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 Vassal 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	

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	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