Bristol, North Somerset and South Gloucestershire
Clinical Commissioning Group

BNSSG CCG Primary Care Commissioning Committee (PCCC)

Minutes of the meeting held on Tuesday 30th October at 9am, 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
Anne Morris	Director of Nursing and Quality	AMor
Lisa Manson	Director of Commissioning	LM
Martin Jones	Medical Director for Primary Care and Commissioning	MJ
Justine Rawlings	Area Director for Bristol	JRa
Colin Bradbury	Area Director for North Somerset	CB
Andrew Burnett	Director of Public Health	AB
Apologies		
Julia Ross	Chief Executive	JR
Sarah Truelove	Chief Finance Officer	ST
David Jarrett	Area Director for South Gloucestershire	DJ
Debra Elliot	Director of Commissioning, NHS England	DE
Sarah Talbot-Williams	Independent Lay Member – Patient and Public Engagement	STW
Sarah Ambe	Healthwatch Bristol	SA
Kevin Haggerty	Clinical Commissioning Locality Lead, North Somerset	KH
David Soodeen	Clinical Commissioning Locality Lead, Bristol	DS
Felicity Fay	Clinical Commissioning Locality Lead, South Gloucestershire	FF
Philip Kirby	Chief Executive, Avon Local Medical Committee	PK
Alex Francis	Healthwatch South Gloucestershire	AF
Jenny Bowker	Head of Primary Care Development	JBo
Sarah Carr	Corporate Secretary	SC
John Burrows	Assistant Head of Finance, NHS England	JB
Georgie Bigg	Healthwatch North Somerset	GB
In attendance		
Rachael Kenyon	Clinical Commissioning Locality Lead, North Somerset	RK
Jon Evans	Clinical Commissioning Locality Lead	JE
David Moss	Head of Primary Care Contracts	DM

FINAL

Nikki Holmes	Head of Primary Care, NHS England	NH
Mark Corcoran	Chair, Avon Local Medical Committee	MC
Robyn Smith	Executive PA *(minute taker)*	RS
Mike Vaughton	Deputy Chief Finance Officer	MV
Geeta Iyer	Clinical Lead for Primary Care	GI
Bridget James	Associate Director of Quality	BJ
Bev Haworth	Models of Care Development Lead	BH
Lindsay Gee	Head of Locality Planning, South Gloucestershire	LG

	Item	**Action**
01	**Welcome and Introductions** 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 approved as an accurate record.	
04	**Action Log** • Ref 29: Further update to be provided at the November PCCC meeting Action remains open. • Ref 31: Ongoing. Action remains open. All other actions were closed.	
05	**Chairs Report - NIL** Nothing to report.	
06	**Local Enhanced Services (LES) Review Update** Martin Jones (MJ) presented an update on the progress of the LES review.. MJ and Jenny Bowker (JBo) attended the membership forums to discuss Anticoagulation, Near Patient Testing (to be renamed Specialist Medicines Monitoring) and Supplementary Services. There is a paper included in the report that highlights the feedback. Anticoagulation In terms of the Anticoagulation discussion, the predominant feedback received from South Bristol, South Gloucestershire and North Bristol localities is that this wouldn't be most effectively supported by individual practices. MJ advised that Inner City and East is currently	

FINAL

	Item	Action
	being approached more formally about this. A question raised at the locality meetings was what will secondary care be asked to do, and how does the budget fit in with that. The CCG have highlighted to the Trust that the CCG will need to understand what they do; and have highlighted to the Trust that they may wish to take a different view in a years' time (2020/2021). Near Patient Testing (to be renamed Specialist Medicines Monitoring) MJ informed the committee that practices have welcomed the change of name from Near Patient Testing to Special Medicines Monitoring. MJ commented that currently anti-psychotics medicines prescribing and monitoring is varied across practices; and advised that it has been suggested that this would benefit from shared protocols and standardisation to help manage risk. Supplementary Services MJ highlighted that there has been some concern raised at a number of the items included within the specification. There is a specific concern that has been raised about increasing the specification to include ear syringing as currently included in the South Gloucestershire and North Somerset specifications. There are also concerns about the totality of work represented by the contents of the 'basket' and the need to review the content. A key factor that will enable a more in-depth review of the specification is to generate a list of agreed EMIS codes. Mark Corcoran (MC) referred to ear syringing and commented that it is a procedure that has risks. A procedure associated with litigation for practice nurses; therefore need to be careful to protect primary care workforce against risk. MC expressed a specialist service would be favourable, and suggested this could perhaps be located in a Hub instead of each practice. The governance issues around safety procedures also need to be considered. MJ added that currently South Gloucestershire practices have asked what was happening about their pre-existing 'basket' enhanced service. This is an additional specification paid at 16p per patient and is currently being investigated by the CCG further as this will need to formally come within the scope of the review. AMoo asked if there is a process for tracking if there are any further 'baskets' that the CCG may not be aware of. Lisa Manson (LM) commented that this can be tracked by the finances and the money that is spent. GP Practice Support to Care Homes with Nursing The schedule for practice care home support is included in the paper. MJ commented that there are some interesting ideas in terms of how	

FINAL

	Item	Action
	care homes are managed in the future. There are some differences across BNSSG, for example North Somerset is currently only funded to support care homes with nursing. The view was that extension to care homes without nursing would be beneficial; however, there may be some financial implications in doing so. Justine Rawlings (JRa) echoed MJs comments that each locality has slightly different arrangements and suggested a conversational approach that builds a model that works in each local area. There are some principles that constitute what is appropriate support; and then considering the best way to deliver that in each local area. John Rushforth (JRu) asked how the CCG measure the data reported in care homes to ensure the CCG are paying for things they should do. MJ explained there is some success criteria in the document; however, it needs some further work. AMoo referred to 2.2 of appendix A, local defined outcomes, and commented that this has not been populated. AMoo suggested there is an opportunity for the outcomes to be truly outcome focussed rather than process measures. MJ noted that there needs to be a sense of both quality and system outcomes being measured. RK commented that primary care have taken on various things for secondary care and expressed that GPs will welcome the opportunity to review that. As commissioners the CCG should be looking towards what the future should look like for the population. In terms of next steps MJ advised these are to develop and engage with the membership, the LMC and the committee on draft specifications for Diabetes and Dementia (action). There has been some feedback in terms of people thinking about the Diabetes LES. There were some discussions at the Diabetes Programme Board last week that raised some issues; which are helpful in terms of understanding why things are done the way they are. The Primary Care Commissioning Committee: • Noted the feedback received on draft specifications shared with the membership and the LMC contained in the main report • Discussed the draft GP Practice Care Homes with Nursing Support specification in appendix A and recommended that extension to care homes without nursing was developed as part of the next steps, noting that this is currently available in South Gloucestershire and Bristol and financial modelling is needed to support this • Noted the highlight report in appendix B and the proposed next steps set out within the main report and the highlight report	MJ

FINAL

	Item	Action
07	**General Practice Resilience & Transformation (GPRT) Mandate**	
	Bev Haworth (BH) informed the committee of the approval of the GPRT programme mandate at the Healthier Together Sponsoring Board on 24th September 2018. GPRT is one of the 10 key workstreams within Healthier Together.	
	The mandate was taken to the Time for Care event in September 2018. Workshops were carried out at the event asking for feedback on whether the priorities were right. BH advised they are now in a position of establishing a steering group; and an initial workshop was held on 25th October. Another workshop will be held to ensure the right stakeholders are included going forward.	
	Jon Evans (JE) queried what the definition of resilience is. BH commented that a hierarchy of need is used, rather than a definition, to put together a framework which now needs to be tested with a wider audience. MJ commented that it is wise to acknowledge that there is a lot of work going on to support practices and resilience; but at the centre of this as well there is another piece in terms of understanding what is good about practices. Although working at scale there is still a piece around what practices would like to look like, how will the job be doable, and how do the CCG support practices to develop whilst they are developing with the wider system.	
	JRu asked how the governance of this system interacts with the work of the committee and how that is going to work. BH explained the steering group, once established, will feed in to the Integrated Care Steering Group. AMoo referred to the implications for public involvement section, and highlighted that the slide presentation talks about working with the citizen panel. AMoo expressed the importance of strong public engagement. LM suggested a seminar session for the committee would be helpful to have some further discussions in support of development through the committee *(action)*. It is proposed that following this we will establish regular dual reporting lines from this programme to both the Primary Care Commissioning Committee and the STP.	BH
	The committee discussed the five objectives of the programme and it was agreed to go back and relook at the five points and the tone of the message in terms of the use of the word 'resilience' *(action)*.	BH
	The Primary Care Commissioning Committee: • Noted the approval of the GPRT programme mandate and commented on and discussed the next steps	

FINAL

	Item	Action
08	**Primary Care Quality Report** Anne Morris (AMor) highlighted the following updates within the quality report. • Four practices have had Care Quality Commission (CQC) inspection reports published. All received an overall rating of 'good'. One practice received a 'requires improvement' in the safety domain which related to medicines; it was noted that the medicines optimisation team are liaising on this. • Friends and Family Test (FFT) for August 2018 had a compliance rate of 58%, which is a slight drop from the previous month's position. It was noted that the quality team will be contacting the practices who have not submitted data for two consecutive months. • The quality team looked at themes in terms of the complaints regarding primary care in quarter one. These were in relation to communication and staff attitude. The focus quality domain this month was Children's GP services. There are four indicators regarding children's health, these are all immunisation metrics. They demonstrate that BNSSG as a whole has a higher compliance rate for the four indicators regarding children's immunisation than the national average, although this does remain below the target. Immunisations are commissioned by NHS England (NHSE). Monitoring performance is managed through the Local Authority Health Protection Committees. The LES was offered to all practices within BNSSG in 2018/19 to support active recall of patients that had incomplete MMR vaccination records. 67 practices signed up to the LES. Andrew Burnett (AB) queried if the MMR is in relation to the first vaccination. Geeta Iyer (GI) advised it is incomplete vaccination. AB commented that the second MMR is also an issue nationally. AMoo referred to page four of the report which notes specific work has been undertaken in the last six months in Bristol and South Gloucestershire to improve this, but not North Somerset and queried why. AMor commented that she will have to check this *(action)*. MC asked if there was a national drive to educate and encourage parents regarding MMR immunisation. AB commented that Public Health England is concerned about the current national outbreak of measles; however he is unsure whether they are planning a national programme to promote MMR immunisation. The quality improvement section of the paper talks about the CCGs Datix incident reporting that has recently been implemented across all	AMor

FINAL

	Item	Action
	BNSSG practices and this is for reporting of secondary care issues and concerns. The team are also now in the process of establishing a single point for reporting serious incidents and serious adverse events via this method for GP practices. At a recent Quality and Surveillance Hub meeting a theme of medication errors relating to use of dosette boxes was identified and learning from these will be shared through Pharmacy and GP Bulletins. RK suggested it would be good to get some clear guidance in terms of dosette boxes for both community pharmacy and general practice; so the CCG can understand when there is a problem why that has occurred. AMor will pick this up with medicines optimisation colleagues to see what opportunity there is for the CCG to do some work around this *(action).* JE referred to the FFT data and asked if the actual numbers could be included in terms of the response rate, alongside the percentage. AMor confirmed this can be included in future reports *(action).* Reference the primary care complaints, JE asked if the complaints are redirected by NHSE and is there a conversation with the complainant about liaising with the practice. Nikki Holmes (NK) confirmed there is choice for patients, and have to respect that if a patient wants to raise it with NHSE they can do so. The complaints team will then liaise with the clinician in terms of how to then respond, and also link with the contractor. The Primary Care Commissioning Committee: • Noted the updates on monthly quality data and specific performance indicators for Primary Care Children's services	AMor AMor
09	**Contracts and Performance Report** David Moss (DM) presented and confirmed the paper provides an overview of CCG contracts and their performance in 2018-19. DM noted the performance for Improved Access (IA) in August 2018 has decreased to 39.2 minutes per week across general practice. It was suggested this may be due to the nature and time of the year. DM informed the committee that work is underway in regards to referral data; however it is not yet in a place to share with the committee. Essentially GP variation of more than two standard deviations is being looked at. It is being considered with the area teams the best way to work with practices on this is through the localities to have a conversation around practices that are outlying in specialties and what the best course of action is to support outside the BNSSG corporate	

FINAL

	Item	Action
	referral service. Work is underway to establish a meaningful way of reporting this information to the committee for future reports. In terms of the other contractual updates, the CCG have received an application for a boundary change, and a temporary closure. A remedial notice has been served which is being worked through with the Primary Care Operational Group (PCOG) to understand the response to that and what that will look like. An update on each of these points will be provided in detail in the November report to the committee. AMoo commented, when looking at the actions to support reducing variation, there is not an action noted for supporting specific practices. DM confirmed this specific information can be included in future reports *(action).* The Primary Care Commissioning Committee: • Noted the performance and contractual status of Primary Care	DM
10	**Improved Access (IA) Contracting – Engaging Practices & Locality Boards** DM noted the paper describes the current and future intended contract arrangements for IA. This is the national drive to have appointments after 6.30pm, weekends and working on a hub basis to support that at scale. Current arrangements are that One Care provide this service with a legacy contract that was with NHSE and novated across to the CCG on the 1st April 2017 and is due to expire on the 1st April 2019. This committee has discussed and agreed in closed session Alliance contracting as a model that they would like to explore from the 1st April 2019. The paper set out what that means in terms of Alliance contracting and how with the CCGs provider board. Alliance contracting is to work at scale, to have a risk share and responsibility for outcomes across a locality footprint rather than a practice level; and to hold and recognise risks and opportunities. It is based on a culture of no fault no blame, and transparency between parties in terms of open book principles. In describing that as a contract model with each practice having a standard contract and then an alliance contract discussing and setting out those risks, and how that working together would work. DM commented that there are some legal considerations to be made once the contract is in a more final state post consultation. There will be some engagement around propensity to risk, and any considerations or fears that need alleviating and steps agreed to mitigate.	

FINAL

	Item	Action
	JE suggested his membership will want to be clear on what support will be given to providers if the decision is to go down this route; particularly in terms of legal considerations and risks. DM noted this is what the CCG will be consulting on, but there is an element of management overhead for the current provision and there is a discussion there to say what that will look like. JRa also noted Primary Care Networks which is about the new initiative to work at scale and also an element of organisational development support. AMoo referred to section 9 of the paper, implications for public involvement, and asked if that is the only extent of public involvement around this concept. DM explained the service specification is is not changing; it is only the contractual vehicle for delivery, hence patients should not see a difference in their experience of the service. JRa informed the committee that there is an evaluation that Peter Brindle (Medical Director, Clinical Effectiveness) team are carrying out around IA which PCOG has asked for; which is looking at those aspects that will need to come back to this committee. The evaluation will be included in the paper to the committee after the engagement. The Primary Care Commissioning Committee: • Recognised and agreed the planned alliance contract engagement with stakeholders throughout November 2018	
11	**Primary Care Finance Report** Mike Vaughton (MV) presented the finance report for month 6. Started with delegated budget of £122,813k. There has been a couple of technical adjustments between budget areas, therefore month 6 the budget is £120,759k, majority of that is linked to contract expenditure with practices. The CCG hold a contingency reserve being 0.5% which is worth £0.6m. In addition, the CCG is holding £527k of general reserves which reflects budget flexibility identified at the beginning of the financial year and which has been applied against an overspend on locum costs. In the period to month 6 the CCG has seen a small underspend in relation to GMS contracts with a breakeven forecast position. MV commented that the biggest area of concern is locum spend which is showing a significant adverse variance. On the basis of advice from NHSE the current level of expenditure appears consistent with the run rate seen during 2017-18 and NHSE believes reflects the impact of changes to the eligibility criteria. This will require a recurrent adjustment to the budget for 2019-20.	

FINAL

	Item	Action
	MV highlighted two risks, the first is funding for the market rent increases of £0.7m. The CCG has been advised by NHSE that a non-recurrent allocation will be made and this is assumed in the financial position however formal confirmation is outstanding. Secondly the balance of funding for the 2% pay awards announced from April 2018 for primary care are assumed but not yet funded and the CCG are awaiting confirmation from NHSE of funding for c£1m costs. AMoo asked a question about locum costs, having noted that the CCG is supporting recruitment she asked if the CCG expects to see an impact as a result of this work in terms of the financial position. DM explained that the locum costs charged to the CCG under the national rules are for sickness and maternity leave so it is not for all workforce absences that are filled with a locum. There are specific circumstances under which the CCG pay for unexpected absences. RK queried if the CCG is able to gather data from the membership about locum utilisation in general and associated costs to help gauge what the budget should be set for next year. MV commented that the CCG does not have access to the Practice accounts information but it is something that could be done with agreement through the locality groups. The Primary Care Commissioning Committee: • Noted the update on the latest reported financial position for all BNSSG CCG primary care budgets	
12	**Any Other Business** No other business was discussed.	
13	**Questions from the Public** **Question from Shaun Murphy (Protect Our NHS)** 104 interventions are restricted by the BNSSG CCG. https://media.bnssgccg.nhs.uk/attachments/Commissioning_Policies_-_Jun_2018_v1819.1.01.pdf. Not only do these policies ration effective treatments, they also prevent GPs referring patients to specialists for an opinion unless funding approval has been agreed. The risk burden this places on GPs is not acknowledged by the CCG. For example in the case of foot surgery the relevant document https://media.bnssgccg.nhs.uk/attachments/Foot_Treatment_Surgical_Policy_PA_v1617.1.01.pdf states (page 3 paragraph 2), '*Funding approval must be secured by the patient's treating clinician prior to referring patients for surgical opinions.*' In practice this means that patients cannot be referred by a GP for a specialist opinion for any of	

FINAL

	Item	Action
	the restricted conditions even if a surgical procedure is not going to be pursued. Is it not the case that this referral restriction leads to worse diagnosis and treatment for patients, as well as isolating and demoralising GPs? **Response from Lisa Manson, Director of Commissioning on behalf of the CCG** BNSSG CCG is responsible for making the best use of the NHS funds allocated to it to meet the health needs of the local population. Unfortunately, the demand for services is greater than the money available and therefore we prioritise the use of funds carefully with reference to national and local policies to ensure that the treatments, operations or drugs we commission have a proven benefit in meeting the health needs of the population. As such, we work closely with local clinicians, including the GP membership and specialist doctors, to ensure that we have developed a number of commissioning policies which allow routine access to patients who need secondary care treatment at the clinically appropriate time. These policies have all been developed for and approved by our Clinical Commissioning Executive and Governing Body following consideration of the clinical evidence and lengthy and robust clinical engagement to ensure that they meet the needs of the whole patient group. We can confirm that a number of commissioning policies that set out care pathways for patients do require funding to be secured prior to a referral to secondary care for surgical treatment. This is mainly areas where the condition is relatively straight forward to diagnose and the treatment pathways are clearly defined and well established. Such treatment can and does include management in primary care where appropriate. We have developed this approach following feedback from patients who were rightly challenging that having taken time to attend hospital appointments and tests found they did not routinely qualify for surgery. By ensuring that funding approval is secured prior to referral in a small number of routine pathways, a patient and clinician can be assured that should a surgeon agree that surgery is necessary to treat the patient they will be able to complete their pathway. These pathways also enable GPs to access the necessary information to offer effective advice and guidance to their patients as an appropriate first step. Where specialist advice is required even for the conservative management of people's conditions we have established a number of programs that allow quick and easy support for GPs and patients. For example, the policy you cite allows for a referral to be made to our	

FINAL

	Item	Action
	commissioned Musculoskeletal services for initial including Extended Scope Physiotherapists. We have also commissioned a number of 'Advice and Guidance' services to ensure much quicker and more stable access to specialist advice for GPs and patients. For example, we have commissioned a Teledermatology service which enables GPs to receive diagnostic and management advice from consultant dermatologists for patients who would otherwise have been referred to secondary care. Such management advice can include that it is appropriate for a referral to be made to secondary care. This means that when an appropriate referral for a patient is made, they will be seen much quicker than if all of the patients supported via the Teledermatology service had also been referred into secondary care for a face to face appointment. We hope that this response demonstrates how we as a CCG continue to work with our GP membership to ensure that they are supported in providing an enhanced and viable service to local people. If you would like to discuss this further, please do not hesitate to make contact with Dr Peter Brindle (Medical Director - Clinical Effectiveness). The views of GP members of the committee were sought by the member of the public. MJ commented that he finds it helpful, the good thing is knowing which of the pathways GPs can follow. What the CCG are trying to do with Remedy is develop it so that the pathways are very clear, it is also helpful to understand what is evidence based and what is good practice, and how to follow that pathway. There is a referral management tool being developed to encompass all of this. MJ recognised that there are certain things, that over time, are not necessarily good practice based on high evidence, and with those MJ explained he has a conversation with the patient on those particular guidelines so the patient can understand the reasons and rationale. What he needs to know that the committees, supported by clinicians, make the right decisions around those pathways that are based on evidence, and the CCG have a robust way of doing. MC he expressed that the advice and guidance system is very helpful where it is in place. It helps GPs to be able to know how to manage patients in the future, when they come across the same situation again. MC commented that each CCG has a different list of interventions they will not fund and felt that was an issue. MC advised that the General Practitioners Committee (GPC) based with the BMA in London are negotiating nationally to define a list that is used across the country	

FINAL

	Item	Action
	and suggested that policy will be more straightforward if that policy is negotiated nationally.	
	Motion to Exclude Public and Press 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 JRu and seconded by LM. AMoo closed the meeting and thanked everyone for their attendance and contribution.	

Robyn Smith
Executive Personal Assistant
30th October 2018

FINAL