NHS
Lancashire and South Cumbria
Integrated Care Board

Subject to Ratification at the Next Meeting

Minutes of the Extraordinary Primary Care Commissioning Committee Held in Public on 16 January 2025 at 10.00am in the Lune Meeting Room, ICB Offices, County Hall, Preston

Name	Job Title	Organisation
Members		
Debbie Corcoran	Chair/Non-Executive Member	L&SC ICB
Dr David Levy	Medical Director	L&SC ICB
Peter Tinson	Director of Primary & Community Commissioning	L&SC ICB
Corrie Llewellyn	Primary Care Nurse	L&SC ICB
John Gaskins	Associate Director of Finance	L&SC ICB
Craig Harris	Chief Operating Officer & Chief Commissioner	L&SC ICB
Claire Lewis (deputising for Kathryn Lord)	Associate Director – Quality Assurance	L&SC ICB
Neil Greaves	Director of Communications and Engagement	L&SC ICB
Dr Julie Colclough	Partner Member for Primary Medical Service	L&SC ICB
Clare Moss (deputising for Andrew White)	Head of Medicines Optimisation for the Central Lancs MO Team	L&SC ICB
Sarah Danson (deputising for Paul Juson)	Senior Delivery Assurance Manager (Pharmacy Medical & Optometry)	L&SC ICB
Participants		
Donna Roberts	Associate Director Primary Care, Lancashire (Central)	L&SC ICB
In Attendance		
Jo Leeming	Committee and Governance Officer	L&SC ICB
Sarah Mattocks (deputising for Debra Atkinson)	Head of Governance	L&SC ICB

No	Item	Action
Standing Items		
PCCC/ 01/25	**Welcome, Introductions and Chair's Remarks** The Chair welcomed the committee and advised that one member of the public had registered to attend but was not present. Two questions had been submitted to the Board since the committee last met pertaining to the committee's oversight of dental services. These would be responded to by the Patient Experience Team and had also been shared with the ICB Chair ahead of the Board meeting on 15 January. One question had been submitted to the Board since the committee last met regarding access to non-MRNa covid vaccines which would be responded to through the vaccination team and had also been	

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	shared with the ICB Chair ahead of the Board meeting. There were no questions directed to the committee since it last met which pertained to today's agenda.	
PCCC/ 02/25	**Apologies for Absence / Quoracy of Meeting** Apologies for absence had been received from Kathryn Lord (Claire Lewis deputising), Andrew White (Clare Moss deputising), Paul Juson (Sarah Danson deputising), Debra Atkinson (Sarah Mattocks deputising), Amy Lepiorz, David Blacklock, David Bradley, Collette Walsh and Lindsey Dickinson. The meeting was declared quorate.	
PCCC/ 03/25	**Declarations of Interest** **(a) Primary Care Commissioning Committee Register of Interests** Noted. The Chair advised she had recently submitted a reduced entry for the register, but this had not yet been reflected. **RESOLVED: That there were no declarations made relating to the items on the agenda. The Chair asked that she be made aware of any declarations that may arise during the meeting.**	
PCCC/ 04/25	**(a) Minutes of Meetings held on 20 December 2024 and Matters Arising:** **RESOLVED: That subject to the above amendments, the committee approved the minutes of the meeting held on 20 December 2024.** **(b) Action Log** The log was updated accordingly.	
Commissioning Decisions		
PCCC/ 06/25	**General Practice Quality Contract (GPQC) 2024/25 update** The GPQC proposal for 2024/25 was presented to committee in March 2024 and included an outline of the three service areas, the associated financial payments and payment methodology. Funding for practices had been made through 12 equal payments of 80% of their contract value with the remaining 20% to be paid following an annual reconciliation undertaken in April/May 2025. Practices were now in month 9 of this year's GPQC. The enclosed analysis provided an overview of the current delivery across each ICB place between April and November 2024. Delivery across Lancashire and South Cumbria showed steady progress. It was anticipated that achievement would continue to increase up to the end of March 2025. Due to this being a new contract there was no historical data to enable a comparison of previous years achievement. Delivery dashboards had been shared with each primary care Place team to support a midpoint health check of practice delivery of their individual targets. Each practice had received an individualised letter with a tracker of their current delivery. Practices identified with low or high delivery had also been highlighted to Place teams, along with a support prompt to guide additional discussions. Additionally, the Local Medical Committee (LMC) had held place sessions to share good practice. The paper presented to committee in March 2024 also outlined that an assessment of achievement would be undertaken in January 2025 and any under delivery offered out to other practices. Members asked for assurance on how delivery will be maximised. P Tinson	

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	advised that the contract had been reframed in 2024/25 to focus on the three areas of frailty, respiratory and Structured Medication Reviews (SMR) with detailed requests setting out the requirements of each. Work had been undertaken with the LMC to support practices to make improvements and for them to share advice and tips to improve delivery. Typically, practices delivered these types of enhanced services in the latter two quarters of the financial year. A lot of learning had been gathered and reflected on in-year. Place teams had been working with practices and it was expected that performance would continue to improve over the coming months. It was explained that the figures in the tables were correct, but the narrative had incorrectly picked out some numbers and will be updated. Green indicated a large number, not that an area was rated as good. It was noted it would be good to make that connectivity in the end of year report considering frailty and respiratory. P Tinson confirmed this activity was being monitored but other metrics had been considered as part of the original proposal. The outcome and delivery metrics plus the learning would be considered as a final year-end report and review to be received by the committee. It was noted that one of the most challenging aspects was regarding Multi-disciplinary Teams (MDTs) due to the need for wrap around care and the variance in maturity of teams. However, significant learning had been taken from this, which would influence implementation. It was queried why the delivery profile was back ended and if this increased risk of under-delivery, and it was explained that this approach was unique to this year to enable practices to have a planning period in the first quarter of the year. As there were nuances across the patch it meant that it was a new way of working for some, and therefore there were differences in terms of lead in times across the region. It was noted that March 2024 was referenced in the paper, which should be 2025, and will be updated. Members asked for RAG ratings to be defined and applied consistently. It was explained that the RAG ratings were presented in this way as they are enabling local teams to track areas of concern month on month. It was agreed that it would be helpful to see a specified and expected profile for performance and spend at this time of year depending on the maturity of the partnership and where they are now as this would provide a view as to where they are expected to be as a whole. It was confirmed that in 2025/26 there will be clearer delivery plans around what practices can provide and when, and changes around the lead in times. It was noted that co-ordination and bringing in external partners was crucial as all elements needed to be mobilised effectively to ensure the MDT was valuable to a patient. The quality indicators were available for prescribing data and an audit in practice would be good to determine the impact and for the learning to be taken forward to ensure interventions were undertaken well. It was agreed there was a need for a clear methodology for redistribution on any under-delivery which considered commissioning and strategic priorities such as addressing health inequalities and considering needs. The prioritisation framework should provide a practice-by-practice focus, and it would be good to	

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	review the current variation in investment as some practices with less funding have had lower delivery targets, but patient need may actually be greater. This will be considered from next year to inform future approach. It was noted that many of the other targets were based on Primary Care Networks (PCNs) footprint, which was more of a challenge and increased pressure on partners if then operating back on practice model targets. It was questioned how these challenges could be mitigated when it was a practice-based target. It was advised that the question around barriers to implementation was part of the evaluation at year end and how that could inform learning. Monitoring and delivery could be at practice or PCN level. It was advised that there would be a practice-by-practice focus by the end of the month, which would provide an understanding on the forecast outturn position. It was agreed that the report would be amended to ensure the points of accuracy were clarified and a key added for the data in the tables. This version would replace the current version on the website. The presentation of information in future reports will be improved and updated to ensure clear profiling and give clarity onbarriers and any learning that would inform next year's approach. The sequence and timing of mid and end year reports was considered, and it was agreed that the next report would consider the points raised above and would be brought to the committee meeting in February. **RESOLVED: the committee noted the update on delivery of the 2024/25 GPQC, and approach to maximise delivery and impact. Future reporting will be refined to strengthen assurance on the impact and difference made through spend, and outcomes achieved.**	**DR**
Governance and Operating Framework		
PCCC/ 07/25	**PC Integrated Performance Report (performance as at December 2024)** This report contained the latest performance metric data available at December 2024. The report consisted of a summary and benchmarking table, that provided a 'snapshot' overview of the ICB's performance for the metrics, followed by a more detailed overview of each metric displayed on separate pages. Key points of note were: • After two months of being below planned levels the number of GP appointments in L&SC carried out in September 2024 was back on track with the ICB's trajectory, despite a slightly later than normal flu vaccination programme start date of 1 October 2024 (slide 4). • The commencement of the Acute Respiratory Hubs in September had created more than 10,082 appointments over their first two months (slide 5). • In September 2024 27.6% of patients aged over 14 on the learning disability register had received an annual health check, this exceeded the 25% Q2 milestone for the metric. • In August 2024, 59.5% of children had seen an NHS dentist within the past 12 months and performance against this metric continues to demonstrate sustained improvement. Extrapolating the current trajectory forward would suggest that we are on track to deliver the 60% target by March 2025. To support the ongoing development of this report a workshop session was	

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	taking place with the metric Senior Responsible Officers (SROs) to ensure the quality and consistency of the narratives provided; especially regarding details of actions and intended impacts. P Tinson advised that the report continued to be developed. Several changes had been made based on previous feedback including ensuring the executive summary made it clear who had responsibility for which metrics. Data for the acute respiratory hub activity had also now been included. It was noted that, in response to some pressures, there had been reprofiling of the activity which was a flexibility that had been built into the report. It was explained there was a lag in the reporting period and the team accepted that there is a requirement to get tighter in terms of the relationship between actions and the impact on delivery. The section on high dose opioids was queried as there appeared to be a data error in the table, which needed to be amended. The Chair asked for the governance team to review and update the summary schematic showing which Committees have an interest/assurance role on which indicators in the dashboard as there were inaccuracies. This would need to be reviewed again given there would be a review of governance and committees underway across the ICB. RAG ratings needed to be defined and consistently applied, and a key included. The 'plan' column needed to be developed to clarify if this is a target or benchmark position. It was clarified that where there was a plan this was a national target from NHSE, and where there was no plan there was local historical performance data or a target. Reference was made to target 2, the percentage of appointments within 2 weeks of booking, which set out the ICB target to increase this but that the ICB was cautious due to increases in the direct care workforces, which sees a lower proportion of patients within these timescales. It was advised that the GP General Practice workforce was a 50/50 split between GPs and other clinicians. Proportionally, there were fewer GPs per patient in LSC, but more other General Practice clinical and care professional have more employed in other roles so more patients were being seen appropriately by other clinicians within the PC team. It was explained that this model was so different as a patient could be triaged by the GP but then, for example, be seen by a physiotherapist or it could be a medication review with a pharmacist. It was possible to split this out, but currently the data was presenting everything. It was noted that Blackburn with Darwen would regard themselves as not having enough GPs compared to LSC and the hospitals reported they had more patients as they claimed they were unable to get GP appointments. The Committee asked that a consistent approach be adopted to that introduced in Quality Committee, so that a cover report in a triple A format be offered to accompany the report and quickly draw out areas of alert/advice/assurance for committee attention and review against their responsibilities. The committee acknowledged the work of the team, and the progress made to date. **RESOLVED: the committee received the Primary Care performance report and:** - **noted achievement against the key performance indicators in its remit** - **agreed actions to improve reporting and presentation of information**	**SM/PT**

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	- **supported the actions being undertaken to improve performance against metrics in this report.**	
Group Reporting		
PCCC/ 08/25	**Group Escalation & Assurance Report** The report highlighted key matters, issues, and risks discussed at the below group meetings since the last report to the Committee on 20 December 2024 to advise, assure and alert. • Primary Medical Services Group: Peter Tinson (Director of Primary and Community Care) • Primary Dental Services Group: Amy Lepiorz (Associate Director Primary Care) • Pharmaceutical Services Group: Amy Lepiorz (Associate Director Primary Care) • Primary Optometric Services Group: Dawn Haworth (Head of Delivery) • Primary Care Capital Group: Donna Roberts (Associate Director of Primary Care) Each summary report also highlighted any issues or items referred or escalated to other committees or the Board. The risks currently being managed by the respective groups had been appended to the report. Reports approved by each Group Chair were presented to committee to provide assurance that the groups had met in accordance with their terms of reference and to advise the committee of business transacted at their meeting. It was noted there were several items for future committee consideration and a number of operational issues around historic funding requests shared by the Primary Medical Services Group. Committee members asked to understand why the Group's risk rating against their relevant section in the Delegation Agreement for quarter 3 had moved from green to amber, and for detail and assurance on the related risks. It was confirmed that this is because not all contract management risk had been fully mitigated at this point, but actions are in place to address this. This is reflected in the Board Assurance Framework (BAF). The committee raised no concerns for Primary Dental Services Group, Pharmaceutical Services Group, Primary Optometric Services Group and Primary Care Capital Group. Members discussed that a review against the delegations from the Committee to the sub-groups had been completed recently and asked for it to be repeated and recommendations come to the next meeting, to support efficiency and reflect the changing context of the ICB and increased maturity of the sub-groups. Membership of sub-groups may need to be considered. **RESOLVED: The committee received and noted the Alert, Assure, Advise (AAA) reports from the five delegated primary care groups and risk registers from each group.**	**PT / SM**
Items to Receive and Note		
PCCC/ 09/25	**Primary Care Finance Report (Q2)** The paper provided the committee with the quarter 2 financial position for primary care budgets. J Gaskins advised that at the end of Q3, the QIPP remained on track and the	

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	forecast outturn remained in line with the budgets. It was acknowledged that the paper had been shared behind schedule due to the refocusing of the previous agendas on essential items requiring decisions, hence the position had moved on. It was requested that Finance Reports always include the latest month end position. **RESOLVED: The committee noted the financial position at the end of quarter 2 and the year-end forecast.**	
PCCC/ 10/25	**Capital Development Session Summary Report** The paper provided a summary of the Primary Care Commissioning Committee capital development session held on the 22 August 2024 and the next steps. P Tinson advised it had been a good session and was a key focus as the primary care estate was a big enabler in terms of the future of the ICB and what was outlined in the 10-year plan. The committee acknowledged increased demand for investment in the primary care estate across most LSC places and neighbourhoods both from capital and revenue perspectives. Demand will increase and one of the actions was to engage with PCNs and practices to review estates plans to support introduction of a prioritized pipeline for investment. It was noted that this should be included in the workplan for the committee from April 2025. **RESOLVED: The committee:** • **Noted the contents of the report.** ▪ **Agreed that it would receive a further report regarding the proposed prioritised pipeline at a future committee (likely quarter one 2025/26)** ▪ **Support the proposed next steps.**	
Standing Items		
PCCC/ 11/25	**Committee Escalation and Assurance Report to the Board** The Chair confirmed that this would be produced and submitted to Board.	
PCCC/ 12/25	**Items Referred to Other Committees** The issue around General Practitioner appointments per General Practitioner FTE to be picked up with People Committee.	
PCCC/ 13/25	**Any Other Business** None.	
PCCC / 14/25	**Items for the Risk Register** None.	
PCCC / 15/25	**Reflections from the Meeting** Reflecting earlier discussions on committee efficiency and focus, holding future meetings through teams rather than face to face would be considered. The Chair updated that the committee work planner was being reviewed, with business to be tightly focused on agreed dates and not through additional meetings.	
PCCC / 16/25	**Date, Time and Venue of Next Meeting: Thursday, 13 February 2025 10.00am in the Lune Meeting Room, ICB offices, County Hall, Preston**	