Hampshire, Southampton and Isle of Wight
Clinical Commissioning Group

PCCC22/002

PRIMARY CARE COMMISSIONING COMMITTEE

Title of paper	**Minutes of last Primary Care Commissioning Committee meeting**		
Agenda item	3	**Date of meeting**	16 March 2022
Director lead	Matt Stevens, Chair		
Clinical lead (if applicable)	Dr Nicola Decker, CCG Clinical Leader		
Author	Terry Renshaw, Governance Manager		

Purpose	For decision	☒
	To ratify	☐
	To discuss	☐
	To note/receive	☐

Link to strategic objective	• Operational Service Delivery • Supporting people and teams • Transforming services • Strategic planning and engagement

Executive Summary
This paper sets out the minutes from the last meeting of the Primary Care Commissioning Committee of NHS Hampshire, Southampton and Isle of Wight CCG held on 22 September 2021. The 17 November 2021 public meeting of the Hampshire, Southampton and Isle of Wight CCG Primary Care Commissioning Committee was stood down. The meeting was reassigned to a seminar session to formulate the primary care strategy and work programme going forward. As a result of the ongoing challenges within Hampshire Southampton and the Isle of Wight the public meeting scheduled to be held on the 19 January 2022 was stood down.

Recommendations	**The Primary Care Commissioning Committee is asked to:** • **Consider whether the minutes of the meeting reflect an accurate record and, if so, to approve them, noting any updates.** • **Note that the meetings scheduled to be held on the 17 November 2021 and 19 January 2022 were stood down.**
Publication	**Include on public website** ✓

Please provide details on the impact of following aspects	
Equality and quality impact assessment	This paper does not request decisions that impact on equality and diversity.
Patient and stakeholder engagement	Not applicable
Financial and resource implications / impact	Not applicable
Legal implications	There are no legal implications arising from this paper.
Principal risk(s) relating to this paper	Not applicable
Key committees / groups where evidence supporting this paper has been considered.	Not applicable

Primary Care Commissioning Committee (DRAFT)

Minutes of the Primary Care Commissioning Committee Held at 10.00am on Wednesday 22 September 2021 via Webinar

Present

Matt Stevens	Non-Executive Director (Primary Care Commissioning) **(CHAIR)**
Julie Dawes	Chief Nursing Officer
Judy Gillow	Non-Executive Director (Patient and Public Involvement)
Roshan Patel	Chief Finance Officer
Michael Ridgwell	Director of Delivery (Executive lead for meeting and deputising for Maggie MacIsaac)
Judith Venables	Non Executive Adviser - North and Mid Hampshire (co-opted member -non voting)

In attendance

Paul Aubrey-Harris	Associate Director Southampton
David Bailey	Deputy Managing Director and Deputy Director of Finance South East Hampshire
Inger Bird	Non Executive Adviser – South East Hampshire
Elaine Budd	Non Executive Adviser – South West Hampshire
Ian Corless	Board Secretary/Head of Business Services
Steve Cummins	Governance Manager (Technical Support)
Keeley Ellis	Primary Care Lead South East Hampshire (deputising for Sara Tiller)
Mike Fulford	Director of Finance
Dr Karl Graham	Clinical Director - South West Hampshire
Lisa Harding	Director of Primary Care Wessex LMC
Neil Hardy	Associate Director Medicines Optimisation (item 11)
Dr Charlotte Hutchings	Clinical Director - North and Mid Hampshire
Dr Michelle Legg	Clinical Director - Isle of Wight
Tracy Savage	Locality Director, Primary and Community Care and Medicines Optimisation
Sylvia Macey	Acting Deputy Director Primary Care NHS Portsmouth CCG
Priya Mistry	Communications and Engagement Manager
Matthew Richardson	Deputy Director of Quality Southampton
Martyn Rogers	Head of Primary Care South West
Barbara Rushton	Primary Care COVID-19 Lead
Nigel Watson	Clinical Lead Covid Vaccination Programme Hampshire and Isle of Wight (Item 6)
Daniel Williams	Assistant Director of Finance, Financial Planning and Reporting
Dr Sarah Young	Clinical Director - Southampton
Terry Renshaw (Minutes)	Governance Manager

Apologies

Simon Bryant	Director of Public Health HCC and IoW
Dr Nicola Decker	Clinical Leader
Alma Kilgarriff	Primary Care Lead North Hampshire
Maggie MacIsaac	Chief Executive
Andy Purbrick	Medical Director Wessex LMC
Suki Sitaram	Non Executive Adviser Southampton
Sara Tiller	Managing Director - South East Hampshire

	STANDING AGENDA ITEMS
1.	**Welcome and Introductions**
1.1	The Chair welcomed everyone present to the third meeting of the Hampshire, Southampton and Isle of Wight Primary Care Commissioning Committee which is being streamed live, a recording of this meeting will be available on the Hampshire, Southampton and Isle of Wight CCG website.
1.2	The Chair invited the members of the Committee to introduce themselves and their role. The following introductions were made: • Matt Stevens – Non Executive Director, Chair Primary Care Commissioning Committee • Julie Dawes – Chief Nursing Officer • Judy Gillow – Non Executive Director, Lay Member, Patient and Public Involvement • Roshan Patel, Chief Finance Officer • Michael Ridgwell, Director of Delivery and executive lead for this meeting. Deputising for Maggie MacIsaac. The Chair welcomed Judith Venables to the meeting. Judith is Non Executive Adviser for the North and Mid Hampshire local team and has been co-opted onto this Committee (non-voting).
1.3	It was confirmed that the meeting was quorate.
2.	**Declarations of Interest (Paper PCCC21/027)**
2.1	The Register of Committee Members Interests was received. This paper sets out the relevant and material interests of the members of the Primary Care Commissioning Committee of the Hampshire, Southampton and Isle of Wight CCG.
2.2	Attention was drawn to the agenda for this meeting and those present were asked to establish whether there may be any business items where there may be potential or perceived conflicts of interest in order that they can be recorded and mitigated as necessary. Interests declared at this point have been recorded under the relevant agenda item.
2.3	Judith Venables highlighted that her job title is incorrectly recorded in the register however her interests remain the same. This is to be corrected. (Action complete)

3.	**Minutes Of The Previous Meeting – 21 July 2021 (Paper PCCC21/028)**
3.1	The Primary Care Commissioning Committee received the draft minutes of the meeting held on the 21 July 2021.
3.2	Judith Venables drew attention to the fact that Non Executive Advisers are being shown as being present which gives the impression that they are members of the Committee, when in fact they are in attendance. To be corrected going forward. (Action complete)
3.3	**Matters Arising** – There were no matters arising.
3.4	**AGREED:** • **The Primary Care Commissioning Committee approved the minutes of the meeting held on 21 July 2021.**
	PRIMARY CARE STRATEGY
4.	**Primary Care Strategy**
4.1	Michael Ridgwell reported that a written report will be provided at the next meeting and explained that we need to be clear on what we mean in terms of a primary care strategy. Discussions are taking place to progress this work and we are pursuing a joined up approach on how we can support primary care and we see this being taken forward with a focus on the key enablers for example IT, workforce and estates. We need to ensure that all strands are pulled together within HIOW and supporting these enablers is crucial. We are facing various challenges such as the COVID-19 Pandemic, an ageing population and workforce shortages. We need to explore solutions on how we use the workforce we have got in other ways and to be able to attract the additional workforce. We need to promote innovation such as having excellent IT solutions that enable/support different ways of working. We need to bring all these themes together and ensure we connect the inter-linkages so that we can meet the needs of our local population and have models of care that meet these needs which are supported by our enablers.
4.2	As a result of discussion it was: • Questioned if there are two tiers in terms of the strategy e.g. enabling and supporting local teams and what needs to be done at a strategic system level. It was noted that primary care needs to be recognised and applauded for innovation, provision of local services and providing care for local needs. Primary care is at the grass roots of innovation and we need to support the development of new solutions. There are dual aspects to the strategy and we must not stifle innovations but recognise that there will be a need for consistency of outcomes. The system needs to create a framework for delivery. Focus will be on working in primary care and supporting primary care colleagues. The system must be an enabler to place based working. • Stated that it is important that we have a clear direction of travel on how we move forward the integration agenda. There must also be a focus on how we align with other key stakeholder strategies. The policy direction in health and social care focuses on integration and collaboration recognising that when care is delivered it is a multi-disciplinary and multi-agency approach. There is also the secondary care impact on how primary care is delivered and we need to build up integrated working with practices and Primary Care Networks (PCNs) to achieve an alliance delivery model. This will support resilience in primary care and will be a vehicle to enable future ways of working.

	• Attention was drawn to the lived experience of the challenges primary care faces and to produce a strategy for the HIOW geography is challenging in itself. The issues facing primary care have been well articulated and it was agreed a lot of challenges faced in primary care are caused through population growth, demographics and infrastructure issues. Recognising that workforce, digital and estates will need a high degree of agility. It was agreed that we will need to work in an agile way to support primary care and we need to understand how we can respond at short notice. It was said that in terms of agility we do not currently know how much freedom local partnerships will have as we do not yet know what delegations there will be for financial and decision making to allow local flexibility. It was responded that a key element of focus is access in terms of primary care development and integration and all local teams are currently undertaking an overarching piece of work as to how this could look going forward. • Highlighted that ICS development needs to take account of how to support primary care e.g. the relationships are key, backed up with good strong support as close to the practice as possible. • Said that a place based development strategy needs to be built upwards. It was responded that you need to start from the ground up with natural communities of care. At PCN level you are working with all communal areas to build care up and this also includes voluntary and social care structures. To maintain resilience from the ground up we need to learn and share at different levels across the whole ICS and place. It will be apparent as we work to develop the strategy how we interface with our providers, acutes and the social and voluntary sector will be important. There needs to be a golden thread at ICS level that travels down to what is on the ground, even down to the level that relates to the street where you live. PCNs will in future be a unit in the ICS; it is not just what happens in the practices it is what is happening in that local neighbourhood. Agreed that trusted relationships need to be built with local practices and Health and Well Being Boards. On concluding the discussion: • Michael extended thanks for the attention that had been drawn to the voluntary sector as we do not always give enough credit to the vital role they provide at place and we could not do without them. They provide a wealth of services that serve the population and we need to ensure that we factor them into our planning. • The Chair assured the Committee that there will be a strategy produced that will be handed to the ICS that will outline our thinking around the future direction of travel. This strategic framework will be passed on as our legacy.
4.3	**AGREED:** • **The Primary Care Commissioning Committee received an update on the development of a Primary Care Strategy for Hampshire and the Isle of Wight.**
5.	**Primary Care Estate Update (Paper PCCC21/029)**
5.1	Martyn Rogers introduced paper PCCC21/029 and explained that he is presenting this on behalf of Andrew Wood, Director of Strategic Finance and Estate lead. The paper describes the various strands of work being carried out by the ICS Primary Care Estate group and suggests an approach to prioritising and signing off primary care developments.
5.2	It was reported that:

	• To put things in context within Hampshire and the Isle of Wight there are approximately 150 GP practices working out of about 225 buildings. Historically estate issues have been dealt with in individual (former CCG) places but the work of the Primary Care Strategy Group suggests many benefits to working at scale. • The Primary Care Estate Strategy Group was set up approximately 2 years ago, chaired by the Director of Strategic Finance, in response to a mandate from the Primary Care Programme Board to develop a strategy for primary care estates. The group comprises a mixture of primary care and estate leads from each locality, including Portsmouth. A draft strategy has been produced although it has been put on hold during the pandemic and it needs more work and updating, not least because it considers the primary care estate only, when wider community service considerations also need to be taken into account. It is also focused on practice based solutions rather than Primary Care Networks. • The Group was also asked, by the Chair of the PCCC of the HIOW Partnership of CCGs, to develop a prioritisation process to be used at scale to determine which of the many schemes under consideration and development should be taken forward, given limited funding. The Group developed a set of prioritisation criteria which could be used to rate schemes. Schemes are scored against 5 headings. A "Star Chamber", a subgroup of the main Estates Group, was created to work through and score each of the 30 schemes put forward by local systems for consideration. The intention is to reduce the long list to 5 key schemes (regardless of whether they need revenue or capital funding) which the group recommends the CCG/ ICS should take forward. This process is nearly complete and discussions have been taking place with finance colleagues about how we might fund the priorities. Access to funding is potentially more straightforward for revenue based/ third party developer schemes than for capital schemes, because there is currently no primary care capital available. In terms of process and governance, it is suggested that Primary Care Operating Groups (PCOGs) should sign off and put forward their local schemes for consideration to the Estates Group, which will provide expert advice to the PCCC as to which schemes should be prioritised. Subsequent funding approval may need to be sought from the Quality, Finance and Performance Committee or Governing Body, depending on the size of the scheme. • There are currently considerable demands for more space within primary care, driven to a large degree by the extra Additional Roles Reimbursement Scheme roles but also by the historic lack of investment, and community care. Whereas these can be mitigated to some extent through home working, digitisation of records, switching administrative spaces to clinical and use of void spaces, there is clearly a need to invest in more General Medical Services space. Some needs will be met through the use of Improvement Grants, part of the CCG Commissioner Capital allocation. Bids of £1.44m have recently been approved by NHS England. • Our current state of knowledge about the condition and suitability of our primary care estate is inconsistent and to a large degree out of date. However, a national Primary Care Data Collection exercise was launched in 2020 and is being coordinated by the STP/ ICS. This programme seeks to undertake three-facet surveys on all primary care buildings and create a central database SHAPE.
5.3	As a result of discussion it was: • Reflected that estates are not directly owned by the NHS and we manage and commission as a CCG. • Asked that clarification be provided with regard to the Star Chamber, that Roshan Patel is involved in as Chief Finance Officer, in terms of priority setting

	based on H2 funding. Roshan provided assurance that he is involved in the process and had worked with Andy Wood in setting out the criteria for priority setting and also how the Star Chamber is to operate and how the outcomes will feed into the ICS planning process. • Noted it is clear that the estates plan needs to contribute to the primary care strategy. This is critical to support primary care resilience and how we get what is best for the local population and patients. It provides a collective view of issues and things that we need to unlock and gives us more levers to help determine how local issues can be unlocked and resolved and also bring primary care to forefront in accessing money for infrastructure projects. • Reflected that by establishing an estates database it will help as by understanding what you have got helps you to engage in a more coherent way across the system. In terms of having one public sector estates agenda it will enable organisations to come together to make the most of what buildings we have got. • Questioned if when we are looking at estates requests in terms of the point around delivery of high quality care are we using CQC findings and issues that are recorded on the Risk Register to inform decision making. It was responded that we do to ensure that we meet the requirements for NHS estates in terms of quality, infection prevention and control and equality of access. • Noted that this paper is welcomed by the Primary Care Operational Group Chairs and is very much needed. The length of time it takes to agree projects was highlighted as some are still waiting approval after a number of years. • Clarification was sought on the process for the communication plans once schemes are approved will this be done centrally of will this be at local level. • It was questioned how we involve patients and the public in decision making and how we provide feedback. In response the following example was provided in terms of the Hythe Hospital redevelopment where extensive engagement with local stakeholders and patients was undertaken that included the interior design of the premises by a cohort of patients who will be using the building. • Said that practices need to think about how quickly their populations are going to increase recognising that this factor puts pressure on practices and some practices are still quite small. This can be addressed by encouraging practices to work closer together within their PCN. We are looking at a different future for primary care, one that is supportive of each other and looking at innovative ways of working. • Reflected that we need to think about the future in terms of the estates project pipeline and how priorities from localities can be fed into the Star Chamber. • Highlighted that in terms of the consultation process we need to consider how we communicate with the public and businesses that is ensuring that GPs are involved in business case development and appropriate public involvement.
5.4	**AGREED:** • **The Primary Care Commissioning Committee noted the update on the current work streams and provided comment on the suggested approval route for primary care premises investments.**
6.	**COVID-19 Vaccination Programme (Presentation)**
6.1	Nigel Watson undertook a presentation on the COVID-19 Vaccination programme and drew the Committees attention to the following: • **Current position:** • Cohorts 1-9 - 94% have received 1st and 91% 2nd dose of a Covid vaccine – for those aged 18 -29 86% have received 1st and 81% 2nd dose of Covid

vaccine.
- 12 to 15 year olds who are Clinically Extremely Vulnerable are to be vaccinated
- For 16 to 17 year olds, who have been offered one dose over 65% have been vaccinated

- **Recent Change**s:
  - **Booster doses** – Are to be offered to all aged 50 and over, frontline health and social care staff and those clinically at risk
  - **3rd Doses for those who are Immunosuppressed** - As the immunity in this group may be compromised.
  - **12 to 15 year olds who have no underlying health conditions** – Are to be vaccinated by the school immunisation service.

  It was said that this work is pivotal as we move into Phase 3 which is more about boosting immunity. Recognising that there are challenges associated with the vaccination of fit and healthy 12 to 15 year olds.

- **People aged 12 to 18:**
  - **12 to 15 year olds –** Those who have no underlying health conditions are offered a 1st dose of Pfizer BioNTech Covid vaccine. Those who have an underlying heath condition are offered 2 doses of Pfizer BioNTech Covid vaccine spaced 8 weeks apart.
  - **Underlying health conditions** - Chronic neurological, heart, lung, kidney, bowel or liver disease, diabetes, other endocrine diseases and those who are immunosuppressed.
  - **16 and 17 year olds** – Are offered a 1st dose of Pfizer BioNTech Covid vaccine.
- **12 to 15 year olds who have no underlying health conditions:**
  - Very few healthy children and young people with COVID-19 infection go on to have severe disease
  - Vaccinating children should help to reduce the need for children to have time off school and to reduce the risk of spread of COVID-19 within schools.
  - Long Covid, recent evidence suggests that between 2 to 14% of children have symptoms caused by Covid 15 weeks later
  - The four Chief Medical Officers have said that vaccinating 12 to 15 year olds will reduce impact of school disruption on children's mental health.
  - Myocarditis, there is concern about the risk of myocarditis, that is normally mild and self limiting but this is atypical and the long term prognosis is uncertain.
  - Consent will be an issue in a small number of cases if the child wants the vaccine and is deemed to be Gillick competent and the parents do not want the child to have the vaccine.
- **Clinical Issues:**
  - **Vaccine Induced Thrombotic Thrombocytopenia** reported earlier in the year following vaccination with AstraZeneca or Janssen Covid vaccination.
  - **Myocarditis and Pericarditis** – Very rare complication of Pfizer BIONTech and Moderna vaccines. This is generally mild and self-limiting for most cases.
  - **Pregnant women** current uptake is poor in this group, approximately 50-60%. There are national communications and also a local task and finish group are working to increase uptake. Pop up clinics in Ante Natal clinics have been held and we are organising pregnancy clinics at large vaccination centres.
  - **Anaphylaxis** remains a concern with Pfizer and Moderna and therefore a 15

	minute observation period in place post vaccination. • **Flu Vaccination** – Last year the number of people infected with the flu virus was very low, largely due to lockdown and the control measures such as washing hands, wearing face masks and social distancing. The result of this is the level of immunity in the general population will be lower than normal. Public Health England have predicted that we may see flu levels that are up to 50% higher than seen in a normal year and this may occur earlier than normal. This poses a major risk especially if occurs at the same time as another wave of Covid. Therefore we must not delay the flu vaccination programme. The JCVI has now stated that Covid vaccination can be given at the same time as a flu vaccination. However, some patients may choose to have a gap between the two vaccinations because of concerns about increase in side effects. • **Neutralising Monoclonal Antibodies** – A clinical trial has shown that this drug may be used to prevent infection, promote resolution of symptoms of acute COVID-19 infection and can reduce the likelihood of being admitted to hospital due to COVID-19. On concluding the presentation Nigel said that as a vaccinator it has been an honour and a privilege to give vaccinations and it is a rewarding role and the patients are pleasant and so grateful to receive the vaccination. All PCNs have signed up to deliver Phase 3 are now in the process of sending appointments out. 2.62m vaccines have been delivered in HIOW and public health data shows that this has saved 3,000 lives and avoided 4,000 hospital admissions. The COVID-19 vaccination programme has been successful but it is just one part of the strategy as we move forward to get on top of the pandemic as it is important to realise that even though vaccinated it is not guaranteed that you will not catch Covid.
6.2	As a result of discussion it was: • Questioned if there are any concerns around the ability to deliver the vaccination programme, especially the booster programme. Do we have the confidence, capacity and ability within the system. It was responded that yes we are assured and we have the capacity needed. GP and nurse returners and non-registered vaccinators are available minimising the requirement on front line staff to be vaccinating. • Asked if the supply chain is now smooth. It was responded that we are operating a catch to pull model and we are expecting to administer a number of vaccinations in the next few weeks. We are confident that supply will be available to deliver in the time and at scale. However, the six month gap between the second vaccination and the booster is the limiting factor.
6.3	**AGREED:** • **The Primary Care Commissioning Committee received the update on the COVID-19 vaccination programme.**
7.	**Patient Survey 2021** (**Paper PCCC21/030)**
7.1	Priya Mistry explained that she is a Communications and Engagement Manager for the Hampshire, Southampton and Isle of Wight CCG and her role is supporting primary care communication. Priya introduced paper PCCC21/030 and drew attention to the following: • This summary paper enables the communication and engagement team to support primary care to take on board the feedback and support them to respond and look at how they work. • It is great to see that in total 9 in 10 people (90%) found their GP practice

	receptionist very or fairly helpful especially in the challenging times that primary care is currently facing. During the pandemic feedback is so important and we need to hear the patient voice/experience to shape what we are doing. • Changes need to be communicated to patients in a clear and timely way. There is currently a national media Daily Mail campaign around face to face appointment requests. Access is challenging and we need to support practices to communicate why the model has changed and that there is in fact a wide range of people that can be seen. Primary care managers on the Island have co-designed an on-line information campaign as to who else you might see for example nurse, therapist and why you may be treated by them rather than by being seen by a GP. • A BBC South Today presenter recently spent the day at a GP practice in Basingstoke and this included the opportunity to speak to patients. • Due to the pandemic and social distancing requirements Patient Participation Groups (PPGs) moved to meeting virtually, which resulted in some dis-engagement. We are now looking at how we can re-establish the links to ensure that the patient voice is there. • The number of appointments increased in July. In HIOW 800k appointments were filled, this demonstrates that primary care is open and appointments are being given. The Chair thanked Priya for the report which makes interesting reading.
7.2	As a result of discussion it was: • Highlighted differing views on access issues. It was questioned if there is evidence that older age groups are less able to access their GP surgeries via digital solutions such as on-line appointments. It was responded that work could be undertaken to see if there is any evidence within other engagement work that has been undertaken to see if there are any links. Plus we could look to see if we can breakdown the patient survey data further. It was said that this information will be helpful as it will help to inform our primary care strategy. • Reflected that this provides encouraging feedback for practices but we should not be lulled into a false sense of security. Two-thirds of people (66%) responded to say they were satisfied with their choice of appointment. However, there are lots of patient experience stories around the patch that patients are unhappy about approach. It was said that linkages with Patient Participation Groups and localities is crucial and we need to ensure there is a focus on this. This is key nationally but also locally in some areas. In terms of what has been said we need to be thoughtful about what we are seeing but also being careful about what we don't know/see in terms of what we tackle and focus our attention on. • Messaging/comms needs to go out in respect of face to face appointments and what that means for primary care. From January we need to ensure that we are aligned as we move forward. • Highlighted that we need to look at inequalities within other groups with diverse backgrounds who may find it difficult to access services. • Reflected that there is a huge amount of need and patient expectation out there. Patients are saying that phone lines are blocked. It was reinforced that there are other health professionals available for example nurses and clinical staff who can prioritise and deal with those who have most need. A benefit of triage is that test results can be requested and obtained before a face to face appointment takes place. It was recognised that practices are working hard to prioritise those who really need to be seen quickly. • Said that in terms of our primary care strategy this demonstrated how important digital solutions are in supporting our GP practices.

	On concluding the discussion Priya said that the CCG is involved in regional work with Healthwatch and it will be helpful to share with them the feedback received today.
7.3	**AGREED:** • **The Primary Care Commissioning Committee discussed and noted the findings of the patient survey 2021.**
	DECISION MAKING
8.	**Living Well Partnership (Southampton) and St Lukes Surgery (South West Hampshire) Contracts Merger (Paper PCCC21/031)**
	The following declarations were received: • Dr Sarah Young is a GP in Southampton and provides hot services for SPCL of whom LWP are shareholders. • Phil Aubrey-Harris reported that he is due to leave the CCG in Mid-December to take up a role in a GP practice in Southampton this is not related or in conflict with the report being presented today.
8.1	Phil Aubrey-Harris introduced paper PCCC21/031 and said that he will also be referring to his colleague Martyn Rogers due to the merger crossing two of the areas that our place based teams align. Attention was drawn to the fact that this is an application from the Living Well Partnership (LWP) to merge their two General Medical Services (GMS) contracts; LWP (Southampton) and St. Luke's Surgery (South West Hampshire). Via these contracts, LWP deliver primary medical services to circa 39k patients living in East Southampton and Eastleigh Southern Parishes. A number of other supporting papers are also included within the agenda pack to provide contextual information. It was reported that: • LWP is a partnership of 11 partners with two General Medical Services (GMS) contracts; LWP (Southampton), serving approximately 28k patients and St. Luke's Surgery, serving approximately 11k patients. LWP (Southampton) operates from 5 sites and St. Luke's from 2 sites. LWP was formed in 2016 following the merger of partnerships and contracts of two Southampton City CCG practices, Ladies Walk and Weston Lane. In 2017 the LWP partnership grew to include former partners of two further partnerships who had contracts for Bitterne Health Centre and St. Luke's Surgery. In October 2017 the Southampton City CCG approved the merger of the Bittene Park GMS contract with that of LWP (Southampton). Since that time the LWP has been a single partnership operating two GMS Contracts – one for LWP (Southampton) and one for St. Luke's Surgery (South West Hampshire). • Prior to 1 April 2021 the Southampton City CCG was responsible for managing the GMS contract for LWP (Southampton) and West Hampshire CCG was responsible for managing the GMS contract for St. Luke's Surgery, both under respective delegation agreements with NHS England. In April 2021 the Hampshire, Southampton and Isle of Wight CCG was formed, replacing predecessor organisations including West Hampshire and Southampton City CCGs. • In May 2020 the Southampton City CCG and West Hampshire CCG Primary Medical Care Committees separately approved an application for the LWP practices of LWP (Southampton) and St. Luke's Surgery to form a single Primary Care Network under the terms of the NHS England Network Contract Direct Enhanced Service (DES). At the same time the Committees separately also approved an arrangement whereby all LWP sites would be branch sites of both LWP (Southampton) and St. Luke's Surgery, thus allowing patients of both

	practices to receive services at any LWP site. In February 2021, the LWP informed the CCG of their intention to formally apply for merger of their two GMS contracts from 1 October 2021. • This merger will support the development of a single service with consistent provision e.g home visits, booking appointments, essential and additional services, opening hours, extended hours and a single IT and phone system. This will also support practice resilience. • The patient and stakeholder engagement report is included within the agenda pack and tested the views around the contract merger and gave LWP the opportunity to respond. • The case for contract merger was presented to both the Southampton City Primary Care Operational Group (PCOG) and the South West Hampshire PCOG and both recommend to the Committee that the LWP application is approved.
8.2	The Chair asked if there is assurance that the merger will provide better quality delivery to registered patients and if there will be further engagement with patients moving forward. It was responded that assurance has been received from LWP that there are no plans to restrict or change access arrangements. Going forward we will continue to monitor patient experience, access and quality.
8.3	The Chair asked members of the Committee if they supported the recommendation that the application for a merger of the LWP, Southampton and St Luke's Surgery, South West Hampshire GMS contracts. The Committee indicated their support of the recommendation.
8.4	**AGREED:** • **The Primary Care Commissioning Committee supported the application for a merger of the Living Well Partnership (Southampton) and St Luke's Surgery (South West Hampshire) GMS contracts.**
9.	**Urgent Decisions Relating to Shakespeare Road Practice, Basingstoke**
9.1	In the absence of Alma Kilgarriff, Judith Venables provided the following statement: There are resilience issues at the Shakespeare Road Practice in North and Mid Hampshire. We are working on those issues to help resolve them. An agile approach has been adopted and we can demonstrate that we are looking to work collectively across the North and Mid system and CCG. This is commercially sensitive and there will be a further briefing within the confidential part of this meeting as the technical questions can be more efficiently dealt with in the confidential forum. The public can be reassured that clinical services will remain at that practice. The Chair reiterated that current services will be continuing and we can provide reassurance to patients and the public that they are. We are negotiating still in terms of format and shape of practice going forward.
9.2	**AGREED:** • **The Primary Care Commissioning Committee received an update relating to Shakespeare Road Practice, Basingstoke.**
	PRIMARY CARE ASSURANCE
10.	**Blood Tube Shortage**

10.1	Charlotte Hutchings noted that Committee members may have seen in the public domain coverage of the national disruption to supply chain that started in August. We have worked to reduce the risk to critical supply of blood tests and impact to patients. On 16 September 2021 NHSE/I provided an update and said that the supply situation is likely to improve. Stocks have been secured from the USA but these will take time to come through and return to normal practice. It is anticipated that situation will be resolved and back to normal by the end of November beginning of December, which we will continue to monitor.
10.2	As a result of discussion: • Clarification was sought as to whether the issue was availability of raw materials or the tubes itself and concern was expressed around the long term impact on patients not getting tests. It was responded that the situation is being monitored carefully and commissioners are working together with primary and secondary care. There is a lot of clinical input by both individuals and groups to identify those patients that are at high risk. We are monitoring incidents and to date we are not aware of any. • It was questioned if going forward will prioritisation take place on the basis of need. It was noted this has been happening and those patients who are clinically urgent have not been refused a test. • It was noted that the consequences of delaying a blood test will not be seen instantly, but is likely to materialise in two to three months' time and this will be monitored carefully. • It was highlighted that quality issues may be something for the future. On the Island already looking to see if there are any quality issues arising as a result of this.
10.3	**AGREED:** • **The Primary Care Commissioning Committee received the status update report.**
11.	**Primary Care Prescribing Report (Paper PCCC21/032)**
11.1	Neil Hardy introduced paper PCCC21/032 that summarises the work of the medicines optimisation teams within the CCG, including their response to the COVID-19 pandemic.
11.2	Particular attention was drawn to: • The graph at the top of page 4 of the report that shows the prescribing spend by 'place' within the CCG. These figures are not currently weighted for population size. Consideration is currently being given as to whether a weighting should be included. We are monitoring at place for a number of items. • Section 3.3 of the paper where a graph is included showing the monthly total prescription items for antibiotics. • At the last meeting the use of broad spectrum antibiotics such as co-amoxiclav, cephalosporins and quinolones was raised. A graph has been included showing the Hampshire, Southampton and Isle of Wight CCG percentage against the national average by month. It was highlighted that the use of broad spectrum antibiotics is discouraged unless included in guidelines and clinically indicated. A scatter plot on page 9 demonstrates the CCGs position with respect to total antibiotic items per weighted population and percentage of broad spectrum agents. • A graph is also included on page 9 that shows the number of antibiotic

	prescription items dispensed for 0 to 4 year old children. There was no winter peak, but up to June 2021 there has been a significant increase in prescribing volume. This unusual spike can be explained via a combination of factors such as less social distancing resulting in an increased mix of infections. July data has just been received and the position has dropped considerably from June. • The section on polypharmacy has been removed for this month's report. However, a national plan has been launched – Good for you, good for us, good for everybody that was published today. A full summary of the national report will be available at the next meeting.
11.3	As a result of discussion it was: • Questioned if the national report provides information on good practice and activity in order to help identify/speculate potential actions. In response, it was noted that approaches to address issues need to be multi-factorial and are about patient centred good structured medication review. • Questions about spend on prescribing budgets going forward. It was noted that there is a relationship between spend and how we prescribe. We use a range of indicators to provide insight on what is happening in each system/localities. The three area prescribing Committees within HIOW have the benefit of local area oversight and we need to consider whether a single Committes should be formed to provide consistency and oversight across the ICS. • Reflected that this is an important report and we need to note the level of prescribing taking place.
11.4	**AGREED:** • **The Primary Care Commissioning Committee noted the primary care prescribing report.**
12.	**Primary Care Finance Report (Paper PCCC21/033)**
12.1	David Bailey introduced paper PCCC21/033 and drew attention to the following key highlights: • The CCG only has a confirmed allocation for half of this year (termed H1 - April to September; with H2 being the second period of the year), so both the budgets and the forecasts stated in the reports are reflective of this period only. £150m available for primary care budget and £139m for prescribing. • As at month 5 the CCG is not reporting any significant year to date or forecast variances on the overall primary care budget, delegated and non-delegated. • Delegated is showing a £0.25m underspend on Quality and Outcomes Framework (QOF). The year to date and Forecast Outturn overspend on QOF is due to the impact of the increased QOF points for 2021/22. However, the CCG has specific budget for this in reserves and will look to move this into the delegated budget in the coming months as part of H2 planning, Therefore, this current shortfall is fully mitigated. • Other GP services - This overspend is driven by locum cost pressures regarding maternity and sickness claims. This is an area of spend which is outside of the control of the CCG as reimbursable locum cover is variable and cannot be predicted. This is covered by reserves. • Conversely GMS is showing a large underspend within this category of spend and is due to some contingency held as well as budget for list size growth that has not materialised to the assumed levels. • The CCG currently has a value on the balance sheet to cover historic rent reviews, which on average is calculated at 3% growth on existing valuations, so are assured that any rent increases upon District Valuer valuations are fully

	covered. • Prescribing is overspent year to date by just over £1m and is forecasted to continue to overspend for the remainder of H1. Costs in June were significantly higher than was originally predicted, with the impact of coming out of lockdown being a potential factor behind this. The overspend in prescribing is currently being managed by underspends elsewhere in the CCG, mainly through the release of CCG reserves. However, the Prescribing Report provides an early sight of the July data and shows there is a drop in prescribing costs.
12.2	There were no questions or comments.
12.3	**AGREED:** • **The Primary Care Commissioning Committee noted the Primary Care Finance Report and its contents.**
	OTHER
13.	**Primary Care Operational Groups Terms of Reference (Paper PCCC21/034)**
13.1	Martyn Rogers introduced paper PCCC21/034 and explained that this Committee had produced a set of Terms of Reference and Scheme of Delegation for the Primary Care Operational Groups (PCOGs). PCOGs considered and endorsed these documents and accepted them as being suitable, noting minor local variances in the terms of reference largely around attendance requirements and to reflect local nuances around how the committees operate.
13.2	There were no questions or comments.
13.3	**AGREED:** • **The Primary Care Commissioning Committee approved the Terms of Reference of the five place based Primary Care Operational Groups.**
14.	**Any Other Business** – There were no items identified.
15.	**Key actions arising from discussion of agenda items to be included on the Primary Care Risk Register** – There were no items identified.
16.	On closing the meeting the Chair apologised for over-running and stated that it was really important that the debate within the first part of the agenda had been allowed to flow. Members and those present were thanked for their attendance.
17.	**Date of next meeting –** The Committee will meet next on Wednesday 17 November at 10.00am.

I confirm the minutes of the meeting were agreed as an accurate record

Signed by

Chair: …… **Date: ……**