Bristol, North Somerset and South Gloucestershire
Clinical Commissioning Group

Primary Care Commissioning Committee Open Session

Minutes of the meeting held on 29th September 2020 at 9am, held via Microsoft Teams

Draft Minutes

Present		
Alison Moon	Chair of Committee, Independent Clinical Member, Registered Nurse	AM
Georgie Bigg	Healthwatch North Somerset	GB
Colin Bradbury	Area Director for North Somerset	CB
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
Martin Jones	Medical Director for Primary Care and Commissioning	MJ
Philip Kirby	Chief Executive, Avon Local Medical Committee	PK
Lisa Manson	Director of Commissioning	LM
John Rushforth	Independent Lay Member, Audit, Governance and Risk	JRu
Rosi Shepherd	Director of Nursing and Quality	RS
Sarah Talbot-Williams	Independent Lay Member, Patient and Public Engagement	STW
Apologies		
Sarah Carr	Corporate Secretary	SC
Rachael Kenyon	Clinical Commissioning Locality Lead, North Somerset	RK
Mathew Lenny	Director of Public Health, North Somerset	ML
Jon Lund	Deputy Director of Finance	JL
Julia Ross	Chief Executive	JR
Sarah Truelove	Chief Finance Officer	ST
In attendance		
Jenny Bowker	Head of Primary Care Development	JB
Kate Davis	Principal Medicines Optimisation Pharmacist (Bristol Area)	KD
Loran Davison	Team Administrator, Corporate Services	LD

Jamie Denton	Head of Finance – Primary, Community & Non Acute Services	JD
Bev Haworth	Models of Care Development Lead	BH
Geeta Iyer	Primary Care Provider Development Clinical Lead	GI
David Moss	Head of Primary Care Contracts	DM
Lucy Powell	Corporate Support Officer	LP
Sian Trew	Head of External Communications	STr

	Item	Action
01	**Welcome and Introductions** Alison Moon (AM) welcomed members to the meeting. The above apologies were noted.	
02	**Declarations of Interest** There were no new declarations of interest. It was noted that the GP Practice Partners, Felicity Fay (FF), David Clark (DC) and Alison Bolam (AB), had an interest in item 8 as this item discussed the reimbursement of funds to GP Practices.	
03	**Minutes of the Previous Meeting** The minutes were agreed as a correct record with the following amendments: • P4, 1st paragraph amended to read "…governance to understand…" • P5, 3rd paragraph amended to read "It was anticipated…" and "…the budget to be committed." • P7, 1st paragraph amended to read "…to access primary care."	
04	**Action Log** The action log was reviewed: • **Action 164 –** Jamie Denton (JD) confirmed that discussions had been delayed due to the covid-19 response but funding had been provided to cover the underlying deficit. • **Action 181 –** On the agenda for the September meeting. Action to be closed. • **Action 184 –** Rosi Shepherd (RS) noted that the action was broader than presenting the action plans to the Committee and explained that following a meeting with the practice there were wider concerns than those raised within the Care Quality Commission (CQC) report. It was agreed that an update would be provided at the October Committee meeting during the closed session. Lisa Manson (LM) highlighted that in terms of the CQC action plan this would be published on the CQC website. • **Action 194 –** This action was closed.	**RS**

	Item	Action
	• **Action 198 –** Jenny Bowker (JB) confirmed that an update on the care home Directed Enhanced Service paper would be provided to the Executive Team next week. The action was closed. • **Action 199 –** JD confirmed that direct primary care support was defined as out of scope of the discharge to assess scheme and instead covered by enhanced support. It was confirmed that a CCG Clinical Lead was involved in this work. It was agreed that Jon Lund would contact Alison Bolam and Rachael Kenyon for their involvement in the pathway development. • **Action 200 –** Hospices were confirmed as involved in the discharge to assess modelling. The action was closed. • **Action 201 –** JD confirmed the concerns had been shared with the regional team. Jon Lund to confirm that the concerns had also been shared with Julia Ross. • **Action 203 –** The units within the tables were reviewed and amended. This action was closed. • **Action 204 –** Meeting has been arranged. This action was closed. • **Action 205 –** The report has been reviewed and discussions have been held on how to develop the slides. It was agreed to close this action. RS agreed to provide the amended report slides with the concerns included as part of the quality report in November. All other due actions were closed	**JL** **JL** **RS**
05	**Corporate Risk Register (CRR) and Governing Body Assurance Framework (GBAF)** AM highlighted the primary care risks and the risk management audit and asked whether there were any comments on the paper. FF highlighted the risk related to cancer management and noted that one of the mitigations was the independent sector carrying out investigations and asked how long this capacity was in place for. LM confirmed that capacity had been contracted to 31st March 2021. It was noted that patients undergoing urgent cancer treatment and those clinically assessed as a priority had been prioritised for treatment and the Trusts had developed methods to keep patients safe including green wards. Providers continued to monitor patients who had chosen not to attend for treatment.	

	Item	Action
	AM highlighted the objective related to developing Primary Care Networks (PCNs) and suggested that the rationale for target risk was reconsidered as this did not currently describe the rationale. FF highlighted the objective for locality development into delivery and the variety in the maturity of the PCNs and queried whether it made sense to have frailty, mental health and urgent care considered within the same objective. Martin Jones (MJ) noted that these would be considered alongside the clinical leads review that Colin Bradbury (CB) and David Jarrett (DJ) were leading. DJ confirmed that the Governing Body had reviewed the assurance framework for 2020/21 and noted that the objectives had not yet been updated for the amendments which would be approved by the Governing Body. DJ noted that some of the highlighted risks would be moved into locality development and would be monitored through the Primary Care Operational Group rather than through the assurance framework. **The Primary Care Commissioning Committee:** • **Reviewed that appropriate and effective mitigations were in place for risks reported on the CRR and GBAF specifically those areas relating to the Committee's remit** • **Considered whether the CRR and GBAF were an accurate reflection of the risks brought to the Committee's attention** • **Agreed to amend the Committee Terms of Reference in line with the proposal and review this amendment at the October meeting**	**MJ**
06	**Primary Care Covid-19 Current Position** MJ presented the key points for recovery: • There was a focus on vulnerable people and risk stratification • Personal Protective Equipment (PPE) logistics was transferring to a new system • The offer to primary care around community phlebotomy continued to be developed • Care home work continued in preparation for the implementation of the Enhanced Health in Care Homes Directed Enhanced Service (DES) from 1st October. • Flu planning continued and was discussed weekly at the primary care cell	

	Item	Action
	• 111 First was also discussed weekly at the primary care cell MJ highlighted the work of the digital sub group including 111 First direct bookings and video and online consultations. Bev Haworth (BH) noted that health inequalities were being addressed through the wider system digital inclusion programme. MJ shared the findings from the Rapid Covid-19 Intelligence (RACPI) project and noted that one of the challenges identified had been restarting face to face consultations and a plan to support the findings from the project would be presented to the Clinical Cabinet alongside the wider system plans for primary care. The phase three letter has been received and the CCG continued to support practices to protect vulnerable patients. Data sets have been developed to target high risk groups and those that will benefit most. Public listening events have taken place and the CCG worked closely with the voluntary and community sector to develop primary care plans. MJ highlighted the system priorities including changes to pathways and outpatient transformation. The CCG was working through modelling primary care capacity to better reflect how this fed into the system wide capacity. Geeta Iyer (GI) highlighted that primary care needed to agree how to undertake risk stratification for vulnerable patients and the CCG was working with practices on identifying vulnerable patients and interventions required. The primary care cell, working with OneCare and the Local Medical Committee (LMC), have developed a pragmatic way to identify these patients and to prioritise the work to be delivered. The identification tool considered a combination of risk factors and using the tool practices would be provided with a list of patients considered vulnerable. The approach had been tested with the Clinical Executive Committee, the Integrated Care Steering Group and the GP Collaborative Board and aligned with the PCN Population Health Management work. FF asked when the practices would receive the lists, GI confirmed that the lists would be sent to practices within the week to sense check and test the approach. FF also asked how 111 direct booking would be managed when capacity was fully utilised. DJ highlighted that Bristol, North	

	Item	Action
	Somerset and South Gloucestershire was first nationally for the number of practices configured for direct bookings. BH noted that the challenge was ensuring that primary care capacity had been modelled correctly and triangulated with the primary care opel status and explained that there was a primary care/111 first pathway design meeting planned for today. BH noted that the utilisation of slots was currently at 21% and an escalation plan was in place for when the slots hit capacity which would feed into other system pathways. FF asked about the impact of the accuRx charge and the change to the rheumatology pathway. MJ noted that practices were mixed on rheumatology injections and therefore the pathway was being reviewed. BH assured that the team were working through the accuRx charge impact and noted that practices would be able to use the standard version but the CCG was investigating a way forward for the more complex version. AB highlighted that there were benefits particularly around administration of accuRx over other systems for receiving photos from patients. The Committee thanked the teams for their work with the practices. **The Primary Care Commissioning Committee noted the report**	
07	**Primary Care Strategy Update** GI updated on the progress of the strategy and outlined the key areas of focus and described the enablers to take these forward. GI highlighted the pragmatic approach to identifying vulnerable patients as well as the community pharmacy work to support primary care. GI noted that next steps included addressing health inequalities through continued work with patient groups and the citizens panel and extending the care home support work. Opportunities have been developed for supporting mental health services using voluntary and community sector support and a communications and engagement plan would be developed to progress these next steps. GI highlighted the strategic focus and noted that the governance and structure continued to be reviewed. Sarah Talbot-Williams (STW) asked about the areas that hadn't progressed and GI confirmed that the lessons learnt from the covid-19 response were being flagged against the delivery plan where work had not progressed against the plan. JB confirmed that the areas that had paused were workforce planning and	

	Item	Action
	training hub activities which involved people coming together and the team were considering how this could be undertaken remotely. AM asked whether there was a timeline which outlined when and what the expectations were for the outcomes. GI noted that pre covid-19, the team were working with Sirona on an outcomes framework and this would be mapped against the current plan. GI noted that although some areas had not progressed, other areas had progressed rapidly including mapping of care home workforce which would help PCNs plan and would form part of the strategy and pulled into the locality plans. AM asked whether there was capacity to undertake this and GI explained that prioritisation would need to take place. BH confirmed that prioritisation changed based on need and advice from NHS England. STW highlighted that identifying vulnerable people and addressing health inequalities was different and asked how these would be integrated. BH noted that this integration was forming a subset of the health inequality, prevention and population health management groups. GI noted that the Strategy Board had representatives from Public Health and work needed to be completed to understand the overlap of patients between health and social care as well as patients that were unknown to the health system. **The Primary Care Commissioning Committee received the update**	
08	**Primary Care Networks Directed Enhanced Service (DES) - Workforce Returns and Next Steps** JB highlighted the timeline to identify the workforce intentions noting that the investment for the Additional Roles Scheme in 2020/21 was £6.9m of which £4.1m was held by the CCG with the rest held by NHS England which could be drawn down once the allocation was committed. JB outlined the 10 roles that could be recruited to in 2020/21 and noted the additional roles that had been identified for the future. PCNs needed to submit indicative intentions by the end of October. JB noted that currently there was an unclaimed pot of £1.34m that PCNs could bid for under national criteria. JB noted that local criteria had also been developed which included the requirement that bids could not create recurring cost pressures,	

	Item	Action
	that the CCG would consider practice resilience as part of the bid, and would consider whether the bid supported a system approach to workforce development. The CCG was discussing the potential flexibility in the use of funds with NHS England. The criteria have been discussed with the PCNs and a comment had been received regarding high deprivation being considered as a higher priority within the criteria. It was noted that all PCNs required continued support through the process and this was taking place through the workforce group. AB asked what would happen to the money not bid for and noted the challenging timelines for submission. JB noted that those discussions were being had with NHS England, however there was a chance that the money could be lost. JB explained that the deadline had been communicated to PCNs and the CCG had requested that Clinical Directors inform the CCG if the timescales were too challenging. DJ asked how the intended workforce compared to other systems. JB explained that given the current situation it would be expected that there would be more intended social prescriber roles and clinical pharmacists however where role recruitment was low, the workforce group was communicating the potential opportunity for those roles. JB explained that the Committee was being asked for their view on whether the factors of deprivation should be given higher weighting over the capability to recruit for the unclaimed funds. FF noted that the approach was appropriate and thorough but noted the lack of uptake in certain roles and suggested that the training hub could provide the PCNs with the opportunities that the under recruited roles could provide. FF noted that estate was an issue as there was no room to house some of the new roles and suggested community hubs as additional estate. AB agreed with supporting recruitment for practices with higher deprivation particularly due to the health inequalities experienced from covid-19 but acknowledged that providing funds to the practices most likely to recruit would mean that the money would not be lost. STW agreed that deprivation was an important factor	

	Item	Action
	and noted that areas with higher deprivation might not always be the areas that were unable to recruit. AM noted the Committee supported weighting deprivation and added that the practices needed to understand the value the roles could provide and suggested that the training hub provide case studies on how the roles could be utilised. MJ noted it was important to work with practices and understand the support they required and highlighted this as a key role for the area teams for providing support in completing the returns. STW asked whether central hubs for resource had been considered including floating resource across the system. JB confirmed that work was ongoing through the community workforce group to develop a primary and community care bank and a project officer is being recruited to take this forward. There was an opportunity to review the learning from the covid-19 system workforce bank. JB noted that currently the PCN Clinical Directors had not supported a mass recruitment drive but those discussions continued. **The Primary Care Commissioning Committee reviewed and approved the proposed process subject to final engagement with PCN Clinical Directors.**	
09	**Supplementary Services and Local Enhanced Service (LES) Review for 2021/22** JB presented the paper noting that this was a project mandate for the Committee to approve to establish a review of the supplementary services and the LES offer. JB noted that it had been made clear that the services were integral to the five year PMS reinvestment agreement. JB outlined the project objectives and noted that all funded agreements with practices due to expire in March 2021 were within scope of the project excluding Improved Access, Prescribing Incentive Scheme and enhanced services commissioned by other parties. JB highlighted that practice capacity to engage in the process during the winter period was a significant risk particularly if there was a second spike of covid-19 which could also impact CCG capacity. Capacity would be evaluated by the project steering group who would develop and review the timeline and mitigations. JB outlined the reporting structure and highlighted that the benefits	

	Item	Action
	of the project were to improve health outcomes for the local population and ensure consistency of services. John Rushforth (JRu) asked whether the project would link with the population health management work and JB confirmed that this was the case. AM asked whether there were plans to engage with the local population on the project and JB confirmed that engagement would be built into the approach. AM asked whether there were alternative plans in place in case the project was challenged. JB noted that the first role of the steering group was to review the timeline and ensure that a risks and mitigations plan was in place. AB asked whether the project would review the entire basket of services across Bristol, North Somerset and South Gloucestershire. JB confirmed this but noted that there would be increased focus on the supplementary services due to the higher value of these and noted that the LES had been through a review recently and the areas to test had already been identified. MJ noted that the project would consider outcomes and ensure that the money was used in the most sensible way for the population. Lisa Manson (LM) noted discussions would be held with the practices who did not undertake the specified services so these services could be provided in a different way. JB highlighted that the aim of the project was to develop consistent, high quality and evidence based enhanced primary care which met the needs of the population and demonstrated value for money. AM noted that progress reporting would need to be taken through this Committee and JB agreed that highlight reports would be provided. **The Primary Care Commissioning Committee supported the project to review the enhanced offer**	**JB**
10	**Influenza Planning Update** GI highlighted the various groups convened for flu planning across the system and noted that there had been good engagement and feedback on the system plans. Assurances on progress, health inequalities, front line vaccinations and delivery models for housebound and vulnerable patients had been received. There was a gap in ordering stock due to the additional cohorts but details on how to access more stock would be provided soon.	

	Item	Action
	Uptake has increased from last year already following increased public awareness and it was noted that national communications would begin next week. GI confirmed that local communications had started and engagement with specific population groups, and vulnerable and shielded patients was progressing. GI highlighted that potential school closures had been raised as a risk to the school programme and there was a risk that social care reliance on community pharmacies may lead to stock issues, the flu groups were monitoring these risks. GI highlighted that the Acute Trusts were currently focused on vaccinating staff and pregnant women and had not yet committed to the wider patient groups. It was agreed that the update next month would include further detail on the risks and mitigations. **The Primary Care Commissioning Committee received the update**	**DC**
11	**Budget Setting Methodology for Primary Care Prescribing in 2019/20** Kate Davis (KD) was welcomed to the meeting and provided the background to the paper highlighting the method used in 2019/20 to share the prescribing budget. KD noted that 41 practices were prescribing within their fair share with 8 more practices moving closer to this in 2019/20. Deep dives were being undertaken into the practices that had not achieved their budget. For 2020/21, the team would utilise new software and were working with Business Intelligence (BI) colleagues to review activity and further review whether the budgets set were fair to practices. AB highlighted that the majority of practices above their fair shares were within South Gloucestershire. KD noted that there had never been a prescribing quality scheme in South Gloucestershire and therefore this was new to the area. Some practices had made good progress towards fair shares and the CCG was working with those who hadn't. FF asked whether the warfarin switches had affected the fair shares achievement for some practices. KD confirmed that adjustments had been made to the budget for issues outside of	

	Item	Action
	the practices' control in 2019/20 and this would be repeated again at the end of the year for 2020/21. Rosi Shepherd (RS) asked whether there were any quality issues relating to the underspending practices. KD highlighted that the new software would help to review practice prescribing activity and would provide alerts for patients on unsafe combinations of prescriptions. STW asked how health inequalities were factored into the budget setting. KD confirmed that the prescribing allocation from NHS England took into account deprivation and population and that the fair shares budget was calculated using Quality Outcomes Framework (QOF) data in the four clinical areas. AM noted the work with BI to review activity would provide more information for next year's report. KD noted that the ambition was to review spending at PCN level as work towards prescribing hubs continued. **The Primary Care Commissioning Committee noted the outcomes from the last year of budget setting and agreed the fair share budget setting methodology to continue for 2020/21**	
12	**Primary Care Finance Report** JD reported that the combined primary care budgets were currently £1.8m overspent of which £1.5m was related to prescribing. This was an improvement on month 3. Key risks were outlined as the unidentified savings targets. JD noted that the position had been helped by NHS England reimbursing covid-19 related costs to the medicines management budget. JD highlighted that the CCG had received £2.5m in transformation and resilience funding but noted that some funding had not yet been received. JD highlighted that some funding schemes, such as fellowships would be held by NHS England and required bids to access. JB noted that these were mentorship and fellowship schemes. AM noted the mitigations for the savings and JD highlighted that the allocations received from NHS England were non recurrent. AB highlighted that some of the tables had lost the units and JD agreed to include these in the next report. AB asked about the	**JL**

	Item	Action
	underspent funds and asked whether the money would be spent or allocated. JB confirmed that the training hub were developing plans for the funding including GP retention schemes and supporting the wider workforce. AM requested that more detail on the uncommitted funds be included in the next report. **The Primary Care Commissioning Committee noted:** • **The summary financial plan** • **The key risks and mitigations to deliver the financial plan** • **That at month 5, combined primary care budgets were reporting a year to date overspend of £1.8m of which £1.5m related to prescribing**	**JL**
13	**Primary Care Quality Report** RS reported that the CCG was working with the CQC where there were particular practice concerns and noted that where primary care activity had restarted as part of the covid-19 response, plans were in place to monitor quality, a key focus was noted as safeguarding. AM asked for more information on the practice nurse plans and asked whether the plans developed the ambition for nurses to become PCN clinical directors in the future. RS noted that the necessity for organisational development to be avaible to multi-disciplinary teams had been raised at the workforce group. **Medicines Optimisation Update Report** KD highlighted the patient safety and quality work within the team noting that the Community Pharmacy Patient Group Direction (PGD) service continued to be monitored and 109 pharmacies were providing this and PGD consultations were taking place. Work was ongoing supporting primary care with patients with allergies and work continued with the children's hospital on antibiotics. KD highlighted the new prescribing support software which identified when patients were at harm from their medicines. FF asked when the environmental sustainability of inhalers would be considered. KD noted that new guidance regarding low carbon inhalers would be linked with new COPD guidance and noted that although this switch could not be supported currently the guidance would be sent to practices. FF asked about the accreditation of the PGD pharmacies. KD clarified that pharmacists were accredited	

	Item	Action
	rather than the pharmacies. Training had been put on hold due to covid-19 however this was now being undertaken virtually. It was agreed that a list of pharmacies with accredited pharmacists would be circulated to practices. AM noted the increased C Diff rates. KD noted that there was a mini audit taking place with practices to review if antibiotics were being prescribed as per the guidance. **The Primary Care Commissioning Committee noted the contents of the reports**	**DC**
14	**Contracts and Performance Report** DM presented the report noting that the CCG was reporting 100% coverage of care homes at PCN level to NHS England. **The Primary Care Commissioning Committee noted the contents of the report**	
15	**Agenda Forward Plan** **The Primary Care Commissioning Committee received the forward plan for information.**	
16	**Questions from the Public – previously notified to the Chair** There were no questions from the public.	
17	**Committee Effectiveness** The Committee noted that the meeting had overran but that the items had required robust discussion.	
18	**Any Other Business** AM noted that NHS England had concluded that the independent clinicians were unable to Chair the Primary Care Commissioning Committee and therefore Alison Moon would be handing over Chair of the Committee to Sarah Talbot-Williams from October. AM would continue to be a member of the Committee. MJ thanked Alison for her hard work and support to the primary care teams and thanked Sarah for taking on the Chair role.	
19	**Date of next PCCC:** Tuesday 27th October 2020	
	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 JRu	

Lucy Powell, Corporate Support Officer, October 2020