NHS
Hampshire, Southampton and Isle of Wight
Clinical Commissioning Group

PCCC22/015

PRIMARY CARE COMMISSIONING COMMITTEE

Title of paper	**Minutes of last Primary Care Commissioning Committee meeting**		
Agenda item	3	**Date of meeting**	18 May 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 16 March 2022.	
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.**
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 16 March 2022 via Webinar

Present

Matt Stevens	Non-Executive Director (Primary Care Commissioning) **(CHAIR)**
David Bailey	Deputy Managing Director and Deputy Director of Finance South East Hampshire (deputising for Roshan Patel
Dr Nicola Decker	CCG Clinical Leader
Judy Gillow	Non-Executive Director (Patient and Public Involvement)
Tessa Harvey	Executive Director of Performance (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

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)
Martyn Davies	Non Executive Adviser – Isle of Wight
Keeley Ellis	Primary Care Lead South East Hampshire
Dr Karl Graham	Clinical Director - South West Hampshire
Dr Will Howard	Medical Director - South East Hampshire, Wessex LMC
Dr Charlotte Hutchings	Clinical Director - North and Mid Hampshire
Kirsten Lawrence	Associate Director Primary Care
Dr Michelle Legg	Clinical Director - Isle of Wight
Dr Hassan Majeed	GP (Item 8)
Lisa Medway	South East Hampshire Estates Lead
Leanne Parmenter	Associate Director of Primary Care, North and Mid Hampshire
Jason Peet	Prescribing Lead – South East Hampshire Locality (Item 6)
Martyn Rogers	Head of Primary Care South West
Dr Barbara Rushton	GP, Chair South East Hampshire PCOG
Josie Teather-Lovejoy	Deputy Director, Primary Care Lead Southampton
Tracy Savage	Locality Director, Primary and Community Care and Medicines Optimisation
Daniel Williams	Assistant Director of Finance, Financial Planning and Reporting
Dr Sarah Young	Clinical Director - Southampton
Terry Renshaw (Minutes)	Governance Manager

Observing

Olivia Crispin	Private Secretary Chair and Chief Executive Office
Margaret Scott	Independent Chair

Apologies

Julie Dawes	Chief Nursing Officer
Maggie MacIsaac	Chief Executive
Roshan Patel	Chief Finance Officer
Alison Smith	Managing Director – Isle of Wight

	The meeting was taken out of sequence but for ease of reference the minutes are set out in accordance with the order of the agenda.
	STANDING AGENDA ITEMS
1.	**Welcome and Introductions**
1.1	The Chair welcomed everyone present to the fourth 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 and attendees to introduce themselves and their role. Introductions were made.
1.3	It was confirmed that the meeting was quorate.
2.	**Declarations of Interest (Paper PCCC22/001)**
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.
2.3	Dr Charlotte Hutchings reported that she has changed roles, previously she was a salaried GP at Odiham and Old Basing Surgery and is now a GP Partner at the Clift Surgery. It was noted that the register will be updated for the next meeting. Dr Will Howard reported that he has not completed a Declaration of Interest form. A form is to be sent to Dr Howard and the register will be updated for the next meeting.
3.	**Minutes Of The Previous Meeting – 22 September 2021 (Paper PCCC22/002)**
3.1	The Primary Care Commissioning Committee received the draft minutes of the meeting held on the 22 September 2021.

3.2	**Matters Arising** – **Minute Reference 10 Blood Tube Shortage -** The Chair drew attention to the update received at the September meeting relating to the issues around the national disruption to the supply chain that started in August 2021 and asked if this issue has now been resolved. It was reported that there are still some national issues, and these are being managed via the logistical cell across the ICS. There is currently no direct impact on general practice and is not an issue for now as the situation is being well managed through the routes that have been put in place.
3.3	**AGREED:** • **The Primary Care Commissioning Committee approved the minutes of the meeting held on 22 September 2021.** • **Received an update on the National Blood Tube Shortage.**
	PRIMARY CARE STRATEGY
4.	**Primary Care Strategy**
4.1	Nicola Decker provided an update on the development of the Primary Care Strategy and explained that the frame for this piece of work is around what we have spoken about previously in terms of NASA and putting a man on the moon and the fact that you need to align everyone from the man who sweeps the floor to the astronaut who gets there. We are working within an environment of five merged Clinical Commissioning Groups (CCGs) and we are working closely with Portsmouth CCG. We are creating a team that is more aligned with a common purpose whilst recognising that there are local differences. To achieve a shared work plan we have used the acronym VMOST. VMOST analysis stands for vision, mission, objectives, strategy, tactics and by presenting a strategy in this simple format it allows teams to understand and identify any areas that are not aligned, as well as see where they fit within the business. Following the November 2021 workshop further work has been undertaken to look at problem areas and inter-dependencies to contextualise the plan. Attention was drawn to the fact that Dr Claire Fuller is currently leading a wide-ranging national stocktake on how systems work within primary care and others to improve integration of patient care. This is a collaborative thorough review and includes wide stakeholder engagement. The ambition is to help Amanda Pritchard, NHS Chief Executive Officer, achieve how primary care can best be supported within the emergent Integrated Care Systems (ICS) to meet the health needs of people in their local areas. The framework is being worked through and we are contributing to this piece. There is still the opportunity to contribute to this work via a crowd density platform. The outcome of this stocktake will influence our work plan. A slide was shared on screen that outlined the VMOST pyramid and the strategic context to the primary care work programme. It was highlighted that we have combined the vision/mission into one-person centred statement: *Primary Care is delivered in a person centred and joined up way by resilient teams working in Primary Care Networks and in partnership with others* That is dependent on working with our community/voluntary sector colleagues and others to embed the Primary Care Networks and stresses that we need resilient teams. It was stated that person centred join up is important to us and this reflects how we want to be treated as an individual and as a team working together. It was highlighted that we have two broad ambitions for the year ahead and these are around:

	• Expanding primary care capacity to improve access to services with the aim of improving our populations' overall health outcomes and reducing health inequalities.
	• Adapting and integrating care across all our Primary Care Networks - transforming the delivery of services
	The work programme has been cut into sub-sets and the details were shared on screen, attention was drawn to the tactics and strategies to be adopted.
	
	To improve access, we need the ability to understand what is needed. The key message is aligned around the ambition to buy/invest in a data analytics tool to get a better understanding of our capacity and demand. This is not about counting widgets or activity, but we need a good understanding on the ground around what we will achieve for example in the next three months. This tool will help the delivery team to map what is happening in primary care so we have a full picture of the offer and can give a broader more thorough picture.
	
	For adopting/integrating, this will be a collaborative/open approach working with PCNs on how we work, adapt, listen, and join up. We also need:
	• Clear efficient funding streams and decisions for estates projects linked to digital funding.
	• A clear communication and engagement strategy
	• A clear workforce/people plan.
	
	On concluding the update:
	• Nicola expressed her gratitude to all those who have contributed to the development of the work programme and for putting this into an NHS template. We will need to adapt this regularly in order to hold ourselves to account. The aim now is to translate this into versions:
	  • For the public and patients using clear language.
	  • For primary care colleagues and the LMC to ensure they relate to this.
	• Kirsten Lawrence drew attention to the amount of effort that has taken place in terms of the breadth and depth of the work that has been undertaken and took the opportunity to echo her appreciation of the way that the CCGs within Hampshire Southampton and the Isle of Wight have come together plus with the involvement and working with Portsmouth CCG has resulted in this Integrated Care System (ICS) piece of work. There is a lot happening at local level and we are coming together and sharing learning and agreeing joint approaches.

4.2	As a result of discussion, it was: • Said that appreciate the aspiration, but the important part of this is the challenge we are setting for general practice and by default to PCNs which is enormous given the current state. It is felt that currently general practice is being bombarded from every angle. There are reviews taking place around what general practice will look like in the future, of how the ICS might integrate PCNs in ICS networks and various think tanks. We need to provide a resilient service for the future but there are elements that are beyond our control for example workforce, external factors such as Covid and you should not underestimate the impact that this has had. Workforce is currently at its least resilient and we need to get back to the status quo pre-Covid and the challenge around this is enormous. • Observed that it is an excellent strategy and particularly like the vision and mission, but we need to remember that it is fluid. Already mentioned earlier the Fullers stocktake that is working from the ground up and working throughout the ICS. This is about primary care interface with all assets within the system and

this provides a huge opportunity within primary care to shine as these teams are closest to our population. This is dependent on the behaviour of our people and how we can keep people safe from Covid when we are in a time with no legal restrictions. We can learn from Covid and apply this to other interventions/programmes such as stopping smoking or exercise. We need to look at how we integrate with our partners in the community and ensure we are close to the acute workforce as well. Workforce is not limited to this alone, together we can adapt primary care to ensure we are truly in this together. We need to integrate and encourage people to do as much for themselves as they can in terms of self-care.

- Highlighted that we talk a lot about primary care and general practice workforce, but we need to start communicating that we have a team consisting of different experts. Communication with the public is key around how the public engage with general practice and the wider NHS. We need to promote primary care as a team of different experts, and it is not just about seeing a GP. This will require a change in mindset in that you will not automatically see a GP but will be directed to see the right person at the right time. Therefore, appointments will be offered with other specialist members of the team. It was recognised that changing behaviour will take time. We need to have alignment to avoid confusion for example comms around the fact that you do not need to see a GP for a blood pressure check there are other options available to you. Communicating the new way general practice works is critical, for example how do you promote the times one door message. It was reported that we are extending a broader offer and it is an improvement on the offer. The communication teams are committed to working at each local delivery system (LDS) and practices around this for example including information on websites. We need to shift public expectation from GP doing everything to using a language that explains the broader offer and it is time that we bring those resources together. The communication team will work with practices to do that, and we need ideas on how we can do that better. Patient Participation Groups have digital connectivity for example via Facebook and we need a digital strategy, involvement in these around inter-dependencies and the transformation team will be looking to pull this together to ensure it all aligns. The language needs to translate into reality, and we need to commit to embed the language into every team and organisational strategy.
- Remarked that enabling strategies are key to achieving objectives and increasing the use of digital solutions. The key objective around increasing the use of digital and to get the public more attuned to that is key and there is the need to identify other ICS supportive strategies and ensure priorities are aligned. It is recognised that we do have pockets of digital poverty and we need to ensure that we are not putting pressure on people in terms of that digital will not be the only mode of delivery. It was stated that it is important that patients understand the new model and understand the whole system.
- Highlighted that we need to consider how we slice/dice communities in different ways for example, demographic, equality, inequality. Different patients/members of the public enter the system/pathways in different ways. There is a difference between those entering the system for the first time versus those who can't get to see a GP as the perception is the default position is to go to A&E. This is the imponderable problem of how to help people to enter the system through the right door at the right place.
- Reflected that differentiation creates chaos and inequity. Work is being undertaken to look at pathways becoming more standard and there is a coming together in LDS to look at those stories. The interface with urgent care, NHS 111 and the ambulance service is huge and is dependent on where you live for example in North and Mid Hampshire there are less Urgent Treatment Centres

	than in the South. We are currently mapping work through urgent care teams on what is where to provide clarity and inform what we need to do faster/better. Working within a LDS you get a view locally as to what is important to enhance local care models that are already working. Recognising that some elements work differently across HIOW to manage demand and be more effective. We need consistency to manage differently. Clarity is needed around clinical pathways, and we need to look at the language and make urgent care pathways more standard it is not just ED and primary care on the day demand or community crisis response it is not silo care. It is about working together in a local delivery system and looking at those stories. Work is happening in the local delivery systems to get a consistent pathway. Urgent care space has localised what's important and local care models have been enhanced already. This is what this strategy is driving at in terms of working together to get a consistent approach to managing demand more effectively.
	• Clarification was sought on the timescale for the completion of the Fullers stocktake. It was reported that this will come together at the end of March.
	• Highlighted that work is ongoing around the data set/analytics requirements and various options are being explored. Further detail will be shared later once due process has been followed.
	• Questioned if there is a case being put forward regarding primary care representation at both the Integrated Care System and Integrated Care Board in the future. It was reported that primary care representation will be throughout the ICS, and this is the strap line. In terms of what it will look like it is around:
	  • Honouring/valuing the good clinical leadership that primary care already has in place.
	  • Phase working through 80% local but primary care influence throughout ICS. Taking account of PCN perspective around pure commissioning function as well as transformation.
	Taking account of the fact that clinical involvement within patches is at different levels of maturity and we need to harness this. The challenge now is how do we harness this and reflect back to ensure that people know they have been heard. Clarity is also required around the questions we are asking taking account of the complexity of the environment in which we are operating.
	
	On concluding the discussion, the Chair reflected that he was impressed with the focus, the mission and how we will move forward to adapt and integrate. We will also need to retain the change in working practices and the transformational elements that have resulted from the Covid-19 pandemic.

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.**
	ENABLING AND CONNECTED PROGRAMMES
5.	**Primary Care Estate Update (Paper PCCC22/003)**
5.1	Lisa Medway introduced paper PCCC22/003 and explained that she is presenting this on behalf of Andrew Wood, Director of Strategic Finance and Estate lead. This paper provides an update on the various strands of work being carried out by the ICS Primary Care Estate group.
5.2	Attention was drawn to:

- **Developing a primary care estate strategy** - 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 focussed on practice-based solutions rather than Primary Care Networks, so it makes sense to put this work on hold until it can be properly informed by PCN estates strategies. Discussions are also ongoing about developing a wider Primary Care Programme Plan, of which the estate strategy will be one element.
- **Process to prioritise primary care developments** - The Group has developed 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 are used to rate schemes. Schemes are scored against 5 headings:
    - Consistency with service strategy
    - Deliverability
    - Functional suitability and operational efficiency
    - Strategic flexibility and innovation, and
    - Wider economic benefit

  With a number of more detailed questions contained within each category.
  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/ Integrated Care System (ICS) should take forward.
  This process is nearly complete. 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, although revenue funded schemes can lead to other issues, not least around affordability. Frustratingly, no specific capital funding was identified for primary care schemes as part of the recent three-year national Spending Review. It appears that primary care capital requirements will need to be funded from the, already heavily oversubscribed, ICS annual capital allocation. We are working with NHS England to understand how this might work. In terms of process and governance, it has been proposed 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 Primary Care Commissioning Committee (PCCC) as to which schemes should be prioritised. Subsequent funding approval may need to be sought from the Quality, Performance, Finance and Workforce Committee or Governing Body, depending on the size of the scheme.
  We will also be developing a pipeline of other schemes to be possibly taken forward in the future, as some schemes are not currently worked up in enough detail for the Group to prioritise them. Clearly, where a scheme appears not to be a priority, we can then give early notification of this to the relevant practice/ PCN to prevent further costs being incurred and to allow alternative solutions to be sought.
- **Premises Improvement Grants and GP IT in 2022/23** - We have received an allocation of £3.132m for these two areas for the next financial year. This sum is now part of the main ICS Capital allocation but is ringfenced within it. It can be added to, to fund primary care capital schemes, for instance but not

	reduced. The balance between Improvement Grants and IT will depend on the level of bids and need. A process to collect bids for Improvement Grants for 2022/23, together with an indicative sum for each local system, will be commenced shortly; GPIT schemes are also being worked up. All schemes need to be signed off by NHS England although we have not been formally advised yet of the process for 2022/23. • **Support for Primary Care Networks in developing their estate strategies** - 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, some buildings have not had 6 facet surveys carried out for ten years or more. However, a national Primary Care Data Collection exercise was launched in 2020 and is being coordinated by the ICS. This programme seeks to undertake three-facet surveys on all primary care buildings and create a central database. Although there have been inevitable delays to the process due to the pandemic good progress has been made and the national SHAPE database has been populated as a central repository of information. As the next step of this work Community Health Partnerships, who have been supporting the data collection exercise nationally, have been engaged to work with our PCNs to develop their estate strategies, however this support will not be available until the new financial year. The South East and South West have engaged additional external support to help develop their strategies in the meantime. We recognise however that there are real current pressures relating to the estate and available space in primary care, with the lack of clinical space now having an impact on the recruitment and retention of the Additional Roles Reimbursement Scheme roles currently being created. We are therefore currently seeking some immediate external support to work with the local teams to help describe the overall short-term estates needs and work with the local teams to implement solutions.
5.3	As a result of discussion, it was: • Stressed how important the support to PCNs in terms of the development of the toolkit is, recognising that PCNs are at different states of organisational development and ability. • Questioned in relation to the reference within the paper to 'Frustratingly, no specific capital funding was identified for primary care schemes as part of the recent three-year national Spending Review'. Does this mean a squeeze on primary care funding as it will all now be coming out of 'one bucket'? It was responded that ultimately it will, we have previously had the Estates and Technology Transformation Fund to bid on, and we no longer have this so will need to ensure we have robust schemes going forward that are affordable and deliverable. It is capital allocation not revenue as this sits with the CCG. • Highlighted that concern is being expressed within South West Hampshire that estates is rising on the risk register and issues are around lack of funding and availability of a specialist with the right information to put together a business case. We are restricted in what we can invest and there is the potential for this risk to rise. PCNs/practices need to work in a safe way, and it was asked how much pressure can we apply up the line to NHSE about the real status of our estate and the fact that we need to do something now. • Reflected that it is good to have the issues laid out that are causing the delays so that we have a base to start from. We need to build on the paper that was presented last September. It was requested that the Chair allow further discussion around estates matters within the confidential meeting to consider the various governance aspects. • Highlighted that in addition to the additional roles staff in PCNs there is also an increase in working together with both social and community care and the need

	to look at more community based solutions and how we use the wider estate better. • Stressed that estates is important as it is such an enabler. If we improve our community/primary care offer estates will be at the centre of this. Recognise that there are financial constraints, but we ask for flexibility where this is possible, so that we can use additional money if it is an estates piece that is needed to improve transformation. • Reflected that arising from discussion there are two inconsistent messages, and these are constraints around finances and estates and the aspiration that PCNs and primary care need to deliver. This needs to be linked to the message to patients and public around managing expectations. • It was reported that the process for accessing NHS capital is to follow the Treasury Five Case Model which is the approach for developing business cases recommended by HM Treasury, the Welsh Government and the UK Office of Government Commerce. The lack of capital available to us slows things up and this message is being fed back up the line. We also need to look at ways of obtaining additional funding. We need to be clear that we are bound by policy in terms of reimbursement and how we do things. There are some things that are in our control/out of our control and there are constraints on how we manage this. The need to work flexibly at local level and quickly when funding becomes available was stressed. It was reported that local estates forums bring together transformation teams and these are the forums to hold these types of discussions around how we work together around estates issues. The focus is not only on clinical accommodation there are some non-clinical requirements that could be provided elsewhere. It was recognised that we need to work together more closely and tell people what we are doing and share that positive information. On concluding the discussion, the Chair reported that Estates will feature as a standing item on the Primary Care Commissioning Committee agendas going forward.
5.4	**AGREED:** • **The Primary Care Commissioning Committee received the update on the current work streams and provided comment.** • **Agreed that primary care estates will feature as a standing agenda item going forward.**
6.	**Primary Care Prescribing (Paper PCCC22/004)**
6.1	Jason Peet introduced paper PCCC22/004 and explained that he is presenting this on behalf of Neil Hardy, Associate Director Medicines Optimisation. The report summarises the work of the medicines optimisation teams within the CCG, including their response to the Covid-19 pandemic. The report also highlights the key medicines optimisation priorities and actions being taken to address these. It was noted that prescribing data from the NHS Business Services Authority (BSA) are available to June 2021. Particular attention was drawn to: • **National DOAC (Direct-Acting Oral Anticoagulants)** - The NHS recently initiated a national procurement agreement for directly acting oral anticoagulants (DOACs) with the aim of making expanding access more affordable and saving money for both the health service and the taxpayer from the reduction in strokes. The new agreement will make DOACs more affordable allowing the NHS to provide treatment to an additional 610,000 more patients. This level of uptake will help to prevent an estimated 21,700 strokes and save the lives of 5,400 patients from a fatal outcome over the next three

	years. The commercial agreement went live from the 1 January 2022 and HSI CCG has signed up to the agreement. As part of signing up to the national framework any local rebate schemes cease. There is an immediate saving to the CCG and the potential for additional savings (which are then available to fund the increase in the use of DOACs) depending on the choice of DOAC. NHS England / Improvement (NHSE/I) has published commissioning recommendations to encourage further identification (Detect), treatment (Protect) and optimisation (Perfect) and where appropriate, greater use of lower costs DOACs. As part of the agreement, up to £40 million investment nationally will be made in 'Detect, Protect and Perfect' pathway initiatives which will also help identify people with Atrial Fibrillation (AF) and move them onto effective and appropriate treatment. As part of the CCGs signing up to the commercial agreement, hospitals will also have access to the framework prices. The pricing of the four DOACs in the national agreement is confidential. It is also important to note that all four DOACs are licensed to treat AF and have been recommended by NICE. The clinician, in conjunction with the patient, will continue to determine the most appropriate treatment for their clinical needs. Edoxaban is already the preferred first choice DOAC on formularies across HIOW. The use of Edoxaban has just been included in the Investment and Impact Fund (IIF), which forms part of the Primary Care Network (PCN) Direct Enhanced Services (DES).
	• **Medicines optimisation response to Covid-19** - The Covid-19 pandemic accelerated the collaborative approach with provider chief pharmacists, CCG lead pharmacists, the chief officer of HIOW LPC and the medicines optimisation lead for the Wessex AHSN meeting regularly, initially on a weekly basis, at the start of the pandemic. These meetings have continued and have increasingly focussed on other priorities in addition to the pandemic. During the Covid-19 period the medicines optimisation team focussed on the following:
	  • Primary care prescribing support work including facilitating the timely availability of medicines used in palliative care, dealing with medicines shortages, supporting the greater use of EPS/eRD.
	  • Implementation of the medicines optimisation requirements within the national care homes support guidance. This included supporting enquiries from care homes, the introduction of 'proxy ordering' for care home residents, structured medication review including those residents newly admitted or discharged from hospital and dealing with stock shortages. A medicines optimisation in care homes sub-group is in place to support this work stream.
	  • CCG and PCN pharmacists and pharmacy technicians have been supporting the PCN Covid-19 vaccination sites to immunise priority groups. Support includes providing pharmaceutical oversight, guidance and answering queries, diluting, and preparing the vaccines and administering to patients. This support was increased in December 2021 to support the booster programme with all available team members deployed to support the programme.
	  • Support to the deployment of the neutralising monoclonal antibody (nMAB) therapies and antivirals for the treatment of people with Covid-19.

6.2	As a result of discussion, it was: • Highlighted that the medicine optimisation teams are ahead in mapping and alignment of cost savings for example, in terms of Edoxaban being the preferred choice of DAOC it provides an incentive to use contract levers to encourage clinicians to prescribe a drug that is more affordable. • Questioned in terms of seeing an increase in spend, does this mean we have a cost pressure and are we overspent? It was responded that we spend £284m

	on drugs and the year-end forecast is reporting an underspend position, of circa £0.5m. The reasons for this are various and examples include the reduction in price for mental health drugs and a lot of the cost saving measures put in place have helped keep us in plan. It was suggested that this needs to be celebrated as it shows how GP colleagues working with prescribing colleagues results in more efficient and effective working. • Attention was drawn to the graph relating to electronic repeat dispensing (eRD) which shows that some are doing a lot, and some are not doing any at all and it was questioned if we have a plan to ensure all practices plan to do some. This is hugely convenient approach for patients for having their prescription sent direct to the pharmacist of their choice. It was responded that the implementation of eRD is a fundamental shift in response to Covid-19 to reduce the need for frequent repeat prescription requests. We are aware that practice usage varies. The medicine optimisation teams continue to support practices to implement this in suitable patients and the Wessex Academic Health Science Network has a group in place to support this initiative. Learning events have been held to encourage uptake and we are also reinvigorating the work to demonstrate benefits for patients and the role of community pharmacies in reducing work within general practice. It was asked if this approach is widely known by patients who want a prescription? It was said that when this works well it is seamless. The national relaxation of consent rules has helped, and patients have benefitted in terms of Out Of Hours who are not reliant on paper scripts. We now have information around how current system constrains us and we can build on a new system for the future. • Questioned when will hospital colleagues have the same ability to prescribe rather than the hospital discharge summary directing you to contact your GP for a prescription? It was responded that it is close and there are a number of clinical systems with the electronic internal ability to switch this on. However, the timescale per hospital is different. An accreditation process is currently being worked through. It was said that local Clinical Directors will be able to help triangulate this with local Trusts. Attention was also drawn to a pilot at Southern Health where community providers are also looking electronic prescribing. This approach will bring real benefits to our system. On concluding the Committee commended the clarity and quality of the paper.
6.3	**AGREED:** • **The Primary Care Commissioning Committee received the Primary Care Prescribing Report**
7.	**Primary Care Finance Report** (**Paper PCCC22/005)**
7.1	David Bailey introduced paper PCCC22/005 and drew attention to the following key highlights: • Of the £300m spend per year on primary care as at month 10, the CCG reported a forecast outturn of over £4.6m overspent across all Primary Care budgets, but this is essentially fully mitigated as it is due to two items of available allocation not yet received that are: • **Winter Access Funding** – NHS England have set aside £7.781m of allocation for the Hampshire and Isle of Wight (HIOW) Integrated Care System (ICS) and the CCG is forecasting to spend this in full. However, as at month 8 the CCG has only received £3.254m of the allocation, and the remainder is due to flow through in stages between month 11 and month 12. Therefore, this currently means that there is a pressure in the forecast of £4.527m, because of this, but this will be fully covered by the year end once

	any additional required allocation is received. Details of the aims of the programme and funding are contained within the paper, along with a summary of the plans and progress to date. • **Additional Roles Reimbursement Scheme (ARRS)** - The ARRS is showing a pressure as at month 10 but this is because the CCG only has approximately 55% of the available ARRS allocation in their baseline with the rest held centrally. Now the CCG is entering the second half of the year this budget is starting to be exceeded, and as at month 10 there is a reported forecast pressure of £2.190m but the CCG can draw down on additional funding if there is an overspend against this line. This is reported to NHS England and Improvement via the CCGs monthly Non-ISFE return and allocations can then be adjusted retrospectively with this allocation adjustment expected to come through in month 12. Therefore, like the Winter Access Funding the £2.190m pressure on ARRS is fully mitigated. Additionally, the CCG is reporting a £1.5m benefit on the GP Forward View Investment line. This is allocation that has recently come to the CCG and is currently being reviewed as to where this specifically needs to be allocated and utilised before the end of March, so until this is established no expenditure is currently assigned to this pot. • After taking into account the above the CCG is in fact not reporting any significant pressures or variances as at month 10, with the expectation that the CCG will land within their annual budget for all of their Primary Care services/functions (delegated and non-delegated). • **2022/23 Financial Planning Delegated Primary Care** - The Hampshire and Isle of Wight Integrated Care Board (ICB) has a confirmed initial allocation of £296,630k for Delegated Primary Care in 2022/23, this includes Portsmouth CCG. The financial planning exercise is still progressing, but the expectation is that the ICB will be able to manage all of their contractual commitments within this envelope, with a detailed breakdown/apportionment of this allocation to be worked up at locality level in due course. Attention was drawn to the fact that there will be no Hospital Discharge Scheme allocation in 2022/23 and that the Covid allocation has been halved from £170m to £80m. The GP Contract was published last week, and work is being undertaken to break this down into detailed plans. • In terms of comments made around estates issues earlier in the meeting in terms of long-term capital we will need to be more innovative around how we address estates issues for example not going for a new build but look at rental options. We will need to look at how we get the best use out of the funding that we have available next year.
7.2	There were no questions or comments.
7.3	**AGREED:** • **The Primary Care Commissioning Committee received and noted the Primary Care Finance Report.**
8.	**COVID-19 Vaccination Programme (Presentation – shared on screen)**
8.1	Hassan Majeed provided an overview of the Covid-19 Vaccination programme that included: • **Cumulative number of vaccinations by month and site type** – Since December 2020, the ICS has delivered 3.9m vaccines, 75% of these via local vaccination sites, primary care and pharmacies. • **Blended model** – Throughout the pandemic our vaccine model has been blended between multiple delivery channels for example we have delivered

	2.3m vaccines through PCNs, 740k through vaccination centres, 589k through pharmacies, 182k through hospital hubs and 75k through school aged immunisations. This has demonstrated tremendous joint working across the system.
	• **Vaccine offer** – Going forward our vaccine offer will be coordinated through four main campaigns for the rest of 2022. This will be via continued Evergreen offer, 5-11s, Spring and Autumn boosters. To successfully deliver the campaigns, delivery models will be locally tailored with common themes across the ICS for each of the main 2022 campaigns.
	• **2022 Campaigns** – A lot of work has been undertaken with local areas to ensure they are clear on the areas and groups they need to target to ensure that 2022 campaigns are as equitable as they can be. A variety of hyper-local plans are in place to target these priority geographical areas and demographic groups.
	• **Vaccination sites** – We will have multiple different types of sites across all localities to ensure our whole geography is covered for example vaccination centres, PCN led sites, community pharmacies, pop-ups and hospital hub. In addition, flexible roving provision targets hard-to-reach groups and can be directed to areas of higher deprivation. In rural North Hampshire where there is a larger coverage gap, we will particularly rely on local roving services to ensure take-up.
	• **Communications and engagement** - Joined up communications and engagement with the public. This is key to delivery and key planning principles have been developed. We will ensure that messaging is co-ordinated at ICS level, but at same time encourage local communications/tailored messages. This was demonstrated recently by a campaign targeting 12 to 15 year olds in Portsmouth over February 2022 half term.
	• **Future considerations** – As an ICS we have a number of considerations to ensure the long-term success of the programme:
	  • **Estates** - Formalised plans outlining our longer term estates plans including health hubs on commercial sites and contingency plans.
	  • **Workforce** – Develop a flexible vaccines workforce across the ICS that is aligned to both the needs of the vaccine programme and to overall health population. A thank you was extended to all those volunteers who have helped with the programme to date.
	  • **Communications and engagement** – A decision is needed on continued funding for local comms initiatives, including vaccine champions whose role will expand to include a broader health agenda.
	  • **Equalities** – Broaden equalities agenda for ICS with a greater emphasis on place based planning.
	  • **Data** – Agree a platform of metrics with primary care and providers to allow us to continue collecting data which improves delivery.
	  • **Places** – All local planning and priorities should be defined at place level including Covid-19 vaccinations.
	
	On concluding the presentation Hassan thanked all those who have been involved in the planning process and thanked the general public for coming forward and receiving the vaccine.

8.2	As a result of discussion: • Attention was drawn to slide 7 of the presentation where each place with the exception of North and Mid Hampshire lists the homeless population as a priority demographic group. It was questioned if lessons learnt as a result of the North and Mid Hampshire approach could be rolled out to other areas. It was responded that innovative approaches have been taken within the North and Mid Hampshire place and some were outlined. We need to recognise that the

	homeless are a distinct community, and it is not just people who are living on the street, it also includes those who are living with others. We also need to remember it is dynamic and people move in and out of homelessness. Availability of data will enable us to target that community. • Asked in moving forward the programme will it include the delivery of anti-virals and is there an update? It was responded that there is no update as it is still work in progress. • A huge thank you was extended to primary care who have delivered the lions share of this vaccine programme, which has been hand to mouth and a top-down approach. We must respect those who do not wish to receive the vaccination, but we have delivered an impressive number of vaccinations with 4 million people coming forward. However, people are still catching Covid and we need to maintain the momentum. • Attention was drawn to as primary care returns to business as usual; we need to be able to capture/retain those individuals who volunteered/came out of retirement to support the programme in order to be able to call on them again in the future. A number of doctors and nurses who have come out of retirement continue to support the Evergreen offer and will be supporting the autumn programme. Thanks were extended to GPs, those who have come out of retirement, volunteers and practices for delivering this programme. • It was highlighted that we need to be careful around how we get the message out there that there is a still need for boosters as Covid has not gone away and is still with us. Also, there are costs associated with Long-Covid. It was responded that this will be part of the ongoing role of vaccine champions, people within our communities and influential community voices. This is really important, and comms will also be an important aspect in terms of changing the narrative and expanding the prevention agenda.
8.3	**AGREED:** • **The Primary Care Commissioning Committee received the update.**
	OTHER
9.	**Any Other Business** – There were no items identified.
10.	**Key actions arising from discussion of agenda items to be included on the Primary Care Risk Register** – Estates particularly in terms of safe sites and general practice resilience.
11.	**Date of next meeting –** The Committee will meet next on Wednesday 18 May at 10.00am.

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

Signed by

Chair: …… **Date: ……**