NHS LIVERPOOL CLINICAL COMMISSIONING GROUP

EXTRA-ORDINARY GOVERNING BODY

Minutes of meeting held on
TUESDAY 29 SEPTEMBER 2015
1pm – LACE CONFERENCE CENTRE, LIVERPOOL

PRESENT:

VOTING MEMBERS:

Dr Nadim Fazlani	Chair/GP
Katherine Sheerin	Chief Officer
Prof Maureen Williams	Lay Member – Governance/Deputy Chair
Dr Simon Bowers	GP/Clinical Vice Chair
Jane Lunt	Head of Quality/Chief Nurse
Dr Fiona Ogden-Forde	GP
Dr Fiona Lemmens	GP
Dr Janet Bliss	GP
Dr Maurice Smith	GP
Dr Shamim Rose	GP
Dr Rosie Kaur	GP
Tom Jackson	Chief Finance Officer/ Healthy Liverpool Integrated Programme Senior Responsible Officer
Dr Monica Khuraijam	GP
Moira Cain	Practice Nurse

NON VOTING MEMBERS:

Dr Paula Finnerty	GP – North Locality Chair
Dr David Webster	GP – Matchworks Locality Chair
Dr Rob Barnett	LMC Secretary
Dr Sandra Davies	Interim Director of Public Health
Tina Atkins	Practice Manager

IN ATTENDANCE:

Cheryl Mould	Head of Primary Care Quality & Improvement
Carole Hill	Healthy Liverpool Integrated Programme Director
Ray Guy	Retired Practice Manager
Stephen Hendry	Acting Head of Operations & Corporate Performance
Alison Ormrod	Interim Head of Finance
Lynn Collins	Chair of Healthwatch Liverpool
Phil Wadeson	Director of Finance, NHS England Sub Regional Team
Kate Warriner	Healthy Liverpool Digital Care & Innovation Programme | ILINKS Managerial Lead
Ellen Gerrard	NHS Management Trainee
Carol Hughes	Minutes

APOLOGIES:

Dr Donal O'Donoghue	Secondary Care Doctor
Ian Davies	Healthy Liverpool Programme Director – Hospitals & Urgent Care
Dr Tristan Elkin	GP – Liverpool Central Locality
Councillor Roz Gladden	Liverpool City Council
Dr Rob Barnett	LMC Secretary
Dave Antrobus	Lay Member – Patient Engagement
Tony Woods	Healthy Liverpool Programme Director - Community & Digital Care
Councillor Roz Gladden	Liverpool City Council

Public: 9

PART 1: INTRODUCTIONS & APOLOGIES

Introductions were made for the benefit of the members of the public present.

1.1 DECLARATIONS OF INTEREST

There were no declarations made specific to the agenda.

PART 2: STRATEGY AND COMMISSIONING:

2.1 Healthy Liverpool Strategic Direction Case Report: GB67-15

The Chief Officer introduced the Report, the purpose of which was to describe the overarching Healthy Liverpool model, to set out the formal definition of the 5 core Healthy Liverpool programmes and to seek approval to fully mobilise the Healthy Liverpool Programme.

The engagement which had taken place with hundreds of clinicians and others and members of the public was acknowledged and the further work required in terms of engagement was highlighted.

It was noted by the Chief Finance Officer/Healthy Liverpool Senior Responsible Officer that the case for change in Liverpool remains compelling, with a growing ageing population and some of the poorest health outcomes in the country.

It was highlighted that the Prospectus for Change in November 2014 sets out the case for change in Liverpool, with a 5 year 'live strategy' with principles for a person centred, outcomes focused and clinically led system. Since then there has been significant dialogue with clinicians to describe how the ambitions will be delivered, and this is described in the Strategic Direction Case.

The following areas were highlighted:

The vision of Healthy Liverpool is to provide a health care system in Liverpool which is Person centred, supports people to stay well and provides the very best in care.

The ambition of Healthy Liverpool is:

- To reduce years of life lost
- To improve the quality of life for people with long term conditions
- To reduce avoidable emergency admissions
- For hospitals to be in the top 10 for good patient experience
- For community based care to be in the top 5 for patient experience

Each ambition has measurable targets, and the programmes within Healthy Liverpool are designed to achieve these.

It was noted that Healthy Liverpool consists of 5 Transformation Programmes:

- Living Well
- Community Services
- Digital Care and Innovation
- Hospital Services
- Urgent and Emergency Care

Highlights were given for each area:

Living Well: Dr Maurice Smith:

Dr Smith highlighted that the vision for the Living Well Programme is that ***'Liverpool will be the most Active City in England by 2021, inspiring and enabling people who live and work in the city to be active every day for life,***' aiming to engage an additional 118,000 people to undertake at least 30 minutes of activity one day per week by 2021.

The recommended guidelines of 30 minutes activity 5 times per week would save over 400 lives per year, prevent 5,000 cases of diabetes, people would live longer and be more healthy and would be less likely to get chronic diseases. Those with chronic diseases who become more active would result in less admissions to hospital.

Work is being done in partnership between the CCG and Local Authority engaging multiple stakeholders across the city to get the inactive active, the moderately active more active and to ensure the active remain active with investment of £2.8m over 2 years to make this a reality and to put in a good position to support the rest of the Healthy Liverpool agenda.

Community: Dr Janet Bliss

Dr Bliss highlighted that the vision for the Community Programme is to ***'make the most of the city's assets to deliver the very best in community based care and support, to improve the health and wellbeing of the people in Liverpool.'***

Work is being undertaken with partners and stakeholders to look at programmes and design principles have been produced against which all projects within the programme will be checked.

Dr Bliss confirmed the 6 design principles:

- **Person Centred –** needs of the individual rather than organisations
- **Promoting a proactive approach -** in addition to responding when there is a need in crisis – to deal with patients before that need arises
- **Eliminating avoidable variation in the quality of care**
- **Improving access to services in the community**
- **Integrated across health, social care and voluntary sector**
- **Making the best of digital technology.**

The 4 elements of the Community Care Model were highlighted:

Community Care Teams - offering all patients access to community nurses, social workers and wellbeing services working together to deliver community based care in both a reactive and proactive way. Teams will be delivered on a neighbourhood footprint so they are local to people needing them and promoting good working relationships and continuity of care, with access to a wider range of therapists.

Specialist Clinical Integration – This is for people with certain conditions, mostly long terms conditions, which are better managed in the community rather than hospitals with specialists (including Hospital Consultants) working in a community setting, sharing care of the patient with GPs which will improve outcomes overall and management of conditions.

Managing Complex Needs – recognition that the universal offer does not meet the needs of all of the people such as individuals with specific needs e.g. complex alcohol, addictions etc., with services targeted towards people in these groups.

Neighbourhood Collaborative – neighbourhood teams working closely with other partners and agencies to promote health and wellbeing e.g. schools, fire services, other community leaders, bringing the community together to promote health and wellbeing messages to enable us to build and strengthen communities.

Enablers – will support the model and huge overlap with the other programmes was noted.

Digital Vision: Dr Simon Bowers

Dr Bowers highlighted that the vision for the Digital Programme is ' ***to be in the top 10 most digitally advanced health and social care economies in Europe by 2020'.***

This will enable people to use digital technologies to manage their own care, ensure information is available to the right people in the right place, at the right time and create and deliver information exchange across health and social care, whilst fully exploiting data and intelligence available to maximise effectiveness of services.

Dr Bowers referred to Digital Model and particularly highlighted the Person Held Records which would give access by every patient registered with a Liverpool GP, giving Liverpool the leading edge for NHS digital. So far we have 5.5m shared records, the largest deployment of tele-health in Europe (2000 patients), 600 community champion volunteers, and support for an E-health cluster to develop services and products for the NHS.

Urgent Care: Dr Fiona Lemmens

Dr Lemmens highlighted that the vision for the Urgent Care programme was to ***'deliver an urgent and emergency care pathway that is recognisable and clear to patients, public and healthcare professionals, delivering the right care at the right place, first time.'*** reducing unnecessary journeys around the system for patients.

It was noted that the scope for the Urgent Care system was for more self-care from patients to access community service, primary care, walk in centre and A&E departments through to major trauma centres, with a need to understand and respond to public expectations and demand, to consider what the patient and system needs, and to think about what patients and the public expect from those services.

The 5 principles for service design were referred to and the following areas highlighted:

Support for Self Care – to help patients to help themselves, with community pharmacies at the centre of the health care system

Maximising survival and recovery for those with serious and life threatening conditions – major trauma and emergency centre for the city to deliver highest quality care and meeting targets.

Connecting all parts of the urgent care system – to be better at using different part of the system to work together and support each other.

The overlap for urgent care with other programmes was noted and the following areas were highlighted:

NHS 111 – This is a critical area to help patients look after themselves, with a new provider from October 2015 for local 111 being a partnership between NWAS and out of hours GP services, giving more integrated and increasingly useful services for patients and professionals.

Community Pharmacies – were highlighted as a significant resource that we need to maximise

Primary Care – to develop access to primary care in the city 7 days per week (routine and urgent care) and to look at different ways of interaction with GPs e.g. skype and telephone

Urgent Care Centres – A national idea from the Keogh report to put together services, consideration to be given to think about how this would work locally.

Aintree - Regional Trauma Centre for Cheshire and Merseyside, need to work to ensure A&E is increasingly efficient

Ambulance Services – moving towards a service about treatment and less about transport e.g. telephone advice, treatment on the scene and referral to GP

Payment reform – Urgent Care is expensive so working with providers and NHS England to look at new models of paying for urgent care to make it more sustainable in the long term.

Hospitals: Dr Fiona Lemmens

Dr Lemmens highlighted that the vision for the Hospitals programme was for a '**Centralised *University Teaching Hospital Campus delivered through centres of clinical & service excellence'***. With an aim to have the best hospital care system in the country, for all patients to receive the right care in the right place the first time, a safe health care system that provides quality service, sustainable clinically and financially and maximising patient outcomes and experience.

Dr Lemmens highlighted the key principles:

Single Service Teams – reducing duplication across hospital services e.g. single cardiology team for the city.

Standardisation – reducing duplication in the system and to make sure everyone works to best possible standards.

Locally where practicable, centralised where necessary, a recurrent theme is that doctors and clinicians want where possible for care to be delivered as close to the patient as possible to get the best possible outcomes.

Discussion and clinical conversations have led to the conclusion that the city needs a centralised university teaching campus supported by local district hospitals and specialist providers.

This will enable delivery of 7 day services across the city, will address significant workforce issues in the city and will allow world class research and development by linking in with the university and pharmaceutical companies.

This strategic direction is endorsed by the clinical community and managerial leaders in the city.

Phase 1 priorities will include:

- Delivery of 7 day services
- Cancer
- Women's services
- Cardiology
- Stroke

Financial Strategy: Tom Jackson:

Tom Jackson noted that whilst the case for change for this programme was not financially driven, we will face significant financial challenges in this health system if we do not realise changes quickly. however it is moving towards a financial challenge commissioner led with a £1.2b annual spend on Health and Social Care, with the bulk spend remaining within treatment in the hospital sector.

It was highlighted that over the next few years, flat cash (zero growth) or up to 1.5% per year is likely, against growing demand equivalent to circa 4%. This would result in a £50 – 100m shortfall.

It was noted that 19% of the population in the city is classed as unwell with spend over 60% of the budget.

For the 308 people in the highest need group, hospital admissions average 9 times per year at an average cost of £36k each and we need to look at how to improve their clinical outcomes and have more efficient delivery of services.

Investment in transformation was highlighted:

	£
2013/14	25,182
2014/15	25,840
2105/16	29,343
2016/17	44,569
Total:	**124,934**

Next Steps: Carole Hill (Interim Programme Director)

Carole Hill explained the work done to date to engage local people and the next steps required.

- work with 18 community partners working to engage with specific communities and groups
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- 63 road shows across the city which engaged over 8,000 people
- Online engagement
- Social media campaign to raise awareness

Information from the above will be presented in a report to the November Governing Body.

More formal public consultation will be required for any major service changes. More imminently, further in depth engagement on the models and principles described in the Strategic Direction Case will be undertaken.

The Chair asked for comments and questions from Governing Body members:

Dr Maurice Smith commented that plans had been described and developed over a long period by the Governing Body and highlighted the incredibly powerful work to provide a coherent programme over the next few years and the commitment to invest in Liverpool to make the city more healthy.

In response, the Chief Office commented that we are currently in a fortunate position to plan for the future to make changes to services, to look at investment required to reduce health inequalities, and to bring this together in a whole programme with an investment strategy we really need to bring the public with us to make the changes needed.

Dr David Webster referred to the hospital presentation which highlighted the desire to improve services and to give better quality services for residents nearer to home rather than being spread across the city.

Professor Williams reiterated how fortunate we are as an organisation to be able to commit £75m to the NHS in Liverpool, the benefit of which will be seen over the next few years .

In conclusion, the Chair noted that this was a plan which has involved a high number of stakeholders, including the Local Authority, NHS Trusts locally and beyond, together with engagement with clinicians, managers and the public over the last 2 years. The Strategic Direction Case was formally submitted for approval by the Governing Body.

The NHS Liverpool CCG Governing Body:

- **Approved the Healthy Liverpool Programme Strategic Direction Case.**

3. QUESTIONS FROM THE PUBLIC

6.1 A question had been received from Mr S Semoff:

Mr Semoff referred to an article in the Health Service Journal in September 2015 in which Monitor is using a computer management model to forecast 4 types of out of hours care all of which are part of the CCG Strategy. What elements in the Strategy contradict the conclusions of Monitor and where is the evidence that the aspects of the CCG Strategy will actually work?

The Deputy Chair responded that it has been made clear that the reconfiguration of services is not starting from the basis of trying to save money but from the basis of trying to deliver better health outcomes through better service. There is significant evidence about the best way to deliver clinical results though reconfiguration of service delivery which is where we start from. However as we move along there is no guarantee that anything will be saved but what we do guarantee is that we will try and achieve better health outcomes.

Mr Semoff asked if a citation could be provided.

In response, the Chief Officer advised that there was a lot of international evidence that the key clinical service that impacts on health inequalities is Primary Care, with more money invested in deprived areas which is the direction of the Healthy Liverpool Programme.

The Chair noted that as hospital services move into the community, although not always cheaper, it is better for patients which is summarised in a number of papers from the Kings Fund and citation can be provided.

6.2 A member of the public referred to a recent article in the Liverpool Echo where the Local Authority will discuss abolishing the discount for council tax payers in the lowest band, thus making more people homeless as they will not

be able to afford to pay and which will have an effect on health issues. Has this issue been considered, together with other factors like homelessness in the city and how it will affect the Healthy Liverpool Programme?

The Deputy Chair responded that there was a need to be realistic as the obligation as a CCG is to commission health services. The social determinants of health were clear e.g. housing, employment, education which to that extent is outside of Healthy Liverpool. However, the CCG has a real commitment to working with the Local Authority and a number of different organisations in the region, across the city and in Europe looking at partnerships with housing organisations and transport etc., in order to maximise and impact on these issues.

In response, the member of the public commented that it would affect the results of the Healthy Liverpool Programme.
This was acknowledged by the Deputy Chair who commented that we can only do the best we can, which is currently being done.

The Practice Nurse member commented that there is a firm goal to reduce inequalities in health and noted that this is not just about doctors etc., but includes social determinants.

6.3 A member of the public noted that agencies up to the level of government have had firm commitment to reduce health inequalities for 40 years and we are still waiting for that to happen and inequalities are increasing. Can the CCG give a response to say why it believes evidence collected in the Monitor report is not relevant for Liverpool and how the Healthy Liverpool Strategy will overcome the problems identified in the Monitor report?

Can the CCG say how person centred and how outcome focussed it is by explicitly committing itself that no reduction or transfer of services will occur until an equivalent level of services is provided in the new setting.

The Chief Officer confirmed the commitment that the level of service will be at least as good as the service it replaces.

In response to the issues raised in the Monitor report, this had been responded to.

6.4 A member of the public noted that a document included on the City Council website details how it is intending to transfer the budget and services to the Liverpool City Region, including commissioning of Primary Care and asked for views from the CCG on that.

The Chief Officer confirmed that there is discussion across the CCGs and Local Authorities regarding Devolution. However, this is about budgets or powers 'coming down' from Central Government, existing powers remain with existing statutory bodies so the CCG powers and responsibilities will remain the same

The representative from NHS England noted that this is about seeking greater powers to take control of local destiny and giving more local control.

6.5 A member of the public commented that Dr Bowers had previously mentioned data, and in terms of the government selling personal health records to the insurance industry asked what the policy of the CCG was for the use of personal care records.

Dr Bowers agreed that clinical data should only be shared to improve clinical care and this is the CCG's position. When sharing of GP records started, patients were informed through information in the waiting rooms, leaflets etc., and there has always been an option for patients to opt out.

In addition, the current consent model still exists at point of care, with consent to view any data from outside organisations you are presenting to and that consent model will not change.

The member of the public queried whether every resident in the city would be contacted to ask if they are prepared for their records to be used in the way Tim Kelsey, NHS England, National Director for Patients and Information, recently announced they will be used?

Dr Bowers confirmed that every resident would be contacted, should we wish to use information in that way and advised that there is less than a 0.1% opt out rate locally and that Healthy Liverpool will take into account information governance and ethical responsibilities to keep patients informed.

6.6 A member of the public referred to the increased use of community pharmacies and relayed details of an incident in Croydon, and asked for assurance that unqualified staff will not be used to triage patients in a pharmacy setting.

The Deputy Chair confirmed that any new service would have a clear specification with standards of delivery.

Performance of providers is robustly monitored and they are held to task if they are not performing. There is robust governance and quality and safety procedures and work is undertaken at multi levels with multiple partners to ensure services are commissioned and provided. All providers are subject to robust and transparent performance and comply with contract management protocol and data governance procedures.

6.7 A member of the public referred to Devolution discussed earlier and commented that the Local Authority was wrong to use NHS money to the detriment of peoples health in the city.

The Chair responded that devolution was about those responsibilities currently central being delegated but that health budgets will remain with the NHS.

6.8 A member of the public referred to SSP and asked why the CCG did not act sooner.

The Deputy Chair in response advised that this was due to the CCG not having the responsibility for this service.

The Chair noted that the responsibility for SSP was with NHS England before April 2015 and the Chief Officer commented that the CCG was still providing support to practices.

4 DATE AND TIME OF NEXT MEETING

Tuesday 13 October 2015
1.00 pm – Blundell Suite
Blue Coat School, Church Road, Wavertree