

**NORTH EAST LINCOLNSHIRE JOINT CO-COMMISSIONING COMMITTEE**

**NOTES OF THE MEETING HELD ON THURSDAY 29th OCTOBER 2015, 14.00 -15.30**

**TRAINING ROOM 1, CENTRE4, 17a WOOTTON ROAD, GRIMSBY, DN33 1HE**

**PRESENT:**

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| Mark Webb  | Chairman of NELCCG, Chair of Joint Co-Commissioning Committee |
| Dr Thomas Maliyil | GP lead for Primary Care, NELCCG |
| Zena Robertson | Director of Nursing, NHS England |
| Dr Derek Hopper | GP Chair of CoM, NELCCG |
| Christine Wallis | Primary Care Triangle Lay Member |
| Steve Pintus | Director of Public Health, NELC |
| Chris Clarke | Assistant Head of Primary Care, NHS England |
| Cllr Jane Hyldon King | Portfolio Holder for Health / Deputy Leader of the Council |
| Julie Wilson | Assistant Director Programme Delivery & Primary Care – deputising for Cathy Kennedy |

**IN ATTENDANCE:**

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| Kaye Fox | PA to Executive Office, Note taker |
| Paul Glazebrook | Health watch Representative |
| Russell Walshaw | LMC Representative |
| Lisa Hilder | Assistant Director Strategic Planning NELCCG |
| Judith Wild | NHS England (Shadowing Zena Robertson) |

**APOLOGIES:**

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| Cathy Kennedy  | Deputy Chief Executive/CFO, NELCCG |
| Geoff Day | Head of Co-Commissioning Localities, NHS England |
| Debbee Walker | Service Lead, NEL CCG |

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|  | **ITEM** |  |
|  | **Apologies** As noted above |  |
|  | **Minutes of the Previous Meeting** The minutes of the meeting held on the 1st September 2015 were agreed as an accurate record. |  |
| 1. **2**
 | **2 Matter Arising**1. **Update on 7 day working projects**

Julie Wilson provided an update on the 7 day working projects. The commencement of the NEL Docks Collaborative project (10 Practices working together) has been delayed due to the NHS England funding not being released, although this has now been resolved. Due to this, the project has been revised and split into 4 phases. Phase 1 has now commenced. A meeting was held yesterday between the CCG, NHS England and representatives from the NEL Docks Collaborative and it was agreed that a revised project plan will be submitted. They have also agreed to share some data regarding capacity and demand, as well as a proposed reporting template. The reporting template will be brought to a future meeting of the Co-Commissioning Committee, so that members can see the measures that the project is aiming to achieve.**7 day project for other Practices** – As reported previously, the CCG offered non-recurrent funding to the remaining practices to develop a further 7 day project. Initially it was thought that they would develop a separate proposal, but following some workshops with the practices concerned, it was agreed to follow the NEL Docks Collaborative model. Practices are awaiting information regarding the impact/outcomes from the Docks group before moving forward, so this will be later than originally planned due to the delayed start of the NEL Docks project. In the meantime, the CCG has offered to use some of the non-recurrent funding available to the other Practices to support the move towards 7 day working, such as capacity and demand work, and the GP Development Group agreed to undertake a piece of work looking at options to source a bespoke programme. There is also the opportunity for the NEL Docks project to access some of this non-recurrent funding if this would support swifter implementation and realisation of the benefits.Julie Wilson stated that it is now likely to be March 2016 before the NEL Docks project will have outcomes available. Once these outcomes are identified a decision will be made as to when we move forward with all Practices, and what the future commissioning arrangements should be.**The committee noted the current position**1. **Review of current Enhanced Services (incl. >75s service)**

Julie Wilson stated that the >75’s enhanced service had been previously discussed at the meeting held in September, when an agreement in principle had been reached to re-align this funding to the alternative ‘Support to Care Homes and those with Multiple Complex Conditions’ model, which would be across the whole of North East Lincolnshire. This was subject to the Committee having a better understanding of the model and being aware of the discussion and agreement reached at the Council of Members regarding this. The paper presented today provides an update on this and also provides an overview of all existing enhanced services that are commissioned, with a view to agreeing further joint work to create better alignment with the CCG strategy. Agreement is requested for a small working group comprising of representatives from the CCG, NHS England and the Local Authority to work through the list in detail to put forward proposals to re-align resources. In terms of the ‘Support to Care Homes and those with Multiple Complex Conditions’ model, the CoM meeting supported this as a direction of travel, but questions had been raised around the specification; these were discussed at an evening workshop following the CoM discussion. A working group has now been established to take forward the implementation of this model, and an update will be brought back to a future meeting of the Joint Co-Commissioning Committee.The Committee are also being asked to approve a set of principles that are listed within the paper. These principles will help guide our decisions regarding re-alignment of existing funding to strategic service development. The Chair asked that the principles listed within the document are shared with the Care Contracting Committee for consistency in terms of making decisions and investment. **Post meeting note: The ‘Principles’ paper is on the CCC Agenda for the meeting for the 11th November 2015.****The Committee noted the existing enhanced services and the total resource committed. The Committee also agreed the suggested principles for determining future commissioning arrangements and for further joint work to make proposals on future commissioning arrangements for enhanced services.**1. **Update on Board decision regarding fully delegated, and awareness of recent NHS England communication**

Julie Wilson stated that it had been recommended at the Extra-Ordinary Joint Co-Commissioning Committee in September that the CCG would remain at Level 2 Co-Commissioning in 2016/17 but prepare for fully delegated arrangements by April 2017. This recommendation was agreed at the Partnership Board meeting in September 2015. Very recently, NHS England has written out to CCGs to encourage them to move to fully delegated from April 2016. This has not changed the CCG’s decision, but it was felt appropriate to make the Committee aware of this communication. **The Committee noted the recent communication and that the decision regarding full delegation remains unchanged.** | **Agenda** |
| **4.** | **The Chair agreed to amend the agenda to allow Agenda item 7 to be moved to Agenda item 4, the rest of the Agenda will follow the format as agreed.****Accessible Information And Translation Service – New Standards -Lisa Hilder**Lisa Hilder talked through the presentation on Accessible information standard which was approved by NHS England in June 2015.  The new standards promote the best possible care for individuals. All organisations must comply with these standards by 31st July 2016. A question was asked whether the text phone facility is still available, Lisa Hilder confirmed that it is.  **Interpretation and Translation standards –** Lisa Hilder informed the Committee that there is a current on-going consultation by NHSE on guidelines and standards for interpreting and translation services.  The Chair asked if the new standards applied to all our providers within Health and Social Care as some community groups may not be able to comply, the Chair also asked whether anything was being put in place to help these organisations and whether this is something that we need to be able to evidence before doing business with them and to explore what kind of service we commission from smaller providers. It was confirmed that the CCG would need to look at this in more detail once the consultation on standards is completed and would determine the precise requirements with smaller providers depending on what we commission from them.A key consideration is around independently interpreted consultations as there are safeguarding issues when reliant on a family member to translate when accessing care.  Further work is required to promote why this is important and the ability to access services in a timely manner.  This will be looked at in more detail once the consultation on standards is completed.  It was agreed that using a family member takes away confidentiality, it was also noted that with more people coming to the UK this may become a bigger issue.A suggestion was made to look at jointly providing the Interpreting and Translation standards, to ensure that all organisations are using the same approach.  It was asked if there is a resource implication whether the service could be provided in a joint way across the system rather than by separate departments using different systems.  Lisa Hilder stated that NHSE hold a database of services that comply with the standards and stated that capacity may be an issue if we all choose the same provider.  It was noted that demand for the service would need to be identified to enable the infrastructure to be set up to enable these services to be provided within the local area.  Relevant time would need to be included within appointments to meet the need for the interpreter/translator.  The Committee was in agreement that we need to be able to respond appropriately to interpreting needs of individuals and not rely on family members.  Lisa Hilder agreed to update at a future meeting on the Interpreting and Translation standards once the consultation outcome is known.**Lisa Hilder left the meeting at this point.** |  |
| **5.** | **Declarations of Interest** Dr Hopper declared an interest in Agenda item 8 as his Practice is located in the same building as those being discussedJane Hyldon-King declared an interest in Agenda item 8 as she is a Patient of one of the Practices being discussed. |  |
| **6.** | **Commissioning of Primary Care Substance Misuse Service – Stephen Pintus**A paper was presented to the Committee to advise and seek approval changes to the commissioning arrangements for Primary Care Substance Misuse services, which has been the sole responsibility of NEL council since 1 April 2013. The new arrangements are proposed to be Joint Commissioning of the service by NELC and NEL CCG, with the procurement, contract and funding hosted by NEL CCG.An extended review has taken place taking in to account a related service currently provided by Practices through an enhanced services contract with the CCG, and this will be incorporated into the new contract. The presentation clarified that the proposed approach was for the transfer of funding for contracting for Primary Care Substance Misuse Treatment Services from NEL Council and NELCCG, to enable a new specification that incorporated the current enhanced service and NELC contracts. The procurement would be led by NEL CCG and the consequent contract and contract funding would be hosted by NEL CCG. To enable this to happen, the budget would be transferred from the NELC Public Health grant into the CCGs existing pooled budget, and the scope of the Section 75 agreement would be widened to include the joint commissioning of Primary Care Based Substance Misuse Treatment Services (PCBSMTS). The new contractual arrangements will be put in place through a new specification and single contract with an alliance of GP practices, which will enable the services to be better organised. This arrangement does not need to go to external procurement because the specification will require that the service is provided to patients by their registered GP, to ensure overall continuity and integration of their healthcare needs. Stephen Pintus confirmed that both the legal team at the Local Authority and the specialist procurement advisors at the CCG were in agreement that this procurement approach did not contravene procurement rules. A query was raised around a paragraph in the report which stated that the performance for the substance misuse related outcomes are not performing as well as it previously did. Stephen Pintus stated that there is variable performance within Primary Care which is expected to be resolved by the new specification and contract arrangement outlined in the paper. There have been some issues with the new secondary care service including recruitment problems. The current secondary care model of one size fits all is being challenged as there is a need to do things differently for different client groups. The young people’s element of the service has been improved which has seen the usage increase, there are still issues with adult services and these are continuing to be reviewed. The secondary care service is currently challenging to be bottom of the league in the Country, and the council needs to ensure that it will be going in the right trajectory by Christmas.A query was also raised around the new Contract and what will happen during ‘Out of Hours’ in relation to prescriptions, advice and access to medication, if something goes wrong within out of hours who picks this up. Steve Pintus agreed to look into this and respond back. Stephen Pintus stated that with the service being provided by one organisation it should be easier. It wouldn’t be possible to fund an ‘Out of Hours’ drug and alcohol service.**ACTION: Stephen Pintus agreed to look in to the Out of Hours query and respond**  **back to Dr Maliyil.****The Committee approved the transfer of the procurement and contract funding responsibilities for the new Primary Care Based Substance Misuse Treatment Service from NEL council to NEL CCG.** | **S Pintus** |
| **7.** | **Local Authority Commissioned Services - ODS codes for use on FP10s – Mark Webb**A paper was presented to the Committee to consider the details within the factsheet and ask the Committee to clarify the extent to which these requirements are being adhered to within North East Lincolnshire.It stated within the document that in relation to prescribing, Councils should be paying for prescribing relating to services that they commission from GP services. Organisations outside the NHS require their own ODS codes to avoid the cost being set against the GP practice prescribing budget. Stephen Pintus stated that they are working through issues with the Prescribing Authority, the national treatment agency are keen to know how much is being spent on drug and alcohol services and where the money is. The budget required should have been identified in transition as part of the Public Health monies in 2013 but the expenditure was not separately identifiable at that time. The expenditure now requires identifying and putting against the councils budget. The same issue exists with Sexual Health and Smoking Cessation. There is a need to ensure that the legalities are sorted in respect of ODS codes and agree how we manage these arrangements to ensure that accountability follows the budget.Stephen Pintus stated that he will be able to confirm the ODS codes to the Committee by the May 2016 meeting.**ACTION: Stephen Pintus to update the Committee at the May 2016 meeting.** | **S Pintus** |
| **8.** | **PMS Contract variations requests**List closure requests **Dr Hopper and Jane Hyldon-King did not participate in this part of the Agenda due to their conflict of interest as noted above in Agenda item 5.**Woodford Medical Centre and Littlefield Practice have applied to close their patient lists to new registrations.  Woodford Medical Centre has applied for a list closure for a period of 3 months and Littlefield for a 6 month period.The Committee  is being asked to:* Note the contents of the report that has been submitted for the meeting
* Reject the 6 month closure request from Littlefield Practice
* Approve a revision of Littlefield Practice’s application to close their list for 3 months
* Approve the closure of Littlefield for 3 months

Chris Clarke informed the Committee that following the receipt of an application from a practice the usual process involves consultation with local stakeholder and practices to help determine any potential impact on local service provision. An account of the situation within the practice that has led to the application needs to be made and this is usually covered through a meeting between the practice and NHS England. Chris Clarke confirmed that he had had a conversation with the practice manager but it had not been possible to visit the practice in the period prior to the Co-Commissioning Meeting. The purpose of the visit and meeting is to understand the problems, what can be done possibly to alleviate the issues and if any support can be put in place.The practice manager had confirmed that they are registering a higher than usual number of patients with complex needs. The Woodford practice was short of clinicians and had not been able to recruit. The period for closure would allow time for the practices to recruit to vacancies within the clinical team and review the patient list, as both practices had a number of patients registered with them that live outside of their practice area. A lengthy discussion took place around the issues that could arise if the closure of these Practices is agreed, including the potential impact on patients and other Practices in the area. As part of this, it was suggested that Practices with closed lists should not be offered the opportunity to take on additional services, when they are not able to deliver core services to their existing patients.The Chair noted that the meeting with the practices had not taken place as yet and this was important in ensuring that the decision was taken when fully appraised of the situation in the practices. It was agreed that these discussions must include exploring options to help alleviate the difficulties and potentially avoid the need to close the list to new patients.  Once the information from the discussions is known the application can be reconsidered and a final decision can be made.   Chris Clarke stated that such applications were not routine in NEL and that to his knowledge only 1 practice prior to these applications had closed their list in the last 11 years.It was suggested that for future decisions on list closures, the information available needed to include the outcome of discussions with the Practice including exploration of options to alleviate the pressure and waive the need to close the patient list.  It was noted that applications need to be turned around within 28 days, but that this can be delayed with agreement; the Committee agreed that the report could then be agreed virtually if in order to meet the new agreed timeframe.**ACTION:    Chris Clarke to update the report to include the additional section** **showing the comprehensive details of the discussion that has taken** **place and the criteria to enable a virtual response to be given.****The decision of the Committee was not to accept the application at this time but for NHS England to arrange a site visit for a more in depth conversation to go through the background of the application and identify what others may be able to do to help.** **ACTION:    Chris Clarke to go back to the Practices to delay response and arrange to visit and meet the practices to confirm factors that led to the application being submitted.** | **C Clarke****C Clarke** |
|  **9.** | **Scheme of delegation for Primary Care service and contract decisions**A paper was presented to support a discussion amongst members of the Committee regarding a scheme of delegation for decisions on issues pertaining to General Practice.The paper submitted to the Committee is in draft format and the Committee is asked to suggest any potential amendments to support the preparation of a final version.Following discussion the following amendments were agreed:* It was agreed to remove the category ‘Joint NHSE/CCG officer decision - notified to next committee “for discussion”’ and include items under that heading within ‘Joint NHSE/CCG officer decision - notified to next committee “for information”’, on the basis that the Committee would not be able to overturn any decision already made; therefore those items are for information. Under any items ‘for information’, the Committee can raise queries for discussion if they wish
* List closure – it was agreed to seek virtual decisions, or call an extra-ordinary meeting of the Co-Commissioning Committee, where decisions need to be made before the next scheduled Committee meeting
* Committee decisions – It was pointed out that there are certain times of the year when it can be anticipated that meetings will be required to discuss those items under this heading, for example guidance has just been issued regarding the next round of Primary Care Infrastructure bids (now called Primary Care Transformational fund) and there will need to be decisions made before the end of February 2016. It was agreed that we may need to look at scheduling of meetings and/or arrange extraordinary meetings to create a best fit for those decisions that are not suitable for virtual agreement.

**ACTION: Julie Wilson to amend the document as agreed by the Committee** | **J Wilson** |
| **10** | **Sustainability Principles**Julie Wilson presented the paper to seek the approval of the Committee on the final version of the principles that has been prepared in conjunction with the LMC and NHS England to support General Practice sustainability.Julie Wilson informed the Committee that the document has previously been through the GP Development Group and this Committee in draft format for comment. The paper had received a good response from the GP Development Group, and the final version has been updated based on some of the comments received and some points have been elaborated on to make them clearer.**The Committee approved the Document – Sustainability Principles.** |  |
| **11** | **Bursaries For Overseas Recruits**A paper was presented to the Committee detailing the CCGs strategy to match bursary funding in relation to potential Dutch GP recruits. The paper was seeking endorsement of the approach/principles and agreement that the final decision will get appropriate authorisation within the CCG Structure. Julie Wilson talked through the paper and stated that the CCG is proposing to make the recruitment package for Doctors coming to work in NEL more attractive by matching the National Recruitment Office funding for each candidate during their training phase. Julie Wilson confirmed that there is a recruitment budget which will be used as Dutch recruits commence over the next few years. The approach to match the bursary funding will be signed off through the CCG Remuneration Committee but a view is sought on the approach from the Committee.Discussion took place and a number of points were raised. It was agreed that the arrangements should specify that the CCG would claim back the package if the Dutch GP withdrew from the Contract. There was a wider discussion around GP recruitment to the area, and the need to promote NEL to attract good high level candidates, be more pro-active and identify barriers that are stopping applicants applying, and to target young local people to take up a medical career. It was noted that HYMS are trying to encourage people from disadvantaged backgrounds to apply for medical careers. **The Committee agreed to support the recommendations being considered by the remuneration committee, subject to the addition of a proposal that the CCG element of bursary funding should be paid back if the Dutch GP leaves within 2 years.** |  |
| **12** | **Items for Information:****a) Update from GP Development Group – Action Summary Sheet** The paper was noted by the Committee |  |
| **13** | **Primary Medical Services Budget (Summary)**1. **NHSE**
2. **NEL CCG**
3. **NELC**

No update was provided by NELC. The paper circulated for the meeting was noted as showing the current financial position of NHSE and NELCCG. |  |
| **14** | **Any Other Business** A question was raised around Disclosure and Barring Service (DBS) as part of the recruitment checks. The LA and the CCG operate slightly differently in terms of the frequency of renewing checks. Four Practices have refused to sign up to Health Checks because of the DBS requirements, as the LA renew checks on a 3 yearly cycle while GP Practices renew 5 yearly. This will have a significant cost implication to Practices if they move to 3 yearly checks. **The Committee agreed that there needs to be harmonisation between NHSE, CCG and LA, need to identify what is good practice and agree for uniformity.** **Action: Stephen Pintus to discuss with Jan Haxby, Director of Quality** | **Stephen Pintus** |
| **15** | **Date of next meeting:****Date: 28th January 2016****Time: 2pm to 4pm****Venue: Training Room 1 Centre 4** |  |