Leicester City Clinical Commissioning Group
West Leicestershire Clinical Commissioning Group
East Leicestershire and Rutland Clinical Commissioning Group

Meeting Title	**Commissioning Committee (Joint Committee) - Meeting in Public**	**Date**	**Thursday 15 April 2021**
Meeting no.	**7**	**Time**	**2:15pm – 2:30pm**
Chair	**Ms Gillian Adams Independent Lay Member West Leicestershire and Rutland CCG**	**Venue / Location**	**MS Teams**

REF	AGENDA ITEM	ACTION	PRESENTER	PAPER	TIMING
CCP/21/24	Welcome and Introductions		Gillian Adams		2:15pm
CCP/21/25	Apologies for Absence • Professor Lakhani • Fiona Barber • Dr Varakantam • Caroline Trevithick	To receive	Gillian Adams	**verbal**	2:15pm
CCP/21/26	Notification of Any Other Business	To receive	Gillian Adams	**verbal**	2:15pm
CCP/21/27	Declarations of Interest on Agenda Topics	To receive	Gillian Adams	**verbal**	2:15pm
CCP/21/28	To receive questions from the Public in relation to items on the agenda only	To receive	Gillian Adams	**verbal**	2:15pm
CCP/21/29	Minutes of the Commissioning Committee (CC) meeting held on 18 February 2021	To approve	Gillian Adams	**A**	2:20pm
CCP/21/30	Matters Arising from Commissioning Committee (CC) meeting held on 18 February 2021 – the action log is not included as it does not contain any outstanding actions	To receive	Gillian Adams	**B**	2:20pm
THERE ARE NO ITEMS FOR DECISION, ACTION AND ESCALATION					
CCP/21/32	Items of any other business.	To receive	Gillian Adams		2:25pm
The next meeting of the Commissioning Committee will take place on **Thursday 20 May 2021**					

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Minutes of the LLR CCGs' Public Commissioning Committee meeting held on Thursday 18 February 2021 at 1:00pm via MS Teams

Present:

Ms Gillian Adams	Independent Lay Member, West Leicestershire CCG (Chair)
Dr Andy Ahyow	Vice Clinical Chair, East Leicestershire and Rutland CCG
Ms Fiona Barber	Independent Lay Member, East Leicestershire and Rutland CCG
Ms Fay Bayliss	Deputy Director of Integration and Transformation, LLR CCGs (deputising for Rachna Vyas)
Ms Nicci Briggs	Executive Director of Finance, Contracting and Performance, LLR CCGs
Mr Ket Chudasama	Deputy Director of Strategy & Planning, LLR CCGs (deputising for Sarah Prema)
Professor Azhar Farooqi	Clinical Chair, Leicester City CCG
Mr Zuffar Haq	Independent Lay Member, Leicester City CCG
Dr Avid Prasad	Assistant Clinical Chair, Leicester City, CCG
Dr Nil Sanganee	Vice Clinical Chair, West Leicestershire and Rutland CCG

In attendance:

Ms Lynnette Farmer	Executive Assistant to Executive Director of Strategy and Planning (Minute Taker)
Ms Julie Stone	Senior Elective and Cancer Services Manager, LLR CCGs **(CCP/21/16)**

PUBLIC GALLERY The meeting was not attended by any members of the public.

ITEM		LEAD RESPONSIBLE
CCP/21/09	**Welcome and Introductions** Ms Gillian Adams welcomed the Committee members to the meeting of the Public Collaborative Commissioning Committee held via MS Teams.	
CCP/21/10	**Apologies for Absence** Were recorded as follows: • Ms Rachna Vyas, Executive Director of Integration and Transformation, LLR CCGs • Ms Sarah Prema, Executive Director of Strategy and Planning, LLR CCG • Dr Vivek Varakantam, Clinical Chair, East Leicestershire CCG • Professor Mayur Lakhani, Clinical Chair, West Leicestershire CCG • Mr Richard Morris, Deputy Director of People and Innovation, LLR CCGs The meeting was confirmed as being quorate in order to conduct the	

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	business of the committee.	
CCP/21/11	**Notifications of Any Other Business** Ms Adams confirmed that she had not received notification of any other business for discussion.	
CCP/21/12	**Declarations of Interest** Ms Adams reminded members of their obligation to declare any interest they may have on any business arising at the meeting which might conflict with the business of NHS Leicester City CCG, East Leicestershire and Rutland CCG or West Leicestershire CCG. Ms Adams added that each CCG maintains a conflicts of interest register and any declarations raised at the meeting would be documented in the minutes of the meeting and action(s) would be taken to manage the conflict(s) at the meeting in line with the conflicts of interest policy. No specific conflicts of interest were declared in relation to the public session. It was **RESOLVED** to: • **NOTE** the conflicts of interest information above.	
CCP/21/13	**To receive questions from the Public in relation to items on the agenda.** There were no questions received in advance of the meeting from members of the public in relation to the agenda items.	
CCP/21/14	To **APPROVE** Minutes of the Collaborative Commissioning Committee (CC) meeting held on 21 January 2021 (**Paper A**) The minutes of the Collaborative Commissioning Committee held on 21 January 2021 were recorded as a true reflection of the meeting, with the following point of accuracy recorded: Ms Barber referred members to the top of page one where it stated "chair" after Ms Barber's job title. Ms Barber asked for this to be removed as Ms Adams had chaired the January 2021 meeting. It was **RESOLVED** to: • **AMEND** the minutes as requested above and once completed **APPROVE** the minutes of the Collaborative Commissioning Committee meeting held on 21 January 2021.	
CCP/21/15	To **RECEIVE** Matters Arising from Collaborative Commissioning Committee (CC) meeting held on 21 January 2021 (Paper B) Paper B was not presented as all actions had been completed at the	

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	CC meeting on 17 December 2020. It was **RESOLVED** to: ➢ **NOTE** that there had not been any matters arising from the previous meeting and all previous actions had been completed at the CC meeting on 17 December 2021. Ms Stone joined the call	
CCP/21/16	To **APPROVE** East Midlands Familial Hypercholesterolemia Service (**Paper C**) Ms Adams welcomed Ms Stone to the meeting and asked if she would provide background on Paper C to the CC. Ms Stone provided background as follows and explained the paper related to the Familial Hypercholesterolemia Service across the East Midlands. The LLR Sustainability and Transformation Programme (STP) were approved by the East Midlands Clinical Network to provide the service. The East Midlands Clinical Network offered £71,000 to support services and the business was approved at the time. Ms Stone explained the purpose of attending the Collaborative Commissioning Committee meeting was to request approval of an East Midlands Familial Hypercholesterolemia Service. The CCGs would become the lead commissioner as University Hospitals Leicester (UHL) had been appointed as the host organisation. The full investment requested for 2021-22 is £81,000 and for 2022-23 it would be £79,000. At Ms Adams request Ms Stone provided an overview of the paper as follows: Familial Hypercholesterolemia is a genetic condition and as part of the Long Term Plan, a commitment was made to diagnose 25% of the LLR population. Currently there are approximately 5000 people across LLR that are undiagnosed. UHL, as the host, would employ one whole time equivalent (WTE) nurse who would work across primary and help to identify patients for the service. In addition, there would be a Programme Manager and funding for admin support, including IT and accommodation. The posts would be recruited to and funded by UHL. Ms Stone invited questions and/or comments from the CC and the following points were noted: Dr Sanganee stated that he was in support of the paper and asked if the nurse running the service would be offering training to primary care staff which would enable primary care to provide the service in the future? Familial Hypercholesterolemia is not a widely recognised condition in primary care and is only partially managed by clinicians. It would be beneficial to have a specialist training programme so that	

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	it could be picked up by primary care in the future. In response, Ms Stone informed there would be satellite clinics across LLR and training would be provided. Currently looking for recurrent funding for two years and at the end of the two years there would be a review. The aim is to have a primary care model for the service rather than having a UHL hosted service. Professor Farooqi explained that LLR was one of a few areas in country that did not have a familial hypercholesterolemia service and informed that the West Midlands have had a very effective service for some time. The proposed service would be cost effective and the CC could be reassured that not only is it a good thing but it should save money too. Primary care would have a big part to play in this in terms of identifying patients from their lists. At this point Ms Barber informed she had a minor conflict of interest as her spouse is a member of the familial hypercholesterolemia family. Ms Barber went on to say she though the proposals were excellent and it was the right time to make this service much more effective for people across LLR. Ms Barber asked Ms Stone if the following areas had been explored: Engagement and Communication with patients; the model presented in the business case has been a successful model in the West Midlands; but has the team discussed this with patients across LLR to ascertain their thoughts and views? Reference to section 14 consultation is missing from the paper. Although the service has existed, this is a new way of delivering it and engagement is required. Professor Farooqi has touched on the impact of this. Ms Barber asked; how would people know when if the service has successful? What would success look like across LLR? Where would patient outcomes be reported? There does not seem to be a clear sense of patient reported outcomes and what those outcomes might be. Ms Barber stated she would like to have a better understanding of the above areas and see them articulated in the paper more clearly. Ms Adams explained that the needs to seek assurance that any obligations under section 14 of the act have been carried out in relation to patient engagement. **Ms Stone was asked to feed patient engagement back to the East Midlands Steering Group.** Ms Stone agreed there was more work to do in relation to patient engagement and informed the paper included an example of a case study from the West Midlands. In terms of outcomes; this cannot be looked at as a financial service.	Ms Stone

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	It is a quality model and the outcomes should be the number of patients identified and the number of undiagnosed patients reducing. Ms Barber added that the number of patients identified would be the output and when talking about the outcome, this would be the raw data particularly around patient reported outcomes, ie where patients provide information about how the treatment has impacted on their quality of life. This is an area that the CCGs need to improve on and requires someone to look at it. Professor Farooqi suggested the data should clearly show the actual prevalence versus the expected prevalence. The data is important and should assist picking up the patients that should be picked up. Professor Farooqi agreed that patient experience should be measured and stated the condition is symptomless but there are measurables that would be worth looking at. Ms Adams stated the CCs understanding of Section 14 of the 2006 and 2012 Acts was the obligation to consult when there is to be a change in service and this should be done prior to designing the service and implementing it. It is important that for future services where service changes are required that patient engagement is undertaken beforehand. It has not been done on this occasion and would encourage the CCGs and STPs to think about how they can do some rapid patient engagement for this service. **Ms Stone to feedback at the next East Midlands Steering Group meeting.** Ms Stone informed that LLR does not have a familial hypercholesterolemia testing service currently and it is a brand new service but understood there were some patients who would benefit from some type of engagement. Mr Haq asked if training could also be provided to opticians and if BME patients from the list of cholesterol and cardio-vascular patients in particular could be reviewed. The results would be fewer heart attacks from that patient cohort. Mr Haq stated he accepted the point about consultation; however there is a pandemic and there are lots of heart and cancer conditions going undetected at the moment and less use of primary care in general. Opticians are seeing a lot of patients with problems that have occurred quite rapidly as primary care and the hospitals are struggling. Ms Adams asked GPs to comment on Mr Haq's point about familial hypercholesterolemia? Dr Sanganee informed opticians were very good at sending in reports to GPs when they notice cholesterol in patients. However, this is a genetic condition that can be transmitted through families. Testing and NHS health checks have been stood down during the pandemic and practices have put these things on the back burner whilst they have been dealing with COVID and have not generally diagnosed patients with this condition.	Ms Stone

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	Dr Ahyow raised a number of points as follows: 1) He had made the assumption that as part of the nurse led clinics, patients would receive the appropriate counselling for familial hypercholesterolemia. 2) Regarding family contacts Dr Ahyow asked if the service contacted families and processed them, sent out letters and information to explain the condition or if that would be the responsibility of the family member? Would family contacts have adequate counselling through this service? 3) The service should refer patients onto the relevant specialist service, ie the lipid clinic, cardiology, etc and Dr Ahyow asked if children would be referred to the paediatricians? 4) Could the CC be assured the service would engage with specific communities in LLR who may already struggle to engage with services and their GP? 5) Could the service ensure it would not widen health inequity? The patients practices wish to target are those patients that do not attend; thereby this could inadvertently widen the health inequity gap. Ms Stone responded to each question in turn as follows: 1) Counselling: Ms Stone explained that part of the National Institute for Health and Care Excellence (NICE) criteria was that counselling was included in the service and trained nurses would provide the counselling. 2) Cascade testing would be undertaken by the nurses based on the patients' giving their consent for family members to be contacted. 3) Specialist Services: Patients would be referred back to the Lipid Clinic, which is the specialist service and the lipid clinical also picks up children. 4) Support would be provided to practices to identify cases and patients would also be identified from the UHL lipid clinic list. 5) Health Inequity: Ms Stone stated she would like to go back to the steering group and request that this be monitored by geography and ethnicity to ensure it is captured and does not lead to widening the health inequity. Professor Farooqi asked if something could be included in the standard operating procedure on how language barriers would be dealt with. Ms Adams stated quite a high figure (£18k) had been included in the	

ITEM		LEAD RESPONSIBLE
	paper for travel and accommodation and asked if this cost was still relevant in the new virtual world. Ms Adams asked if the steering group could also consider a virtual model with a view to reducing costs. **Ms Stone to take back the above comments to the Steering Group and update the CC accordingly.** It was **RESOLVED to:** • **SUPPORT** the business case to implement a regional East Midlands Hypercholesterolemia Service and the recommendations within the paper. Ms Barber asked for it to be recorded that **APPROVAL** would be granted by the CC following successful patient consultation across LLR and suggested Ms Stone approach HealthWatch for support with this.	Ms Stone
CCP/21/17	Any other business: None recorded. Meeting concluded at 1.31pm Committee members and the presenter(s) left the meeting call.	
Date of next meeting: The date of the next LLR CCGs' Public Collaborative Commissioning Committee will be held on Thursday 18 March 2021 at 1:00pm		

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