NHS
North East Lincolnshire
Clinical Commissioning Group

MINUTES OF THE PRIMARY CARE COMMISSIONING COMMITTEE
HELD ON TUESDAY 30th July 2019 – 2pm to 4pm
AT CENTRE4, IN TRAINING ROOM 1

PART A

Present:

Voting Members:

Laura Whitton	NELCCG Chief Finance Officer
Phillip Bond	Deputy Chair, PPI member of Governing body
Cllr M Cracknell	Portfolio Holder for Health Wellbeing and Adult Social Care
Jan Haxby	NELCCG Director of Quality and Nursing
Mark Webb	NELCCG Chair
Dr Sinha	GP Partner and CCG Clinical Lead for Adult Services (Deputising for Dr Ekta Elston)
Stephen Pintus	Director of Health and Wellbeing, NELC

Non-Voting Members:

Saskia Roberts	Medical Director, Humberside LMCs
Tracy Slattery	Delivery Manager, Healthwatch North East Lincolnshire

In Attendance:

Lezlie Treadgold	NELCCG PA to Exec Office
Jo Horsfall	NELCCG Finance Support Officer
Julie Wilson	Assistant Director, Programme Delivery & Primary Care, NELCCG
Geoff Day	NHS England representative
Rachel Barrowcliff	NELCCG Service Manager, Service Planning and Redesign
Erica Ellerington	NHS England representative
Sophie Hudson	Service Manager, NELCCG
One member of the public	

	ITEM	**Action**
1.	**APOLOGIES FOR ABSENCE** Voting Members: Dr Ekta Elston Non-voting members: N/A	
2.	**DECLARATIONS OF INTEREST** The Chair reminded members that if at any point during the meeting they note a conflict of interest this needs to be declared and members should ensure that this is listed on their declaration of interest form.	

Name	Agenda number	Nature of Interest and Action Taken
Dr Sinha	8	Dr Sinha is a local GP and potential recipient of PMS reinvestment funds.

		He stayed in the meeting but did not take part in decision making
Dr Sinha	10	Dr Sinha is a local GP and will be affected by the decision regarding potential clawback. He stayed in the meeting but did not take part in decision making.
Dr Sinha	12	Dr Sinha is a local GP and has been a member of a Federation in receipt of the GPFV non-recurrent funds. He stayed in the meeting but did not take part in decision making
Dr Sinha	13	Dr Sinha is a local GP who is involved in extended access service provision and will be affected by the decision. He stayed in the meeting but did not take part in decision making.
Dr Sinha	15	Dr Sinha is a local GP and could be affected by decisions made regarding use of funds by other practices. He stayed in the meeting but did not take part in decision making

3.	**MINUTES OF THE PREVIOUS MEETING / VIRTUAL DECISION LOG RATIFICATION – 28th May** The minutes of the meeting held on the 28th May 2019 were agreed as a true and accurate record.	
4.	**MATTERS ARISING AND ACTION LOG** The action log circulated for the meeting was updated as per attached.	
	GOVERNANCE	

5.	**DELEGATED COMMISSIONING AUDIT FINAL REPORT AND ACTION PLAN** The Committee received a copy of the final audit report for delegated commissioning arrangements at the May 2019 meeting, which set out a number of actions to be completed. An update was provided on the actions that have been completed, and in particular the requirement for the CCG to have in place an Immediate Disruption to Service Procedure, which has been developed to ensure continuity in service to patients should there be an immediate GP Practice closure. The checklist requires approval by this Committee in order for it to be adopted as a formal procedure within the CCG, which can be appended to the existing Failing Services Policy. MW queried whether a provider contact list is available should the need arise for the commissioner to put in place an urgent provider arrangement. **Action: RB to produce a contact list.** **Resolved** **The Committee members noted the update on the actions arising from the delegated commissioning audit and approved the Immediate Disruption to Service procedure.**	**RB**
	STRATEGY	
6.	**PRIMARY CARE STRATEGY UPDATE** a. Primary Care Network update The Primary Care Strategy has been discussed at previous meetings with agreement that JW would provide updates at regular intervals. The implementation action log was shared with the following progress highlighted: PCNs: • PCNs received final approval 31st May 2019 • PCNs confirmed network agreements in place as at 30th June 2019, and networks deemed formally constituted from that point • PCN workforce baselines agreed by 30th June 2019 (this applies to the 5 additional roles that PCNs will be eligible to receive funding for) • PCN funding commenced from 1st July 2019 • Local supplementary schemes under discussion with PCNs – awaiting proposal regarding medicines optimisation • Meeting arranged between PCNs and existing Social Prescribing services to discuss potential for alignment if PCNs recruit to the Social Prescribing Link Worker role • Work underway between CCG and Public Health team to develop population health management approach with PCNs • PCNs being supported by CCG with data and intelligence to inform priorities • Community nursing service meeting with PCNs to discuss alignment of services • Regular meetings with PCN Clinical Directors agreed, to support development JW also highlighted the good progress locally with the implementation of online consultation. An example of this being used by a care home to seek support for care for residents was also provided. MW queried consent implications with regard to care homes speaking to practices on behalf of patients. **Action: JW to check consent arrangements.**	**JW**

	A discussion took place around the importance of patient engagement with PCNs, particularly Patient Participation Groups (PPGs). Guidance is still emerging regarding how PCNs should do this, but it was noted that there is the potential for PCNs to develop super-PPGs which represent all practices and it was felt that it may be wise to instigate this now rather than later. PB requested that this be added as an action to the implementation plans. **ACTION: JW to ensure that PCN patient engagement is added to the implementation plan**. JW highlighted the actions which currently have a red RAG rating and a brief discussion took place around the challenges, particularly in relation to the requirements for 25% of appointments being available online and new patients having full prospective access to their record. It was noted that there is currently no process by which CCGs can access data to verify this, and there is no national guidance regarding the expectations for monitoring of these requirements. The CCG has therefore developed a self-assessment for practices to return to the CCG which also allows them to identify where there are issues in achieving compliance and support required to do this. Some practices have raised concerns about underutilisation of the slots made available online, which could impact on capacity, and the CCG is working with a few practice managers to develop a policy around this in the absence of national guidance. The Committee noted that the requirement for direct appointment booking appears to be at odds with the care navigation approach and does present a challenge in terms of ensuring most effective use of the appointments. JW asked if the Committee were content with the format of the update, and the members confirmed they were. It was agreed that JW will provide an update to alternate PCCC meetings in future unless anything significant arises. **Resolved** **The Committee members noted the update regarding the implementation of the primary care strategy.**	**JW**
7.	**HUMBER COAST AND VALE PRIMARY CARE STRATEGY** GD talked the Committee through the attached presentation and explained that the HCV Primary Care Strategy is a requirement along with the CCG Primary Care Strategy. A query was raised regarding quality and how this is reflected at HCV level. It was noted that there is a quality group at that level, which should pick up primary care issues too. It was highlighted that this presentation appears to be inward looking for general practice/PCNs, and doesn't seem to focus on working with other partners outside of the PCN, particularly community groups and the voluntary sector. However GD clarified that there is reference to that within one of the slides, and the more detailed narrative does include working with community and voluntary sectors and other outside agencies. He agreed he would be happy to share the detail. **Action: GD to share detailed narrative that sits behind the slides.** **Resolved** **The Committee members noted the information provided.**	**GD**
8.	**PMS RE-INVESTMENT PLANS** Dr Sinha declared a conflict of interest; he remained in the room but didn't take part in decisions.	

	JW talked through the report, which had been prepared to seek approval of proposals for use of the PMS reinvestment funds in 2019/20. Committee members were reminded of the background to this premium funding, which is a result of NHS England undertaking a review of the PMS contracts within North East Lincolnshire in 2014/15. The aim of the review was to ensure an equitable payment between General Medical Services (GMS) and PMS contracts. This resulted in a reduction to the core PMS contract payments and the identification of a PMS premium for reinvestment back into local general practice services. NHS England stated that the premium must be ring fenced to general medical services in the CCG area, but not solely for investment back into PMS contracts. The reinvestment has been phased over 4 years (2015/16, 2016/17, 2017/18 and 2018/19), and the original phased transition period is now complete, and the funding has now become part of the overall primary care budgets. The Committee were also reminded that NHS England has since identified that there would still be a differential between the GMS and PMS payment in April 2020, so a further reduction will take place as of April 2020. This will release a further £200k back into the CCG's primary care budget from that point. The proposed investment for 2019/20 was reflected in the table attached to the paper. JW explained that it reflects the need to support the CCG's overall primary care budgets, due to the lower than anticipated uplift. The financial update was provided to the last Primary Care Commissioning Committee meeting, identifying a gap of £550k in the primary care budget once all of the mandated payments had been honoured. This gap is therefore being covered, in part, by the flexibility within the PMS premium, whilst retaining the investment in primary care enhanced services that has already taken place, and some flexibility for services that are currently in development. SR raised concerns that it appears that funding is being taken away from practices, which will have a number of consequences and queried whether these consequences had been considered. JW clarified that that there is no funding being removed from any scheme that is already set up and running, and it still leaves flexibility for investment in new schemes that may be up and running before the end of the year, e.g. shared care. GD reminded the Committee that one of the principles associated with the PMS review was that this premium should be reinvesting back into additional general practice services locally. LW and JW confirmed that the changes made ensure that funding is still available for practices, but a challenge was put back that this proposal meant that the funding was being used to support core funding and address shortfalls, when it should be additional to core. It was acknowledged that there may be confusion in the way that the proposal has been presented, and LW and JW agreed to review the overall primary care budgets again and make adjustments to these proposals, as appropriate. The Committee asked that this be brought back to the September Committee meeting for final approval, but JW highlighted that it would need to be agreed sooner than this and a paper would therefore be sent out for virtual approval. **Action: JW/LW to consider the points raised today and share an updated proposal for virtual approval.**	**JW/LW**
	QUALITY	
9.	**PRIMARY CARE QUALITY UPDATE (STANDING ITEM)**	

	JW updated that there have been three recent Care Quality Commission (CQC) inspections of general practices. The CCG has offered supportive visits ahead of the inspections. CQC reports have yet to be published but will be shared with Committee members once available.	
10.	**2018/19 QUALITY SCHEME ASSESSMENT** Dr Sinha declared a conflict of interest; he remained in the room but did not take part in the discussion or decision. SH informed the Committee members that the local quality scheme for 2018/19 has now been concluded and this report has been prepared to update the Committee regarding the Federations' achievements against the requirements. As with the previous year, the scheme focused on joint working between Practices at Federation level, to encourage peer review, shared learning and collaboration to support quality improvement. The scheme was broken down into 4 key areas: • Infection Prevention and Control o Part a – Reduction in Gram Negative infections o Part b – Sepsis • Mortality Reviews • Referral management • Medicines optimisation Mandatory evidence was specified for each section of the scheme, and the Federations were also required to share findings for some elements of the scheme with other Federations and the CCG through presentations at the March 2019 Protected Learning Time events. In summary, all three Federations achieved all requirements with the exception of two Federations, which did not meet the prescribing budget element. It is proposed that funding is clawed back for those practices within each Federation that did not achieve the prescribing target. The suggestion is that half of the funding for that element is clawed back, as the Federations did evidence other requirements against that section. As the Federations have now been superseded by the Primary Care Networks, it is proposed that the funding is deducted from the relevant individual practices' regular payments, as there is no corresponding scheme at Federation level this year to apply this deduction to. The LMC queried whether the Federations were already aware that they would not have met this requirement. It was confirmed that they had been receiving regular reports on the prescribing activity and budgets and they had already queried with the CCG whether there would be any claw back, as they were aware that they had not met the target. SR also queried whether there had been notice given for withdrawing the quality scheme, as specified within the agreement. JW clarified that the practices had been made aware that the quality scheme was deferred, pending the transition to PCNs. It has now been superseded by PCN supplementary schemes. **Resolved** **The Committee members noted the summary of the submissions by federations and agreed the approach to claw back of funding.**	

	OPERATIONAL	
11.	**PRIMARY CARE COMMISSIONING FINANCE REPORT** JH presented an overview of the finance report. The key points to note were: • Overall increase of £918K to the total Primary Care Allocation is due to the receipt of the expected allocation for the Improving GP Access scheme, net of confirmed expenditure adjustment relating to last financial year. • PMS Premium funding of £1,956K has been transferred between Core Primary Care and Delegated Primary Care to fund locally commissioned schemes – this is the same process as previous years. • We are still awaiting receipt of the £434K allocation for the remainder of the Apex Insight Workforce toolkit – this is not currently reflected in the figures. Allocation is due to be received at the end of month 4. • YTD variance of -£31K against NELC's Substance Misuse scheme is due to the phasing of the budget – the scheme is forecast to spend to budget by the end of the year. Following further work, plans have been finalised to address the "funding gap". Details of the following are incorporated in the 'PMS Re-investment Plans' paper: • Shared Care • Quality Scheme The planned in year slippage of the new PCN Additional Roles scheme which commences 1st July will be factored in to the forecast from Month 4, based on the receipt of practice claims. **Resolved** **The Committee members noted the year to date and forecast position for the Primary Care budgets for the period ending 30th June 2019.**	
12.	**2018/19 GPFV NON-RECCURENT FUNDING – END OF YEAR ASSESSMENT** Dr Sinha declared a conflict of interest; he remained in the room but did not take part in the discussion or decision. SH informed members that this report has been prepared to update the Committee regarding the achievement of the Federations against the requirements of the 2018/19 GPFV Federation Development Monies. As a reminder, NHS England Shared Planning Guidance 2017 to 2019 set out a requirement for CCGs to make £3 per head of population non-recurrent funding available for general practice transformational support; NELCCG provided this over 2 years (2017/18 and 2018/19). An element of this funding, equating to £1.20 per head of population per annum, was set aside specifically to support practices to develop collaborative / 'at scale' arrangements. This was aimed at helping practices with the development work required to transition to collaborative arrangements through backfill and/or temporary support. SH summarised the requirements, as set out within the paper provided to the Committee, and drew attention in particular to the Accountable Care Partnership (ACP) meeting attendance requirements. JW explained that the meeting arrangements have evolved in year, moving to fortnightly meetings and alternating between the Integrated Care Partnership (ICP – was formerly referred to as ACP) and Integrated Urgent Care Alliance meetings. In addition, various sub-groups of the IUC Alliance had been established, which the Federations had also attended but which were not all minuted. It had therefore been difficult to assess the 90% requirement. Attendance at all ICP or	

Alliance meetings had been checked and all 3 of the Federations had attended at least 15 meetings over 11 months (as the scheme was not offered out until after the start of the financial year), i.e. more than one per month. It was therefore proposed that the measure of at least monthly attendance be adopted instead of the original 90% requirement.

It was confirmed that all 3 Federations had met the requirements of the remainder of the agreement.

Resolved

The Committee members noted the summary of the assessment of achievement of requirements by the Federations and approved that the GPFV requirements were met, taking into account system changes that affected those requirements.

13. EXTENDED ACCESS UPDATE

Dr Sinha declared a conflict of interest; he remained in the room but did not take part in discussion or decision.

JW informed the Committee that this paper had been prepared to update the PCCC regarding the current interim Extended Access service and to request that the PCCC considers the option to extend the interim service to March 2020, pending the outcome of the national access review.

Committee members were reminded that the CCG's Care Contracting Committee (CCC) had previously supported the decision to commission an interim service within North East Lincolnshire, to enable the service to be established within shortened national timescales and to allow for data collection and evaluation to inform the future service specification. As the CCG also wished to retain the link to the registered patient list, local practices were asked to collaborate to deliver this service; the vehicle used to do this was the Federations. Now that that there is a nationally recognised vehicle for commissioning from networks of practices, the advice from the CCG's contracts team has been to novate these interim arrangements across to the lead practices for the PCNs, and this change has taken place*.* This does not represent any change in service, as the practices are continuing to deliver the service in the same way.

Prior to publication of the NHS Long Term Plan and the introduction of PCNs, the CCG had been intending to undertake a procurement process at the end of the interim service. However, the national direction set out within the Long Term Plan and GP Contract requirements is that PCNs will be entitled to the Extended Access services by 2021, or sooner; this is dependent upon the current contract arrangements in place. CCGs where the contract ends sooner than 2021, can choose to transfer the funding to the PCNs earlier.

The CCG's position is that it would not be reasonable to undertake a procurement exercise for the service for such a short term period when the entitlement for PCNs is due to come into effect. Furthermore, as part of a set of Frequently Asked Questions, NHSE has recently advised "NHS England and NHS Improvement will be undertaking a review of extended access services this year. In the interim, it would make sense to only contract at £6 per head (or less) for the duration of the 2019/20 financial year, so as not to pre-empt the outcomes of the review". It is therefore suggested at this point that the interim service be extended to 31st March 2020, pending the outcome of the national access review.

Resolved

The Committee members noted the update regarding the current Extended Access service and approved the proposal to extend the interim service from October 1st 2019 to March 2020, commissioned via PCNs.

14. PRIMARY CARE NETWORK SUPPLEMENTARY SCHEMES

JW updated the Committee that the CCG was awaiting further proposals from the PCNs regarding potential supplementary schemes. Some outline ideas had been included within the paper which was presented regarding PCN approval at the May 2019 Committee Meeting, but further detail was due to be sent to the CCG. This will replace the previous Quality Scheme.

15. KEELBY PREMISES PROPOSAL

Dr Sinha declared a conflict of interest; he remained in the room but did not take part in the decision.

JW explained that the Roxton Practice currently operate general practice services from a branch surgery within Keelby. These premises are in need of development and, as a result, they have considered a number of options for future provision. These options were set out within the attached outline business case and include:

- ‘do nothing’
- redevelop existing building
- close premises in Keelby and relocate services to Immingham
- new build.

The preferred option is for a new purpose built centre, located within a proposed new housing development, the development of which the practice intend to fund themselves. The case was brought for consideration by the Primary Care Commissioning Committee previously due to the fact that it will result in an increase to revenue costs that the CCG will need to fund, i.e. rent reimbursement and rates increase is likely to result in an additional £25k per year (the current rent reimbursement is £19,402.08). It is not a request for capital funding.

Other considerations for the CCG are the likely impact of the existing premises being vacated and the potential for continuing to fund void space. NHS Property Services do have an option to dispose of buildings, but this requires confirmation from the CCG that those premises are no longer required for healthcare.

It was noted that the Committee has previously approved this increase in revenue, in principle, and the proposal is being brought back for ratification now that the development is entering into public consultation and initial outline planning phase (the timeline is set out on page 7 of the attached).

Further detail regarding the practice premises development will be brought back to a future meeting as the development progresses.

Resolved

The Committee members ratified the decision to support, in principle, the new development and associated revenue increase.

16.	**PRIMARY CARE COLLABORATIVE (AT SCALE) SERVICES: TRANSITION TO PRIMARY CARE NETWORKS** This item was taken before item 13. JW explained that NEL CCG has commissioned two services to date from local practices on the basis that they collaborate, which they did through the 3 local Federations: these are the Interim Improving (Extended) Access Service and the Primary Care Chronic and Complex Service. The reason these services were commissioned at this level was because of the link to the patient registered list, but recognising the benefits of delivering at a larger scale through a collaborative approach between practices. The approach to commissioning these services was agreed through the CCG's Care Contracting Committee. Now that the Primary Care Networks have been established, this provides a nationally recognised vehicle for primary care at scale services. As soon as the PCNs were formally established the CCG took advice from the contracts team and formally transitioned the existing arrangements to the PCNs, with effect from 1st July 2019. This change does not constitute a change in service delivery, it reflects the change in funding flows. There are no changes to the financial values; the only change is that the funding flow would be via PCNs instead of Federations. **Resolved** **The Committee members noted the transitioning of the primary care collaborative services to PCNs with effect from 1st July 2019.**	
	INFORMATION	
17.	**ACTION SUMMARY SHEET - GP PROVIDER DEVELOPMENT GROUP MEETING (Standing item)** The last GP provider development group meeting was cancelled; there were therefore no new actions to share.	
18.	**ANY OTHER BUSINESS** None discussed.	
19.	**DATE AND TIME OF NEXT MEETING** 24th Sept 2019 11am to 1.30pm 26th Nov 2019 2pm to 4.30pm	