Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group

Primary Care Commissioning Committee

Open Session

Minutes of the meeting held on 30 April 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
David Jarrett	Area Director for South Gloucestershire	DJ
Sarah Talbot-Williams	Independent Lay Member – Patient and Public Engagement	STW
Felicity Fay	Clinical Commissioning Locality Lead, South Gloucestershire	FF
Rachael Kenyon	Clinical Commissioning Locality Lead, North Somerset	RK
Colin Bradbury	Area Director for North Somerset	CB
Justine Rawlings	Area Director for Bristol	JRa
David Soodeen	Clinical Commissioning Locality Lead, Bristol	DS
Lisa Manson	Director of Commissioning	LM
Andrew Burnett	Director of Public Health	AB
Apologies		
Sarah Ambe	Healthwatch Bristol	SA
Jenny Collins	Contracts Manager for NHS England (NHSE)	JC
Philip Kirby	Chief Executive, Avon Local Medical Committee	PK
David Moss	Head of Primary Care Contracts	DM
Nikki Holmes	NHSE	NH
Sarah Truelove	Chief Finance Officer	ST
Kevin Haggerty	Clinical Commissioning Locality Lead, North Somerset	KH

Alex Francis	Healthwatch South Gloucestershire	AF
Debra Elliot	Director of Commissioning, NHS England	DE
Rob Moors	Deputy Director of Finance	RM
Georgie Bigg	Healthwatch North Somerset	GB
Janet Baptiste-Grant	Interim Director of Nursing and Quality	JBG
In attendance		
Rob Ayerst	Head of Finance (Primary & Community Care)	RA
Jenny Bowker	Head of Primary Care Development	JB
David Moss	Head of Primary Care Contracts	DM
Laura Davey	Corporate Manager	LD
Bridget James	Associate Director of Quality	BJ
Sarah Carr	Corporate Secretary	SC
Geeta Iyer	Clinical Lead for Primary Care Development	GI
Adwoa Webber	Head of Clinical Effectiveness	AW

	Item	Action
01	**Welcome and Introductions** AM welcomed everyone to the meeting and noted apologies as above.	
02	**Declarations of Interest** There were no declarations of interest relating to the agenda.	
03	**Minutes of the Previous Meeting** STW asked that paragraph 4 on page 4 be amended to read 'STW asked if patients could be at risk from receiving a late diagnosis and or treatment if referrals were returned to practices and queried if there was any data that assesses this risk.' The committee discussed this question and MJ and DJ agreed to undertake a qualitative impact assessment around referral management services FF asked that the last paragraph of section 7 be taken out of the minutes. AM noted a typographical error in section 7. With the above amendments the minutes were approved as an accurate record.	MJ/DJ
04	**Action Log** Action 58 – BJ confirmed an update was ready to be shared and that she would do this. Action to close	

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	Action 62 – AM noted this action will remain open until GBs return to the committee Action 79 – the presentation was on the agenda. Action to close. Action 83 – BJ noted she would confirm the wording for this action Action 84 – DM confirmed this had been considered and that reporting would be made to the committee on a quarterly basis. Action to close Action 85 – RA agreed to look into this and it was agreed this action would be assigned to him Action 86 – DM confirmed he would request data from the Business Intelligence Team and bring this to the next meeting Action 87 – MJ reported he had confirmed an agreed process with JR for the inclusion of a Practice Manager on the committee. Action to close. Action 88 – MJ confirmed he was in contact with all local CCGs to seek attendance from an out of area GP. Action to close.	
05	**Resilience Support for General Practice** JB presented noting the report provided an update on the overall programme of work on General Practice sustainability and the Resilience Support Toolkit. JB noted the detail in the report around the time for care programme which the CCG was actively engaged in. This included the Time for Care Event where the CCG hosted a 10 High Impact Actions Showcase event in partnership with NHS England's Sustainable Improvement Team in September. The event was attended by around 120 delegates with approximately 70% of practices represented. JB reported on the Intensive Support Site (ISS) programme noting unmet demand had been addressed in 6 of the 10 practices that had introduced the new "front door" online access system and that patient satisfaction has increased. JB noted the planned follow up evaluation and that a further report will come to the committee in September. JB explained the paper then addresses the process for identifying and supporting practices which request resilience support. This can involve applications for Section 96 funding and the process	

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	for these requests is set out in the attached papers. JB commented on the STP General Practice Resilience and Transformation Programme noting feedback had been taken on board and incorporated into the resilience triangle which was being tested with practices. JB invited the clinical members of the committee to be involved in the testing. AM thanked JB for the update. RK commented on feedback and shared learning and FF queried if there was feedback on the interventions offered from practices outside the ISS programme. JB confirmed feedback was predominantly from those within the programme however including a wider group was something that could be looked at. Practices which are participating in the Time for Care programmes are sharing their learning and did so at a recent BNSSG practice manager meeting. JRu queried the delivery of support to practices and how self-evaluation was validated. JB confirmed validation would be achieved through the early warning signs which were identified in the metrics of the toolkit. This would result in initial conversations with practices. JB noted support is available to all practices not only those in crisis. CB joined the meeting. JR commented that the self-assessment tool was not a performance management tool noting the intention was to support practices. DS queried if Locality Leadership Groups were involved and JB confirmed she would ensure their representation would be evolved going forward. CB noted the reference to practices in crisis qualifying for Section 96 support and queried if support to these practices was affected by the type of crisis if for example it was sudden or if it was a result of ongoing issues. DM noted the support was described as and intended to be non-recurrent and that offers are not of a purely financial basis. If funding was required on a regular basis this would need to be looked into to identify the underlying problem that needs addressing.	JB

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	STW queried the role of localities in driving the tool and the impact of the Primary Care Networks on its use of the tool. JB confirmed that this formed part of the next steps and noted through using the tool Primary Care Networks would be supported in understanding resilience. **The Primary Care Commissioning Committee:** • **Noted the BNSSG CCG General Practice Sustainability & Resilience Support Toolkit and process which have been developed and are in use and provided comments** • **Following PCCC feedback in February, noted the progress on the GP Sustainability and Resilience Self-Assessment tool – previously tabled as the Resilience Hierarchy – and agreed the next steps.**	
06	**New GP Contract 2019/20** DM presented the report noting the new five year GP contract was published on 29 March. DM confirmed the Primary Care Network contract would be introduced from 1 July 2019 as a Directed Enhanced Service. DM explained each Primary Care Network would need to sign an agreement setting out how the parties will work together. Five of the seven new national derived Primary Care Network services were planned to start by April 2020 with the other two to start in 2021 as set out on page 2 of the report. DM noted Local Enhanced Services arrangements would also need reviewing to ensure there was no duplication. DM highlighted the ambitious IT developments and the road shows that took place in April as set out on page 3 of the report. DM advised registrations were being received and that governance arrangements for signing off Primary Care Networks had been shared. DM highlighted the key dates set out in section 5 of the report. FF noted the challenge for Primary Care Networks to plan with limited detail and asked what the timescale for guidance was for the improved access national review. FF commented that it would be useful to communicate with Primary Care Networks about the support for developing social prescribing through the VCSE. FF also shared her concern around Care Home Pharmacists being transferred when the scheme ends in March 2020 noting these	

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	staff were a valuable resource. DM responded to confirm that the national mandate would come in two years' time. DM confirmed the transfer of Care Home Pharmacists was optional and that this would be considered as part of the wider work around care homes. JRa confirmed that work with others continues to support the existing arrangements around social prescribing. JR noted the importance of considering the use of staff resource is used across the system rather than the focus being on recruitment. AB queried how Social Services and Public Health Services could be more involved in anticipatory care. It was noted details of anticipatory care have not yet been released to identify the level of support needed. AB noted that cardiovascular case finding had substantial overlaps with Local Authority funded health checks and commented on the need for a collaborative approach to tacking inequalities. AM noted although the detail was not yet available for these topics it was important that the system continued to work together. AM asked if there was sufficient detail on the new Quality Outcomes Framework arrangements to move forward. DM confirmed there was and that this work was in hand. AM thanked DM for the paper. **The Primary Care Commissioning Committee:** • **Recognised the national updates to the 2019/20 GP contract** • **Recognised how the CCG has engaged with general practice since its publication** • **Recognised the agreed local principals for signing off a PCN and agreed the CCG governance to sign off PCN registrations**	
07	**APMS Procurement** DM explained that the Bishopston and Northville APMS contracts are both due to expire on 30 September 2019. These contracts provide primary medical services to over 15,000 patients. Engagement activities were underway and DM highlighted the following: • Patients can continue to use their GP services as usual	

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	• Over the next few months, the CCG will be working with local GP practices and providers to ensure ongoing GP provision form 1 October 2019 DM noted the three possible outcomes of the work as set out on page 2 of the report and noted the survey that had been designed to collate patient views which was developed in collaboration with Healthwatch. DM also noted the customer services team was now in place and highlighted their contact details to the committee. DM confirmed advice around purdah had been sought and approval to continue had been given. DM noted the next steps set out in the report and that a paper would come back to the committee in June. DS queried the risk around staff resignation and patients deregistering. DM confirmed the six surrounding practices were involved in discussions and that the expectation was of a 1-3% expected movement of patients which was not considered as a cause for concern. STW queried if there would be further work with the community and how a broader group of patients could be engaged. DM responded to confirm contact had been made with the Patient Participation Groups to identify cohorts of patients that may benefit from a different engagement approach. **The Primary Care Commissioning Committee:** • **Noted the next steps for engagement with both patients and local stakeholders** • **Noted the communications strategy and key messages** • **Recognised the intention to bring a paper to PCCC in June 2019 for decision**	
08	**Approach and Timeline for Developing Primary Care Strategy** Geeta Iyer, Clinical Lead for Primary Care Development (GI) explained the paper proposed an approach to updating the CCG's Primary Care Strategy (PCS) and the associated timelines. GI talked the committee through the report and noted the areas of engagement on page 3 of the report and next steps set out on page 6.	

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	AM queried the risks and mitigations and GI confirmed the risks were in respect of developing the process for the strategy. STW noted the development of a health inequalities strategy and queried how this would align to the Primary Care Strategy. GI confirmed this would form part of work to review the gaps in the strategy for which there was an initial meeting to be held later in the week. JR noted the work relating to population health management which would support the identification of inequalities. AM noted she felt the paper set out a clear and detailed process. **The Primary Care Commissioning Committee:** • **Noted the revised approach and timelines for updating the BNSSG Primary Care Strategy.**	
09	**PCCC Forward Plan for the year** JB presented the suggested forward work plan for the committee. It was proposed to hold 8 business meetings and 3 seminar sessions with no meeting taking place in December. JB noted the workplan would be subject to change through the year. DJ asked the Locality Transformation Scheme be added to the June agenda. JR suggested the May seminar could be used to address how quality is reviewed for primary care through the year which would support the intention to have a Quality Strategy in place by quarter 3 or quarter 4 at the latest. JB would update the workplan. DM noted it was helpful to receive feedback from members on any topics they would like to be discussed at the seminar sessions. **The Primary Care Commissioning Committee:** • **Noted and comment on the proposed forward plan for the Open Session meetings attached at Appendix 9.1.**	JB
10	**Primary Care Finance Report** RA explained allocations have been reviewed and finalised. The report detailed how the financial position had been reached. RA	

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	talked through the underpinning assumptions and highlighted the following: • The CCG had submitted a balanced financial plan breaking even against its allocation of £127.66m • Planned expenditure of £129.6m against the income allocation equating to a planned deficit of £2m before additional funding • Three income streams have been assumed in order to submit a balanced plan this includes 300k of non-recurrent GP Forward View funding which has been confirmed and 700k of market rent funding which was considered to be low risk • In 2018-19 the CCG received funding of £1m from NHSE in relation to cost pressures from the GP pay award and locum spend. The plan assumes this funding will be available again in 2019-20 this is considered to be higher risk and mitigations include the 0.5% of uncommitted funds that the CCG was required to set aside in its planning process along with an additional £200k set aside for Section 96 funding requests. • With the potential for 31 PCNs there is a substantial financial implication as the CCG could be committed to 31 of each additional role. This is considered to be low risk due to the dependency on having 31 PCNs in place and staff being available to fill the roles. RA noted funding is not transferred until staff are appointed. DJ queried if the 50% slippage on additional roles was in addition to the £2m planned deficit giving a total position of £2.8m risk and RA confirmed this was correct. JRu noted in 2018-19 wider primary care budget supported the overall CCG financial position and queried if there was a similar expectation for this year. RA confirmed he would present the wider primary care budget to a future meeting. This would show the assumption of recurrent savings. The committee discussed the financial position and JR noted that it was recognised that the original allocation was incorrectly assessed and the intention is to work this through with NHSE bringing the CCG to a point of clarity on the recurrent baseline. RA confirmed he would bring an update to the next meeting.	RA RA

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	JRu queried how the Primary Care Strategy took into account the current underlying deficit. JR responded that, whilst the contract was nationally mandated and did not allow for flexibility at a local level, the strategy could address some areas of discretionary spend such as reducing the use of locums which would improve both quality of service and the financial position. **The Primary Care Commissioning Committee:** • **Noted the confirmed Primary Care Medical revenue resource limit for 2019/20 of £127,655K** • **Noted the financial planning assumptions as outlined above and the expenditure plan totaling £129.6m before additional income as summarised above and detailed in Appendix 1 of the report** • **Noted that a balanced plan has been submitted based on the assumption that the CCG will receive an additional £2m of income** • **Noted the other risks to delivery of this plan as outlined in Section 5 of the report.**	
11	**Primary Care Quality Report** BJ presented the report pulling out key highlights from each of the sections including noting that planning for the next flu season was in place and that the FFT data showed a compliance rate of 76% which was above the national average of 62%. BJ reported that in relation to the patient experience quarterly update that minimal data relating to complaints had been received. The CCG would work with NHS England to obtain additional data. BJ noted the focused quality domain of Mental Health and highlighted to the committee that within the baseline data there was 6 indicators regarding mental health that can be nationally benchmarked. BJ also confirmed work was underway with the Medicines Optimisation Team in respect of the variation in prescribing across areas. BJ highlighted the physical health checks for severe mental illness in primary care noting the aim to get more parity of esteem for these patients. BJ drew attention to Cardiovascular Care and introduced Adwoa Webber, Head of Clinical Effectiveness (AW). AW noted the development of the five year plan which would be supported by	

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	population health management information. AW commented that the national specification was expected in the next two years. There was a risk of this impacting on local plans however it is the aim of the local health system to support one coordinated approach to CVD prevention. AW commented on practices achievement of QOF targets and noted that this only offered one perspective of available data and that when making comparisons with similar practices in other part of the country there are further improvements that can be made. AW confirmed work is underway to address the needs of the local population and that Healthier Together has a CVD prevention workstream. FF asked if the mental wellbeing leaflet at appendix 3 was in use. It was confirmed the leaflet had been circulated with clinical leads. BJ agreed to find out if formal approval had been received. The importance of public health and social care involvement in CVD prevention work and the mental health work was noted. DS commented that the metrics did not give a clear picture of mental health suggesting questions around integration would be more beneficial. JR noted the importance of being clear on what metrics should be used and gaining support from primary care to achieve these metrics. JR commented on the triangulation of data across the system which Primary Care Networks would help to drive forward noting this would start to come through in the development of the Mental Health Strategy. CB queried the benchmarking of the cardiovascular indicators. There was a discussion regarding the challenge for the CCG since the merger in recognising who to benchmark against. JR suggested cities such as Birmingham and Greater Manchester and confirmed there is a core group of CCGs with similar demographics that we can benchmark against. JR asked that the references to short, medium and long term on appendix 1 of the CVD report be clarified. JR also asked further information on patient experience measures be included. **The Primary Care Commissioning Committee:** • **Noted the updates on monthly quality data, and the specific information regarding Mental Health and**	BJ BJ

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	Cardiovascular Disease care.	
12	**Contracts and Performance Report** DM presented the report and highlighted: • Following self-assessment it had been identified that 21 practices were not complaint with core hours and this had been addressed with each practice. There are 7 practices that remain non-compliant and this is being followed up • The February improved access rate of 49minutes JR noted the importance of practices being open during core hours and noted the two practices that have declined to participate in the DVT scheme. JR commented on the importance of ensuring the population remains covered by the scheme even where the practice is not participating and DM confirmed he would be taking this forward. **The Primary Care Commissioning Committee:** • **Noted the performance and contractual status of Primary Care**	DM
13	**Any Other Business** There was no other business	
14	**Questions from the Public – previously notified to the Chair** No questions were 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 STW and seconded by JRu.	
	Date of next meeting: Tuesday 28th May, 9-12pm (Clevedon Hall, Elton Rd, Clevedon, BS1 7RH)	

Laura Davey, Corporate Manager
30 April 2019