Agenda Item No: 10
Date of Meeting: 25th May 2017

Governing Body Meeting in Public

Paper Title: Joint Co-Commissioning Committee Minutes

Decision or Approval □  Discussion □  Information □

Report author: 
Report signed off by: 

Executive Summary: To note the minutes of the Joint Co-Commissioning Committee

Recommendations to the members: 

Conflicts of Interest involved: 

Conflict of Interest Definitions

The following table describes the sub-classifications of interests:

<table>
<thead>
<tr>
<th>Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Direct (or personal) financial interest</td>
<td>A direct financial interest is one where there is or appears to be opportunity for personal financial gain or financial gain to close family members, close friends and associates, and business partners (dependent on the circumstances and the nature of such relationships).</td>
</tr>
<tr>
<td>Indirect (or non-personal) financial interest</td>
<td>An indirect financial interest involves payment or other benefit to a department or organisation in which the individual is employed or otherwise engaged but which is not received personally.</td>
</tr>
<tr>
<td>Non-financial interests</td>
<td>A non-financial interest is one where there is or appears to be an opportunity for non-financial gain (e.g. status), or where an individual’s decision making is or could be compromised for example due to a conflict of loyalty.</td>
</tr>
</tbody>
</table>
Joint Co-Commissioning Committee Meeting Public

Salisbury Suite, Beales Hotel, Comet Way, Hatfield, Herts, AL10 9NG
Thursday 26 January 2017, 10:00-12:00

Present from ENHCCG
Harper Brown [HB]  Director of Commissioning
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
Yvette Twumasi-Ankrah [YT]  Chair / Lay Member – Co-Commissioning
Nicky Williams [NW]  Deputy Chair (ENHCCG) / GP Lead, Upper Lea Valley

In Attendance from ENHCCG:
Denise Boardman  Programme Director
Robin Christie  Clinical Lead for Primary Care Workforce Planning and Education
Beverley Flowers  Chief Executive
James Gleed [JG]  Associate Director of Commissioning Primary Care
Maryla Hart [MH]  Project Officer – Primary Care Projects
Cath Slater [CS]  Associate Director of Quality and Patient Experience

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
Nicholas Ince [NI]  GP and Pharmacy Contract Manager, Primary Care

In Attendance:  - Non-voting Committee Members
Rachel Lea [RL]  Local Medical Committee
Michael Taylor [MT]  Patient Representative - Healthwatch
## MINUTES

<table>
<thead>
<tr>
<th>Item</th>
<th>Subject</th>
<th>Action by</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>WELCOME AND APOLOGIES FOR ABSENCE</td>
<td></td>
</tr>
<tr>
<td></td>
<td>The Chair welcomed all to the meeting. Apologies were received from:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Dianne Desmulie [DD] Lay Member, Patient and Public Engagement</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Alan Pond [AP] Chief Finance Officer</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Sheilagh Reavey [SR] Director of Nursing and Quality</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>DECLARATIONS OF INTERESTS</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• RC declared that he is a specialist adviser to the CQC, in relation to item 5: Quality and Information and Risk Sharing Group Report.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• AJ, DK and NW declared an interest in item 7: Premises, Estates and Technology Transformation Fund Update.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• NW declared an interest with regards to Wallace House, in relation to item 8, contracts update.</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>MINUTES OF PREVIOUS MEETING AND MATTERS ARISING</td>
<td></td>
</tr>
<tr>
<td></td>
<td>The minutes of the Public meeting held on 21 April 2016 were approved as an accurate record.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>The minutes of the Public Meeting held on 20th October 2016 were agreed as an accurate record subject to the following alteration being made:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Page 11: HP to be changed to HB.</td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>MATTERS ARISING</td>
<td></td>
</tr>
<tr>
<td></td>
<td>There were no matters arising</td>
<td></td>
</tr>
</tbody>
</table>

### ACTION TRACKER

The contents of the Action Tracker were discussed and the following actions were agreed to be closed:

1: NHSE Primary Care Budget 2016-17
2: Sustainability GP improvement fund
3: 2016/17 Flu Season Locality Plans
6: Draft Co-Commissioning Working Group; Terms of Reference
7: Draft Co-Commissioning Working Group; Terms of Reference
The following updates were provided:

5. Joint Co-Commissioning Terms of Reference (TOR): YT is to write to Aly Rashid to discuss the Terms of Reference for JCC with regards to NHSE Medical Directorate representation.

5. Quality And Information & Risk Sharing Group Report, INCLUDING:

CS ran through the report. 50 practices have been inspected under the new CQC regime. CCG support focuses on practices rated as requiring improvement or inadequate. There are 3 practices in each of the above categories in this report and since it was written, Peartree Surgery has also been classed as inadequate.

The CCG provides help with action planning and processes and has offered more intensive support around infection control. Practice Nurse Tutors and RC are offering support. Some practices that required improvement are now rated as good. This is to be celebrated.

Practices with disappointing Friends and Family Test results are learning from practices doing well in this. There are a number of actions around this.

Stockwell Lodge is rated good by the CQC but faces challenges with patient feedback. This is a longstanding problem. The CCG will soon conduct a detailed quality visit to help them.

**Action:** A Quality Monitoring Framework is being developed by the CCG. This will go to JCOG for review and comment prior to sign off.

**Workforce**

RC gave an update on workforce, taking the paper as read. The Workforce Planning and Educational network has been operational for over a year. The practice workforce data response rate is 96%. Some localities have taken the findings to task and finish groups to develop locality plans. This is proving useful for developing skills, especially around practice nurses and forums in all localities.

The CCG has been invited to a Health Education conference in April to represent and feedback on their work.

The CCG has been working with the University of Hertfordshire regarding bids for them to become a provider for Physician Associate training.

NI asked whether there are any bids for clinical pharmacists. RC replied that he did not currently know. A discussion took place about the clinical pharmacists scheme and the following
points were raised:

- There are still reservations regarding diminishing funding and mentoring. These issues resulted in Stort Valley and Villages Locality (SVV) pulling out of the scheme at the last minute.
- One pharmacist for 30,000 people does not make much difference to the skill mix.
- There is value in looking into how this has been done elsewhere.
- JG advised it is important to understand how pharmacists fit into practices and degree of work substitution.
- GPs are already pushed with registrars and mentoring nurses.
- This is a rolling programme.

**Action:** NI to Check regarding flexibility over the rate of one pharmacist per 30,000 people.

DK questioned to what degree is support of practices being joined up with Productive General Practice and NHSE?

A suite of support is being offered under the GP Resilience Programme.

**Action:** There is a need to share learning and be proactive with practices so they don’t fall foul of CQC. The CCG could work with practices on this and link to training opportunities such as TARGET. RC to consider as part of his review of TARGET.

LF said it was good to see so many positive results of CQC inspections. LF asked whether there is a CCG policy regarding the role of locality chairs if their practice is struggling (ie. should they focus on the basics in practice).

BF replied that there is an informal approach but not a formal one. This needs to be looked at in order to achieve the best outcomes for patients.

SE asked whether there are general themes and therefore universal support required for inadequate practices, like an off-the-shelf package. It would be useful to include actions and outcomes in reports in the future. CS advised that there are checklist type templates that practice can use.

RL advised that the CQC seems quite arbitrary regarding what they pick up on. They suddenly started looking at high risk medications and have now started picking up on Occupational Health Services. This is subjective according to the GP Inspector. The CQC are also changing their methods of inspection.
A conversation took place and the following points were raised:

- DK advised that she thinks locality provider boards will move towards supporting GPs to be better GP providers.
- RC declared that he is a specialist adviser to the CQC before advising that additional support for practices is evolving.
- When practices are rated as requiring improvement, most practices put measures in place very fast to improve. However, the label sticks for some time.
- In ENHCCG 2 of the practices rated as requiring improvement/being in special measures now have a new provider or have undergone a merger.
- The CQC allows 6 months for a new provider to establish themselves before they re-inspect.
- The new Sollershot provider is not in Special Measures. The rating relates to the provider, not the surgery. Presumably the situation at St Nicholas Health Centre is similar.
- It is confusing for patients and better communication is needed.

**Action:** Lynda Dent take forward issue of comms re. CQC with Patient Participation Group Chairs.

MT advised that:

- He is reassured by what RC said.
- One of the surgeries rated as requiring improvement also has very happy patients who rate the surgery as excellent.
- He believes that time was wasted getting doctors to do things that were unnecessary.
- MT wondered whether GPs and pharmacists are working together and whether patient groups, surgeries and localities can be involved a little more. Health Watch could be more involved and they have good skills.

NW thought this was a good idea. Locality patient groups could communicate the issues and the improvements made. This news may be more positive than that in the newspaper.

### 6. ANNUAL CYCLE OF BUSINESS

The JCC **agreed** the Annual Cycle of Business subject to the follow amendments being made:

- STP Update to be moved to public meeting.
- The Co-Commissioning Item to be brought forward to April.

**Action:** MH to make the above changes.
### 7. PREMISES, ESTATES AND TECHNOLOGY TRANSFORMATION FUND (ETTF) UPDATE

HB introduced the paper and took it as read.

The CCG is following processes under the ETTF. There is a moving agenda regarding rules. Practices are initialising plans and working together. Some scheme from Cohort 1 have been approved centrally. The CCG is looking at a detailed work up of schemes to the time tables agreed. Capital is tight across the NHS and there is a lack of certainty as to how revenue versus capital will play out. Processes need to be water-tight and well documented to get through the approval mechanisms for each scheme.

LF expressed frustration about the need to get extra funding. Working with NHS Property Services (NHSPS), how does the CCG make sure they support us and make things happen sooner rather than later regarding logistics?

JG advised that SF is working very closely with key partners and this is being tracked through the Joint Committee Operational Group (JCOG) on a fortnightly basis.

BF advised that she had received a flurry of emails on legacy schemes recently. The schemes are very old, going back to PCT days. BF was anxious to get the schemes closed down. There are increasing issues on ongoing lease arrangement and historical legacy business issues with practices.

MT asked for clarification regarding Garden City Surgery's involvement with the Secretary of State for Health as outlined in the document. It was explained that this is in relation to the rules regarding ownership of asset by the NHS. The Department of Health needed to know about change of use.

DK declared an interest as her own practice premises plan is one of the ETTF schemes and she is also helping with the Herts and Essex Community Hospital (HEH) planning. Cohort 2 is to be delivered by March 2019. There is no time to waste. Project management resources needed to ensure that HEH will be delivered. There are issues with the building. How can we expect practices to give up their inadequate premises to move into other inadequate buildings? There is a need for reassurance that NHSPS can manage these risks. DK gave detail of some existing sewage and heating problems.

A conversation followed and the following issues were raised:
- Issues in other CCGs where service charges have been ramped up.
- There is a list of things that GPs need to understand. This includes costs (funding is not very clear), what the town wants and what the CCG wants. GPs need answers.
| • This project can be picked up at JCOG. It needs to move faster. |  |
| • There is an estates problem in all localities. |  |
| • BF advised that there is money in ETTF to deliver a physical building scheme from the premises scheme. There is not money for changing hearts and minds. |  |
| • HB highlighted the new requirement for NHSPS to run the HEH project. |  |
| • DK advised that a deep dive is needed around each locality to support localities through transformation. |  |
| • The Local Estates Forum is trying to pull this together. |  |
| • Some practices are going through rent reviews. Issues include: is this GMS space? These issues stop practices wanting a councillor on the premises or something else that is not GMS. These issues must be addressed. |  |
| • The provider board has lots of stakeholders. The CCG needs to project structure around each of them and play in outputs. The CFF is enabling money. |  |

**Action:** JG to speak to SF – to scope resources and project structure around each scheme presently, and what might be required. The next EFFT update to provide the following for each scheme:

- the money allocated to the project under the scheme and what this is for (e.g. surveyors fees)
- what is currently in place in terms of project team structure for each scheme
- what is required for each scheme for successful delivery and therefore the gap

**Action:** SF to include legacy schemes in next premises update

**Action:** JG to ensure that lease arrangements are considered in future practice mergers & procurement

---

### 8. CONTRACTS UPDATE

NI ran through the contract update.

**List Closure**

A meeting has been arranged with the Letchworth practices.

Wallace House’s list closure until 1st April was previously agreed, as was Sollershott’s. The first day of opening will be Monday 3rd April.

NW declared an interest with regards to Wallace House. JG advised that there will be workshops with staff from Wallace House to discuss findings from their diagnostic and the direction of travel. The expectation is that they will be ready to reopen their list by 3rd April.
NI advised that NHSE are getting increasing numbers of requests for list closure.

NW advised that it has taken a year to get Wallace House ready to open again.

A discussion took place about whether the experience of working with Wallace House on list closure can be used as a future case study and for estimating time scales. The following points were raised:

- Supporting Vulnerable Practices (SVP) and the GP Resilience Programme (GPRP) have not been the slickest processes, but should be better in future. NHSE have employed extra staff to support the GPRP.
- Staffing and workforce has changed at this practice.
- Wallace House should not be taken as a benchmark for the future process as, due to the above factors, the process is expected to be faster in future.

RL voiced concern that 3 practices in Letchworth applied to close their lists well before Christmas and have not had a response. They are supposed to have a decision within 3 weeks. Putting in the application means that something is seriously wrong. These 3 practices are not even mentioned in the paper. If a list closure application is refused it has a serious impact on the practice. RL hoped that the Joint Commissioning Operational Group (JCOG) will help process these quicker.

JG advised that a decision had not yet been made. RL added that traditionally when a practice applies for list closure it has been up to them to sort themselves out. This may be changing.

**GP Resilience Programme**

There are further opportunities for practices to express an interest. NHSE has asked for clarity from practices and localities. The Stanmore / St Nicholas merger has been resourced via this programme. A GP Forward View project management resource is to be recruited and should be coming on board next month or so.

**Contractual Mergers**

Stanmore and St Nicholas have not submitted a formal merger application to date. A period of variation before the merger takes place has been encouraged by the commissioner. NHSE continues to follow up and liaise with them. There are no issues to date.

Dolphin House and the Maltings are working through some issues. They are moving towards a full merger in the near future.

**Procurements**
Sollershot have had a provider appointed on an emergency basis. This is a single tender action from 1st January this year. There has been continuation of service. NHSE have regular calls with the practice.

Ware Road and Orchard procurement is now in a standstill period. NHSE will inform the CCG of the outcome.

The Spring House contract has been extended until 31 March 2018 to allow for consultation and engagement. DC ran through the timeline.

Appendix 1 shows the support package provided by LMC. LF asked who the “commissioner” in the document refers to. It was advised that this is mixed. NHSE is the lead contractor. With regards to Stanmore and St Nicholas, the CCG and NHSE approached this jointly.

9. Joint Co-Commissioning Committee Operational Group (JCOG) Terms Of Reference (TOR); Updated

JG presented the JCOG TOR and ran through comments he had received on this version. JG explained that JCOG believes it should meet fortnightly after much internal discussion. JCOG could review this in future. No objections to this were raised from members.

Responsibilities
Concerns were raised that JCOG has too great a remit – uncertainty whether GPFV sits with an operational group.

JG highlighted fact that the GP Forward View has 2 elements. The Operational part e.g. rolling out training feels like a good fit with JCOG. More strategic planning elements are perhaps not part of the group’s remit.

Membership
- It is not realistic for Governing Body Lay Members to have full JCOG Membership. They can be representatives in attendance.
- Membership is said to be too large. Some core members could be removed and given standing invites.

LF raises the lack of NHSE representation, and stated that membership is not evenly balanced. LF asked for this to be minuted. LF mentioned the plans to create a new Director of Primary Care post and suggested that they could be a member.

NI advised that NHSE has brought in a new project manager who had attended recently. At the last meeting there were 4 NHSE staff in attendance. NHSE does try to address the balance.

Action: MH to send dates of JCOG meeting to LF and everyone who has a standing invitation in the Terms of
Reference

LF asked why there is not someone from NHSE’s Nursing and Quality Team on the membership.

DC advised that he supports a core membership of 5 people to get things done. Regarding NHSE Quality Team membership, there is an Information and Risk Sharing group. DC does not want to duplicate work of this group at JCOG. DC stated there is an issue on resource: It will not be equal 1 for 1.

BF asked whether, given the amount of work the CCG has to do, there too many people attending? For example Pharmacy and Medicines Optimisation don’t need to be in the core membership. BF thinks the core group should be small and then call in expertise from both organisations when needed.

Action: JG to move some existing members from core membership to representatives in attendance.

DK questioned whether more detailed work on premises schemes e.g. Herts and Essex Hospital could be undertaken at JCOG.

Rachel Lea pointed out that the LMC has not been invited. Have patient reps or Practice Managers been invited? RL is concerned that she does not know what is going on.

JG advised that he meets with the LMC monthly. The JCOG evolved organically. Membership has grown. NI added that the strength is that this is a doing group. It does not want to be too bureaucratic.

MT advised that he would like Healthwatch or Patient Reps listed as other non-core members in section 2.4. They would like to send someone if they can to support certain items on the agenda. MT would like to see agendas.

JG agreed that the group would ensure that they invite MT and other external guests, including the LMC for relevant agenda items.

Action: HB suggested that the JCC identify items which are standing items for all agendas and the CCG agrees who is leading on them for producing reports and papers. That way other items only have to be dealt with as they arise. Eg. procurement items are ALL NHSE papers.

LF raised concerns that the attendance level for quoracy was too low

Action: JG to check with Sarah Feal re quoracy. JG to then make edits and get the TOR out within a week to bring the document to a conclusion.
The JCC agreed to approve the final document via email once JG had made changes, as per his action above.

<table>
<thead>
<tr>
<th>10.</th>
<th>GP FORWARD VIEW (GPFV) PRESENTATION</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>DB introduced the item and advised that she has been asked to coordinate the next GPFV submission.</td>
</tr>
<tr>
<td></td>
<td>A weekly working group has been set up. The CCG has shared its December submission with other CCGs and they have shared theirs with us. This process helps the CCG to look at the approach throughout our STP footprint and beyond.</td>
</tr>
<tr>
<td></td>
<td>The process will be dynamic and not end in March when the next iteration of the document is submitted. The submission should give the direction of travel. Two days of additional project officer support has been assigned to this work.</td>
</tr>
<tr>
<td></td>
<td><strong>Extended Access</strong></td>
</tr>
<tr>
<td></td>
<td>JG raised requirement to deliver extended access by April 2019. The CCG must commission this although not every GP surgery must provide it.</td>
</tr>
<tr>
<td></td>
<td>HB advised that the National Audit Office has just released “Improving Patient Access to General Practice”. It has some important key messages. One is that NHSE has not fully considered cost implications for extended access. The CCG, which is not delegated, is very concerned about the source of funding to deliver this.</td>
</tr>
<tr>
<td></td>
<td>DB talked through GPFV requirements and plans in relation to training admin and clerical staff, new online consultations and supporting transformation. DB highlighted that CCGs will be required to invest £3 non-recurrently across the next two years to support transformation of primary care.</td>
</tr>
<tr>
<td></td>
<td>Engagement with localities and member practices will be important in developing the next submission. An agreed plan is needed for implementation of change.</td>
</tr>
<tr>
<td></td>
<td>DB asked for thoughts about the practically of making this a joint plan with NHSE and delivering any area of the plan at STP level.</td>
</tr>
<tr>
<td></td>
<td>RC agreed that that feeding into STP structure is important.</td>
</tr>
<tr>
<td></td>
<td>DK advised of the need to use the results of the audit from Lower Lea Valley Locality (LLV). The audit report focuses on demand management, skill-mix, workforce, self-management and communication strategies with service users to achieve a cultural change. The report also contains good information on what to do and how to implement it at locality level.</td>
</tr>
</tbody>
</table>
NW thanked the team for the clear summary.

DK advised that there is a need to be explicit on where the £3 is coming from.

BF confirmed that the CCG will invest £1.50 per patient in 2017-18 and again in 2018-19. The expectation is that this is will be used for transformational support. This will not be part of the existing CFF £10.10 per patient and will not be amalgamated as part of the CFF.

BF highlighted that there are a whole host of things already available for patients and practices which are not linked to funding. This includes the new national process for electronic referral to hospital services ‘e-referral’. This potentially saves times for patients and professionals. This involves winning hearts and minds. BF commented that this should be reflected in the submission.

LF commented that a lot of time is spent talking about transformation and integration of care but not what the care is.

Digital roadmaps
JG advised that a digital roadmap has just been published. An item on technology could be brought back to JCC separately. A GP IT lead is being recruited.

Time for Care Programme
Alice O’Neill is scheduled to attend JCOG to bring clarity on the Time for Care Programme and Productive General Practice. She has advised that ongoing CCG support for practices will be required. BF advised that where this sits in order of prioritisation will need to be considered.

The national audit shows that 46% of practices close at some point during core hours. Some close before 3pm on some week days. This links to the capacity assessment that LLV and SVV are undertaking. This must be done across the patch. There are big pressures and expectations from the population. It is a matter clinical need versus convenience. Self-management is a key area.

Action: NW and DK asked for the following changes to the presentation:
- Extended access to be clearly defined
- Clarify the new ‘medical assistant’ role
- Consistency of language
- Clarify workflow optimisation & care navigator training
- Be explicit on the source of the £3 for primary care transformation
The JCC agreed to continue developing the plans.

<table>
<thead>
<tr>
<th>11.</th>
<th>FINANCE REPORT</th>
</tr>
</thead>
<tbody>
<tr>
<td>DC took the paper as read and opened the floor up to questions.</td>
<td></td>
</tr>
</tbody>
</table>

MT asked how the information in the audit papers is obtained. HB advised that the National Audit Office report ‘Improving patient access to general practice’ came out last week and is a public document. It can be accessed at http://tinyurl.com/kupupfu. The report asks NHSE for further clarity on what was actually required by 8 to 8 services 7 days a week.

The Lower Lea Valley Locality Local Access and Capacity Audit indicated that more than 60% of patients would be willing to a clinician other than a GP if required. It was acknowledged that local Patient Participation Groups were crucial in this work.

<table>
<thead>
<tr>
<th>12.</th>
<th>NEW RISKS GOING FORWARD</th>
</tr>
</thead>
<tbody>
<tr>
<td>No new risks were identified.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>13.</th>
<th>ANY OTHER BUSINESS</th>
</tr>
</thead>
<tbody>
<tr>
<td>None raised.</td>
<td></td>
</tr>
</tbody>
</table>

There were no questions from the public.

<table>
<thead>
<tr>
<th>14.</th>
<th>DATE OF NEXT MEETING</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thursday 20th April 2017, 10am-1.30pm, Focolare Centre for Unity, 69 Parkway, Welwyn Garden City, Room 2</td>
<td></td>
</tr>
</tbody>
</table>