Oxfordshire
Clinical Commissioning Group

MINUTES:

OXFORDSHIRE PRIMARY CARE COMMISSIONING COMMITTEE (OPCCC)

05 March 2019, 14.30 – 16.30

Conference Room A, Jubilee House, OX4 2LH

Present:	Duncan Smith (EDS), Lay Member OCCG (voting) – Chair
	Julie Dandridge (JD), Deputy Director, Head of Primary Care and Localities OCCG (non-voting)
	Roger Dickinson (RD), Lay Vice Chair OCCG (voting)
	Diane Hedges (DH), Chief Operating Officer OCCG (voting)
	Ginny Hope (GH), Head of Primary Care NHSE (non-voting)
	Colin Hobbs (CH), Assistant Head of Finance NHSE (for Steve Gooch) (non-voting)
	Catherine Mountford (CM), Director of Governance OCCG (voting)
	Dr Meenu Paul (MP), Assistant Clinical Director Quality OCCG (voting)
	Jenny Simpson, Deputy Director of Finance OCCG (non-voting)
In attendance:	Lesley Corfield – Minutes

Apologies	Dr Kiren Collison (KC), Clinical Chair OCCG (voting)
	Steve Gooch, Director of Finance NHS England (non-voting)
	Louise Patten (LP), Chief Executive OCCG (voting)
	Rosalind Pearce (RP), Healthwatch (non-voting)
	Val Messenger (VM), Interim Director of Public Health (non-voting)
	Richard Wood (RW), CEO Berkshire, Buckinghamshire & Oxfordshire LMC (non-voting)

		Action
1.	**Declarations of Interest** JS declared a minor interest with regard to Item 6, South Oxford Health Centre as she had a personal connection with the lead GP. RD declared he was a patient at Hightown surgery in Banbury.	
2.	**Minutes of the Meeting Held on 6 November 2018** The approved minutes of the meeting held on 6 November 2018 were noted.	
3.	**Action Tracker** *Developing OPCCC*	

	To be picked up under Item 8. *Review of Locally Commissioned Services (LCS)* Work continued and the committee noted that there was close working with Buckinghamshire CCG. *Priorities for 2019/20 and GP Forward View Update for 2018/19* Outstanding data on GPs, including retirement date estimates was being collected and would be shared when available. *Engagement* The format of committee report front covers was under review, linked to the new way of working and potential changes to the Committee's terms of reference, and would be picked up under agenda item 8.	
Commissioning		
4.	**Long Term Plan (LTP) and GP Contract Reform** **Implications for Oxfordshire Commissioned Services** JD presented Paper 3a explaining the LTP had been issued at the beginning of January and the new framework for the GP contract at the end of January. The LTP focussed on integration of community and primary care services and the formation of Primary Care Networks (PCNs), which would become the 'building blocks' for delivery of NHS services. The contract reform started to put some shape on the PCNs format. The paper looked at the overlap between the LTP and the contract framework. JD felt there might potentially be more overlap with the LCS as the new framework stated the LCS could be delivered by the PCNs through the new network Direct Enhanced Service (DES). As the contract would not be in place until 1 July and the LCS needed to be in place by 1 April, it was proposed to continue commissioning these services from practices for 2019/20 and change to PCNs next year. Under the contract reform, there would be seven national service specifications and a review of OCCG local services would be necessary when more detail was known. It had been agreed to extend for six months the proactive support to care homes LCS whilst an alternative service was put in place but as there would be a national service specification from April, it was recommended to wait and understand this requirement before putting a new service in place. Some further work would also be required around the Deprivation LCS to understand the impact of the new framework. DH advised the Deprivation LCS had originally been set up to address people not accessing the right services and the need to work harder for those populations. This had not quite been achieved in the distribution of services. There had not been enough discussion with GPs for a broader view and this would be undertaken before proposing any changes. The Joint Strategic Needs Assessment (JSNA) which would shortly be published provided more insight around where resources should be targeted.	

	JD reported the new framework impacted the Local Investment Scheme (LIS) with the likelihood that some elements currently supporting practices to undertake areas of work would be covered by the new network agreement. £336k had been released from the PMS Premium for 2019/20 and a decision would need to be taken on how to use the funding in primary care. A recommendation was to use the funding to improve physical health in serious mental illness with any remaining funding to offset the costs expected from the LCS being provided to more of the population when commissioned under a network DES. MP felt it was important to consider how OCCG communicated with GP colleagues around the GP contract reform as there was quite a bit of uncertainty and there would be a need to help the GPs in the transition to PCNs. CM advised the subject had been discussed at the CCG Executive Committee and recognition of the changes in funding flows. JD had committed to try and map out as clearly as possible the funding flows to enable practices to understand the changes. CH reported something might be issued nationally but information on this was still awaited. JD commented that the Local Medical Committee (LMC) had a key role in terms of the GP contract reform and ensuring their members understood it. EDS pointed out there had previously been a list of priorities for use of the PMS Premium as it was released over 5 years and the only recommendation coming forward to the Committee was in relation to mental health. He was also concerned to ensure services were not being paid for twice via added services, as well as those in the core contracts and felt there was a need for some assurance to the Committee. DH explained it was hoped this year to agree priorities as a system and how primary care would play a part. Mental Health was a priority and this funding would count towards the mental health investment. DH remarked the system was working better together and work was being taken forward through the Health and Wellbeing Board (HWB). CM observed addressing health inequalities was one of the major priorities and the proposal fitted with that priority. EDS reiterated that the Committee had only been given the one option for the use of the PMS Premium release and no supporting background for the recommendation from the Executive. He understood if the Executive Team had reviewed the options and this had been put forward as a high priority, but also noted there was a significant gap in the mental health baseline. JD would provide information on where funding had been spent in previous years. DH advised there was a need to work hard on the care home support	**JD**

	scheme to understand how a future model would look. The review process was taking longer than expected and assurance needed to be provided to the Committee as currently best value was not being achieved. **OPCCC noted:** • **The locally commissioned services would continue to be commissioned at practice level for 2019/20, with gaps in provision requested at PCN level.** • **The changes to the Local Investment Scheme** **The Committee supported the use of the PMS premium for the Severe Mental Illness Locally Commissioned Service.** **Primary Care Networks in Oxfordshire** JD presented Paper 3b explaining it looked at the network component of the contract. Currently there were 17 PCNs across Oxfordshire and practices had until 15 May 2019 to agree the network formation. Some funding was available from NHS England (NHSE) to help and support PCNs to be ready to deliver and discussions had been held with partners around the process and support required. As part of this funding, some protected learning time was being put in place for practices to come together to discuss the implications of the formation of networks and to start addressing the integration agenda. A system wide strategic workshop was being organised to help address this area. The CCG needed to have a process to agree the network formations to ensure there was 100% geographical cover, that networks were contiguous and that all practices were covered. There was a proposal in the paper for OPCCC to delegate the running of that process to the Oxfordshire Primary Care Commissioning Operational Group (OPCCOG). The LMC had held a Buckinghamshire, Oxfordshire and Berkshire West (BOB) wide roadshow on 26 February and would be working jointly with OCCG on the first workshop in April. GH commented the LMC roadshows had been very helpful in other areas. The Federations were working with the PCNs to understand what support they could offer. The networks could use the Federations as their delivery arm if they wished to do so. The funding route would be through the networks directly and it was for them to decide where monies were spent. Committee members asked about the inclusion of Oxford Health but not Federations at the meeting to confirm PCNs. The guidance was clear network formation should be alongside the LMC but the formation would impact on Oxford Health NHS Foundation Trust (OHFT) as community	**DH**

	services needed to align to the network configuration. The Federations had a different role: more service provider than formulising the network shape. CM stressed the need to be clear on the rationale for the inclusion of OHFT and what input they were able to have. EDS expressed concern around the number of networks and queried whether value for money and economies of scale were considerations in the formation of the networks. JD advised there had been quite a bit of debate on population size and number of networks: whether 50,000 was the maximum or if networks could have a bigger population. Currently it was not clear whether the funding would be per head or per network, or in fact some other format. There was nothing to stop networks sharing an infrastructure. JD advised there was a national move to a support network for PCNs and locally OCCG was considering how support could be provided to the Clinical Director of each network. Each network had to have a nominated Clinical Director. EDS voiced some unease around delegating management of the process to OPCCOG in terms of possible Conflicts of Interest and requested assurance be provided between meetings. **OPCCC :** • **Agreed the support offer to develop the maturity of the Primary Care Networks.** • **Agreed delegating the agreement of the Primary Care Network formation to OPCCOG subject to the assurance requested around Conflicts of Interest.**	**JD/CM**
5.	**Decision Tree** JD presented Paper 4 explaining the Decision Tree had been co-produced with input from patient groups, the Health Overview and Scrutiny Committee (HOSC) and colleagues in Buckinghamshire among others. The Committee was being asked to give permission for OCCG to start using the Decision Tree. EDS observed it was clear from the paper that there had been really good co-production in its development. RD cautioned against getting locked down in a tick box exercise pointing out there would always be exceptions. JD concurred, commenting it was clear that not every situation would lend itself to use of the Decision Tree. The Decision Tree had been tested on case studies to see where it would be appropriate for it to be used before a 'live' pilot. CM reported the Decision Tree had been presented at the last HOSC and the approach had been welcomed. EDS welcomed the initiative and invited JD to provide feedback to the	**JD**

	Committee once the Decision Tree had been tested in a 'live' environment and noted the Decision Tree could change based on the learning. **The OPCCC approved the Decision Tree for use when a practice circumstances changed.**	
6.	**South Oxford Health Centre (SOHC)** JD presented Paper 5 advising the practice had handed back its contract and the Decision Tree, and procurement advice was being used to look for a solution to provide primary care services for this practices patients. The Patient Participation Group (PPG) had been extremely engaged and taken active steps in informing the Health Centre patients. A draft timescale had been included in the paper. RD commented that he had been pleased to see a briefing issued to stakeholders. DH pointed out the process would need to be undertaken in line with procurement law. **OPCCC:** • **Noted that OCCG had a statutory responsibility to ensure medical services provision for the patients registered at South Oxford Health Centre.** • **Agreed that OCCG should follow the process as detailed in the Decision Tree.** • **Noted the papers outline process and steps needed to achieve a solution for South Oxford Health Centre and the proposed timescales, understanding that this would be the responsibility OPCCOG to oversee and deliver.**	
7.	**Primary Care Workforce Strategy** JD presented Paper 6 explaining there had been some small updates since the previous version of the document had been presented to the Committee workshop in January. The new contract framework included some funding for networks to take on new roles, which were not reflected in the Workforce Strategy but these did address some of the gaps the document had identified. There was a need to proceed with implementation and as a consequence support from the Committee for the document as it stood was requested whilst the Committee also noted that it would be a fluid document which would be adapted and modified as new national initiatives were announced. EDS commented more assurance around the overall project management arrangements had been requested at January workshop and he felt there was a need for the management team to provide some assurance to the Committee on this issue. DH advised the JSNA, which would be presented to the HWB, highlighted a richer skill mix of GPs in Oxfordshire compared to the national picture. She thought the Committee should be aware as she	**JD**

	did not believe this was included in the strategy. She added that some real successes in primary care workforce had been reported to the A&E Delivery Board but that these might be impacting on paramedics in the South Central Ambulance Service (SCAS) and the primary care workforce should be set in the context of system working. She advised OxFed used paramedics on a rotation through SCAS, which was an excellent piece of system working. JD concurred, commenting the approach should be in the context of all workforce issues in Oxfordshire across the system. EDS observed the wellbeing of staff in primary care needed to be picked up. MP had requested that this be considered at a future OPCCC workshop. EDS commented that the GP supply chain assumptions and establishment estimates would be impacted by there being more GP roles developed outside of primary care, which led to a material gap in workforce projections. There were a lot of assumptions in the strategy but the strategy did not fully mitigate the workforce challenges. The difficulty for the Committee in approving the strategy, was the gap and although some of the national announcements in terms of direction would assist in closing that gap the strategy did not fully address this. Despite these concerns EDS did believe the Committee should agree to support the strategy rather than delaying its implementation. He felt the Committee should support the draft strategy and ask that the initiatives set out were taken forward but felt that the final strategy should take into account the national work to increase the supply chain and GP roles outside primary care. He expected the strategy to come back to the Committee in nine to 12 months times, with a sizeable update in terms of the national initiative. **OPCCC supported the Workforce Strategy with the caveats detailed above.**	**JD** **JD**
Business		
8.	**OPCCC: New Ways of Working Update** CM advised a paper had been taken to the CCG Executive Committee on changing some of the ways OPCCC worked, its remit and membership. This now needed to be reconsidered in light of the LTP, PCNs governance, the GP contract reform and system working. A piece of work had also commenced across the Sustainability and Transformation Partnership around areas where there could be more joined up working and it was felt the primary care committees could be one area where there was a committee in common. EDS remarked that he and RD had tried to engage their counterparts in Buckinghamshire but it had not been a very fruitful discussion and he hoped there might be a better outcome from the STP piece of work. DH commented some issues were the same in Oxfordshire and Buckinghamshire and there was a need to have conversations together	

	about the issues with LMC around the table. **The OPCCC noted the update.**	
9.	**Committee Annual Report** JD presented Paper 7 explaining due to the timing of meetings, the Annual Report needed to be written ahead of the March meeting and the draft would be updated. The Annual Report would be presented to the May OCCG Board meeting. The Report set out the work undertaken by the Committee in line with its duties. A section on NHSE Assurance had been included at the end of the report. No changes to the Committee Terms of Reference were recommended at this stage. Points raised included: • Other reports featured a future focus section. JD to include. • The report to include a piece explaining that review of functioning of the committee was work in progress. • The patient representative had resigned and sourcing a replacement was tied in with the work around future ways of working. Reference to be made to the public member of the Committee and that a representative would be sought. • Although not actually a merger, reference should be made in the approving practice mergers section to the arrangements for Banbury Health Centre and the wider Banbury solution. • The NHSE Assurance section would be updated before presentation to the Board if more information became available. • The level of assurance from the PCC Audit to be included. • The section around links to the Quality Committee to be strengthened. • The Workforce Strategy work to be included under Duty 1. This had been a good piece of work and should be recognised in the Annual Report. **OPCCC agreed the Annual Report subject to updates and revisions as above and agreed no changes to the Terms of Reference or duties were required prior to submission to the OCCG Board.** JD to circulate the final report to the OPCCC Chair for sign-off prior to presentation to the OCCG Board.	**JD** **JD** **JD** **JD** **JD** **JD** **JD** **JD**
10	**Finance Report** JS presented Paper 8 advising OCCG had moved from a net financial risk of £4.0m to a net 'nil' risk and all material risks identified were covered by mitigations. Part of the reason for the risk reduction was the agreement of year end positions with provider organisations. Delivery of the delegated co-commissioning budget was still on plan and the reserves were still being held. The OCCG budget for prescribing had moved its forecast out to £0.5m underspend, although this was still based on Month 8 data. The Medicines Optimisation Team still had concerns around impacts later in the financial year from exiting the EU.	

	OPCCC noted the Finance Report and considered risks were being managed effectively. **2019/20 Financial Plan for Primary Care** JS presented Paper 8a explaining it related to the primary care elements only. A draft plan had been submitted on 12 February. There had been an increase in the allocation for delegated co-commissioning. The 0.5% contingency required under business planning rules had been built back in. Elements around the GP pay settlement, which was expected to be higher than the original assumptions, had also been built in. CH advised the PCN Clinical Director posts needed to be funded from the delegated budget. Another submission of the plan was due on 4 April. Clarity around the key assumptions would be included and the plan circulated to the Committee. JS advised the requirement for £1.50 per head investment in Primary Care for the PCNs would be met from existing primary care budgets. The £1.0m for care home support had also been retained in the plan. There had been a high inflationary uplift in terms of planning for the prescribing budget but savings targets were built in resulting in a budget at a similar level to the previous year. The population growth in Oxfordshire being significantly below other areas was queried. It was thought that this was due to the way ONS based projections were undertaken. CH was asked to see if Buckinghamshire was in a similar position to Oxfordshire. **OPCCC noted the planning assumptions for 2019-20 and the draft plan submission on 12 February 2019. The final version to be circulated and signed off virtually.**	**JS** **CH** **JS**
11	**Quality Performance Report** MP presented Paper 9 advising the Quality Team had a wide remit, which included looking at data from various different sources. MP wished to highlight the Right Care data which informed OCCG on areas where a difference could be made: this might not necessarily be at practice level. Other areas drawn to the attention of the Committee were: • Care Quality Commission (CQC) inspections: Only one practice out of 70 had been rated 'requires improvement'. Four practices were outstanding: Luther Street, Windrush Medical Centre (Witney), Millstream (Benson) and Sonning Common. Support had been provided to practices around CQC preparation and practices had been given a CQC checklist. • Quality and Outcomes Framework (QOF): Oxfordshire had scored slightly higher than the national average and 11 practices had achieved the maximum score. The average Exception Rate was just below the national average and the team was working	

	with those practices identified as high exception reporters to enable them to improve. Guidance was awaited on a new reporting system which would be more patient specific. One practice had a drop in its QOF score and a visit would be arranged. The Team would work with the practice on an improvement plan and follow up to ensure the plan was put in place. • Quality Improvement Visits had been undertaken. The impact of the Contract reform quality improvement component needed to be considered. • A clinical evaluation of test result protocols had been undertaken and the report was about to be finalised. It had been a useful exercise as it had highlighted that many practices needed to do some work on this aspect. MP presented the Dashboard and advised there would in the future be a dashboard that the PCNs would need to review. She advised there would be a need to be careful with the management change in primary care to ensure quality of care remained stable. DH observed on the dashboard how Henley and Wallingford were beacons of green and queried whether high performing practices were ever congratulated. The differential in performance and how deprivation and inequalities could impact was discussed. MP to check whether there were any practices in a given area performing well who might be able to offer support and learning to other practices within that area. EDS was pleased to note the improvement in CQC inspection results and asked MP to feedback to the Quality Team the Committee's gratitude for their hard work. **OPCCC noted the Quality Performance Report.**	**MP** **MP**
12	**Deputy Director, Head of Primary Care and Localities Report** JD presented Paper 10 and advised: • Cogges Surgery: the paper confirmed the outcome for the partners to continue to provide services and the termination notice of the contract had been rescinded. • Cropedy Surgery Emergency List Closure: the surgery was experiencing sustainability issues following the loss of its Practice Manager. In early January, it had been agreed the surgery could temporarily close its list. In the longer term the PCNs would support a vulnerable practice but it had been necessary to provide support in the meantime. • Hightown Surgery: the practice had decided not to take forward funding for a new site. OCCG was working with NHSE to see if the funds could be transferred to another Oxfordshire project or to a feasibility study to look at growth across Banbury and that the estate was fit for purpose. • The Primary Care Estate Development Manager was now in post and was working across both Oxfordshire and Buckinghamshire.	

	• Online Triage Roll Out: the project had commenced and there had been good feedback. This was part of the GP contract reform and was a significant piece of work for practices. **The OPCCC noted the Deputy Director, Head of Primary Care and Localities Report.**	
Governance		
13	**Forward Plan** JD presented Paper 11 and queried how the GP Forward View (GPFV) would interact with the LTP, as the five years were not yet at an end. GH advised the intention was to integrate the two to become one plan. JD requested information around what was left of the GPFV and what needed to be delivered. JD had included some ideas for workshop topics on the plan. EDS remarked he would be interested in seeing some information on innovation and outcomes of the work in vanguards. Any other items for 4 June meeting to be submitted to LC. **The OPCCC noted the Forward Plan.**	**GH** **All**
14	**Risk Register** CM presented Paper 12 advising it was the standard register document with one Strategic and two Operational Risks. EDS queried whether the Committee felt the rating of 12 for Workforce in Primary Care risk was too low. After some discussion the Committee decided the rating should remain but that more specifics such as the low number of partners should be included. EDS felt there was a need to work though the risk in a systematic fashion to identify the gaps and provide these and the controls. and assurances for the next meeting. **The OPCCC noted the Risk Register.**	**CM**
15	**Papers Circulated/Approved Between Meetings** No papers had been circulated or approved between meetings.	
For Information		
16	**Criteria Change for NHS England Clinical Pharmacists in General Practice Programme** The OPCCC noted the changes in criteria for the Clinical Pharmacists in the General Practice Programme.	
17	**Confirmation of Meeting Quorum and Note of Any Decisions Requiring Ratification** It was confirmed the meeting was quorate and no decisions required ratification.	
18	**Any Other Business** There being no other business the meeting was closed.	
19	**Date of Next Meeting** 4 June 2019, 14.30 – 16.30 in Conference Room A, Jubilee House.	

	EDS thanked everyone for the quality of the papers presented. He noted there would be a significant amount of work in relation to the national changes and was aware this would cause pressure on the Primary Care Team.	