Bristol, North Somerset and South Gloucestershire
Clinical Commissioning Group

Primary Care Commissioning Committee

Open Session

Minutes of the meeting held on 29th October 2019 at 9am, at The Vassall Centre, Gill Avenue, Bristol, BS16 2QQ

Minutes

Present		
Alison Moon	Independent Clinical Member – Registered Nurse	AM
Colin Bradbury	Area Director for North Somerset	CB
Lodee Dudley	Consultant in Public Health	LD
David Jarrett	Area Director for South Gloucestershire	DJ
Martin Jones	Medical Director for Primary Care and Commissioning	MJ
Justine Rawlings	Area Director for Bristol	JRa
Julia Ross	Chief Executive	JR
John Rushforth	Independent Lay Member – Audit, Governance and Risk	JRu
Sarah Talbot-Williams	Independent Lay Member – Patient and Public Engagement	STW
Julie Thallon	Interim Director of Quality	JT
Apologies		
Mathew Lenny	Director of Public Health	ML
Lisa Manson	Director of Commissioning	LM
Sarah Truelove	Chief Finance Officer	ST
Georgie Bigg	Healthwatch North Somerset	GB
Jenny Bowker	Head of Primary Care Development	JB
Sarah Carr	Corporate Secretary	SC
Felicity Fay	Clinical Commissioning Locality Lead, South Gloucestershire	FF
Kevin Haggerty	Clinical Commissioning Locality Lead, North Somerset	KH
Nikki Holmes	NHS England	NH
David Soodeen	Clinical Commissioning Locality Lead, Bristol	DS

In attendance		
Rob Ayerst	Head of Finance (Primary & Community Care)	RA
Alison Bolam	Clinical Commissioning Locality Lead, Bristol	AB
Gillian Cook	Primary Care Workforce Development Lead	GC
David Clark	Practice Manager	DC
Bev Haworth	Models of Care Development Lead	BH
Geeta Iyer	Primary Care Development Lead	GI
Bridget James	Associate Director of Quality	BJ
Philip Kirby	Chief Executive, Avon Local Medical Committee	
Rachael Kenyon	Clinical Commissioning Locality Lead, North Somerset	RK
David Moss	Head of Primary Care Contracts	DM
Lucy Powell	Corporate Support Officer	LP

	Item	Action
01	**Welcome and Introductions** Alison Moon (AM) welcomed everyone to the meeting and apologies were noted as above.	
02	**Declarations of Interest** There were no new declarations and no declarations relating to the agenda.	
03	**Minutes of the Previous Meeting** The minutes of the previous meeting were agreed as a correct record with the following amendments: • A post meeting note was added to item 8, Central Weston Estate Update, to confirm the evaluation criteria would be approved by the Strategic Finance Committee. • Page 13, Local Medical Council was corrected to Local Medical Committee.	
04	**Action Log** **Action 85** – Rob Ayerst (RA) updated the action noting that a paper would be presented to the Primary Care Operational Group outlining the CCG's case for increased baseline funding in relation to locum expenditure. RA explained the paper analysed benchmarking for both locum and maternity spend. It was agreed an update would be provided in November. **Action 105** – The update was noted and it was agreed to add Incident Reporting to the Committee forward planner. The action was closed. **Action 122** – Martin Jones (MJ) noted the action had been completed through a Board to Board meeting with Pier Health. It was suggested that Dr John Heather present the future of Pier	**RA**

	Item	Action
	Health development at a Locality Leads meeting. The action was closed. **Action 124** – Evaluation criteria would be presented to the Strategic Finance Committee on the 1st November 2019. This action was closed. **Action 125** – Action closed through update to action 85. **Action 126** – November Primary Care Operational Group to receive paper on locum expenditure. This action was closed. **Action 127** – RA confirmed that there were mitigations that remained dependent on assumptions around additional funding from NHS England and suggested the action remain open. **Action 129** – BJ confirmed quarter 1 and 2 complaints data had been requested from NHS England. NHS England confirmed that complainants who had not consented for their complaints to be investigated were contacted after two weeks to request consent again. NHS England confirmed that clinical complaints were reviewed by the appropriate teams regardless of whether they were investigated as a formal complaint. The action was closed. **Action 132** – David Moss (DM) explained a paper regarding the procurement would be presented at the October closed meeting with an paper presented to the November open meeting. It was agreed to close the action. **Action 133** – DM confirmed the quarter 2 care home Local Enhanced Service (LES) report would be presented to the Primary Care Operational Group and the Commissioning Executive Committee as well as the Primary Care Commissioning Committee. AM asked whether there was a similar LES for care homes for patients with learning disabilities. DM explained that there was a Direct Enhanced Service (DES) that supported health checks for patients with learning disabilities. The LES does allow practices to support homes for patients with learning disabilities although the specification did not differentiate between the different types of homes.	**DM**
05	**Primary Care Network Update** MJ noted the work ongoing regarding Primary Care Networks (PCN) and workforce, and informed the Committee an organisational development event had been held for PCN Clinical Directors and Locality Leads.	

	Item	Action
	Gillian Cook (GC) explained the CCG received monthly information updates from NHS England and these were collated with local updates for a monthly PCN bulletin distributed to the PCNs. The self-assessments of all 18 PCNs have been received following the Co-Design event held. GC explained the event had been split into 5 workshops representative of the 5 domains of the maturity matrix. The majority of the PCNs scored themselves at pre-foundation or foundation stage and the CCG was reviewing the support that could be offered to the PCNs to help them progress. Meetings have been arranged to design organisational development and a representative from each locality has been requested to attend. GC confirmed the area teams have been involved in these discussions. Following NHS England guidance on naming conventions, the CCG was undertaking a review of the PCN names. The PCN names have been changed on the quality reporting platform to fit with NHS England requirements, but remain unchanged for all other purposes. All PCNs have submitted plans to deliver extended hours and more than 500 hours of additional capacity has been identified. The CCG undertook a review of the baseline of the reimbursable roles workforce within the PCNs. The CCG has ensured that PCN Clinical Directors have approved and signed off the baseline and the approved baseline has been submitted to NHS England. The CCG has set up a process for reviewing job descriptions for the new roles including clinical pharmacists and social prescribing link workers. The Committee discussed the recruitment to additional roles and GC noted that as part of the agreed financial plan for 2019/20, there was already an assumption that there would be 50% slippage on the maximum roles reimbursement. Work was ongoing to understand the forecast expenditure, however it was not anticipated that there would be a significant level of uncommitted funding in 2019/20. Service requirements would be complemented by the introduction of the Network Dashboard and Impact and Investment Fund from 2020/2021.	

	Item	Action
	Julia Ross (JR) asked whether the CCG had been clear in what roles they believed the PCNs need to function and what type of support the CCG was able to provide. MJ confirmed the CCG had met with locality providers to review current teams and potential additional roles. However, as new bodies, there were areas where the PCNs were unsure on what was required. JR reiterated that the CCG needed to provide the necessary support to describe the expectations of the PCNs so they were clear on the work the CCG was expecting from them such as driving integrated care. JR noted that the Primary Care Commissioning Committee had previously discussed shared roles across organisations such as paramedics and mental health clinicians and asked why this hadn't been included within the paper. GC explained part of the PCN bulletin would outline rotational posts for pharmacists and the opportunities for system working. JR asked how a similar strategic approach could be taken for other system roles. GC confirmed that South West Ambulance Service Foundation Trust (SWASFT) had begun training paramedics for a primary care led system. However, it was important to ensure that clinicians were not being removed from other parts of the system. The Committee requested a seminar session on PCN workforce and suggested inviting the PCN Clinical Directors to attend. JR asked how the CCG would engage with the delivery of the national specifications to ensure these were not cutting across local workstreams. Justine Rawlings (JRa) agreed to contact the national team and gain assurance. JR asked how the CCG supported and challenged the PCNs to self-assess positively and not be overly risk averse. GC noted the locality teams have been working closely with PCNs on the maturity matrices. MJ highlighted the need for the CCG to consider how to challenge the PCNs to be both positive about their progress and realistic. Peer support was suggested as a possible option. Dave Jarrett (DJ) noted the additional roles reimbursement and suggested that the roles recruited to appeared lower than 50% and asked what the impact of this was. RA explained the assumption was 50% of roles would be recruited to with any unspent money clawed back, however this approach needed to be confirmed by	**MJ** **JRa**

	Item	Action
	NHS England. DJ noted that as part of the recruitment processes PCNs could jointly commission services as opposed to hiring posts. GC confirmed that this was an option and some PCNs had commissioned link working social prescribing services and this had been undertaken through localities. This had happened in areas where there were already strong local offers. JR asked how this would be formally evaluated and noted that these services needed to provide the best benefit to patients not the PCNs. JRa noted that social prescribing was being reviewed as part of the integrated care work and measures on outcomes have been put in place through this workstream. Sarah Talbot-Williams (STW) referenced section 11 and noted that reducing health inequalities was the responsibility of PCNs and this was in line with the Primary Care Strategy. DM highlighted that this was part of the national service specification for locality working and delivered at PCN level with Healthier Together to ensure the work was joined up. JRa highlighted the importance of local knowledge to know which areas needed data review at which level, practice or PCN. MJ suggested the CCG should focus on how reducing health inequalities could be practically addressed. STW noted that there could be duplication working at both practice and PCN level. AM noted the dashboard and highlighted the need for outcomes and measures to be included on the dashboard rather than processes. It was suggested that prior to the dashboard starting in April 2021 the CCG should undertake a shadow run to ensure the dashboard fulfils local CCG needs. **The Primary Care Commissioning Committee:** • **Noted the findings from the PCN self-assessment** • **Noted the proposed organisational development next steps and the implementation of the additional roles**	
06	**Primary Care Finance Update** RA updated the Committee on the month 6 position noting the CCG had now formally reflected a number of risks within a revised forecast outturn position resulting in the CCG reporting a forecast deficit of £24.9m, with a further £1.1m risk to delivering the revised forecast. The inclusion of the risk within the position has been reported to NHS England.	

	Item	Action
	RA noted the revised forecast outturn deficit of £68k against delegated budgets and highlighted the areas of slippage including the non-recurrent allocation from NHS England, lower than forecast growth on population and lower than planned seniority payments. RA highlighted the unplanned costs in year including costs associated with practice list dispersals. RA noted that the cost pressures were mitigated by the release at month 12 of the 0.5% contingency, uncommitted budget that could be used to mitigate against in year cost pressures. RA explained there was still an assumption of a further £700k allocation from NHS England and the Chief Finance Officer was in discussions with NHS England regarding these funds. RA confirmed there had been no further slippage on the additional roles funding, recognising that PCNs would need time to establish. RA highlighted the significant overspend on category M drugs, noting that this was a national issue and a non-recurrent allocation from NHS England was assumed as a mitigation to this. JR noted the underutilisation of the anti-coagulation LES and asked what the impact of this was for patients. JR also asked whether there were other options for these services if the LES was underutilised and asked what the possible options were if this was not delivering. It was agreed to include these considerations in the LES paper to the November Committee. DJ asked about the assumed mitigations from NHS England funding. RA explained that the work ongoing to review local expenditure should evidence the areas where there is baseline underfunding. This was just one of many queries for NHS England regarding funding and these were being addressed. **The Primary Care Commissioning Committee received the primary care finance report and noted:** • **Combined primary care budgets were reporting a year to date overspend of £1.2m** • **The revised forecast outturn (£119k surplus)** • **The forecast outturn assumes £2.7m of additional funding from NHS England** • **The risks to delivery of this plan**	**DM**

	Item	Action
7	**Primary Care Quality Report** BJ provided the quality update noting that that the paper also suggested changes to future quality reports. Two practices have received their Care Quality Commission (CQC) reports, Lawrence Hill and Cadbury Heath. Lawrence Hill was rated as 'requires improvement' in two domains, there were no breaches of regulations and no "must do" recommendations were set. The CCG has requested their action plan for review. Cadbury Heath were rated outstanding in 4 of the 5 domains and the CCG would review their report outlining good practice and encourage this to be shared with other practices. BJ highlighted the CQC state of care report for 2018/19 had been summarised within the report. For BNSSG, 96.6% of practices were rated as good or outstanding, nationally this was 95% of practices. The Committee discussed the changes in assessment by CQC and BJ noted the quality team were discussing these changes with the CQC and assessing the impact on local practices. Friends and Family Test reporting remains consistent across BNSSG and the recommendation rate has improved above national average. Flu vaccinations have started and a task and finish group has been arranged to support practices uptake figures. The group will support practices which have reported previous low uptake rates. BJ explained that the quality domains have been reviewed and noted that updates have been included which utilised data from other sources than QOF. There was a proposal that QOF data was no longer used for updates but other data was reviewed to provide further detail. JRa noted Lawrence Hill's CQC report and asked whether the rating needed to be considered in terms of the population of the practice and health inequalities work. There would be implications on how the CCG supports practices taking this into account. The Committee suggested the population health management team, locality and quality data was reviewed to see if population metrics affected CQC ratings.	**BJ**

	Item	Action
	John Rushforth (JRu) asked whether the CCG expected the CQC rating for Lawrence Hill. BJ explained neither the CCG nor the practice had expected the rating. The Committee discussed whether the CCG could anticipate CQC ratings through available data. JR noted that some of the suggested actions were business as usual and MJ noted that these would not be reported on the resilience dashboard. The Committee discussed how the teams can review CQC measures using soft intelligence available to the CCG including triangulating quality and population information. Racheal Kenyon (RK) noted that practices were stretched and suggested the CCG provide a summary of best practice from outstanding rated practices and distribute through PCNs or localities. JR asked what support the CCG can provide to help practices prepare for their CQC inspections. David Clark (DC) noted that One Care can provide support. BJ noted that the best practice guidance to be circulated to practices would help support future CQC inspections. The Committee discussed support to practices for CQC inspections and it was agreed to discuss this issue further at the Primary Care Operational Group. JR commented on the paper noting that the quality processes were well outlined but there was little reference to outcomes. It was asked that future iterations of the report outlined the outcomes of the information included. JR highlighted that only 50% of practices had signed up to the respiratory NHS Improvement scheme and it was asked what the impact of this was. JR asked whether the lack of sign up indicated that this particular scheme was not required in BNSSG and outlined that all the implications of the take up rate were considered. It was agreed to consider this through the integrated care route. JR also commented on how the CCG can ensure good quality in primary care and how this would be identified. JR suggested that this work take place with practices, who can also identify what good quality looks like for them and this can be built into future reports. AM highlighted the consideration that needed to be given to patients with learning disabilities and how annual health checks, flu vaccinations and deterioration to health for these patients can be built into the report and measured to provide the CCG assurance.	**BJ** **BJ** **JRa**

	Item	Action
	The Primary Care Commissioning Committee received the primary care quality report.	
8	**Contracts and Performance Report October 2019** DM presented the report noting that the CCG now held 81 contracts, which was a reduction from 84 following the closure of Bishopston, Northville and Clarence Park. DM reported the number of improved access minutes delivered in August was an average of 38 minutes per week. It was noted that appointments on Sundays were particularly underutilised. JR noted the long length of the contract terms for Broadmead Medical Centre and Emersons Green Medical Centre and noted that due to their long length these contracts needed to be reviewed and an increased level of assurance provided. It was agreed to provide an update following practice visits. **The Primary Care Commissioning Committee received the contracts and performance report.**	**DM**
9	**Governing Body Quarterly Report** The Committee praised the paper and agreed this should be presented to the Governing Body. **The Primary Care Commissioning Committee agreed the Governing Body should receive the report.**	
10	**Papers progressing to Governing Body** The Committee agreed the Governing Body Quarterly Report should be presented to the Governing Body.	
11	**Questions from the Public – previously notified to the Chair** There were no questions from the public.	
	Date of next PCCC: Tuesday 26th November 2019 9am-12pm Clevedon Hall, Elton Road, Clevedon, BS21 7RQ	
	The "motion to resolve under the provisions of Section 1, Subsection 1 of the Public Bodies (Admission to Meetings) Act 1960 that the public be excluded from the meeting for the period that the Clinical Commissioning Group is in committee, on the grounds that publicity would be prejudicial to the public interest by reasons of the confidential nature of the business" was proposed by STW and seconded by JRu.	

Lucy Powell, Corporate Support Officer
November 2019