Oxfordshire Clinical Commissioning Group

Date of Meeting: 31 January 2019

Title of Paper: CCG Executive Committee Minutes – 23 October and 27 November 2018

Paper is for: 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.

Author: Lou Patten, Chief Executive

Clinical / Executive Lead: Dr Kiren Collison, Clinical Chair; Kiren.collison@oxfordshireccg.nhs.uk

Date of Paper: 21 January 2019
MINUTES:
CCG Executive Committee
Tuesday 23 October 2018, 09.30 – 12.00
Conference Room B, Jubilee House

Present

<table>
<thead>
<tr>
<th>Present</th>
<th>Stephen Attwood (SA)</th>
<th>David Chapman (DC)</th>
<th>Gareth Kenworthy (GK)</th>
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<tr>
<td></td>
<td>Kiren Collison (KC)</td>
<td>Shelley Hayles (SH)</td>
<td>Catherine Mountford (CM)</td>
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<td></td>
<td>Jo Cogswell (JCo)</td>
<td>Diane Hedges (DH)</td>
<td>Lou Patten (LP) – Chair</td>
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In Attendance

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<tr>
<th>In Attendance</th>
<th>Ros Kenrick (RK) (Minutes)</th>
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Apologies

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<th>Apologies</th>
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<tbody>
<tr>
<td>Miles Carter</td>
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<tr>
<td>Ed Capo-Bianco</td>
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<tr>
<td>Jonathan Crawshaw</td>
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<td>Sula Wiltshire</td>
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Action

1. **Declarations of Conflicts of Interest Pertaining to Agenda Items**
   GPs present declared potential conflicts of interest at Item 5: Contracting Community Services and GP Access and Item 7: Community Gynaecology Service, should their practices wish to provide the services.
   The Chair determined it was appropriate for all GPs to participate in the discussion and decisions on these items.

2. **Minutes of the Meeting Held on 25 September 2018 and Action Tracker**
   The minutes of the meeting held on 25 September 2018 were approved as an accurate record and the action tracker reviewed.
   It was requested that in future each action is given just one owner.

Overview Reports

3. **Finance Performance Report**
   GK updated the Committee on the OUHFT M5 reporting. The £2.4m overspend at M2 had reduced to £2.0m at M5. The forecast outturn was now £7.0m-£9.5m. A proposal for the year end position for Oxford University Hospitals NHS Foundation Trust (OUHFT) would be available for the November meeting. OUHFT was aware of OCCG’s financial situation and might enter negotiations for next year’s contract soon. In negotiation OCCG would need assurance on recovery of the elective position.

   The Demand and Capacity meeting on 19 October had elicited verbal updates on OUHFT’s initiatives to tackle elective performance. There would be insourcing: an external company would provide staff to run
theatres over the weekends alongside internal OUHFT staff and others. This would focus on day cases, freeing capacity for more complex cases. There remained a risk if winter pressures became high.

OUHFT would be outsourcing approximately 7 Gynaecology cases to RBFT per week to reduce the backlog. DC noted that City patients were reluctant to go to Reading.

The Committee had concerns about possible up-coding of cases at OUHFT. GK reported that coding exercise on the top three HRGs had shown a possible overcharging of £1.5m, but full audits would be required to confirm this. The Committee asked to see the results of the analytical exercise.

It was noted that it was proposed as part of the development of more integrated working that OCCG’s contracts were to be block next year. The significant overspend in Specialist Commissioning may affect Planned Care if some elements were to be taken on by CCGs next year. There would be an opportunity here for Neighbourhoods and Localities to support OCCG.

GK reported pressures on the Adults with Care and Support Needs and in the Better Care Fund pooled budgets. The projection was for c£1.0m overspend, despite an increase in expenditure last year on continuing healthcare.

SH asked why there were empty beds at Wallingford hospital whilst there were high DTOC figures. DH said that the McKinsey work would help with identification of capacity across the system. LP asked DH to find out when a McKinsey update could come to Executive Committee.

£1.3m had been offered to Oxford Health as a contract variation for 2018/19. GK still awaited a response on how OHFT wanted to spend the money. LP noted that Oxfordshire was expected to work within its budget and that next year would require a rebasing of the system’s contracts. CM acknowledged that there would need to be well considered public messaging.

4. **Integrated Performance Report (IPR)**

DH concentrated on the Quality elements of the report. SW had suggested that outpatient communications, inpatient and test results should be considered as one item, not separately. This was supported.

Quality Committee had been concerned about the increase in never events. The Director of Clinical Services at OUHFT had been asked to find out how sighted OUHFT Board members were on these. LP said that the OUHFT Director of Nursing was monitoring the never events closely. It appeared that OUHFT could be counting more incidents as never events, but it was concerning that they seemed to be clustering in some specialties, such as gynaecology, and there appeared to be no cross-Trust learning. LP had asked SW to apply more pressure and to
escalate problems through Executive Committee.

SH voiced her concerns about cancer performance. The Cancer Board was not yet in place and neither was a cancer plan. Performance remained under target. LP thanked SH for highlighting the issue and would be escalating cancer, gynaecology and never events to the CEOs.

DC requested an update on HART. DH said that the final plan was not in place yet, but hoped to see it this week.

DC also asked that Committee members read the CAMHS report noting that Oxfordshire’s contract requirements were tighter and more ambitious than nationally, but that children were still not receiving the best service. SA noted the capacity problems. There were not enough clinicians in the service.

### Business and Quality of Patient Care

#### 5. Contracting Community Services and GP Access

Julie Dandridge presented the paper. Contracts were ending in March 2019 and OCCG would look at how they sat with community services going forward, particularly the urgent care pathway. There needed to be careful monitoring of GP capacity in out of hours and practice.

The proposals were:
- To extend the contracts on the basis of getting a collaborative approach
- To move to managing contracts through the OCA with all providers present
- To hold a multi-organisational co-design workshop

There was anxiety about direct booking. JC advised that OCCG looked at other geographies in which this was underway for comparison.

DH advised that GP streaming with nurse triage was resulting in lower numbers of patients going to the GPs than had been expected. The 111 triage was being more clinically driven and referrals to GPs were becoming more effective. LP noted that OCCG needed to have an overview of where patients were going and the effect on clinicians. DC and SA remained unassured about the appropriateness of referrals to GP appointments from 111. LP suggested that OCCG looked at the experience of the hub in Woking where there had not been inappropriate referrals. She suggested that someone from the Woking hub be invited to Executive Committee to explain the system.

The Executive agreed the proposals with the caveat that they that the impact on primary care needed to be closely monitored.

#### 6. Mission Critical Options List

The paper presented by DH showed the emerging methodology for agreement of the top priorities for OCCG. Highlight reports were drawn from Verto and the paper would provide a briefing for the Executive
going forward. Project Managers had been asked to RAG rate key areas.

It was noted that workforce did not appear on the list.

Clinical leads would be members of each OCCG Programme Board.

Population Health Management was an important area, but it was questioned whether this should be discussed at Executive Committee or at the wider STP meetings. It was hoped that one place for holding the documents could be identified for access by all organisations.

The Executive was asked to note that this was not a comprehensive list of projects undertaken by OCCG, but a list of the highest priorities. An additional column would be added to the table to state into which Programme board a project reported.

Clinical leads needed access to Verto.

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<thead>
<tr>
<th>7.</th>
<th>Community Gynaecology Service</th>
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<td>SH presented the proposal for this service. Long waits at OUHFT were rising due to a lack of capacity. There was capacity in the community to undertake simple procedures and train GPs to perform more complex procedures. There would be a need to ensure consultant governance, indemnity of the GPs and IT issues. There would be cost implications to OCCG for next year’s budget, but costs would be lower than those should all the service be provided in the hospital. This would aid OUHFT by taking out activity.</td>
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<td>GK agreed that this was an investment business case, but he would require a business case for the specialty as a whole. This was only a part of the solution. DH noted that it was a part of the elective care plan.</td>
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<td>The proposal would be taken to the Federations to discuss risk share arrangements. Federations would be asked to work with OUHFT to bring a proposal for the service to OCCG for approval.</td>
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<td>The Executive delegated final approval to GK, CM and LP or DH.</td>
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<th>8.</th>
<th>Capacity Alerts</th>
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<td>The Executive Committee agreed to extend the alerts for a further three months.</td>
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<th>9.</th>
<th>Neighbourhoods Further Development</th>
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<td>KC explained the greater emphasis in national policy towards neighbourhood working over recent months. She informed the Executive that all Oxfordshire practices belonged to a Neighbourhood and work was already taking place in some Neighbourhoods. She proposed that OCCG continue to work with and support the Federations and others with ongoing development.</td>
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<td>JD suggested that the Local Incentive Scheme (LIS) could be directed at Neighbourhood level, but the Executive wondered where all the</td>
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required resource would be found.

LP had attended a national briefing that indicated that Primary Care Networks might be in line for funding.

OCCG would need to set out how it would envisage Neighbourhood working. For instance, multi-disciplinary teams (MDTs) and long term conditions (LTC) (respiratory) could be handed over to Neighbourhoods to develop. LP undertook to investigate the funding question.

10. **Oxfordshire GP Forum**

   KC presented the proposal to have one countywide GP forum that would bring together GPs from various GP bodies (CCG, Local Medical Committee [LMC], Federations). It would provide a single point of access to a GP view, allow a GP voice to be represented at high level discussions and be a vehicle for closer working between the different GP bodies. It would be likely to evolve over time. KC asked for support from the Executive. KC would discuss with JCo how she could disseminate information about this group to the system.

   **KCJCo**

**White Space**

11. **What are the strategic issues that came out from today?**

   The Executive discussed the ISDB and where it fitted into OCCG’s governance process. The ISDB was a forum for Oxfordshire system management leaders to work together on system matters in order to align Oxfordshire with the rest of BOB. ISDB was the delivery (programme) board for this work. OCCG’s statutory duties and reporting requirements would remain with OCCG.

   There was the potential for ISDB to become an Integrated Care System Board, but were this to happen, OCCG (as commissioner) would no longer be a member. GPs, as commissioners, would remain with OCCG, but their role may become more strategic.

   The Executive discussed how OCCG would develop in the future. There were concepts to discuss, but no answers to date. These concepts would be developed into a communication to localities and stakeholders within two weeks to engage them in the direction of travel.

   **JCo**

**For Information**

12. **Other Meetings for Consideration**

   The meetings were noted.

13. **Papers Circulated / Approved Between Meetings**

   No papers were circulated or approved between meetings.

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**

   27 November 2018
Declarations of Conflicts of Interest Pertaining to Agenda Items

There were no conflicts of interest pertaining to agenda items.

Minutes of the Meeting Held on 23 October 2018 and Action Tracker

KC advised she had made some slight amendments to Items 9 and 10 which had been provided to LC. These were for clarity and had not made any material difference to the minutes. Subject to these amendments the minutes of the meeting held on 23 October 2018 were approved as an accurate record and the action tracker reviewed.

Communication Around the General Strategic Direction
CM advised this should be aligned with the long term plan. Work had started on a sustainability and transformation partnership (STP) wide narrative to ensure any communications were congruent if not the same. A meeting for the CCG Executive had been set for 22 January 2019 to discuss the 10 Year Plan.

Concern was expressed around the lack of communication to the Localities on a number of areas including GP access, neighbourhoods, a new structure under the Health and Wellbeing Board (HWB) and the move to an Integrated Care System (ICS). The concern centred around the suggestion not to hold January Locality meetings in order to free up time for GPs to manage winter pressures. Without January meetings there would be a need to present information on all these areas to Localities at their December meetings but insufficient information was currently available on form and structure. However, if
communication to Localities was left until the February meetings, with the expectation that an ICS would commence in April, this would be too late and the Localities would consider they had not been consulted.

KC concurred with this view stating this had been her reason for raising the issue previously. She reported she had emailed Locality Clinical Directors (LCDs) to query the best approach for informing Localities including whether this should be at a Locality meeting or a larger event with other attendees.

CM advised a paper on the HWB strategy would be presented to the OCCG Board at its meeting on 29 November 2018. The paper was in the public domain and could be used to inform the Localities. She explained that the 10 Year Plan was still awaited and it was not possible to do anything before this was released as the system would need to work together on implementation. It would be necessary for the ICS to be provider led and OCCG would be required to implement the NHS England (NHSE) guidance.

SH commented that a paper to the Localities was not the same as communicating. The North Locality had discussed neighbourhoods at its last meeting. It was important for the membership to have time to consider items. Formal oversight would be required once the membership had had time to consider and discuss within practices.

LP stated there was a need to agree a communications plan with the LCDs but explained an ICS was a way of working and not a formal entity. It was agreed KC would work with the Communications Team to issue something before Christmas. A discussion on the content would take place at the Tuesday morning clinical catch-up meeting.

Musculoskeletal (MSK) Deep Dive
The report from Healthwatch had been circulated and the item could be closed. A letter from Oxford University Hospitals NHS Foundation Trust (OUHFT) on the impact on referral to treatment (RTT) had been received and was being formally responded to.

Project Overview
CM advised this was linked to the work around system governance and reporting and how the HWB worked with other groups. The HWB development report had been circulated as part of the Board papers. In addition the CCG Executive received a Key Projects report at each meeting. The action was closed.

Audiology
SA advised there was still not a clear understanding of the data and the team continued to work on the issue. DH remarked an agreed key reflection on the learning from the MSK procurement was the need for in principle agreement with system partners in this instance, with OUHFT. DH and GK to ensure a conversation took place. A verbal
update to be provided at the next meeting.

Neighbourhood Working – Primary Care Networks
Julie Dandridge attended for this item. KC apologised for the late tabling of the paper explaining a meeting had taken place on 13 November 2018 with representatives from OCGG, the Local Medical Committee (LMC), Federations and Oxford Health NHS Foundation Trust (OHFT) to discuss the current position. The minutes of that meeting had also been circulated.

JC advised there were two different funding streams for this work: one through the aspirant ICS funding stream and the other through the primary care funding stream. The requirements for obtaining the money were being looked at as well as what needed to be put in place in order for the money to be released. The Federations and the Oxford Care Alliance (OCA) would be asked to consider how the money could be used in year. If the CCG Executive supported the paper there would be an opportunity for discussion at December Locality meetings.

JD stated the need to agree network boundaries and to establish whether the monies needed to be used in year or whether they could be committed and used in 2019/20. LP advised as the money would be for organisational development (OD) work (paying clinicians to come out of practices to undertake this work) it would enable the monies to be used in the next year.

JD explained the paper asked the CCG Executive Committee to agree to adopt the new terminology of Primary Care Networks to describe the progression of the neighbourhood working in Oxfordshire. It was also proposed that part of the December Locality meetings could be used for establishing the baseline and assessing the neighbourhoods against the Primary Care Networks maturity matrix. A plan had been submitted to NHSE for funding and there was a degree of confidence this would be forthcoming.

There was some discussion around use of funding in respect of the maturity matrix, the fact some PCNs would be more mature than others and how the support would be provided. It was commented that most of the exemplars would have undertaken the work through need whilst others were not yet ready and they should not be forced up to a certain level. There was general agreement to support exemplars whilst supporting and sharing learning to help others. LP commented the funding was one-off, non-recurrent which should be used to help areas get to a stage from where it would be easier for work to be taken forward.

The CCG Executive agreed the principles around changing the terminology, that the OCA would drive forward the work to progress the maturity of Primary Care Networks, supported the use of the December Locality meetings to advance the work to
baselines and assess current status.

The need to be clear on an exit strategy for the non-recurrent funding was emphasised. The Federations and the OCA were being asked to come back with proposals. It was noted a small group would be needed to agree the right key performance indicators (KPIs) and outcomes were in place.

### Overview Reports

#### Finance

GK presented Paper 2 and advised that table 1 showed the likely year end position. OCCC was in the process of negotiating a fixed year end position with the OUHFT. There were three parts to this: the elective run rate; winter; and high cost drugs. A clinical coding audit would be undertaken whether or not a fixed year end position was agreed. The proposal for next years' contract was a form of block contract. NHSE/NHSI were changing all the tariffs and it was expected there would be some confusion when this took place.

Other overspends included community health and continuing care issues where a risk share on the pooled budget had not been agreed. It had been agreed there would be aligned budgets this year and not a risk share. There had been a £300k increase on the OCCC risk. The increase in continuing health care spend had continued into this year and currently was a 15% increase. Referrals had remained steady but the stays in placements were longer.

Areas of discussion included:

- Spending money in primary care might reduce demand on other areas and lead to savings. There was £160k uncommitted on nursing home locally commissioned services which could be used in primary care
- Historically OCCG looked to the acute sector for solutions to winter problems but the A&E Delivery Board (AEDB) had looked at a number of non-elective prevention schemes. There was a case for the integrated teams to be able to make an impact throughout the year not just in winter and an opportunity if some of the networks were willing to run services differently over a period of time. It was a confidence issue and a reluctance to take risks preferring to continue doing what had always been done
- The Winter Director, Tehmeena Ajmal (TA), had contacted the Federations around ideas for support and funding this winter. Any other suggestions should be submitted to TA
- It was believed no primary care suggestions with a quantified impact had been turned down
- Schemes needed to be worked up by provider organisations
- Some GPs present stated there had been systematic underinvestment in primary care. If the underinvestment continued it would lead to problems
- Primary care schemes sometimes had a lead-time before admissions were reduced. There needed to be some faith in the proposals and funding should not be reversed.
- All areas would need to be considered when looking at how to address the mental health funding gap. Decisions could not be binary and there would be a need to look at other parts and not individual streams.

GK advised the position would be kept under review and attempts made to manage the uncertainty. He commented if the year-end position with the OUHFT was fixed it might release funding to use elsewhere in system although this would not be possible until some of the risks were closed down.

The latest reported RTT position was a significant increase in run rate. This was being investigated to understand whether it was Oxfordshire patients.

**The CCG Executive Committee noted the paper and considered OCCG was managing its risks effectively in order to deliver its financial objectives.**

### 20 Operational Planning 2019/20
CM presented Paper 3 and explained there was an emphasis on system planning with an expectation of a move towards system control totals. More guidance was expected in the 10 Year Plan. CM would lead the process but requested a named clinical lead to read various items without necessarily needing to attend all the planning meetings. As there would be themed pieces in the narrative other LCDs could review these rather than one LCD undertaking the whole task. As a minimum each LCD would need to read their area and one person would need to sense check the whole document. To be discussed outside of the meeting.

GK advised although the national planning guidance was still awaited OCCG had had sight of the running costs. CCGs were being asked for a 20% reduction in running costs which needed to be delivered in full by 2021. This equated to £2.5 – 3.0m.

**The CCG Executive Committee noted the national guidance and the plans to develop the Oxfordshire Operational Plan 2019/20.**

### 21 Integrated Performance Report
DH introduced Paper 4 advising cancer targets remained an issue. A letter had been received confirming funding for the Child and Adolescent Mental Health Service (CAMHS) four week waiting time project and also separately support to schools, although the letter was currently embargoed. DH reported workforce issue were affecting bed numbers as there were not enough staff to staff the beds.

DC observed the Improving Access to Psychological Therapies (IAPT) figures were not moving in an upward direction. He pointed out the
need to keep a watchful eye as the target was due to change to 21% and the current target was not yet being achieved. DC added that following the paper switch off for referrals, 10% of all referrals were still going via paper. Practices needed to be aware and the hospitals would not be paid.

**Gynaecology Plans to Achieve Referral to Treatment (RTT) Performance**

OUHFT had been struggling to meet RTT and Cancer standards for gynaecology for nearly two years. One of the main issues was capacity did not meet demand and some services had been developed in an unplanned way without business case support. Outpatient waits were at 40 weeks plus whereas to meet the RTT standard they needed to be at 10 weeks. The Trust proposed stopping referrals to several sub-specialities at OUH (patients could be referred to other providers) for a period of 12 weeks allowing the backlog to be cleared and management of the run rate to bring back into the position where the RTT standard was met.

The document had support from the gynaecologists at the OUHFT and the Clinical Lead GP for gynaecology was fully informed and understood the issues. Significant work needed to be undertaken by OUHFT to engage the other providers locally to ensure they would have capacity for additional referrals or could provide additional capacity.

There had been a good sustainability and transformation partnership (STP) meeting on 26 November concerning gynaecology. OUHFT needed help and assistance from Buckinghamshire and Berkshire to find a solution. DH believed this was the right approach and queried whether the CCG Executive was happy for work to be undertaken with other providers to find a solution. SH added that the request would be not to refer to Oxford for three months but to another provider where it was anticipated the patient would be seen earlier. However, patients could still choose Oxford but would need to understand that there would be a longer wait.

In order to encourage people to use alternative providers a discussion with Buckinghamshire and Berkshire around giving consideration to positioning consultants closer for the initial consultation might be required. DH suggested a paper be brought back to the CCG Executive in December with a proposed plan. OUHFT were quoting a need to reduce theatre quotas by 20%. The request was for support for the way forward but not the detail until it had been reworked.

**The CCG Executive:**

- Noted the proposal for OUHFT to stop taking referrals for a 12 week period but required further work up and evidence
- Wished to see evidence other providers would accept referrals
- Expressed some concern as to whether the action would create a surge later on if patients did not attend another provider
- Noted the need to agree the communications and message for the decision.

The CCG Executive delegated the decision on bringing a further paper to the December meeting to SH.

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<th><strong>22 Priority Projects</strong></th>
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<td>Paper 5 was noted.</td>
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**Business and Quality of Patient Care**

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<th><strong>23 Parkinson’s Disease Service Review</strong></th>
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<td>SH presented Paper 6 explaining there was a need to improve the service for patients. This was a quality standard that OCCG ought to be looking to implement. SH felt investing additional funding would have a good knock on effect in patient care.</td>
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The papers embedded in the document to be circulated.

LP stated the CCG Executive had received the information on the basis that the business case was being worked up. She commented that it was a good example of how a commissioner could work up a proposal which could be passed over to provider organisations to take forward. LP felt it was an opportunity to share with Federations and explore how items could be worked up in the future.

CM requested the business case should be written from a system perspective.

The CCG Executive noted the paper.

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<th><strong>24 Commissioning an Integrated Homeless Healthcare Pathway</strong></th>
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<td>Chris Walkling (CW) attended for this item.</td>
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DC presented Paper 7 explaining the pathway particularly related to rough sleepers. People with acute complex needs were able to access O’Hanlon House in Oxford City but housing providers in other areas had closed down, although a hostel was due to open in Oxford City. Those with the most complex needs in the districts were able to go to O’Hanlon House but only if there was space. Rough sleepers were sometimes admitted to hospital but there was then an issue with their discharge. The more mobile were discharged to the streets. Those with more complex needs required care in a community setting. It was possible for people to be discharged to O’Hanlon House but only if space was available. The idea was to look at the broader issues when people were discharged from hospital. O’Hanlon House was currently the only place able to receive people with complex needs.

Responding to a query as to whether there were sufficient checks in the system to stop Oxford becoming a magnet as it provided a good service, CW advised the greater numbers were partly due to Oxford’s
proximity to London but also to people ‘holidaying’ in Oxford during the summer. There was no evidence to support the services offered were attracting people.

DH advised the continued investment in housing was one aspect of the paper but there was a need to ensure this provided an incentive approach. There had been some step up from the districts but there was a need for more rapid support and tracking of progress. Another issue raised in the paper was the question of recommissioning the service currently provided by Luther Street Medical Centre (LSMC). LSMC was a good practice but there was a need to continuously review and ensure a primary care service to meet future patient presentations was designed.

CW advised the proposal was an integrated pathway across the system.

The CCG Executive Committee:
- Supported the development of an integrated homeless pathway across primary and secondary care
- Supported the ongoing recommissioning of specialist primary care services
- Agreed to maintain the £150k per annum investment in the homeless housing pathway for the years 2020-2022.

25 Mental Health Counter Offer from Oxford Health NHS Foundation Trust (OHFT)
GK presented Paper 8 requesting approval on the proposed use by OHFT of the balance of the ring fenced £1.3m Mental Health Investment Standard (MHIS) to support core services rather than for Five Year Forward View (FYFV) service improvement. There were two components: agreement to the use of ring fenced MHIS reserve and the request by OHFT to temporarily suspend the contract mechanism. The temporary suspension would be for the remainder of the financial year. From a commissioning and financial perspective the temporary suspension was supported and the CCG was working towards reviewing the key performance indicators (KPIs) to make these stretching but achievable.

There had also been discussion with the Child and Adolescent Mental Health Service (CAMHS) team and agreement to waive the KPIs for year two with a renegotiation of the KPIs in year three.

For the general OHFT contract DH advised there was an agreed list of KPIs which would be suspended for the winter period and the Quality Team had been involved in the discussion.

The CCG Executive Committee:
- Noted the OHTF position in proposing only to use the MHIS funding to support core MH services
- Supported the commissioner and finance decision to
accept this position, on condition that OHFT delivers the actions described in the paper.

- Noted there would be another paper with confirmation of the final position to the December meeting, along with an action plan of work being progressed following the results and recommendations of the Trevor Shipman review into the level of investment in mental health in Oxfordshire.

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<th>26</th>
<th>Oxfordshire Primary Care Commissioning Committee (OPCCC): New Ways of Working</th>
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<td>CM presented Paper 9 explaining the OPCCC Chair wished the CCG Executive Committee to comment on the paper before it was submitted to OPCCC for approval.</td>
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<td>After discussion CM commented that the paper was obviously not clear enough and directed members to the table on page 10 which detailed areas OPCCC would no longer deal with in isolation but would be addressed as a system. It was agreed the items should be aligned to the format used in the Finance Performance Report.</td>
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<td>Any additional comments to be provided to CM by the end of the week.</td>
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<td></td>
<td>DH felt the paper needed a piece on quality and this would be picked up by DH, CM and SW outside of the meeting.</td>
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<tr>
<td></td>
<td>The CCG Executive noted the paper and would supply any further comments to CM.</td>
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<tr>
<td></td>
<td>CM</td>
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<tr>
<td></td>
<td>All</td>
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<tr>
<td></td>
<td>DH/CM/ SW</td>
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<table>
<thead>
<tr>
<th>27</th>
<th>CCG Executive Committee Forward Plan</th>
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<tbody>
<tr>
<td></td>
<td>Noted for information.</td>
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<table>
<thead>
<tr>
<th>28</th>
<th>Locality Meetings and Seasonal Pressures</th>
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<tbody>
<tr>
<td></td>
<td>Paper 11 was presented and a discussion ensued around whether or not the January Locality meetings should be cancelled as it was anticipated winter pressures might lead to GPs needing to spend more time in practices. Concern was expressed around the rapidly changing environment, the move towards an ICS and neighbourhoods and the discussions that were required. Cancelling the January meetings would require fast work up of information in order that it could be presented to the December meetings and some of that information was not yet available, or leaving any discussion until February which would not leave much time for debate and could lead to a charge from the Localities that they were not being consulted. The consensus was leaning towards not cancelling the January meetings. However if pressures were being felt at this time then the meetings could be stood down.</td>
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<td></td>
<td>The CCG Executive agreed the meetings would remain in the diary; a review would be undertaken in December which would consider the areas for engagement; a final decision would be taken two weeks before the meetings.</td>
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<thead>
<tr>
<th>29</th>
<th>Gynaecology Plans to Achieve RTT Performance</th>
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<tr>
<td></td>
<td>Discussed under Item 5, the Integrated Performance Report.</td>
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</table>
30. **What are the strategic issues that came out of today?**
- Communication with practices/Localities
- Neighbourhood working
- Gynaecology referral proposal
- January Locality meetings

**Jubilee House**
SH raised the state of Jubilee House and the seemingly inordinate length of time for issues to be resolved. LC to pick up with GK outside of the meeting.

**Sustainability and Transformation Fund (STF)/GP Access Fund (GPAF) Workshop**
KC reported a workshop was due to take place that afternoon which would look at integrating GP access fund, sustainability and transformation fund (STF) and out of hours. KC was concerned people would arrive at the workshop worrying about funding streams and sustaining primary care.

SA understood the logic but was concerned that a programme which had started as something to sustain primary care had shifted to sustain the system which might lead to funding being taken away from programmes that were deemed as not successful as they had not yet realised their full benefit. Investment in primary care had been for additional services not core primary care.

LP advised on the need to work as a system as the funding would be lost if OCCG could not prove it was being used where support was required. The funding should also enable and empower Federations and practices to be assured of income and to work a bit more flexibly around what was expected.

The need for providers to work together was stressed. The GP Access Fund and out of hours services needed, as far as possible, to be contracted together. If it was decided not to go out to procurement on GP access there would be a need for at least a Memorandum of Understanding (MOU) between the Federations and OHFT under the OCA.

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**For Information**

<table>
<thead>
<tr>
<th>31</th>
<th>Papers Circulated / Approved Between Meetings</th>
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<tbody>
<tr>
<td>No papers were circulated or approved between meetings.</td>
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<thead>
<tr>
<th>32</th>
<th>Confirmation of meeting quorum and note of any decisions requiring ratification</th>
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<tbody>
<tr>
<td>It was confirmed the meeting was quorate and no decisions required ratification.</td>
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<thead>
<tr>
<th>33</th>
<th>Any Other Business</th>
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<tbody>
<tr>
<td>There being no other business the meeting was closed.</td>
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<thead>
<tr>
<th>34</th>
<th>Date of Next Meeting</th>
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<tbody>
<tr>
<td>18 December 2018</td>
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