NHS
Liverpool
Clinical Commissioning Group

Status of these minutes *(check one box)*:	
Draft for Approval:	☐
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Report to:	**Governing Body**
Meeting Date:	**17 June 2022**

MINUTES OF THE MEETING OF

Primary Care Commissioning Committee

Date:	15 February 2022	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 LCCG
Cathy Maddaford (CMA)	Non-Executive Nurse
Carol Rogers (CRO)	Lay Member for Patient & Public Involvement
In Attendance:	
Scott Aldridge (SAL)	Senior Performance Manager
Val Attwood (VAT)	Deputy Chief Contracting Officer
Rob Barnett (RBA)	Liverpool Medical Council
Stephanie Gallard (SGA)	General Practitioner
Paula Guest (PGU)	Head of Planning and Delivery – Out of Hospital
Dave Horsfield (DHO)	Director of Transformation Planning & Performance
Lindsay Humphreys (LHU)	Clinical Quality and Safety Manager
Cheryl Lowes (CLO)	LNA
Cheryl Mould (CMO)	Director, Provider Alliance
David O'Hagan (DOH)	General Practitioner
Ian Pawson (IPA)	LNA
Adrienne Taylor (ATA)	LNA
Sarah Thwaites (STW)	Healthwatch
Apologies Received:	
Richard Houghton	Director of Transformation Planning & Performance
Fiona Lemmens	Chair LCCG
Jane Lunt	Head of Quality / Chief Nurse
Amanda Williams	Deputy Director of Quality, Outcomes & Improvement

ISSUES CONSIDERED
2022

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 MEETING ETIQUETTE

2. GGR advised the committee to raise a question or comment by using the hands up feature, reminding attendees that the meeting was open to the public and would be recorded and uploaded to LCCGs website.

A3 APOLOGIES FOR ABSENCE

3. The apologies for absence received for the meeting were as detailed above.

A4 DECLARATIONS OF INTEREST

4. In addition to the declarations already listed on the LCCG register RBA and PFI commented that as GP partners it was possible that items may be discussed which they may declare an interest in as they arose. Members agreed that a clinical perspective would be valued, and items would be discussed on an individual basis with any conflicts dealt with accordingly. This was also true of other GP members in attendance whether they were partners or employees. GGR advised there was a conflict in Part B of the meeting and the GP's agreed not to attend that part of the meeting.

A5 MINUTES OF THE MEETING HELD ON 21 DECEMBER 2021.

5. The minutes of the previous meeting held on 21 December 2021 were accepted as an accurate record subject to the following amendment:
   1) HDE advised that paragraphs 37 and 42 contained typing errors which were to be rectified. Paragraph 81 had a typo with GGU to be changed to GGR.
   2) CMA advised that there were anomalies on the membership list which were remedied.

A6 ACTION LOG

6. The action log was discussed with the following points made:
   a) Item 1 – Discuss transfer of patient records outside of committee. Informatics Merseyside had provided an update showing multiple issues between GP-to-GP transfer which had been escalated to NHS digital. JLE advised that the action taken by the CCG was complete. This was a national issue and the CCG had done what was expected – item closed. DHO to provide feedback from NHS Digital in future performance reports if applicable.
   b) Item 2 – Quality Audit Report. Paper provided at meeting by JLU – item closed.
   c) Item 3 – GP names to be updated on network agreements. VAT advised the CCG had written to the network and was awaiting confirmation which should be available at the April meeting – item ongoing.
   d) Item 4 – Check LCCG website covers PCN membership list - DHO confirmed the relevant information was present on the website – item closed.
   e) Item 5 – Commence discussion with RBA and Primary Care Colleagues to plan estate strategy. CMO advised that she had spoken to Peter Evans and Trish Hogan about the estate strategy and the action would now be passed over to the LNA Leadership team. item closed.
   f) Item 6 – Primary Care Recovery Report. Item for discussion at meeting – Item closed.
   g) Item 7 – ICS Governance – Committee to be updated in terms of progress and changes in original plans, subject to Covid-19 situation. DHO advised that going forward any updates would be brought to the meeting – item closed.
   h) Item 8 – Revised Terms of Reference to go forward to the Governing Body for noting. DHO advised this will be on the agenda for the next Governing Body meeting – Item ongoing
   i) Item 9 – Ensure correct codes are used for Baby Immunisations and report back to RBA. DHO advised that SAL had sent data to practices regarding the new coding and this data would be sent to the LMC in case any queries come through and RBA could respond directly. DHO to

follow up – Item ongoing

j) Item 10 – STH to report to Primary Care regarding Long Covid-19 Enhanced focus groups and interviews with patients' progress. STH advised that it was with LUHFT and an update would be provided at the June committee meeting – Item 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

A7 COMMITTEE WORK PLAN

7. DHO presented the committee work plan noting it was the 2021-22 workplan running until the end of the financial year.
8. DHO advised that he would continue with the scheduled workplan for the April and June meetings. However, the creation of the ICS from 1st July meant it was expected that responsibility and governance arrangements would change.
9. DHO advised that he would add an item regarding handover to the workplan. This would include risks and other items that the committee wished to report on for the hand over to the ICB. DHO stated that he would prepare a draft work plan ready for a final report for the handover for primary care commissioning to enable the committee to be confident regarding what was being handed over.
10. HDE agreed the handover action was a good idea and that other committees had not produced anything from July onwards as there was no certainty what that might look like. DHO agreed and advised that he would "grey out" future items on the workplan from July onwards until there was further clarification.

Action	Lead	Timescale	Status
Recommendations approved by the committee, namely: • Note the committee work plan			
Further actions required: • None identified.			

B UPDATES

B1 LNA UPDATE REPORT

11. Adrienne Taylor, Ian Pawson, and Cheryl Lowes presented the Local Network Alliance (LNA) update.
12. IPA advised that the team were looking to develop as a standalone organization to have the sustainability to support PCN's, as well as providing a voice for GP Practices within the healthcare system.
13. IPA stated that work was needed in developing relationships with system partners and to deliver more effective healthcare as well as addressing health inequality across the system, a significant aspect of this was noted as supporting PCNs to develop and become strong in their own right to deliver services.
14. IPA referred to the list of aims and priorities and how it had extended due to the challenges faced in the last 12 months.
15. IPA advised that the team were looking at establishing a voice for general practice and it beginning to link a lot more effectively than previously with a lot of work been done on organisational development.

16. ATA then provided an update regarding hosting and organisational structure. Hosting began in November 2020 which was later than originally planned. The delay was a consequence of getting processes in place to facilitate finance and HR to engage and employ people, plus procurement of contracts.
17. ATA stated that the organisational development contract was procured for Liverpool Heart and Chest Hospital (LHCH). There were delays due to staffing at LHCH and a challenge from a procurement bidder. Since the delay ATA noted that things had progressed, and the work should be completed by the end of May.
18. ATA then discussed the LNAs purpose and what the LNA needed to do next in terms of strategy and delivery plans. ATA confirmed that the main focus had been the business plan. A 12-month extension at LHCH had been requested due to delays as a result of the pandemic.
19. ATA reported that a significant amount of work on organisational development and the development of relationships was underway with system partners and that PCN's would be supported to maximise additional roles expenditure that had been created.
20. ATA spoke of the unemployment hook and that LNA had created an electronic rota system to aid all PCN's particularly non-clinical clinical staff which had begun in January. It was in its early stages and there was hope it would be successful with more feedback to follow.
21. IPA advised that the team did a lot of work with clinical directors to get a clearer picture of what enhanced access may look like with the notion that it would be a seven-day access for general practice appointments outside of normal working hours. IPA stated that this was up and running delivering enhanced access services within a central PCN covering around 110,00 patients across the city with PC24 covering the rest of the city.
22. Consultations began with patients, with most preferring to be seen face to face, however with the flexibility to book across practices this was now a possibility with essentially 95% of the service delivered Monday to Thursday and then the remaining weekend period subcontracted to PC24.
23. Feedback so far had been good, and IPA advised that he hoped to bring more data to the next update.
24. CLO advised that the team had worked with Mersey Care Foundation Trust (MCFT) and aligned the funding over the next year to ensure no duplication of roles, instead creating roles which complimented each other.
25. CLO stated that the model produced was considered a trail blazer for developing the One Liverpool delivery principles with the hope that this could be scaled up across Liverpool.
26. CLO then spoke about the challenges faced over the last 12-18 months and the operational development of the LNA. CLO noted that Covid-19 had played a huge part in delaying the project.
27. CLO advised that two PCNs had chosen to work collaboratively to tackle specific health inequalities that they shared across the two networks, and this was a success. They were open to working with other PCNs on other matters.
28. CLO summarised that the team needed to complete the ODI work and support was needed for the PCNs to grow, mature, and reach their potential, to ensure that the maximum could be achieved for health and social care for the residents of Liverpool.
29. DHO questioned whether it was possible to do all that had been discussed as it was a lot to take on for a small organisation and wished to discuss outside of the meeting the GP specification and business plan sustainability. DHO also stated that there would need to be a discussion regarding aligning the separate organisations in terms of the new guidance and planning.
30. CLO agreed that it would be very helpful for that discussion to take place.
31. RBA noted two PCNs not part of the LNA and the rebranding of general practice as the two PCNs had stated that they did not want the LNA speaking on behalf of their networks and practices.

32. CLO thanked RBA and noted that it was particularly important that partners knew the door was always open.
33. MBA agreed with DHO's comment and spoke about the sustainability and lifespan given the CCG was becoming the ICB asking was it self-sustaining. MBA stated that a discussion would need to be had outside of the meeting to look at the data and see the figures regarding the LNA and PCNs.
34. CRO referred to the challenging landscape and the uncertainty around when the CCG joined the Integrated Care Board asking how the LNA would fit within the framework.
35. MBA advised that it was a fair challenge and generally it was hoped that there would be a period of sustainability in year one of CCG/ICB integration noting that there would be greater challenge around consistency. MBA stated that the LNA would come under scrutiny however, if it could show that it had made a good impact and would continue to do so that would help its legacy.

Action	Lead	Timescale	Status
Recommendations approved by the committee, namely: • Note the update.			
Further actions required: • Hold conversations outside meeting as discussed.	D Horsfield	ASAP	On April 22 PCCC agenda.

C GOVERNANCE

C1 PRIMARY CARE COMMISSIONING COMMITTEE RISK REGISTER

36. DHO presented the Primary Care Commissioning Committee (PCCC) Risk Register (RR) reporting that there were only a few updates namely to items 5, 7, 11 and 12.
37. DHO advised that not all networks were delivering to clients, and the LNA update provided more information on this. PCN's were at different stages of maturity and whilst this remained a risk work was ongoing to mitigate. The Covid-19 vaccination programme was progressing, and the risk register reflected this success.
38. DHO referred to item 12 which was the elective care and primary care recovery. DHO noted that the primary care recovery meeting had been postponed slightly to enable the team to be more prepared for discussion on how the recovery of services would work and the register would be updated once feedback was available from colleagues regarding operational recovery.
39. RBA stated that it was very wise to postpone the meeting in terms of the recovery plan as he was concerned that the plan was far too ambitious and unachievable. RBA stated that rather than give false hope to people it was fairer to say it would take at least two years to create a meaningful recovery within services, as there was a backlog within secondary care which had also impacted primary care and efforts to relieve this were not helping the overall recovery.
40. GGR asked the committee to approve the risk register. The committee approved the risk register.

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: • None identified			

C2 PRIMARY CARE COMMISSIONING COMMITTEE ANNUAL REPORT

41. DHO presented the Primary Care Commissioning Committee (PCCC) Annual Report noting that it had been submitted to the Audit and Risk Committee. The report contained an overview of performance and effectiveness of the committee over the last 12 months. The report contained terms of reference, duties of the committee and attendance figures. DHO stated that quoracy was good in terms of the committee.
42. DHO referenced the work plan and how the committee had met the needs of the workplan despite the disruption caused by Covid-19.
43. DHO summarised that that the committee had done its job well during the previous 12 months and had been reasonably agile in moving things around to make sure that priorities required for primary care had been met.
44. GGR agreed that the report was very much in line with the previous year business and was favorable.
45. DHO noted that the committee had also been audited by MIAA and the feedback from the audit was very positive.

Action	Lead	Timescale	Status
Recommendations approved by the committee, namely: The Committee is asked to: • To consider review the effectiveness of the committee over the last twelve months. • Approve submission to the Audit & Risk Committee •			
Further actions required: • None identified			

D PERFORMANCE

D1 PRIMARY CARE COMMISSIONING COMMITTEE PERFORMANCE QUALITY AND CONTRACTS REPORT

46. DHO delivered the performance report noting there were some items suspended for general practice in order to support the vaccine programme which was likely to change as the committee looked towards recovery. However, there were no clear dates at present.
47. DHO explained that in terms of the Covid-19 enhanced service there was a large number of practices signed up for referrals. The referrals were promising as it helped understand issues around long Covid such as what were the symptoms and how they could be managed. DHO confirmed that the service was running at different tiers and progressing well.
48. RBA wished to note that on page 55 of the paper it spoke about the weight management enhanced service and stated that all practices signed up. However, the report then went

on to say that 18 practices hadn't sent any referral. RBA queried whether any action had been taken in relation to the same and had practices, that did sign up, been reminded to reply.

49. SAL advised that he had spoken to the individual practices that had not sent referrals and since then he had received the practice's referrals.
50. HDE asked how performance indicators were being managed with the suspension of some services.
51. DHO advised that the numbers in the report reflected what was stepped up and stepped down, stating that the committee was somewhat beholden to what instructions they were asked to follow in terms of priorities going forward and to some extent this would become more relevant going into the new financial year where there would be clear direction for the operational plan and a lot more services stood back up again. DHO believed this would give a clearer indication of what recovery might look like.
52. RBA noted that the numbers were essential, although frightening to look at, to show how much work needed to be done to get back to the operational capacity prior to the Covid-19 pandemic.
53. GGR agreed declaring that LCCG would keep working to the best of its ability until the ICB took over.

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

D2 PRIMARY CARE COMMISSIONING COMMITTEE FINANCE UPDATE

54. MBA presented the finance report up to month 9, December 2021 for the H2 period.
55. MBA advised that there was an underspend largely due to a prescribing underspend. The CCG was on track with the primary care budget which was pleasing.
56. MBA advised there was a big underspend in additional roles, this would be discussed via a separate paper later in the meeting.
57. MBA advised there was information regarding LCCG's 2019/20 investment in primary care and stated that this was mandatory reporting and was sent to the LMC to show levels of allocation and spend.

Action	Lead	Timescale	Status
Recommendations approved by the committee, namely: The Committee is recommended to: • Note the contents of the report and the 2021/22 forecast financial position as at December 2021 (Month 9). • Note the information shared with the Local Medical Committee which details primary care investment in 2020/21. •			

Further actions required: • None identified.			

D3 GENERAL PRACTICE DEEP DIVE REPORT

58. LHU presented the General Practice Deep Dive Report. LHU advised that her team were asked to put together a deep dive report for PCCC and felt that it would also be a good opportunity to round up the year to date and use the report as part of the legacy handover document to the ICB. It was a collective report between performance and quality and provider alliance colleagues.
59. The report looked at safeguarding, medicines optimisation, and complaints, with a focus on long term conditions and immunisations and it was fundamental to show the fantastic work that was being done around Covid vaccination. The report also highlighted the issues with reducing rates of childhood immunisation uptake, which was a national issue and not specific to Liverpool.
60. LHU welcomed feedback and suggestions from the committee stating that this was the first deep dive report the team had been asked to produce for PCCC.
61. CMA stated that she thought the report was very good and gave an overview of a whole range of different aspects which was extremely helpful. CMA queried the issue regarding safeguarding and serious incidents noting that there were seven domestic homicides and 14 adult safeguarding reviews. CMA asked whether this was typical or had Covid-19 exacerbated the situation. CMA also queried how much GPs were involved in the reviews asking if they had an opportunity to attend review meetings to contribute appropriately.
62. LHU advised that she understood GPs were invited to the reviews and if unable to attend would send a report to the meeting.
63. CMA thanked LHU noting that the GPs would have a wealth of knowledge which would influence the outcome of the review meetings.
64. RBA advised that the CCG did not fund practices to attend or write papers for the review meetings and this had been a bone of contention for some time as GP's had an obligation to support the process. RBA stated that his last correspondence with the CCG regarding the issue stated that the CCG was waiting for a judicial review. RBA noted that the review stated that GPs were expected to participate and there needed to be some acknowledgement of the time commitment to participate in the process noting that there had been no further discussion. RBA stated that it was unlikely the CCG would resolve the issue as it was nearing closure and hoped that the ICB would pick up the issue as it was having an impact.
65. RBA wished to state that more work could be done in relation to the medicine safety report declaring that he was a part of the Medicines Optimisation Committee. RBA noted that it had been a useful development and had helped to show practices where they were in relation to others and in terms of picking up high risk issues when prescribing which was a benefit to patient care.
66. RBA then discussed childhood immunisations noting that there was a lot of concern due to the reduction in uptake and asked what the CCG was doing to improve the situation. RBA referred to vulnerable families asking how the CCG was ensuring they were appropriately vaccinated. RBA stated that the CCG would say it was the local authority's responsibility as they managed health visitors. However, RBA stated that it was equally everyone's responsibility and they needed to come to shared agreement and solution.
67. LHU replied to RBA stating that the Childhood Immunisation Group would be restarted and welcomed RBA's attendance.
68. CMO advised she was part of the Bronze Group and the learning t from the vaccination programme and partnership working was invaluable. In essence CMA wanted to evolve the group into a screening and immunization group to build on what had already been established. CMO noted that it was imperative to understand how to reach into the community. CMO requested that LHU and herself have an offline conversation to bring everything together and create an action plan across screening and immunisation rather than having separate groups.

69. LHU agreed that would be beneficial.
70. HDE wished to provide feedback on the report namely that she would have preferred more context, despite it being thorough and showing how busy everyone was. HDE referenced CMA's point regarding the homicide deaths and safeguarding issues stating that context would have helped to understand whether this was normal or higher than average.
71. LHU welcomed the feedback and advised she would amend the report to provide more context prior to handover as a legacy document.
72. JLE wished to add to the discussion advising that the report needed comparative data, but this needed to be in respect of core cities and population to give an indication of how the CCG was performing and where there were areas to improve on.
73. LHU again welcomed the feedback and would include comparative data with RBA stating that it would probably need to be data pre-Covid-19 as the last few years had not been "normal".
74. RBA then asked JLE if she could advise regarding attendance fees for safeguarding meetings. JLE replied that she would investigate the issue.

Action	Lead	Timescale	Status
Recommendations approved by the committee, namely: • The Primary Care Committee is asked to note the content of the report and gain assurance from the processes in place within the CCG to review and challenge the quality and performance of commissioned services in general practice. • The committee is asked to provide feedback on how this report can be developed for future use. The committee is also asked to accept the report as a legacy document in readiness for the • ICB/S.			
Further actions required: • Discuss immunization uptake and ways to increase uptake outside meeting. • Investigate attendance fees for safeguarding issues for GPs	C Mould J Ledward	ASAP ASAP	On April 22 PCCC agenda. On April 22 PCCC agenda.

E STRATEGY AND COMMISSIONING

E1 GP SPECIFICATION

75. PGU presented the GP Specification noting that there was a task and finish group operating during the previous year to add new metrics to the contract after the previous contract expired prior to the start of the pandemic. PGU referenced the impact of Covid-19 stating that the true impact of Covid-19 was yet to be felt as it had not gone away.
76. PGU stated that GPs were in a better position prior to the pandemic and that contracts were being awarded on a two-year basis to be novated by the ICS.
77. PGU noted that there were a number of principles and schemes which supported primary care and its recovery. PGU referenced RBA's regarding returning to 'normal' acknowledging that a mountain would exist after the impact of pandemic. The metaphorical mountain was forming on the horizon and it was big. The need to support primary care was crucial especially as it recovered.
78. PGU reported that the CCG was in receipt of planning guidance and the expectations of GPs was broadly understood despite the lack of target measures being present.
79. PGU acknowledged the deep dive report on GPs, advising that GPs did have a greater understanding of long-term conditions, and this had a huge impact on inequalities. There

was a need to draw people's attention to the gap between most and least deprived quartiles, with life expectancy decreasing by 5-8 years.

80. PGU suggested including a number of measures to make recovery achievable and to give practices an opportunity to focus, referring to the long-term recovery plan where there may be an opportunity to incorporate some new initiatives. People were being asked to do a lot extra tied into the delivery of what was agreed were the priorities for each area. The aim was to simplify things and focus tightly on recovery and long-term conditions.
81. PGU discussed diabetes teams and the community respiratory teams that could offer more enhanced support to primary care to help those patients identified as at high risk. With primary care responding to 50% of enquiries this was having a real impact on patient cohort on at-risk areas. The idea was to work with PCN groups to help them to develop while relieving some pressure from primary care.
82. PGU mentioned using specialist teams and building relationships to encourage greater integrated working while targeting at-risk patients, noting that the specialist teams would work alongside GPs in high-risk areas that worked for the two-year period.
83. PGU asked the committee to support the proposal to take pressure off primary care with the contract in place for quarter two.
84. PGU declared that SLT had already agreed that it could be a good way forward as it directly tied funding to the delivery of what was needed. PGU pointed out that it did not disadvantage those practices already demonstrating this operation, moreover it provided an incentive for them to continue.
85. DHO advised that as the CCG joined ICS there would be a focus on the guidance regarding taking a population health approach and aligning this with health inequality. Taking this approach now with the GP specification would place the CCG at an advantage moving towards the ICB.
86. RBA advised the paper was very helpful commenting that the CCG was being realistic in its aims in terms of inequality whilst trying to ensure there was appropriate support for practices regarding long-term conditions.
87. CMO advised that it was imperative to build on both points. Including one local strategy and the population segments in their long-term conditions being imperative i.e., dementia and complex lives. However, emphasis needed to be on neighborhoods and networks, with focus on long-term condition uptake rates.
88. PFI agreed that this was sensible and pragmatic. Focusing on practices that did not normally engage and incentivise hard to reach patients was absolutely the way forward.
89. DOH advised that the GP Specification did what was intended, which was to encourage people to work in primary care particularly in areas of high deprivation noting that most of Liverpool was in the lowest 20%.
90. SGA asked how much capacity the secondary care teams had at that point.
91. PGU advised that the secondary care teams would be those working in the community with GPs not taken from trusts. It may be that the secondary teams need support to bolster them. If this approach aided primary care then it would be explored. As yet the ideas had not been explored in detail, they would need to be tested to see how realistic they were.

Action	Lead	Timescale	Status
Recommendations approved by the committee, namely: The Committee is asked to: • CCG officers to review the schemes developed by the task and finish group, with a remit to identify those unlikely to have a significant impact in delivery of the aims for primary care stated in the planning guidance and the long-term conditions recovery plan.			

• CCG officers to propose alternative schemes which support the long-term conditions recovery plan/addressing health inequalities; and delivery of the other aims for primary care stated within the planning guidance, including supporting the development of PCNs and the integration with community services. • CCG officers to propose a trajectory of targets over the two-year period of the contract. • Outcome of the officers' recommendations to be presented to the task and finish group which did the earlier work, the Senior Leadership Team and the Primary Care Commissioning Committee (or its successor); for comment and agreement prior to the start of contract negotiations. • It is unlikely that this work can be completed in time for issuing of contracts at Q1 and it is proposed that the current alignment with national priorities should remain for Q1, with protected income for practices for that period. This will support a period of workforce recovery within primary care (assuming no further surges of the pandemic). •			
Further actions required: • None identified.			

E2 ARRS REPORT

92. DHO delivered the ARRS report noting that the guidance stipulated that organisations were to spend as much of the allocated amount as possible.
93. DHO confirmed that discussion had taken place with PCNs confirming their positions regarding anticipated spend with the understanding that there would be a significant underspend in excess of £1,000,000 on the overall budget. PCNs were then invited to bid for the underspend as this complied with the guidance. The expenditure was valid and underway.
94. DHO asked the committee to approve the bid from the central PCN for the underspent funding, and the proposals listed in the supporting document.
95. The committee agreed the proposal.

Action	Lead	Timescale	Status
Recommendations approved by the committee, namely: The Committee is asked to: • Support the bid from Central PCN for an allocation of £531,982 from the underspent funding • Support in principle the bid from iGPC PCN for an allocation from the underspent funding, subject to evidence from the PCN that: **a)** it will spend all its current allocation before the end of March 2022 and			

b) additional monies which may be allocated will be limited to the amount the PCN will spend by March 2022. • Support a review of the process for redistribution of underspent ARRS expenditure with PCNs and the LMC, in line with the new requirement within the DES. • The review should also consider how PCNs can be supported to spend more of the ARRS allocation in future years; and how the CCG can be assured that this is being progressed.			
Further actions required: • None identified.			

F FOR NOTING

F1 QUALITY REPORT FOR 2021

96. LHU presented the quality report for 2021 in JLU's absence.
97. CMA referred to the incidence of MRSA mentioned in the report which stated that five people had been infected. CMA asked was this the case and if so, had there been an investigation into this.
98. LHU stated there had been a typo in the report and it was not MRSA, LHU advised she would come back with more feedback on what the infection was, but that it was possibly a C. diff outbreak.
99. RBA noted that eating disorder, ADHD and autism spectrum disorder services were totally inadequate and in a worse state than they were when the CCG came into being which was a shame.
100. STH advised that Healthwatch do hear from people with similar concerns about the condition with the service. STH noted the Bousefield CQC report was available regarding Dr Jude's practices and there were some points of concern within it, and she would welcome a conversation regarding this with colleagues outside of the meeting.

Action	Lead	Timescale	Status
Recommendations approved by the committee, namely: The Committee is asked to: • Note the quality risks and the associated levels of assurance • Note the work in train to support quality improvement and increase assurance • Determine if any further intervention or escalation is required			
Further actions required: • Discuss CQC report outside meeting	J Lunt	ASAP	On April 22 PCCC agenda.

G ANY OTHER BUSINESS

G1 SUMMARY OF BUSINESS/RISK REVIEW

101. GGR summarized the business of the committee. There were no items for escalation.

G2 ITEMS SHARED ACROSS COMMITTEES FOR NOTING

102. No items.

G3 ITEMS TO ESCALATE (GB AND/OR NHSE/I)

103. No items.

G4 ANY OTHER BUSINESS

104. No other items of business were discussed. The meeting closed.
105. The next meeting will be held on Tuesday 19th April at 10.00am. Papers due by 8th April 2022.