Bristol, North Somerset and South Gloucestershire
Clinical Commissioning Group

BNSSG CCG Primary Care Commissioning Committee

Minutes of the meeting held on 30th May at 4pm, at the Vassall Centre, 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
Mike Vaughton	Deputy Chief Finance Officer	MV
Colin Bradbury	Area Director	CB
Andrew Burnett	Director of Public Health, North Somerset	AB
Debra Elliott	Director of Commissioning, NHS England	DE
Apologies		
Justine Rawlings	Area Director	JRa
Sarah Truelove	Chief Finance Officer	ST
David Jarrett	Area Director	DJ
David Soodeen	Clinical Commissioning Locality Lead, Bristol	DS
Felicity Fay	Clinical Commissioning Locality Lead, South Gloucestershire	FF
Rachel Kenyon	Clinical Commissioning Locality Lead, North Somerset	RK
Rob Ayerst	Head of Finance – Community and Primary Care	RA
Philip Kirby	Chief Executive, Avon Local Medical Committee	PK
In attendance		
Sarah Carr	Corporate Secretary	SC
David Moss	Head of Primary Care Contracts	DM
Kevin Haggerty	Clinical Commissioning Locality Lead, North Somerset	KH
Jon Evans	Clinical Commissioning Locality Lead, South Gloucestershire	JE
Nikki Holmes	Head of Primary Care, NHS England	NH
John Burrows	Assistant Head of Finance, NHS England	JB
Sara Ambe	Healthwatch Bristol	SA

Georgie Bigg	Healthwatch North Somerset	GB
Laura Davey	Corporate Manager	LD
Jenny Bowker	Head of Primary Care Development	JBo
Bev Haworth	Models of Care Development Lead	BH
Kate Rush	Associate Medical Director	KR
Robyn Smith	Executive PA *(note taking)*	RS

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01	**Welcome and Introductions – Aim of Meeting** Alison Moon (AMoo) welcomed all to the meeting and apologies were noted as above.	
02	**Declarations of Interest** No conflicts of interest were identified.	
03	**Minutes of Previous Meeting** The minutes were agreed as an accurate record subject to the following amendments. • Page 4, item 5.1 should read "Premises have been showing a positive variance due to rate reviews and additional support has also been required for practices mainly in the Bristol area." • Page 4, item 2 remove the reference to a future Healthwatch merger as the reference was incorrect.	
04	**Action Log** • Ref 01: five members of PCCC still yet to complete a declaration of interest form. Action remains open. • Ref 02: Declarations of interest register to be included in the papers for all meetings going forward. Action remains open. • Ref 07: Quality metrics paper to come to the June meeting. Action remains open. • Ref 08: Workshop session on primary care on track. Forward plan to be included on the June agenda. Action remains open. All other actions were closed.	
05	**Specification for Improved Access** Kate Rush (KR) presented the improved access service specification for primary care for approval. There is a tight timescale for implementation by October 2018. The CCG intends to commission this through the locality transformation scheme to overall get primary care	

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	to start working at scale across seven days in a more integrated way. It is a big shift for primary care to be open seven days a week and as such the paper is minimum requirements for October that moves towards a position of being more integrated and working at scale. The three new requirements are around 111 being able to book directly into primary care, having Sunday appointments at a locality level and opening over Christmas and bank holidays. KR confirmed she has been visiting each of the provider leads within the locality areas. Provider leads have been asked to produce a plan in June, ready for July, to start implementation in October. KR is having regular meetings with the leads for NHS England (NHSE) to discuss requirements such as having a GP that is available seven days a week as well as working more creatively around how the CCG engage with other providers to provide and meet the needs of the population. The group discussed contracting implications arising from the model. The CCG will need to contract with a legal entity to deliver the service. Risks to delivery were highlighted within the paper. However, KR set out the opportunity that primary care at scale gives us to develop greater resilience in primary care and that this approach to improved access helps to mitigate these risks. John Rushforth (JRu) asked, whether an assessment had been made of whether the funding available to practices was sufficient to deliver the service requirements.KR explained that we are proposing that localities use skill mix to deliver the model in recognition that primary care needs can be met by a range of clinical staff and that this will make the most of the resources. We therefore do believe that the funding is sufficient to deliver the service. Georgie Bigg (GB) asked how the approach will work across BNSSG and how much flexibility there will be for different practices and will they be expected to deliver the same or adapt this to the local need. KR commented that it is adaptable because each locality area has different needs and that can vary. In terms of being flexible and understanding the population need, the CCG have been working with providers to share with them information from public health and Joint Strategic Needs Assessment (JSNA); and making the most of the data practices already have to hand. Julia Ross (JR) commented in terms of working across BNSSG, the locality leads all come together regularly every month and share what they are doing in practice and share ideas. Andrew Burnett (AB) referred to page three of the paper which references health inequalities and a suggestion that practices use data	

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	from the JSNA. From a North Somerset perspective AB would be pleased to meet with practices and the CCG to discuss both the health inequalities and what the JSNA means. If this would be helpful AB suggested that his Bristol and South Gloucestershire colleagues will be prepared to do something similar. **Action: Kate Rush to meet with the Directors of Public Health to discuss health inequalities.** The group discussed how we would capture information on the effectiveness of primary care and improved access within this. KR reported that there is a wider piece of work within the CCG to look at how we develop primary care data. Jon Evans (JE) expressed it is really important that the risks are mitigated to the greatest rate they can be before accelerating this piece of work. This could be a basis on which practices can collaborate and provide a different environment and on a different level. Debra Elliott (DE) explained this particular piece of work was asked for next year; however the timeframe was brought forward by six months; and expressed thanks to the CCG for responding so positively and professionally on this matter. JRu asked if a requirement for evaluation will be built in to the specification. Lisa Manson (LM) confirmed it will be, particularly as each of the localities have come up with a slightly different response so therefore they will need to be evaluated and we will need to be confident that we have the best solution for each locality. The Primary Care Commissioning Committee approved the draft service specification for implementation across BNSSG, for plans to be made in June 2018, ready for implementation in October 2018.	
06	**Approach to Primary Care Resilience** Jenny Bowker (JBo) provided an update on the approach to primary care resilience. There has been a programme of work that has been undertaken over the past few years and the CCG are now looking at how to take a fresh approach going forward. Part of this is mandated as part of the GP Forward View (GPFV) in terms of supporting resilience in primary care, and is part of the CCG's primary care strategy. The paper provides an overview and background and explains where we are now. There is a context where the CCG have developed a resilience programme working with NHSE and One Care locally, and the focus of that was to try and generate collaborative discussions	

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	amongst some small groups of practices so they could share information about their resilience. There were a number of different things these groups looked at, and looking at small actions they could take as a group of practices to support the efficiency of their business. We are now at a point in time where the CCG want to look to the future, and how to develop an approach that supports resilience and how to stratify the CCG response going forward. One of the key things that we have learnt is that it is really fundamental that we understand at CCG level what the resilience looks like across the practices. The CCG aim is to develop a single quality data set that will give a view about quality and resilience across BNSSG practices. The data set will provide information about practice workforce, practice finances, any quality indicators through Care Quality Commission (CQC) and other clinical outcome measures. There is a working group established which is taking this work forward. The data set will then enable the CCG to stratify practices in to a rough red, amber and green (RAG) rating. Green will be practices that are in relatively good health and resilient. Amber will be practices where there may be some indicators to suggest the practice may need some support and a conversation should be had with practice to understand what the data is telling us and whether we can offer support. Red practices are high risk for perhaps a combination of reasons; there may possibly be a contractual solution that would then be applied. The CCG then want to stratify the response accordingly; and want to have an approach to resilience overall for practices across BNSSG. The CCG are engaging with the GPFV programme and the Time for Care programme; and the aim is to launch that across BNSSG with a planned launch event for September. The launch event will give practices an opportunity to engage in those programmes. AB queried if resilience includes the concept of being able to manage a major incident such as severe weather, and have business continuity plans in place. LM explained that at this stage it is not included; each practice is required to have its own business continuity plans in place, but are not formal responders as yet. Kevin Haggerty (KH) suggested it is important to bring it down to locality level, local intelligence is very important and involving localities in coming up with solutions, if that can be embedded with localities it would really work well. Resilience needs to be thought about at locality level and some of the solutions may be about how practices come together to meet the needs of that particular area population given the workforce they have.	

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	JRu asked how much of the approach will be about forecast and plans, because financial forecast can give a different indicator. JBo commented that in terms of what data is accessible, there is more information available on what has previously happened, and what is happening currently. The CCG do know about the financial forecasts for practices following a personal medical services (PMS) review programme so the CCG are aware of the financial five year plan across each practice. In addition, workforce data on the proportion of professionals aged 55 and over gives us a potential predictor for risk. AMoo suggested it might be helpful for the next iteration to be clearer on the RAG rating definitions. Referring to the support for the amber practices, which is noted on page five of the paper, AMoo suggested workforce issues wasn't quite clear and commented that workforce will be part of the answer as well as the issue. JBo highlighted that there is a workforce plan in place for the CCG to develop resilience in workforce, which includes looking at new schemes coming online and also developing professional pathways. There are a number of workstreams on workforce to support overall resilience. It was noted that practices that may be red does not mean they are not providing high quality, clinically safe services. Practice identifiable data would not be shared in public meetings, it would be an aggregate position and is only a judgement designed to help the CCG know where to be looking to provide support. The Primary Care Commissioning Committee noted progress on the approach to primary care resilience.	
07	**Primary Care Quality Report** Anne Morris (AMor) provided an update on the proposed plans for primary care quality monitoring. The final draft of the memorandum of understanding (MoU) has now been received, this is now being finalised whilst liaising with NHSE. The CCG quality leads have met with NHSE to agree the process for informing the CCG about any issues that may arise which impact on safety and quality. The Quality Resilience Group has now been established and is developing the approach to quality monitoring. The CCG are reviewing and agreeing the data, and looking at quality metrics for the dashboard. AMor explained that BNSSG CCG are also liaising with other CCGs that are further along in terms of delegated commissioning to look at how their dashboards have been created and how they are accessing their quality data.	

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	AMor explained that although the CQC outcomes on the dashboard demonstrate practices that may be rated overall as outstanding and good, there is still value in more thematic reviews as they may have some requires improvement ratings in some areas such as safe and well led. AMoo suggested it would be good to look at areas of best practice as there may be some other areas around the country that will presumably be a lot further ahead than surrounding CCGs. DE confirmed there are CCGs further up the country that could be looked at and offered to share this with AMor. **Action: Nikki Holmes to contact Anne Morris with some other suggestions of CCGs in terms of contacting them to look at best practice.** The Primary Care Quality and Sustainability Hub will share quality issues. The most recent Hub meeting has reviewed quality issues and looked at CQC issues; also taking information from the Avon Local Medical Committee (LMC). AMoo commented that it would be helpful for PCCC to understand what the Hub does and where it links in; and asked if the Hub discusses specific practices. AMor confirmed they do discuss specific practices, therefore in terms of sharing the information with PCCC; there would be a need for both an open and closed report. The Primary Care Commissioning Committee noted the update on the approach for monitoring and gaining assurance regarding primary care quality.	
08	**Medical Contract Overview Report** David Moss (DM) highlighted some key points from the report. All single-handed contracts have been reviewed, and Cedars Surgery will be contacted to advise that the single handed GP contractor assurance framework will be distributed to them shortly for completion. This is something NHSE are leading on across the region and will pick up in the contract. Feedback will be provided at the Primary Care Operational Group (PCOG). In terms of procurements, there is a lot of work happening around the Locality Health Centre, a paper on this will be taken to PCOG in June as to what that plan looks like in terms of procurement. It was also noted that a request for contract extension has been submitted to the national contract extension group for Northville Family Practice to seek agreement for the contract to be aligned to the timescales for procurement with the other practices in the Brisdoc group.	

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	DM referred to closed list applications and explained that there is a challenging timeframe in this and suggested that as a system we need an agreed approach in terms of delegating decision making. If a list application comes in the CCG has 20 days to respond. DM advised this will be taken through as a discussion at PCOG and propose a recommendation is brought back to PCCC. JR referred to point 6.1 of the report, temporary practice hour changes, and asked if those are now completed and if practice hours are now back to business as usual. Nikki Holmes (NH) advised that practices are not required to inform NHSE that they have finished their fixed temporary arrangements; however suggested that they are confident that all 11 practices are now delivering their normal hours. JR requested that practices are asked to confirm that their fixed term temporary request has ended and that they have resumed normal hours. DE confirmed this can be done going forward. **Action: David Moss to add to future reports whether practices have confirmed if practice hours are back to business as usual.** The Primary Care Commissioning Committee noted the overview of primary medical contracting and commissioning activity in the BNSSG area.	
09	**Criteria for Evaluating Local Enhanced Services (LES)** Martin Jones (MJ) updated the PCCC on the proposed methodology for evaluating the LES across BNSSG. It was requested at the last meeting of the PCCC that a two stage process is considered. Stage one addressing a rapid assessment of those schemes to see what could be judged as important and necessary, and those that would need some further work and engagement with practices to understand the value, the benefit and how they fit with the overall system. MJ referred to both appendices. Appendix one summary table of LES; finance has provided detailed information around the uptake of various schemes, how they fit across the various CCGs; and how the CCG currently pay. Appendix two desktop review template; which does not include one single value or question because when looking at them in detail it is quite apparent that a number of schemes are very long standing and what is in place wouldn't necessarily have a baseline. JR referred to the criteria and noted it is very thorough and comprehensive; however given the number of questions asked if it would be possible to narrow it down slightly. MJ explained that the assessment of them is different for each one. We are not necessarily expecting answers to each question for every area; but there are areas	

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	which need to be thought about in more detail and really delving into the information available because not all the information will look the same. JR asked how the decision will be made as to whether a scheme will continue. MJ suggested there is an expectation that the answers from the questions will determine whether the scheme represents value for money by any judgement that can be made given the information available. Some questions may need to be taken further and some schemes into part two in order to review properly and take the evaluation further. The Primary Care Commissioning Committee noted the next steps and supports the proposed criteria and methodology.	
10	**Primary Care Finance Report** John Burrows (JB) presented the year end finance report. It was noted that the future reporting will come from the CCG finance team. The report informs the committee of the final financial position of the NHSE (South West) primary care medical budgets for the BNSSG area for 2017/18. It was noted that allocations will be discussed and picked up at the BNSSG CCG Strategic Finance Committee. The Primary Care Commissioning Committee noted the final position of the NHSE (South West) primary care medical (delegated) budgets for BNSSG for 2017/18.	
11	**Terms of Reference (ToR)** MJ highlighted the minor changes that were agreed at the last meeting. The ToR will be reviewed in 12 months by PCCC, or earlier if any significant changes happen prior to May 2019. The Primary Care Commissioning Committee noted the Primary Care Commissioning Committee ToR and the Primary Care Operational Group ToR.	
12	**Any Other Business** No other business was discussed.	
13	**Questions from the Public**	

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	There were no questions asked. AMoo closed the meeting.	
	Date of next meeting: Tuesday 26th June, 9.30-12pm (The Vassall Centre, Gill Avenue, Bristol)	

Robyn Smith
Executive Personal Assistant
30th May 2018