Oxfordshire
Clinical Commissioning Group

MINUTES:

OXFORDSHIRE PRIMARY CARE COMMISSIONING COMMITTEE (OPCCC)

4 June 2019, 14.30 – 16.30

Conference Room A, Jubilee House, OX4 2LH

Present:	Duncan Smith (EDS), Lay Member OCCG (voting) – Chair
	Jo Cogswell (JC), Director of Transformation OCCG (voting)
	Dr Kiren Collison (KC), Clinical Chair OCCG (voting)
	Julie Dandridge (JD), Deputy Director, Head of Primary Care and Localities OCCG (non-voting)
	Roger Dickinson (RD), Lay Vice Chair 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)
	Val Messenger (VM), Interim Director of Public Health OCC (non-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)
	Jenny Simpson, Deputy Director of Finance OCCG (non-voting)
In attendance:	Lesley Corfield - Minutes

Apologies	Steve Gooch, Director of Finance NHS England
	Louise Patten (LP), Chief Executive OCCG (voting)
	Richard Wood (RW), CEO Berkshire, Buckinghamshire & Oxfordshire LMC

		Action
1.	**Declarations of Interest** RD advised he was a patient at Hightown Surgery, Banbury.	
2.	**Minutes of the Meeting Held on 5 March 2018** The approved minutes of the meeting held on 5 March 2019 were noted.	
3.	**Action Tracker** *Developing OPCCC* The Oxfordshire Primary Care Commissioning Committee Operational	

	Group (OPCCOG) Terms of Reference (ToR) are due for approval by OPCCC, as it is now a sub-committee of OPCCC. It had been necessary to update the ToR due to the formation of Primary Care Networks (PCNs) and the ToR would come to the 6 August OPCCC meeting for approval. It was noted the OPCCC ToR would also need to be amended following the change in board director responsibility. *Engagement* CM advised this now formed part of a wider piece of work and the front covers for all the board committees would be reviewed and consideration given to reflecting working with the wider system. EDS commented on the need to ensure the engagement box on the front sheets was used properly and not completed as a tick box exercise. The item was closed. *Long Term Plan (LTP) – Care Home support scheme* JD reported the action had been superseded by the GP Contract reform and from April 2020, there would be a national care home scheme. The action was closed. *Primary Care Workforce Strategy* EDS commented the Strategy was due to come back to the Committee in nine to 12 months' time but there was also a link to the risk paper on the agenda (Item 13), as the Committee was not assured that the Strategy would meet the workforce challenge and there was a sizeable gap in terms of mitigation in changes to workforce. JD advised that when discussed in March, the final details of the GP Contract reform were awaited. It was now known that this would bring additional funded workforce for PCNs. There would be a need to understand the impact of national initiatives on the workforce gap identified, how working as networks would make a difference, and how the integration of community and primary care would impact. It was agreed three of the actions would be amalgamated into "the Committee requested assurance around how the primary care workforce gap would be closed". The wellbeing of staff in Primary Care would remain a separate item as a national strategy was being produced but it was not known when this would be published. There was a need to await the national strategy for the action which would be assigned to MP. It was felt this could be a topic for a future workshop. *2019/20 Financial Plan* The Financial Plan had been circulated between meetings. JS advised there had been some questions on risk which had been answered. The Plan was signed off and the action closed. *Quality Performance Report* MP advised the action had been superseded by the GP Contract reform	**LC** **LC** **LC** **LC**

	and there would be a need to undertake through networks rather than individual practices. JD commented the new quality improvement component of the Quality Outcomes Framework (QOF) would be a good initial step for learning to be offered to other practices. The action was closed.	**LC**
	Deputy Director Head of Primary Care and Localities Report – deterioration in satisfaction rates for GP appointments JD reported OCCG had been requested to speak to the Health Overview and Scrutiny Committee (HOSC) about GP appointments. The paper would be shared with the Committee in mid-June.	**JD**
	There had been a great deal of focus on same day appointments and access but it was for routine appointments that waiting times were longer and causing dissatisfaction with patients. A more in-depth review was suggested for a future workshop.	
	RP commented on the need to ensure clear messages to the public in relation to satisfaction rates and for this to be co-produced with Patient Participation Groups (PPGs).	**JD**
	Forward Plan GH felt the action had been superseded by the formation of the Buckinghamshire, Oxfordshire and Berkshire West (BOB) Primary Care Programme Board (PCPB), which was leading on transformation and the GP Forward View (GPFV). CM observed there was a board at BOB level but it had not been agreed which areas would be delivered at this level and OPCCC still held responsibility. The question in the action was whether the GP Contract reform had replaced the GPFV and to understand which aspects of the GPFV there was still a need to report.	
	RP stressed the importance for primary care to be delivered in Oxfordshire and for it to fall under 'place', whether the Committee existed or not in the future, the strategy and plan for Oxfordshire should lie in Oxfordshire.	
	JC advised a piece of work was being presented to the Health and Wellbeing Board (HWB) on 13 June around the Sustainability and Transformation Partnership (STP) strategy. Schemes and services could be undertaken across the STP footprint, which would be to Oxfordshire's advantage. JC advised the HWB paper would answer most of the questions raised. The Committee was advised that KC, JC and JD all attended the BOB PCPB meetings.	
	CM observed OCCG was being encouraged to do more and more as part of BOB but remained the statutory body. This was an item for consideration at the next Board workshop, with the intention to avoid duplication and drive out efficiencies. The HWB paper would be shared with the Committee. GH to confirmation the areas of the GPFV where reporting was still required.	**JD**

	Risk Register Was an agenda item.	
Commissioning		
4.	**Primary Care Networks** JD presented Paper 3 reminding members that at the last meeting, the Committee had agreed to delegate the decision in relation to PCNs configuration to the Operational Group and the paper circulated between meetings had been to provide assurance on the process. A meeting to approve the PCN configurations had been held and 19 PCNs of varying sizes from just over 30,000 to 66,000 had been agreed. The largest was in Banbury. There remained three issues: • Sibford Surgery who had taken a decision not to be part of a network. OCCG had worked with the PCN covering the Sibford area and it was likely the North Oxfordshire Rural Alliance (NORA) would provide network services to the patients. • No decision had been made around South Oxford Health Centre (SOHC) at the time the paper had been written following receipt of the notice to terminate their contract. With the decision on the future of SOHC made, as detailed in Paper 4, SOHC would be covered by the PCN of the main practice. • The third issue related to the Luther Street contract, as detailed in Paper 5. It had been discussed whether Luther Street should be part of a PCN and the formal OCCG position was that it should be included. One of the City networks was keen to include the practice, although there was a need to understand the implications of their services on targets such as access. It was expected there would be 100% coverage of the population by the PCN. OCCG had worked closely with the Local Medical Committee (LMC), who had been supported to ensure there was 100% coverage. JC advised the close involvement with LMC had been well received and enabled OCCG to respond to practices. The approach in Oxfordshire had been very collaborative and it was hoped this would result in a strong basis from which PCNs could build. JD advised the second part of the paper concerned funding flows. The changes for practices were detailed on page 6 of the paper – the bottom three items were from the NHSE delegated budget and the top three items from OCCG core allocation. RP expressed some concerns regarding Luther Street being included in a PCN and requested assurance. JD explained patients from Luther Street are unlikely to stay registered with the practice forever as when a patient moved into housing they registered at their local GP practice. It was not known at this time what the impact of Luther Street as a core	

	network practice would mean for the PCN but it would be access to evening appointments. For Luther Street this was 15 minutes once a week and, if additional roles were employed by the PCN, how these (such as a clinical pharmacist) would be deployed. OCCG had worked with Beaumont Street and it was likely Luther Street would the PCN that covered this practice. The PCN would need to provide additional hours and OCCG would work with the practices to understand how patients in that cohort received services. Some general work on PCN communication had commenced. The Patient and Public Forum of West Oxfordshire had invited the CCG to lead a meeting with local councillors, PPGs and voluntary organisations to enable them to start to understand PCNs and what the public, patients and community could offer back to the PCNs, as there was a need for them to be part of the new integrated services. RP advised Healthwatch was planning an event in the next week and late October to offer the opportunity for PPGs to network and consider how they could work together. PPGs were keen to know how to approach and work with other PPGs within a PCN. She stressed the importance for patients to be involved at the beginning. Due to the amount of work involved, EDS queried if communications and PCNs working with patients and the public should be a priority for a OPCCC workshop. JC commented that engagement and communication about the changes and delivery of integrated care were important. On 13 June, a workshop would take place for PCNs, community service providers, local authorities, Locality Clinical Directors and others, where working together would be discussed. JC felt this would be appropriate for an OPCCC workshop and could be considered after the13 June workshop. MP observed for patients and those working in primary care, PCNs were a fundamental change in the way primary care worked. Communication would be really important. KC pointed out there was a lot of PCN communication in the public domain already but that did not necessarily mean it would be read by the public. She reported that in the past, she had written articles for newspapers and suggested this might be a good route to consider. EDS recapped the discussion and the need for a workshop around communication, engagement and working with the public and patients. He remarked that there was no reason why the workshop could not be opened up to include other people outside the Committee. **The OPCCC noted the process to ensure 100% population cover and the funding flows as a result of the introduction of PCNs.**	**JC**
5.	**South Oxford Health Centre (SOHC)** EDS commented Paper 4 was for information as it had been received	

	by the Committee between meetings and a decision taken. JD advised following an agreed process, the contract had been awarded to St Bartholomew's Medical Centre who would provide services from SOHC. All staff would be retained. JD reported the PPG had been very instrumental in helping OCCG with the contract award and communication with patients. The next steps would be to develop an Implementation Plan with St Bartholomew's, write to all the patients to inform and assure them that there was no need to take any action, and to provide further information on the way forward. Any patient could register elsewhere if they wished. MP requested the Quality Team be involved with the work to ensure patient quality was maintained. EDS commented it had been a sound and transparent process with a good outcome. **The OPCCC noted the agreed recommendation.**	
6.	**Recommissioning of Specialist Homeless Primary Care Services** JD presented Paper 5 advising the Committee was being asked to agree the procurement of the model outlined in the paper. KC commented that it was a good paper and was pleased it had not just focussed on Luther Street or a Oxford city centric view but had branched out to other parts of Oxfordshire. RP stressed the need to maintain and develop the Luther Street service and not allow whoever was awarded the contract to let the service drop. EDS drew attention to the withdrawal of funding from homeless services by Oxfordshire County Council (OCC) with a view to distribute services across Oxfordshire. The question around evaluation of the impact would be taken back to the author of the paper. JD explained there was no 'one size fits all' and the Team had talked to service users about what was good or bad with the existing service and what needed to change, which had helped shape the service. There would also be stakeholder engagement to help in shaping the requirement. RP pointed out Luther Street had a good PPG and JD agreed, stating it was well led and had engaged with people. **The OPCCC approved the proposal to proceed with procurement in line with the model described within the paper.**	**JD**
7.	**Primary Care Services for 2019/20** JD presented Paper 6 outlining the impact of new national guidance on Oxfordshire primary care schemes and making recommendations for 2019/20. The proposals for each item were summarised in the table under point 6.	

	KC advised concerns were raised at the PCN workshop by practices in areas of high deprivation. A meeting had been held to understand these concerns and to consider the management of the population in those PCNs. She felt there was some good work already but that the Committee should be aware of the concerns. JC advised at the calendar year end, the system needed to be able to state how it would award or allocate recurrent funding to PCNs/practices. This would either be by a form of weighted population or using a population health management (PHM) approach with work targeted on specific issues. RP pointed out the lack of a measure for rural deprivation, commenting isolation was often a key determinant of health. MP advised there was a difference in the way deprivation was measured in children and adults. KC remarked on the pockets of deprivation in wealthy areas commenting on the need to use more than just the indices of multiple deprivation (IMD) scores. VM felt the PCNs would help more widely with deprivation, pointing out healthcare was only 20% of the impact and extra resource would be required in the wider non-health services working together to stop the demand coming into practices. **The OPCCC accepted the recommendations in Paper 6.** Following a suggestion for a wider topic on deprivation for an OCCG Board Workshop, CM felt the right place for a discussion needed to be considered as this was within the remit of the Health Improvement Board and the HWB. EDS felt the Committee would like to receive an update paper.	**JC**
8.	**BOB STP Primary Care Strategy** JC presented Paper 7 explaining STPs/Integrated Care Systems (ICSs) needed to include a primary care strategy (Strategy) as part of the ICS strategy that would be developed in Autumn 2019 in response to the Long Term Plan (LTP). The Strategy was required to set out how the sustainability and transformation of primary care and general practice would be ensured as part of the overarching strategy to improve population health. Draft Strategy needed to be submitted at the end of July. RD felt the paper lacked 'strategy' and there was no information on activities to be undertaken. CM advised the comments were similar to the discussion at the CCG Executive Committee meeting. MP observed as a GP and patient she had liked the piece on what would change and what that would look like for me/the patient. She felt the language used had been really helpful. JD advised it was the first time general practice services had been presented alongside optometry, dentistry and pharmacy services.	

	EDS remarked that it was a pity the document had been put in the public domain in its present format and he looked forward to the next version. He also queried the public and patient input into the strategy. **The feedback from OPCCC was noted.**	
Business		
9.	**Finance Report** JS presented Paper 8, the Finance Report to Month 12 closing off the financial year. OCCG had achieved its plan and made a small surplus. The audit process had been completed with the Auditors giving an unqualified opinion. The delegated co-commissioning budget had come in on-plan. The CCG primary care budgets were under-plan due to the prescribing position. The under-spend had been used to offset the over-spend in-year to bring OCCG to a balanced position. Allocations were received for the year and needed to be used in that year. Only in exceptional circumstances could monies be taken forward. The paper set out the risks for 2019/20 and JS advised the first months reporting for 2019/20, which would confirm the budget, would be brought to the next meeting. **The OPCCC noted the Month 12 Finance Report.**	
10	**Quality Performance Report** MP presented Paper 9 updating on the work of the Quality Team (Team) to assure the quality of primary care medical services: • Care Quality Commission (CQC) Update: the practice rated 'requires improvement' had been re-inspected and, although overall remained 'requires improvement', there had been improvements on areas within the rating. The Team was working with the practice to support its continued improvement. QOF 2018-19 had not yet been reported but should be available for the next meeting • Flu outbreak management in general practice: the first planning meeting for next year had been held • Quality Improvement Visit Programme: support had been provided to 14 practices, with 24 visits since the programme commenced in October 2018 • Local Investment Scheme (LIS) for Primary Care: as part of the LIS practices were funded to review their protocols for the management of test results and clinical correspondence. All but one of the practices undertook an audit and the Team was following up with that practice • Significant Events Management: the majority of issues were raised in the Hospital although were mainly before the patient entered and the incidents were listed in the paper. A learning	

	summary would be produced for practices. On the general attitude to quality improvement, KC observed that each organisation in Oxfordshire had its own team and quality processes. There would be a need to ensure good quality work across and this would be the responsibility of all partners. MP commented on the amount of duplication in the quality processes and felt it would be good to understand how organisations linked with each other in order to improve quality. JD advised there was a community and primary care integration workstream. Responding to a query, MP advised there were no significant event recurring themes in the different practices. Any very serious incidents had to be reported to the CQC. The Team always requested the outcomes and details of any changes from the practices to ensure the events would not happen again. JD pointed out the PCNs were not yet formed and current work was trying to shape the outcomes for the first year and those that were required as there would be considerable expectation on the PCNs. Community integration would be a key component alongside addressing system wide issues, such as A&E attendance. JC reminded the Committee there was a five year trajectory and it was early days. Consideration was being given to scoping the phases in which pieces of work would take place such as: working with partners and community services; what the road map would look like; where support was needed; and where the challenges were; etc. EDS stated OPCCC would be looking to the Quality Committee for assurance that the practice requiring improvement had an improvement plan agreed with OCCG that if implemented in full would return the practice back to a 'good' rating. **The OPCCC noted the content and actions in the Primary Care Quality Assurance Report.**	
11	**Deputy Director, Head of Primary Care and Localities Report** JD presented Paper 10, her report on Primary Care in Oxfordshire, and drew attention to item 3.1 on page 5 of the document on Bicester Primary Care. JD advised there had been a helpful and well run engagement event for a new primary care estate, with around 200 people attending. Most of the people accepted the need for change but the choice of site and transport were raised as issues. The practices had considered the transport options, which might allay some concerns. The business case would be presented to the Finance Committee. JD advised she had previously referenced the Primary Medical Care Policy and Guidance Manual, which was followed by all commissioners of NHS Primary Medical Care. The document had been updated to	

	reflect the changing landscape in primary care co-commissioning. RD reported he had attended the meeting in Bicester, which had been well run and practices had provided some good information in the meeting. He commented that it had been good to see the one practice which was not moving to the new site in attendance and explain its reasoning. RD queried the Islip boundary change, which JD explained was due to two PCNs covering the North East. The PCN boundaries were causing some confusion as services were delivered to the population registered to a practice. Increasing, the boundary gave more choice to patients. EDS emphasised the Finance Committee had only seen the beginning of the outline business case for Bicester and there was still an amount of work to be undertaken. Responding to a query, GH advised the PCN return was one of various returns for primary care but data around contracts was through the Primary Care Commissioning Activity Report (PCAR) return. **The OPCCC noted the Deputy Director, Head of Primary Care and Localities Report.**	
Governance		
12	**Forward Plan** JD presented Paper 11, the Forward Plan advising a number of topics on specific areas the Committee had discussed had been built in for further discussion over the four meetings in the year. Main topics for the workshop would be PCN engagement and GP appointments. **The OPCCC noted the Forward Plan.**	
13	**Risk Register** CM presented Paper 12, explaining it was the normal report but, as had been highlighted at the OCCG Board meeting and OCCG Board workshop, the management team would review the Risk Register in its entirety. Any comments from the OPCCC would be fed into the review work. RD felt the workforce score of 12 was quite low given the reports nationally on workforce issues and the issues for PCNs. EDS added that there was not enough assurance around ways to address the gap. He accepted there might be more assurance once the national work was further advanced but felt the score was low. CM advised this would be considered in-depth along with how the risk was articulated as it could be a system risk. She added that using the workforce in the system in the best and most appropriate way whilst recognising the issues would always be a challenge. The primary care workforce risk assessment was interesting, as compared to the rest of the country, Oxfordshire was well resourced.	

	JD was concerned if the primary care workforce was seen as separate from the system as part of the Risk Register, as it could not be looked at it in isolation. CM advised there would be a workforce risk but believed it would be articulated in a different way. An updated proposal would be brought to the next meeting. **The OPCCC noted the Risk Register.**	**CM**
14	**Papers Circulated/Approved Between Meetings** *OPCCC Primary Care Final Plan Submission* The OPCCC had approved the Primary Care Final Plan Submission. *Primary Care Networks Approval Process* OPCCC supported the PCNs Approval Process. *Horsefair Surgery* Following a due diligence exercise, the Committee had made a decision 'virtually' to allow Principal Medical Ltd (PML) to take over the running of Horsefair Surgery. *South Oxford Health Centre* See agenda Item 5 above.	
For Information		
15	**Confirmation of Meeting Quorum and Note of Any Decisions Requiring Ratification** It was confirmed the meeting was quorate and no decisions required ratification.	
16	**Any Other Business** JC and VM were welcomed to the meeting by the Chair.	
17	**Date of Next Meeting** As JD and JC were on annual leave on 6 August 2019, an alternative date for the meeting to be found. *Subsequent to the meeting it was advised the next meeting would be on Thursday 15 August 2019, 14.30 – 16.30, in Conference Room A, Jubilee House.*	**LC**