NHS
Tameside and Glossop
Clinical Commissioning Group

GOVERNING BODY MEETING

Title of Subject:	Ratified Minutes of the Primary Care Committee – MAY 2020 (**Part A**)
Date of paper:	8 June 2020
Prepared By:	Catherine Cane
History of paper:	Primary Care Committee – 6 May 2020 – ratified at 3 June 2020 meeting
Executive Summary:	To inform Governing Body members of the discussions held at the Primary Care Committee, Part A, meeting.
Recommendations required of the Governing Body **(for Discussion and Decision)**	To note the contents of the ratified minutes
QIPP principles addressed by proposal:	All
Has this been reviewed in line with the Governing Body Assurance Framework	Yes
Direct questions to:	Carol Prowse

PRIMARY CARE COMMITTEE
PART A – MINUTES

Wednesday 6 May 2020
Held virtually via email

Comments received from

Members:	Carol Prowse (Chair)	CCG Lay Member for Commissioning
	Asad Ali	GP and CCG Governing Body Co-Chair
	David Swift	CCG Lay Member for Audit and Governance
	Jessica Williams	CCG Director of Commissioning
	Kate Hebden	GP and CCG GB Member for Primary Care
	Liz Sabel	Finance (representing CCG Deputy Director of Finance)
Non-voting Members:	Alan Dow	GP and LMC Secretary
	Amir Hannan	LMC Chair
	James Mallion	Consultant in Population Health
	Janna Rigby	CCG Head of Urgent Care/Primary Care Workforce Development
	Martin Ashton	Associate Director for Commissioning – Living Well
	Peter Denton	Healthwatch
	Tori O'Hare	CCG Head of Primary Care

1. **Declarations of Interest**

The following reported declaration of interest, made over and above those already formally notified to the CCG, was **noted.**

Name	Position Held	Declared Interest		
		Type of Interest	Nature of the Interest	Action to Mitigate Risk
Kate Hebden	GP and Governing Body Member: Primary Care	Direct Financial Professional	For items 5, 6 and 7. Practice provides one of the hubs for 24hr ECGs.	Comments reviewed and accepted.

2. **Minutes of the previous meeting/Matters Arising/Action Log**

The minutes of the meeting held on 1 April 2020 were approved as a correct record; subject to noting the feedback to Pandemic Resilience Management Group (PRMG) and by AD regarding the inclusion of the LMC in PRMG had been reflected with a change to the PRMG membership with the inclusion of both a LMC rep and a PCN rep. (Item 11)

All outstanding matters and actions arising, as highlighted in the action log, were reviewed, commented upon and the log updated accordingly.

3. **One Equality Scheme Review 2020**

Committee received a report which focussed on the One Equality Scheme (2018-22); the joint organisational scheme for Tameside & Glossop Strategic Commission. The report provided an update on the annual review for 2020 which had been informed by practical examples and related projects from the past 12 months. The report further provided an update on key equality and diversity related projects that the Strategic Commission had

delivered or been part of. These supported our commitment to delivering on our equality objectives and ensuring we adhered to the requirements set out in the Public Sector Equality Duty.

CP noted the good work undertaken and enquired as to whether there was an equivalent scheme in Glossop. AD commented that it was a commendable set of CCG and TMBC achievements but also enquired as whether colleagues knew how Derbyshire County Council compared regarding its High Peak Residents.

DS commented that the data in the appendix showed clearly that we lag behind the rest of England average in most indicators.

MA commented that it was a very detailed report, although it was not clear how the work outlined in appendix A had been informed by the needs of the population.

JR also commented that it was a very comprehensive and detailed report; the level and range of examples where the integrated approach was demonstrating benefits was brilliant. It would be good to be able to show how the work that was happening in neighbourhoods and networks was making a difference to people's health and care, with focus on specific groups including care home residents, work to reduce social isolation, homeless access to primary care, military veterans covenant etc.

TOH mentioned there was a need to give consideration of how colleagues bring general practice through the document further with specific consideration of the role of PCNs, and how best to utilise PEN further.

JM commented that Population Health were very supportive of the document. It was vital that colleagues continued to improve our approach to engagement and co-production and ensure equitable approaches in all our work. Noted that there were several population health pieces of engagement and wider work included in the case studies and they would continue to feed into this across the teams with further examples.

PD suggested that a review of our locality's Information Standard achievement be formally included in future year's reports.

AH commented that the case studies did not seem to include examples for the Asian community and the work being done there to support some of the most deprived population and how we are meeting their needs. He noted that the links to the Equality Impact Assessments are not live and was unable to see what evidences there were and how people had been included in those assessments.

Committee **noted** the content of the report.

4. **Hospital Home Visiting Service**

Committee received a paper which reported on the Hospital at Home service which had been developed to provide the appropriate levels of additional medical support to patients in their own home (including care homes).

The Covid-19 pandemic placed high levels of strain on Health and Social Care services in Tameside and Glossop. Some patients who would normally be directly admitted to hospital may need to be managed differently based on their assessed needs and preferences in the community. It was noted that there was no Provider in place to deliver the assessment and care that was required. The Hospital at Home service was therefore developed and delivered utilising an additional cohort of GPs and provided the appropriate levels of additional medical support to those patients either in their own home or in care homes.

CP mentioned that it was an impressive new system and process, although she was unsure how it impacted on end of life patients when they lived alone. Would this still be required when the Acute Trust had considerable capacity available?

DS commented that, in terms of the award of temporary contract, the Primary Care Committee step could have been accommodated by seeking Chair's action and confirmed in retrospect. He was unsure whether the SCB had the authority, although the PCC Chair was a member of SCB. He mentioned that colleagues would need to go for single tender waiver via Audit Committee.

Action: MA to seek tender waiver via Audit Committee.

DS was also unsure of the effective utilisation of the service. If the CCG is only paying for what it uses (i.e. 5 a day) then utilisation was cost-effective, but if it is paying for 20 a day and using 5, then utilisation was less effective, and if demand stays low then a contract variation may be warranted.

AA commented that the process was being carefully reviewed to ensure it remained fit for purpose. A number of options remained available to the CCG at this point.

Both JW and JR commented that since introducing the service, it had become apparent that the level of demand was below where originally predicted. Discussions would need to continue regarding how best to utilise the service going forward. It would, however, be interesting to see the positive impact of this provision on the outcomes for the individuals who had been managed through this service, to identify any learning.

KH commented it had become apparent in the early stages of the Hospital at Home service that there was the potential for uncertainty around the role of the patients' GP in the processes.

Further discussions were ongoing as to how the service might adapt to support primary care in the best way possible whilst enabling the patient's own GP to be central to the assessment and decision making re admission part of the pathway.

JM was supportive of the service but requested colleagues to consider the possibility of potential further waves of COVID spread and the requirement for this service to remain in place beyond its initial 3 month period.

TOH enquired, for future plans, as to what was the future requirement/role for this pathway to sit alongside PCN Network specification of Enhanced Health in Care Homes.

PD commented that the insight they were receiving from the local population suggested that they were unsure about how PPE and social distancing were supposed to be implemented by services. They felt anxious in terms of infection risk because they did not know what to expect. It would be helpful if there was some easily accessible (and ideally more than just online) information that could be given to patients using this service – to put their minds at rest and help them understand infection control measures that were in place.

AD commented that we have developed a very integrated health and care system over the last few years; that the infrastructure and organisations were already here and working together had permitted notable "best in country" services to be scaled up and new services deployed. SCB has had opportunity to make super decisions from which all our patients and residents are benefiting.

Committee **noted** the report and that the award of the temporary contract had gone to *gtd Healthcare*.

5. **24HR ECG Suspension**

Committee received a paper requesting them to consider the temporary suspension of the hub based 24hr ECG. The area of the service in focus was the neighbourhood based 24 hour ECG service including provision of ECG machines and remote interpretation of all ECGs. It was noted that Tameside and Glossop CCG commissioned Broomwell Healthwatch TeleMedical Monitoring Services Ltd to deliver the community cardiology diagnostic services.

Broomwell had notified the CCG on 16 March that one of the hubs could not take any more referrals due to COVID 19. Following that notification another practice had also contacted Broomwell to say they were cancelling all ambulatory ECG appointments and were doing urgent work only.

The CCG Co-Chairs and Long Term Conditions Clinical Leads therefore took the decision that the service should be suspended. A communication was sent to all practices to inform them of the change in service. Due to the suspension of the 24hr ECG service consideration was required as to whether the CCG kept the service suspended or look at other options.

CP commented that she felt that this was a vital service and should not be suspended. It should have equal access for all not just based in large practices.

DS sought assurances that, since the Contractor initiated the first suspension, that the CCG was not paying them whilst the situation persists.

Action: MO to clarify the position as regards on-going costs to the contractor.

KH commented that clinically she felt the service should be restarted, and suggested that practices previously providing one of the 'hubs' should be approached to see if they were happy to offer this once again. The decision to refer into the service would be made by a clinician after assessing the patient with due consideration as to the benefits vs risks associated with it. KH requested that a comms be sent to practices stressing this.

Action: Communication to be sent to practices regarding the provision of the service to enable it to be restarted.

LS commented that to suspend and review on a monthly basis could mean additional pressure on secondary care at a time when they were already stretched. She would, therefore, prefer Option 2 in that the CCG, along with Broomwell, organise a re-balance of the service so that it was based in individual surgeries, rather than it being dependant on 'hubs' who no longer wish to accept referred patients; as long as this would not cause pressures to the practice and is financially viable.

JM felt that options to continue a reduced level of service may be preferable to pausing this service completely. Lack of detail in the paper to consider the implications / costs etc. and options of an amended service as per Option 2. Also unclear of the rationale and reason for practices to be suspending this service altogether. RCGP guidance does specify 'routine annual ECG' as an activity that should be deprioritised and stopped during COVID, however there may be cases where ECG was clinically indicated which may be appropriate to go ahead.

JR commented that whilst a temporary suspension of the service may seem the most straightforward option, it was not clear in the report how many patients would normally access the service and the medical impacts of not having this access available. Taking this in balance, it would be good to understand the views of the clinical members of PCC and if

safe to do so, approve a temporary, short term suspension, with a review of the decision to take place in line with the wider discussions for incremental opening of non-urgent, non-covid (BAU) type services.

TOH acknowledged that she could not comment clinically; but in the context of general practice being open as usual and the national patient comms encouraging people to continue to access their practice if they have health concerns – there must still be some need for this service and therefore struggled to agree either option presented but would recommend it needed to be available but on a PCN basis to ensure availability for 100% of the population – not just large practices.

PD commented that, for the avoidance of doubt, Broomwell Healthwatch Tele-Medical Monitoring Services Ltd. was in no-way part of the National Healthwatch programme which was established by the Health and Care Act 2012. He felt it unfortunate that they were using the Healthwatch Trademarked name in their business name.

From a patient care perspective, PD requested that the Committee be mindful of the potential negative impact on someone's health if they were not able to access an ECG in a timely manner. Healthwatch trusted that the commissioner was mindful of this and had appropriate measures in place for patients who had an urgent need for an ECG.

AD felt that a blanket suspension of provision was a mistake: Covid was going to be here for a long long time and lockdown was a population response and not applicable to a lot of individual people with certain clinical conditions and presentations. They will always need to be, assessed on a case by case basis and making access to diagnostics/monitoring difficult would inevitably lead to harm.

AD further felt that there was no justification provided for the assertion in option 2 that this should be provided by larger practices "based in individual [especially, larger] surgeries"; especially noting that it was one of our largest surgeries that suspended provision. Provision should be reopened ASAP sticking to the AWP/AQP format for sites without favouring on the basis of practice size.

Committee **proposed** that this be delegated to PCDIG for action, noting the feedback at PCC and the importance of provision, and equity of provision for the population.

6. **Primary Care Commissioned Services – Funding Arrangements**

NHS England produced regular update letters regarding the emerging COVID-19 situation, the letter of 17 March included details of the freeing up of capacity and also financial stability for NHS providers.

Committee, therefore, received a paper which set out the detail of that in relation to general practice and outlined recommendations for the approach for a range of services commissioned from general practices for 2020/21.

DS commented that colleagues needed to ensure that the Investment and Impact Fund was not used to support any aspects of Covid-19 costs which have been turned down by CCG panel.

For Section 3.7 – KH had difficulty supporting this assumption. There was no national guidance on what this money should be spent on. There was, however, some early clear guidance that Covid related spend would be reimbursed by the CCG. Our Covid claims procedure proposed did not include any requirement for practices to have approached the PCN for funding first line.

AD commented that he felt it worth noting that in many areas LCS income had been preserved for practices. In discussion with DH/NHSE the GPC/BMA have not met with no resistance from NHSE that the preservation of LCS income for practices should follow the same model as QOF during this pandemic. He thought this had already been agreed (17 March was a long, long, time ago but even back then the NHS set out its intention that "The key principle is that from 1 April we free up practices to prioritise workload according to what is necessary to prepare for and manage the outbreak, and therefore guarantee that income will be protected if other routine contracted work has to be substituted" and "…ensuring that all GP practices in 2020/21 continue to be paid at rates that assume they would have continued to perform at the same levels from the beginning of the outbreak as they had done previously, including for the purposes of QOF, DES and LES payments') - but it may yet have to work its way towards individual CCGs and Finance arrangements. Destabilising practice income, because of the changing workflow of the pandemic, would clearly be ill advised and we should see our local CCG as a GM exemplar of investing in the frontline of general practice and not only hospital provision. Up front "stabilisation" payments take away worry and distraction and are vitally important.

Committee therefore:

1. **Noted** the funding arrangements agreed nationally in relation to QOF;
2. **Supported** the progression of PCN Network Contract DES delivery, including the Additional Roles Reimbursement Scheme and **noted** the changes to the Investment and Impact Fund announced for 2020/21;
3. **Supported** the flexibility for practices in relation to Extended Hours DES delivery; and
4. **Supported** the recommendation of ringfencing of Minor Surgery DES budget noting the expectation of delay in activity but pending a potential catch up surge later in the year.

7. **LCS Payments – 2020/21 Proposal**

Committee received an update, further to the paper presented in February 2020, on proposed developments to the LCS framework from 2020/21.

During the challenging and unprecedented times and recognising the intense pressure that general practice was under as the COVID 19 pandemic increased, the paper sought to clarify the expectations and payments mechanism for General Practice in the delivery of the 2020/21 Locally Commissioned Services.

CP commented that she supported the proposal but noted no payments for the very poor and disappointing LD results. Too far off the target which was not good.

DS commented that it seemed inconsistent to make a payment at PCN level and one at Practice level; if any practice had hit their 80% for LD he felt the CCG should consider paying them. He approved payments being made based on 1 April 2020 list size, but as regards Para 4.2, it was still difficult to reconcile our aims and priorities as a CCG with a proposal which only applied to 4 neighbourhoods. He suggested suspending this scheme until the CCG could work something out with DCC to cover all five neighbourhoods.

KH approved payments for the SMI element and agreed no payments in relation to the LD element. However, she would like to take the opportunity to thank those practices and PCNs that did make a significant increase in their delivery of LD checks compared with previous years and I hoped that this could be carried forward this year.

KH further approved payment on list size; however when considering payment per patient on GSF register she sought some assurance that the data extraction proposed was the same as that used previously to calculate the numbers and that the codes being pulled out of the clinical system had not differed.

KH was concerned that only paying activity based claims later in the year would have 2 unintended consequences:

1) It may consciously or unconsciously affect clinical decision making; where patients are then brought into practices for elective procedures e.g. NHS health checks, potentially putting either themselves or the clinicians or both at risk of contracting Covid-19. NHSE in its guidance had been extremely clear that LCS funding should be protected to prevent this from occurring.

2) Practices who chose not to expose their patients to this risk were put at increased financial risk where they were unable to 'catch up' this activity later in the year – either due to lack of additional staff time or estate capacity. Taking into account that practices were already reporting gaps in workforce and lack of clinical space this is highly likely.

   This is complex but the safety of patients and our mantra to "first do no harm" must come first. It may require a compromise position, perhaps meeting practices half way in terms of funding providing they commit to trying to do their best in terms of catch up activity. I would urge the Chair to recommend that a firm CCG position on this be deferred until such a time when PCC is able to 'meet' virtually and discuss in full. I would be happy to work with the Head of Primary Care and the LMC to put forward a number of different positions for discussion.

JW approved the payments for SMI and agreed no payments should be made for LD due to no PCN achieving the 80% target even when last 3 weeks of March being taken into account.

JM commented that Public Health bundle budgets would remain ring-fenced and that he was supportive of a further review of the position in September.

PD commented that Healthwatch valued the emphasis given to SMI, these were challenging times in terms of mental health and this group of patients would almost certainly require support. Healthwatch understood the reasons behind suspending the LD element.

AH commented that 80% seemed a very high figure to attain and needed to understand why this was so low and whether colleagues needed to look at what was achieved and see if it could be reviewed for LD assessments. Either that or a lot more work needed to be done to change the way this was done as it appeared the current processes were not working.

AD requested that in noting his comments to item 6 above the decision was made to invest this sum of money in general practice (in the expectation of improved attainment). The increased performance could not happen because of Covid-19; however that money should remain committed to supporting practices, in other ways.
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AD further commented that the Extended Hours DES arrangements are appreciated and sensible as are upfront payments honouring the intention and expectation as when the bundles were created.

Committee:

1. In relation to the MH bundle for 2019/20, **approved** the payments proposed for the SMI element and **agreed** no payments were due in relation to the LD element.
2. In relation to weighted list size based payments for 2020/21, **approved** the payments be made to practices, based on 1 April 2020 list size, as set out in the bundle specifications.
3. In relation to activity based claims, **supported** the ringfencing of budget at this time acknowledging an expectation of delayed activity and the review of the position in relation to funding to practices will be brought back for further discussion at the June meeting.

Action: Update to be provided at next meeting.

8. Primary Care Quality Reporting

Committee received an update on primary care quality reporting in light of the rapid changes to delivery of general practice that had been put in place as a response to COVID-19 and the process established to support practices in the safe delivery of health care and safeguarding patient safety, outcomes and experience.

The primary care general practice response to COVID-19 had been to rapidly implement new models of care including the remote triaging of all patients, using remote consultations where possible, safely separate cohorts of patients – patients with symptoms of COVID-19; shielded patients and the wider population – and converting to electronic prescribing. In addition, contractual changes had taken place enabling practices not to have to undertake activities which were previously a contractual requirement.

The CCG needed to be sure that it could protect patients and general practice providers while learning from any negative experiences patients had; to enable learning to be shared across the system. To be able to do this, while the focus of primary care was still on the response to COVID-19 and share that learning while it had the value of being able to inform the delivery of care during the current situation, colleagues had put in a place a data capture system for quality.

CP felt that the report did not provide a comprehensive overview. It followed national guidelines but potentially to the detriment of patients. She was concerned over suspending aspects of normal service e.g. over 75 health reviews, new patient assessments but appreciated that the demand on practices needed to be managed with the need to get back to normal services asap to avoid indirect health issues. There was no guidance to what the forms were and how rigorous they would be and requested a further report.

Action: CM to provide further guidance on the data capturing forms.

AD supported the process but requested sight of the query forms for clarity.

JR commented that the process was clear and simple and whilst it had been put in place in response to the pandemic situation we were working in, it may be worth considering the relative merits of continuing with this going forward, for consistency, clarity and resilience within the primary care team to respond.

PD supported the need for continued quality monitoring and recognised the need for systems and processes to change. In addition to the process outlined in the paper it should be noted that Healthwatch was continuing to collect insight from our local population and sharing this with commissioners and providers through existing channels.

Committee **noted** and **approved** the process put in place for primary care quality reporting, noting the request for further guidance on the data capturing forms.

9. COVID-19 Spend Claims Process

Committee received a paper requesting consideration and agreement of the approval and governance of expenses submitted by practices as a direct result of Covid19.

As part of the work in response to the National Pandemic, the government shared a document on - Next Steps on NHS response to COVID-19 which included additional measures to seek to reduce the spread across the country. The guidance document

recognised the intense pressure the NHS was under and would continue to be as this outbreak peaks and sets out important actions asked of every part of the NHS.

To support our practices an email was sent to all Practice Managers on asking, where additional costs had been incurred by the practice in relation to COVID-19, they complete a table giving details of the expenses incurred and also submitting a corresponding invoice. Practices were incurring extra staff costs due to staff isolating, additional PPE, marquees to ensure additional space at a safe distance along with other items to facilitate working in different ways.

DS requested the CCG explicitly uses its delegated authority, so the financial ceiling was that of the most senior person signing the invoice. If it looked as if the sign-off limits would be a constraint, then a proposal for a temporary increase in an individual's delegated limit could be agreed by email by Audit Committee.

DS suggested that at para. 2.6, it may need to specify that KH will not be involved in agreeing payment for her practice and prudently not for her PCN either. The flexibilities mentioned of using The Co-Chairs in lieu may alleviate this. He felt that GP colleagues could feature as 'technical support' in the process, but invoice authorisation would be via the Officers.

DS further suggested adding explicitly that the CCG only pays on original invoices. Para 2.3 raises a point which requires 'consideration' in that locum rates are coming in 'far in excess' of the stipulated rates. He was unsure who makes that decision, but thought there needed to be flexibility, given the economic rules of supply and demand.

JR, having been part of the discussions as part of the Task and Finish Group, supported the principles for considering each claim. The value for claiming was arbitrarily set at £500 and under for automatic approval and over £500 to be given further scrutiny. She suggested that this is reviewed as claims are submitted to ensure this was an appropriate level to work from, alongside national guidance and advice.

Committee **noted** and **agreed** the approach suggested for approval of claims, advising of any financial ceiling or limits to be taken in to consideration.

10. GP Contract Change – May Bank Holidays

At its April meeting Committee received an initial paper on the NHS England changes to the GP Contract in relation to 2020 April and May Bank Holidays. NHS England agreed a change to the GP Contract in relation to the two Easter Bank Holidays to be treated as ordinary working days and provision for the same to be applied for the May Bank Holidays.

Committee received a further paper confirming that the contract change had been enacted for the early May (Friday 8 May) Bank Holiday and noted the local approach to secure provision across T&G, balancing demand on services with the need to ensure support to the workforce,

AA wanted to thank GP practices for giving up their bank holidays.

JR was supportive of providing as much notice as possible for general practices for the conversion of what would normally be non-working days in terms of staffing, and for communicating these decisions to other primary care services including PCAS.

Committee **supported** the same process be applied for Monday 25 May, as with Friday 8 May, if it was also re-categorised as a normal working day by NHS England.

11. Pandemic Resilience Management Group (PRMG) – Terms of Reference Update

An initial briefing paper on the introduction of a Pandemic Resilience Management Group to support Primary Care during the Covid 19 pandemic was presented to Primary Care Committee in April 2020. A further paper was therefore provided to Committee with a small update to the Terms of Reference of that group.

PD commented that he supported the additions to the membership and valued the addition of the LMC. Healthwatch Tameside was keen to support the work of this group should they feel it helpful.

Committee **noted** the changes that had been made to the Terms of Reference; ensuring total system general practice engagement to that group for the continued resilience and consistency through a cohesive and flexible response.

12. Finance Report

Committee received, for information, the financial position for Month 12 (M12) of 2019/20 for the Primary Care, Delegated Commissioning and CCG allocation, as at the end of March 2020. The report showed an increase in the forecast underspend estimated for the year, of £674k (£498k on Delegated services, £175k on Locally Commissioned Schemes); a movement of £39k compared to the position reported at Month 11.

DS thanked colleagues for the good level of detail in the explanations provided.

TOH reiterated the recommendation, to show wider context of total CCG position, to be incorporated in the finance report for 2020/21.

AD requested colleagues to remember that a £674k underspend (£498k on Delegated services, £175k on Locally Commissioned Schemes) was an even bigger cost accrued elsewhere in our single system.

Committee **noted** the report.

13. Date and time of next meeting: set for Wednesday 3 June 2020.