Agenda Item 4.0.

Subject to approval at next meeting

NHS Morecambe Bay Clinical Commissioning Group

MINUTES OF A MEETING OF THE PRIMARY CARE COMMISSIONING COMMITTEE
Thursday 1 October 2020 at 10.00 am
Microsoft Teams

PRESENT:

Hazel Parsons	Lay Member, Morecambe Bay CCG (Chair)
Mike Bone	Lay Member, Morecambe Bay CCG
Anthony Gardner	Director of Planning and Performance representing the Chief Finance Officer, Morecambe Bay CCG
Jerry Hawker	Chief Officer, Morecambe Bay CCG
Dr Andrew Severn	Secondary Care Doctor for the Governing Body, Morecambe Bay CCG
Margaret Williams	Lay Nurse

In attendance:

Peter Higgins	Chief Executive, Lancashire and Cumbria Consortium of Local Medical Committees
Kate Hudson	Head of Primary Care, Morecambe Bay CCG
Dr Geoff Jolliffe	Clinical Chair, Morecambe Bay CCG
Dr Rahul Keith	GP Executive Lead - Quality and Performance, Morecambe Bay CCG
Kay Wilson	Primary Care Commissioning Manager, Morecambe Bay CCG (Minutes)

Action

74/20 **WELCOME AND INTRODUCTIONS**

Hazel Parsons (HP) welcomed members of the Primary Care Commissioning Committee (PCCC) and members of the public to the meeting.

75/20 **APOLOGIES FOR ABSENCE**

Apologies for absence were received from Anne Burns, County Councillor Cumbria and Health and Wellbeing Board Lead Member for Children, Barbara Carter, Corporate Affairs Support Manager and Hilary Fordham, Chief Operating Officer.

76/20 **DECLARATIONS OF INTEREST**

Declarations of interest were requested that would be relevant to the items to be discussed on the agenda. A declaration of interest was declared by Dr Geoff Jolliffe for agenda item 7.0. (item 80/20) Barrow and Millom Primary Care Network (PCN) - Application for

Approval to Sub-Contract Clinical Services. Dr Rahul Keith raised a declaration of interest for agenda item 8.0. (item 81/20) General Practice Funding - Atypical Populations and agenda item 9.0. (item 82/20) General Practice Funding - Local Enhanced Services (LES) Funding for 2020/21. Recorded declarations of interest can be viewed on Morecambe Bay CCG's (MBCCG) website.

77/20 **MINUTES OF THE LAST MEETING HELD ON 18 AUGUST 2020**

The minutes of the meetings held on 18 August 2020 were agreed as a correct record.

78/20 **MATTERS ARISING INCLUDING REVIEW OF ACTION SHEET**

Matters Arising

There were no matters arising.

Action Sheet

The action sheet was reviewed and updated as follows:-

Item 27/18 - Primary Care Networks/Co-Commissioning Budget Proposal. Kate Hudson (KH) confirmed that work in this respect was on-going, the deadline for roll-out had been extended until the end of the financial year and agreed to provide a further update to the Committee at the next meeting.

Item 16/20 - Funding to General Practices with A-typical Populations. On-going.

Item 48/20 - Application for a Contract Variation in Respect of Additional Premises Site - Duddon Valley Medical Practice. It was noted that there had been a provisional start date of 3 August for the opening of the branch surgery, although KH had reported at the last Committee meeting that this had slipped to the end of September. KH informed the Committee that there were some complications in respect of the purchase of the land and the anticipated start date was now towards the end of October. KH confirmed that the practice had plans in place to ensure that all eligible patients in the Askam area received vaccinations for Flu. KH was very hopeful by the next Committee meeting date the branch surgery would be operational.

79/20 **WINDERMERE AND BOWNESS MEDICAL PRACTICE - FEEDBACK FROM ENGAGEMENT EXERCISES**

HP asked KH to summarise the paper which had been presented to the Committee.

KH explained that at the meeting in August 2020, the Committee had noted that the current holder of the Windermere and Bowness

Medical Practice GMS Contract had confirmed its intention to withdraw from the contract initially with effect from January 2021, although this had been extended to 31 March 2021. At the August meeting, the Committee had asked for two specific pieces of engagement to be undertaken: (i) full patient and stakeholder engagement to understand the views and wishes of these groups, and (ii) market engagement to understand the potential level of interest from other providers should the Committee decide to undertake a procurement exercise, and KH confirmed these had been completed.

In terms of engagement with patients, KH explained that patient surveys had been available within the Windermere and Bowness practice site as well as letters being sent to each household registered with the practice to highlight the survey. The CCG had received 1,567 completed surveys which equated to approximately 28% of the patient list. The first question in the survey asked patients whether they would prefer a service to continue at the present site or to register with another GP/Practice. Of the responses received, 95% expressed a wish to retain a service based at the current premises. In addition to this question, the survey also asked patients to express preferences as to how services could be provided in the future. The highest response from patients was around the location of the current practice. A significant number of patients said that the other services provided at the current site were important to them. In answer to the question about the impact should the surgery not continue, the majority of patients said this would have a significant impact; some patients said this would require additional travel although it was noted that approximately half would be able to drive to alternative locations. KH confirmed that a small number of completed questionnaires were from patients registered with other local practices.

KH commented that the response rate for the survey was very high and the CCG was pleased that a significant number of patients had had the opportunity to voice their concerns and wishes through engaging in the process. The CCG had also spoken to a number of stakeholders involved in the local area and given an opportunity for them to provide feedback.

In terms of market engagement, the CCG had worked with North East Commissioning Support (NECS) team to complete a Request For Information (RFI) process. KH confirmed that 8 valid completed documents were received; the breakdown of responses was set out in the paper. The RFI process was completed to understand what the potential interest would be if the decision was taken to procure a new contract. KH confirmed that, should the Committee decide to undertake a procurement exercise, this would not preclude any other provider from submitting a bid for the service as this would be an open procurement process. The CCG had also received notification from one provider who had not seen the RFI document

but would have completed this if they had been aware.

KH was asked if the CCG knew whether the landlords of the current premises would be receptive to continuing with the lease. KH confirmed that the CCG had spoken to the landlords and it was the CCG's understanding that the premise would be available in the future. However, KH explained, that there were viable options if this was not the case as the CCG had also been approached by an owner of alternative premises which could also be available.

Dr Geoff Jolliffe (GJ) asked if patients had understood the nuance in the question around the building remaining open for use by a new provider as opposed to staying open and used by the existing provider. KH explained that there had been some initial confusion as patients felt that if the GP practice was closing then the entire premise would close. However, the CCG had worked with One Medical to ensure that this was corrected and any direct communication to patients had reinforced this position. KH confirmed to Members that the decision related solely to the contract for primary medical services, but it was acknowledged that this could have an impact on other services provided in the building. In respect of a local existing provider wishing to take on the practice as a branch site, KH confirmed that the CCG had not received any notification to this effect, but that all local providers were able to submit a bid for the contract should the option be to undertake a procurement exercise. However, any applications from existing providers for additional sites could not be included in a procurement process.

In terms of the patient engagement JH said that this had given a very clear indication that the current site should be retained and he felt it was an important factor to take into consideration when making a decision but said that the CCG could not guarantee this would happen. KH confirmed that the Goodly Dale site houses a number of services and it was expected those could continue irrespective of the decision made by the Committee. The one exception KH said was in relation to the pharmacy; as this was based near to a current GP site, if the patient list was dispersed, this could have an impact on the number of prescriptions dispensed. KH reminded Committee Members that, despite the decision taken, the continued use of Goodly Dale could not be guaranteed by the CCG as it would be a matter for negotiation between the successful bidder and the landlord.

Dr Andrew Severn (AS) asked about the services which were offered from the current site, such as Community Drug and Alcohol Service, particularly the impact on these services if the list was dispersed or if a procurement was undertaken. He also asked if the Committee agreed to undertake a procurement, what the impact on the PCN would be; whether the tender documentation could stipulate that the successful bidder must join the PCN as well as what the view of the PCN was. In respect of the PCN, KH

referenced the letters which had been received in advance of the meeting held in August 2020 together with the letter from Councillor Ben Berry. The PCN view was, she said, that the preference would be for the list to be dispersed which had been borne out in subsequent conversations with practices. However, in response to this, KH said that there was an opportunity to include in the procurement documentation for the successful bidder to work with the established Primary Care Network.

The Chair, Hazel Parsons (HP), said the Equality Impact Assessment would identify any risks and set out appropriate mitigation. KH confirmed an EIA was being undertaken and would be presented as soon as possible.

JH commented that the feedback from the market engagement was helpful, but he asked if the procurement was unsuccessful and the contract ended, what would be done in that scenario. KH confirmed that there was always a risk any procurement could be unsuccessful for a variety of reasons, however the advice from the North East Commissioning Support (NECS) team was that with the level of interest received in response to the market engagement, gave a good indication that a procurement exercise would give a positive outcome. If the procurement failed, KH said there would only be a short period of time before the contract expired; the alternative option in this situation would be the dispersal of the list.

The Committee asked if Covid-19 would impact on a list dispersal if this was done. KH said this would have an impact although the majority of patients would be within the boundary of St Mary's Surgery. KH reminded the Committee that St Mary's Surgery sent a letter to the last Committee meeting setting out ways in which they could support patients by expanding both their estate and service to accommodate the majority of patients. If the majority of patients chose to register at St Mary's Surgery, it would potentially increase the list size by 92%; this together with the impact of Covid-19 would be difficult for the practice and this process would need to be managed.

KH confirmed that in order to complete the procurement there was a tight timescale until 31 March 2021, but that she believed this was achievable. It was a possibility that a provider was not found, and that this remained a risk, but that the CCG did believe the procurement would be successful. However, in relation to the potential dispersal, KH said that there had not been any evidence of patients wanting to move from the current practice.

Peter Higgins (PH) asked if there were any lessons to be learned from the current situation. He said that a company from outside the local area had taken on the contract and asked whether this had presented a challenge. PH said that he would like to ask if any thought had been given to the risk of a provider that was not local taking on the contract. He said that he agreed with KH's comments

that if the list size of a neighbouring practice almost doubled in size in a short period of time, then this presented a risk also. PH said that it was a case of attracting additional clinical staff to work in the locality and he asked if any short-term alternative to procurement or dispersal had been explored. In other health communities, PH said, one alternative had been for the practice to enter into an agreement with a stability partner for a short period of time, from 6 to 12 months, to enable a robust solution to be developed.

KH said that were risks with all options. In terms of the type of provider the CCG may contract with, the paper did detail the variety of providers that had expressed an interest. However, KH said that the challenges faced by the current provider were in respect of recruitment issues and finance and that the CCG was aware of these. However, there was reasonable confidence that there would be interest from a wide range of providers in the procurement. KH confirmed that it was the intention of the CCG to involve local stakeholders from the PCN and, where possible, patients from the practice in the procurement process. KH said that if the procurement failed, or if it was felt it was not possible to disperse the list in a short period of time, then there remained the option of appointing a provider to undertake a caretaking role to provide a period of stability.

JH said that he wished to reiterate KH's comments that the decision for the Committee was an important in terms of the potential risks and the lessons learned from the current situation. PH said that the full LMC had not been asked formally for a view. In answer to a question from the Committee, KH confirmed that in order to keep to the proposed timeline should the option of undertaking a procurement be agreed, preparatory work had started in terms of the procurement.

In terms of list dispersal, GJ said that in his career as a GP he had twice absorbed the list of another practice but had the benefit of keeping the clinical staff. These changes increased the practice list size by 30% to 40%, he said, and in his view the task of taking on another patient list was not to be underestimated.

HP asked members to consider the two options put to the Committee, noting the additional considerations for each option, and asked each Member to confirm their decision.

In reaching the decision, Members acknowledged the risks and benefits with both options but acknowledged the feedback from the patient engagement exercise.

Members supported the option of undertaking a procurement exercise.

KH thanked the Committee for their decision and acknowledged that this had been taken before the Equality Impact Assessment

had been finalised but confirmed that this would be circulated as soon as possible and also confirmed that formal engagement with the LMC would be completed. KH confirmed that a further paper would be presented to the Committee setting out the procurement plan. This would need to be signed off by the Committee and would include the service specification together with the proposed questions bidders will be asked to answer. Also included would be information around the contract price and contract length.

80/20 **BARROW AND MILLOM PRIMARY CARE NETWORK (PCN) - APPLICATION FOR APPROVAL TO SUB-CONTRACT CLINICAL SERVICES**

The Committee noted a declaration of interest in relation to this item from GJ.

KH explained the background to the request from Barrow and Millom PCN to sub-contract part of the core contractual requirements, specifically in terms of home visits. The proposal involves the engagement of 1.5 WTE Paramedics who would support practices during core hours. The paper presented to the Committee described the information received which had been presented to the practices.

PH asked for clarification on whether this was planned to be a temporary sub-contract as the proposal suggested that the arrangement was until Paramedics could be reimbursed through the Additional Roles Reimbursement Scheme. PH also asked what the current situation was in relation to the baselines for PCNs; for example, if the PCN funded these roles now, he asked if this would affect the PCN's ability to claim reimbursement in the future. He supported the concept of a home visiting service.

KH confirmed that in terms of the duration of the agreement, that information had not been provided and this was one of the issues that Barrow and Millom PCN had been asked to confirm. The proposal is that the practices do fund the roles from their own financial resource. Kate explained to Members the background to the funding available through the PCN DES for additional roles, including Paramedics, employed by PCNs. The reason for staggering the introduction of reimbursement for particular roles was to avoid destabilising existing services.

It was noted that there were certain exclusions from the proposal put forward by Barrow and Millom PCN, for example pregnant women or patients with severe mental health problems. However, the Committee wondered if patients in care homes were included or excluded from this. KH confirmed that clarity on this was also required.

KH confirmed that Paramedics would be reimbursed through the PCN DES once this was part of the Additional Roles

Reimbursement Scheme. In terms of PH's question, the PCN would be able to claim reimbursement although there would be a check on whether these roles were already employed by the PCN.

In terms of the core details of the proposed sub-contracting arrangement, KH said that the information received did not provide all these details. HP asked what the arrangement were for patients that were excluded and whether individual practices would pick up this group of patients and it was noted that in this scenario the patient's registered practice would undertake the visit. JH said that the Committee did need reassurances around the two clauses set out in Section 3 of the paper presented to the Committee (clause 5.9 of the GMS contract).

The Committee noted that the proposal put forward by Barrow and Millom PCN referred both to the employment of Paramedics by Morecambe Bay Primary Care Collaborative (MBPCC) as well as this group of staff being hosted by MBPCC and the Committee asked for clarity on this arrangement. The Committee felt that this needed to be clear for patients. The Committee said it was very important for patients to understand that the appointment was not with their normal clinician and that the Standard Operating Procedure (SOP) set out in Appendix 2 of the document reflected that the accountability for the service remained with the registered practice and that this did not change because of the sub-contract arrangement. The Committee asked that this point was fed back to the PCN and the practices. KH agreed that this was an important point to feedback and acknowledged that there was an anomaly in the SOP in terms of employment. KH said that the SOP also needed to reflect that the fact that the service could not be further sub-contracted to another organisation. A further requirement was to ensure that the sub-contractor met the requirements to hold a GMS contract and as Commissioners, the CCG needed to complete a process of due diligence to ensure this was the case.

AS asked around the principle of Paramedics carrying out home visits and how this fitted with their normal duties when responding to 999 calls; for example it could be determined that a patient had an illness which could be managed at home with a visit the next day. The core skill of Paramedics was to deal with an urgent problem and to transport people safely to hospital and he was concerned that the principle of a home visit was not lost. PH said that the service was not an urgent care service, it was for the treatment of people who would normally be treated by a primary care team and he would be concerned if this became an urgent care service. GJ said that he felt the key component to the service was good triage by GPs. If it was determined that a face to face house call was needed, it was a question of the most appropriate person carrying out that visit. He said that taking into account the exclusion criteria as described in the paper, together with care homes, then the level of care needed would normally be routine primary care. In terms of quality of care for patients, GJ said that during the pilot of the

service, there had been some learning which had formed the basis of the service being rolled out, but there had not been any significant issues. Neither, he said, had hospital admissions increased during this period. AS asked why Paramedics had been chosen rather than, for example, a nurse. GJ accepted that Advanced Nurse Practitioners would also be able to provide the service, but that the PCN had taken the decision to use Paramedics. JH said that urgent care was provided by all providers across the health and care system; for example, pharmacists, dentist, GPs all provided forms or urgent care. He felt the key concern was to ensure that to ensure that the right service was provided by the right person and that urgent care could mean the services provided in the community.

KH summarised by saying that the Committee had been asked to consider the request for sub-contracting clinical services; the paper presented to the Committee contained a number of recommendations. KH said that if the Committee were to approve this request, the four issues discussed needed to be included: (i) reassurance in terms of the employment of the Paramedics; (ii) clarity on the situation in respect of care homes; (iii) accountability for the patient remains with the registered practice, and (iv) practices needed to sign to confirm acceptance of these criteria and return these to the CCG.

Members approved the application from Barrow and Millom PCN to sub-contract clinical services (limited to home visits) to Morecambe Bay Primary Care Collaborative subject to the points set out in paragraph 5 of the paper and the points discussed at the meeting.

81/20 **GENERAL PRACTICE FUNDING - ATYPICAL POPULATIONS**

Dr R Keith made a declaration of interest in relation to this item. However, as the paper did not propose specific decisions in respect of individual practices, the Chair proposed that Dr Keith remain present during the discussions.

KH summarised by saying that the topic of identifying practices serving atypical populations has been a matter of debate both locally and nationally since the guidance note was published by NHS England.

There are three types of atypical populations; these are:-

1) Unavoidably small or isolated practices.

2) University populations.

3) Significantly high proportion of non-English speaking patients

The guidance note was introduced as it was believed that for those three elements of general practice there could potentially be

additional challenges for practices. KH confirmed that at the present time two practices within Morecambe Bay CCG which had previously been assessed as serving atypical populations.

The purpose of the paper was to determine whether the CCG needed to undertake a review of this position, although this was made more difficult as the guidance published by NHS England did not go into a great deal of detail about how practices should be assessed against the criteria. Consequently, with a view to ensuring that the CCG acted as openly and transparently as possible, the work carried out to date had been a desktop review of all practices against a range of indicators drawn from information available to the CCG including the criteria set out in the national framework as well as local criteria which was used during the assessment of the two practices within Morecambe Bay. KH explained that the paper did state that there were a number of ways in which practices could be assessed to determine whether they served atypical populations. However, the cut-off proposed in the paper was where practices met 8 or more of the criteria and, therefore, could be deemed as having atypical populations although it was acknowledged that the majority of criteria related to issues of rurality.

KH said that the paper was very open and transparent in terms of the process followed and the criteria used and said that this was not an exact science; the paper presented to the Committee was a review of the criteria.

KH asked if the Committee agreed with the potential atypical practices. At this stage, the names of practices had not been included within the document nor had these been shared with Committee members. This was to enable the Committee to make a decision based on the criteria set out in the document. KH said that if this was agreed, or if alternative criteria were proposed, there would need to be a secondary discussion that would need to take place in relation to what type of support may need to be implemented. However, the decision for the Committee at the moment related to the criteria for assessment and determination of atypical populations.

Peter Higgins (PH) confirmed that he had been part of the national working group looking at the criteria for rural and isolated populations and at that time he did have some small practices within Cumbria in mind. The criterion of University populations was always meant to be where there was a major impact and where the University population skewed the practice list significantly. PH said that the Carr-Hill formula undervalues the weighting for this population. The third criterion is mainly for city areas with large ethnic communities and a significant number of migrants which could have a significant impact on practice workload. He believed the criteria was sound.

Jerry Hawker (JH) said that he wished to thank Kate Hudson and the team for the work done in producing this paper; this was something he was particularly concerned was undertaken since being in Morecambe Bay largely because the CCG wanted to be fair and transparent in its approach to this issue. He was mindful about basing this on the criteria written in 2016 and explained to Members that this was guidance and therefore it was a matter for the CCG to implement. He also wanted to reinforce that this was about atypical populations and not atypical practices; the guidance was intended to ensure that patients had equitable access to services. He said that the onus was on ensuring that a fair and balanced approach and commended KH and the primary care team on interpreting the guidance in a fair and transparent way.

JH asked KH about the 20% figure used in terms of the University populations and whether this was in the guidance or whether this was something created locally. KH confirmed that this was not in the national guidance. However, the team was aware that there are a number of residential schools and facilities within the CCG area and whilst the national guidance was clear this related to University populations, the team was mindful of the significant number of live-in schools and wanted to asses, in terms of the practice list size, what the proportion of students was in relation to the whole list size. The figure of 20% was used following discussions within the team as one fifth of the list size being a student population was felt to be a significant proportion of the overall list size. The team did ask the question that if the figure was less, what the impact of this would be and it was felt that 20% was a reasonable percentage of patients. There was only one practice that exceeded that amount. JH said that, given the figure was arbitrary, it may need to be kept under review as it would be difficult to argue why this figure was chosen opposed to the 16.4% for example. KH agreed with this and added that the pseudonymised data was consistent so the practice with 16.4% did not meet this criterion but it did meet other criteria. KH agreed that the criteria needed to be kept under review, particularly as the impact on university students following lockdown was not known.

Dr Andrew Severn (AS) said that his question had been answered through the discussion between JH and KH. He had been concerned that the difference in the two practices with 21% and 16% was 1 in 5 opposed to 1 in 6 and that this seemed to indicate that one had a significant higher impact that the other. He said that he had been concerned that unless the practice with the 16% could be incorporated into the formula it seemed that the CCG had to be careful about excluding that practice on an arbitrary number. As the practice qualified due to other criteria he was happy with the proposal.

Hazel Parsons (HP) said that she agreed that 5 practices had populations that were atypical and rural and also agreed that a further report be developed to look at the support for those

practices.

Mike Bone (MB), AS, Anthony Gardner (AG) and HP all supported the recommendation as outlined in the paper. JH also supported this but wanted to be clear on the timescales. KH and JH said that given the fact that this issue potentially had an impact on other decisions made by the Committee they said that the timeframe for the review needed to be relatively short. In terms of determining what qualifies as an atypical population, once that had been identified, the Committee needed to determine what level of support was appropriate for those practices and that a paper needed to be presented to the next Committee.

82/20 **GENERAL PRACTICE FUNDING - LOCAL ENHANCED SERVICES (LES) FUNDING FOR 2020/21**

Conflict of interest were declared by Dr Rahul Keith.

The paper presented to the Committee summarised the position in terms of LESs for 2020/21. In summary, payments for these schemes were based on activity which for the current year had been impacted due to Covid-19. The recommendation was that income for practices was maintained similar to previous years.

In respect of the activity GJ said that most activity had decreased, but there was an increase for some services and asked if practices wanted recognition for this increase or whether the proposal was to pay based on last year's income. He said that in the paper there were a number of recommendations including the proposal to increase the funding for practices in Lancashire for Prostate Cancer Injections as well as to fund the Wound Care LES. KH confirmed that the proposal was to fund practices based on last year's activity but with additional payments in relation to Prostate Cancer Injections and Wound Care.

The Committee agreed to accept recommendation 5.2 in the paper; to fund practices based on 2019/20 outturn with additional payments in respect of Prostate Cancer Injections and Wound Care as set out in paper presented to the Committee.

83/20 **GP EXTENDED ACCESS**

It was noted that the Committee had used its powers outlined in the Terms of Reference to make a decision between formal Committee meetings. Therefore, the decisions taken by the Committee on 3 September 2020 and 25 September 2020 were formally noted by the Committee.

AG summarised the progress that had been made over the summer and confirmed that the Committee had taken the decision on 25 September 2020 to award the contract to MBPCC subject to enhanced monitoring to ensure that the full due diligence process

was completed. In terms of the outstanding actions that needed to be completed, AG informed the Committee that some of this was due to timing and that, for example, a number of the policies had now been reviewed and improved by the Federation and the outstanding actions were for the CCG to check these. AG explained that the recommendation to the Committee was that these outstanding actions were completed by the end of November with a subsequent report to the Committee to provide assurance that the due diligence process had been completed. Attached to the paper presented were copies of the previous reports that were provided to the Committee remotely during September 2020.

AG confirmed that the requirement for the Committee was to ratify the decision which had been taken remotely. He also wanted to express his thanks the Primary Care Team, as well as other staff within the CCG, for the work undertaken throughout September in order to resolve the issues. AG also wanted to acknowledge the amount of work undertaken by MBPCC in a short period of time.

In terms of the clinical model, GJ said there was a lot of support for this, but the issue had been related to the governance structures behind this. He was confident that the clinical model was good and had wide support.

The Committee noted that the issues around due diligence were similar to the discussion in respect of the application for sub-contracting clinical services and noted the amount of work undertaken by MBPCC to complete the due diligence process.

The Committee formally noted the decisions taken in September 2020 to award the contract for Extended Access to MBPCC from 1st October 2020 to 31st March 2021 subject to enhanced monitoring to ensure the due diligence process was completed. A further report will be presented to the Committee in due course to provide assurance that this issue has been resolved.

In respect of completing the due diligence process, JH raised the question whether this would need to be completed every time a contract was awarded to a provider. He said this was particularly relevant in relation to the sub-contracting application by Barrow and Millom PCN which had been approved by the Committee subject to certain checks being made. However, if the due diligence process was completed for MBPCC by 30th November 2020, he asked if this would apply to the decision in respect of Barrow and Millom PCN and he compared this to the process the CCG used when awarding contracts to the Trust for example. KH agreed that this needed to be discussed further and it was agreed this would be discussed further within the CCG.

84/20 **HAVERTHWAITE SURGERY AND CARTMEL SURGERY - SUB-CONTRACTING AGREEMENT UPDATE**

The Committee noted that an application had been received in 2019 from Haverthwaite Surgery and Cartmel Surgery for approval for each practice to sub-contract clinical services one afternoon per week to the other. The Committee had reviewed the draft agreement at that time and asked for further clarification to be given around how the arrangement would work.

A revised sub-contracting agreement had been presented to the Committee which clarified the points which had been raised. KH confirmed that signed copies of the revised agreement had been received by the CCG from both practices.

The Committee gave approval for Haverthwaite Surgery and Cartmel Surgery to enter into a sub-contracting agreement for the provision of clinical services as set out in the sub-contracting agreement set out in Appendix 3 of the paper presented to the Committee.

85/20 **PRIMARY CARE COMMISSIONING OPERATIONAL GROUP QUARTERLY REPORT**

The Quarterly Report from the Primary Care Operational Group was presented to the Committee, which covered the work of the Operational Group, and in turn the Primary Care Team, for the preceding four months. KH said that the report included the support that the CCG had implemented for practices as well as the standard items in the report. The report also included some of the recommendations that had also been presented to the Committee for approval. Both HP and KH thanked the Primary Care Team for the support provided to practices.

JH said that he had noted the report confirmed the re-starting of virtual Quality Assurance visits to practices and felt that this was a pragmatic approach to take at this time and was pleased that this was a partnership approach. Whilst there was an overwhelming desire to support practices and practice staff, he said that this did need to be balanced with ensuring the quality of services provided. KH confirmed that the appropriateness of carrying out these visits had been discussed at the Operational Group a number of times and it was felt the visits provided an opportunity assess the level of support needed to practices.

Members noted the Primary Care Commissioning Operational Group Quarterly Report.

86/20 **PRIMARY CARE FINANCE REPORT**

The Committee noted the report. AG reported the current position was £900,000 overspend across all primary care budgets; £200,000

of which directly related to Covid-19 expenditure and is due to the fact that the CCG has not received reimbursement of these costs at this time. The largest amount related to the prescribing budget with a £600,000 overspend, which he said was a challenge nationally. AG said one reason related to a higher level of prescribing at the start of the pandemic as patients took the opportunity to ensure that they had sufficient medication, although this had now started to ease although there was concern that this would increase again if there was a second wave. Another concern was the impact on prescribing budgets of exiting the EU as set out in the paper accompanying the finance report.

In respect of the delegated primary care commissioning budget, there was a £100,000 overspend on this. AG said that the CCG had received, in the last few months, a top-up across all budgets which would put the CCG in a balanced position by month six.

The allocations for months 7 to 12 had been received and were being worked through by the Finance Team to understand the implications for all budgets including primary care. AG said that the Finance Team was working with other CCGs within the ICS to understand whether the position was replicated across the ICS; if this is the case, then this would be flagged to the ICS.

GJ asked about the position with the PCN DES Additional Roles Reimbursement Scheme and whether the CCG would be able to retain any underspend. KH explained that the primary care team had reviewed the recruitment to date to these roles as well as the planned recruitment for the remainder of the financial year. This led to some work with the PCN Clinical Directors to understand the recruitment plans of PCNs. There was, however, no lack of ambition or desire to recruit to these posts KH said, but that there remained a potential underspend. KH had made an approach to NHS England about the use of this funding confirming that PCNs had come together with the Acute Trust, Community Services and the Enhanced Training Hub managed by Morecambe Bay Primary Care Collaborative to draw up plans for the use of this underspend by bringing in additional capacity across the whole health system over the winter period. This was currently being considered by NHS England and the ICS, but KH said that she would continue to pursue this option.

PH confirmed that he supported this approach; he said that it was frustrating that the Clinical Pharmacy posts were hard to recruit to as these would help practices in the future by redirecting some areas of work to Clinical Pharmacists, especially in relation to patients in care homes. He asked if the ICS had plans in relation to the shortage of Clinical Pharmacists, as it was important to retain the funding within primary care. JH said that whilst he supported this approach, he said that this needed careful thought. If it was not possible to spend the funding on Clinical Pharmacists, then consideration needed to be given as to how the funding could

support the delivery of services and patient care. KH said that the Additional Roles Reimbursement Scheme funding could only be used on the roles set out in the documentation. However, KH said that she had approached NHS England specifically about the recruitment of Clinical Pharmacists on a lower banding and was liaising with the Acute Trust around working collaboratively whilst ensuring that these plans adhered to the national guidance. AS asked if recruitment at a lower band would restrict the ability for the individual to work independently and KH confirmed that this had been discussed and resolved across the PCN network.

It was agreed that a further finance report would be presented at the next Committee meeting.

87/20 **ANY OTHER BUSINESS**

There was no other business.

88/20 **DATE AND TIME OF NEXT MEETING**

Thursday 14 January 2021 at 9.30 am via Microsoft Teams.