Oxfordshire
Clinical Commissioning Group

Oxfordshire Clinical Commissioning Group
Board Meeting

Date of Meeting: 30 November 2017	**Paper No: 17/85c**

Title of Paper: Minutes of the Oxfordshire Primary Care Commissioning Committee, 7 November 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:

- NHSE are in the process of appointing an independent third party to review the OCCG proposals. The specification for the scope of the review had been provided to bidders and would be circulated to the Committee.
- The first engagement meeting had been held in Witney and the event had been well attended but there had been mixed reviews, as it had not been a Dear Park meeting but a wider Witney and West Oxfordshire engagement event. Engagement from the public at the tables had been excellent.

Horsefair Surgery:

- The CQC carried out an unannounced inspection in August and published its report and recommendations in October. The report showed there were still some concerns for patient safety. OCCG issued a remedial notice indicating the practice was in breach of Regulation 17 (Good Governance) and Regulation 18 (Staffing) and requested a clear update on what was happening and what actions were being taken.
- The Quality Team was supporting the practice to ensure a plan to address CQC concerns was available by 15 November. OCCG has been receiving fortnightly updates.
- The Committee requested further independent assurance that the action plan was comprehensive and robust, and would leave the practice in a sustainable position.

Banbury Health Centre (BHC) Consultation Plan: The Committee considered the options for BHC, the consultation plan and the engagement work that was being undertaken with key stakeholders. The plan was on the agenda for the next HOSC meeting.

Primary Care Locality Place Based Plans: The Committee was pleased to receive an update on the development of the locality plans and the emerging priorities. The plans are being evaluated and prioritised for funding in 2017/18 – 18/19 and proposals for investment will be considered an approved (subject to wider public engagement) at an extraordinary meeting of OPCCC later in November and reported to the November Board.

Finance Report: The only material change from the previous reported OCCG position relates to financial risk, which was now full covered by the reserves held. The Committee noted the month 6 position for the primary care budgets and were assured that the risks were being managed effectively.

Terms of Reference (ToR): The Primary Care Advisory Group (PAG) was set up to advise on the development of the early draft of the Primary Care Strategy, which was later superseded by

the Primary Care Framework (PCF). As work on the PCF is continuing at locality level there has been less for the PAG to consider and the role of the group has become less clear. It has been decided the PAG should be disbanded and primary care issues will be fed into the two monthly Locality Forum Chairs meeting of which the OPCCC primary care representative is a member. As a result the OPCCC ToR need to change to remove the reference to the PAG. The Committee approved this change and the ToR are appended to the minutes. The OCCG Board is asked to ratify the amendment.

Financial Implications of Paper:

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

Action Required:

The Board is asked to ratify the OPCCC Terms of Reference.

There are no further actions for the Board arising from this meeting. The Board will receive a report on the primary care locality 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:

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. The executive summary above also sets out how the OCCG with use the financial headroom in the existing primary care budgets to invest further in services. Mitigation - Disinvestment in hospital services and reinvest in integrated community services, through the transformation programme and a 5-10 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 the 6 Localities are developing plans to deliver new service models, part of the Oxfordshire Transformation Programme. Between 2016/17-17/18, £8.0m of new funding has been invested in primary care. The Committee supported a workforce plan to support practices address the GP recruitment challenges faced and this will be extended to the wider primary care workforce. The locality 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 Oxfordshire Primary Care Commissioning Committee

Clinical / Executive Lead: Dr Joe McManners, Clinical Chair

Date of Paper: 17 November 2017

MINUTES:

OXFORDSHIRE PRIMARY CARE COMMISSIONING COMMITTEE (OPCCC)

7 November 2017, 14.30 – 16.30

Conference Room A, Jubilee House, OX4 4LH

Present:	Duncan Smith (EDS), Lay Member OCCG (voting) – Chair
	Dr Kiren Collison (KC), Deputy West Locality Clinical Director and Clinical Chair elect OCCG (voting) [deputising for Dr Joe McManners]
	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 Richard Chapman) (non-voting)
	Catherine Mountford (CM), Director of Governance OCCG (voting)
	Rosalind Pearce (RP), Healthwatch (non-voting) [from 15.00]
	Dr Paul Roblin (PR), Chief Executive Berkshire, Buckinghamshire and Oxfordshire Local Medical Committee (non-voting)
	Jenny Simpson, 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

Apologies	Richard Chapman, Director of Finance NHS England
	Diane Hedges (DH), Chief Operating Officer OCCG (voting)
	Dr Joe McManners (JM), Clinical Chair OCCG (voting)
	Dr Meenu Paul (MP), Assistant Clinical Director Quality OCCG (voting)

		Action
	Welcome EDS welcomed everyone to the Oxfordshire Primary Care Commissioning Committee (OPCCC) explaining it was a meeting held in public. EDS welcomed KC to the meeting deputising for JM and offered congratulations on her appointment to the Clinical Chair role. The Committee members were introduced.	
1.	**Declarations of Interest** CW and RD advised they were patients at Hightown Surgery, Banbury.	

2.	**Minutes of the Meeting Held on 5 September 2017** The approved minutes of the meeting held on 5 September 2017 were noted.	
3.	**Action Tracker** *Information from NHS Digital and NHS England (NHSE) specifications linked to the GP Forward View (GPFV)* GH reported the guidance had now been issued and some funding was available. An update would be circulated between meetings. *Deer Park Medical Centre: Independent Reviewer* GH advised NHSE was in the process of appointing an independent third party to review the OCCG proposals. The specification for the scope of the review had been provided to bidders and would be circulated to the Committee. *Horsefair Surgery* An update was provided in Paper 3, Report from the Deputy Director, Head of Primary Care and Localities.	**JD** **GH**
Commissioning		
4.	**Deputy Director, Head of Primary Care and Localities Report** JD presented Paper 3, her report to the Committee for September and October 2017, and reminded the Committee of previous discussions held concerning Horsefair Surgery, advising the practice had formed a new partnership in December 2016 with business administration support provided by Integrated Medical Holdings (IMH). A Care Quality Commission (CQC) inspection in August 2016 had rated the practice as 'requires improvement'. An action plan was implemented and some improvements were made but a follow-up CQC inspection in May 2017 found a number of actions had not been implemented and an overall rating of 'inadequate' was given. OCCG assisted the practice in developing a further action plan and in delivering against that plan. The CQC carried out an unannounced inspection in August 2017, which showed there were still some concerns for patient safety. OCCG issued a remedial notice indicating the practice was in breach of Regulation 17 (Good Governance) and Regulation 18 (Staffing) and requested a clear update on what was happening and what actions were being taken. Horsefair Surgery challenged the CQC on areas it felt were inaccurate in the report and due to this challenge, did not provide OCCG with a response to the remedial notice within the requested time. The CQC published its report and recommendations in October 2017 and OCCG wrote again to the practice requesting a fuller update and report. The first iteration had been received. OCCG also requested the practice consider increasing the number of GPs until such time as the new Clinical lead deemed the service safe and efficient, and to increase use of the GP access hub for appointments. JD advised MP had been working with the practice undertaking additional audits to ensure they were on track for the next CQC inspection. Fortnightly updates on staff rotas, test results outstanding and other areas had been requested from the practice and were being fed through to the OCCG Director of Quality. EDS stated the Committee needed assurance the action plan was fit for purpose, robust and would put the practice in a sustainable position. He	

	understood the Quality Team was supporting the practice to ensure the plan was available by 15 November. The Committee needed assurance risk mitigations were being taken, whilst the action plan was being implemented to address the issues identified in the CQC report.	**JD**
	CW understood one reason the CQC had inspected the practice was as a result of complaints from a care home that the practice was not providing adequate clinical input. JD confirmed this issue had been picked up and addressed. JD advised the quality paper, Paper 8, indicated the number of complaints received by NHSE and the practice, adding OCCG was only able to investigate those complaints that were submitted to it.	
	PR commented that it was common for nursing homes to misunderstand the General Medical Services (GMS) contract and what they were entitled to, which led to incorrect expectations. It did not always follow that where a complaint was made there was an issue. PR queried the origin of the regulation quoted in the report but subsequently confirmed the regulations referred to above were from the Health and Social Care Act 2008.	
	RD expressed some concern around the possibility of OCCG being held responsible for the situation at the practice because of MP being present in the practice and the support being provided by the Quality Team. He queried whether an independent view should be obtained to provide further assurance. Although this was felt to be a good suggestion CM proposed waiting until the action plan was available and then obtaining assurance on the plan from another Locality Clinical Director with input from PR and the Local Medical Committee (LMC).	
	The Committee resolved that it required independent assurance under a formal process, that the final version of the action plan that had been developed by the practice, supported by the OCCG Director of Quality and MP, would address the concerns raised by CQC and deliver an operationally sustainable practice. EDS confirmed that it would be acceptable for this assurance to be provided through a review by one of the clinical directors not previously involved with the Surgery.	
	DS observed a number of items had been requested from the Surgery and depending on the outcome, suggested there might be a need for DH and DS to attend a meeting with the Surgery's partners and the Chief Executive of IMH to obtain further assurances. If these were not received OCCG would need to agree the further action to be taken. Horsefair was one of the largest practices in Oxfordshire and OCCG needed to ensure it was on top of the situation. DS reported OCCG was also linking with the CQC around the actions to be taken.	
	EDS commented the15 November was a key date and that the Committee should still have independent assurance on the action plan, even if the OCCG officers felt they were assured. The Committee should be updated between meetings, at the earliest opportunity and a further report brought to the January meeting.	**JD**

	CW queried to what extent the partners were accountable, as reportedly one of the GPs was a partner of a practice in Kent, which had been rated twice by the CQC as 'inadequate' and one partner appeared to be singlehandedly running a practice in Kent. JD advised the contract was with the partnership. CM added that the partners were accountable and should ensure services were delivered in the practice but they did not have to deliver those services themselves. OCCG was holding the practice to account, which was why a remedial notice had been issued. EDS suggested the information should be noted and whether there were any implications for delivery on the contract followed up and reported back to the Committee is the January update. JD explained making more use of the GP access hub should relieve some pressure in the practice to allow time for more long-term patients to be seen. She advised this was being actively monitored and MP was undertaking audits on the clinical work undertaken. The CQC inspection had also shown up failings in the peer review of the advanced nurse practitioners; a process to undertake peer reviews was now in place and audits were being undertaken. Test results were also being audited. JD reported OCCG had had no direct involvement with the practice Patient Participation Group (PPG). An open day had been held by the practice, which had been relatively successful. Contact details for JD had been passed to the Chair of the PPG but no contact had yet been made. JD believed OCCG should now contact the PPG. CW reported the North Locality Forum Chair (LFC) had attended the last PPG meeting and had left with serious concerns. JD hoped that if the LFC had concerns that these would be fed back to her. CM advised OCCG was unable to address issues or concerns it did not know about. She added OCCG was not allowed to have PPG details and the LFC needed to provide information to OCCG if the issues were to be followed up. EDS and RD volunteered to attend a meeting with the PPG. JD to organise and provide a date. DS stated if discussions involving the PPG raised issues around the practice, these needed to be fed back to the practice. OCCG had a contractual relationship with the practice and there was a need to follow a formalised process. OCCG should not cut across proper responsibilities lines and the LFC should feed back to the practice as the practice was unable to address the concerns if it was not informed. JD reported a further assessment of the GPFV plans by NHSE had been received. JD expressed disappointment that the level of assurance had not changed, despite the work undertaken by OCCG. Part of the reason related to the digital component on which further information had been awaited from NHSE but work was continuing on the online component to allow patients to access prescriptions and appointment bookings. A piece of work had been commissioned for production of a Tactical Delivery Plan, looking at primary care estates across Oxfordshire and linking with locality plans to establish where the issues were and the state of urgency. The report would be to JD and the OCCG Finance	**JD** **JD**

	Director by mid-November and would be brought to the Committee at a later date. JD reported some slippage from the Estates Technology and Transformation Fund (ETTF) funding had been secured for White Horse practice in Faringdon. Workforce was a key enabler and some Locality Place Based Plans were looking at skill mix but a detailed piece of work on primary care workforce would be required on a cross-county basis. NHSE had commissioned the Violent Patient Scheme (VPS) and going-forward, OCCG was now looking to take a different approach. The current service was in place until 30 June 2018, from when a practice would be commissioned to provide the service. The date for expressions of interest had closed and OCCG had some leads to follow-up. JD advised the Primary Care Team had been increased by one whole time equivalent, which had provided more senior capacity within the Team. EDS felt the information on workforce should help development of a strategic approach and queried whether a strategic document, and mobilisation plan would be available in the last quarter of the year. JD stated workforce was clearly a key enabler and a more detailed strategic approach was required. She advised some money had been identified to support its delivery and it was hoped to have further details by Quarter 4. CW queried whether the sign-off and submission of the Project Initiation Document (PID) for the new building for Hightown Surgery, located at Longford Park, allowed the development to be taken into account in the plans for Banbury. JD advised sign-off by the Director of Finance meant it was possible to progress to the next stage, which would be for NHSE or the regional panel to approve the business case to move to the next level. Due diligence would need to be undertaken but funding was committed to the practice. GH commented as the project was proceeding to the next stage, it gave some degree of confidence the scheme would continue. The OPCCC noted the Deputy Director, Head of Primary Care and Localities Report for September and October 2017.	
5.	**Deer Park Independent Reconfiguration Panel (IPR) Update** CM presented Paper 4 providing an update on progress to address the actions required following the Secretary of State's response to the Deer Park Medical Centre (DPMC) referral. Meetings had been held with the Oxfordshire Joint Health Overview and Scrutiny Committee (HOSC), the LFC for West Oxfordshire and with RP. The first engagement meeting had been held in Witney on Wednesday 1 November 2017. The event had been well attended but there had been mixed reviews, as it had not been a DPMC consultation meeting but a wider Witney and West Oxfordshire engagement event. Engagement from the public at the tables had been excellent and many positive thoughts and comments on the proposals were forthcoming and would be taken into account, particularly those around prevention and access issues.	

	The second engagement event was due to take place in Carterton on 8 November. Other meetings would be held with the Town Council, the local MP and West Oxfordshire District Council, as well as following-up with the HOSC. At the end of October, 317 DPMC patients remained unregistered and a further letter would be issued. JD advised it had not been expected that all the patients would re-register and the figure of 317 was lower than had been anticipated. CM reported NHSE advice had been sought and although three letters to patients was probably sufficient, it had been felt on this occasion a fourth letter should be sent. RP commented on the short notice of a change in venue for the Witney event. CM acknowledged the point, advising it had arisen from a misunderstanding with the original venue, which had led to the smaller rather than larger room being booked. A room swap had not been possible and a larger venue needed to be provided. All the people who had registered to attend were informed by email and/or telephoned on Monday 30 October and it was clear from the Save DPMC Facebook page comments that people had received the emails. An individual had also been present at the old venue to direct people to the new venue. CW reported the LFC for West Oxfordshire had been positive about the meeting, as it was felt from the feedback received from the people attending the meeting, that there was confidence in the draft Locality Plan. The Committee was informed HOSC was due to set up a meeting with both the Oxford Health NHS Foundation Trust (ONFT) and the Oxford University Hospitals NHS Foundation Trust (OUHFT) but as yet, no details were available. GH advised she expected to know the name of the NHSE person to undertake the independent review in 2 weeks' time. The OPCCC noted the progress made to address the recommendations.	
6.	**Banbury Health Centre (BHC) Consultation Plan** JD presented Paper 5 advising the first paper provided some context to the wider issues in Banbury and the second brought in options for BHC. She advised that the second paper was a consultation plan and not the consultation document. The consultation plan had been developed in conjunction with BHC PPG. Four meetings had already taken place and another was due to take place in December 2017. The plan was on the agenda for the HOSC meeting on 16 November 2017. RD felt the document should be more patient centric and the benefits to the patient be shown at each stage; the terminology was very 'NHS speak' and ought to be more positive from the patient point of view; and it contained no explanation of what PML or a PPG were. JD advised the patient group had been through the document and made comments, which had been taken on board but she would look at this further. RP suggested two sides of A4 to provide a brief about the document. CM mentioned the HOSC was used to receiving OCCG consultation plans in this format. DS noted BHC, West Bar and Woodlands were all mentioned in the document but none of the other practices in Banbury. He felt this would	

	be confusing for patients in other practices and that the document did not contain the whole story. He highlighted the comment in section 3.1 around a single provider caring for at least 24,000 patients, which could be confusing as to whether it applied to everyone in Banbury. He suggested unless people knew the background to the situation in Banbury, it would raise questions. CM observed there was a need to be clear the consultation was around the services currently contracted to BHC. CW endorsed the comments made around patient context, as the HOSC would consider the document from a patient perspective. He suggested unless the paper enabled the HOSC to do this, that there would be resistance. He stated patients did not like Alternative Provider Medical Services (APMS) contracts and the Royal College survey evidence could be used to support not continuing with an APMS contract. CW advised he had looked at the quality information available for Banbury as a whole, which did not support the view that small practices were 'bad', as it was the larger practices that had fallen over. CW noted a transport survey was being undertaken and queried whether a survey on patient experience and expectations from BHC should also be carried out. EDS observed there were obviously some concerns from the Committee around the document and felt the advantages and disadvantages for each of the options were difficult to follow and compare. He suggested if it was too late to change the paper for HOSC but that there was a need for an additional paper to be appended to the front. PR also felt the title was wrong, as the document was about two Banbury practices working in conjunction with Principal Medical Ltd (PML) trying to do something for sustainability in the future. JD advised an earlier version had been taken to the Community Partnership Network; a meeting attended by Councillors, MPs and members of the press among others, and had been well received, and seen as something that needed to be undertaken at scale. Committee members to email any other issues to JD. CM felt the Committee should acknowledge the work undertaken by JD and the Communications Team, and the involvement of the PPG at an early stage, which was learning taken forward following the failure to re-procure services for DMPC. The LFC for North Oxfordshire had reported on the good way JD and Ally Green, Head of Communications and Engagement, had engaged with the PPG. The OPCCC noted the content of the report.	**All**
7.	**Primary Care Plan / Priorities for 2017/18 or 2018/19** JD presented Paper 6 advising OCCG was starting to frame the priorities for 2018/19 and there were likely to be cross cutting schemes arising from the Locality Place Based Plans. There had been some slight slippage in quality priorities due to difficulties in recruitment but a quality manager was now in place and it was hoped these would pick-up.	

	CW advised at the LFCs meeting with OCCG, it had been reported planning applications were being monitored and objections raised if there was no health consideration. JD confirmed this was the case for all those schemes where OCCG received notification. The OPCCC noted the progress in delivering the Primary Care Priorities and approved the emerging priorities for 2018/19.	
8.	**Primary Care Locality Place Based Plans** JD presented Paper 7 updating on plans and outlines for the prioritisation process for initiatives. JD advised progress had been good, with all Localities submitting draft plans at the end of October. The prioritisation stage was now in place. The initial sorting of proposals had taken place in the previous week with good input and a lot of consensus. The list would be presented to Locality Clinical Directors (LCDs), stakeholders and Federations on 9 November 2017. OCCG would be asked to commit non-recurrent funding from the GMS budget. Patient and public engagement events were continuing with events planned on every Tuesday and Thursday throughout November across the county. These would feed back into the plans. A draft overview of each of the plans was contained at the back of the document but the final plans would be subject to the patient engagement and feedback. CM advised in governance terms, primary care funding was for OPCCC to approve rather than OPCCC making a recommendation to the OCCG Board. Further funding for primary care would depend on agreement of the OCCG Board in the 2018/19 plan. DS reported the Director of Finance would be presenting a paper setting out the resources for next year, commitments against the resource and the level of the financial gap and how it would be addressed at the November OCCG Board meeting. There would be a need to identify new areas of investment, which would include primary care. EDS expressed concern there was not an approved budget for 2018/19. CM advised the £1.2m showing in 2018/19 was part of recurrent resources available and was uncommitted money within primary care commissioning allocation. JD reported there would also be a further Personal Medical Services (PMS) release in 2018/19. JS advised in the previous year, OCCG had submitted a two-year plan, which had been signed-off by the OCCG Board, and the use of monies had been factored into the year-end position. DS stated the £1.2m would be spent on primary care and anything over and above this figure would be considered in terms of setting the budget for the next year. EDS suggested there might be a need for an OPCCC extraordinary meeting to agree the initial investment in the Locality Plan schemes. CM observed that any meeting would have to be held before the OCCG Board papers were published. RP remarked on the short period of time for engagement and queried how this would affect plans that were due to be signed-off in three weeks' time. DS explained if decisions were not made quickly, it would not be possible to spend the money before the end of the year. RP felt it was important to communicate this fact to the outside world and that it	

	was not about plans for the next 20 years. CM commented the plans to be published were draft plans and subject to engagement and feedback. JD hoped OPCCC would make a decision on the 2017/18 funding allocation and 2018/19, pending patient feedback in order to enable the process to start. JD advised the £1.2m would also be available recurrently and as a result, it was unlikely a service would be commissioned for just a year. There was also some non-recurrent money from the delegated commissioning budget but the amount required for an increase in indemnity costs had not been known until very recently, which had prevented establishing how much would be available and committing spend earlier in the year. CH advised it had now been possible to quantify a number of the financial risks. CW commented, whilst there was still some criticism of the process, encouragement should be taken from how well the Witney engagement meeting had gone. He stated the Committee should be more optimistic about patient groups being very enthusiastic. Consideration to be given to arranging an OPCCC extraordinary meeting. The OPCCC: • Noted the progress made in development of the Locality Place Based Plans • Noted the process on prioritisation of initiatives • Agreed the timetable for recommendation of initiatives and publication of plans • Felt an extraordinary meeting would be required to approve or not the prioritisation list. • Thanked everyone involved in developing these plans, for their hard work in progressing them to this stage.	**JD**
9.	**Primary Care Quality Dashboard** JD presented Paper 8 and reported the Quality Team had tried to add to the information already being presented in terms of performance indicators in immunisations. The Team was trying to improve flu coverage against the previous year. MP had also provided a good update on the work being undertaken by the Team with those practices the CQC had rated as 'requires improvement' or below. CW advised a workshop had been held around the GP Patient Survey to obtain patient ideas and thoughts on how to use the GP Patient Survey. The results had not yet been published and as CW felt this was a worthwhile exercise, he hoped the results would be published. The Committee welcomed the report but wished to refer back to the Quality Committee in terms of obtaining assurance in relation to the improvement in practice RAG ratings. The OPCCC noted the content and actions of the paper.	**JD** **MP**
10	**Finance Report** JS presented Paper 9 on the financial performance of the CCG Primary Care budgets to Month 6, advising OCCG was still on plan. The only	

	change from the previous reported position was the financial risk position, which was now covered by the reserves held. The overspends in the acute budgets were offset by underspends in prescribing, primary care investment, other acute and the level of NHS property recharges. Contingency had been released to offset pressures discussed in previous months and £902k remained to fund the pressures remaining in-year. Three main underspends were reported in primary care and the prescribing national programmes were having a significant impact. Some funds were held nationally and these might be released later in the year. There was also a national issue around many items of cheaper stock not being available, leading to the use of more expensive drugs, rather than a low-cost generic. This was significantly up on previous years. Usually there were 20 drugs in this category but the figure currently stood at 90. There was a risk OCCG might not be able to hold the forecast going forward. CH suggested including in the final sentence of the key points where it referred to the remaining £902k: 'or to be utilised to fund locality plans'. CH advised the £697k variance figure for GP Seniority and Locums in Table 2, linked to Table 3, as it included the indemnity fees cost pressures; of the three items listed at 2.3 issues not yet reflected in the forecast, the first two items were risks and the third a potential opportunity or gain; there were no in year ETTF projects which would impact but rent reviews were on-going, which were a financial risk but not material. DS noted the variances due to population growth, the lagging funding to sort this and locum costs but observed the £377k for indemnity fees had hit the primary care and OCCG budget, for which there was no extra funding. CH advised NHSE had stated there would be no reimbursement to practices until the end of the financial year but had requested a reserve was set to cover 100% of the cost. Any reimbursement amount would not be known until the end of the year. It was a provision for the 'worst' case scenario. The OPCCC noted the Month 6 position for the Oxfordshire CCG Primary Care budgets and were assured that the risks were being managed effectively	
Governance		
11	**Forward Plan** The Committee noted Paper 10, the Forward Plan. EDS stated priority in terms of time on the agenda for the next meeting should be the Primary Care Framework and Locality Plans.	
12	**Risk Register** CM presented Paper 11, the OCCG Primary Care Risk Register. There were three risks in the Primary Care risk register two of which continued to be Red/Extreme risks (risk rating of 20): AF26 Delivery of Primary Care Services and 789 Primary Care Estate. The OPCCC noted the updates to the OCCG Primary Care Risk Register since its last meeting on 5 September 2017.	
13	**Update to Terms of Reference (ToR)**	

	JD presented Paper 12 advising on the discussion with CW around the Primary Care Patient Advisory Group (PAG), which had been set up to provide advice on the Primary Care Strategy, which had subsequently become the Primary Care Framework. As more work was being undertaken at locality levels, there was a feeling that the original purpose of the PAG no longer stood. A good workshop, which encompassed most of the people within the PAG, had taken place and it was felt rather than continuing regular PAG meetings, there should be more workshop style engagement. CW was now a member of the LFCs meetings and bringing primary care into that forum was the right thing to do, as it enabled primary care to be discussed alongside other services. It was felt the PAG had reached a natural course of history and reference to the PAG should be removed from the ToR. The PAG was tasked with identifying a representative but it was felt, like the Quality Committee, it should become an appointed role, although CW would continue to cover the role until October 2019. CW reported at the LFCs meeting, two of the LFCs were unhappy with the proposal that the PAG or similar group should cease and another would have expressed a similar view if they had been present. CW proposed that RP should consider adding this item to the work around primary care engagement generally. RP stated the Committee should decide its ToR. The question was where would a representative be recruited or selected from. CM advised there had been an advertisement for the representative on the Quality Committee, which had been issued through the LFCs. The idea was to be more consistent in approach and clearer on the requirements, with the intention to make it more inclusive. The proposal was for someone to serve a term and then repeat the selection process. The OPCCC agreed the change to the Terms of Reference and to recommend the change to the OCCG Board.	
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** 2 January 2018	

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 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
- Chief Operating Officer and Deputy Chief Executive, OCCG
- Director of Governance, OCCG
- Two GPs (Clinical Chair OR Deputy Chair and one other), OCCG
- A clinical person

In attendance

- Deputy Director, Head of Primary Care
- Deputy Director of Finance
- County Councillor from Health and Well Being Board
- HealthWatch representative
- Patient/Public representative
- 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.

VDraft1.2-November 2017
Terms of Reference to be reviewed November 2018