Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group

Primary Care Commissioning Committee Open Session

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

---

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
Rachael Kenyon	Clinical Commissioning Locality Lead, North Somerset	RK
Julia Ross	Chief Executive	JR
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		
Mathew Lenny	Director of Public Health, North Somerset	ML
Sarah Truelove	Chief Finance Officer	ST
Philip Kirby	Chief Executive, Avon Local Medical Committee	PK
Lisa Manson	Director of Commissioning	LM
Geeta Iyer	Primary Care Provider Development Clinical Lead	GI
In attendance		
Jenny Bowker	Head of Primary Care Development	JB
Sarah Carr	Corporate Secretary	SC
Debbie Campbell	Deputy Director Medicines Optimisation	DCa
Bev Haworth	Models of Care Development Lead	BH
Jon Lund	Deputy Chief Finance Officer	JL
David Moss	Head of Primary Care Contracts	DM

Sian Trew	Head of External Communications	ST

	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 and no interests related to the agenda.	
03	**Minutes of the Previous Meeting** The minutes were agreed as a correct record with the following amendments: • P4 item 5 duplication in top paragraph to be removed • P2 item 9, 3rd sentence to read "…new premises." • P15, 2nd para 2nd sentence to read "…secondary care…"	
04	**Action Log** The action log was reviewed: • **Action 161** – David Moss (DM) confirmed the reimbursement scheme was discussed regularly with PCN Clinical Directors. The action was closed. • **Action 164 –** Jon Lund (JL) confirmed he was the action owner and asked for the deadline for completion to be extended to September. The action remained open. • **Action 175 –** the query regarding QoF had been answered and QoF achievement would be reported quarterly. The action was closed. • **Action 176 –** the action remained open. • **Action 181 –** the deadline for completion of the action was extended to September 2020. • **Action 183 –** This duplicated action 176 and would be removed. • **Action 184 –** the deadline for completion of the action was extended to September 2020. • **Action 187 –** the deadline for completion of the action was extended to September 2020. All other due actions were closed	
05	**Covid-19 Update and Recovery** Martin Jones (MJ) drew attention to the key focus areas highlighted in the paper: • The Equalities Impact Assessment (EIA) had been completed for the Primary Care Cell work programme. The Cell and the Primary Care Strategy Programme Board would monitor the implementation of actions. The	

	Item	Action
	relationship between the Primary Care Cell and the Strategy Programme Board was important. • A system-wide approach to the distribution of PPE was being developed. • Work continued to develop community phlebotomy hubs and pilot sites • Practices had been contacted to gauge demand for community based staff antibody testing • Support was being offered to practices to complete staff risk assessments The extension of Wi-Fi into clinical and administrative areas was on hold; a bid had been submitted for additional funding to support this. The GP IT budget supported digital services in practices. Attention was drawn to the work taking forward: CareFlow, Direct Booking and On-line consultations. Expressions of interest had been invited for the ADHD Local Enhanced Scheme. Improved Access would resume in August 2020. Peer Review Assessments for Covid-19 costs reimbursement were in place. Activity in primary care was increasing, with patients being seen using digital technologies where appropriate. Practices had been contacted about the restart of Improved Access and Extended Hours in August. Practices were encouraged to consider different ways to deliver these to meet patient need. The Primary Care Cell continued to work with Planned Care, Diagnostics, Mental Health and Urgent Care Cells to support a shared approach to system recovery. The paper drew attention to the areas covered in the national letter on the Second Phase of General Practice Response to Covid-19. The CCG was working to understand the targeting of QoF, for example cancer diagnosis, patients at high risk of harm and areas of health inequalities. MJ highlighted the key actions relating to primary care and phase three planning set out in the paper. Work to develop and consolidate key population metrics was noted. There were a number of issues to be addressed and there was cross system work with OneCare and practices to take forward information sharing. JR asked for clarity regarding the roles and responsibilities of the Primary Care Cell, the Primary Care Strategy Programme Board and the Locality Cells. MJ agreed it was important to ensure there	**MJ**

	Item	Action
	was no duplication across the groups, there was clear governance to understand how to achieve maximum impact from the way the groups were organised. FF welcomed the development of an primary care “opal” status report. FF asked if increased PPE needs related to flu’ clinics had been taken into account. FF asked if the numbers of patients attending the South Bristol Hospital community phlebotomy Hub had increased. FF noted Improved Access was an opportunity to help address challenges faced by patients when accessing primary care due to covid-19. FF asked if the release of EIA data in August at the same time as the restart of Improved Access was a mismatch. MJ commented the flu’ vaccination programme would be a significant undertaking due to the increased cohort and its delivery needed consideration. Debbie Campbell was leading this work. Guidance relating to PPE and flu’ vaccinations was being considered. The timing of the release of the EIA data would be explored. MJ explained there had been discussions with Sirona about the community phlebotomy services. DM noted there were a number of complexities in setting up the pilot and these had been worked through with partners whilst activity was reduced and the service would now be scaled up. Rosi Shepherd confirmed guidance for PPE use during vaccinations was being explored with regional colleagues due to concerns about safety and practicalities. RK commented Woodspring Locality had discussed community phlebotomy and the number of tests conducted. The locality practices would use specific, consistent codes to indicate which patients required specific tests and support capacity. MJ welcomed the approach, which would improve patient experience and data collection. AM asked if there were concerns that primary care was not in a position to complete staff risk assessments. MJ explained there were no concerns and the CCG was working with practices to ensure all risk assessments were completed. AM welcomed the targeting of QoF and asked if this would be based on outcomes and outputs. MJ confirmed this and a targeted approach provided an opportunity to focus on health outcomes and reducing health inequalities. Alison Bolam (AB) asked if the number of practices expressing interest in the ADHD LES was available. MJ agreed to share this with AB. **The Primary Care Commissioning Committee noted the report**	**MJ**

	Item	Action
06	**Primary Care Network Update** Jenny Bowker (JB) presented the report. The NHSE Second Phase of General Practice Response to Covid-19 letter reiterated the emphasis on PCN workforce expansion with support from systems, highlighted the launch of the New to Partnership Payment and the use of the PCN organisation development fund in line with guidance from August 2020. JB drew attention to the progress to date described in the paper. The lifting of the cap on the recruitment of First Contact Physiotherapists (FCPs) had been shared with PCN Clinical Directors. There had been a presentation to PCN Clinical Directors about the Sirona offer and role of FCPs in the MSK pathway to encourage PCNs to consider how the overall pathway could be supported. JB highlighted the progress made regarding support to Care Homes set out in the paper. Attention was drawn to the items discussed at the 21st July PCN Clinical Directors meeting. The opportunity to bring forward the recruitment of primary care mental health workers was discussed. The Cancer Research UK support offer was noted; this would support PCNs in understanding data and establishing quality improvement projects with a specific focus on patients with Learning Disabilities. The section on PCN organisational development was highlighted. The PCN organisational development allocation had not been confirmed. It was anticipated this would be received in August 2020. The NHSE letter indicated this would be used to support new roles induction and retention; the CCG had additional priorities discussed with PCNs which would be supported with this and other funding streams. The local organisational development priorities previously identified were described in the paper. JB highlighted PCNs were required to submit workforce plans by 31st August 2020. The workforce template would set out the number of roles to be recruited in 2020/21; this would provide an overview of the budget to be committed. The aggregated return would be shared with NHSE. Attention was drawn to the deadlines for Enhanced Care for Care Homes set out in the paper. There were a couple of care homes still to be aligned. A number of respite homes had been identified that did not fully meet the requirements of the DES. This would be explored further. The dates for the DES remained on track. The detail of plans would now be developed with Sirona for the 1st October. The overall next steps were noted.	

	Item	Action
	FF asked when the FCP would be able to start. JB explained they could start once recruited. The CCG had asked PCNs to share job descriptions in advance of recruitment to support PCNs get the best from the recruitment process. JR explained the Healthier Together partnership board had supported the paper on Integrated Care Partnerships (ICP) and attention would now focus on moving this forward at pace. JR noted there was a tactical, operational focus on workforce and it was important to seek a strategic approach to workforce. The community mental health ICP model was highlighted; the consideration of the contribution of the primary care mental health workers was important. JR observed aligning FCPs to the rest of the system was vital. JR asked that a strategic approach to workforce was taken forward in plans and reflected in reporting. JR highlighted the importance of building on the approach to vulnerable patients developed as part of the Covid-19 response and asked for an update on this. JR asked if the homes referred to were rehab or respite homes. Rehab homes would fit the specification and it was important not to leave these out. JB agreed a strategic view on workforce planning was required. The PCCC workforce seminar in February 2020 had focused on the benefits of system wide approaches. There had been a mixed approach with PCNs working with Sirona and recruiting FCP directly due to the impact of the Covid-19 response. It was important to have an approach that supported the roles regardless of employer. A principle needed to be agreed that focused on the role of the FCPs within the wider system. It was important to ensure the roles included the competencies needed and there was career progression. It was essential the roles sat within the wider MSK pathway and discussions were now looking at this. The presentation to the PCN clinical directors regarding the primary care mental health workers focused on supporting PCNs with their mental health surge alongside the system wide opportunity. A working group would take this forward to ensure momentum was maintained. JR welcomed the work and asked for this to be included in future presentations; It was important to understand how PCNs and practices were taking forward the integrated agenda to best meet the needs of the population and ensure best value.	**JB** **MJ/JB**

	Item	Action
	JB explained elements of the support to PCNs regarding prioritisation approaches involved supporting vulnerable patients, for example, the cancer specification included quality improvement work to support people with Learning Disabilities, the structured medication reviews also included support to prioritise vulnerable patients. The Primary Care Cell was looking at further work to support vulnerable patients and refresh understandings of what constituted 'vulnerable' based on national and local learning. Work would also look at what was needed to support people to access primary care. JR commented it was important to develop a systematic, structured approach to risk identification in the population and delivering proactive care. There was an opportunity for GPs to lead across the wider system as ICPs. JB noted there had been work on this as part of population health management which needed to be reviewed and refreshed through the cells. MJ commented there was an opportunity to take QoF and population health management together and consider how to encourage and support targeting specific groups. JB confirmed there were a number of respite homes where people lived on a temporary basis. The DES encouraged patients to be re-registered with an aligned practice. People in respite homes would be expected to retain their existing GPs. RK highlighted the importance of clear guidance in relation to respite homes, noting this could include palliative care for patients. It was agreed a further update on this would come to the committee. MJ commented it was important to have patients at the centre of decision making and not have patients passed between practices. It was important to have an agreed BNSSG position. David Jarrett (DJ) asked if sharing the formal evaluation of the previous organisational development activity was part of the PCN agreement. Would the progress of the PCNs' development be evaluated through an assessment against the maturity matrix? JB confirmed PCNs had been asked to share the outcome of self-assessments as part of the expression of interest process. Further evaluation had been delayed by the pandemic. This would be taken forward and involve evaluation against the maturity matrix. AB asked if patients in "discharge to assess beds" were included in the respite/care home requirements noting the length of stay for	**JB**

	Item	Action
	patients could vary and patients were not fully registered. MJ commented it was important to consider what was best for the patient. There was a discussion about the issues and it was agreed further consideration and guidance would be helpful. JL explained he was involved in the discharge to assess pathway review. The planning was to use care homes to support discharge to assess and optimise pathways. JL agreed to ensure primary care input into the work and involve AB and RK. JR asked that hospices were also involved in the pathway work. AM commented it would be helpful in future to understand the views of secondary care and mental health colleagues in relation to PCNs. JB explained the peloton programme was extended to PCN Clinical Directors and provided a platform for relationship building across the system. DJ commented there were positive levels of engagement with secondary care through the partnership groups. **The Primary Care Commissioning Committee noted the report**	**JL** **JL**
07	**Primary Care Finance Report** JL confirmed he would attend future meetings as Sarah Truelove's deputy. A new Head of Finance for Primary and Community Care had been appointed. Finance reports were now discussed at PCOG meetings prior to the PCCC. JL drew attention to sections 2.2 and 2.3 of the paper. There was uncertainty regarding the NHS financial regime following the pandemic. Planning was based on the assumption that Primary Care Investment confirmed prior to the pandemic would remain unchanged. JL highlighted: • The delegated primary care budget structural deficit of £1.9 million. Mitigations were being developed to address this position. It was anticipated there would be an underspend arising from the delay in recruitment to Additional Roles. This would not address the structural position. • A further £1.9 million deficit position for the Medicines Management budget. The Medicines Optimisation Team continued to focus on mitigations to this position. • Additional funding for Covid-19 costs related to PPE, Shielding and sickness was expected. JR noted there would be discussions with PCNs regarding any underspend accrued due to delayed recruitment. It was important there was a transparent process in place to agree the use of funds with PCNs. JR asked about the non-covid-19 related prescribing budget overspend, observing a fair shares budget was in place for	

	Item	Action
	each practice. JL explained there had been a further national increase in the cost of Category M drugs. JR asked if a review of the fair shares budget was required. DCa confirmed the main drivers of the budgetary position were Category M drug price increases and the impact of No Cheaper Stock Obtainable. These were accounted for in the fair shares budgets. It was agreed details of the position would be shared with JR who would escalate concerns with the NHSE South West Regional Director, Elizabeth O'Mahony. AB noted the table on 5 referred to £,000K which was not consistent with the table on page 4 and the text. JL agreed to review the tables and confirm the figures. FF noted the reference to a switch to a more expensive replacement to Warfarin. FF observed the new drug would reduce testing and monitoring costs. JRu noted the position was challenging and if national commitments were realised the target position would be achieved. JL confirmed this. JRu noted the reference to drugs now not covered by the covid-19 reimbursement. JRu commented it would be important not to commit the reserve budget at this point given potential uncertainties. JL explained work was underway to explore the reserves to understand whether this was an recurring issue or a one off positions. The expectation was this would offset the savings short fall. AM asked about the reference to drugs not included within Covid-19 additional costs. JL confirmed this issue had been escalated through the regional finance team. DCa commented on the Warfarin position explaining a national scheme had been announced unexpectedly. This was being explored further. DM confirmed this issue had been raised through the Primary Care Team. JR confirmed this would be added to the escalation to the Regional Director. **The Primary Care Commissioning Committee noted the:** • **summary financial plan** • **key risks and mitigations to delivering the financial plan** • **At month 3, combined primary care budgets reported a year to date overspend of £4.1 million, of which £3.9 million related to prescribing**	**JL/DCa** **JR** **JL**
08	**Primary Care Quality Report** RS highlighted there were no changes to CQC ratings. The CQC was restarting its visiting programme and details of the primary	

	Item	Action
	care visiting programme were expected. Activity had focused on Infection Prevention and Control (IPC). Training had been provided to all practices using the cascade Super Trainers programme, supported by OneCare, to ensure a consistent approach. The flu' planning update was highlighted. An ICP workshop was planned for August that would include flu' planning. FF asked about the availability of vaccine stock given the extension of the cohort to receive flu' immunisations. DCa explained the intention was to ensure priority groups received the vaccine first and then assess further stock requirements. RK asked if there would be opportunities to work with Sirona to develop ways to deliver vaccinations, for example hot sites. It was confirmed options were being considered; PPE and IPC issues would be taken into account. JR asked that future reports included information about health checks for People Learning Disabilities; it was important to ensure that these were not tick-box exercises. JR asked that further information about SEND and CAMHS and the role of primary care in North Somerset be reported at the next meeting. RS confirmed information about health checks for People Learning Disabilities would be presented to the Committee. RK explained there had been positive discussions with AWP about the North Somerset CAMHS service. Locality discussions had focused on pre CAMHS services and an update would be presented to the Committee. JR noted issues were not wholly related to investment and discussions needed to include the local authority. RK confirmed the local authority was involved in discussions. It was noted SEND services and CAMHS were issues across BNSSG and it was agreed future reports would include information about these services in relation to primary care. RS highlighted the work being taken forward by the quality and transformation teams and agreed to discuss this further with RK. AB asked if the plans to prioritise flu vaccinations would restrict the potential for "opportunistic" vaccinations. DCa commented it was important to balance issues and ensure stock was available for vulnerable groups. DCa would raise this with colleagues **The Primary Care Commissioning Committee noted the report**	**RK/RS** **RS** **RS**
09	**Contracts and Performance Report**	

	Item	Action
	DM drew attention to the care homes to be aligned to PCNs. This would be resolved by the end of the month. It was noted the Homeless Health Service and the Special Allocation Scheme were due for re-procurement in 2021. Work was underway with the transformation team looking at wider health services for homeless people which would include the primary care service. Learning from Covid-19 would feed into this work. There were no questions. **The Primary Care Commissioning Committee noted the contents of the report.**	
10	**Questions from the Public – previously notified to the Chair** There were no questions from the public.	
11	**Any Other Business** none	
12	**Committee Effectiveness** Members considered the checklist. It was felt the meeting was effective. JL observed it was helpful to attend the Committee to understand the interface between primary and secondary care. JR noted this included integration and as ICPs developed it was important to be clear about the role of the Committee.	
13	**Date of next PCCC:** Tuesday 29th September 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 JR	

Sarah Carr, Corporate Secretary, July 2020