Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group

BNSSG CCG Primary Care Commissioning Committee (PCCC)

Minutes of the meeting held on Tuesday 27th November at 9am, at the Vassall Centre, Bristol.

Minutes

Present		
Alison Moon	Independent Clinical Member – Registered Nurse	AMoo
John Rushforth	Independent Lay Member – Audit, Governance and Risk	JRu
Anne Morris	Director of Nursing and Quality	AMor
Lisa Manson	Director of Commissioning	LM
Martin Jones	Medical Director for Primary Care and Commissioning	MJ
Andrew Burnett	Director of Public Health	AB
Julia Ross	Chief Executive	JR
David Jarrett	Area Director for South Gloucestershire	DJ
Sarah Talbot-Williams	Independent Lay Member – Patient and Public Engagement	STW
David Soodeen	Clinical Commissioning Locality Lead, Bristol	DS
Felicity Fay	Clinical Commissioning Locality Lead, South Gloucestershire	FF
Sarah Carr	Corporate Secretary	SC
Georgie Bigg	Healthwatch North Somerset	GB
Rachael Kenyon	Clinical Commissioning Locality Lead, North Somerset	RK
Nikki Holmes	Head of Primary Care, NHS England	NH
Apologies		
Justine Rawlings	Area Director for Bristol	JRa
Colin Bradbury	Area Director for North Somerset	CB
Sarah Ambe	Healthwatch Bristol	SA
Sarah Truelove	Chief Finance Officer	ST
Kevin Haggerty	Clinical Commissioning Locality Lead, North Somerset	KH
Alex Francis	Healthwatch South Gloucestershire	AF
Debra Elliot	Director of Commissioning, NHS England	DE
Philip Kirby	Chief Executive, Avon Local Medical Committee	PK
In attendance		
Robyn Smith	Executive PA *(minute taker)*	RS
Mike Vaughton	Deputy Chief Finance Officer	MV
Amanda Deeks	Chief Executive of South Gloucestershire Council	AD

Jenny Bowker	Head of Primary Care Development	JBo
David Moss	Head of Primary Care Contracts	DM
Chris Chubb	Clinical Commissioning Locality Lead, North Somerset	CC
Adwoa Webber	Head of Clinical Effectiveness	AW
Andy Newton	Head of Unplanned Care	AN

	Item	Action
01	**Welcome and Introductions** Alison Moon (AMoo) welcomed all to the meeting and apologies were noted as above.	
02	**Declarations of Interest** No conflicts of interest were identified.	
03	**Minutes of Previous Meeting** The minutes were approved as an accurate record.	
04	**Action Log** • Ref 33: Seminar sessions considered for February 2019. • Ref 34: As above. General Practice Resilience and Transformation (GPRT) will report back on through the GPRT seminar in February. All other actions were closed.	
05	**Chairs Report - NIL** Nothing to report.	
06	**Local Enhanced Services (LES) Review Update** Martin Jones (MJ) presented an update on the progress of the LES review. The request today is for the committee to note the feedback for draft specifications shared with membership around the diabetes, dementia, and care homes enhanced services. Also introducing DVT again at this stage; although it has been through the CCG review processes on several occasions, part of the work done by practices would sit within an enhanced service therefore we wanted to bring it back to the committee in its entirety. The committee were also asked to note the appraisal for anticoagulation, which includes a clear recommendation for the way forward.	

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	There was a lot of feedback from many sources around the diabetes LES; this is now starting to come together with the diabetes work that is proceeding across BNSSG. Each of the localities are in a slightly different position. There was some feedback from the BNSSG Diabetes Programme Board which suggested that, from the point of views of the diabetic nurse specialists and secondary care, we have variability in terms of how the practices are undertaking insulin initiation across BNSSG. Therefore, the Diabetes Programme Board were particularly keen on looking at a locality based service because that would enhance the ability to manage all patients, ensuring all patients have an inclusive service in the community and primary care. We recognise that there is some work to be done in terms of how the CCG contract with localities, the suggestion is this is put out at practice level at the moment, and encourage movement towards locality level by the end of 2020. MJ referenced the dementia LES and noted that that has been discussion about whether there will be less resource if spread across all three areas. It is more about the wider pathway, and making sure there are guidelines around CT referrals in place; and also support pathways in place and are they resilient. There has been a lot of discussion around the care home LES. Practices were keen for this to be care homes with and without nursing. There is a debate about how this is resourced, and what the offers to practices will be. MJ advised the DVT pathway is currently going through a procurement process to understand what the secondary care offer would look like in that. Jenny Bowker (JB) highlighted some other comments around care homes. Some of the additions that have been included in the revised specification, highlighted in yellow, are focused on how to manage influenza outbreak and medications. Feedback received is about how this is managed in terms of 12 hour responses, particularly for a flu outbreak if it takes place on a Friday. There is more work to be done in terms of talking to practices about that particular pathway; and also to BrisDoc about what role they play in that scenario. There was also feedback that there is a need to recognise the GP as the lead to support care homes, but that there is also a multi-disciplinary approach, and a broader team who are developing care plans, supporting ward rounds and other elements. Felicity Fay (FF) commented that the recording of the feedback, from a South Gloucestershire point of view, is very accurate and inclusive. FF asked if the feedback received has been translated in	

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	to changes to the specifications and appendices. JB advised the feedback has not yet been incorporated in the draft documents, and explained that the CCG wanted the committee to see the versions that were shared with the membership. The next step will be to review the specifications in light of all the feedback before they are presented to the Committee for approval in January. David Soodeen (DS) referred to the number of patients receiving a vitamin K antagonist across BNSSG; and queried whether the 5,766 total figure incorporates the secondary care patient numbers. JB advised they are different data sources so there is small discrepancy between the numbers captured from primary care and those secondary care. The number in secondary care is the number on the books at that time of data capture who are having a dose monitored. *Nikki Holmes joined the meeting.* Julia Ross (JR) commented it is great to see the work coming together and the team are doing a really thorough job. In terms of care homes the localities feel really important, it is about how the whole provider alliance supports and enables better care in care homes. It is about bringing in the community provider, mental health provider and social care in a more systematic and structured way. JR expressed that she feels that health support to care homes should be shifting more towards a locality approach. Some practices have developed a multidisciplinary team, others less so; JRs view is that it should be a locality approach where all the resources can be optimised. JB commented that there is something around the contract terms, particularly for those that the CCG want to move to a locality model. JR suggested it is also about linking with building the new service specification for the community procurement, and that 2020 is the right time. The CCG also need to be clear with practices that is the expectation; and that increasingly these LESs will work towards population level. JR commented that it is difficult to sign off the specifications without any financial analysis. JB confirmed the financial analysis will come back to the committee next month *(action)*. David Jarrett (DJ) noted that the level of engagement with the membership has been excellent. Building on the financial issue, the practice impact has been highlighted a number of times. In terms of the CCGs assurance in terms of the mini basket in South Gloucestershire, DJ confirmed there are no others, that has been confirmed through a finance audit trail.	JB

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	JR sought clarification regarding care homes; and asked if the CCG are expecting people in care homes to change their GP. MJ confirmed yes that is correct; however, if we are asking individual practices to have named care homes, we need to be careful how we do that and residents will still have the option of retaining their existing GP. JR expressed that she is expecting this to be carefully covered in the QIA; and to see a clear implementation strategy laid out in the QIA. Nikki Holmes (NH) suggested, as other areas have done, taking a phased approach and allowing the time to be able to make that choice; and supporting care homes to have that conversation with patients. AMoo expressed thanks to MJ, JB and the wider team for the work they have done throughout this process. The Primary Care Commissioning Committee: • Noted the feedback received on draft specifications shared with the membership and the LMC contained in the main report. • Noted the highlight report in appendix B and the proposed next steps set out within the main report. • Noted the options appraisal for anticoagulation and supported the recommendation within the paper to offer a common basic level service across BNSSG and an advanced service only to those currently providing this in 2019/2020 whilst a full evaluation is made of the comparative merits between an entirely primary care led model and a partial primary care delivery model supported by secondary care provided dose monitoring.	
07	**Ethical Framework for Decision Making** Adwoa Webber (AW) provided an update on the development of the ethical framework for decision making. It was noted it is important for it to be owned by those making the decisions; and understood and implemented by the Governing Body, Commissioning Executive and the Primary Care Commissioning Committee. The draft framework has been developed through a process of co-design to this point. This is based on the fact that the CCG is making decisions on behalf of the population and as decision makers need to be clear about how we are arriving at those decisions. There are five principles for decision making included in the framework; along with a section about how the CCG can use consensus decision making	

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	in committees, ensuring all decision makers are satisfied with their decisions. The CCG has gone through an engagement process with GP member practices, and has taken feedback from them in their meetings in November. The CCG has asked all of their providers that they commission with in terms of NHS providers, but also independent sector providers, for their feedback. Andrew Burnett (AB) noted it is an ethical framework and it does not mention medical ethics; there are four principles which he felt should be included. These principles are beneficence, non-maleficence, autonomy and justice. AB suggested if the framework is being used for decisions about particular individuals it should perhaps include exceptionality. It is important, for decisions that are made regarding funding for individuals, to make it clear that we are not making a clinical decision whether the patient should have the treatment, but a decision whether the CCG should fund it. JR noted the committee are not making medical decisions, they are making decisions about what we fund. This particular framework is about generic decision making; there is a separate policy which is about Exceptional Funding Requests (EFR) which is about how the CCG makes decisions for individuals who want treatment that the CCG do not routinely fund. JR sought Amanda Deeks' (AD) view, and asked if the CCG should be engaging wider with the councils, as we are currently only engaging with Public Health. AD suggested engaging with the Health and Wellbeing Boards, particularly as we joint commission more and increasingly make decisions together, the framework will need to work for both organisations. AD suggested starting a debate about whether this works across both, and noted that perhaps just the language may need to be different. AMoo referred to section three of the paper that notes the timeline of the process, and suggested including, not only the internal process, but also the points about where else this needs to go for discussion, such as the Health and Wellbeing Board. There was a general consensus that the framework needs to be tested. We need to think about how it will be implemented, and how it will be used as it develops. The Committee suggested that we get the framework to a final draft that is signed off and then test it in real scenarios to understand if it needs to be revised. JR commented that she has a meeting with the council Chief Executives quite soon and suggested this can be taken to that meeting initially *(action)*.	JR

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	The Primary Care Commissioning Committee: • Noted the progress that has been made and the future involvement on Governing Body and PCCC in developing, approving and implementing the framework.	
08	**Primary Care Quality Report** Anne Morris (AMor) highlighted the following updates within the quality report. • Four practices have had Care Quality Commission (CQC) reports published between 5th October and 16th November. All received an overall rating of 'good'. One practice received a rating of 'requires improvement' within the 'effective' domain; the main areas for improvement were focused on the nursing team and it related to assurances on recruitment documentation, access to GP clinical support and supervision, and continuity of care. This particular practice does not have a nurse manager lead; the CCG has put in some support for the practice utilising a colleague in the LMC. • Friends and family test (FFT) showed a compliance rate of 62% for September 2018. Further contact has been made with each practice which has not submitted data. The CCG acknowledge this is only one method of gaining patient experience data. • BNSSG CCG is currently above the national average with regards to flu vaccination uptake. JR referred to the compliance rate for FFT and queried what the ambition of the CCG is. AMor explained the quality team are working with practices to understand why their compliance rates are below average, however, this information has not yet been provided in the report. The report needs to describe what the practices are telling us the issues are and then the CCG can look at how the process can be managed going forward. We need to fully understand what it is that needs to be done to get practices above the line. FF asked if BNSSG CCG have to stick with FFT, is it the best measure, and could an alternative be considered. AMor explained that the CCG do have other measures; FFT is the current national benchmark, however other measures could be looked at as well as FFT. AMor commented that there were data collection issues, which can be resolved, and that needs to be looked at with practices. The committee discussed the various tools used by practices to collate the data; these include paper surveys, text	

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	messages, website for patient comments, and feedback from patient participation groups (PPGs). Sarah Talbot-Williams (STW) felt that we could do more to be clear about what good looks like. JR suggested asking the Primary Care Operational Group (PCOG) to do a piece of work on this, working with Alex Ward-Booth (Head of Insights and Engagement), generating some thinking and perhaps getting the clinical leads involved *(action)*. DS commented that most of FFT is dependent on the patient being literate and understanding English; and suggested it would be helpful to benchmark across BNSSG. The quality report tells you what is going on in BNSSG, but it does not tell you the locality differences. The committee agreed locality based data would helpful going forward *(action)*. The Primary Care Commissioning Committee: • Noted the updates on monthly quality data.	AMor AMor
09	**Contracts and Performance Report** David Moss (DM) presented and confirmed the paper provides an overview of CCG contracts and their performance in 2018-19. DM noted the performance for Improved Access (IA) in August and September 2018, with extra hours delivered in the month of September. 100% of practices are now advertising IA; there is a national push now in terms of some advertising coming out nationally. It was noted that the contracting team have received the quarter two (Q2) claims for enhanced service payments, and they are in the final stages of being processed. A summary of enhanced local spend and activity will be presented in the next report to the committee. DM referred to the MMR active call scheme. The contracting team put in a LES, for the period ending September 2018, of a £1.50 payment. 70 practices signed up, and to date 56 have submitted claims. That has resulted in 22,619 call backs going out to patients for the identified group. Initial findings will be shared with colleagues in Public Health England, and a further update will be presented in the next report. JR queried if we have done any triangulation of the MMR vaccination rates against practices that took up the LES and those	

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	that didn't. DM advised that the contracting team are continuing to get the full picture as we have not got the full returns yet. AD commented, that from a public health perspective, seeing the measles outbreaks by locality, there are two particular issues. One is around schools where there were larger numbers; the other issue was Somalia communities. Perhaps the question is whether we are targeting the areas where we know there are particular issues. *Georgie Bigg joined the meeting.* AMoo referred to referral data and the action within the paper that notes referral variation information will be included in a broader information pack, and asked if the committee will see more at the next meeting in terms of referral variation. DJ explained the information was developed through the Planned Care Control Centre last year and was shared with practices highlighting areas where they were at significant variation to others. That suite has been refreshed this year, and through PCOG it was decided not to wait for a broader suite of information, but to send that information out to practices in the same way as last year. A summary of the key points will be presented to the committee at the next meeting. JR commented that she wants to see practice variation in the report *(action).* DS highlighted the number of Improved Access hours primary care offered in June is double that is in December, and asked if this is correct. DM advised this is what is being reported through the One Care contract. DM will go back to One Care to understand what were the issues and will report back to the committee at the next meeting *(action).* The Primary Care Commissioning Committee: • Noted the performance and contractual status of primary care.	DM DM
10	**Primary Care Finance Report** Mike Vaughton (MV) presented the finance report for month 7. The budget for delegated commissioning stands at just under £121m which has not changed since month 6. There are some variances in terms of financial performance in the seven months' year to date. The CCG sees a continuing trend of a small underspend on the GMS/PMS/APMS contract position; at month 7 that is worth £145k. Premises costs are reporting a £94k year to date overspend.	

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	The main variation against budget, which has been discussed by the committee previously, is the locum costs overspend. In the period to the end of October 2018 the CCG are reporting £458k overspend on reimbursement for locum costs. The full year impact of that at the moment is assessed at £785k. However, overall the year to date position for primary care delegated budgets is showing an underspend at month 7 of £184k, and a forecast balanced position for the year end. MV advised the committee that there are two reserve budgets; one is the 0.5% (c£600k) contingency budget that the CCG is required to hold and the CCG has assumed an application against this for the full year of £130k. The second is a general reserve of £527k and the CCG are assuming will be fully applied at year end to support delivery of a balanced financial position. MV highlighted two risks. One is the risk of market rent funding, which in principal has been agreed. The notified allocation value was less than the CCG were expecting, therefore the CCG have gone back to query this with NHSE colleagues. At the moment the assumption is that the market rent increase is fully funded, this will be confirmed as soon as the CCG knows. The second is funding for the second tranche of the notified pay awards; two pay awards were announced for primary care. 1% was announced at the beginning of the year, funded as part of the CCGs allocation, the second tranche of 1% funding was announced more recently. The CCG are assuming the second tranche funding at 1% will also be funded and is approximately £1m. At the moment the CCG are assuming full funding for those in the forecast positions. JR queried if this will be recurrent. MV agreed to review and advise *(action)*. MV then reported on the 'other' primary care budgets which are worth just under £35m. The significant risk to the forecast position is with regards to the current out of hours' contract costs, that is standing at just below £1m; that cost pressure is also reflected in the overall CCG financial position that is reported. JR queried the reporting of the savings target. MV advised that the CCG has agreed a savings target of £0.5m for primary care budgets which will be drawn from two areas; underspending on the improved access funds and adjustments agreed for the South Glos Compact & Bristol Primary Care Agreement (BP CaG). He advised that the finance report will include a reconciliation to the savings target in the future. The Primary Care Commissioning Committee: • Noted the update on the latest reported financial position for all BNSSG CCG primary care budgets.	MV

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11	**PCCC update to Governing Body Quarterly Report** DM noted the PCCC update to Governing Body. The Q2 report summarises what this committee has received, and the work of this committee. It is good practice for the committee to see the report before it is presented to Governing Body. FF referred to page four of the report, IA and Alliance contracting, and commented that the committee did not agree to commission localities to provide IA via an alliance contract; but did agree to explore this with localities. DM will amend this in the report *(action).* DS highlighted there are some elements included in terms of quality, but not on contract performance. AMoo suggested ultimately the performance report the Governing Body received would include primary care. JR queried when the committee will see a paper that concludes how the CCG will contract IA from 1st April because the committee has not yet approved the contract vehicle for 2019/2020. Lisa Manson (LM) advised the consultation closes on the 28th December to then collate the information and bring back to the committee on the 3rd January 2019 in open session for decision *(action)*. The Primary Care Commissioning Committee: • Recognised the work the PCCC has overseen through quarter two 2018/19. • Proposed the Governing Body receives the report to support its own work plan and decision making.	DM LM
12	**Intensive Support Scheme (ISS) Presentation** JB introduced the presentation. It was noted that the CCG felt it would be helpful to share the work of the ISS in Weston and Worle. This is one of seven national pilot sites looking at developing a series of intensive interventions between now and March 2019 to help support and improved GP retention. Chris Chubb (CC) provided a brief background of the programme. Seven ISS sites were created, with £400k allocated to generate activities to improve the situation within a very tight timescale. The Weston and Worle bid was successful for several reasons, including high number of patients to GPs and long term recruitment and retention problems. The case for change is evident that standstill is not an option.	

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	What was recognised in the bid is that GP surgeries in Weston have been communicating together for quite some time. 11 practices involved in Weston have been meeting regularly, and all practices have been engaged. CC noted that those engaged have been very positive and receptive to change. CC highlighted the deliverables which have been divided into three elements, people, process and technology. • People – is about coaching and mentoring for GPs, looking at apprenticeships, and talking about developing a shared home visiting service. • Process – is looking at redesigning the appointments process. Proposing to offer an appointment system which will be adopted by practices in Weston. It was noted that patients who cannot use computers can still phone the surgery. This booking system will be implemented early next year. • Technology – will be looking at practice websites. One Care have started going into practices to implement various schemes to improve back office systems. CC highlighted progress to date includes development of Pier Health, an umbrella organisation. Is was noted this is not a merger, each practice will still hold their own contract, but around that is a super partnership with a board. The idea is to get the best of working at scale and an organisation that can hold contracts; but similarly still maintain autonomy and work in small teams. MJ referred to the appointment booking system and asked how this will be managed in terms of performance, in particular how many appointments will be offered and how it could help to distribute capacity across Weston. CC explained the advantage of the technology booking system is that it has the option of working remotely. For example, if a surgery is particularly busy, another surgery can log in to their platform and triage their appointments. It is about working more efficiently and having the ability to be able to manage that. Georgie Bigg (GB) highlighted that different patients need different access. From a Healthwatch point of view it was noted that the population in Weston are high mobile phone users and suggested that a mobile app could also be an option. GB asked if volunteers have been considered to test the new system, and offered some volunteer support from Healthwatch. JB will feed this back to Denys Rayner to make contact with GB *(action)*. AMoo asked how often the committee can expect updates. JB advised the proposal is to come back to the committee in February	JB

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	2019 as there will be significant developments in terms of rollout to update on *(action)*. The Primary Care Commissioning Committee: • Noted the Weston and Worle Intensive Support Site project update.	JB
13	**Any Other Business** AMoo advised the committee that this was Mike Vaughton and Anne Morris' last meeting and extended her thanks to both for their contribution to the committee and particularly during the transition phase; both personally and on behalf of the committee. No other business was discussed.	
14	**Questions from the Public** AMoo explained that the question has not been given in advance of the meeting, and the committee would provide a response to the question on the website within the minutes. However, the Chair will accept the question on this occasion, but requested that all questions going forward must be notified to the Chair prior to the meeting. <u>Question from Charlotte Paterson (Protect our NHS)</u> Referenced item five of the agenda and asked a question regarding low referral rates. The referral rates are now lower than many parts of the country. This is positive in terms of saving money. However, will the committee discuss whether this is a good thing as far as patients go, in particular in terms of health and equality. For example, hip replacement referrals, there is very strict criteria on who can and cannot be referred. If this is applied there are some patients who could manage to find the money to go privately; however, there are many that could not. <u>Verbal response from MJ, DJ and JR</u> MJ advised the focus of referral management is not about financial pressures but ensuring that the correct pathways are followed and patients received the most appropriate care. Primary care in Bristol, North Somerset and South Gloucestershire appears to have a relatively low referral rate; but that also has to be tempered against other things. For instance, the other referral rate is increasing, that is in part because the CCG have encouraged secondary care specialists to follow the pathways. In terms of the referral rates for hip replacement, as a practicing GP, we refer the right people, and the patient outcomes are some of the best in the country.	

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	DJ commented that the outpatient referral rates are low, but if we look at diagnostic rates they benchmark highly. Primary Care clinicians are accessing diagnostics at a higher rate than elsewhere; which is making sure that the onward referral is the most appropriate referral. It is important to look at the whole pathway of care and not just individual elements. JR advised when a clinical protocol is agreed an Equality Impact Assessment (EIA) is always completed to assure that there is not a differential impact. The question cannot be answered in full today, the committee will take the question and address it *(action)*. <u>Post-meeting addendum:</u> Although BNSSG benchmark low for referrals overall, in 16/17 the 3 CCGs benchmarked high for Orthopaedic activity. We were undertaking approximately 10% more procedures than similar populations elsewhere in the NHS. The orthopaedic policies (including hip replacements) were introduced to provide consistency in thresholds for surgery and improve patient care. The policies ensure that patients have undergone suitable conservative treatments before referral, which might prevent a procedure for some patients, whilst also ensuring patients were optimised for surgery if required. In general, the CCG believes that the low referral rates reflect the quality of primary care in BNSSG, ensuring that patients are managed in primary and community care wherever possible. Primary care is supported by the CCG Referral Support Service and MSK interface service, which provides a GP or Expert physiotherapy led clinical triage service for all referrals. Information on local and best national clinical pathways, and when to refer is provided on the CCG developed support tool (http://remedy.bnssgccg.nhs.uk/). In addition, GPs have excellent direct access to diagnostic tests such as MRI and CT, which is more extensive than in many other areas of the NHS. Each of these measures support GPs in managing patients in primary care and lead to low referral rates into secondary care.	DJ

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	Motion to Exclude Public and Press The "motion to resolve under the provisions of Section 1, Subsection 1 of the Public Bodies (Admission to Meetings) Act 1960 that the public be excluded from the meeting for the period that the Clinical Commissioning Group is in committee, on the grounds that publicity would be prejudicial to the public interest by reasons of the confidential nature of the business" was proposed by STW and seconded by MJ. AMoo closed the meeting and thanked everyone for their attendance and contribution.	

Robyn Smith
Executive Personal Assistant
27th November 2018