Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group

DRAFT

Primary Care Commissioning Committee

Open Session

Minutes of the meeting held on 28th January 2020 at 9am, at the Vassall Centre, Gill Avenue, Bristol, BS16 2QQ

Minutes

Present		
Alison Moon	Independent Clinical Member – Registered Nurse	AM
Kirsty Alexander	Clinical Commissioning Locality Lead, Bristol	KA
Colin Bradbury	Area Director for North Somerset	CB
David Clark	Practice Manager	DC
Felicity Fay	Clinical Commissioning Locality Lead, South Gloucestershire	FF
David Jarrett	Area Director for South Gloucestershire	DJ
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
Lisa Manson	Director of Commissioning	LM
Julia Ross	Chief Executive	JR
John Rushforth	Independent Lay Member – Audit, Governance and Risk	JRu
Sarah Talbot-Williams	Independent Lay Member – Patient and Public Engagement	STW
Julie Thallon	Interim Director of Quality	JT
Apologies		
Alison Bolam	Clinical Commissioning Locality Lead, Bristol	AB
Georgie Bigg	Healthwatch North Somerset	GB
Kevin Haggerty	Clinical Commissioning Locality Lead, North Somerset	KH
Mathew Lenny	Director of Public Health, North Somerset	ML
Justine Rawlings	Area Director for Bristol	JRa
Sarah Truelove	Chief Finance Officer	ST
In attendance		
Rob Ayerst	Head of Finance (Primary & Community Care)	RA
Jenny Bowker	Head of Primary Care Development	JB
Sarah Carr	Corporate Secretary	SC
Gill Cook	Workforce Development Lead	GC

Bev Haworth	Models of Care Development Lead	BH
Geeta Iyer	Primary Care Development Lead	GI
Bridget James	Associate Director of Quality	BJ
Tim James	Estates Manager	TJ
David Moss	Head of Primary Care Contracts	DM

	Item	Action
01	**Welcome and Introductions** The apologies were noted; Kirsty Alexander (KA) attended on behalf of Alison Bolam. Georgie Bigg had shared an update explaining Healthwatch was discussing deputy arrangements to enable full attendance at meetings. The Healthwatch primary care work plan included: • A BNSSG Primary Care Strategy volunteer readers group; this would comment on the language used in the public document Working with the CCG on the GP Access consultation • Up-coming GP Enter & View visits, co-ordinated with the CCG, CQC, and GPs • Supporting the development of the BNSSG PPG Chairs Network Updates on the programme would be provided at future meetings	
02	**Declarations of Interest** There were no new declarations; RK had a declared interest in relation to item 14. There were no other declarations relating to the agenda.	
03	**Minutes of the Previous Meeting** The Committee reviewed the minutes of the previous meeting. The first paragraph, page 4 would be amended to read “Felicity Fay…” With this, the minutes were agreed as a correct record.	
04	**Action Log** The action log was reviewed: **Action 85** – Rob Ayerst (RA) confirmed locum spend would be monitored through the Primary Care Operational Group. Action 85 and Action 127 were duplicates and were closed. Rachel Kenyon (RK) asked how the budget would be managed going forward. RA confirmed expenditure levels were factored into the five-year plan. **Action 142 –** NHSE had emailed the CCG about attendance at meeting; Alison Moon (AM) would discuss this with Julia Ross (JR) and Lisa Manson (LM). **Actions 143, 144, 145** were due to be completed June 2020. It was agreed to remove these actions from the log and add them to the committee work programme.	

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	Action 148 – David Moss (DM) was working with colleagues to clarify the dementia LES data. The action remained open. **Action 149 –** the action would be part of the table top review. The action remained open. **Action 150 –** The action remained open. **Action 151 –** This action would be part of the discussion of the primary care strategy. The action was closed. **Action 153 –** Bridget James (BJ) was to meet with Martin Jones to discuss the Green Impact Scheme. The action remained open. **Action 154** – BJ confirmed members of the quality team had reviewed with Healthwatch the plan and regular meetings were in place. The action was closed. Julia Ross (JR) asked for visit reports to be received by the Committee. This was agreed. All other due actions were closed	**BJ/RS**
05	**PCCC Assurance Framework and Risk Register Primary Care** It was explained the Governing Body had reviewed the Corporate Risk Register and Governing Body Assurance Framework at its January meeting and approved the removals and additions recommended. Three risks relating to Pier Health were reported on the Corporate Risk Register. These had been considered at the CCG Quality Committee. There was a discussion about how the risks were reported and it was agreed the executive directors would review the risks and refine these as appropriate. JR asked why the target risk score for the Governing Body Assurance Framework (GBAF) risk relating to PCNs had been changed. Jenny Bowker (JB) explained there had been a previous discussion regarding the target risk score that had concluded the initial target was set inappropriately. JR asked for an update on the gaps in assurance reported and emerging new risks related to PCNs. JB explained the role of the primary care strategy was changing to oversee the implementation and delivery of the primary care strategy. Primary Care Networks and their development was a core element of the strategy. The new Strategy Group would report to the Integrated Care Steering Group as well as reporting to the Primary Care Commissioning Committee. The strategy group would help to close assurance gaps. JB explained the emerging risks would be reported through the risk register. There was a discussion about PCN roles within localities. Martin Jones (MJ) explained there had been meetings with PCNs and localities. The CCG considered PCN development	**CB/LM/ JT /MJ**

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	and wider Locality development to be elements of the same thing. PCN Clinical Directors shared this view however, Locality Directors and One Care had raised concerns and action to clarify the position was underway. JR asked that these elements were added as updates to the GBAF. JR asked that the risk score for the Supporting Primary Care resilience risk reported on the GBAF be revisited to ensure the likelihood score was reported correctly. Felicity Fay (FF) noted the risk relating to ADHD referred to a new model and the impact of this on primary care had not been noted. Commissioners would review this. **The Primary Care Commissioning Committee:** • **reviewed the Corporate Risk Register and note the addition of risks relating to primary care commissioning** • **identified further high level risks for inclusion on the Corporate Risk Register** • **reviewed and commented on the Governing Body Assurance Framework**	**MJ** **MJ** **LM**
06	**BNSSG Healthier Together Primary Care Strategy** Geeta Iyer (GI) set out the background to the development of the strategy. The engagement with stakeholders, including GPs and members of the public was highlighted. The strategy covered the Healthier Together priorities and recognised primary care as a core element of the system architecture. Healthwatch and the Patient and Public Involvement Forum would review the strategy this for accessibility of language. The Primary Care Working Group would transition into a delivery and oversight group with extended membership including providers, Locality and PCN leads. Oversight of the strategy would sit with the Integrated Care Steering Group within Healthier Together and the Primary Care Commissioning Committee. Bev Haworth (BH) explained each priority area would be reported through the Verto system to provide an overarching primary care assurance mechanism. The Primary Care Commissioning Committee and the Integrated Care Steering Group would receive this primary care highlight report. FF commented on the draft summary: the inclusion of examples would be helpful in the 'what this means for patients' section, tables 2 and 3 needed clarifying, and the 'why change is necessary' section could be placed earlier in the summary. BH explained feedback from the Patient and Public Involvement Forum had informed the format. The Healthwatch readers group	

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	would help highlight language issues. There would be further work with the CCG Communications Team focusing on the design of the summary. KA asked if there was sufficient clarity regarding new ways of working to ensure members of the public continued to part of the delivery. BH highlighted the support of the CCG Patient and Public Involvement, which had guide the engagement process. To support the implementation a patient reference group was being formed. There was a discussion about the summary and it was agreed more emphasis on key messages focused on the concerns of patients was required. These included Continuity of Care, prevention and patient engagement. Sarah Talbot-Williams (STW) explained the Patient and Public Involvement Forum had asked for a wider consideration of accessibility. BH confirmed the Communications team had developed a plan. JR observed the development of the strategy had been exemplary. She asked about feedback from practices. GI explained the strategy incorporated this feedback. Discussions with practices now focused on delivery. JR noted the distance between the ambitions voiced in the strategy and the current position. JR emphasised the importance of the delivery plan and the need for it to describe outcomes and their achievement within available resources. It was agreed the Delivery Plan would be presented for discussion. There was a discussion about the engagement of practices to ensure ownership of the plan. GI commented ensuring strong provider representation on the delivery and oversight group would promote engagement. MJ commented it was important to have true distributive leadership. JR observed it was important to have practice working with the CCG; currently there were some concerns voiced regarding engagement with the strategy. CB commented the delivery of the strategy would be linked closely to Locality development and the integrated care model. AM asked for further clarity regarding the roles of the Integrated Care Steering Group and the Primary Care Commissioning Committee in relation to monitoring. JR offered to discuss this further. AM asked for the rationale underpinning the phasing of the implementation to be included in future updates.	**MJ**

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	The Primary Care Commissioning Committee recommended the Strategy to the Governing Body	
07	**Primary Care Network Update** JB drew attention to the draft PCN specifications summaries. The CCG had submitted a response to the NHS England consultation developed following discussions with the PCN Clinical Directors and a meeting with the LMC. The CCG response supported the ambitions for integrated care and the phasing in requirements. The response voiced concerns about the deliverability of the proposals given the early stages of PCN development and the impact on practice workload and PCN resilience. The delivery of specifications would be resourced through recruitment to additional roles. Locally PCNs were recruiting to additional roles; these were not fully in post however and not fully trained to deliver some of the requirements of the specifications. It was anticipated that the specifications would be amended following the consultation. CCG clinical leads had been asked identify where transformation plans were in place to support the delivery of the specifications; this would be shared with PCN Clinical Directors. JR observed there were concerns that some of the specifications would be withdrawn. She emphasised the CCG was committed to making the specifications viable for local people. Attention was drawn to media reports that NHSE had expected CCGs to fund PCNs. JR explained this was not the case and that there were no additional funds in the baseline position. John Rushforth commented it was important to have a match between specifications and resources to be able to demonstrate where there gaps between resources and expectations. The funding allocated to support PCN organisational and leadership development was discussed. This funding was non-recurrent however, it was likely that there would be further allocations in future years. There had been a series of meetings with PCN colleagues and this had informed the proposed approach. There was a desire to share good practice across PCNs. The proposal for personal leadership recognised the different leadership experience across PCNs. The proposed expenditure to develop the PCNs and the PCN leadership set out in the paper was highlighted. AM asked how value money would be assessed. JB explained the required expression of interests	

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	included the 'what good looks like' criteria. This identified organisational development opportunities linked to the maturity matrix. The self- assessment against the maturity matrix would be repeated to demonstrate if development opportunities had made a difference. AM asked how PCNs would be supported to make applications to ensure all PCNs were able to access funding. JB explained Area Team colleagues were supporting PCNs requiring extra support. RA highlighted the Long Term Plan had confirmed there would be transformation funding in addition to the resource allocation which would be available for the next 4 years. This would support organisational development. JB noted there was interest in population health management and 5 PCNs were being supported through an intensive, NHSE sponsored, programme. FF noted the need for GP leads to support the specifications. She observed PCNs might struggle if there was insufficient GP resource to support the specifications. It would be difficult for PCN Clinical Directors to complete the additional roles templates until the specifications were confirmed. JB explained the templates were not a one-off exercise. JR observed GP leadership was needed at community and Locality level; the specifications could not be delivered at an individual practice level. The LLG leads had a key role to support discussions. It was agreed there would be more focus on this issue at the February seminar; the PCN clinical directors had been invited to this. DJ commented on the area team support to PCNs noting the lessons learnt from the allocation of organisational development to localities would underpin this. JR asked how PCNs had been involved in the organisational development proposals and what the response had been. JB explained the CCG had worked with PCN Clinical Directors at two full meetings and two teleconferences. Feedback had focused on the need to recognise and support PCN's individual needs. The proposal recognised the need for a tailored approach. Information about the Peloton programme had been shared with the Clinical Directors. There was recognition and support for leadership development and Clinical Directors requested some flexibility in recognition of individual experience. Detailed information about the Peloton programme would be shared. AM invited Philip Kirby (PK)	

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	to provide the LMC view. PK commented there was a wide understanding of the organisational development funds. Concerns had been raised about the process to access funds. JR asked if the CCG needed a different approach. PK commented it was important that the funds benefited PCN organisational development. JR asked the LMC to work with the CCG to ensure the process to access funding was straight forward. Gill Cook (GC) drew attention to the additional roles set out in the paper at table 1. The maximum number of reimbursable roles in BNSSG was 64. To date there were 28.5 additional roles in place. This included 13.5 clinical pharmacists transferring from the NHSE clinical pharmacy scheme. The CCG was working with PCNs to support recruitment; this included looking at how physiotherapists could work across systems to minimise the impact of recruitment on other providers. The employment models were highlighted. JT noted the positive impact of social prescribing link workers and asked if some PCNs were reluctant to recruit to this role. GC explained recruitment in some PCNs was delayed. Some PCNs felt they had a sufficient number of social prescribing roles. The area teams were working with PCNs to ensure the effective use of roles. Discussions were ongoing to understand recruitment gaps. JR asked if reimbursements were being made. GC explained the NHSE return had demonstrated there were more roles in place than had been claimed. The CCG was reminding PCNs to submit their claims. DM explained the process included a stage to test, ahead of recruitment, that roles were reimbursable. Some PCNs had seen this as a block to claims. JR asked that further feedback from PCNs be sought to ensure the process was streamlined. JR commented it was important to remove as much administrative burden from PCNs as was possible. FF commented it was important to understand why additional roles were not being employed and noted the 30% on costs for some roles was significant. The impact on estates was also an issue. **The Primary Care Commissioning Committee:** • **approved the proposals for supporting PCN Leadership and organisational development** • **discussed the implications arising from the paper and reviewed the next steps**	**DM**
8	**Local Enhanced Services (LES) Review 2019/20**	

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	MJ set the context for the paper. An initial assessment of the LES had indicated a small number required minor amendments. A further set of LES overlapped with the national specifications. A desktop review assessing each of these schemes was nearing completion. The outcome would come to the Committee. MJ drew attention to the Care Home LES, which overlapped with the draft Enhanced Health in Care Homes DES. These had been reviewed and there had been discussions with PNC Clinical Leads. The CCG had committed to ensure a robust transition phase between the LES and national specification was in place. The Sirona programme, LES and national specification would be congruent and be aligned to the required outcomes. The national guidance looked at supporting primary care and funding issues were being considered. It was important to ensure resources were invested effectively. A care home support working group would be established with a multi-stakeholder membership to develop the model of care support. The Committee discussed the care home LES. The review was welcomed as an opportunity to clarify the requirements and increase uptake and impact. Suggestions included looking at areas within BNSSG with good outcomes to identify and share good practice. It was also asked that the review considered the metrics used and considered measures such as place of death, and appropriate admissions. It was explained Sirona was part of the review group. It was noted the LES was an annual scheme and the question was whether to recommission. The LES was an opportunity to develop integrated working and it was important localities were involved in the review and development process. It was agreed the Care Home LES would be presented to the Committee in the summer 2020. AM asked if the desk top review would sufficiently capture outcomes. MJ agreed it was important to consider the outcomes. DM noted more delivery data would be available for the next report. **The Primary Care Commissioning Committee noted the paper and supported the proposed actions and timetable**	**JB**
9	**Online consultation** MJ highlighted the programme was at an early stage; it was important to consider what outcomes were expected and how wider change could be supported. BH provided a brief background	

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	to the pilot. The aims were to improve access to primary care advice, support management of workload and learn for the wider rollout of online consultations. There was no specific aim relating to urgent care, however this had been considered as part of the pilot. It was found neither off-the-shelf products delivered across all of the aims. The activity to support practices with the introduction of the products had most impact. The findings had been discussed with the Area Teams and at practice managers meetings. Practices and patients had a mixed understanding of online consultations. The proposal was for a project team to work with practices, PCNs and Localities to support an informed decision to choose a single product. CB commented it would be helpful to make a distinction between online consultations and video consultations. BH explained to avoid having too many products in place the intention would be to procure a product with this capability. JR observed it was important to focus on the ambition and outcomes required and then consider the technology required. KA noted other areas using online consultations had found systems needed regular review. Local findings supported this and providers would be asked to work with practices to develop the product. JR sought confirmation that the algorithm products did not have a significant impact. BH explained that due to the volume of uptake there had not been a significant difference. Of these products, two were interoperable with EMIS and this was a key issue. JR commented it was important to have a baseline and asked if the intention was to aim for a question-based product. BH commented this would be tested with practices to understand their needs. JR observed it was important to maintain a focus on the intended outcomes and it was important to use the output of the evaluation having piloted the products. CB noted where practices were not committed to the product it was difficult for the product to be successful. It was agreed the technology was an enabler and not the starting point. JR highlighted it was important to invest in change management. FF asked about the next steps. BH confirmed the Committee discussion would inform the development of recommendations. These would come with the full evaluation to the Committee in March 2020. AM asked if an assessment of the impact on	

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	equalities to understand the impact of the product across all protected characteristics would be completed. Further detail regarding this would be reported in the next report. **The Primary Care Commissioning Committee noted and discussed the initial findings of the evaluation and noted the next steps**	**BH**
10	**Primary Care Workforce Development Update** GC described the governance arrangements and the current projects supporting primary care workforce as set out in the paper. It was explained PCNs had been asked to estimate Additional Role types and numbers to establish a workforce projection. The Committee welcomed the detailed report. The seminar would focus on workforce issues; AM encouraged members to ask questions to be explored at the seminar. Matters to consider at the seminar included: • More information on the levels of resource required and the impact of the projects overtime. GC reported in 2018 there were 556 wte GPs, currently there were 586 wte GPs and the aim for the end of 2020 was 609 wte. This needed to be looked at in the context of what primary care would look like in future. • More information regarding how roles were maximised • What was in place with universities to develop the new roles • more detail about the Health Inequalities Fellowships and how learning was being shared • Risk and opportunities; how key issues could be targeted AM asked about future reporting. It was confirmed this would be part of the overarching report to the Committee. **The Primary Care Commissioning Committee discussed the governance arrangements for Primary Care Workforce, the current projects being delivered and future workforce project plans**	
11	**Minor Improvement Grants 20/21 and 21/22** MJ highlighted the governance arrangements for the approval of Minor Improvement Grants (MIG) Tim James (TJ) explained in previous years NHSE had prioritised applications. For 2020/2021 the process had changed with CCGs asked to prioritise requirements across MIG, IT and LD. Practice expressions of interest for MIGs had been requested. It was proposed applications were assessed by a workgroup using the six principles established in the Estates Strategy. Following assessment, the applications would be scored using the process adopted in previous years. Due to the NHSE timescale, applications would not be presented to the Committee for	

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	approval. It was proposed authority was delegated to the Director of Commissioning, supported by the Area Directors, to approve the prioritisation of applications. This was an amendment to the recommendation. FF asked if the sustainable estate referred environmental sustainability. TJ confirmed the criteria included environmental issues. KA asked what happened to bids agreed previously in principle. TJ explained practices had been asked to resubmit bids. There was a discussion about the appropriate executive director sponsor for the paper. It was agreed to discuss this outside the meeting. **The Primary Care Commissioning Committee approved the process proposed for assessing and prioritising schemes and approved the revised recommendation that authority for the approval of the prioritisation of the schemes be delegated to the Director of Commissioning in conjunction with the Area Directors**	**Execs**
12	**Primary Care Finance Report** The forecast breakeven position against the delegated primary care allocations was highlighted. Rob Ayerst (RA) explained the £4 million forecast overspend relating to prescribing, previously held as a risk, had formally moved into the forecast outturn. The overspend was due to cost increases to category M drugs and category A drugs. Category A drugs were generic pharmaceuticals and the cost increase was likely due, in part, to shortages in generic drugs resulting in temporary replacements with No Cheaper Stock Obtainable concessions. There was a forecast overspend of £400,000 relating to personally administered items due to back dated claims and practices maximising their entitlements to reimbursements. There was a discussion about the backdated period for claims. It was confirmed this was a nationally negotiated arrangement. The overall forecast deficit across primary care budgets at month 9 was £4 million. At month 9 all risks and mitigations had been brought into the forecast position and there were no additional risks or mitigations to report. Following the submission of the Long Term Plan an Operational Plan and Budget Setting plan would be presented to the Primary Care Committee in March 2020. AM asked if the UK exit from the EU would have an impact on prescribing. LM explained there would be negotiations during the 2020 transition period. **The Primary Care Commissioning Committee noted:**	

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	• **at Month 9, combined primary care budgets reported a year to date overspend of £3.9M** • **the £4m forecast overspend relating to prescribing, previously held as a risk, had been formally moved in to the forecast out-turn** • **the overall forecast deficit across Primary Care budgets of £4M at Month 9** • **a further £700K non-recurrent allocation from NHSE had been received to support the Delegated Primary Care budget** • **the forecast break-even position against the Delegated Primary Care allocation**	
13	**Primary Care Quality Report** Julie Thallon (JT) explained a revised report, adopting a new format would be presented from April. BJ drew attention to the flu vaccination uptake. Teams were working with practices reporting the lowest uptake rates. A full report would come to the June meeting. The deep dive – equality and provision of care focused on the Quality Outcomes Framework which indicated whether specific interventions had been undertaken for appropriate patient groups. Exception reporting by Indicator and PCN was given at figure 15. Bristol Inner City and East PCN had a high exception-reporting rate. The data was reviewed against similar areas nationally to provide a benchmark. Analysis indicated Bristol Inner City and East practices had lower intervention rates across the majority of indicators. This had been shared with the Locality team. The CCG lead practice nurse was carrying out a review in two practices in the PCN. Once completed the outcome would be shared with the Locality team. The quality improvement projects in place were highlighted. FF asked about the review. BJ explained the practice had initiated the survey; there would be a wider review depending on the outcome. FF asked if quality improvement projects would align to PCN actions. This was confirmed. AM asked whether the CCG Clinical Effectiveness team had contributed. BJ explained the team contributed to the quality improvement projects; there was more to do to obtain information on intervention rates. AM asked about the other sources of patient experience information noted in the report. BJ explained the data was held by practices and was not available. The previous year's CQC reports was being reviewed. The practice surveys were	

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	reported when available. It was asked that the information available was reviewed and areas for improvement and actions in place were reported. This was agreed. It was agreed in future the deep dive on equalities would be reflected in the mandatory report sections for health inequalities and equalities. This was BJ's last meeting and the Committee thanked her for her contribution. **The Primary Care Commissioning Committee received the report**	**BJ/JT**
14	**Contracts and Performance Report** RK had a declared interest relating to this item. DM highlighted the request by Monks Park Surgery to add the partners of Mendip Vale to the contract. The practice managers had been reminded the contract variation was not a contract merger. Locality delivery of Improved Access had increased in line with winter planning. The forecast out turn was for the delivery of the full 45 minutes across localities. There were no questions. **The Primary Care Commissioning Committee received the report**	
15	**Quarterly Report to Governing Body** This was information. There were no questions. **The Primary Care Commissioning Committee received the report**	
16	**Papers to be presented to Governing Body** Papers from the meeting to be presented to the Governing Body included: Primary Care Strategy, Primary Care Network Update	
17	**Questions from the Public – previously notified to the Chair** There were no questions from the public.	
18	**Date of next PCCC:** Tuesday 31st March 2020 9am-1pm, Clevedon Hall, Elton Road, Clevedon.	
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 JRu and seconded by STW	

Sarah Carr, Corporate Secretary January 2020