Oxfordshire
Clinical Commissioning Group

OXFORDSHIRE CLINICAL COMMISSIONING GROUP BOARD

Date of Meeting: 29 November 2018	**Paper No: 18/77b**

Title of Paper: CCG Executive Committee Minutes – 28 August and 25 September 2018

Paper is for: (please delete tick as appropriate)	**Discussion**	✓	**Decision**		**Information**	✓

Conflicts of Interest (please delete tick as appropriate)	
No conflict identified	✓
Conflict noted: conflicted party can participate in discussion and decision	
Conflict noted, conflicted party can participate in discussion but not decision	
Conflict noted, conflicted party can remain but not participate in discussion	
Conflicted party is excluded from discussion	

Purpose and Executive Summary:
The CCG Executive Committee minutes are designed to provide assurance to the OCCG Board that there is focus and wider input on clinical issues and operational delivery including performance, finance and delivery of major work programmes.

Engagement: clinical, stakeholder and public/patient:
Not Applicable

Financial Implications of Paper:
None

Action Required:
The Board is asked to note the minutes of the CCG Executive Committee.

OCCG Priorities Supported (please delete tick as appropriate)	
✓	Operational Delivery
✓	Transforming Health and Care

✓	Devolution and Integration
✓	Empowering Patients
✓	Engaging Communities
✓	System Leadership

Equality Analysis Outcome:
Not Applicable

Link to Risk:
Not applicable. Papers presented to the CCG Executive Committee identify the risk they are linked to.

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Date of Paper: 16 November 2018

MINUTES:

CCG Executive Committee

Tuesday 28 August 2018, 09.30 – 12.00

Conference Room B, Jubilee House

Present	Stephen Attwood	Jo Cogswell (JCo) (until 11.55)	Shelley Hayles
	Ed Capo-Bianco	Jonathan Crawshaw	Diane Hedges - Chair
	Kiren Collison	David Chapman	Gareth Kenworthy
In Attendance	Lesley Corfield (Minutes)	Sarah Breton – Item 6	Paul Swan – Item 12
	Sharon Barrington (SBa) – Item 10 and 12	Julie Dandridge – Item 7	Sara Wilds (SWi) – Item 8

Apologies	Miles Carter	Lou Patten	Sula Wiltshire
	Catherine Mountford		

	Agenda items were taken in the order: 1, 2, 3, 4, 6, 7, 10, 11, 12, 9, 8, 5	**Action**
1.	**Declarations of Conflicts of Interest Pertaining to Agenda Items** Being partners in GP practices ECB, JC and DC declared an interest in the Prescribing Incentive Scheme. It was agreed the GPs could remain and take part in the discussion as the paper did not require a decision to be made. SA continued to have an interest in a practice premises in Bicester.	
2.	**Minutes of the Meeting Held on 24 July 2018 and Action Tracker** Subject to some slight amendments the minutes of the meeting held on 24 July 2018 were approved as an accurate record. The action tracker was reviewed and updates provided.	
Overview Reports		
3.	**Finance Performance Report** GK presented Paper 2, the Month 4 (August) report and highlighted the funding for the acute sector. He advised there was still an outstanding concern with Oxford Health NHS Foundation Trust (OHFT) around the mental health contract and that there was a need for a conversation between the Directors of Finance on how the system was faring. GK advised the paper still supported the need for a Financial Recovery Plan (FRP). The maximum overspend that could be afforded on the Oxford University Hospitals NHS Foundation Trust (OUHFT) contract was £8.0m. This was manageable with FRP assumptions. At the point the FRP was triggered the action related to Month 2 data which if straight-lined would be an overspend of £12-14.0m. The FRP was designed to target the difference of £6.0m and progress was being made against this target.	

	The overperformance had plateaued in Month 3 at £2.5m. The indicative for Month 4 was £3.0m, a half million deterioration. If this overperformance was straight-lined it would be heading to £9.0m, but this did not take into account any winter pressures. In activity terms A&E was 3% up year on year, non-elective as a whole was 6% up, which was the driver for the overperformance. Of broader concern was the elective activity being 4% down at this time compared to last year. Capacity was an issue and with increased activity elsewhere elective work could not be undertaken. Although the run rate had eased on OUHFT activity, there was a risk due to the elective underperformance. More funding was being made available for IT but would be made available via the sustainability and transformation programme (STP). As both OHFT and OUHFT were Global Digital Exemplars (GDE) it was more likely funding would be provided in Buckinghamshire than Oxfordshire. There remained a risk to the prescribing budget from the national pricing change around category M drugs and the residual effect of No Cheaper Stock Obtainable (NCSO). There was also a need to review the Healthshare contract as there were activity pressures within the contract. The initial output of benchmark work from the review of Oxfordshire investment in mental health services being undertaken by Trevor Shipman was expected to be available later in the week. Initial diagnostics had been undertaken of the Activity Management Plan (AMP). There were a number of lines of enquiry: counting and coding, either actual or coded acute increases, Monmouth would be leading three key specialities: cardiology, neurology and respiratory; ambulatory pathways which required clinician involvement, Anne Carlile was leading this work and dates for involvement would be discussed; a review of the GP streaming service, the pace was a little concerning; review of lengths of stays in some particular areas. A meeting of the Finance Committee was scheduled for Friday 31 August and would contain some of the diagnostics and an update on the FRP which would include the AMP. Concern was expressed that clinical decisions for funding, particularly in the negotiations with OHFT, appeared to be being made by the Directors of Finance with no clinical input. GK did not believe this was the case. The executive discussion on the Children and Adolescent Mental Health Service (CAMHS) had agreed this would be a priority from the MH funds. DH reported Dr Andy Valentine, OCCG Clinical Director of Quality, had been involved in the discussions and suggested DC should discuss any concerns with him. SH commented that it was important that clinicians should be involved	

	in the work up of areas for savings. KC advised there had been a discussion in the Clinical Catch-up session as to whether it was felt there was enough clinical input and stated that it was important clinicians were involved and had sight of the process. DC added that he believed clinicians should be scoring schemes with managers and that schemes should not be scored by managers on their own. GK observed it was clearly written in the process that budget holders and managers should involve clinicians. DH believed the process had been followed. DC was adamant the clinician name should also be on the paper. GK advised there was a list of initiatives and actions for the budget holders and managers. DH would circulate the workstreams spreadsheet which detailed the clinician names. The CCG Executive Committee noted the Month 4 position and considered Oxfordshire CCG was managing its risks effectively in order to deliver its financial objectives.	**DH**
4.	**Integrated Performance Report (IPR)** Paper 3 contained the Integrated Performance Report (IPR). SA expressed concern around the OUHFT overperformance and the referral to treatment (RTT) gap. JCo commented the system needed to resolve the issues and that it was attracting a great deal of focus from regulators. SH queried whether there was a point at which OCCG could raise issues with the regulators to ask for some assistance in resolving matters. She explained a lot of work had been undertaken around cancer services but still much needed doing. There was insufficient staff and theatres and the situation was leading to a number of patients not receiving timely treatment. This had a knock on effect to primary care with patients coming back to primary care. It was not confined to RTT but affected the whole system. SA remarked that he was also concerned that whilst the system focussed on acute care planned care was not being delivered which was likely to cause issues for the future. JCo advised there had been emphasis on the 4 hour target in the System Assurance Meetings but it was also clear a system response to RTT and cancer were areas of concern to the regulators. Although the solutions were not ‘quick fix’, JCo commented OCCG should not lift any pressure to resolve. DH summarised the need to understand what was happening with diagnostics across the two pathways of elective and urgent care. GK observed other areas were managing to achieve targets and there was evidence from Vanguards for initiatives around urgent care although these did appear to have a knock-on impact on planned care.	

	DH reported revised urgent and elective plans were expected from OUHFT. DH had written to the OUHFT Deputy Director of Clinical Services stating OCCG required further assurance around planned care. DH suggested the situation should be reviewed once the revised plans had been received and the confidence they provided before following up with LP on her return from leave. DH reported the £851k overperformance figure for the OHFT in the Executive Dashboard on slide two of the report was incorrect. The figure was nearer £351k. The IPR had been corrected in the version to be presented to the Quality Committee. The CCG Executive noted the content of the report.	**DH**
5.	**Priority Project Report** DH advised slide 2 contained a list of 49 projects, which was not the totality. There were 54 projects logged on Verto and 57 'business as usual' schemes which were deemed significant enough to also be logged. Slide 3 detailed the A&E Delivery Board (AEDB) and winter plan priorities; slide 4 listed items considered "mission critical" in her view; and slide 5 questions to help define the approach. There would be a need for a hierarchy for schemes and "mission critical" items to come to the CCG Executive Committee for assurance. All were asked to review the priorities list and provide any comments.	**All**
Strategy and Development		
6.	**Children and Young People's Plan (CYPP)** Sarah Breton (SB) attended for this item to present Paper 4 advising the CYPP was not statutory but best practice. The CYPP covered the next three years. The CYPP had been taken to the Clinical and Management Forum (CMF) in March and the views expressed were taken back. An engagement process had been undertaken from September 2017 to May 2018 and all comments had been fed in to the Plan. There had also been considerable engagement with children, young people, parents, carers and the voluntary sector. Four key areas of focus had been identified: be successful; be happy and healthy; be safe; and be supported. Dr Matthew Gaw had stood down as the OCCG Children's Lead and the role would be picked up by Dr Miles Carter (MC). DC felt the CYPP did not differ to any great extent from previously. He commented that there was little in the Plan around deprivation which he felt should be a focus as this was a real driver to children's issues. SA observed it was a massive challenge to deliver the CYPP against a background of fading resources. A number of areas of support for vulnerable young families had changed and there were the added issues of the difficulties recruiting to the CAMHS service. SB explained the CYPP had been slimmed down to reduce the number	

	of words and instead hyperlinks had been used which might make it appear items had been missed. The Plan tried to focus on the areas which a wide range of stakeholders had identified for doing something different. The areas that had emerged as a priority were: focus on children missing out on education; focus on social and emotional well-being and mental health; focus on domestic abuse. Work was already being undertaken in all the areas but these would receive more focus. DH stated that a Director should attend each meeting as it was important the OCCG should have influence and feedback on work being undertaken around children. SB to review the dates and resolve attendance between SW, MC or DH. SB would feedback the comments made such as those around deprivation. KC remarked that she liked the poster however, with obesity being such an issue she would have anticipated it would be a priority. DH commented Oxfordshire has one of the highest scores for a ward in the whole STP in child obesity figures. SB commented the link to the Health Improvement Board (HIB) was useful as health improvement was not within the remit of the Children's Board but the HIB. Public Health also sat with the HIB. Comments were made concerning the Vision statement suggesting that it should be more around achievement but this was countered by the explanation that it was meant to imply the provision of opportunities in life for children to realise their potential. DH felt there was a need to ensure OCCG was more involved in the debate when the CYPP was next considered and comments made when the Plan was presented to the OCCG Board should be written up and provided to the Children's Board as a view from OCCG on how the work could be further enhanced. KC commented prevention and health inequalities should run through every programme. Subject to the comments made being fed back to the Children's Board, the CCG Executive Committee approved the Children and Young People's Plan and recommended it to the OCCG Board.	**SB** **SB** **SB**
7.	**Approach to Locality Working** Julie Dandridge (JD) attended for this item. JCo presented Paper 5 advising the diagram in Appendix 3 captured the main points and discussion from the Clinical Management Forum (CMF) on 21 August 2018. JCo advised the purpose was to have a discussion of the paper and a conversation on next steps. A paper was required for the Oxfordshire Health Overview and Scrutiny Committee (HOSC) on 20 September providing an update on the approach to the future reshaping of services as Phase 2 of the transformation programme was no longer being implemented. JCo suggested putting forward the emerging	

framework, as per Appendix 3, as an example of evidence based decision making process.

Points of discussion included:

- The move towards working in concert with Federations would require some effort and there was a need for someone to give time to plan the strategic approach and take forward
- Other areas, such as Hampshire, had started to make an impact but how would OCCG manage the resource shift
- There were a number of challenges in planned care which would be applicable to the county and could possibly be managed at county level whereas other aspects might be more manageable at the point of access, although an interface would still need to be managed
- Key to integration would be ensuring no one area was overwhelmed
- If an ICS was to be in place from April 2019 there is need to start planning the necessary changes.
- Much of the Locality work was provider rather than commissioner. There was a need to articulate the ICS and show how the Localities would fit in. Under the Constitution the Localities had a particular function. How would this fit with an ICS as this role would no longer exist under an ICS
- There was a need to wait for a decision from NHS England (NHSE) around the make-up of an ICS. A commitment had been made as a county to work towards becoming an ICS by April 2019 with the integration of services in: District General Hospitals, the community, mental health, social care and GP out of hours and Access. It was believed this would be the format of an ICS but indications were that further areas might be included
- There was a need to consider in Oxfordshire the areas that could be shaped and influenced. A shared management approach might assist although in Farnham some excellent work had been undertaken using a slightly different approach
- The aim was to set a framework on which all work taking place in Localities (place/area specific) could be hung. A clear process would benefit everyone and ensure everyone was on the same page
- Some concern not enough time had been spent on system working. Currently the vision for a whole integrated system was not being delivered
- There was a need to engage the OUHFT, OHFT and voluntary sector among others
- The concept was simple but implementation was challenging. As an example, representatives from the Emergency Medical Unit (EMU) had been invited to, and accepted a Locality meeting but no one had turned up on the day
- The System Urgent Care Lead role had been advertised the previous week and interviews were due to take place later in the

	week. The role would be accountable to the system Chief Executives and would lead an integrated team through winter. This was a significant event as it represented a system wide agreement by the Chief Executives. • There was a finite pot of money and the controllers of that pot would decide where the priorities were. What would be the role of the Localities and who would make the decision? DH observed it was not possible to answer these specific questions at the moment and further information would need to be brought back to the next meeting. Clarity was required for Localities around what they would be empowered to do. JCo commented the document was intended as a moment in time from which to move forward. DH summarised that more work was required on the practicalities of locality working and whether implementation should be incremental or otherwise. JD remarked the important step would be to resolve the role of the Localities and the work required. JD advised conversations with practices had already started in the North with the Integrated Front Door discussion. There was a need to consider how these were taken forward. SA reported the North East would be starting Locality and Federation integrated meetings. DC queried whether this provided an opportunity to revise the structure into three Localities: North Oxfordshire, Oxford City and South Oxfordshire. When considering plans a large population should be used and currently only Oxford City had a commensurate populace. SA agreed there was a need for links but felt a layered approach would be better as schemes worked at different levels. JCo observed the right geography would surface for the right issue and if it was more logical to change boundaries this could be debated but JCo was not aware of an appetite for this at the moment. JCo reported the HOSC had expressed concern at the length of time Wantage Hospital had been closed. The HOSC had requested a timetable for their next meeting. JCo was proposing to take a paper to HOSC indicating a process, such as the framework in Paper 5, would be used in Wantage and there would be an assessment of the health needs of that population. The CCG Executive generally agreed the direction of travel.	
Business and Quality of Patient Care		
8.	**Managing Repeat Prescriptions** Sara Wilds (SWi) attended for this item to present Paper 6 outlining the proposed approach to strengthen the project on repeat prescribing. The need to engage with all parties before implementing was noted. DC raised concerns regarding the Quality and Outcome Framework (QOF) payment as no 'flag' was raised for patients on repeat prescriptions to be called in for a review. SW advised the Medicines	

	Optimisation Team was working with practices around repeat prescribing. The CCG Executive Committee supported the approach to repeat prescribing subject to close engagement with the Local Medical Committee (LMC) and the impact assessment. SWi advised an informal conversation had been held with the LMC and the proposed approach had the potential to achieve significant savings. SWi to work up a clear implementation plan.	**SWi**
9.	**Prescribing Incentive Scheme Evaluation** Paper 7, the 2017-18 Prescribing Incentive Scheme Evaluation, was presented for information. The CCG Executive noted the contents of the paper, the learning points identified under item 5 and the opinions detailed in the conclusion.	
10	**Musculoskeletal (MSK) Deep Dive - Healthshare Pathway Evaluation** Sharon Barrington (SBa) attended for this item. SA advised there had been many challenges and difficulties in bringing several pathways together and a number of concerns had arisen in the early days of mobilising Healthshare. Three fundamental areas had been identified: communication between GPs and Healthshare and Healthshare and patients; a mismatch of the activity being undertaken; and the contract content. There had been a lot of positive feedback from patients once they were actually in the service. Work had commenced on the communications issues and to quantify the activity and funding. There had also been some initiatives to clear the backlog and waiting list. The waiting list for Healthshare had reduced. The Level 2 physiotherapy triage had reduced the numbers waiting whilst the Level 1 physiotherapy had remained at about the same level. DH advised the paper was intended to provide assurance and to work towards assuring the Committee we are in an improving situation. Some general themes had emerged, communication and capacity, and regardless of how good the service was, if people had to wait too long for treatment, they would not be happy. There was a need to look at the activity and referrals but it would not be possible to achieve the activity within the current financial envelope. SA commented on the need to sort out the contracted activity going forward, addressing the backlog and funding the service on an ongoing basis to ensure the key performance indicators (KPIs) were achieved. SBa advised the patient data was being reviewed to ensure there were no duplicates and that the patients were all Oxfordshire patients. The issue was the number of patients coming into the service rather than the activity. A report to come back in October to confirm actions had been undertaken and other work, including demand action, completed. Meetings would take place outside of the CCG Executive Committee	

	meeting to discuss spend with GK.	**SBa/GK**
11	**Headache Pathway Evaluation** SBa attended for this item and presented Paper 9 on the evaluation of the Community Headache Clinic Pilot. The pathway had been a success, delivering the intended outcomes of improved quality of service and access for patients and there had been good patient satisfaction. The pilot clinics were held in the Horton Hospital and Abingdon. There had been more referrals to the service than had been expected and patients saw the GP with special interest (GPwSI) rather than a consultant. The pilot period would conclude at the end of October and a decision would then be required on how to take the service forward. The pilot was paid for by a block payment which for July would have equated to a notional tariff of £201 per patient. The draft tariff of £100 per patient in the paper was based on bottom up modelling. A realistic tariff would need to be agreed with OUHFT and was likely to be slightly higher but would include any follow-up appointments. If the headache service was commissioned long term there would be more clinics throughout Oxfordshire. SBa to produce a graph for the IPR to show for each of the areas of service redesign the rates of referrals and follow ups pe and post redesign. The CCG Executive Committee endorsed the recommendation to commission the headache service long-term as part of the overall OUHFT contract based on the pilot model following the conclusion of the pilot on 31 October 2018.	**SBa**
12	**Integrated Respiratory Team Pilot** Paul Swan (PS) attended for this item. DH advised Paper 10 had been brought to check support for a pilot Integrated Respiratory Team (IRT). A discussion had been held at the Clinical and Management Forum (CMF) where support had been given to implementation in Oxford City and the North in the first instance and then the rest of Oxfordshire if the concept was proven. The paper stated the City and North initially and a roll out after six months but it was felt it should be established if the set of indicators were correct and if the IRT worked as envisaged before roll out. PS confirmed the relevant data to support analysis of the scheme would be obtained. DC reported the team in Oxford City was very enthusiastic and the scheme should be progressed. SA agreed it was a good scheme and should be implemented. PS referred to the updated cost and outcome modelling advising without the contribution from Boehringer Ingelheim savings would still be made. Support to ECB at the South East Locality meeting to be considered and advised. PS advised requested commitment of costs to meet the commitment for	**DH/PS**

	an early consultant start – it was noted this should be manageable within any slippage of the project. This commitment would be honoured irrespective over if the project agreed. PS queried whether there should be two gateways for decision: at six months and another at 12 months; and where would be the end point ie if the decision was taken at 12 months would the scheme be rolled out to 15 months or a decision taken to implement at that point. He commented it would be necessary to give Boehringer a timeframe. The CCG Executive supported the revised assumptions and recommendation to the Board.	
For Information		
13	**Papers Circulated / Approved Between Meetings** • Training and Development Policy: approved (responses from GK, JC, SH, DC) • Healthshare Performance Against Contract (circulated for information) • Emergency Preparedness Resilience and Response (EPRR) Documents: approved (responses from CM and SA)	
14	**Confirmation of meeting quorum and note of any decisions requiring ratification** It was confirmed the meeting was quorate and no decisions required ratification.	
15	**Any Other Business** There being no other business the meeting was closed.	
16	**Date of Next Meeting** 25 September 2018	

MINUTES:

CCG Executive Committee

Tuesday 25 September 2018, 09.30 – 12.00

Conference Room B, Jubilee House

Present	Stephen Attwood	Jonathan Crawshaw	Gareth Kenworthy
	Miles Carter	David Chapman	Catherine Mountford
	Ed Capo-Bianco	Neil Fisher	Lou Patten (from 11.55)
	Jo Cogswell (JCo)	Diane Hedges - Chair	Sula Wiltshire
	Kiren Collison		
In Attendance	Lesley Corfield (Minutes)	Sharon Barrington – item 6	

Apologies	Shelley Hayles		

		Action
17	**Declarations of Conflicts of Interest Pertaining to Agenda Items** There were no declarations of conflicts of interest pertaining to agenda items.	
18	**Minutes of the Meeting Held on 28 August 2018 and Action Tracker** The minutes of the meeting held on 28 August 2018 were approved as an accurate record and the action tracker reviewed. *Integrated Performance Report (IPR)* The Child Adolescent and Mental Health Service (CAMHS) had advised contact was made with people approaching sixteen weeks wait and regularly thereafter. A written process and protocol for 16 and 52 week waits to be provided to the Quality Committee. The action was closed. *Prescribing Incentive Scheme* The action relating to the new risk was outstanding. DC reported Oxford City had not yet signed up to the Scheme as further information had been requested. MC would respond to the queries and the Prescribing Team would provide an estimate on the length of time it would take to obtain the information. *Communication Around the General Strategic Direction* JCo advised the work had commenced in a paper presented to the Oxfordshire Health Overview and Scrutiny Committee (HOSC) meeting on 20 September and was ongoing. A draft would be taken to the next Clinical and Management Forum (CMF) before coming back to the CCG	**SW** **MC**

	Executive. *Musculoskeletal (MSK) Deep Dive – Healthshare Pathway Evaluation* A meeting had been held and actions would be taken forward with the provider. It was noted the waiting list numbers had reduced but not yet to the level required. The key concern for both the CCG and Health share remains the higher than predicted referral demand. It was acknowledged there was learning that the CCG from this procurement. There had been a competitive procurement process and as such there is an expectation that bidders carry out their own due diligence. However, it is recognised that there is a shared responsibility for the figures used for the procurement and contract. An agenda item at the CMF to reflect on the procurement, look at lessons learned and consider how the procurement could be undertaken differently next time was agreed. The HOSC was undertaking a deep dive into the MSK process which would be publically reported in the New Year. The action was closed. *Headache Pathway Evaluation* DH advised the graphs were for all transformation projects and were outstanding for inclusion in the IPR.	**JCo** **DH**
Overview Reports		
19	**Finance Performance Report** GK presented Paper 2 and advised there was emerging national concern around elective performance against plans. There remains a clear as to deliver on the three key plan elements of urgent demand, money and elective waiting times which will be challenging. The national concern on elective is reflected locally with a c£1.0m underperformance YTD in the OUH contract. We cannot plan on this continuing. A straight line extrapolation from Month 4 on the contract would indicate a £9.0m overspend. If we reverse the elective underperformance the outturn would be in the region of £11.0m. At this value there remains the need to progress with the CCG's Financial Recovery Plan actions. An independent review of mental health investment had been undertaken for Oxfordshire. Phase 1 of this work has now been reported with the conclusion that as a system we fund comparatively less than peer group and national averages. This might be considered to be a financial gap, however, this first phase report has not then identified whether this is matched by any gaps in patient outcomes or access to services. With lower investment there may be the expectation that this would have impacts locally, however, these have not yet been identified. Oxfordshire appears to have developed a 'hyper-acute' model of secondary care mental health services with relatively low capacity in both bed-based and community services treating the most acutely unwell. There are low numbers of referrals to community services. The ongoing work needs to asses if this model has a significant impact in terms of outcomes and access to services. It is	

	necessary to agree the conclusions from the first phase of work and the key next steps to inform investment plans into next year. Additional comments made were: • The Oxfordshire investment in Improving Access to Psychological Therapies (IAPT) was higher than benchmarked peers although noted this was included in the overall figure • It was suspected but not yet evidenced that there was higher investment in mental health services through specialist commissioning • The hyper-acute mental health service was run by a specialist provider and was very efficient. There was a small community load and a low referral rate • The point at which investment in mental health services became lower than benchmarked was not known. • There may be a shift from community teams to primary care management. This aligns to the need for effective management of the physical health of these individuals. • There was a need to collect data and identify the number of patients being treated in community care and primary care (practices) • A further meeting was required to consider the residual issues and next steps. GK advised OCCG remained in financial recovery mode, explaining that the current affordability of the Oxford University Hospitals NHS Foundation Trust (OUHFT) contract was only possible due to the work undertaken so far on budgetary control and savings. The £4.5m in the OCCG contingency reserve has been fully committed. The system could come under pressure again if there is a further national push on elective improvement, including more outsourcing to the independent sector. At Month 4 OUHFT was 1% down on elective work compared to the same time last year. Financial recovery was the first phase of a broader turnaround. Looking ahead to the next year there would be a need for genuine turnaround. In effect this meant a continuous financial recovery plan. The 18/19 NHS pay award would likely be the first call on funding for the next year. **The CCG Executive noted the position and considered OCCG was managing its risks effectively in order to deliver its financial objectives.**	
20	**Integrated Performance Report (IPR)** SW introduced Paper 3 advising the underperformance by OUHFT on referral to treatment (RTT) had raised concerns patients might come to harm. The Trust had internal processes to review people on the waiting list and it had now been agreed OCCG would have some oversight to ensure patients were not coming to harm. A pro forma was being produced with the Trust to ensure both organisations were working to the same standards. GPs were also using Datix to report any issues. OUHFT was looking to outsource some of the workload although the	

	Ramsey was only Care Quality Commission (CQC) registered for orthopaedics whilst the Manor was also registered for gynaecology. Of particular concern were the stage 2 or 3 ovarian cancer patients and these would be transferred to either Northampton or Southampton depending on where in the county they were based. This would be approximately 50 patients a year. NHS Improvement (NHSI) had issued OUHFT with enforcement undertakings on planned care, non-elective and workforce and governance and oversight from the OUHFT Board was being reviewed. A CQC visit and a governance review by Deloitte were also due to take place. There had been no trolley waits but concern remained around Clostridium difficile (Cdiff), in the community rather than the acute sector; test results, discharge summaries and out-patient letters. SW intended to write to the OUHFT Quality Director. A new Medical Director would be joining the Trust in January (Professor Meghana Pandit). There had been a review of mixed sex accommodation across the south region and reporting arrangements had changed slightly. This had resulted in an increase in numbers being reported. A request was made for more narrative on this item to understand how breaches were counted. DH reported the OCCG Head of Planned Care and Long Term Conditions now attended the fortnightly Elective Delivery Board and a change in responsibility taken by the Trust had been noted. The Trust was not yet able to share the elective plan but there appeared to be more understanding of the importance of process and plans and taking responsibility. Conversations had taken place with the Trust following deterioration in the diagnostic service and OCCG had been advised it would be six months before the service recovered. The Trust Diagnostic Lead had been asked to produce a paper on the requirements to enable faster improvement. **The CCG Executive noted the Integrated Performance Report.**	
Strategy and Development		
21	**Project Overview** DH advised there were 100 areas on Verto. Any requests for additional items needed to be supported by a benefits realisation plan. Areas that had been requested were diabetes; prevention; personalisation; and population health. A Population Health Management (PHM) paper had been taken to the Integrated System Delivery Board (ISDB). It was hoped this would be a formal project by the end of the calendar year. The PHM work wrapped into the prevention work and meetings had been held with District Councils. JCo commented there was a great	

	deal of health and wellbeing work OCCG should be more attuned to for the long term conditions work. A process was in place for agreeing additional items for inclusion on Verto and PHM would be included. The winter plan would be overseen by the A&E Delivery Board (AEDB). As the system governance grew it was expected over time items would sit in different areas. Concern was expressed that clinicians were not sighted on decisions. Although each area had a clinical lead it was suggested some consideration of the flow through of information might be required together with more formal feedback to CCG Executive. Highlighted as an example was the Crisis Café which was an important part of the mental health service. A decision on funding had been made at the AEDB in which the mental health clinical lead had not been included. There was a general feeling that continued funding had been agreed. DC stated the information had not been communicated, the Café had started to wind down operations and MIND was telling the staff it would be closed. KC observed there were quite a few examples which could be quoted and queried how communication could be improved. CM and JCo would include in the discussion around the ISDB and governance. JCo commented if all programmes had the right documentation then it would be possible to ensure everyone could see it and be able to decide who should be involved and at what point. Elements could also be relevant to various areas and this would enable decisions to be made on where projects should be presented. Using Verto would ensure information was available for people. It had recently been agreed that the system would use Verto. Verto was good for project work but not quite so straightforward to use on business as usual work. Any tool needed to add value and be the right tool for processing, mandates and extracting highlight reports. If Verto was not adding value it would consume capacity. Verto should be a tool to draw out good practice. Next steps would be to agree the project list and clinical leads, confirm project outcomes and timings, and identification of key milestones to ensure delivery. The project on the Role of Localities in Delivery, Demand Management and Performance was raised and its overlap with the work of the Oxfordshire Care Alliance (OCA). KC commented she had raised this issue six months ago and had written and circulated a paper. The work was step by step. Locality meetings had been attended by GPs only but many now included representatives from the Federations, the Local Medical Committee (LMC) and District Councillors. DC pointed out the OCA was waiting for confirmation of support from	**CM/JCo**

	OCCG. DH believed it had been agreed to work with the OCA as a body on relevant areas, GP Access and Oxford Health NHS Foundation Trust (OHFT) out of hour's service. DC stressed the need for OCCG to show a definite financial commitment. He added that there was a need for someone from OCCG to be more actively involved in the management in order for the work to be taken forward. GK expressed some concern around the requirement for a financial commitment as there had been a high overhead figure to the contract and it had been advised this was for managing the contracts. CM observed if there was a move to an integrated care system there should not be two parallel groups. It was agreed a further discussion should take place at the CMF meeting.	
Business and Quality of Patient Care		
22	**Audiology – Bucks/Oxon Commissioning** Sharon Barrington attended for this item. SA presented Paper 4 advising the current contract was due to end in April 2019. It was a joint contract with Buckinghamshire who were the contract lead. Views from primary care supported a direct referral route and this was proposed in the paper. A lower tariff was proposed and an approval process using the Blueteq system. It was believed the cost would not increase greatly over the current contract. JC observed patients attending a community provider received two hearing aids whilst OUHFT only provided one. Currently OUHFT were not far off the cost per patient. If all patients attended SpecSavers any potential savings would evaporate. SB reported the OUHFT service had advised 90% of patients received dual hearing aids though this is not what the data presented showed. JC felt there was a risk if OUHFT did not apply for the contract and if the numbers were correct as the service could cost more. SB commented with an aging population there was the potential for an increase in numbers and savings not being achieved. DC felt the pre-assessment questionnaire should include asking the patient if they would wear a hearing aid as experience indicated many patients would not. GK remarked when first discussed at a previous CCG Executive he had expressed a preference for a more controlled way to move to self-referral and for it to be phased in over the life of the contract. He felt there should be a gateway approach in order to provide confidence the pathway was working before implementing self-referral which might increase demand. It was advised there was no shortage of capacity to provide the service and there might be adverse reaction from primary care if asked to triage audiology for another year. GK commented he would be more comfortable with self-referral if there was a clinical	**SB**

	threshold. SB reported the Blueteq form contained a clinical threshold. SB believed the proposed approach would make the process more transparent and provide the ability to audit the service. She added currently the CCG did not have information on why patients were given hearing aids or whether they were actually required. DH recapped that questions had been raised on timings and self-referrals, accuracy of data and whether savings would be achieved. SB advised the proposals were for the same price for all providers. If the OUHFT did bid for the contract it would see the biggest drop in payment. DH reiterated the need to understand the numbers and mitigate the risk. There was learning from prior procurements where the data was not robust and with questions around the data there was a need for this to be checked. SB did not consider there was a risk to the service if the OUHFT decided not to bid for the contract as it was believed there was sufficient capacity in the community. Discussions had been held with private providers and in contract meeting with OUHFT. DC requested confirmation contract discussion had been held with the providers of the service with OUHFT not just in contract meetings.	**SB**
	GK and SB to discuss the numbers with OUHFT, consider risk mitigation and look at where Blueteq sat and who approved it. A report to be brought back to the next CCG Executive. It was noted there might be a need to extend the contract by single tender waiver (STW) as the work required would curtail the procurement time.	**GK/SB**
White Space		
23	**Annual Public Meeting (APM)** Louise Patten joined the meeting at this point. A discussion had taken place at the Clinical Catch-up session on the areas to be covered by the Locality Clinical Directors (LCDs) at the APM. The APM agenda would be issued later in the day or on Wednesday 26 September. Information boards and refreshments would be in the café area. The format would be an introduction by KC, a finance section, the LCDs question time piece and Q&As. Post-it notes would be provided prior to the meeting for people to write questions and these would be collated and, where possible, organised into areas of questions in order for a fuller response to be provided. **Health Overview and Scrutiny Committee** JCo reported the paper on Planning for Future Population and Health Needs had been well received, as had the Winter Plan paper and the proposed approach to Cogges surgery in Witney following the decision by the partners to hand back their contract. KC advised the approach to Wantage Community Hospital had been accepted although the discussion had repeatedly referred back to the beds and there had been cheers from the audience each time a HOSC	

	member had said the beds should be opened. At the end of the discussion the HOSC Chair had asked OCCG to take on board the comments around the framework in general in order to ensure the Localities did not compete against each other for services; OHFT to take a recommendation to its next Board meeting to release capital funding for remedial works at Wantage Hospital; OCCG to accelerate the process by which it was to assess the health needs in order that concrete proposals could be taken to the November HOSC meeting. LP advised there would be a discussion with the HOSC Chair to confirm expectations for November to ensure all parties were in agreement. The November HOSC meeting fell on the same day as both the OCCG and OHFT Board meetings. The HOSC Chair had advised the meeting could not be changed but OCCG items would be scheduled for the afternoon session. The first Horton HOSC would be held on Friday 28 September 2018. The papers would be circulated. LP reported together with the Executive Managing Director - NHS South East for NHSI and NHSE, she would be meeting Victoria Prentis MP on 4 October 2018. She intended to ask if the new Director of Strategy at OUHFT could also attend.	**CM**
For Information		
24	**Papers Circulated / Approved Between Meetings** No papers were circulated or approved between meetings.	
25	**Confirmation of meeting quorum and note of any decisions requiring ratification** It was confirmed the meeting was quorate and no decisions required ratification.	
26	**Any Other Business** There being no other business the meeting was closed.	
27	**Date of Next Meeting** 23 October 2018	