NHS
North West Surrey
Clinical Commissioning Group

Agenda Item: 9
Report Number: GB153-16
Venue: NWS CCG HQ, 58 Church St, Weybridge, Surrey, KT13 8DP.
Date: Monday 28 November 2016
Meeting: North West Surrey CCG Governing Body - Part One

Title of Report	Primary Care Commissioning Committee Minutes	
Purpose of the report	This report is on the agenda for the Governing Body to note for information the minutes of the Primary Care Commissioning Committee meetings held on 23 September and 21 October 2016.	
Reason for presentation to the Governing Body	For Information	✓
	For Discussion	
	For Decision	
	Describe: For the Governing Body to be aware of work undertaken by the Primary Care Commissioning Committee, and be assured that this work is being carried out in accordance with the delegation agreement between NHS England and the CCG.	

Prepared and Presented by:	Prepared by : Ian Pocock, Governing Body Secretary & Secretariat. Presented by : Julia Dutchman-Bailey			
Relative Legislation & Source Documents:	N/A			
Freedom of Information:	Restricted		Open	✓

This report has previously been presented to the following Committee/Group/s	Clinical Executive		Quality Committee	
	Operational Leadership Team		Contracts and Finance Committee (*Now Strategic Finance Committee*)	

(please state date)	Audit and Risk Committee		Remuneration and Nominations Committee	
	Primary Care Commissioning Committee	✓		
The outcome of previous presentation/s or reviews	The minutes of the meetings held on 23 September and 21 October 2016 were approved at the October and November meetings respectively of the PCCC			

Executive Summary

- Two set of minutes are being presented for information.

Recommendations:

- The Governing Body is asked to receive the minutes, for information.

NHS
North West Surrey
Clinical Commissioning Group

Agenda Item: 3
Report Number: PCCC44-16
Venue: NWS CCG HQ, 58 Church Street, Weybridge, Surrey,
Date: 21 October 2016
Meeting: North West Surrey Primary Care Commissioning Committee (Part 1)

Unconfirmed minutes of a meeting of the Primary Care Commissioning Committee (Part 1) held on 23 September 2016 from 2.30pm

Job Title	Name	Attended / Apology
Voting Members		
Independent member of the governing body (PCCC Chair)	Julia Dutchman-Bailey	√
Independent member of the governing body (Lay Member Governance and Deputy Chair)	Paul Hopper (PH)	**A**
Chief Executive	Julia Ross (JR)	√
Director of Finance	Mark Baker (JM)	√
Independent GP from another CCG (Surrey Downs)	Dr Claire Fuller (CFu)	√
Independent GP from another CCG (Surrey Downs)	Dr Andy Sharpe (AS)	**A**
Lay/Patient Representative	Catherine Brunton-Green (CBG)	√
Chief Nurse	Clare Stone (CSt)	√
Surrey and Sussex LMC Medical Director (or deputy)	Dr Julius Parker	√
Director of Public Health (or deputy)	Ruth Hutchinson (RH)	√
NHSE Representative	Kirsty Lewis	√
Non-Voting Members		
GP representative of SASSE Locality	Dr Njaimeh Asamoah (NA)	**A**
GP representative of Thames Locality	Dr Seda Boghossian-Tighe (SB)	**A**
GP representative of Woking Locality	Dr Deborah Shiel (DS)	√
Operational Practice Manager	Liz Reynolds (LR)	**A**
Surrey Healthwatch representative	Kate Scribbins (KS)	√
Surrey County Council, Chair of Health and Wellbeing (or deputy)	Helyn Clack (HC)	√
Chair of Primary Care Commissioning Operational Group	Karen Thorburn (KT)	√
Interim Director of Strategic Commissioning	Sumona Chatterejee (SC)	√
Interim Director of Corporate Development and Assurance	Anthony Shipley (AS)	√
In Attendance		
Deputy Director of Finance	Claire Fuller (CF)	√
Head of Locality Development	Nikki Mallinder (NM)	√
Acting Associate Director of Contracts	Rachael Graham	**A**
Senior Contracts Manager	Helen Snelling (HS)	√

Governing Body Secretary	Ian Pocock (IP)	√
Governing Body and Committee Administrator	Elizabeth Ure (EU)	**A**

No.	Item	Action/ Decision
1	**Introduction and apologies**	
1.1 The chair welcomed all attendees to the meeting. She welcomed Dr Seda Boghossian-Tighe to her first meeting as a non-voting observer for Thames locality. 1.2 Apologies for absence were received from Dr Andy Sharpe, Dr Njaimeh Asamoah, Liz Reynolds, Paul Hopper and Rachael Graham. 1.3 The chair confirmed that the meeting was held in public, rather than being a public meeting.		
2	**Declarations of Conflict of Interest**	
2.1 Members of the committee confirmed that: • their entries in the register of interests were up to date, accurate and complete; • their entries in the hospitality, gifts and sponsorship register were up to date, accurate and complete; • there were no declarations of interest pertinent to items on the agenda.		
3a	**Minutes**	
3.1 The minutes of the meeting held on 22 July 2016 were approved as a correct record.		
3b	**Matters Arising/Action Log**	
3.2 Progress on the matters arising/action log was noted as follows: Item 20 Conflicts of Interest Guidance The director of corporate assurance reported that progress was progressing on implementing new conflicts of interest guidance in accordance with the project plan which had been put in place. Registers of interest were being produced for publication. A conflicts of interest guardian had also been appointed, Paul Hopper, chair of the audit and risk committee.		

Item 24 Primary Care Strategy The head of locality development reported that consultation work was on-going on the Primary Care Strategy. The strategy would be brought to the committee for consideration when the consultation had been completed. Item 25 Committee Development Information had been received on an NHS England training event on 11 October 2016 for PCCC members. This would be circulated. Item 26 Practice Payments The deputy director of finance reported that this remained an on-going issue. Further discussions with NHS England were scheduled. The item would remain rated as amber until the issue had been resolved. Item 27 Estates and Technology Fund This was an agenda item. Item 28 Primary Care Commissioning Dashboard This item had been postponed to the next meeting. Item 29 Risk Register This was now a standing item and would be closed on the risk register. Item 30 Delegated commissioning budget analysis and reports The director of finance reported that, due to pressure on the agenda, the latest budget report had been circulated to members rather than formally being included with the agenda. A workshop session on the delegated budget would be held at the next meeting. Item 31 Memorandum of Understanding with NHS England. The senior contracts manager reported that some amendments had been proposed to NHS England. This item would remain on the log.		
4	**Ashford Health Centre**	
4.1 The acting director of strategic commissioning introduced this item. She noted that the paper for the committee reviewed the outcomes and options following the consultation which had taken place on the future of the alternative personal medical services contract (APMS) at Ashford Health Centre. 4.2 The acting director noted the background to the discussion. Ashford		

Health Centre had both a walk in centre and a GP practice. The contract for the GP practice had expired and had been extended. Legally however the CCG was not now in a position to extend the contract further. The options were therefore to disperse the list or re-procure the service. The previous meeting of the PCCC had taken the decision to undertake a consultation. Following that consultation exercise the committee now needed to consider the options for the future. 4.3 The acting director noted that the demographics of the practice included both NW Surrey CCG and Hounslow CCG patients. The age profile was predominantly adult and middle aged. 4.4 The acting director summarised the action which had been taken to date. An evaluation had been undertaken to establish the availability of alternative provision in the area. Within a two mile radius seven of nine practices had capacity for additional patients to register. There were 5790 patients on the Ashford Health Centre list, and alternative capacity within a two mile radius totalled around 8000. 4.5 Consideration had also been given to commercial issues affecting the financial viability of the contract. The disadvantages of dispersing the practice list were recognised, but if a procurement exercise were to be undertaken it would not be possible to provide a like for like service. Further information would be provide later in the meeting. 4.6 The CCG had undertaken an equality impact assessment and gap analysis and confirmed that there was no adverse impact. Drug and alcohol services could be provided by other practices within NW Surrey CCG. The violent patients scheme would be separately commissioned by NHS England. 4.7 In terms of patient and stakeholder engagement and consultation, there had been extensive engagement with patients who would be affected by any dispersal of the practice list. A discrete website had been set up to help ascertain patients' views. There had been a 4% response rate. The overwhelming concerns had been about access and capacity. 4.8 It was acknowledged that the current service provided extensive access from 8.00am to 8.00pm seven days a week. The alternative services would not provide exactly the same level of access. All the alternative practices did however provide extensive hours and the walk in centre at Ashford Health Centre would continue. 4.9 The assessment which had taken place of additional capacity had taken account of additional population growth currently anticipated for the area. The CCG would continue to keep this under review in its plans for the area. 4.10 In terms of decision making, the acting director outlined the options available. One option was to carry out a procurement exercise for the service at Ashford Health Centre. However, there were issues with the financial viability of the service, and the current provider, Greenbrook, had expressed concerns that they might not be able to tender for the service under the current terms. If an open procurement were carried out, the viability would be affected by a lower payment rate. This related to the demographic of the	

practice which was largely adult with fewer frail and elderly people.

4.11 Additionally, in reaching a decision about this service there was a need to consider equity of provision across the CCG area. This would be addressed through the Primary Care Strategy that was being developed for the CCG.

4.12 The existence of capacity in other practices led to the conclusion that re-procurement was not the best course of action.

4.13 The head of locality development gave some further background to the development of the CCG's primary care strategy, and the development of the 'hub and spoke' model which would deliver more consistent access to care for patients across the CCG area. This model would be based on localities and practices coming together to deliver new models of care. Support would be provided for practices and to develop their workforces. The draft strategy was currently with practices for consultation.

4.14 The chair invited questions.

4.15 Dr Claire Fuller felt that the report represented a thorough and complete process. She asked about the impact of the proposed dispersal on the walk in centre which would remain at Ashford Health Centre. The chief executive clarified that GPs would not be present at the walk in centre, but that would bring the service into line with other equivalent services within the CCG.

4.16 Helyn Clack also commented that the process an consultation had been thorough. Her understanding was that capacity for existing patients existed in the immediate area and that patients would be able to find a local GP. Her question was similar to Dr Claire Fuller's. If a patient were to attend the nurse provided service and needed a GP, what would happen? The chief executive reported that the nurses working in walk in services were very skilled and would be able to deal with the majority of patients presenting. If a GP services were needed patients would be asked to make an appointment with their GP or contact their surgery's out of hours service if necessary. If the case were an emergency an ambulance would be called. This was in keeping with practice elsewhere in walk in centres. Dr Deborah Shiel noted this mirrored existing practice in the Woking locality.

4.17 Kate Scribbins noted that additional capacity was available for patients to register in the areas, but asked how easy it would be in practice for patients to register. The senior contracts manager reported that registration events would be held to assist patients and one to one advice would be offered if required. Patterns of dispersal would be monitored to assist individual practices if they experienced a surge in demand. The chair noted that it was helpful to hear that there would be on-going monitoring of the situation.

4.18 Kirsty Lewis, on behalf of NHS England commented that she echoed Dr Fuller's comments in terms of the process. NHS England were supportive of the recommendation to disperse the practice list. In doing so NHS England recognised the difficulty for patients in changing GPs. Unfortunately there was not an option to procure a like for like service.

4.19 Catherine Brunton-Green asked if the CCG were confident that, in the short term, patients with alcohol and drugs problems would be catered for. Ruth Hutchinson provided reassurance that from a public health perspective there was confidence that patients could be cared for by neighbouring practices. 4.20 The chair asked if there were any further comments from a quality perspective. The chief nurse confirmed that she had worked with the contracts staff as the consultation was being carried out and had been involved in the assurance of the outcome. No issues in respect of quality had been identified. 4.21 The chair of PCOG (and director of system redesign) confirmed that the decision the proposal to disperse the list was in keeping with the CCG's strategic direction. The Primary Care Strategy would further develop the offer available to patients across the CCG area. 4.22 Dr Julius Parker thanked the CCG for the nature of the consultation with neighbouring practices which had been very helpful. 4.23 Dr Claire Fuller asked about any potential unintended consequences of the dispersal, for example additional pressure on walk in or A and E services as opposed to patient attendance at the GPs. The director of system redesign confirmed that the CCG would monitor any shift in activity carefully. 4.24 The chief executive noted that it was helpful to receive feedback that the consultation process had been well managed, but that did not diminish the nature of the decision. It was appreciated that the circumstances were difficult for the patients of the practice, and it was a difficult decision for the committee. It was important to emphasise that this was not a decision about the quality of care provided at Ashford Health Centre which was as good as that of other practices in the CCG area. If the contract were not ending the CCG would not be seeking change. 4.25 The chief executive also reported that the analysis of spare capacity in other practices had been shared. One practice had felt there to be some inaccuracies so this had been reconfirmed with all of the practices in questions. 4.26 Helyn Clack asked about the GP workforce currently employed at Ashford Health Centre. It was confirmed that several had moved on to different roles within the CCG area. Whilst not necessarily a role for the PCCC the committee were reassured that the health centre were primarily resourced by locums and the change would not have a negative impact on the GP workforce in North West Surrey. 4.27 The chair confirmed that there were no other questions from members of the committee. 4.28 The chair asked the committee to consider the recommendations set out in the paper: 1) To disperse the registered patient list in line with the expiration of the contract	

2) NWS CCG to maintain and enhance links with the local authority planning department in order to ensure; a. early awareness of residential development plans; b. prompt identification of potential population growth and increasing healthcare service demand; 3) NWS CCG to work with all local practices and the Community Health Services provider to develop and enhance Primary Care services to meet the increased demands of the dispersed list population in a convenient and accessible way. On the basis of its discussion of the options, the committee agreed that its consensus view was to the dispersal of the list in accordance with recommendations 1, with one abstention by Dr Julius Parker of the Local Medical Committee. The committee also agreed to recommendations two and three. 4.29 The chair invited questions from members of the public. • A member of the public asked question of clarification about the decision. It was confirmed that the practice list would be dispersed but that the walk in centre at Ashford Health Centre would be retained with a nurse practitioner service from 8.00am to 8.00pm. • A member of the public asked what would happen if the GP of her choice was unavailable in re-registering with another practice. The senior contracts manager responded that the CCG would be running registration evens to assist patients and help resolve any problems. • A member of the public commented that the decision went against nationally stated priorities of extended hours. The NHS England representative commented that there was difficulty in that the Ashford Health Centre contract was ending, and nationally contractual arrangements were not in place to support this type of service. The chief executive additionally commented that all practices provide a level of extended hours although not 8.00am to 8.00pm. The CCG did have to consider its responsibility to the whole population, and the Primary Care Strategy which had been discussed was aiming to do that. • In a second question the member of the public asked if the accommodation currently used at Ashford could be used for future services in the area. The chief executive agreed that it would an ideal location for a locality hub in the future. • In a third question the member of the public asked if the Ashford list was disadvantaged by demographics and associated funding. The chief executive acknowledged the additional per capita payments for frail and elderly people could create financial challenges for practices who did not have these patients in their profile. She however provide reassurance that the CCG's Primary Care Strategy was aimed at ensuring good services for all groups.	Acting Director of Strategic Commissioning

The chair concluded the discussion by noting a number of written questions that had been received. The issues raised in these written questions had been addressed during the committee's discussion and the responses to questions from members of the public at the end of the discussion. The chair provided a further response to the written questions in a general statement which is reproduced at Annex A. along with the written questions.		
5.	**Risk Register**	
5.1 The senior contracts manager introduced this item, which was largely for information. As background she noted that the memorandum of understand in relation to support from NHS England was still being finalised. She highlighted difficulties with PCSE (Capita) in processing practice payments and other financial issues. The deputy director of finance confirmed that this issue would remain on the log whilst the CCG worked with NHS England to manage the transition. 5.2 The committee agreed to the closure of issue 1-004 as contractual information had now been received.		
6	**Premises Update**	
6.1 The Head of Locality Development updated the committee on the process for Estates and Technology Transformation Fund (ETTF) and Minor Improvement Grant (MIG) bids. 6.2 The ETTF bids had been reviewed on a regional basis. There was now a requirement for the CCG to prioritise and resubmit its bids during the following week. 100% funding of schemes was unlikely. It would probably be set at 66%. 6.3 In respect of MIGs, £77,000 was available to the CCG on a 'fair share' basis from the funds allocated for the region. There would be a maximum contribution of 66% to cost of works. 6.4 The head of locality drew attention to the schematic in the paper which set out the process for managing the bids An invitation had been sent to all practices. The locality manager proposed that the process for prioritising MIG bids be managed in the same way as that agreed for ETTF, through a panel consisting of LMC representatives, a lay member, a CCG director, and the deputy director of finance. The committee approved this process. 6.5 The chief executive asked about the CCG's allocation for ETTF. The head of locality development clarified that this would not be on a fair share basis, but subject to prioritisation by the NHS England regional offices. The chief executive noted that it would be difficult for the CCG to support practices with the additional 34% funding required, but it would be equally difficult for the practices. The deputy director of finance confirmed that there was no additional CCG funding, unless there were some slippage on other schemes. It was agreed that would be helpful to make representations to NHS England to see if an additional level of support could be provided.		Head of Locality Development

7.	**Primary Care Operational Group**	
7.1 The chair of PCOG introduced the confirmed minutes of the meeting which had taken place on 1 July 2016. The following points were noted: • A GPwSI accreditation process was in development and would be presented to a future meeting • The LMC was working in collaboration with the CCG in respect of a letter to practices regarding core activity. The risk register noted the potential for cost pressures. Dr Julius Parker confirmed that he would discuss the letter with the chief executive before it was sent to practices. • The ADHD children's local commissioned service had been agreed by the PCCC at its July meeting. • The CCG would be working with practices to support the workload associated with the National Diabetic Audit.		
8.	**Any other business**	
8.1 In response to a further question from a member of the public, The acting director of strategic commissioning explained that the difficulty in re-procuring the Ashford Health Centre rest in part with the difference between a General Medical Services (GMS) and Alternative Personal Medical Services Contract. She agreed to provide further explanation at the conclusion of the meeting 8.2 A further question asked if there were any appeal process in respect of the Ashford Health Centre decision. The NHS England representative explained that the only appeal process would be by judicial review. This process would examine whether the CCG process for reaching the decision had been appropriate rather than an appeal against the decision itself. 8.3 There were no items of any other business		
9.	**Date of next meeting**	
9.1 The date of the next meeting was confirmed as 21 October 2016 at 1.00pm		

Appendix A

Statement responding to all letters received (not supporting dispersal)

Ashford Health Centre's GP contract was originally drawn up in response to previous government policy to create GP led walk-in centres in every Primary Care Trust area (the organisations which preceded Clinical Commissioning Groups). The original contract was agreed for five years and was extended for a further two. Under contract law North West Surrey CCG could not extend the contract further.

Today we had two options (1) to re-procure the service or (2) disperse the GP list and support all practices in the area to offer more flexibility to patients. North West Surrey CCG has always been clear and transparent stating publically its preferred option was to disperse the service. Today, the committee has voted to not to disperse the GP list.

North West Surrey CCG will now reassess the future for GP provision at Ashford Health Centre following today's decision by the committee.

We would like to reassure every patient of Ashford Health Centre's GP service that the Walk-In centre element of the health centre will remain and continue to offer care from 8am-8pm 7 days a week. From 1st April 2017 the Walk-In centre will be managed as part of our community services contract rather than by the current provider, Greenbrook Healthcare.

Statement responding to all letters received (supporting list dispersal)

Ashford Health Centre's GP contract was originally drawn up in response to previous government policy to create GP led walk-in centres in every Primary Care Trust area (the organisations which preceded Clinical Commissioning Groups). The original contract was agreed for five years and was extended for a further two. Under contract law North West Surrey CCG could not extend the contract further.

Today the committee had two options available to them (1) to re-procure the service or (2) disperse the GP list and support local practices to develop and enhance Primary Care services to meet the need to access healthcare in a convenient and accessible way. North West Surrey CCG has always been clear and transparent stating publically its preferred option was to disperse the service. Today, the committee has voted to support that recommendation.

Firstly, we would like to reassure every patient of Ashford Health Centre's GP service that the Walk-In centre element of the health centre will remain and continue to offer care from 8am-8pm 7 days a week. From 1st April 2017 the Walk-In centre will be managed as part of our community services contract rather than by the current provider, Greenbrook Healthcare.

We acknowledge that Ashford Health Centre GP service provides a unique and highly valued service. Through the consultation we heard particularly that people value the extended opening hours. This along with the other key themes we have considered carefully today as part of our decision making process. Unfortunately, even if we were to retender the service, it is unlikely in the current climate that we would be able to secure a similar level of extended opening hours as it is unlikely that this would present a viable commercial proposition to anyone bidding to provide a new GP service.

Ashford Health Centre GP Service does cater for a number of vulnerable patients. However, our research shows that there are 14 other practices in the North West Surrey CCG area who offer enhanced services to these patients – five of these practices fall within the local area. In addition, there is support from alternative providers for violent and homeless patients within the Surrey area.

The Committee has given a clear direction that the CCG will work with practices across North West Surrey to support them offering greater flexibility to patients. Again, it's important to reiterate that the Walk-In centre element of Ashford Health Centre will remain and offer a 8am-8pm 7 day a week nurse-led service.

Statement responding to all letters received (not supporting dispersal)

Ashford Health Centre's GP contract was originally drawn up in response to previous government policy to create GP led walk-in centres in every Primary Care Trust area (the organisations which preceded Clinical Commissioning Groups). The original contract was agreed for five years and was extended for a further two. Under contract law North West Surrey CCG could not extend the contract further.

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Original letter from Suzanne Louis

I would like to know why CCG are even considering closing the GP practice when none of the other practices in the area offer the range of appoint time and days that the Health Centre GP practice does? None of the other practices offer 8-8 appointments on 7 days per week. This is a real bonus for people who work shifts etc.

Yours sincerely,

Suzanne Louis

Original letter from Studholme Medical Centre

Re: Meeting 23rd September 2016 regarding the future of the

GP Facility at Ashford Health Centre - Public Questions

In accordance with your request for questions from members of the public regarding the above matter, we are submitting the following.

1. How can the CCG justify the closure of this GP centre with its unique extended and weekend opening hours at a time when the UK Government's initiative is to promote extended opening hours at GP surgeries throughout the UK? In the short term at least, none of the other local GP practices will be able to match these opening hours and should the CCG proceed with their closure option, they will be letting down many of the current Health Centre patients. It would appear that our CCG is working in opposition to the Government's wishes.

2. During its lifetime, the GP facility at the Health Centre has developed a speciality in the treatment of patients who suffer drug and alcohol addiction problems. In the short term it is unlikely that other GP facilities in the area will be able to offer this degree of speciality. How do the CCG propose to address this problem in order not to let down this extremely vulnerable group of patients?

Thank You

From - John Anton, Pat Morrison, Susan Claxton

(Patient Participation Group - Studholme Medical Centre)

22nd August 2016

I am responding to your email dated 19th August 2016 concerning your forthcoming meeting to vote on the future of the Ashford Health Centre Practice. As a member of the public I have two questions to submit relating to this matter:

1) What is the benefit to the patients presently at the Ashford Health Centre by closing this practice?

I and another person both asked this question during the consultation meeting on the 4th August 2016 and did not receive a satisfactory answer. The other questioner stated at the time that her question had not been answered. This key point was not recorded in the email claiming to summaries key points raised during the meeting,

2) Please identify the regulation or statute involved and quote the clause or clauses which govern this action.

Your email dated 25th August states “Greenbrook Healthcare’s contract to run GP services at Ashford Health Centre began in July 2009 for five years. In 2014 the contract was extended by two years to 31 March 2017; for legal reasons we are unable to simply extend the contract further.”

Your email dated 19th August 2016 says questions must be submitted 48 hours before the meeting but as your email was sent at 13.51 on the 19th September and the meeting is at 14.00 on the 23rd of September a reasonable amount of time has not been allowed for the email to be read and for a considered response to be prepared. It would be reasonable therefore for you to accept these two questions even though they are a little late.

Kind regards,

William Reeves

NHS
North West Surrey
Clinical Commissioning Group

Agenda Item: 3
Report Number: PCCC(2)37-16
Venue: NWS CCG HQ, 58 Church Street, Weybridge, Surrey,
Date: 18 November 2016
Meeting: North West Surrey Primary Care Commissioning Committee (Part 1)

Unconfirmed minutes of a meeting of the Primary Care Commissioning Committee (Part 1) held on 21 October 2016 from 1.00pm

Job Title	Name	Attended / Apology
Voting Members		
Independent member of the governing body (PCCC Chair)	Julia Dutchman-Bailey	√
Independent member of the governing body (Deputy Chair)	Paul Hopper (PH)	√
Chief Executive	Julia Ross (JR)	√
Director of Finance	Mark Baker (MB)	√
Independent GP from another CCG (Surrey Downs)	Dr Claire Fuller (CFu)	**A**
Independent GP from another CCG (Surrey Downs)	Dr Andy Sharpe (AS)	**A**
Lay/Patient Representative	Catherine Brunton-Green (CBG)	√
Chief Nurse	Clare Stone (CSt)	**A**
Surrey and Sussex LMC Medical Director (or deputy)	Dr Julius Parker (JP)	√
Director of Public Health (or deputy)	Helen Atkinson (HA)	√
NHSE Representative	Stephen Ingram (SI)	√
Non-Voting Members		
GP representative of SASSE Locality	Dr Njaimeh Asamoah (NA)	**A**
GP representative of Thames Locality	Dr Seda Boghossian-Tighe (SB)	**A**
GP representative of Woking Locality	Dr Deborah Shiel (DS)	√
Operational Practice Manager	Liz Reynolds (LR)	√
Surrey Healthwatch representative	Kate Scribbins (KS)	**A**
Surrey County Council, Chair of Health and Wellbeing (or deputy)	Helyn Clack (HC)	√
Chair of Primary Care Commissioning Operational Group	Karen Thorburn (KT)	√
Interim Director of Strategic Commissioning	Sumona Chatterjee (SC)	√
Director of Corporate Development and Assurance	Anthony Shipley (AS)	**A**
In Attendance		
Deputy Director of Finance	Claire Fuller (CF)	**A**
Head of Locality Development	Nikki Mallinder (NM)	√
Acting Associate Director of Contracts	Rachael Graham	√
Senior Contracts Manager	Helen Snelling (HS)	√

Governing Body Secretary	Ian Pocock (IP)	√
Governing Body and Committee Administrator	Elizabeth Ure (EU)	**A**

No.	Item	Action/ Decision
1	**Introduction and apologies**	
1.1 The chair welcomed all attendees to the meeting 1.2 Apologies for absence were received as noted above.		
2	**Declarations of Conflict of Interest**	
2.1 Members of the committee confirmed that: • their entries in the register of interests were up to date, accurate and complete; • their entries in the hospitality, gifts and sponsorship register were up to date, accurate and complete; • there were no declarations of interest pertinent to items on the agenda.		
3a	**Minutes**	
3.1 The minutes of the meeting held on 23 September 2016 were approved as a correct record, with the following amendments: Page 2 para 2.1 Paul Hopper to be included in the list of apologies. Page 4 Para 4.8 *'extensive'* to read *'extended'.* Page 4 Para 4.*10 'Greenbrook were not in a position to tender for the service'* to be amended to *'had expressed concerns that they may not be able to tender for the service under the current terms'*. Page 5 Para 4.*16 'If GP services were needed patients would be asked to attend their GPs'* to be amended to *'make an appointment with their GP or contact their surgery's out of hours service if necessary'.* Page 6 Para 4.24 *'Received'* to be corrected to *'receive'* Page 6 Para 4.26 *'that there would be no shortage of roles for the GP workforce in the future'* to be amended to *'the Health Centre were primarily resourced by locums and the change would not have a negative impact on the GP workforce in North West Surrey'.*		

Annex A To delete a duplication of the first two paras on page 10.		
3b	**Action Log**	
3.1 The committee noted the position in respect of action log items as follows: Action 24 Primary Care Strategy The chair of PCOG reported that a date had yet to be set but that the Primary Care Strategy would be brought to PCCC for discussion as part of a formative process to develop the strategy. Action 26 Practice payments The committee noted the chief executive had followed up issues relating to problems with payments to practices with both NHS England and Capita. These issues were not yet fully resolved but NHS England were investigating. Action 27 Estates and Technology Fund and Minor Improvement Grants Agenda item Item 28 Primary Care Commissioning Performance and Quality Dashboard Agenda item Item 30 Delegated commissioning budget analysis and reports Agenda item Item 31 Memorandum of Understanding with NHS England The senior contracts manager reported that a six month handover meeting had been held with NHS England. Changes to the MoU had been discussed and an amended version was awaited, Item 32 Ashford Health Centre Agenda item.		
4	**Finance Report**	
4.1 The director of finance introduced this item. He explained that the first part of the agenda item would be a general workshop session to support committee members in understanding the budget for delegated commissioning. The second part of the item would be the financial report for delegated commissioning for month 6.		

a. Workshop session on the delegated commissioning budget.

4.2 The primary care finance manager gave a presentation which was circulated to members after the meeting. The following points were noted during discussion of the presentation:

Slide: Allocation

The committee noted the confirmed allocation of £39.75m, including a 1% reserve and 0.5% contingency. The contingency element was important to allow for unforeseen circumstances in the first year of responsibility for delegated commissioning.

Slide: PMS Review

The committee noted that thirteen out of fourteen practices in the CCG area had converted from Personal Medical Service(PMS) to General Medical Service(GMS) contracts. The head of locality development confirmed that funding from PMS contracts had been ring fenced for reinvestment in primary care.

Slide: Risk and Flexibilities

The committee noted that the majority of costs were driven by factors outside the CCG's control, but that major in year variations were not expected. The main risk was associated with premises costs. The management of premises by NHS Property Services was moving to a more commercial basis and this could have an impact on the CCG.

Stephen Ingram, NHS England, noted that one other issue the CCG might want to bear in mind was the uncertainty associated with practice closures and the difficulty of re-providing the service at the same cost.

Appendix A

Dr Julius Parker of the LMC noted that the Minimum Practice Income Guarantee was being phased out. This could create some stress for practices but this would be reduced by a phased change.

Slide: PMS Contract Payments

The primary care finance manager noted £36K had been freed up as a result of the PMS review. An incorrect figure had been given in the finance paper included with the agenda and an amended version would be circulated.

Slide: Alternative Personal Medical Services Contracts (APMS)

The committee noted that the only APMS contract in the CCG area related to Ashford Health Centre where the decision had been taken to disperse the list. Discussions were underway with the contract holder, Greenbrook Ltd, on arrangements for the remaining months of the contract.

Slide: Enhanced Services The committee noted that there were some problems with enhanced services payments being made to practices. These were being followed up with NHS England. *Slide: Premises* The primary care finance manager noted the requirement for a three yearly rental review. At present the CCG was attempting to clarify the position on these, and there was uncertainty about the impact. *Slide: Other Costs* The primary care finance manager agreed to clarify the identity of the GPs providing the sessions for safeguarding training. Dr Julius Parker reported that there was a national initiative to support practices with occupational health services. Stephen Ingram reported that further information was awaited on this. 4.4 The chair thanked the primary care finance manager for his helpful presentation. **b. To receive a delegated commissioning budget report** 4.3 The director of finance introduced the month 6 finance report. It was noted that the year to date variance of (139) on contract payments should be corrected to (54) and a corrected version of the paper would be circulated. The reserve for future investment in primary care services was £66K rather than £122k. This represented practices receiving increased funding and a reduced resource available for transition. Overall the bottom line of the budget remained unchanged, The updated report would be e mailed to members. 4.4 The head of locality development noted that a piece of work was also being undertaken on the GP forward view. This would be brought to either the next or subsequent meeting. 4.5 The committee noted the month 6 finance report.	**MM** **NM**
5. Ashford Health Centre Update	
5.1 The senior contracts manger introduced this item. She noted that following the decision which had been taken to disperse the practice list at Ashford Health Centre, a letter had been sent to all patients informing them of the decisions. NHS England had also been informed, along with neighbouring CCGs and other stakeholders. 5.2 Various work streams were in progress to support the dispersal of the practice list. Weekly meetings were taking place with Greenbrook Ltd to support the transition. Payments to Greenbrook for the practice list would reduce alongside the reduction in list size. The company were continuing to provide the	

walk in service. The CCG was working with Greenbrook to ensure a good level of service to all patients in the transition period. 5.3 Three meetings had been held for patients to support re-registration with other practices. Greenbrook were also assisting by displaying information in the health centre. A further letter to patients about re-registration would shortly be sent. Vulnerable patients were being identified so that they could be provided with particular support. The practice list to disperse had originally been 5800 patients and had now reduced to 5,500 so 300 patients had re-registered. 5.4 The committee discussed the process for dispersing the list, recognising that a good process had been put in place. The committee noted that a significant number of patients still had to re-register before the end of March. Priority would be given to ensuring the continuity of arrangements for vulnerable patients. The nature of the list, with significant numbers of people of working age who did not attend their GP frequently, was one challenge. Staff members reassured the committee that they would be working hard to avoid a large number of patients still outstanding to re-register at the end of March 2017. It was agreed that the committee would receive monthly updates and the action plan for the list dispersal would be brought to the next meeting. In the monitoring information the total number of patients and the number of vulnerable patients would be identified. 5.5 The senior contracts manager explained to the committee that NHS England had, in similar circumstances, offered an advance payment to practices to support increased list size if in excess of 1000 new patients registered. The committee agreed that this approach was appropriate to support the dispersal of the Ashford Health Centre list. 5.6 The acting associate director of contracts also outlined that would be helpful to consider how the remainder of the period of the contract with Greenbrook Ltd was managed. A proposal would be brought to the next meeting.		**MM** **RG**
6	**Procedure for Accreditation of GPs with Special Interest (GPwSI)**	
6.1 The chair of PCOG introduced this item, presenting the paper on behalf of PCOG. The development of the procedure had been through a number of iterations and had been developed to align with good practice and be as simple and straightforward as possible. It was important to have the procedure to support assessment by the Care Quality Commission. The procedure included the NICE improvement guide and had been approved on behalf of the LMC by Dr Richard Brown. 6.2 The chief executive asked if it were clear that appropriate representatives could be identified for the panels to support the process. The LMC offered to support with the identification of representatives from outside the area. 6.3 The committee noted that a question on funding had to be resolved as the process had for a time been provided by the deanery. 6.4 The committee approved the process.		**JP** **KT**

7.	**Risk Register and Issues Log**	
7.1 The head of locality development introduced this item. 7.2 In respect of risks, she noted risk GP10 which identified a risk relating to the re-provision of the contract for violent patients at Ashford Health Centre. There was however now a possibility that a new provider would be identified close to the current location. The second risk related to the possibility that primary care providers could cease activity over and above the requirements of the core contract. The rating of this risk had been reduced following previous discussion at the committee. 7.3 In respect of the issues log, it was noted that the dispersal of the Ashford Health Centre list would be added. Issue I-004(Lack of contractual information) had been closed and would be removed. It was confirmed that issue I-003 could also be closed as the financial information to support the CCG's delegated commissioning responsibilities had been received. 7.4 In respect of issues I-001 and I-002 (Challenges in GP recruitment and lack of local skill set in primary care) the chief executive asked if these could be quantified to provide definition of the problem that the committee could consider. The senior contracts manager would review this item. 7.5 The committee discussed the issues outlined in I-008, problems with payments not being made to practices by Primary Care Support England (PCSE). The committee noted that this was a serious concern. It was a national issue and Dr Julius Parker of the LMC noted that concerns were being escalated via both the General Practice Committee and NHS England. Practice managers were being asked to provide the LMC with weekly updates which were being relayed to NHS England. The problems did link to arrangements to manage the dispersal of the practice list at Ashford Health Centre and it was important that services were available to support that process. 7.6 The senior contracts manager reported that a named contact at PCSE would support the Ashford process. The acting associate director of contracts noted that mitigating actions would be identified in the action plan. 7.7 The committee noted the position that assurance could not currently be provided but that these issues were being addressed nationally.		
8.	**Performance and Quality Dashboard for Primary Care**	
This item was considered in Part 2 of the meeting.		
9.	**Premises Update**	
This item was also considered in Part 2 of the meeting		
10.	**Primary Care Operational Management Group**	
10.1 The chair of PCOG asked the committee to note the confirmed PCOG minutes of the meeting held on 2 September 2016. 10.2 Paragraph 9 of the minutes highlighted issues for PCCC consideration.		

Membership of the Locally Commissioned Service review panel had been considered at the previous meeting of PCCC along with panel members for the minor improvement grant process. The cellulitis pathway would be brought to PCCC when finalised.		
11.	**Any other business**	
11.1 There were no items of any other business.		
11.	**Date of next meeting**	
9.1 The date of the next meeting was confirmed as Friday 18 November 2016 at 1.00pm.		