# Minutes of the Joint Co-Commissioning Committee Meeting in Public

**Salisbury Suite - Beales Hotel**  
**Comet Way**  
**Hatfield**  
**AL10 9NG**  
**21 April 2016, 10:00am** 

**Present:**  
- Yvette Twumasi-Ankrah (YTA), Chair of The Joint Co-Commissioning Committee, ENH CCG  
- Dominic Cox (DC), Locality Director, NHS England, Midland & East (Central Midlands)  
- Sharn Elton (SE), Director of Operations, ENH CCG  
- Linda Farrant (LF), Governance and Audit Lay Member ENH CCG  
- Dr Alison Jackson (AJ), Governing Body GP, Lower Lea Valley, ENH CCG  
- Kimberley Kingsley (KK), Deputy Director of Nursing, NHS England - Midlands and East (Central Midlands)  
- Alan Pond (AP), Chief Finance Officer, ENH CCG  
- Dr Nicky Williams (NW), GP Governing Body Deputy Chair, ENH CCG  
- Harper Brown, Director of Commissioning, ENH CCG  

**Attendees:**  
- Stephen Makin (SM), Head of Finance, NHS England, Midland & East (Central Midlands)  
- Rachel Lea, Liaison Manager (Herts), LMC  
- Cath Slater, Associate Director, Quality, ENH CCG  
- Deborah Kearns, GP Board Member and Co-Chair of Stort Valley and Villages Locality, ENH CCG  
- James Gleed (JG), Associate Director of Commissioning Primary Care ENH CCG  
- Nicholas Ince (NI) GP and Pharmacy Contract Manager, Primary Care, NHS England - Midlands and East (Central Midlands)  
- Andrew Tarry (AT), Assistant Contract Manager, Primary Care NHS England - Midlands and East (Central Midlands)  
- Emily Perry, Project Officer – Primary Care, East and North Herts CCG  
- Sara Kumari, Locality Team Administrator, East and North Herts CCG  

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<th>ITEM</th>
<th>ACTION</th>
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<td><strong>1.</strong> Welcome, introductions &amp; apologies</td>
<td>Yvette Twumasi-Ankrah welcomed members of the committee.</td>
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| | Apologies were noted:  
| | Dr Aly Rashid - Medical Director, NHS England (Central Midlands)  
| | Michael Taylor – Healthwatch |
| **2.** Declarations of Interests | YTA asked all members to ensure all declarations of interest were clearly stated. |
| **3.** Minutes of the Last Meeting and Matters Arising and Action Log | The notes of the previous meeting held on 27th January 2016 were accepted as an accurate record.  
| | Action tracker: PCS and budget information will be discussed during meeting. |
| **4.** NHSE primary care budget 2016-17 | Stephen Makin introduced the NHSE primary care budget 2016-17 paper to the committee.  
| | SM highlighted that the paper represents a point in time – it is a draft set of budgets for NHSE and ENHCCG, subject to third validation review, NHSE |
will be working on this over the next month and suggested an updated paper is brought back to the next committee meeting in July.

NHSE published revised resource allocations for the CCG and primary medical services in early January. Table 1 within the paper sets out all of the non-delegated organisations in the Hertfordshire footprint.

ENHCCG’s growth allocation is 6.3% - as part of the Pace of Change Policy. Work that has been done by the national team indicates that there are some issues around the baseline of primary medical services in East and North Herts – this will move to increased capitation.

Organisations are taking on responsibility for primary medical services only at the moment. The transition to moving other services in future (ophthalmology, dental, community pharmacy) will be subject to national policy.

From a reporting point of view, while NHSE do publish annual payments made to GPs on HSCIC they don’t usually report this at CCG level.

NHSE have developed a methodology for budget setting and will bring back budgetary information at CCG level in the future – NHSE will work with the CCG on this to refine it.

A vast majority of expenditure can be allocated to a CCG – this represents about 97% of expenditure. 3-4% apportion based upon methodology (e.g business rates, translation fees, clinical waste, costs associated with NHSPS). Work still needs to be done to refine this methodology.

The amount spent in 2015-16 in ENHCCG is £61.83million – there was a notional allocation of £63 million. Although some elements of that cost base still need reviewing, e.g QOF achievements – these will be clarified and further refined in Q1.

The budget needs to be adjusted around national changes for the GP contract – further validation and review is needed and the impact at practice level needs to be looked at. The assessment of QOF and legacy green schemes also need to be looked at further and aligned. The consequences of PCTF developments need to be viewed at practice level and reflected.

The variance is just short of £1.2million. It was noted that 0.5% has been held back by NHSE but 1% is in the budget above.

AP raised that some information needs bottoming out, e.g premises – it is important to know if there’s enough in the budget to support schemes.

LF asked for the next update to be clear about the 1.5% being held back by NHSE. Highlighted that page 6 – green premises schemes, are not full aligned, queried what does that mean and asked for clearer language in next report.

SM informed the committee that in respect of green premises schemes, there are revenue consequences and capital – the CCG don’t currently pick this up but going forward under delegated costs this would then be aligned with each CCG (charged to CCG).

DC informed the committee that ENHCCG is in a relatively good position, some CCGs are spending more than their budgets and that needs to be worked through.
HB informed the committee that the ENHCCG population is growing rapidly, there is a 6.5% difference between actual and weighted populations – there are enormous pressures and local practices have demand and capacity pressures and how the money is used needs to be agreed quickly.

**Action** – SM, AP, JG, HB and DC to work together outside meeting on this and NHSE to bring update to next meeting (28 July 2016).

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<th>5. <strong>ENHCCG Primary Care Strategy</strong></th>
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<td>JG updated the committee on the work that has taken place on the Primary Care Strategy (PCS). The document was signed off by the ENHCCG Governing Body in April 2016. Leading up to this, a considerable amount of engagement work took place with member practices the LMC and the LPC.</td>
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<td>JG highlighted the importance of remembering that the document is a strategy, and doesn’t set out details of delivery – the mechanism of delivery will be through Locality Commissioning Plans and Consolidated Funding Framework (CFF) and will be bespoke for each locality – stakeholders will continue to be engaged as this happens. It is also important to stress that although this has only just been signed off by GB, a lot of work has already taken place.</td>
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<td>DK highlighted that it has been a two year process to finally publish the PCS and that it is a working document. The CCG have come a long way in locality transformation in this time, particularly around the CFF. It has to evolve and is not set in stone.</td>
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<td>HB signified the importance of primary care in out of hospital care – General Practice is the core of out of hospital services. A cultural change is needed and the CCG is looking across all contracts to integrate services. The CFF is looking towards measuring improvements at population level on health – we are looking to improve the lives of patients. 60% of those coming through urgent care have LTCs. Also we are looking to get more joint working with community pharmacy as well as the Vanguard scheme for care homes. The PCS is the over-arching document that has this information in and we are looking to pull together more coherent integrated plans.</td>
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<td>NI felt it was very positive that the PCS has now been published and will focus on the health needs of a locality rather than across the whole CCG – he felt this was the real strength of it. NI confirmed that many pharmacists want to do more rather than just dispense drugs and that NHSE are happy to work with CCG on this as they have close links to community pharmacy.</td>
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<td>RL highlighted that it is important to ensure GP and pharmacy work is truly integrated and not competitive (e.g such as issues around flu).</td>
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<td>LF welcomed the document and asked if we can translate each section into an image with milestones and timelines (outputs and outcomes) – feels that it would be good to see progress on these and that they are making a difference etc.</td>
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<td>HB stated that the PCS is integral to the CCG’s plans. Cancer, diabetes, learning disabilities, mental health etc are key clinical priority areas the Governing Body have decided to focus on. We need to look at differences in early diagnoses across locality level (e.g bowel screening differences).</td>
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6. **Quality and Risk Sharing Committee report**

CS informed committee that Risk Sharing Committee has recently met. The meeting focused on looking at intelligence that is available from different organisations. The Memorandum of Agreement was agreed as the Risk Sharing Committee need to be sure of roles and responsibilities. The focus has been on CQC inspections and GP survey access, they are now looking at how the group can support NHSE and CCG visits.

JB informed group of the outcomes of CQC inspections, there have been 15 inspections, 5 of which require improvement.

National patient survey was discussed – at the last meeting it was requested to have more in depth access. The data shows that we are in line with the national picture. There is a lot of variation (e.g. online booking etc in practices access arrangements). Outliers in survey will be offered support.

KK highlighted that the committee is an information sharing group, the first meeting had excellent attendance (CQC, NHSE, CCG etc), soft intelligence was shared and the meeting will develop as it goes on.

LF declared an interest as a member of the independent audit committee of the CQC. LF commented on the CQC section and raised that Stockwell Lodge comes out as good but in some data we have seen it comes out as very low. There were concerns that this seems to be inconsistent.

CS responded that the group wanted to use the dash board and will be working with CQC going forward to work together to reflect a framework.

RL raised that the CQC gets all of this information and spends a whole day with a practice. Asked if the group are at risk of repeating the same things that CQC have already done? Concerns were raised that it feels like lot of work is being repeated.

KK responded that although CQC do visits, it feels as if there isn’t a lot of communication, so it is good to have them around the table at these meetings. They will be agreeing with a CQC a minimum data set of info that can be shared at the meetings.

RL commented that the group must ensure that if a practice is given an action plan from the CCG and CQC these need to be complimentary.

JG raised that the CCG may focus on things that fall out of regulatory standards outside of the CQC remit and felt that the more detailed breakdown of the survey was very helpful.

7. **Premises, PCTF and SEP update**

Declarations of interes:

DK – GP in SV&V – there is a Herts and Essex scheme. Also property owning GP at Central Surgery (Central Surgery also have a scheme).

NW – GP in ULV – there is a ULV scheme.

AJ – GP in LLV - there is a LLV scheme.

The panel met on 8 April to review bids and feedback has subsequently been given to practices. The electronic portal will open in early June 2016 for three weeks – the
CCG has been asked to upload bids in rank order.

JG expects there may be greater clarity on the scheme and finances in the future and expects that there will be changes to cost direction. The CCG will be writing to practices with new information shortly asking for final business case to be sent in to them by 26 April. JG highlighted the importance of finding an objective way to put the schemes in rank order and confirmed that the CCG will be completely transparent with this process.

HB raised that there are great expectations and there is clearly a need out there, felt it would be enormously helpful if NHSE can produce the official guidance so that the CCG can manage expectations better.

DC confirmed that further information is due to be released imminently.

8. APMS procurement update

GPs were welcomed to voice their opinion but would not be involved in voting if there was a vote required.

JG informed group that as a minimum today we need to agree if there will be any significant change in options going forward (e.g any stop in services). Locality view has been sought from WelHat and ULV.

NI informed group that he will be having a phone call with the procurement team this afternoon. NHSE have a series of care taker contracts across the area and want to resolve these. It is very important to ensure good engagement takes place. There is a January deadline. All patients should be made aware that their current practice is in a care taker arrangement and engagement with patients will continue throughout this process.

DC raised importance of looking at how this fits into locality plans etc. It is important to think pragmatically within the timescales as primary care strategies for each locality were still in development.

**Welwyn Hatfield - Spring House**

JG informed group it would be helpful to play in the localities view. WelHat localities view (leads and NHSE colleagues) is that Spring House should continue to run 7-day access 8-8, however further it is felt that conversation is needed around the catchment area. It is felt that it is a helpful service that takes pressure off of urgent care. This would be a national procurement.

NW asked if there was any way of looking at the extended hours service being able to be used by other patients within WelHat locality.

AP reminded committee that we’ve just taken away walk-ins at Spring House. Cost of each patient at Spring House is much larger than other practices (£203 per patient weighted, average spend in other practices is approx. £105 per patient). Elsewhere conversations are taking place about how practices can work together to provide access to patients across localities.

**Upper Lea Valley – Orchard and Ware Road**
A discussion took place at a meeting last week in ULV, although not all practices were in attendance but relevant practices were (Buntingford and Orchard) Buntingford growth is expected to be 4,500 with new growth and development.

If patients were dispersed they would have options to go to Buntingford practice or one in Royston. Dispersal from Orchard was an option but not so much with population growth. The preference was to go back to GMS.

Ware Road – has a bigger population with close links to other practices around. None of the other practices have capacity to take on patients so dispersal is not an option; procurement is the only sensible option on a like for like basis. There is an issue around length of contract as locality is still in discussions around how practices in Ware and Hertford can work together and are looking at future use of Hertford County Hospital - keen to look at a shorter contract as possible.

The CCG have met with EHDC and discussed the option for another facility or s106 for growth in Buntingford.

RL asked how closure and dispersal supports the CCG’s Primary Care Strategy?

JG highlighted that consolidation of services and being able to provide better consolidated practices would come as part of this if closure and dispersal were to happen.

AP informed committee that there is greater resilience in a larger practice – e.g more GPs / Practice nurses etc.

YTA asked group if all were happy that closure and dispersal was not an option for Orchard Surgery, Buntingford.

AP queried whether closure and dispersal of list means loss of infrastructure? Could practice be dispersed and new practice still use current premises?

NI confirmed that this would have to be part of any negotiations. Could be dispersal but not a physical dispersal. However this may be out of our control (e.g owner of premises may want to sell, may not).

NW informed group that the localities view is for the list at Orchard to be dispersed. However it was felt that if NHSE won’t support dispersal, they are keen to see a shorter contract implemented to give flexibility in future.

AP asked even with housing growth in Buntingford what do we think growth will be? Is it big enough for two practices working at scale? If no, we will want to bring practices together, why not do this sooner rather than later?

HB advised that growth expected in Buntingford is 51% of what their current population is.

YTA raised that it feels we can’t move forward, more information needs to be brought back. YTA asked committee if all are happy to proceed with two pronged approach taking into account localities view point on dispersal, and if not shorter contract for Orchard Surgery.

NI advised that patients should be consulted on all options, it is important to seek
opinions and then put forward NHSE/CCG view.

YTA – as a committee we need to put forward our preferred option: locality view is closure and dispersal, if that’s not viable we go to procurement for a contract.

RL felt there wasn’t enough information in paper for group to make decision. Asked for more information in future.

JG advised that some information was redacted due to discussion in public

YTA re Ware Road, given discussion, asked if group are happy to move forward with locality view going out to procurement on a shorter term contract - 3 +2 years = all agreed.

Spring House – 2 options, to keep like for like or make some changes. Group happy to agree with like for like with consultation in catchment area and access for Stevenage and WelHat practices (5+5). All agreed.

NI – we need to look at the amount of people who are currently registered to SH who are out of boundary.

HB raised that Spring House has 8,000 registered patients and only 59 people over age 75. People travel from Stevenage because they want weekend appointments. We should look at working together across localities to help with access. We need to see if this is affordable. Do we have one extended hour’s contract per locality?

JG advised there is a need to look at how much this off-sets the cost on the urgent care system.

YTA suggested procure like for like on Spring House on a shorter 3+2 contract.

AP asked for NHSE to advise here, shorter contracts = less interest. What are the possibilities of other practices out of hours being able to book into out of hour’s slots?

NI agreed that this was something that should definitely be looked at.

AP suggested extended hours stays and other WelHat patients can book into extended hours, although worried about value for money but could work if practice linked into other practices in locality for out of hours visits

LF raised concerns around other localities with equal needs.

YTA confirmed Spring House is looking at like for like in terms of hours – and look at 5+5 with a subject to being able to have booking by all practices in locality to extended hours. Further issues to be discussed at the consultation. Agreed 5 + 5 like-for-like with consultation on catchment restriction and access from other WelHat practices outside core GMS hours.

9. Consolidated Funding Framework
YTA asked if committee had any queries, comments or opinions on paper?

None were raised.

10. Declarations of Interest Register
YTA advised there are gaps in this information from:

Aly Rashid
Manjit Darby
Michael Taylor
Michael Downing

CCG will be in touch with above for information and will be coming back to each meeting.

11. **Joint Committee Terms of Reference**
   Need to add Cath Slater, AD for Quality for ENHCCG to TOR.

12. **ANY OTHER BUSINESS**
    Duncan Ferguson, Director of Ephedra Healthcare raised concerns from the public audience. DF informed committee that the views of ULV APMS representatives from Orchard and Buntingford were not present in that discussion as they weren’t allowed to be and he feels that they should have been. **HB to investigate.**

    NW asked for update on flu campaign – would like to see data on how much flu activity was done by pharmacy.

    JG informed NW that the CCG are also chasing this this information.

13. **DATE, LOCATION & TIME OF NEXT MEETING**
    Thursday 28 July 2016, Beales Hotel, Hatfield, 10am – 12:30pm
Joint Co-Commissioning Committee Meeting in Public
Focolare Centre, Meeting Room 2, Welwyn Garden City
20th October 2016, 10:00-12:00

Present from ENHCCG
Harper Brown [HB] Director of Commissioning
Dianne Desmulie [DD] Lay Member, Patient and Public Engagement
Sharn Elton [SE] Director of Operations
Linda Farrant [LF] Lay Member, Governance and Audit
Alison Jackson [AJ] GP Lead, Lower Lea Valley
Deborah Kearns [DK] GP Lead, Stort Valley and Villages
Alan Pond [AP] Chief Finance Officer
Yvette Twumasi-Ankrah [YT] Lay Member, Co-Commissioning
Nicky Williams [NW] Deputy Chair of ENHCCG, GP Lead, Upper Lea Valley

In Attendance from ENHCCG:
James Gleed [JG] Associate Director of Commissioning Primary Care
Maryla Hart [MH] Project Officer – Primary Care Projects
Cath Slater [CS] Associate Director of Commissioning Primary Care

Present from NHS England, Midlands & East (Central Midlands)
Dominic Cox [DC] Locality Director

In Attendance from NHS England, Midlands & East (Central Midlands)
Tom Bailey [TB] Quality Assurance Manager
Joanne Harrison [JH] Head of Quality
Stephen Makin [SM] Head of Finance (Finance Item)
Andrew Tarry [AT] Assistant Contract Manager, Primary Care

In Attendance – All other organisations / Members of the Public
Rachel Lea [RL] Local Medical Committee
Duncan Ferguson [DF] Ephedra / Practice Manager of Burvill House Surgery
David Law [DL] Chief Executive, HCT.
Karen Taylor [KT] Lead for Community Workstream, STP
Executive Director, Integration & Partnerships HPFT
MINUTES

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<th>Item</th>
<th>Subject</th>
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<td>1.</td>
<td>WELCOME AND APOLOGIES FOR ABSENCE</td>
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<td>The Chair welcomed all to the meeting. Apologies were received from:</td>
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<td><strong>ENHCCG</strong></td>
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<td></td>
<td>Sheilagh Reavey [SR] Director of Nursing and Quality</td>
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<td><strong>NHS England, Midlands &amp; East (Central Midlands)</strong></td>
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<td>Manjit Derby [MD] Director of Nursing</td>
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<td>Ally Rashid [AR] Medical Director</td>
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<td>Nicholas Ince [NI] GP and Pharmacy Contract Manager, Primary Care</td>
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<td>2.</td>
<td>DECLARATIONS OF INTERESTS</td>
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<td>Attendees declared the following interests:</td>
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<td>DK advised that she had interests to declare with regards to items affecting GPs – Item 6 on Premises, Estates and Technology Transformation Fund and SEP Update.</td>
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<td>DD advised that she is a Patient Representative for Hanscombe House.</td>
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<td>LF advised that there is nothing specific for GP members - no practices are mentioned.</td>
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<td>DK advised that she also has an interest with Item 6 for which her practice is a hopeful candidate.</td>
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<td>3.</td>
<td>MATTERS ARISING</td>
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<td>Matters arising included the budget and a discussion about the resilience programme.</td>
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<td><strong>Action Tracker</strong></td>
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<td>NHSE primary care budget is on the agenda. This action can be closed.</td>
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<td>JCC Terms of Reference is on agenda. This action can be closed.</td>
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<td>Committee members were unsure of what ‘Sustainability GP Improvement Fund’ was and concluded that this was a conflation of the GP Resilience Programme and other financial support set out in the GP Forward View.</td>
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**Action:** NI to collate & share different funding streams.

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<th>4.</th>
<th>QUALITY AND RISK SHARING GROUP REPORT</th>
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<td><strong>Care Quality Commission (CQC) Inspections</strong></td>
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CS advised that she had met with the CQC.

37 practices have been inspected by the CQC and received their outcomes and 22 are awaiting outcomes. 29 practices are rated as good; 7 require improvement. The CCG and nurse tutors offer these practices support.

One practice was assessed as inadequate in Letchworth. They are receiving support from the CCG and the Local Medical Committee (LMC). Some of the main concerns include practice structures and administration. The CCG is supporting this practice on these issues.

**GP Quality Data**
CS reported that the CCG continues to monitor GP quality data through and to carry out joint practice visits with NHS England (NHSE).

Visits to Abbey Road and Stockwell Lodge have been postponed until the new year as the practices are currently carrying out work on capacity.

The CCG has developed a visit framework for practices to self-assess against based on domains from the CQC; this helps focus the visits and prepare practices for CQC inspections.

The CCG continues to work on the primary care workforce and is pushing mentorship with nurses and practice nurses. The CCG has collected rich information on workforce in general practice, and CS hopes this will help inform locality plans.

There are 6 GPs on the GP fellowship scheme.

As a result of conversations about the CQC, it has become apparent that there is a need for more structured support and training for practice managers, as the skills required for them have moved on. The CCG is working in partnership with the University of Hertfordshire on this.

NW asked about Friends and Family test data and whether the response is consistent across other CCGs. AT advised that this is a contractual matter. Even within this area there will be a huge variance in the number of responses per practice. This probably mirrors what happens nationally. TB advised that having a huge number of responses for a practice is the exception. He does not think that we are not in a bad position compared to other CCGs on our patch.
DK advised that South Street Surgery, who have a good response rate, text their patients on friends and family. This may be worth rolling out.

NW asked about workforce data collection which should have been available as of a couple of days ago. CS advised she would look into finding this data.

RL mentioned the paper about the GP Resilience Programme. Some practices in ENHCCG who were vulnerable are not mentioned in this paper. JG advised that he would pick up under the resilience programme paper.

SE commented that the paper is really helpful, and helps form a robust framework.

LF advised that this paper shows good joint working with primary care. LF suggested that the CCG start keeping a log on how long the CCG spends doing Primary Care work to help understand the demands on its time. This will help the CCG be more informed on decisions going to delegated and will help resource taking on the correct amount of staff going forward. There is also an impact on the Quality team and across the board.

CS advised that the team is looking at this. They have already spent 35 hours on inadequate practices.

CS advised that the Quality visit template is a self-assessment and RL requested a copy.

The Committee noted the report.

5. 2016/17 FLU SEASON - LOCALITY PLANS
JG introduced and ran through the report. JG advised that the position last year deteriorated from 2014-15 levels. Last year a range of initiatives was taken to promote flu vaccines. This year the CCG decided to invest £30K across all localities to support new local initiatives. Localities were asked to submit a plan and identify a flu lead. Locality leads have been asked to feed back to the Governing Body on this.

The early data suggests that the coverage for patients registered at most East and North Herts GP practices is either better or the same than at this time last. There may be a link to the extra investment that the CCG has made this year.

The Committee discussed the issues around having both practices and pharmacies offering vaccines. The following points were raised and discussed:

- Practices claiming that they were losing income as a result of pharmacies offering vaccines.
- A consensus that the most important point being that the
patients do get vaccinated somehow.

- Patient choice.

JG advised that this year pharmacies should be using PharmOutcomes, an electronic information sharing system which should notify practices once patients are vaccinated. It will go into SystmOne and EMIS patient records. RL advised that the purchase and use of PharmOutcomes is a local decision. JG advised that pharmacies are contractually obligated to notify GPs of vaccinations whatever system they use.

RL added that PharmOutcomes does not put information directly into the patient records. There is an extra step that the practice has to take. JG added that it is important for practices to raise instances where vaccination information is not received.

The following further points were raised:

- Unfortunately the situation has created some unhealthy competition.
- It was asked whether the rivalry is perceived or real. RL advised that it is real. The LMC (Local Medical Committee) gets stories from constituents. The LMC knows that pharmacists have told patients they can give the vaccination now and that the patient can cancel their vaccination with their GP. GP posters tell patients not to go to pharmacist. The vaccines generate income for both parties and they are chasing the same cohort of people.
- RL advised that the original idea was that there is a cohort of patients that won’t go to the GP which the pharmacist would vaccinate. But the resulting evidence does not suggest this is happening.
- DC advised that there is an early indication that vaccination rates are better this year than this time last year.
- RL advised that where practices have particularly low vaccination figures, they are in areas where pharmacies are not particularly promoting the flu jab. Better targeting and promotion is needed.
- DC advised that the information sharing and gathering process has improved.
- JG advised that reported inappropriate professional practice goes to an NHSE group and is being followed up. He encourages GPs to report any such practice.
- Regarding vaccine ordering problems, more will become apparent at the end of the flu season.
- HB advised that the fundamental issue is a growing number of dependent patients. The number that needs vaccinating annually is increasing as the dependent population is increasing. More people are to be vaccinated in each group. Even if you meet all your targets there are still more patients to be vaccinated.
The Governing Body has taken the brave decision to ask practices and pharmacies to work together. This is about encouraging collaboration – the CCG will look at whether this has worked this year.

JG is copied into the invite list for Stevenage GP flu meetings with pharmacists.

The committee discussed the pathway for midwives performing vaccinations. NW advised that her community midwife in her practice is not providing the flu jab and pregnant women have to come back and see the nurse.

**Action for Lynda Dent / Maryla Hart:** MT who is a patient representative said that his surgery is doing better than ever on the flu jab. Promotion of the flu vaccine programme is a discussion that the patient group should look at as well. It would be helpful if a note on this were emailed round to the chairs.

The committee **noted** the report.

### 6. PREMISES, ESTATES AND TECHNOLOGY TRANSFORMATION FUND AND SEPTEMBER UPDATE

AP ran through the paper and gave a new update. Further to the information given in the paper, all of the CCG’s 7 schemes have been unveiled as approved subject to due diligence. These schemes are:

- Astonia House
- Herts and Essex Health and Wellbeing Centre
- Garden City Practice (WelHat Locality)
- Stanmore Road
- Puckeridge Surgery
- Sawbridgeworth
- Ware Primary Care Scheme.

AP advised that people are asked to carry on subject to what they could do regarding for example design fees and/or architects. The CCG hopes there will be an announcement of the next steps soon.

RL thanked Sue Fogden for working with both Herts CCGs.

### 7. THE SUPPORTING VULNERABLE PRACTICES (SVP) AND THE GENERAL PRACTICE RESILIENCE PROGRAMME (GPRP) UPDATE

AT advised that the SVP came out in December 2015 and is not a recurrent programme. 3 practices self-identified in North Hertfordshire Locality. One is in the phase of improvement and action planning. The other two are not taking improvement work forward through the scheme. Events have been somewhat
overtaken by the National GP Resilience Programme, part of the GP Forward View.

Funding for NHS England, Midlands & East (Central Midlands) came down to £1.3 million.

There was a potential issue with practices not wanting to identify themselves as vulnerable. In terms of timing it has been tight. There was a good level of response around Central Midlands. Individual practices self-referred and locality and town based approaches have been received. NHSE is looking at burning issues now and also the long term benefits of working with practices more effectively.

AT advised that right now he does not have more details to share. What had been asked from practices at this stage is an expression of interest. The next steps will involve going back to those practices and getting more clarity regarding requirements, identifying funding and taking forward feasibility.

The support provided by the GP resilience programme is not necessarily money. A lot is still not known. It could be expert tools or advice. There is no way of knowing costs or where support comes from. There is pressure from all sides to spend money this year. The LMC wrote out to practices who are thinking of merging. JG advised that practices could present a joint application even if they are not thinking of merging.

AT advised that there are 3 APMS contracts in ENHCCG: Ware Road, Orchard and Spring House.

Ware Road and Orchard had single handed GMS contracts that were handed in. They have had a care taker provider in place since last April and May 2015. They are now at the stage of going out to full procurement. Both have undertaken patient consultations.

The consultation surveys received a very good response especially Ware Road. The procurement process will take place from November using an open market nationwide approach, with a view to having new contractors in place for 1st April 2017.

Spring House used to be a Darzi Centre and previously had a walk-in element which was taken out in 2015. This linked in with the opening of the Urgent Care Centre (UCC) at the QEII. It is necessary to decide the service specification for the contract going forwards. The Spring House APMS contract has been extended to 31 March 2018.

8. JCC TERMS OF REFERENCE (TOR)

JG ran through the changes discussed in the previous meeting. In the new TOR for the Joint Co-Commissioning Committee he has included practice list closures and the CCG’s Lay Member for Patient and Public Engagement as a member of the
Committee.

In addition to the changes made there is also be a transfer of vice chair to Dianne Desmulie.

JG explained vote weighting. Last meeting the committee spoke about removing the NHS Medical Director from the membership. JG is concerned about having only 2 voting members from NHSE with 5 votes each versus 10 CCG voting members with one vote each.

LF – explained that the vice chair will pass from her to DD as she should attend in the capacity of her governance role. LF agreed that the voting weighting seems out of sync. This is a joint committee but seems one sided. She is concerned from a governance point of view.

AP raised a concern about the skills and background of members and quality of debate & challenge but is less concerned about voting as the committee has not needed to make many formal decisions. The CCG has 3 GPs so for balance there is also a need for a medical view from NHSE. It would be helpful to have a doctor, for example a deputy medical director.

DC advised that he supports the principal of balance and also thinks the issue is not about the number of votes. DC advised that Herts Valleys CCG has a medical director.

It was raised that post-April ENHCCG could well be delegated.

A proposal was put forward that the CCG’s medical vote could be reduced from 3 to 1. DK advised that she would not mind this alternative solution.

RL asks about list closure and time frame as this does not fit in with the cycle of meetings. YT advised that a working group is proposed and is to have operational decision making authority.

AP advised that NHSE needs to put in the same amount of effort as the CCG. NHSE needs to get someone from their Medical Directorate to quarterly committee meetings to ensure that this is a rounded committee not dominated by the CCG, and that it can challenge and get decisions made.

The JCC agreed the changes set out in the TOR

**DC to pursue NHSE medical representation on committee**

**Bring TOR back to next JCC meeting**
<table>
<thead>
<tr>
<th>9.</th>
<th><strong>CO-COMMISSIONING WORKING GROUP DRAFT TERMS OF REFERENCE</strong></th>
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<tbody>
<tr>
<td></td>
<td>YT gave an introduction. JG apologised that not everyone had</td>
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<td></td>
<td>received a printed copy.</td>
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<td>The following points were raised in discussion:</td>
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<td>- Is membership senior enough? Is a Lay Member needed</td>
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<td>in the core membership?</td>
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<td>- Delegated decision making power.</td>
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<td>JG ran through the proposed membership and proposed the</td>
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<td>addition of a CCG finance manager for primary care. AP</td>
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<td>advised that the CCG does not have one and this should sit</td>
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<td>with NHSE.</td>
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<td>AP did not agree with the membership which he saw as too</td>
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<td>CCG dominated. He advised that in his opinion the work</td>
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<td>delegated to this group has done the committee out of a job.</td>
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<td>SE advised that the two terms of reference were very similar.</td>
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<td>JG advised that one of the key drivers of the working group</td>
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<td>is that the committee meets so infrequently.</td>
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<td>DC added that having a working group to drive the agenda of</td>
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<td>the committee seems the right thing to do. It needs to be</td>
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<td>smaller, tighter and more focused.</td>
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<td>LF advised that she does not think this working group should</td>
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<td>approve so many things.</td>
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<td>DD advised that JG could take out all the “approves” from</td>
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<td>the document. JG added that this could be done apart from</td>
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<td>those processes that require decisions to be made between</td>
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<td>JCC meetings.</td>
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<td>NW advised that the working group should approve 6 month</td>
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<td>list closures.</td>
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<td>AP advised that he wants the team to do work with primary</td>
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<td>care to drive the agenda forward. AP asked what practice</td>
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<td>mergers we need to achieve. What should be taken into</td>
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<td>account before agreeing a list closure? Parameters should</td>
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<td>be set and the team should be allowed to work within them.</td>
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<td>If they have dilemmas they can escalate to a director, they</td>
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<td>don’t have to get a committee together.</td>
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<td>JG advised that there is currently a framework to support</td>
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<td>decision making. For example, list closures sit with the</td>
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<td>NHSE Primary Care Panel. Therefore the working group is not</td>
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<td>starting off with a complete blank sheet.</td>
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<td>JG advised that the group needs to agree some key objectives</td>
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and a work plan to deliver these.

RL advised that she sits on the working group with Herts Valleys CCG. Their working group allow more thrashing about of ideas and it works with other teams.

JG agreed on the points about balance between organisations.

**Action for Rachel Lee:** to share Herts Valleys JCC and Working Group TORs with James Gleed.

MT advised that he sees Healthwatch mentioned. He or Peter Chapman would be happy to help to make it work.

The JCC **agreed** that more work needs to be done.

**Action for all:** To send further details and comments to JG so he can produce an amended document for January’s JCC meeting.

### 10. Item 10 – Primary Care Budget

SM presented his report and advised it is similar to that presented at Q1.

Page 4 shows the summary financial position: ENHT versus the notional allocation. The position sets out NHSE’s notional underspend versus their notional allocation. There are some small elements to apportion. Some estimates have been made using list size inflation and historical data. It is fair to say that this is an estimate depending for example upon QOF achievement, variation of GP list sizes.

AP asked SM to clarify various points on the £1.5m reported underspend. Firstly, that the report showed forecast spending under the heading systems resilience 1% to be held of £0.7m, but there wasn't actually anything committed yet so the likely underspend was £2.2m. Secondly, that there were also accrual write-backs from 2015/16 which would increase the underspend in 2016/17. A figure of £1.7m across Central Midlands had previously been reported and £0.4m for this CCG area. AP then asked if NHSE could release any of this underspend for investment in services this year, particularly those non-recurrent in nature.

SK confirmed both of the points made by AP were correct, but that NHSE had to consider their whole portfolio and that there were pressures elsewhere within their budget, on other services and in other geographical patches.

DD asked how the table works as it does not show allocated budgets. SM advised that line by line budgets had been set, but that the summary report here only showed expenditure against the total budget, i.e. the allocation.
DD also asked under which heading does support and developing practices come. SM advised that NHSE nationally has funding to support a number of policy initiatives, including supporting vulnerable practices, but this is not allocated locally and not therefore shown in this report.

DD asked why, if we have a £1.5m underspend in our area, we would not be directing some of the underspend towards supporting and improving vulnerable practices? SM advised that they are prepared to receive business cases for the use of this money, but that NHSE had to balance its books in total rather then by single geographies.

DC advised that some of this will be looked at as part of practice specific issues in Part 2 of the meeting.

**LF specifically asked for the following to be noted:**
The CCG is not being permitted by NHSE to use any of this underspend to support delivery of the Primary Care Strategy for this area. She is disappointed that this is a joint committee, but we have not been allowed to make joint decisions on use of resources.

DC spoke about balancing the budget as a statutory responsibility. If there are areas that NHSE want to spend together with ENHCCG this can be worked on, but cannot be agreed in this meeting.

DC advised that if the CCG took delegated commissioning responsibilities, NHSE would allow the CCG to make its own spending decisions including utilisation of the current underspend. DD pointed out that this would then mean that NHSE could not use the underspend in this area to offset overspends elsewhere, so why couldn't they release the funding now. DC agreed that with delegated commissioning in this area, NHSE would have greater difficulty in balance their position. However, the national direction is all CCGs moving to delegated commissioning over time.

AP advised that he has some sympathy with NHSE locally. The current financial commitments have largely been inherited by the team and whilst they have responsibility for all primary care they will be expected to offset over and under spends. If following delegated commissioning they are left only with overspends there will be little they can do and NHSE nationally will have to resolve.

HB advised that although this is supposed to be a joint committee, the cheque book sits with NHSE. With delegation the CCG would have the cheque book but would still do joint work.

HB advised of the need for a detailed investment and development plan for primary care. HB asked whether we can
use some of this money to invest in capacity in primary care to help with long term condition management via investment in practices.

DK asked why we have an underspend but can’t use it for delivering management capacity to become delegated. One of reasons we didn’t want delegated was due to there being no money from NHSE to fund the additional running costs associated with the additional responsibilities.

AP advised that there are two pots of money, programme and admin. The programme money must be spent on healthcare, not admin. However the CCG is currently funding workforce development, GP tutors and GP fellows. This could be pushed into the primary care programme pot. That would free up money for staff; not a large amount.

| 11. | SUSTAINABILITY AND TRANSFORMATION PLAN (STP) UPDATE – PRIMARY AND COMMUNITY CARE WORKSTREAM. |
|     | David Law introduced himself and his item. On behalf of the STP footprint he is leading on the community & primary care services work stream. |
|     | The footprint of our STP is Hertfordshire and West Essex. We have identified 3 main works streams: |
|     | • Acute services  |
|     | • Primary and community services  |
|     | • Prevention.  |
|     | **Primary and community services**  |
|     | The issues have been around for a number of years. Requirements from the STP are nothing new, it is just articulating how to have a sustainable system across the patch.  |
|     | The 9 strategic ambitions from the CCG strategic plan are all encompassed in the STP.  |
|     | Within the primary and community services workstream the aims are to:  |
|     | 1. Maintain people in the community  |
|     | 2. To support people to manage their own health and wellbeing  |
|     | 3. Reduce the burden of disease  |
|     | The focus and approach are consistent with what has been done to date: building integrated health and social care teams around practice populations. This builds on rapid response, care home Vanguard, and so on.  |
|     | It is clear that we need to focus services and enhance their impact; align them more closely with general practice. Also focus on frail elderly – reducing admissions – respiratory, |
dementia, etc. There is work to be done on management of people at home.

The diabetes pathway is big – managing but also preventing diabetes. Need to ensure parity of esteem for mental health and that the mental health system works well.

**We need to absorb current demand for activity.**
Demand is increasing rapidly and that activity needs to be maintained.

We need to release cash to invest in primary and community services. There is a need to have a sense of scope and of the task we face. How will we deliver services and phase them. Building on work we have already done – group work already in place. Integrational services among populations.

There is a need to look at how we work with different levels of population.

DD asks what involvement patient representatives have in the group that DL is currently leading. DL advised none at the moment.

The nature of the task is being clear about the need to have a strong level of engagement – predominantly at local level in neighbourhoods and localities. DL would like to promote engagement where it appears to be most purposeful. The plan is to be published without public input at this stage.

DK spoke about engagement of STP leads and localities, including isolated localities.

DL spoke about using the Integrated Programme Board structure (which may be renamed) to add strong locality focus to create a locality management function across services and the local community.

KT advised agreeing on STP best practice and then taking this down to Localities and on the ground to deliver. The STP is trying to give extra support to Stort Valley and Villages (SVV) Locality to make this happen. The STP will pull in expertise when necessary. The National Association for Primary Care has offered them formal support.

DK advised that there are offers for development support from a number of different areas and this can be confusing. It would be good to have an overview.

AJ advised that this is a big and complex piece of work. Implementation is crucial. In the last 2 years there have been lots of high level meetings. This needs to get down to locality level. Building and strengthening collaborative relationships is central. Localities need to feel they own the STP and this is not
happening everywhere. It needs to happen at all levels e.g. between GP practices, providers, acute, etc.

DK mentioned that LLV (Lower Lea Valley Locality) are in a better position as providers are working closer together as they have invested in community services through Home Frist. DK needs assistance to bring it together in SVV.

HB agreed that the STP is heading in the right direction. Structures and governance need to be brought together. There is a need to align staff and to have an open conversation about realigning capacity. Transparency regarding the workforce in primary care is needed, as well as to focus on personalised budgets and care, including for multiple conditions.

DL agreed that joint working is important, as it the debate on governance and structure.

DK spoke about the Herts and Essex Hospital Project. One challenge here is thinking more creatively about how to use the amazing community resource of that hospital. This is also linked to ETTF (Estates, Technology and Transformation Fund) money. How do we use this money to deliver hub community services?

MT asked DL about localities – is he suggesting there will be new ones or will they combine? DL replied that we should align the services within localities and management decisions about the resources available should be delegated to locality level.
12. **ANY OTHER BUSINESS**  
**Minutes and Agenda on the CCG website**  
Duncan Ferguson commented about the shortage of staff to put the JCC meeting agenda and papers on the CCG website last week. Hopefully the minutes and agenda will be put up in good time in advance of the January meeting. JG apologised regarding the team’s temporary staffing shortages and advised that the agenda and papers had been on the website prior to the meeting, albeit not as early as would have been ideal. JG did not expect this to be an issue going forwards.

**Flu vaccinations.**  
DF advised that his surgery had the vaccinations delivered earlier this year. The concern regarding pharmacies is that Boots were vaccinating earlier than GP practices on 6th and 7th September. DF advised that national pharmacy chains are able to access stock earlier than general practices. His practice use 3 companies and all could deliver during the week of 12 September at the earliest.

DF gave some statistics and advised he does not think there will be huge increase in uptake through the programme.

JG advised that he understood from Public Health England that the delivery date for vaccine was down to the supplier that had been selected.

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13. **DATE OF NEXT MEETING**  
Thursday 26th January, 10:00-12:00  
Salisbury Suite, Beales Hotel, Comet Way, Hatfield, Herts, AL10 9NG