**WOLVERHAMPTON CLINICAL COMMISSIONING GROUP**
**PRIMARY CARE COMMISSIONING COMMITTEE**

**Minutes of the Primary Care Commissioning Committee (PUBLIC)**
**Tuesday 7 May 2019 at 2.00pm**
**PA025 Marston Room, Technology Centre, Wolverhampton Science Park WV10 9RU**

**MEMBERS ~**

**Wolverhampton CCG ~**

| Name | Position | Present |
|---|---|---|
| Sue McKie | Chair (voting) | Yes |
| Les Trigg | Lay Member (Vice Chair) (voting) | Yes |
| Steven Marshall | Director of Strategy & Transformation (voting) | Yes |
| Sally Roberts | Chief Nurse (voting) | No |
| Dr David Bush | Locality Chair / GP (non-voting) | No |
| Dr Manjit Kainth | Locality Chair / GP (non-voting) | No |
| Dr Salma Reehana | Clinical Chair of the Governing Body (non-voting) | Yes |

**NHS England ~**

| | | |
|---|---|---|
| Bal Dhami | Contract Manager | No |

**Independent Patient Representatives ~**

| | | |
|---|---|---|
| Sarah Gaytten | Independent Patient Representative | No |

**Non-Voting Observers ~**

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|---|---|---|
| Tracy Cresswell | Wolverhampton Healthwatch Representative | No |
| John Denley | Director of Public Health | No |
| Dr B Mehta | Wolverhampton LMC | Yes |
| Jeff Blankley | Chair of Wolverhampton LPC | No |

**In attendance ~**

| | | |
|---|---|---|
| Dr Helen Hibbs | Accountable Officer (WCCG) | No |
| Mike Hastings | Director of Operations (WCCG) | No |
| Liz Corrigan | Primary Care Quality Assurance Coordinator (WCCG) | Yes |
| Peter McKenzie | Corporate Operations Manager (WCCG) | Yes |
| Gill Shelley | Primary Care Contracts Manager (WCCG) | Yes |
| Sarah Southall | Head of Primary Care (WCCG) | Yes |
| Tony Gallagher | Director of Finance | Yes |

**Welcome and Introductions**

WPCC500 Ms McKie welcomed attendees to the meeting.

**Apologies**

WPCC501 Apologies were submitted on behalf of Dr M Kainth, Dr D Bush, Jeff Blankley, Sarah Gaytten,Tracy Cresswell (Healthwatch), Mike Hastings, Sally Roberts and Helen Hibbs.

It was noted that Sarah Gaytten had given her intention to resign as patient representative. Sarah was thanked for her work as a patient representative.

**Declarations of Interest**

WPCC502 Drs Reehana and Mehta declared that as a GP they had a standing interest in all the items relating to primary care.

Ms McKie declared that in her role for Walsall and Wolverhampton on the Child Death Overview Panel, she has a standing interest in all items related to Primary Care.

As these declarations did not constitute a conflict of interest, all participants remained in the meeting whilst these items were discussed.

**Minutes of the Meeting held on the 2nd April 2019**

WPCC503 The minutes of the meeting held on 2 April 2019 were agreed as an accurate record.

**RESOLVED: That the above was noted.**

**Matters Arising from the Minutes**

WPCC504 There were no matters arising from the minutes.

**RESOLVED: That the update was noted.**

**Committee Action Points**

WPCC505 **Minute No: WPCC452 (Action 30) – Primary Care Strategy Update.** A verbal update was provided at today's meeting. Draft Strategy to be submitted to June 19 committee.

**Minute No: WPCC468 (Action 31) – Primary Care Networks**. A report was presented to committee.Agenda item 8a, minute no: WPCC510

**Minute No: WPCC491 (Action 32) – Primary Care Reports.** As the revised Friends and Family (FFT) data was emailed to members on 08/04/19, this action was closed.

**Minute No: WPCC496 (Action 33) – Primary Care Networks.** A report was presented to committee to sight them on the geographical options of Primary Care Networks (PCNs), agenda item 8a, minute no: WPCC510

**Minute No: WPCC497 (Action 34) – Audit Report & Action Plan.** Action closed as the patient list sizes will be presented to the Private Primary Care Commissioning committee on a quarterly basis going forward.

**Minute No: WPCC499 (Action 35) – NHS Benchmarking Network.** Report deferred until July meeting.

**Primary Care Quality Report**

WPCC506 Ms Corrigan presented the report, providing an overview of activity in primary care. The following points were noted:-

- Work was beginning early to look at the Flu vaccine programme in light of last year's issues. Everyone had ordered flu vaccine early and there was plenty in the system to go around. The Local Medical Committee (LMC) had said the vaccines may be available from the end of September. Flu vaccine training was being arranged for the end of July for nurses and healthcare assistants.
- With regard to Quality matters, there had been a slow response from practices but was now up-to-date with new ones coming through and the previous problem resolved. One matter was outstanding, from an optician, which required an NHS number, but as opticians don't have access to NHS numbers it will be closed.
- Two Serious incidents were currently being reviewed by practices. One provided a root cause analysis (RCA) and although the other was a near miss, the practice also provided a RCA. These are on-going and will go to scrutiny before referral to the NHS England Performers Information Gathering Group (PIGG).
- Complaints: awaiting Q4 data due in June
- Started afresh with the Friends and Family Test (FFT). The uptake was much better than both the national and regional average at 1.8% - 2.3%. It can vary month to month but seems to be connected to SMS texts availability of system on the tablet. The Qualitative data is not available as NHS England does not collect it, however practices do collect it and they use it to try and make improvements discussing matters at Patient Participation Groups, displaying on surgery noticeboards and through comments sheets in practice.
- Ratings were slightly lower than the national average of people saying they would recommend their GP but this was possibly because the uptake in Wolverhampton is so much higher so it was felt this was a realistic reflection of what patients thoughts on the service actually were.
- CQC: Two practices require improvement and are both being managed locally. One has merged with another practice and one is being managed by the VI team with no reports of any problems or requests for support. Awaiting re-inspection and new report from CQC.
- Workforce development: Looking at developing something for healthcare staff who are resident in the UK and Black Country but not actually

working because they have come from overseas. Dr Reehana is involved looking at the GP side and Mrs Corrigan is working with the LMC. The Sustainability and Transformation Partnership (STP) are currently considering a practice nurse retention programme similar to the GP retention scheme. They are looking at induction and inceptorship, portfolio careers mentorship and retirement planning.

- Healthcare apprenticeships: Currently there are five people interested. They are either working in practice as new healthcare assistants or are staff working on reception who want to move across. Funding received from NHS England and expanding into nursing associate apprenticeship with three people already showing a tentative interest. Awaiting workforce numbers from NHS digital which are due next month.
- The 10 point plan around the practice nurse strategy that was presented to committee last month, is due to go to the clinical leads group next Thursday for approval at STP level and other CCGs are to take it through their own Primary Care Commissioning committees. Once approved will be able to plan the launch, hopefully for June time.
- The current Training Hub arrangements across the Black Country are under review. Health Education England (HEE) are leading the process and will seek approval from the STP on the preferred model for the future. The STP are keen to introduce a Training Academy and this is being explored by the Joint Commissioning Committee. Further meeting scheduled on 28 May where HEE are likely to share a Terms of Reference with a view to introducing a STP Training Hub Board. SS has suggested that this board and that required by NHS England for the GPFV are combined, a response is awaited. A local meeting among training hubs is also scheduled for 16th May.

**RESOLVED:**

1) **That the update be noted.**

**Primary Care Operational Management Group Update**

WPCC507 Committee agreed that the report was read and there were no specific comments other than a typo on front page, AMPS should read APMS.

**RESOLVED:**

1) **That the update be noted.**

**Primary Care Contracting Update**

WPCC508 Ms Shelley provided an update

The APMS contract transition, now in its second month with Health & Beyond, was going well and there was a meeting planned for next week to review status and identify action plans. The process had gone smoothly despite teething problems.

The Consultation on the closure of Tettenhall Medical Practice, Wood Road

branch commenced today.

**RESOLVED: That the update was noted.**

**Primary Care Strategy Update**

WPCC509 Mr Marshall deferred the report to Mrs Southall to present.

Mrs Southall stated that the Primary Care strategy was to be fully reviewed although much of it would be predetermined by the NHS 10 year plan. The draft strategy would be shared with GP colleagues and other stakeholders initially for comment then presented to committee at the beginning of June.

An engagement event is planned in Wolverhampton for 23rd May to capture final input from patients and members of public in relation to the STP strategy but will focus on primary care at place-based level.

The chair suggested to be mindful of how the information is communicated in particular with the use of acronyms.

**RESOLVED: That the update was noted**

**Primary Care GP Networks & DES (& Map)**

WPCC510 Mrs Southall circulated a map with a detailed report for committee to view.

Members meeting discussions had taken place on 3rd April, where practices and practice managers reviewed the different guidance in place to assist the practices in coming together as Primary Care Networks (PCNs).

The report included the presentation of what was covered which was very well received and fostered much debate and group discussion. It culminated in being able to identify some practices who were prepared to move to help the networks form more sensibly within their immediate geography.

Networks are now preparing in anticipation of the application deadline of 15th May 2019.

A situation report was submitted to NHS England on 30th April to confirm the network formations and numbers in order that they had a good understanding of what state each network was at with regard to the appointment of their clinical director.

A members meeting focused on a plethora of guidance with the most topical subject being the Direct Enhanced Service (DES) as this is where funding is coming from for network formation and importantly by 30th June each network is required to have a fully completed network agreement.

A CCG panel meeting on 16th May will consider each application and will confirm outcomes and notify partners. It was hoped that all applications would be approved.

NHS England will be holding a networks commissioner event on 17th May, which the Primary Care team will attend and CCGs will have to confirm network coverage by 21st May.

NHS England, CCGs and LMC will be required to resolve local disputes by early June and network DES will go live on 1st July.

New roles will be identified in the formation of the PCNs, for example, clinical pharmacists and social prescribers. Funding for social prescribers will be available from 1st July. Currently in the process of identifying what the preferred model for social prescribing link workers will be.

An engagement event for social prescribing is to be arranged with PCN leads and existing service providers to build on what is already in place and to complement the additional cohort of link workers, so as not to jeopardise the existing good work.

Group Leads and members have been actively involved in discussions and patients were advised about this particular area of development at the Patient Participation Group (PPG) chair's meeting back in March.

Risks identified of possible overlap between some of the groups as indicated by the map. The impact from a financial perspective is that the funding for the Direct Enhanced Service (DES) is expected to be funded by the CCG however this was known early on and so planned to make the money available to avoid cost pressure.

Quality & Safety have been actively involved in the discussions. No Quality Impact Assessment (QIA) has been undertaken pending the formalisation of the networks.

The map highlighted two potential networks and attempted to balance geographical factors with building on previous good working that has taken place across the city.

Discussion ensued about the different groups within the potential networks and the need for PCNS to have between 30,000 and 50,000 patients. Some of the existing groupings would need to divide in order to meet this requirement and the Vertical Integration (VI) Group configuration would therefore potentially result in a network with less than 30,000 patients. The committee was advised that groups in this position could be approved in exceptional circumstances, particularly if there was the potential for growth.

It was asked that should a group with significantly below numbers be approved, and there was no growth, what would be the likely impact. It was noted that community services would be serving a potentially smaller population but there was some mitigation in that there were practices nearby however, until the discussions with the Trust had taken place as to as to how they are going to organise community services, it was hard to say.

A question was raised as to whether the cost for the medical Director for each of the PCNs would come from CCG baseline budgets. It was

confirmed that it would be part funded by NHS England and the remainder through the network DES but this could be reduced if one network and two neighbourhoods had the same clinical director. The VI group were still considering whether to make an application for one network made up of 2 neighbourhoods or one network, if one network there would be two outlying practices or significant overlap.

The report provided assurance to the committee that the CCG is moving in the right direction and working toward the NHS England timelines. Once the panel meeting had taken place on 16th May, a further update would be provided to committee in June and the committee will be kept informed month on month on the pace of development.

The Committee was asked to confirm which network map they supported, they concurred that 6 Networks (VI comprising of 2 neighbourhoods) was their preferred option.

**RESOLVED: That the update was noted**

**Spirometry Service**

WPCC511 Mrs Southall presented the report on behalf of Ms Morrissey. The report was compiled as a result of the suggestion to provide a Spirometry service at network level in the community.

Currently the service was purchased from Royal Wolverhampton Trust (RWT) and was a time-limited service commissioned on a 12-month basis.

The Association for Respiratory Technology and Physiology (ARTP) spirometry qualification is the recognised competency requirement for practitioners undertaking spirometry within the healthcare setting.

The Care Quality Commission (CQC) also expected practices to be able to demonstrate that staff performing the activity are duly competent in accordance with the CQC competency framework and that this should also be reflected in their CQC registration.

The recommendation was for Committee to consider the business case to provide a quality assured spirometry service through Primary Care networks (PCNs) as opposed to buying this service from the Trust.

The report had been presented to programme board on a couple of occasions, where amendments were suggested with a view for committee to make the decision to approve the provision for taking forward

The business case provided detail of the number of patients being cared for. The total number of patients referred into Royal Wolverhampton Trust up to 2nd November 2018 was 537 with a projected total by 31st March of 863. The report also provided anticipated numbers by practice group.

The committee were given 3 options to consider:

- Option 1 to stay the same with the service procured from Royal Wolverhampton Trust (RWT).
- Option 2 to develop a quality assured spirometry service within primary care giving PCNs the opportunity to own and deliver a developing service at scale for their practice and patient cohorts enabling them to develop the local workforce in line with the GP forward view.
- Option 3 to develop a quality assured spirometry service for individual GP practices. The concern with this last option would be that the throughput might not be significant at individual practice level for staff to maintain competencies. An email had been received from Dr Kainth to say that he agreed the service was needed in primary care but he did not think it needed to be a network function but as earlier this was discounted due to the heavy regulation and maintaining competencies

There were no significant risks but a number of benefits, not least that the cost of providing the service at network level would be almost halved at just over £100,000

A question was raised that if additional tests provided additional diagnosis would treatment costs subsequently increase. It was felt as the treatment for COPD mainly consisted of pulmonary rehabilitation such as stopping smoking and undertaking exercise, the cost of treatment was not particularly high but the avoidance of admissions would be significant. Three days in-patient can cost around £2500.

The recommendation for committee was for agreement to commit to the financial resource to enable care to be delivered closer to home.

It was acknowledged that training would need to take place as although some nurses were already competent others would need to be brought up to the same standard. The plan was that RWT would continue to provide the service in the first part of year with more activity in general practice from the second half of the year and with the full service being delivered from PCNs from April 2020.

The committee approved for the service to be taken forward at PCN level and for the financial resource to be committed.

**RESOLVED: That the update was noted**

**Financial Position Q4 2018/19**

WPCC512 Mr Gallagher presented a report which detailed the financial outturn for 2018/19 which he advised was still subject to audit.

At section 3 it was stated that the delegated primary care underspend of £776,000 comprised mainly of premises £351,000; QOF non- achievement £74,000 and enhanced services delegated £111,000.
In meeting the underspend the CCG had made a provision around Showell

Park list sizes and a challenge around application in reduction of the Personal Medical Service (PMS) premium of around £400,000.
As a result of the underspend, consideration had been given to bringing forward 2019/20 developments but given the timing of the identification of the underspend this would have been challenging.

Going forward the aim was to identify how much of the underspend was recurrent in order to identify and make available a development pot for to pilot more schemes or to bring forward schemes.

It was recognised that Investment in Primary Care was required to bring about transformational change. The 2017/18 financial year was a learning exercise due to it being the first year of primary care delegation and the question for the CCG this year was should it set the budget at 100% or should it acknowledge that circa 95% will be achieved with the remainder being put into a development pot.

The finance director then talked through the detail in the body of the report raising significant points.

As prescribing was one of the key areas for Quality, Innovation, Productivity and Prevention (QIPP) it was felt important to note not only the savings on drug values but also on volume of drugs being prescribed and that reduction in numbers of drugs being prescribed helped to support the QIPP value reductions.

It was recognised that the report showed areas where investment in Primary Care had been made but for future reports it was felt it would be beneficial to include more granular analysis, , in regards to why investment was made and to view variances in particular areas and suggest areas for development of future schemes.

A question was raised as to how the underspend of £776,000 compared to the previous year. It was acknowledged that the underspend was a combination of the 2017/18 and 2018/19 financial years as 2017 was the first year of delegation. Now that 2 years' worth of information was available it would enable the CCG to determine how much flexibility there is for future developments or to bring projects forward.

A question was raised as to whether the budget for this financial year was planned to be spent recognising the increase in budget. It was felt that although great progress had been made in terms of plans, identification of the repeat underspend would need to take into account any potential slippage against those plans and whether there were any other plans.

It was agreed to plan expenditure profiles in the event of slippage against any schemes and if wanted them to come to committee to give notice and bring earlier rather than later.

**RESOLVED: That the update was noted**

**Any Other Business**

WPCC513 There was no further business.

**Date of Next Meeting**

WPCC514 **Tuesday 4th June at 2.00pm in PA025 Marston Room, Ground Floor, Technology Centre, University of Wolverhampton Science Park WV10 9RU**