Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group

BNSSG CCG Primary Care Commissioning Committee (PCCC)

Minutes of the meeting held on Thursday 3rd January 2019, at 1pm, at the Vassall Centre, Bristol.

Minutes

Present		
Alison Moon	Independent Clinical Member – Registered Nurse	AM
John Rushforth	Independent Lay Member – Audit, Governance and Risk	JRu
Lisa Manson	Director of Commissioning	LM
Martin Jones	Medical Director for Primary Care and Commissioning	MJ
Andrew Burnett	Director of Public Health	AB
Julia Ross	Chief Executive	JR
David Jarrett	Area Director for South Gloucestershire	DJ
Sarah Talbot-Williams	Independent Lay Member – Patient and Public Engagement	STW
David Soodeen	Clinical Commissioning Locality Lead, Bristol	DS
Felicity Fay	Clinical Commissioning Locality Lead, South Gloucestershire	FF
Georgie Bigg	Healthwatch North Somerset	GB
Rachael Kenyon	Clinical Commissioning Locality Lead, North Somerset	RK
Justine Rawlings	Area Director for Bristol	JRa
Colin Bradbury	Area Director for North Somerset	CB
Philip Kirby	Chief Executive, Avon Local Medical Committee	PK
Jenny Collins	NHSE	JC
Apologies		
Sarah Ambe	Healthwatch Bristol	SA
Sarah Truelove	Chief Finance Officer	ST
Kevin Haggerty	Clinical Commissioning Locality Lead, North Somerset	KH
Alex Francis	Healthwatch South Gloucestershire	AF
Debra Elliot	Director of Commissioning, NHS England	DE
In attendance		
Rob Moors	Deputy Director of Finance	RM
Jenny Bowker	Head of Primary Care Development	JB
David Moss	Head of Primary Care Contracts	DM
Bridget James	Associate Director of Quality	
Sarah Carr	Corporate Secretary	SC

	Item	Action
01	**Welcome and Introductions** Alison Moon (AM) welcomed all to the meeting. The apologies were noted as above.	
02	**Declarations of Interest** There were no new declarations of interest. No declared interests conflicted with items on the agenda.	
03	**Minutes of Previous Meeting** There was an error on page three, paragraph two which should have read "…that there…" with this correction the minutes were approved as an accurate record.	
04	**Action Log** Committee members reviewed the action log: • Ref 39: financial modelling was included in the papers for the meeting and further modelling would be presented to the January 29th meeting in closed session. The action was closed. • Ref 40: Local Authority Chief Executives had asked for the Ethical Framework to be presented to the Health and Wellbeing Boards. It was confirmed this would be discussed at the three Health and Wellbeing Boards. The action was closed. • Ref 41: this action was for completion in February. It was agreed to assign the action to Bridget James (BJ) • Ref 45: it was explained that additional funding was not available from NHSE. Further information on the position would be given at item 9. It was agreed to assign this action to Rob Moors. The action remained open. • Ref 48: it was confirmed that Healthwatch would be contacted the relevant PPI leads were following up the action. The action remained open. • Ref 50: it was confirmed that a response had been added to the minutes and posted on the CCG website. The action was closed. All other actions due were closed. David Moss (DM) provided an update to action reference 47 Improved Access. The CCG had engaged with Practices during November regarding the proposed approach, meeting with each locality, the LMC and the current provider. The feedback from these meetings resulted in a Frequently Asked Questions briefing which was shared with Localities in December. A joint letter was received from the six Localities expressing support for the proposed approach. Work was ongoing to confirm the specification and further review the approach. It was highlighted that the LMC had played a crucial role in supporting Localities and that its input had been an important positive factor. The LMC had offered further independent review of the contract which was welcomed by the CCG. Julia Ross observed	

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	that the letter from the Localities had been very positive and acknowledged the support of the LMC.	
05	**Chairs Report** Alison Moon (AM) explained there was no report for this month.	
06	**Local Enhanced Services (LES) Review Update** AM noted the progress made and thanked all involved. Martin Jones (MJ) presented this item, thanking the teams involved across the CCG for their input and highlighting the level of clinical engagement. There had been changes to the Supplementary Services specification following engagement with practices and the revised specification was supported by the LMC. Work was ongoing to finalise the GP Practice Care Home Support specification which would be presented at the January 29th meeting. The proposed tariff and contract terms were highlighted. Attention was drawn to the outcome of the desk top review of the South Gloucestershire 16p GP Basket. The Committee considered the specifications. MJ highlighted the key changes in the Type 2 Diabetes Insulin Start LES**,** and the move to a single tariff across BNSSG. The LES represented an intermediate stage in the overall development of the service, supporting a reduction in variation relating to insulin initiation and reinforcing the pathway. A locality based service, with expertise supporting community clinics, was the long term aim. It was noted that the HG Wells programme roll out was approaching 74% of practices; the LES would support practices and encourage the development of expertise. Felicity Fay (FF) asked if members would be able to comment further on the specifications. It was explained that this was the final sign off. FF asked how, under the locality model, practices would be identified to receive payments for activity. It was explained that this issue would be worked through prior to a move to the future locality model. Work was ongoing to review the national diabetes audit and align this to the CCG's data. There was a discussion about the National Outcomes Framework and it was noted that work was underway locally to refine outcomes and identify information to be collated. FF asked if it the intention was for nurses already undertaking insulin initiation to have up to 10 supervised initiations assessed. FF asked if a caveat could be added to acknowledge experienced	

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	staff. It was commented that wording to reinforce "up to 10 initiations" could be added. JR commented that there were concerns about the variation in services across BNCCG and it was important to be assured of the quality of service provision. Variation in practice was not expected and supervision was an important aspect of quality. It was important to ensure that experience was matched with quality. Assessment was part of peer-review. Rachael Kenyon (RK) supported the work, noting the standardisation to access to care and the opportunity to stop medication that was no longer impacting on a patient's health.	**JB**
	The specification for the Recognition and Management of People with Dementia was discussed. AM asked whether the basic level was required in the specification. It was agreed that the basic level would be merged with the enhanced level. It was noted that there was a robust template supporting the service that included evaluation and the returns form.	**JB**
	The DVT pathway for patients presenting in general practice had been previously discussed by the Committee. JR asked if this service would move to a locality model and whether a one-year contract length would be more appropriate. It was confirmed that a locality model could be appropriate and it was agreed to reduce the proposed contract length with a view to reviewing this as needed.	**JB**
	The specifications for the Anticoagulation LES: Basic and Advanced Services were considered. The two specifications reflected the current context; a different approach would be adopted in future. David Soodeen (DS) observed that the specification set out that current practice would continue with no difference for patients and questioned this. Jenny Bowker (JB) explained that it had been previously agreed by the Committee that practices offering the advanced service could move to the basic service however the advanced model would only be available practices that currently offered this. It was agreed to clarify this as part of inviting practices to express an interest in signing up to the LES.	**JB**
	The Committee considered the Specialist Medicines Monitoring specification. This was intended to standardise practice across BNSSG and there were no significant changes. There were no comments on the specification.	

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	The Supplementary Services specification was discussed. There had been significant discussion about this with Localities, practices and at the LMC. Changes following these discussions were highlighted in the specification. It was confirmed that the South Gloucestershire 16p GP Basket was included in this specification. AM noted that there was no evaluation or monitoring of activity of the 16p GP Basket and asked if this would change once it was part of the Supplementary Services specification. JB explained that although there was significant overlap with the Supplementary Services specification not all the services were included; it was confirmed that there would be monitoring and evaluation of the overlapping services. It was agreed that this should be extended to those services that did not overlap with the Supplementary Services. There was further discussion about the recommendation to include the 16p GP Basket. JR expressed support for the principle underpinning the funding and commented that it was important to develop the service and understand what was being delivered for the funding. There would be significant changes over the next two years that would require services to develop. JR asked that this was revisited. There was a discussion about the position of practices. RK suggested that the CCG establish what evidence was required for the 16p and then collect this information from Practices. It was confirmed that this was the intention and agreed that this should be extended to those services that did not overlap with the Supplementary Services. MJ invited Philip Kirby (PK) to comment. PK agreed that Practices were finding the current climate challenging and it was likely that there would be changes in the next two years. It was important to support practices to move to future models. MJ commented that the LMC's help and support to achieve this would be useful. PK confirmed that the LMC would continue to support this. The Committee considered the financial modelling at appendix 1 and the underpinning principles. Attention was drawn to table 1 setting out the forecast impact on income at Locality level based on proposed 2019/20 LES tariffs. The planning assumptions were based on 2018/19 quarter 1 and 2 activity. The modelling assumed full take up of the schemes. No changes had been made to the Supplementary Services tariff as previously discussed, recognising the five-year funding commitment made to practices.	**JB** **JB** **JB**

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	JB highlighted the changes indicated in table1. There was an overall reduction related to the Insulin Initiation LES and increases in the Dementia, Anticoagulation and Specialised Medicines Monitoring LES'. JR asked how the budgets sat within the overall primary care budget and how it was accounted for within the budget. JB explained that decisions had been made to discontinue the Bristol Primary Care Agreement and the South Gloucestershire Compact, whilst a decision regarding minor injuries was pending. The impact would be cost neutral. There was a discussion about the QIPP requirement. JRa reported that, following discussions with finance colleagues, her understanding was that the required control centre savings, the LTS funding and LES funding were within the budget. MJ confirmed this. JR sought assurance that the resource required was available and would not be required from other budgets, taking into account the Care Homes element. It was asked that the resource requirement was explained in the context of the overall budget. It was agreed that further work to demonstrate the financial position would be completed. It was agreed that the Committee would continue to consider the specifications and that the financial information would be presented to the Committee at the 29th January 2019 meeting. DS asked if the figures given against the Specialised Services Medicines Monitoring LES for North Somerset and South Gloucestershire were correct. It was agreed to review these figures and report back to the next meeting. DS asked about the position for Inner City and East Bristol and South Bristol in relation to the decrease in funding for the Insulin Initiation LES, noting the high prevalence of diabetes in these areas. There was a discussion about the potential impact of this on prescribing practice. It was noted that the LES was part of wider pathway transformation and was part of a transition period. It was agreed that the Medicines Optimisation Team would monitor prescribing practice in this area. FF sought clarity about the LTS phase 3 funding. It was confirmed that the figures in the paper related to phase 1 and phase 2. FF asked that the information presented to the meeting on the 29th January detailed how the discontinuation of the Bristol Primary Care Agreement and the South Gloucestershire Compact would be offset by the LTS phase 3 funding. JRa explained that work was	**JB and RM** **JB**

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	underway with Locality provider colleagues to support the transition to the new locality models. It was important to note that the same practice level benefits would not necessarily be available under the new locality transformation scheme. It was noted that the LTS proposals had been previously agreed. JR commented that NHSE's preparation for planning guidance had signalled a continued investment in supporting Practices to operate at scale. Once the national guidance emerged it would be important to clarify the resources to support practices scale and the resources related to services. This would be taken forward by the executive team. DS observed that there was a reference in the main paper to a business case in support of the locality frailty or mental health models and that this should be frailty *and* mental health models. JR asked about the locality provider plans. DJ commented that locality flexibility based on the agreed priorities would be built into the plans. **The Primary Care Commissioning Committee:** • **Noted the progress and next steps set out within the main report and within the highlight report within Appendix 2.** • **Noted the proposed finance tariffs and analysis paper set out in Appendix 1 for the set of specifications under consideration and** • **Agreed that further detailed information about the finance tariffs and the overall context would be presented to the meeting on 29th January** • **Approved in principle the set of specifications attached in Appendix 3 pending any further practice level impact assessment to be brought to the Committee in closed session at its 29th January meeting, with the amendments proposed by the Committee** • **Approved the proposed contract terms for the specifications under consideration set out in the main report, with the amendments proposed by the Committee,** • **Supported the outcome of the desktop review for the 16p basket of additional services in South Gloucestershire**	
07	**Primary Care Quality Report** Bridget James (BJ) highlighted the CQC inspection report for Sea Mills practice which was given an overall rating of 'Good'. There had been a decrease in the overall practices response rate for the Friends and Family Test (FFT) in October. The Quality team had contacted practices not submitting data to provide support to improve response rates. The Quality team was working with	

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	commissioning and contracting colleagues to explore the contractual options available to encourage increased reporting. The breakdown of the FTT data across the three localities was highlighted. The flu vaccination uptake position as at 9th December 2018 was highlighted. The position for both groups was above the national uptake. The latest figures for the 65 and Over group now exceed the national end of season ambition. The Medicines Optimisation Team was working with NHSE, working with practices with low uptake. The availability of vaccinations had been investigated and the Medicines Optimisation Team was working with practices and pharmacies to identify providers with excess stock. Attention was drawn to the Cancer quality indicators; two indicators regarding Cancer Care could be nationally benchmarked, detection rates for new cancers and cervical screening. The overall positions for both for BNSSG were slightly above the NHSE national average. Cervical Screening was commissioned by NHS England and a public health campaign was planned for March 2019. JRu observed that the North Somerset FFT response rate had significantly improved and asked if there were specific reasons for this that could be replicated in the other areas. It was explained that there were not clear reasons for this although monthly contact was now made with practices who did not submit. DS commented that it would be helpful to present flu vaccine uptake figures by Locality at the end of the season. JR commented that the paper RAG rated the over 65's vaccine uptake as green although it was below the national ambition for end of season uptake. It was commented that the national ambitions were not high. JR observed that 71 practices were rated as amber against the Cancer Care quality domain and one was rated as red and this was not a good position. It was asked for more detail about the actions the CCG was taking to improve performance. FF asked that the national best alongside the national average was included in future reports. MJ commented that it would be more helpful to have information for each indicator separately. There followed a discussion about indicators. JRa noted that Localities were undertaking work to improve performance and it was important to	**BJ** **BJ** **BJ** **MJ**

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	reflect this in the report. AM asked if Peter Brindle had reviewed the paper. MJ agreed to raise this. AM noted that the percentage of patients recommending practices in one Locality had deteriorated over the last two months and asked whether this information was triangulated with other performance data. BJ confirmed that this was underway with the contracting team. AM asked if the FFT nationally would be discontinued for GP practices. Jenny Collins (JC) commented that the FFT had been reviewed nationally; it was likely that there would be changes however the FFT would not be discontinued. AM noted it was important to work with GP colleagues to encourage them to view the FFT as a positive tool. BJ confirmed that this was the approach being taken with practices. JR commented that the CCG needed to have a way to know about patient experience more widely of General Practice. Georgie Biggs (GB) commented that there had been discussions at Patient Practice Groups in North Somerset about the FFT and how those groups could assist practices in gathering more information. GB agreed to share further information with the Quality team. **The Primary Care Commissioning Committee noted the updates on monthly quality data and specific performance indicators for Primary Care Cancer services**	**GB**
08	**Contracts and Performance Report** DM drew attention to Improved Access. October was the first month of the locality models for Improved Access. The number of minutes offered had decreased however it was expected to rise in November and December as Localities delivered additional minutes across winter. Early indications were that November had seen the expected number of minutes delivered. There had been technical difficulties nationally that had impacted on the delivery of the requirement for the ability for patients to be directly booked a practice appointment by NHS 111. A working group was in place to resolve issues locally between Brisdoc, One Care, the CCG and practices. The aim was to pilot the project with six practices from February 2019. This would be an enabler for winter resilience. The CCG had been informed by One Care that 100% of practices were advertising the availability of Improved Access on their websites. An audit undertaken by the CCG indicated that	

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	information was not routinely available on all websites. The CCG had asked One Care to revisit this and this would be raised with One Care at the next meeting. There were contract penalties linked to the requirement to advertise. One Bristol practice had been unable to offer full coverage of Improved Access. This was due to a large merger and site closure. The practice recognised the need to undertake further work and the CCG continued to work with One to Care to gain assurances that the transformation period would end in April 2019. Attention was drawn to referral data information. This had been shared with Localities and workshops were planned for January and February to review outlying practices and understand the issues. A further report on the outcomes of the workshops would be made. It was explained that four PMS contracts remained unsigned. The CCG and NHSE were working with practices to resolve issues. Core Hours Assurance was highlighted. Five practices had been reported as not opening in line with expectations. Work to resolve this had been undertaken and discussions had indicated the position had improved with the exception of one residual issue with a practice that was exploring how a lunch time closure could be mitigated. The CCG would continue to work with the practice to ensure that contractual obligations were met. The CCG would review the results of the next e-declaration to check progress. An application for the temporary closure of a branch for 4 days had been received. The CCG met with the practice to discuss the request. DM explained the branch served approximately 400 patients, with a significant proportion of these in residential care homes. Work was ongoing with the practice regarding its patient and public engagement responsibilities to consider the permanent closure of the branch. Subsequent to the request, the branch opened on one of the proposed closure days. For the three days that the branch closed it was agreed that the reception would remain open to signpost patients to the main practice site and telephones would be answered. Based on the mitigations agreed the CCG gave permission for the temporary closure and requested that the practice work with local town and parish councils to	**DJ**

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	communicate their plans. The practice had been asked to review work force planning to avoid similar future situations. A remedial notice remained in place with one practice which was required to demonstrate remedial action by 16 January 2019. The CCG was confident this would be achieved. FF sought confirmed that, regarding Improved Access, 15 minutes of the 45 could be offered in hours. This was confirmed. AM asked, regarding MMR uptake, why only 70 practices had signed up. It was explained this an offer made as a LES and the decision to take up the offer would have been a business decision. AM voiced concern regarding the incorrect information provided by One Care. LM explained that this issue was being followed up through contractual arrangements with One Care and agreed that it was a concerning issue. JR observed that it was important that the CCG was assured by information provided by One Care and asked that the proposed re-audit was completed as a matter of course to confirm the position and provide the required assurance. AM observed that this was a worrying position and that from this discussion it was understood that commissioning colleagues were also concerned and following this issue up. DS asked if the GP referral data would be managed through the Locality Fora. DJ confirmed this and explained that, in addition, each practice would receive their data with a summary identifying the key areas for focus. JR sought confirmation that the objective was to reduce variation and asked how this would be achieved. DJ confirmed that the intention was to understand the drivers underpinning referral patterns and to reduce variations. It was agreed to look at this in more depth at a future seminar session. RK explained that the letters to practices would come from the locality chairs. JR asked what action was being taken to resolve the issues relating to the PMS contracts. LM confirmed that the CCG was working directly with the practices to ensure that contracts were signed and all issues resolved. The LMC had agreed to support the resolution of issues. A further update would come to the January 29th meeting. PK commented that it was likely that the issues were points of clarification. JR asked about the tables presented at sections 6.1	**DM** **DJ** **LM**

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	and 6.2 what the CCG column referred to? DM explained that the heading in the table was a typo and would be corrected in future reports. **The Primary Care Commissioning Committee noted the performance and contractual status of Primary Care**	**DM**
09	**Primary Care Finance Report** Rob Moors (RM) reported that the overall forecast outturn for both Delegated Primary Care and Other Primary Care had moved adversely by approximately £100,000. The allocation for the market rent increases had been received; this was below the forecast for the total cost and this would be managed within the bottom line. There had been no change in the forecast outturn for Delegated Primary Care. Attention was drawn to locum payments; the forecast outturn had increased in line with claims received to date. There had been an adverse movement in the Other budget line which related to increases in CQC fees. Both issues related to emerging information during the first year of business. To mitigate these risks resources from the Contingency budget had been release, reducing the amount of Contingency available for the rest of the year. It was explained that the CCG was supporting increases in recurrent expenditure through non recurrent means and that there would be an impact on the opening budget position for 2019/20. RM highlighted the increase in the adverse position regarding Out of Hours in the Other Primary Care budget. This related to non-recurrent expenditure. The System Financial Recovery Plan was highlighted. It was explained that the target for the year would be achieved. This would be, in part, supported through non-recurrent measures. Planning for 2019/20 would need to focus on the recurrent and non-recurrent elements. JR noted that locum costs had been discussed with NHSE when the budget transferred, and asked that this was revisited with NHSE. JR commented that the management of this budget was important. The CCG needed to identify a reasonable cost envelop and establish how this would be monitored. JR noted that there was a wider workforce development issue and reducing dependency on locums was an aim. DM noted that there was a significant amount of maternity leave and sickness leave currently and information had been sought through the PCOG. It was agreed that these were issues to take forward.	**RM**

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	JR sought confirmation of the Out of Hours budget. RM explained that the variance related to the one-year extension. JR observed that the savings target would double for 2019-20 and it was important to focus on how this would be achieved. It was confirmed that this was a focus of discussions at the control centre. MJ asked how this was being looked at. It was confirmed that this would be approached as with other savings requirements. Savings were required across all of the CCG budgets. JR commented that the CCG needed to achieve the outturn position expected by the end of 2019-20. AM asked that plans for 2019-20 to be presented to the Committee at the February meeting. **The Primary Care Commissioning Committee noted the current financial position, the key risks, issues and mitigations**	**RM**
14	**Questions from the Public** There were none	
	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 STW and seconded by JR	

Sarah Carr
Corporate Secretary
January 2019