NHS
Bristol, North Somerset
and South Gloucestershire
Clinical Commissioning Group

DRAFT

Primary Care Commissioning Committee Open Session

Minutes of the meeting held on 26th May 2020 at 9am, held via Microsoft Teams

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Minutes

Present		
Alison Moon	Independent Clinical Member – Registered Nurse	AM
Alison Bolam	Clinical Commissioning Locality Lead, Bristol	AB
David Clark	Practice Manager	DC
Martin Jones	Medical Director for Primary Care and Commissioning	MJ
Rachael Kenyon	Clinical Commissioning Locality Lead, North Somerset	RK
Philip Kirby	Chief Executive, Avon Local Medical Committee	PK
Julia Ross	Chief Executive	JR
John Rushforth	Independent Lay Member – Audit, Governance and Risk	JRu
Rosi Shepherd	Director of Nursing and Quality	RS
Sarah Talbot-Williams	Independent Lay Member – Patient and Public Engagement	STW
Apologies		
Georgie Bigg	Healthwatch North Somerset	GB
Jenny Bowker	Head of Primary Care Development	JB
Colin Bradbury	Area Director for North Somerset	CB
Sarah Carr	Corporate Secretary	SC
Felicity Fay	Clinical Commissioning Locality Lead, South Gloucestershire	FF
David Jarrett	Area Director for South Gloucestershire	DJ
Mathew Lenny	Director of Public Health, North Somerset	ML
Lisa Manson	Director of Commissioning	LM
Sarah Truelove	Chief Finance Officer	ST
In attendance		
Rob Ayerst	Head of Finance (Primary & Community Care)	RA
Debbie Campbell	Deputy Director Medicines Optimisation	DCa
Louisa Darlison	Senior Contract Manager, Primary Care	LD
Kate Davis	Principle Medicines Optimisation Pharmacist	KD
Bev Haworth	Models of Care Development Lead	BH
Rob Hayday	Associate Director of Corporate Services	RH

Geeta Iyer	Primary Care Provider Development Clinical Lead	GI
Tim James	Estates Manager	TJ
David Moss	Head of Primary Care Contracts	DM
Lucy Powell	Corporate Support Officer	LP
Lisa Rees	Principle Medicines Optimisation Pharmacist	LR

	Item	**Action**
01	**Welcome and Introductions** Alison Moon (AM) welcomed members to the meeting. The above apologies were noted.	
02	**Declarations of Interest** There were no new declarations of interest and no interests related to the agenda.	
03	**Minutes of the Previous Meeting** The minutes were agreed as a correct record with the following amendment: Item 9: The repeated word 'queries' was removed.	
04	**Action Log** The action log was reviewed: **Action 170** – Martin Jones (MJ) confirmed that further work to identify vulnerable patients had taken place by the primary care cell and localities through engagement with acute trust specialists and primary care. Letters have been sent to any additional patients identified. Alison Bolam (AB) suggested that this approach could be taken for high or moderate risk patients and Julia Ross (JR) noted that developing this continued contact with patients was an opportunity. The action was closed. **Action 171** – MJ assured the Committee that the approach taken to identify high risk patients was reasonable and noted the difficulty in setting up a single system process due to differences in identification arrangements. The action was closed. **Action 172** – Practice resilience to be discussed in further detail at the May closed session. This action was closed. **Action 173** – Meeting to be set up to further discuss how communications regarding online consultations can reach patients with protected characteristics. This action was closed. **Action 174** – Communications around patient concerns regarding attendance at secondary care have been explored with the communications team and has further informed work which would be discussed at the Clinical Cabinet. This action was closed. **Action 175** – Rob Ayerst (RA) explained that the CCG had budgeted for 97% Quality and Outcomes Framework (QOF)	

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<tr><th></th><th>Item</th><th>Action</th></tr>
<tr><td></td><td>achievement. However, 98% had been achieved and this had resulted in an £120k overspend. RA noted that the achievement percentage was calculated nationally and it was agreed that the QOF domains would be incorporated into the monthly finance report.</td><td>RA</td></tr>
<tr><td>05</td><td>Terms of Reference and Committee Effectiveness Review
AM thanked the Committee members for completing the committee effectiveness survey and welcomed Rob Hayday (RH) to the meeting. RH explained that the survey suggested the Committee worked well and was well chaired. The survey showed that the members felt able to challenge and therefore the Committee was felt to be effective. The survey suggested areas of development and RH outlined the possible suggestions for the Committee to consider:
Increase the length of the meeting to allow more time to discuss the papers
Withdraw papers unavailable within 4 working days of the meeting with the approval of the Chair
Considering the committee effectiveness checklist at each meeting
The Committee agreed that there was little value in increasing the length of the meeting. David Moss (DM) suggested the 4 working day deadline was manageable but noted that there were occasions when the Committee would benefit from the most up to date information. It was agreed in these cases to provide a verbal update at the meeting. AM agreed to provide time for reflection at the end of the meeting using the committee effectiveness checklist.

JR highlighted that a comment had been raised in the survey asking for clarity on the commissioning role of Committee and those present particularly GPs. It was agreed to review the comment and provide an update at the next meeting.

RH noted that there were no proposed changes to the Committee Terms of Reference.

The Primary Care Commissioning Committee:
Discussed and agreed the next steps based on the suggested actions
Approved the Terms of Reference</td><td>

SC</td></tr>
<tr><td>06</td><td>Covid-19 Update</td><td></td></tr>
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	Item	Action
	MJ outlined the key points from the update: • The areas of focus were; support for vulnerable groups, Personal Protective Equipment (PPE), community phlebotomy, the principles of recovery and care homes. • Work continues to provide guidance for primary care on vulnerable groups • The CCG was working with the logistics cell to ensure Personal Protective Equipment (PPE) was received • Plan for community phlebotomy has been agreed at Silver and Gold and was ready to be delivered • Principles for recovery have been discussed at GP membership meetings. • A working group has been established to oversee delivery of the national guidance on primary and community care model for care home support. • Localities were working with their partnership boards to provide support to care homes and shielded patients. • The digital sub group continued to implement digital solutions for primary care and consideration has been given to how data can be shared across the system. MJ noted that there have been difficulties with GP Connect. • The workforce sub group have developed a process for requesting additional support and this has been communicated to practices. • A paper highlighting the work to support care homes would be discussed later in the meeting. • Temporary site closures where practices have multiple sites have been approved as appropriate. • Practices have received confirmation that income would be protected in regards to Enhanced Services and a process has been established to review the additional costs submitted by practices due to covid-19. Rachael Kenyon (RK) commented that it was positive that stakeholders were collaborating through the locality sub groups. RK then asked how the online consultations were impacting patients and practices. MJ highlighted that the switch to online consultations had been smoother for some practices for other, particularly those that already had these processes in place. Bev Haworth (BH) outlined the support the CCG was providing given the significant changes in processes for some practices.	

	Item	Action
	JR asked for more information on GP Connect. BH explained that all practices had access to GP Connect and through this portal the practices should receive covid-19 related referrals through the Covid Clinical Assessment Service (CCAS). The national suggestion was that 1 in 500 appointments were kept free for CCAS referrals, however for the local practices the slots were not being utilised. However, the practices were now receiving more referrals though this route and it was expected that this would continue. The Committee considered the site closures and the next steps. David Moss confirmed that 7% of patients continued to attend practices for face to face appointments and the CCG was reviewing what could be safely opened and ensuring space was available for safe sites. The current action plans for attending patients would be reconsidered when estate began to open. JR highlighted the need for engagement with the Patient Participation Groups (PPGs) regarding recovery and the management of primary care services post covid-19. DM noted that the practices were providing communications to the PPGs. MJ highlighted that locality groups were considering virtual conferences with PPGs as well as ways to engage with the wider population. AB highlighted that online consultations were not yet functional in all practices. BH confirmed that all practices had completed the necessary training and the 10% of practices not yet implemented were completing the tasks required. BH agreed to provide an update on implementation at the next meeting. RK noted that online consultations may be set up at a practice but the usage was also important. BH confirmed that practices have taken different approaches with some needing further support which the CCG was providing. MJ suggested that the Primary Care Commissioning Committee would need to consider the strategic position on the changes implemented. AM suggested that this could be considered as part of the recovery work. **The Primary Care Commissioning Committee noted the report**	**BH**
07	**Minor Improvement Grants – Schedule of Schemes and Approval Process**	

	Item	Action
	Tim James (TJ) gave the background to the minor improvement grant process noting that the expressions of interest have been submitted to NHS England/Improvement and supported in principle. TJ noted that there could be some reallocation of budget dependent on whether schemes were cancelled. The risks related to covid-19 were outlined and TJ explained that although there had been inevitable delays to work starting, contractors were coming back to work and working evenings and weekends when practices were closed. NHS England/Improvement were proving funding those projects continuing so the it was important to ensure contractors were undertaking the work. Sarah Talbot-Williams (STW) asked how stakeholder engagement had affected the plans for the minor improvement grants and noted that public involvement needed to be an integrated approach as opposed to a tick box exercise. It was noted that the minor improvement grants were typically to fix minor issues with practice infrastructure which wouldn't affect patient experience but the Committee agreed that the form needed to show patient feedback had been considered and actioned. TJ agreed to discuss the format of form with STW outside of the meeting. JR asked about the prioritisation process for these schemes. TJ explained the received expressions of interests were scored by members of the estates, contracting and locality teams and assessed against the principles in the estates strategy. JR suggested that in the future the localities and Primary Care Networks should be involved in the decision making process. John Rushforth (JRu) asked who held the risk if contractors became bankrupt and were unable to continue the works. TJ confirmed the contracts were between the practice and the contractors, and noted that these were very minor works and so the proportionate level of due diligence would be undertaken by the practice. JRu requested a report be presented to the Committee on the allocation decisions. **The Primary Care Commissioning Committee:** • **noted the update on the work undertaken and the noted the process being put in place to deliver the programme of work in 2020/21**	**TJ/ STW** **TJ**

	Item	Action
	• **Agreed delegated approval to the Director of Commissioning and the relevant Area Director in approving individual schemes to proceed once the pass through due diligence.**	
08	**Final Gloucester Road Medical Centre Extension Full Business Case** TJ provided the background to the business case and reported that the ETTF panel had been delayed by a week due to covid-19. TJ provided assurance that the practice and NHS England had agreed that the consultation rooms would be built slightly smaller than the NHS England guidance size of $16m^2$. It was noted that there were buildings within the Primary Care Network (PCN) footprint with rooms of $16m^2$. TJ reported that due to the uncertainties related to the covid-19 crisis and the complexity of some of the build phases, the capital cost was 8% higher than the estimate. NHS England have agreed to fund the difference and 100% of the capital costs. Although the notional rent for the build has increased the CCG will have an overall programme saving. TJ noted that the work on the practice would be phased in order to keep the building operational. Should the current situation continue the site on Neville Road could be utilised to relocate some services. The CCG locality team were working on the relocation plan with the practice. STW noted that much of the patient engagement within the paper was related to the closure of Bishopston and Northville rather than the development and asked whether any changes were made to the plans as a result of the engagement undertaken. TJ agreed that future estates reports would include information on the changes and amendments made to plans following engagement. It was noted that engagement continued regarding the use of the Neville Road site. **The Primary Care Commissioning Committee approved, subject to the NHS England ETTF panel final approval, the Full Business Case and for construction to proceed.**	**TJ**
09	**Prescribing Quality Scheme**	

	Item	Action
	Kate Davis (KD) was welcomed to the meeting and gave the background to the prescribing quality scheme noting that this year the scheme had been delayed until July 2020 due to the covid-19 response. KD noted that the practices were set the target budgets based on fair shares methodology and the CCG monitored achievement against budget, taking into account factors the practice cannot influence such as increased Category M drug costs, No Cheaper Stock Obtainable issues (NSCO) and costs related to covid-19. The proposed quality scheme had been presented and discussed at the Locality Forums and the Primary Care Operational Group. Themes had been chosen to support the covid-19 response and to link to projects from the Long Term Plan. JR asked how the CCG had progressed fair shares budgets for primary care. KD noted that this was the second year for fair shares budgets and explained that for this year the spend was based on the spend to month 10 however this was not quite finalised and there were some adjustments to make. Debbie Campbell (DCa) added that practice spend was reviewed continuously to understand whether the budgets set were correct and confirmed that budgets were set against fair shares allocation. It was agreed an update on the fair shares allocation would be presented to the Committee once finalised. AM asked whether the quality improvement element allowed for in year flexibility. KD confirmed there was flexibility which could be utilised this year for potential additional work with care homes and other safety work. **The Primary Care Commissioning Committee approved the Prescribing Quality Scheme for 2020/21 including the split of funding; 50% based on financial achievement against budget and 50% for delivery of a series of quality based work that has wider system benefits, and the quality project themes.**	**DCa/ KD**
10	**Primary Care Finance Report** RA outlined the interim payment mechanisms during the response to covid-19 and confirmed that all variable sources of practice income continued to be paid during this period. The payments were paid at the rates set prior to the outbreak. At PCN level, it was confirmed that payments continued as per contracts and enhanced service specifications. PCN support payments and	

	Item	Action
	additional roles payments continued. RA noted the national GP Contract Investment and Impact Fund had been suspended for the first 6 months. A process has been set up to review the practice payment claims relating to covid-19 costs noting that the primary care contracts team have set up a panel to review and a process to capture the claims. Where the costs can be reimbursed from NHS England, half of the claims have been paid already and the rest have been returned to the practices for additional information. RA reported that for 2020/21 the monthly primary care finance report would be reflected at locality and PCN level. **The Primary Care Commissioning Committee received the update.**	
11	**Primary Care Quality Report** RS reported that the Care Quality Commission (CQC) has suspended their normal inspection programme and were putting a new programme in place with a light touch approach to data gathering. Where there were concerns the CQC would undertake a phone call review and assessment with the practice and signpost to training and support whilst regulatory action was considered. AM highlighted the practices the CQC had rated inadequate and RS and MJ confirmed the detailed action plans would be presented in closed session at the next meeting. JR praised the format of the report and asked that RS continued to work with MJ to highlight the key areas of focus the Committee needed to discuss. **The Primary Care Commissioning Committee received the report.**	**RS/MJ**
12	**2019/20 Flu Season Debrief** Lisa Rees (LR) was welcomed to the meeting and gave the background to the paper noting that 2019/20 showed the flu peak a week earlier than the previous year. It was highlighted that the flu vaccine uptake was higher in South Gloucestershire than that of North Somerset and Bristol and the team were reviewing whether there was best practice from South Gloucestershire which could be shared.	

	Item	Action
	LR reported that an EMIS search had identified that 48% of patients with learning disabilities had been vaccinated. LR confirmed that in the plans for 20/21, the vaccine would be promoted to this cohort of patients earlier and higher profile communications would be developed. LR reported that CQUINs were in place for staff uptake in 2019/20 with a national target set of 80% of frontline and clinical staff. The CCG had seen an uptake rate of 54% of staff vaccinated in the office, though the actual percentage reported may be higher as some staff would have received their vaccination through their GP or local pharmacy and clinical leads would likely have been vaccinated via their GP Practice. LR noted the plans for 2020/21 which were outlined in the paper, explaining that the CCG had reviewed the lessons learnt from 2019/20 and shared the positive steps with the system. Learning from other CCGs and other areas from the system had also been incorporated. Consideration was being given to how covid-19 would affect delivery of the vaccine to school aged children and shielded patients. RK praised the paper and commented that there were other vaccination programmes which hadn't been administered as the schools were closed and noted that this was something to be aware of. DM noted that for this coming flu vaccination programme new operating models were being considered by the central South West team such as car park drive through type services. The primary care contracting team planned to link with the Medicines Optimisation team and the screening and immunisation teams regarding updates. JR suggested the CCG prioritise clinical staff such as those working in Medicines Optimisation and Continuing Health Care and report on the percentages for these staff. AB suggested that it would also be sensible for care home residents and staff to be vaccinated earlier this year. STW highlighted the importance of providing the opportunity for patients with learning disabilities to be vaccinated and asked	

	Item	Action
	whether working with the voluntary sector on communications could increase the rate of vaccinations. AM agreed and noted that LeDeR reviews had identified flu vaccinations and annual health checks as key for those patients with learning disabilities. AM asked whether the use of population demographics at a PCN level could enable the CCG to review equity of access. LR confirmed that population groups have been identified where take up of the vaccine was low and work has been undertaken with these groups to develop additional support. Geeta Iyer (GI) noted that the Population Health Intelligence Group would review flu vaccine delivery and link with the Medicines Optimisation team with any learning. **The Primary Care Commissioning Committee:** • **Acknowledged the work undertaken in 2019/20 and the potential next steps subject to the publication of the second national flu letter and guidance for 2020/21** • **Supported the recommendations outlined in the paper**	
13	**Primary and Community Support to Care Homes** GI presented the paper noting that NHS England had outlined the role expected of primary and community care to support care homes, explaining the model of care would be adapted to support the national care home Directed Enhanced Service (DES). GI noted that the response was at PCN level and involved working with local partners to deliver. The three core components to implement were outlined as: • Delivery of consistent weekly check ins to review patients • Development and delivery of personalised care and support plans • Provision of pharmacy and medication support GI reported that mobilisation of the plans has begun and a working group has been formed, which included clinicians. GI highlighted the support to care homes currently provided through the Local Enhanced Service (LES) and noted that the process to align care homes to a PCN had already begun, supported by the CCG. It was confirmed that there were care homes which needed to be aligned to a PCN and work was ongoing to decrease the number that required cover under the scheme.	

	Item	Action
	The CCG continued to work with PCNs, Practices and the Local Medical Committee (LMC) throughout and the support had been discussed at the associated cells as well as the membership meetings. The initial mapping exercises have been sent to the practices and comments have been requested. GI noted that wrap around support teams have been undertaking the weekly check ins, however there was more work needed to provide further clinical pharmacy support and a sub group has been formed to address this. The first situation report was provided to NHS England on the 13th May, with subsequent returns completed weekly. GI highlighted the key risks and noted that the implementation required additional resource which had been covered by the covid-19 reimbursement. It was noted that the teams were working with the communications team to develop communications which can be shared with care homes, residents and practices. A webinar for primary care was also being developed with a care home focus. JR noted the huge amount work and the work by the Care Provider Cell as well as the joint working with the Local Authorities to deliver the support. JR noted that the joint working meant that funding needed to support all the organisations involved in the delivery and asked how can we ensure this happens and suggested that this was related to Integrated Care Provider models. GI noted that there was a lot of work to undertake in the next few months to map the funding model. RA explained that the CCG needed to identify the total resource available to support care homes which would support the cross over from the LES to the national specification. It was noted that the final model would probably be different to the LES currently. It was agreed to review this and update the Committee. JR highlighted that it was important for the model to work locally and then fit the work to the NHS England reporting. GI confirmed that this was the approach the CCG had taken. AM asked about the impact of the CCG not achieving full coverage of care homes and likelihood of this situation. GI confirmed there were a few issues which needed to be worked through. Louisa	**GI/RA/ DM**

	Item	Action
	Darlison (LD) explained that there were some border issues to resolve and there were historical arrangements which needed to be unpicked and noted that the team were still waiting for some of the returns from the practices. It was confirmed that with support from the local authorities and the LMC the issues could be resolved. LD noted that where there were queries regarding whether care homes were within scope, these were being discussed with NHS England. It was asked what NHS England was doing to address patient choice in care homes. LD noted that the guidance states that commissioners and PCNs are to encourage patients to reregister with a practice in the aligned PCN. The guidance states that if the patient declines they will not benefit from the enhanced care home model. It was noted that communication to patients was very important. DCa highlighted the clinical pharmacy report and noted the work ongoing with the GP Membership Forum and the discussions around the pharmacy workforce modelling. DC confirmed that medicine supplies were in place and work was ongoing with local partners. AM suggested hospices should be included as a member of the Care Provider Cell and noted the importance of evaluating the work undertaken. **The Primary Care Commissioning Committee noted the contents of the report and the ongoing work to provide a comprehensive primary and community Covid 19 response to supporting care homes in BNSSG.**	
14	**Contracts and Performance Report** DM highlighted the key messages: • The CCG continues to work closely with the partners of the Eastrees practice. OneCare have been commissioned to provide support with the merger implementation. • Helios Practice was operating as a single handed practice and the CCG were supporting the practice with the necessary requirements. • A boundary change request from Beechwood Medical Practice was currently on hold.	

	Item	Action
	• There were 7 temporary branch closures in place as part of the covid-19 response. **The Primary Care Commissioning Committee noted the contents of the report.**	
15	**Questions from the Public – previously notified to the Chair** There were no questions from the public.	
11	**Any Other Business** AM asked Committee members to reflect on the meeting and asked: Whether items presented were relevant: agreed Whether attendees felt able to contribute: agreed Were there any further comments on how the meeting was run: none AM confirmed that in future members and attendees could consider sending deputies if they are unable to attend.	
12	**Date of next PCCC:** Tuesday 30th June 2020 9am-1pm	
13	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 JR	

Lucy Powell, Corporate Support Officer, June 2020