WEST LEICESTERSHIRE CLINICAL COMMISSIONING GROUP

Minutes of the Primary Care Co-commissioning Committee (PCCC), held on Thursday 19 January 2017 at 9.30am in Boardroom 2, Woodgate, Loughborough

PRESENT:
Ms Gillian Adams  Lay Member (Chair)
Mrs Fiona Barber   Healthwatch
Mrs Ruth Brutnall  Head of Corporate Governance (deputising for Mr Ket Chudasama)
Dr Geoff Hanlon   Board GP/Clinical Lead
Mr Ray Harding   Lay Member
Dr Mike McHugh   Consultant in Public Health
Mr Ian Potter   Deputy Chief Operating Officer (deputising for Mrs Angela Bright, Chief Operating Officer)
Mr Andrew Roberts  Head of Management Accounts (deputising for Mr Spencer Gay)
Dr Nil Sanganee  Non-Board GP
Mrs Caroline Trevithick  Chief Nurse
Dr Chris Trzcinski   Board GP/Clinical Lead

IN ATTENDANCE:
Mrs Ruth Waddington         Head of General Practice Contracts and Quality
Ms Alison Moss   Committee Clerk (minutes)

<table>
<thead>
<tr>
<th>Item</th>
<th>Discussion</th>
<th>Action</th>
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<tbody>
<tr>
<td>PCCC/17/001</td>
<td>Welcome and Apologies</td>
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<tr>
<td></td>
<td>Apologies for absence were received from Ms Lynne Sanders, CQC, Ms Liz Hart NHS England and the LMC representative.</td>
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<td>Ms Adams confirmed that the meeting was quorate.</td>
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<td>PCCC/17/002</td>
<td>Report for the Conflict of Interest Panel and Declaration of Interest</td>
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<td></td>
<td>There were no conflicts of interest noted.</td>
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<tr>
<td>PCCC/16/103</td>
<td>Minutes of the meeting held on 15 December 2016</td>
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<td>In relation to the PCCC/16/106 IM&amp;T Update, Mr Potter clarified the point recorded in the fifth paragraph on page 5, regarding the local digital roadmap aligning with other plans. Mr Potter explained that the Local Digital Roadmap had been produced prior to the publication of the Operational Planning and Contracting Guidance which provided more detail on the IM&amp;T requirements. Going forward the section of the Local Digital Roadmap would be received and updated. Mr Potter said the action could be removed from the action log.</td>
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<td>The minutes of the meeting held on Thursday 15 December 2016 were approved and accepted as an accurate record.</td>
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<tr>
<td>PCCC/17/004</td>
<td>Matters Arising from meeting held on 15 December 2016</td>
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<td></td>
<td>In respect of the action recorded under Internal Audit – Follow Up Report, it was noted that NHS England had confirmed attendance for the confidential meeting.</td>
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The Primary Care Co-commissioning Committee

- **NOTED** the action log and updates.

### PCCC Risk Register

Mrs Waddington presented the Committee’s Risk Register. It was noted that the Register had not changed since the last meeting.

With respect to risk no. 6 ‘Practices are placed in to CQC Special Measures following an inspection’ it was questioned whether the score was appropriate given the recent indication that a practice was to be placed in special measures. Mrs Brutnall advised that the risk was there to facilitate oversight about preventing practices going into special measures and the mitigations rather than managing specific instances.

The risk at no. 4 ‘The CCG does not secure enough interest through a local process to secure provision of urgent caretaking arrangements as required’ was highlighted. It was suggested that the likelihood score be raised from 2 to 3. Mrs Trevithick asked what the impact would be on other practices and whether it could be perceived as catastrophic. It was considered that the failure of caretaking arrangements could overload neighbouring practices to the point they were unable to cope. It was noted that the risk was meant to refer to the CCG’s ability to respond to immediate crises and not the same intervention as for Centre Surgery which was a more managed process. It was agreed to review the risk having considered the report on Centre Surgery. Dr Hanlon suggested that ‘engagement with federations’ would be a useful control to note on the Register.

The Primary Care Co-commissioning Committee

- **NOTED** the PCCC Risk Register.

### General Practice Forward View (GPFV)

Mr Potter updated the Committee and agreed to circulate the presentation.

Mr Potter noted that Dr Hanlon and he sat on an LLR-wide group which had been tasked with taking forward the work within the STP on primary care. The group was at an early stage of development. There were working groups which sat below the group and one of these was concerned with I&MT. Another group was looking at Workforce issues and Dr Barlow and David Muir attended that group.

The General Practice 5 Year Forward View - Operational Plan 2017-2019 had been presented to an extraordinary Board meeting in December 2016. The Board had noted that in certain areas, such as care redesign, the plan lacked ambition. Further work would be undertaken under the auspices of the Integrated Primary Care Improvement Board.

It was reported that Mrs Bright was leading on the development of Integrated Teams which enabled social and healthcare professionals to work together.

It relation to the workforce a training hub was being developed. The Practice Nurse conference had been well supported. It was noted that Mrs Stead was working with the federations to bid to secure additional clinical pharmacists. If it was approved there would be one pharmacist for each locality. Mrs Barber noted that 120 applications had been received for the fund. The funding would taper over a three year period with NHS England providing 60% of the funding in the first year, 40% in the second year and 20% in the third and final year.
In respect of the work stream ‘workload’ there was an LLR bid and co-ordination for ‘Time to Care Programme’ which would be launched at an event on 9 February where consideration would be given to the 10 high impact actions articulated within the GPFV that could be taken. Detailed plans were being finalised for training Care Navigators and online general practice consultations.

Funding for 7-day access to GPs would be forthcoming in 2018/19 and consideration given to the appropriate model that connected with the integrated urgent care model. Dr Hanlon said that the integrated urgent care model established the model for 7 day access and that it was sensible to build upon that.

Mr Potter outlined the funding available over the next five years and the LLR General Practice Programme Board Structure. Mr Potter agreed to circulate the slides.

Ms Adams asked, in respect of GP resilience, what assurance the Committee could have that it was back on track. Mr Potter said that there was some way to go. Mrs Bright and Mr Potter would be talking to Mr Sacks at ELRCCG the following day and would be taking proposals to the steering group.

Each Accountable Officer for the STP was required to provide a detailed plan which would be discussed at SLT. It was agreed to report back to the Committee and for the General Practice Forward View to be a standing item on the agenda.

Dr Trzcinski noted that £1.29M had been allocated in 2018/19 and £2.3M in 2019/20 for access to primary care. He asked whether there would be any investments before then and it was thought not. It was noted that this would account for an investment of £3 per head rising to £6 per head.

A question was asked about the federations and the extent to which they could be seen to be duplicating work with the CCG. Mr Potter said that as elements of the work programme developed there needed to be clear engagement with practices. Whilst the federation managers and leads were familiar with the programme the information might not have filtered down to individual practices. Dr Hanlon concurred and said that the federation boards were well sighted on the programmes.

It was noted that progress could be hindered as LLR-wide agreement was needed. Each CCG was independent and needed to give approval. Mr Potter acknowledged the risk but added that there was scope for different forms of delivery locally.

The Primary Care Commissioning Committee
  • NOTED the presentation on General Practice Forward View.

PCCC/17/008  Workforce Update

The item was deferred to a future meeting.

PCCC/17/009  On The Day Access

Mrs Waddington presented the paper which updated the Committee on the scheme to provide additional on-the-day appointments in general practice during the winter period. WLCCG had bid for and received an allocation of £163k. Mrs Waddington said that 47 of the 48 practices had signed up and verbal confirmation had been received from the remaining practice that they would be taking part.
Ms Adams suggested that feedback from the schemes would be useful in reviewing appointment systems and capacity. The scheme would run until the end of February 2017 and a return would be required by NHS England for the number of appointments offered weekly and DNAs. A report would be made to the Committee in March.

It was noted that the number of patients seen varied according to the ability of the practice to deliver additional appointments. Mrs Waddington thought any underspend would be minimal. There could be the option to extend the scheme beyond February subject to funding.

Mrs Barber asked what the impact on practices had been. Mrs Waddington said the feedback was positive. In the previous two years practices had been surveyed after the scheme and said they were able to manage demand better and were not deferring patients. There had been a smaller cohort of practices who said it had felt like extra work. However, she noted that the current scheme was for fewer appointments and was more flexible. Dr Sanganee said that the flexibility of the scheme was welcome.

It was noted that there were two extra appointments per 2,500 patients and the offer to practices was dependant on list size.

Dr Trzcinski said that the main benefits were for reception staff who had to manage patient requests for urgent appointments.

Ms Adams asked about the evaluation of the scheme. Mrs Waddington said that the CCG was required to follow the NHSE monitoring process and as part of this, record utilisation rates. It was thought helpful for the CCG to collate feedback although this was not a mandatory requirement. It was agreed that the evaluation of the scheme should not increase the burden on general practice.

Dr Sanganee added that for the current scheme the GPs were required to collect feedback from the patients and ask them where they would have gone if they had not received an appointment that day.

Mrs Barber said that such feedback and the softer commentary was useful together with case studies. Dr Hanlon said that the feedback received to date was not helpful as very few patients would say they would have attended A&E. Mrs Barber said that if the patients said it was the first time they did not have a difficult conversation with the receptionist, then that would be a good news story. It was noted that practices were reluctant to promote the scheme. It had been referenced at the PPG network and at engagements events.

Dr Trzcinski said that some GPs experienced greater stress as the scheme created more work for them. Dr McHugh said that whilst the additional funding should be welcomed small practices would not be able to engage locums on the level of funding on offer. He felt that it masked the underlying problem regarding the overall funding of general practice.

Mrs Trevithick referred to the Hinckley event where the PPG had conducted a straw poll and found that DNAs were at a high level. It was noted that costs would be reduced if the level of DNAs could be brought down. Dr Trzcinski said that the level of DNAs was dependent on the local population and appointment system operating. Mrs Barber reflected that at a national level best practice regarding DNAs had been identified. The approach was to give positive messages and thank those patients who kept their appointments. It was noted that there was an opportunity to review this approach linked to the implementation of the ten high
impact actions for best practice, and could be explored further through the work being undertaken by the federations in February.

The Primary Care Commissioning Committee

- **NOTED** the report on On the Day Access.

**PCCC Finance Report Q3**

Mr Roberts introduced the report and noted that the reported position at month 9 was an overspend of £1.9m. The forecasted position at the end of the financial year was an underspend of £632k. The forecast was reliant on significant prescribing QIPP being delivered in the remainder of the year.

Mr Roberts reported on some one-off adjustments that had been made to the budget. For example, the federations were paid £120k each year for the last two years. They became a debtor at the year-end for the underspent resource.

In respect of the GP IT there was a capital resource for system migration and the replacement programme. Some revenue costs for training, system migration and installation would be charged to the capital budget.

Mr Roberts considered that the GP Quality QIPP had been optimistic. Whilst prescribing had improved over the last few months there was still a risk to the QIPP and estimated £1M savings by the end of March. It was noted that as there was a time lag in obtaining the prescribing data there would have to be an estimate for the accrual.

It was noted that there were some underspends under DES.

Dr Trzcinski asked about overspends in enhanced services and community based services as the Board had received information about the community services being underspent. It was thought that that referred to community *health* services, which was a different service.

Mr Potter reported that a review of community based services was underway to ensure they were cost effective.

Mr Harding noted the overspend at month 9, despite the financial adjustments, was largely down to prescribing.

It was noted that the budget for GP sickness/locum cover had been inherited from NHS England and based on previous experience. Dr Trzcinski noted that there was an increase in the number of younger women coming into general practice and maternity costs had increased. It was noted that sickness was also increasing. It was fortunate that NHS England had retained the budget for suspended GPs as it proved costly.

Mr Potter said the intention was to draw down external funding for GP IT and that WLCCG would need to act quickly when it became available.

It was noted that the Committee would look at the financial plan for 2017/18 at its meeting in March.

It was noted that there were two aspects of the QIPP. The first was the federations' scheme. The second aspect was for prescribing. It was reported that this needed to be rebased in order to encourage practices. Federations were looking at third party ordering. It was suggested that a report could be made to a
future meeting and Mrs Trevithick undertook to speak to the Head of Prescribing.

Dr Sanganee said that a change in the IT systems affected the pattern of prescribing.

Mr Roberts was thanked for producing a very clear report.

The Primary Care Commissioning Committee

- RECEIVED and NOTED the report PCCC Finance Report Q3.

CQC update

Mrs Waddington presented the report which provided an update on the schedule of CQC visits and findings from those practices which had been visited.

It was noted that CQC had inspected 38 out of 48 practices (79%) in West Leicestershire. There were two practices in Quarter 3 that required improvement. The Committee was assured that the practices were engaging with the process. Work was underway to ensure confidence in the contractual performance.

It was noted that Anstey Surgery required improvement and had expressed surprise at the findings as they had received more reassuring feedback on the day. There had been a triangulation of the data in respect of the contractual performance and Mrs Waddington said there were no concerns from that perspective.

Mrs Trevithick made the point that the feedback given at the end of inspections was, on occasion, at odds with the final report. It was noted that following inspections the CQC had a process of internal verification before issuing the report.

The reports issued were listed in appendix 1.

It was queried what themes emerged from the inspections. It was noted that a report on the themes was presented to the Quality and Performance Committee. The report informed the work of the Quality Team in supporting the practices. Dr Trzcinski said that that many of the findings related to infection control and he believed the standards applied were more appropriate for treatment rooms that GP consulting rooms.

Ms Adams expressed concern about the delay in receiving reports following an inspection.

It was noted that Silverdale practice should be removed from appendix 3.

Dr Sanganee said that it was positive that there were so many practices rated as green.

The Primary Care Co-commissioning Committee

- NOTED the CQC Update.

Any Other Business

There was no other business.

Date of Next Meeting

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The next meeting of the Primary Care Commissioning Committee would be held on Thursday 16 February 2017 at 9.30am, Woodgate, Loughborough.