Oxfordshire Clinical Commissioning Group
Board Meeting

Date of Meeting: 29 November 2016	**Paper No: 16/87c**

Title of Presentation: Minutes, Oxfordshire Primary Care Commissioning Committee, 6 October 2016.

Is this paper for (delete as appropriate)	**Discussion**		**Decision**		**Information**	✓

Executive Summary

The Committee draws to the attention of Board members, the following:

Risk Register:

- Banbury practices: There has been a greater rise in A&E attendance at the Horton Hospital than at the John Radcliffe and there were real primary care pressures in Banbury. A piece of work would be undertaken to understand the rise in A&E attendance at the Hospital.
- Primary care capacity is rated as a 'extreme' risk for OCCG, an increase from 'high' the previous month. Increasing numbers of practices are reporting difficulties in GP and healthcare professional recruitment, resulting in a reduction in primary care capacity. The Committee needs assurances around the impact on patients and was not assured that the controls and actions identified in the Risk Register would address the risk and the actions detailed in mitigation, would not bring the residual risk rating within an acceptable level. The Committee, through its work, must assure the OCCG Board and the public in terms of OCCG having plans in place to manage the emerging crisis in primary care. Next steps needed to be agreed and the Committee was looking for an integrated plan to address this risk.

Deer Park Medical Practice: It had been decided a contract could not be awarded and the only option had been to disperse the list. An impact assessment had been undertaken and mitigation work commenced. The contract had been extended to provide a longer timeframe in which to undertake the mitigation work and meetings had been held with the practice PPG and the Chair of the Oxfordshire Health Overview and Scrutiny Committee.

Additional funding: OPCCC had agreed additional funding for primary care and this decision was supported by the OCCG Board at the extraordinary board meeting held on 25 August 2016.

GP Access Fund: The criteria had been released on 23 September and OCCG was working with Locality Clinical Directors and GP Federations on the new national requirements, with an aim was to have contracts in place and services commencing from the beginning of November.

Financial Implications of Paper:
There were no further financial implications arising from the work of OPCCC.

Action Required:
There are no actions for the Board arising from this meeting. The detailed work of OPCCC provides further assurance to the Board that OCCG is managing its primary care commissioning in accordance with the framework approved by this Board.

NHS Outcomes Framework Domains Supported (please delete tick as appropriate)	
✓	Preventing People from Dying Prematurely
✓	Enhancing Quality of Life for People with Long Term Conditions
✓	Helping People to Recover from Episodes of Ill Health or Following Injury
✓	Ensuring that People have a Positive Experience of Care
✓	Treating and Caring for People in a Safe Environment and Protecting them from Avoidable harm

Equality Analysis completed (please delete tick and attach as appropriate)	Yes	No	Not applicable ✓
Outcome of Equality Analysis			

Author: Duncan Smith, Lay Member, Chair, OPCCC.	**Director Lead:** Joe McManners, Clinical Chair.

MINUTES:

OXFORDSHIRE PRIMARY CARE COMMISSIONING COMMITTEE

6 October 2016, 14.30 – 16.00

Conference Room B, Jubilee House

Present:	Duncan Smith (EDS), Lay Member OCCG (voting) – Chair
	Julie Dandridge (JDa), Deputy Director, Head of Primary Care and Medicines Optimisation OCCG (non-voting)
	Roger Dickinson (RD), Lay Vice Chair OCCG (voting)
	Diane Hedges (DH), Director of Delivery & Localities OCCG (voting)
	Ginny Hope (GH), Head of Primary Care NHSE (non-voting)
	Colin Hobbs (CH), Assistant Head of Finance NHSE (for Richard Chapman) (non-voting)
	Dr Joe McManners (JM), Clinical Chair OCCG (voting)
	Catherine Mountford (CM), Director of Governance OCCG (voting)
	Dr Meenu Paul (MP), Assistant Clinical Director Quality OCCG (voting)
	Rosalind Pearce (RP), Healthwatch (non-voting)
	Dr Paul Roblin (PR), Chief Executive Berkshire, Buckinghamshire and Oxfordshire Local Medical Committee (non-voting)
	David Smith (DS), Chief Executive OCCG (voting)
	Chris Wardley (CW), Patient Advisory Group for Primary Care Chair (non-voting)
In attendance:	Lesley Corfield - Minutes
	Ali Albasri, Doctor of Philosophy student in Pharmacology (shadowing JM)
	Samia Fazil, Leadership and Organisational Development Project Support Officer Thames Valley and Wessex Leadership Academy (shadowing CM)
	Dr Paul Park (PP), Deputy Clinical Chair and North Locality Clinical Director OCCG (voting when JM not present)
	Jenny Simpson (JS), Deputy Finance Director OCCG (non-voting)

Apologies	Richard Chapman, Director of Finance NHS England

		Action
	Welcome EDS welcomed the members of the public to the meeting and advised the OPCCC was a meeting in public not a public meeting. He advised he had asked whether the Deer Park PPG representatives would like to make a statement to the Committee but they had declined. Introductions were made.	
1.	**Declarations of Interest** JM advised he was a partner at the Manor Surgery in Headington and the practice was a member of the OxFed federation; MP advised she was a GP at The Surgery, Islip and the practice was a member of ONEMed federation; CW and RD were patients at Hightown Surgery; EDS was a patient at Marcham Road Surgery.	
2.	**Minutes of the Meeting held on 4 August 2016** Subject to amending the second sentence of Item 7 Finance Report to read 1.0% non-recurrent headroom and 0.5% contingency reserve; and including a piece on metrics on page 9; the minutes of the meeting held on 4 August 2016 were approved as an accurate record. JD confirmed there had been a discussion around quality and performance metrics and how these could be used by Patient Participation Groups (PPGs), as the information was in the public domain. JD suggested producing a one-sided piece of paper advising where the information could be found. Action: JD to discuss with the Deputy Director of Quality.	**JD**
3.	**Action Tracker** *Delegated Primary Care Resource Issues* JD advised this remained a risk, as an appointment had been made to one of the vacant posts but the other was still vacant. Help for individual practices had been offered from a good array of expert practice managers. Due to the concerns raised at the OCCG Board meeting on 29 September, JM requested the action be kept live on the Action Tracker. *Risk Register* Work continued with NHS Property Services around how funds should be spent on premises. A six facet survey was due to commence in practices. Funding for the survey had been received and consideration was being given to how to proceed so it would not be too onerous for practices and did not repeat work already undertaken for CQC inspections. *Quality Report – Breach notices* JD advised that if a breach notice was a one-off it would be dealt with by the operational group. Only if repetitive breaches or the action plan to address a breach was not satisfactory, would it be brought to OPCCC. JD reported there had only been a handful of breach notices over the last two years. PR advised breach notices had to be	

	discussed with the Local Medical Committee (LMC).		
4.	**Forward Plan** It was agreed to discuss the Forward Plan at the end of the meeting: see Item 9 below.		
5.	**Risk Register** CM reported the Risk Register built on the report to the previous meeting but due to changes within the Governance Team, not all the items raised at the August meeting had been picked up in the report presented. A discussion had been held at the OCCG Board around whether the 'sustainability' risk as described, was iterated clearly and if the risk was so 'large', would it prevent the organisation delivering on its strategic aims. There was a need to look at how the risk was iterated, reported to the OCCG Board, time and the actions being taken forward and mitigations that were being developed, all of which might not be as transparent at board level, as the OCCG Board would like it to be. DH advised there was a greater rise in A&E attendance at the Horton Hospital than at the John Radcliffe and there were real primary care pressures in Banbury. A piece of work would be undertaken to understand why the rise in A&E attendance at the Horton was greater than the John Radcliffe and whether it was directly linked to the primary care issues. It was beginning to feel as though there might be some evidence of primary care pressure pushing into performance elsewhere in the system, although as yet this could not be evidenced. JM commented more pressure and less time in primary care led to the likelihood of more referrals into secondary care. MP added some services traditionally undertaken in primary care were no longer being carried out, as they were considered over and above the General Medical Services (GMS) contract. CW observed press coverage on the Horton in Banbury might also be a factor. CM believed OPCCC needed to consider whether risk 769 should be split or become a strategic risk rather than an operational risk. As a red risk this was an issue and needed to be looked at in more detail and assurances provided on how it would be addressed. JM stated the areas of the organisation at risk were: transformation, performance, and direction of travel. EDS observed OPCCC needed assurances around the effect on patient services, particularly access. EDS was not assured that the controls and actions identified in the Register would address the risk and the actions detailed in mitigation, would not bring the residual risk rating within an acceptable level, whether it was a strategic or operational risk. RD commented it all seemed to be piecemeal and reactive. JM felt the actions were too small scale to have any significant impact. CM stated the OPCCC role was to identify the gaps and decide whether they could be addressed. EDS commented on the need to assure the OCCG Board and the public in terms of OCCG having plans in place to manage the emerging crisis in primary care. Next steps	

	needed to be agreed in terms of putting an integrated plan together to address the risk. CM and JD to take outside of the meeting for discussion at the Directors' Risk Review meeting. To be brought to the next meeting. In response to a query from CW, DH advised the work was not yet complete on the workforce strategy but what was available could be shared. EDS commented the work could not be a control if it was not complete. This would be picked up further in the private session and EDS suggested a note of the actions agreed during the private session could be published. JM observed a robust plan was required by the next OCCG Board meeting. In terms of some of the challenges for a robust plan, DH advised OCCG could invest more money but this would not fully sustain primary care. Some of the answers were transformation and quite radical in relation to the way people worked together. There was more which could be undertaken towards securing a sustainable service but the proposals would need to be discussed elsewhere. PR advised the bulk of activity in general practice was delivered under 'global sum services', which was funded inadequately and whilst this continued, services would be insufficient to meet the demand on primary care services. The amount primary care received for one patient for a whole year (for an average of six consultations) was the same cost as one hospital out-patient appointment. JM commented on the need to consider how GMS services were sustained and 'core' services maintained until transformation had been implemented. DS queried whether enough was being done to communicate with public and practices around the sustainability of primary care and transformation. JM felt there was a need for OCCG to be clear around local work on national issues. CW stated patients should also be engaged and represented. **The Committee noted:** • **The content of the OCCG Primary Care Risk Register and the one 'extreme' risk and two 'high' risks** • **The Primary Care Estate risk 789 had an overall 'high' risk rating of 16** • **The Primary Care Capacity risk 769 had increased from a rating of 16 to 20 ('extreme')** • **The GP Prescribing Budget risk 736 had a 'moderate' rating of 6.**	**CM/JD** **CM**
6.	**Deputy Director Delivery & Localities, Head of Primary Care and Localities Report** JD advised following one merger and one closure, there were now 72 GP practices in Oxfordshire. It had been decided a contract could not	

	be awarded for the Deer Park Medical Practice in Witney and the only option had been to disperse the list. JD had held a meeting with the PPG and two further meetings were due to take place in the next week to discuss how best to support patients. An impact assessment had been undertaken and mitigation work commenced. The contract had been extended to provide a longer timeframe in which to undertake the mitigation work. Discussions had been held with the three other practices in Witney, who were implementing plans to increase capacity in order to accept patients from Deer Park. PR queried whether the failure to procure was due to the fact a private company was not able to live within the financial envelope, which he assumed was the 'global sum'. JD advised the contract could not be delivered within the sum identified, which was significantly more than the 'global sum'. The offer had been a different specification to be delivered within the contract sum, which was not acceptable. JD hoped the national GP workforce survey, which was due to be undertaken for the first time, would provide data on vulnerability and where difficulties existed. PR commented once it became widely known that general practice was a highly stressful environment in which to work, it would become unpopular and affect recruitment. DS observed although very good at debating the problems, there was a need to talk about solutions, as some of these were very difficult and included money, recruitment and the attractiveness of primary care. He also recommended maintaining a perspective, as not every practice in Oxfordshire was unable to cope. He stressed the need to make sure OCCG was undertaking all it could and that there was a proper strategy in place, within which actions could be taken. EDS concurred that an integrated plan would enable OCCG to move forward. JD advised that there was also funding as part of the vulnerable practice fund, but this was now changing to the general practice resilience fund, which, she explained, should make more funds available for general practice resilience. Practices had been asked to self-declare vulnerability and OCCG was working with NHS England (NHSE) on areas which could be undertaken at Thames Valley, regional and local levels. It was hoped to bring more information to the next meeting. CW reported at his practice in Banbury, they had considered different methods of working and it was felt the practice could manage if patients adjusted the way they interacted with the practice. JM believed this was a good point, adding there was a need to identify problems and then support practices to make changes, based on evidence of success elsewhere. CM commented on the need to recognise where some of this work was already taking place via the locality investment schemes, which provided 'thinking space', to develop proposals around how to	 **JD**

	work differently and these proposals should be shared with other practices. DH commented on the need to reflect on the learning from the Deer Park exercise. A contractual exercise to replace a practice in its current form had been undertaken and had not worked, mainly due to the size of the practice. The learning from this experience was that re-procurement would not be successful for smaller list sizes and there was a need for either larger list sizes or practices working in partnership. She felt the future was 'neighbourhoods' of practices effectively working together to address sustainability and transformation and OCCG would need to consider the minimum planning size for a practice to be contracted. OCCG went out in good faith to contract for a service at Deer Park, believing it would be possible to contract, which ultimately led to insufficient time to consult, when it became clear that a service could not be contracted within the financial envelope despite it being over and above GMS contract sums. EDS requested a formal piece on learning from the Deer Park experience to be brought to the December meeting. JD advised meetings had been held with the practice PPG and the Chair of the Oxfordshire Health Overview and Scrutiny Committee (HOSC). Regular meetings to engage all the way through the process were being arranged and meetings with the PPGs of the other Witney practices would be organised. In relation to the pressure on Banbury practices, it was proposed that that patients would be discouraged from transferring between practices, as this was costly and time consuming for practice staff. There was an agreement between practices that this would not happen unless there was a good reason for the transfer. Two practices in Banbury had asked to be able to close their lists. There was a risk all the practices might request list closure and Banbury currently had no capacity for new growth. A short-term proposal whilst the wider issues in Banbury were resolved and more sustainable care was in place would be required. JM commented that it should be possible to quantify and establish if there was a high movement of patients in Banbury, as a different price was paid for new patients, which would allow a percentage change to be seen. It was observed continuity improved efficiency and there was a need to fix the root cause behind patient transfers. CM agreed the need to quantify figures and queried if patients were being encouraged not to move, whether practices should also be requested to refrain from asking patients to move practices. GH mentioned whatever was agreed, there would have to be patient and public engagement and there was a need to recognise the constitutional right of patients to be able to activate choice and change	**DH**

	practices. The Committee resolved to support the short-term initiative to discourage patient transfers between practices in Banbury. OPCCC had agreed additional funding for primary care and this decision was supported by the OCCG Board at the extraordinary board meeting held on 25 August 2016. JD advised letters of intent and variations to contracts were in place and would be finalised in contracts by the end of November. All investment was in line with the approved business case. Two new locally commissioned services would be commencing shortly: dermatology in the South West and a home phlebotomy service in the North. The minor eye conditions service (MECS) had launched in September under which patients were able to see an optometrist for minor eye conditions. Optometrists were able to refer directly to the eye hospital as part of this scheme. Issues with the service were being picked up by Dr Shelley Hayles, the North Deputy Locality Clinical Director and clinical lead for this area of work. The criteria for the GP Access Fund (GPAF) had been released on 23 September. OCCG was working with Locality Clinical Directors and GP Federations on the new national requirements. The aim was to have contracts in place by the end of the month and services commencing from the beginning of November. There would be an additional 309 hours per week of appointments for Oxfordshire paid at £6 per weighted population, although it was not yet clear how the population would be weighted but it was anticipated the total figure would be around £4.2m for Oxfordshire. This would be on-going funding for the next 3 – 5 years. Not all the extra appointments were required to be GP appointments. It was noted that some of the Estates and Technology transformation fund (ETTF) monies needed to be invested during the current year. CW referred to the point he had raised at the last meeting concerning PPGs and advised it was a contractual requirement for practices to have a PPG and the evidence confirming this had been circulated to the Committee. **The Committee noted the contents of the report.**	
7.	**Finance Report** JS presented the first combined Finance Report advising the format was in line with other reports for the OCCG Board and Finance Committee. The Overview set primary care in context with the rest of OCCG finances. Feedback on the report template and content to be sent by email to JS. Overall, OCCG was reporting to be on financial plan, year to date and forecast outturn but this was only due to the Financial	**All**

	Recovery Plan (FRP). The FRP had three main impacts on primary care: £1.2m of slippage had been moved non-recurrently from the primary care development budget; £0.5m from the prescribing budget and would be reviewed for next year's budget setting and; the primary care reserve had been reduced by £534k. This was necessary as part of the FRP to achieve OCCG's financial targets. There were three new allocations in Month 5: the GP resilience programme; reception and administration training; and the vulnerable practices pilot. Year to date, CH advised: the delegated primary care funds had a £55k favourable variance, due to slippage on enhanced services, as not all practices had signed up to the extended hour's service; a favourable variance on GP premises but this was not expected to continue as when the backlog of rent reviews reduced premises reimbursement would increase; GP drug payments where there was an adverse position due to an overstatement of the Month 5 accrual for quality payments; and clinical waste activity which was slightly below plan. DH advised discussions had taken place elsewhere around the need to see the report developed to provide a forward look, taking into account commitments made by OCCG, undertaking more proactive planning. EDS queried whether there was an opportunity to use the forecasted underspend. CM and JS confirmed it had been agreed the £534k underspend at year-end would be treated as part of the FRP and could not be spent. DS requested a review of the £10.0m spent on GP premises as this was a significant sum of money to be spent on buildings/reimbursing premises costs. MP commented the District Valuer set the property valuations. DS advised the trusts were also being asked to see where some of the high cost of estate could be released into staff. **The Committee noted the first combined Finance Report.**	 **CH**
8.	**Quality Report** MP presented the Quality Report and tabled the Care Quality Commission (CQC) practice scores. Oxfordshire was in line with the rest of the country. Six practices had been rated as 'require improvement'. None of the practices had yet been re-inspected. The North Bicester surgery had now closed. Normally practices were re-inspected six months after the first inspection. Botley and Berinsfield would probably be re-inspected quite soon, whilst the others had only just had their first inspections and it would be a while before the re-inspections took place. CW advised the feedback from the PPG groups indicated the CQC process was demoralising for practices, with the process causing upset and effected GP morale. MP advised there was disparity between inspections and this inconsistency had been fed back to the CQC.	

	JM advised at a meeting held with practice managers, the CQC inspections had been a topic of conversation and their inconsistency had been raised. The practice managers had been requested to pull together feedback from across the county, which could be provided collectively to the CQC. To be followed up outside of the meeting. MP reported the table would be revised to show the original inspection rating and the rating following the re-inspection in order that the progress could be seen. JM commented previous quality reports had been broader, whereas the report presented was quite narrow and focussed on the CQC inspections. MP advised the other aspects would be included in the next report. The national primary care dashboard was awaited before compiling a more comprehensive report. DS felt the Committee should be receiving wider quality and performance data, remarking all other areas had a dashboard of metrics but there was nothing for primary care. JD advised the national work would fall alongside the development of a local dashboard. EDS requested this should be shared with the Executive Team prior to being presented to this Committee. CW believed changes in senior partners and practice managers should be a metric, as this could an indicators of potential issues, a warning or risk flag. DH advised the Integrated Performance Report contained access figures and this report was in the public domain. She added the Oxfordshire performance was good when benchmarked and a credit to practices. PP commented that there was a need for more quality data in addition to the Quality and Outcomes Framework (QOF) and prescribing incentive scheme. He advised the Primary Care Data Group was looking at the data gap. **The Committee noted the Quality Report.**	**JM/MP** **JD**
9.	**Forward Plan** In addition to the standard items and those listed on the Forward Plan, EDS suggested workforce, an update on vision and strategy and an update on Didcot and Bicester projects should be on the agenda for the next meeting. JM queried whether the Primary Care Business Plan would be brought to the December or February meeting or shared electronically between meetings. EDS suggested a discussion would be required and there might be a need for an extraordinary meeting.	**LC**

	JD confirmed the submission on the GP Forward View would be presented to the December meeting as it would form part of the Operational Plan to be submitted on 23 December.	**JD**
10	**Any Other Business** PR queried in which forum the concerns of Primary Care Support England (PCSE) were discussed. GH advised this had been picked up at a meeting with primary care leads across the Thames Valley. The reporting route was through NHSE and the issue had been escalated. CM stated if there were residual work that NHSE was still undertaking and these needed to be reported at OPCCC and the Committee made aware of the position. JD to discuss with GH. PR queried the mechanism by which the agenda was constructed. It was advised this was via the forward plan, items discussed in the meeting and suggestions supplied to JD. PR felt PCSE was of sufficient importance to be an agenda item. EDS suggested this should be picked up in the Risk Register and if it was considered appropriate it should be included on the agenda.	**JD/GH** **CM**
11	**Date of Next Meeting** 1 December 2016, 14.30 – 16.30, Conference Room B, Jubilee House.	

EXCLUSION OF PUBLIC
On recommendation of the Chair, the Oxfordshire Primary Care Commissioning Committee RESOLVED:
"that to enable the Oxfordshire Primary Care Commissioning Committee to consider business of a confidential nature, publicity on which would be prejudicial to the public interest, the public be excluded from the meeting in accordance with sections 1(2) and 1(3) of the public bodies (Admission to Meetings) Act 1960"