NHS DORSET CLINICAL COMMISSIONING GROUP

PRIMARY CARE COMMISSIONING COMMITTEE

4 October 2017

PART ONE PUBLIC - MINUTES

Part 1 of the Primary Care Commissioning Committee of NHS Dorset Clinical Commissioning Group was held at 2pm on 4 October 2017 at Vespasian House, Barrack Road, Dorchester, Dorset, DT1 1TG.

Present: David Jenkins, Vice Chair, Primary Care Commissioning Committee (DHJ) (in the Chair)
Anu Dhir, Primary Care Lead (AD)
Stuart Hunter, Chief Finance Officer (SH)
Sally Shead, Director of Nursing and Quality (SSh)
Mike Wood, Director of Service Delivery (MW)

In attendance: Micki Attridge, Senior Workforce Lead (MA)
Neal Cleaver, Deputy Director of Nursing and Quality, DCHFT (NC)
Sam Crowe, Deputy Director of Public Health (DP)
Margaret Guy, Vice Chair, Healthwatch Dorset (MG)
Conrad Lakeman, Secretary and General Counsel (CGL)
Rob Payne, Head of Primary Care (RP)
Dr Andy Purbrick, LMC Representative (AP)
Louise Trent, Personal Assistant (LT)

Action

1. Apologies

Jacqueline Swift, Chair of the Primary Care Commissioning Committee
Tim Goodson, Chief Officer

2. Quorum

2.1 It was agreed that the meeting could proceed as there was a quorum of Committee members present.

3. Declarations of Interest

3.1 Declarations of Interest were made as follows:

- The Primary Care Lead (AD) and the LMC Representative (AP) declared an interest in agenda item 7.1 – Enhanced Frailty Service and agenda item 7.2 – Improving Access to GP Services service specification.

It was agreed they could remain for each debate but could not vote on either issue.

4. Minutes

4.1 The draft minutes of Part 1 of the meeting held on 2 August 2017 were **approved** as a true record.

4.2 The draft minutes of the Primary Care Reference Group meeting held on 13 September 2017 were noted.

5. Matters Arising

5.1 For all items with an action response 'to be updated at the October meeting of the Committee', the Chair was assured these had been addressed in the reports.

5.2 7.2.10 – Old Dispensary Practice contract dispute. The dispute process had been concluded and the contract had now been signed.

5.3 The Committee **noted** the Report of the Chair on matters arising from the Part 1 minutes of the previous meeting.

6. Chair's Update

6.1 The Chair introduced his update.

6.2 The Governing Body had communicated the outcome of the Clinical Services Review (CSR) on 20 September 2017 and the Committee enquired how the implementation of the strategies would impact on Primary Care.

6.3 The Director of Service Delivery said the Primary Care Strategy had been developed in conjunction with the CSR. The Primary Care Team and Locality Leads had worked on localised plans that were consistent with the review proposals. This had also been incorporated into the work on Integrated Primary and Community Services (IPCS) and Improving Access to General Practice Services (IAGPS).

6.4 The conclusion of the review phase provided the opportunity for Primary Care services to move beyond the elements of the CSR and widen out in line with the Sustainability and Transformation Plan (STP) and the Accountable Care System (ACS). The Committee directed that priority be given to ensuring that the requirement for Primary Care representation at a high level was clarified for both the STP and ACS. CGL

6.5 The Committee **noted** the update of the Chair.

7.1 Enhanced Frailty Service

The Primary Care Lead (AD) and the LMC Representative (AP) declared an interest. It was agreed they could remain for the debate but could not vote on the issue.

7.1.1 The Head of Primary Care introduced the Enhanced Frailty Service Report.

7.1.2 The current Over 75 schemes had been reviewed with a proposal to evolve the current provision into an Enhanced Frailty Service. This would build on the existing Over 75s scheme to encompass support for people in a wider age bracket to manage all patients with frailty, with a focus on need rather than age. The proposal aligned with the Primary Care Strategy and the aims of the CSR.

7.1.3 There was recognition that providing the service to a larger cross-section of patients would be challenging for smaller practices. To support this, the new specification encouraged collaborative working for practices and other service providers in the local health community.

7.1.4 The funding would remain the same with GP practices continuing to receive funding per capita of over 75s. There was concern that the addition of patients outside the over 75 age bracket would dilute the current service with no additional funding provided. As the new model of care was developed to deliver the service across a broader population further work would be required on the financial modelling.

7.1.5 The Committee **approved** the recommendations set out in the Enhanced Frailty Service Report.

7.2 Improving Access to GP Services Service Specification

The Primary Care Lead (AD) and the LMC Representative (AP) declared an interest. It was agreed they could remain for the debate.

7.2.1 The Director of Service Delivery introduced the report on Improving Access to GP Services Service Specification.

7.2.2 The CCG had been identified to receive funding for the delivery of Improving Access to GP Services (IAGPS). This was in line with the Primary Care Strategy and the ambitions of the GP Forward View (GPFW).

7.2.3 Expressions of interest had been received from all 13 localities.

7.2.4 The Healthwatch Representative noted the reference to completed patient surveys on the local provision of services with over 1800 responses received. The Committee directed the Head of Primary Care to provide a further detailed breakdown of the figures, including how many people had been approached to take part. RP

7.2.5 The Secretary and General Counsel said that the report had been to the Governing Body on 20 September 2017 but had not been approved as the GP Members had been conflicted due to the likelihood of gain to their own practices and there remained insufficient members to form a quorum. The specification had now been altered. This allowed for it to be dealt with under the 'Urgent Decision' process and this had now been approved by the Deputy CCG Chair and the Chief Officer.

7.2.6 The Committee **noted** the Improving Access to GP Services Service Specification.

7.3 Primary Care Strategy Update

7.3.1 The Director of Service Delivery introduced the Primary Care Strategy update.

7.3.2 He said the Internal Audit information incorporated into the update regarding the assurance review of Primary Care Commissioning provided useful assurance for the Committee.

7.3.3 More detailed planning work was underway for delivering the Primary Care Commissioning Strategy and the GP Forward View and the Committee enquired whether there was a progress timeline. The Head of Primary Care said that work was progressing on the initial outline locality plans. The Primary Care Team would work with the Locality Leads to strengthen these aligned with the GP Five Year forward view.

7.3.4 The Committee enquired regarding the position on public and patient engagement through the various Primary Care workstreams. The ongoing work was valuable but was currently of quite low visibility to the public and engagement was a critical area to ensure that patients understood and had an opportunity to influence the services.

7.3.5 Recent engagement with the public had been mainly focussed on the CSR. The Committee directed that Comms and Engagement raise awareness of the work the CCG had undertaken in Primary Care. CS

7.3.6 The Committee **noted** the Primary Care Strategy Update.

7.4 Medicines Optimisation Group Report

7.4.1 The Director of Nursing and Quality introduced the Medicines Optimisation Group report.

7.4.2 There was resistance within some GP practices to change to generic prescribing on certain medications due to discounts practices could command from suppliers. The Committee noted that the CCG paid the gross price to the practices with the practice receiving the discount direct. This provided the practice with a disincentive to move to generic prescribing.

7.4.3 The Director of Nursing and Quality confirmed that the CCG currently had no leverage to challenge the issue. A proposal for the creation of a Pharmacy Reference Group (PRG) would be considered at the Clinical Reference Group (CRG) meeting on 5 October. The PRG would cover the strategic and financial implications on medicines, pharmacy and prescribing across the STP and this issue would come under their remit.

7.4.4 The move to an ACS would provide an opportunity to build accountability for best use and value for the provision of best practice for prescribing.

7.4.5 The CCG had been making progress on antibiotic prescribing as part of the Quality Premium. Some practices had not yet achieved this however there had been targeted work to support practices to help them meet the standard.

7.4.6 The Committee **noted** the Medicines Optimisation Group report.

7.5 Learning Disability Health Checks

7.5.1 The Director of Service Delivery introduced the Learning Disability Health Checks report.

7.5.2 The current position on Learning Disability Health Checks remained poor however there had been an improvement in the performance for the first quarter. A realistic current trajectory would be an achievement of 60% this year. It was noted that the figures aligned with the national position.

7.5.3 The Committee was concerned with the ongoing issue regarding providing services to disadvantaged groups and whether there was scope to move the service to a specialist provider. The Director of Service Delivery said that the services should not be marginalised or specialised as vulnerable people should be encouraged to attend their GP surgery for checks and build a

relationship in the same way as those without a Learning Disability.

7.5.4 The Committee noted the difficulty for GP practices to encourage disadvantaged and vulnerable patients to attend for health checks and directed that links with the voluntary sector be explored to provide additional support to Primary Care to deliver the proposed actions. MW

7.5.5 The Committee was concerned that the current trajectory for achievement was not improving at an acceptable rate. The Committee directed that Learning Disability Health Checks be added to the Performance Report for the Governing Body. MW

7.5.6 The Committee **noted** the Learning Disability Health Checks report.

7.6 Primary Care Workforce Planning

7.6.1 The Senior Workforce Lead introduced the Primary Care Workforce Planning report.

7.6.2 A baseline workforce profile had been developed for each locality. This data would be validated to project the requirements and gap analysis for workforce in Primary Care and would inform the development of a Workforce Plan.

7.6.3 Workforce was one of the elements required for assurance by NHS England as part of the GP Five Year Forward View. This could not be delivered without sufficient recruitment and workforce expansion. Recruitment was currently underway for two Workforce-Redesign Leads to take forward.

7.6.4 The baseline profiling work had highlighted a shortage in the future provision of practice nurses. This created a challenge to primary care workforce for services under the remit of practice nurses. Smaller practices would struggle to fund the recruitment of nurses.

7.6.5 The Committee **noted** the Primary Care Workforce Planning report.

8. Public Health Update

8.1 The Deputy Director of Public Health introduced his Public Health update.

8.2 The next step for the Prevention at Scale (PAS) initiative was to address moving from planning to implementation. A platform for large-scale engagement with Locality Leads was required. This

would enable PAS to be taken forward within localities to explore communication and visibility with practices and patients.

8.3 The LMC representative highlighted that Livewell Dorset was already used in practices with a majority of GPs already working this into their consultation with patients. When patients accessed the service, they were subsequently signposted back to their GP for a referral. This created access barriers for both patients and GPs and should be considered within the provision of Prevention at Scale.

8.4 Engagement with school age children should be explored as a method of education on how to access the health service appropriately.

8.5 The Committee directed that Prevention at Scale be a standing agenda item for Locality Meetings to inform practices and to explore how to achieve Prevention at Scale in the practice setting. RP

8.6 The Committee directed that Prevention at Scale be added to a future Governing Body workshop agenda. ES

8.7 The Committee highlighted the link the CCG had with Parish and Town Councils with agreement in place to communicate health messages through their newsletters, receive feedback and to provide speakers at events. The Committee directed that this be explored as a means of communication for PAS. CS

8.8 The Committee **noted** the Public Health update.

9. Any Other Business

9.1 The Director of Nursing and Quality said that the CCG had been successful with a bid to the Academic Health Science Networks (AHSN) in conjunction with Pfizer for funding a project on improving the identification and management of patients with Atrial Fibrillation (AF) to reduce stroke risk and Venous Thromboembolism (VTE). The decision to bid had been close to the date of submission so had not yet been through the relevant governance processes. A report would be provided to the next meeting. SSh

10. Date and Time of the Next Meeting

10.1 The next meeting of the Primary Care Commissioning Committee would be held at 2pm on Wednesday 6 December 2017 at Vespasian House.

11. Exclusion of the Public

11.1 Resolved : that representatives of the Press and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business transacted, publicity of which would be prejudicial to the public interest.