Bristol, North Somerset and South Gloucestershire
Clinical Commissioning Group

Primary Care Commissioning Committee Open Session

Minutes of the meeting held on 28th September 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
Colin Bradbury	Area Director for North Somerset	CB
Ben Burrows	CCG Clinical Lead Clinical for Governance and Quality	BB
Katrina Boutin	Clinical Commissioning Locality Lead, Bristol	KB
David Clark	Practice Manager	DC
Geeta Iyer	Primary Care Provider Development Clinical Lead	GI
David Jarrett	Area Director for Bristol and South Gloucestershire	DJ
Lisa Manson	Director of Commissioning	LM
Alison Moon	Independent Clinical Member, Registered Nurse	AM
Michael Richardson	Deputy Director of Nursing and Quality	MR
Apologies		
Jenny Bowker	Head of Primary Care Development	JB
James Case	Clinical Commissioning Locality Lead, South Gloucestershire	JC
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 Pottenger	Associate Director Medicines Optimisation	LP
Julia Ross	Chief Executive	JR
John Rushforth	Independent Lay Member, Audit, Governance and Risk	JRu
Rosi Shepherd	Director of Nursing and Quality	RS
Kat Showler	Senior Contract Manager Primary Care	KS
Jacci Yuill	Lead Quality Manager – Primary Care	JY
In attendance		
Debbie Campbell	Deputy Director (Medicines Optimisation)	DCa
Sarah Carr	Corporate Secretary	SC

Sukeina Kassam	Interim Head of Primary Care Contracts	SK
Louisa Darlison	Senior Contract Manager Primary Care	LD
Bev Haworth	Models of Care Development Lead	BH
Sandra Muffett	Head of Clinical Governance & Patient Safety	SM

	Item	Action
01	**Welcome and Introductions** Sarah Talbot-Williams (STW) welcomed members and the public to the meeting. It was confirmed the meeting was quorate. The above apologies were noted.	
02	**Declarations of Interest** STW declared that an existing interest as Vice Chair at Together for Short Lives had been extended for a further three years following re-election. 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: **Actions 164** – it was agreed to defer this action to October. Alison Moon (AM) observed that the action arose from the March 2020 meeting and asked if the issue had become a business as usual matter. It was agreed that John Lund would be asked to review the action to confirm that it should remain open. **Action 262 –** Michael Richardson (MR) recommended that this action was reviewed to understand the position. It was agreed that the outcome of the review would be reported to the Quality Committee and if required reported to this committee. It was agreed to close the action. **Action 263 –** Lisa Manson (LM) confirmed the Immunisation Strategy had been discussed by the COVID programme board. A task and finish group had been established. LM noted that this would take into account the potential impact of receiving delegated authority for Independent Contracts from NHSEI. Work currently focused on data collection and the aim was to develop an all-age immunisation strategy for BNSSG. LM noted that it was important to develop a flexible strategy, which embedded mass vaccination campaigns into business as usual. Future updates would come to the committee. It was agreed to close the action. **Action 264 –** Geeta Iyer (GI) confirmed work was in progress regarding community provider support and discussions were planned. It was agreed to close the action. **Action 265 –** This action remained open.	**JL** **MR**

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	All other due actions were closed.	
05	**PCCC Assurance Framework and Risk Register Primary Care** Attention was drawn to the risks added to the Risk Register relating to primary care. A risk relating to the diagnosis of type 2 diabetes in primary care would be added to the register. GI explained that workforce and capacity related risks were managed through the primary care escalation work-stream and would be discussed later in the meeting. AM asked whether the level of risk relating to the availability of blood bottles had reduced. GI explained concerns remained and a phased approach to reinstating tests was in place. The risk score was, however reducing and GI would review it. DJ commented that mitigations were in place relating to other risks reported and agreed to review the risk scores in advance of the Governing Body meeting. The Executive team had reviewed the Assurance Framework with a particular focus on key risks. These changes would be presented to the October Governing Body. It was agreed that the revised Assurance Framework would be circulated to committee members after the Governing Body meeting. **The Primary Care Commissioning Committee:** • **Reviewed and ensured that appropriate and effective mitigation were in place for risks reported on the Corporate Risk Register (CRR) and Governing Body Assurance Framework (GBAF) and specifically those areas relating to the Committee's remit** • **Reviewed those risks recommended for closure to ensure the Committee was assured that the risk score has been sufficiently reduced** • **Considered whether the CRR and GBAF were an accurate reflection of the risks brought to the Committee's attention** • **Considered whether the objectives and risks reported on the GBAF fall within the Committee's remit**	**GI/DJ** **SC**
06	**Covid-19 and Recovery Update** GI drew attention to the new specification for Phase 3 of the mass vaccination campaign and the delivery of the booster to the 'at risk' cohorts. The Phase 2 specification had been updated and expanded to include children and young people aged 12-15 years old. The vaccination of children without under lying health conditions was restricted to the school nursing service. PCNs could be commissioned to vaccinate this cohort in collaboration with local school aged immunisation services in exceptional	

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	circumstances only. GI highlighted the data on vaccination provided; the CCG was performing well compared to national averages. The programme was focused on: • continuing the Evergreen offer • providing booster doses for at risk cohorts, and second doses for expanded cohorts • supporting the system, including where to deploy workforce to ensure delivery of the programme • offering booked and walk in appointments GI explained that outreach work, including pop-up clinics, continued. Support was being offered to the Afghan Refugee Resettlement programme. Fresher's Fairs were being targeted and Family Clinics for the provision of the covid and flu vaccines were being explored. Communications activities targeting the younger demographic were highlighted. The team had been nominated for a Health Service Journal 'Reducing Health Inequalities' Award. The team had been highly commended at the NHS Communications Awards for the use of insight and data for innovation in communications. GI paused for questions. STW asked if there would be an evaluation of the outreach work. GI explained that there had been an evaluation of the Phase 2 in May that had been published on the Healthier Together website and shared with stakeholders. GI would confirm that this had been shared with the committee. The Phase 3 evaluation would be based on this. The evaluation would inform the development of the Immunisation Strategy AM asked about the risks and mitigations. GI explained that workforce capacity was a significant issue. The covid and flu campaigns were significant and balancing these with business as usual was challenging. There had been delays to deliveries of vaccines. The aim was to co-administer the two vaccinations as much as possible and to reduce duplication of efforts. There were twice weekly meetings to consider priorities and direct workforce to key areas. Katrina Boutin (KB) highlighted the risks related to home visits to give vaccinations and the impact of the 15 minute wait on the number of vaccinations that could be delivered. There had been issues with availability of flu vaccination stock. PCNs had provided mutual aid to each other. KB explained that there was a risk that	**GI**

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	two home visits would be required to administer the vaccinations if they could not be co-administered. Bev Haworth (BH) presented the slides relating to general practice resilience and the challenges faced by primary care. The increase in reported staff absences due to staff isolating, summer leave and a shortage in locum cover was highlighted. Primary care resilience continued to be monitored to enable targeted support. Issues had been raised through regular situation reporting, with One Care providing active support to practices. Communications regarding business continuity, PCN and locality resilience plans, digital support for remote working and communications support with patients continued. BH highlighted that the two way communication with primary care had provided Bronze reports, shared with the wider system and helped identify the support that primary care could offer the wider system. BH drew attention to the work in place to support capacity including the development of staff sharing agreements and the use of system bank staff to support the vaccination programme and expand its use beyond the covid campaign. Work to develop a community, primary care and social care workforce bank was being taken forward. The initial focus was on supporting PCNs with the Additional Roles. KB observed that general practice felt very challenged at this time. There were significant pressures on workforce and a notable increase in demand across the system. There were risks and these needed to be considered. AM asked if the centre could be lobbied to ensure that consistent messages were being given out, noting that messaging from the centre had appeared mixed. GI noted that GP representative bodies had lobbied nationally for consistent messaging about access to primary care. DJ commented that the CCG communications team were active in delivering clear and consistent messaging locally; highlighting the pressures on the local NHS and the part patients could play. GI provided an update on blood bottle availability. There had been a temporary restriction on ordering routine blood tests in primary and secondary care. The Clinical Cabinet had provided guidance on priorities so that Learning Disability health checks and Severe Mental Illness health checks continued. Other tests prioritised included cancer diagnosis and those required in urgent care. Stock of bottles was monitored weekly. National guidance had	

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	lifted restrictions in primary care and phased back activity. Locally the Medicines Optimisation team had worked with secondary care colleagues and GPs to draft further guidance about deferring blood tests and patient safety. This was signed off by the Clinical Cabinet and would be published. The situation would continue to be monitored through EPRR mechanisms. LM confirmed that the weekly stock takes would continue to ensure confidence in availability. BH highlighted the slides detailing the PCN contract letter 2021/22 and 2022/23. These outlined the requirements for 21/22 and 22/23. Details about the Investment and Impact Fund (IIF) were included. BH drew attention to the change in focus to Clinical Directors ensuring that funding met conditions. The five PCN objectives were highlighted. The focus for 21/22 would be on the gradual introduction of the specifications for cardiovascular disease prevention and diagnosis and tackling neighbourhood health inequalities. BH noted there was a focus on wider system support; PCNs were being asked to support the analysis of data related to A&E minor conditions attendance rates to reduce unnecessary attendances and admissions. In 22/23 the focus would be on the continued delivery of the specifications already in place and the introduction of the deferred specifications for anticipatory care and personalised care. BH commented there would be a combined extended access offer. This was not yet clear and there would be discussions with the collaborative boards and PCN Clinical Directors to take this forward. Debbie Campbell (DC) commented on the new pharmacy contract and the opportunity to work collaboratively across community, primary care and pharmacy to reduce health inequalities. BH explained that this had been discussed at the Primary Care Strategy Board. The Chair of the Local Pharmacy Committee (LPC) had been present and the team was working closely with LPC. An action had been taken at the Board to follow this up. **The Primary Care Commissioning Committee noted the report**	
07	**Delegation of Primary Care Services to the Integrated Care System** LM presented the paper explaining that the ICS Executive Group had considered the expression of interest to NHSEI to assume the delegation of pharmaceutical and optical services from April 2022 subject to a full diligence process, and dentistry services by April	

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	2023. Assuming responsibility for wider primary care services would provide the opportunity to commission services across the whole pathway for the BNSSG population, securing better services that would be embedded within the both the ICPs and the wider ICS. The delegation process would require the demonstration of the case for change and ensure that further financial risk was not built into the system. LM highlighted the opportunity to align priorities through Local Enhanced Schemes. There would also be the opportunity to build a more integrated clinical leadership model reflecting the wider primary care system. AM asked whether the due diligence process would include a review of funding and whether the resource to be transferred would be the current funding or the level of funding required to deliver the service. LM explained that the learning from the delegation of authority for primary care services would inform the process for these services. It was important that the implications of delegated authority and the potential financial impact was fully understood including the overall impact on financial resources and the impacts within each contractual arrangement. LM noted the impact in terms of the potential need to invest in commissioning capacity. These issues would be part of the due diligence undertaken. LM noted this was part of a wider approach to delegated authority by NHSEI and highlighted the benefits and the potential to take learning from programmes such as the mass vaccination campaign and apply this to the other areas. STW asked about the recommendation and whether the paper would be presented to the Governing Body. LM confirmed this was for the Committee to note. **The Primary Care Commissioning Committee noted the proposals and the support for the approach from the ICS Executive Group**	
08	**Flu' report Update** This item was taken at this point. DC reported that over 900,000 vaccinations had been delivered, approximately 7.6% of the population. DC drew attention to the trajectory presented in the report and the difference between the requirements relating to the under 65's in 2021/22 compared to 2020/21. The risks and issues were highlighted. In additional to risks related to capacity there was a risk relating to stock levels and potential delays in deliveries. The potential impact of this on the ability to co-administer the vaccine with the Covid programme was noted. The	

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	Medicines Optimisation Team was working with primary care colleagues regarding mutual aid. The work with maternity services to encourage vaccination uptake by pregnant people was highlighted. There were no questions **The Primary Care Commissioning Committee noted the report**	
09	**Community Phlebotomy Update** GI explained the slides provided on the Local Enhanced Service, which had been launched in July. There had been excellent uptake of the LES. Communications were in place within the trusts and practices. The Phlebotomy Operational Group met weekly. There were a number of areas for further work post launch and task and finish groups had been set up to refine the standard operating procedure. The Medicines Optimisation team and GI had worked with pharmacist, GPs and secondary care colleagues on Red/Amber drug monitoring. Clinical leadership was established in the trusts to support and champion the service. Online training had been provided for practices and the revised Standard Operating Procedure would be disseminated. A single communications platform had been established for primary and secondary care with a library of resources. Work continued to ensure that communications were in place with patients. Activity within the trusts signalled that there had been a transformation in the service. The final launch of the service would be on 31st October. A further update would come to a future meeting. AM welcomed the service development and asked whether patients would be able to access their test results without going through their practice. GI explained that some of this information was already available to patients. Further work would be required to pull together different sources information for patients and that taking this forward would sit within Healthier Together as part of the outpatients transformation work stream. AM asked if the ability for patients to access blood test result was consistent across primary care. GI explained that patients needed to request permission from their practice to view their results; practices could set up patients to view results on Patient Access and the NHS App. There followed a discussion about the potential risks relating to the availability of test results on line for patients to access. Katrina Boutin (KB) noted that there were concerns that patients would access test results that needed to be communicated in person by	

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	clinicians. Sukeina Kassam (SK) explained that a configuration process was required before patients could access information. There were risks to sharing information and these were mitigated through the settings that could be put in place when configuring the app for individual patients. STW noted that Georgie Bigg had commented that it was important to educate patients about accessing medical records to assist with self-care. GI noted it was important that patients had ownership. Information about how to manage patient access to test result shad been shared with practices however there were concerns about some aspects of information sharing that had been identified and shared with digital work stream colleagues who were exploring this. Ben Burrows (BB) commented on the concerns that patients would access key test results prior without the support of discussions with clinicians and potential increase in demand on primary care services as patients sought reassurance. It was important that patients were able to access information to help them with self-care. It was also important that patients were supported to understand complex medical information. KB noted that there were also safeguarding concerns about access to health records. BB agreed and noted that, as Safeguarding lead, this was an issue that caused concern. MR asked GP colleagues to raise any specific concerns with him directly so that they could be explored and resolved. LM agreed to share concerns that had been raised directly with NHS Digital. It was agreed that a paper on patient access to information on digital platforms would come to a future meeting. **The Primary Care Commissioning Committee noted the report**	**LM/SK**
09	**Primary Care Finance Report** STW noted that due to illness there were no representatives from the finance team present. STW asked members if there were questions on the paper. There were none. It was note that actions 164 and 265 remained open and these would be raised with Jon Lund for closure at the next meeting. **The Primary Care Commissioning Committee:** • **Noted the summary financial plan** • **Noted the key risks and mitigations to deliver the financial plan** • **Noted that month 3 (June), combined Primary Care Budgets were reporting a small overspend, which will be retro-funded, the underlying position continues to be breakeven**	**SC**

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10	**Primary Care Quarter One Incident Report** Sandra Muffett highlighted the year on year increase in reporting of 175%, which was in part due to the CCG Prescribing Quality Scheme Medicines Safety Project for 2020/21. This was a positive development. SM highlighted the risk that due to the increase in number of incidents, reported 82 incidents were on hold and pending action. The Incident Policy was being reviewed to ensure the inclusion of a timeline for closure of primary care incidents. SM explained that the Medicines Optimisation team monitored and reviewed all medication related incidents, investigating them and reporting to primary care colleagues and other providers. SM drew attention to the next steps to embed the Patient Safety Strategy in primary care as set out in the paper. A project manager had been recruited to support taking the strategy forward. SM highlighted the reported discharge related incidents and the action agreed in the meeting to review this and report to the Quality Committee. SM explained there would be an expert review of the incident reporting system to strengthen the quality of reporting to committees. MR commented that the team was focused on improving the systems and governance relating to incident reporting. AM asked why the increase in reported incidents was a positive development and whether there was a timeline for the review of the incidents on hold. SM explained that the increase in reporting reflected significant awareness raising with primary care colleagues regarding incident reporting. A trajectory for the review of the incidents on hold had not been set, however the work to review incidents was a priority. STW asked whether the increase in the reporting of incidents correlated to the rising profile or to an increase in the number of incidents. SM explained there had been an increase in reported incidents since the start of the awareness campaign. Confirmation that there was a correlation would be available over time as trends became identifiable. BB commented that as confidence that reported incidents would be investigated grew it was likely that more incidents would be reported. The evidence was that organisations with higher levels of incident reporting were ‘safer’ organisations. There was the potential for some of the incidents reported to be linked to the Covid outbreak and this trend would become apparent over time. SM confirmed that the team provided feedback to primary care colleagues about incidents and this encouraged further reporting.	

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	DC noted that nationally there was an under reporting of medicines related incident reporting and that the team actively encouraged reporting. As reporting levels increased it was anticipated the number of serious incidents reported would decrease. It was important to reflect this trend in the reporting to committees. MR emphasised that the aim was to encourage the reporting of all incidents. STW thanked the team for the report. **The Primary Care Commissioning Committee noted the report**	
11	**Contracts and Performance Report** SK explained that the CCG was waiting for further assurance from the contractor relating to the application to amend the partnership for Helios Medical Centre. The extension of the Homeless Health Service contract had been agreed in principle at the August Closed meeting of the committee. Work was in progress to finalise the outstanding financial arrangements and a further update would be provided to the next committee meeting. Attention was drawn to the Weight Management Local Enhanced Service. Public Health colleagues at Bristol City Council had confirmed that a pilot tier 2 service was starting. There would be a phased roll out of the service and further detailed information would be shared with the CCG. This would be passed to the Healthier Together Health and Wellbeing Group. SK highlighted the work in place to provide primary care support to interim accommodation centres as detailed in the paper. Enhanced health checks were being provided to identify health and social care needs. SK drew attention to the extension of the pod initiative detailed in the paper. SK highlighted the indicative costs in the paper and noted the links to general practice resilience support. There were no questions. **The Primary Care Commissioning Committee noted the report**	
12	**Questions from the Public** A member of the public asked about the pressure on primary care referred to earlier in the meeting and if there was evidence that GPs were leaving the NHS. GI explained that this was a concern. The recruitment and retention of primary care staff, including GPs, was a national issue. The pressures across the health and social care system were a significant challenge. Locally there was a focus on workforce capacity and a targeting of action across the system to provide support and promote resilience. The member of the public commented that there had been a comment about mixed messages earlier in the meeting and asked	

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	what this meant. GI explained that this was a reference to the national drive to transform the delivery of primary care services at the start of the pandemic, moving to telephone consultations and using digital solutions to ensure primary care services remained available. This was now balanced with the need to provide face-to-face consultations where these were needed. It was important to ensure that the right messages were being given to the public and that it was clear that primary care services were open and available.	
13	**Committee Effectiveness Review** STW invited MR to comment on meeting effectiveness. MR thanked STW for this opportunity and commented that: • The meeting had run to time • There had been a good discussion about the risks across the system, and specifically primary care • The papers had covered the breadth of the committee's remit. The covid recovery paper and flu' report were highlighted. The update on primary care services delegation had been helpful. • The discussion about the community phlebotomy service had highlighted the work and level assurance about the service. This had indicated issues about access to records that would be explored further. • It was more helpful if comments were provided in person rather than reported on the comments bar. • A pragmatic approach had been taken towards the finance paper • The challenge of assumptions and the review of incidents had been helpful • It was good to see staff acknowledged in the meeting. • The meeting had been well chaired and all had made contributions	
14	**Any Other Business** STW congratulated GI and SC on winning awards at the recent staff awards event. There was no further business.	
15	**Date of next PCCC** Tuesday 26th October 2021	

	Item	Action
16	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 STW and seconded by AM	

Sarah Carr, Corporate Secretary, October 2021