NHS
Bristol, North Somerset and South Gloucestershire
Clinical Commissioning Group

Primary Care Commissioning Committee Open Session

Minutes of the meeting held on 30th November 2021 at 9.30am, held via Microsoft Teams

Draft Minutes

Present:		
Sarah Talbot-Williams	Chair of Committee, Independent Lay Member, Patient and Public Engagement	STW
Georgie Bigg	Health watch Bristol, North Somerset and South Gloucestershire	GB
Katrina Boutin	Clinical Commissioning Locality Lead, Bristol	KB
Colin Bradbury	Area Director for North Somerset	CB
Ben Burrows	CCG Clinical Lead Clinical for Governance and Quality	BB
David Clark	Practice Manager	DC
Geeta Iyer	Primary Care Provider Development Clinical Lead	GI
David Jarrett	Area Director for Bristol and South Gloucestershire	DJ
Philip Kirby	Chief Executive, Avon Local Medical Committee	PK
Lisa Manson	Director of Commissioning	LM
Alison Moon	Independent Clinical Member, Registered Nurse	AM
Julia Ross	Chief Executive	JR
Rosi Shepherd	Director of Nursing and Quality	RS
Apologies		
James Case	Clinical Commissioning Locality Lead, South Gloucestershire	JC
Matt Lenny	Director of Public Health, North Somerset	ML
John Rushforth	Independent Lay Member, Audit, Governance and Risk (Chair)	JRu
Michael Richardson	Deputy Director of Nursing and Quality	MR
In attendance		
Jenny Bowker	Head of Primary Care Development	JB
Nina Buckley	External Communications Manager	NB
Sarah Carr	Corporate Secretary	SC
Debbie Campbell	Deputy Director (Medicines Optimisation)	DCa
Louisa Darlison	Senior Contract Manager Primary Care	LD

Jamie Denton	Head of Finance – Primary, Community & Non Acute Services	JD
Bev Haworth	Models of Care Development Lead	BH
Sukeina Kassam	Interim Head of Primary Care Contracts	SK
Sandra Muffett	Head of Clinical Governance & Patient Safety	SM
Lucy Powell	Corporate Support Officer	LP
Kat Showler	Senior Contract Manager Primary Care	KS
Lisa Reese	Principal Medicines Optimisation Pharmacist	LR
Jacqui Yuill	Lead Quality Manager	JY

	Item	Action
01	**Welcome and Introductions** Sarah Talbot-Williams (STW) thanked John Rushforth (JRu) for chairing the previous meeting and welcomed members and the public to the meeting. STW introduced Jeff Farrar (JF) interim chair of ICS and Chair Designate who was joining the meeting as an observer. The above apologies were noted.	
02	**Declarations of Interest** There were no other new declarations and no declared interests related to agenda items.	
03	**Minutes of the Previous Meeting** The minutes were agreed as a correct record.	
04	**Action Log** The action log was reviewed and due actions were closed. **Action 164 –** Jamie Denton (JD) explained the temporary financial regime continued in the second half of the year (H2) and the funding shortfall was covered by this. There was no risk to the CCG. The details of the financial framework for 2022/23 were expected in January 2022 and at this point there would be further clarity enabling the action to be closed or the position to be pursued with NHSE. JD confirmed that the potential risk was to commissioners and not general practice providers. The action remained open **Action 265** – JD explained the 3% 2021 Agenda for Change agreement did not apply to GPs who were covered by a pre-existing agreement. The Agenda for Change award was applied to Additional Roles. The action was closed. **Action 267 –** Rosi Shepherd (RS)confirmed this action was on track. Alison Moon (AM) asked whether a report would be presented to the Quality Committee. This was confirmed **Action 270 –** Geeta Iyer (GI) confirmed the evaluation had been circulated and published. The action was closed.	

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	Action 271- Lisa Manson explain that the concerns about accessibility of information on the App were being explored with NHSE and the outcome of these discussions would be shared with colleagues. The action remained open **Action 274 -** Lisa Rees (LR) explained that the Medicines Optimisation Team had explored using prescribing hubs with PCN Clinical Directors; given current pressures a number of PCNs were not keen to pursue this. Work was going forward with those PCNS that had expressed an interest. The action was closed All other due actions were closed	
05	**Any Other Business** There were no matters for any other business.	
06	**Primary Care Operational Group (PCOG) Terms of Reference** David Jarrett (DJ) explained the terms of reference had been revised as part of an annual review. DJ noted there would be a wider review of primary care commissioning governance arrangements as part of the transition to an Integrated Care Board (ICB). DJ drew attention to the changes to the terms of reference which were highlighted in the paper including changes to the membership of the group to include GP provider leads. DJ highlighted the approach to managing conflicts of interests which involved holding part 1 and part 2 meetings with sperate meeting invites. AM noted that PCOG had been in place for a number of years and that it had a broad agenda. AM asked if there were other changes to the PCOG that would support its move into the ICB. DJ explained that the learning from the previous years had been taken on in the review of the terms of reference. The group had also been considered in terms of other fora, for example the Primary Care Cell, the Primary Care Locality Development Group and the GP Collaborative Board, to ensure the correct focus. The review had also considered the role within the ICB and impact of extended primary care delegation. Julia Ross (JR) noted that One Care was not included in the membership and asked for this to be revisited. JR questioned the proposal that the Clinical Lead for Primary Care Development chaired the meeting in the absence of the Area Director; noting the potential for conflicts of interests, particularly in relation to part 2 meetings. JR observed that the terms of reference needed greater clarity on the part 1 and part 2 meeting arrangements.	

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	JR reflected on the remit of the group in relation to the PCCC and the Integrated Care Steering Group (ICSG) and the addition of LTP transformation to the group's responsibilities. JR commented that this was the explicit role of the ICSG. JR noted that there were a number of amendments that would create dual reporting. The initial focus of the group on resilience and contracting gave it a discreet role in relation to other fora more focused on transformation and wider system change. DJ welcomed the comments and agreed to review the terms of reference. **The Primary Care Commissioning Committee asked that the Terms of Reference were reviewed and presented to a future meeting**	**DJ**
07	**Covid-19 and Recovery Update** GI provided an update on the vaccination programme drawing attention to the slide deck. The latest statistics for BNSSG had changed since the submission of the paper. The number of vaccines given as part of the outreach programme had increased to over 20,000. The focus of the programme included maintaining the evergreen offer, continuing the administration of third doses for severely immunocompromised people and the provision of booster jabs in order of priority cohorts. GI highlighted the over 40 cohort was now live. The provision of 1st does for 12-15y olds without underlying health conditions continued alongside 2nd doses 12 weeks apart for 16-17y olds and 2nd doses 8 weeks apart for clinically vulnerable 12-17y olds. Clinics were being provided in schools and evening and weekend clinics were available at UWE. The change in guidance requiring a 12 week wait following a positive PCR test had delayed the campaign due to the high number of cases in that cohort. This was due to the slightly increased risk of pericarditis. GI noted that for clinically vulnerable individuals this risk was outweighed by the risk of infection and the interval for vaccination remained at 8 weeks, in line with national guidance. Ensuring communications provided reassurance to young people and parents was a priority for the communications campaign. There continued to be a focus on increasing uptake in pregnant women through antenatal clinics and working with the flu programme. GI noted that the PCNs had been required to opt-in to delivery for the over 40y olds cohort. 16 of the 19 PCNs had opted in for cohort 10 and in two PCNs not all practices continued to provide vaccinations. Work was ongoing with existing delivery sites to	

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	ensure coverage for the population of these areas. Work continued across all PCNs to ensure the offer remained sustainable and robust. The recruitment of staff as vaccinators and administrators continued and estates colleagues continued to identify potential future vaccination sites. GI explained that as cohorts increased sites were updated on eligibility. GI drew attention to the outreach programmes. Successful family clinics had been held in the St Pauls and Hartcliffe areas of Bristol. Both adult and child covid vaccinations had been administered alongside child flu' vaccines. Feedback indicated the clinics had been used by people who would not normally have accessed the service. This approach would be built on. Clinics had been offered at the Avonmouth Amazon depot and in the Bournville area of Weston-Super-Mare. The communications programme was highlighted. This included clear messaging for young people and parents about the vaccination intervals and messages about access to different types of vaccines. The walk-in offer had been reduced to target workforce resources to areas of need. Communications related to the first-year anniversary of the campaign were in development. A leaflet promoting the vaccinations available during pregnancy had been designed. STW noted previous presentations had highlighted groups where uptake was low and asked if issues continued. GI explained the main focus of the programme recently had been on children and young adults. This had been challenging due to the prevalence of covid and other respiratory infections in this cohort. GI noted that people, including older adults, continued to present for 1st doses at the pop-up clinic in Cabot's Circus. There was also a focus on people with Learning Disabilities. Additional clinics were being held at UWE which had been popular with this cohort. AM welcomed the outreach programme and asked for future reports to include information about actual numbers, noting that information was available about the registered population with Learning Disabilities and also the number of pregnant women. AM asked how the team worked with services, such as maternity services. GI confirmed that the detail numbers against cohorts would be provided in the next report. The numbers of people with	**GI**

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	learning disabilities receiving vaccinations were increasing, partly through maximising routes such as the annual health checks. The programme was working with the antenatal services to provide a presence at clinics and also visiting post-natal wards Lisa Manson (LM) explained that, in line with the change to the Joint Committee on Vaccination and Immunisation (JCVI) guidance, work was now on going to open up bookings to further cohorts. This would follow previous booking arrangements. Julia Ross (JR) commented that the regional steer was to phase out walk-in clinics to support the targeting of resources and asked what impact this would have on the local programme. JR also asked for more information in future reports about antibody testing and antivirals. GI commented that the walk-in clinics had been very successful with high up-take. GI noted the local offer was being reduced to focus resources on those at risk. JR observed that Bristol population was different to rest of the population in the South West and it was important that the right service was offered for the population. GI confirmed there had been a significant increase in up take with the introduction of the walk-in clinics and it was important to maintain the balance and maintain the offer. Katrina Boutin (KB) highlighted the impact the change in guidance had on practices and PCNs, noting for her practice the number of people eligible for boosters had increased from 2000 to 9000. The increased workload would affect other services. GI explained that discussions about capacity and how to make best use of workforce and ensure that the offer was maintained. It was important to have clear robust communications in place about eligibility and the booking process. A balance was needed with the other work that practices, PCNs and community pharmacists were required to deliver during the winter. JR commented that work to identify what could be paused by primary care during December and January to facilitate the vaccination programme was in progress. It had been suggested that some of the elements of the Quality and Outcomes Framework (QOF) could be considered and local flexibility to review this would be welcomed. JR suggested that she wrote to the Regional Director outlining the flexibilities that would help	**JR**

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	primary care. JR asked KB and GI to discuss this further and for GI to share these discussions with JR. GI confirmed that future reports would include information about antivirals and antibody treatment. Sukeina Kassam (SK) noted that the antivirus contract was in place. KB presented the eight Winter Access Proposals developed with the LMC and prepared in response to the NHSE letter, focused on improving capacity and resilience in general practice, reviewing variation, increasing on the day appointments and urgent care needs, and supporting access and patient experience. It had been agreed at system level that the 20% of practices identified as requiring support would not be individually named. A robust support and resilience programme had commenced. Alongside this would be support and resilience offers open to all practices across BNSSG. The second proposal was for the Collaborative Staff Bank. This built on the vaccination programme experience and supported existing staff to work as a collaborative bank across primary, community and social care. The GP Clinical Network Service (GP-CNS) provided a GP homeworking option and supported GPs who had taken a career break or recently retired. The aim was to provide additional GP support to practices. The Digital remote consultation offer was highlighted. KB noted that there had been some discussion about this proposal and the potential impact on systems in place. A number of practices had voiced concerns. The mental health offer provided mental health practitioners across each PCN, providing an additional 16,200 appointments in response to the increased demand for mental health services. The Same Day Urgent Care/Expansion of Improved Access proposal involved using locums and current staff working additional hours to increase urgent care across practices and PCNs. Other proposals focused on the System Clinical Assessment Service, an expansion of the Community Pharmacy offer through the consultation service, patient group directions, and acceleration of the prescribing hubs. The proactive insights and engagement work was highlighted. KB noted that there had been an increase in reports of abuse aimed at primary care colleagues and this was an opportunity to work with communities to improve knowledge and understanding. Attention was drawn to the proposal for a widespread cloud	**GI**

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	telephony service in support of the national telephony programme. The final proposal to improve communications and referral interface systems required further scoping. The intention was to ensure that communications between primary, community and secondary care were effective and improve responsiveness. Improving direct communications would support elective recovery. Jenny Bowker (JB) highlighted the next steps. A number of the initiatives had started and all initiatives were being launched. Expressions of Interest would be invited from those wishing to participate in the remote digital consultation and Same Day Urgent Care offers. The proposed governance arrangements included weekly management through the Primary Care Locality Development Group and regular reporting to the General Practice Collaborative Board (GPCB) and the Primary Care Commissioning Committee. AM asked whether the mitigations relating to the capacity and workforce risks were sufficiently strong and what else could be put in place. JB commented that the action to share with NHSE areas of flexibility for primary care was important. There were practices that had capacity to mobilise quickly and go further whilst there were some practices that would struggle. It was important to understand the impact of the widening of the cohorts for the booster. Prioritising the primary care workload would be a significant mitigation. KB noted that the biggest risk related to workforce. JR asked whether workforce issues had been quantified and fully understood. JB explained that the NBT Staff Bank and PCN vaccination arrangements allowed some insight into workforce issues. More was required to understand workforce gaps and a proposal to develop an electronic staff record had been supported through local system funding. JB noted the national workforce tool provided information that was one month in arears. More timely data was needed to ensure resources were directed to where they were most needed. JB presented the primary care activity plan for the second half of 2021/22 (H2). The plan was not part of the H2 submission requirement and had been developed locally. The activity plan included additional activity currently absent from the national general practice appointment dataset.	

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	STW thanked the team for the report. The Committee took the flu report at this point. Flu' levels remained low in the South West. LR highlighted that stock levels varied across system. National stockpiles were available where extra stock was required. LR drew attention to the overall uptake by cohort. Uptake in the over 65yrs old cohort was approaching nearly 80%. Uptake in the at-risk group was less strong and within this cohort there were specific groups with poor uptake. Additional communications to highlight eligibility for these groups was being developed and work was progressing with secondary care colleagues to target specific groups. Uptake within the 2yrs to 3yrs old cohort was highlighted. This was low and communications to practices would be circulated encouraging practices to target this group. The outreach programme and family clinics had been discussed earlier. The current position regarding Frontline Health Care Worker vaccine uptake was highlighted. The Trusts were taking a proactive approach. UHBW offered a roving vaccination and drop-in clinic and had launched a Fights Flu week. NBT had also increased the number of flu clinics available and added late clinics for staff. AWP and Sirona were using the Vaccination Tracking System to support their vaccination programmes. Sirona offered vaccines for staff at the UWE site. LR highlighted that the antiviral pathway for care homes had been finalised and signed off in support of the outbreak management plan. There were no questions. STW thanked the team for the report and noted there would be a longer discussion about the flu programme at the next meeting. **The Primary Care Commissioning Committee noted the reports**	
08	**Primary Care Finance Report** JD drew attention to the month 7 year to date position which was an overspend of £731,000. The key variance was within the primary care prescribing budget with an overspend of £808,000. This was an improvement on the reported month 6 position. The overall forecast was for a £1.3 million overspend at the end of the financial year. The risk pool providing financial support for the primary care prescribing budget was highlighted. The committee would continue to receive variance reports. The primary care core budget and primary care delegated budgets continued to present a break-even position. JD highlighted the appendices 2a and b: the primary care prescribing finance report and M7 prescribing cost	

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	analysis. JD highlighted the cost pressure relating to itemised prescribing payments and explained how the overspend was apportioned across 'no cheaper stock obtainable', drug tariff pressures category M increases, and how this was extrapolated to the end of year forecast position. Appendix 2b presented growth by BNF Chapter. JR asked if the main drivers of the overspend position were 'no cheaper stock obtainable', drug tariff pressures and category M increases? JD explained that the key driver was the increase in the costs of items and not an increase in quantity prescribed. JR asked what opportunities there were to address the increase. JD explained the Medicines Optimisation team was leading work programmes aimed at reducing costs however inflationary cost pressures were outside of the CCG's control. There were no further questions **The Primary Care Commissioning Committee noted:** • **the summary financial plan** • **the key risks and mitigations to deliver the financial plan** • **that at Month 7 (October), the combined Primary Care reported a £731k overspend before considering the risk pool. After applying the Risk Pool, the net position was a small underspend.**	
9	**Primary Care Quality Report** Sandra Muffett (SM) drew attention to the CQC inspections reported, noting the positive reports for the Montpelier Health Centre and Coniston Medical Practice. The outcome for Montpelier had moved from 'Requires Improvement' to 'Good', with a rating of 'Good' across all domains. Both practices had received support through the quality and resilience support programme, offered by the quality, medicines optimisation and contracting teams in collaboration. The CQC report for Coniston Medical Practice would be reported to the next meeting. The findings of the Graham Road and Horizon CQC Inspections and the CQC action plan update were highlighted. Next steps included further support to embed and implement the action plan. The CCG quality team held regular meetings with the leadership team at Graham Road and Horizon. CB asked about the timescales for the implementation of the action plans. SM confirmed that a meeting was arranged with the leadership team to confirm timescales for implementation. CB	

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	asked if there would be separate plans for the two sites or one plan covering both Graham Road and Horizon. SM explained there would be one plan for both sites however there would be a number of site-specific actions. Rosi Shepherd (RS) commented that it was important to ensure there was a focus on both CQC deadlines for the completion of actions and deadlines set by the CCG to ensure that actions were embedded prior to a reinspection. STW welcomed the report and the work carried out by the teams in support of Graham Road and Horizon. STW noted the Committee had previously discussed the issues reported and it was important to maintain close links with Health watch. RS explained that Health watch attended the system quality group and that she held separate meetings with Health watch and the regulators prior to these meetings. JR welcomed the report and highlighted the positive findings in relation to Montpellier Health Centre and Coniston Medical Practice. JR asked how confident colleagues were that Graham Road and Horizon were on the right trajectory. SM explained significant support was being provided and the teams were working with the newly appointed Practice Manager and the relationship with the leadership team was positive. The overall position was improving. RS noted that improvements were being made and the key issue was sustaining this over time. SK commented that she and Michael Richardson had met with Georgie Bigg from Health watch and agreed to provide a further update and ensure that links between links between Health watch and Graham Road and Horizon were maintained. STW asked when the action plan would be presented to the Committee, noting there would not be a December meeting and it was important that actions were taken forward quickly. SM agreed to present a report to the quality committee in December. **The Primary Care Commissioning Committee noted the report**	**SM**
10	**Primary Care Contracts, Performance, Quality and Resilience Report** SK drew attention to the contract termination relating to Helios Medical Centre due to the retirement of the contract holder. One formal list closure application had been received; this application had now completed the due process and a three-month list closure	

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	had been approved. The CCG was working with the practice, Greenway Community Practice, to support actions enabling the reopening of the list in three months. All neighbouring practices had been informed, and information shared with the customer services team to support members of the public. Attention was drawn to the phase three PCN mass vaccination Direct Enhanced Service (DES). SK explained that since the time of writing new announcements had been made and four PCN's had opted out of the DES. The CCG was now looking to ensure that affected patient populations had access to the campaign. Primary care support to interim accommodation centres was highlighted. There were no accommodation centres currently in the area however the Bristol area had been placed on standby. The adult TB screening programme, part of the resettle programme, had been completed and the Children's screening programme had started. There had been strong multidisciplinary working across health and social care teams and the local response was considered to be exemplary. Data showed that from April to October 2021 practices used Improve Access for a range of activities with 25% of the provision used for mass vaccinations. Communications about Christmas and New Year provision had been shared with practices. As noted earlier in the meeting the Winter Access programme had commenced. The support provided to practices through the resilience programme was highlighted. SK reported that two Section 96 applications had been made and the outcome of panel discussions would be reported to the next meeting. Attention was drawn to the primary care premises update. SK highlighted that there were challenges to the programme related to construction as a result of disruptions to the supply of materials and inflationary costs. AM commented on the coversheet to the paper and the section relating to reducing health inequalities. AM noted that the mass vaccination campaign had a significant positive focus on reducing health inequalities which was not referred to in the section. AM asked that coversheets to future reports consistently reflected the impact on health inequalities of the primary care workstreams reported. SK agreed to raise this with colleagues who contributed to the report. STW supported this. STW asked for a further update on the risks relating to premises to come to the next meeting.	**SK** **SK**

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	The Primary Care Commissioning Committee noted the report	
11	**Questions from the Public** There were no questions from the public.	
12	**Committee Effectiveness Review** DJ provided feedback on the committee effectiveness: • The Chair had successfully returned the committee to the planned timings; noting that the first item discussed had overrun. This was something to consider when the team was agenda setting. • The introduction of people attending the committee at the start helped to remind those present of the different roles and responsibilities of those present. • the Chair asked presenters to focus on key issues and ensured that the majority of those present contributed to the discussion • The information presented regarding the vaccination campaigns was helpful in terms of organisational planning and objectives, and the discussion about the PCOG terms of reference was helpful • the administration support to the meeting was exemplary and the team was thanked STW thanked DJ for his feedback and also thanked the administration team.	
13	**Any Other Business** There was no further business.	
14	**Date of next PCCC** Tuesday 25th January 2022	
15	The "motion to resolve under the provisions of Section 1, Subsection 1 of the Public Bodies (Admission to Meetings) Act 1960 that the public be excluded from the meeting for the period that the Clinical Commissioning Group is in committee, on the grounds that publicity would be prejudicial to the public interest by reasons of the confidential nature of the business" was proposed by JR and seconded by AM	

Sarah Carr Corporate Secretary, December 2021