**WEST LEICESTERSHIRE CLINICAL COMMISSIONING GROUP**

**Minutes of the Primary Care Commissioning Committee (PCCC), held on Tuesday 18 September 2018 at 15.00pm in Boardroom 1, Woodgate, Loughborough**

**PRESENT:**

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| Ms Gillian Adams | Chair, Lay Member |
| Dr Nil Sanganee | Board GP |
| Dr Mike McHugh | Public Health Representative |
| Mr Ian Potter | Director of Primary Care |
| Mr Spencer Gay | Chief Financial Officer |
| Dr Sumit Virmani | LMC |

**IN ATTENDANCE:**

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| Ms Louise Guss | Interim Head of Corporate Governance |
| Ms Laura Norton | Head of General Practice Contracts & Quality |
| Ms June Telford | Interim Head of General Practice Contracts & Quality |
| Mr Andrew Roberts | Head of Management Accounts |
| Mrs Sonal Chudasama | Contract Support Manager |
| Ms Kay Bestall | Primary Care Contract Support Manager |
| Mrs Stephanie Neal | Committee & Corporate Affairs Assistant (minutes) |

| Item | Discussion | Action |
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| **PCCC/18/050** | **Welcome and Apologies**<br><br>The Chair welcomed everyone to the meeting. Apologies for absence were received from Ray Harding, Dr Geoff Hanlon, Melanie Whittall, Caroline Trevithick, Ket Chudasama and Stuart Houlihan.<br><br>The Chair confirmed that the meeting was quorate. The Chair introduced June Telford, the new Interim Head of GP Contracts & Quality to the Committee. | |
| **PCCC/18/051** | **Report for the Conflict of Interest Panel and Declaration of Interest**<br><br>The following declarations were noted:<br><br>• PCCC/18/055 – Quality Impact Assessment – All GPs declaration only<br>• PCCC/18/056 – Christmas & New Year 2018-19 Opening Arrangements – All GPs declaration only<br>• PCCC/18/059 – Co-commissioning Budget Finance Report – Month 5 2018/19 – All GPs declaration only<br>• PCCC/18/060 – General Practice Forward View (GPFV) Update Report – All GPs declaration only | |
| **PCCC/18/052** | **Minutes of the meeting held on Tuesday 10 July 2018**<br><br>The minutes of the meeting held on Tuesday 10 July 2018 were agreed as an accurate record. | |
| **PCCC/18/053** | **Matters Arising from Tuesday 10 July 2018 & Action Log**<br><br>The action log was received and updated and would be appended to the November meeting minutes.<br><br>The Primary Care Commissioning Committee | |

- **NOTED** the action log and updates.

**PCCC/18/054** **National Patient Experience Survey**

Mrs Chudasama introduced the report which outlined the results of the GP Patient Survey (GPPS). The survey provided practice-level data about patient's experiences of accessing services at their GP practices which allowed CCGs to benchmark performance against national averages for a variety of indicators. The response rate for the 2018 survey was 43% compared to 45% in 2017. East Leicestershire and Rutland CCG (ELRCCG) had a response rate of 44% and Leicester City CCG (LCCCG) had a response rate of 28%. The results of the survey could not be compared to the results from 2017 due to extensive changes to the patient questionnaire.

Mrs Chudasama confirmed that the CCG was performing in line with national averages and noted the following;

- 85% of patients described their overall experience as good
- 70% of patients found it easy to get through to their practice by phone whilst 30% did not find telephone contact easy. It was the largest variance between the highest and lowest performing practices.
- 90% of patients found receptionists helpful
- 76% of patients were satisfied with appointment times

Mrs Chudasama stated that The Cottage Surgery had the best results nationally and five other West Leicestershire GP surgeries were ranked in the top ten. 15 practices in West Leicestershire had an average of less than 85% in all areas.

It was confirmed that the outcomes of the survey would be discussed at locality meetings, board development sessions and at internal practice meetings. All practices that fell below average on the survey indicators would also be addressed through the Practice Appraisal Programme. Mrs Chudasama suggested that the CCG could triangulate the results with a practices contractual responsibility, as if a practice performed low on an indicator, there could be a risk that they might not meet their contractual obligations.

Ms Guss asked if the survey produced any unexpected results. Mrs Chudasama responded that the variance on telephone access was unexpected (one practice performed at a 100% and another only 26%) but when compared to other CCGs the variance was similar.

Ms Norton commented that of the 5 West Leicestershire practices in the top ten, a number of those practices were also highlighted by NHS England (NHSE) as having low opening times and all were closed on Thursday afternoons. The GPPS was a useful tool but it had to be considered as part of a larger piece of work as patient views did not always equate to how successfully or non-successfully a practice was performing in terms of clinical quality.

Dr Virmani agreed with Ms Norton and noted that a patient's perspective of a good service did not mean that the service was clinically correct. As an example, Dr Sanganee referred to recent a journal article which outlined that patient satisfaction in another area of the UK was highest at practices with high antibiotic prescribing. Dr Sanganee also felt that it was important to note that one third of patients chose to go straight to A&E rather than to their GP.

Mr Potter stated that the results could not be considered in isolation and the results of the lowest and highest performing practices would be triangulated with

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| | other data collected by the CCG. He confirmed that the Communications and Engagement Team would conduct interviews with practices, taking into account their difference in size, and any themes produced from the interviews would be used to support the lower performing practices.<br><br>Dr McHugh noted that practices were under an increasing amount of pressure but the GPPS figures were encouraging.<br><br>Ms Adams summarised that as a result of the report, the Primary Care Team would triangulate the data, consider the involvement of the Patient Participation Groups (PPGs) and the Communications and Engagement Team would conduct interviews with the highest and lowest perfoming practices.<br><br>It was agreed that Mr Potter would provide a further update in November.<br><br>The Primary Care Commissioning Committee<br>• **NOTED** the contents of the report.<br><br>Mrs Chudasama left the meeting. | **IP** |
| **PCCC/18/055** | **Quality Impact Assessment**<br><br>It was noted that all GPs had declared a conflict of interest in PCCC/18/055.<br><br>Mr Potter presented the Quality Impact Assessment (QIA) which was designed to anticipate any potential risks to the key quality areas of patient safety, clinical effectiveness and patient experience and to identify any mitigating actions.<br><br>Dr Sanganee felt that the QIA was reassuring but queried how the impact was interpreted on the risk to patient experience.The intention of the CCG was to improve patient access but it would be through a reduction in secondary care usage. The reduction might therefore affect patient experience.<br><br>Mr Potter said that the focus would be to ensure that good quality referrals were made.<br><br>With regards to the question on page two of the QIA which asked if any unintended consequences had been identified, it was agreed that the lack of funding for general practice would have a negative impact and should be referred to in the document.<br><br>The Primary Care Commissioning Committee<br>• **REVIEWED** the Federation QIPP Quality Impact Assessment | **IP** |
| **PCCC/18/056** | **Christmas and New Year 2018-19 Opening Arrangements**<br><br>It was noted that all GPs had declared a conflict of interest in PCCC/18/056.<br><br>Ms Norton introduced the report which outlined the request from the Leicester, Leicestershire and Rutland (LLR) Local Medical Committee (LMC) to support practices in closing at 4pm on Christmas Eve and New Years Eve, with cover provided between 4pm and 6.30pm. The CCG supported the early closure of practices in December 2015 but support was not necessary in the following years as Christmas Eve and New Years Eve fell at a weekend when practices were closed.<br><br>Dr Virmani informed the Committee that Christmas opening hours were discussed | |

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| | at a national level by the British Medical Association and it was agreed that it was not an issue if the right cover was provided.<br><br>Dr McHugh asked if there was a cost to the CCG for practices to close early. Ms Norton advised that there would be no cost to the CCG and that Federations might contribute towards the costs or practices might fund the closure themselves.<br><br>Dr Virmani reminded the Committee that Christmas closure times were optional for practices and some practices might chose to remain open.<br><br>Ms Guss asked how patients would be signposted if they needed medical assistance whilst the surgeries were closed. Ms Norton confirmed that patients would receive an automated message when calling the practice line or they would be automatically diverted to the 'out of hours' provider. Practices would also advertise the cover arrangements in advance to ensure that patients were aware of how they could access any necessary care. Mr Potter noted that extended access appointments would also be available.<br><br>Ms Adams queried if there would be sufficient pharmacy cover for patients. It was confirmed that the majority of pharmacies would remain open (including 24 hour pharmacies) as they would need to provide medication for the out of hours provider. A patient's usual pharmacy might not be open but there would be a pharmacy available nearby that would be open over Christmas.<br><br>Mr Potter confirmed that there would be good cover for patients and the data provided by the LMC on previous Christmas appointment utilisation demonstrated that there was not a high volume of patients that required an appointment over the holiday period.<br><br>Ms Adams noted that from a patient's perspective there would not be a lot of coverage. For example, on Monday 24th December practices would be open at reduced hours, practices would then be closed Tuesday 25th and Wednesday 26th December and then some practices would also operate a half day closure on Thursday 27th December. Ms Adams requested that practices that were usually closed on Thursday afternoons were encouraged to look at their Thursday opening hours and consider opening for a full day on Thursday 27th December.<br><br>Mr Potter confirmed that he would write to practices and encourage them to re-look at their Thursday opening times on the 27th December.<br><br>Dr McHugh asked if staffing was an issue over the Christmas period. Dr Sanganee advised that generally staffing was not an issue as staff were paid a premium to work over Christmas and not all staff celebrated the holiday.<br><br>The Primary Care Commissioning Committee<br>• **NOTED** the contents of the report.<br>• **CONSIDERED** the request for practices to close at 4pm on Christmas Eve and New Years Eve, with cover provided between 4pm and 6.30pm.<br>• **APPROVED** the request for practices to close at 4pm on Christmas Eve and New Years Eve, with cover provided between 4pm and 6.30pm. | **IP** |
| **PCCC/18/057** | **Risk Register**<br><br>Ms Bestall entered the room.<br><br>Mr Potter reported that the risk register had been updated following its review at | |

the Committee in June 2018 and a new risk had been added (PCCC14) regarding reduced influenza vaccination rates in patients aged over 65. The risk had been RAG rated as an 8 and therefore would not require escalation to the Board Assurance Framework.

Dr Sanganee stated that his practice were experiencing the opposite problem and were struggling to obtain vaccines for the under 65s due to issues with pharmacy deliveries. Dr Virmani said that the LMC were aware of the problems and practices should receive a delivery that week.

Dr McHugh felt that vaccinations were a challenging issue as there were two different vaccines and pharmacies were in competition with primary care in relation to vaccine provision. GPs should not give the over 65 vaccine to the under 65s unless there was no other alternative.

Dr Sanganee asked if the risk would be more suited to the Quality and Performance (Q&P) Risk Register instead of the PCCC Risk Register. Ms Adams agreed and felt that if it was added to the Q&P Risk Register it would then be able to be escalated through the quality routes.

It was agreed that the risk would be removed from the PCCC Risk Register and added to the Q&P Risk Register. It was also agreed that the risk would be updated to include the under 65s.

Dr McHugh commented that along with NHS staff, care workers were also entitled to free vaccinations and queried if the CCG had issued any communications specifically to care workers as there was a often a poor vaccination uptake. It was noted that it was a care homes responsibility to provide and promote free vaccinations for care workers but Mr Potter asked Ms Telford to consider if the CCG should issue communications to increase awareness for this cohort of staff. **JT**

Mr Potter proceeded to discuss each risk on the risk register and the following comments were noted;

- PCCC1 – unable to meet revenue consequences of Estates & Technology Transformation Fund (ETTF) premises developments. It was agreed that the risk level would remain at an 8.

- PCCC2 – threat to the sustainability of GP workforce. It was agreed that a new action would be added noting that NHSE funding of £142k across LLR had been secured. The risk level would remain at 16.

- PCCC3 – commissioning budget overspent at the end of the financial year. It was agreed that the likelihood of the risk should be increased to a 4 which would raise the overall risk level to 16. The actions should also be updated to include commentary on prescribing issues such as No Cheaper Stock Obtainable (NCSO). Mr Potter stated that the work being discussed at the GP Resilience Programme Board in relation to discretionary investment and the alignment to priorities in the system should also be included in the narrative.

- PCCC4 – the CCG did not not secure enough interest through a local process to secure provision of urgent caretaking arrangements. It was agreed that the risk level should remain at a 10.

- PCCC5 – the relationship with stakeholders to ensure successful co-

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| | commissioning was not maintained. It was agreed that the risk should be updated to reflect the guidance from internal audit on delegated commissioning.<br><br>• PCCC6 – practices in the CCG were placed into Care Quality Commission (CQC) Special Measures following an inspection. The Committee did not feel that any changes were required.<br><br>• PCCC9 – the mobilisation of caretaking arrangements was unsucessful or incomplete in timescale. It was agreed that the risk level should remain at an 8.<br><br>• PCCC10 – procurement and mobilisation of Extended Access failed to deliver improved patient pathways. It was noted that the risk could not be updated at that point but would be monitored by the Committee.<br><br>• PCCC11 – implementation of GPFV at WLCCG and LLR level failed to address unprecendented challenges faced by General Practice. It was agreed that Ms Telford would update the next steps section and consider if there was more that the CCG could do to manage the risk.<br><br>• PCCC12 – planned switch off of GP paper referrals resulted in delays in appointments and patient care. It was noted that the risk was being managed well and it was agreed that the likelihood of the risk could be reduced to a 2 and therefore the overall risk level would reduce from 9 to 6.<br><br>• PCCC13 – delays by Primary Care Support England (PCSE) in making changes to records, prescribing codes and registrations causing financial pressure on practices. It was felt that it was a key issue and the likelihood of the risk should be increased. Mr Roberts suggested that the risk could be updated to include the impact on pensions but Dr Sanganee felt that the impact on pensions and workforce should not be underestimated. It was agreed that a new risk would be created specifically in relation to pensions.<br><br>It was noted that Ms Telford would update the risk register and it would be presented to the Committee in November 2018.<br><br>The Primary Care Commissioning Committee<br>• **NOTED** the contents of the risk register<br>• **DISCUSSED** the risk register | **JT**<br><br>**JT** |
| **PCCC/18/058** | **Ratby Surgery – Boundary Variation**<br><br>Ms Bestall advised that during a recently boundary review conducted by WLCCG and ELRCCG, it was identified that a small area adjacent to the A47 in Leicester Forest East was not covered by any GP surgeries. Ratby Surgery in West Leicestershire and Forest House Surgery in East Leicestershire had both agreed to extend their current practice areas to encompass the area. The changes in the boundary for Ratby Surgery also reflected the areas from which the practice already accepted patient registrations but which were not formally recognised as part of the surgeries catchment area.<br><br>The Committee approvied the boundary variation for Ratby Surgery. | |

The Primary Care Commissioning Committee

- **NOTED** the boundary variation request by Ratby Surgery
- **APPROVED** the boundary variation request by Ratby Surgery.

Ms Bestall and Ms Norton left the meeting.

**PCCC/18/059** **Co-Commissioning Budget Finance Report – Month 5 2018/19**

It was noted that all GPs had declared a conflict of interest in PCCC/18/059.

Mr Roberts presented the finance report which summarised the financial position at the end of August 2018. The report noted an overspend of £1.5m with a forecast of £3m, of which £2m was attributed to the prescribing budget. With regards to general practice, there was a forecast overspend on the Global Sum budget of £390k due to the increase to the GP contract which was backdated to 1st April 2018.

Mr Roberts noted that in relation to prescribing, there was a risk of an additional £1.4m expenditure (above the £2m forecast overspend) based on information to date. NSCO was still an issue as drugs removed from the list of NCSO drugs had been added to the drug tariff at a higher price which was not expected. There was a risk of increasing overspend through prescribing but if the CCG received an allocation from NHSE to cover the increased cost of the GMS contract then that would improve the financial position.

Dr Virmani left the meeting.

Mr Potter stated that the QIPP target to deliver £500k for enhanced services was reviewed by the Corporate Management Team (CMT) and Clinical Leads and it was noted that the level of saving (£500k) would not be achieved by the CCG. Mr Roberts reassured the Committee that although not all areas would meet their QIPP target, other areas might over deliver.

Ms Adams queried if the Regional Medicines Optimisation Committee (RMOC) had discussed a review of high cost drugs. Dr Sanganee explained that if the CCG wanted to decommission certain drugs, the Medicines Optimisation Team would be required to conduct an individual medication review for each drug that was intended to be decommissioned. If Gillian Stead, the Head of Medicines Optimisation, had more pharmacy support then savings could be made more quickly as decommissioning drugs was a time consuming task and with additional support, the work could be completed in a shorter timeframe. The self-care agenda was currently being optimised but as the drugs were relatively cheap, savings would be created in the longer term rather than in the short term.

Ms Adams questioned if data could be obtained on biosimilar drugs which could produce QIPP savings for the CCG. Biosimilar drugs were drugs that were highly similar, but not identical to the existing biological medicine and were often significantly cheaper to purchase. Due to this, the savings on biosimilars would be substantial.

Dr Sanganee agreed that savings through the use of biosimilars would be substantial and mentioned that biosimilars had previously been discussed at the Finance & Performance Committee. It was also noted that some CCGs across the UK had received a judicial review in relation to the approval and use of the biosimilar of Avastin.

Ms Adams requested that potential savings on biosimilars were looked into further

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| | and Mr Potter agreed to arrange a discussion with Ms Stead and feedback to the Committee.<br><br>The Primary Care Commissioning Committee<br>• **RECEIVED** the report<br>• **NOTED** the contents of the report | **IP** |
| **PCCC/18/060** | **GP Forward View Update Report**<br><br>It was noted that all GPs had declared a conflict of interest in PCCC/18/060.<br><br>Mr Potter suggested that the Committee discussed an area of the GPFV at each meeting, similarly to how a deep dive would be arranged at the Quality & Performance Committee. This approach was agreed by the Committee.<br><br>The Primary Care Commissioning Committee<br>• **NOTED** the contents of the report<br>• **AGREED** that progress updates should be received at each meeting with a focus on one area in particular. | |
| **PCCC/18/061** | **Any Other Business**<br><br>There was no other business. | |
| **PCCC/18/062** | **Date of Next Meeting**<br><br>The next meeting of the Primary Care Commissioning Committee would be held on Tuesday 20th November at 55 Woodgate, Loughborough. | |