NHS LIVERPOOL CLINICAL COMMISSIONING GROUP
PRIMARY CARE COMMISSIONING COMMITTEE
Minutes of meeting held on Tuesday 16TH JUNE 2015 at 10am
Boardroom Arthouse Square

Present:
Voting Members:

Dave Antrobus (DA)	Governing Body Lay Member – Patient Engagement (Chair)
Nadim Fazlani (NF)	GP Governing Body Chair
Katherine Sheerin (KS)	Chief Officer
Tom Jackson (TJ)	Chief Finance Officer
Dr Rosie Kaur (RK)	GP Governing Body Member/Vice Chair

Non voting Members:

Moira Cain (MC)	Practice Nurse Governing Body Member
Tina Atkins (TA)	Governing Body Practice Manager Co-Opted Member
Sarah Thwaites (ST)	Healthwatch
Dr Adit Jain (AJ)	Out of Area GP Advisor

In attendance:

Cheryl Mould (CM)	Head of Primary Care Quality and Improvement
Colette Morris (CMo)	Locality Development Manager Liverpool Central Locality
Scott Aldridge (SA)	Neighbourhood Manager - North Locality/Local Quality Improvement Schemes and Veteran Health Lead
Tom Knight (TK)	Head of Primary Care - Direct Commissioning, NHS England
Alan Cummings (AK)	NHS England
Derek Rothwell (DR)	Head of Contracts & Procurement
Kim McNaught (KMc)	Deputy Chief Finance Officer
Michelle Urwin (MU)	Transformational Change Manager
Alison Ormrod (AO)	Chief Accountant
Paula Jones	PA/Note Taker

Apologies:

Jane Lunt (JL)	Chief Nurse/Head of Quality
Paula Finnerty (PF)	GP – North Locality Chair
Simon Bowers (SB)	GP/Governing Body Member
Prof Maureen Williams (MW)	Lay Member for Governance (Vice-Chair)
Samih Kalakeche (SK)	Director of Adult Services and Health (Health & Wellbeing Board Non-voting Member)

Dr Sandra Davies (SD) Interim Director of Public health
Rob Barnett (RB) LMC Secretary

Public: 5

PART 1: INTRODUCTIONS & APOLOGIES

The Chair welcomed everyone to the meeting and introductions were made. It was highlighted that the public were in attendance but any questions they wished to raise needed to be done via the public Governing Body meeting.

1.1 DECLARATIONS OF INTEREST

It was noted that there were no specific declarations of interest to be made.

1.2 MINUTES AND ACTIONS FROM PREVIOUS MEETING ON 19TH MAY 2015

The minutes of the meeting on 19th May 2015 were approved as an accurate record subject to the following clarifications:

- KS noted re Section 1.2 legal responsibility lay still with NHS England but the role of the CCG under delegated responsibility was much stronger than "influencing" and the minutes needed to be amended to reflect this.

- KS noted that the Terms of Reference required clarification in the section around changes and review date. Also the minutes should read that MW should not be the Vice Chair. There might be changes made to the Terms of Reference prior to the Review Date but these could be approved by the Primary Care Commissioning Committee. It had been agreed post meeting that KS would be the Vice Chair. It was agreed that the Terms of Reference would be amended and brought back under matters arising.

- Section 2.1 Transition Plan – KS noted that the minutes required clarification as some of the areas in red referred to areas that did not need to have happened yet, and should be coded differently.

- Item 2.3 Liverpool APMS Contract – Process for Decision Making with Regard to Contract Extension – KS noted that page 5 3rd bullet "Difficulty in finding appropriate interim provider" should be a separate paragraph and not part of the list of bullets around the indicators used and process.

The Primary Care Commissioning Committee:

- **Noted the approval of the minutes.**

1.3 MATTERS ARISING – Verbal

1.3.1 Action Point One – it was noted that the Risk Register was on the agenda.

1.3.2 Action Point Two – APMS Contract – this had not been agreed and the CCG was considering another approach to the issue.

The Primary Care Commissioning Committee:

- **Noted the issues raised under matters arising.**

PART 2: TRANSITION ISSUES

2.1 TRANSITION WORKING GROUP FEEDBACK – REPORT NO: PCCC 04-15

CM fedback to the Primary Care Commissioning Committee on the last meeting which had taken place on 3rd June 2015 when the Transition Plan had been discussed.

The key issues outstanding were:-

- Premises - NHS England had been asked to present a detailed overview at the next meeting.
- Contract Management – no confirmation received yet of current contract status of all practices, this would be provided within the next 2 weeks.
- Clinical Quality Reporting Service ('CQRS') – access still to be given to CCGs. NHS England continued to approve

payments. it was confirmed for DA that this was a payment system not a service.

- Primary Care Performance Report – a framework was to come to the Primary Care Commissioning Committee in July 2015.
- The Group was now to meet monthly rather than weekly and two senior members of NHS England were based in Arthouse Square one day a week. CCG staff were also encouraged to go to Regatta Place

The Primary Care Commissioning Committee:

- **Considered the report and recommendations from the Working Group.**

PART 3: STRATEGY & COMMISSIONING

3.1 ENHANCING ACCESS TO PRIMARY CARE 2014/15 – REPORT NO: PCCC 05-15

The purpose of the paper was to update the Primary Care Commissioning Committee on the Enhancing Access to Primary Care Scheme and its impact during the winter period 2014/15 and to propose recommendations for the continuation of the scheme subject to the development and implementation of the primary care model for seven day working in Liverpool.

- Set up in November 2014 as part of the winter resilience, to increase capacity which would influence ACS/Emergency admissions. This was a scheme to increase patient GP/Nurse Practitioner/Telephone consultations from the commissioned 70 appointments per 1,000 weighted population either to 75 or to 80 appointments per 1,000 weighted population. The total budget approved was £2m.
- In addition there was also the Review of Older Peoples' Framework funding of £5 per head for the over 75s and risk profiling therefore there were three schemes in total looking at reducing hospital admissions (discussed later in the meeting).
- The Improving Access scheme had been extended to 30th September 2015 by the CCG Approvals Panel in April 2015. All 80 participating practices agreed to continue to deliver

the same level of Enhancing Access through to 30th September 2015.

- 90,000 additional appointments available i.e. 4,000 additional appointments per week.
- A&E activity and ACS admissions had seen an increase overall but at a lower rate in practices participating in the Enhanced Access Scheme.
- Qualitative findings section of the paper – full details contained in Appendix 3 – as a result it was proposed in the paper to extend the scheme until April 2016.

DA commented that this was an excellent and comprehensive report. AC queried about practices wanting to provide out of hours additional capacity rather than in hours. CM responded that this had been offered last year and the uptake had been very poor. KS noted that the use of the term "reduction" in the paper was misleading as it was acknowledged that demand for ACS/A&E had increased everywhere just that the increase was lower in participating practices.

RK endorsed that GP Specification A&E attendances and ACS Admissions were lower than the 2014/15 activity in practices participating in the scheme although higher than the 2013/14 activity for over 75s, under 75s and all ages.

NF noted that this was extremely positive but that there were caveats to be considered re comparing like for like.

CM noted the importance of understanding the position for the practices which had not participated in the scheme in order to avoid increasing variation.

NF noted that the Seven Day Working Model would be presented to Member Practices at a meeting in September 2015 and was not anticipated to be in place earlier than April 2016 therefore the paper recommended that the Enhancing Access to Primary Care Scheme would continue for a further six months until 31st March 2016 until the new model for Seven Day Working was in place.

The Primary Care Commissioning Committee:

- **Noted the content of the report**
- **Noted the findings from the evaluation**

- **Supported the recommendation to continue with the Enhancing access to primary care scheme through to 31st March 2016 or until the new model for 7 day working in primary care is in place**

3.2 REVIEW OF OLDER PEOPLE'S FRAMEWORK INTRODUCED IN 2014-15 (£5 PER HEAD SCHEME) – PCCC 06-15

MU presented a paper to the Primary Care Commissioning Committee to brief on the delivery and impact of the introduction of the Older People's Framework (£5 per head) and to provide recommendations for consideration for how future funding should be invested. This had come out of the national planning guidance 'Everyone Counts' 2014/15 asking CCGs to identify £5 per head per patient aged over 75. The four areas within the Older Peoples' Framework were:

1. Comprehensive Geriatric Assessment
2. Anticipatory Care plans
3. Comprehensive Medication Review
4. Proposals around addressing social isolation.

The schemes went to the Approvals Panel for authorisation. 80 practices signed up representing 29,500 patients aged over 75 accounting for 88% of the overall Liverpool population aged over 75.

£2.5m was the allocated budget of which the CCG had already approved £1.6m for the Older People's Framework and £97k for social isolation.

The March 2015 Governing Body had approved an extension of the Framework to July 2015 in order for practices to complete what they had agreed to undertake. At the end of March 2015 6,258 (of the 9,495 planned) Comprehensive Geriatric Assessment and 603 (of the1,467 planned) Anticipatory Care Plans were in place. 7,884 (of the 15,128 planned) Comprehensive Medication Reviews had been carried out hence the need for the extension.

Emergency admissions in 2014/15 had increased 15% but practices participating in the scheme had seen less of an increase. Emergency admissions from Care Homes had risen by 9.8%, the highest number being during winter but again less for those linked to participating practices.

Hospital Admissions due to Falls for over 80s: had risen substantially from 2013/14 to 2014/15 but a greatly reduced increase for participating practices.

Dementia Diagnosis: this had shown continual improvement – Liverpool had met the agreed diagnosis rate of 64% at the end of March 2015.

Qualitative Review:

56% of practices completed a telephone review, the scheme had not specified how the additional capacity would be delivered and this had been left to individual practices to decide, however the bulk had been delivered in hours by existing staff. 91% of practices felt the schemes had benefitted their patients and 93% of patients felt that the funding should continue.

There were weaknesses identified: the potential for variation between practices across the city and the increase of health inequalities, and the discouragement for practices to work together collaboratively with other organisations as funding went directly to the practices.

For this reason the recommendation in the paper was to end the Scheme at 31st July 2015 and the national funding recommendation of £5 per head to be allocated in principle to support delivery of the Older People's component of the Community Model of Care as part of Healthy Liverpool. The Matchworks Locality was working closely with the CCG to develop a proposed model. The Vision was set out on page 13 of the paper to enable older people to live safely in their usual place of residence for longer by positively maximising independence. It was noted that "Frailty" usually referred to over 65s but could be younger depending on specific criteria. The key features of the Frailty Model were set out on page 14 of the paper being equitable, person centred, timely/responsive, person centred and high quality. There would be additional resources for Neigbourhoods to meet local needs and to build in prevention/self care. There would be systematic Risk Stratification of patients and proactive/reactive response and joined up care. Ease of access to services from clinicians was required.

The Frailty Response was contained on page 18 of the report. A reactive response involved a Comprehensive Geriatric Assessment using the Rockwood Frailty Tool sever, moderate and mild frailty. A proactive response involved risk

stratification/identification using national tools such as the GAIT test and Prisma 7. This would be sent to the Locality Multi-Disciplinary Team and would lead to the completion of a Comprehensive Geriatric Assessment.

Page 19 of the report showed the step up/step down bed base structure using the correct level of support/reablement to ensure patients were transferred safely back to home.

MU noted the model was still being built and the Sheffield model had been looked at. MC advocated using the More Independent Programme as a way of being proactive. It was agreed that the Comprehensive Geriatric Assessment was key to the model. MC asked for all possible tools/points of contact with patients to be utilised, giving the example of Practice Nurses.

KS referred to emergency admissions for over 75s and the rise from the previous year and stressed the need to understand why and consider it in the new model and not lose momentum therefore be clear about what was required to be in place September/October/November. It would be good to do some financial modelling and produce a paper on what the cost would have been to practices if they had not participated in the scheme. NF noted that the community model was key, this was a complex area and could not be replaced overnight, the learning from the previous year should be used to begin the process. MU explained that there was a whole team involved in this therefore a plan of work areas to "pick off" was required for best use of resources. AJ reinforced the need for a collaborative approach and for training to be targeted specifically, not just GPs but also care home staff. MC noted that it would be a real step forward for the CCG being able to offer training to care home staff.

RK highlighted the need to maintain engagement with the 80 practices already signed up and the need for simplicity and clarity re templates to be completed.

ST stressed the importance of the Voluntary Sector being kept in the loop for the services they provided.

The Primary Care Commissioning Committee:

- **Noted the contents of the report**
- **Agreed to end the current Older Peoples Framework scheme at 31st July 2015**

- **Agreed that instead the national funding recommendation of £5 per head population to support older people, be allocated in principle to support delivery of the older people component of the Community Model of Care.**

PART 4: GOVERNANCE

4.1 INTERIM PROVIDER POLICY – REPORT NO: PCCC 07-15

RK presented a paper to the Primary Care Commissioning Committee on an interim provider policy for consideration and approval.

There were four options outlined in the paper:

1. Provision of core contract
2. Provision of core contract plus public health initiatives e.g. vaccinations and immunisations
3. Provision of core contract, GP specification and public health initiatives
4. Provision of core contract, GP specification, public health initiatives and enhanced services

Option 4 was the preferred option as this would ensure that patients were not disadvantaged when an interim provider was in place.

The paper proposed that should an interim provider be required and the period of service provision did not exceed 18 months the CCG could write to all Liverpool Member Practices only to invite expressions of interest provided that:

- Individual practice's most recent CQC report had an overall rating of "outstanding" or "good"
- Individual practices did not have a contract breech or remedial notice in the last 12 months
- Individual practices did not have GP Specification funding reclaimed in the last 12 months.

ST asked for patient survey results/patient feedback to be considered in the process although not to be an exclusion criterion

per se. KS felt that his should not be an exclusion criterion but could be included in the template and feed into the weighting/analysis.

DR felt that more detail was required in the pro forma but the process itself was good. CM noted that an Evaluation Panel would be considering the principles and then applying evidence weighting. DR would review the process and then the recommendation would go to the Finance Procurement & Contracting Committee. In response to a query from AC SA confirmed that it was the contract holder who could apply.

TJ felt that the weighting process needed to be defined now and should the policy take into account de minimis requirements should there only be one applicant.

The Primary Care Commissioning Committee:

- **Adopted the policy that has been developed**
- **Approved option four for service provision**
- **Approved the process and exclusions listed which prevents a provider to apply**
- **Noted that slight amendments would be made to take into account legal advice.**

4.2 RISK REGISTER – REPORT NO: PCCC 08-15

The Primary Care Co-Commissioning Risk Register had been circulated to the committee in advance of the meeting. DA noted that no risks had worsened. It was agreed that this would be brought quarterly to the Primary Care Commissioning Committee.

The Primary Care Commissioning Committee:

- **Noted the risks and agreed that the risk scores accurately reflected the level of risk the CCG is exposed to given the current controls and assurances**
- **Agreed that the Risk Register would be presented on a quarterly basis.**

5. ANY OTHER BUSINESS

None

6. DATE AND TIME OF NEXT MEETING

Tuesday 21st July 2015 – 10am to12pm.