Bristol, North Somerset and South Gloucestershire
Clinical Commissioning Group

Primary Care Commissioning Committee

Open Session

Minutes of the meeting held on 30 July 2019 at 9am, at The Vassall Centre

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Minutes

Present		
Alison Moon	Independent Clinical Member – Registered Nurse	AM
Julia Ross	Chief Executive	JR
John Rushforth	Independent Lay Member – Audit, Governance and Risk	JRu
Martin Jones	Medical Director for Primary Care and Commissioning	MJ
Lisa Manson	Director of Commissioning	LM
Mathew Lenny	Director of Public Health	ML
Apologies		
Sarah Ambe	Healthwatch Bristol	SA
Alex Francis	Healthwatch South Gloucestershire	AF
Philip Kirby	Chief Executive, Avon Local Medical Committee	PK
Nikki Holmes	NHSE	NH
Debra Elliot	Director of Commissioning, NHS England	DE
Jenny Collins	Contracts Manager for NHS England (NHSE)	JC
Sarah Talbot-Williams	Independent Lay Member – Patient and Public Engagement (some comments provided)	STW
David Jarrett	Area Director for South Gloucestershire	DJ
Colin Bradbury	Area Director for North Somerset	CB
Justine Rawlings	Area Director for Bristol	JRa
Felicity Fay	Clinical Commissioning Locality Lead, South Gloucestershire	FF
David Soodeen	Clinical Commissioning Locality Lead, Bristol	DS
Rachael Kenyon	Clinical Commissioning Locality Lead, North Somerset	RK
Janet Baptiste-Grant	Interim Director of Nursing and Quality	JBG
Sarah Truelove	Chief Finance Officer	ST

Kevin Haggerty	Clinical Commissioning Locality Lead, North Somerset	KH
Rob Moors	Deputy Director of Finance	RM
Jon Lund	Deputy Chief Finance Officer	JL
Rob Hayday	Associate Director of Corporate Services	RH
Jenny Bowker	Head of Primary Care Development	JB
In attendance		
Georgie Bigg	Healthwatch North Somerset	GB
David Moss	Head of Primary Care Contracts	DM
Laura Davey	Corporate Manager	LD
Sarah Carr	Corporate Secretary	SC
Bridget James	Associate Director of Quality	BJ
Rob Ayerst	Head of Finance (Primary & Community Care)	RA
Gillian Cook	Workforce Development Lead	GC
Geeta Iyer	Clinical Lead, Primary Care Development	GI
Tim James	Estates Manager	TJ

	Item	Action
01	**Welcome and Introductions** AM welcomed everyone to the meeting and apologies were noted as above. AM welcomed Matt to his first meeting and formally noted thanks to Andrew Burnett for his contribution. AM welcomed Georgie Bigg back to the committee after a period of absence.	
02	**Declarations of Interest** There were no declarations relating to the agenda. It was noted ML would need to complete a CCG Declarations of Interest Form and LD would arrange this.	LD
03	**Minutes of the Previous Meeting** JR commented on Item 5 noting it was agreed the CCG could only support a gain share in respect of this work if the CCG was on budget overall. The discussion around the 40% gain share would only apply if the budget was available and it was noted that investment had to come out of budgeted funding. Regarding the £1.50 funding JR commented that the committee had noted the need to be careful in understanding what the CCG was expecting that £1.50 to fund. JR commented on Item 8 noting it was agreed the CCG would actively follow up baseline budget issues with NHSE. AM asked	

	Item	Action
	RA if an update was available and he confirmed this would come as part of his response to Action 103 on the action Log. JR asked the word correct in the sentence 'having correct clinical governance' on page 10 be changed to robust. JR asked an action be added under item 11 that the committee would at the end of each meeting identify any papers being progressed to the Governing Body. LD agreed to amend the minutes to reflect JRs comments. With the above amendments the minutes were agreed as an accurate record.	LD
04	**Action Log** **Action 85** – It was agreed this action should be assigned to RA. RA noted this action related to a letter sent from the CCG partway through last year which flagged the underlying deficit inherited by the CCG when it took on delegated commissioning. This was largely in respect of the change in reimbursements for locum expenditure. RA confirmed the letter had been resent to the new Director of Finance for NHSE and that a response had been received from Jenny Collins confirming this was being reviewed by the Finance Team and that a formal response would be shared with the CCG. Action to remain open **Action 89** – MJ noted the paper was being finalised and would come to the next meeting. Action to close **Action 95** – it was noted the action was recommended for closure and BJ also gave a further brief update confirming that she was working closely with the clinical effectiveness team on this and a further update would be brought to the committee in due course. Action to close **Action 96** – MJ noted this was addressed in item 8 of the agenda. Action to close **Action 99** – It was noted LM would be assigned as the lead for this action and that it should remain open. LM confirmed she would bring an update to the next meeting. **Action 103** – It was agreed this action would be assigned to RA. RA noted he overlap with Action 85 in respect of gaining a formal response form NHSE regarding locum expenditure. RA noted the action also related to the overall picture of risk which was built into	

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	the plan. RA noted confirmation had now been received from the national allocations team that the market rent funding was now held within the CCGs growth allocation and therefore had to be managed within the CCGs existing allocation. This did not affect the overall breakeven position that was being formally reported or the associated £1.6m of risk that was being reported against this position. RA recommended the action be closed noting it would form part of standard reporting at committee meetings. This was agreed by the committee. Action to close. **Action 105** – AM noted the guidelines around incident reporting had now been drafted and would be shared with Area Leadership Groups. AM queried if a further timeline was known. BJ confirmed some initial feedback had been received with more due in August and that the guidelines would then be shared with practices in September. A further update would come to the committee in the September report.	BJ
05	**Chairs Report** AM gave a verbal report to the committee noting the Long Term Plan had now been published and that primary and community care both feature heavily. AM noted it would be helpful for the committee to receive a written report on the Long Term Plan in relation to Primary Care and that JB would produce this in due course. This report would also detail how the CCG was positioned to respond to the requirements set out in the Long Term Plan. **The Primary Care Commissioning Committee:** • Noted the update	JB
06	**Estates Strategy** TJ presented noting feedback from consultations had been incorporated into the final version of the strategy. TJ noted a more succinct version would also be produced for staff and that work streams were now in development and would include subject matter experts. AM queried if the committee was approving or recommending to the Governing Body and TJ confirmed approval on the primary care sections was sought along with a recommendation of the whole document to Governing Body. GB queried plans for the site at Mill Cross noting concern in the community around this. TJ confirmed an internal review of the longer term options for the site was underway but that no decisions had been made. LM thanked TJ and queried if a clear set of priorities was in place	

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	across primary care in terms of the investment required. TJ noted the strategy does provide this where an investment related to bringing buildings up to standard but that when looking at the more transformative side such as brining the strategy in line with PCN ambitions there is more work to be done around this. JRu queried how delivery would be tracked including specifically where action plans or investment plans would be monitored. TJ noted this level of detail was emerging but that action plans would likely be brought through the committee. JR noted that the CCG did not have a regular capital budget and that the strategy therefore focused on allowing maintenance issues to be prioritised and delivered. JR commented on the wider system piece which included the development of localities and PCNs noting this would define the way forward for that wider context. TJ noted the recent ETTF bidding and that the CCG had received more capital than any other in the region from that. TJ also noted that the Estates Group was in place and due to meet later that afternoon, TJ also noted that the estates work steams had been identified and were in development. JR noted next steps should include the development of an Estates Plan and that this would detail the practical steps to be taken should capital be unlocked again. JR noted capital was expected to be unlocked following the comprehensive spending review that was currently underway. DM commented on the challenge that most practices were privately owned by landlords and that these landlords were the GPs themselves, any plan would therefore need to recognise this and work with the locality structure as well as with the wider system piece. TJ noted the level of expertise in the acute trusts and that there was a view to pooling resources across the STP to assist with business case development work. TJ confirmed discussions around this were taking place. JR agreed this was an important approach and asked this be raised at the STP Estates Group meeting. AM noted the two risks identified in the cover paper and that mitigation to system wide risks would come from such arrangements. JR asked for clarification on responsibilities regarding back log maintenance. TJ noted the backlog maintenance issues were wide ranging but also that where GPs owned their own premises, around 5% of their notional rent sum was specified for maintenance of the estate. JRu queried if any collaborative work with GPs to look at vehicles	TJ

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	that could pool resource had been undertaken.TJ confirmed there were a number of funding models available and that some new approaches were being taken with Local Authorities in respect of this. ML checked the CCG had the right connections with the Local Authority for this work and TJ confirmed this noting Local Authority representatives also attend meetings of the STP Estates Group. **The Primary Care Commissioning Committee:** • Approved for recommendation to Governing Body the Healthier Together Estates Strategy, which incorporates the Primary Care estate and implications of planning growth, which will impact on all services.	
07	**STP Workforce Plan – Primary and Community Care Training Hubs** MJ presented thanking GC for the report. MJ noted the change in terms of local delivery and commented that the work of the hub would need to fit into the STP plan and that this would form part of the next steps. GC noted the Hubs were a work in progress and commented on the national work to link the hubs with primary care networks. GC commented that previously the Hubs had focused on the training and upskilling of staff but that this was changing with more work now being undertaken around workforce planning and arranging placements. GC noted the CCG had been successful in a bid for a practice based placement pilot that would look at the skill mix in primary care with the focus being on specific skills rather than roles. GC confirmed the CCG was host employer of the Training Hub and that staff were employed on one year fixed term contracts. Moving forward contracts were expected to be extended to 5 years which would improve stability of the service. AM thanked GC for the report and noted the positive move towards 5 year fixed term contracts. AM noted current expertise in the system and queried if the Hub would become an STP resource. GC confirmed the hub was not intended to exist as a standalone entity but would form part of an informal network of expertise across the STP. JR commented that the hub already sat as a subgroup of the Workforce Steering Group and noted the increasing ambition for integration. AM commented on degree level apprenticeships and queried if	

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	the CCG was taking advantage of these. GC confirmed work was underway noting the Apprenticeship Group which links closely to the Primary Care Workforce Group and that the Hub would also be promoting apprenticeships. MJ confirmed the CCG had good links with UWE and in particular around the training of paramedics which was supported by SWASFT. GC noted that apprenticeships were also taking place through the STP. LM queried if the work around the Training Hubs aligned to the 5 year plan. GC noted the CCG was working through the maturity matrix and looking to ensure system priorities for example from the STP, NHSE and the CCG were built into that work. JR confirmed the Training Hub would need to align to future plans. JR thanked GC for the paper and commented on the background section of the report which referenced that the Training Hub funds would be held by the CCG. JR noted it was important to be clear that this was to enable the CCG to wrap around appropriate governance arrangements but that the money was and would remain for the Training Hub and not for the CCG. JR queried the structure for the Training Hubs and to what degree this could be adapted at a local level. GC confirmed the Hubs would be defined nationally but that there would be flexibility available at a local level. JR noted that the Hub would need to be adapted to the needs of the BNSSG population and local priorities. JR noted should conversations need escalating to ensure this happened she would want to be involved. JR commented on placement capacity noting the challenge to the STP around workforce gaps particularly registered and practice nurses. JR noted the low number of placements offered in the area. JR commented this was an area to be focused on and prioritised. MJ noted this could be built into the development of primary care networks. AM commented on the national practice nurse survey that took place around two years ago identified that some practices that took medical placements but not nursing placements AM commented that the learning environment should therefore already exist within those practices. JR noted the biggest gap was in respect of care workers and that primary care through localities could support this. JR noted she was pleased to see the inclusion of rotated integrated placements. It was noted a report would come back to the committee in October and AM asked this include some description around what success for the hub looks like. **The Primary Care Commissioning Committee:**	

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	• Noted the changes to Training Hubs and the new guidance. • Noted that a report will come back in October 2019 setting out proposals for how we develop the full functions of the training hub.	
08	**Primary Care Strategy briefing and update on PCNs** MJ noted the report was to provide an update on progress to the committee. GI noted the background to the report including that the strategy was being updated in light of the Long Term Plan and that Appendix 1 showed the engagement that had been undertaken to date. GI reported that a live survey was available on the CCG website and was also in progress of being rolled out to the external websites of other organisations. GI noted there were seven service specifications for primary care networks to deliver on which were detailed in the paper and that this would be delivered alongside Improved Access. To support this a national framework was in development and was due mid-August. Following this networks would need to use it to evaluate their development needs. GI commented on the key principles for the plan as set out in the report. GI noted the recommendations in the report. AM noted STW had shared a question in her absence. STW queried the risks around the relationships between primary care networks and localities, noting for example challenges that could occur if primary care networks were looking for a high level of independence. GI noted this was still very much in the early days of development. JR agreed noting that primary care networks were still in the process of establishment and that each primary care network Director sat on a Locality Board. JR noted the patient survey that GC had commented on and that this was something the local media could support through promotion with the public. JR noted the CCG was keen to engage with as many patients and members of the public as possible. JR noted the importance of being clear about localities and their roles and ensuring this is continually reinforced as work around primary care networks and strategy progresses. AM queried if the DES's would need to be in place by April 2020 or ready to start in April 2020. LM noted one DES was in place and the expectation for further national services at PCN level that these DES's would be in place and contracted for by 1 April 2020.	

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	GB noted the importance of services aligning to the needs of patients but noted her concern around the potential for variation across practices and how this could be interpreted by patients when comparing one practice with another. GI confirmed some aspects of the specifications would be adapted by all practices whereas others would be delivered at a network or locality level and that this would be determined through the needs of the local population. JR confirmed the focus would be on the availability of services noting, where a service was available in one practice it must be available to the whole population within that network area. Regarding potential travel time for patients JR noted that networks covered a relatively small geographical area and therefore any travel for patients would not be significant. The focus on equal access to patients was reiterated. ML noted the Local Public Health teams would be able to help support this work and commented on the importance of aligning commissioning intentions. MJ agreed this would be important moving forwards and also commented on the benefits particularly in relation to drug and alcohol services. Regarding these services MJ noted there was a level of variation across the patch and that it was being recognised that in terms of need and outcomes that there was data to suggest there were benefits in treating drug and alcohol issues separately. **The Primary Care Commissioning Committee:** • Noted the updates provided within the briefing and commented on the proposed principles and approach to progressing a development plan for Primary Care Networks.	
09	**GP Forward View Report** MJ presented the dashboard and commented on the ratings given to each of the areas of work. MJ noted the one amber rating on the report for Practice Infrastructure and highlighted some detail on this to the committee including noting issues around the 111 service and that work was in hand to improve this rating including discussions within localities and primary care networks. MJ confirmed targets were being met around the care redesign work and that in respect of time to care many practices were involved. MJ commented on the work around infrastructure noting there were 12 practices trailing a number of digital systems. MJ noted that learning from this pilot would be brought back to the committee along with a plan for rolling this out further. MJ noted	

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	this would be a considerable change piece for many practices in the area. AM shared a question from STW in her absence and noted her Involvement in the recruitment panel. STW had noted the number of national recruits was lower than had been predicted and that recruitment was a key component to the primary care strategy. STW had noted the green status within the report and queried what was realistic in terms of recruitment for 2019-20 and what impact this would have on the GP gap. GC confirmed that nationally the international recruitment programme has been rated as amber. This was due to the numbers of recruits coming through being far lower than originally predicted. GC noted an agency was working to recruit international GPs, mainly from eastern Europe. GC noted an initial recruitment event has recently been held at which four GPs were interviewed. GC noted one had already applied for a post in Cornwall, one was looking to relocate to London, one to Swindon and one to BNSSG. Within our area there was also a further two recruits already placed. GC noted that recruitment numbers for BNSSG were higher than other areas but recognised the national challenge. MJ noted the future modelling plans for primary care and that with the addition of new roles within practices there may be responsibilities that can be passed over resulting in a need for less GPs than was first identified. **The Primary Care Commissioning Committee:** • Noted the Report	
10	**Northville/Bishopston** DM presented noting the report provided an update on the two contracts. These contracts covered a patient base of circa 10,000 for Bishopston and 5,000 for Northville. These patient lists had been handed back to the CCG and Brisdoc had provided cover in the interim period. DM commented on the process that had been followed and that following the paper shared at the committees closed session in June, the committee had made the decision to disperse the patient lists and manage a re-registerisation process with the surrounding practices. In respect of Northville DM commented on the largest patient age group of 25-34 years, that all patients over 16 had been sent a letter regarding the contract expiry and next steps. The letter also	

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	contained a link to an online survey and the offer of a meeting with the CCG. DM noted main concerns were around continuity of care and any change of location. DM noted staff feedback had included engagement through meetings and surveys. DM noted an Equality Impact Assessment had been completed and that details of how vulnerable patients and other high level impacts would be managed was given in the report. DM confirmed the CCG had identified in terms of indicative numbers where patients were expected to re-register and that it had been ensured that these practices would be able to receive patients on dispersal. In respect of Bishopston DM reported that the largest patient age group was ages 15-44 years and that noting the demographic engagement sessions had been held in the evening as well as in the daytime. The building location had been raised as a concern along with continuity. Administrative staff and triage processes were praised in the feedback. DM noted as may be expected form the demographic 50% of patients wanted face to face appointments with the other 50% not minding on the approach taken. DM confirmed as with Northville a list of vulnerable patients would be produced to ensure these patients land safely. DM noted since the paper had been written 3000 patients had moved practice and of those there had only been one complaint. A working group continues to manage the process. AM thanked DM for the paper and GB commented to note the impressive amount of work around engagement that had been undertaken with patients noting the benefits in replicating this engagement model elsewhere. AM noted STW has passed on a question in her absence relating to Northville on Appendix 1, page 3. STW noted the patient participation group had been offered a meeting with the CCG but that the meeting was not forthcoming. STW asked to confirm why the meeting had not taken place. DM noted this was a virtual group that did not routinely meet and the lack of uptake for such a meeting was felt to be representative of this. MJ noted that moving forward practices would need to understand within their localities the needs of their local population as defined by the set-up of primary care networks and that although initial	

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	work was underway in terms of working together there was more to be done. AM noted the regular updates the committee had received through closes sessions and the recommendations in the report. **The Primary Care Commissioning Committee:** • Noted the decision to disperse the two APMS contracts at Bishopston and Northville and the content of the associated appendices	
11	**Primary Care Quality and Resilience Dashboard Update** MJ presented and noted the work undertaken to date on the dashboard as well as the next steps needed to take this forward. MJ commented on the need to support the resilience of practices and noted the aim of the dashboard as an early warning to resilience issues. MJ noted quality measures were now included and could be reported through both primary care network and locality areas. MJ noted the dashboard was already starting to be shared with practices along with discussions taking place to address the resilience issues identified. All data used so far is available publicly but there is a question around how the information is presented in the most useful format and this was being worked through with the area teams and localities. JR noted the low friends and family test uptake and queried if the patient experience survey could be used. MJ noted this had been discussed as a way forward noting the survey results reflect the resilience data on the dashboard. BJ noted the latest results were being reviewed by the Business Intelligence team at the CCG. AM queried how far were the CCG was from Primary Care networks/localities being able to support practices in a consistent way across the patch. MJ responded noting the variation across practices and that a level of full working across localities or Primary Care Networks had not yet been achieved but was being worked towards. MJ noted data sharing was increasing but using it to address the day to day issues remained forthcoming. MJ noted progress would be made as Primary Care Networks became further established. LM queried if the intention was to share at locality level as opposed to practice level. MJ confirmed those with amber and red ratings had seen the dashboards for their individual practices and	

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	that he felt the data should be shared with both. MJ noted the aim to identify the most useful way to present the data for localities and practices noting the sensitivity around the RAG ratings. JR noted there could be differences in what practices viewed as public in this context and noted that she felt peer review through localities would be a positive move for practices. AM agreed and noted the move away nationally in some areas from RAG ratings as they can result in false assurances. JR noted it was helpful to recognise good performance in practices and commented on CQC ratings noting they left room for improvement on even those rated at the highest level. Jr noted this supports maintaining the level of assurance. JR suggested a test of validity would be useful and asked a review of accuracy of the dashboard be undertaken at an appropriate time to show the progress made on any issues that had been identified. MJ agreed this would be a useful analysis to build into the process and that it should also consider where improvements were not made the reasons for that. MJ noted there would be a level of reliance on the willingness of practices to engage. DM noted monthly meetings were held with the CQC regional inspector to support their visits. **The Primary Care Commissioning Committee:** • Noted the work undertaken to implement the actions requested by PCCC in April 2019 • Supported the wider use of the quality and resilience dashboard being taken forward by the Area Team working with the CCG Business Intelligence team, as described in the paper	
12	**Primary Care Finance Report** RA presented and noted the report provides detail on primary care finance as at Month 3, June 2019. RA noted prescribing and medicines management costs had been added to the report but noted the two month time lag in data coming through to the CCG from the prescriptions pricing authority and that therefore detailed spend would not be seen until Julys report. RA asked the committee to note the in-year non recurrent allocation for GP Forward View commitments in 2019-20 had been received. RA confirmed the Month 3 reported position that the CCG was on plan to deliver breakeven position. But noted emerging risks associated with this including around market rent and locum costs. RA noted conversations around these risks had	

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	been escalated and were under discussion at regional level. RA noted it was becoming apparent through discussions that a number of CCGs have a planning gap against their delegated allocation and were therefore struggling to fund all the commitments from the GP contract within the allocation growth. RA commented on the local emerging risks including the non-recurrent financial implication to list dispersals noting there was a premium attached to a practice that had taken a patient from a list dispersal. RA commented on the prescribing position noting Category M pricing increases which were managed nationally and the notification of an extraordinary price increase from 1 August. RA confirmed this would equate to £15m per month nationally and around £250,000 per month for the CCG. There was a time lag in respect of this and so the increase would not been seen until October but RA noted this was a significant cost pressure. AM how frequent extraordinary price increases were. RA confirmed one had taken place over each of the last 3 years but that a price reduction has also then been made later in the year. RA noted that despite the current breakeven position there would be significant risks arising from the emerging position. JR noted the increasingly vulnerable positon of the CCG in respect of the primary care finances and that she was pleased conversations regarding the funding gap were being progressed. JR commented on the APMS contracts and queried if the premium could be managed through the transition. RA confirmed there was a clear intention to ensure absolute clarity on what was included in the allocation growth as well as providing NHSE with clarity on the position that the CCG inherited. Regarding the APMS contract RA confirmed the intention that this position would improve in 2020-21. DM noted there was an action from the closed session that would address this in more detail. JR noting the challenges faced and although not something that was desired queried at what stage the CCG should reconsider delegated commissioning given the growing risk. The committee recognised the benefits of integrated working to support patient pathways resulting in the best possible outcomes and experiences for patients but also the risk faced by the CCG. AM suggested this could be discussed at the committees next seminar session and this was agreed. RA noted the five year financial plan and queried if it would be useful for the committee to have sight of the CCGs recurrent and non-recurrent commitments over this timeframe to support the discussion. The committee agreed and RA confirmed he would draft the paper. JR	LD RA

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	recognised that NHSE were members of the committee but that given the potential implications of the discussion suggested a formal invitation also be made to NHSE. JRu noted the level of risk and queried the discretional spend asking what options would be available to manage these risks should they materialise. RA confirmed options were minimal. RA noted the CCG was mandated to hold a contingency fund which equated to around £600,000 and that the CCG was pursuing additional funding with regional and NHSE colleagues. RA also confirmed slippage had already been assumed in plans. MJ also noted the significant risk but that access, performance and quality was dependant on change in primary community services. JR agreed and noted the importance of weighing up the risks of continuing and not continuing with delegated commissioning recognising that there were risks from both sides. LM noted she would ask the Lead Director of Primary Care from NHSE if he or one of his senior team would attend the August seminar. **The Primary Care Commissioning Committee:** • Noted the confirmed additional non-recurrent resource allocations received in June for GPFV (£1,241K), and the anticipated allocation transfer to support PCN OD (£708K) to be allocated to budges in July • Noted that at Month 3, primary care budgets are reporting a break-even year to date position and forecast out-turn against budget • Noted the emerging risks to delivery of this plan as outlined in Section 5 above, and the associated mitigations	LM
13	**Primary Care Quality Report** BJ presented and noted the following highlights: • There had been two CQC reports, we should say what ratings the practices had and discussion regarding the actions being taken were in hand with practices • An overview of CQC actions and monitoring are shown in appendix 1 to the report • The response rate for the Friends and Family Test showed a slight decrease however it remained above the national rate. BJ also noted the recommendation rate had also dropped and that this data was being reviewed • There was a delay in quarter 4 complaints data advised by	

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	NHSE. BJ noted there was a small amount of data available from the CCGs Customer Service Team that could be triangulated with the NHSE data and that work around this would take place through August. • Improved engagement across patient pathways in respect of HCAIs including the development of a system wide RCA tool • The work underway around catheter care practice • The two QOF metrics relating to Dementia care as shown on page 11 of the report noting the CCG performs well in the second metric but is below target in respect of the first • The Dementia LES is now in place • Newly appointed clinical lead for dementia in the CCG • Named nurses and GP for dementia in practices AM thanked BJ for the report and noted the improvements since the first quality report seen by the committee. MJ noted the dementia LES and the importance of having one enhanced service across the patch. JR thanked BJ for the report also noting the improvements made. JR commented on the HCAI data noting uptake was not where it needed to be. JR queried plans to involve primary care colleagues with this work. BJ noted this was an area that needed focus and that the HCAI Group did not have primary care representation but that this was being addressed. BJ also noted an online tool was in development and that work with the area teams was underway to raise awareness. JR commented the performance data around dementia was disappointing and queried the prevalence expected from the population which would in turn provide a benchmark going forward. BJ responded to confirm that she would liaise with Public Health England to obtain some data around this and ML confirmed Public Health England would be able to support this. JR noted the benefits of the LES but queried why it was needed to engage practices in delivering the QOF metrics noting the funds could potentially be better used elsewhere. MJ noted the intention of the LES to make Dementia a wider topic than it was from the QOF metrics alone and that it gave a clear focus on the management of patients. JR agreed this was important but again highlighted the importance in considering the balance of spend. GB agreed it was important to focus on Dementia and noted current data sets were suggesting significant increases in the number of people being diagnosed in the future.	

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	JR asked for the actions and next steps in the report to provide more specific detail in the next report. JR also asked for a further report on Dementia is shared at a future committee meeting and this was agreed. AM noted the delay in complaints data and asked BJ to request this data was received for quarter 1 of 19/20 as well as quarter 4 18/19 for inclusion in the next report. AM noted the e-platform for focused learning and queried the timeframe around this. BJ confirmed this work was almost complete. AM noted the importance of balancing encouragement to providers alongside expectations. AM commented on the quality element of the report and noted that more work was needed around quality improvement. There was a cultural shift that has been seen in other providers but primary care needed to engage further to reach this point. BJ agreed and noted this would be supported through the work with PCNs and localities. **The Primary Care Commissioning Committee:** • Noted the updates on monthly quality data and the specific performance indicators for dementia care and associated actions.	BJ BJ BJ
14	**Contracts and Performance Report June 2019** DM presented noting the number of average minutes delivered per week in April was 36.6. DM commented on the contracts due to expire noting further detail on each would be presented in the closed session. **The Primary Care Commissioning Committee:** • Noted the report	
15	**Governing Body Quarterly Report** The committee noted the report. JR commented on the Primary Care strategy noting that localities were critical to future plans as they enabled provider integration and that this needed to be reflected in the strategy. **The Primary Care Commissioning Committee:** • Received the report to support its own work plan and decision making	

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16	**Papers progressing to Governing Body** The committee noted the estates strategy would be progressed to the Governing Body for approval	
17	**Questions from the Public – previously notified to the Chair** There were no questions received.	
	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.	
	Date of next PCCC: Tuesday 27th August 2019 (Seminar Session) Clevedon Hall, Elton road, Clevedon, BS21 7RQ **Date of next open meeting:** Tuesday 24th September 2019 Vassall Centre, Gill Avenue, Bristol, BS16 2QQ	

Laura Davey, Corporate Manager
30 July 2019

Bristol, North Somerset and South Gloucestershire
Clinical Commissioning Group

Primary Care Commissioning Committee

Open Session

Minutes of the meeting held on 24th September 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
Martin Jones	Medical Director for Primary Care and Commissioning	MJ
Mathew Lenny	Director of Public Health	ML
Lisa Manson	Director of Commissioning	LM
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Julia Ross	Chief Executive	JR
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Sarah Truelove	Chief Finance Officer	ST
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Kevin Haggerty	Clinical Commissioning Locality Lead, North Somerset	KH
Nikki Holmes	NHSE	NH
Philip Kirby	Chief Executive, Avon Local Medical Committee	PK
David Moss	Head of Primary Care Contracts	DM
In attendance		
Jenny Bowker	Head of Primary Care Development	JB
Georgie Bigg	Healthwatch North Somerset	GB
Sarah Carr	Corporate Secretary	SC
Debbie Campbell	Deputy Director (Medicines Optimisation)	DC

Felicity Fay	Clinical Commissioning Locality Lead, South Gloucestershire	FF
Dr John Heather	Lead GP for Pier Health Group	JH
Bridget James	Associate Director of Quality	BJ
Tim James	Estates Manager	TJ
Rachael Kenyon	Clinical Commissioning Locality Lead, North Somerset	RK
Jon Lund	Deputy Chief Finance Officer	JL
Clare McInerney	Head of Locality Development, North Somerset	CM
Lucy Powell	Corporate Support Officer	LP
Denys Rayner	ISS Programme Manager	DR
Lisa Rees	Principal Medicines Optimisation Pharmacist	LR
David Soodeen	Clinical Commissioning Locality Lead, Bristol	DS
Ruth Thomas	Head of Locality Development, South Gloucestershire	RT

	Item	Action
01	**Welcome and Introductions** AM welcomed everyone to the meeting and apologies were noted as above.	
02	**Declarations of Interest** There were no declarations relating to the agenda. Sarah Talbot –Williams (STW) declared a new interest as Non-Executive Director at United Communities.	
03	**Minutes of the Previous Meeting** The minutes of the previous meeting were agreed as a correct record.	
04	**Action Log** **Action 85** – It was agreed to keep this item open. Jon Lund (JL) to update as part of the finance report. **Action 99** – Paper has been prepared for Strategic Finance Committee to discuss the issues raised. This action was closed. **Action 105** – Bridget James (BJ) explained that guidance had been developed and shared with Area Directors for comment. An update on distribution to practices would be provided in October. **Action 110** – Matt Lenny (ML) was reminded to complete a CCG declarations of interest form.	**BJ**

	Item	Action
	Action 112 – The Long Term Plan and primary care were discussed at the August seminar session. This action was closed. **Action 113** – Tim James (TJ) explained discussions regarding developing business plans which included consideration of pooled resources were being had the STP Estates Group. This action was closed. **Action 114 and 115** – Delegated commissioning was discussed at the August seminar session. This action was closed. **Action 116** – Nikki Holmes attended the August seminar. This action was closed. **Action 117** – The requested level of detail on the actions and next steps has been included in the quality report. This action was closed. **Action 119** – BJ confirmed the quarter 4 complaints data had been received from NHS England and would be incorporated into the next report. The quarter 1 data had not yet been received. BJ noted the quality team had requested the quarter 1 data again. This action was closed.	
05	**Primary Care Commissioning Committee Assurance Framework and Corporate Risk Register Primary Care** Sarah Carr (SC) explained the Primary Care Commissioning Committee Assurance Framework and Risk Register which related to primary care. SC asked the Committee for their view on the risks included and whether there were other priorities the Committee members would expect to be included. Lisa Manson (LM) recognised the need for the directorate risk registers to be shared with the corporate team so appropriate risks can be included within the risk register. Julia Ross (JR) suggested the risks needed to be described in more detail particularly around practice resilience and finance. JR also suggested the risk related to Primary Care Networks was scored too highly.	

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	The Committee discussed the risk register and assurance framework and agreed that increased detail and focus on the primary care elements of the risks needed to be included. Several new risks were suggested including primary care involvement in the delivery of Same Day Urgent Care (SDUC) and other related system programmes. Rachel Kenyon (RK) and Justine Rawlings (JRa) both highlighted the need for the key drivers behind the risks to be identified so mitigations can be focussed and more detailed. Alison Moon (AM) thanked SC for her work and reflected the documents were a work in progress. It was agreed to present the Primary Care Commissioning Committee Assurance Framework and Corporate Risk Register Primary Care to the Primary Care Operating Group every month and to the Primary Care Commissioning Committee quarterly. It was agreed to update the forward planners to reflect this. It was agreed the individual risk leads would update their risks with more detail. A risk relating specifically to primary care finance to be added to the register. **The Primary Care Commissioning Committee received and discussed the Corporate Risk Register and Primary Care Commissioning Committee Assurance Framework and agreed to receive these papers quarterly**	**JB** **MJ/CC /LM/ST**
06	**Weston and Worle Intensive Support Site Local Evaluation** Denys Reyner (DR) and Dr John Heather (JH) were welcomed to the meeting to outline the learning from the project and the impact on local health services. Jenny Bowker (JB) introduced the paper and explained that a local evaluation had taken place as well as a national evaluation by the national research and evaluation team. DR reminded the Committee this had been a 6 month project with the aim to support recruitment and retention of GPs in the Weston and Worle area through coaching as well as changes to the front door system for practices. There was a significant project to implement a new patient appointment system 'askmyGP' to practices. DR confirmed that despite some significant challenges for some practices and the change in working style for GPs, the	

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	patient feedback from the new system had been positive. Following the project, there have been clear benefits identified including the repeat prescription hub implementation and plans for collaborative back office functions. JH described the benefits of the project which included decreased waiting times for patients. JH also noted the issues some practices have encountered with the new system. Felicity Fay (FF) highlighted the learning within the report for BNSSG and asked JH whether the new system had increased morale for GPs. JH suggested askmyGP was not the solution for all GP practices, but the project had illustrated that capacity was a major factor for low GP morale. The introduction of other staff members such as pharmacists was found to reduce the capacity pressure within practices. JR asked for an elaboration on the future vision of Pier Health for GPs and localities and asked how services would evolve to engage with the wider system. JH confirmed the vision for primary care to integrate fully with other local acute and community services. JR queried what would be required to ensure this integration. JH suggested that resilient practices with consistent processes, including centralised back office functions would be a good start. JR praised the success of the project and noted next steps would need to be developed for a tangible plan for the future. It was agreed that the future development of Pier Health and the learning from the ISS work would be discussed at a future seminar. JR requested the locality provider leads were asked to attend the seminar. RK agreed with the coaching approach. JH noted coaching had proven a significant culture change for some GPs some of which did not recognise the value. Martin Jones (MJ) thanked the team for their hard work on the project and JH for his support. **The Primary Care Commissioning Committee received the report.**	**MJ**

	Item	Action
07	**Graham Road and Clarence Park Merger Application** LM informed the Committee a merger application had been submitted for Graham Road and Clarence Park. The proposal included consolidating services and staff to one site with the plan to introduce new roles to the multi-disciplinary team. It was noted that patients were currently offered appointments at both sites and the Patient Participation Group has been kept updated on the situation. An Equality Impact Assessment has been undertaken and it is understood the closure of Clarence Park will have a neutral impact. However, there would be an impact for the elderly and those with mobility problems. Alternative transport options and home visitation options have been reviewed, as well as consideration given to parking options and the suggestion of a nearby administration hub with parking. The Committee discussed the listing of the Clarence Park site on Right Move and it was confirmed that this had been a mistake following a recent valuation of the building. **The Primary Care Commissioning Committee noted the approved application to merge Clarence Park and Graham Road as of 30th September 2019**	
08	**Central Weston Estate Update** Colin Bradbury (CB) outlined the high profile work taking place in North Somerset to improve healthcare services and explained the presented paper outlined the options for sites for a new central Weston primary care facility. Clare McInerney (CM) and Tim James (TJ) outlined the options and explained 16 site options had been evaluated and shortlisted to 6 sites. TJ highlighted the potential to enter a section 2 agreement with North Somerset Council to facilitate the transfer of capital funds for development. CM highlighted the requirement for the site to be suitable as a multi-use site to allow for primary, secondary and community care usage. A clinical options sub group has been set up to scope additional services that could be located at the site. It was confirmed that Sirona have been engaged and this would continue throughout the process.	

	Item	Action
	The next steps would include stakeholder evaluation workshops of the final sites with the full business case expected to be submitted to NHS England in January 2020. The Committee discussed the potential revenue impact of the project and noted that the impact costs to the CCG needed to be included within the Business Cases. TJ highlighted the potential section 2 agreement which would reduce costs. CB confirmed that the business case was expected to be presented to the Primary Care Commissioning Committee for approval before submission. AM asked that the risks and mitigations within the report were provided in further detail at the next stage, as although the risks were managed by the project group the Committee needed to review and understand the risks and associated mitigations before making decisions. JRu asked who approved the option criteria to be evaluated against and CB confirmed the team would ensure the Primary Care Commissioning Committee approves the criteria. It was agreed CB would review the timeline and ensure criteria approval was added to a future committee agenda. FF highlighted the need for the criteria to include environmental considerations. *(Following the meeting, it was agreed the Strategic Finance Committee would approve the criteria)* **The Primary Care Commissioning Committee noted the progress of the project to date and agreed the next steps to define a preferred site for the development of an Outline Business Case.**	**CB** **CB**
09	**New Community Pharmacy Contract for 2019/20 to 2023/24** Debbie Campbell (DC) and Lisa Rees (LR) were welcomed to the meeting. DC outlined the key changes to the community pharmacy contract as well as the changes to the funding. The most significant change was highlighted as the community pharmacist consultation service which was a national service developed to support the urgent care system. Additional training has been provided for pharmacists and the service was reported to commence in October 2019.	

	Item	Action
	DC informed the Committee there were plans to roll out further pilot schemes related to prevention schemes and the CCG was waiting for further details from the national team such as the criteria for involvement. The teams were preparing to bid for involvement in the pilots. AM noted the quality scheme was opt in for the pharmacies and asked whether there was interest from the pharmacies to opt in and whether the Key Performance Indicators for the scheme were measurable. DC confirmed that most of the pharmacies signed up to the scheme due to the financial incentive to do so and noted that the data received from the scheme was collated nationally rather than locally. DC explained this was the reason for the recommendation to work with the Local Pharmaceutical Committee in order to collect local data. JR highlighted the need to educate pharmacists to support them to provide the contracted services. The Committee discussed support for training potentially through sponsorship. DC noted that the consultation service pilot had been reported as successful with monthly reports presented to the urgent care groups and the Primary Care Operating Group. Both national and local evaluation processes have been set up. The Committee discussed the schemes and noted the importance of community pharmacists in offering lifestyle advice. JRu asked about the contract changes and how the controls would be assessed for payment. DC noted information on quality is provided to the CCG and the payments would be made based on this. LR noted the required IT systems have been set up and outlined the systems the pharmacists need to sign up to in order to receive payments. **The Primary Care Commissioning Committee noted the changes to the new community pharmacy contractual framework and agreed to:** • **Encourage good links with community pharmacy to help promote a local integrated healthcare system**	

	Item	Action
	• **Encourage greater utilisation of community pharmacy services** • **Actively plan for and encourage the use of these funded services in patient pathways** • **Work with the Local Pharmaceutical Committee to collect data and record outcomes from the community pharmacy services locally** • **Receive a further update to the Committee once more detail on the contract is known**	
10	**Primary Care Finance Report** Jon Lund (JL) presented the report informing the Committee that prescribing budget information had been included this month. Primary care budgets were showing a small underspend despite cost pressures. The cost pressures were shown as mitigated by additional funding being released by NHS England. JL reported the overspend in locum costs was mitigated by a £1m funding release from NHSE as well as additional costs for premises of £700k. Following discussions with NHS England £300k has been identified and the CCG would be developing a case to receive a share of the funding to include the additional impact on services if this funding was not received. JR remained concerned about the lack of recurrent funding to mitigate annual cost pressures and noted that the baseline allocation for primary care should be raised if incorrect. JR asked JL to discuss this further will NHS England. The Committee discussed locum spend noting that the majority of spend was due to sickness cover. AM noted other providers were monitored on the sickness levels of staff and queried whether this could be monitored for primary care. It was agreed the Primary Care Operational Group would undertake some investigative work on locum costs and provide a plan for improvement. JL reported the prescribing budget was showing a significant overspend. It was anticipated the commencement of savings schemes would return the budget to break even. Category M drugs provided the CCG with a cost pressure of £2m and JL confirmed this was a national issue and the CCG was assuming additional NHS England funding to mitigate the pressure. JR asked why the CCG was assuming full offset of risks through additional NHS	**JL** **MJ**

	Item	Action
	England funding when there was no evidence to support the CCG receiving the additional funds and asked for a review into the confidence levels in the mitigations reported. JRu assured the Committee the Strategic Finance Committee reviewed the financial risks and mitigations monthly. **The Primary Care Commissioning Committee received the primary care finance report and noted:** • **The confirmed additional non-recurrent resource allocations received for additional GPFV funding** • **At month 5, primary care budgets are reporting breakeven year to date position and forecast outturn against budget** • **The emerging risks to delivery of this plan as outlined in section 7 and the associated mitigations**	**JL**
11	**Primary Care Quality Report** BJ presented the quality report noting the focus on patient experience and feedback. BJ reported Montpelier Health Centre had received their CQC report which showed requires improvement in 2 domains. The CCG has met with the practice and are supporting with the action plan. The Business Intelligence team were reviewing the QOF data for exception reporting. It was requested that the initial report and action plan was presented to the Committee at the next meeting. The July data for the Friends and Family Test showed the CCG had higher than the national average for response rates, the recommendation rate remained the same for the majority of practices with a slight drop for Weston and Worle practices. The GP patient survey data undertaken between January and March 2019 has been released. The CCG response rate was noted as above national average with overall experience better across BNSSG that nationally. The CCG benchmarked well in questions regarding management of mental health needs and long term health conditions. The CCG benchmarked lower for GP access via the phone. It was highlighted that the Ask My GP pilot in Weston had not been in operation at the time of the survey. The survey data has been reviewed and work has already begun in the areas	**BJ**

	Item	Action
	which require improvement. The data has been shared with the locality teams. BJ noted key points from published Healthwatch reports had been included within the report. The Committee discussed the complaints data for quarter 4 received regarding GP Practices in BNSSG. The Committee commented on the number of complaints which were raised and not investigated due to the complainant not providing consent to investigate. AM queried whether there was an issue here that people didn't feel confident enough to consent for their complaint to be investigated. It was requested the team discuss this issue further with NHS England as well as request the quarter 1 data for complaints. To support ReSPECT (Recommended Summary Plan for Emergency Care and Treatment) a GP working group has been established supported by the local Academic Health Science Network. An EMIS template for the required form was reported as awaiting approval. This electronic form would be available to other providers through Connecting Care. Preparations for influenza vaccinations are continuing and local planning was being developed and reviewed. The Committee expected improvement on the 2018/19 uptake rate and asked that an action plan was developed to ensure practices were supported to improve coverage. It was requested the action plan was presented to the Committee at the next meeting. DS requested that issues from 2018/19 were addressed and learnt from in 2019/20. JRa suggested the focus should be the practices where the uptake rate was lowest and suggested this could be incorporated into the work around health inequalities and the work of the Insights team. JR asked whether the CCG had expected the CQC rating for Montpelier Health Centre and asked that a report be presented to the Committee with an action plan. It was confirmed the teams were not expecting the report rating and a report would be presented to the October meeting. JR asked whether the CCG can anticipate "requires improvement" ratings and JB highlighted the exception data from the QOF could provide a good indicator.	**BJ** **BJ** **BJ**

	Item	Action
	The Primary Care Commissioning Committee received the primary care quality report.	
12	**Contracts and Performance Report September 2019** LM outlined the key points within the report: • There were currently 84 contracts with practices, with the closure of Northville Family Practice, Bishopston Medical Practice and Clarence Park Surgery this will decrease to 81 as of the 1st October 2019. • There were 2 single handed contractors holding contracts and the contracts team have received requests from both to add additional partners to the contracts. These requests are being reviewed. • Further information regarding the procurement of the Charlotte Keel Medical Centre would be presented to the Committee in November. • 43.6 minutes were provided through Improved Access in June. LM reported that uptake of the extra sessions was low particularly on a Sunday. • A range of new Locally Enhanced Services have been approved to be paid through automatic review. • 25 practices have not submitted their manual claims for Locally Enhanced Services in quarter 1 and where the CCG has not received the assurance that the care home visits are taking place this has been reflected in the finance report. JRa asked whether the lower uptake of sessions on a Sunday was a national issue and whether there were any areas that had better Sunday access rates. LM explained that schemes were being implemented to improve Sunday rates and then reviewed for improvement. AM noted the lack of impact of the care home Locally Enhanced Service and asked whether the other 3 services had had a positive impact. LM noted that the practices have been unable to demonstrate support to the care homes and the demand on urgent care services from care homes had not reduced. It was suggested a paper be presented to the Commissioning Executive Committee on this issue.	**LM** **LM**

	Item	Action
	The Primary Care Commissioning Committee received the contracts and performance report.	
13	**Primary Care Commissioning Committee Terms of Reference** MJ noted that despite the work undertaken to attract two out of area GPs to become members of the Primary Care Commissioning Committee, the CCG had not been successful in recruiting to these posts, therefore it has been recommended to remove these posts from the Terms of Reference. The Committee agreed that despite the removal of these posts from the Terms of Reference, the aspiration for out of area GPs to sit on the Committee was still present. The amended Terms of Reference would be presented to the Governing Body in November. JR noted the Local Medical Comittee had given apologies to several Primary Care Commissioning Committee meetings and JB agreed to contact the Committee to discuss this. **The Primary Care Commissioning Committee agreed the amendments to the Terms of Reference.**	**MJ** **JB**
14	**Papers progressing to Governing Body** None	
15	**Questions from the Public – previously notified to the Chair** Ms Eileen Means presented the following petition to the Committee: "We the undersigned are concerned about the decision to close the Bishopston Medical Practice on 30 September. The five alternative practices being suggested are Horfield, Monks Park, Fallodon Way, Gloucester Road and Montpelier. However, there may not be room at these surgeries and this could leave many residents without access to a truly local GP service. The loss of Nevil Road surgery could particularly affect elderly residents and those with limited mobility and transport. It may also put increasing pressure on the other GP surgeries in Horfield, Montpelier and Ashley Down. We call on Bristol, North Somerset and South Gloucestershire CCG and NHS England to take all necessary steps to enable existing patients to retain permanent access to a local GP surgery." Ms Means praised the CCG staff who had been involved with the drop in sessions for patients. LM explained the CCG had reviewed the concerns raised by patients following engagement particularly	

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	regarding any potential impact on travel. The practices have assured resilience in order to accommodate the additional patients and have identified whether any additional estate or financial support would be required. JR thanked Ms Means for the petition and noted the CCG understood that service changes can have an emotional impact on patients. The CCG made the decision to close the practices as this was in the best interests for patients. It was noted that any financial resource allocated per patient would transfer to the practice the patient registered to. AM thanked Ms Means for attending and providing feedback and explained a full response to the petition would be provided on the CCG website.	**LM**
	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.	
	Date of next PCCC: Tuesday 29th October 2019, 9.00am – 12.00pm The Vassall Centre, Gill Avenue, Bristol, BS16 2QQ	

Lucy Powell, Corporate Support Officer
September 2019