Bristol, North Somerset and South Gloucestershire
Clinical Commissioning Group

Primary Care Commissioning Committee (Open Session)

Minutes of the meeting held on 26-02-19 at 9am-11.15am, at Clevedon Hall

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Draft Minutes

Present		
Alison Moon	Independent Clinical Member – Registered Nurse	AM
John Rushforth	Independent Lay Member – Audit, Governance and Risk	JRu
Lisa Manson	Director of Commissioning	LM
Martin Jones	Medical Director for Primary Care and Commissioning	MJ
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
Justine Rawlings	Area Director for Bristol	JRa
Colin Bradbury	Area Director for North Somerset	CB
Georgie Bigg	Healthwatch North Somerset	GB
Janet Baptiste-Grant	Interim Director of Nursing and Quality	JBG
Andrew Burnett	Director of Public Health	AB
Julia Ross	Chief Executive	JR
David Soodeen	Clinical Commissioning Locality Lead, Bristol	DS
Jenny Collins	Contracts manager for NHS England (NHSE)	JC
Apologies		
Sarah Ambe	Healthwatch Bristol	SA
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
In attendance		
Rob Ayerst	Head of Finance (Primary & Community Care)	RA
Jenny Bowker	Head of Primary Care Development	JB
Laura Davey	Corporate Manager	LD
Bridget James	Associate Director of Quality	BJ
Sarah Carr	Corporate Secretary	SC
Aileen Edwards	Chief Executive, Second Step	AE
Stephanie Maidment	Contracts Manager for Primary Care	SM
Adwoa Webber	Head of Clinical Effectiveness (Item 6)	AW
Debbie Campbell	Deputy Director Medicines Optimisation (Item 11)	DC
Kate Davis	Principle Medicines Optimisation Pharmacist (Item 11)	KD
Ruth Taylor	One Care	RT

	Item	Action
01	**Welcome and Introductions** AM welcomed everyone to the meeting and noted apologies as above. JB introduced AE, AE was shadowing JB as part of the STP Shadowing programme.	
02	**Declarations of Interest** There were no declarations of interest relating to the agenda.	
03	**Minutes of Last Meeting** The minutes were approved as an accurate record. It was queried if NH was at the meeting and it was agreed to review this.	**LD**
04	**Action Log** The Committee reviewed the action log: • Actions 33, 34, 69 were closed. • Action 41 – the action remained open; an update would come to the March meeting • Action 49 – this would be presented at the March meeting. The action was closed. • Action 58 – BJ confirmed the data had been shared with Peter Brindle, Medical Director and Alison Wint, Bristol North and West LLG member and area representative for Bristol; a written brief would come to the March meeting. • Action 62 – GB confirmed a report would come to the March meeting Actions 63 and 65 – DJ confirmed these actions were on track to be presented at the March meeting	

	Item	Action
05	**Chairs Report** AM commented no chairs actions had been taken since the last meeting. **The Primary Care Commissioning Committee received the update**	
06	**Ethical Decision Making Framework** AW, Head of Clinical Effectiveness presented to the committee. AW thanked the committee for its previous feedback that had been incorporated into the framework and noted the Framework had been approved by the Governing Body. The next step was to implement the Framework across the CCG. AM thanked AW for the report and asked how the Framework would be used by the Committee and whether there would be a reference in the meeting templates. AW explained there would be no changes to meeting templates; the intention was for the Framework to support decision making by identifying matters for consideration. AM asked how the Committee would be informed that the Framework had been used to inform recommendations made to it. It was explained that the intention was to develop more expansive reasoning underpinning decisions. RK welcomed the paper and asked if adding a requirement to refer to the Framework in templates would draw out key points in a more descriptive way. AB commented that adding the Framework as a checklist would help demonstrate the thinking behind decision making in respect of ethics. It was agreed AW would discuss the adaption of meeting templates further with the Corporate Team. **The Primary Care Commissioning Committee:** • **Noted that Governing Body had approved the BNSSG CCG Ethical Framework for Decision-Making** • **Approved the BNSSG CCG Ethical Framework for Decision-Making for use by Primary Care Commissioning Committee**	**AW**
07	**General Practice Resilience and Transformation Programme Presentation** MJ presented the paper, noting this was a combination of the wider primary care strategy and STP General Practice and Resilience work stream. The presentation gave an update on the current position. It was noted that activity taking the work forward	

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	continued. The proposed governance arrangements, membership of the programme steering group and the public involvement to date were highlighted. Attention was drawn to the work streams. MJ commented on the need for practices to work with partners and to be strong, resilient and able to take on new challenges. MJ highlighted the 'Resilience Triangle' developed by a working group that included representatives from the CCG, LMC and One Care. The aim was to define resilient general practice. MJ invited comments on the model, noting the need to test the definition of resilience and consider how it could be used. It was explained that a flowchart will be brought to a future meeting detailing the approach to be used to support practices that required support. It was explained that workshops had been held to test the Resilience Triangle with practices. The Resilience Triangle would help to move the Primary Care strategy forward. The Resilience Triangle needed to be considered in context of the developing Primary Care Networks. FF asked if an assessment approach based on a triangle had a negative connotation. There was a discussion about the potential for a maturity matrix model aligned to the PCN maturity matrix. It was noted that the triangle was based on Maslow's Hierarchy of Needs and it was commented that the references to the five tiers of need were not appropriate. It was agreed that the icons were more relevant to the context. Ruth Taylor (RT) explained that a number of the issues raised had been addressed in the latest version; it was agreed to update the model to include the comments from this meeting and circulate this to the Committee. DS commented that: • Not all practices had business plans in place • There could be variation in the quality pf business planning and other areas. Information on best practice would be helpful • Terms such as collaboration required further definition • A template for assessment would be helpful. GB highlighted that key to practice success was working with the community and suggested consideration be given to how this could be expressed within the framework.	**MJ**

	Item	Action
	JR welcomed the work to date and noted that the work streams related to resilience; it was important to include sustainability and to define this. Primary Care Leadership supporting provider alliance performance and development should be included. It was noted that members of the Healthier Together Core Team had contributed to the development of the model; this would be clearly referenced in future iterations. The motivational theory underpinning the approach used was noted. It was suggested that further consideration was given as to how to describe hope and ambition. The role of practices in providing direction for community resource required further consideration. The options suggested were considered and it was commented that all three should be adopted with the addition of a toolkit of responses that could support primary care. MJ and JB welcomed this and confirmed this was the intention. CB joined the meeting. MJ welcomed the comments and confirmed that discussions regarding the role of practices to provide clarity of direction for community resource were ongoing. AB raised concerns regarding standardising mortality ratios noting the potential for misleading data due to differences in practices. It was agreed that this would be removed. AB offered to advise on alternative wording. STW queried the arrow indicating “hope” on the diagram saying that more than hope was required to drive motivation and success. JB explained that the language used had been based on comments received about the different perceptions of sustainability and resilience. JRu commented on the potential to use the approach with all practices including those facing particular challenges was highlighted. JRu noted the importance of maintaining system resilience in the workforce. The GP membership of the GPRT Steering Group was discussed. It was explained that the GP members included the CCG Medical Director for Primary Care, the GP clinical lead Primary Care Development, the Medical Director for One Care, the Chair of the LMC and the GP Provider Lead to give provider representation. It was agreed to increase the GP membership and that commissioning representation was required.	**AB** **MJ**

	Item	Action
	AM asked for an update to be presented to a future meeting. It was agreed that that a final model would be presented, with an implementation plan, to the Committee in the early spring. **The Primary Care Commissioning Committee noted the presentation**	**MJ**
08	**GP Contract Reform Update for 2019** LM presented the report and highlighted that the framework for contract reform addressed a number of issues, set out in the paper. The commitment to existing programmes to support the delivery of the extra doctors in general practice target was highlighted. LM also noted the framework for contract reform described the creation of the 'Additional Roles Reimbursement'. This new scheme would be established as part of the new Network Contract DES and would start 1st July 2019. Funding would support the expansion of a practice multi-disciplinary team and the creation of five specific roles detailed in the paper. New arrangements for QOF from 19/20 were included in the framework; 28 indicators would be removed from April 2019. It was felt that the indicators were either not aligned to national evidence based guidance, had poor measurement properties, or were viewed as core professional responsibility.15 clinically appropriate indicators covering five areas would be introduced; these were explained in the paper. Two Quality Improvement modules within a new quality improvement domain would be created that would cover prescribing safety and End of Life care. CCGs currently funding these schemes were expected to reinvest funding. LM reported on the Network Contract DES. Each Network would have a named accountable Clinical Director and a Network Agreement setting out details of the collaboration between its members. JR observed that the expansion of primary care multi-disciplinary teams could present a risk, noting the workforce pressures and numbers of trained staff available. GB noted the social prescribing link workers and highlighted the intention to ensure that their work complements the work of practices and the work of the patient participation groups and that any further work should also align rather than duplicate.	

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	DS commented that further detailed information about QOF would be welcomed. The potential to impact on prescribing and the CCG prescribing incentive scheme was noted. STW queried the impact on localities and DJ confirmed the framework would build on the work established within the localities. LM explained that further detail on QOF was expected. JR commented on the calculation for the reimbursement for posts in year one and its potential impact on the CCG. The CCG had raised this matter and was looking to secure the appropriate resource. JR noted the intention for the larger localities to work in clusters but that this was at their discretion. AM left the meeting and STW took the chair. DS noted workforce challenges included drop-out rates and commented that retraining staff that had left the workforce was an option. It was noted that this approach was used with nursing staff. AM returned to the meeting and took the chair. JR asked what the planned approach was to take the contract reforms. LM explained that work was on going and more detail would be presented to the March Committee meeting. FF commented that it was important that practices had clarity regarding the Primary Care Networks, the specific requirements on these and resource available. JR explained that the CCG was actively clarifying the position; in relation to the Additional Roles scheme it was noted that it was a reimbursement model. It was important to resolve these issues to enable discussions to focus on how to invest in and organise primary care networks to deliver best for the population and the scale of appropriate leadership required. Work on this is ongoing including conversations with the NHSE Executive Director of Service Transformation and, Director of Primary Care. RK observed it was helpful for providers to have information at the earliest opportunity. JRa explained that discussions with providers were planned. DJ confirmed further clarification from with NHSE was expected. Conversations with the LMC were taking place to ensure a consistent message. Sessions were planned with practices to provide an opportunity to discuss the new contract.	**LM**

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	The Primary Care Commissioning Committee noted the update	
09	**Financial Plan for 19/20** RA gave an update on the draft financial allocations for 2019/20, emerging national planning guidance, and the financial implications of reforms to the GP Contract. Place-based funding averaged real term growth over a five-year period of 3.6% for BNSSG as a system, compared with the national average of 3.4%. There were three funding streams, the CCG core allocation, the primary medical care delegated allocation, and the specialist commissioning allocation. As a system, for 2019/20, BNSSG was 0.9% under its fair share target allocation. CCG Core and Primary Medical Care allocations were further below target fair shares than the system average, off-set by the specialist commissioning allocation (commissioned by NHS England), which was above target. The BNSSG system would reach its fair share allocation by 2023-24. RA noted the draft Primary Care allocation in 2019-20 was £131.4m (3.28% below fair-share target allocation), which represented cash growth, unadjusted for inflationary impacts of 6.4%. RA highlighted the primary care planning guidance and finance business rules. Commissioners were expected to plan to spend the full allocation. There was a requirement to set aside a contingency of 0.5% and demonstrate through the assurance process that adequate mitigations were in place. A minimum of £1.50 per head would be allocated to support the management and organisational development of Primary Care Networks. Delegated budgets were to be used to support all the practices in the context of Primary Care Networks. A detailed local plan was required by 1st July indicating the active engagement of all practices; activity was to be completed by 31 March 2020. Local practice development plans were to continue to identify practices requiring more intensive and immediate support to stabilise, build their resilience and become sustainable. The links to the General Practice Resilience and Transformation Programme and the importance of building financial indicators into the toolkit were noted.	

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	At the time of publication detail regarding the Global Sum had not been released. This was now available and would be built into the financial plans for primary care. JR asked if the Global Sum uplift resolved the distance from target issue. RA explained it did not. JR asked whether additional roles funding was within the basic allocation. RA confirmed it was and that this was also clarified in the FAQ which directed that CCGs were required to fund it in full. JB noted discussion took place between the national contract team and NHSE team and this had been confirmed. JR observed it was important to resolve this matter. It was noted the expectation did not align to the GP contract documentation; RA confirmed clarification was being sought. The CCG would submit the financial plan on 4 April and delegated sign off would be sought for this from the Governing Body to this Committee and the Strategic Finance Committee. **The Primary Care Commissioning Committee:** • **Noted the key changes that need to incorporated in the CCGs financial planning assumptions** • **Noted that a detailed budget setting paper will be presented for approval at March PCCC ahead of submission of the CCGs overall financial plan submission on the 4th April**	
10	**Primary Care Finance Report** RA reported that at Month 10 there was a year to date overspend of £843k against a year to date budget of £101,187k. RA presented the report noting the following: • The overspend on GP contracts related to the in-year pay award, previously reported in the risk schedule and funding had been received to offset this overspend • There were no allocation changes in Month 10 • In line with National Planning Guidance 0.5% of the total delegated commissioning budget was be held as a non-recurrent contingency. This equated to £614,000 for the CCG MJ asked whether the contingency was included in the allocation uplift. RA confirmed it was part of the baseline allocation and would be planned for non-recurrently.	

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	The Primary Care Commissioning Committee noted the current financial position, the key risks, issues and mitigations.	
11	**Fair Shares Prescribing Budget for GP Practices 2019/10** DC introduced Kate Davis, Principal Pharmacist who presented the report. KD noted the differing budget setting methods of the three CCGs prior to the merger. For 2018-19 each GP practice was allocated their outturn for 2017-18 as their indicative budget as the first stage in alignment. Discussion has been held at a budget setting working group, at the 3 individual Area Leadership Groups and also presented at the fora for comment and feedback. There had been a review of other CCG approaches to practice budget setting. This suggested that, while many options were available, there was a preferred option. The conclusion was that designing a bespoke model would ensure engagement from GP members. The recommendation was that the CCG adopted fair share budget setting for primary care prescribing budgets at practice level for 2019/20. Agreement of the proposed methodology to calculate the budgets was also sought. FF noted it was important to understand the reasoning behind any practices underspending. KD explained this represented a starting position. DC commented that there would further analysis and review of the position. JRu asked what happened if a practice overspent. DC explained this allowed the CCG to review spend and work with practices. JR commented that there were incentives to be within budget. DC noted the 'buy in' from practices supports this. JRu asked why the four identified areas were chosen. KD explained these were key areas of spend for primary care and QOF registers were available for these groups of patients. JR noted that the methodology applied was local. It was important that the CCG was able to justify this local approach and demonstrate that practices would not be advantaged or disadvantaged. JR asked AB to work with KD to look into this and ensure an evaluation at intervals during the financial year. **The Primary Care Commissioning Committee:** • **Agreed to proceed with calculating Primary Care Prescribing Indicative budgets at practice level using Method 5 for the financial year 19/20.**	**AB**

	Item	Action
	• **Agreed there is a phased approach over 2 years to get all practices to spending within their allocated budget**	
12	**Primary Care Quality Report** BJ presented the report noting the following: • The CQC had published four practice inspection reports since the January 3rd meeting. One practice received an overall rating of 'requires improvement'. • Friends and Family Test (FFT) data for December 2018 showed a compliance rate of 61%. This was a one percent increase on the November position, however, the position remained below the national average of 62%. • Flu vaccine uptake figures were above national average. It had been confirmed there would be no future phasing of vaccinations which had caused some issues in availability • The focus area for the February report was Diabetes DS asked why there were disparities between the National Diabetic Audit and the Local Search Outcomes data. MJ commented that differences in data extraction potentially accounted for some of the disparities. DS asked if there would be two types of flu vaccine in the future. It was agreed to explore this and report back to the next meeting. DS commented on the update on cervical screening within BME communities. The advice given to practices focused on sending letters to patients. It was noted that this approach was not necessarily appropriate given language barriers and potential issues such as literacy skills. Local advocates would be a more supportive approach. It was agreed to explore this. FF asked if there was any information available on the structured education courses for patients in respect of diabetes. It was agreed to report back on this to the next meeting. JR asked that future reports include the actions being taken as a result of any issues identified in the papers. BJ noted that BNSSG CCG had the highest reported uptake in the South west for the over 65's and second highest for the 4 -65 at risk group. AB noted the achievement in flu uptake figures and asked that thanks were shared with practices. It was agreed LM would do this through the GP bulletin and the GP Locality Fora.	**BJ** **BJ** **BJ** **BJ** **LM**

	Item	Action
	The Primary Care Commissioning Committee noted the updates on monthly quality data, and specific performance indicators for Primary Care Diabetes Care	
13	**Contracts and Performance Report** LM presented the report and noted all PMS practices were offered a new PMS contract by NHS England. One PMS contract remained outstanding due to a change in circumstances. The practice was in contact with the Primary Care Contracting team who were providing support with the appropriate variation process, as well as providing support with any sustainability concerns. During the previous e-Declaration submission, 5 practices were highlighted as not opening in line with expectations. These issues were now resolved with one exception. This exception would be resolved with a change to the practice telephony system. This would ensure compliance with call direction during lunchtime closures. A draft merger application had been received from Clarence Park and Graham Road. Mary Adams, the Patient and Public Engagement Manager, and the Primary Care Contracts Team continued to work with the practice to ensure the correct process was followed. A change to the Tyntesfield Medical Group boundary change had been agreed to ensure a clear boundary that reflected the merged practice. Utilisation on a Sunday continued to be challenging. BrisDoc provided an hour per week of Sunday face to face appointments for four localities, across three bases, in December 2018. Utilisation of these appointments was 5%. Further work by both OneCare and the CCG was required to fully understand and demonstrate demand for appointments across the week. It was anticipated that sufficient advertising and signposting of the availability of these slots would support utilisation. It was noted that other areas had scaled back Sunday provision. OneCare had confirmed that the two practices which had not advertised Improved Access on their websites would do so from 11th February 2019. Both the CCG and the provider would re-audit the position before the end of March 2019.	

	Item	Action
	JRa asked if there were identifiable trends in the Sunday attendance data. JR noted it is recognised that A&E attendance increased while routine primary care attendance decreased on Sundays. The potential to learn from A&E attendance data to inform the Improved Access offer and general practice response was noted. It was important that data was fully understood. AM returned to the meeting and took the chair. JR noted the referral data and asked that further detail was shared with the Committee in future. DJ confirmed this would be included in the next report. JR asked why, in the analysis of the referral data, three standard deviations from the mean were used. RK explained that this approach provided a more granular picture of the variation. Once the detailed position was understood two standard deviations from the mean would be used. AM left the meeting and STW took the chair. **The Primary Care Commissioning Committee noted the performance and contractual status of Primary Care**	**DJ**
14	**Any Other Business** There was no other business.	
15	**Questions from the Public – previously notified to the Chair** Dr Richard Brown, Chief Officer of Avon Local Pharmaceutical Committee asked the following question: Can you please advise when and how you envisage Community Pharmacies getting involved with the emerging Primary Care Networks? STW responded to confirm that a meeting is being arranged with Dr Richard Brown to discuss the involvement of community pharmacies with the emerging Primary Care Networks. JR thanked Dr Richard Brown for his question noting the importance of engagement with the community pharmacies.	
	Date of next meeting Tuesday 26th March, 9-12pm, Vassall Centre, Bristol, BS16 2QQ	
	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.	

Laura Davey, Corporate Manager, 26 February 2019