Bristol, North Somerset and South Gloucestershire
Clinical Commissioning Group

Primary Care Commissioning Committee Open Session

Minutes of the meeting held on 28 April 2020 at 9am, held via Microsoft Teams

Minutes

Present		
Alison Moon	Independent Clinical Member – Registered Nurse	AM
Alison Bolam	Clinical Commissioning Locality Lead, Bristol	AB
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
Rachael Kenyon	Clinical Commissioning Locality Lead, North Somerset	RK
Martin Jones	Medical Director for Primary Care and Commissioning	MJ
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
Apologies		
Georgie Bigg	Healthwatch North Somerset	GB
Mathew Lenny	Director of Public Health, North Somerset	ML
Philip Kirby	Chief Executive, Avon Local Medical Committee	PK
Lisa Manson	Director of Commissioning	LM
Rosi Shepherd	Director of Nursing and Quality	RS
Sarah Truelove	Chief Finance Officer	ST
Rob Ayerst	Head of Finance (Primary & Community Care)	RA
In attendance		
Jenny Bowker	Head of Primary Care Development	JB
Sarah Carr	Corporate Secretary	SC
Bev Haworth	Models of Care Development Lead	BH
Tim James	Estates Manager	TJ
Jon Lund	Deputy Director Finance	JL
David Moss	Head of Primary Care Contracts	DM
Lucy Powell	Corporate Support Officer	LP

	Item	Action
01	**Welcome and Introductions** Alison Moon (AM) welcomed members to the meeting. The above apologies were noted.	
02	**Declarations of Interest** FF declared a new interest relating to prison health services; she was a director of Hanham Secure Health, a brand of Hanham Health Services. There were no other 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.	
04	**Action Log** The action log was reviewed: **Action 150 –** JB explained that the GP Forward View update would be part of a wider report on the Primary Care Strategy. The action was due July 2020. JR informed colleagues that the strategy had been received at the Healthier Together Partnership Boar for sign-off. OneCare had questioned whether it could sign off the strategy, as it had not consulted with its membership. Following discussions it had been clarified at the time of development OneCare was not a membership organisation. The CCG had committed to reviewing the strategy post covid-19 to identify any changes required. **Action 163** – the action would be taken as part of the agenda item for this meeting relating to Online Consultations. **Action 164** JL commented that the matter would be raised with NHSE in June. It was unlikely that this would change the budget for 2020/21 however could affect the 2021/22 allocation. It was agreed to defer the action to June. **Action 165 –** MJ confirmed that patients with visual and hearing impairments were not included in the shielded group of vulnerable patients. National direction had been issued on this matter. The shielded group included patients who were very high risk. The action was closed. Rachael Kenyon (RK) commented whilst patients in this cohort were not vulnerable in relation to covid-19 as a population group there were issues, which needed to be considered. MJ noted this was a helpful point for GPs to consider in relation to their patients. JR commented that she had concerns about the clarity of the message in the next phase regarding what was expected of people in high-risk groups. It was important to consider how primary care and the CCG would work with and	

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	support the wider group of high-risk patients. MJ agreed to explore this. Alison Bolam noted that current methods of communication disadvantaged patients with hearing impairment. JR asked if a full Equality Impact Assessment was available or had been planned. David Moss (DM) commented that there was an Equality Impact Assessment that could be used. JR asked that the CCG standard Equality Impact Assessment was also used. It was agreed to complete an Equality Impact Assessment. **Action 166 –** MJ provided an update on the process for the production of the letters for vulnerable people. The list had been produced centrally; GPs were asked to check their records against a list as were hospital specialists and a national list was generated with a letter for patients. This was an iterative process that would continue as patients were added to the list. The CCG work on searches had been used to compare locally held information with nationally generated lists to ensure the lists captured vulnerable patients. It was agreed the action was closed. AB noted that NHSE guidance continued to be updated. STW asked if there were patients who received letters who should not have. MJ confirmed this had happened and patients had discussed issues with specialists. MJ noted the distribution of the letters to vulnerable patients was a significant exercise. JR commented that the Insights and Engagement Team would be asked to explore people's experience during the covid-19 response. Primary Care would be asked to facilitate access to patients as part of this. A particular issue to be explore would be how clear individuals were about their status as vulnerable or not vulnerable patients and what action they should take. Members expressed concern about those patients who were not being picked up as high risk and not appearing on searches particularly where patients had multiple conditions. Concern was expressed regarding the lack of consistency and changes to guidelines. It was important for patients that there was greater clarity as shielding continued. MJ highlighted the discretion for primary care colleagues to add patients to the list of vulnerable patients. It was agreed these concerns would be reported into the primary care cell and other key groups. FF commented that it would be helpful to have clarity regarding multiple morbid conditions and frailty to ensure there were clear definitions for primary care to apply consistently.	**MJ** **MJ**

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	JR noted the nationally changing picture. It was helpful to have local conversations and a local consensus about who would be identified as vulnerable and high risk particularly as the lockdown was lifted. It was the role of the primary care cell and more widely the Clinical Cabinet to consider this across pathways. MJ welcomed this and highlighted that there were ongoing discussions across different fora. Helpful discussions were being held with NHSE South West. It was agreed to explore a local BNSSG consensus. This would be picked up at the Primary Care Cell, the Silver Cell and the Clinical Cabinet. MJ and JR would discuss this further. **Action 168 –** JB confirmed guidance had been circulated. The action was closed. All other due actions were closed.	**MJ**
05	**Covid-19 update** MJ highlighted: • the reporting arrangements for the Primary Care Cell through the Operational Command and BNSSG Health and Care bronze and Silver Commands. Locality Transformation now sat within the Silver Command structure. • A primary care daily sit rep was now available, supported by OneCare, which fed into Alamac. • A staff testing process, supported by OneCare was in place. There were no reports of staff being unable to access tests. • Work continued with the Logistics Cell to ensure primary care providers received PPE as quickly as possible using a new reporting tool. • Heads of Localities were working through the Localities Sub Group to further develop local practice resilience plans and whole system integrated locality plans for covid-19 including: - joint home-visiting service with Sirona - care home 'wraparound' teams and advanced planning - community end of life care support • The Digital Sub Group had made significant progress with the distribution of and support for IT equipment and software • Daily communications with primary care were in place • Significant progress had been made through the workforce cell; the training hub, OneCare, the LMC, and SevernSide continued to develop a local offer to support the deployment of additional workforce using the primary care Sit rep.	

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	• 75% of practices had shared Business Continuity Plans and emergency contact numbers had been received. Work continued with individual practices. • Temporary site closures related to branch surgeries and allowed practices to consolidate staff on one site. Practices had received confirmation that LES and Extended Hours DES income would be protected with a commitment to pay practices for quarters four and one. Arrangements had been established for the covid-19 cost reimbursement. FF asked: • was there a timescale for the covid-19 cost reimbursement • was there confidence Care Homes had adequate access to PPE • there were issues relating to care homes and Wi-Fi access which affected online consultations and support would be helpful DM explained the panel had met and its decisions were to be ratified prior to payments being made. JR noted that concerns about access to PPE by Care Homes had been raised by local MPs. There was sufficient stock for Care Homes with supply available on a 'just-in-time' basis. Work was underway to ensure that a local stock of PPE for Care Homes was held. MJ confirmed that this was a focus for the Care Home and Infection Control and PPE Cells. David Jarrett (DJ) provided an update on the Locality Sub Group. At the start of the response phase, an interim Locality structure had been established with 6 Heads of Localities. The focus had been on resilience planning. There was good joint working with partners including Sirona and OneCare. There was support from the PCN Clinical Directors for resilience planning. The focus was turning to the recovery phase and the development and delivery of services. JR asked: • What was the impact of the out patients transformation programme and the advice and guidance service. • how was the Localities sub group approaching the recovery phase after lockdown and how would background covid-19 be managed	

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	• What had been the impact of moving minor urgent activity into Minor Injury Units and Urgent Treatment Centres and had there been an impact on primary care • The committee needed to be aware of practices that were experiencing specific resilience issues and what were the risks MJ explained the advice and guidance was being managed through STP arrangements. Advice and guidance for a number of specialities was being rolled out. This was supported by the Clinical Cabinet and sat alongside the diagnostic work. Discussions about the recovery phase approach were ongoing within the Locality Sub Group. Primary care colleagues had not reported increased presentations of minor injuries or illness. Practice resilience was an important issue, this would be discussed in the closed session, and a paper would come to the next meeting. JR stressed it was important to retain the new model in the recovery phase and not return to high attendance levels at A&E departments. It was also important not to return to the old model of managing outpatients and ensure a proactive approach to ensure the transformation was embedded. MJ agreed it was important to maintain the changes made to support the support. AM commented on a Midlands approach described as 'no going back'; this captured the transformations. AM asked if there was the capacity to take the approach suggested. JR commented there was an opportunity to manage the immediate future and the longer term. DJ noted discussions about the recovery phase had started and the latest model would be shared with Localities and taken forward through the locality cell. AB noted individual practices were discussing how to retain new models. AB asked about booking covid-19 assessment appointments. BH explained a standard operating procedure would be shared with practices. The number of bookings would increase. JR asked how the learning from across primary care would be collected to achieve a consistent approach across the system. AB noted there would be a top down approach from the primary care cell and down up approach from practices.	**MJ**

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	Rachael Kenyon (RK) commented practices were seeking feedback from patients to inform the recovery phase and asked for the primary care cell to explore the potential for a consistent approach to collecting comments. RK commented on practice activity data which was reported as reducing; online contacts were increasing and it was important that monitoring data and data collection picked up all activity correctly. FF asked about recovery and transformation cell and was this work part of that cell. JR confirmed this. JR welcomed the comment from RK regarding patient surveys and supported a single questionnaire approach across the CCG to ensure a consistent approach. AM welcomed the real time situation report as a development to retain. **The Primary Care Commissioning Committee noted the report and the next steps**	
06	**Online consultations** MJ thanked the team for taking this work forward. This had been a complex matter. BH set out the background to the programme. The Committee had agreed an offer of 2 digital products in January 2020. Subsequently, as part of the NHS covid-19 response, NHS Digital had mandated the Total Triage Model, the implementation of video consultations by 17th April 2020 and online consultations by the end of April 2020. The CCG approach to support practice resilience in implementing the Total Triage Model was highlighted: • remote working had been enabled through the supply of IT equipment to practices • triage had been aligned to known technology where possible • AccuRx had been deployed with full functionality. • a weekly dashboard was used to monitor the number of video consultations; this was used to flag practices requiring training support. Online consultations had been discussed with the PCN Clinical Directors. The question of 'why now' was raised. It had been explained there was an opportunity to support the cultural change this way of working required. PCN Clinical Directors had indicated there was no capacity to choose between products as this point. As a result, a decision to rollout e-Consult was made. The product had been evaluated previously and could be 'bolted-on' to practices existing systems. The product had best interoperability with EMIS. The decision followed due process through NHSE and CCG procurement guidance. Practices with a solution in place	

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	already would continue to use it. Practices wishing to use alternative solutions would be required to fund the difference in cost. Communications with practices continued through PCN Clinical Directors and daily Primary Care communications. Twice weekly training sessions were in place. The priority was to take all practices through the implementation process. The recovery phase was in planning and would include working with Patient Participation Groups. Feedback through e-Consult continued to be monitored. Evaluating the impact on patients with protected characteristics and on inequalities would be a focus. AB welcomed the introduction of AccuRx and asked if patient contacts made via AccuRx, then moved to video consultation were counted twice and what was the number of video consultations? BH explained calls were not considered as converted to video consultations. The percentage of video consultations was not available although the number of video consultations was tracked weekly. The focus was to help practices with low numbers. STW asked about the evaluation of the impact on protected groups. STW asked how patients unable to use the digital options were supported through messaging to other forms of access. BH explained that communications had not gone out and agreed to work with STW to ensure wording supported patients. AM noted that this was a 'no-going-back' initiative. BH explained the next steps for the programme would be to present a report on the impact of the implementation. This would include understanding how the culture of face-to-face contact had changed. This would come to the July meeting. FF noted that e-Consult could be used in different ways. It was important the evaluation considered this. JL noted the other digital transformation work and the importance of sharing learning across this work. BH confirmed Sirona and acute providers were involved with the primary care digital sub group **The Primary Care Commissioning Committee noted the report**	**BH**
07	**Primary Care Networks (PCNs)Update** JB highlighted: • The DES Structured Medication Review and Medicines Optimisation Service Specifications were postponed until at least October 2020. The GP Support to Care Homes	

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	Specification continued as planned. The Early Cancer Diagnosis Specification would continue subject to the covid-19 response. In recognition of the impact of the covid-19 response, the submission of planning templates for PCN workforce needs was delayed until August 2020 to allow more discussion. • All PCNs were invited to reconfirm participation in the PCN DES 2020/21 by 24 April. No changes were anticipated. • Extended hours remained a requirement of the PCN DES. There had been a national indication that the use of extended hours could be flexible during the covid-19 response period. Discussion as to how this capacity could support recovery would be held. • Work on the Enhanced Health in Care Homes specifications continued. Care homes had been aligned to PCNs with the support of the Care Home Cell. PCNs would be written to starting the allocation process. The emphasis on remote consultations was highlighted. • The majority of PCNs had submitted Organisation Development proposals. Funds for the PCN programme were committed. The remote delivery of the Peloton programme was being explored. Once confirmed Clinical Directors would be invited to participate. • Discussions had been held with Clinical Directors about sharing learning, the impact of covid-19 on proposed activities and principles for 2020/21 JR commented the PCN Clinical Director discussion had been positive. The use of the organisational development resource to build management capacity was raised. JR asked how this was being taken forward. JB explained that the issue would be raised at the Executive Team meeting. There was a balance between PCNs needed needing additional management capacity to co-ordinate activity. A number of PCNs had invested in extra capacity to management support. An issue to explore was how PCNs were deploying resources to best effect. This linked to locality working to understand where resource and capacity sat. CB commented that this was part of the wider conversation about the development of Integrated Care Partnerships.	

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	AM commented the number of people presenting for two weeks waits relating to cancer had dropped. AM asked what would be done to support GPs regarding the early diagnosis. The national campaign was noted. Could the timing of the LES come forward to support this? JB confirmed this was discussed with the PCN Clinical Directors. Concerns about patients not presenting were raised. Some PCNs were proactively communicating with patients. The CCG was exploring further support and this would link to recovery planning. Smear tests were identified for review as part for recovery planning. RK noted that patients were concerned about attending hospital settings if referred. RK noted in relation to smear testing, this could be taken forward as joint work through PCNs. JB welcomed the comments about patients concerns regarding attendance at secondary care, which would be used to inform communications. How messaging could support patients with expectations would be explored with the communications team. JR commented that this was part of the recovery cell work. MJ commented that it was easier to bring patients into primary care than keeping outpatient appointments. JR commented it was important to retain and capitalise on the outpatient department transformation. **The Primary Care Commissioning Committee noted the report**	**JB**
08	**Primary Care Finance Report** Jon Lund (JL) explained the paper focused on the year-end position. The core primary care budget ended the year at an approximately break-even position. This was due to slippage on the Additional Role Reimbursement Scheme, which had been budgeted for from the start of the year. Additional non-recurrent funding had been received from NHSE supported the position. These risks to the 2020/21 budget were highlighted. The prescribing budget was significantly overspent due to increases in Category M drug prices and No Cheaper Stock Obtainable drugs. The prescribing expenditure was received two in arrears and did not include the impact of covid-19. This would be monitored. FF ask why the Qof achievement was higher than planned. JL agreed to explore this. FF noted that savings on the Additional Role Reimbursement Scheme were not positive. JL agreed. RK asked if the CCG would ensure that practices were not disadvantaged in relation to Qof if there had been an improvement	**JL/RA**

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	in performance. DM confirmed that practices would not be disadvantaged. MJ confirmed that the CCG did not want to make savings through funds for new roles. This had been discussed with PCN Clinical Directors; the focus would be on how to ensure as a community that resources were used in the right places to mitigate risks. **The Primary Care Commissioning Committee noted:** • **at Month 12, combined primary care budgets reported an overspend of £4.4M; this did not include additional costs incurred as a response to the Covid-19 pandemic** • **the report reflected the final year-end outturn expenditure, and was subject to external audit as part of the CCG's statutory year-end process**	
09	**Primary Care Quality Report** It was agreed that in Rosi Shepherd's (RS) absence any queries on the paper would be minuted and shared with RS for clarification. AM noted that there had been discussions about quality and primary care and the impact of covid-19. MJ explained that he was discussing these issues with Rosi Shepherd. MJ and RS were interviewing candidate for the quality clinical lead role. **The Primary Care Commissioning Committee noted the report**	
9	**Contracts and Performance Report** DM reported that to enable practices to manage immediate and continuing covid-19 pressures 7 practice branch surgeries across the BNSSG footprint were temporarily closed. Action plans had been submitted from each practice providing assurance of continuity of care. The CCG had been notified that Helios Medical Centre was now a single-handed practice. A paper on LES would come to the May meeting. **The Primary Care Commissioning Committee noted the report**	
10	**Questions from the Public – previously notified to the Chair** There were no questions from the public.	
11	**Any Other Business** There was no other business for discussion.	
12	**Date of next PCCC:** Tuesday 26th May 2020 9am-1pm	

	Item	Action
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	

Sarah Carr, Corporate Secretary, 1st May 2020