NHS
Oxfordshire
Clinical Commissioning Group

Oxfordshire Clinical Commissioning Group
Board Meeting

Date of Meeting: 25 May 2017	**Paper No: 17/39c**

Title of Paper: Minutes of the Oxfordshire Primary Care Commissioning Committee, 2 May 2017

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:

Deer Park Medical Centre, Witney: The practice closed at the end of March. There were still 700 ex-practice patients that had not registered with another practice but the local practices were all reporting they were able to manage these patients. Feedback from the Secretary of State on the initial assessment undertaken by the Independent Reconfiguration Panel, as a result of the referral by the Oxfordshire Joint Health Overview and Scrutiny Committee, was still awaited.

Kennington Health Centre: Botley Medical Centre successfully took over the running of Kennington Health Centre on 1 April.

Additional investment: The CCG has invested a further £4.0m in a sustainable and transformational primary care. The Primary Care Visiting Service had been well received and the locality-based Hubs have provided additional appointments. Performance of the Hubs was strong in the North East and West localities but there was some slippage against plan in the North locality, because of workforce challenges although March data showed an improvement in capacity. The Committee will review the take-up of the additional capacity by patients at its next meeting, when it is hoped data from OxFed will also be available.

Enhanced diabetes service and a service to improve outcomes around deprivation and inequalities: The Committee approved a £472k reinvestment of PMS premium in these new services.

Local investment scheme for 2017/18: The Committee approved a £1.2m scheme for 2017/18.

Prescribing Incentive Scheme: The Committee approved the 2017/18 Incentive Scheme, which aims to deliver savings of £1.5m, however, there is also opportunity for additional savings through agreement of individual practice plans. Practices will have to submit and have approved, their Medicines Optimisation Benefit Share Plan.

Primary Care Framework: The Committee was briefed on the next steps in relation to the delivery of the Primary Care Framework. The 6 localities are being asked to develop their plans and the Committee was looking for these to be co-produced with the public, patients and other key stakeholders. The CCG is planning to stage wider

engagement events later in the production process and the Committee had a constructive discussion in relation to patient participation groups and patient forum engagement.

GP Forward View (GPFV): Good feedback has been received from NHS England on the CCG's plans. There is a requirement to publish these but the CCG has already published its Primary Care Framework, which encapsulated the GPFV.

GP Access Fund: The Committee received an update on the use of this national funding stream and noted that there was a need to increase the utilisation rate (currently 70%) before building additional capacity but also recognised the need to promote the new services to patients.

Work Force Plan: The Committee supported the invest of £345k and mobilisation of a short-term plan to support recruitment of GPs in Oxfordshire and noted the next stage in the development of the plan, was to address issues in the wider primary care workforce, especially in related to practice nursing.

Finance Report: The delegated commissioning budget was forecast to be on plan and delivered the required £535k underspend.

Risk Registers: The Committee was advised that three out of five partners at Horsefair Surgery in Banbury had resigned and the CCG was working with the remaining partners to ensure sustainability of the practice going forward.

Terms of Reference (ToR): The Committee reviewed its ToR and minor changes were made. A track changed version of the ToR is attached to the minutes as Appendix A for ratification by the Board.

Financial Implications of Paper:
There were no further financial implications arising from the work of OPCCC.

Action Required:
The Committees annual report was approved and will be presented to the Board.
The Board is asked to ratify the amended Terms of Reference for the OPCCC.
There are no further actions for the Board arising from this 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:
The OPCCC has oversight of the following primary care risks
AF 26 – Delivery of Primary Care
767 – GP Primary Care – Finance
769 – Primary Care capacity
789 – Primary Care estate

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

Clinical / Executive Lead: Dr Joe McManners, Clinical Chair

Date of Paper: 8 May 2017

MINUTES:

OXFORDSHIRE PRIMARY CARE COMMISSIONING COMMITTEE (OPCCC)

2 May 2017, 15.00 – 16.30

Conference Room A, Jubilee House, OX4 4LH

Present:	Duncan Smith (EDS), Lay Member OCCG (voting) – Chair
	Julie Dandridge (JD), Deputy Director, Head of Primary Care and Localities OCCG (non-voting)
	Roger Dickinson (RD), Lay Vice Chair OCCG (voting)
	Diane Hedges (DH), Chief Operating Officer OCCG (voting)
	Ginny Hope (GH), Head of Primary Care NHSE (non-voting)
	Colin Hobbs (CH), Assistant Head of Finance NHSE (for Richard Chapman) (non-voting)
	Dr Joe McManners (JM), Clinical Chair OCCG (voting)
	Catherine Mountford (CM), Director of Governance OCCG (voting)
	Rosalind Pearce (RP), Healthwatch (non-voting)
	Jenny Simpson (JS), Deputy Director of Finance OCCG (non-voting)
	David Smith (DS), Chief Executive OCCG (voting)
	Chris Wardley (CW), Patient Advisory Group for Primary Care Chair (non-voting)
In attendance:	Lesley Corfield - Minutes
	Heather Motion (HM), Lead for Medicines Optimisation OCCG – Item 5

Apologies	Richard Chapman (RC), Director of Finance NHS England
	Dr Meenu Paul (MP), Assistant Clinical Director Quality OCCG (voting)
	Dr Paul Roblin (PR), Chief Executive Berkshire, Buckinghamshire and Oxfordshire Local Medical Committee (non-voting)

		Action
1.	**Declarations of Interest** There were no declarations of interest relating to agenda papers.	
2.	**Minutes of the Meeting Held on 28 February 2017** The approved minutes from the meeting held on 28 February 2017 were noted.	

3.	**Action Tracker** *Head of Primary Care and Localities Report: Schematic* The schematic was anticipated for the autumn as it would be populated with the work undertaken on the locality place based plans. *Head of Primary Care and Localities Report: Level of assurance around initiatives* It was agreed this item would be closed as this was monitored through review of the reports to the meeting. *Head of Primary Care and Localities Report: Involvement of patients in contract meetings* This would be discussed with Hannah Mills, Head of Contracts and Procurement, and JD would report to the next meeting. *Head of Primary Care and Localities Report: Involvement of Patients and the Public* A discussion had been held at the last Locality Forum Chairs (LFCs) meeting, where Healthwatch had also been an attendee, around involvement of patients and the public in the Primary Care Framework work and this aspect was being developed. Patient and public involvement was included within the Delivery of the Primary Care Framework paper later on the agenda. *Learning from the first nine months of delegated commissioning: publicising good aspects of OCCG work* CM advised some aspects had been included in the Annual Report and a piece on primary care would be separately produced. The item was closed. *Primary Care Priorities: GP Forward View (GPFV)* A more detailed specification for the GPFV on-line consultation was expected. GH reported guidance from the National team was still awaited. *Primary Care Infrastructure* Other opportunities for funding improvement in infrastructure had been discussed with Gareth Kenworthy, OCCG Director of Finance. Scoping, in which NHS Property Services were involved, was underway and a paper would be brought to a future meeting. In addition a paper detailing primary care estate requirements for large housing developments was being developed. Once agreed this could be shared with developers and planners on the health implications of such developments. It was expected this paper would come to the next meeting. *Finance Report* JS offered to circulate a table from the technical guidance on business rules explaining the surplus requirements. CH reported he had met with Gareth Kenworthy, OCCG Director of Finance and JD to discuss the reserves. He explained at the planning stage, it had been believed the delegated budget required a surplus but this was not the case. However, the pay award to GPs had exceeded the budget and the surplus had offset the extra amount. JS reported the budget had been signed off at the February OPCCC meeting, the overall plan signed off at the March Finance Committee, submitted to NHS England (NHSE) on 30 March and the budget would be uploaded on to the system. The	**JD** **JD** **JD**

	specific changes around the primary care budget and the GP pay award would be reflected in the Month 2 Report. It was agreed a paper would be submitted to the Finance Committee to update on the changes to the budget and confirm the surplus position. *Primary Care Dashboard* JD explained the Dashboard was being further developed. It was hoped to present to the Quality Committee to enable further shaping before coming back to OPCCC. EDS expressed concern OPCCC had been meeting for a year but was not yet receiving a comprehensive performance report. He stated a report was required for the July meeting. DH explained it was for OCCG to design the quality indicators and this would be picked up outside of the meeting. *Forward Planner* The action was closed.	**JS** **JS** **DH/JD**
Commissioning		
4.	**Deputy Director, Head of Primary Care and Localities Report** JD presented Paper 3, her report updating the Committee on Primary Care in Oxfordshire. JD highlighted the electronic approval by virtual Committee of the reinvestment of the PMS premium, the local investment scheme for 2017/18 and the commissioned services for the next year. JD reported Deer Park Medical Centre, Witney, had closed at the end of March. The number of patients still currently unregistered with other practices was around 700. Arrangements had been made for the electronic records to remain online for six months but there was the possibility to extend this time period if necessary. The local practices were all reporting they were able to manage the remaining 700 patients. Feedback from the Secretary of State on the initial assessment undertaken by the Independent Reconfiguration Panel, as a result of the referral by the Oxfordshire Joint Health Overview and Scrutiny Committee (HOSC), was still awaited. It was anticipated this would be delayed due to purdah following the announcement of the General Election. Healthwatch had held a meeting with representatives from Deer Park Patient Participation Group (PPG) and the CCG. A stakeholder engagement event was being planned for June on primary care services for Witney. The additional support to practices would continue for another three months post transfer. JD advised practices had recruited additional clinical staff. RP advised Healthwatch had received a Freedom of Information (FOI) request on Deer Park Medical Centre. It was confirmed OCCG was also in receipt of an FOI request. CW reported concerns had been expressed during the West Oxfordshire Locality Group meeting around the universal telephone number not being answered. He had requested details by email but these had not yet been received. CM advised the number was only manned during office hours but all calls received should have resulted in an email communication. She would raise the issue with Sula Wiltshire, OCCG Director of Quality, but would need the specific details.	**CW/CM**

	JD requested the Committee note Botley Medical Centre had successfully taken over the running of Kennington Health Centre on 1 April 2017 and the practice was operating well. JD drew attention to the commissioned services and in particular the Near Patient Testing locally commissioned service where a review had revealed a number of Shared Care Protocols had been omitted, resulting in the primary care workload not previously being funded. Work had been undertaken and some funding from within the prescribing budget contingency of the region of £126k would be required to fund this service. With regard to investment for a sustainable and transformational primary care, JD reported: • The Primary Care Visiting Service had been well received • Locality-based Hubs provided appointments additional to the quotas under the GP Access Fund (GPAF). Performance in the North East and West had been strong but there had been under provision in the North. This situation was being monitored and March showed an improvement in provision for the North • Utilising GPFU funding, a course on medical terminology had been commissioned starting at the end of April. Over 200 receptionists and staff had already signed up for the course and it was possible to take up to 400 people. JM reported he had met the Oxford West and Abingdon MP who had been complimentary about the work undertaken for Kennington Health Centre. With regard to the transformational work, he queried the lack of data from OxFed. JD explained data was still awaited, advising OxFed reported they were still in the planning stage. It was hoped to be able to bring a more detailed report to the next meeting. JD also confirmed the resilience funding allocation was reducing year on year. The Committee noted the blanks (XXXs) under Priority Two on page 11 remained. GH would check with NHS Digital when the information was expected. EDS summarised: the Committee had taken a decision and approved the £126k additional funding for Near Patient Testing; more assurance around the OxFed Hub performance would be provided to the July meeting; further assurance in relation to the North locality hub overcoming workforce issues would be supplied with hopefully two to three months data being available to provide that assurance at the next meeting. JD commented appointments were being provided but not utilised and this needed to be picked up. **The Primary Care Commissioning Committee:** • **Noted the report** • **Noted the electronic approval of the:**	**GH**

	○ **Reinvestment of PMS premium in an enhanced diabetes service and a service to improve outcomes around deprivation and inequalities** ○ **Local investment scheme for 2017/18** ○ **Commissioned services for 2017/18 to remained as 2016/17 with the exception of:** ▪ **The planned termination of the 1 year diabetes longer appointment** ▪ **Changes to the warfarin service** • **Approved the addition of more drugs to the Near Patient Testing commissioned service and £126k from the prescribing budget contingency.**	
5.	**Prescribing Incentive Scheme** As a partner at Manor Surgery, JM declared an interest in this item. Heather Motion (HM), OCCG Lead for Medicines Optimisation attended for this item. DH introduced Paper 4, the Prescribing Incentive Scheme. HM advised feedback had been received from GPs within the organisation, representing the GPs in primary care around having the freedom to address areas they had identified for savings. The Incentive Scheme offered this freedom. On paper, the Scheme was complicated as a number of criteria were required to ensure the Scheme and risks were managed. As a result, the Scheme was slightly different to previous years. A three page summary version had been issued to practices, together with baseline data and savings opportunities. The deadline for expressions of interest from practices had been put back by a week. Practices were required to achieve a minimum saving equivalent to £2.00 per patient and this figure was confirmed as being in the financial year. DH reported feedback had been received from the Local Medical Committee (LMC) in terms of not sharing the scheme with the LMC at an early stage. This had been acknowledged and accepted as an error by OCCG and processes were being reinforced to ensure in future LMC were involved from an early stage. The CCG Executive (the Executive Team, Locality Clinical Directors and Clinical Chair) had discussed the complexity of the Scheme and whether to continue. The CCG Executive acknowledged the reservations from the LMC but decided the Scheme should be continued. As he was unable to be present at the meeting, PR had circulated an email to Committee members highlighting the LMC reservations and advising the Oxfordshire LMC had RAG rated the Prescribing Incentive Scheme as 'red'. CW queried the advantages of some practices employing their own clinical pharmacists. HM advised if the resources were available practices could employ a clinical pharmacist and this could be of benefit to the practice in achieving the target. The premise was that the pharmacist would release GP time. She added that the Medicines Optimisation Team also provided information around switching from	

	branded to generic drugs, which could be provided to all practices. JM observed if investment was made for a pharmacist to work in a practice, they were able to work with patients to reduce drug usage. It was possible for the savings achieved by these reviews to cover the cost of the pharmacist. DH reported another observation from the LMC concerned confidence in the Scheme to allow practices to undertake what was needed to achieve savings. She advised the Medicines Optimisation Team would be working with practices. HM observed the data released was not different or new to work previously undertaken with the practices and it was hoped this would offer reassurance. If themes emerged from the information received from practices, the Medicines Optimisation Team would look at targeted support. Currently support was led through the offering of advice. To date, just over half the practices had submitted expressions of interest. In terms of how the Prescribing Incentive Scheme would be of benefit to patients, HM advised some menu items would involve a patient review to ensure they were on the best medication for their circumstances. The savings would come to both OCCG and practices. The practices would need to submit a plan to OCCG on how the monies saved would be spent to benefit patient care. EDS noted the Committee had received some assurances in relation to the issues raised by the LMC. EDS requested an update on-sign up to the Scheme was reported to the Committee through the Head of Primary Care and Localities Report. **The Primary Care Commissioning Committee approved the Prescribing Incentive Scheme.**	**JD**
6.	**Delivery of Primary Care Framework** JD presented Paper 5, Delivery of the Primary Care Framework, advising the paper detailed the next steps for delivery of the Framework in terms of roll out of the plan and development across the Localities to produce six locality based plans; how the public would be involved in development of the plans, as discussed with the LFCs at the meeting last week; together with how more engagement could be achieved. Locality discussion commenced in April at a high level but should become more detailed going forward. There would be a need to consider some external support to help shape the six plans. RP observed there was recognition that not all PPGs engaged with their Forum and queried how this could be supported and resourced. JD advised work was underway with the Communications Team on how to develop and engage with each Forum. Initially this would be through Locality meetings but it was planned to hold wider engagement events in late summer. CW was disappointed the LFCs meeting had not produced an action	

	plan for the LFCs. JD advised engagement was an item on each locality fora meeting agenda and OCCG would be working with each locality to determine what was best for each area. CW commented the communications plan was key and would need to be practice based and patient focussed to ensure they were engaged and felt they had been consulted. JM felt there was a need for the engagement to be wider than a patient representative at a Locality meeting or a Forum chair and there might be a need to pick up on consistency across the Localities. JD advised an event would take place in each Locality. CW stated engagement needed to take place both at an early stage and later, as plans progressed. CM remarked on the need to ensure the right engagement in terms of how it was handled, resources managed, purdah implications and in line with other engagement events for Phase 2 of the consultation. DH reported there were requirements of the national urgent care programme, which included some timeframes requiring OCCG to undertake a gap analysis around urgent treatment centres by the end of June, for implementation in October. Out of Hours services and GP Access would need to align with current Minor Injury Units and the future Emergency Access Units. JD stated there was a need to link with the Oxfordshire Transformation Programme team to consider the implications. It was commented that Primary Care Streaming was supposed to be up and running by the end of October. CW queried how the 111 service fitted with the requirement. DH advised the Urgent Care Network expected directly bookable appointments from the 111 service. EDS recapped the discussion: the Committee supported the proposal to engage external support to help shape the Locality based plans; noted concerns around engagement, the timetable for engagement suggesting some earlier engagement and the need for work around the treatment centres. EDS also noted the linkage to Paper 6 and queried whether Localities would be asked to look at how specialists fitted with Locality Teams. JD advised this was a focus within the planned care workstream rather than within the Framework and this would include a component looking at both out-reach and in-reach requirements. **The Primary Care Commissioning Committee noted the paper on delivery of the Primary Care Framework.**	
7.	**GP Forward View (GPFV)** JD presented Paper 6a, a summary report on the NHSE assessment of the GPFV plan. EDS requested clarification as the Primary Care Framework had been taken as the plan and encapsulated the GPFV. The OCCG Board had signed off the Framework and OPCCC signed off the submission to GPFV plan to NHSE. JD advised OCCG was awaiting clarification on NHSE expectations, as the Primary Care Framework had already been shared. OCCG was exploring the exact requirements for Oxfordshire rather than the implications for the STP footprint.	

	JD advised the Committee should note the overall NHSE level of assurance, mainly RAG rating the plan 'green'. The 'amber' rated areas were mostly within NHSE control. These two areas, Workforce and Estates, were also on the OPCCC Risk Register. The paper tried to pick up on the feedback from NHSE, particularly around how this would be managed and monitored going forward. CW noted a discrepancy between the infrastructure fund of £1.1m for the Hightown premises and the budget of £2.5m but would raise this outside of the meeting. He declared a personal interest being a patient at Hightown Surgery. JD advised OCCG was well aware that the GP resilience fund at £99k was significantly less than previous years and was considering how best to utilise the money. She commented this was not the only route of funding to support practices but it was a challenge. JD commented on the need for the Committee to be sighted on implementation of the GPFV plan and advised updates would be included in the Head of Primary Care and Localities Report. **The Primary Care Commissioning Committee noted the Summary Report on NHS England Assessment of GPFV Plan and Paper 6b, the letter received from NHS England on the Assessment of GPFV plans for Oxfordshire CCG.**	**JD**
8.	**Streaming to Primary Care in A and E** DH presented Paper 7 on Primary Care Streaming in ED and advised the bid submitted for infrastructure by the John Radcliffe for phase 1 had been unsuccessful. The report had been brought to the OPCCC because primary care streaming would have a big impact on the primary care workforce. The North of the County were taking a more bottom-up approach around the capacity available and then looking at this alongside the urgent care resources at the Horton Hospital. Due to the bid being unsuccessful there would be a need to consider what can be undertaken around primary care management within the ethos of streaming where this was the right route. NHS Improvement (NHSI) had requested a meeting and a date was being sought. **The Primary Care Commissioning Committee noted the report and the challenges relating to the delivery of Primary Care Streaming in ED.**	
9.	**GP Access Performance Report** JD presented Paper 8, and update on GP Access Fund (GPAF) schemes. The paper contained details of appointments, delivery and next steps. In the table on page 3, the appointments required were of 30 minutes per 1000 of population; the Total was the number of appointments offered; and the final figure the number of appointments used by patients. There was a need to increase the utilisation rate before building additional capacity. One issue was the promotion of the service to patients. Every practice needed to highlight the service and	

	the options available to patients. OxFed had not yet submitted data but this should be available for the next meeting. JD advised the c70% utilisation rate was not acceptable and OCCG was investigating the reasons, which could be the booking system or the fact patients did not wish to travel. DH added in regard to the urgent care piece of work, there was also a need to advertise the available slots. JS reported there had been some slippage at the start of the scheme but services should all be up and running and it was expected the budget would be spent. **The Primary Care Commissioning Committee noted the update on GP Access Fund Schemes.**	
10	**Work Force Plan** JD presented Paper 9 on the GP Workforce Plan and advised the paper looked at support in the recruitment of GPs. JD advised the new OCCG website would contain information on working in Oxfordshire and links to other resources would also be available. A scheme via a recruitment agency had also been identified and although there were certain criteria for supporting practices, it was hoped the scheme would increase the GP workforce going forward. The scheme had been undertaken successfully in Lincolnshire and Liverpool. The fee payable, was based on a guaranteed 8-session GPs for 12-month placement. It was recognised this scheme did not address the lack of practice nurses and a process for support was needed or the need for a wider skill mix. RD commented on building the 'Oxfordshire' brand and the workforce page advising there would be value in a 'click through' from practices, which would also provide awareness to patients of the work being undertaken. The point was acknowledged, as well as noting a number of posts were advertised by practices on the LMC on their website. RD observed, if it was intended for the general plan to be published on the website. there should be reference to the A&E changes in Paper 7 and the need for more GPs should be highlighted. Responding to a query as to why GP practices did not brand themselves as being part of OCCG, CM advised practices were members but also independent bodies from whom OCCG commissioned services. **The Primary Care Commissioning Committee:** • **Supported the continued implementation of the GP Workforce Plan** • **Noted the next stage in the development of the local plan to address issues in the wider primary care workforce especially related to Practice Nursing.**	
11	**Finance Report** *Budget Report*	

	JS presented Paper 10, the Finance Report to Month 11 (February 2017) advising the Month 12 figures were not available in time to prepare a report. JS advised OCCG had achieved its target surplus for 2016/17. The delegated commissioning budget was forecast to be on plan and delivered the required £535k underspend. Most variances to budget had been reported previously but there had been a material movement in the Prescribing budget from a forecast breakeven position to an underspend at year end. There had been some slippage in the Sustainability Transformation Fund due to the start date and alternative uses of the funding in line with NHSE guidance had been discussed. CH reported the Section 96 had been included in the admin overspend and was a non-recurrent issue. DH observed due to the Funded Nursing Care issue, it had been a difficult year in relation to spending the monies and with the benefit of hindsight, she believed if in a similar position again a different case would have been made. EDS advised a parallel conversation had been held in the Finance Committee. EDS reported the Finance Committee was expecting a reflections paper to be presented after the year end in relation to the use of reserves, however, JS reported that there were some adverse material movements in month 12 and it was necessary for the CCG to hold reserves and take a prudent approach. It was agreed the Month 12 report would be circulated between meetings. **The Primary Care Commissioning Committee noted the Month 11 report, the updates provided, and considered the risks were being managed effectively.**	**JS**
Governance		
12	**Forward Plan** Any changes to the Forward Plan to be emailed to JD and the Forward Plan updated outside the meeting.	**All/JD**
13	**Risk Register** CM presented Paper 12, the OCCG Primary Care Risk Register, advising the report was in the standard format and there had been some updates since the OCCG Board meeting. The 'extreme' risks remained the same. A revised front sheet, which included a risk section had been implemented for all OCCG committees. CW reported on an announcement on the Horsefair website and queried whether it was correct. JD advised at Horsefair in Banbury, three out of the five partners had resigned and the resignations would become effective around the end of June. OCCG was working with the remaining partners to ensure sustainability of the practice going forward. A meeting was due to take place in two weeks' time, which should provide further assurance.	

	The Primary Care Commissioning Committee: • **Reviewed the changes to the Primary Care Risk Register since the last OCCG Board meeting** • **Noted the three Extreme Risks with risk ratings of 20:** ▪ **769 (Primary Care Capacity)** ▪ **789 (Primary Care Estate)** ▪ **AF26 (Delivery of Primary Care Services).** • **Noted 767 (GP Primary Care – Finance) continued to have an overall High Risk Rating of 12** • **Noted the OPCCC risk register did not present the risks in order of severity.**	
14	**Committee Annual Report** CW suggested the Annual Report should contain more information around the duty of the Committee to involve patients. JD had seen patient involvement as a duty for OCCG and all its committees rather than just the OPCCC but it was agreed some of the work undertaken this year should be reflected in the report. RD observed the fact the meetings of the Committee were in public should be included. DS pointed out the Committee only had responsibility for the oversight of the delegated budget and not responsibility for the budget as stated under the Financial Implications section of the front sheet to the paper. EDS advised the Committee's Annual Report supported the Governance Statement signed by the Chief Executive and the Annual Report would be presented to the OCCG Board. **The Primary Care Commissioning Committee approved the Annual Report subject to the amendments noted above.**	**JD**
15	**Terms of Reference (ToR) Review** CM presented Paper 14, a review of the Committee Terms of Reference, advising the only changes made were to titles of individuals. The ToR had been agreed in April 2016 and was based on the NHSE template. Based on the experience of the last 12 months the Committee was asked to consider: • The Medical Specialist Advisor had become a member of the Quality Committee rather than OPCCC – did the Committee wish to appoint another GP • The County Council had not nominated a representative to attend the Committee– did the Committee wish to continue to recruit a representative or remove the County Council from the attendee list • The NHSE Director representative had always nominated a deputy to attend – this was not reflected in the membership • Whether the Deputy Director of Finance should be a non-voting member • NHSE requirements were for quarterly meeting which had been adopted by most CCGs – did the Committee wish to continue to meet bi-monthly.	

	Point 1: CM questioned what the Committee thought it lacked from the present membership in terms of work over the past year which would require an additional member. The Committee discussed whether it required another GP member; whether this would be an issue in terms of conflict of interest; whether it was appropriate for the Committee to have three GP members; if there was to be an additional role whether this should be from outside the GP base; whether someone with another type of clinical background should be considered; a practice nurse would provide a clinical voice, not be conflicted and might be nearer to patients in terms of communication; the skill mix in the way OCCG thought about primary care. It was suggested that the terms of reference should be amended to include a 'clinical role' and further consideration given to the type of person required.	**CM**
	Point 2: It was agreed to keep a County Council representative as an attendee of the Committee and to remind the County Council of the opportunity after the local elections had taken place. It was observed in view of the importance of social care in health, that a further push should be made for attendance at meetings.	**CM**
	Point 3: It was felt Dr Shahed Ahmad, the Medical Director, would be more appropriate than the Director of Finance and might resolve the need for further clinical input in point 1 above. GH to feedback to NHSE.	**GH**
	Point 4: It was agreed the Deputy Director of Finance should be a non-voting member of the Committee.	**CM**
	Point 5: It was noted most CCGs held quarterly meetings and OPCCC had a greater range of topics presented to the Committee than at those meetings of other CCGs. RD advised he would be happy with a change of the wording to meeting a minimum of four times a year but felt for the time being the meetings needed to remain bimonthly because of the early stage of developing delegated commissioning. EDS commented in terms of the volume of business, he would be reluctant for any increase in business conducted by email. He suggested the Forward Planner should be reviewed with a view to removing some items. CM observed there was something about the way OCCG operated as an organisation in being able to fill the agenda no matter how frequent the meetings. It was agreed the frequency wording in the terms of reference would be amended to a minimum of four meetings a year and consideration would be given to the content of the agenda.	**CM/DH**
	The Primary Care Commissioning Committee agreed the changes to the Committee Terms of Reference as noted in the points above.	
For Information		
16	**NHS England Memorandum of Understanding** DS highlighted the issue of resourcing primary care commissioning	

	functions, requesting the Committee noted no additional monies had been transferred. He advised part of the discussion around the Sustainability and Transformation Plan (STP) was the support that would come to the STP but there would be no extra funding for delegated functions to OCCG. **The Primary Care Commissioning Committee noted the Memorandum of Understanding for Primary Medical Services Support to delegated CCGs.**	
17	**Confirmation of Meeting Quorum and Note of any Decisions Requiring Ratification** It was confirmed the meeting was quorate and no decisions required ratification.	
18	**Any Other Business** *Petition* OPCCC acknowledged receipt of a petition from the local residents of Western Vale in relation to sufficient funding to build facilities to support the population. There being no other business the meeting was closed.	
19	**Date of Next Meeting** 4 July 2017, 15.00 – 16.30, Conference Room A, Jubilee House	

Adjournment to Part II

To consider the motion that representatives of the press and other members of the public be excluded from the remainder of the meeting, having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest (Section 1(2) of the Public Bodies (Admissions to Meetings) Act 1960).

Appendix A

Oxfordshire
Clinical Commissioning Group

Oxfordshire Primary Care Commissioning Committee
Terms of Reference

1 Purpose and statutory framework

In accordance with its statutory powers under section 13Z of the National Health Service Act 2006 (as amended), NHS England has delegated the exercise of the functions specified in Schedule 2 to these Terms of Reference to Oxfordshire CCG.

The CCG has established the Oxfordshire CCG Primary Care Commissioning Committee ("Committee"). The Committee will function as a corporate decision-making body for the management of the delegated functions and the exercise of the delegated powers.

Arrangements made under section 13Z may be on such terms and conditions (including terms as to payment) as may be agreed between NHS England and the CCG.

Arrangements made under section 13Z do not affect the liability of NHS England for the exercise of any of its functions. However, the CCG acknowledges that in exercising its functions (including those delegated to it), it must comply with the statutory duties set out in Chapter A2 of the NHS Act and including:

a) Management of conflicts of interest (section 14O);
b) Duty to promote the NHS Constitution (section 14P);
c) Duty to exercise its functions effectively, efficiently and economically (section 14Q);
d) Duty as to improvement in quality of services (section 14R);
e) Duty in relation to quality of primary medical services (section 14S);
f) Duties as to reducing inequalities (section 14T);
g) Duty to promote the involvement of each patient (section 14U);
h) Duty as to patient choice (section 14V);
i) Duty as to promoting integration (section 14Z1);
j) Public involvement and consultation (section 14Z2).

The CCG will also need to specifically, in respect of the delegated functions from NHS England, exercise those in accordance with the relevant provisions of section 13 of the NHS Act

The Committee is established as a committee of the Governing Body ("OCCG Board") of Oxfordshire CCG in accordance with Schedule 1A of the "NHS Act".

The Committee members acknowledge that the Committee is subject to any directions made by NHS England or by the Secretary of State.

2. Secretariat

The OCCG Business Manager will provide secretarial support to the Committee including preparation and distribution of papers, the taking of minutes and facilitating agendas. The Business Manager will be responsible for supporting the Chair in the management of the Committee's business and for drawing the Committee's attention to best practice, national guidance and other relevant documents as appropriate.

A record of actions and decisions will be circulated by the Business Manager to the Committee within seven working days. The minutes/notes as agreed by the Committee Chair, will be circulated to attendees of the Committee at the latest within 15 working days of each Committee meeting.

3. Frequency and Notice of Meetings

The Committee will meet ~~bi-monthly~~ a minimum of four times a year in public.

Papers will be issued five working days before each meeting. The dates of the meetings and papers will be available on the website.

The Committee may resolve to exclude the public from a meeting that is open to the public (whether during the whole or part of the proceedings) whenever publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution and arising from the nature of that business or of the proceedings or for any other reason permitted by the Public Bodies (Admission to Meetings) Act 1960 as amended or succeeded from time to time.

4. Authority and reporting

The Committee is established under Oxfordshire Clinical Commissioning Group's constitution as a committee of the OCCG Board and will make decisions within the bounds of its remit.

The Committee will present its minutes and an executive summary report to NHS England South Central and the OCCG Board for information.

The Committee will make decisions within the bounds of its remit. The decisions of the Committee shall be binding on NHS England and Oxfordshire CCG.

The Committee may delegate tasks to such individuals, sub-committees or individual members as it shall see fit, provided that any such delegations are consistent with the agreement entered into between NHS England and Oxfordshire CCG, are recorded in a scheme of delegation, are governed by appropriate terms of reference and reflect appropriate arrangements for the management of conflicts of interest.

5. Membership

Voting Members (Lay and Executive majority)

- Lay Member, OCCG (Chair)
- Lay Vice Chair, OCCG (Vice Chair)
- Chief Executive, OCCG
- ~~Director of Delivery and Localities~~ Chief Operating Officer and Deputy Chief Executive, OCCG
- Director of Governance, OCCG
- Two GPs (Clinical Chair OR Deputy Chair and one other), OCCG
- ~~Medical Specialist Advisor (or another GP), OCCG~~A clinical person

In attendance

- Deputy Director, Head of Primary Care ~~and Medicines Optimisation~~
- Deputy Director of Finance
- County Councillor from Health and Well Being Board
- HealthWatch representative
- Patient/Public representative from the Primary Care Patient Advisory Group
- LMC representative
- NHS England representative (one Director and Head of Primary Care)

6. Quoracy and Voting

The Committee shall have a Lay/Executive majority at all times. The quorum shall be a minimum of 4 members to include one Lay member, one CCG officer and one clinician.

Each member of the Committee shall have one vote. The Committee shall reach decisions by a simple majority of members present, but with the Chair having a second and deciding vote, if necessary. However, the aim of the Committee will be to achieve consensus decision-making wherever possible.

Members of the committee, with agreement from the Chair, may send a designated deputy with full authority if they cannot attend in person.

7. Remit and Responsibilities

The Committee has been established in accordance with the above statutory provisions to enable collective decisions on the review, planning and procurement of primary care services in Oxfordshire, under delegated authority from NHS England, in the context of a desire through co-commissioning to increase quality, efficiency, productivity and value for money and to remove administrative barriers. The Committee will take its commissioning decisions on services in primary care as part of an overall integrated pathway of care for patients. The Committee brings the NHSE and OCCG primary care commissioning funding streams together and also integrates primary care performance.

In performing its role the Committee will exercise its management of the functions in accordance with its terms of reference, delegation of authority and the agreement entered into between NHS England and Oxfordshire CCG.

The role of the Committee shall be to carry out the functions relating to the commissioning of primary medical services under section 83 of the NHS Act. This includes the following:

- Agreeing the primary care aspects of the overall CCG commissioning strategy
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- GMS, PMS and APMS contracts (including the design of PMS and APMS contracts, monitoring of contracts, taking contractual action such as issuing branch/remedial notices, and removing a contract);

- Providing assurance to the Board and NHS England on quality, performance and finance of all services commissioned from primary care which incorporate the delegated funding and funding from the core CCG allocation (for example prescribing, incentive schemes and local primary care contracts).

- Newly designed enhanced services ("Local Enhanced Services" and "Directed Enhanced Services");

- Design of local incentive schemes as an alternative to the Quality Outcomes Framework (QOF);

- Decision making on whether to establish new GP practices in an area;

- Approving practice mergers; and

- Making decisions on 'discretionary' payment (e.g., returner/retainer schemes).

- Agreeing and monitoring a financial plan and budget; risk assessment, performance framework and annual workplan

9. Linkages

The Committee will bring commissioning, performance, quality and finance together to effectively monitor primary care performance. This will require clear linkages with both the Quality and Finance Committees of the Clinical Commissioning Group to avoid duplication.

10. Sub-structure

The joint committee may establish task and finish groups as required; these will be properly constituted with terms of reference signed off by the Committee.

Terms of Reference to be reviewed ~~April 2017~~May 2018