Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group

BNSSG CCG Primary Care Commissioning Committee

Minutes of the meeting held on 31st July 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
Sarah Talbot-Williams	Independent Lay Member – Patient and Public Engagement	STW
Julia Ross	Chief Executive	JR
Anne Morris	Director of Nursing and Quality	AMor
Lisa Manson	Director of Commissioning	LM
Martin Jones	Medical Director for Primary Care and Commissioning	MJ
Justine Rawlings	Area Director for Bristol	JRa
Colin Bradbury	Area Director for North Somerset	CB
Andrew Burnett	Director of Public Health	AB
Apologies		
Debra Elliot	Director of Commissioning, NHS England	DE
Sarah Truelove	Chief Finance Officer	ST
David Jarrett	Area Director for South Gloucestershire	DJ
Sarah Ambe	Healthwatch Bristol	SA
In attendance		
Felicity Fay	Clinical Commissioning Locality Lead, South Gloucestershire	FF
David Soodeen	Clinical Commissioning Locality Lead, Bristol	DS
Rachel Kenyon	Clinical Commissioning Locality Lead, North Somerset	RK
David Moss	Head of Primary Care Contracts	DM
Nikki Holmes	Head of Primary Care, NHS England	NH
John Burrows	Assistant Head of Finance, NHS England	JB
Philip Kirby	Chief Executive, Avon Local Medical Committee	PK
Sarah Carr	Corporate Secretary	SC
Jenny Bowker	Head of Primary Care Development	JBo
Laura Davey	Corporate Manager	LD
Mike Vaughton	Deputy Chief Finance Officer	MV
Georgie Bigg	Healthwatch North Somerset	GB
Gillian Cook	Primary Care Workforce Development Lead	GC

Rosemary York	Interim Primary Care Workforce Development Lead	RY
Kate Rush	Associate Medical Director Clinical Leadership	KR

	Item	Action
01	**Welcome and Introductions** AMoo welcomed everyone to the meeting and apologies were noted as above. It was noted Mike Vaughton was deputising for Sarah Truelove.	
02	**Declarations of Interest** STW noted that she has declared a new interest as a Trustee for Together for Short Lives but that it should not impact anything on the agenda. There were no other declarations to be made.	
03	**Minutes of Previous Meeting** GB noted she was not listed on the attendance and that Sarah Ambe (SA) was also missed NH commented to request the following change on page 4: LM highlighted that if the merger were approved the new contract for the merged practice will be under a General Medical Services (GMS) contract, with Sunnyside Surgery giving up its Primary Medical Services (PMS) contract. Revised to: LM highlighted that if the merger were approved, Sunnyside Surgery will exercise its right of return from a Personal Medical Services (PMS) to General Medical Services (GMS) contract, with the merged entity holding a GMS contract. With the above amendments noted the minutes were agreed as an accurate record.	
04	**Action Log** All actions apart from Action Ref 16 were closed.	

	Item	Action
05	**Introduction to Primary Care Commissioning** DM presented noting the presentation covered: • Types of GP Contract • Practice Payments • Delegated Commissioning • Recent and Current Commissioning Changes DM talked the committee through the different types of GP contract highlighting GMS – 11 held by the CCG PMS – 67 held by the CCG APMS – 8 held by the CCG NHS Standard Contract - Used to contract for service provision not covered by core contracts e.g. Locally Enhanced Services (LES). DM commented that the Quality Outcomes Framework (QOF) is intended to support the improvement of diagnosis management of some of the most prevalent diseases. QOF is paid 70% upfront by monthly payments with up to 30% then paid on achievement at the end of the year. JR confirmed there is little definition within the national primary care core contract which does pose a challenge. It was noted that QOF is a framework and is part of the core contract and that it is also dependant on delivery. It was noted that QOF is a framework and is part of the core contract and that it is also dependant on delivery. AMoo queried who was signed up to QOF and it was confirmed all practices were. AMoo queried the flexibility and JR commented that there will be opportunity for flexibility as relationships develop. Jr highlighted that for there to be flexibility all primary care practices must be in agreement. The opportunity for flexibility on a national level is currently unknown. DS queried if we could adapt to meet local needs for example mental health needs of the local population and it was noted this was possible but again with the agreement of primary care practices.	

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	JRu noted each practice can get up to 500 points and queried the average. FF confirmed most are at 90% or higher however DS noted some practices outside the patch are as low as 400 points. DM drew the committees' attention to the bullet points under the premises reimbursements heading of the presentation. RK joined the meeting DM commented on other payments noting the locum payments claimed for sickness, maternity, study leave etc. In relation to the committees' responsibilities JR noted in summary the CCG is not involved in matters relating to individual GPs or complaints, although it was noted complaints do sometimes come through the CCG. DM noted the CCG was currently reviewing Locally Enhanced Services. In respect of the PMS review DM highlighted that this was intended to introduce consistency across GP services and was led by NHS England. The Primary Care Commissioning Committee • Noted the report	
06	**Local Enhanced Services Review Progress** MJ presented and noted the recommendations. MJ drew the committees' attention to the following: • The revised proposal for the Bristol Primary Care agreement and South Gloucestershire Compact Release in-year savings to the CCG of around £220k • The average in-year reduction of income for practices in Bristol and South Gloucestershire arising from the proposal is £3.1k compared to last year • The analysis of the financial impact to the CCG arising from the review recommendations for April 2019 will be presented at the September PCCC meeting	

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	MJ noted the list of enhanced services and rationale for the recommendation to provide notice to practices from 1 august as shown on page 1 of the report. MJ confirmed the revised proposals amount to a 30% reduction in value full year and 12.5% pro rata for the last 5 months of the financial year. This additionally would provide time for practices to plan the transition to phase 3 of the LTS. MJ confirmed a risk assessment of practices positions was being undertaken. JR queried how much the figures equate to per head and noted there is an importance of understanding the quantification and also how this fits into the wider context. JB commented there is an additional £7m investment in GPFV funds and MV commented the figure per head is around £1. The totality of CCG investment in primary care over and above the delegated sum for contracts is close to £20 million and it was agreed that it would be helpful to set this out clearly to the Committee and to practices at the next meeting. DS noted there is concern around increased workload for 2019-20 alongside a reduction in finances. The committee agreed clarity on where value for money lies is important and also noted primary care is central to community health. The committee commented on the need to implement changes as early as possible and to analyse what will be recurrent moving forward. GB commented she is pleased these changes will bring greater equality in access to services and queried how patient will know of the changes. JR commented localities would be working on this and JRu confirmed the need to engage and involve constructively with the public and service users. JRu noted a paper will come to the September PCCC meeting that will address the questions raised at this meeting. FF queried if there was opportunity for further membership engagement at the event in September noting some GP partners felt they would like to see information earlier than they do and it was noted the CCG does its best to ensure membership involvement	

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	and engagement and JB confirmed all membership meetings have been attended and presented to and this will continue. JR commented on the decision to continue providing the Minor Injuries Service and the rationale behind this. JB confirmed the service will continue until March 2018 and that a decision on its future beyond that point would need to be agreed in September. MJ noted the service is liked by GPs and patients and JR noted she would want to understand the detail behind what is meant by 'the service is liked' and also to understand in detail what the service is providing and how this is being done. AMoo took the committee through the recommendations, in respect of the first recommendation it was noted if agreed the letters would be sent 1 August. JR queried how the notice period would be managed and JB noted it could be varied by mutual agreement in year but the CCG would need to give formal notice for those contracts which exceed March 2019. It was noted that 6 months' notice is needed for the South Gloucestershire Minor Injuries LES which is why the timescale takes us to March of next year. **An update to the September PCCC meeting on the LTS and MIU was agreed.** The Primary Care Commissioning Committee • Approved that practices are formally notified of the CCGs intention to extend existing Enhanced Services until 31 March 2019 • Agreed practices in Bristol and South Gloucestershire be provided with a revised offer for the Bristol Primary Care Agreement and south Gloucestershire Compact for the period November 2018 to March 2019 • Agreed that practices be provided with contracts for all LES by the end of September for 2018-19 • Noted the progress of the review of LES as shown in Appendix A	
07	**Bishopston / Charlotte Keel / Northville APMS Contracts** DM presented and noted the recommendation should read 2019 not 2018.	

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	Three APMS contracts in the BNSSG area are due to expire one at the end of January 2019 and two at the end of March 2019. These contracts provide primary medical services to over 32,000 patients. The current contracts are: • Northville Surgery • Charlotte Keel Medical Practice • Bishopston Medical Practice The contracts were procured temporarily as APMS contracts following hand back by the GP partnerships between 2016 and 2017. The report also sets out the next steps for considering the longer term options for the services provided at these locations from April 2019. Further work, particularly regarding patient engagement, is required before the procurement is initiated fully. The current provider for each of the contracts is Brisdoc. DM brought the committees attention to the recommendations. **DM agreed to circulate Appendix A as this was missed from the papers.** GB commented on the different patient base in each of the practices yet the report state no inequalities identified. DM commented that the report presented an extension of the current contracts and any changes would be brought back as a further paper should the extensions be agreed. JR queried the impact of changing contracts in year and LM confirmed it does not have an effect in the way another provider contract would and has been done with other practices. JR commented the use of APMS contracts noting they serve a purpose so there may be times where this type of contract is appropriate but the CCG needs to be clear on the rational when this is the case and document it in the review. JR queried the sentence on page 6 of the report “In order to engage with patients regarding the future of the services at each of the	

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	three practices above, the CCG has various deliberations to make". LM noted there were some areas to work through but agreed the wording was unclear. DS noted his declaration in relation to Charlotte Keel practice. DS commented the impact of the 400% increase in the service charge. **STW asked to see the Impact Screening Assessment and DM confirmed he would share it with the committee.** The Primary Care Commissioning Committee • Recognised the current status and risks within each contract • Agreed to the extension of all three APMS contracts until 1 October 2019	
08	**Quality and Performance Report** AMor presented the report noting the new formatting. Amor highlighted the following: • The primary care web tool was launched in June • Data is shown from different quarters so is hard to review • An updated dataset will be presented to the committee in September • The most recent results for the Friends and Family Test (FFT) data (for May 2018) show that 42 BNSSG CCG practices submitted their data to NHS England as required. This is a compliance rate of 47%, which is lower than the national rate of 62% and this is being followed up. • In respect of recommending your GP the BNSSG rate is lower than the national average • There is a reduction in prescribing broad spectrum antibiotics • Further work is being undertaken in relation to CDiff rates • Feedback from Root Cause Analyses show some prescribing outside guidelines and this is being addressed • CQC – one practice is rated as requires improvement and a follow up CQC inspection has been undertaken and the results are awaited • Serious incident reporting – this will be reviewed again in September when the CCG will be taking full ownership of this process • Datix is now live and will allow the CCG to better understand themes and trends in data for improvement	

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	• Low numbers of incidents are being reported in practices and more work needs to take place with practices to understand the reasons for this. JRu queried what achieving practices meant and it was agreed clear definitions on this and other such wording were needed. Jr noted from the perspective of CQC inspections of 88 practices in BNSSG area all are rated as good/satisfactory and only one rated as requires improvement. Amor confirmed work was being undertaken to include complaints data. AMoo noted the friends and family test data is recent – May 2018 noting a large difference in some of the national average data compared with data from the BNSSG area particularly the number of people who would recommend their GP. JR noted the need for significant improvement on this and that currently there is a downward trend. MJ commented access is a part of the problem but this is not reflected in the data collection. **AMor to provide an update on the FFT data and triangulate with latest GP patient survey data.** It was noted that the Clinical lead for Quality is keen to establish a Quality Governance Lead for each practice to assist with learning and quality improvement. JRa noted learning can be shared across practices. DM reported to the committee on the work being undertaken to ensure the delivery of core hours confirming the key issues were around work to IT systems and training of staff. MV noted the importance of looking at variation and how the medicines optimisation team can bring this into their reporting. **AMor to include medicines optimisation variation into future reports.** It was noted the referral team are going through a restructure and that reviews of pathways and governance will be undertaken. AMoo asked to see the plan and timetable for the single BNSSG referral team. **DM to include in future reports.**	

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	DS suggested that morbidity and mortality were included in the data and noted some of the QOF data was unassigned. The Primary Care Commissioning Committee • Received and noted the report	
09	**Primary Care Finance Report** MV presented and noted the following highlights: The CCG finance team is working with NHSE colleagues on the transition plan for financial management of primary care budgets There has been a movement in funding between budget areas detailed on page 2 The month 3 position shows a modest year to date underspend of £28k net which includes an overspend to month 3 on premises costs which reflects the impact of the market rent adjustment – NHSE will advise when they know what funding is to be allocated against this. General reserves are showing an underspend for the year to date in line with a straight line profile for the year which partially offsets the market rent issue. The contingency reserve has been accrued to budget and therefore is unapplied at month 3. The forecasted position is in line with the financial plan In respect of risks MV raised two issues: • potential costs if market rent impact is not funded by NHSE • NHS England intelligence indicates a rise in locum expenditure however this is not yet showing in the financial figures but is under review JRu queried if the target takes into account the CCG giving notice on contracts and MV confirmed it did. The Primary Care Commissioning Committee • Noted the report	
10	**GP Forward View Workforce Topic Discussion** MJ introduced the report noting the governance structure to the committee. RY Presented the report and highlighted the following: • Funding to expand placements for students in primary and community care	

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	• Expansion of apprenticeships with development opportunities which will be good for retention of staff • Success in bidding for funding • Delivery of an Integrated Primary Care Workforce and Workforce trajectory for submission to NHS England by 31 August FF queried in numbers how close we are to filling staffing gaps and RY confirmed the gaps offered an opportunity to look at what will be needed in the future rather than replacing like for like. Minimum number of GPs, paramedics etc. has not yet been identified but is being worked towards. JB commented workforce profiling across the system was key and the committee agreed. DS commented admin, reception and Nurse Practitioner roles are all used in different ways across practices and this along with pay would also impact on recruitment. JR noted patient to clinician ratios are below average and we need to look into how we address this. RY commented that there is helpful work ongoing at STP level and work to increase the number of paramedics is underway and well supported by the ambulance trust. The Primary Care Commissioning Committee • Noted the report	
11	**Update from the Primary Care Operational Group** DM commented that the ToR for the PCOG subgroups were under discussion. The Primary Care Commissioning Committee • Noted the update	
12	**Any Other Business** GB reported that Healthwatch North Somerset had now published 'A Patient's View of North Somerset General Practice, Enter and View Summary Report'. The report summarises enter and view visits made to 28 North Somerset Practice sites during November 2017 and April 2018.	

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	The project identified: • 126 examples of good practice • 97 examples of changes made following feedback shared with Healthwatch North Somerset Enter and View representatives • 49 changes that the Practices would make to improve access to services for patients at the Practice The report can be found at: https://www.healthwatchnorthsomerset.co.uk/wp-content/uploads/2017/09/HWNS-GP-EV_FinalReport_Published-10072018.pdf Reports on individual Practices can also be found on the website https://www.healthwatchnorthsomerset.co.uk/about-us/our-work/ There was no other business.	
13	**Questions from the Public** AMoo noted a number of questions had been received from a member of the public and passed to the committee late the previous evening. These questions covered topics not solely in relation to the PCCC. **AMoo confirmed the CCG would provide a written response and publish this on the CCGs website.** Shaun Murphy from Protect Our NHS asked the following question: In a small survey of 31 people conducted by Protect Our NHS, over 50% of people said they or someone in they knew had difficulties in making an appointment at a GP practice, and nearly 30% had, had to wait more than 3 weeks for a routine appointment. When accessing the quality and performance of providers of GP services does the CCG collect data on ease of making appointments, refusal of appointments and waiting times for appointments. Is it acceptable for a medically unqualified receptionist to refuse a patient an appointment with a GP and tell the patient to go to their local pharmacy? JR confirmed that the CCG would look into the comment around unqualified receptionists if the individual was happy for the specific information to be passed on but at this point in time would be	

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	unable to comment without the full details and facts. JR confirmed the CCG understands the challenges in getting appointments and work to address this is ongoing, in addition it was noted service users do not always make use of the most appropriate channels for their care. JR noted the quality report was the first one received due to the committee being newly established. It was agreed access to primary care services would be added into the Quality Report and JRu asked the data around missed appointments etc. also be included. **AMoo confirmed a written response would be provided.** There were no other questions.	

Laura Davey
Corporate Manager
31st July 2018