NHS
Bristol, North Somerset and South Gloucestershire
Clinical Commissioning Group

Primary Care Commissioning Committee Open Session

Minutes of the meeting held on 27th April 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	Healthwatch Bristol, North Somerset and South Gloucestershire	GB
David Clark	Practice Manager	DC
Geeta Iyer	Primary Care Provider Development Clinical Lead	GI
David Jarrett	Area Director for South Gloucestershire	DJ
Philip Kirby	Chief Executive, Avon Local Medical Committee	PK
Mathew Lenny	Director of Public Health, North Somerset	ML
Jon Lund	Deputy Director of Finance	JL
Lisa Manson	Director of Commissioning	LM
Alison Moon	Independent Clinical Member, Registered Nurse	AM
Michael Richardson	Deputy Director of Nursing and Quality	MR
Julia Ross	Chief Executive	JR
John Rushforth	Independent Lay Member, Audit, Governance and Risk	JRu
Apologies		
Rosi Shepherd	Director of Nursing and Quality	RS
James Case	Clinical Commissioning Locality Lead, South Gloucestershire	JC
In attendance		
Jenny Bowker	Head of Primary Care Development	JB
Debbie Campbell	Deputy Director (Medicines Optimisation)	DCa
Sarah Carr	Corporate Secretary	SC
Bev Haworth	Models of Care Development Lead	BH
Sukeina Kassam	Interim Head of Primary Care Contracts	SK
Susie McMullen	Primary Care Resilience and Quality Improvement Lead	SM
Rebecca Murch	Acting Head of Communication and Engagement	RM
Lucy Powell	Corporate Support Officer	LP

Lisa Rees	Principal Medicines Optimisation Pharmacist	LR
KatShowler	Senior Contract Manager – Primary Care	KS
Jacci Yuill	Lead Quality Manager – Primary Care	

	Item	Action
01	**Welcome and Introductions** Sarah Talbot-Williams (STW) welcomed members to the meeting and the above apologies were noted. STW noted that James Case (JC) had joined the committee.	
02	**Declarations of Interest** There were no declared interests relevant to the agenda and no new declarations.	
03	**Minutes of the Previous Meeting** The minutes were agreed as a correct record.	
04	**Action Log** The action log was reviewed: • **Actions 238 and 245 –** Michael Richardson (MR) explained that the Primary Care Quality Report was to be revised following feedback at the last meeting. Item 10 on the agenda related to this. As the work was in progress, it was agreed the action remained open. All other due actions were closed	
05	**Annual Review of Committee Terms of Reference** SC drew attention to the proposed amendments highlighted in the terms of reference. There was a discussion about the Committee membership and the continued inclusion of a medical director. It was agreed that Dr Geeta Iyer was the appropriate senior Primary Care Clinical Lead. Julia Ross (JR) highlighted that the GP attendees were not voting members of the Committee. GP attendees for North Somerset and Bristol were to be confirmed. Debbie Campbell noted that medicines optimisation was not referred to in the terms of reference. It was agreed to refer to medicines optimisation in the report and add to the attendance list. **The Primary Care Commissioning Committee approved the Terms of Reference subject to the additions agreed**	**SC** **SC**
06	**Committee Effectiveness Review** STW noted the comments in the paper relating to challenge. STW commented that there was good debate at meetings however, this did not always stretch across the full committee membership. STW commented that she would continue to review the structure of the agenda with the team in advance of meetings as proposed in the next steps. Lisa Manson (LM) referred to the next steps action	

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	regarding NHSE/I attendance and clarified that a representative would come when requested and would not routinely attend. There was a discussion about the level of challenge at meetings. JR observed that all members had the opportunity to contribute to discussions and it was the responsibility of all to ensure they participated. JR noted the survey was shared with attendees and asked that in future the circulation focused on committee members. It was important that members felt able to challenge and understand what prevented them from participating. LM added it was important that the Committee was able to challenge constructively to ensure it worked in the best interest of the population. STW commented she did not feel that there was a block to challenge and it was important to encourage participation. She highlighted the discrepancy in responses noted in the paper. The survey would be reviewed and a further update would come back to the committee at a future date. John Rushforth (JRu) commented that it was not always necessary to ask questions where update papers gave clear information. JRu suggested it would help to reflect on which papers were matters for information and which were for discussion. JRu noted the value of seminars as an opportunity for discussion. Alison Moon (AM) agreed it was important there was the opportunity for challenge and that it would be helpful to explore outside of the meeting what prevented some members from contributing more. STW thanked members for their helpful comments. Jenny Bowker (JB) explained that a proposal for June seminar had been discussed with STW and a seminar programme was being planned. STW informed members that she would consider the survey comments and comments made in this meeting. STW observed there was an ongoing responsibility on the Committee to ensure it delivered the best outcomes for the population and thanked all. **The Primary Care Commissioning Committee discussed and agreed the next steps**	**STW/ SC**
07	**Primary Care Covid-19 Response and Recovery Update** GI drew attention to the Oximetry at Home project. Sirona managed the service, reviewing positive test results and proactively contacting patients, offering them the service. Evaluation of the service was ongoing. The wider model was being reviewed to bring together the service and the Virtual Ward work	

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	to explore the wider implications of how to look after people at home. The update on the Community phlebotomy service was highlighted. An EMIS protocol for working with the acute trusts was in development. There had been engagement with GPs regarding the service and it was proposed to move to an activity based payment method. The Local Enhanced Scheme (LES) was being developed which would come to the Committee for approval. JB provided an update on the Covid mass vaccination programme. Over 620,000 vaccinations had been delivered in BNSSG, including over 148,000 second doses (as at April 18th). PCNs had delivered 64% and Community Pharmacies had delivered 12% of these. The national ambition was completion of the 1st dose vaccination campaign by the end of July; the national booking service was now open to people aged 45-49 and PCNs could invite this cohort if supplies were available. The PCN mass vaccination national enhanced service had been extended to support PCNs wishing to continue the vaccination programme for the next cohorts. All 19 PCNs in BNSSG had opted to continue. The Moderna Vaccine was now available at Aston Gate and national guidance relating to the use of the Astra Zeneca vaccine in the under 30's cohort was being shared with PCNs. Active searches were being conducted to identify people who had missed their second dose. Vaccination coaches, supporting PCNs by calling people with concerns about the vaccine were being trialled. Communications were now aimed at younger people included working with youth organisations and a webinar to inform 'influencers'. Areas of low uptake were being targeted and clinics for specific cohorts were provided at Ashton Gate. BNSSG was on track to complete the first dose vaccination programme by the national schedule subject to vaccine supply. STW welcomed the update and asked, how BNSSG compared to other areas, and what the main challenges to meeting the national delivery schedule. LM noted that BNSSG compared well both nationally and in the South West. It was agreed that comparisons would be shared when available. AM asked if there were concerns about the second dose uptake and if there were proactive communications planned to mitigate this risk. GI agreed this was a potential issue although there were no indications that the risk was	**JB**

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	materialising. Communications to encourage uptake of the second dose were discussed at the Delivery Group. Where some people had been identified as not receiving the second dose, the first dose had been administered elsewhere. AM asked if there was a national response to address this. RM agreed to check the national position. JB explained that the main challenges related to notification about availability of supplies and the simultaneous opening of booking for first doses through both the PCNs and the national booking system without visibility of whether patients were already booked elsewhere. Work continued as a system to ensure optimal working between the two systems. David Jarrett (DJ) sought confirmation that the Oximetry at Home service and the Virtual Ward had come together as a cohesive programme under the ICS Respiratory Board. GI confirmed this. DJ asked that the Board shared with the localities the next steps for this work programme. GI agreed. DJ sought confirmation that PCNs were providing second doses of vaccines where supplies allowed. JB confirmed there were sufficient doses for second doses and stock was held. The distribution of supplies for first doses was being reviewed to identify and fill gaps with existing stock. The issue related to supply concerned supplies to meet demand created by the increasing numbers of first doses as new cohorts came on line. JRu highlighted his declaration of interest relating to the University of West of England. He asked if discussions had started with local universities regarding the return of students in September. JRu noted there would be instances where students had received their first vaccinations elsewhere, including overseas and the potential for students to have received vaccines not released in the UK. GI explained there was an understanding that when people moved into the area and had received their first dose elsewhere the schedule would be completed. LM agreed to raise the issue at the Mass Vaccination Programme Board and with the Local Authority who worked closely with the universities. People booked through national booking service would be able to see availability of slots for second doses. How students not booked through this service, for example how overseas students would book a second dose, would be an issue.	**RM** **LM**

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	JB presented the operational plan 2021/22 draft narrative. The workforce element would be submitted as part of the system response. JB highlighted the following in the narrative: • The section Supporting the health and wellbeing of staff and taking action on recruitment and retention included embedding new ways of working and delivering care. This was an important area of focus and actions included supporting the workforce with virtual consultations and developing group consultations. A staff bank for community and primary care would be created. • Growth for the future: key actions included working with schools and colleges, developing fellowships and mentoring schemes for newly qualified GPs, and supporting the recruitment and retention of PCN additional roles. The Training Hub was creating communities of practice. Work continued to expand undergraduate placements. • Restoring and increasing access to primary care services: improving data quality was a key element. It was important to understand activity to support the restoration of appointments. There was a focus on implementing guidance for the General Practice Activity Dataset by the end of quarter one. Work would continue to support and improve ethnicity coding. Resources would be aligned to support primary care recovery. • The continued focus on health inequalities was highlighted. Support for clinically vulnerable patients continued. Other key areas included supporting patients with Learning Disabilities, Severe Mental Illness Physical Health Checks and early detection of cancer with a focus on lung cancer pathways. • Capacity and demand modelling was key, with the continued use of Improved Access and Direct Booking. • Key enablers included digital developments, an estates review and the continued focus on resilience to understand where practices need support. The first draft narrative would be submitted for 6th May with the final submission on 3rd June. JR commented that there was no sense of the scale of recovery challenge for primary care in the narrative. It was not clear what actions would have an impact and make a difference. What would enable primary care to recover and grow for the future, and how the innovations seen in the past year would be retained and built on? There was no reference to the development of ICPs and	

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	Community Mental Health, frailty and same day urgent care. JR commented that it was not clear which of the actions listed were priorities. GI explained that work focused on activity and outcomes to provide baseline figures was ongoing. Discussions were being held with PCNs to understand their support needs including core work. Discussions were also focused on enabling actions. Practices were seeking guidance on appointments and were keen to restore services. JR commented that it was important to have practical inputs that made a difference; there was no indications of the priority areas and impacts. GI confirmed the narrative would be reviewed to include context and ensure it was clear and explained how actions would have an impact. STW noted that Bev Haworth (BH) had commented that the draft narrative sat alongside the activity submission. The outcomes and activity group was reviewing the activity submission and the narrative would be updated accordingly and the feedback from this meeting would be included. JB noted that data quality was a significant challenge, for example, general practice appointment data included some mass vaccination activity. The complexities of the data needed to be addressed to ensure confidence. A data submission would be part of narrative. JB confirmed that links to ICPs and other strategic programmes of work would be added. AM commended the work to date. AM commented that it was not clear whether references to activity levels referred to a return to pre-pandemic levels or an increase. It was not clear if pre-pandemic levels of activity were what was wanted. It would help to indicate best practice developed over the past that would be retained. AM asked if there were further layers of detail that looked at key performance indicators, demonstrating achievements. Georgie Bigg (GB) commented on the scale of the task and asked that it was not done in isolation of the public. Healthwatch received lots of feedback on general practice and how it operated. GB noted it would be a significant communications task and provided an opportunity to explain to the public how they could be better served through new ways of working. GB noted that the majority of the public wanted to see a return to face-to-face appointments. JR thanked GB for her comments and noted that there was also evidence from public engagement supporting the new ways of	**GI/JB** **GI/JB**

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	working. It was important to design services so that capacity matched demand. JB thank the committee for its feedback which would be used to strengthen the submission including: indicating the key actions and their impact, making clear what would be different, retaining the innovations from the last year, continued public engagement and communications, and links to strategic initiatives. GI confirmed that data from the citizen's panel and listening events would be incorporated into the approach and noted that a session with communications colleagues to discuss public engagement and ICPs was planned. **The Primary Care Commissioning Committee received the update**	**GI/JB**
08	**Budget Setting 2021/22** JL drew attention to the financial headlines in the slide pack and explained they sat in the context of a transition back from covid finance work to a full year Primary Care Medical allocation and a return to the Long Term Plan allocation model. Acute and community services continued to operate on the short-term financial model. For primary care the focus on a return to the ambitions of the Long Term Plan. Attention was drawn to the additional resources available. This included an increase in the Allocated Revenue Resource Limit, which was allocated directly to the CCG and the Unallocated Additional Roles Funding, which was retained nationally for additional roles. The CCG would draw down this funding when roles were recruited. If the roles were not recruited to, the funding would not be retained by the CCG. JL explained that a structural deficit of £1.9 million remained. Mitigations included the release of contingency funds, leaving an unidentified savings target of approximately £1.2 million. JL explained there was confidence that the savings target would be achieved. JL explained, as context to the deficit, that the CCG had a distance from target allocative pressure of £4 million. The CCG received £4 million less than the NHSE Fair Shares Funding Model implied. JL highlighted the focus was now linking investment to workforce and capacity planning and outcomes. JL took the committee through the slide describing the distance from target. JL explained the majority of primary care funding was allocated directly to practices through the global sum. The CCG passed the uplift onto primary care and held the deficit element. JL	

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	explained population growth was another element of allocative pressure. The assumed population growth that underpinned the allocation of funding was below the actual population growth in BNSSG. Population growth was currently slowing which was moving the CCG back towards the population target. JL highlighted the revised allocation. JL explained a key assumption in the planned budget related to the reduction of premiums payed on APMS contracts. Other contract support continued and this was accounted for. The growth in the global sum was noted. This was increasing year on year by 3.6%. QOF points were also increasing in value by 3.2%. The PCN additional roles recruitment scheme was noted. JL explained that in 20/21 the payment for PCN Additional Roles was approximately £4.1 million. In 21/22 BNSSG was able to access up to £12.1 million, which was a significant uplift, and it was important to link this investment to workforce plans and outcomes. JL highlighted the risks and mitigations detailed in the final slide. JRu welcomed the allocation of additional funds and noted there were additional commitments and the CCG remained in a deficit position. JRu commented it would be helpful to have the assumptions underpinning the short terms savings from slippage in detail to allow the tracking over time. JRu noted there was no reference in the paper to a budget allocate for Section 96 support. He asked, given the pressures on GP practices, how confident was CCG that there would be no demand for Section 96 support. JL explained there was a contingency budget that could be called on. JRu noted the contingency was a mitigation for other risks. JL explained that significant levels of investment were being made in primary care. The solutions to financial risks within practices should come from redesigning services and the use of new funding. JB added that resilience finding was included as part of the Long Term Plan transformation resources. JR commented that the opportunity to invest significantly in primary care could not be missed and it was important to make the transformations required. The savings needed to be framed within the context of using investment to transform the way primary care was delivered. The transformation of primary care was about how it worked together and in collaboration with the out of hospital environment. JR felt it was important to have a narrative that aligned to the strategic ambitions and goals. The operating plan	

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	would be easier to articulate along these lines. It was important to optimise all the investment in primary care to transform the model. **The Primary Care Commissioning Committee agreed the submission of a balanced plan for Primary Care Medical as part of the CCGs overall financial plan for 2021/22, recognising delivery of this plan was dependent on an uncommitted contingency funding of 0.5%, and identifying £1.18m of in-year savings**	
10	**Primary Care Finance Report** JL presented the month 12 financial report and highlighted that there were underspends on the prescribing budget which contributed to an under spend across whole budget for the year. Underpinning this was an over spend in the core primary care budget, linked to the structure deficit referred to in the previous item. This was offset by the prescribing underspend. There were no comments or questions. **The Primary Care Commissioning Committee noted:** • **The summary financial plan** • **The key risks and mitigations to delivering the financial plan** • **That at Month 12 combined primary care budgets were reporting a year end £0.96m surplus**	
11	**Primary Care Quality Assurance Process and Quality Escalation Plan** Michael Richardson (MR) introduced the paper, explaining the proposal was for a quality assurance process that standardised the areas for focus for targeting quality support for practices. The paper took into account the primary care quality and resilience dashboard, and set out a process of using a quality stocktake tool. Jacci Yuill (JY) explained the process set out a structure and escalation plan to respond to deteriorations in quality metrics, patient safety indicators and patient experience. Currently performance was identified through the Primary Care Quality and Resilience dashboard. Practices also approached the CCG for support as a result of CQC inspections or complaints. The proposal set out a process to allow a better understanding of the quality support practices required. Practices would undertake the quality assurance programme. JY highlighted the quality stocktake tool, which would be shared with practices to allow them to benchmark and identify where improvements were needed. The framework included a list of available support; primarily this would be provided by the quality team, the resilience team and area	

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	team colleagues. The quality escalation plan would be implemented where programmes of support had not been successful. MR highlighted the flowchart setting out the process. JR welcomed the paper and asked about the level of engagement with GP practices, observing that that GP ownership was critical to the process's success. JR commented that it was not clear how the process aligned with the CQC regime. JR noted that some of the indicators included subjective descriptions, for example, the reference to an easy complaints process and asked how these would be defined. JR commented that the complaints section did not clearly indicate how the learning loop would be closed. MR explained the paper had been discussed and agreed at the Primary Care Operational Group (PCOG). JY added that the process had been shared with the LMC Nurse Lead for comment and the quality stocktake tool had been shared with three practices that were working with the CCG. JR asked Philip Kirby (PK) for the view of the LMC. PK explained that the LMC was supportive of the proposed process and would like further conversations. JR asked for a process for engagement that would include the LMC as a key partner. LMC endorsement was critical. PK observed that the LMC wanted to have in place a process that it could support. Sukeina Kassam (SK) noted that the LMC had participated in the PCOG discussion. JB added that the stocktake tool was being tested with three practices and the learning would be used to refine it, similarly to the development of the resilience toolkit. SM noted that the resilience toolkit had been adapted as it was used by practices. STW noted that clarity regarding engagement was being asked for. MR commented, in response to the question about alignment with the CQC, that all learning from practices would be shared with the CQC. AM welcomed the process and asked what level of support processes would be available to practices. AM asked for the learning from best practice to be highlighted. AM commented that the stocktake tool included closed yes/no questions and that more information would be elicited if these questions were made more open. MR welcomed the comments on the stocktake tool and these would be taken on board. MR noted that the process would shape future quality reports identifying themes that would be reported. Debbie Campbell (DC) noted that there would be further information in quality reports related to medicines. MR confirmed	**MR/JY** **MR/JY**

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	the complaints section would be reviewed to ensure learning loop was closed. **The Primary Care Commissioning Committee approved the:** • **Primary Care Quality Assurance Process (SOP)** • **Quality Stocktake Tool** • **Escalation Plan**	**MR/JY**
	Medicines Optimisation Report DC explained the report was for information and assurance. Attention was drawn to work of the BNSSG Area Prescribing Medicines Optimisation Committee, the BNSSG Joint Formulary Group and the Medicines Quality and Safety Group. The Community Pharmacy Patient Group Direction (PGDs) service was working well and its use was increasing. It was planned to expand the range of PGDs to other areas/conditions. The Antimicrobial Stewardship update was highlighted. A cellulitis pathway was in development. The final page presented areas of work related to avoiding harm and increasing medicines safety. Reporting by GP practices had increased. DC highlighted the launch of a system wide medicines safety newsletter. There were no comments or questions. **The Primary Care Commissioning Committee noted the report**	
	End of year 'Flu Reporting DC explained that uptake was better than the previous year across all groups. Staff vaccinations had improved with the exception of NBT. The Trust had now appointed to a role to support the 201/22 flu season. There had been close collaboration with the communications team, which had helped increase the reach of the campaign with key groups. Close collaboration across the system had worked well. The higher uptake reported for people with Learning Disabilities was noted. Work with vulnerable groups and populations that were harder to reach had been positive and informed the covid mass vaccinations campaign. Planning for the 2021/22 flu season would link to the covid mass vaccination programme. This would help support increased uptake in the 'at risk' groups particularly within in deprived populations. JR thanked the team and welcomed the report recommendations. JR asked how the equalities data on compared to previous years and if there was an indication of the impact of the actions taken to improve uptake in minority communities. LR explained it was difficult to obtain accurate data for previous years. The covid data collection tool had been used for 2020/21 and a comparison would	

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	be available for 2021/22. There were increases that potentially related to actions taken, for example household leaflet distribution in areas of deprivation. Feedback was that approaches to communications had helped, in particular multi-language leaflets and the video amination. AM welcomed the report and explained she had a question related to NBT that she would follow up outside the meeting. AM asked whether the issue of data sharing agreements with GP practices were significant. DC explained this not fully resolved; the issue was that not all practices had signed sharing agreements. This had been raised with OneCare. DC noted that a single data sharing agreement that covered all situations would be helpful and would potentially be resolved with the move to an ICS. JR explained that there was an ICS plan to address this and there was a national drive to make data sharing an expectation across partners. STW welcomed the report and highlighted the positive impact of the communication strategy, effective engagement and outreach. **The Primary Care Commissioning Committee noted the recommendations**	
12	**Contracts and Performance Report** SK provided the key points from the report: • A formal application had been received from Helios Medical Centre to take on new partners. • All but two of the temporary branch closures during the covid pandemic had been restored. A formal application was expected from one practice. The other closure remained in place due to structural issues and the branch would reopen in May. • There were no updates related to LES, recovery and Improved Access. There were no questions. **The Primary Care Commissioning Committee noted the report**	
	Six Monthly Report for Governing Body JB explained the paper summarised the Committees activities during quarters three and four for the Governing Body. There were no comments or questions. **The Primary Care Commissioning Committee noted the report**	
13	**Questions from the Public – previously notified to the Chair** A member of the public asked, “I have recently been appointed as team lead for the North Somerset Dementia Action Alliance /	

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	Dementia Friendly Communities 2021 team which is led by our new Alzheimer's Society North Somerset Dementia Friendly Communities Co-ordinator. May I ask how many members of the commissioning team are Dementia Friends and would any who are not please consider becoming one to help us make North Somerset and the wider BNSSG area as Dementia Friendly as we can. Thank you?" LM thanked the questioner, noting a similar question had been put to the Governing Body. There were two considerations for the CCG, how it ensured that it was dementia friendly organisation and how, as a commissioning body, it worked with all providers to ensure that they worked to become dementia friendly organisations. This would be taken forward as part of the programme of work. JR added that the CCG had made progress in terms of becoming a dementia friendly organisation. RM explained the documentation was being completed to evidence the CCG's intention to become a dementia friendly organisation. Pre-pandemic there had been a focus on raising awareness with sessions for staff held. Once confirmed as part of the scheme the staff awareness sessions would be reinstated. Commissioner activities would include a focus on the CCG's public engagement work. The member of the public thanked the committee.	
14	**Committee Effectiveness Review** STW thanked staff for their continuing support and the continued quality of papers.	
15	**Any Other Business** MR informed the Committee that a helpful Learning Disabilities report relating to Covid had been received that provided learning for the system. The team would engage with primary care colleagues to identify how to translate the learning into practice.	
16	**Date of next PCCC:** The date of the next open meeting was 25th May 2021	
19	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 AM and seconded by JR	

Sarah Carr, Corporate Secretary, April 2021