Oxfordshire
Clinical Commissioning Group

Oxfordshire Clinical Commissioning Group
Board Meeting

Date of Meeting: 25 January 2018	**Paper No: 18/12b**

Title of Paper: Minutes of the Oxfordshire Primary Care Commissioning Committee, 2 January 2018

Paper is for: (please delete tick as appropriate)	**Discussion**		**Decision**		**Information**	✓

Purpose and Executive Summary:

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

Meetings had been held to discuss how OCCG and the Committee engaged the public in relation to primary care, the effectiveness of the Committee in communicating with key stakeholders, understanding roles of Committee members, and issues around more co-production of key documents for engagement and consultation. A series of recommendations have been made to OCCG Executive Team and a response, and feedback on the recommendations was awaited.

Horsefair Surgery: A further planned inspection had been undertaken by the CQC at the beginning of December and the CQC report was awaited. There had been a recommendation for OCCG to meet with the Horsefair Patient Participation Group and an offer to meet had been made, and OCCG invited to the February meeting.

Closed patient lists: The Leys Health Centre had reopened its patient list and there were now no practices in Oxfordshire with closed lists.

Locality Place Based Plans - Public Feedback:

- A total of nine events were held, with three taking place in West Oxfordshire. In addition, an on-line survey was available for completion and OCCG staff had attended other meetings with individuals and groups..
- There had been a considerable amount of feedback, which fell into the following main themes: communications; timely access; continuity of care, when this was important and when not; use of IT; and workforce including whether staff were appropriately trained and if others were able to undertake some GP work.
- There had been concerns from members of the public around access to their own doctor for non-urgent appointments. The expectation aspired to by OCCG was contained in the Primary Care Framework and this was based on discussion with the public.
- There had been an extensive amount of engagement using a lot of resources, but concern was expressed in the Committee that the total numbers attending the engagement events were quite small.
- The Committee debated whether all the feedback from the locality events and on-line had been captured and made available to members.
- There was also concern expressed in the Committee around the general public understanding of engagement and consultation, and there was a need to be clearer on this aspect.

- The Committee discussed the co-production of the patient facing documents – this is being taken forward with the Locality Forum Chairs.
- The Committee was advised that the first version of the Locality Place Based Plans would be published at the end of January and these plans would be further developed.

Locality Place Based Plans – Mobilisation:

- OPCCC decision to approve the prioritisation list of primary care sustainability schemes for 2017/18 and 2018/19, subject to patient engagement feedback, was taken at an extraordinary OPCCC meeting on 14 November 2017 and endorsed at this meeting.
- A total of £1.157m recurrent and £1.676m non-recurrent funding was approved.

Deer Park Update: The Committee received assurance on the progress made to address the recommendations from the Independent Reconfiguration Panel to the Secretary of State. The North East London Commissioning Support Unit would be the independent third party undertaking the review of the plan for primary care and related services in Witney and its surrounds. An externally facilitated workshop would take place around the review of the working practices of the Oxfordshire Joint Health Overview and Scrutiny Committee with the NHS.

Banbury Health Centre: The Committee received an update on engagement around the future of the Centre and next steps for the public consultation.

Finance Report: There has not been a material change in the financial position. Funding in respect of primary care sustainability schemes for 2017/18 and 2018/19 was from within existing budgetary approvals.

Primary care workforce: It was noted that the workforce risk had been recognised in various papers to the Committee and a workforce plan, including recommendations to address the challenges primary care faced, would be available by the end of March. A bid with neighbouring CCGs for the recruitment of international GPs had been made and the outcome was awaited.

Financial Implications of Paper:

There were no further financial implications arising from the work of OPCCC.

Action Required:

There are no further actions for the Board arising from this meeting. The Board received a report on the Locality Place Base Plans at its November meeting.

The detailed work of OPCCC provides further assurance to the Board that OCCG is managing its primary care commissioning in accordance with the framework approved by this Board.

OCCG Priorities Supported (please delete tick as appropriate)	
✓	Operational Delivery
✓	Transforming Health and Care
✓	Devolution and Integration
✓	Empowering Patients
✓	Engaging Communities
✓	System Leadership

Equality Analysis Outcome:

Not applicable.

Link to Risk:

789: Primary Care Estate – Mitigation: further work is being undertaken to formulate a tactical delivery plan.

799: Workforce in Primary Care – Mitigation: workforce plan is being developed for March 2018.

Author: Duncan Smith, Lay Member, Chair Oxfordshire Primary Care Commissioning Committee

Clinical / Executive Lead: Dr Kiren Collison , Clinical Chair

Date of Paper: 15 January 2018

MINUTES:

OXFORDSHIRE PRIMARY CARE COMMISSIONING COMMITTEE (OPCCC)

2 January 2018, 14.00 – 16.00

Conference Room A, Jubilee House, OX4 4LH

Present:	Duncan Smith (EDS), Lay Member 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)
	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)
	Catherine Mountford (CM), Director of Governance OCCG (voting)
	Louise Patten (LP), Chief Executive OCCG (voting)
	Dr Meenu Paul (MP), Assistant Clinical Director Quality OCCG (voting)
	Jenny Simpson, Deputy Director of Finance OCCG (non-voting)
	Chris Wardley (CW), Public/Patient Representative (non-voting)
In attendance:	Lesley Corfield - Minutes
	Ally Green (AG), Head of Communications and Engagement OCCG – Item 5

Apologies	Steve Gooch, Director of Finance NHS England
	Diane Hedges (DH), Chief Operating Officer OCCG (voting)
	Rosalind Pearce (RP), Healthwatch (non-voting)
	Dr Paul Roblin (PR), Chief Executive Berkshire, Buckinghamshire and Oxfordshire Local Medical Committee (non-voting)

		Action
1.	**Declarations of Interest** MP advised she was a GP locum in Oxfordshire which included undertaking regular sessions at Banbury Health Centre (BHC).	
2.	**Minutes of the Meeting Held on 7 November 2017** The approved minutes of the meeting held on 7 November 2017 were noted.	
3.	**Action Tracker** *Horsefair Surgery* JD advised the action had been to obtain some independent assurance of the action plan produced by Horsefair Surgery to address the	

	concerns raised by the Care Quality Commission (CQC). A further planned inspection had been undertaken by the CQC at the beginning of December and the focus of work had been preparation for this visit, rather than obtaining the independent assurance. The Quality Team had seen the plan and was satisfied at that time and CQC had accepted the plan. The CQC report following this further visit was awaited when an updated action plan would be produced. EDS stated the close working of the Quality Team with the practice was a reason for the independent assurance and review of the work. MP reported a GP had been identified who did not work at OCCG to undertake audit work at the practice. EDS pointed out two months had passed since the request for the independent assurance and as the CQC website indicated patients were at risk, the action should have been prioritised. He stated the independent assurance should be completed and the process for implementing actions requested by the Committee picked up outside of the meeting. CM requested clarification on whether the request for independent assurance was of the action plan produced by the practice and/or assurance around the mitigations to address any shortcomings. JD advised due to the further visit from the CQC, the action plan on which assurance had been sought was now no longer current. MP added that separate from the CQC visit, there were issues which could be independently verified and this work would take place. CW remarked that until the next CQC report was available, the practice should be working on the current action plan and it should not be stated that it was no longer relevant. He presumed the action plan had identified areas for improvement and the existing plan should be updated as these areas were undertaken. CM stated she would take this away with JD and MP, and would come back with a recommendation. EDS remarked 'virtual sign-off' by the Committee could be undertaken if that was appropriate. *Quality Committee* MP advised assurance in relation to the improvement in practice RAG ratings had been discussed and agreed at the Quality Committee and would be implemented. The action was closed.	**CM/JD/ MP**
Commissioning		
	EDS reported meetings had been held to discuss how OCCG and the Committee engaged the public in relation to primary care, the effectiveness of the Committee in communicating with key stakeholders, understanding roles of Committee members, and issues around more co-production of key documents for engagement and consultation. A series of recommendations had been made to the management team and a response, and feedback on the recommendations was awaited. He proposed this should be picked up at the next meeting, although advising that a couple of the recommendations related to the OPCCC meetings and should be taken forward. There were six dates in the diary for OPCCC meetings and consideration was being given to how the meetings could be used more effectively, and to use two of the	

	meetings to undertake training for Committee members or 'deep dives', which would not normally be undertaken in an open meeting. EDS advised RD would pick this up further under Item 11, Forward Plan.	
4.	**Deputy Director, Head of Primary Care and Localities Report** JD presented Paper 3, her report, and advised: • There had been a recommendation for OCCG to meet with the Horsefair Patient Participation Group (PPG). An offer to meet had been made and OCCG invited to the February meeting. OCCG had offered to meet earlier than this date and was waiting to hear back from the PPG • The Leys Health Centre had reopened its patient list and there were now no practices in Oxfordshire with closed lists • National detail and information on allocations for GP online consultations, which were being locally termed 'online triage', had been received and work was underway to understand how this could be rolled out. This would be managed as a service 'change' project, rather than IT implementation. OCCG was also looking at the possibility of procuring with neighbouring CCGs across the Buckinghamshire, Oxfordshire and Berkshire West (BOB) footprint • A bid with neighbouring CCGs for the recruitment of international GPs (20 GPs for Oxfordshire) had been made and the outcome was awaited • OxFed had increased the use of GP access hub appointments with two new hubs available at Botley and Summertown and would be adding extra hours from the Leys Health Centre. Continuing communication in the media and on practice websites to ensure the hubs were advertised and there had been national advertising over the Christmas period • There had been a 100% submission from practices of the annual electronic practice self-declaration (eDEC) return. An analysis of the data would be undertaken and it was hoped to present a report to the next meeting • A workshop looking at mergers and working at scale had been held prior to Christmas and was well received. JS confirmed the £575k minor improvement grant (MIG) monies had been received. KC felt the report was very clear and provided a good overview. She queried whether Oxford Infracare LIFT considered the full cost of estate projects as there was no revenue information. JD confirmed the preferred route of finance would be looked at, advising some projects would require capital, with revenue implications, whereas, others would be looking for revenue only and there was a need to understand precisely what each project required. She added it was anticipated the revenue implications would be an additional £4.0m on top of the current £11.0m to meet the primary care needs of population growth over the next few years. JD advised the locality place based plans had been developed and had considered primary care estate. There was a need to link the plans to One Public Estate. CW commented there was considerable variance in information published around individual practices depending on where you looked	**JD**

	for it and queried whether the eDEC data would improve this situation. JD was hopeful but advised organisations publishing data had different ways of updating their information, for instance NHS Choices relied on practices, whilst the CQC relied on their own data sources. EDS observed that CW had previously raised the issue of the lack of information on services offered by individual practices across the county and queried whether this was something the Committee should look at in a 'deep dive' session. CW agreed and commented that it should be used for the locality based plans, as patients would read the plans from the perspective of what it meant for their surgery. He hoped this aspect would be picked up. On the subject of estates, CW commented that of the £2.0m granted for Oxfordshire £1m had been allocated to Hightown Surgery but he understood there was an issue with acquiring land. CM advised this would need to be taken outside of the meeting, as although obtaining the land was important, if the practice was undertaking dialogue with a commercial developer, the Committee should not discuss the matter in a public meeting. CW stated it was a big issue and risk, and there was a need to review to what extent the Committee was aware of what was going on. JD reported the Estates Technology and Transformation Fund (ETTF) funding was closely monitored by NHS England (NHSE) and was managed through that route. CW advised he had raised the matter as the provision of land for primary care services was a political issue which should be handled by the Chair and Chief Executive Officer, and he wished to have some assurance that this was happening. EDS observed the Committee had previously received a paper with an overview for discussions with District and County Councils. He requested an update for the next meeting. CW commented a number of concerns had been raised by the public around Horsefair Surgery, which he thought would have been answered if there had been adequate communication with the public. He also noted insufficient use of the advantages of the facilities and resources available at the hub had previously been reported, and queried whether this had changed. JD reported an increase in the use of hub services had been seen. She added that communication was important and the Horsefair PPG was working with the practice to develop a communication plan to ensure patients received messages. EDS advised dissatisfaction from patients had been reported at the last couple of OPCCC meetings and these had been addressed by JD and her team. JD advised the Committee would see in Paper 4, that feedback from every locality engagement event included the need to improve communication with patients. Further work around communication was required as well as publishing access to online facilities. EDS reported a clear recommendation had been made to management, as referred to above, and this would be picked up at the next meeting when feedback from management was available. RD observed there had also been the lessons learned from Deer Park Medical Centre, which had been adopted by OCCG.	

	The OPCCC noted the report from the Deputy Director, Head of Primary Care and Localities.	
5.	**Locality Place Based Plans** **Public Feedback** Ally Green, OCCG Head of Communications and Engagement joined the meeting for this item. JD advised AG and team had been instrumental in setting up all the engagement events. There had been a considerable amount of feedback, which fell into some main themes: communications; access and transport; continuity of care, when this was important and when not; IT; and workforce including whether staff were appropriately trained and if others were able to undertake some GP work. AG re-stated the events were engagement to inform the development of plans and not consultations on the draft plans. A total of nine events had been held, with three taking place in West Oxfordshire. In addition, an on-line survey was available for completion and OCCG staff had attended other meetings with individuals and groups. KC reported attendees at one of the West events had mainly appeared to be retired and white and queried how other groups and younger people were being reached. AG advised this was not being strongly promoted at this point, although the events were not the only engagement being undertaken by OCCG and there had been work in Colleges earlier in the year, particularly around primary care. A regular comment from these meetings had been a lack of enthusiasm for using technology, which had been a surprise. The survey responses could be reviewed to see if anyone had declared themselves from a particular group. The survey had also not been translated into other languages but OCCG had a team who liaised with the harder to reach parts of the community. KC was concerned plans did not become biased towards the white retired and away from harder to reach groups. CW reported comments he had received on the survey suggested the questions were not open enough and in some places had perhaps been leading. He advised that at the engagement event in Banbury, 25 people had attended and six had referred to concerns about Horsefair Surgery. He questioned why these concerns were not included in the feedback report or the appendices. AG advised she would check, explaining that at the event, every table had a scribe; the papers were gathered and written up with key themes being drawn out. The notes were not verbatim but if it was felt something was missing in the feedback, the notes could be checked. It was also possible the comments had been anonymised, for instance, stating communication was an issue but not identifying the particular practice. There was also another section on other themes and concerns, which were not relevant or particular to the engagement topic. These had been taken away to be picked up separately and the comments might have been included in this work. CM stated that the appendices were an analysis of the surveys and not the meeting comments. CW did not believe the context had been set around why the plans were being developed and that people would feel the report of that particular meeting was not fair and proper.	**AG**

	EDS recognised the point and stated this needed to be looked at, as if feedback from other meetings was not being specifically picked up, he questioned how the feedback could be received by the Committee. He added at the South East meeting he had chaired, comments were made in relation to the community hospital but these had not been reported. However, CW advised the comments made in the North East were reported. EDS stated the feedback loops appeared to be 'open' but questioned whether it was appropriate for all the detailed information from engagement exercises to be reported to the Committee, and this should be picked-up.	**JD/AG**
	AG advised that the questions in the on-line survey were exactly the same as those used at the events and were not 'closed' questions. The events and survey had deliberately been undertaken in this way. After the feedback from the events and survey had been gathered, and published, a second survey had been issued for any further comments. CW to ascertain whether the comments related to the first or second survey.	**CW**
	EDS observed there had been an extensive amount of engagement using a lot of resource but expressed concern that the total numbers attending the engagement events were quite small. He also continued to be concerned around the general public understanding of engagement and consultation, which was apparent from the criticism received around the time to respond and there was a need to be clearer on this aspect.	**AG**
	EDS advised there had been concerns from members of the public around access to their own doctor for non-urgent appointments and queried their expectation for non-urgent appointment. CM reported the expectation aspired to by OCCG was contained in the Primary Care Framework and this was based on discussion with the public. She thought there might be a need to look at where OCCG was currently, as opposed to expectations. The Primary Care Framework stated seven days for non-urgent appointments and this was with the most appropriate healthcare professional, by the most appropriate route.	
	EDS requested some assurance in terms of co-production of the patient facing documents. AG observed people had different ideas of the term co-production and cautioned that it could produce a really poor document advising when there was more engagement in developing a document; the end result could be something not quite as good as anticipated. AG reported as well as working with Healthwatch on all documents as they were prepared, OCCG worked with members of public who were not involved in any other way with OCCG to look at the documents and understand if they were in as plain English as they could be. OCCG would also sometimes work with a group over a period of time to develop a plan and document. EDS queried the actual plan for the patient facing document in this instance. AG reported work would be undertaken with Healthwatch and the Locality Forum Chairs (LFCs) were also keen to provide feedback or someone from their locality. JD advised although the plans would be published at the end of January, this would only be the first version and the plans would be	

	developed going forward. EDS asked the Committee members if they were happy with the proposal and felt working with Healthwatch and the LFCs would suffice. CW reported that to ensure diversity in the reviewers, the LFCs were looking to have more than one person involved. CM remarked that some drafts could go to a wide group for comment but editorial control would be necessary as with a number of groups commenting it was possible there could be a wide range and diverse views which would not coalesce as a plan. JD reiterated the need to recognise that once the plans were written and published, it was not the end and the plans would be further developed. EDS stated having raised concerns over the content and style, there was a need to listen to the Committee and ensure others were involved, despite the tight deadlines. The OPCCC noted the feedback to the plans and approved the next steps to publication.	
6.	**Locality Place Based Plans** **Mobilisation** EDS advised Paper 5 was presented to reaffirm the decisions taken by the Committee on 14November 2017 - The Committee had agreed a robust process had been run around the schemes and had approved the funding. The Committee was being asked to note the prioritisation of the plans as agreed on 14 November, to approve the minutes of that meeting and to note the plans for mobilisation of the locality place based plans. RD commented Appendix 1 indicated 41% of available funds would be allocated to Oxford City and queried how this balanced between the different constituencies in the Oxfordshire boundary. JD advised a few meetings ago the Committee had looked at whether funds should be allocated on a per capita or case for need basis and it had been agreed for this process to use a case for need. She pointed out that these proposals did not take into account the need for estates funding and drew attention to the table on page 12, highlighting in the South West, there was a need for estate funding and their plan had been more around the estate than service development. Oxford City and the North also had high levels of deprivation, requiring more of the funds. RD acknowledged the points but observed when more funds became available, Oxford City was due to receive a significant amount and yet there were no 'invest to save' workstreams from Oxford City to provide some funding back for investment. JD reminded the Committee, the first phase of investment was designed to achieve primary care sustainability and the most vulnerable practices were in the North and Oxford City. She advised it was also easier to undertake cross practice schemes in the North and Oxford City, than in the South of the region, where there were geographical issues to cross practice working. CM reminded the Committee that OPCCC had signed off the prioritisation process and advised the schemes had been scored using the process agreed. OPCCC had also signed off the distribution of funds and an allocation of additional funding on "fair shares" implied that	

	the base funding was equitably allocated. EDS commented a piece of work around OCCG spend at locality and practice level had been commenced by the OCCG Director of Finance and felt it would be useful for the Committee to receive and update, particularly when further funding decisions had to be made. JS to follow up. CW stated a criticism of the plans in some quarters, had been that they were not achievable as funding was not available. He queried whether the funding could now be included in the published draft plans, as it was available. JD advised the funding approved was only a small proportion of the total requirement and had been allocated during the process. Plans would detail those areas being taken forward. The estates information was anticipated towards the end of March. The OPCCC: • Noted the prioritisation of the plans that had taken place on 14 November 2017 • Approved the draft minutes of the extraordinary OPCCC meeting on 14 November 2017 • Noted the plans for mobilisation of the locality plans • Approved a total of £1.157m recurrent and £1.676m non-recurrent funding. JD advised each workstream identified would have a project charter, clearly laid out milestones and benefits realisation, which would be monitored through the Committee by exception.	**JS**
7.	**Deer Park Update** CM presented Paper 6 and advised North East London Commissioning Support Unit (CSU) would be the independent third party undertaking the review of the plan for primary care and related services in Witney and its surrounds. GH advised North East London CSU would produce and publish a report by the end of January. It had been requested that they kept their report aligned with publication of the draft locality plans. An externally facilitated workshop would take place around the review of the working practices of the Oxfordshire Joint Health Overview and Scrutiny Committee (HOSC) with the NHS. CM, AG and Sarah Adair, the joint Head of Communications and Engagement with AG, would lead on the relationship work with HOSC for OCCG. LP would attend if available. The two Trusts would send representatives, although these would not be clinicians. Oxfordshire County Council (OCC) would be sending the Chair of the HOSC and four or five other members. EDS queried whether an OCCG lay member should be included. CM would consider the suggestion but advised the HOSC had a scrutiny function. GH reported HOSC had also approached NHSE for a representative to attend. CM reported the paper aimed to demonstrate to the Committee that OCCG was acting on the recommendations from the IRP to the Secretary of State. HOSC, the Committee and patients needed to feel assured OCCG had addressed the recommendations made to the Secretary of State. It was noted as an assurance paper an action plan was not required.	

	The OPCCC noted the progress made to address the recommendations from the Independent Reconfiguration Panel to the Secretary of State.	
8.	**Banbury Health Centre (BHC)** JD presented Paper 7 providing an update on engagement around the future of BHC and next steps for the Consultation. She advised the Consultation Plan had been brought to the last meeting and had also been taken to HOSC, and the Community Partnership Network (CPN). Further meetings had been held with the BHC PPG and feedback had been incorporated into the Consultation Plan and consultation document. The aim was to go out to consultation for six weeks from early next week. The Consultation would be supported by a patient survey, open meetings and a letter to all patients at BHC. The recommendation would be brought to an extraordinary decision making meeting of OPCCC towards the end of March, which was when the BHC contract came to an end. A Transition Plan for the current provider was being developed. The Committee was asked to delegate final approval of the consultation document to the OPCCC Chair, LP and Diane Hedges (OCCG Chief Operating Officer). MP felt advertising in waiting rooms would be a good idea and the use of a patient response box. There was a need to encourage those who used the service to provide feedback and to be proactive with the hard to reach groups. RD suggested the survey could be handed out at the Surgery reception and patients could then complete it whilst waiting for their appointment. JD advised on previous occasions, members of the Primary Care Team had been sent to a practice to speak with patients in the waiting room. JD explained BHC did not feature in the North locality plan as the outcome of the consultation was required before it could be fed into the plan. CM pointed out the consultation addressed the first priority of the plan, ie sustainability of primary care. RD believed the paper did not address proposals for GP streaming services at the Horton Hospital. JD advised she and AG were working with DH on the various options which were being shaped, as it was complicated to involve everything. The consultation document included GP streaming at the Horton and it was hoped the final document would have more detail. In response to a query from CW, JD advised the Consultation Plan had previously been presented to the Committee and HOSC explaining how the consultation would be undertaken, with whom and over what period of time. JD stated the Consultation Plan had been shared with the Committee before being presented to the HOSC and, following feedback, a presentation had been prepared for HOSC and was attached to the paper. The OPCCC agreed: • Delegated approval of the final consultation document to the Chair of OPCCC, the Chief Executive Officer and the Chief Operating Officer • Noted the plans for the consultation	

	• Agreed an extraordinary decision making meeting towards the end of March 2018 the format of which would be decided in due course.	
9.	**Primary Care Quality Dashboard** MP presented Paper 8 updating on the CQC ratings of practices in Oxfordshire. Most practices were either good or outstanding. A meeting had been held with inspectors and they were reviewing their approach, and practices rated good or outstanding were likely to be visited less frequently. OCCG was waiting to hear how this would be implemented. Screening offered in primary care was not directly commissioned by OCCG, although this did not mean OCCG should not be proactive in increasing screening rates. OCCG would be working with the leads in the various organisations to look at how rates could be improved. MP felt it would be good in the long-term for the Federations to pick this up and work with the practices, advising this had worked well in other parts of the country. There was still some work to be undertaken around the health checks, as cervical screening was higher than the national average and this would be followed up with exception reporting; breast screening was above the national average but just below the national target. MP observed practices felt a bit distant from the screening as many patients were sent invitations directly and not via the practice, and this area would be worked on in the next month. CW reported that Hightown PPGs had been invited to help with improving the screening rates in the practices but there were found to be too many confidentiality issues for this to be possible. MP advised there were posters in practices and those who did not attend for an appointment were flagged on the system and highlighted the next time they came in to the practice. CW reminded MP when she had reported on the 2017 GP National Survey, that outliers would be picked up and discussed with practices. He queried whether this work had been undertaken. MP advised the work had not yet commenced as someone had only recently come into post but visits were planned from January. CW suggested practices should be persuaded to include the PPG in the visits. MP agreed and would report back at a future date. KC observed the health check percentages were really low. MP advised it was difficult as this was a low priority for practices and to increase the percentages would require an increase in priority. EDS queried whether there was any correlation between take up and locality. MP advised as the information was not OCCG data, identification of practices was not allowed. It was noted the practices were not in the same order on the dashboards provided and one did not correlate with the other. EDS observed that the Committee was monitoring take-up but not outcomes achieved and it would be good to look at both when reviewing	**MP** **MP**

	the success of screening programmes, although appreciated that this information may be presented in other forum or in the public health report. This would be followed-up. CM requested that MP check whether practice identifiable information relating to screening data could be made public, as it seemed strange that patients and OCCG could not be aware of how individual practices were performing. The OPCCC noted the Primary Care Quality Assurance content and actions.	**MP** **MP**
10	**Finance Report** JS presented Paper 9, the Primary Care Finance Report for Month 8 advising the reported position had not materially changed since the last report. Three main points from the report were: the impact of the additionally prioritised schemes included in the forecast outturn for the first time, which meant the forecast outturn underspend remained the same overall but now fell in different places; the risk around whether the approved schemes would be delivered before the end of the financial year; the 'no cheaper stock obtainable' (NCSO) impact on the prescribing budget. The knock on effect of NCSO issue on the prescribing incentive scheme was not yet known. EDS noted the risk around spend on approved schemes would be picked up in the Finance Committee. JD advised all the schemes had been stratified by high, medium and low risk of being delivered. Most schemes were high or medium. Further checks for assurance around the digitisation of notes and whether the notes could be destroyed once digitalised, was being sought. The destruction of the notes would be to relieve space issues within practices. The OPCCC noted the Month 8 report.	
Governance		
11	**Forward Plan** RD advised it had been suggested consideration should be given to the functioning of the Committee, how it worked, member's roles, the decisions taken and how they were taken, and communication protocols between OPCCC and stakeholders. It was proposed that some of the closed sessions could be used to undertake this work, as well as some 'deep dives' into particular primary care service areas. A couple of areas for 'deep-dive' reviews had already been mentioned: update on the estates paper to understanding the level of resources and funding; and communication. There was a need to wait for the management team to come back with a response on the recommendations made and suggestions as to which meetings should be public and which could be workshop/development sessions. It was felt the earliest facilitated meeting could be the May meeting but there was a need to check quarterly and six monthly reporting cycles. JD and CM would take this forward.	**JD/CM**

	The OPCCC noted the updated Forward Plan and the need for feedback from the management team.	
12	**Risk Register** CM presented Paper 11 and advised two of the three risks on the Primary Care risk register remained red rated: AF26 – Delivery of Primary Care Services; and 789 – Primary Care Estate. It was noted that the workforce risk had been recognised in various papers to the Committee and confirmed a workforce plan, including recommendations to address the challenges primary care faced, would be available at the end of March. JS reported NHSE had indicated there might be some further MIG monies available later this financial year for primary care estate. Information was being collected from practices in order to be prepared for a bid, should monies become available. The OPCCC noted the updates to the risks since its last meeting on 7 November 2017.	
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** 6 March 2018, 14.30 – 16.30, Conference Room A, Jubilee House.	