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WEST LEICESTERSHIRE CLINICAL COMMISSIONING GROUP

Minutes of the Primary Care Commissioning Committee (PCCC), held on Tuesday 12 June 2018 at 9.00 am in Boardroom, Woodgate, Loughborough

PRESENT:

Ms Gillian Adams	Chair, Lay Member
Mr Ket Chudasama	Director of Performance and Corporate Affairs
Dr Geoff Hanlon	Board GP/Clinical Lead
Mr Ray Harding	Lay Member
Dr Mike McHugh	Public Health Representative
Mr Ian Potter	Director of Primary Care
Dr Nil Sanganee	Board GP/Clinical Lead
Mrs Caroline Trevithick	Chief Nurse and Quality Lead
Dr Chris Trzcinski	Board GP/Clinical Lead

IN ATTENDANCE:

Ms Louise Guss	Interim Head of Corporate Governance
Mr David Muir	Head of Primary Care Service Redesign & Delivery
Ms Laura Norton	Head of General Practice Contracts
Mr Andrew Roberts	Head of Management Accounts
Ms Alison Moss	Committee Clerk (minutes)

Item	Discussion	Action
PCCC/18/023	**Welcome and Apologies** The Chair welcomed everyone to the meeting. Apologies for absence were received from Ms Melanie Whittall, CQC, Mr Simon Fogell, Healthwatch and Dr S Virmani, LMC. The Chair confirmed that the meeting was quorate.	
PCCC/18/024	**Terms of Reference** The Committee received the terms of reference as agreed by Board on 8 May 2018.	
PCCC/18/025	**Report for the Conflict of Interest Panel and Declaration of Interest** The following declarations were noted: PCCC/18/028 - Finance Report 2017/18 – GPs declaration only PCCC/18/029 - Primary Care Budget 2018/19 – GPs declaration only PCCC/18/030 - Options for repeat prescriptions review – GPs declaration only PCCC/18/033 - Syrian Vulnerable persons update – GPs declaration only PCCC/18/034 - Extended Access –delegation to the Procurement and Investment Committee.	
PCCC/18/026	**Minutes of the meeting held on Thursday 15 February 2018** The Minutes of the meeting held on Thursday 15 February 2018 were agreed.	
PCCC/18/027	**Matters Arising from Thursday 15 February 2018** Mr Potter noted that the Committee Risk Register had been updated in light of the comments made at the meeting in September 2017. The action was complete.	

	With respect to the List Dispersal Policy, Ms Norton said she would report back to the next meeting detailing the areas of difference between WLCCG's and LCCCG's policies. The Primary Care Commissioning Committee • **NOTED** the action log and updates.	
PCCC/18/028	**Finance Report 2017-18** It was noted that all GPs had declared a potential conflict of interest. Mr Roberts introduced the Finance Report which summarised the financial position at the end of March 2018. The report noted an underspend of £544k which reflected the benefit of £1.58M of non-recurrent items including the refund from the rates review and cost of vaccines recharged to NHSE. The position had also improved as a result of the national agreement to refund CCGs with the Category M payments made from August 2017 following the price reduction. Dr Trzcinski noted there had been underspend on enhanced services and thought more should have been done to commission further work from GPs. Mr Roberts noted that the figure reported was based on three quarters' spend and an estimate for Q4. It was noted that there was a QIPP scheme to review community based services. Dr Sanganee asked if there was a reason for the underspend and were practices claiming appropriately. He noted that a couple of practices had stopped providing 'secondary care bloods'. Ms Norton reported that an annual audit verified claims. The findings were that some practices had over-claimed whereas others had under claimed. Mr Potter said that it could be part the financial review which Ms Norton and Mr Roberts offered practices. Mr Potter referred to the FDR/PMS reinvestment budget and said there was a need to understand what the 2017/18 meant for the level of investment in 2018/19. It was agreed to provide a further report giving an historic overview of the budget. Dr Trzcinski noted that the expenditure on locum costs for maternity and paternity leave had doubled. He said that whilst the payments were more reasonable in covering in the costs of locums they did not undertake the full range of duties which created workload pressures for the GPs in the affected practice. Dr Hanlon said the distinction needed to be drawn between funding for primary care and funding for general practice, noting that it was the latter that was key to ensuring a sustainable service. The Primary Care Commissioning Committee • **NOTED** the Finance Report for 2017-18.	**AR**
PCCC/18/029	**Primary Care Budget 2018/19** It was noted that all GPs had declared a potential conflict of interest. Mr Roberts tabled a summary of the Primary Care Budget for 2018/19. Mr Roberts made the following observations on the budget • the non-recurrent adjustments made in 2017-18 had been taken out	

- the budget included uplifts in line with national and local agreements for demographic growth, etc.
- additional provision had been made for the caretaking arrangements for Centre Surgery and Thurmaston practices although there could be additional pressures in relation to Thurmaston Medical Centre
- there was a QIPP target of £500k for the enhanced services review and £70k for Other GP Services – training
- £66k had been allocated for GP IT
- £1.3M had been allocated to support the federations achieve the Federation QIPP with the planned savings of £2.3M appearing in the secondary care budget
- there had been a reduction in claims for mental health care assessments which saved £17k
- for the prescribing budget, in line with national guidelines, no provision had been made for a spike in NCSO prices
- it was expected that WLCCG would pay for flu vaccinations in 2018/19.

Mr Roberts noted the bottom line figure and that £105M was available for primary care.

Mr Harding noted that there was already an overrun of £0.5M on the Primary Care Plan. He asked what impact the year end position would have and what level of expenditure was under challenge. Mr Roberts said that most of the challenges related to the secondary care budgets and that the assumptions made for the year end were robust.

Dr Trzcinski noted that last year the Plan was for £107M expenditure and for 2018-19 only £105M which was £2M less. There was a reduced budget for enhanced services of £0.5M which meant a cut of 15%. He said it would lead to services being undertaken in secondary care which would be more expensive.

It was noted that the WLCCG budget had set a QIPP target of £20M and that £5.2M of that was to be found from primary care. Dr Trzcinski thought that to be disproportionate. Mr Potter acknowledged the point and said the CCG faced significant challenges which included savings in secondary care as well as primary care. He thought it important to acknowledge how far the CCG was from achieving the NHSE measure, S.39, which identified the proportion of the overall budget that should be spent on primary care. He thought it would be useful to reflect on the historical position and progress towards the target. Dr Trzcinski wondered if the budget for primary care and the budget for general practice should be separated out.

Mr Harding noted that the Primary Care Plan was part of WLCCG's budget which had been agreed by the Board. He wondered whether there was value in the Committee receiving the plan in advance of the Board's consideration The Chair agreed and asked whether that could be scheduled for 2018/19. **AR**

Mr Chudasama asked whether there were implications from the Primary Care Plan for other QIPP schemes and whether there was a risk around interdependencies. Mrs Trevithick said that Quality Impact Assessments (QIAs) were being undertaken on all QIPP schemes which took account of the impact on primary care. She agreed that the distinction between primary care and general practice was important. She agreed to present the QIA for WLCCG's budget to a future meeting. **CTrv**

Ms Norton noted the review of community based services imposed a level of

savings which would have a big impact on primary care. She noted that previous reviews had found these represented good value for money and if they were provided elsewhere they would cost more. There was a need to maintain engagement with general practice to achieve a left shift.

The Primary Care Commissioning Committee

- **NOTED** the Primary Care Plan 2018/19.

PCCC/18/030 **Option Appraisal for Repeat Prescription Review**

It was noted that all GPs had declared a potential conflict of interest.

Ms Stead introduced the report which presented a proposal to minimise waste for repeat prescriptions. This followed a series of surveys and audits undertaken throughout the year by the Medicines Optimisation Team demonstrating that over ordering of repeat medicines posed a significant financial burden to the CCG. They also demonstrated that there was a particular problem with over–ordering of appliances, insulin, inhalers and nutritional products. The report recommended various approaches to addressing the by promoting online ordering and/or reduction or removal of third party ordering. It was also noted that some patients needed support through a third party to order their repeat medication.

Ms Stead had estimated that £1M savings could be achieved if the recommendations were adopted. There were further savings to be made but they needed to be balanced against the increased resources needed to realise additional savings.

Ms Stead noted that the reasons for the waste were multifactorial and that practices should review processes to try and address this. She requested that WLCCG supported those practices wanting to stop or reduce third-party ordering but did not consider it appropriate to mandate the change.

Ms Norton commented from the perspective of a patient within ELRCCG. Her practice had stopped third party ordering and that caused significant delays and inconvenience. She agreed that the right approach was to make the change optional.

Ms Stead said those patients who responded to the survey said online ordering was easy. There was need to take the learning from ELRCCG and facilitate discussion with practices and pharmacists to identify those patients who genuinely needed third party ordering.

E-learning materials for practice staff involved in the repeat prescribing process would be available to support practices.

Dr Sanganee congratulated Ms Stead on a comprehensive piece of work. He was not confident about reaching the QIPP target as it required huge behavioural and system change. There was considerable variety in practice and different solutions would be needed. Dr Sanganee commented that repeat dispensing had a role as it was underutilised and for the right patients it could be really helpful.

Dr Trzcinski said there was more chance of over ordering if patients had a number of different medications.

Ms Stead understood the comment about the level of savings to be achieved. She said it would not be realised in the first year but there would be a sufficient reduction. She noted that the spend alone on appliances such as stoma and

catheters was £3.8M. The patient cohort for appliances was small and they could be ordered through DAX.

Dr Hanlon said the report set out a pragmatic option but it did nothing to improve quality over the long term. He wondered whether the changes would be sustained. Ms Stead thought the scheme would find sufficient savings to support efficient prescribing through pharmacists.

The Chair noted that there was broad support for the paper and she added that it was important to support the PPG network in the initiative. She thought there should be communication with the public about the cost of medication and appliances so they would appreciate the value.

Mr Potter asked what could be done to support communication about the scheme noting that there was to be a PPG event on 21 June which might be useful. Ms Stead said the intention was to discuss it at the federation level and for the support to be tailored. Ms Adams thought there should be a communication and engagement plan. Mr Potter thought the scheme was going to lead to considerable change at practice level and asked what resource was needed to support the change.

Dr McHugh thought it was an opportunity to consider polypharmacy and thought the initiative was important give the lack of money in the system. Ms Adams sought reassurance regarding an implementation and plan and it was agreed that Ms Stead would report to CMT. Mr Chudasama said the scale of savings was significant so it was important to achieve engagement with partners and CMT needed assurance regarding that engagement.

Ms Adams added that there would be learning from other parts of the country on similar schemes.

Ms Stead had attended the South Charnwood Practice Managers' meeting who had aired concerns about removal of third party ordering. Having presented some of the audit findings the position shifted and the managers wished to support online ordering. It was acknowledged that whilst there might be enthusiasm for the change whether there was capacity to support it was another matter.

The Primary Care Commissioning Committee

- **SUPPORTED** practices/ Federations which decided to remove or reduce 3rd party ordering on the proviso that vulnerable patients were identified who do require support from a 3rd party to order their prescription medication and appropriate measures put in place.

PCCC/18/031 **Update on the Nursing Associates and the Leicestershire School of Nursing**

Mrs Trevithick introduced the report which updated the Committee on the introduction of the Nursing Associate role in LLR. The Workforce Group was considering the implementation of the initiative and seeking to support placements in primary care. Mrs Trevithick noted that the national process was focussed on the acute sector which made it difficult to raise the profile of nursing in primary care. Work was being undertaken to influence the national process accordingly.

Dr Sanganee who served in the Workforce Group thought there was a lack of awareness of the scheme and there should be greater promotion. Ms Adams asked whether the federations were engaged and Mrs Trevithick said that there were varying degrees of support across the federations and the focus tended to be on delivery rather than education. Mrs Trevithick acknowledged Dr Sanganee's

point and said there was more to be done to ensure visibility of the scheme.

Dr Trzcinski said that he had received a presentation at the Alliance Board which had been supportive.

The Primary Care Commissioning Committee

- **RECEIVED** the update on Nursing Associates and the Leicestershire School of Nursing.

PCCC/18/032 **Committee Risk Register**

Mr Potter introduced the Committee Risk Register noting that the following risks had been closed

- PCCC 7 - Reduction in necessary information sharing to maintain quality and safety
- PCCC 8 - Delayed mobilisation of GP Resilience Programme by NHS England

And the following risks added

- PCCC 11 - Implementation of GPFV at WLCCG and LLR level fails to address unprecedented challenges faced by General Practice
- PCCC 12 - Planned switch off of GP paper referrals results in delays in appointments and patient care

It was noted that PCCC11 was rated as high at 16. PCCC 12 was rated at 9.

Mr Harding referred to risk PCCC 11 and said there was a need for more specific actions to be recorded. Mr Potter said there should be highlight reports to the Committee on the GP Forward View as a standing item. These would outline the mitigating actions. It was agreed to refresh the existing actions column. **IP**

Ms Norton suggested that reference be made to Capita and PCSE as the issues were impacting on practices nationally and affecting finance and sustainability. **IP**

Dr Trzcinski commented on PCCC 2 and the risk to a sustainable workforce. He referred to a GP in LCCCG was retiring from a practice that was at the forefront of innovation. The senior partner who was retiring had seen the patients with complex needs whilst also supervising less experienced GPs who were seeing the 'easier' patients. The GP had felt the workload was not sustainable.

Mr Chudasama asked about IM&T and whether the Risk Register had adequately captured the risks for primary care, He thought the Risk Register should be cross referenced against the IM&T Risk Register.

It was questioned whether the likelihood score was correct in respect of Risk PCCC 9 - Mobilisation of caretaking arrangements is unsuccessful or incomplete in timescale.

Mr Potter said there was a need to identify the next steps and actions to deliver extended access (PCCC 10).

It was noted that the Risk Register would be updated and presented to CMT and feed into the Board Assurance Framework.

The Primary Care Commissioning Committee

- **NOTED** the Committee Risk Register.

PCCC/18/033	**Syrian Vulnerable Persons Resettlement Scheme Update** It was noted that all GPs had declared a potential conflict of interest. The Primary Care Commissioning Committee • **NOTED** the Update on Syrian Vulnerable Persons Resettlement Scheme.	
PCCC/18/034	**Extended Access** It was noted that all GPs had declared a potential conflict of interest. Mr Muir gave a presentation on extended access noting that CCGs were required to commission extended access as part of the General Practice Forward View (GPFV). The deadline to 'go live' had been brought forward by six months to 1st October 2018. This was a mandatory deadline. Funding would be provided from through GPFV. For 2018/19 this would be £1.18M rising to £2.13M in 2019/20. It was unclear whether there would be additional funding for the current year as a result of the 'go live' date being brought forward. Mr Harding asked if the additional money needed was not received what the impact would be on the budget. It was agreed that the funding issues should be raised at the next NHSE checkpoint meeting. Mr Muir highlighted the work that had been undertaken locally emphasising the extended access would be delivered based on currently models of care. The scheme would create additional capacity to control patient flow. In respect of the procurement process there had been an initial options appraisal and risk assessment. There were risks attached and a need to establish the risk appetite. It was recommended that a task and finish group be established to refine the options and identify a clear proposal. Due to the conflict of interests for Board GPs it would be necessary to delegate the final decision to the Procurement and Investment Committee. Mr Muir outlined the next steps highlighting the significant work to be completed in a short time frame. It was noted that the additional appointments needed to be bookable. Practices would do so using Systm1 or the telephone. Dr Trzcinski highlighted the risks regarding interoperability of IT systems noting that Nottinghamshire appeared to have a solution which might be worth considering. Mr Chudasama highlighted the risks around the timelines. He questioned how wide the scope of delegation to Procurement and Investment Committee should be and the impact on the time lines of further involvement from Primary Care Commissioning Committee. Dr Hanlon emphasised that the scheme was building on work undertaken over many years and the main question was how to define which patients were referred to the hubs. Dr Trzcinski thought the scale was greater and Dr Hanlon thought that it was not significant and the Urgent Care Centre was seeing more patients in any case. He thought it was not that complicated.	**IP**

Mr Harding asked if a procurement process was needed if primary care was already doing the work. Mr Potter noted that it had been an NHSE requirement as there was new funding. He added that the three hubs had been established and there needed to be small changes to those to comply with the guidance and add capacity.

Dr Hanlon questioned whether extra capacity had to be procured separately. Mr Potter said there was a need to ensure the right governance for the options and to agree a mechanism to commission additional capacity that creates the least risk to WLCCG.

Dr Sanganee questioned when the DES for extended access would cease. Mr Muir said that no decision had been made but it was thought there was a commitment to the DES until 2019/20.

Dr Sanganee made the point that there should be an equality of provision. He said that the hubs were at different levels and this needed to be taken into account.

Mrs Trevithick questioned whether the Committee could delegate the decision to the Procurement and investment Committee or whether it needed to be Board. Ms Guss confirmed that the terms of reference enabled Board and its committees to delegate to Procurement and Investment Committee.

The Primary Care Commissioning Committee

- **AGREED** that due to the conflicts of interest for GP clinical members of the Primary Care Commissioning Committee, that decisions regarding Extended Access to General Practice Services in West Leicestershire be delegated to the Procurement and Investment Committee.
- **AGREED** that the scope of this delegation would cover:
    - Considering proposals for the approach for the provision of Extended Access to General Practice Services
    - Discussing options for the provision of Extended Access to General Practice Services
    - Making decisions on the provision and or procurement of Extended Access to general practice services in West Leicestershire.

PCCC/18/035 **Committee Effectiveness**

The Committee deferred the report.

PCCC/18/036 **CQC Update**

The Committee received the report.

The Primary Care Commissioning Committee

- **NOTED** the CQC Update.

PCCC/18/037 **Any Other Business**

There was no other business.

PCCC/18/038 **Information Governance Practice Support**

The presentation on Information Governance Practice Support was received for information.

PCCC/18/039	**Date of Next Meeting** The next meeting of the Primary Care Commissioning Committee would be held on Tuesday 10 July 2018 at 9.00am, Woodgate, Loughborough.	