Bristol, North Somerset and South Gloucestershire
Clinical Commissioning Group

Primary Care Commissioning Committee Open Session

Minutes of the meeting held on 26th January 2021 at 9am, 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
Alison Bolam	Clinical Commissioning Locality Lead, Bristol	AB
David Clark	Practice Manager	DC
Felicity Fay	Clinical Commissioning Locality Lead, South Gloucestershire	FF
David Jarrett	Area Director for South Gloucestershire	DJ
Rachael Kenyon	Clinical Commissioning Locality Lead, North Somerset	RK
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
Julia Ross	Chief Executive	JR
John Rushforth	Independent Lay Member, Audit, Governance and Risk	JRu
Apologies		
Mathew Lenny	Director of Public Health, North Somerset	ML
Colin Bradbury	Area Director for North Somerset	CB
Rosi Shepherd	Director of Nursing and Quality	RS
Debbie Campbell	Deputy Director (Medicines Optimisation)	DCa
Sukeina Kassam	Interim Head of Primary Care Contracts	SK
In attendance		
Jenny Bowker	Head of Primary Care Development	JB
Sarah Carr	Corporate Secretary	SC
Louisa Darlison	Senior Contracts Manager – Primary Care	LD
Bev Haworth	Models of Care Development Lead	BH
Geeta Iyer	Primary Care Provider Development Clinical Lead	GI
Denise Moorhouse	Associate Director of Quality	DM

Clare McInerney	Head of Locality – Weston, Worle & Villages	CM
Lucy Powell	Corporate Support Officer	LP
Lisa Rees	Principal Medicines Optimisation Pharmacist	LR
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 new declarations of interest and no declared interests relevant to the agenda items.	
03	**Minutes of the Previous Meeting** The minutes were agreed as a correct record with the following corrections: • P4 first bullet point to read "The CCG advice and guidance to support practices to identify and proactively manage shielded and vulnerable patients was to be rolled out" • P8 second paragraph, to read: "…current and projected…". Third sentence to read, "A primary care estates strategy was being developed that would…". Third paragraph to read "…a standard response." The final sentence to read "The Primary Care Commissioning Committee noted the report"	
04	**Action Log** The action log was reviewed: • **Action 164 –** Discussions were on hold due to the covid-19 pandemic. It was agreed to extend the due by date for this action to June 2021. The action remained open • **Action 192 –** Alison Moon (AM) commented that the action arising from the June meeting related to patients accessing their own blood tests online and asked for the action to be clarified and a further update. Lisa Rees (LR) would liaise with Debbie Campbell (DC). The action remained open. • **Action 216 –** it as noted the action had not been closed. It was agreed the action would be prioritised and taken forward. The action remained open. • **Action 225 –** Lisa Manson (LM) confirmed future reports would have comprehensive information about impacts on health inequalities. The action was closed • **Action 227** LR explained PHE had confirmed swabs for both covid and influenza were carried out in the event of a respiratory outbreak in a residential setting for the first five patients. The action was closed	

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	• **Action 228 -** John Lund (JL) confirmed the action was included in the finance report. The action was closed All other due actions were closed	
05	**PCCC Assurance Framework and Risk Register** Attention was drawn to the updated Assurance Framework and the amendments to the corporate risk register. The committee was asked to consider the new risks added and confirm whether these would fall within its remit for review. The risk closed and removed by the Governing Body were highlighted. FF welcomed the mitigations leading to the reduction of the risk score of the risk related to LeDeR reviews. FF asked if the risks relating to the covid-19 vaccinations programme and hard to reach groups should be included in the risk register. LM commented that the capacity and demand activity supporting the roll out of the programme would be completed and any risks highlighted would be reported through the risk register. STW asked whether the issues related to LeDeR from the previous year continued into 2020/21. AM explained she was chair of the LeDeR Steering Group and commented that capacity to complete reviews had improved with support from Sirona and other partners. Risks were reviewed at the monthly Steering Group meetings. There was a risk relating to establishing a sustainable model for the completion of reviews. Work to develop this model was ongoing. STW asked which committee would have oversight of the risk related to the implementation of mental health support teams. It was confirmed the Clinical Executive would keep this risk under review. Jon Lund (JL) noted the inclusion of the Primary Care Commissioning Committee in the committees with oversight of the CHC risk reported on the Assurance Framework. It was agreed the risk did not fall within the committees remit and the reference would be removed. Denise Moorhouse (DM) noted the planned transformation work would include stakeholder involvement and it would be helpful to raise the service profile with primary care. **The Primary Care Commissioning Committee:** • **Reviewed and ensured that appropriate and effective mitigations were in place for risks reported on the CRR and GBAF and specifically those areas relating to its remit**	**SC**

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	• **Reviewed those risks recommended for closure to ensure that it was assured that the risk score had been sufficiently reduced** • **Considered whether the CRR and GBAF were an accurate reflection of the risks brought to its attention** • **Considered whether other objectives and risks reported on the GBAF fell within its remit**	
06	**Covid-19 Update** Geeta Iyer (GI) drew attention to the paper, highlighting the key focus areas. The Primary Care Cell had merged with the Locality Development Group. The pilot testing of the primary care escalation framework had been launched. Primary care continued to support the system response to the Covid-19 surge. The first tranche of payments of the General Practice Covid Capacity Expansion Fund, which supported the seven national goals, had been made. The second tranche of funds would be released in the final quarter of the financial year. Outcome measures would be in place. PCNs had been invited to submit further bids against the PCN Additional Roles unclaimed funding to support the mass vaccination programme. The local implementation of 111 Direct Booking had been recognised by NHS Digital as a gold standard approach. The accuRx provision for video consultation capability and text services would end on the 31st March 2021. A proposal to ensure continuity of functionality would be presented to the committee. Work supporting the provision of IT equipment to PCNs and practices for mass vaccinations continued. The accuBook appointment booking system had been enabled for vaccination sites. Work continued to improve digital inclusion. A campaign to maximise the update of digital skills training with care homes was being launched. Advice and guidance for the proactive care of shielded and vulnerable patients had been rolled out to practices at the end of 2020. The impact of the guidance was being evaluated and a report would come to the next meeting. Initial analysis showed the guidance had been received positively, enabling patients not already identified to be highlighted. Practices were at different stages of the work and this would be reflected in the support provided.	

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	The system was working with the Academic Health Science Network (AHSN) to establish the covid virtual ward, 'Covid Oximetry @home' service. The service was deployed across care homes, GP practices, and integrated with urgent care including acute services. The next steps included the roll out of the service across the wider population, and evaluation. Jenny Bowker (JB) provided an update on the Covid Mass Vaccination programme. Sites included the Ashton Gate stadium, and 19 PCN sites. Care home vaccinations were delivered by general practice. The acute trusts were providing vaccinations for health and social care staff. A roving model was in development to support the vaccination of housebound and vulnerable groups to be delivered through general practice and Sirona. A pharmacy-delivered model was being developed by NHSEI. All sites operated to the JCVI (Joint Committee on Vaccination and Immunisation) prioritisation criteria. Attention was drawn to the updates on the Ashton Gate and PCN sites. Approximately 70% of the over 80s cohort had been vaccinated and over 70% of care homes had been covered. BNSSG was on track to meet the end of January deadline. There had been significant input by PCNs, which had provided support to the vaccination of care home front line staff and had provided mutual aid across the system. The programme was supported by a Clinical Delivery Design Group, which reported to the Mass Vaccination Cell. OneCare provided programme management support to the Primary Care Network roll out. Question and Answer sessions were held with PCNs three times a week. Offers of support had been received from the voluntary sector and local authorities. Next steps included increasing attendance at Ashton Gate and PCN sites, continuing the rollout of vaccinations across care homes, and the vaccination of new care home residents, rolling out the programme to new cohorts as directed, completing and implementing the roving model and capturing the learning from the PCN and Ashton Gate rollouts. A Community Pharmacy Working was being established to support the rollout of vaccinations through this model. Alison Bolam (AB) asked about the implementation of Elemental for Social Prescribers. Bev Haworth (BH) explained this digital product helped Social Prescribers access the patient record, supporting the tracking of progress. More detail would be included in future reports. AB asked if primary care staff would be able to	

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	access the Social Prescribing record and if EMIS would be accessible to Social Prescribers. BH confirmed this. FF noted demand for the Virtual Ward would increase and asked how Sirona would meet this, given capacity issues. FF asked if patients identified through the ALAMA Covid-age model could be added to the clinically extremely vulnerable list and the category 4 cohort. LM explained Sirona was deploying shielding staff to support the Virtual Ward. GI added capacity issues were discussed at the weekly Virtual Ward meetings. GI commented it was important to understand the implications of adding patients to vaccination cohorts, noting that supply of vaccines was based on national criteria. GI noted that this was an important issue and should be kept under review as data became available. JR commented the direction was to follow the JCVI guidance. JR noted it would be helpful to understand the population groups within the vaccination cohorts and to ensure that 100% of all the people in each cohort had been vaccinated. Georgie Biggs (GB) offered the support of HealthWatch in reaching specific groups. GI would pick this up with GB. AM asked about the governance model for the Virtual Ward. GI explained the weekly Virtual Ward meetings were used to support continual learning and develop the governance model. AM noted PCN involvement in the mass vaccination programme had been positive and asked what lessons had been learnt. JB commented there had been significant collaboration with and between PCNs. STW noted a separate group was looking at health inequalities. David Jarrett (DJ) noted the input of PCNs to the mass vaccination programme and highlighted the support provided to PCNs by the CCG teams. **The Primary Care Commissioning Committee noted the report**	**GI**
07	**Primary Care Network (PCN) Update - PCN Organisational and Leadership Development 2020/2021** DJ explained the paper focused on the funds available to support PCN organisational development (OD). For 2020/21, there had been an increased focus on aligning the OD funds to the system strategic direction, the design and implementation of Integrated Care Partnerships (ICPs) and how PCNs were engaged and embedded in the co-design and leadership of ICPs. The proposal had been shared with PCN Clinical Directors and there had been	

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	general support. JB explained the paper gave an overview of the 2019/20 approach. The Peloton System Leadership programme was suspended due to the pandemic response. There had been good uptake of the programme by PCNs and it would restart later in 2021. JB explained the paper presented a combined approach of local priorities and national priorities and drew attention to the proposed approach that included: • Enhancing the integration and engagement of PCNs in shaping the future of ICPs and developing integrated care. • The expansion of leadership development opportunities • Continuing support to the recruitment and retention of additional roles with a focus on establishing supervision arrangements • Reducing health inequalities through expanding approaches to population health management • Developing capability along the maturity matrix • Developing service improvement capability and capacity, investing in clinical leads and PCN managerial transformation leadership. These were non-recurrent funds JB explained the proposal allocated funds to support personal leadership development opportunities and to support the priorities for PCN development. PCNs would access these funds through the submission of an expression of interest. This was in advance of a formal evaluation of the 2019/20 approach, recognising the impact of the covid-19 pandemic. The paper sought the committee's support for the allocation of funds and the proposed priorities. FF commented the introductory equality section referred to the health inequalities section. There were equalities issues related to recruitment and retention that need to be taken into account. FF commented on the reference in the paper to ensuring that all PCNs were represented at Locality Boards to foster development of the ICPs. FF asked how this could be ensured and whether funds to support this would be ring-fenced. FF asked how PCNs developing at a slower pace would be supported. JB agreed there were issues relating to recruitment and equality and diversity, these would be detailed in future reports. PCN involvement in locality development had been discussed with PCN Clinical Directors. Funds had not been ring-fenced. PCN involvement should be considered in the wider context of locality resources. It was important to recognise PCNs had a role in their community	**JB**

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	and the wider system. FF noted PCNs would be in different places and it was important to have equality. JR welcomed FF's questions. JR observed that PCNs were integral to localities. The challenge to all primary care and system providers was how to address the needs of the population. The ICPs had key role in supporting complex cases and PCNs had a significant contribution to this. The focus on the Community Mental Health Framework delivery model was the proposed vehicle to take this forward. PCNs were engaging with this. JR observed that health inequalities, and equality and diversity were different issues and reports needed to reflect this. JR welcomed support and ideas from the committee as to how PCNs were supported and enabled across BNSSG to understand that they were the locality. It was important the CCG's language was clear about this. **The Primary Care Commissioning Committee approved the recommendations for priorities for PCN OD investment in 2020/2021 and the process for allocating funds**	
08	**Contracts and Performance Report** LD explained the CCG was working with the single-handed contractor and a more detailed paper would come to the next meeting. The closed list application was on hold whilst alternative options were explored. Attention was drawn to the four temporary branch closures due to covid-19. It was noted these had been picked up as themes in complaints and Freedom of Information requests received. The CCG was reviewing the position and an update would come to the next meeting. The rollout of the ADHD LES continued. AWP was regularly updated to ensure appropriate discharge to the service. It was confirmed practices were able to prioritise remaining Improved Access capacity for the delivery of the covid vaccination programme. **The Primary Commissioning Care Committee noted the report**	
09	**Primary Care Finance Report** Jon Lund (JL) explained primary care budgets were on plan for the year. The primary care prescribing year to date underspend was noted. JL explained investment funding had been protected and covid-19 related costs had been externally funded. Attention was drawn the position regarding new roles funding and GP forward View funding. This investment was protected and spending was happening at a slower rate than planned due to system pressures.	

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	It was important to provide reassurance that the funding was available and it needed to be committed. JL reported the overall position for the CCG and system remained on plan. Work to ensure the system returned to the Long Term Plan position was ongoing. The Primary Care Contract had been launched which demonstrated the investment into primary care. AM observed in previous years it was reported that locum costs were above budget. AM welcomed the report that for this year locum costs and budget were the same. AM sought clarity about the position of national funding for Learning Disabilities Annual Health Checks? JL clarified the funding had not been postponed; the performance criteria had been suspended. There were no further questions. JL left the meeting. **The Primary Care Commissioning Committee noted the Summary financial plan, the key risks and mitigations to delivering the financial plan and that, at Month 9 (December), combined primary care budgets were reporting a year to date underspend of £0.53m**	
10	**Supplementary Services and Local Enhanced Service (LES) Review** LD explained the desktop review was on track for completion for the end of the month. The recommendation would be that the majority of the LES continued in their current form with some small amendments. A more in-depth review of the supplementary services was ongoing with a completion date of October 2021. The majority of tariffs would continue as current. Options for the care home tariff were being considered; this would be considered alongside the discharge to assess and pathway 3 beds. The flu anti-viral management specification would be evaluated. This would inform the specification's development. FF asked if the number of emergency admissions was an effective measure for the Care Home LES and DES. FF noted the DES was different to the LES regarding the role of care home managers and a qualitative measure would be more appropriate. FF asked if Healthwatch could engage with residents to understand their views. JB explained the LES group had discussed the need to understand the differential between residential and nursing homes. Admissions was one potential indicator and other indicators would be required. This would be explored with practices and PCNs. JB would discuss this with FF and RK.	**JB**

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	AB asked how the impact of P3 beds and the Discharge to Assess programme on primary care was being evaluated. LD explained more detail would be presented to the next committee. LM observed it was important the work streams came together and the longer term arrangements were considered. GB offered the support of Healthwatch to engage with residents. JB would discuss this with GB. RK supported the comments about the differential input by primary care into residential and nursing homes. The review of the discharge to assess beds was important. LM left the meeting. **The Primary Care Commissioning Committee noted the report**	**JB**
11	**Flu Highlight Report** LR presented the update. Numbers of reported flu cases were low. The early delivery of the school vaccination programme had helped mitigate the risk of the impact of school closures on the rollout. The updates on stock availability, the vaccination of the 50-64 years cohort and the childhood flu programme were noted. Total take up in the over 65 year's cohort had exceeded the national ambition and the previous year's total. The position for the 2-3 years cohort was better than the previous year's. The position for the 'at risk' cohort had also improved. Categories where uptake was lower were targeted. Vaccination uptake in the shielded patients group was 85%. LR explained the outliers in the Uptake box-plot for the at risk group related to data issues. Uptake of the vaccination in the 50-64 years cohort had peaked and was now slowing down. Data for staff vaccinations showed that UHBW, Sirona and AWP had good uptake amongst staff. Uptake at NBT was lower and the Trust was working with staff to improve uptake. The targeted communications to support the Black, Asian and Minority Ethnic (BAME) population aimed at myth busting was noted. Actions to address health inequalities including pop-up clinics were highlighted. These had been positive and learning from this initiative would inform the covid-19 mass vaccination programme. The system work to support and increase vaccine uptake by the homeless population was noted. LR drew attention to the vaccine uptake by demographic group chart. Uptake was lower in areas of high deprivation. It was	

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	important to continue to target these groups. There were no questions. STW welcomed the outreach work. **The Primary Care Commissioning Committee noted the report**	
12	**Primary Care Quality Report** Jacqui Yuill (JY) presented the paper and drew attention to the Care Quality Commission (CQC) update. The position had not changed. The CQC continued to review practices using the transitional monitor framework. The continued risk of covid-19 outbreaks in practices was highlighted. Ongoing risk re outbreaks in practices were highlighted. The quality team continued to monitor and manage quality related issues through the monthly Primary Care Quality/Resilience and Contracting meeting. The team continued to support practices with Requires Improvement CQC ratings. The Quality Team Learning Disabilities lead worked with GP practices to improve uptake of the Annual Health Check. A more detailed paper would be discussed in the private meeting. Attention was drawn to the Contact us Datix Portal report for April-December 2020. The number of reported incidents had doubled compared to the same period in 2019. The increase in reported incidents was positive and allowed the identification of common themes. JY highlighted the main themes in the paper. Reported incidents were reviewed with colleagues in the medicines management team and the clinical lead for quality. Learning arising from reviews was shared with providers and with GPs. FF welcomed the increased reporting. AB noted it was not solely a primary care reporting portal and asked if the Contact Us portal was aligned to the separate advice and guidance portal and where would this be reviewed. GI explained the advice and guidance portal was a separate tool and it would be helpful to consider how this could be reported with David Peel and James Dunn. DM commented it would be helpful to explore this to understand how information could be reported. This would be explored and presented to the Committee. AM welcomed the increased use of the datix portal and observed this was positive if the numbers of serious incidents reported were not increasing and the learning loop was being closed. AM asked if there were explicit communications links with PCNs relating to incidents. JY explained the development of specific links with PCNs was to be taken forward. AM observed there was potential	**JY**

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	for proactive links with PCNs. GI noted the development of PCN quality champions had been put on hold due to covid-19 and this was needed to be taken forward. It was agreed more detail would be provided in the report. RK highlighted the issue of onward referrals commenting that clarity about these would be helpful. RK welcomed the use of Datix, noting it was important to close the learning loop. DM agreed closing the loop was fundamental. DM encouraged primary care colleagues to use the portal. **The Primary Care Commissioning Committee noted the report**	**JY**
13	**Medicines Optimisation Quarterly Report** LR drew attention to the Community Pharmacy Patient Group Direction (PGD) service, noting the sore throat service had been paused due to the covid-19 pandemic. The total number of consultations at 31st October 2020 were noted. Communication plans to increase the numbers of walk-ins were in development. The Valproate update was highlighted and the guidance relating to annual reviews of female patients of child bearing age on this medication. The audit completed by the Medicines Optimisation team was highlighted. The audit findings had been shared with AWP and NBT. Discussions regarding the position and the Trust's internal processes were planned. A further audit of patients who had not been reviewed was planned. More detail would be presented in a future report. The impact of covid-19 on antibiotic prescribing was noted. Overall antibiotic prescribing had reduced, most noticeably in children. The largest reduction had been in the prescribing of antibiotics used to treat upper respiratory tract infections. Work to promote updated community antibiotic guidance was in hand and the monitoring of antibiotic prescribing continued. An audit into clindamycin prescribing showed it was mainly prescribed for cellulitis however not all these prescriptions were appropriate. LR highlighted improvements had been made across most areas reported through the medicines safety tool PINCER. There had been an increase in patients without methotrexate blood monitoring in the required time frame, this potentially linked to the timing of the data upload and the first covid-19 lock down. This would continue to be monitored. The Eclipse-Radar tool would be used in future, which gave more detailed information. The Lifestyle	

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	prescription project had been well received by patients and clinicians. The project would be reviewed to understand if it could be expanded. The resource pack to support the structured medication reviews was noted. The Pharmacy Technician network, supporting these new roles in was highlighted. FF observed pharmacies did not all cover the full range of Pharmacy PGD's and this was confusing for healthcare navigators. LR explained the team was working with the Local Pharmacy Committee to support pharmacy sign up. Pharmacies were asked to liaise with practices and PCNs. FF asked if the practices not engaged with the Pincer medicines safety tool correlated to the practices not involved with the Eclipse-Radar tool LR explained this was not clear and she was aware there had been some technical issues. It was hoped all practices would be live with Eclipse Radar by the end of the month. AM commented the Quality Committee had requested the deep dive into Clostridium difficile cases and Clindamycin prescribing due to concerns about the increase in community cases. .The report was of high quality and commended. Its outputs had resulted in a change of practice across BNSSG. It was noted the CCG area was a national outlier in the use of Clindamycin. AM asked that the next report include progress being made to improve the position. RK commented on the Lifestyle prescription project and welcomed the leaflets. The Mental Health Wellbeing Toolkit had been particularly helpful. RK noted the impact of the project. JR observed the outcomes of the project were impressive and asked if it had ended in July. LR explained the leaflets were still available and pilot data collection had stopped, although patients would continue to be coded on EMIS. JR commented it would be helpful to continue to collect data to see trends over time. JR observed it would be helpful to extend the project and asked how the project integrated with Social Prescribing. LR explained the project aligned to the Social Prescribing programme. JR welcomed the project and asked for a paper outlining the purpose of the pilot and the forward strategy to come to the Committee. RK noted clinicians were required to record consent when issuing the leaflets, providing a data source. **The Primary Care Commissioning Committee noted the report**	**DC** **DC**

	Item	Action
14	**Agenda Forward Plan** FF asked if future PCN updates would include locality updates and progress with ICPs. There was a discussion about this and it was agreed both a PCN and broader update would be appropriate to bring to the Committee.	**JB**
15	**Questions from the Public – previously notified to the Chair** There were no questions from the public.	
16	**Committee Effectiveness Review** The Committee considered the checklist. There were no comments.	
17	**Any Other Business** There was none	
18	**Date of next PCCC:** The date of the next open meeting was 30th March 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, January 2021