NHS LIVERPOOL CLINICAL COMMISSIONING GROUP
PRIMARY CARE COMMISSIONING COMMITTEE
Minutes of meeting held on Tuesday 20th March 2018 at 10AM
BOARDROOM, THE DEPARTMENT

Present:

Voting Members:

Ken Perry (KP)	Governing Body Lay Member – Patient & Public Involvement (Chair)
Simon Bowers (SB)	GP/Governing Body Chair
Jan Ledward (JLe)	Interim Chief Officer
Cheryl Mould (CM)	Primary Care Programme Director
Paula Finnerty (PF)	GP – North Locality Chair
Steve Sutcliffe (SS)	GP

In attendance:

Rob Barnett (RB)	LMC Secretary
Dr Rosie Kaur (RK)	GP, Primary Care Lead
Dr Jamie Hampson (JH)	GP – Prescribing Clinical Lead
Jacqui Waterhouse (JW)	Locality Manager
Peter Johnstone (PJ)	Primary Care Development Manager
Victoria Houghton (VH)	Primary Care Accountant
Dr Adit Jain (AJ)	Out of Area GP Advisor
Tom Knight (TK)	Head of Primary Care – Direct Commissioning NHS England
Sharon Poll (SP)	Primary Care Clinical Advisor
Scott Aldridge (SA)	Primary Care Co-Commissioning Manager
Lynn Jones (LJ)	Primary Care Quality Manager
Tina Atkins (TA)	Practice Manager
Sarah Stephen (SSt)	Neighbourhood Support Manager
Paula Jones	Committee Secretary

Apologies:

Mark Bakewell (MB)	Acting Chief Finance Officer
Helen Dearden (HD)	Governing Body Lay for Governance
Jane Lunt (JL)	Chief Nurse/Head of Quality
Sarah Thwaites (ST)	Healthwatch
Sandra Davies (SD)	Director of Public Health

Public: 1

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 noted that all Liverpool GPs/Practice Staff present (SB, PF, SS, RB, RK, JH, and TA had an interest in item 3.1 Liverpool Quality Improvement Scheme (GP Specification) 2018 -2019 as it involved quality and performance management of practices and financial benefit. However at this point the discussion around the Quality Improvement Scheme was to obtain clinical input on the Key Performance Indicators and was not about the finances therefore the individuals mentioned had an interest they were not conflicted and could remain for and participate in the discussion.

PF declared an interest in item 3.2 Type 2 Diabetes Therapy Optimisation Service Proposal as the GP practice where she was a partner was one of the practices nominated in the proposal. The Chair agreed as per the declarations made re item 3.1 the discussion to be had today was for a clinical decision, not a financial decision so there was no need for PF to be excluded from the discussion.

1.2 MINUTES AND ACTIONS FROM PREVIOUS MEETING ON 29TH AUGUST 2017

The minutes of the 29th August 2017 were approved as an accurate record of the discussions which had taken place.

1.3 MATTERS ARISING NOT ALREADY ON THE AGENDA – Verbal

There were no actions outstanding or matters arising from the previous meeting.

The Primary Care Commissioning Committee:

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

PART 2: UPDATES

2.1 NHS ENGLAND UPDATE – VERBAL

TK gave a verbal update to the Primary Care Commissioning Committee:

- Primary Care Support Services provided by Capita:
  - NHS England were still dealing with issues and Tony Leo was writing to the Service Management Team around pension payments and contractual payments.
  - Communication and feedback from Capita was still poor.
  - There were still issues around the delivery of medical records, label printing etc.
  - The main concern was around the payments and pension payments issues and NHS England had removed specialist expert support from Primary Care Support Services although the national team were still focussed on governance and there was a working group working with Capita on the Key Performance Indicators.
  - Less emails were being received from the Local Medical Committee but this was not necessarily a positive indication and could merely be a reflection of people being tired of complaining and nothing being done.

- There was an opportunity under the Cheshire and Mersey Healthcare Partnership for a development programme to be put together to seek the development of Primary Care Networks across Cheshire & Merseyside. The CCG Accountable Officers had been briefed and would receive a set of written criteria. The aim was to keep the evaluation process simple and develop Primary Care Networks of between 30,000 and 50,000 population. Sign off was awaited by the Cheshire & Merseyside Healthcare Partnership (Sustainability & Transformation Plan ('STP')) and then for rollout as soon as possible.

- Easter Planning: the assurance process from CCGs had been completed. NHS England was to contribute to dental and community pharmacy diversion of patients from NHS 111 to the Community Pharmacy Scheme. Urgent dental capacity had been looked at this year and communication

between practices, dentists and NHS 111 had been improved.

TA confirmed to TK that with regard to Capita the reduction in emails did not mean that matters were improving and asked if TK could attend a Practice Managers meeting to provide a briefing and agreed that the financial issues were the most pressing. RB added that his concern was that nothing was happening and there was no backup plan with no one able to remedy the situation, he had no confidence in any changes which might be implemented. The Interim Chief Officer agreed that she would pick this up with RB outside of the meeting to discuss solutions and an escalation process.

CM noted that individual practices had been written to about dealing with demand over the Easter period. The Urgent Care 24 half day closure provision had been cancelled for Easter to ensure that there was enough capacity in the system. She referred to the development programme and noted that the Liverpool Quality Improvement Scheme (GP Specification) sat alongside this and that she was more than happy to be the Primary Care representative in its development. RK reminded those present that we needed to build on existing work done and the programme of development needed to look at how it supported existing work rather than going off in a completely different direction. TK responded that the intention was that the programme would not be prescriptive and would be used to implement local initiatives.

KP was interested to know if there was clarity of signposting for patients about their options over the Easter Holiday period. CM assured him that there was information on social media, the CCG website and the NHS 111 Directory of Services had been updated. TK added that NHS England had put posters out but a clinical update on Duraphat toothpaste prescribing was required. The Communications Leads from the A&E Delivery Board would communicate with the CCG Communication Leads. RB had concerns about how well NHS 111 worked and gave an example of the service referring a dental issue to a GP practice which he had raised and not heard anything back. TK agreed to pick this up.

The Primary Care Commissioning Committee:

- **Noted the verbal update.**

PART 3: STRATEGY & COMMISSIONG

3.1 LIVERPOOL QUALITY IMPROVEMENT SCHEME (GP SPECIFICATION) 2018/19 – REPORT NO: PCCC 01-18

RK presented a paper to seek approval for the Liverpool Quality Improvement Scheme 2018-19 (GP Specification). As mentioned under section 1.1 Declarations of Interest the Liverpool GPs/Practice staff present had an interest in this item but as the discussion around the Quality Improvement Scheme today was to obtain clinical input on the Key Performance Indicators and was not about the finances they could remain for and participate in the discussion.

The Primary Care Commissioning Committee was being asked to Approve Schedule A and Schedule B (Memorandum of Understanding). She gave a brief background to the Scheme which had been introduced in 2011 to provide additional investment into General Practice in order to "level the playing field". At the end of each year it had been updated as per clinical and NICE Guidance and movements of areas into core contracts. Last year had been an extremely difficult year and the focus had been on demand management. An evaluation of performance from 2011 to date was being carried out involving SP. For next year the same Key Performance Indicators would be used in order to sustain the good work.

Prevalence on disease registers had increased so it was important to keep the Long Term Conditions services as set out in Schedule A. Physical Activity re Hypertension patients and Medication Reviews for polypharmcy patients had been slow to take off so needed to be kept on. The number of clinical indicators remained the same. No funding would be taken back but the Primary Care Team would work with practices around quality continuous improvement.

Schedule B was the Memorandum of Understanding – the aim was to enable Primary Care transformation to deliver placed based outcomes and we needed to look at how practices could work together collaboratively. A lot of good work had been done so far with Neighbourhood collaboration, now the pace needed to increase and practices needed to be supported to have formal arrangements in place. To this end there was non-recurrent funding in place for groups of practices to look at working together (on a Neighbourhood or non-Neighbourhood footprint) based on their priorities, skill mix and how they wished to work with other providers. There were two phases, May 2018 to have some clarity on groupings and footprints and November 2018 for a progress update to be given. The Memorandum Of Understanding was deliberately non-prescriptive and there was no template to complete.

The Primary Care Commissioning Committee commented as follows:

- KP wanted to know what engagement there had been in the production of Schedule A. RK responded that various programme areas had been scrutinised by the Business Intelligence Analysts to determine where to focus attention.

- KP asked how the groupings would be impacted by Local Authority boundaries. The Chair responded that the CCG Neighbourhoods had been aligned with the Local Authority Neighbourhoods a few years ago. A certain amount of pragmatism was required to allow providers the freedom to develop services for the population. We needed to find a way for practices to work with those practices with whom they felt comfortable therefore the CCG had a duty to ensure that the population based services were provided via the community providers.

- SS referred to the difference in reporting population of Liverpool for this purpose, the population was officially 484,000 but an additional 30,000 patients were registered with Liverpool GPs. RB clarified that this dated back to 2000 when the Family Health Services Authority were responsible for patients registered with Liverpool GPs whether or not they lived with the city boundaries. This had caused issues in the past for practices in border areas around matters such as social services but it might work better now.

- RB was concerned about the tight timescale for the practice groupings to be identified and put in place. SB responded that early indications from practices would be extremely useful so that the CCG could start to develop its thinking so that no one was left out. He agreed that the language would be softened. CM commented that the Primary Care Team were close to the GP practices so could update on the progress being made.

- RB also requested clarity to page three of the paper referring to the One Liverpool Plan with the CCG remaining committed to ensuring that Primary Care had a key role in the delivery of the “place” element.

- RB also referred to Appendix 1 page two and the reference in the second paragraph to investment in primary care not being necessarily through individual practice budgets and asked for clarification. Re Schedule A page nine of Appendix 1 on

Diabetes Nice Treatment standards re Cholesterol, HbA1C and Blood Pressure he commented that an academic member of the Local Medical Committee that linking this to prevalence was ludicrous. SS commented that it would be more useful to link admissions with diabetic ketoacidosis, to prevalence of Type 1 Diabetes. It was agreed at the request of KP that RB would work with JLe.

- RB also referred to Schedule B Memorandum of Understanding page 66 of Appendix 1 and advised for caution on the wording around workforce which needed to be changed. Also regarding governance the reference should be to the autonomy of each practice rather than use the word partner.

- KP felt that there was a general theme around reporting and language which would be picked up at a future Governing Body Development session.

- JLe commented that not all practice groupings would be geographically close and there were a significant number of unregistered patients in the city, such as first year students. The workforce issues were about enabling practices to think differently rather than be prescriptive. RB had no problem with that but felt that this did not match what was written in the paper.

- SS felt that the GP Specification focussed on clinical outcomes which were measures of the health system's ability to manage conditions once things had already gone awry. The "One Liverpool Plan" indicated that the wider determinants of health might have a bigger impact on healthy life expectance. Should the GP Specification aimed to maximise outcomes of the 20% that clinical care could influence, or perhaps also encourage consideration of contribution toward the 80% of wider determinants of health? JLe agreed that we could influence in the area of the broader determinants of health and SB agreed, noting that with the wider community model we were starting to incubate a different way for practices to work together. There was a Provider Collaborative which would challenge on the bigger issues.

- PF raised a concern in her capacity as the North Locality Chair/Neighbourhood Lead, that the North practices could be disadvantaged re practice groupings as they would not be chosen/wanted to participate in any practice groupings and so miss out. They would still have their Neighbourhood Groupings

which worked well but was concerned about increasing health inequalities across the city. SB acknowledged that there was a risk here which could be discussed at a future Governing Body Development Session.

The Primary Care Commissioning Committee:

- **Approved the Liverpool Quality Improvement Scheme (GP Specification) 2018 – 2019**
- **Noted and approves the proposed monitoring arrangements.**

3.2 TYPE 2 DIABETES THERAPY OPTIMISATION SERVICE PROPOSAL – REPORT NO: PCCC 02-18

PF had declared her interest in this item as the GP practice where she was a partner was one of the practices nominated in the proposal. It had been agreed that the discussion to be had today was for a clinical decision, not a financial decision so there was no need for PF to be excluded from the discussion.

JH presented a paper to the Primary Care Commissioning Committee asking it to approve the Liverpool CCG Medicines Optimisation Committee's recommendation (endorsed by the Primary Care Programme Group) to support implementation of the prescribing project in relation to Type 2 Diabetes Therapy Optimisation Service. This was a non-promotional service provided by Takeda UK Ltd via a team of clinical pharmacists employed by Interface Clinical Services. Takeda were offering this to practices identified as being in the bottom quartile for achievement of the indicator HbA1c<59mmol/mol: Aintree Park, Dr Hegde & Jude, Ellergreen Medical Centre, Long Lane, Priory Medical Centre and Vauxhall Health Centre. This project was about ongoing quality of clinical services rather than cost savings and was the third project from the Medicines Management Optimisation Committee. The project would involve a patient focussed clinical review looking at the diabetes nine care processes. The appendix to the paper contained the project proposal template and the Primary Care Programme Group recommendations.

The Primary Care Commissioning Committee commented as follows:

- TK was concerned about duplication with the Liverpool Quality Improvement Scheme practices re the diabetes key performance indicator. JH responded that three of the pilot practices were also supported via the Liverpool Quality

Improvement Scheme. PJ added that there were 17 practices employing non Medicines Management pharmacists.

- TK asked if there was a need for public engagement to which JH responded that this was not required.

- JLe felt that the benefit realised from the project needed to be articulated along with what would happen if we did not did not take up this project. She also asked if other providers had been considered in the project, and had we selected the provider with the most beneficial outcome. PJ responded that the offer to the CCG was very robust. JLe felt that the paper needed to articulate very clearly that this was a pilot to inform the quality of care which it did not currently specify.

- SS queried the way diabetes prevalence was assessed and monitored, diabetes care was monitored through the Liverpool Quality Improvement Scheme key performance indicator and we also had the diabetes pathway. He felt that the project was providing additional support to some practices to meet Local Quality Improvement Scheme Key Performance Indicators. JH responded that this was a pilot to prove a concept. If it was successful there would be no issue with other services in place which improved patient care. SS commented that some practices were not hitting their target through no fault of their own (due to say patient demographic) whilst for others it was due to simply not employing the correct staff. JH noted that the election criteria for the practices to be involved which had been received from Takeda were clearly stipulated in the paper and that this was merely a pilot. PJ confirmed that Takeda had set the criteria and selected the pilot practices and would not change the list of practices to be involved.

- RK noted that the issue of clinical pharmacists in general practice was being promoted, the project was about learning and the four practices involved from the North of the city would help them in identifying learning and these practices probably did not have the bandwidth to do this for themselves.

- AJ raised a concern that the company offering the service was also one of the main manufacturers of anti-diabetes drugs and their motive could be questioned. JH responded that the Takeda drug was recognised as one of the most clinically effective so this was not an issue. AJ however felt that the CCG needed to be more transparent.

KP summarised the mood of the committee in that the project might be supported if it was more clearly defined as a pilot and the language changed. JLe agreed that additional quantitative and qualitative information was required and it would be good to have more information on the impact to patients of the project. JH felt that the Commercial Sponsorship/Joint Working pro forma in Appendix 1 contained this. PJ noted that the paper to the Primary Care Programme Group contained a great deal of the governance information which was required and agreed to provide a summary of this for the Primary Care Commissioning. SB felt that the Primary Care Commissioning Committee was generally supportive of the project and perhaps we were making this a little over-complicated. JH noted that pro forma contained evidence around performance across the UK. KP noted the fact that the evidence was in the pro forma but commented that the recommendations in the paper did not fully reflect this.

It was agreed that the Primary Care Commissioning Committee noted that this was a pilot which would then be fully evaluated and the patient view would be obtained. JLe and KP were authorised by the Primary Care Commissioning Committee to follow up on this outside of the meeting. It was supported in principle by the Primary Care Commissioning Committee so the revisions requested would be brought to the next meeting for noting only.

The Primary Care Commissioning Committee:

- **Approved the Liverpool CCG Medicines Optimisation Committee's recommendation to support implementation of the prescribing project in relation to Type 2 Diabetes Therapy Optimisation Service, noting this was an "in principle" approval, and final version would come back to the April 2018 meeting for noting after follow up outside the meeting by JLe and KP.**

PART 4: PERFORMANCE

4.1 PRIMARY CARE COMMMISSIONING COMMITTEE PERFORMANCE REPORT – REPORT NO: PCCC 03-18

RK presented a paper to the Primary Care Commissioning Committee on the key aspects of the CCG's performance in delivery of Primary Care Medical services quality, performance and financial targets for Quarter 3 2017/18.

She highlighted:

- General Practice Patient Survey – the data was as at March 2017 and the overall experience of making a GP appointment achieving 85% respondents who said they had a good experience of making an appointment or 3% increase on percentage of respondents who said they had a good experience was the target. Liverpool practices achieved 77%. The Primary Care Team were taking the data to look at areas where practices might be struggling to help them to improve. NHS England had commissioned a national GP access tool (Edenbridge) to allow practices to monitor flexibility around appointment systems and to forecast demand.

- Inappropriate Prescribing in Primary Care and reduction in inappropriate antibiotic prescribing – performance was Green with an upward trajectory in these areas.

- Hypertension prevalence was increasing and the indicator was Green with an upward trajectory.

- A&E attendances – performance was Yellow but improved from the same point last year Woolton, Allerton, Gateacre, Garston and Aigburth ('WAGGA') Group of Practices were Green.

- Ambulatory Care Sensitive ('ACS') admissions – 38 practices had achieved Band A in October and this had reduced to 36. The Collaboration for Leadership in Applied Health Research and Care ('CLAHRC') was carrying out an evaluation of the Liverpool Local Quality Improvement Scheme (GP Specification) from its start in 2011 through to the 2016/17 year end. Although ACS admissions in Liverpool had increased by 6%, nationally this increase was 20% (with a couple of exceptions). SP added that there was a great deal of staff input into ACS admissions. The output of the academic evaluation would be brought back in due course.

- GP Practice Outpatient referrals – a peer review of referrals had been carried out by practices.

- Polypharmacy patients having medication reviews – this had been a slow start with baseline staring at zero as this had not been measured previously.

- Warfarin safety – performance was Green.

- Antibiotic prescribing – performance was Green and good work as being done by the practices.

CM noted that there was a detailed report on the agenda already describing the Care Quality Commission practice inspection results. Two new reports had been release, one practice was rated overall as "Good" and the other was rated overall as "Requires Improvement". LJ was working closely with this practice over the coming months and an action plan had been submitted to the Care Quality Commission.

Friends & Family Test – 28 practices failed to submit their responses for March 2018. The Primary Care Team would work with those practices.

The Primary Care Commissioning Committee commented as follows:

- SS referred to patient satisfaction which was low despite GPs being commissioned to offer 80 appointments per 1000 patients per week. Was such dissatisfaction because this remained inadequate to meet demand? Was there possibly unhappiness regarding the type of consultation offered(face to face, telephone, e-consult) or with the clinician available (GP, Locum, ANP, Pharmacist.) Answers would be of help with planning delivery of the GPFV and commissioning sustainable primary care.

- RK referred to the response rate to the Patient Survey which was 20% and therefore analysis of trends needed to be treated with caution. SP added that data was to be used for learning not to pass judgement. KP said that he would like to be part of the group looking into the survey results in more detail.

The Primary Care Commissioning Committee:

- **Noted the performance of the CCG in delivery of Primary Care Medical commissioned services and the recovery actions taken to improve performance**
- **Determined if the levels of assurance given are adequate in terms of mitigating actions**

4.2 GENERAL PRACTICE FORWARD VIEW PLAN PERFORMANCE REPORT – REPORT NO: PCCC 04-18

CM presented a paper to the Primary Care Commissioning Committee to inform on progress towards delivery of the General Practice Five Year Forward View Plan, identifying key issues/risks and mitigating actions. A full year end report and planning for the next two years would be brought to the Primary Care Commissioning Committee in April 2018.

JW continued that the GP Five Year Forward View acknowledged that the population was ageing and that brought with it more complex needs which had an impact on workforce and practice resources. This meant looking at recruitment and re-thinking the disciplines required, capacity, training, social prescribing and demand management, collaboration with other practices, estates, accessibility (8am to 8pm 7 days a week), use of e-consultation, telehealth, self-care, digital no wrong door and quality (challenge of eliminating variation and Liverpool had the Local Quality Improvement Scheme to aid this):

- A great deal of work had been done already around the Digital programme, 930 e-consultations submitted to date across 5 sites saving an estimated 656 appointments.

- Extended access would come back to the Primary Care Commissioning Committee at some stage re a procurement process to deliver by October 2018.

- Telephony – this was a huge piece of work, some practices would have the new system by the end of the year.

- Estates – the issues around Hunts Cross and Westmoreland were ongoing.

- Medicines Optimisation workforce was combined with other support from NHS England and a local offer of pharmacists on a Neighbourhood basis.

- 41 practices signed up to the “Time For Care” offer.

- 26 posts including initiatives to provide positions to complement GPs – there was to be a meeting in April/May with practices to manage expectations and explain the process, the first one to be in place by December 2018.

- The resilience programme would be out again soon with funds available from NHS England to develop.

- Appointment management analytical tool to be floated out to practices for analysis of future appointment demand and clinician mix required.

RK mentioned also international recruitment.

JLe asked for a summary of the above measures being taken and a delivery action plan which could be brought to the Governing Body in May 2018, the Governing Body had felt in March 2018 that the Strategic Plan was light regarding Primary Care.

RB articulated concerns about more GPs leaving the NHS than being trained and the impact of a shortage of GPs on the way Primary Care was delivered, there would be more emphasis on self-care, patient expectation on who they needed to see needed to be managed. E-consultation might save face to face appointments but still took up GP time.

SS referred to seven day working and asked if this was really what patients wanted. A great deal of work would be required for a citywide triage process. CM responded that the data from the Winter Pilot would be evaluated and the live model was planned to be in place by October 2018. We needed to ensure that this was the right model for Liverpool and SS had been asked to be a part of this. The model and the specification would be brought to the Primary Care Commissioning Committee and then the Governing Body.

The Primary Care Commissioning Committee:

- **Noted the progress towards implementation**
- **Determined if the assurance to the risks identified were adequate in terms of mitigating actions**

PART 5: GOVERNANCE

5.1 FINDINGS FROM THE CARE QUALITY COMMISSION ('CQC') INSPECTIONS IN LIVERPOOL FROM 2014 TO DATE– REPORT NO: PCCC 05-18

LJ presented a paper to the Primary Care Commissioning Committee to inform of the Care Quality Commission inspections that had been

carried out in Liverpool GP practices and summary of the ratings from 2014 when the new inspection regime came into place.

- In 2014 we originally had 94 practices that were eligible for a CQC inspection. Following the first round of inspections using the new model Liverpool achieved the breakdown as below
  - 1 Ranked as Outstanding
  - 82 Ranked as Good
  - 7 Ranked as Requires Improvement
  - 3 Ranked as Inadequate
  - 2 Not inspected

- At November 2017, with re-inspections, Liverpool CCG saw the following CQC breakdown of Practices:-
  - 2 Ranked as Outstanding
  - 88 Ranked as Good
  - 1 Ranked as Requires Improvement
  - 1 Not inspected.

- Safety was the main concern as 34 practices required improvement for this key Question. The most common areas were:
  - 11 Practices – Health and Safety issues
  - 10 Practices – Lack of DBS checks
  - 9 Practices – No Oxygen or Defibrillator
  - 8 Practices – Outstanding safeguarding training
  - 6 Practices - Required to complete Infection Control inspection
  - 22 Practices - Various reasons including Significant Event Analysis, Cleaning, legionnaire testing, Induction, Poor communication, Clinical Audit, Recruitment.

Practices were offered support before and after inspection. CM commented on the excellent work carried out by LJ in supporting practices before and after the inspections. JLe noted the excellent results from Liverpool practices, particularly given the large number of practices within the Liverpool CCG area.

The Primary Care Commissioning Committee:

- **Noted content of report**
- **Noted actions taken to support GP's and to share best practice/learning.**

6. ANY OTHER BUSINESS

None

7. DATE AND TIME OF NEXT MEETING

Tuesday 17th April Formal Meeting - 10am Boardroom LCCG