Hampshire, Southampton and Isle of Wight
Clinical Commissioning Group

PCCC/028

PRIMARY CARE COMMISSIONING COMMITTEE

Title of paper	**Minutes of last Primary Care Commissioning Committee meeting**		
Agenda item	3	**Date of meeting**	22 September 2021
Director lead	Matt Stevens, Chair		
Clinical lead (if applicable)	Dr Nicola Decker, CCG Clinical Leader		
Author	Terry Renshaw, Governance Manager		

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

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

Executive Summary
This paper sets out the minutes from the last meeting of the Primary Care Commissioning Committee of NHS Hampshire, Southampton and Isle of Wight CCG held on 21 July 2021. **Chair's Action : Special Allocation Scheme** – Following the decision taken at the 21 July 2021 confidential meeting of the Primary Care Commissioning Committee to delegate the final decision with regards to the recommendation for the approval of the Special Allocation Scheme service to the chair under the delegated decision making process. It has been confirmed that the further actions requested around additional negotiations on the costing of the model and the decision taken by the South West area to join in the Partnering Health Ltd contract chair's action has been taken to proceed with the award to Partnering Health Ltd of a twelve month pilot contract, plus a twelve month extension, at a cost of £248,896 for the entire area.

Recommendations	**The Primary Care Commissioning Committee is asked to:** • **Consider whether the minutes of the meeting reflect an accurate record and, if so, to approve them, noting any updates.** • **To note the chair's action taken regarding the Special Allocation Service contract award to Partnering Health Ltd**
Publication	**Include on public website** ✓

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

Primary Care Commissioning Committee (DRAFT)

Minutes of the Primary Care Commissioning Committee Held at 10.00am on Wednesday 21 July 2021 via Microsoft Teams

Present

Matt Stevens	Non-Executive Director (Primary Care Commissioning) **(CHAIR)**
David Bailey	Deputy Managing Director and Deputy Director of Finance South East Hampshire
Inger Bird	Non Executive Adviser – South East Hampshire
Elaine Budd	Non Executive Adviser – South West Hampshire
Julie Dawes	Chief Nursing Officer
Dr Nicola Decker	Clinical Leader
Judy Gillow	Non-Executive Director (Patient and Public Involvement)
Dr Karl Graham	Clinical Director - South West Hampshire
Tessa Harvey	Executive Director of Performance (Deputising for Maggie MacIsaac)
Dr Zaid Hirmiz	Clinical Director - South East Hampshire
Dr Charlotte Hutchings	Clinical Director - North and mid Hampshire
Kirsten Lawrence	Associate Director
Dr Michelle Legg	Clinical Director - Isle of Wight
Roshan Patel	Chief Finance Officer
Barbara Rushton	Primary Care COVID-19 Lead
Sara Tiller	Managing Director - South East Hampshire
Judith Venables	Non Executive Adviser - North and Mid Hampshire
Dr Sarah Young	Clinical Director - Southampton

In attendance

Paul Aubrey-Harris	Associate Director Southampton
Ian Corless	Board Secretary/Head of Business Services
Laura Edwards	Medical Director Wessex LMC
Keeley Ellis	Primary Care Lead South East Hampshire
Simon Garlick	Non Executive Director (Lay Member Governance)
Neil Hardy	Associate Director Medicines Optimisation (item 6)
Tracy Savage	Locality Director, Primary and Community Care and Medicines Optimisation
Matthew Richardson	Deputy Director of Quality Southampton
Martyn Rogers	Head of Primary Care South West
Derek Sandeman	Chief Medical Officer
Daniel Williams	Assistant Director of Finance, Financial Planning and Reporting
Terry Renshaw (Minutes)	Governance Manager

Apologies

Julia Booth	Head of Primary Care NHSE/I
Simon Bryant	Director of Public Health Hampshire County Council and Isle of Wight Council

Debbie Chase	Director of Public Health Southampton City Council
Carol Giles	Primary Care Senior Commissioning Manager NHSE/I
Lisa Harding	Director of Primary Care Wessex LMC
Alma Kilgarriff	Deputy Director of Primary Care Transformation and Medicines Management
Michelle Lombardi	Director of Primary Care Wessex LMC
Michael Ridgwell	Director of Delivery
Maggie MacIsaac	Chief Executive
Dr Andy Purbrick	Medical Director Wessex LMC
Suki Sitaram	Non Executive Adviser Southampton

1.	**Welcome and Introductions**
1.1	The Chair welcomed everyone present to the second meeting of the Hampshire, Southampton and Isle of Wight CCG Primary Care Commissioning Committee. The Chair explained that the meeting was to be streamed/broadcasted live in the absence of face to face meetings and to assist with the smooth running of the meeting highlighted the following: • We will confirm when the meeting goes live • The meeting will be recorded and will be accessible from our website or the CCG's YouTube channel • Committee members should have their cameras on for the duration of the meeting. • All other attendees should by default keep their cameras and microphones off • Only have your camera or speaker on if you are talking. • To ask a question use the "raise hand**"** function– the governance team will support the Chair in managing queries. • Do not use the chat function – If there is a question that needs to be referenced in the minutes then this needs to be verbalised in the meeting. At this point it was confirmed that the live stream had commenced.
1.2	The Chair invited the members of the Committee to introduce themselves and their role. The following introductions were made: • Matt Stevens – Non Executive Director, Chair Primary Care Commissioning Committee • Nicola Decker – CCG Clinical Leader • Julie Dawes – Chief Nursing Officer • Judy Gillow – Non Executive Director, Lay Member, Patient and Public Involvement, Deputy Chair Primary Care Commissioning Committee • Roshan Patel, Chief Finance Officer • Tessa Harvey, Director of Performance and executive lead for this meeting. Deputising for Maggie MacIsaac.
1.3	It was confirmed that the meeting was quorate.
2.	**Declarations of Interest (Paper PCCC21/014)**
2.1	The Register of Committee Members Interests was received. This paper sets out the relevant and material interests of the members of the Primary Care Commissioning Committee of the Hampshire, Southampton and Isle of Wight CCG.

2.2	No interests were declared where there may be a potential or perceived conflict of interest in relation to any of the business items on the agenda.
3.	**Minutes Of The Previous Meeting – 19 May 2021 (Paper PCCC21/015)**
3.1	The Primary Care Commissioning Committee received the draft minutes of the meeting held on the 19 May 2021.
3.2	**Matters Arising** – There were no matters arising.
3.3	**AGREED:** • **The Primary Care Commissioning Committee approved the minutes of the meeting held on 19 May 2021.**
	PRIMARY CARE PROGRAMME
4.	**HIOW Primary Care Work Programme 2021-22 Update (Paper PCCC21/016)**
4.1	Kirsten Lawrence explained that the purpose of the paper is to brief the Committee on actions that have been taken on the work programme. The Committee will remember that the ICS level work programme was presented at the last meeting. Attention was drawn to the following three priority areas for delivery in line with the HIOW Primary Care Strategy: 1. Expand Primary Care Capacity to improve access and strengthen resilience. 2. Partnership working to reduce inequalities and deliver improved outcomes. 3. Delivering integrated health and care. These areas fit with the national and regional priorities and this is currently work in progress. There are a number of interdependencies for example Primary Care Digital Roadmap, Primary Care Workforce Strategy and the Primary Care Estates Strategy and the aim is to bring this all under one work programme.
4.2	Particular attention was drawn to: • Primary care resilience is a key priority for the CCG and to strengthen that foundation a GP Resilience workshop took place on 9 June 2021 with representation across Clinical Leaders, Primary Care Leads and Non-executive Advisers. This provided the opportunity to explore general practice resilience, the early warning signs/triggers for general practice resilience issues, the role of the CCG in enabling practices to adapt and the solutions to enable general practice to adapt. Also looked at who do we actively need to involve in this work programme. • Hampshire Southampton and Isle of Wight Governing Body discussed primary care resilience on the 7th July. The Governing Body supported the intention to develop a general practice circle/package of support, for which a strongly managed programme is needed given that primary care resilience is one of the CCG's top priorities. • The General Practice Patient Survey has been published, in July 2021, from data collected between January 2021 and March 2021. This is the first time this has been published for Hampshire Southampton and Isle of Wight. A more detailed analysis will be undertaken and a summary will be brought back to a future meeting of this Committee. • In line with the NHS Long Term Plan the Community Pharmacy Consultation Service aims to relieve pressure on the wider NHS by connecting patients with community pharmacy, which should be their first port of call and can deliver a swift, convenient and effective service to meet their needs. We are already

	seeing referrals being made into this service.
4.3	As a result of discussion it was: • Reflected that the Hampshire, Southampton and Isle of Wight CCG has only been established since April and as a Primary Care Commissioning Committee we are in our infancy. There is a clear sense that the plan is work in progress and more input and creation will be required as we go ahead. It is an important plan and is to be developed with a strong sense of engagement with all our clinical colleagues. The foundations are in the plan and we need to bring the work streams together and define them more strongly. • Said that it is good to hear that primary care resilience is so important both for practices and patients. We will touch later on the agenda the restoration of services but patients are struggling with access, due to the demand going up. Primary care is working extremely hard and is over performing. There has been a 25% increase in the number of appointments given in the last eight week period. From the data we have it shows that primary care is really open for business. The points raised around primary care being open throughout the pandemic and the current pressures faced was endorsed. • Commented that once the analysis of the Patient Survey is available it needs to come back to us so that we can have a more focused discussion around access and to look at what actions need to be put in place. To help us in this work it was suggested that it would be helpful to link with some of the Practices Patient Participation Groups to learn what local issues are being encountered in terms of problems in obtaining an appointment/missing appointment slots in order to obtain real stories. • Recognised that we need to work closely with local communities. • Said that the comments raised are supported and the word that springs to mind in the shoes of the user/provider is to be human. In the context of the pandemic and the need to adapt the faster we peddle to try to adapt it does not feel as though it is good enough. From a patient perspective we do all the right things but there is still disconnect and we have to stop this. We need to work together to get a joint outcome and to talk about having an adaptive service that we will deliver together. However, the mechanism to do so is awesome. • Reflected that at the recent meeting of the Urgent Care Board there was a refreshing conversation recognising the pressures across the pathway and the fact that for some parts of the pathway it is difficult to get data. It is important that we get this information in order to understand what is going on so that we can then interface with general practice and the Trusts. We need to organise that meeting of minds across HIOW to feed back into the delivery system. Recognising the workforce constraints that we are also facing. • Reported that the ED department IPSOS Mori poll is to be repeated again this year and it is to be extended further to include where people are accessing other services. This will be a complimentary piece of work. • Said in the context of access we need to look at the figures and compare with the 2019 figures as due to the pandemic there has been a change in culture and the way we do things. This feeds through to the management of patient expectation and we need clear communications with patients as to how they can access services. • Suggested that in view of the pressures on primary care should the Committee consider having a patient story slot at the start of our agenda where a patient comes to the meeting, public or private session, and tells us about their experience so that we can hear first-hand the client view. The Chair said that this is an interesting idea. • Highlighted that a lot of work has been done around demand, capacity and access to primary care, it is not so much restoration as reset. As a result of the

	pandemic we have got lots of new assets which are different and flexible. We have also not yet mentioned Primary Care Networks which has given us a greater range of clinical expertise in terms of how people can be seen by the right professional person. Total triage will allow health professionals to: a) See patients and deal with problems quickly b) Determine who is the most appropriate person to see them from the range of people available c) Arrange for any tests needed prior to the consultation to be undertaken. There is a need to celebrate where we are moving to and to recognise that primary care has also been embroiled in the Covid vaccination programme. It was added that the word adaption is more fitting when going forward and what is missing here is bringing the patients along with us. Primary Care is changing and feedback from Patient Participation Groups tells us that some patients really value access to digital services/telephone access as this has benefits in terms of not having to take time off work/taking children out of school. Some patients on the other hand are not so digitally enabled. We therefore need to be honest as people know that we do not have enough GPs, there is also confusion around how and who to access and there needs to be information available on who is available within the system and what you need to do to be to be able to see them. On concluding the discussion it was reflected that this had been a helpful conversation and the key points for example around communications to patients about how to use the pathway need to feed back into the work programme as we develop it further. The Primary Care Work Programme will feature as a regular agenda item going forward.
4.4	**AGREED:** • **The Primary Care Commissioning Committee noted the Primary Care Work Programme Update.**
5.	**COVID-19 Vaccination Programme (Presentation)**
5.1	Kirsten Lawrence introduced this item and explained that the purpose is to update the Committee on where we have got to. Members will be aware that this is a highly successful programme across HIOW and the presentation highlights where we have got to so far and the next steps.

5.2	Dr Barbara Rushton undertook a presentation that covered:
	• Overview/summary of actions taken and issues.
	• Update on Phase 1 and 2 vaccine cohorts:
	  • The most vulnerable groups, Cohorts 1-9 have had excellent uptake.
	  • Phase 1 was about saving lives. Cohorts 1-4 focused on care homes, health and social care workers, people aged 70+ and the extremely clinically vulnerable. 92% of people immunised with first dose and 89% with the second dose. This is important as we reach Phase 3 of Covid across the South East.
	  • Phase 2 is around reducing the risk of transmission and focuses on people aged 18 to 49. This group have a reduced risk of serious disease, hospitalisation and death but have risk of transmission and long Covid. We need to encourage this group to come forward and receive the vaccination.
	• Targeted activities to address inequalities, multi-agency work to support take up of vaccines – Targeted activities taking place include pop-up clinics and outreach work for those with SMI and support to people with learning disability.
	• Communications activity planned/in place – Various activities in place including

	daily communications in conjunction with local authorities, hyper localised communications, conversations and engagement in local communities.
	• Update on the autumn booster Phase 3:
	  • Focus in the autumn is around boosting immunity and will focus on the 50+ age group and the most clinically vulnerable. This will take place between 6 September 2021 and 31 January 2022.
	  • It is known that this winter will see an increase in respiratory illnesses.
	  • Clinically extremely vulnerable children aged 12 to 16 will be offered vaccinations
	  • At this stage we do not know what vaccine will be given as a booster. There is local focus on the Cov-Boost study.
	  • Booster programme is to be delivered largely by general practice supported by community pharmacy and large vaccination centres.
	• Update Long Covid or post Covid syndrome:
	  • Symptoms of Covid last beyond 12 weeks from the start of infection.
	  • Recent study suggests affects about 15% of people who have confirmed Covid infections. Important as affects young people and can be very debilitating.
	  • Post Covid services are being put in place across Hampshire and Isle of Wight.

5.3	As a result of discussion it was: • Stated that 60% of vaccinations have taken place within Primary Care working together within primary care or in Primary Care Networks. We should be proud of our success. Story however is not uniform across our populations as some populations have not taken up the vaccine offer in equal measures. Targeted work has therefore been undertaken to reach those communities for example the homeless and our learning disability population. This work has been undertaken in collaboration with Local Councils and pop up clinics have been put in place within places of worship. This has been supported by a strong media campaign. • Reflected that the effort and energy across health, social care and public health has been immense in terms of galvanising effort and impact in order to get to the high risk groups. There is learning to be taken from this. The task is becoming harder as there are now a very bespoke number of people who need specific interventions and engagement conversations. We need to look at what we need to do as not one model fits all and we need to get vaccinations up to where we want to be. • Stressed that we need to celebrate ‘grab a jab’ and all the good work that has been done in the cities reaching the young. Recognising that university populations have gone home and are off campus and may need to access second dose from somewhere near to home. Attention was drawn to the ‘grab a jab’ session held at Southampton Guildhall last week that demonstrated how important it is to open this up to all. • Questioned in terms of Long Covid what action is the service taking. It was explained that the pathway is accepted nationally. A lot of support will be provided via digital web based apps, MSK support in terms of exercise and mental health in terms of anxiety management, this will be run via different therapists and involves consultant experts where necessary. • Stressed that it is important to note the fantastic work that primary care have done on the vaccination immunisation programme, especially in light of the immense pressures primary care are under. A big thank you was extended to Dr Barbara Rushton and the primary care teams as we are lucky to have the service we have. The Chair added that we need to remember that Primary

	Care Networks are very much in their infancy and across the patch they have stepped up to the mark to provide that service and a virtual huge 'slap on the back' to all involved was extended. Dr Barbra Rushton reflected how encouraging/well received these messages will be by primary care staff and public health colleagues. There is great learning evolving from the experience of the last sixteen months upon which we can build. On concluding the discussion the Chair stressed the need to preserve these new ways of working and the enthusiasm to deliver as we go forward in terms of primary care delivery.
5.4	**AGREED:** • **The Primary Care Commissioning Committee noted the update on the Covid-19 vaccination programme.**
	PRIMARY CARE ASSURANCE
6.	**Primary Care Prescribing Report (Paper PCCC21/017)**
6.1	Neil Hardy introduced paper PCCC21/017 that summarises the work of the medicines optimisation teams within the CCG, including their response to the COVID-19 pandemic. The report also highlights the key medicines optimisation priorities and actions being taken to address these. Prescribing data from the NHS Business Services Authority (BSA) are available to April 2021. This paper covers: • Financial performance including cost-orientated interventions and prescribing rebates • Medicines optimisation response to COVID-19 • Antimicrobial stewardship • Medicines quality, safety and controlled drugs stewardship • Digital initiatives in medicines optimisation • The proposal to create a Hampshire and Isle of Wight (HIOW) Prescribing Committee and align existing medicines formularies • The development of an Integrated Care System (ICS) integrated pharmacy and medicines optimisation plan (IPMO). Medicines remain the most frequent therapeutic intervention in the NHS. In primary care in Hampshire, Southampton and Isle of Wight there were 28 million prescription items dispensed in 2020/21 at a cost of £264 million. Medicines are crucial in preventing ill health and in improving the treatment and care of patients. Reducing medicines-related harm, ensuring antimicrobial stewardship and improving the efficiency and value of medicines use are high priorities.
6.2	Particular attention was drawn to: • Data for May has now been received. • The NHS BSA epact2 prescribing database has been reconfigured to reflect the changes to CCGs and allows analysis at individual prescriber, practice, PCN and CCG level. Local analyses are being updated to reflect the new CCG structures, including places. • The CCG finance team has created a process whereby the monthly spend is attributed to individual 'places' within the CCG and a forecasting model is under development. • During Covid-19 the medicines optimisation team focused on primary care

	prescribing support work including facilitating the timely availability of medicines used in palliative care, dealing with medicines shortages, supporting the greater use of the Electronic Prescription Service / Electronic Repeat Dispensing (EPS/eRD). Supporting patients to switch from warfarin to a directly acting oral anticoagulant (DOAC), that do not need regular INR blood tests, and promulgating guidance via the HIOW wide bulletin. There was an HMRA alert last week around mechanical valves and a rapid piece of work is now being undertaken. • Antimicrobial stewardship and the lack of an increase in prescribing over the last winter is particularly noteworthy. This is not surprising as people and children were not meeting, so there was no winter peak. However, we are aware of a current increase in Respiratory Syncytial Virus in children and we are expecting to see this also in adults as we move into winter. • Dr Keith Ridge (Chief Pharmacist Department of Health and Social Care and NHS England/Improvement) issued a paper 'Leading integrated pharmacy and medicines optimisation – guidance for ICSs and STPs' in September 2020. The pharmacy leaders within HIOW have used this document as a way of further developing our local plans and priorities against the national priorities for medicines optimisation. A draft plan has been submitted to the Regional Pharmacist and was discussed at the HIOW Primary Care Programme Board in June 2021. Individual project plans are now in development for each work stream and cardio-vascular will be a big area for focus over the next year.
6.3	As a result of discussion it was: • Questioned if the epact2 prescribing data base is a measure or a tracker. It was explained that it gives access to prescription data for both prescribed and dispensed items. • Questioned in terms of antibiotic prescribing last year which was low is there any concern currently around a risk to supply this winter. It was responded that there are supply issues regarding certain medicinal products due to a range of factors for example low generic pricing however this is on our radar and is to be raised at a regional level. • Reflected that it is encouraging to see within the graph on page 7 that anti-microbial prescribing has been kept low. However, nationally it is being reported that there is an increase in C-Difficile for reasons in broad spectrum and this is being monitored. It was responded that we are low prescribers in antibiotics in total but we do have hot spots on the broader spectrum and we will need to include all the hot work around C-Difficile. It is a national issue so could include information within the next report. • Said that there is an increase in infection levels expected as social distancing/wearing of masks disappear and it was questioned if we are prepared for this increase in infections. It was responded that a lot of these things were held dormant via social distancing and they can then mutate and spread more easily. • Highlighted that we have in place the Covid@Home virtual ward that is monitoring people at home to keep them safe. Inhaled steroids are being prescribed, Prodecimide, in early treatment of Covid. This has the agreement of NICE and will be helpful in terms of anti-microbial stewardship.
6.4	**AGREED:** • **The Primary Care Commissioning Committee noted the primary care prescribing report.**
7.	**Primary Care Finance Report (Paper PCCC21/018)**

7.1	David Bailey introduced paper PCCC21/018 and drew attention to the following key highlights:
	• A temporary financial regime was put in place by NHSE to cover the H1 period 1 April 2021 to 30 September 2021. As a result NHSE gave CCGs non-recurrent allocations for the first six months of the financial year to reflect expected monthly expenditure. A second allocation for H2 will be received. The reason for this is so that we can adapt to the needs of the financial situation due to the Covid pandemic. Therefore the numbers in the table are for H1 only reflecting a Circa £160m primary care budget and £140m for prescribing
	• The finance tables included within the report show the financial position and forecast as at month 3 for all the CCG Primary Care budgets in totality forecast that we are marginally over budget, but as we work through it is likely that a break even position will be reported. The first six month finances are under control. It was reported that
	  • Table 1 shows a high level total CCG summary of all the Primary Care budgets and prescribing.
	  • Table 2 shows a breakdown of the CCG Primary Care Delegated budget.
	• As at month 3 the CCG is not reporting any significant year to date or forecast variances, given that it is early in the financial year and at this stage everything in Primary Care is predominantly on plan.

7.2	As a result of discussion it was: • Questioned if there is any concern regarding future funding. It was responded that we have what we know to date and what our plans are in terms of what we need to do. We are confident regarding budgetary control for the first half of the year and the settlement for the second half is due soon. Our priority is to invest in community, primary care and mental health in order to keep our services resilient. • Observed that there are a number of premises costs in relation to estates projects. An estates workshop is to be held in September and in advance of this it would be helpful to hear in terms of primary care budgets if there is a risk of a first come/first served approach. It was responded that following the recent merger of six CCGs into one Hampshire, Southampton and Isle of Wight CCG it will lend itself to us managing and prioritising across the whole footprint to ensure a consistent approach to the assessment process and equity as we move forward. • Questioned in terms of benchmarking spend CCG versus other spend for example enhanced services, conscious that we need to invest well, do we benchmark satisfactorily in terms of our spending. It was responded that this information can be reflected within future reports.
7.3	**AGREED:** • **The Primary Care Commissioning Committee noted the Primary Care Finance Report and its contents.**
	DECISION MAKING
8.	**Clinical Waste Contract (Paper PCCC21/019)**
8.1	Kirsten Lawrence introduced paper PCCC21/019 and explained that this paper describes the background to the existing clinical waste collection in general practice which has been commissioned by legacy organisations for many years. This has led to a mixture of arrangements across England. Currently the contract for clinical waste

	collection for all general practices in Hampshire and Isle of Wight Integrated Care System is held by NHS England and the costs recharged to the statutory organisations. Across England, there is a programme of work to understand the issues, support and ensuring formalised arrangements for the provision of clinical waste collections are in place. The national programme includes community pharmacy though this paper relates only to general practice. This paper describes the options for the continuation of this service. The main risk is the likelihood of an increase in costs when the contracts are brought up to date. The finance team are aware of the risk and have stated support for the recommendation. It should be noted that Portsmouth CCG has already considered this and support Recommendation 2.

8.2	Particular attention was drawn to:
	• This is a national issue and we need to align to remedy the situation across the whole of England.
	• Costs incurred within our delegated budget for 2020/21 is £377k. The costs of this service over the last three years have been included within the paper and Portsmouth CCG costs are also included for information as they also would like to be aligned.
	• NHS England have two requests for the HIOW CCGs:
	  • To support a single tender action to direct award to all incumbent providers of this service. This will be a 12-month contract (with option to extend by 6 months) with improved performance measures and quality standards. This will include the extension of the existing contract held by Aneneta Limited.
	  • To support the redesign and re-procurement of primary care clinical waste services led by NHS England for Hampshire Southampton and Isle of Wight CCG.
	• NHSE/I have published a Prior Information Notice detailing the direct award and intention to re-procure after this time.
	• The NHSE direct award and the re-procurement will include the waste services for community pharmacy but the CCGs are only being asked to sign off for the clinical waste collection service to general practice.
	• The benefits and risks arising from the options appraisal as outlined in the Procurement position section of the paper.
	• The Primary Care Operational Groups are all sighted on this issue and the recommendation from each of the local areas is to proceed with Option 2 – Support the NHS England Single Tender Action for the current service provider for 12 months and the national procurement process.
	• The biggest risk is around the financial element as the historical arrangement has not been reviewed for some time for example Covid vaccination waste has seen costs increasing. We will not know the actual costs unless we go through the process. The financial team are aware and have built into planning for the future so it is not an unmitigated cost.

8.3	As a result of discussion it was: • Questioned if there are any quality issues with the current service. It was responded that following the introduction of a managing agent which is seen as a key component to improve the performance of the service, reduce burden for commissioners and has demonstrated value for money where it has been introduced a lot of the issues have been resolved. However, it is not trouble free and there are still challenges but there are no concerns flagged with the existing provider. • Reflected that it is sensible to support the recommendation from a resource utilisation perspective but there are primary care budget risks and we need a conversation to plan for this collectively with NHS England. It was responded

	that it is quite hard to unpick the funding as there are a variety of contracts across the NHS. NHS England's intention is to get the best value for money that we can but we need to be aware of potential financial risk. This will be helped by keeping the managing agent in place.
8.4	**AGREED:** • **The Primary Care Commissioning Committee supported Recommendation 2 – formalise existing contracts for 12 months and for Hampshire Southampton and Isle of Wight CCG to be part of the national procurement. Noting that the Local Primary Care Operational Groups have all supported this recommendation.**
9.	**Any Other Business** – There were no items identified.
10.	**Key actions arising from discussion of agenda items to be included on the Primary Care Risk Register** – There were no items identified.
11.	**Date of next meeting –** The Committee will meet next on Wednesday 22 September 2021 at 10.00am.

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

Signed by

Chair: …… **Date: ……**