

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

**NOTES OF THE MEETING HELD ON TUESDAY 16TH FEBRUARY 2016, 14.00 -16.00**

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

**PRESENT:**

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| Dr Thomas Maliyil | GP lead for Primary Care, NELCCG |
| Dr Derek Hopper | GP Chair of CoM, NELCCG |
| 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  |
| Cathy Kennedy | Deputy Chief Executive/Chief Financial Officer |

**IN ATTENDANCE:**

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| Helen Askham | PA to Executive Office, Note taker |
| Paul Glazebrook | Health watch Representative |
| Russell Walshaw | LMC Representative |
| Nicola McVeighJill Cunningham | Service Lead: Older People, Carers & DementiaService Manager, NELCCG |

**APOLOGIES:**

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| Mark Webb  | Chairman of NELCCG, Chair of Joint Co-Commissioning Committee |
| Zena Robertson | Director of Nursing, NHS England |
| Geoff Day | Head of Co-Commissioning Localities, NHS England |

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|  | **Item** | **Actions** |
| **1** | **Apologies** Mark Webb, Geoff Day, Zena RobertsonIn the absence of Mark Webb, the meeting was chaired by Steve Pintus. |  |
| **2** | **Declarations of Interest** Dr Maliyil declared an interest in agenda items 16 and 18a, as he is a Director at a practice which may be involved in future procurement.Dr Hopper declared an interest in agenda items 9, 16 and 18d. |  |
| **3** | **Minutes of the Previous Meeting / Virtual Decision Log Ratification**The minutes of the meeting held on the 29th October were agreed as an accurate record.**Actions:**1. **Joint Commissioning of Primary Care Substance Misuse Service**

Dr Maliyil agreed to feedback regarding what the impact is on the OOH service as he is not currently doing enough OOH sessions to be able to comment.1. **Joint Commissioning of Primary Care Substance Misuse Service**

Stephen Pintus stated that he will be able to confirm the ODS codes to the Committee by the May 2016 meeting.**Stephen Pintus to update the Committee at the May 2016 meeting.****PMS Contract variations requests**List closure requests 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. To be further reported at this meeting.**PMS Contract variations requests**List closure requests 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. To be further reported at this meeting.**The committee agreed that Virtual Decisions taken between November 2015 and January 2016 are ratified by members of the Committee.** | TMSP |
| **4** | **Terms of Reference** Julie Wilson presented a paper to provide the Committee with a review of the Terms of Reference.* **Publication of Minutes/Distribution of papers**

Members were reminded of their responsibility to share the minutes within their respective organisation arrangements and with the public, as set out in the Terms of Reference. * **Membership**

The Primary Care triangle Lay Member has recently resigned. It was proposed that given the level of Lay Member representation at the Committee meetings, it is not necessary to retain this locally agreed additional role.Due to changes in roles involving Dr Hopper and Dr Maliyil it was proposed to invite the newly elected Vice Chair of CoM to take up the remaining GP membership role.* **NHS England Vote**

Julie Wilson picked up an area that is required to be addressed by the Committee. The local decision has been to have two NHS England representatives, both of whom have been voting thus far. The Terms of reference states that there is one NHS England representative who shall have a vote equal to that of other members for a defined set of decisions. **The Committee agreed that there should be only one NHS England Voting member, although there will still be two attendees.****The Committee noted the requirement for members to share minutes within their respective organisations.****The Committee agreed to amend the ToR to remove the additional (locally agreed) lay member role.****The Committee agreed to amend the ToR to replace GP Lead for Primary Care Development in NELCCG with “Vice Chair of CoM”.****The revised Terms of Reference will be taken to the Governing Body for ratification in March** | AllJW |
| **5** | **Scheme of Delegation for Primary Care service**Cathy Kennedy presented a paper to finalise the Scheme of Delegation for the discharge of joint responsibilities between NHS England and NEL CCG. The original scheme of delegation document presented has been discussed previously at a Committee. Subsequently there has been a practical example of managing a decision regarding temporary practice list closures at committee level on a “virtual” basis. That experience has highlighted significant difficulties with managing temporary list closure decisions through a virtual mechanism, and an alternative method of handling list closure requests was proposed – attached as ‘Draft procedure for consideration of applications for temporary list closure’.In summary, temporary list closures of less than 6 months will be decided jointly by Senior Officers of NHS England and the CCG, subject to the considerations set out in the proposed procedure. List closure applications of over 6 months duration will be referred to the full Committee.**The Committee supported the adoption of an alternative approach to decisions on temporary list closure, and approved the revised Scheme of Delegation.** |  |
| **6** | **Update on 7 day working projects**Julie Wilson provided an update regarding the NEL Docks 7 day project.The project is designed to test out new ways of providing enhanced access to GP services across 7 days. This project was agreed through the national Primary Care Infrastructure Fund in 2015 and is funded by NHS England. Due to a delay in receipt of funding the project did not commence until October 2015, as a result of which the project plan was revised and split into phases:* Phase 1 is now completed and being undertaken by all Practices (GP Triage)
* Phase 2 to be implemented from March 2016, exact date tbc. The timeframe for completion of the rollout is 3 weeks.

The Committee were asked if they agreed with the KPI’s outlined in the paper. The Committee suggested that an additional KPI regarding patient awareness be included, and commented that as long as they were assured that patient satisfaction is being measured on an on-going basis they were in agreement.**The Committee noted the progress of the NEL Docks Collaborative Project, and suggested an additional KPI regarding patient awareness. They agreed with the list of proposed KPI’s.** | JW |
| **7** | **Review of Enhanced Services**Julie Wilson presented a paper to seek approval from the Committee for changes to the way in which services over and above “core” are commissioned from general practice by the CCG, NHS England and NEL Council. It was previously agreed to set up a working group to look in detail at the enhanced services commissioned by all organisations with a view to simplifying arrangements, avoiding duplication and ensuring best value for money. The Committee had agreed a list of principles to guide the discussion regarding the future arrangements. The group has now met and the full proposals are set out in the attached paper. Key issues that were identified, and changes proposed to existing arrangements are highlighted as follows:* Avoiding Unplanned Admissions – the proposal is to develop one specification that pulls together the NHS England requirements with local CCG elements, to ensure alignment with other local service changes, such as the Care Homes project. This would also combine CCG and NHS England funding streams, subject to agreement with NHS England. It would also replace some of the existing ad-hoc ‘Service Improvement Plans’ in future years, subject to a conversation with all practices to fully understand the extent of overlap.
* Extended Hours Access Scheme - the proposal is to develop one specification which includes the requirements of the NHS England extended hours specification and builds in additional expectations regarding enhanced access and a move towards 7 day working. In order that the learning from the NEL Docks Project be incorporated into this, it is suggested that this would not be ready for implementation until 1 September 2016.
* The proposal is for joint commissioning arrangements to be put in place to manage the Primary Care Substance Misuse Service, as already agreed by this Committee.

Potential savings of £600k against the current primary care budgets could be made by implementing the proposed changes, although they were unlikely to be fully realised within the 2016/17 year.Other areas have been identified for further work during 2016/17, including the potential to combine separate Health Check specifications, along with a number of other service improvements outlined in the paper. The Committee agreed that this would involve a lot of work, and a work plan with timescales would need to be developed.  **The Joint Co-Commissioning Committee:*** **Agreed the proposed changed to the commissioning of enhanced services effective in 2016/17**
* **Noted the work planned to take place during 2016/17 for further potential changes from 1st April 2017.**
 | JW |
| **8** | **Ensuring Tailored Care for Vulnerable & Older People (incl. >75s service)** Nic McVeigh gave a progress update on the Support to Care Homes Project and Multiple Long Term Conditions Project, which was agreed at CoM in September 2015.The project came about as feedback suggested support to care homes was ineffective and inefficient. Research has been undertaken looking at services offered in other areas to glean best practice. The local intelligence gathered tells us that many professionals from the same organisation visit the same care home, often on a daily basis, as there is little co-ordination of care. Improved co-ordination of care delivered in care homes could reduce the number of patients admitted to A&E.It is anticipated that this project will require 3 years to ensure full and appropriate implementation and evaluation. This is a large scale project with many positive implications and challenges ahead. A shift in culture is required to break the current pattern, and the CCG looks to involve clinicians to reduce the risks involved. The Committee requested an update be provided at the end of the year to ensure value for money, and highlight risks and challenges. **The Committee confirmed their support that the project be implemented as per the proposed action plan.** | HA |
| **9** | **PMS Reinvestment Proposals, including Phlebotomy Spec**Dr Hopper declared in interest due to his relationship with a local practice.**PMS Reinvestment - Proposed Phlebotomy Specification:**Julie Wilson presented a specification which sets out the requirements for a Phlebotomy Service, aimed at improving access and preventing the need for travel to the hospital solely for phlebotomy. A significant amount of work has been undertaken by a task and finish group in order to develop the specification. The service will need to be made available to all NEL patients, and where there are practices who do not wish to provide the services themselves there is an expectation that they will have this service delivered by other practices as close as possible to their own premises.Healthwatch asked if it would mean that some patients would be referred to secondary care if their practice does not take up the service specification, and the response was the CCG are not looking to return patients to hospitals. This is intended to be a primary care based service. The LMC representative queried the calculation of the payments as these are round figures and this sometimes means the cost has not been properly worked through. The Committee debated the amount proposed, during which they were informed that the actual costs are very variable between practices, but the price is broadly comparable to other neighbouring areas that commission a similar service. It was agreed that this specification is recognition that if practices are already delivering a service, they will be compensated for doing so, which is positive. A review of the implementation of the proposal will be brought to the April meeting. **The Committee approved the specification, for offering to Practices in 2016/17.** **2016/17 PMS Reinvestment: Proposed List of Investment Areas for 2016/17**Julie Wilson presented a paper that sets out a list of proposed areas for PMS reinvestment in 2016/17, for approval by the Committee. During 2014/15, NHS England undertook a review of the PMS contracts within NEL. The aim of the review was to determine the level of premium, if any, being paid to practices and take action to release the premium back into the system. The CCG is responsible for decisions regarding the reinvestment of the premium monies.The CCG undertook work to identify potential areas for reinvestment during 2015/16, gathering views through various groups including Practice managers, the GP Development Group and the Council of Members. A final proposed list is set out in the attached paper for approval by the Joint Co-Commissioning Committee. The plans would leave a residual amount of funding available, which it was proposed could be used to support Practices in-year through transitional arrangements from old to new ways of commissioning services. It was also suggested that Practices should not be disadvantaged by having their PMS premium value removed if there were delays, caused by the CCG, in being able to reinvest in the new areas. **The Joint Co-Commissioning Committee agree to:*** **Approve the areas of PMS Reinvestment for 2016/17**
* **Approve the proposed use of residual funding**
* **Approve the principle that Practices will not be disadvantaged financially if new services are not ready to take up from 1st April 2016, due to a delay on the CCG’s part**
 | JW |
| **10** | **Providers with formal agreement of temporary restricted capacity - implications for service development opportunities**Cathy Kennedy updated the Committee regarding specific providers needing to formally notify and agree with the CCG that they have a temporary capacity restriction.A question has been raised about the implications of such formal arrangements for the provider, and in particular whether the provider should be eligible to continue (or take up new) extended business opportunities with the CCG.The proposed policy is that whenever formal capacity restriction notifications/agreements have been reached with the CCG, the provider:1. Can continue current service provision agreements, even where those are extended services
2. Can apply for enhanced services for their existing client base or registered population

The above would be *subject to* the provider being able to clearly demonstrate how that can be delivered within the capacity available to them. This will avoid that population/client base being unnecessarily penalised for the providers temporary position1. Cannot apply for services spanning a wider populations or client base, unless they can explicitly demonstrate how that can be delivered whilst rapidly moving back to the full expected contract delivery e.g. through use of a separately available workforce.

This would allow the CCG to manage the risk that a focus on new or extended service provision would further exacerbate the issue with service provision to the existing population/client base.Exceptions to this policy would require specific Care Contracting Committee approval. The Committee agreed that the CCG would need to ensure that the message about these restrictions is clearly conveyed to the practices.**The Committee noted that the CCG policy which would be applied to all service providers, and agreed that it should be applied to GP practices as and when such situations arise.**  |  |
| **11** | **Oral Health Strategy**Chris Clarke asked the Committee to confirm who the Oral Health Strategy should be forwarded to. It was agreed that Bev Compton will receive this.  | CC |
| **12** | **Local Quality Scheme** Julie Wilson reported to the Committee the plans for the annual review of the PBC Incentive Scheme. The proposal is to cease the PBC incentive scheme and replace it with a new Quality Scheme, so that the 2016/17 investment has a greater emphasis on quality of care, and is more targeted at specific areas of variation in practice. The Committee were asked to note the new areas for inclusion set out in the paper presented:* Pre-diabetes registers – some practices have these, some do not. A QOF indicator on this is being developed but is unlikely to be brought into effect for at least 2 years. The CCG has an opportunity to get ahead of the curve on this and improve the outcomes for patients at risk of diabetes. This would support the fact that the CCG has been accepted on to the First Wave of the National Diabetes Prevention Programme
* Targeting variation in the management of other chronic diseases
* A patient experience measure – the community rep will be engaging with Patient Participation Groups to identify potential areas for inclusion
* A more specific focus on the appropriate prescribing of broad spectrum antibiotics
* A more specific focus on consistency in other prescribing areas, subject to review of current year information
* A more targeted focus on variation in referrals (by speciality), with a greater emphasis on peer review and working across Practices

**The Committee noted the progress so far, and endorsed the approach, agreeing that this included a good mix of areas.**  |  |
| **13** | **Budgets 2016/17**Cathy Kennedy provided a verbal update to the Committee. It was reported that the ramifications of the three year settlement are understood, and there may be additional pressures from premises costs. This item will be further reported at the April 2016 Joint Commissioning Committee meeting. | HA |
| **14** | **Primary Medical Services Budget Summary**A report was presented to the Committee summarising the financial positions with regards to the funds identified within the scope of primary care joint commissioning for NSH England and NHS NEL CCG to the period ended 31/12/15. This item will be further reported at the April Joint Commissioning Committee meeting. **The Committee noted the position.**  | HA |
| **15** | **Joint Commissioning of Primary Care Substance Misuse Service**Cathy Kennedy presented a paper to define the governance and funding arrangements that will be applied to the co-commissioning of the primary care Substance Misuse Service, and the service specification to be adopted. The paper was taken as read.The Committee welcomed the proposed service which gives an opportunity to provide a service for very vulnerable people, and the new commissioning arrangements which will give equal responsibility to the CCG and NELC. It was noted that the leads within both the CCG and NELC, along with the practices involved, have worked very hard in bringing about these new arrangements. **The Committee approved the proposed arrangements of commissioning of primary care substance misuse services as set out in the papers presented.**  |  |
| **16** | **Appeal of Level 4 Anti Coagulation - Scartho Medical Centre**Dr Maliyil left the meeting room. Dr Hopper abstained from voting towards a decision.Julie Wilson informed the Committee of an appeal against a CCG decision not to fund a request for payment for Anti Coagulation Level 4 services. The paper sets out the background to this case and the requirements of the contract, which was signed by the Practice. The practice argues that the CCG should make payments from the date that they commenced the service, even though their accreditation visit had not taken place, because they had sent an email query to the CCG regarding their visit and had not received a written response back. The CCG argue that the requirement for a visit is clearly outlined in the Contract, and the responsibility was with the practice to follow this up and ensure a visit took place. It was also noted that the practice has only recently made a claim for payments. The Committee asked for assurance that all practices that are being paid for this service have had the appropriate accreditation visits. It was also suggested that a checklist be put in place to provide assurances on key requirements of contracts. The national regulations are to be consulted with regards to a possible next step to the appeals procedure. **Subject to the assurances set out above, the Committee rejected the practice appeal.**  | JWJW |
| **17** | **Ashwood Procurement**Chris Clarke updated the Committee on matters pertaining to the Procurement and Evaluation Strategy for the practice vacancy within Weelsby View Health Centre (former Ashwood Surgery). The attached paper is a working document which still requires further refinement. The document outlines the process required in order to procure a new service provider. The Chair asked how confident the Senior Management Team were regarding the proposed timetable, and it was noted that the timetable has slipped slightly and will be updated in the document. **The Committee received and agree the procurement and strategy document.**  |  |
| **18** | **NHSE Contract Updates**Dr Thomas left the meeting. 1. **Dr Koonar request to vary PMS contract**

Chris Clarke provided an update on a request to change a PMS contract in NEL. The change is to remove Dr Ojadi as partner and add Dr Thomas as a partner to Dr Koonar’s contract. **The Committee recommended that the variation is approved.****b) APMS contract Humberview**Chris Clarke provided an update on matters pertaining to the Humberview APMS contract within NEL. The current APMS contract is due to expire on 31 March 2017. The contract allows for an extension period and as such would not be open to challenge. NHS England are to begin discussions with the current contractors and ascertain if they would be willing to extend. If they do not wish to extend, a full procurement would be required.The Committee discussed the arrangements for extension, and it was noted that the contract could potentially be extended for up to 5 years. It was noted that from a continuity of care aspect there are clear benefits of extending the contract. **The Committee received and noted the update. The Committee suggested a three year extension with an option to extend for a further 2 years.** **c) Dr S Kumar Contract request**Chris Clarke provided an update on matters pertaining to a request to close a patient list and a branch surgery within NEL. Both applications are currently being considered and a report will follow to the Committee for a decision on the branch surgery closures. NHS England and the CCG will be meeting with the practice to discuss the reasons for the list closure request and the officers will make a decision on this, in line with the procedure agreed today. They will also agree the consultation plan for the branch surgery closures with the practice, and provide an update to the Committee in due course. **The Committee received and noted the update. The Committee agreed the arrangements for the list closure application to be considered and a decision to be made before the next meeting.****d) Premises Maintenance Funding**Chris Clarke requested a view from the Committee regarding the future of a local scheme which was set up in the past to subsidise practices for the maintenance of accommodation, as per the terms of their lease agreements. The scheme recognised the significant financial commitment placed on local practices to maintain the internal accommodation. Following the recent review of the PMS contracts, the scheme is no longer included within those arrangements. If the Committee agree to continue such a scheme, funding will be made available by NHS England. Clee Medical Centre had previously been excluded from the scheme, as they did not have a lease at that time; however, this is now the case. They have requested to be included within any agreed scheme.**The Committee considered and agreed to support the continuation of a scheme in NEL, funded by NHS England.****The Committee agreed to support an application from Clee Medical to join the scheme.** **e) PMS Contract Variations**Chris Clarke updated the Committee that all practices in North East Lincolnshire have now signed their PMS contract variations. The new PMS contract will be issued to practices in due course. **The Committee noted this update.** | CC/JW |
| **19** | **2016 Work plan**Cathy Kennedy updated the Committee on the proposed Work plan for the Joint Co-Commissioning Committee for 2016. Any comments are to be passed on to Cathy Kennedy. **The Committee agreed the 2016 Work plan.** | All |
| **20** | **Lessons Learned Ashwood**Julie Wilson provided a draft summary of the lessons learned following an immediate termination for a contract for the provision of primary medical services within North East Lincolnshire. The lessons learned will be used to inform plans for any future occurrences, as well as supporting the development of the CCG’s plans to take on Level 3 Fully Delegated Commissioning arrangements from April 2017.**The Committee noted the content of the draft list of lessons learned.**  |  |
| **21** | **Delivering the Forward View: NHS Planning Guidance 2016/17 – 2020/21 – Requirements of Primary Care**Julie Wilson presented a paper regarding the NHS Planning Guidance 2016/17 which was published on 22nd December, 2015. The paper sets out an initial assessment of the requirements of primary care, along with an assessment of the current position and/or new requirements for each area.This paper will link into discussions around the financial implications, to be tabled for the April Joint Co-Commissioning Committee meeting.**The Committee noted the NHS Planning Guidance requirements for Primary Care.** | HA |
| **22** | **Any Other Business** **Refugees and Primary Care**North East Lincolnshire Council has agreed to resettle approximately 10 individuals from Syria, who are expected to arrive in July. The Local Authority will make a decision on where these people will be housed.It has been proposed that the local Open Door service will initially provide Primary Care support and registrations, as they have all of the appropriate wrap-around services to support these individuals. Funding is offered for the first 12 months from the Home Office, and once established £600 for Primary Care and £2000 for Secondary care will be allocated per person. If total costs for all patients exceed this amount, claims will be made to the Home Office. **The committee approved the proposed arrangement with Open Door.****Dr Hopper retirement**The Committee thanked Dr Hopper for his invaluable input at the Joint Co-Commissioning meetings and wished him well for his upcoming retirement.  |  |
| **23** | **Date & Time of Next Meeting**28th April 2016 14.00 – 16.00, Training Room 1 Centre 4 |  |