NHS
Bristol, North Somerset and South Gloucestershire
Clinical Commissioning Group

Primary Care Commissioning Committee Open Session

Minutes of the meeting held on 25th May 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
James Case	Clinical Commissioning Locality Lead, South Gloucestershire	JC
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
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
Rosi Shepherd	Director of Nursing and Quality	RS
Apologies		
Sarah Carr	Corporate Secretary	SC
Mathew Lenny	Director of Public Health, North Somerset	ML
In attendance		
Jenny Bowker	Head of Primary Care Development	JB
Debbie Campbell	Deputy Director (Medicines Optimisation)	DCa
Louisa Darlison	Senior Contract Manager Primary Care	LD
Kate Davis	Principal Medicines Optimisation Pharmacist (Bristol Area)	KD
Loran Davison	Team Administrator, Corporate Services	LDa
Bev Haworth	Models of Care Development Lead	BH

Sukeina Kassam	Interim Head of Primary Care Contracts	SK
Nicola McGuiness	Locality Board Member (North and West Bristol)	NM
Dominic Moody	Deputy Head of External Communications	DMo
David Moss	Programme Director, Integrated Care Partnership (ICP) Discovery	DM
Lucy Powell	Corporate Support Officer	LP
Kat Showler	Senior Contract Manager Primary Care	KS
Jacci Yuill	Lead Quality Manager – Primary Care	JY

	Item	Action
01	**Welcome and Introductions** Sarah Talbot-Williams (STW) welcomed members to the meeting and the above apologies were noted.	
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 –** Revised quality report would be presented later in the meeting. These actions were closed. **Action 248 –** STW noted that amendments had been made to the agenda to focus on decision and discussion and a discussion paper would be presented in July. STW asked the members to consider how to effectively review the meeting and it was agreed that at the next meeting one person would provide feedback at the end of the meeting. **Action 251 –** Lisa Manson (LM) provided an update and noted that work continued to ensure that students received matching vaccines. LM recognised that this was more challenging with overseas students. This action was closed. **Action 256 –** Rosi Shepherd (RS) confirmed that the information was included in the quality report. This action was closed. All other due actions were closed.	
05	**Covid-19 and Recovery Update** Jenny Bowker (JB) presented the update and outlined the numbers of vaccinations delivered and the programmes developed to support the vaccination programme. JB highlighted the key developments in the JCVI guidance including the requirement for second doses to be brought forward for the most vulnerable cohorts and for under 40's to be offered an alternative vaccine to	

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	AstraZeneca. JB updated the Committee on some key changes including the introduction of invitation for vaccination to be extended to 32 to 33 year olds and the testing of Pfizer vaccine in pharmacies. JB noted that the Pfizer vaccine could now be stored in fridges for 31 days which has supported settings operationally. JB informed the Committee that a letter from NHS England had been sent to GP practices updating the Standard Operating Procedure (SOP) for general practice. JB outlined the key points of the letter highlighting the suggested blended approach of virtual and face to face appointments. JB noted that the CCG did not yet have access to practice level data regarding appointments but data was received at system level and work continued with OneCare to extrapolate the activity data regarding incoming and outgoing calls for primary care. JB highlighted that there was an opportunity to reflect on primary care post Covid-19 amendments to review how the CCG can better support access to primary care. Alison Moon (AM) asked how primary care had responded to the NHS England letter and asked about the opportunities and risks to access in the system. James Case (JC) replied that primary care colleagues felt the letter reflected a lack of understanding of primary care by NHS England and explained that this was an opinion held nationally. JC also noted that the SOP felt unsupported by NHS England and appeared to be advice rather than direction. JB noted that similar feedback had been received from other primary care colleagues and explained that the CCG was working collaboratively with practices and the local population to determine how to support primary care and understand the contribution made by GPs during the pandemic response. JC highlighted the importance of working with GP representatives to ensure the messaging was supportive. Julia Ross (JR) noted that the CCG reflected positively on and appreciated the support primary care had provided during the pandemic. JR highlighted the importance that the CCG and practices continued to provide the best care for the local population. JR also noted that it was important that following the great work of practices through the pandemic, activity baselines were quickly described and the differences in practices identified	

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	in order to define what types of appointments were required to meet demand. JB noted that self-assessment for practices would be undertaken and the CCG would work with the Local Medical Committee (LMC) and local leaders to support practices to assess and reflect on what processes have gone well to support learning and the sharing of good practice. JR highlighted the importance of consistency across practices and noted that the CCG could work with Primary Care Networks (PCNs) to ensure this was undertaken quickly and also highlighted the importance of triangulating data between the assessments and feedback from Patient Participation Groups. JC noted the importance of minimal demand on primary care colleagues to identify the activity, and explained that OneCare had been reviewing this data for years and noted the difficulty in obtaining accurate appointment data. Geeta Iyer (GI) noted the importance of understanding the variations. Philip Kirby (PK) highlighted that primary care had been incredibly busy during the pandemic and were now focused on recovery. Georgie Bigg (GB) shared the importance of balanced access for patients and highlighted the opportunity to communicate the mixed attendance routes to patients. GB noted that this would be most effective undertaken by GPs through a more personalised approach. JB noted that discussions have been held around supporting with communications particularly in using practice websites and common forms of communication and this would continue to be reviewed. Sukeina Kassam (SK) presented the covid-19 expansion fund considerations noting that the split and release of monies had been arranged at PCN level. SK noted that £150k residual money would be rolled over and used to support the PCNs which continued to vaccinate for cohorts 10 and above and met the core criteria. SK highlighted that as part of the core criteria for 2021/22, the achievement target for Learning Disability Annual Health Checks had been increased to 75% with an aspiration of 100%. SK noted that there were further considerations to make regarding the core criteria including the achievement targets for ethnicity recording. JC asked why the proposals were proposed at PCN level and not practice level. SK noted that the LMC had discussed this with PCN Clinical Directors and PCN level was the preferred option and enabled PCNs to work together more effectively. SK	

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	confirmed that the funding would be broken down to practice level as requested to allow PCN Clinical Directors to apportion funding for specific schemes. JR noted that flu vaccination was not one of the core criteria and it was confirmed that flu vaccination achievement was included in another tranche of funding. **The Primary Care Commissioning Committee received the report and agreed the preferred option for the Covid Expansion Fund based on a Memorandum of Understanding with split payment, the second payment based on key deliverables being achieved and 7 core criteria.**	
06	**Local Enhanced Service (LES) Update – Project Mandate for Supplementary Services Review** Louisa Darlison (LD) noted that phase one of the review had been completed and expressions of interest had been circulated to practices. The 11 practices which were adversely affected by the care home funding changes have been contacted and meetings have been arranged to discuss the rationale for the decision and any resilience concerns. It was proposed that from quarter 2 2021/22 payments returned to activity based. This was agreed at the Contract Provider and Finance Cell and the Primary Care Operational Group. The Committee approved the change. LD provided an update on the pathway 3 beds noting that the expressions of interest process has been concluded and beds agreed across the system. The £20 per bed had been agreed until the end of quarter 1 2021/22, however feedback from practices indicated that £20 per bed may not be sufficient and review work with Sirona had begun. LD confirmed that a further update would be provided at a future meeting for discussion. LD confirmed that the agreement regarding the supplementary services and South Gloucestershire basket of services concluded on 31st March 2021 and a review of these services needed to be undertaken to understand whether the services continued to reflect population needs and value for money and whether the covid-19 response changed population requirements. LD noted that the review had encountered data challenges and the team had relied on survey work and complaints intelligence as well as reviews of emerging Integrated Care Partnership (ICP) and Integrated Care System (ICS) strategies. It was expected that the review would be completed by the end of September 2021 with	

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	consultation planned during October and November with the draft specification ready for review and agreement before April 2022. LD noted that risks included lack of resource for the project and the requirement for practices to have the capacity to engage in the process. AM highlighted the importance of understanding population needs and asked for the plan to identify these. LD noted that specific plans had not been developed but at the highest level complaints data had been reviewed for themes. AM suggested utilising the Citizens Panel and voluntary sector organisations to support engagement. JC suggested that the Committee did not refer to the funds as 'additional' as some practices relied on this tranche of funding. Jon Lund (JL) noted that the funding was at the discretion of the Committee and asked the Committee to consider how this would be spent if not on the services within the specification. Lisa Manson (LM) explained that the funding had been identified from the rebalancing of the GMS and PMS contracts and that the five year transition between contracts had concluded and therefore this was the appropriate time to review the services to ensure that the right mix of services for the local population was funded. JR noted that the review needed to evidence that the funded services were providing required services. JC highlighted that the funding provided capacity and removing this could affect performance. This was acknowledged and JR noted that the review was intended to ensure that the population received the services they needed and not to remove funding from general practice. **The Primary Care Commissioning Committee:** • **Agreed payments would return to activity based from quarter 2 2021/22** • **Supported the supplementary service and South Gloucestershire basket project to review the enhanced offer**	
07	**Community Phlebotomy Local Enhanced Service (LES)** David Moss (DM) was welcomed to the meeting for this item. GI provided the background for the development of the new LES and highlighted how it supported outpatient transformation and integrated working. GI noted that the LES supported care	

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	delivered closer to home and that there was currently an informal process in place where general practice undertook blood tests for secondary care outpatients. The numbers of tests undertaken by GPs had increased as part of the covid-19 response. A system wide group had been formed to develop a set of principles for phlebotomy which ensured joined up care for patients and facilitated the return of results to the clinician who requested the test. GI outlined the options considered for testing the model of care and noted that an EMIS protocol had been developed to ensure that activity was captured and engagement has taken place with GPs and patients who attended the pilot locations. The LES specification has been developed and GI noted that the next steps were to present this to the Membership and practices for expressions of interest. GI highlighted the cost of £5.61 per blood test and explained the funding would be initially through the LES underspend and covid-19 funding and then from quarter 3 onwards through the LES underspend and acute growth funding. Consideration has been given to the payment mechanism and the benefits and risks to block and activity based payments were outlined. AM commented that moving activity from secondary care to primary care should also involve the movement of the funding for those activities. AM asked whether the work involved the patients accessing blood test results online and also asked whether the Acute Trusts supported the work. GI confirmed that the Trusts greatly supported the work and supported results being returned to the requesting clinician and noted that in terms of the availability of results online this was not accessible yet but could be considered as the service developed. JL highlighted the challenge in releasing secondary care funding back to the CCG via the LES commissioning and noted that the LES facilitated transfer of resource from secondary to primary care which in practical terms meant that secondary care colleagues could undertake other work. JR welcomed the funding from acute growth but noted that the LES underspend monies could have been utilised elsewhere. JR also noted that activity based payments tended to be considered for low volume activity and suggested that a review of activity was undertaken. JL noted that the activity should be clinically led and	

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	agreed with monitoring the activity. DM explained that during quarter 4, 33 practices were undertaking coding to provide activity levels and noted that the LES represented a culture change and the proposal reflected the work shift. DM suggested the working group look at a blended approach to activity based and block payments and present proposals to a future meeting. PK highlighted the primary care concern of resource following work and LES funding being utilised for secondary care work. JC praised the work and relationships built whilst developing the LES and highlighted the importance of receiving funding for non-core primary care work and the improvement in patient care the LES would facilitate. **The Primary Care Commissioning Committee:** • **Approved the Local Enhanced Service Specification** • **Asked for further work to be undertaken on volume and activity to agree the payment mechanism**	**GI**
08	**Quality Prescribing Scheme** Kate Davis (KD) was welcomed to the meeting to present the annual Quality Prescribing Scheme for 2021/22. KD noted that last year's scheme had been successful with good engagement from practices. KD noted that the 2021/22 scheme continued with the same funding of up to £1 per registered patient with a percentage of the funding linked to cost effective use of medicine and the rest linked to quality projects planned to achieve savings. KD noted that practice proposed plans which demonstrated quality improvements for the local population would be considered for the scheme. This allowed PCNs to develop schemes aligned to population. KD confirmed the scheme had been presented to the Membership highlighting the amendment made to the financial element of the scheme. KD noted that for practices which achieved the Key Performance Indicators (KPIs) but did not achieve the savings as per the fair shares budget would have their prescribing reviewed and if the practice has demonstrated that they have saved as much as possible then a part payment would be received. JR asked about the current arrangements and KD confirmed that for 2020/21 practices received 50p per patient for full achievement	

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	and there was no part payment plan in place. KD noted that for 2021/22 engagement with the financial projects would be incentivised with a potential part payment. JR asked whether this could increase overspend on medicines. Debbie Campbell (DCa) noted that the prescribing costs would be slightly higher in some areas but reduced in other areas. AM noted the importance of the quality projects having the flexibility for amendments for local populations and asked how this would work for the Quality Prescribing Scheme. KD confirmed that the Membership had been informed that the CCG would welcome amended projects and would support practices and PCNs with advice on writing and setting evaluation measures for projects. These projects could then be rolled out to other appropriate areas. **The Primary Care Commissioning Committee:** • **Approved the Prescribing Quality Scheme for 2021/22 and agreed the split of funding** • **Agreed that the payment for the scheme continued to be split 50/50** • **Approved the part payment for practices not achieving their 'fair share' budget if, following scrutiny of their prescribing, they have achieved 80% of the financial targets set by the CCG, specific to the finance projects undertaken by the practice to ensure best practice from these medications** • **Approved the quality project themes**	
09	**Quality in General Practice** GI explained that 'what does quality look like in primary care' had been discussed at the Clinical Leads Forum and at the Clinical Executive Committee. The definition of quality in healthcare and the outline of quality in the Primary Care Strategy had been considered and suggestions had been provided. These included keeping people healthy and independent, continuity of care, access to the right care, and care closer to home. GI noted these discussions highlighted the need for data driven care and supported the quality improvement work aligned with the resilience work. GI outlined the processes in place to support quality delivery in primary care including Datix reporting and access to Remedy. GI also noted that the response to covid-19 transformed how services were delivered and a stocktake of these changes needed to be undertaken and would be considered as part of this work. RS highlighted the next steps in the paper and how these connected	

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	to the wider work around quality improvement as part of the development of the ICS. A workshop has been arranged to design the approach at practice and ICP level. It was confirmed that practices would be asked to complete a survey to identify quality baselines. AM welcomed the work and asked what outcomes the Committee would expect to see in the long term in response to the work and commented that the responsibility section within the Standing Operating Procedures did not mention PCNs. RS confirmed that the Patient Strategy Safety work would develop this work into an outcomes based approach. JR agreed that an outcomes framework needed to be developed and noted that the themes of the complaints received by the CCG regarding primary care were around inconsistency of processes and care. PK was supportive of the proposed approach and highlighted the importance that practices were supported with quality improvement rather than performance managed. JL noted the link between the ongoing quality work and the Community Mental Health Framework which identified the links between quality and quality regulation for secondary and primary care to ensure consistency of approach. GI noted the importance of having these discussions wider than primary care and aligning with other organisations and confirmed that this had been considered. **The Primary Care Commissioning Committee discussed the current approach to quality in general practice and agreed next steps**	
10	**Primary Care Network Update** JB provided the update noting the significant progress of the task and finish group between PCN Clinical Directors and Localities on the development of mental health roles in primary care. Next steps included developing a delivery timeline and agreement of readiness for roles. Formal workforce plans would be resubmitted in August. David Jarrett (DJ) confirmed that all PCN organisational development proposals have been received and these would be reviewed alongside the workforce plans in August and aligned with the additional roles. JB noted that a seminar session would be arranged to further discuss this. **The Primary Care Commissioning Committee received the update**	**DJ/JB**

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11	**2021/22 Primary Care and Prescribing Report** JL presented the proposed delegated budget which had been updated as part of the core CCG budget. JL noted that assumptions had been made for the non-delegated elements of the primary and prescribing budget. Further support has been provided for primary care which mitigated the savings shortfall in core primary care. JL noted that there was little contingency within the planned budget and short term mitigations would need to be identified to offset this. JL confirmed that there was a high level of growth in prescribing and the savings budget was a challenge but deliverable. JL highlighted the 0.5% contingency available within the core CCG budget which could mitigate any savings underperformance. **The Primary Care Commissioning Committee agreed the submission of a balanced plan for Primary Care as part of the CCG's overall financial plan for 2021/22 and recognised that delivery of the plan was dependent on uncommitted contingency and reserves, of equal value to the delegated deficit**	
12	**Primary Care Quality Report** Jacci Yuill (JY) was welcomed to the meeting to present the report. JY noted that notification of incidents had increased with the highest numbers from secondary and community care. The Datix system was being reviewed to support GPs with reporting. The themes of incidents were outlined and it was reported that further work was in train to develop an efficient system to respond to the complex incidents. JY updated the Committee on the ongoing GP Nurse workstreams including promotion of the Nurse Network and sharing of best practice. Leadership training would be delivered and clinical supervision of all GP Nurses was in development. LM asked whether the Datix reporting themes had been compared to complaints data as there were similar themes in both. Michael Richardson (MR) agreed to discuss this with the Customer Services team. AM highlighted the practice nurse health improvement projects and commented that it would have been useful to have been updated on the outcomes of the project especially as this was	**MR**

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	focused on inequalities. AM asked for more information on the progress of an electronic patient record across the system which would support timely completions of hospital discharge summaries and also asked whether staff reporting incidents were informed of the steps taken following the report and asked how the team were reducing the backlog of incidents. JY confirmed that regular meetings were held to review the incidents including the backlog and noted that part of the ongoing work was to ensure that the system was revised so that responses to incidents could be managed by theme and acknowledged that currently responding was labour intensive. JY confirmed that it was expected that the backlog would be cleared by 30th June 2021. RS noted that the identified themes and individual issues would be fed back through the Primary Care Safety Group. It was agreed to provide an update on the electronic patient record. RS noted that the increase in incidents represented an improvement in transparency and increased engagement in patient safety and added that the levels of reporting were continually monitored. JR asked how the system could be assured that primary care incidents were appropriately reported. RS confirmed that incidents were discussed at the Primary Care Quality Group. GI noted that the GP newsletter contained information regarding themes of incidents but explained that the CCG could not monitor how this information was disseminated. The Committee discussed how it would be useful to know who was learning from these incidents and what learning was applicable across the system. **The Primary Care Commissioning Committee noted the contents of the report**	**RS/JY**
13	**Contracts and Performance Report** SK provided the key points from the report: • The team needed to meet with the Helios Medical Practice contract holder to progress the partnership application • Discussions continued with the Special Allocation Scheme provider regarding their contract provision • An options paper for the language services contracts would be developed for the next meeting • Two branch closure applications were expected, the first follows completion of the Weston Parklands Village Full Business Case	

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	and the second was for a branch surgery (Caple Road) that was temporarily closed due to covid-19 • All PCNs have signed up to the mass vaccination programme, however two PCNs may opt out. The team was working through exit plans and provision planning for those populations. **The Primary Care Commissioning Committee noted the report**	
14	**Care Home LES Funding** LD noted that the decision had been taken at closed session and the paper had been anonymised for presentation at the open session and presented for information only. **The Primary Care Commissioning Committee noted the**	
15	**Questions from the Public – previously notified to the Chair** A member of the public asked the question: "The salutogenic benefits of increasing creative engagement & physical activity for people who are elderly, frail, and particularly for people living with dementia are well known and understood and is the foundation stone on which the NHS 10-year plan's investment in social prescribing has been based. Benefits include, but are not limited to, significant reductions in the use of medications, improvements to balance & strength which leads to reduced instances of falls & emergency hospital admissions, and addressing issues of social isolation & loneliness. Unfortunately, many of our smaller residential care & nursing homes are currently in serious financial distress and facing closure & no longer have the financial or human resources, or know-how, to provide these activities for the people they care for. My question is, given the well-known health benefits and importance of these health interventions, could the CCG please look at assuming responsibility for the oversight, quality, quantity, and commissioning of these health services to residential homes across the BNSSG area especially in homes who are currently unable to provide them for whatever reason?" LM confirmed that the CCG purchased care from a home for an individual and creative engagement and physical activity was expected as part of the care. The CCG worked with Local Authority colleagues to ensure good market engagement and to support care homes and explained that the CCG could not take on the responsibility of these health interventions but would work with the Local Authorities to ensure that the services commissioned were provided. RS highlighted that a care provider transformation	

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	group had been set up to review the care home market and the quality of care delivered. The CCG was working closely with Local Authorities to mitigate the impact on care homes from covid-19.	
16	**Committee Effectiveness Review** STW asked the Committee members to reflect on the changes made to the agenda and to consider whether the new order had improved the running of the meeting. It was agreed at the next meeting, one person would provide feedback on the effectiveness of the meeting.	
17	**Any Other Business** There was none	
18	**Date of next PCCC** Tuesday 27th July 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 LM and seconded by AM	

Lucy Powell, Corporate Support Officer, May 2021