MINUTES:

OXFORDSHIRE PRIMARY CARE COMMISSIONING COMMITTEE (OPCCC)

6 November 2018, 14.30 – 16.30

Conference Room A, Jubilee House, OX4 4LH

Present:	Duncan Smith (EDS), Lay Member OCCG (voting) – Chair
	Dr Miles Carter (MC), West Locality Clinical Director OCCG until 15.30 (representing Dr Kiren Collison)
	Julie Dandridge (JD), Deputy Director, Head of Primary Care and Localities OCCG (non-voting)
	Roger Dickinson (RD), Lay Vice Chair OCCG (voting)
	Dr Neil Fisher (NF), North Deputy Locality Clinical Director OCCG from 15.30 (representing Dr Kiren Collison)
	Diane Hedges (DH), Chief Operating Officer OCCG (voting)
	Ginny Hope (GH), Head of Primary Care NHSE (non-voting)
	Catherine Mountford (CM), Director of Governance OCCG (voting)
	Rosalind Pearce (RP), Healthwatch (non-voting)
	Jenny Simpson (JS), Deputy Director of Finance OCCG (non-voting)
	Chris Wardley (CW), Public/Patient Member (non-voting)
	Dr Richard Wood (RW), CEO Berkshire, Buckinghamshire & Oxfordshire LMC (non-voting)
In attendance:	Lesley Corfield - Minutes
	Matthew Epton (ME), Lead Primary Care Manager OCCG – Item 5
	Helen Ward (HW), Deputy Director of Quality OCCG – Item 8

Apologies	Dr Kiren Collison (KC), Clinical Chair OCCG (voting)
	Steve Gooch, Director of Finance NHS England
	Colin Hobbs (CH), Assistant Head of Finance NHSE (for Steve Gooch) (non-voting)
	Louise Patten (LP), Chief Executive OCCG (voting)
	Dr Meenu Paul (MP), Assistant Clinical Director Quality OCCG (voting)

		Action

1.	**Declarations of Interest** MC advised he was a GP in Witney. His practice was next to Cogges Surgery and would be directly affected by any changes at this practice. RW advised he was the clinical lead for neurology for OCCG and worked as a GP specialist for Oxford University Hospitals NHS Trust.	
2.	**Minutes of the Meeting Held on 4 September 2018** The approved minutes of the meeting held on 4 September 2018 were noted.	
3.	**Action Tracker** Primary Care Workforce Strategy: JD reported the draft strategy was near to completion and would be presented to the CCG Executive Committee at the end of November review before being issued to the Committee in December for comment and approval. She added that the Sustainability and Transformation Partnership (STP) was working on a piece in parallel but not at the detailed level required by OCCG. EDS commented the work programme would be looked at later on the agenda and suggested a workforce 'deep dive' could be undertaken in the January Workshop. The Committee agreed to review and approve the Strategy by way of a 'virtual' meeting. Review of Risk Register: CM reported the request by the Committee for the Risk Registers to be sharper on the risks and the mitigations strengthened, had been discussed at the Directors Risk Review meeting and there would be more focus on the mitigations to ensure they were clearly written. Performance Report: An update on the Local Incentive Scheme was included in the Deputy Director Head of Primary Care and Localities Report and the action could be closed. Developing OPCCC and changes to terms of reference: EDS advised a paper had been circulated with recommendations and requested feedback to LC. The paper, incorporating the feedback, would then be presented to the CCG Executive Committee at the end of November, following which it would be updated and circulated to the Committee for virtual approval, rather than waiting until the next meeting in March 2019. DH stressed the need to be clear on the areas to be moved to other Committees and the authority to act.	**JD** **LC** **LC**
Commissioning		
4.	**Significant changes to GMS Contracts in Oxfordshire** JD presented Paper 3 advising the purpose of the paper was to outline to the Committee some significant changes that could take place with two GMS contracts. The Committee received progress reports on changes to GMS contracts at South Oxford Health Centre (SOHC) and Cogges Surgery, and were assured on process, the use of an independent panel (Cogges Surgery option assessment), legal advice had been taken where appropriate and the level of engagement to date. OCCG are working towards securing	

	resilient long-term services from these two practices, consistent with the Primary Care Framework agreed by this Committee. JD would ensure that the actual engagement undertaken by the CCG is clearly set out in future papers to provide full assurance to the Committee and an audit trail if OCCG was challenged further on in the process. An update on the situation in Banbury would be provided under item 9, the Deputy Director Head of Primary Care and Localities Report. **OPCCC:** • **Noted the process for SOHC and felt this was a good solution.** • **Noted the verbal assurance around further engagement to be undertaken in relation to OHSC.** • **Noted the change in process to allow the partners of Cogges Surgery to take part in the procurement process agreed by the Committee, agreed by the Chief Executive following consultation with the Chair of OPCCC, having taken legal advice, and the extension to the timeline to allow this.** • **Resolved to delegate the decision making process for the preferred provider for Cogges Surgery to the Chair of OPCCC and OCCG Chief Executive.**	
5.	**Review of Locally Commissioned Services (LCS)** Matthew Epton (ME), Lead Primary Care Manager, attended to present Paper 4. EDS advised the paper had been requested by the Committee with the suggestion a report should be brought annually, which concentrated on the benefits realisation from the LCS. EDS commented the paper should be taken as read but invited ME to highlight any specific areas which Committee members should focus on. ME observed the points to note were summarised quite clearly at the start of the paper. Points of discussion included: • The underspend in the Proactive GP Support to Care Homes LCS was due to the LCS not being taken up by all GP Practices • A piece of work was being undertaken with the Medicines Management Team to understand the significant forecast underspend for the Warfarin monitoring LCS. It was believed this was due to a move towards Direct Oral Anticoagulants (DOACs) and away from warfarin • The increase in overspend of the Near Patient Testing LCS was being looked at by the team. Double counting was a consideration as a new technique had been implemented and it was possible there were some teething problems with the software • Quality of services was built into the specifications for the LCS.	

	Quality audits were undertaken together with a review of outcomes at the end of each year. There might be a gap in patient and public involvement in the quality of services although RW felt there was excellent communication between OCCG and practices with practices feeding back on patients' views and priorities. He commented it might not appear in this forum but OCCG did receive feedback on what was happening on the ground • The ability to invest any underspend in winter planning would need to be considered under the Financial Recovery Plan (FRP) – to be considered further under item 7, Finance Report EDS stated the need to quantify some of the underspend variances and for the CCG Executive Committee to consider and take a decision on the overall financial position and whether funds could be used in a constructive way over the winter period to relieve pressure on primary care services. He also requested further information on the work with Buckinghamshire CCG to explore whether management/administrative efficiencies could be made and where patient involvement might be appropriate. DH suggested the Committee should place reliance on the work of the Quality Committee in relation to obtaining more detailed assurance on the quality of services under this initiative and the outcomes achieved. JD could update the Committee through the Head of Primary Care and Localities Report. EDS stated that the question for the Committee was, had the CCG delivered what it said it would do and to the right quality standard. **The OPCCC noted:** • **The activity levels of the Locally Commissioned Services and the forecast spend against planned budgets.** • **That it would receive a final outturn report and assurance on quality.**	**DH** **JD** **JD**
6.	**Priorities for 2019/20 and GP Forward View Update for 2018/19** JD presented Paper 5 advising that the paper started to identify the priorities for primary care in 2019/20. A rationale for each area was provided and there was a clear link to the CCGs risk register, as estates, workforce and sustainability of primary care were all assessed as 'high' risk areas for the system. JD stated planning and delivery at 'neighbourhood' level (populations of between 30-50k) would be a key component of the new national 10 year plan, which was consistent with the Primary Care Framework, except where there would be a need to look at how a broader range of integrated services and pathways were developed, not just primary care. Further discussion internally and with stakeholders would be required to ensure the priorities were correct. Input from the Committee on the priorities identified or other areas was requested. JD suggested 'deep dives' into any of the areas could be undertaken at a subsequent workshop.	**All**

	Areas of discussion included: • Involvement of the respective county and district councils in estates was not clear in the paper. A key piece of work would be around understanding how to better work together. The One Public Estate formed only part of the work. • The list of people involved with developing the proposed priorities did not include patients or the public. As a minimum involvement of the locality forums would have been expected. It was important that the paper should state patients and public would be involved in production of the priorities and would not just be asked to comment on the priorities decided. • Some countywide thinking would be required around the estates considering investment and workforce whilst also looking at the local level. • This was the third item on the agenda where it had not been explicit about patient/public involvement. It could give the impression that it was not high enough priority for development. In reality there was engagement and co-production but this was not detailed in the reports. OCCG could be selling itself short and giving the wrong impression. • The priorities were being set in an ever-changing environment. Although the Committee was concerned with primary care it should be looking at how the system delivered health and social care services needed in the Localities. It was hoped future reports would take a broader view and detail where primary care fitted. This would make services stronger and more sustainable • Papers should acknowledge the constraints there were in terms of funding available for discretionary use. • It was hoped the primary care workforce strategy would provide a breakdown of the GP need based on retirement figures. The breakdown would be circulated by email. **The OPCCC noted the progress with the 2018/19 priorities and the proposed priorities for 2019/20. Concern was expressed around the estates from a financial perspective, specifically in relation to the impact on revenue costs and it was felt this element should be picked up by the Finance Committee. A more in depth review of the 2019/20 priorities could be undertaken in the January workshop.**	**JD** **EDS** **JD**
Business		
7.	**Finance Report** JS presented Paper 6 on the financial performance of the OCCG Primary Care budget to Month 6 (September), 2018/19 financial year. JS advised there were three key points: the overall OCCG position was still a net risk position of £4.0m, which was a slight improvement over month 5; under the delegated co-commissioning there had been a possibility NHS England (NHSE) would fund the uplift to GP pay but notification had been received that this would not be the case and	

	around £730k would need to come from the delegated budget reserves; £900k of the prescribing budget had been moved back to NHSE as part of a national change, this would have a nil effect on the OCCG 'bottom-line', as NHSE would be directly incurring the cost of flu vaccines this year. In answer to queries JS advised: • A detailed report would be taken to the next Finance Committee on the impact of No Cheaper Stock Obtainable (NCSO) and changes to Category M drugs to the prescribing budget. EDS requested a short briefing on this item for OPCCC members. • No information was yet available on the Premises Rate Rebates following a national appeal process and it had not been reflected in the delegated budget. • A report on discretionary and non-discretionary spend would be taken to the Finance Committee. EDS requested this was also shared with Committee members. RW queried whether practices could be given the opportunity to use the underspend from the Proactive GP Support to Care Homes LCS. DH advised the monies had been specifically identified for investment in the Care Home LCS and were not available as a consequence of the FRP. CM explained the OCCG Board in public had taken the decision to stop discretionary spend and to return uncommitted budgets back to balance the financial position. This had been agreed on every single area of spend. EDS commented it had been agreed earlier in the meeting, to quantify the overall primary care budget position and whether there was funding which could be used non-recurrently to relieve winter pressures on primary care. JD reported attempts were still being made to increase the care home coverage, which may reduce the in-year positive budget variance. DH advised OCCG was also looking at a range of different models for care homes, some of which may be more cost effective than the one currently used. **The OPCCC noted the position for the OCCG Primary Care budgets and considered risks were being managed effectively.**	**JS** **JS**
8.	**Quality Performance Report** Helen Ward (HW), Deputy Director of Quality, attended to present Paper 7 and advised since the last Committee meeting, the Care Quality Commission (CQC) had inspected a City practice and immediately issued two warning notices. The rating had not yet been released but it was likely to be that the practice needed support from the CCG to address the issues. One practice in Banbury remained on a rating of 'requires improvement' but good progress had been made and it was hoped the rating would change soon. The Quality and Performance Dashboard was attached to the report but HW advised some of the data had yet to be validated. The Quality	

	Team was undertaking supportive quality visits to practices The two areas highlighted by the CQC in the Oxford City practice were around medicines management and governance. Support and input had been offered in both areas. At its previous inspection, the practice had been rated 'good'. The CQC inspection regime had changed since the last inspection and it was felt that could be a factor. A wider and more detailed quality performance and sustainability piece of work was being undertaken across all Oxfordshire practices but JD thought that this would not have identified any concerns with this City practice. OCCG needed to see the CQC report and fully understand the issues raised under the new inspection requirements. These would then be used to review actions. RP queried other elements of patient involvement as the only part included in the Quality and Performance Dashboard seemed to be the GP Patient Survey. HW advised that personally, she thought the GP Patient Survey was a more responsive survey than others but feedback was also received from Locality PPGs and members of the public who alerted OCCG to concerns, together with other instances which helped to inform the priority for practice visit. RP suggested OCCG was understating the level of proactive engagement with practices on quality and thought additional information in committee reports, further assurance could be provide to stakeholders of the level of work undertaken with practices and the PPGs. CM stated in view of all the comments today under each of the Committee agenda items, consideration would be given to the structure of the front cover for papers and clearly demonstrating a link to the Primary Care Framework. NF reported NHS Rightcare had started to roll-out benchmarking at neighbourhood level on a more robust and useful basis. CW stated at the last meeting the issue of patient and public involvement had been raised and it had been hoped this would have been better reflected in the report. He had also queried whether the PPG could be involved in practice reviews or if the practice concerned could be asked if they were willing to involve the PPG. HW explained the visits were targeted for specific areas but would consider how PPGs could be effectively involved. She added that a patient experience report was taken to every Quality Committee, where there are patient members. EDS expressed some frustration that the range of metrics previously developed with the Committee for use in the quality and performance dashboard were more appropriate and it had been agreed that the dashboard would be further developed at practice level and used at the Quality Committee, which would enable OPCCC to place reliance on the work of the Quality Committee. This had not happened and it	**CM** **HW**

	needed to be escalated as there is clearly a gap in assurance. DH remarked on the need for the Management Team to take away the challenges on PPI at this Committee and hoped it was another case of 'underselling', as there was a big and ambitious forward programme of work laid out from the last set of dashboards. She advised there were 70 practices in Oxfordshire and it was not possible to have a patient engagement report on every single practice as the resources were not available. However, DH stressed the need for the Management Team to provide the Committee with assurance there was a systematic approach through all aspects of quality assurance work being undertaken. CM endorsed the comments advising not only were there a range of indicators but 'deep dives' were also undertaken, an example area was flu vaccine uptake. She suspected it was again 'underselling' the work carried out. HW advised that the Quality Team had a programme of targeted practice visits, as it had been felt 24 of the 70 practices would benefit from a visit and a sample practice quality data pack would be shared with members for information. As the Committee was not due to hold a meeting until March, EDS suggested a few people should meet and capture exactly what quality and performance information the Committee wished to see at meetings and how assurance of the work of the Quality Committee could be reported into this Committee. JD was tasked with organising a meeting. **The OPCCC noted the Primary Care Quality Assurance Report for October 2018.**	**HW** **JD**
9.	**Deputy Director, Head of Primary Care and Localities Report** JD presented Paper 8 updating the Committee on activities between August and October 2018. There had been a couple of requests to close lists and in each case, the PPG had been supportive but it was felt closing the lists would not provide a 'neighbourhood' level solution. The practices had been asked to work together to find a 'neighbourhood' level solution. There was a move to a joint primary care workforce strategy with the Oxfordshire Training Network, an organisation dedicated to making NHS healthcare organisations in Oxfordshire great places to learn, develop and work, by providing training and support across Oxfordshire. A joint bid to the GP Retention Scheme from the Buckinghamshire, Oxfordshire and Berkshire West (BOB) had been successful and £215k had been allocated to use across the area. There was an NHS England (NHSE) requirement to undertake an audit looking at delegated commissioning. The Committee was asked to	

	confirm it was content to use the internal audit undertaken in October 2017 to provide assurance to NHSE in line with the guidance. Further information from NHSE on other areas to be reported against was expected. RW observed Malthouse and Abingdon practices had very different reasons for closing their lists but the same reason had been given for declining the request. JD explained both practices had put in requests for different reasons but OCCG needed to know how the 'neighbourhood' would deal with the closure of lists at two practices. CW advised that in similar circumstances in Banbury, the practices in the 'neighbourhood' working together had produced a resilient solution which would not have arisen through the normal routes. NF commented that although on paper it might appear 'black and white', there were a number of aspects which needed to be considered and JD advised the situation was being closely monitored. RP suggested undertaking some education with contract holders to prevent them working in isolation, commenting if they were aware they might be asked to work together on a preferred solution, this approach could have been adopted first. With regard to the solution for Banbury, JD advised there had already been good joint work across the practices and good examples of sharing workforce. The contractual change had been held up by issues around the premises leases but this had not stopped the joint working. **The OPCCC noted the report and agreed the use of the internal audit undertaken in October 2017 to provide assurance to NHSE in line with their guidance.**	
Governance		
10	**Forward Plan** JD presented Paper 9, the forward plan for meetings and the two workshops for the next year. There would be a need to review the forward plan in line with changes from the more system wide approach that was emerging and consider how primary care fitted in, especially with regard to the Locality Place Based Plans. A discussion on areas to be covered at the January workshop was also required, although members had identified a number of areas through their discussions today. EDS felt one of the topics should be the estate, unless the outsourced piece of work on estates would be available at the March meeting. An Estates Manager had been appointed across Buckinghamshire and Oxfordshire to help with estates planning. Relationships with PPGs were raised and CM advised support for PPG development had been discussed at the last Locality Forum Chairs (LFC) meeting. Part of the work Healthwatch had been commissioned to undertake was around PPG development and RP would be providing a report to the next LFC meeting.	

	EDS felt another area for the January workshop could be innovation elsewhere in the country and DH suggested inviting other non-committee members to the workshop as it might be useful for them to hear and take part in the discussion. JD would develop a workshop agenda. **The OPCCC noted the updated Forward Plan.**	**JD**
11	**Risk Register** CM presented Paper 10 and confirmed that Director Risk review Committee had proposed a reduction in score for the primary care estate risk as an Estates Manager had been appointed, work was in progress and plans were being developed. With regard to the estates risks, EDS again expressed concern around the impact of investment on revenue cost. JD advised the population was growing, which would lead to an increase in the delegated budget and this may might offset some increase in the revenue costs, although she acknowledged it was clear that there was a material investment needed in the estate to deliver the Primary Care Framework. **The OPCCC noted the updates to the risk register since the 4 September 2018 meeting and that there were three risks on the Primary Care Risk Register, one of which, risk 789 Primary Care Estate, was a Red/Extreme risk.**	
12	**Papers Circulated/Approved Between Meetings** No papers had been circulated or approved between meetings.	
For Information		
13	**Confirmation of Meeting Quorum and Note of Any Decisions Requiring Ratification** It was confirmed the meeting was quorate and no decisions required ratification.	
14	**Any Other Business** There being no other business the meeting was closed.	
15	**Date of Next Meeting** 5 March 2019, 14.30 – 16.30, Conference Room A, Jubilee House	