NHS
Newcastle Gateshead
Clinical Commissioning Group

Primary Care Commissioning Committee

Tuesday 28 November 2017, 5.15 pm – 5.45 pm
in the Pandon Room, Newcastle Civic Centre, NE1 8QH

Agenda

N°	Timing	Item	Papers	Presenter
1	5.15	Welcome and Apologies for Absence	-	Chair
2		Confirmation of Quoracy	-	Chair
3		Declarations of Interest	Enc	Chair
4		Minutes of the Primary Care Commissioning Committee meeting held on 31 October 2017	Enc	Chair
5		Action Log	Enc	Chair
6	5.25	The Impact of Integrated Multi-Morbidity Clinics in General Practice – Qualitative Outcomes	Enc	Sam Hood
7	5.40	Any Other Business	-	All

Date and time of next meeting:
Tuesday 19 December 2017, Riverside House

Declarations of Interest Register 2017/18

Declaration of Interest Register

Newcastle Gateshead Clinical Commissioning Group

					Type of Interest					Date of Interest			Committees						
Surname	**Forename**	**Current Position(s) in CCG**	**DOI/Status**	**Declared interest- (name of organisation and nature of business)**	**Financial Interest**	**Non-Financial Professional Interest**	**Non-Financial Personal Interest**	**Is the interest direct or indirect?**	**Nature of Interest**	**From**	**To**	**Action Taken**	**Governing Body**	**QSR**	**Audit Committee**	**Primary Care Commissioni**	**Remuneration**	**Exec Committee**	**Staff**
Coppin (Taylor)	Mandy	Lay Member	Self	StreetwiseYoung People Project, received funding from Newcastle LA and CCG towards counselling support work with young people 13-25 years x 12 month contract.	Yes			direct	CEO		Ongoing	Will be declared at meetings as necessary	Y			Y	Y		
Corrigan	Joe	Chief Finance Officer		Sibling is GP whose practice is a member of Cumbria Commissioning Group	No							Will declare in meetings where relevant	Y		Y	Y		Y	Y
Costello	John	Gateshead HWB representative on Primary Care Commissioning Committee	self	Gateshead Council	Yes			direct	Senior Officer		ongoing	Will declare if needed at meetings				Y			
			spouse	NHS England			Yes	indirect	employee		ongoing	Will declare if needed at meetings				Y			
Cunliffe	Bill	Secondary Care Clinician	Self	Care Quality Commissioner	Nil				Member of CQC Inspection Team	2013	to present		Y	Y	Y	Y		Y	
Edusei	Steph	Healthwatch representative on Primary Care Commissioning Committee	self	Healthwatch - Newcastle	Yes				CEO		on going	Will be declared at meetings as necessary				Y			
Hurst	Jeff	Lay Member and Deputy Chair	Self	Newcastle YMCA. The YMCA hold public health funding for anti-obesity programme.	yes			direct	chief Executive Officer		on-going	will declare at meetings if necessary	Y		Y	Y	Y		
				Personal friend with Dr D Howarth and family, Senior Partner, Denton Turret Medical Group. Friendship started 10 years ago.	No	no	yes	indirect	Close Personal friendship dating back 10 years.		On-going	will declare at meetings if necessary	Y		Y	Y	Y		
Kirk	Stephen	Clinical Director						direct	Partner in Practice in CBC		on-going					Y		Y	Y
McGrath	Jill	Head of Finance	Spouse	NTW NHS FT				Indirect	Emergency Care Assistant	Pre-dates CCG	Ongoing	No conflict			Y	Y			Y
Milne	Eugene	Newcastle Wellbeing for Life Board representative on Joint Commissioning	Self	National Institute for Health and Care Excellence	Sessional payment	Yes			Vice Chair Technology Appraisal Committee	2006	Present	No conflict	Y			Y			
			Self	Tyne & Wear Sport Board - Trustee		Yes			Trustee Board member	2015	Present	Will declare at meetings as required	Y			Y			
			Self	Association of Directors of Public Health - Board Member and Honorary Treasurer	Yes	Yes	No		Sessional payments	2006	Present	Unlikely to be a conflict - will declare as necessary	Y			Y			
			Self	Durham University	No	Yes	No		Academic honorary status	2009	Present	Unlikely to be a conflict - will declare as necessary	Y			Y			
			Self	Newcastle University	No	Yes	No		Academic honorary status (and Vice-Chair of FUSE strategy board)	1999	Present	Unlikely to be a conflict - will declare as necessary	Y			Y			

Declarations of Interest Register 2017/18

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			Self	National Institute for Health Research	No	Yes	No		Programme Advisory Board Member	2014	Present	No conflict	Y			Y			
			Self	Journal of Public Health	No	Yes	No		Joint Editor - Unpaid - Faculty of Public Health	2013	Present	No conflict	Y			Y			
			Wife	Queen Elizabeth Hospital Gateshead / City Hospitals Sunderland				Indirect	Consultant Histopathologist	1997	Present	Will declare at meetings as required	Y			Y			
Morris	Neil	Medical Director		Gateshead CBC	Paid employme nt			Direct	GP Deputy		Ongoing	Declared at relevant CCG meetings	Y	Y		Y		Y	Y
Mulholland	Jane	Director of Operations and Delivery	None										Y	Y		Y		Y	Y
06-Apr-17																			

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D R A F T

Minutes of a meeting of the Primary Care Commissioning Committee held on Tuesday 31 October 2017 at Riverside House

Present:

Members:

Mr Jeff Hurst	Lay Member (Chair)	JH
Ms Mandy Coppin	Lay Member	MC
Dr Bill Cunliffe	Secondary Care Clinician	BC
Dr Steve Kirk	GP Clinical Director	SK
Ms Jill McGrath	Head of Finance	JMc
Dr Neil Morris	Medical Director	NM
Ms Jane Mulholland	Director of Operations and Delivery	JM

In attendance:

Ms Hilary Bellwood	Head of Planning & Development (item 6 only)	HB
Mr John Costello	Gateshead Health and Wellbeing Board	JC
Mr Neil Hawkins	Head of Corporate Affairs	NH
Ms Katharine McHugh	Designated Lead for Primary Care	KM
Prof Eugene Milne	Newcastle Wellbeing for Life Board	EM
Ms Wendy Stephens	NHS England	WS
Members of the Public		
Ms Sue Tulloch	PA Support	ST

10/17 **01** **Welcome and Apologies for Absence**

The Chair welcomed members of the public to the meeting and introductions were given. There were no apologies received.

10/17 **02** **Confirmation of Quoracy**

The Committee was confirmed as quorate.

10/17 **03** **Declarations of Interest**

Declarations of interest documentation had been circulated with the agenda. There were no further declarations made relating to items on the agenda.

10/17 **04** **Minutes of the Previous Meeting held on 18 July 2017**

The minutes of the previous meeting were agreed as an accurate record.

10/17 **05** **Action Log**

There were no outstanding actions for today's meeting.

10/17 **06** **STP Delivery Plan for Primary Care – NHS England Cumbria & North East and Newcastle Gateshead CCG Versions**

Hilary Bellwood attended to present an overview of the STP Delivery Plan for Primary Care, for information.

NHS England Cumbria & the North East (NHSE CNE) are required to submit a Sustainability and Transformation Plan (STP) Delivery Plan for Primary Care to NHS England by 28 November 2017.

The Newcastle Gateshead CCG local version of the Delivery Plan represents a baseline assessment to be used by CCG staff and stakeholders in delivering the General Practice Forward View (GPFV) initiatives. It will be refined further and then be part of a wider STP for the region.

The Committee commented:

- The document was lengthy, difficult to read and digest and lacked an executive summary. It was recognised that the format was imposed.
- The document content was commended bringing together disparate areas of work. It is hoped it will help in the move towards care closer to home.
- GP workforce was highlighted, noting the importance of ensuring local interests are protected and all possible efforts are made to attract GPs to work in the area.

Hilary acknowledged the comments made by the Committee and reported that the document will be presented to the STP Oversight Group on 30 November 2017.

10/17 **07** **Ponteland Road Health Centre – Options Appraisal**

Wendy Stephens summarised the report. With the current contract at Ponteland Road Health Centre due to terminate on 31 March 2018, the future of services for registered patients is to be determined. Following patient and stakeholder engagement two options were taken forward for consultation:

Option 1: Procure a standalone GP practice under an APMS contract
Option 2: Disperse the practice list

The consultation outcome report, local practice information and the scoring matrix were provided for the Committee. Feedback from the consultation indicated a 96.7% strong preference for retaining the GP practice at Ponteland Road.

The scoring framework had been established locally as there is no mandatory NHS framework and it was confirmed that the framework had been received and agreed by the Committee.

The workforce issues at the practice were noted with recruitment a major problem. A CQC report had rated the practice ‘Good’ but had commented on clinical staff levels.

The practice building is a temporary structure and the Council is not granting any further planning permission so a permanent building would be required if procuring.

The Chair invited public attendees to comment:

Councillor Stephen Lambert (Kenton) commented on the work that has been invested into the Cowgate estate over a number of years to make improvements for the people of the area and deal with difficult issues of social deprivation. To close the practice would undo so much of this work and would be a sad decision for the local population.

Tony Bone (Office of Chi Onwurah MP) was concerned about the health outcomes for people in the area. It was a young population with families, pressures to find work and a reliance on public transport.

The Committee recognised the difficulties regarding access but noted there are other practices relatively close by and some residents already choose to travel to another practice.

Councillor Sue Pearson (Blakelaw) raised concerns about patients' access to other practices highlighting that the distance may seem relatively short but when relying on public transport this could mean more than one bus and travelling into, then out of, town. She said that when the practice first opened it was hugely important for the area and closing it would leave residents disadvantaged. She asked that it be given a chance within permanent premises which would help improve its performance.

The Committee noted that at the start of the contract in 2009 the practice list was expected to grow to 6000 by year 5. However, it had only reached half this level and therefore this will make it difficult to attract potential providers. The current contract cannot be extended further.

The Committee noted that if a decision was made to procure and the procurement was unsuccessful the time for patients to find alternative provision at other practices would be greatly reduced.

Councillor Oskar Lavery (Blakelaw) commented that there was a growing African community in the area experiencing racism and for them travelling to another practice would be an extra concern. The transport links to the area could make it an option for patients to come from other areas if this was promoted. He was concerned that a lot of weight had been put on the market survey and that for the patients' sake procurement should be attempted.

It was noted that patients cannot be directed to other practices and this would raise the question of sustainability of other practices.

Mr A K Jassal, Ponteland Road Pharmacist, said his pharmacy had recently been renovated and had the space to accommodate a GP service and asked for this option to be considered.

Councillor Jane Streather, Kenton Ward, commented on the deprivation and high social and medical needs in the area and the additional transport costs to be faced if the practice closed. She asked what assistance would be given to patients registering elsewhere.

It was confirmed that should the practice list be dispersed, all patients would be informed in writing and provided with a list of alternative practices, being mindful of any clinically vulnerable patients. Registering would be monitored and anyone not doing so would be registered at the nearest practice.

Members of the Committee were asked to vote on the two options. The result was tied (3 votes each). The Chair's casting vote was for Option 1: Procure a standalone GP practice under an APMS contract. The reasons given for this decision are the robust consultation process and options appraisal report along with the wide representative input to the process and at today's meeting. The body of evidence is to go out to procure and by doing so it will provide the definitive outcome on the market position. The risks were noted, including the short timescale to ensure patients are registered at other practices, should a provider not be found.

10/17 **08** **Grainger Medical Practice – Future Provision**

Wendy Stephens summarised the report. The contract for Grainger Medical Practice is due to expire on 31 March 2018. Following market and patient / stakeholder engagement two options were taken forward to the consultation stage.

Option 1: Procurement of one practice at Elswick only
Option 2: Procurement of one practice with a site at Elswick Health Centre and Scotswood GP practice

The risks and benefits of the two options were highlighted. There is a compulsory purchase order on the premises at Scotswood and significant housing development planned which indicates a future need for a service. The CCG plans to have a multi-practice local hub for primary care delivery in the near future but there would be a risk until the hub arrangements are finalised and the premises planned have been built.

The Chair invited the attendees from the public to ask questions or comment:

Councillor Felicity Mendelson (Vice Chair, Newcastle Scrutiny Committee) recognised the difficulties with Grainger practice and that procurement is challenging but said the need is there with deprivation in the area and further housing planned. She asked about the chances of success in procuring one site.

It was noted that there is no guarantee of contract providers coming forward for either option. The NHS nationally is no longer offering GMS contracts which provide more stability and, therefore, are more attractive to providers than APMS contracts. Tony Bone said that the MP's office was willing to pursue the problem of contracts as it is failing residents.

Councillor Oskar Lavery (Blakelaw) highlighted the deprivation in the area and ensuring that the contract retains the current provision.

Members of the Committee were asked to vote and the result was unanimous for Option 1: Procurement of one practice at Elswick only. The reasons for this decision were the evidence presented in the paper, the scoring matrix and the robust discussion around the table including the contribution from members of the public.

10/17 **09** **Primary Care Budget Monitoring Month 5, 2017/18**

Jill McGrath presented the quarterly update on the financial position. There is a small year-to-date underspend and the year-end forecast is for break-even but there are potential risks ahead. The report was accepted.

10/17 **10** **Primary Care Group Terms of Reference**

Neil Morris presented the Primary Care Group (PCG) draft terms of reference following a 12 month review. The PCG considers matters that may require onward referral to this Committee. Following earlier discussions the issue of options or recommendations being provided to the Committee will be considered. There were no other issues and the terms of reference were accepted.

10/17 **11** **Any Other Business**

There was no further business

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Agenda item 5

Primary Care Commissioning Committee – November 2017

Action Log

Meeting date	Minute reference	Action	Lead	Due	Status
27/06/16	07/16 **07**	**Update on Integrated LTC Clinics in Primary Care** • Quantitative measures of success to be presented to the PCCC • Report to the Governing Body on the patient outcomes / experience	S Hood S Hood	Nov 2017 Nov 2017	Due Due
27/06/17	06/17 **06**	**Central Resilience Funds Proposal** Feedback to the PCCC following engagement workshops	K McHugh	Jan 2018	Ongoing

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Cover Sheet

Meeting Title	**Primary Care Commissioning Committee**
Date	**28 November 2017**
Agenda Item	**6**
Report Title	**The Impact of Integrated Multi-Morbidity Clinics in General Practice – Qualitative Outcomes**

Synopsis

At its June meeting the PCCC received an update paper on implementation of Integrated LTC Clinics in Primary Care in Newcastle & Gateshead. Following this the PCCC requested the following further information:

- Data relating to quantitative measures of success – this data is currently being collected as part of the scheme in Newcastle and will not be available until the end of this financial year. It is proposed to bring this data to a PCCC meeting at the end of 2017/18.
- The Committee asked for information relating to the patients' perspective and experiences of the scheme to be assured that it is making a positive difference for patients. It was agreed that a report on the patient experience should be submitted to the Governing Body under the Patient Engagement Section – this presentation is being delivered to the CCG's Governing Body meeting on 28 November. This takes the form of a wider presentation on the patient experience of Care and Support planning and how patients have been involved in planning this.

The presentation we've planned for the PCC Committee is focusing upon the impact care and support planning within integrated LTC multi-morbidity clinics has had on patients and staff. The presentation incorporates emerging findings from the formal evaluation of the Gateshead British Heart Foundation funded element of the programme.

The presentation will be delivered on the day but please find attached two case studies / patient stories as a pre-cursor to the presentation – one detailing a Gateshead patient's experience of having her care delivered in an integrated multi morbidity clinic which uses the Year of Care Approach to Care and support planning and one that is a case study from a Practice Nurse in a Newcastle practice around her

	practice's experience of introducing this approach to caring for patients with Long Term Conditions in her practice.
Implications and Risks	Practices do not adopt this approach to LTC care resulting in continued pressure on General Practice resources and reactive management of LTCs.
Recommendation	The Primary Care Commissioning Committee are asked to note the content of these case studies in advance of the presentation to the PCCC.
Report history	Update paper on implementation of Integrated LTC Clinics in Primary Care in Newcastle & Gateshead was delivered at the June 2017 Primary Care Commissioning Committee.

Lead Director & Report Author	Director: Dr Steve Kirk Title : Clinical Director - Delivery	Author: Sam Hood/Sarah Chapman/Jody Nichols Title: Portfolio Manager/Year of Care Project Manager/ Research Facilitator
Classification	**Official**	
Purpose (click one box only)	**Decision** ☐	**Information** ☒

Benefits to patients & the public	• Provision of Holistic Integrated Care • Empowered patients • Proactive approach to care • Improved use of NHS Resources • Improved outcomes for patients with LTCs
Links to Strategic objectives	• Collaboration and wellness • Coordination and personalisation • Care closer to home • Responsive, needs based care • Commissioning of High Quality Health Services • Alignment of 6 national service patterns • Improved patient experience of care • Sustainability and quality of general practice
Identified risks & risk management actions	Practices do not adopt this approach to LTC care resulting in continued pressure on General Practice Resources and reactive management of LTC's.
Resource implications	£449K per year across Newcastle & Gateshead Training for practice staff; support to develop EMIS/System 1 templates, project management support from CCG Delivery Team
Legal implications & equality and diversity assessment	
Sustainability implications	Ongoing funding in practices until this approach to care is embedded in practice systems
NHS Constitution	1. The NHS provides a comprehensive service, available to all 2. Access to NHS services is based on clinical need, not an individual's ability to pay 3. The NHS aspires to the highest standards of excellence and professionalism 4. The patient will be at the heart of everything the NHS does
Next steps	Continue implementation and monitoring of this scheme during 2017/18
Appendices	1. Patient Story – Mrs B 2. Reflections on a First Year of Care and Support Planning

Appendix 1

Patient story Mrs B

Mrs B is a patient in a surgery that has implemented the Year of Care annual reviews including care and support planning for patients with long term conditions. Mrs B was interviewed to gain the patient persctives on the Year of Care implementation.

I had a heart attack quite a few years ago. I started to get some pains which I thought were related to my gastric problem, so I ignored them. Two days later I woke up in the middle of the night, with pain in my arm. The pains continued for several days but I kept saying 'oh I'm fine, I'm all right now'. After a few days when I was out shopping but felt terrible. By the time I got home I was fighting for my life. An ambulance was called and with the blue light sirens blaring, I was taken to the hospital. The staff were all in a line waiting for me outside the Freeman Hospital, They were fabulous. I had a couple of stents fitted and immediately felt better. '

A few years later I had another illness and was very unwell for many months. My illness meant that I was very inactive and I put on a lot of weight. I reached 12 stone 6, which is a lot as I am only 5'1". Also I can't get around as I should, because of arthritis in my hip.

I have just had my annual review. My surgery offers a 2 stage appointment and I really like it. You have all the rigmarole with the health care assistant, getting weighed, blood pressure and blood tests. You have the results sent to your home and then come back to see the nurse a week or so later. My nurse is fabulous she puts you through everything and she asks you what you want to change in the next year. This is the second time I have had this type of appointment.

Last year, the nurse asked me what I would like to happen in the next year and how would I like to change things. I said I wanted to lose some weight as I was shocked when I saw what my weight was. Being so ill before and not being able to get around, I had piled on the weight. So I started the next day. I don't call it 'a diet' anymore, it's just healthy eating. Because I can't really exercise, I bought one of those little pedal bikes that you can sit on the sofa. And just started pedalling.

And it worked. Sometimes it was a pound a week or sometimes I went three weeks without losing anything. But I plodded on. At my appointment this year, I have lost three stone. I was a size 24 and I am now a size 14. So that appointment helped me a hundred percent.

Again this year I saw the health care assistant first, who weighed me, took my blood pressure and other tests. I had my results sent through the post. I knew to expect them and I was keen to know what my results were as I am 'dead nebby'. It explained all the different things, what all the different scores mean, which is great. The front had things that I might talk to my nurse about. I put rings around what I wanted to discuss. This was good because when I got the form out at the surgery, I could go through with the nurse the things that I wanted to talk about. I thought it was good. Naturally when you go to see a doctor or nurse things slide right out of your head. This this was very handy. It meant I could talk about what problems I had.

My nurse is lovely, I was pleased that it was her when I went back for my second appointment. She is really supportive and listens to me. She went through everything on the form and asked how I was. I couldn't fault her. I never really understand about blood pressure but she talked me through all my results and what they meant. I was able to discuss all the things that I felt I needed to know, including all the things that I had circled. Like last year, she asked me what I want for the year ahead. I said I want to get to nine stone. It so annoying to have these arthritis pains in my hip and lower back that reduce my activity. But I am determined.

My annual review has been a good experience from start to finish. I would be very disappointed if the style changed because I like it like this. When you get the letter with your results you can look at it and take it in. I still have the one from last year, so that I can check over how I am doing. That's why I asked about my blood pressure because it was different from the time before. My nurse told me that it had probably come down with my weight.

Appendix 2

Reflections on a First Year of Care and Support Planning

Karen Hammond - Walker Medical Group

After attending the Year of Care training, our team started to get going with care and support planning. There were initial challenges, it was important that other practice staff understood the benefits of both care and support planning and the idea of single reviews for patients with multiple LTCs. Some staff were concerned about not having enough time for consultations where patients had a number of conditions, and worried that the relevant results for each condition would not all be available at the review. In fact, what we have found is that the HCA appointment enables all the information to be ready and there, everything is done and in one place.

I had no reservations about care and support planning from a patients' perspective, it is an opportunity to encourage patients to be more proactive, get involved and take more responsibility for their own health. We have found that birthday month recall works well; it's an easy way for patients to remember their review date. Before we implemented care and support planning, care provision felt a bit disjointed; patients would come in for separate reviews for each of their conditions. Nothing ran together or flowed correctly and to me it felt jumbled up. For example a patient would attend for their hypertension review, and their medication would be checked, but not those taken for any of their other conditions. And for people with comorbidities, it might be that only one of their conditions is troubling them. If a patient attending for a heart review was having more problems with their COPD or Asthma, there wasn't always enough time to address both; if you did the clinic would run over and if you didn't the person would often need another appointment.

This way everything is looked at together and we can treat people more holistically. It allows you to consider what is important to the patient; if their breathing is more of a problem then their heart; it provides a fuller clinical picture. It is better for older patients too; it means we are not bringing them back several times a year. It's a one stop shop – an opportunity to look at everything in one go and to encourage patients to think about their lifestyles.

One of our admin team and a Health Care Assistant go through birthday month list, and send letters inviting patients to come in for a pre-review check. Patients see one of the HCAs or Practice Nurses to have bloods, weight, blood pressure and foot screening done. The HCA talks to them about the aim of the care and support planning appointment and books the appointment for 2 weeks. Patients are reminded to look out for a letter containing their results, and encouraged to read it, think about them and bring the results with them to discuss when they come back in.
One of the keys to success was getting everybody on board from the start, and telling patients about how their care was going to change. Every patient is given an information leaflet that explains what is happening, letting them know what care and support planning is about. The benefits of care and support planning to me as a clinician are that it feels like I am offering a more holistic care package. We have two weeks to prepare for the appointment, the patient has been seen for all their tests, and because their care and support planning appointment has been made at their visit to the Health Care Assistant, they more likely to attend. When they do attend, they

know what it is about, and getting their results can encourage them to think more about their health.

Patients like receiving their results, although some bring their letters back with them and haven't yet done much with them. But others have really studied their results and the information. We had a short-lived technical glitch recently, during which we were unable to send results letters, and during that time patients complained about not receiving them!

Some patients come into their appointment saying "Yes I got it and I want to go through it", others are not as sure; people need time to adjust to the change. One patient showed her husband and he was really interested too. And because they have something written down, developing an action plan is easier, it needs practice to get the structure of the conversation right to encourage patients to take the lead a bit more. Some patients still expect to be 'told what they've done wrong'. Some people comment on their results compared to the previous years, they see that it's better or worse than last years, but they often then talk about why and might say "Oh it's because I've been to a wedding" or "I've been on holiday" etc. Having results beforehand provides a bit of structure and an opportunity for them to think about changes they might make, it has got to be their plan. If the patient doesn't bring up something that is important clinically I might say "Can we have a closer look at this aspect of your results" or "Is this causing you any concern or worries?" to try to tease something out.

We started by introducing care and support planning for people with diabetes and other co-morbidities, and by next year, once we have birth month recall well established, we aim to be including people with respiratory disease. We want everybody to get comfortable with how care and support planning is working and then we will begin to introduce the other LTCs. Eventually we will start to look at how we could incorporate medication reviews into care and support planning appointments for some people. It might mean that some patients who are stable, happy and not on medication may not need to come back every 6 months, but know that if they do have any problems they have that option.