NHS
Liverpool
Clinical Commissioning Group

Status of these minutes *(check one box)*:	
Draft for Approval:	☐
Formally Approved:	☒

Report to:	**Governing Body**
Meeting Date:	**28 May 2021**

MINUTES OF THE MEETING OF

Primary Care Commissioning Committee

Date:	16 February 2021	Time:	10.00am
Venue:	MS Teams		

Name	Job Title (Division/ Organisation*) *if not Liverpool CCG
Present:	
Gerry Gray (GGR)	Lay Member for Finance - Chair
Mark Bakewell (MBA)	Chief Finance & Contracting Officer
Helen Dearden (HDE)	Lay Member for Governance
Jan Ledward (JLE)	Chief Officer
Fiona Lemmens (FLE)	Chair LCCG
Cathy Maddaford (CMA)	Non-Executive Nurse
In Attendance:	
Scott Aldridge (SAL)	Senior Performance Manager
Val Attwood (VAT)	Deputy Chief Contracting Officer
Rob Barnett (RBA)	LMC Secretary
Kellie Connor (KCO)	Senior Contracts Manager
Paula Finnerty (PFI)	GP Director
Paula Guest (PGU)	Head of Planning and Delivery – Out of Hospital
Stephen Hendry (SHE)	Head of Governance and Corporate Services
Dave Horsfield (DHO)	Head of Transformation & Programmes
Victoria Horton (VHO)	Primary Care Accountant
Peter Johnstone (PJO)	Head of Medicines Optimisation
Jane Lunt (JLU)	Director of Quality, Outcomes & Improvement (Chief Nurse)
David O'Hagan (DOH)	GP Director
Maurice Smith (MSM)	GP Director
Jacqui Waterhouse (JWA)	Senior Programme Delivery Manager
Debbie Richardson	Committee Secretary, Liverpool CCG
Apologies Received:	
Kerrie France (KFR)	Deputy Director Quality, Outcomes & Improvement (Deputy Chief Nurse)
Richard Houghton (RHO)	Corporate Services and Governance Manager
Sallyanne Hunter (SHU)	Deputy Head of Corporate Services & Governance
Cheryl Mould (CMO)	Programme Director Provider Alliance
Carol Rogers (CRO)	Lay Member for Patient & Public Involvement

ISSUES CONSIDERED
2021

A1 WELCOME

1. GGR welcomed all those present to the meeting noting that business would be conducted on the assumption that members had read all papers ahead of the meeting.

A2 APOLOGIES FOR ABSENCE

2. The apologies for absence received for this meeting were detailed above.

A3 DECLARATIONS OF INTEREST

3. In addition to the declarations already listed on the LCCG register PFI declared that her husband had worked at Priory Medical Centre which would be discussed under the last item on the agenda. PFI agreed not to comment on this item. GP members present declared an interest in the LQIS and ARRS items.

A4 MINUTES OF THE MEETING HELD ON 15 DECEMBER 2020.

4. The minutes of the previous meeting held on 15th December 2020 were accepted as an accurate record subject to the following amendments:
    1) Point 36 be amended to: '…was needed in expecting PCNs to provide support to GP practices. PCNs are made up of GP practices with limited resources in terms of leadership and managerial capacity as that is provided by a small number of GPs and practice staff themselves, in contrast to much bigger organizations such as hospital trusts with their well established and resourced managerial structures.'
    2) Point 63 be amended to: '…to be monitored.'

Action	Lead	Timescale	Status
Recommendations approved by the committee, namely: • Approve the minutes of the previous meeting			
Further actions required: • Update minutes in line with discussions	D Richardson	ASAP	Completed

A5 ACTION LOG

2. The action log was discussed with the following points made:
    1) Item 1 – Primary Care Performance Matrix. This action had been completed previously, Mersey Care Foundation Trust (MCFT) were accepting referrals into dementia services. Item closed.
    2) Item 2 – Primary Care Commissioning Committee Risk Register – this item was on the meeting agenda. Item closed.
    3) Item 3 - Primary Care Commissioning Committee Quality and Contracts Report – VAT reported that national guidance had suggested extended hours could be put towards the delivery of the vaccination programme and Covid19 response. RBA responded that PCNs were already working in excess of contracts and would continue to do so for the foreseeable future. DHO commented that not all areas stood down the service as LCCG did and the expectation was that the funded activity would be directed toward the vaccination programme or the Covid19 response and the CCG was aware of the demands on PCNs. Item closed.
    4) Item 4 not yet due remains ongoing.

Action	Lead	Timescale	Status
Recommendations approved by the committee, namely: • Note the progress with previous action points.			
Further actions required:			

• Update the action log in line with discussions.	D Richardson	ASAP	Completed

A6 COMMITTEE WORK PLAN

3. MBA presented the committee work plan asking members to feedback any comments they had regarding the level of detail and that the correct aspects were being covered. The committee intended to continue on this basis going forward and this was a standard approach across the committees.
4. CMA asked if as part of the audit trail the committee was required to approve the work plan and HDE commented that it appeared sensible noting that as it was a living document it should be amended on an ongoing basis particularly looking towards 2021-22. HDE suggested the work plan was a standing agenda item for every meeting.
5. There was a need to be clear if the committee was looking backwards or forward, the intent was to close the audit action and set out a plan for the next year. The work plan was forward facing for 2021-22.
6. Members took the opportunity to formally approve the work plan and agreed to it being a standing agenda item.

B UPDATES

7. There were no updates to note from NHSE.
8. JWA updated members on the two Additional Role Reimbursement Scheme (ARRS) waivers that had been approved virtually. In December 2020 the North PCN had requested two additional pharmacy technicians. One was approved by NHSE in December 2020. The second application was for Central Liverpool PCN again for two pharmacy technicians and these were approved in January 2021 by NHSE.
9. PFI asked if the PCNs had managed to use the funding available via the reimbursement scheme and JWA responded that she was not in position to confirm this yet, she would find out and let members know.
10. MBA stated that there was more detailed information contained in the finance report and he had concerns that the CCG would reach the numbers quoted. The year to date spend did not reflect the actual number and the team was trying to obtain workforce modelling figures. There was a small level of underspend which carried risks regarding recruitment and work continued here.

C GOVERNANCE

C1 PRIMARY CARE COMMISSIONING COMMITTEE RISK REGISTER

11. JWA reported that item number 10 on the risk register regarding the flu vaccination programme was coming to an end and was due to finish at the end of February. Uptake of the flu vaccine had been good despite Covid19 except for pregnant women which had been a national issue and one that recurred annually. The programme had included 50-59-year olds for the first time this year with 58% of this cohort in Liverpool being vaccinated. The assumption was that the programme would be open to this age group for 2021-22.
12. Item number 11 was a new risk added during February 2021. The CCG had delivered around 111000 vaccinations for Covid19 in Liverpool and were the second highest CCG in the Cheshire and Mersey (C&M) system for a successful delivery. The CCG had 11 Pillar one sites, pillar 3 sites within PCNs and plans for supplementary sites for the next cohorts with plans to have sites at Anfield, Ellergreen and Princes Park aiming to cover areas of high depravation. Three pillar four pharmacy sites were also available. Care home residents had been offered the vaccine and the CCG was now looking towards cohorts five and six. The communications team was offering support to help people with enquiries regarding how to book their vaccinations with two updates on the risk register.
13. RBA pointed out that the flu vaccination programme was due to end in March. RBA commented there was a lot of confusion in the communication around the vaccine

programme particularly for cohort 5 and this was a risk; the fact the vaccine communications were orchestrated nationally via letters that were written in a language people could not always follow meant that some people were finding it difficult navigating through the system despite everything the CCG was doing to alleviate this.

14. MSM commented that he could find no target for flu vaccination uptake for the 50-64 cohort noting that GPs had seen hardly any cases of flu during recent months and this was probably due to hygiene and social distancing and it would be useful to copy this campaign in subsequent years. MSM echoed RBAs comments mentioning vulnerable patients receiving letters asking them to attend sites for vaccination which were often some distance away and not practical. This needed to be fed back to NHSE if possible.
15. RBA responded that this had been fed to NHSE several times already.
16. GGR enquired if hospital diseases were reducing in correlation with the reduction in flu outbreaks to which FLE responded that viral types of infections had appeared to reduce however no formal data was available to investigate this yet.
17. CMA asked members to ensure risk owners were updated on the register referencing items listed under Sam James who no longer worked at the CCG.
18. DHO had replaced Sam James as risk owner on the register and would update this commenting that he was looking at the wording of risk number one which was on the meeting agenda later. Following that discussion, the wording would be revisited.
19. HDE commented that leaving out of date information on the register suggested it hadn't been considered thoroughly. Risk number 8, medicines shortage was a high risk and HDE asked if the risk should be escalated or could it be changed as the target risks were red and it involved patient safety. JLE agreed noting that there may be national shortages of a drug but then colleagues should be looking for alternatives and a target risk score of 20 should not be agreed. GGR pointed out that a target risk of 20 would result in an escalation to Governing Body.
20. SHE informed members that following discussions with CMO the risk register had been refreshed and the Corporate Governance team would be taking a more active part in the process of updating the register for each meeting. Target scores needed to be looked at and there was a gap in how the Medicines Optimisation committee looked at assurance and how it was discussed at Clinical Forum and this needed to be clarified to move forward deciding which parts of the relevant business areas belonged where.
21. PJO noted that there was a guide to where the Medicines Optimisation Committee reports and this would be brough to the committee for information.
22. RBA commented that the risk was not so much for the CCG but was an amazing risk for the patient and an annoying risk for GPs, prescribers and pharmacists that may need refocusing. Regarding the risk of failure of GPs to deliver Covid19 vaccinations RBA suggested GPs and PCN should be congratulated on what they had achieved to date, while there may have been a risk any concerns were obviously ill founded.
23. GGR commented that any reports he had received, anecdotal or otherwise, regarding the roll out of the vaccination programme was about how remarkable the efficiency and effectiveness of the programme had been.
24. PFI reported that although the experience had differed amongst different PCNs in delivering the vaccines the programme was running very well with people very emotional as they had been unable to leave the house since the previous March. PCNs had risen to the challenge very well.

Action	Lead	Timescale	Status
Recommendations approved by the committee, namely: The Committee is asked to: • Note the contents and updates of risks for the commissioning of General Practice • Consider current control measures and			

whether action plans provide sufficient assurance on mitigating actions, Review the mitigations and progress • Agree that the risk scores accurately reflect the level of risk that the CCG is exposed to given current controls and assurances.			
Further actions required: • Review risk 8 with risk owner regarding residual score and escalation • Share guide regarding MOC with various committees.	D Horsfield P Johnstone	ASAP ASAP	On April 21 PCCC agenda. On April 21 PCCC agenda;

D PERFORMANCE

D1 PRIMARY CARE COMMISSIONING COMMITTEE PERFORMANCE QUALITY AND CONTRACTS REPORT

25. DHO delivered the performance report reminding members that the issues were already known to the committee. The top two issues remained annual health checks for learning disability patients and annual health checks for people with severe mental health issues. Practices had been written to and those with low to nil returns were being asked what help they needed if any. The target had reduced from 50% to 40% and the CCG was now focusing on hitting the SEND target by the end of the year.
26. JLU reported that there was significant event analysis work ongoing which was analogous to never event work ongoing with trusts and albeit to a different degree of proportionality with primary care. The CCG was trying to extract the learning however alongside the Covid19 response and the vaccination programme it seemed burdensome although an important aspect of improvement and quality assurance. There was an underdeveloped process for some practices in primary care and the team was trying to support the cultural shift, with three practices in progress at the time of writing. Work continued with other parts of the system to extract learning too.
27. VAT highlighted two main points from a contract perspective were the contract changes listed within the report. Several changes would take place over the next few months and the changes would be recorded with any items for consideration being brought back to the committee. The enhanced access service had been stood back up with a slightly different model of delivery during Covid19. One change to also note was that the CCG would be extending local contracts in line with national guidance to March 22. This guidance was not received I time to include it with the report.
28. MSM referred to the health checks asking how well working with secondary and primary care providers was going? JLU responded that this was something that needed to be revisited, often individuals with mental health conditions may have other physical conditions that contributed to their illnesses and it would make sense that when people were seen for a mental health check their physical health was checked too in order to make every contact count. JLU agreed to check this was happening across the system.
29. CMA pointed out that the indicators stated three times that no extraction had taken place yet and why was this. SAL reported that this had not happened nationally however PJO and his colleagues had undertaken research and the business information team would be asked to replicate the searches to obtain the data to see what assurance could be gained.
30. DHO reported that Mersey Care Foundation Trust (MCFT) were investigating solutions around health checks for patients they supported. The issue had stalled mainly due to MCFT being in business continuity mode recently and they were working through how to plan for this while struggling with the ongoing Covid19 response.
31. HDE asked if there were any consequences to patients not being seen when they would normally have been seen for routine health checks and if there were any patient safety concerns here particularly with less appointments available to patients.

32. RBA responded that colleagues in primary care were probably working harder than they had done for quite some time. The number of appointments offered hadn't decreased however the intensity of the work people had to cope with had increased with a huge increase in the mental health community from people struggling with lockdown and Covid19 generally added to patients not getting secondary care services, not getting diagnostic services and with people working in the vaccination campaign it was miraculous there was a functioning service with people working in it. It was important to work safely and effectively but the system was running on petrol fumes as opposed to petrol and there was concern how colleagues were going to cope in the coming months when it was hoped things would be getting back to normal. RBA stated that he believed the recovery period would take at least two years not just for patients but also for those dealing with managing the crisis.
33. PJO noted the underspend listed commenting that some people were staying indoors and issues such as hypertension, cholesterol and cardiac issues will come to light as things go back to normal and there would be massive pressure to get the system back to where it used to be saying this would take a couple of years and the struggle would be ongoing. This was not a criticism of general practice but a recognition that people cannot or will not engage with general practice while they felt they were at risk.
34. FLE reported that anecdotally there was an increase in patent complaints to practices. These were being dealt with by practice managers and so may not come to the CCG and practice managers were working exceptionally hard to allay complaints mainly around access.
35. JLE commented that complaints mainly come through an MP and the CCG haven't had any through since the vaccine programme started. Complaints go to NHSE and the CCG was not aware of any increase. If practices were experiencing this then the CCG needed to know about it to understand more.
36. SHE stated that the CCG complaints team hold initial records and contact details of all calls and could provide data to members if required. Members were asked to contact SHE directly if they wished to view the data.

Action	Lead	Timescale	Status
Recommendations approved by the committee, namely: The Committee is asked to: • Note the performance of the practices in delivery of Primary Care performance. • Note the performance of the CCG in delivery of Primary Care Medical commissioned services.			
Further actions required: • Check mental and physical health was being checked for individuals when attending appointments. • Replicate searches for assurance regarding extraction data.	J Lunt S Aldridge	April 21 April 21	On April 21 PCCC agenda. On April 21 PCCC agenda.

D2 PRIMARY CARE COMMISSIONING COMMITTEE FINANCE REPORT

37. VHO presented the finance report commenting that it was very similar to last month.
38. Prescribing had a £500k underspend at October which was due to a loss of activity historically although December was normally a high prescribing month so this may change next month along with the impact of lockdown three when prescribing may increase as it did in lockdown one.
39. There was a small amount of slippage on local enhanced services due to the finalization of prior year expenditure. The ARRS claim value had dropped from 64% to 55% which equated to around £400k of unutilized funding. Work was underway with the LNA to

request workforce planning data from PCNs to enable more robust recruitment plans however based on recent estimates the slippage was around 45%.

40. MBA commented that the CCG does ask NHSE regularly what they will do about the ARRS scheme. Usually with this type of budget PCNs can carry funding over if they report it in a particular way however this year it will be clawed back if it is not spent.
41. RBA stated that it was not easy for PCNs to recruit and carrying the funding forward would be sensible asking what representation was being made to try to vary the claw back circumstances. RBA went on to mention the number of excess deaths and subsequent reduction in the population, asking was there any link to the decrease in prescribing in primary care as initially deaths occurred in people with comorbidities and or was it tied to not having the same population base as the region usually had referring to the reduced student population.
42. MBA responded that he had raised the expectation with NHSE and he would continue to put the message across as the CCG was aware of the lost opportunity and the benefit of the roles. MBA went on to say it was interesting to see the reduction in prescribing in a numerical sense and allowing for the time lag the team would consider the reasons behind it.

Action	Lead	Timescale	Status
Recommendations approved by the committee, namely: The Committee is recommended to: • Note the contents of the report and the forecast financial position for 2020/21 as at December 2020 (Month 9)			
Further actions required: • None identified.			

D3 PRIMARY CARE PERFORMANCE MANAGEMENT PROCESS

43. VAT presented the report noting that a flowchart was missing from the document which was subsequently circulated to members.
44. The performance process was agreed in August 2019 and was a standard process which largely followed the national process. Contractual processes had been stepped back while practices supported the Covid19 response however the CCG was preparing for when the contract was put back into place.
45. The flow chart had been revised to GP Core, Quality and GP Specification data would be published monthly at which point the Performance Team would review the data against practice trajectories.
46. Where there were quality concerns, these would be highlighted to Performance and Quality Sub-Committee. A member of the quality team would assess the clinical risk and recommend if a planned face-to-face visit was required or a more formal contract 'query' needed to be raised. Based on this a site visit could be carried out or evidence submitted in response to any contractual query letter would be reviewed and the outcome of either of these would be taken to PCCC for a decision on the next step with regard to a formal contract notice with the decision on formal contractual action taken at PCCC.
47. The Contracts team would follow the national core contract monitoring process as outlined at: https://www.england.nhs.uk/publication/primary-medical-care-policy-and-guidance-manual-pgm
48. The improvement plan would then be reviewed and in light of all the available information, a decision would be made as to whether there was assurance that performance would be recovered. Practices would be given a maximum of 2 opportunities to clarify / improve their plans before final submission to committee for the final assurance decision.
49. During September 2021 any practices that were not achieving their trajectories, the default position would be that their GP specification payments would be tapered down to reflect

the non-achievement of the indicator, unless PCCC decides that there were exceptional circumstances which meant that funding should continue at the full level.

50. HDE noted that there was a range of actions available from do nothing to issue a breach notice and how did the CCG ensure it was consistent across all practices in any action it took not to treat one more favourably than another.
51. VAT responded that it depended on the nature of the breach stating that some could not be remedied as the NHSE framework was prescriptive. HDE stated that she was assured by the process to be followed. VAT reported that Rocky Lane Medical Centre was given several opportunities and this process ensured all practices were given the same opportunity.
52. JLE commented that the CCG needed to be clear what the process was noting that the intention wasn't for practices to go down this route however if practices were struggling there was a need to put something into place formally. The CCG had tried to avoid this but it needed to be clear where it would work with practices to develop and where this was not possible this needed to be put in the public domain openly.
53. RBA responded that the diagram helped sharing that he had been involved and it was correct, the CCG did need a process stating that this helped practices for moving forward into 2022 and for neighbouring CCGs, practices did not want to take a retrograde step in a years time.
54. While it was not yet clear what the future direction of travel was as NHSE was not clear on this yet JLE reported that all CCG were required to follow similar processes and this was trying to add value.
55. MSM commented that the lowest level soon was likely to be C&M asking could this process operate at a place-based level if the function was to be provider led. It was noted that this layered onto conversations yet to be had regarding how the system would evolve.

Action	Lead	Timescale	Status
Recommendations approved by the committee, namely: The Committee is asked to: • Approve the updated Primary Care Framework. • Notes the performance of the CCG in delivery of Primary Care Medical commissioned services.			
Further actions required: • None identified.			

E STRATEGY AND COMMISSIONING

E1 LQIS SCHEMES 2021-22

56. DHO presented the LQIS schemes referring to a paper which came to the committee in December which subsequently went to the LMC and the paper at this meeting was a response to questions raised by the LMC. The specification did require further information and the response listed how this would happen. The template provided simplified the process for practices to collect and report information.
57. Upon review it was agreed that consent for treatment was still required going forward and it was appropriate to record this. It would be reconsidered with if it became a problem.
58. The LQIS response will remain as it is and the additional reporting will not be required until the end of quarter one. At the end of this period the situation will be reconsidered and a decision will be made regarding how to move forward from the information available at this point which would be July 2021.
59. Feedback had been received on specific schemes and amendments would be made to wording based on this. It would be clarified that the method for commissioning would be

open and not just via PCNs. The frequency of injection wording would also be addressed to reflect that practices would not be affected adversely.

60. There was a lot of monitoring information in the new scheme regarding asylum seekers and the CCG planned to look closely into each part of it to see if all the information requested was necessary.
61. FLE thanked DHO and RBA and colleagues for actioning the scheme so quickly noting the effective conversation that had taken place.

Action	Lead	Timescale	Status
Recommendations approved by the committee, namely: The Committee is asked to: • Note the content of the report.			
Further actions required: • None identified			

E2 PRIMARY CARE ESTATES – LEASE DECISIONS

62. VAT reported that two requests for sale and leaseback arrangements had been received for Fulwood and Priory Medical Centre's. There was an identified landlord for Fulwood and the request was to implement a 21-year lease. National guidance suggests a typical period would be 15 years however there was a pharmacy on site with a 21-year lease which was a commercial lease and was separate to any CCG arrangements. The recommendation was to maintain a 15-year lease.
63. A landlord had not yet been identified for Priory medical centre which meant a lease contract could not be drafted as it may be subject to change once a landlord had been identified. The practise had instructed Capsticks to work alongside them drafting paperwork, considering lease options and this also duplicates the process the CCG would normally go through. The CCG could not agree a draft lease from an NHSE perspective and were recommending that the practise paid for a separate district valuer report alongside the Capsticks report. This will mean the process will be further along and once the landlord is identified it will not delay progress on the lease.
64. The CCG recommended that Priory Medical Centre continued to operate the parallel process to progress through the normal process once a landlord is identified.
65. The CCG was also suggesting primary care is reminded of its obligations regarding lease changes once the system became more settled.
66. GGR clarified that the agreement being sought was in principle for the process for Priory Medical Centre as they needed to go through the value for money process later. For Fulwood Medical Centre it was the principle of a 15-year lease not a 21-year lease as had been requested that was being recommended.
67. GGR asked what would happen should a centre close before the lease expired to which VAT responded that the CCG would have some liability here, it was part of a long term strategy regarding where practices should be located and a process would be followed.
68. RBA reported that he had been in touch with both practices regarding the matters. Regarding Fulwood the premises cost directions were out of date and in part three regarding the term of leases the only criteria where a 15-year lease was specified was in relation to notional rent and this was not a notional rent. RBA went on to state that current market rent made no reference to the term of lease and in reality this CCG and others had approved leases for 20 or 25 years and it seemed strange to be taking the 15-year option here.
69. VAT delivered her apologies for any miscommunication noting that she had consulted with the primary care estates lead and she would feed the comments back.
70. With regard to Priory Medical Centre, RBA had been in discussions with NHSE and Priory Medical Centre regarding their requirements and regulations and the general consensus was that if they wanted something and were prepared to pay for it then to allow them to do

so given there was no additional cost to the NHS.

71. MBA stated that he would take this away and seek further advice. There was a need to develop the estate strategy with a view to how to make best use of resources which was the role of the committee. There was an intention to develop a framework regarding estates with a strategy for moving forward so decisions could be made with an awareness of the wider implications and wider Estates and this hadn't been able to progress in the last 12 months. The CCG would like to pick this back up when it could to have a plan in place in the future to see how estates linked together. The CCG was hesitant to make a formal agreement until it knew how estates joined together. MBA proposed to continue with the work plan communicating with LNA and PCNs with the intention of gaining their input on how to develop this
72. HDE agreed saying she was uncomfortable making a decision without considering the wider strategy. HDE was unclear what the thinking was behind the sale and leasebacks asking were there potentially a number of these in the pipeline and would more follow noting that the potential to make decisions in isolation was not ideal.
73. RBA commented that the system was somewhat confused, people have had strategy after strategy over premises, over many years; GPs have taken risks over primary care premises with help to cost rents in the last couple of years and GPs who have invested have realised they have now got to get out of the system. These GPs are finding it difficult to get people to buy into premises as it is unclear where the NHS is going. People can only realise assets by selling them or by developing them and this is what they will do. It was not unreasonable for GPs to do this particularly as the NHS had been slow to find way of dealing with premises in the community. It is likely that there will be more of this and several developments in the city used to be owned by GPs. Decisions are not made on the spur of the moment and it was not clear when they would follow but they would follow.
74. MBA stated that the intent was to speak to practices to seek their intent and develop a document to list the focus then work to assess the wider estates impact. It was a piece of work to bring this all together.
75. MSM noted that the issue of NHS value for money was important nevertheless in terms of talking about a long-term estates strategy. The Government had decided the CCG was not going to exist in a year so the risk of waiting for the strategy needed to be considered and whether it was unrealistic.
76. In response MBA reported that a first iteration was available with over 30 plans in place. Support was available in the background in the form of Peter Evans, Estates Implementation Manager, furthermore an estates strategy would still feature in the new format and so the work would still have value and would be in the CCGs interests to be done to hand over the approach taken. The expectation was that the ICS/HCP would be looking for pipeline approaches to capital and revenue allocations and this would need a strategy supporting it.
77. RBA fully supported the need for an estates strategy noting that particular aspects could not be viewed in isolation. The strategy needed to take real life into account and what happened on the ground, building would still be required where there was a population and decisions needed to be made taking that into account.
78. KST reported that practices eligible for notional rent would not need to have a lease in place as they would be owned buildings. The 15-year lease was to allow a standardised approach to the different levels of rent reimbursement.
79. GGR clarified that the reason for sale and leaseback was for cashflow and to manipulate accounting rules previously but this had changed now. The CCG needed to be wary of taking on responsibilities of rent for fixed periods. The committee needed to ensure NHSE and CCG policies were adhered to and so clarification of the 15-year position was sought before the committee could agree to the proposals submitted by Fulwood Medical Centre.
80. With regard to Priory Medical Centre the committee was happy for the proposal to progress.
81. VAT thanked members for the discussion noting that if it was helpful she would seek approval virtually to save time when clarification regarding the 15-year lease was received.
82. MBA agreed to reactivate the estates strategy.

Action	Lead	Timescale	Status
Recommendations approved by the committee, namely: The Committee is asked to: • Note the Commissioner responsibilities in terms of the Premises Cost Directions 2013 and the process followed. • Consider and approve the recommendations with regard to Fulwood Green Medical Centre's proposal for a sale and leaseback for 15 years. • Consider and approve the recommendations with regards to Priory Medical Centre proposal for a sale and leaseback process. • Communicate to Primary Care a high-level summary of the Premises Cost Directions 2013 and clarification of the contractual obligations.			
Further actions required: • None identified			

F ANY OTHER BUSINESS

83. No other items of business were discussed. The meeting closed.