Oxfordshire
Clinical Commissioning Group

Oxfordshire Clinical Commissioning Group
Board Meeting

Date of Meeting: 29 March 2018	**Paper No: 18/25b**

Title of Paper: Minutes of the Oxfordshire Primary Care Commissioning Committee, 6 March 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:

Engagement and co-production: OCCG will be undertaking a review with key stakeholders on working with the public, which would pick up how and when the public would be engaged, when co-production should be undertaken, and how the public feedback fitted with the decision making structures. The first step would be a workshop at the end of April. All the issues raised by the Committee and in other forums, would be picked up through this work.

Deer Park Referral Assurance Report: The Committee received assurance that OCCG had undertaken the work requested by the Secretary of State. NHSE had stated at the Health Overview and Scrutiny (HoSC) meeting in March that OCCG had met the requirements set upon it. 285 patients had not re-registered and would be allocated to a practice in Witney. A workshop in January involving key stakeholders had discussed the recommendation from the Independent Reconfiguration Panel (IRP) to the Secretary of State in relation to strengthening the working relationship between OCCG and the HOSC. An update would be included in the Chief Executive's Report to the OCCG Board.

Primary Care Schemes 2018/19: The Committee approved the Local Investment Scheme for 2018/19 but a further meeting was required to approve the Locally Commissioned Services before the end of March. The Finance Committee will be reviewing the benefits realised from the proactive medical support to care homes business case. The Committee did not approve the budget setting methodology for the prescribing budget as a further paper setting out the impact for individual practices and providing assurance as to how the financial risk at practice level would be managed, was required.

Prescribing Incentive Scheme (PIS) 2018/19: The Prescribing Incentive Scheme for use in 2018/19 was approved.

Finance Report: OCCG was on plan year to date and the forecast outturn was to be within budget. The biggest risk was further underspend on recently approved schemes.

Deliverables from Locality Place Based Plans: The Committee received an update on the benefits to be delivered from the plans and the deliverability of schemes allocated non-recurrent funding. The Committee requested a further assurance report in relation to the committed non-recurrent schemes, where there was slippage on spend in-year and whether the funding would be still available in 2018/19

Oversight of Quality Performance and Primary Care: The Committee was advised that

Oxfordshire was now in a good position, with all bar one practice being rated by the CQC as 'good' or 'outstanding'. Horsefair Surgery had been removed from 'special measures'.

Financial Implications of Paper:

The Finance Committee on 22 March will consider the implications of in-year slippage of primary care schemes funded from non-recurrent monies and provide further assurance to the Board.

Action Required:

The Chief Executive's Report to the OCCG Board will included further information in relation to strengthening the working relationship between the Oxfordshire HoSC and OCCG.

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:

767: There is a risk that the CCG will take on responsibility for primary care and there could be a need for significant investment. OCCG recognises the requirement to make significant investment in primary care and community services to support transformation of health services in Oxfordshire, and deliver operational and financial sustainability. In 2017/18, OCCG has invested £4.0m in primary care sustainability from a growth in its allocation, with a further £4.0m from national funding. Mitigation - Disinvestment in hospital services and reinvest in integrated community services through the transformation programme, and a 5-10 year mobilisation and investment plan to deliver the Primary Care Framework.

769 – Pressure on primary care capacity. Mitigation – The Primary Care Framework has been published by OCCG and Locality Placed Base Plans are in development to deliver new service models. Further funding from within existing budgets is being made available to support the sustainability of primary care in 2017/18-18/19. These plans will be underpinned by county wide workforce, IT and estates plans.

AF26: Sustainability of primary care impacts on the wider health system. Mitigation – Oxfordshire Transformation Programme, deliver operational and financial sustainability.

Author: Duncan Smith, Lay Member, Chair OPCCC.

Clinical/Executive Lead: Dr Kiren Collison, Clinical Chair, OCCG.

Date of Paper: 15 January 2018

MINUTES:

OXFORDSHIRE PRIMARY CARE COMMISSIONING COMMITTEE (OPCCC)

6 March 2018, 14.30 – 16.30

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)
	Colin Hobbs (CH), Assistant Head of Finance NHSE (for Richard Chapman) (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)
	Chris Wardley (CW), Public/Patient Representative (non-voting)
In attendance:	Lesley Corfield -– Minutes
	Heather Motion (HM), Lead for Medicines Optimisation OCCG – item 7
	Helen Ward (HW), Deputy Director of Quality OCCG – item 10

Apologies	Steve Gooch, Director of Finance NHS England
	Diane Hedges (DH), Chief Operating Officer OCCG (voting)
	Ginny Hope (GH), Head of Primary Care NHSE (non-voting)
	Louise Patten (LP), Chief Executive 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 reported she had been appointed the GP Clinical Lead for Banbury Health Centre.	
2.	**Minutes of the Meeting Held on 2 January 2018** The OPCCC noted the approved minutes of the meeting held on 2 January 2018.	
3.	**Action Tracker** *Locality Place Based Plans: Public Feedback* CM advised on the action linked to the Deer Park Referral Assurance Report paper and the external review by North East London	

	Commissioning Support Unit. OCCG would be undertaking a wider piece on working with the public, which would pick up how and when the public would be engaged, when co-production should be undertaken, and how the public feedback fitted with the decision making structures. The subject had been discussed at the Locality Forum Chairs (LFCs) meeting and with the public member of the Quality Committee. The first step would be a workshop at the end of April*, following which a refreshed approach to public engagement would be built. All the issues raised by the Committee, and in other forums, would be picked up through this work. Two of the LFCs were involved in the planning for the workshop. Members of the Committee attending the workshop would provide assurance back to the Committee. EDS requested the report to be presented to the OCCG Board be brought to the OPCCC for consideration. KC queried whether the two-day workshop being organised by Oxfordshire County Council (OCC) linked to this work. CM advised the workshop organisers were linking with OCC and that the OCC Adult Social Care Team had formally adopted their approach to co-production. Representatives from OCC would be attending the workshop in April. CM advised OCCG did not have a definition of co-production or when it might be used. On looking into a definition it had been discovered different organisations had differing definitions of co-production. All actions were closed and a new action would be created from the output of the work and report to OPCCC. *Locality Place Based Plans: Mobilisation* JS advised the action was still open and could potentially be a large piece of work. She suggested as a first step to look at the delegated budget and primary care budget. EDS reminded the Committee the action was in the context of looking at future investment. The first phase to be brought to the July OPCCC Workshop meeting. *Primary Care Quality Dashboard* MP reported information on those practices to be visited as a result of the GP Survey was contained in Paper 9. Screening data was available by individual practice and a link had been included in Paper 9. The action was closed. *Function of OPCCC* This area would be covered as part of the July workshop meeting. Action closed.	**CM** **CM** **LC/CM** **JS** **LC** **LC**
Commissioning		
4.	**Deer Park Referral Assurance Report** CM presented Paper 3, an update on the outcome of the independent review commissioned by NHS England (NHSE) into the work undertaken by OCCG to develop the West Oxfordshire Locality Plan; the discussion with the Health Overview and Scrutiny Committee (HOSC) and the workshop planned to strengthen the approach to public involvement. The paper was proposed as a final assurance report for OPCCC to sign-off that OCCG had undertaken the work requested by	

	the Secretary of State. CM reminded the Committee of the update provided at the last meeting, when the external report had not been available at that time and this presented report updated that position. The recommendations made would be picked up in the wider piece on involvement referred to above in the Action Tracker section. A presentation had been made to the HOSC. At the meeting three patients had petitioned before the meeting and NHSE had stated in their view, OCCG had met the requirements set upon it and NHSE would work with the CCG to consider the action plan to be put in place to respond to the report's recommendations. At the time of the HOSC meeting, 285 patients had not re-registered and NHSE had advised HOSC that they wished for those patients to be allocated to a practice. A piece of work to allocate patients to the three Witney practices was underway. Details would be provided in the patient's allocation letter on how they could change to another practice if they wished to do so. The primary concern was to ensure that patients had access to a named practice. KC commented at the time Deer Park closed there had been a discussion about whether patients could be allocated to practices but this had not been allowed. She queried why it was now possible to do so. JD explained it was partly patient choice: patients had been given four chances to choose where to re-register and as these particular patients had not done so, they would now be allocated; the decision at the time had also been based on advice from NHSE. For the future, OCCG had now undertaken to allocate patients to another practice after they had been sent three letters. There had been 4,300 patients registered at Deer Park and the latest count showed 279 had not re-registered and these would now be allocated. There had been a discussion with the HOSC at the September 2017 meeting where one member had argued for the allocation of patients but this had not been supported by the rest of the HOSC. JD observed there had been challenge throughout the process and if OCCG had allocated patients earlier in the process, it could have been construed as forcing the closure Part of the learning was that a list clean should have been undertaken earlier in the process, so only those patients registered and had responded, would be asked to reregister. CM advised on the recommendation from the Independent Reconfiguration Panel (IRP) to the Secretary of State in relation to strengthening the working relationship with the HOSC. It had previously been reported a workshop would be held in January. This had been useful and resulted in a good outcome, which had been reported by the HOSC Chair to the February HOSC meeting. The HOSC had agreed all but one of the recommendations from the meeting. The Committee would be provided with a link to the meeting minutes when they were available as part of the April HOSC meeting papers. An update would be included in the Chief Executive's Report to the OCCG Board. CM and JD would pick up with GH a formal response from NHSE confirming they considered OCCG had met the requirements of the IRP, as the agreement had been to set up a follow-up meeting, after which a	**LC** **CM/JD**

	final letter would be issued to close the matter down. NHSE were required under the recommendations to the Secretary of State to commission an independent review. On the basis of that review and discussions with OCCG, NHSE had determined the requirements had been met. **The OPCCC:** • **Noted the outcome of the external review** • **Noted, subject to written confirmation, NHSE had confirmed in their view OCCG had met the recommendations of the IRP** • **Noted the planned workshop to develop and strengthen the OCCG approach to public involvement on 26 April 2018** • **Confirmed the Committee had received adequate assurance OCCG had addressed the recommendations made by the IRP to the Secretary of State.** A report would be brought back to the Committee once it had been agreed with NHSE the basis of the response to the CSU review recommendations and how this would feed into the workshop.	**CM**
5.	**Primary Care Estates Update** JD presented Paper 4 providing an update on minor improvement grant (MIG) investment for 2017/18; estates projects identified as part of the Locality Place Based Plans; prioritisation criteria and rent reviews. JD asked the Committee to note the work undertaken to estimate the impact on revenue costs of rent over the time period to 2031 of approximately an additional £3.5m per annum on an £11.0m budget. JD advised the MIG monies had been allocated to practices. Extracts from the Locality Place Based Plans had been included in the report to detail estate requirements. These would now be prioritised using the primary care estate principles. EDS requested an update on the larger schemes in Bicester, Wantage and Didcot. *Didcot* OCCG was working closely with the Council to secure land on the Great Western Park development for an option for a primary care facility. A reserved matters application was need for July 2018. *Wantage* OCCG was working with the practices, the landlord and Oxford Health NHS Foundation Trust (OHFT) looking at population growth in and around Wantage, and the impact on primary care and community services. The practices were stretched and options to reconfigure the space and provide for the future were being considered. A piece of work was underway to identify the size of primary care estate required. OCCG was working with the practices to encourage integration within the building and to understand from OHFT their accommodation needs going forward. *Bicester* Archus was working closely with OCCG to take the work forward. A land search was being undertaken for potential areas to develop as primary care sites. It was hoped a report would be ready in early April.	

	At the moment OCCG was planning for population growth to 2031 but all plans would need to be flexible to cope with future changes. CW reported the project for Culham also seemed to be making progress. There had been many protests and publicity but it looked likely to receive support although would be referred to the Secretary of State as it was green field land. CW stated the Local Authority was keen for the project to proceed. In response to a query around engagement with County and District Councils, JD advised some areas were more focussed on the 'One Public Estate' initiative than others. One 'Public Estate' was not much of a feature in Wantage but there were regularly meetings with South Oxfordshire and the Vale of White Horse District Councils. A meeting had been held with councillors in Bicester in February. RD commented his query had been more around Council buildings becoming vacant as their staff numbers reduced. JD advised OCC was actively leading on the 'One Public Estate' piece of work. Some site based reviews had been undertaken and better use of facilities was being considered. OCC had submitted a bid on behalf of system to develop the One Public Estate agenda. It was not known if the bid had been successful and this would be picked up outside of the meeting and fed back**. CW commented the report provided a broad view of all the work and the information helped to make a judgement on the future but that there seemed to be two pieces of information missing: timescales; and the additional patient population the plans were designed to accommodate. He stated without this information it was hard to judge if the report provided assurance. EDS advised the numbers and indicative timescale had previously been provided to the Committee but requested the next update provided assurance on three areas: • General governance, reporting and accountability • How 'One Public Estate' fed in or created a framework for the primary care estate development • Process in terms of timetables, keeping key assumptions up to date CM commented this linked with assessing schemes against the principles. JD advised the next piece of work would be prioritising schemes and deciding whether growth in a particular area would be solved by building new premises or providing care through a different model in existing premises. EDS observed there was a danger the Committee might get into too much detail but stressed the need for assurances. He noted the timelines were quite clear on when areas would see increased demand and mitigating solutions needed to prepared. The Committee required assurance on material developments even if the dates were going to move. JD advised the South West Plan was quite detailed. EDS commented OPCCC should be focussed on the material schemes and making sure they met the public care demand. CW expressed concern the Hightown project, which had been due to start in April 2017, had not progressed, as a site had not yet been found	**JD** **JD** **JD**

	and the project accounted for half the money available for this financial year. JD explained this would need to be raised with NHSE as they managed the Estates Transfer and Technology Fund (ETTF) monies. CM advised OCCG had no authority over the ETTF monies. It was an agreement between practices and NHSE, and the practices reported to NHSE. OCCG received a tracking report, which had previously been shared with the Committee. EDS felt the Committee needed assurance around timescales and the risk to patients. CM advised large practice changes had previously been completed and past experience showed that practices coped with population growth and found ways to manage whilst the scheme was developed. Projects did not get to a stage where patients did not receive care. Premises were not used every hour of every day and it was possible to provide more care by changing procedures within a practice. JD advised that her report contained information on Hightown Surgery requesting to close its list, which would help to mitigate issues arising from the delay. EDS observed that it was legitimate for concerns to be raised through the OPCCC and stated there was a need for assurance on mitigation against delays with the scheme and any risk to patients. He wished this to be reported back for recording in the minutes of the next meeting. **The OPCCC noted the contents of the paper, the next steps, and that progress reports on the actions identified would be brought to future meetings.**	**GH**
6.	**Primary Care Schemes 2018/19** JD presented Paper 5 providing progress to date on the primary care schemes/funding streams for 2018/19. Efforts were being made to be more proactive on the Locally Commissioned Services (LCS) and achieve 100% population coverage. Previously practices had been allowed to choose if they signed up to an LCS. The choice would remain but if some practices in an area had not signed up, other arrangements would be put in place to ensure patients had access via a different route or practice. A few changes to the LCS had been suggested on page 4 of the document but most remained unchanged as they had been commissioned for a two year period. Some Read Codes were changing and these would need to be altered in year. Three schemes were not yet ready for approval: proactive medical support to care homes; deprivation; and diabetes. It was proposed to agree the deprivation and diabetes services via a virtual meeting of OPCCC. The proactive medical support to care homes LCS was still under scrutiny by the Finance Committee to ensure it delivered value for money. OPCCC was being asked to approve the changes recorded in the paper; approval by virtual meeting of the deprivation and diabetes LCS; and approval of delegation to the Finance Committee to approve the proactive medical support to care homes LCS. CW commented that care homes had been discussed at the OCCG Board meeting in Thame and there had been a suggestion further investigation was required on quality of care. EDS advised the suggestion around the care homes business case had been from a financial aspect, reviewing whether the scheme had delivered the projected benefits and whether the scheme provided value for money. EDS had proposed a ‘deep dive’ in a closed session of the Committee but the Chief Executive had suggested it should be a bigger piece in	

	terms of the whole pathway. CM explained the Finance Committee would review what the scheme had been set up to do, what it had been set up to deliver, whether it was delivering, the fact the scheme did not cover all the nursing homes in Oxfordshire and if OCCG should wish it to continue to roll-out the scheme. EDS advised the Finance Committee would undertake a review and OPCCC could also review the report to the Finance Committee in its first closed session. RD noted an underspend in Appendix 1 of £706k and queried whether this would be carried forward into 2018/19 and not lost from the budget. JD advised some of the £706k had been released into funding non-recurrent Locality Place Based Plans for the current year and the budget for 2018/19 would be the same as 2017/18. RD questioned if it was known early enough in the next year that the budget would not be spent, whether OPCCC could decide where it should be re-allocated. CM confirmed the Committee could decide how the monies were spent, as once the budget had been set by the OCCG Board, OPCCC could reallocate within it unless the OCCG Board froze the monies. CW queried the extent to which patient experience was taken into account, commenting if a decision were to be taken to spend more or less money on a particular service, whether the views of the patients should be taken into account around if it 'was' or 'was not' a good service. EDS felt this was a good question for the workshop on 26 April to consider. **The OPCCC:** • **Noted the work in progress and the virtual meeting required to sign off Locally Commissioned Services before the end of March. Two papers and a recommendation would be circulated to the Committee** • **Supported the strengthening of approach to achieve population coverage as per the Care Quality Commission local system review** • **Approved the following Locally Commissioned Services for 2018/19, in line with the recommendations stated:** ▪ **Near patient testing (no change)** ▪ **Arrhythmia diagnosis** ▪ **DVT testing** ▪ **Primary Care Memory assessment** • **Noted a paper would be presented to the Finance Committee on the proactive medical support to care homes looking at the original benefits realisation part of the business case. The scope for the Committee 'deep dive' would be agreed and the paper would then be made available to OPCCC if the Finance Committee agreed to continue the scheme. A suggestion to compare to arrangements in other areas and the need to approve a process for agreeing the scope of the 'deep dive' was noted** • **Approved the Local Investment Scheme for 2018/19. It was noted the outcome of the 2017/18 schemes would come later in the year and would inform schemes for 2019/20** • **Did not approve the budget setting methodology for the prescribing budget as a further paper setting out the impact**	**JD** **JD**

	for individual practices and providing assurance as to how the financial risk at practice level would be managed, was required. This paper would be provide to members and a final decision would be undertaken via a virtual meeting of OPCCC • **Noted the further details of the Prescribing Incentive Scheme provided in the next paper**	**JS**
7.	**Prescribing Incentive Scheme (PIS) 2018/19** Heather Motion attended the meeting for this item and presented Paper 6. EDS welcomed HM to the meeting, thanked her for an informative paper, proposed she should take the paper as read and invited her to highlight anything she wanted to bring to the attention to the Committee and update from the CCG Executive review of the paper. HM advised the scheme had been different in 2017/18 and would revert to a more familiar format for 2018/19. The scheme had four elements, with delivery of element one being the trigger for payment for the whole of scheme. An option had been agreed with the Director of Finance for the first element to be measured at practice or locality level. An improvement in the resources and support to help practices achieve had also been put in place. The funding set aside was about £600k and full payment if practices achieved the scheme would be 80p per patient. The feedback from the CCG Executive had been positive, with only one suggested change: with measurement moving from locality to practice for the first element, ie it would be necessary to be in budget to achieve the gateway. MP remarked that some practices were always overspent and queried how they could be incentivised to undertake other elements of the scheme. HM advised the new budget setting model would be an influence. It was also possible to apply a cap and collar and discussions had taken place around sense checking. It was felt if the new model was used it would provide more assurance around budget setting to practices. The deadline for sign up was usually within the first couple of months of the new financial year. HM reported the impact of the 'no cheaper stock obtainable' (NCSO) issue was beginning to tail off. CCGs had been informed in the planning guidance to not factor NCSO into budgets for next year. CM advised in terms of achievement by practices, there was a clause around exceptional circumstances outside the control of a practice and NCSO fell within this category and practices would not be penalised. CW queried to what extent the PIS was a nuisance for practices and did not add to patient care. KC reported the PIS was generally well received by practices as it highlighted areas where improvements to prescribing could be made. CM pointed out elements two, three and four of the scheme all related to high quality prescribing. Practices had bought into the scheme for years, which indicated continued support. MP added that it was not possible to fudge the numbers and practices had to prove they had done the work and achieved the savings. KC advised practices could directly see what they did had an impact and by	

	doing something it changed behaviour. HM advised the more expensive flu vaccine had been submitted as part of the budget and would be taken into consideration although OCCG had been told NHSE would be making a payment towards the cost. RD queried how successful the scheme had been in 2017/18 and what percentage of the £600k cost had been reached. HM advised the exact figures were not yet available but the estimated target was £2.5m. It would not be known until the end of the year the level that would be achieved, which made it difficult to assess at this stage. JS reported at Month 10, in terms of outcome forecasting, the figure was £750k. CW requested future papers should contain some context to the previous year. EDS reminded the Committee this information was supplied in the Annual Review received in the summer but commented the detail could have been forgotten by members 6 months on when the Committee was asked to sign-off the budget, therefore supported the recommendation. EDS expressed surprise there was not an Oxfordshire policy on repeat prescribing. HM explained it had been found that each practice worked slightly differently and wanted something more tailored on the management of repeat prescribing. There were a number of tools available but this year, work was underway with practices on a consistent approach, whilst allowing them to tailor to their practices processes. HM advised the prescribing team linked with the Local Pharmaceutical Committee and worked closely with pharmacies. **The OPCCC:** • **Considered the proposed Prescribing Incentive Scheme for 2018/19** • **Supported the recommendation from the CCG Executive to measure element one at practice or locality level and agreed the amendment** • **Approved the Prescribing Incentive Scheme for use in 2018/19.**	
8.	**Finance Report** EDS observed the paper for Agreement of Budgets 2018/19 had not been received. JS apologised, explaining the issues and advised it would be circulated for virtual sign off by the Committee. The first draft was expected to be ready on 8 March for final sign off on 30 March 2018. JS presented Paper 7 on the financial performance of the CCG Primary Care budgets to Month 10 (January) 2017/18 financial year. The OCCG was reporting to be on plan year to date and forecast outturn. The biggest risk was further underspend on schemes. Schemes had been approved in November but there had been difficulty in getting the schemes off the ground. There would be a review of the position and schemes approved before the year end and an update provided to the Finance Committee. RD expressed concern that the underspends would not be carried	**JS** **JS**

	forward and available in 2018/19. **The OPCCC noted the Primary Care Finance Report Month 10.**	
9.	**Deliverables from Locality Place Based Plans** JD presented Paper 8 describing the progress made with the Locality Place Based Plans; the benefits of the plans and the deliverability on the non-recurrent funding spend. Each project had a charter to detail the benefits to be realised. The paper provided the status as at the end of February 2018 and highlighted that a number of schemes would not start in 2017/18 and would look to commence in 2018/19. A key scheme was the digitalisation of patient notes but there was concern the actual notes could not be destroyed and there was a need to deal with the governance issues. The matter was being considered at a national level. A public facing version of the plans had previously been discussed by the Committee. It had been hoped these would be available by the end of February but this timeline had slipped. A meeting had been held with one of the LFCs to try and shape the format of public facing plans so that they would be more accessible and understandable, and the work was now moving forward. EDS queried the meaning behind the key to the table on page 5 and whether a 'green' box meant funding had been committed, services commissioned or money spent. JD advised it meant money going out in the current year. JS advised it was not possible to give full assurance all the underspend could be carried forward although there were some safeguards to enable carry forward. MP raised concerns around the £400k for digitalisation of patient notes and the delay with the scheme as it was a large amount of funding to lose if it could not be carried forward. EDS stated the Committee recognised the concerns at the potential underspend and the risk this posed and wished to have assurance from the Director of Finance the funds would be available for 2018/19. He requested a report to the Audit Committee in April and a report back to OPCCC. JS remarked on the need to agree non-recurrent schemes earlier in the year. CM added as the schemes were all priorities through the Locality Place Based Plans and it was reasonable to assume they could be taken forward. CW pointed out that in relation to the £600k for mental health workers there appeared to be some uncertainty and confusion on the options open for practices and that there was already national funding. JD advised she was unaware of any NHSE money for mental health workers and with regard to the practice options, there were two proposals to Localities: one followed the model in the North and the other used a charity to support patients, and to direct them through the services. Each locality considered which option it wished to take up. The issue was what would happen at the end of the financial year, as the money was non-recurrent. The Localities had submitted proposals	**JS**

	on the option they wished to take forward and the money had been committed but not yet spent. MP referred again to the digitalisation of patient notes and queried if the delay was a national issue whether the money could be transferred to another area. EDS advised a process had been followed to allocate the non-recurrent funding but the Committee had the delegated power to agree budget virements. **The OPCCC:** • **Noted the progress made** • **Noted the project benefits to be realised** • **Noted the plans for spending the non-recurrent funding** • **Requested a further assurance report in relation to the committed non-recurrent schemes where there was slippage on spend in-year and whether the funding would be still available in 2018/19** JD advised update reports would be six monthly.	**JS** **JD**
10	**Oversight of Quality Performance and Primary Care** Helen Ward attended the meeting for this item and presented Paper 9 on how OCCG managed and addressed quality in its commissioned services. She advised the proposal was to present a high level report to the OPCCC with detailed work being undertaken at a working group of the quality and primary care teams to inform areas taken to the Quality Committee. HW advised Oxfordshire was now in a good position with all bar one practice being rated by the CQC as 'good' or 'outstanding'. Practices would be supported for scheduled visits and the strong base would be used to do more quality improvement work. CW stated an area the Committee should seek assurance on from the Quality Committee was the extent to which reviews involved patients and their opinions as well as at practice level with Patient Participation Groups (PPGs). HW advised this came within the areas detailed at the bottom of page 2 around safety, effectiveness and patient experience, GP patient satisfaction survey, the Friends and Family Test as well as complaints and other patient feedback used as sources of information. The Quality Team worked with practices that had not scored well in the last patient survey on how they could improve. CM clarified the point CW had tried to make was around talking to practices or engaging with patients when issues arose. CW stated PPGs ought to be allowed to influence a practices service delivery. A very comprehensive patient survey had been designed and undertaken by a PPG but the practice had said it was not appropriate and they did not have the time to consider it. CW suggested that this issue should be picked up by the Quality Committee and this was supported. HW commented any survey would be welcomed as feedback. CM advised the question being asked was how the patient experience element would be increased in the work of the Quality Team. HW advised it could be added to the list of information requested from practices and, if the PPG were happy to do so, the Quality Team could meet with them. EDS suggested this could be explored further at a closed session and	**HW**

	HW and the Director of Quality could be invited to attend. JD felt it could be picked up at the workshop in April as it should not be taken in isolation. EDS added the approach would strengthen the governance. CM felt it was important to emphasise the first principle was improving quality and supporting practices to deliver high quality care. EDS was anxious not to lose the excellent quality dashboard that had been created for the Committee and queried whether that would continue to come to the OPCCC or be presented to the Quality Committee. To be discussed outside of the meeting. EDS expressed some anxiety in terms of conflict of interest for the Quality Team when supporting primary care with issues and queried whether there would be some mechanism to ensure an independent assurance was available in all cases where there was concern about a practice. To be picked up by the Quality Committee. Three members of OPCCC were members of the Quality Committee which would create a link between the Committees.	**JD/MP** **MP**
Governance		
11	**Deputy Director, Head of Primary Care and Localities Report** JD presented Paper 9, her report covering January and February 2018 and advised Horsefair Surgery had been removed from 'special measures' and Hightown had applied to close its list, which related to the lifting of the moratorium to discourage inter-practice transfers due to staffing and estates issues, and the request had been approved. OCCG had performed reasonably well in the NHSE Improvement and Assessment Framework (IAF), although there were a few exceptions which were being addressed. An Internal audit of delegated commissioning had been undertaken and a number of the recommendations related to the Locality Place Based Plans, which had not been fully developed at the time of the audit. EDS queried the IAF work in terms of the GP Learning Disability Register. JD advised OCCG was ensuring the GP Learning Disability Register was complete. It had been included in the Local Investment Scheme (LIS) for 2017/18 and it was intended to also be included in the LIS for 2018/19. It was hoped the 2017/18 data would show an improvement. OCCG was generally a low prescriber of antimicrobials but this meant when they were used, they were broad spectrum antimicrobials. This had also been included in the PIS or LCS which would hopefully address the issue. JD confirmed the Prior Information Notice (PIN) seeking a provider of services from Banbury Health Centre had been issued. The deadline for responses was mid-February. Work was underway with procurement to understand the next steps. **The OPCCC noted the report from the Deputy Director, Head of Primary Care and Localities for January and February 2018 and the**	

	Internal Audit Report, together with its recommendations.	
12	**Forward Plan** JD presented Paper 10 advising that the July 2018 and January 2019 meetings were proposed as workshop sessions. The July workshop would consider the functions of the Committee with the possibility of an external facilitator to aid discussion. EDS proposed as a group, the discussion should be about how the Committee functions and roles of the members, and training required. EDS requested members to advise LC of any specific areas for discussion in the workshop, what they would hope to get out of a workshop and in relation to 'deep dives', and how it would help the Committee to discharge its duties and responsibilities. He felt some external facilitation would be helpful.	**All**
	In addition to the functions of the Committee, CM suggested a follow-up of the locality funding allocations (as highlighted earlier in the meeting) discussion and RD suggested that there would be value in returning to the issues of communications and engagement. It was noted that the session would only be two hours and to include both areas may be too much for the time available but the agenda would be reviewed with the Chair.	**JD**
	CW queried whether the suggestion of a second Public/Patient Representative would be taken up. CM advised this would form part of the wider engagement work as OPCCC was not the only Committee with a public member. EDS clarified there would be a normal public meeting in May, where the agenda for the July workshop session would be approved. He commented the facilitator should be involved in the agenda setting. The proposals for the workshop session to be circulated before the next meeting. MP suggested the session should also consider expectations from each other as well as individual roles. **The OPCCC noted the updated Forward Plan.**	
13	**Risk Register** CM presented Paper 11 advising the report was in the normal format. CM reported the Audit Committee and the Directors Risk Review had considered the rating of AF26 should be reduced. Horsefair Surgery was no longer rated as 'inadequate' and plans were in place for the future of healthcare in Banbury. The proposal was to reduce the rating to 16 if the Committee agreed. EDS observed there was very different feedback on this risk depending on the area of Oxfordshire. OCCG had successfully managed some significant challenges, actively built some resilience at scale, there was now a strategic framework, and additional monies were available to support sustainability, although recognising that a clear workforce plan was still required if we were going to effectively mitigate this high risk. From the work undertaken, EDS felt the risk was no longer such a high level. MP felt it should be noted that Horsefair coming out of special measures	

	was not an insignificant achievement. KC queried whether there was any other practical support which could be given to practices. She observed support had been given to practice managers in the past and wondered if there was any help that could be given to make businesses leaner. CM advised the Directors Risk Review had also considered the Primary Care Estate risk and felt that until a more strategic plan was in place, the risk should remain 'red' rated but once the strategic plan was available the risk could be reduced. **The OPCCC noted the updates to risks since its last meeting on 2 January 2018. The OPCCC agreed with the Executive Team that the rating of risk AF26, Delivery of Primary Care Services, should be reduced but recognised that this risk was still assessed as unacceptably high and the workforce strategy and plans were urgently required to mitigate the risk. The rating of risk 789, Primary Care Estate, be reduced once an estate strategic plan was in place.**	**CM**
For Information		
14	**Confirmation of Meeting Quorum and Note of Any Decisions Requiring Ratification** It was confirmed the meeting was quorate and no decisions required ratification.	
15	**Any Other Business** There being no other business the meeting was closed.	
16	**Date of Next Meeting** 1 May 2018	

* Subsequent to the meeting it was advised the workshop had been postponed.

**Subsequent to the meeting JD advised the OCC bid on behalf of the system to develop the One Public Estate agenda had been successful.