Bristol, North Somerset and South Gloucestershire
Clinical Commissioning Group

Primary Care Commissioning Committee Open Session

Minutes of the meeting held on 30th March 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
Alison Bolam	Clinical Commissioning Locality Lead, Bristol	AB
Colin Bradbury	Area Director for North Somerset	CB
David Clark	Practice Manager	DC
Geeta Iyer	Primary Care Provider Development Clinical Lead	GI
David Jarrett	Area Director for South Gloucestershire	DJ
Rachael Kenyon	Clinical Commissioning Locality Lead, North Somerset	RK
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
Apologies		
Georgie Bigg	Healthwatch Bristol, North Somerset and South Gloucestershire	GB
Debbie Campbell	Deputy Director (Medicines Optimisation)	DCa
Sarah Carr	Corporate Secretary	SC
Felicity Fay	Clinical Commissioning Locality Lead, South Gloucestershire	FF
Mathew Lenny	Director of Public Health, North Somerset	ML
Philip Kirby	Chief Executive, Avon Local Medical Committee	PK
Rosi Shepherd	Director of Nursing and Quality	RS
In attendance		
Jenny Bowker	Head of Primary Care Development	JB
Louisa Darlison	Senior Contracts Manager – Primary Care	LD
Loran Davison	Team Administrator	LDa
Becky Garland	Contract and Project Support Officer (Primary Care)	BG

Beverley Haworth	Models of Care Development Lead	BH
Sukeina Kassam	Interim Head of Primary Care Contracts	SK
Clare McInerney	Head of Locality – Weston, Worle & Villages	CM
Rebecca Murch	Acting Head of Communication and Engagement	RM
Lucy Powell	Corporate Support Officer	LP
Lisa Rees	Principal Medicines Optimisation Pharmacist	LR
Katherine Showler	Senior Contract Manager – Primary Care	KS
Jane Taylor	Director, Deloitte LLP	JT

	Item	Action
01	**Welcome and Introductions** Sarah Talbot-Williams (STW) welcomed members to the meeting and the above apologies were noted. STW noted that Alison Bolam, Felicity Fay and Rachael Kenyon were stepping down from their role on the Committee and thanked them for their insightful and effective input into the Committee. The Committee members agreed that they would be missed.	
02	**Declarations of Interest** Alison Moon (AM) declared a new interest as she had joined the North Bristol Trust (NBT) bank and was undertaking vaccinations at Ashton Gate. There were 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: • P2, Action 192, amended to read "…accessing blood test results…" • P8, last paragraph, amended to read "…attention was drawn to the position…".	
04	**Action Log** The action log was reviewed: • **Action 192 –** AM commented that there were no timelines included within the closed action for when patients would be able to access blood test results online. Beverley Haworth (BH) noted that access to results depended on the infrastructure of the practices and the processes in place to allow patients to register to the system. BH noted that work continued in this area and agreed to provide an update as part of a future paper. • **Action 216 –** Discussions have been held regarding the support Healthwatch can provide. It was agreed to close this action.	**BH**

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	• **Action 223 –** The terms of reference are to be presented in April. • **Action 234 –** Jenny Bowker (JB) noted that future reports would separate out health inequalities and inequalities. It was noted that the training hub was securing a fellow for Equality and Diversity within Primary Care. It was agreed to close this action. • **Action 235 –** JB confirmed that GP engagement had been secured and noted that an update would be presented at the March closed session. It was agreed to close the action. • **Action 236 –** Healthwatch have been contacted and engagement will be followed up. It was agreed to close the action. • **Action 238 –** It was agreed to follow up on this action and update at the April meeting. • **Actions 239 and 240 –** To be updated as part of the April Medicines Optimisation report. • **Action 241 –** JB confirmed that future PCN updates would include the work to develop Integrated Care Partnerships (ICPs) and noted that the next update had been included on the forward planner for May. It was agreed to close the action. All other due actions were closed	
05	**Governing Body Assurance Framework (GBAF) and Corporate Risk Register (CRR)** STW introduced the paper noting that the key changes had been highlighted in the cover paper. AM asked whether the risk relating to cancer delays had been discussed at the Committee from a primary care viewpoint to provide the required assurances. Geeta Iyer (GI) noted that the risk was also discussed at Clinical Executive Committee where the clinical leads outlined the improvement activities within primary care. AM noted that some of this work would have a positive impact on the risk and highlighted the need to link the improvement with the wider workstreams. **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** • **Reviewed those risks recommended for closure to ensure that it was assured that the risk score had been sufficiently reduced**	

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	• **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** JB provided an update on the primary care response to Covid-19 noting the weekly Primary Care and Locality Development Group meetings which were transitioning into an operational group supporting the work of the Integrated Care Steering Group. Primary Care Networks (PCNs) have been reminded to submit bids for additional roles and the North Bristol Trust (NBT) staff bank has been promoted to support mass vaccinations. NHS 111 First continued to monitor redirection of patients to primary care as part of the development of the 111 First programme. JB highlighted that communications to primary care continued including information regarding the development work for the recovery phase. GI and JB outlined Oximetry @ Home noting access to pillar 1 and 2 test results were available to both primary care and Sirona who reviewed the results daily to ensure patients were supported. GI noted the longer-term work of aligning with the respiratory programme board as well as work with the Acute Trusts on the impact of length of stay for patients. Julia Ross (JR) asked how this programme of work was aligning with vulnerable groups. GI noted that this was being mapped with the health inequalities work and eligibility had been extended. JB noted that over 448k vaccines had been administered with 66% of these delivered by PCNs and explained that the national ambition was for the vaccination programme to be completed for first dose by July 2021. JB noted that the CCG was supporting PCNs to ensure cohorts 1 to 9 were vaccinated before vaccinating those under 50. Focused task and finish groups have been convened to maximise uptake. These groups were reviewing specific populations and developing innovative methods of delivery to support vaccination including vaccination clinics in hostels and at religious centres. PCNs and Sirona were working together to vaccinate housebound patients and local experts were vaccinating other groups including Avon and Wiltshire Mental Health Partnership NHS Trust (AWP). JB noted that there was a lowered vaccine rate in those where English was a second language and	

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	the teams where ensuring that translated support materials were available and providing dedicated clinics. STW highlighted the great work of the task and finish groups, particularly outreach and peer support, supported by the voluntary sector. JR highlighted the roving model and the positive impact of population health management work and the citizens insight panel feedback into the mass vaccination programme. JR asked about the bid for health coaching and asked whether this could be opened up beyond those where English was a second language. It was confirmed that this could be opened up to support others. JB noted that work was required to target resources and support localities to support PCNs to maximise benefit. JR asked if all PCNs had signed up to phase two and JB confirmed that all 18 PCNs have opted in and the covid expansion fund would be used to focus on recovery as well as supporting the vaccination programme. JR noted that the money provided needed to include funds for recovery. Sukeina Kassam (SK) noted that as part of the process each PCN had outlined their recovery plans and identified potential areas where further support was required. JR noted the importance of services not being double funded. Jon Lund (JL) outlined the governance processes related to the funding including the operational group in place to monitor the work. JR noted the funding was for serving the local population and access to services. GI agreed and explained that these funds funded continuing business as usual and covid vaccinations and the CCG had made it clear that further support would not be provided through additional funding but by considering models of care and other resources. Lisa Manson (LM) noted that there were additional considerations on how to spend the non-recurrent resource with engagement of the Integrated Care Partnerships and this would be discussed further in April. Rachael Kenyon (RK) praised agile working and the support from the whole system as well as volunteers. RK noted that PCNs had redefined business as usual as part of the current working arrangements and therefore how could the Committee be assured that what was now business as usual continued. GI agreed and noted that PCNs were all in a different position and noted that this work would be picked up the CCG Business Intelligence team in terms of activity. JB highlighted that the funding was in place for 6	

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	months and would be split into monthly allocations and would continue to support the 7 national goals. Any additional proposals would be presented to the Committee. JR highlighted the need to increase annual health checks for people with learning disabilities as a priority. Alison Bolam (AB) highlighted the lower vaccine supply for April and asked about the impact of this including the possibility of vaccinating and undertaking annual health checks at the same clinic session if less vaccination sessions were expected. JB noted that activity levels were expected to remain high as the second phase of vaccinations was mobilised and noted that there remained plenty of vaccine to vaccinate cohorts 1 to 9. **The Primary Care Commissioning Committee received the update**	
07	**Primary Care Network (PCN) Update** JB noted that PCN Organisational Development bids had been received and a further update would be presented once these had been reviewed. National confirmation had been received regarding the four new specifications for the Network Contract DES which would not be introduced until 1st October 2021. PCNs have been reminded to use the Additional Roles programme to support the vaccination programme. JB provided an update on the additional roles programme and noted that NHS England were working with the ambulance services to review employment models for the paramedic roles such as rotational models. JB noted that PCNs were keen for these roles to be embedded in primary care and noted the plans for future growth in terms of primary care and the ambulance service and highlighted that discussion on local models continued. JB confirmed joint funding plans for community mental health roles had been shared with AWP and noted that these roles would be employed by AWP. A task and finish group had been established to identify the needs of patients presenting in primary care settings and what gap in skills AWP is being asked to support. JB noted that limits on role numbers have been removed for some roles and that CCG teams were supporting analysis of the recruitments against the plans.	

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	JR noted the differences between the paramedic role as part of South Western Ambulance Service NHS Foundation Trust (SWASFT) and the role within primary care and asked whether these roles were too different to recruit into primary care. JB noted that that it was harder to identify the mutual goal between the two roles and highlighted that discussions were ongoing between PCNs and SWASFT. JB highlighted the challenge of developing a model to support both needs to minimise any negative impact. JR asked if there was opportunity to work with SWASFT and University West of England (UWE) to develop a role that was built on a paramedic role but suited to what primary care needs. JR highlighted that there was a significant difference in emergency care and urgent care, and the model for urgent care in the community needed to be defined. AB suggested learning from practices where the paramedic role had succeeded. JR noted the importance of PCNs reviewing roles based on urgent care need within their local populations and how to expand on this. JB noted that the training hub have been talking to paramedics to understand retention in the role and the paramedics had explained that a different type of role would be a draw for recruitment. AM highlighted the scale of modelling workforce and noted that this needed to start from what was needed for patients and the competencies of the current roles. AM highlighted the opportunity with these new roles to shape the outcomes that the PCNs are trying to achieve for their populations. RK asked about the impact on secondary care of physiotherapists working in primary care. JB noted the need to monitor this but explained that secondary care colleagues had worked with Sirona to discuss monitoring as part of workforce reviews. JR highlighted the need for these roles to be included as part of ICPs and community mental health work programmes. **The Primary Care Commissioning Committee received the update**	
08	**Primary Care Strategy: Addressing Health Inequalities** GI provided an update on the work to address health inequalities and support clinically vulnerable populations as part of the ongoing work of the Primary Care Strategy. GI noted that work continued to support practices to identify the clinically vulnerable members of	

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	the population and help them to prioritise the clinical work based on a framework for use in primary care. Group 1 and group 2 lists were developed, and practices were asked to review the lists against their own and additional clinically vulnerable people had been identified by the practices using the lists. It was confirmed that additional work continued to improve ethnicity recording, increase learning disability annual health checks, and supporting patients with severe mental illness. GI highlighted that all these considerations worked towards personalised care and built on the work of the Healthier Together Population Health Management group. GI also noted that further work needed to be completed to combine this work with that of the non-medical vulnerable populations to develop a comprehensive framework for care and development of ICPs. BH noted that practices appreciated the resources and guidance provided. AM highlighted the 65 responses from practices and suggested that more responses would have provided further detail and data. AM highlighted the risk related to data sharing and asked how this was being worked through. AM praised the increase in ethnicity coding and the annual health check inputs but asked whether there were ways to identify whether the outcomes of these actions were improving the health of the population and what work should continue to keep improving. BH explained that the Population Health Management group continued to review agreements on data sharing and highlighted that the challenge was cross organisational sharing. BH explained that the covid related sharing agreements had been extended with NHS England support. GI noted that with the introduction of QCovid practices could make their own vulnerable patient lists and identify what needs to be completed to mitigate the related risks. BH noted that assurance had been received that practices were putting processes in place and reviews have been undertaken. Follow ups were being undertaken with practices that had not yet responded. AM asked whether additional support was required for the data sharing challenges and GI confirmed issues had been escalated to the Population Health Management Group. JR asked for more detail regarding the data sharing risk as data was shared widely through Connecting Care which also contained social care data. It was noted that given the extension of the covid data sharing agreement the risk would be reviewed.	**GI**

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	GI highlighted that that next steps were to broaden this out to the wider partnership through the Primary Care Strategy Group and to understand the identification of vulnerable people through voluntary sector and Local Authority perspectives. GI highlighted that this type of joint working was the core of ICPs and their development. It was asked where the work needed to be monitored in order to move into ICP development and GI confirmed that following discussion with Healthier Together the Integrated Care Steering Group had been suggested. GI noted that the important aspect to consider was that every ICP was accountable for the risks. David Jarrett (DJ) noted that these discussions would continue and were linked to the maturity matrices and development of the culture of the locality partnerships. **The Primary Care Commissioning Committee received the update**	
09	**Proposed relocation of Graham Road Surgery – Communication and Engagement Plan** Colin Bradbury (CB) provided the background to the preferred site and noted that the relocation was an important part of the regeneration of primary care services in the local area. CB noted that the plan outlined the consultation and engagement as the next part of the process and this would be led by Pier Health Group Limited (PHGL) as provider of the services. Clare McInerney (CM) confirmed that this included the coproduction of workshops for the community and stakeholders. Graham Road and Horizon Health Centre would design the workshops with Healthwatch and Project Manager support to take the work forward. The CCG continued to support the process. STW welcomed the plan and particularly the engagement of Healthwatch within the process. **The Primary Care Commissioning Committee approved the Communication and Engagement Plan for the Graham Road GP surgery relocation.**	
10	**Primary Care Finance Report** JL presented the month 11 financial reporting and noted the predicted break-even position for primary care. JL noted the small overspend in delegated budgets which had been offset by the underspend in the non-delegated budgets. JL reported that that there was likely to be an underspend against the GP Forward View transformation funding and additional roles funding following	

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	deferment of recruitment due to covid-19. The funding would carry into 2021/22. JL explained the planning guidance for 2021/22 had been delayed as the financial settlement for the NHS had not been agreed and noted that further information would be provided at the April meeting. JL noted that the published guidance proposed that the primary care Long Term Plan investment was recommitted and would be reallocated and that other strands of primary care funding would continue including covid-19 costs. The full impact would be reported in April. AM asked for further detail regarding QIPP schemes. JL confirmed there was likely to be some structural challenges including locum spend and population growth but the savings should be achievable despite these challenges. **The Primary Care Commissioning Committee noted:** • **The summary financial plan** • **The key risks and mitigations to delivering the financial plan** • **That at Month 11 combined primary care budgets were reporting a year-to-date breakeven position** • **As a result of delays to national information/guidance, financial planning for 21/22 would be completed over the course of next month**	
11	**Primary Care Quality Report** Michael Richardson (MR) provided an overview of the practice quality ratings noting that these were overall good with several outstanding ratings. The quality team continued to support practices where quality improvements were required. It was noted that the Infection Prevention and Control tactical support team had received funding from Local Authorities to continue working until quarter 2 2021/22. MR highlighted the success of local practice nurses who received awards in the NHS England South West General Practice Nurses Celebration. JR noted that the report contained high level information but asked what the real quality issues were and how can the Committee be assured these were being addressed and the timelines for this. MR agreed that the report only showed a snapshot of the key themes and actions. JR noted that there needed to be clarity on	

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	what good quality in general practice looked like and what did practices think good looked like. STW agreed and also suggested that quality related trajectories, trends and impacts needed to be outlined in the report. JR asked GI to lead a piece of work to identify what good quality looked like in primary care and GI suggested that Clinical Executive Committee would be a useful forum for these discussions. RK clarified that the children and adolescent mental health service (CAMHS) set up in North Somerset was not a tier 2 services but a pre-CAMHS service. RK welcomed this service. AB highlighted the importance of understanding what 'requires improvement' meant for the 8 practices rated red on the dashboard. MR agreed and considered breaking this into themes for the report. JB highlighted that a fuller report on quality and resilience would be developed. **The Primary Care Commissioning Committee noted the report**	**GI** **RS/MR**
12	**Contracts and Performance Report** SK provided the key points from the report: • There have been no contractual changes within the practice register • The pharmacy enhanced service has been extended by a year • All 18 PCNs have signed up to phase 2 of the mass vaccination programme • The plan to merge Improved Access and Extended Hours has been delayed to 2022. Practice performance has been noted and allocations have been agreed this month. • The changes to the Local Enhanced Services in response to Covid-19 support were outlined **The Primary Care Commissioning Committee noted the report**	
13	**Questions from the Public – previously notified to the Chair** A member of the public asked a question about the commissioning of falls awareness & falls prevention education & training in residential care & nursing homes. "30% of people over 65 & 50% of people over 80 (PHE 2018c) experience a fall each year. People living with dementia are 8 times more likely to fall than the general population and people with Parkinsons at 26% higher risk. In 2019 the NSCP Residential	

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	Home Support Team & our CIC worked on a number of falls awareness & prevention projects which reduced falls across 13 residential homes over a three-month period by 73%, reduced UTI's by 40%, increased frame recognition to 100%, and reduced hospital admissions by 60% . A number of other projects and initiatives had been planned pre pandemic to build on these gains and share best practice across other residential homes. With the demise of the RHST may I ask if there are any plans to commission a similar service to the RHST to address the issue of falls in residential & nursing homes across the BNSSG area?" In response, GI noted that these were helpful points about the learning and outcomes the CCG wants for the population. GI confirmed this was being reviewed with Sirona and the integrated care teams. GI noted that work was also ongoing to review the support needed from the multi-disciplinary teams working with the care homes. GI noted that all care homes were supported by a PCN and support work continued to be rolled out to all care homes.	
14	**Committee Effectiveness Review** STW informed the Committee that the Committee Effectiveness Survey report would be presented at April's meeting as would the review of the Terms of Reference.	
15	**Any Other Business** There was none	
16	**Date of next PCCC:** The date of the next open meeting was 27th April 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	

Lucy Powell, Corporate Support Officer, April 2021