NHS
Oxfordshire
Clinical Commissioning Group

MINUTES:

OXFORDSHIRE PRIMARY CARE COMMISSIONING COMMITTEE (OPCCC)

4 September 2018, 14.30 – 16.30

Conference Room A, Jubilee House, OX4 4LH

Present:	Roger Dickinson (RD), Lay Vice Chair OCCG (voting) - Chair
	Dr Kiren Collison (KC), Clinical Chair OCCG (voting)
	Julie Dandridge (JD), Deputy Director, Head of Primary Care and Localities OCCG (non-voting)
	Diane Hedges (DH), Chief Operating Officer OCCG (voting) (Until 16.10)
	Ginny Hope (GH), Head of Primary Care NHSE (non-voting)
	Colin Hobbs (CH), Assistant Head of Finance NHSE (for Steve Gooch) (non-voting)
	Louise Patten (LP), Chief Executive OCCG (voting)
	Rosalind Pearce (RP), Healthwatch (non-voting)
	Jenny Simpson, Deputy Director of Finance OCCG (non-voting)
In attendance:	Lesley Corfield - Minutes
	Helen Ward (HW), Deputy Director of Quality OCCG – Item 7

Apologies	Steve Gooch, Director of Finance NHS England
	Catherine Mountford (CM), Director of Governance OCCG (voting)
	Dr Meenu Paul (MP), Assistant Clinical Director Quality OCCG (voting)
	Dr Paul Roblin (PR), Chief Executive Berkshire, Buckinghamshire and Oxfordshire Local Medical Committee (non-voting)
	Duncan Smith (EDS), Lay Member OCCG (voting)
	Chris Wardley (CW), Public/Patient Representative (non-voting)

		Action
1.	**Declarations of Interest Pertaining to Agenda Items** RD advised he was a patient at Hightown surgery which was mentioned in one of the papers later on the agenda.	
2.	**Minutes of the Meeting Held on 1 May 2018** The approved minutes of the meeting held on 1 May 2018 were noted.	
3.	**Action Tracker** *Primary Care Estates*	

	Assurance around the Hightown project: GH advised due diligence on the project was being undertaken through the NHS England (NHSE) business case process and oversight from an external source. GH believed the project to be on track. GH confirmed the project was receiving support and risk assessment and would only be brought to the OPCCC if any issues arose. The action was closed or would be escalated if there were any concerns on delivery. *Deliverables from Locality Place Based Plans* The action would be picked up under Item 5. *Quality Dashboards* The Dashboard should be ready for the November OPCCC meeting. LP advised the action relating to work with the National Team concerned the Integrated Care System (ICS) Primary Care and could be closed as there was regular dialogue and information sharing. *Forward Plan* Deep Dive Areas: JD advised communications and engagement had been suggested but felt this should be expanded to a wider system workshop not just primary care. RD proposed premises and property for primary care. LP commented the state of the estate as a high level view would be really useful. JD to bring to the January workshop. Meeting Dates: JD had suggested a slight variation to the meeting dates in the Forward Plan. *Risk Register: Workforce* JD reported it was hoped the primary care workforce strategy would be available in draft form for the November OPCCC meeting. She proposed once this was available the risk should be closed as the work should be part of the system wide workforce piece rather than looking at primary care in isolation. JD advised the Oxfordshire level workforce work was feeding in to the sustainability and transformation programme (STP) work. It was noted issues were predominantly emerging around the retirement/resignation of GP partners and partnership arrangements which were a risk. JD reported the whole partnership model was being considered centrally to understand whether this was still the best model. Given the linkage to liabilities for partners LP suggested the estate deep dive should also describe how the various estate was set up such as whether it was mortgaged or leased; how the companies were formed – all limited or partnerships; as this would provide the Committee with an idea of fragility. KC raised a concern around succession planning. JD advised a workforce survey had been undertaken at the end 2017 which had collected information on how many GPs would retire in two, five and 10 years. It was intended to repeat the survey in Quarter 3 and to standardise in order to provide the same information across all the Localities. JD commented the skill mix was interesting and work had	**LC** **LC** **JD** **LC**

	started to model how this would look. JD remarked the shortage of GPs affected not only practices but also the 111 service, out of hours, GP streaming and a number of other areas. The Workforce Group was looking at how best GPs could be used across all areas.	
Commissioning		
4.	**A Solution for Banbury Primary Care – An Update** JD presented Paper 3 reminding the Committee of the discussions held for a number of months on the sustainability of primary care in Banbury particularly relating to Banbury Health Centre (BHC). A proposal to procure a wider sustainability solution was outlined in the paper. A new contract had been awarded to Principal Medical Ltd (PML) for provision of services from BHC on expectation of delivery of the wider partnership solution with local practices. Some of the prior components of the contract had been provided going forwards in other places (for example unregistered patients) and these were shown at the top of page 4 of the paper. In relation to the wider Banbury sustainability issue, the proposed model for Woodlands, West Bar and BHC to come together to be a single practice serving 30,000 patients was moving forward. Details were included in the paper of some of the services to be offered and Appendix 1 outlined the contracting steps. PML and the practices would now work on internal issues and getting their agreements in place. The timeline had slipped slightly but it was hoped the new entity would be in place by early 2019. Following queries JD confirmed the £227,943 was a one off transition cost to mainly bring the three practices together after which they would be expected to work together; and the model would provide further resilience to seven day working delivery as the larger practice meant staff could be best utilised and link with the hub and best practice component. The weekend hub was in the BHC and would continue to operate. JD advised the model would be one organisation operating out of several buildings. The model might require the movement of some patients if a clinic was run from one particular building but patients would have the option to go to any site for routine appointments. LP explained the three practices would be working under one management umbrella. She added that exactly how the model would be taken forward still needed some clarity but everything would be undertaken through controlled measures. DH reported the population of Banbury had made clear their preference that the BHC site should be retained and PML/Practices were aware of that fact. RD raised a question from EDS concerning the risk register for the work and whether it could be seen by the Committee. JD advised the project was managed through Verto and had a risk register reporting up through the Executive Team. A copy could be shared outside of the	**JD**

	meeting. Sustainability of primary care in Banbury formed part of risk AF20. **The OPCCC noted:** • **The virtual decision to award the contract to PML** • **The contracting route in Appendix 1** • **The proposed delivery of the model** • **The next steps.**	
5.	**Locality Place Based Plan (LPBP) Update** JD presented Paper 4 updating the Committee on the implementation of LPBPs. The table at the end of the paper gave the current status. JD advised it was likely some of the schemes would now report to other Committees rather than OPCCC. Locality health care and planning was now a focus and would be undertaken more in conjunction with partners in Health and Social Care. A paper was due to HOSC on locality planning and proposals would change as work was taken forward. A number of the schemes were on track to deliver although a couple had fallen by the wayside such as the ambulatory model in the South East where a business case was awaited. JS reported two of the amber schemes had now been agreed via the Financial Recovery Plan (FRP) process to go ahead and a further amber scheme would go to a future meeting of the Task Force. Further discussion would be picked up under the finance paper, Item 6. RD queried whether there was a timescale for the various items to move from OPCCC to other Committees. DH advised the plan was to let integrated contracts for April 2019 and there was a need to consider how the budgets would link up with the opportunities. LP stated for those projects whose expected delivery was reduced secondary care activity there would be a need for them to be operationally managed differently before winter and to look to ensure patients did not go to the wrong place. She advised it should be possible to provide an update to the next meeting adding that Paper 7 gave headlines on where the various items would go. Proposals would be taken to the CCG Executive Committee for oversight before coming back to OPCCC. There would then also be a discussion at the A&E Delivery Board (AEDB) around the appropriate place for each scheme. **The OPCCC noted:** • **The progress on the implementation of plans** • **The impact of the FRP on some areas** • **Acknowledged and recognised that as time progressed various schemes would not report to OPCCC.**	
6.	**Finance Report** JS presented Paper 5, the Month 4 report, advising OCCG was still reporting to be on plan with a net risk position of £5.6m. There had been concern around the overperformance at the Oxford University Hospitals NHS Foundation Trust (OUHFT) but the latest set of data had shown an improvement in the rate. There was some concern around	

	the level of elective activity which was lower than expected. Other pressures included the delegated co-commissioning budget which was on plan but the GP pay award had been higher than expected leading to a potential pressure of just over £700k. The OCCG primary care budget was on plan except for out of hours (OOHs) which was being investigated. Notification had been received of an end to a price reduction for Category M drugs from August which would put pressure on the prescribing budget. It was forecast that this could be up to £2.0m. This price increase; the No Cheaper Stock Obtainable (NCSO) issue and drugs going out of NCSO, which would be at a higher price, were three potential pressures on the prescribing budget. Any impact from the Category M drugs would not be seen until October due to the usual two month delay in reporting from the Business Services Authority. There were three elements to the FRP: savings; a budget review and the OUHFT Activity Management Plan (AMP). A budget review process had been undertaken over the summer. In Month 4 some budgets had been returned to the CCG Risk Reserve although none from primary care. In Month 5 it was anticipated there would be further tranches to the OCCG risk reserve including some from primary care. The CCG had also ring fenced certain elements of the primary care budget. These budgets would not be released until later in the year subject to the overall financial position of the CCG. RP questioned if the contract with Oxford Health NHS Foundation Trust (OHFT) had not yet been signed how the budget could be managed when the allocation was not known and if a higher figure was agreed, what impact would there be on primary care. JS advised a provisional contract figure had been agreed and services were being delivered in accordance with this. The challenge was around whether OCCG was investing enough in mental health. A piece of work to benchmark spend and outcomes achieved was underway to ascertain if there was a case for further investment. Any impact from this work was to be longer term. OHFT was still delivering services in line with the contract and so there was no impact on primary care. LP commented it was sensible to be aware of the potential problem and if the benchmarking showed OCCG had a lower spend per population for mental health there could be a need for adjustment. OCCG should know before Christmas. There was the potential for this to be a significant sum and if there was a need to increase investment OCCG would be required to consider primary care and other areas of spend to see whether OCCG was investing higher or lower than other areas. JD queried whether the GP pay award and other pressures out of OCCG control could be offset by the enhanced services slippage and rate rebates. CH reported the enhanced service slippage was enough to cover and no extra risk was being reported at the moment but this would be kept under review as the Department of Health had yet to	

	confirm the current assumption that central funding would be available to cover the GP pay award cost in excess of the national planning assumption. KC asked if there was a further update on the schemes in the South localities. DH advised the original proposal had been a six month contract in the South with a small incentive element linked to the use of non-elective secondary care services. Following agreement with Finance Committee the contract would be extended to cover the full year but the element which related to secondary care usage had been increased to 30%. RD raised a question from EDS on the Section 96 monies and how much had been committed not just paid. JD advised a report would be taken to the possible sub-committee of OPCCC (subject to paper 7 below) which provide clearer reporting on commitments. The figure was probably under £100k to date but there were other funding routes by which OCCG supported practices. **The OPCCC noted the Month 4 position for the OCCG Primary Care budgets and considered the risks were being managed effectively.**	
7.	**Quality Performance Report** Helen Ward (HW) attended for this item and presented Paper 6, a high level quality report setting out areas of work and the approach to support practices to reduce variation and achieve standards. The Care Quality Commission (CQC) had commenced its new five year programme of visits. All except one practice in Oxfordshire had been rated 'good', with four being 'outstanding'. The team continued to work with the practice rated 'requires improvement' to improve and meet the standard. The recording of the management of patients with long term conditions had been the reason for the recent concerns from the CQC and OCCG were investigating this concern. The Quality & Outcomes Framework (QOF) data had not yet been validated but indications were 11 of 70 practices would achieve full points, 35 should achieve over 96%, only eight had achieved below the average of 97.5% and all but one of those achieved over 90%. HW described the quality work with practices. There was a need to follow up the NHS Health Checks to ensure all patients were picked up. The National Patient Survey results had been published and Oxfordshire had performed above average. Nationally and locally there had been a drop in satisfaction which it was believed reflected the pressure on services resulting in a poorer experience for patients. It was the beginning of the flu season and the team was supporting practices to deliver flu immunisations. The team was also supporting practices to report and investigate significant incidences and share learning. Updated data would be brought to the November meeting and the team was continuing to look at wider working with Buckinghamshire.	**HW**

	LP queried whether 11 of 70 practices to obtain full QOF points was up or down on previous years and whether there was a trend. HW would check. She advised the lowest performing practices tended to be those that required more help. With regard to the sharing of learning, particularly around significant events or practices rated 'good' or 'outstanding', HW advised it was currently on an informal basis with some information also being provided through newsletters. LP commented it was a key aspect to driving up quality.	**HW**
	DH also reflected in recent BOB figures OCCG had the highest exception rates and local exploration had been requested. This initial look indicated further investigation as it appeared there was no correlation with Practices serving the more deprived populations in Oxfordshire which might have explained the variation.	**HW**
	A question from EDS concerned the impact on patients in a practice that did not achieve 90% of QOF points. HW advised on the attempts to standardise the treatment received by cohorts of patients and a wish to reduce variation. LP commented the Committee required assurance the Quality Committee scrutinised practices where there were areas with a significant drop in QOF.	**HW**
	HW advised apart from the National Patient Survey, which she believed was one of the stronger surveys, patient satisfaction was also measured through Patient Participation Group (PPG) feedback and directly from patients. The Quality Team was trying to bring all the different areas together.	
	HW advised when a complaint was received which related to multiple places a lead agency would be appointed who would bring together all the responses. HW explained a multi-agency investigation was difficult as there was a tendency for organisations to investigate individually and then the results were brought together. The team was trying to get all those involved in one room which also helped with understanding but there was currently no policy for multiagency investigations. It was advised that a policy existed in Buckinghamshire and HW was tasked with obtaining a copy.	**HW**
	RP remarked that many patients believed they had made a complaint only to discover that this was not the case as their letter did not state it was a formal complaint. She felt there needed to be a clear set of statements for people around making a complaint. It was noted that primary care complaints were managed by NHSE.	
	An update on the progress of the Local Incentive Scheme (LIS) was requested.	**JD**
	HW advised there had been a widespread awareness programme in relation to the Health Checks programme which was commissioned by the County Council. RP reported Healthwatch had just commissioned a	

	report on health check awareness which, among other questions, asked how patients liked it and how they had obtained information about the health checks. The results had been quite interesting but the programme sat with Public Health and RP felt it might need a systemwide approach. JD advised the health checks did come under the systemwide agenda. **The OPCCC noted the content of the report and the actions taken.**	
Governance		
8.	**Developing Oxfordshire Primary Care Commissioning Committee** DH presented Paper 7 explaining the paper was the result of time taken at the OPCCC workshop to consider the enhanced role and function of the Committee. The proposal was to consolidate the role of the Committee around the delegated primary care functions and section 2.2 of the paper highlighted some of the projects and how they would be treated. For the function the Committee was required to fill there was a need for it to have a strategic and high level role. In order to achieve this consideration had been given to making the Oxfordshire Primary Care Commissioning Operational Group (OPCCOG) a formal sub group of the OPCCC in order to be able to delegate functions and seek assurance. DH explained there had always been an expectation that a member of the Health and Wellbeing Board (HWB) would be a member of the Committee but this had never been fulfilled. Concern had also been raised around conflicts of interest (CoI) and an external clinician would negate any CoIs. RD added that looking forward to a more system approach, particularly around the delegated authority, a contribution from a HWB member would be welcomed. JD advised having a HWB representative was a recommendation in the Primary Care Committees' standard terms of reference. LP observed following its review the membership of the HWB had changed and commented that when OPCCC was clearer on why a HWB representative was required it would be possible to state the best type of HWB member for the Committee. She added that if the Director of Public Health (DPH) joined the Committee then it would cover both aspects of a HWB member and an external clinician. DH pointed out that members of the Health Improvement Board (HIB) were members of the HWB and that might be another option for an additional OPCCC member if the DPH was unable to join the Committee. It was advised there were no plans to change the voting structure of OPCCC. The comments had been included to highlight that there had been a question and merited discussion. KC observed that not all GPs were partners or permanent employees. LP acknowledged the point explaining any decision on whether there was a conflict would be taken at the time of a vote based on the specific circumstances. JS highlighted the role of the OPCCC was intended to focus on	**DH**

	delegated commissioning only but the Terms of Reference (ToR) referred to other primary care areas. RD advised the ToR might need to change as it was decided to move areas away from OPCCC. JD pointed out the ToR were defined nationally and whilst AEDB might decide to commission a service from primary care any Local Enhanced Service (LCS) would need to be approved through OPCCC. This might require each situation to be taken as it arose. LP commented using that example if AEDB decided to contract out of hospital provision it would do so through the Alliance and as a consequence an LCS would not be required. RP observed that OPCCC had oversight of primary care but the proposals seemed to be moving to a piecemeal approach which would reduce the capacity to be effective across primary care as decisions would be made elsewhere. She queried how strategy could be set if the Committee did not have the wider picture. RP was concerned how the changes would enable the Committee to add value. RD advised the changes were trying to ensure there was detailed discussion of issues. The delegation to OPCCOG would ensure operational and project management were considered and OPCCC received assurance. RP understood and agreed the assurance was necessary but felt a lack of confidence that the Committee would have the knowledge and strategic confidence to add value. She was concerned the Committee might become a rubber stamp committee and the role of Healthwatch was to seek assurance. DH felt it was a fair challenge but advised under the current construct there had been system acceptance that work was being undertaken in a strategic vacuum but also within silos. There was a need for the renewed HWB strategy and an older people's strategy as the Committee was not able to look in the overarching way it should for patients. The Committee had insufficient membership in the room to address the wider issues. There was a requirement to work within the national guidelines but DH believed this could be better achieved. RP suggested there was a need to be clear on the role of the OPCCC going forward as she felt if someone were to ask her what the Committee did her response would be that the work was undertaken elsewhere. LP suggested the concerns raised by RP should be logged and reviewed in a short while. She pointed out work was currently underway to separate out functions and obtain different areas of operational management. How this worked could be reviewed over the next couple of meetings and then the concerns revisited. RD asked that the voting section of the OPCCOG ToR be reviewed as currently the situation could arise where there might be a GP majority which was not permitted under the national guidelines. **The OPCCC broadly agreed the proposals. The suggestion for the**	 **CM/JD**

	Director of Public Health to become a member of the Committee would be explored. The OPCCOG ToR would be reviewed and brought back.	
9.	**Forward Plan** JD presented Paper 8 explaining the Committee now held four meetings a year and these had been spread out to be more evenly spaced. The two workshop sessions would be held in January and July. Following the discussion under Item 8 it was noted that a formal review of the workings of the Committee should be added probably for the June 2019 meeting. RD commented the Committee Annual Report might need to be moved to March in order for it to be able to feed into the OCCG Annual Report. JD suggested the ToR review should be brought forward to September 2019 to align with the review and discussion that had taken place in the meeting.	**JD**
10	**Risk Register** DH presented Paper 9 advising the wording of Operational Risk 789 Primary Care Estates had been updated and queried if the Committee were happy to accept the changes. The mitigation of Strategic Risk AF26 Delivery of Primary Care Services had changed due to the changes in Banbury and the West Locality. RD commented the current wording did not actually contain the mitigation and suggested something around locality level engagement should also be included. RP observed throughout the Risk Register there was very little reference to patients working with GP surgeries around mitigation of risks. DH advised this had been underplayed as the team had spent a lot of time out and about working with patients. LP commented that the work should be listed as mitigation. Strategic Risk AF26 would be amended. DH advised the mitigation was also changing on Operational Risk 799 Workforce in Primary Care. RD pointed out the final sentence detailed the problem and was not mitigation. He stated the engagement and draft workforce strategy for November should be included. LP felt the Risk Register required a review commenting on the need to be sharper on the risks and to bullet point the mitigations. **The OPCCC noted the updates since 1 May 2018.**	**CM** **CM** **CM** **CM**
11	**Deputy Director, Head of Primary Care and Localities Report** JD presented Paper 10, her report updating the Committee on items over the last few months. She highlighted the approval to increase the practice boundary for Alchester Medical Group; the Local Investment Scheme (LIS) year-end achievement; the recommissioning of the Special Allocation Service (SAS) from a new provider which was working well; closer working and sharing of processes with Buckinghamshire and the consideration of how the GP Forward View (GPFV) assurance assessments could be reported once for both CCGs.	

	LP observed historically the SAS had been provided via the goodwill of certain GPs and this might be a diminishing group. She queried whether there was a piece of work that could be undertaken across the STP around succession planning. GH hoped the agreement which had been signed would be for a reasonable amount of time. She explained when the re-procurement work had been undertaken there had been little appetite for one provider across the footprint which was why local providers had been commissioned. GH agreed there might be a need for a discussion around engaging providers differently going forward. JD observed if the model of primary care changed in the future it might create an opportunity to do something differently but concurred there was a need to commence modelling the service earlier rather than later. LP commented that there was a collective responsibility to commission primary care services for patients where there was a new Alternative Provider Medical Services (APMS) contract and queried whether there was a process to cover all areas where issues commissioning had been experienced in order to avoid a commissioning gap for services for which there was a legal obligation. It was noted this approach needed addressing in future. KC drew attention to the LIS year-end achievement and queried whether there was any sign the 24 practices out of 70 who had not achieved 100% were potentially not coping or whether there were other good reasons why they had not engaged. JD advised the lack of achievement of the QOF would be used as one of the components to be considered in terms of vulnerability. As part of the reason why some practices had not achieved the higher percentage were the difficulties in holding diabetes multidisciplinary meetings due to a delay in roll out. Clearer guidance going forward had been provided to help ensure patients received the enhanced quality of care this aspect promoted. 2018/19 was currently out with practices and was being monitored by teams in OCCG. The diabetes multidisciplinary meetings were a quality component in the LIS for 2018/19. DH left the meeting at this point. RD queried whether alternative methods were considered for addressing boundary changes. JD commented it had been an unusual request as normally practices made a request to shrink their boundary. Work had been undertaken with all the practices in the Upper Heyford area and it was clear this was a pocket of Oxfordshire that was underprovided. All practices in the area would be encouraged to consider their boundaries to deal with growth in this area. **The OPCCC noted the Deputy Director, Head of Primary Care and Localities report for May to July 2018.**	**JD** **JD**
12	**Papers circulated/Approved Between Meetings – Cogges Surgery** JD presented Paper 11 advising the paper had been brought for the Committee to note the decision made virtually to find a local solution to	

	the notice of contract return; ideally an Oxfordshire practice to deliver services from the Cogges site. Confirmation the building would be available for the provision of services was still awaited. Expressions of interest had been requested and more than one surgery had shown an interest. A process to review the expressions of interest was being put in place. The website was being kept up to date and login data confirmed it was being used and viewed. The Committee was reminded of the agreement to delegate responsibility to OPCCOG to oversee and deliver the solution. RD felt it was good to see the options and presumed work would continue to move forward on the other three items whilst work continued to ensure no ground was lost. LP queried whether the Collaborative Commissioning Framework covered the statutory obligations for commissioning and limited the challenge. JD advised the work had been undertaken with the reference group from the local community who had helped to shape the proposals. It was believed as much as possible had been done to find a solution in the right time and framework and reduce the risk of challenge as far as possible. Local patients would be involved as part of the selection panel through linkage to PPG and the Locality Forum Chair (LFC). The reference group was also being kept up to date. **The OPCCC noted the decision made by virtual means, the delegation to OPCCOG and the progress made to identify a local solution.**	
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** It was noted that PR had retired as Local Medical Committee (LMC) Chief Executive and an LMC representative for the Committee would be picked up outside of the meeting.	**LC**
15	**Date of Next Meeting** 6 November 2018	