimentary about the OUHFT approach but there remained delays that needed to be addressed. However, there were also delays that were not to the emergency department but hand over to other units/wards. A constructive conversation had been held between SCAS and the Medical Director and the Director of Clinical Services/Deputy Chief Executive at OUHFT to explore these issues.

There had been a good response on improving access to psychological therapies. There had been some data glitches and these would be picked up with those in OHFT submitting the data.

The Children and Adults Mental Health (CAHMS) service performance had continued to dip but an improved performance would be shown in the next report with a move from 49% to a figure in the 60s. The single point of access (SPA) was due to start on 5 February. It was hoped the SPA together with third sector involvement would make a difference.

The Director of Quality advised the 12 hour trolley waits had not previously been a feature of the local emergency departments but there had been a sudden increase in numbers. As this was not normal custom and practice for the Trust they had not been as focussed as OCCG would have wished. A conversation had taken place with the Chief Nurse and a root cause analysis would be undertaken. OUHFT would be introducing SHINE, an ED safety check list, which would focus on moving the patient through the system.

Aspects of infection control were regularly reported to the Board. There had been four cases of MRSA with no lapses of care identified.

Although 'flu immunisation rates were improving there was a need to encourage uptake, particularly for children, and a need to not become complacent.

A business case had been presented to the OUHFT Board for voice recognition recording for out-patient letters. It was hoped 80% of out-patient letters would be undertaken in this manner by the end of the year which should improve the situation. There had been optimism that the situation regarding duplicate discharge summaries had been resolved but there had been some continued occurrences and this was being looked at. The Trust had undertaken some work around the management of test results and was encouraging clinicians to follow through their responsibility to monitor and sign-off results.

Following a query from the North LCD around delayed transfers of care (DTOC), the Chief Operating Officer advised she did not believe the trajectory in January would be met. The trajectory by January was supposed to be under 100 patients

and the current position looked to be in the region of 107. The reablement service, HART, patient choice, self-funders and community hospital discharges had all impacted. Progress from the original 144 had been maintained but the numbers were not decreasing in the way they needed to. Clear conversations around the reablement service were required. There was a good and clear pathway but despite the mitigations there were still a significant number of people waiting for reablement services and discussions were continuing with social care. The OCC Director for Adult Services advised the contracts were performing at their highest level but as 18 months from instigation approached, there was a need to discuss as a system if this was the right road as there was clearly a big issue. There had been some progress around G codes with OHFT paying for a dedicated social worker to work on the G codes in the community hospitals. The HART service was doing better but was not yet where the system would wish it to be. There had been a challenging trajectory around DTOC. The November trajectory had been met and confirmation received that the BCF for next year had been secured.

The Chief Executive acknowledged the significant scrutiny through the A&E Delivery Board but queried assurance of the rest of the system response to urgent care challenges, what support there was to ensure discharges were timely and confidence that the care in community hospitals was supporting that discharge. She understood the challenges around GP resilience but questioned whether response times to SCAS were measured. The Chief Operating Officer advised the G code targets were set by the Chief Operating Officers in OUHFT and OHFT. She reported an exercise had been undertaken a couple of weeks ago around the number of planned discharges every single day to manage best practice bed occupancy. Everyone had worked well and agreed a grid of numbers around what was required on a daily basis. In some areas the numbers currently being achieved were quite a distance from these figures and a step change in view point would be necessary. The system had done really well but was not yet where it needed to be. The Chief Executive expressed concern for patients waiting to be discharged as if they received little input there was a risk they might end up requiring a significantly more enhanced package of care.

The Oxford City LCD queried the SCAS categories and the Chief Operating Officer advised it was too early to be able to say whether those attending on category three and four were frail elderly who did not require urgent admittance. Although the new system would provide more ability to see what was going on, the base line to measure whether the service was better or worse was not yet available.

The Lay Member (voting) queried whether the Board should be concerned at the Clostridium difficile (C.diff) numbers which were well above the limit. He wondered if there could be some benchmarking and the issue picked up by the Quality Committee. The Lay Member (voting) noted the point and technical issue concerning discharge summaries but expressed the view that 15% of OUHFT patients and 45% of OHFT patients discharged without a summary was not acceptable and put patients at risk. He felt a recovery plan for long waits in the CAHMS service was required in order to have a trajectory in terms of how these would be reduced as it was necessary for the Board to have some sort of assurance. He felt there had been a good quarterly report analysis of the RTT situation but that there was a need to look at the contract report to establish performance by specialty against plan and triangulate this against change in the waiting list. The Lay Member (voting) asked whether the Trust was struggling to meet the growth in referrals or whether it was due to OUHFT not meeting the delivery commitment made.

The Director of Quality explained the number of C.diff cases tended to drop at this

	time of year. The team was considering how this might be reported in future as there was generally a peak in the summer and a drop at this time of year. She advised C.diff was reported to the Quality Committee with all cases being reviewed to check there were no lapses in care. It had also been noted that a number of patients were discharged quite quickly from the acute sector and then readmitted. With regard to the discharge summaries, improvement and timeliness had been included in the OHFT contract and further working was underway. A fuller explanation would be brought to the next OCCG Board. The Chief Executive advised in Buckinghamshire when there had been a big backlog of waiting lists more patients had been moved to have their procedure as day patients which had been a benefit to patients and helped control the waiting list backlog. She felt this could be managed from a clinical point of view. The Chief Operating Officer reported the cancellations had produced a good result as some patients had been moved to day cases. The Chief Operating Office advised a CAHMS recovery plan was expected by 30 January and the Clinical Lead would take a view around whether it provided assurance. The request for triangulation would be passed to the Delivery and Localities Performance Manager. The Chair queried whether there had been any progress from the recent DTOC and care support recruitment drive. The OCC Director for Adult Services reported the campaign had been launched and a follow up workshop was due to take place on 30 January where senior input was expected. The most up-to-date statistics would be available for that Workshop. There had been 50 applications via the website in the last few months. These would now be tracked to understand whether the applicants attended for interview, if they were appointed and, if they were, how long they remained in the role. An update would be provided to the next OCCG Board. **The OCCG Board noted the Integrated Performance Report.**	**SW** **DH** **KT**
Governance and Assurance		
13	**Annual Equality Publication** The Director of Governance presented Paper 18/09 explaining Section 149 of the Equality Act (2010) required organisations to demonstrate compliance with the Public Sector Equality Duty (PSED) which placed a statutory duty on organisations to address unlawful discrimination, advance equality of opportunity and foster good relations between people when carrying out their activities. OCCG needed to: • Publish information demonstrating compliance by 31 January each year • Publish information in a way which made it easy for people to access it • Publish Equality Objectives at least every four years. The Director of Governance advised Paper 18/09 was the Annual Equality publication for OCCG and detailed the equality and diversity work in 2017. During the year OCCG had continued to work with the Equality Reference Group and the Staff Partnership Forum to undertake and publish Equality Delivery System (EDS2) and Workforce Race Equality System (WRES) reports. The Director of Governance commented that although the paper provided an overview and summary the important point was imbedding equality through everything the CCG undertook. There was focus on access to some groups which remained an issue and looking at improving areas of work such as the vulnerable adults mortality review and focus on more upstream care in order to improve outcomes and the partnership approach with the local authority on refugee and asylum seekers.	

	The Lay Member PPI highlighted the section on the Transformation Programme and the Integrated Impact Assessment report around equity issues for the local population, travel times and their impact on deprived communities which should be borne in mind going forward for changes in services and areas where there was likely to be consultation. There were difficulties around undertaking relevant travel analysis and a piece of work should be undertaken to better model the effect on groups such as those in rural areas and those with learning difficulties. The Lay Member PPI said there was some disparity from stage one and the potential for further effect on deprived communities from service reconfigurations in stage two and OCCG should be prepared and undertake better modelling from the data. She felt there were many good items in the report, including some good analysis, but some forward projection and modelling around how communities would be affected and how services could address inequality issues was required. The South West LCD noted the comment the NHS was committed to equal pay for work of equal value and given the recent paroxysms in other parts of society queried how this was addressed in the health service. The Director of Governance reported the Agenda for Change (A4C) pay scale and approach to grading jobs had been introduced and should provide the outcome that jobs of equal value received the same reward. The Oxford City LCD observed the grading had not resolved the problem as different people were still graded differently. The jobs were graded by other people who made a judgement call and this resulted in inequalities. The Director of Governance advised it had been agreed by having a single grading structure the NHS was in a better starting position. OCCG jobs were graded by a panel in the Commissioning Support Unit. Although an audit could be undertaken within groups around grades and gender, it was difficult to know what OCCG would do with the results. The Chief Executive suggested that piece of work fell within the remit of any of the local workforce groups rather than OCCG. **The OCCG Board approved the Annual Equality Publication.**	
14	**Corporate Governance report** The Director of Governance introduced Paper 18/10 which reported on formal use of the seal and single tender action waivers. It also included details of hospitality and declarations of interest. It was noted that the Chief Executive's continuing responsibility for Buckinghamshire CCGs needed to be included in the Register of Interests. The Director of Finance reported he had been appointed as a Director on the Oxfordshire Infracare LIFT company which meant he had sight of and the opportunity to influence the estates work. The Director of Finance had also been appointed a Member of the Council of Governors at OUHFT in place of the North LCD. The register to be updated. **The OCCG Board noted the Corporate Governance Report.**	**LC**
15	**Strategic Risk Register and Red Operational Risks** The Director of Governance presented Paper 18/11 explaining the paper provided an at-a-glance view of the current status of all risks on the Strategic Risk Register and Extreme/Red risks (risks graded $\geq$ 20) on the Operational Risk Register. The detail of the risks had been considered in Committee meetings. The changes were indicated on the front sheet and the Director of Governance highlighted in particular the increase in scoring of AF25. Four strategic risks were now 'red' rated and there were three 'red' Extreme/Red Operational risks. **The OCCG Board noted the recent updates to OCCG risks and the four Red Strategic Risks with a rating of 20:** • **AF21 - Transformational Change**	

	• **AF19 - Demand and Performance Challenges** • **AF25 – Achievement of Business Rules** • **AF26 - Delivery of Primary Care Services** **The Board particularly noted the risk score for AF25 had been increased from 16 to 20 to reflect the forward view information 2018/19. Financial plans indicated a £25-30m financial gap before mitigations and approach to prioritisation. The pressure used forecast in the NHS Five Year Forward View in line with the profile of funding for the NHS. OCCG and system approaches to deal with the gap were to be prioritised.** **The Board noted there remained three Extreme / Red Operational risks:** • **797 – A&E Four Hour Wait** • **789 – Primary Care Estate** • **758 – DTOC**	
	Oxfordshire Clinical Commissioning Group Sub-Committee Minutes *Finance Committee* The Lay Member (voting) as Chair of the Finance Committee presented Paper 18/12a, the minutes of the Finance Committee held on 23 November 2017. The Lay Member (voting) advised there was an error in the Action Required section of the report. The report on the decision to approve the prioritisation list of primary care sustainability schemes had been reported to the November Board meeting. *Oxfordshire Primary Care Commissioning Committee (OPCCC)* The Lay Member (voting) as Chair of the OPCCC presented Paper 18/12b, the minutes of the OPCCC held on 2 January 2018. He reported a number of discussions had been held around the functioning of the Committee and undertaking engagement and consultation. Recommendations had been made to the management and a response was expected. The Lay Member (voting) had also undertaken one-to-one meetings with the LCDs and would feedback to the Chair on those discussions. The Lay Member (voting) queried whether there had been any feedback from the CQC following a planned inspection of Horsefair Surgery at the beginning of December. The Director of Quality advised the public report was still awaited. She advised support had been provided to Horsefair on a regular basis. The surgery had increased its number of telephone lines in order to improve access but unfortunately there had been some staff sickness. OCCG had encouraged the practice to man the telephones to ensure calls could be answered. The Director of Quality had separate meetings arranged in the next week with the practice and the Patient Participation Group (PPG). The Lay Member (voting) understood OCCG would no longer be following the consultation route regarding Banbury Health Centre (BHC) and requested an update. The Chief Operating Officer advised OCCG had reflected on what had been heard from patients and the public through the engagement events and from discussion with JHOSC, the Community Partnership Network (CPN) and the PPG. There had been a lot of engagement in Banbury and feedback was very strong around a desire to maintain services within the GP surgery in BHC. OCCG had taken on board that feedback and was looking at how services could be continued at that site. OCCG had met with Cherwell District Council and a further meeting was planned to discuss charges for the property. Discussions were around delivering services for the next two to three years. OCCG was working closely with the practices involved. A partner to take forward the General Medical Services (GMS) provision elements at BHC was being sought. Continuation of GP services had been secured and OCCG was looking for support to work with the partner. As there was a solution to move forward there was no longer a consultation requirement.	**EDS**

Quality Committee

The Lay Member PPI as Chair of the Quality Committee presented Paper 18/12c, the minutes of the Quality Committee held on 21 December 2017. The Lay Member PPI requested that the point about the Quality Surveillance Group (QSG) concerns with OUHFT be clarified. The Director of Quality advised the NHS England QSG looked at all organisations across the health economy and where organisations had a number of 'reds' a closer look would be undertaken. This involved pulling together quality risk analysis by approaching all organisations to understand if concerns were shared. It was a process to see if a trust needed to be measured more or less frequently. Due to the issues OUHFT had been experiencing it had raised concerns. The review was not yet concluded but the results would be shared. **SW**

The Lay Member PPI advised the first full year report on interim maternity units, including all the freestanding units in Oxfordshire, had been received by the Committee. The Horton as a midwife led unit (MLU) was still maturing. There were some issues which would need to be looked at in the longer term if the Horton remained a freestanding MLU. Nationally MLUs were underused and research was being undertaken nationally to look at this. MLUs were a resource which could be used more widely if women were assured they had good support and would deliver in the unit rather than being moved. The Lay Member PPI advised the Horton transfer rate was high.

A report on the learning from the transfer of Learning Disability services had been received and the Committee had looked at the learning from the way the services had transferred to the current provider but had also looked back at how the system had not learned from the transfer of services from Ridgeway to Southern Health. The Committee had been encouraged by the learning and how it had been put in place. This particular instance had been more complicated as OCCG was not the only commissioner of services. The Lay Member PPI stated it was the responsibility of all parties to ensure systems were put in place for safe transfer. The Committee was assured some good learning had come out of the exercise and it had been helpful to understand how to take lessons for the transfer of substantial services between providers.

The Oxford City LCD stated that the Quality Committed had been assured on the safety of the Horton MLU which was not out of line with other areas and some members of the Committee felt it was not necessary to keep looking at this MLU in any more depth than any other. He advised transfer rates had increased across all MLUs and the Committee was assured the Horton MLU was doing what it should.

The Lay Member (voting) picked up the point about issues with workforce in the MLUs and assumed the Committee had received assurance the risks were fully mitigated and if any units had closed at Christmas OCCG would have been informed. The Lay Member PPI advised the issue had not been about winter but that it was predictable birth rates would be higher in some months. This problem would not go away and the provider ought to find a way to mitigate the problem as it happened every year. It was an ongoing problem around the recruitment of midwives. The Director of Quality advised the Trust tended to recruit all the cohort of midwives due to graduate from Oxford Brooks at the end of the summer. The Trust had a process and escalation plans. The process was to call in midwives to where the units were busiest and this it did on a regular basis. In the MLUs community midwives were called in as more patients attended but the workforce continued to be a challenge.

The Chair observed there were always peaks and troughs in any service and plans were in place to address if a situation arose. She reported the Horton had

	only been shut on one very short occasion in December but no patients in labour were in the unit at the time. Staff had to be moved to where they were required. A clear response to the questions received would be uploaded to the website. The Chief Executive commented that part of the remit of the Quality Committee was to look at workforce and she suggested this should perhaps be picked up later in the year. **The OCCG Board noted the Sub-committee minutes.**	**LW**
For Information		
	Any Other Business There being no other business the meeting was closed.	
	Date of Next Meeting: Thursday 29 March 2018, 09.00 – 12.45, Banbury Town Hall	