NHS LIVERPOOL CLINICAL COMMISSIONING GROUP
PRIMARY CARE COMMISSIONING COMMITTEE
Minutes of meeting held on Tuesday 17TH NOVEMBER 2015 at 10am
Rooms B&C Childwall Neighbourhood Health Centre

Present:
Voting Members:

Katherine Sheerin (KS)	Chief Officer (In the Chair)
Prof Maureen Williams (MW)	Lay Member for Governance/Deputy Chair of Governing Body
Tom Jackson (TJ)	Chief Finance Officer
Dr Rosie Kaur (RK)	GP Governing Body Member/Vice Chair
Nadim Fazlani (NF)	GP Governing Body Chair
Jane Lunt (JL)	Chief Nurse/Head of Quality
Paula Finnerty (PF)	GP – North Locality Chair

Non voting Members:

Moira Cain (MC)	Practice Nurse Governing Body Member
Tina Atkins (TA)	Governing Body Practice Manager Co-Opted Member
Dr Adit Jain (AJ)	Out of Area GP Advisor
Rob Barnett (RB)	LMC Secretary
Cheryl Mould (CM)	Head of Primary Care Quality and Improvement

In attendance:

Scott Aldridge (SA)	Neighbourhood Manager - North Locality/Local Quality Improvement Schemes and Veteran Health Lead
Colette Morris (CMo)	Liverpool Central Locality Development Manager
Alison Ormrod (AO)	Chief Accountant
Tom Knight (TK)	Head of Primary Care - NHS England
John Adams (JA)	NHS England
Paula Jones	PA/Note Taker

Apologies:

Dave Antrobus (DA)	Governing Body Lay Member – Patient Engagement (Chair)
Sandra Davies (SD)	Interim Director of Public Health
Simon Bowers (SB)	GP/Governing Body Member
Dyane Aspinall (DAs)	Assistant Director Adult Social Care & Health, Liverpool City Council
Sarah Thwaites (ST)	*Healthwatch*

Samih Kalakeche (SK) *Director of Adult Services and Health (Health & Wellbeing Board Non-voting Member)*

Public: 3

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 in writing.

1.1 DECLARATIONS OF INTEREST

It was formally noted that the GPs/clinicians present had an interest in the Liverpool Quality Improvement Scheme which was on the agenda. However it was noted for the record that this was proportionate to being a GP in Liverpool.

1.2 MINUTES AND ACTIONS FROM PREVIOUS MEETING ON 15TH SEPTEMBER 2015

The minutes of the meetings on 15th September 2015 were approved as an accurate record of the discussions subject to the correction of the title of MW to include Deputy Chair of Governing Body rather than Vice Chair.

The Primary Care Commissioning Committee:

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

1.3 MATTERS ARISING – Verbal

1.3.1 Amended Terms of Reference – these had been changed to add:

- Role of the Committee point 5 that the committee would oversee all commissioning of General Medical Services.

- Point 5 addition to sub-section e) that the committee would consider issues such as workforce, training and development and changes to models of care in order to deliver the ambitions of the Healthy Liverpool Programme and ensure continuous service improvement.

- Point 9 membership – due to previous issues around quoracy it had been agreed that the Head of Primary Care Quality & Improvement should become a voting member. The Interim Director of Public Health was already a non voting advisory member and was invited to attend the meetings.

MW felt that in addition to what was added to point 7 sub-section e) there should be mention of delivering the ambitions of Healthy Liverpool and secure continuous service improvement.

KS referred to the quorum requirement of 5 voting members the majority of which must be lay/executive members and to include 2 GPs. Point 16 outlined the arrangements for dealing with conflict and the possibility of using another CCG committee or inviting attendees on a temporary basis from Governing Bodies of other CCGs. Later on in the meeting a discussion would be taking place around the Local Quality Improvement Scheme and additional investment into practices which meant that the GPs/clinicians presented were conflicted. It was not practical to bring in additional attendees from other CCGs. RB stressed the importance of the GPs not being seen to be paying themselves for work undertaken.

For this reason KS and MW decided to take the matter of additional investment into the Liverpool Quality Improvement Scheme to the CCG Finance Procurement & Contracting Committee (when the quorum does not require practice members) to make a recommendation around the investment and review in terms of value for money. However, the clinical discussion needed to be in the public domain so should be discussed at Primary Care Commissioning Committee.

It was agreed to endorse the changes to the Terms of Reference with immediate effect. The Committee agreed that the quorum needed to be amended to 5 voting members who must be non-conflicted in any decisions taken.

Terms of Reference to go to the Governing body for approval.

1.3.2 Action Point One – it was noted that there was a paper on the agenda about transition but this did not include Primary Care Support Services – in the light of the discussions at the November 2015 Governing Body meeting this would be an item on the Agenda for the December 2015 Primary Care Commissioning Committee.

1.3.3 Action Point Two – it was noted that GP Information Technology had been approved at the Finance Procurement & Contracting Committee and the Governing Body for the funding and procurement route.

The Primary Care Commissioning Committee:

- **Noted the issues raised under matters arising.**
- **Revised Terms of Reference to go to the Governing Body for Approval.**

PART 2: UPDATES

2.1 PRIMARY CARE QUALITY SUB-COMMITTEE FEEDBACK – REPORT NO: PCCC 19-15

RK updated the Primary Care Commissioning Committee on what had been discussed at the Primary Care Quality Sub-Committee on 29th September 2015:

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- Musculoskeletal Redesign Model – some areas of clinical model needed changing around referral and access.

- Liverpool Quality Improvement Scheme 2016/17 – each Key Performance Indicator had been agreed approved and also agreed with the Local Medical Committee.

The Primary Care Commissioning Committee:

- **Considered the report and recommendations from the Primary Care Quality Sub-Committee**

PART 3: TRANSITION ISSUES

3.1 PRIMARY CARE COMMISSIONING TRANSITION PLAN BETWEEN NHS ENGLAND AND LIVERPOOL CCG 6 MONTH PROGRESS REPORT – REPORT NO: PCCC 20-15

CM presented a paper to the Primary Care Commissioning Committee on the progress made in the delivery and implementation of the transition plan between NHS England and Liverpool CCG, setting out key risks and issues that were still to be addressed. Appendix 1 contained the Transition Plan. In May 2015 22 functions had been red, 2 amber and 12 green, by November 2015 there were 0 reds, 23 ambers and 14 greens. Contract management, procurement, practice performance and commissioning of Primary Care Medical Services had been successfully delegated to the CCG. The functions which required further work were management of delegated funds and premises.

Re the Financial position AO commented that as at the end of October 2015 there was an underspend of £162k but the year-end position was forecast to break even.

CM highlighted the issues of premises and that the CCG was working closely with NHS England and a strategy paper on premises would be brought to the December 2015 meeting.

TK continued to talk about the staffing model and the options available which were:

- Assignment of NHS England staff.
- Secondment
- Direct Employment.

As yet there had been no formal confirmation on staffing models from NHS England re a preference so CCGs were being advised to look at all three. NHS England were looking to resolve this issue.

CM refereed to the outstanding issue of Counter Fraud and Information Governance and who was the responsible organisation if issues were to arise.

The Primary Care Commissioning Committee members commented as follows:

- TA asked if any underspend would be lost. AO confirmed that this was not a problem and that it would be included in the baseline for the next year. It was noted that if there was an underspend it was a minimal percentage of the overall budget.

- CM noted that a co-commissioning network had been set up to consider the allocation of staffing resources across all the CCGs.

- TJ noted that the Estates Strategy could provide a useful backdrop to the discussion in December on premises. With regards to the proposed staffing model options he stressed the need for a Service Level Agreement/Memorandum of Understanding. Re Counter Fraud he stressed that the CCG did not have a service level agreement with any provider for counter fraud services therefore NHS England would need to pick this up. TK agreed to provide an update on the Memorandum of Understanding for the next meeting. He stressed that no formal assignment had been undertaken.

- The Primary Care Commissioning Committee members were concerned about how long transition support would be available from NHS England, given that more and more CCGs were opting for delegated responsibility. TK noted that this would be challenging for NHS England but the aim was to support all CCGs.

The Primary Care Commissioning Committee:

- **Noted the content of the report**
- **Noted the progress made in the delivery of the transition Plan**
- **Noted the outstanding risks and issues**

PART 4: PERFORMANCE

4.1 LIVERPOOL QUALITY IMPROVEMENT SCHEME (GP SPECIFICATION) 2014/15 – REPORT NO: PCCC 21-15

RK presented a report to the Primary Care Commissioning Committee outlining the 2014/15 position on delivery of Key Performance Indicators within the GP Specification and a summary of the validation committee findings. The scheme had been implemented in April 2011 to improve outcomes for patients through setting clear standards of delivery for all practices to adhere with additional investment which also equalized funding, some of which is at risk if key performance indicators aren't achieved.

The key points to note are:

- Vaccinations/Immunisations and Health Check and COPD/Heart Failure removed.

- New Key Performance Indicators: Diabetes 9 care process and significant event analysis.

- A&E Attendances: the indicators definition was the rate per 1,000 HCHS weighted population of in-hours, self-referred, unplanned, minor attendances where procedure code was recorded as prescription, guidance and advice or nor and excluding disposals to a clinic or other provider, for 2014/15 the indicator was amended to remove attendances to St Paul's Eye Unit and AED attendance for Trauma. There had been an increase between 13/14 and 14/15 of 5.4%.

- Emergency admissions for ACS conditions: the indicator definition was the rate per 1,000 hospital weighted population for admissions for a selection of ACS conditions where these conditions were coded in the primary diagnosis – for 2014/15 the indicator baseline position was recalculated to reflect the Liverpool average for 2012/13. ACS emergency admissions had increased from 6,590 in 13/14 to 7,328 in 14/15 for all conditions with significant increases for respiratory, Asthma and COPD.

- For the areas of A&E attendance and ACS conditions where there were increases between 2013/14 and 2014/15 it was noted that the percentage increase was less for practices involved in the winter enhanced access than those not involved as previously reported.

- GP referred outpatients: the definition of the indicators was the rate per 1,000 HCHS weighted population for GP referred first outpatient attendance to Dermatology, ENT, Gastroenterology, Gynaecology, Rheumatology, Trauma and Orthopaedic, Urology and Vascular Surgery. There had been a 9% reduction between 13/14 and 14/15 driven by gynaecology and Trauma and Orthopaedics.

- Prevalence: substantial increases had been made to the numbers of patients on disease registers but there was still more which could be done.

- Exception reporting: the Key Performance Indicator was in the GP Specification.

- Alcohol Brief Interventions: the percentage of patients drinking over the recommended levels being offered brief interventions had increased by 2.02% between March 2014 and March 2015. However alcohol intake recording had dropped off.

- Diabetes 9 Care Processes: Band A had a 70% threshold, the baseline position for the city was 58.33% at the end of March 2014. which had increased to 65.14% by the end of March 2015.

- Choose & Book referrals had risen steadily from 75% to 81.5%.

- Medicines Management: the CCG had achieved a substantial reduction in prescribing costs in 2014-15 with an overall 5.4% reduction.

- CM presented the findings from the Validation Committee: this was the 4th year in operation. Practices failing to achieve Band A had the opportunity to challenge and submit additional evidence for the Validation Committee to consider over a three day period in July. For 2014/15 73 practices were required to submit evidence for validation. The Validation Committee found that five did not meet the standards, of which two decided not to appeal. The committee found that seven practices would benefit from a further visits from Dr Ogden-Forde regarding the 9 Care Processes for Diabetes.
    - Lessons Learnt:

- Some St Paul's data was still appearing in the A& E data sets.

- Practice Appeals: two practices did not appeal the Validation Committee decision and monies were to be recovered. The other three practices received practice visits and the findings were submitted to the Primary Care Quality Sub-Committee and the Primary Care Commissioning Committee was asked to support the recommendations as set out in the paper:

  - Practice A (antibiotics) – investment to be recovered

  - Practice B (Diabetes 9 Care Processes) – investment to be recovered

  - Practice C (antibiotic prescribing) – practice to retain the investment,

  - Practice D (in hour AED attendances) – the practice to retain the investment

  - Practice E (9 Care Processes for Diabetes) the practice to retain the investment.

KS thanked RK for a comprehensive report. NF noted that many other CCGs had copied elements of the Scheme but had not adopted it in its entirety. The fact that Liverpool had the scheme had meant that General Practice in Liverpool had fared better than the rest of the country in dealing with the pressures facing it. RB added that one of the issues facing practices was renewal of workforce, Liverpool had weathered the storm longer than other places due to the Scheme. RK pointed out that the Scheme performance indicators were devised around evidence of what was possible for practices to control and influence.

TJ praised the paper but commented that the impact on health inequalities had not come out strongly and how to ensure resources are used in the most cost effective way.

The Primary Care Commissioning Committee:

- **Noted the end of year position for 2014/15**
- **Approved the recommendations from the Primary Care Quality Sub-Committee in relation to recovery of investment**

PART 5: STRATEGY & COMMISSIONING

5.1 LIVERPOOL QUALITY IMPROVEMENT SCHEME 2016-17 (GP SPECIFICATION) – REPORT NO: PCCC 22-15

KS noted that the paper needed to be considered by the Finance Procurement & Contracting Committee to discuss the business case, procurement route and value for money for onward recommendation to the Governing Body for approval re the recurrent investment. However the overall service model needed to be debated at the Primary Care Commissioning Committee.

RK highlighted the key achievements since the implementation of the GP Specification:

- Prevalence – 15% increase (19656 extra patients) since March 2012
- A&E - 6% decrease on GP specification defined attendances for adults and children combined since 2011 compared to benchmark trusts
- Prescribing - narrowed gap between Liverpool and national cost despite pressures from high levels of deprivation and a large number of specialist centres within the city using high cost drugs whilst maintaining a focus on improving quality and outcomes
- ACS – moved from reporting the highest ACS admission rates in 2009/10, ranked 68 out of 68 CCGs within North of England Region to being ranked 31 out of 68 in 2014/15
- Childhood Vaccinations – consistently achieved higher uptake rates compared to England benchmarks 2011 – 2014; since this was removed from the GP specification in April 2014 a slight dip in performance has been reported

The specification provided for a range of services to be delivered by every practice with a key element of this being the level of access practices are required to offer. Prior to 2011, the funding provided for 50 GP appointments per weighted 1000 population. This was uplifted from April 2011 to 70 GP/Nurse Practitioner/telephone appointments and to ensure patients were treated out of hospital and as near to home as practically possible.

Changes had been made to the Local Quality Improvement Scheme by a sub group of the Primary Care Quality Sub-Committee for 2016-17 and consultation held with stakeholders.

The latest version had been peer reviewed by a panel of GPs from outside Liverpool. The proposed changes were:

Access

Current standard 15/16	New standard 16/17
70 GP/Nurse Practitioner/Telephone appointments per 1000 weighted population	80 GP/Nurse Practitioner/Telephone appointments per 1000 weighted population

Childhood Vaccinations and Immunisations

Current standard 15/16	New standard 16/17
Not included in GP specification	Practices are required to undertake to immunise children under 5 with relevant immunisations, including any catch up campaigns identified and to achieve the higher target of 95%

Physical Activity

Current standard 15/16	New standard 16/17
Not included in GP Specification	Practices are required to record physical activity levels for patients aged 16 years and over and for those who do not meet the recommended 150 minutes of physical activity per week to receive brief advice and be offered specialist support where indicated/appropriate.

- A&E attendance – target had been stretched which means the aim is for fewer patients to attend A&E in hours with a primary care condition
- ACS admissions – amended from 7 conditions down to 4 conditions (COPD, Flu/pneumonia, Angina and Asthma) which account for over 60% of total ACS admissions and their associated costs. This will enable a greater focus on these conditions.
- Alcohol consumption recorded – amended from 10% uplift on practice baseline position to a bandings approach in line with the rest of the specification. Also time period amended from 12 months to 3 years
- Outpatient attendances – activity relating to Trauma and Orthopaedics removed from definition due to changes in referral pathway in year and limited opportunity for general practice to influence outcomes (all referrals triaged through MCAS before onward referral to secondary care if appropriate).

The targets had also been amended:

	Current Targets 2015/16			New Targets 2016/17		
Area/Band	A	B	C	A	B	C
A&E attendance rate per 1000 patients	7.91	11.40	12.79	6.29 TBC	7.35 TBC	10.36 TBC
ACS admissions rate per 1000 patients	9.97	12.19	12.97	7.30	8.01	9.79
Alcohol % patients aged 18+ with alcohol consumption recorded	10% uplift on practice baseline position up to Liverpool average 34%			38.6% TBC	32.8% TBC	27.4% TBC
Alcohol brief intervention	93.8%	>93.8 to <= 86.9%	>86.9 to 75.7%	93.8% TBC	>93.8 to <=86.9% TBC	>86.9 to 75.7% TBC
Outpatient attendance rate per 1000 patients	82.42	87.22	102.57	63.48	66.57	74.83

Changes to weightings: there had been revised weightings for 2016/17 on ACS admissions, outpatient attendances and antibiotic use.

Discontinued Key Performance Indicators: Choose & Book (as target had been met), Heart Failure, Kidney Disease/statins prescribing and hospital discharge.

Investment Proposal: in order to support the additional activity of the Specification/Scheme it was proposed that an additional £10 per weighted patient should be provided. Practices will be required to provide additional clinical sessions to increase access, as well as implementing new systems and processes to support the delivery of childhood vaccinations and immunisations and the recording of physical activity levels. All of this will impact on the level of clinical and non-clinical resource required. The changes proposed to the Key Performance Indicators detailed in section 5 of the paper would also require additional effort and a much more targeted approach by practices to achieve the more stringent targets set.

Finally, with this additional investment, it was proposed that the maximum resource 'at risk' to each practice is increased from £15 per weighted patient to £20 per weighted patient.

The Primary Care Commissioning Committee members commented as follows:

- MW was concerned about double counting re care homes and the continuing struggles around access. RK noted the difficulty in measuring access as it was not always a matter of seeing a GP but about having equitable access to other services in addition to A&E. CM noted that over the coming 12 months there would be a review of the system to understand how practices could improve access, this was ongoing and reports would come to the committee in due course.

- NF raised the issue of sexual health and HIV testing This was not a key performance and therefore was not being paid for and clarity was required as to where the responsibility lay, with Public Health or General Practice.

- RB referred to the childhood vaccination & immunisations and the increase of the target from 90% to 95% and how challenging this target would be for practices to reach.

- TJ noted that it was good that the proposals had been peer reviewed – he was supportive of the general direction, he noted the issue of access from recent public engagement and that it would be useful to explore the strategic alignment with other agendas (i.e. 7 day working), value and payments and assurance from the validation process.

- TK noted digital technology and that national work was being carried out already to look at capacity in general practice and how technology could assist.

- KS referred to the amount of £20 per patient re funding at risk and noted that this should be clarified to per weighted patient.

- MW requested that the Business Case should include findings from the Peer Review .

- MW also requested that the findings from the access review are reported to the Primary Care Quality sub-Committee.

The Primary Care Commissioning Committee:

- **Noted and approved the changes proposed to the Liverpool Quality Improvement Scheme 2016/17**
- **Noted and approved the changes proposed to the Key Performance Indicators from April 2016**
- **Noted a paper will go to Finance, Procurement and Commissioning Committee for confirmation of procurement route and for assessment of value for money provided for the investment proposed.**

PART 6: GOVERNANCE

There were no items for discussion.

7. ANY OTHER BUSINESS

None

8. DATE AND TIME OF NEXT MEETING

Tuesday 15th December 2015 – 10am to12pm Boardroom The Department