Bristol, North Somerset and South Gloucestershire
Clinical Commissioning Group

BNSSG CCG Primary Care Commissioning Committee

Minutes of the meeting held on 25th April at 11am, at the Holiday Inn, Bristol.

Minutes

Present		
Alison Moon	Independent Clinical Member – Registered Nurse	AMoo
John Rushforth	Independent Lay Member – Audit, Governance and Risk	JRu
Sarah Talbot-Williams	Independent Lay Member – Patient and Public Engagement	STW
Julia Ross	Chief Executive	JR
Lisa Manson	Director of Commissioning	LM
Anne Morris	Director of Nursing and Quality	AMor
Martin Jones	Medical Director (Primary Care and Commissioning)	MJ
Justine Rawlings	Area Director	JRa
Colin Bradbury	Area Director	CB
Apologies		
Sarah Truelove	Chief Finance Officer	ST
David Jarrett	Area Director	DJ
Andrew Burnett	Director of Public Health, North Somerset	AB
Kevin Haggerty	Clinical Commissioning Locality Lead, North Somerset	KH
Rachel Kenyon	Clinical Commissioning Locality Lead, North Somerset	RK
In attendance		
David Moss	Head of Primary Care Contracts	DM
Felicity Fay	Clinical Commissioning Locality Lead, South Gloucestershire	FF
David Soodeen	Clinical Commissioning Locality Lead, Bristol	DS
Debra Elliott	Director of Commissioning, NHS England	DE
Nikki Holmes	Head of Primary Care, NHS England	NH
John Burrows	Assistant Head of Finance, NHS England	JB
Philip Kirby	Chief Executive, Avon Local Medical Committee	PK
Sara Ambe	Healthwatch Bristol	SA
Sarah Carr	Corporate Secretary	SC
Rob Moors	Assistant Chief Finance Officer	RM
Rob Ayerst	Chief Finance Manager	RY
Jenny Bowker	Head of Primary Care Development	JBo
Robyn Smith	Executive PA *(note taking)*	RS

	Item	Action
01	**Welcome and Introductions – Aim of Meeting** Alison Moon (AMoo) opened the first Bristol, North Somerset and South Gloucestershire Primary Care Commissioning Committee and welcomed members. Introductions were made; and apologies noted as above. AMoo thanked the three previous CCGs and NHS England (NHSE) for all the work that has been done to bring the CCG to this point. AMoo advised this is a meeting held in public, and not a public meeting; there is a section on the agenda for members of the public to ask questions. Julia Ross (JR) expressed that it is great for the CCG to be in this position taking on delegated commissioning. It is a good acknowledgement of the progress the CCGs have made over the last year; particularly with the way NHSE have worked with the CCGs. Taking on delegated primary care is a great way to reintegrate how the CCG commission services for the whole of the population. Primary care is a critical part of the services that the BNSSG population need and want, and the CCG very much wants to make sure primary care is fully integrated as a part of the wider system to provide integrated services with community providers, mental health and social care. It was noted that the Primary Care Commissioning Committee stands alone as a decision making committee; however the minutes are reported in to the Governing Body. Whilst GPs are on the committee, they are not voting members of the committee. JR welcomed Healthwatch, and advised that the CCG are looking at Local Authority (LA) involvement. We are also looking at how to bring in GPs from outside BNSSG to give a primary care view without having a vested interest in the decisions the CCG make.	
02	**Declarations of Interest** AMoo has requested that a copy of the register of interests for committee members is provided at each meeting so the committee has clarity. Sarah Carr (SC) confirmed a subset of the corporate register of interests, that is relevant to the group, can be provided for the meetings in the future. SC advised that conflicts of interest are divided across four different themes, which are financial, non-financial professional, non-financial personal and indirect. The four different themes are explained in detail on the register, along with how the CCG manage those interests.	

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	Action: Sarah Carr to check if all members of the committee have completed their declaration of interest. **Action: Robyn Smith to bring a subset of the declarations of interest register to all future meetings to include committee members only.** No conflicts of interest were identified.	**SC** **RS**
03	**Minutes of Previous Meeting and Action Log** The minutes were agreed as a correct record subject to the following amendment. • Page 6, item 6 should have read "procurement – will remain with the CSU on behalf of NHSE during transition." All actions were closed as per the recommendations.	
04	**Terms of Reference – Primary Care Commissioning Committee** Martin Jones (MJ) proposed the committee considers the positions and the committee members, as well as the quoracy for meetings. Debra Elliott (DE) explained that there is an outstanding issue on the membership that has been discussed and is subject to a discussion being finalised with JR. JR commented that the view is that the Vice Chair would move from the audit and governance lead to the patient and public engagement lead. AMoo referred to the membership compared to the Primary Care Operational Group (PCOG) terms of reference, on page 4 it is noted that the Area Director will be the Chair of PCOG; however the PCOG terms of reference notes the Chair will be the Medical Director. MJ confirmed that the Area Director will be the Chair of PCOG. Felicity Faye (FF) suggested that a quorum of four members seems quite minimal. SC confirmed it is usual practice to be one third of the voting membership, which it is. JR noted the importance of the quoracy is that it must include the independent member, clinical member and executive member. Sarah Talbot-Williams (STW) referred to the title for the patient and public engagement member representative and suggested the title be rephrased. Committee members agreed. Sara Ambe (SA) explained that it was proposed that Healthwatch	

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	share attendance, which will be fine for Bristol and South Gloucestershire. However North Somerset is a separate entity at this stage and therefore they have objected to sharing attendance at the committee between the three Healthwatch areas. **Action: Colin Bradbury to discuss with Healthwatch representatives the agreed approach to attendance at future meetings.** The Primary Care Commissioning Committee approved the Primary Care Commissioning Committee terms of reference subject to the amendments discussed. **Terms of Reference – Primary Care Operational Group (PCOG)** As discussed, the Chair of the PCOG will be the Area Director. MJ advised that the PCOG reports to the Primary Care Commissioning Committee, and it was noted that the group is not a decision making committee. MJ advised that he discussed with Philip Kirby (PK) the Local Medical Committee (LMC) being a member of the group. MJ advised it was agreed that it would be appropriate to add LMC to the membership. Committee members agreed. SC asked if quoracy for the group needs to be considered, and also a deputy chair role. JR suggested this be discussed at the PCOG meeting and the terms of reference be brought back to the PCCC for final approval. **Action: Jenny Bowker to clarify with PCOG the quoracy and deputy chair arrangements; and to feedback to PCCC at the next meeting in May.** Nikki Holmes (NH) requested that the NHSE contract manager be added to the terms of reference as attending. The Primary Care Commissioning committee approved the Primary Care Operational Group terms of reference subject to the amendments discussed.	**CB** **JB**
05.1	**Primary Care Finance Report** John Burrows (JB) presented the month 11 finance report. There is a budget of £121m, with a few small variances. Premises have been showing a positive variance due to rate reviews and additional support	

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	has also been required for practices mainly in the Bristol area. There are two particular issues noted in the paper that were requested at the last committee; one is the breakdown of 'other', which is a variety of things such as translation fees. There was also discussion at the last meeting about how primary care allocations are calculated; this has been included in appendix 3. JR interprets the paper as saying in 2018/19 there is a £100k cost pressure in terms of allocations in appendix 3. JB explained there is a difference between the target allocation and actual budget. If the allocation was set at target then the CCG would have £100k extra. The national team have a view that if the CCG is within 5% of target that is as close as they can support; therefore budgets are set according to that. JR commented that last year under NHSEs operation it was £1.6k over target and this year under CCG allocations is £100k under; and queried what the shift has been and how. JB suggested it needs a discussion at a more senior level. **Action: Debra Elliott to arrange a meeting with Julia Ross to discuss the CCG allocation.** The Primary Care Commissioning Committee noted the contents of the report.	**DE**
05.2	**Delegated Commissioning Budget** Rob Moors (RM) presented the budget paper for approval. The way the budget has been set is laid out in the paper. The main component part to the calculation is looking at the weighted patient population, and national agreements on global sum. There is a 0.5% contingency in the budget. There is no mandated stipulation for headroom but there is the 0.5% which is £614k to manage in-year cost pressures. There is also a budget for section 96 for non-recurrent payments to support practices. RM advised there is still an issue around the market rent increases from NHS Property Services and that is an ongoing risk in to 2018/19. The GP dispensing fees of £1.3m at this stage will not be transferred to the CCG and that responsibility will remain with NHSE. The budget has been set, with the 0.5% contingency; there is also a residual reserve balance of £211k. JR asked what the quantum of the estates market rent problem is. RM advised it is between £700-800k.	

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	The consolidated expenditure budget is proposed at £121.4m against the expected allocation of £121.6m. RM advised Rob Ayerst (RA) will be the finance lead for primary care for the CCG going forward. John Rushforth (JRu) referred to the contingency and noted that some of that is allocated for cost pressures and queried what sort of cost pressures this would include. He also asked what happens to the budget for a residual surplus. The budget does not have any comparatives compared to what has been spent previously; and it is split over the three CCGs however this is now a combined CCG. RM commented in terms of the contingency that is a prudent thing to do from a finance perspective. It is also not possible to determine what the cost pressures will be at this stage and it has not yet been allocated so is effectively a reserve. RM advised for reporting purposes going forward it will be one consolidated CCG position. It was also noted that it would be helpful to see the report split in to localities. The Primary Care Commissioning Committee approved the BNSSG budget for primary medical services 2018/19.	
06	**Project Mandate for Review of Local Enhanced Services (LES)** MJ provided a brief background for committee members. BNSSG CCG invests around £15m across primary care in a range of local enhanced services (LES) across the three former CCGs. The project aim is to assess going forward what meets the needs of the population locally; taking the opportunity to look across all three patches. A detailed process has been set up to do this and finish by September 2018. The process has been set up by which a number of objectives have been created. STW commented that the population health needs are talked about in the paper, however it does not refer to engagement of patients and queried where that evidence will come from. JR suggested there are two phases to the process. One is looking at the current LES as they currently exist across the three areas and harmonising them; and saying within that harmonisation are there any that the CCG think are not appropriate. JR expressed that this should	

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	first and foremost be a desktop exercise with some key people, for the example the LMC would expect to be engaged on behalf of the practices. The second phase of the process can be to look at how we support wider primary care transformation and development to meet CCG strategic priorities and this will need to involve service users and other stakeholders. FF asked how GPs will be involved and engaged in the process. MJ advised the clinical leads will be involved throughout, although the governance for the review will sit with the Primary Care Commissioning Committee to ensure potential conflicts of interest are managed appropriately. David Soodeen (DS) made an assumption that one of the issues is to use some of the funds to drive integrated care; and if driving integrated care it is going to have an impact on various different clinical pathways across the system. MJ confirmed this was the case, and part of the process will be looking at areas such as care homes, nursing homes etc. and how to address that as a whole system. JRu asked how value for money can be determined, how that will be tackled and what percentage of the review will be data driven. MJ suggested there are some things that can be measured more easily than others; and the data would affect the decision making. SA explained that one of the strategies Healthwatch are writing in to their work plan for this year is around GP primary care practices and doing questionnaires. SA suggested that Healthwatch are happy to be involved if there is a bespoke piece of work the CCG need to do, Healthwatch would be happy to pick it up and report on it. MJ thanked Healthwatch and noted it would be really helpful and perhaps something to consider as part of phase two of the process. DE also offered support from NHSE in terms of the evaluation and the value for money for quality matrix. JR referred to the slide “Project Scope” it says out of scope is enhanced service commissioned by other parties; and suggested it may be the right moment to start trying to bring public health enhanced services. One of the benefits the CCG can offer is that it can have one payment mechanism and one administrative process. The CCG could take this opportunity to talk to the 3 Local Authorities and see whether this could be done together. MJ/JBo to take forward discussions with local authority colleagues. AMoo noted, in terms of the governance, there is a high level of interest in the committee about this piece of work. Phase one needs to	

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	come back to the committee relatively quickly; and an agreement from the committee on the content of phase two. It was also agreed that a further communication to practices following the PCC discussion should be provided to practices setting out the proposed approach. JBo is to take this forward. **Action: Agree the set criteria for testing value for money at the May meeting date. Martin Jones to present the results of phase one to the committee in June for review.** The Primary Care Commissioning committee approved the approach to the review of Local Enhanced Services as discussed.	**MJ/JBo**
07	**Change Request – Bradley Stoke Boundary Extension** Nikki Holmes (NH) presented the change request paper for Bradley Stoke. The request is to extend the boundary to formally include 1000 patients that are in that extended area. There are three other practices that cover the same area; these three practices have not raised any concerns as part of the consultation phase undertaken before bringing the paper for decision. The practice discussed this with their Patient Participation Group (PPG) who support the application they have made. NHSE are recommending that the extension of the boundary be approved. JR sought clarification as to whether the three other practices in the area have simply not responded or whether they have proactively said they have no concerns. NH confirmed all the practices in the area were contacted and asked if they wanted to raise any concerns; no concerns were raised. JR asked what the impact is on the other practices in the area. DE suggested a potential hindrance to growth in the other three practices. NH advised the patients in the area are already registered in Bradley Stoke, so the competition is already there. STW queried, if a practice can have registered patients outside of the boundary with the same full service, what is the benefit of changing the boundary. NH explained that practices can choose to register people that are outside of their formal boundary and therefore they have to make a judgement in terms of their ability to provide full services out of their boundary area. AMoo highlighted there is no section on risk, and asked if that is because there are no risks. NH commented this is why it was important to give the neighbour practices an opportunity to comment.	

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	The Primary Care Commissioning Committee approved the change request.	
08	**Primary Care Quality Development Report** Anne Morris (AMor) presented the paper which describes the quality development reporting, and it is for the committee to note the proposed plans within the paper for monitoring and gaining assurance for primary care quality. To ensure quality surveillance and manage correctly, a transition group has been established with stakeholder representatives including NHSE. To support the key quality monitoring functions during transition a memorandum of understanding has been drafted. The paper describes the quality areas identified as part of the transition and it also describes those which will remain with NHSE. There is a primary care hub which the CCG are members of and are proactively leading and this shares the key issues between the CCG and stakeholder colleagues around quality improvement. Quality monitoring will be reported through the PCOG and assurance will come to this committee. AMor commented that the paper is designed to describe the development for quality monitoring and assurance; it is not the final piece. AMor advised that NHSE have produced a report detailing the approach to quality monitoring. The sources of data and example dashboards are attached as appendices. AMoo discussed the section which described the quality metrics being reviewed by the PCOG, and assurance coming to the committee; AMoo asked what that assurance will look like and what form will it take. AMor advised that is still in development, but looking at a combined dashboard approach, attached as appendices are some examples however this may not be what the final version will look like. JR expressed a concern with quality being managed through the PCOG and suggested it should be managed through this committee, particularly when discussing individual practices it needs to be done very sensitively and in closed session of the committee. Committee members agreed. AMoo referred to the quality indicators and notes the quality metrics will be improved by the end of June; and asked if patients will be involved in determining what quality means to them. AMor expressed that this is an ongoing project, to provide assurance to the committee. An engagement process will be planned and developed. **Action: Anne Morris to bring the quality metrics back to the committee in June.**	**AMor**

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	DE praised the work of the CCG in terms of what is being articulated about what the process will be and the timeframe this is a good position. AMoo asked what the committee will see differently in the paper next month. AMor confirmed a more advanced dashboard will be presented and to at least describe how points that have been made are being taken in to account. The Primary Care Commissioning Committee noted the proposed plans for monitoring and gaining assurance regarding primary care quality following delegation of the commissioning responsibility to the CCG.	
09	**GP Forward View (GPFV) Update** Jenny Bowker (JBo) provided an update on the GP forward view. The report mirrors the GPFV chapter headings to deliver robust and transform, primary care by the five year forward view timescale. It is a work in progress and it will be refined moving forward. The aim is to give a visual overview of some of the key areas that are being developed against the chapter headings. The aim is also to reflect the CCG assurance status; the red, amber and green (RAG) rating is to reflect where the CCG is in terms of the assurance of each of the chapter headings. The key area to highlight is that the current status on each is amber, which is the CCGs current assessed assurance rating. JBo reported that there is significant progress that has been made, however there are still some risks and there is still work to be done. There has been a lot of work to develop workforce planning approach, and also investing in workforce profiling skills. There has also been a lot of work that has been done with the nursing directorate in responding to the primary care general practice nursing 10 point plan. Equally in terms of resilience there has been a lot of work supporting practices to work collaboratively across groups and clusters to look at their resilience and develop plans across the 10 point high impact actions. JR also highlighted the significant progress in developing our locality providers who are working to develop plans for improved access and integrated ways of working with community providers. JR commented that the ambition is to have a green RAG rating across each, and asked what the trajectory to get there is. JBo responded to say there are a number of actions to get a number of the indicators to green by October; there are a range of indicators that need to be delivered around improved access which the CCG will be more fully	

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	assured on by October. JRu highlighted that the financial aspects are not clear, and asked what the trajectories are being modelled against. JBo responded to say that this needs to be pulled together in terms of the consolidated position around GP funding streams for the CCG for this financial year. There are some funding streams that will support this work, some of which comes through the CCG and some through NHSE, and this information can be shared with the committee. Rob Ayerst (RA) reported that in future finance can share a budget update with the committee that combines both the delegated primary medical budget and the CCG's existing primary care budget including GPFV funding streams. MJ commented that one of the points made is how does it fits in with the wider sustainability and transformation plan (STP) work and what are the opportunities, and what are the understandings across other providers about where this fits. There was a suggestion that a broader session on more detail be organised. **Action: Jenny Bowker to arrange a workshop session on primary care more broadly.** The Primary Care Commissioning Committee noted the GP forward view update.	**JBo**
10	**Medical Contract Overview Report** NH presented the brief overview. The report will be developed further with PCOG once established. The report highlights some of the future decisions for the committee going forward around procurements and mergers. The other thing to note is some positive Care Quality Commission (CQC) reports from some recent reviews. The Primary Care Commissioning Committee noted the medical contract overview report.	
11	**Update on Review of Legacy Payments** DE informed committee members that NHSE carried out a review, with the LMC and CCG, to review the payments that have been made by NHSE to practices for non-reimbursable items, predominantly relating to premises. NHSE, the CCG and LMC met all 24 practices in January and discussed the changes with each of them and also advised them how they could apply for financial support should that be required. Of the 24 practices, 13 applied for support. NHSE held a panel, again	

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	with the LMC and the CCG, to review and consider the applications; and of the 13, 12 were approved for support. AMoo asked if it was made clear to the 13th practice why their request for support was not approved. DE advised there is a national criteria that must be met. There was an appeal from the practice following the decision; therefore the application was heard by a different and independent panel. The second independent panel upheld the first panels request not to approve the application. The Primary Care Commissioning Committee noted the update on the review of legacy payments.	
12	**Locality Governance Update** Justine Rawlings (JRa) shared a paper that is due to be presented to the CCG Governing Body meeting in May. JRa referred to appendix 1 which sets out in diagrammatic form the various groups. It is important to ensure that everyone is aware of the full breadth of the locality area structures in the new BNSSG to ensure there is good engagement and also accountability to the CCG membership. There were some similar arrangements within the Bristol CCG around locality and commissioning, the CCG have been able to review what did and did not work. There is now a very consistent approach across BNSSG and new leadership in place. It was noted that Area Directors and area teams work very closely together to ensure there is a consistent way of working with membership and that will continue to develop over the year in the new BNSSG CCG.	
13	**Any Other Business** No other business was discussed.	
14	**Questions from the Public** There were no questions asked. AMoo closed the meeting.	
	Date of next meeting: Wednesday 30th May, 2-4.30pm (The Vassall Centre, Gill Avenue, Bristol)	

Robyn Smith
Executive Personal Assistant
25th April 2018