Oxfordshire
Clinical Commissioning Group

MINUTES:

OXFORDSHIRE CLINICAL COMMISSIONING GROUP BOARD MEETING

29 March 2018, 09.00 – 12.45 Banbury town Hall, Town Hall Buildings, Banbury, OX16 5QB

	Dr Kiren Collison, Clinical Chair
	Louise Patten, Chief Executive
	Dr Stephen Attwood, North East Locality Clinical Director (voting)
	Dr Ed Capo-Bianco, South East Locality Clinical Director (voting)
	Dr Miles Carter, West Locality Clinical Director (voting)
	Dr David Chapman, Oxford City Locality Clinical Director (voting)
	Heidi Devenish, Practice Manager Representative
	Roger Dickinson, Lay Vice Chair (voting)
	Diane Hedges, Chief Operating Officer (non-voting)
	Gareth Kenworthy, Director of Finance (voting)
	Catherine Mountford, Director of Governance and Business Process (non-voting)
	Dr Paul Park, North Locality Clinical Director (voting)
	Dr Guy Rooney, Medical Specialist Adviser (voting)
	Duncan Smith, Lay Member (voting)
	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
Apologies:	Dr Jonathan Crawshaw, South West Locality Clinical Director (voting)
	Dr Jonathan McWilliam, Director of Public Health Oxfordshire (non-voting)

Item No	Item	Action
1	**Chair's Welcome and Announcements** The Chair welcomed everyone to the meeting and reminded those present the OCCG Board was a meeting in public and not a public meeting. She advised the public would have the opportunity to ask questions under Item 3 of the agenda. The Chair expressed her thanks and gratitude to the North Locality Clinical Director for his contribution to the OCCG over many years who was attending his last Board meeting and to the Lay Member (non-voting) who had stepped down from the Board due to work commitments. The Director of Quality introduced the Patient story, a video of a patient's experience of the Thame Community Hub, and thanked the patient for their consent.	
2	**Apologies for absence** Apologies were received from the South West Locality Clinical Director and the	

	Director of Public Health Oxfordshire.	
3	**Public Questions** The Chair advised a number of questions had been received via the website and these would be addressed either at the relevant item on the agenda or with a written response. Answers to all questions would be posted on the website within 20 working days. The Chair invited questions from members of the public. Jenny Jones read out the questions she had submitted by email and responses were given as follows: The MRI unit had been at the Oxford University Hospitals NHS Foundation Trust (OUHFT) John Radcliffe site for a year. The unit was on a dedicated pad and was not using any car parking spaces. It had not been possible to place the unit at the Horton Hospital as no suitable site was available although this would be looked at for the future. Since October 2016 only one neo-nate had been transferred out of area and this had been for non-clinical reasons. The Director of Quality did not have the answer to the question relating to how many hospitals ran a neonates unit without paediatrics alongside and would obtain the information and both the question and answer would be uploaded to the website. Other questions raised: Would the Board explain the impact on the Horton Hospital of the Independent Reconfiguration Panel (IRP) report; what services would be retained as a consequence of the report; what would be the process for consultation on the future of maternity services; and how would OCCG involve South Northamptonshire and South Warwickshire as Banbury is the centre of an area colloquially known as 'Banburyshire'. The Chair advised this question would be addressed under agenda item 10. Could OCCG reassure Banbury that OUHFT had accommodation for maternity services should the review go forward to a point where there might be a decision to return obstetrics to the Horton Hospital. The people of Banbury needed assurance the review was not a paper exercise. The OUHFT had been asked for assurance the building was capable of taking back the service. OCCG needed to make this clear especially as the Ramsey Treatment Centre building was not available following sign off of a further three year contract for service provision. The Chief Executive commented that this was a fair question and advised as OUHFT had not planned for any change there should still be capacity but she would check with OUHFT and make the communication clear in public. The Chair advised the written submissions had been around Wantage and the Community Hospital, several on the Horton Hospital which would be picked up later in the meeting, diagnostics, beds, whether the Horton Hospital buildings were fit for purpose, and the collaborative model. Answers to all questions would be posted on the website within 20 working days.	**SW** **LP**
4	**Declarations of Interest** There were no declarations of interest over and above those already recorded and none in relations to the agenda items. .	
5	**Minutes of OCCG Board Meeting held on 25 January 2018** The minutes of the meeting held on 25 January 2018 were approved as an accurate record subject to amendment of some typographical errors.	**LC**
6	**Matters arising from the Action Tracker and Minutes of 25 January 2018** The actions from the Action Tracker and 25 January 2018 minutes were reviewed and updates provided where these were not covered under items later on the agenda.	

	Board to Board with OUHFT The Chair advised regularly meetings were held by the Chair and Chief Executive with the Chair and Chief Executive of OUHFT and it was felt a Board to Board should not be held for the time being. The action was closed. *Exit Interviews* The Director of Quality advised the action concerned all exit interviews not just those around the Child and Adolescent Menth Health Service (CAMHS). Oxford Health NHS Foundation Trust (OHFT) had employed someone external to the Trust to undertake exit interviews as people who left were sometimes reluctant to participate in an exit interview with their colleagues. There was nothing significant to share at the moment. *Discharge Summaries and OHFT Electronic Discharges* The Director of Quality advised these were in place for the mental health service although they differed from the OUHFT system as they did not go straight into the GP system; there was not the same approach between the two organisations; a system was not yet in place for community services; and there were different timeframes. Work was being actively taken forward through the Information Taskforce. The Oxford City Locality Clinical Director advised OHFT was now using the same discharge system straight into the GP system. The action was closed. *Referral to Treatment (RTT)* The Chief Operating Officer advised an RTT quarterly report had been produced and reviewed by the Lay Member (voting) and the Lay Vice Chair and would now be taken on a regular basis to the Quality Committee. The action was closed. *Recruitment Campaign* The OCC Director for Adult Services advised a presentation providing an outline of numbers who had applied for posts following the recruitment campaign would be shared with Board members. A watching brief would be kept to see whether those who had clicked on the site were appointed and if so, how long they remained in the role. The action was closed but an update would be provided in six to 12 months' time.	**KT**
	Better Care Fund (BCF) The Lay Vice Chair advised in view of the activity on integrated care and the Provider Framework, a meeting would be organised in late May with the non-executive directors of OUHFT and OHFT and appropriate officers from Oxfordshire County Council (OCC) to discuss governance issues.	**RD**
	Oxfordshire Transformation Programme To be covered under Item 10 on the agenda. *Business Case for Planned Care Work* The Lay Member PPI advised the OUHFT had been asked to consider planned care particularly in regard to other sites such as the Horton Hospital. She queried when the business case would be ready and when it would be considered by the OCCG Board. She stated there was also a need to be clear on the implementation of 90,000 out-patient appointments and the expansion of the Horton Hospital emphasising these were decisions which had not been contentious. The Chief Executive explained redesign and modernisation of out-patients would be part of the workstream. There was also a need for this work to link in with the move forward to locality and place based commissioning and the discussion on community assets and buildings. Bringing services such as out-patients to the community was supported but needed to be alongside	

	modernisation. This work was being undertaken nationally and involved looking at out-patients slightly differently, such as the use of video conferencing, but OCCG remained committed to getting out-patients at the Horton Hospital. The Director of Governance advised the Judicial Review process was not necessarily over as the interested party was appealing the judgement that an appeal could not be made. The Chair reiterated the CCG intention but observed changes could not be undertaken whilst a Judicial Review was pending. The Lay Member PPI commented there was also the question of restoring good faith in the CCG's processes and working with providers and the public that the CCG would deliver on decisions made. *The Director of Public Health Annual Report X* The Lay Member (voting) commented that it did not feel as if much had happened since the Board had reviewed the Director of Public Health Annual Report X. He felt it did not appear that the prevention agenda was working its way through to the priorities and financial plans. The Chief Operating Officer reported a lot of assistance had been received from Public Health in the review of the Strategic Needs Assessment and in reviewing the locality plans. Regular monthly meetings were now held to go through the Public Health Best Practice and Joint Health Needs Assessment. The Chief Operating Office advised more clarity was required around children and self-harm and a paper would be taken to the CCG Executive and the work around the prevention agenda was being pulled together to take to the CCG Executive in May. The Chief Executive stressed the need to quantify and describe the work in order for it to be evidenced at the Board. The Oxford City Locality Clinical Director observed prevention and related services should be part of Locality Plans to help prevent people being admitted to hospital. There was a need to look at redressing health inequalities and deprivation. The North East Locality Clinical Director reported prevention work was being implemented and drew attention to the Bicester Healthy New Town project which had a massive agenda and where actions were beginning to bear fruit. The Chair did not feel the work being undertaken was clear in all the programmes and requested a review to identify gaps which could then be addressed. She added that prevention needed to be one of the priorities.	**DH**
	Cancelled Operations The Chief Operating Officer advised due to winter pressures a number of operations had to be cancelled although children's and urgent care were maintained. She advised there had been another period of pressure during March. The Chief Operating Officer reported there had been minimum impact on the Horton Hospital as elective care was stand-alone and in the main day cases were undertaken. The impact had been mainly on the hospitals in Oxford city. *OPCCC Minutes: 121 Meetings with LCDs* Feedback from the meetings with Locality Clinical Directors would be taken to a Board Workshop. *Quality Surveillance Group* The Director of Quality reported OUHFT was no longer subject to additional surveillance as the risk level had reduced. Overall the report had been positive although there were pockets where further work was required. *Workforce*	

	The Director of Quality reported a local workforce group had been formed, which she would chair, with input from all parties. This group would feed into the wider STP group and would be an active piece of work going forward. A report would be brought back at a later date. The Lay Member PPI advised workforce formed part of the remit of the Quality Committee and the work described by the Director of Quality fed in but how workforce issues impacted on services already being delivered and any effects on quality also needed to be considered. The Oxford City Locality Clinical Director reported the pay increase for NHS staff was having an impact on the third sector as a pay freeze had been in place for these staff for longer than NHS and as a result they were struggling to recruit. He felt this needed to be incorporated into the workforce plans. The OCC Director for Adult Services advised feedback had been shared locally from the consultation Facing the Facts, Shaping the Future – a health and care workforce strategy for England to 2017. The positive news of NHS pay rise had also been fed back but this did raise a question around what it meant for other public sector areas.	**SW**
Overview Reports		
7	**Chief Executive's Report** The Chief Executive introduced Paper 18/15 updating the OCCG Board on topical issues including performance against national targets, Quarter 3 NHS England (NHSE) Improvement and Assessment, Care Quality Commission (CQC) Local System Review, Health and Wellbeing Board (HWB) Review and the Deer Park Referral/Work on West Locality Plan. The Chief Executive commented performance was an issue particularly for referral to treatment (RTT), cancer and A&E which was still under significant pressure. The Chief Executive wished to acknowledge the pressure on frontline staff and their hard work in addressing the issues. Easter planning had been carried out and there was an extra cap across the system as well as some cross party working to make the system as efficient as possible. The Q3 Assurance meeting had been the first time organisations had been assured as a system. The Chief Executive remarked that it had been an interesting exercise which had looked at the CQC Review and questioned how work on this was progressing; the need for more pace around delivery, particularly A&E, had been recognised and it was felt the Operational Plans needed to reflect more integrated working. OCCG continued to learn from the Deer Park Medical Centre experience in developing its approach to involving the public. The CQC Review had been very helpful. It had not contained any surprises and there had been a need to quickly turn around an action plan. A Task and Finish Group had been formed to focus on the Action Plan. The Chief Executive advised on the review of the HWB which she felt was very helpful as the HWB could set the overarching strategy under which the Integrated Care Delivery Board (ICDB) would deliver the strategy. The Chief Executive advised the North Locality Clinical Director was standing down from his role and from the OCCG Board and the Lay member (non-voting) had resigned. She thanked them both for their hard work and efforts on behalf of the OCCG and reported the skills required of the Lay Members would be considered before taking forward any recruitment. The Chief Executive was happy to report that both the Lay Vice Chair and Lay Member (voting) had both been reappointed for a further term.	

	The Lay Vice Chair stated he wished to also thank the North Locality Clinical Director and the Lay Member (non-voting) who had undertaken a lot of good work as well as working across the Committees. He commented recruitment of another Lay Member was dependent on the skills set requirement particularly in light of the Commissioner Provider Framework. The North Locality Clinical Director expressed his gratitude to those who had thanked him stating it had been an honour and a privilege to work with OCCG. **The OCCG Board noted the Chief Executive's Report.**	
8	**Locality Clinical Director Reports** Paper 18/16 contained the Locality Clinical Director Reports. The North Locality Clinical Director reported there had been some strong feeling at the NOLG meeting around the issue of practice receptionists and the fact they were front line staff and the first point of contact for 80% of the NHS. Receptionists undertook a complex job and they were not always appreciated. NOLG members felt it should be recognised that receptionists carried out a difficult role and were not unappreciated. Responding to queries from the Lay Member (voting), the North Locality Clinical Director advised the mental health workers in the North were in the rural cluster and there was an issue around interface with OHFT mental health. Work on this issue had been undertaken over the years and it was hoped this would continue in the future as the service expanded to other practices. The North Locality Clinical Director advised there were concerns around how to maintain the GP commissioning voice as it was natural for GPs to think in the first instance as providers. The Chief Executive observed providers working together could produce a solution to address a particular issue. She suggested the new Conflicts of Interest guidance might allow a relaxation of the position but it would be necessary to work hard to ensure the commissioner voice was not lost. The Oxford City Locality Clinical Director advised the City practices worked closely with OxFed which had matured as an organisation. In Oxford City there was a conflict as there were some very prosperous areas and a very deprived section of the City. The Federation represented each practice equally but there was a requirement for the commissioner to provide an overall strategy. The West Locality Clinical Director referred to previous discussions around development in the county and funding for GP practices. He reported on discussions to use Section 106 monies and working with developers on a new site for his practice only to be informed that the rent would not be funded. The Director of Finance advised he did not have the facts to hand to be able to give a response and would take away and feedback to the West Locality Clinical Director. The West Locality Clinical Director felt there was a need for a process to be in place to ensure when negotiations were undertaken with developers participants could be confident the correct notional rent would be applied otherwise developers would not be interested in developing schemes with practices. The director of Governance reminded the Board that the appropriate place for this discussion was the Oxfordshire Primary Care Commissioning Committee (OPCCC). The Lay Member (voting) reported a piece of work was being undertaken through the OPCCC around the estates strategy for primary care. This would come back to the OPCCC and be fed into the financial strategy. The Chair stated this was a high priority and important for Oxfordshire and would be picked up outside of the meeting. The Lay Member (voting) commented that he was delighted to see information in the City report about a housing project for those with long term conditions and	**GK**

	mental health and felt it would be good to see the initiative taken up by other localities. He queried how the City officers integrated. The Oxford City Locality Clinical Director advised the scheme was still being worked up with limited funding. It was believed the housing officers understood the population need adding the scheme was very helpful as organisations did not necessarily share information. **The OCCG Board noted the Locality Clinical Director Reports.**	
Strategy and Development		
9	**Operational Plan Refresh** The Director of Governance presented Paper 18/17, a final draft of the 2018/19 Operational Plan submission for 30 April 2018 and advised the Board was asked to delegate authority for sign off prior to submission to the Chief Executive. The Director of Governance advised it was a refresh of the two year plan agreed in January 2017. This was a transition point as there was a need to refresh in line with the overall strategy. The Director of Governance would ensure sections on prevention and reducing inequalities were included before the Plan was submitted. Although as part of the Q3 Assurance process issues around alignment with providers were raised, the system was not yet at a point where it was possible to have a single operating plan but there was a move towards aligning financial and performance submissions. The Director of Finance reported the paper reflected the initial planning submission to NHSE at the beginning of March. This year the planning guidance and detailed confirmation of allocation had not been available until mid-February. The Operational Plan and OCCG were compliant with business rules. The key risk to the financial position would be the position agreed in the contract negotiations. Agreement had not yet been reach with the two main providers and a full briefing would be provided when agreement was reached. The Lay Member PPI commented on the bid for the joint Buckinghamshire, Oxfordshire and Berkshire West Sustainability and Transformation Programme (BOB STP) Wave 2 NHSE funding for perinatal mental health which seemed to be a forward going bid but the minutes of the last meeting advised a bid had been submitted. The Chair reported at the time of the last meeting the CCGs were on the verge of submitting the bid. The bid had been submitted and a decision on whether or not funding would be received was awaited. The Lay Member PPI also commented on the aspiration to increase hours on labour wards. The Director of Quality advised the OUHFT Obstetrics Lead wished to implement this goal for Oxfordshire. Although agreeing OCCG should not be provider led, the Director of Quality observed discussion had just taken place around working together and there should be respect for individuals who took responsibility and accountability for services. She added that recruitment challenges might mean the level could not be achieved and the figure might change through the year. The Director of Quality remarked OUHFT also had tertiary responsibility for patients coming from other areas of the country so OCCG should listen to their guidance. The Lay Member (voting) queried whether there would be an opportunity for the Board to review the final draft before it was submitted as the challenge to the Board was whether it believed the Operational Plan could be delivered. He cited as an example that the Quality Premium Standards had as yet not been achieved and questioned how OCCG expected to be able to achieve these in 2018/19. He felt there was a need for priorities to be measurable, have base lines, and be clear on what could be delivered and that the report should be written from the perspective of the patient as it did not explain what would be delivered or the	

	outcome for patients and contained a lot of jargon. He recognised OCCG had to use templates when producing the report but suggested if it was written from a patient perspective it would help with engagement and prioritisation. The Oxford City Locality Clinical Director observed in the section on contracting three main providers were mentioned: OUHFT, OHFT and primary care. The contract negotiations had focussed on two of the three and he queried what engagement had taken place with primary care. The Director of Finance advised over the past year there had been Federation engagement in the Risk Mitigation Group. Principal Medical Ltd (PML) had been well represented on the Group which discussed the change requirement to manage risk in the system. PML had been sighted on the type of contract being shaped but the Director of Finance recognised this was not full engagement. He reported the way the contracts were shaping allowed for time to better engage with the Federations as provider collaboration primarily around the urgent care pathways. The Oxford City Locality Clinical Director advised the point being made was about system working and risk across the system as the Federations were unable to take financial risk. The Chair stated the Operational Plan was a good report which showed there was a lot of hard work going on and the piece around urgent care highlighted not just the issues with A&E but how the system including primary care worked together to prevent admittance and to get patients out of hospital quickly. The Lay Member (voting) stressed that it was important for the Board to own the document and reiterated his suggestion to circulate to Board members to provide comment on anything material prior to submission. **The OCCG Board:** • **Noted the timescale and progress towards the final 2018/19 Operational Plan submission on 30 April 2018** • **Noted the changes to the second year of the 2017/18 – 2018/19 Operational Plan** • **Agreed the proposed delegated authority for sign off and submission of final plans following circulation to Board members for final comments.**	**CM**
10	**Oxfordshire Transformation Update** The Chief Executive presented Paper 18/18 providing a summary of the current position with the challenges to the decisions made as part of Phase One of the Oxfordshire Transformation Programme and outlining the work required to address the recommendations made to the Secretary of State by the Independent Reconfiguration Panel (IRP). The Chief Executive advised the paper proposed a different way of going forward. In Phase One some of the decisions had been subject to challenge: in the Judicial Review the claimant's grounds were not upheld but an application for appeal had been submitted by the interested party, no updates were available as yet; the Joint Health Overview and Scrutiny Committee (JHOSC) referral to the Secretary of State, advice had been received from the IRP and the Secretary of State had written to both the JHOSC and the OCCG – a link to the IRP advice was available on the OCCG website. The Chief Executive felt a key sentence in the letter from the Secretary of State was looking forward to seeing a joint proposal for taking the work forward and early engagement with the Joint Overview and Scrutiny Committee (OSC). Since receiving the letter from the Secretary of State the Chief Executive had held conversations with the MP for Banbury and the Chair of JHOSC. The Chief Executive ran through a summary of requirements and stressed it was not just Oxfordshire – there was a need to take a wider view. Although this was taken into	

consideration during Phase One OCCG now needed to address the wider view taking into account where the patients who used the Horton Hospital originated. The advice contained a strong message about reviewing the process and considering need.

The Chief Executive advised there was a piece of work for the Board to undertake around setting-up a plan and working with the Chair of the JHOSC to start to negotiate what a Joint OSC would look like. The plan and proposals would need to take into account that the majority of patients came from Oxfordshire with some from other counties. At the next JHOSC meeting OCCG would need to outline the plan and timescales for the OCCG Board and for the Joint OSC. The Chief Executive emphasised that whilst the work was being undertaken no permanent changes would be made to services. She explained it was necessary to take time to ensure all aspects of the plan were right and there would be a need to go to Clinical Senate and check what further work they were doing and for this work to be checked back with the Joint OSC.

A reset and rethink around the way of working in a more integrated way for Phase Two was being developed and had been triggered by a number of things such as the CQC Review. Traditional divides were increasingly getting in the way of developing coordinated and personalised health services and there was a need to work in a different way looking at system management. The transformation programme would be reviewed to see if it was fit for purpose. The paper provided some insight into areas for Phase Two. OUHFT had been clear the Emergency Department and associated services at the Horton General Hospital were needed to support acute care for Oxfordshire. The Chief Executive stated there was no co-dependency between paediatric and obstetric services advising obstetrics linked to neonates and the special care baby unit. These services were clinically sustainable and would remain in place. The midwife led units (MLUs) operate in a cost effective way and were used by patients. The MLUs would remain regardless of the outcome of arrangements at the Horton Hospital. With regard to the Community Hospitals, there was a need to describe the health and care needs of the local people before these buildings could be addressed.

The Chief Executive thought Bicester was a very good illustration where conversations had been led by Healthwatch and was a good example of engagement. There would be frequent involvement with the JHOSC and check backs to ensure agreement OCCG was taking the right approach as well as working with the Joint OSC in Oxfordshire and where OCCG boundaries crossed with other areas.

The North Locality Clinical Director on behalf of the NOLG practices was pleased to see the assurances in the paper. He added that it would also help to heal the wounds of the last year if OCCG and the health system could present a clear and costed view for the Horton Hospital going forward. Assurance that OCCG and OUHFT would reopen the obstetric unit if the workforce allowed would also be welcomed.

The Lay Member PPI felt the Joint OSC would be crucial and could signal a mechanism to deal with the current issues as well as becoming a permanent approach to future working. She queried how soon the Joint OSC would be set up and whether it could have a remit beyond addressing the current requirements of the IRP.

The Chief Executive advised a meeting had been held with the JHOSC the previous evening where OCCG had pushed for the committee to be expedited as quickly as possible. There were, however, County and District elections due to take place which gave issues with purdah requirements but the JHOSC believed a

first meeting could take place by the end of May. The Chief Executive felt it was possible the Joint OSC might review other issues as it was not just local residents who used the Horton Hospital.

The Lay Member PPI commented that there was considerable research around the evidence that underpinned the decisions in Phase One. She commented that many of the vanguards with their bottom up approach resulted in changes to service models and achieved savings. She stated there was an absence of evidence about safe staffing levels although the Royal College of Nursing provided some guidelines. The Lay Member PPI felt there was a need to be clear on the evidence used for decision making and that OCCG should be mindful of the different evidence; including that which added or detracted. She suggested independent clinical advice relevant to the decision to be made should be sought.

The Chief Executive cautioned, in terms of the expertise, how this was taken forward as any expert may not be deemed suitable to all stakeholders. She advised the local Clinical Senate had offered support in terms of advice but also that a different Clinical Senate could provide a completely independent review and that offer may be taken up.

The Oxford City Locality Clinical Director observed Phase Two would be about a locality based approach and affordability. He pointed out the IRP advice and the letter from the Secretary of State talked about how maternity services linked throughout Oxfordshire and not just their use in Banbury. OCCG had been asked to frame the review in terms of delivery for maternity services throughout the whole of Oxfordshire and currently the services where not delivering and he queried how this would be fed in. The Chief Executive reported there was a piece of work currently under development looking very specifically at that recommendation and the work would be set in terms of the wider services across Oxfordshire as this was what the CCG had been asked to do and the Chief Executive would make sure it happened.

The North East Locality Clinical Director felt the statement around the Community Hospitals being part of a local place based solution implied there was a process and he hoped this would be specifically endorsed by the Board as it was an important way forward. The Chief Executive commented in developing the local community aspect there would also be a need to consider a network view as not all areas would be able to have all the services all of the time.

The OCCG Board:

- **Noted the content of the letter from the Secretary of State and the IRP advice concerning the decision to permanently close the obstetric service at the Horton General Hospital**
- **Agreed the approach to address these recommendations outlined in section 2.2.2**
- **Agreed the approach to integrated health and care services should change to focus on solutions developed through place based discussions and early engagement**
- **In line with views from OCCG clinicians and the OUHFT, agreed the following services should remain:**
  - **The Emergency Department and associated services at the Horton General Hospital**
  - **The Paediatric Services at the Horton General Hospital**
  - **The current three permanent freestanding Midwife Led Units (in Chipping Norton, Wantage and Wallingford)**
- **Confirmed the review of the proposed elements of Phase Two**

	meant there would not be a Phase Two consultation • **Noted the future provision of an obstetric service or change to a permanent freestanding midwife led unit at the Horton General Hospital would be determined by the outcome of the work undertaken to address the recommendations from the Secretary of State.**	
11	**Commissioning Provider Framework** The Chief Executive presented Paper 18/19 explaining in recognition of both the operational and financial challenges faced by the Oxfordshire system in 2018/19 and beyond, the CCG was keen to explore opportunities available to formalise the collaborative arrangements emerging with local providers to support improved experience and outcomes for Oxfordshire residents in a more sustainable manner. The Chief Executive commented on the need to encourage providers to create an integrated approach and deliver the best services for the population of Oxfordshire. Services were often in siloes without much integration. The Framework set out a clear declaration that OCCG intended to continue to procure services but would have a clear expectation for providers to work with each other and collaborate together to provide the best services for the population. There would be a clear statement on how bids would be evaluated and the criteria would be heavily weighted towards integrated working and services. The clinical implications had been considered at the CCG Executive meeting. The Director of Finance observed the paper set out quite well how to navigate through the complex procurement regulations in this area. The overarching principle was integration of services and to achieve this there was a need for providers to work together collaboratively. The Director of Quality stated the approach made sense from a patient perspective. She felt if it was possible to be more efficient with scarce resources and the workforce that the method would hopefully reap benefits. The Oxford City Locality Clinical Director advised a lot of the content was covered in the Mental Health Outcome Based Contract (MH OBC) developed in Oxfordshire. Having patients defining the outcomes had been the first step and he stressed the outcome approach should involve patients. The Oxford City Locality Clinical Director observed this would involve quite a change of mind-set and would not be easy to instigate as a lot of people were entrenched in their ways of working and even after signing a deal, a lot of work would be required to make it work properly. The MH OBC worked on a prime contractor model but this still led to problems. The governance arrangements had been set up but there was a need to have an idea of the money flow. When one organisation held the contract it held power and there was a need for the skill to ensure it worked in a way that would deliver outcomes. There were a lot of fine details that needed to be nailed down to make it work. The Chief Executive agreed, commenting on the need to share experience and learning from the Integrated Care System in Buckinghamshire. The Lay Member (voting) believed in the direction of travel and the need to make it work. He observed there had been a lot of discussion in the last year but plans had run into problems when working with the providers and it had not been possible to agree a model to take forward. He assumed the model was tried and tested and felt it would be good for the Board members to receive lessons learned from other systems particularly around what had or had not worked. The Chief Executive advised in terms of timescale, this would be the Framework	

by which any future commissioning would be undertaken. OCCG would no longer commission in silos. Implementation would be dependent on when contracts came up for renewal. Previous attempts had been isolated and did not have national support but the Vanguards and Integrated Care Systems provided the opportunity to learn from other areas and receive national team support. The suggestion to share experience was welcomed and taking this forward through a workshop would be considered. The Chief Executive pointed out that the co-production work and engagement should have been undertaken as at the point the Framework was applied the CCG should be ready to the procure service. One of the check points would be to ensure engagement had been undertaken. The model also gave smaller providers the opportunity to come together as groups and bid for services for which they would not have been able to compete on their own but could do so as part of a group.

The Chief Executive explained it related to the money available for the whole of Oxfordshire and how it was distributed depending on areas of greater need. Dividing up by Localities and populations would not work but this could not be explored in detail until consideration had been given to the services to be provided.

The Lay Vice Chair queried and/or suggested: whether the Framework had been signed off by other stakeholders; that OCCG was currently negotiating a block contract and hence this was already one year ahead; that public and patient involvement should be included as part of the Framework; whether there were tried and tested examples of navigation through procurement which would be needed particularly for smaller participants as well as some kind of education programme; felt it would be useful for Members during a Board Workshop to work through a real example and be walked through an example to flush out any issues; any Prior Information Notice should include a financial envelope although this would be amorphous at start of the process; and how co-commissioners would sign up to a Framework.

The Chief Executive stated the CCG was entitled to set out how it wished to engage with providers and this was the most important reason why the document had been presented to the Board. It had attracted some national interest as Blackpool, Buckinghamshire and now Oxfordshire were the only areas to take a Framework forward. There would be the need for some slight adjustments as the process was worked through. Signing contacts did not preclude implementing a Framework and providers would be forewarned that they would be expected to sign up to the Framework in the next year. All other contracts would come under the Framework. The Chief Executive cautioned the Board that this would be a completely different way working and an enormous amount of facilitation with providers on ways of working and encouragement to work together would be required and the amount of time this would take should not be underestimated. The Framework had been discussed with the Chief Executives of the main providers who understood this would be the way forward and how OCCG would commission in future.

The Chief Operating Officer advised the document had been taken to the Joint Management Group (JMG) and discussed at the Oxfordshire County Council (OCC). In commissioning terms OCCG and OCC were getting closer and it was important to find ways to strength that relationship. The OCC Director for Adult Services advised the MH OBC had been a good example. Discussion on the Framework had taken place with Adult Social Care and although further discussion with OCC colleagues was required, there had been a positive reception.

Responding to a query around how this related to cross boundary working, the

	Chief Executive expected organisations who worked with OCCG to adopt the Framework. The Director of Finance advised as a framework some of the detailed design was left open meaning other commissioners could be associated with whatever OCCG agreed. The Chair observed this led back to the place based discussion and working with other organisations. She reported she had been introducing this concept around the county and although it was a culture change and change in mind-set, it would make ways of working more streamlined and ultimately would be better for patients. **The OCCG Board agreed the process described in the Framework.**	
Business and Quality of Patient Care		
12	**Finance Report Month 11** The Director of Finance presented Paper 18/20 providing the financial performance of OCCG to 28 February 2018; the risks identified to the financial objectives and the current mitigations. Detailed scrutiny of the full Finance Report had been undertaken at the Finance Committee. The Director of Finance reported OCCG was on target to deliver its financial plan for 2017/18. The target was to breakeven and this would be achieved but under instruction from NHSE, OCCG had also been holding a half percent non-recurrent reserve. OCCG had now been instructed by the NHSE Finance Committee to release the reserve which would move the position from breakeven to a surplus. The surplus would be in the region of £5-6m at year end. As this was a directive from NHSE, OCCG had no choice in the matter. The paper outlined the risks that had been managed throughout the year: the acute over-performance, the pooled budgets especially Continuing Healthcare, and the prescribing budget. **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.**	
13	**Integrated Performance Report** The Chief Operating Officer introduced Paper 18/21 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 there had been significant improvement in year in cancer performance but the 31 day target had not been met in January. The Chief Operating Officer did not believe this signified a trend but was around management of the pathway which was now receiving more focus. There were two compounding issues to the referral to treatment (RTT) waiting list: workforce and resources to treat the number of patients. RTT continued to be an issue but there had been a reduction in the total number of people waiting. A series of projects were being implemented and these were detailed on page 8 of the report. The new musculoskeletal (MSK) service was starting to garner real results and would be an important part of managing the contract in terms of the activity going through. Cardiology referrals were reducing since the GPs became involved in the pathway. An extensive demand management approach was sitting alongside the work with OUHFT. The Chief Operating Office expected to bring a more comprehensive report on the impact of the initiatives to the next meeting.	

The Chief Operating Officer advised OCCG was intending to invest more in planned care in the next year which would enable more procedures to be undertaken. OCCG was continuing to work with OUHFT for more activity to be delivered at the Horton Hospital.

There had been a slow improvement in delayed transfers of care (DTOC). The lowest level in OUHFT DTOCs, 47, was reported on Wednesday 28 March 2018. Some national expertise was supporting and working with the Trust and discussing the decommissioning of patients in hospital and how they should be supported in the early stages. There had been joint working with Social Care around people in the short stay unit. Getting people more quickly out of hospital stopped them being reliant on a bed and becoming more dependent.

The Chief Operating Officer referred to the question concerning reopening beds in the Horton due to the pressure on beds and reported all the advice received was for organisations to do whatever they could to get people home and not open beds. It was recognised that too many winter pressures hub beds had been opened and the staff was stretched too far. A smaller cohort of beds properly managed with the intensive staff support and addressing the front end of the pathway was required.

The Chief Operating Officer advised Age UK Oxfordshire had worked brilliantly with the system and deserved recognition from the Board on how they had helped OCCG to implement a different pathway and she was pleased to report a real degree of system work. The OCC Director for Adult Services observed the role of the voluntary sector had brought a fresh approach to patients when they were first admitted to hospital. She added when considering the position previously the downward trajectory had been held even it was not as fast as the system would have wished.

The Chief Operating Officer commented with regard to the concerns around the Child and Adolescent Mental Health (CAMHS) waiting times, a good discussion had been held with OHFT on launching contracts, expectations, and risks in delivery. There had also been a discussion around the CAMHS incentive payments and consideration would be given to using the money to ensure as many patients as possible went through the system. The single point of access was now open and the model was beginning to change although the Trust had acknowledged it was taking longer to mobilise than expected.

The Chief Operating Officer reported the provider of the Mental Health service was under some degree of duress and the service had asked to extend waiting times. Letters had been sent to GPs. The Oxford City Locality Clinical Director confirmed the service was under stress. He commented the way the adult system framework had been set up had in effect produced an open door. An explanation had been requested. The Oxford City Locality Clinical Director remarked the impact on primary care as a result of changing waiting times had not been considered. He advised the pilot in the north of the county worked on a model using independent community psychiatric nurses (CPNs) (ie not provided by OHFT) and if there were staff shortages it did not necessarily make the system work better. There was a need to ensure the pressure on workforce did not affect the Mental Health workforce.

The Chief Operating Officer reported trajectories had previously been agreed for the CAMHS service but these had not been met. Discussions were due to take place in the next week where it would be necessary to ensure the trajectories were met. The Director of Quality was tasked with ensuring this was reviewed by the Quality Committee before the next OCCG Board meeting. The West Locality Clinical Director advised a better system had been implemented by CAMHS and it

SW

	was hoped an improvement would be seen soon. The Oxford City Locality Clinical Director explained the third sector was not well developed in children's Mental Health which had caused problems. It was a good concept and efforts were required to ensure it was delivered. The Director of Quality advised there were safety concerns around the length of time children were waiting and the Trust had implemented a process to review the lists and liaise with patients.	
	The Lay Member (voting) queried whether the Quality Committee would be able to provide some assurance and benchmarking around the Clostridium difficile (C.diff) cases.	
	The OCCG Clinical Director of Quality was working with the Trust. Mixed sex accommodation and trolley waits were red due to an inability to move patients smoothly through the system. The Trust was undertaking a lot of work in this area. There was no clinical harm from a patient and family perspective but it was not satisfactory. A root cause analysis would be undertaken.	
	Various tools had been introduced within the emergency department to ensure people were looked after and those who were waiting on trolleys had received very good care due to the heightened awareness of their situation.	
	There had been six Never Events, five in the acute and one in the community. OUHFT had invited in external support to identify the reason and a root cause analysis would be carried out.	
	There were still issues around the number of Cdiff cases but NHSE had advised it was not necessary to undertake a post review on the MRSA cases although there was a need to undertake some benchmarking work and this would be brought back at a later stage.	**SW**
	OUHFT had reported they did not believe the target set for discharge summaries and test results was achievable. Work was underway to agree a target they felt was realistic and would be achieved. Voice recognition technology had been introduced and it was anticipated this would move performance forward positively.	
	Three CQC reports had been received for maternity services, one for Oxford Centre for Enablement outcome and one on the 'well led' domain. As the reports had only just been received there had not yet been the opportunity to discuss with the Trust and further information would be brought to the next Quality Committee meeting.	**SW**
	The Lay Member (voting) felt the DTOC news for OUHFT was good but disappointing for the OHFT and queried whether this received as much focus as the acute trust. The Chief Operating Officer explained the OHFT delays were in the main around the reablement service and patient choice. She assured the Board those delays that were within the gift of OHFT had dramatically improved through collaboration with OCC and employing additional social worker support. Reablement remained difficult mainly due to workforce issues. OUHFT was not assuming a patient would move to a community hospital bed and the guidance was clear that the approach should be to get a patient back home wherever possible. This methodology had significantly reduced the number of people waiting for a community hospital bed although the process ensured any patient requiring a community hospital bed did receive one. There would be a need to check how this affected the rate of demand for community hospital beds.	
	The OCC Director for Adult Services advised there had been a strategic review of the reablement pathway. Some useful data was now available and consideration was being given to whether assess to discharge was the right approach. She	

	reported the review should be concluded in the next month. The Lay Member (voting) felt it would be useful for the Board to see the output from the OCC review given its importance. He added that there was significant underperformance against plan in the elective work and was concerned the Board did not consider the clinical impact of long waits and suggested gynaecology might be good place to start and see some assurance on outcomes. The Medical Specialist Adviser reported this was raised specifically through the Quality Committee. The Oxford City Locality Clinical Director informed the Board of the switch off of paper referrals in October 2018 advising this would then enable a clearer picture of referrals to be seen. He queried whether how the data could be used had been considered. The Chief Operating Officer advised access to the referral data would be of assistance and a meeting had been scheduled with the Trust to look at the referrals and a shared reliable source of data would help with some of the conversations taking place. **The OCCG Board noted the Integrated Performance Report.**	
14	**Safeguarding Update** The Director of Quality presented Paper 18/22 updating the OCCG Board on safeguarding issues advising the issues were considered in depth at the Quality Committee whilst the paper contained only highlights. The Director of Quality advised the main reason for a child being placed on a plan was due to neglect. The number of 'looked after children' was increasing and a piece of work was underway to try to ensure all children were given a health check at the point they were taken into care. An initiative had commenced to partner refugees with medical students and a new pro forma was being developed to supply information. There were issues with Did Not Attend patients but for children it was a case that they could not attend and the term was being changed to Was Not Brought in order to alert the clinician that a child had not been present for appointment and that action was required. The Lay Member PPI advised a Safeguarding Report was presented to every Quality Committee and there had been a considerable amount of work on many of the areas with some significant improvements being noted. There were on-going issues around achieving the level of safeguarding training OCCG would wish to see in provider organisations. Front line staff in the NHS was crucial to keeping children and vulnerable adults safe and providers should be achieving the expected levels of safeguarding training. **The OCCG Board noted the Safeguarding Activity Update Report.**	
Governance and Assurance		
15	**Corporate Governance report** The Director of Governance introduced Paper 18/23 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 Governance highlighted the two Declarations of Hospitality advising two members of the Health and Wellbeing Group had attended the Oxfordshire Sports and Physical Activity award ceremony and OCCG had won an award. She explained the Health and Wellbeing Group organised a number of activities throughout the year for staff. The Director of Governance advised there was a different format to the Declarations of Interest to ensure OCCG was fully compliant with the new guidance. The document had been populated as much as possible outside of the meeting and Members were asked to provide any changes, details of start dates and finishing dates if relevant. The West Locality Clinical Director apologised to the Board for his comments	**All**

	under Item 8 explaining the point he had been trying to make around a long term plan had not been specifically about his surgery but it had been inappropriate to connect it. **The OCCG Board noted the Corporate Governance Report.**	
16	**Strategic Risk Register and Red Operational Risks** The Director of Governance presented Paper 18/24 explaining the paper was the usual report, there remained three Red Strategic Risks and four Extreme/Red Operational risks and the score for risk AF26 had reduced from 20 to 16 due to the reduction in pressure within Banbury. **The OCCG Board noted:** **There were three Red Strategic Risks with a rating of 20:** • **AF21 - Transformational Change** • **AF19 - Demand and Performance Challenges** • **AF25 – Achievement of Business Rules** **The score for risk AF26 – Delivery of Primary Care Services had reduced from 20 to 16 due to the reduction in pressure within Banbury.** **There were four Extreme/Red Operational risks:** • **758 - DToC** • **762 – Pooled Budget Arrangements** • **789 – Primary ~Care Estate** • **797 – A&E Four Hour Wait** **A summary of all live risks was presented in Appendix 1.**	
17	**Oxfordshire Clinical Commissioning Group Sub-Committee Minutes** In response to a query from the Chief Executive the Director of Governance advised the sub-committee minutes presented to the Board were approved electronically by the respective Committee as waiting until the next meeting meant the minutes were very out of date when they came to the Board. The Director of Quality accepted this reasoning but explained it led to some issues as the 'approved' minutes were sometimes challenged at the next meeting. It was agreed a discussion should be held at the Audit Committee on the best way to ensure the Board received timely information and a suggestion was made to present the old minutes but for the front sheet to include the top three items from the most recent meeting. *Finance Committee* The Lay Member (voting) as Chair of the Finance Committee presented Paper 18/25a, the minutes of the Finance Committee held on 25 January 2018. *Oxfordshire Primary Care Commissioning Committee (OPCCC)* The Lay Member (voting) as Chair of the OPCCC presented Paper 18/25b, the minutes of the OPCCC held on 6 March. *Quality Committee* The Lay Member PPI as Chair of the Quality Committee presented Paper 18/25c, the minutes of the Quality Committee held on 22 February 2018. The Lay Member PPI commented the 12 hour trolley wait figures were concerning and should not become the new norm; the new maternity arrangements were being kept under review including transfers and other outcomes; a report had been received on perineal trauma for all units explaining there were issue around the levels of perineal trauma and the Committee was pressing for action to be taken as soon as possible as this had significant on-going issues for women and their health. **The OCCG Board noted the Sub-committee minutes.**	**RD/CM**

For Information		
	Any Other Business There being no other business the meeting was closed.	
	Date of Next Meeting: Thursday 24 May 2018, 09.00 – 12.45, Jubilee House, 5510 John Smith Drive, Oxford, OX4 2LH	