Bristol, North Somerset and South Gloucestershire
Clinical Commissioning Group

Primary Care Commissioning Committee Open Session

Minutes of the meeting held on 30th June 2020 at 9am, held via Microsoft Teams

Minutes

Present		
Alison Moon	Independent Clinical Member – Registered Nurse	AM
Georgie Bigg	Healthwatch North Somerset	GB
Colin Bradbury	Area Director for North Somerset	CB
Alison Bolam	Clinical Commissioning Locality Lead, Bristol	AB
David Clark	Practice Manager	DC
Felicity Fay	Clinical Commissioning Locality Lead, South Gloucestershire	FF
David Jarrett	Area Director for South Gloucestershire	DJ
Martin Jones	Medical Director for Primary Care and Commissioning	MJ
Rachael Kenyon	Clinical Commissioning Locality Lead, North Somerset	RK
Philip Kirby	Chief Executive, Avon Local Medical Committee	PK
Lisa Manson	Director of Commissioning	LM
Julia Ross	Chief Executive	JR
John Rushforth	Independent Lay Member – Audit, Governance and Risk	JRu
Rosi Shepherd	Director of Nursing and Quality	RS
Sarah Talbot-Williams	Independent Lay Member – Patient and Public Engagement	STW
Apologies		
Mathew Lenny	Director of Public Health, North Somerset	ML
Sarah Truelove	Chief Finance Officer	ST
In attendance		
Rob Ayerst	Head of Finance (Primary & Community Care)	RA
Jenny Bowker	Head of Primary Care Development	JB
Sarah Carr	Corporate Secretary	SC
Debbie Campbell	Deputy Director Medicines Optimisation	DCa
Bev Haworth	Models of Care Development Lead	BH
Geeta Iyer	Primary Care Provider Development Clinical Lead	GI
Tim James	Estates Manager	TJ

David Moss	Head of Primary Care Contracts	DM
Joe Poole	Head of Locality Development	JP
Lucy Powell	Corporate Support Officer	LP

	Item	Action
01	**Welcome and Introductions** Alison Moon (AM) welcomed members to the meeting. The above apologies were noted. This was Rob Ayerst's (RA) last meeting. AM thanked RA for his contribution to the Committee and wished him well in his new role.	
02	**Declarations of Interest** There were no new declarations of interest and no interests related to the agenda.	
03	**Minutes of the Previous Meeting** The minutes were agreed as a correct record with the following amendment to the final sentence of the first paragraph, page 6 "NHS England/Improvement were providing…"	
04	**Action Log** The action log was reviewed: • **Action 164** – RA explained assurance meetings with NHSE had been placed on hold during the covid-19 response. Updated planning guidance was expected and there would be further discussions with NHSE to consider the 2021/22 position. It was agreed to keep the action open pending a further update on the publication of new planning guidance and further discussions. • **Action 169 –** Martin Jones (MJ) would confirm the action required with Sarah Carr (SC). All Cells were completing Equality Impact Assessments (EIA) and this would include an EIA focused on the use of digital communications for people where English was not their first language. The action remained open. • **Action 175 –**the query regarding QoF had been answered and QoF achievement would be reported quarterly. The action was closed. • **Action 176 –** it was agreed SC would discuss the action with Julia Ross (JR). The action remained open. • **Action 177 –** Bev Haworth (BH) explained the South Bristol Locality was still to implement on-line consultations. There had been discussions with the practices about the timing of the implementation and contractual requirements. Bridge View Practice was using on-line consultations and the learning	**MJ/SC** **SC/JR**

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	would be shared across the locality. David Jarrett (DJ) asked for progress on discussions to be shared with him. Issues would be escalated at the next Locality and PCN leads meeting. The action was closed. • **Action 179 –** it was agreed the action would be placed on the forward planner for September. The action remained open. • **Action 182 –** Rosi Shepherd (RS) clarified no practices had an 'inadequate' CQC rating. Some practices had been rated as 'inadequate' for specific domains. The newly appointed clinical lead for quality would work with the team and practices where there were inadequate ratings for domains. The action was closed. The outcome of discussions with practices about action plans would come to the next closed committee meeting. • **Action 183 –** This was an agenda item. The action was closed. AM asked for the action log to be updated prior to meetings.	**RS**
05	**Governing Body Assurance Framework (GBAF) and Corporate Risk Register (CRR)** SC highlighted the changes on the CRR. The Silver Cell Risk Register used the CCG risk-scoring matrix and risks on this register scored 15 and above were included on the CRR. The MRSA risk score was under review. Felicity Fay (FF) asked why the risk score for the Weston CAMHS had been reduced. This related to the transfer of CAMHS services; RS explained there would be a meeting with AWP to explore and review the risk. The Governing Body was considering the principal objectives for the GBAF and a revised version would come to a future meeting. FF asked if the risks 7.1 and 7.2 reported on the GBAF were the same. It was explained 7.1 related to planning and 7.2 related to delivery. This would be confirmed. AM commented it had been reported at the Quality Committee that two-week wait referrals for a number of cancers were lower than normal. AM asked if there was an action for primary care. LM explained the core risk for primary care consideration related to patients waiting for referral to or delayed on the two-week pathway and access to diagnostics. Rachael Kenyon (RK) noted some patients were presenting later with symptoms and there was potential for an increase in diagnoses made on emergency admission. It was important GPs clearly communicated that general practice was not closed. FF agreed patients were concerned about the risks of Covid-19 in healthcare settings. FF commented on the potential impact of	**SC**

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	changing processes and the use of advice and guidance. Alison Bolam (AB) sought confirmation there were delays in the pathway once a referral was made. LM explained capacity in endoscopy and the availability of imaging and x-ray were reduced due to Infection Prevent and Control requirements. JR noted this was a national issue and the local position had been exacerbated by Covid-19. Work was starting with the Clinical Cabinet on how diagnostics would be prioritised. It was important primary care was part of this. Colleagues on the committee were invited to engage with this work. MJ confirmed the LMC were part of the discussions; RK, FF, and AB volunteered to contribute to the work changing processes and the use of advice of guidance. **The Primary Care Commissioning Committee reviewed and discuss the CRR and the GBAF and considered whether the documents were an accurate reflection of the risks brought to its attention**	
06	**Covid-19 Update** MJ outlined the areas of focus: • The provision of guidance to support practices in providing "healthy shielding" advice to patients in vulnerable groups. Work was underway to support Covid-19 Care sites housing homeless people not registered with a GP. • The Logistics Cell work focused on providing PPE to primary care. OneCare was co-ordinating and procuring PPE on behalf of primary care • Planning for hubs for community-based phlebotomy for secondary care initiated tests was progressing. The South Bristol Hospital was now live as a pilot site. • Work was underway to develop and make available staff antibody testing for primary care. Work undertaken by the Digital Sub Group was highlighted. Webcams had been distributed to practices and video consultations were averaging at 7,500 per month. A joint position statement from the CCG, LMC and OneCare encouraging the implementation of online consultations across practices had been issued. MJ reported 60% of Care Homes had access to NHS mail. Support had been provided to social prescribers to access NHS Mail accounts for EMIS access and remote working. All practices had GP Connect functionality. Work continued with Care UK and practices to implement 111 Direct Booking. It was noted as the model for urgent care and ED changed direct booking with GP	

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	Connect would be key. The Community and Primary Care Workforce Group met in June and the weekly primary care workforce cell sub group would be stood down. The workforce recovery governance would step up with reporting to the system workforce Cell and People Steering Group (the Local Workforce Action Board). It was proposed Improved Access restarted in August 2020; this would include a move away from face to face delivery with a focus on understanding needs related to Covid-19, supporting the urgent care system and looking for innovative ways of working. The process to categorise costs to identify those for peer review assessment for reimbursement was established. AM asked if the number of Care Homes without access to NHS Mail would have a negative impact. BH explained the national target was for 70% of Care Homes to have access to NHS Mail. The CCG was working towards this. Access to NHS Mail was not mandatory for care homes. The CCG was working with GPs and Care Homes to promote the benefits of NHS Mail. Capacity and capability in relation to access to Wi-Fi and ability to use technology were noted. AM asked if the ambition was to achieve 100% of Care Homes accessing NHS Mail. This was confirmed. AM asked if there was sufficient learning to inform actions in the event of a second surge. MJ confirmed plans had been made at Locality and PCN level, which would be stood up in the event of a second surge. David Jarrett (DJ) noted Localities had Resilience Plans, which were ready to be deployed. The plans would be presented to the committee. FF asked how many practices did not use Connecting for Care and why. BH explained the number was unknown. Recent communications had been circulated to practices encouraging the adoption of Connecting for Care. AB asked if staff antibody testing had been paused. MJ confirmed testing had not been paused. LM explained the CCG was working through solutions to support primary care, dentists, optometrists, and community pharmacists. DJ reported the focus of the Locality Cell had been on community phlebotomy and recovery. DJ thanked Rosi Shepherd (RS) and the team for the Shielding Guidance. This was a local development with clinical support and it had been well received by Locality colleagues. **The Primary Care Commissioning Committee noted the report**	**DJ**

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07	**Primary Care Recovery** Geeta Iyer (GI) presented the paper, which set out the changes in the delivery of services by general practice since March, learning points, and the approach to recovery. General practice moved to a total triage and remote assessment approach supported by the CCG digital team in mid-March. Areas of focus included the primary and community care response to care homes and the development of Locality and PCN Resilience Plans. General practice introduced zoning within practices and across PCNs and made adaptions to deliver care to people who were shielding. Workforce plans and continuity plans were developed. The impact of these changes was considered at the Primary Care Cell. Observations included • There was an initial drop in the volume of patients contacting their GP • Proactive messaging to patients about arrangements was helpful and encouraged patients to access primary care • An unintended consequence of moving to total triage was the widening of health inequalities. This needed to be understood and this would be a focus of the recovery phase. This would look at access issues including where English was not a first language, access to Wi-Fi and digital technologies. • There would be changes across other areas of the system that would require primary care support including outpatient transformation and the use of advice and guidance. • Not all primary care interventions could be delivered remotely and there were instances where face-to-face consultations were valuable. • Workforce changes could mean more than one person in primary care delivered continuity of care. • When considering primary care recovery a priority should be placed on high quality, high value activity. GI explained the proposed delivery of Improved Access, Extended Hours and Core Services going forward. Improved Access and Extended Hours would become a single specification from April 2021. Four options for Improved Access were set out in the paper. These had been discussed with the membership, the PCN Clinical Directors, Locality Leads and at the Primary Care Commissioning Operational Group. The risks and benefits of each option were	

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	described in the paper. The recommendation was Option three, to stand up Improved Access from August 2020, to be taken forward. There were no national proposals to change the Extended Hours agreement. It was proposed to use Extended Hours in quarter two to support the recovery process, for example to offer appointments for patients who were shielding. Core activities were set out in the spreadsheet at appendix 2. This was based on the Royal College of General Practitioners and the BMA spreadsheet of core activities produced in March to help general practice with prioritisation. A clinical reference group, including CCG and LMC clinicians, had reviewed the spreadsheet. Appendix 2 included feedback from the CCG membership, CCG clinical leads, Sirona, Public Health, and the Clinical Cabinet. The spreadsheet was reviewed regularly at the Primary Care Cell. The spreadsheet supported resilience work and was reviewed at the Localities Cell. The majority of LES delivery had been prioritised according to clinical need and activity had continued in quarter one. The focus now was on how to expand this work in quarter two. Attention was drawn to membership feedback detailed in the paper, including: • understanding the level of activity relating to flu' planning and • how recovery would continue to be supported as primary care workload changed and increased as the rest of the system implemented recovery plans, such as reviewing practice-held lists for secondary care referrals, using advice and guidance routes instead of referring directly, and also the impact of extra time needed for appointments for donning/doffing PPE and reduced capacity in estates due to social distancing. The ongoing Covid-19 response was highlighted. Next steps would include sharing proposals for primary care recovery with the wider system to ensure alignment with other key areas. There would be continued engagement with the CCG membership. Support to care homes would continue ahead of the PCN DES and national guidance to support outbreak management would be implemented. The roll out of 111 Direct Booking would continue. Population health would be evaluated to understand the impact of interventions and identify where services needed to be targeted. The ongoing resilience programme continued as business as	

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	usual. It was noted more practices could require support as recovery continued. Patient engagement was an important part of recovery. The CCG communications team was working with the regional and national team on shared messages for the public, which would be tailored to meet local needs. The Communications team had updated PPG's about the changes to primary care access. The Primary Care Cell and primary care strategy programme board were working with the communications and insight teams to understand intelligence from the citizens' panel about how people felt, how they accessed care, and where a more tailored approach was required. Plans were in place to work with the Patient and Public Involvement Forum sub group. FF asked if information was available on health inequalities and specifically access to primary care to help practices in advance of the proposed equality survey. GI explained practices had data about patients; a paper identifying patient cohorts at risk had been shared with practices and it was agreed to recirculate this. David Moss (DM) explained FAQs were being developed and information on protected characteristics to support practices with planning would be included. JR welcomed the paper and the actions completed noting the level of transformation. JR supported the dialogue about how continuity of care would be provided. JR observed there would be further discussion about ensuring advice and guidance and other alternative models to consultant appointments were increased. JR commented the work relating to vulnerable people was a real achievement and was in line with the ambition to be more proactive in the care of people. It was important to move this agenda on, building on the work to date. JR encouraged the engagement to focus on how things had changed for people to help understand the impact of Covid-19 on individuals. JR asked why spirometry was rated as amber. GI explained there was discussion as to whether spirometry was an aerosol generating procedure and would require a higher level of PPE. This would be discussed at Clinical Cabinet. The quality of assurance of spirometry needed to be considered and whether the footprint for the delivery of the service needed to change to ensure	**GI** **DM**

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	consistency and resilience. Discussions were ongoing with Sirona. The service was part of the aftercare needs of Covid-19 patients. JR commented the service was clinically important. JRu noted the focus on survey tools to understand the impact of digital technologies. JRu sought reassurance that survey tools would be co-designed. JRu asked how the impact would be measured overtime. BH explained prior to the pandemic a communications and engagement plan for all digital work had been established. Listening events were planned for the older population and disabled people. Due to the pandemic these events would be through virtual platforms. There were plans to have more robust, ongoing engagement on inequalities. JR observed many groups work with people the CCG wanted to reach and these could be used to support this work. RK highlighted the importance of the consistency of the advice and guidance process. RK noted support and advice for NHS workers within the vulnerable category as lockdown was lifted was important. RK asked why Med3 on page 17 of appendix 2 was amber. GI agreed to clarify this. There was a discussion about future reporting to the committee on progress. It was agreed this would be a standing agenda item for future meetings and could be a brief update or more detailed report as appropriate. **The Primary Care Commissioning Committee discussed the proposed delivery of Improved Access, Extended Hours and Core Services in quarter two, noting the Covid-19 challenges**	**GI** **GI/LP**
08	**Care Homes - Next Steps** Jenny Bowker (JB) explained the paper provided an update on support to care homes, the link to the Care Home DES specification and the broader model for primary care and community support to care homes. An update on the alignment of care homes to PCNs was given. Named leads were in place through the Sirona and Local Authority wrap around service. An update was provided on the roll out of the Covid-19 care home support model, which had three elements: weekly check ins, a process for the development of personalised care and support plans, and clinical pharmacy support, including medication review for care home residents.	

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	Eight care homes were still to be aligned to a PCN and plans were being finalised to align these. To date, with the support of the LES and Wraparound service, the CCG was able to report 100% of care homes were benefiting from weekly check-ins and 97% of care homes had all three elements in place. Clinical pharmacy support had increased; this included having processes in place for reactive support in the event of an outbreak. There was a longer-term focus on proactive structure medication review for all residents. The Medicines Optimisation team was looking at these areas. JB drew attention to the forward dates for the PCN DES. The target for the alignment of all care homes by end of July would be met. PCNs had been asked to confirm the list allocated to them and the named clinical lead; 15 PCNs had submitted the returns and all returns would be submitted by the target date. The action for PCNs to have in place a plan with community providers and other local partners about how the requirements would operate was highlighted. JB reported the Woodspring Locality had developed a standard Operating Procedure for supporting care homes; this had been shared across localities. The South Gloucestershire Locality was developing models of ways of working with Sirona. The intention was to share good practice through the Locality Cell. The communications team was developing proactive communications to be shared with care homes explaining the benefits of aligned practice support JB explained a plan would be developed to bring together the Covid-19 response, the LES arrangements in place until the end of September and the DES arrangements starting the 1st of October. The paper recommended an immediate action to complete a desktop review to support the development of interim options. This would be presented to the committee in July with membership engagement in August. This would address the funding position and provide general practice with clarity. There was a longer-term action involving Local Authorities, care homes and residents to look at the model, using the learning from the Covid-19 response. The Integrated Care Steering Group would sponsor this. RK explained care homes in Clevedon had a similar piece in place prior to the Covid-19 response. Discussions with the Medicines	

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	Optimisation Team had highlighted the duplication regarding pharmacy visits and work to address this had helped support care homes. Debbie Campbell (DC) explained there had been an opportunity to work with care homes and explain how a consistent approach would provide support and avoid duplication. FF commented the South Gloucestershire Locality had worked positively with Sirona. FF highlighted the quality of care plans varied and the DES required a detailed and comprehensive assessment. FF asked if there would be locally commissioned services going beyond the scope of the DES. JB explained the desktop review needed to be completed to determine whether there were areas warranting additional investment. It was important to continue support to care homes; there had been significant work by primary and community care to support care homes. The Covid-19 care home support care-planning template was a high-level summary, which was not as comprehensive as the DES requirement. How practices were supported with the transition to the DES approach would be part of the implementation. The work to roll out the RESPECT process was highlighted. Care planning training was being rolled out. JRu noted the recommendation to extend payments for care homes outside of the LES and asked if this would be reimbursed from central funds and was there confidence extra activity would be resourced through additional funds. RA confirmed the increased cost for extending the LES would be part of the national claims process. This would stop with the implementation of the national DES in October. It was important to understand whether in the interim period this could be claimed through the national process. Activity related to the Covid-19 response would be reimbursed. JR noted care plans described how people lived their best lives, enabling people to be as independent as possible and RESPECT was an important element. AM highlighted the bullet points on page three of the paper setting out the elements of the care home model practices and community providers would want to ensure. AM asked how would the impact and outcomes of having the elements described in the bullet points be understood. AM noted an emphasis on what RESPECT would bring would be useful. JB explained a care homes dashboard with metrics was being	

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	developed. This included information from Local Authorities and care homes and business intelligence accessed by the CCG. This would help track outcomes. An evaluation plan of the Covid-19 response was being developed; this would look at how the multidisciplinary approach has benefit care homes and their residents. **The Primary Care Commissioning Committee:** • **noted the report and the ongoing work to provide a comprehensive primary and community Covid 19 response to supporting care homes in BNSSG, and** • **agreed the proposed approach to review of the current care home models in the transition towards the 1 October deadline for the introduction of the EHCH DES**	
09	**Lawrence Weston Full Business Case** Joe Poole (JP) attended for this item. JP set out the context for the paper noting the previous discussions at the committee. Attention was drawn to the revenue implications and the final approval by the NHS England ETTF Assessment Panel on 10th July. The programme would deliver hub and spoke working across the existing sites and a new premises. A preferred contractor had been identified through a procurement programme and planning permission had been granted. The capital implications for NHS England were noted. The revenue implications for the CCG were highlighted. Overall the estates programme would result in a revenue saving for the CCG. The legal agreements were noted; the CCG was working to support the complex legal negotiations relating to the funding agreement. Questions were invited. There were no questions. AM commented on the previous detailed committee discussions. STW welcomed the use of stakeholder engagement to inform the business case. The committee congratulated the team. **The Primary Care Commissioning Committee approved, subject to NHSE ETTF panel final approval (20/07/20), the Full Business Case, and in turn construction to proceed**	
10	**Primary Care Finance Report** RA highlighted the revised financial framework in place in the first quarter as part of the response to the Covid-19 pandemic. All GP practices continued to be paid at rates that assumed achievement in line with levels prior to the outbreak, for the purposes of QOF, DES and LES payments. The CCG expected to the reimbursed for reasonable net additional costs incurred to respond to Covid-19.	

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	No decisions had been made at a national level about funding and commitments against planned investments set out in the NHS Long Term Plan such as PCN Investment and impact funding, and Primary Care Transformation Plans. An update would be presented to the next meeting. Further allocations expected included £1.4M related to the Investment & Impact Fund, Care Homes DES and Revised GP Contract. Guidance on a further non-recurrent £2.5M allocation related to funding streams established before the GP Forward View was expected. RA explained £3.5M costs had been incurred relating to the Covid-19 response. Details of areas of expenditure were included in the paper and included £450K practice Bank Holiday cover costs, and Individual practice reimbursements for Covid claims of £700K. These costs primarily related to PPE, and backfill costs for sickness. Increased prescribing costs £2.3M were highlighted. This position was based on March data. Nationally, there was a 9.3% increase in items dispensed in March. The CCG experienced an increase in actual prescribing costs of 14% (£1.5M higher than normally expected March levels). This included increased costs for inhalers, national directives around medication switches, and further price concessions as a result of No Cheaper Stock Obtainable (NCSO). It was noted April data unavailable. The reporting position at the end of Month two was noted. The combined primary care budgets reported a year to date overspend of £3.8M. Covid-19 related costs were the main driver for this. The CCG expected this to be reimbursed. The combined year to date impact of the 'planned deficit' against delegated budgets (£322K) and unidentified QIPP Savings in Medicines Management (£330K) was £652K. This position was offset by uncommitted budget within 'Other Primary Care' underspend. The PCN DES allocations had not yet been received. The allocation for Additional Roles Reimbursement (ARRS) would be accessed on a 'draw-down' as required. The CCG had funding of £4.1M for ARRS with a further £2.8M that could be accessed nationally if required. There were no questions. RA was thanked for his contribution to the committee. **The Primary Care Commissioning Committee received the update.**	

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11	**Primary Care Quality Report** RS highlighted the support to primary care relating to Infection Prevention and Control and PPE. The IPC training provided to care homes was being rolled out across primary care. Work had completed on shielding guidance and developing a consistent approach to face coverings in primary care. RS reported a Clinical Lead GP for Quality had been appointed. This role would look at a range of issues with a specific focus on primary care quality. A key area of work would be the review of those domains in primary care rated inadequate by the CQC to identify actions to improve ratings. The IPC work plan was under review. Covid-19 would be added to the work programme alongside business as usual planning such as Flu' planning. AM welcomed the appointment of the Clinical Lead for Quality. AM asked how practice data related to annual health checks for people with Learning Disabilities completed would be reported to the committee. RS confirmed this information and other details of other health checks would be included in the report in future. It was important to consider how these health checks would be delivered given the current constraints. AM commented LeDeR reviews indicated the quality of annual health checks could vary. It was agreed to present this data at the closed meeting. RK noted David Soodeen had an interest in this area. RS confirmed his involvement; discussions to ensure learning arising from LeDeR Review was included in the Learning Disabilities were in place. RK noted the importance of including Public Health in discussions. **The Primary Care Commissioning Committee received the report.**	**RS**
12	**Medicines Management Optimisation Report** DC highlighted the Medicines Quality and Safety Group update. The group looked at incidents and high-risk medicines. There was a focus on consistent reporting across the system including primary care. Insulin and anticoagulants. Work in the quarter had supported the Covid-19 response across the system, including guidance on specific medicines, monitoring frequencies of specific high-risk medicines to help reduce patient contacts. This would contribute to recovery work. The work to increase the uptake of electronic prescribing and repeat dispensing was highlighted; uptake was nearing 90%. As repeat prescription hubs came online this would increase.	

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	Attention was drawn to the red drug prescribing audit results. The audit highlighted areas where the documentation of red drugs could be improved in GP practices and identified where patients had bloods taken in primary care. There was a lack of assurance that secondary care picked up and actioned the results. There would be a link to the Phlebotomy work currently taking place to ensure clear governance was built into processes. The Community Pharmacist Consultation service (CPCS) and locally an extension to include PGDs were highlighted. Initial feedback was positive and the service was gaining momentum. Reporting was in place to monitor the service. The Sore Throat PGD had been suspended due to Covid-19. Regarding Antimicrobial stewardship, all practices were prescribing less than 10% of the three antibiotics identified in the report. Further progress was required to reduce prescribing to below the national average. FF noted the comments relating to the community phlebotomy service and patients welcomed having bloods taken by the GP practice. AM noted patients should be able to access blood results on-line. JR asked whether results were shared with patients. MJ confirmed this was in place. JR asked if this was clear for patients. It was agreed to review this. AB noted the number of PGDs reported in the paper and asked if this was lower than expected. DC explained the position reported was for a short period and training was being rolled out across community pharmacists. There would be a more detailed quarterly report on this service in future reports. AB commented asked if there had been a rise in antibiotic prescribing with the move to online prescribing. DC explained a rise was not reported however, more analysis was being completed to understand the local position. GI commented the next Primary Care Strategy update would include the PGD and community Pharmacy. DC agreed to provide a quarterly report and it would include a regular update on the CPCS and PGD activity **The Primary Care Commissioning Committee noted the report**	**DC** **GI** **DC**
13	**Contracts and Performance Report** There were no questions from the committee **The Primary Care Commissioning Committee noted the contents of the report.**	
15	**Questions from the Public – previously notified to the Chair** There were no questions from the public.	

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11	**Any Other Business** none	
12	**Committee Effectiveness** Members considered the checklist. It was noted the meeting did not run to time. It was reiterated it would be helpful to have the action log updated outside of the meeting. It was felt the meeting was effective.	
13	**Date of next PCCC:** Tuesday 30th June 2020 9am-1pm	
	The "motion to resolve under the provisions of Section 1, Subsection 1 of the Public Bodies (Admission to Meetings) Act 1960 that the public be excluded from the meeting for the period that the Clinical Commissioning Group is in committee, on the grounds that publicity would be prejudicial to the public interest by reasons of the confidential nature of the business" was proposed by STW and seconded by JRu	

Sarah Carr, Corporate Secretary, July 2020