NHS LIVERPOOL CLINICAL COMMISSIONING GROUP
PRIMARY CARE COMMISSIONING COMMITTEE
Minutes of meeting held on Tuesday 17th APRIL 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
Mark Bakewell (MB)	Acting Chief Finance Officer
Helen Dearden (HD)	Governing Body Lay for Governance
Jane Lunt (JL)	Chief Nurse/Head of Quality

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)	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
Gina Perigo (GP)	Living Well - Physical Activity Programme Lead
Paula Jones	Committee Secretary

Apologies:

Tina Atkins (TA)	Practice Manager
Sarah Thwaites (ST)	Healthwatch
Sandra Davies (SD)	Director of Public Health

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 noted that all Liverpool GPs/Practice Staff present (SB, PF, SS, RB, RK, JH, and TA (apologies) had an interest in item 3.2 Liverpool Quality Improvement Schemes as it involved quality and performance management of practices and potential financial benefit. However at this point the discussion around the Quality Improvement Scheme was to obtain clinical input on the Schemes included and was not about the finances therefore although 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 1.3.1 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 3.2 the discussion to be had today was for clinical input on the additional information for noting, not a financial decision so there was no need for PF to be excluded from the discussion, her clinical input was valid and she had not be involved in any decision making.

(Added post meeting: AJ have declared an indirect interest re 3.2 LQIS that wife is partner in Liverpool GP practice – however no conflict as decision clinical rather than financial.)

1.2 MINUTES AND ACTIONS FROM PREVIOUS MEETING ON 20TH MARCH 2018

The minutes of the 20th March 2018 were approved as an accurate record of the discussions which had taken place subject to the following amendments:

- Page 7 item 3.1 Liverpool Quality Improvement Scheme 2018/19 last bullet – SS asked for the first sentence comment from himself to be amended to “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?".

- Page 7 item 3.1 Liverpool Quality Improvement Scheme 2018/19 second bullet next to last sentence, SS asked for the comment from himself to be amended to read "SS commented that it would be more useful to link admissions with diabetic ketoacidosis, to prevalence of Type 1 Diabetes".

- Page 12 item 4.1 Primary Care Commissioning Performance Report – SS asked for the second to last bullet comment from himself to be amended to "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 General Practice Forward View and commissioning sustainable primary care".

- RK highlighted a typographical error on page 15 item 5.1 Findings from Care Quality Commission inspections – defibrillator was spelt incorrectly.

1.3 MATTERS ARISING NOT ALREADY ON THE AGENDA – Verbal

1.3.1 Type 2 Diabetes Therapy Optimisation Service Proposal – Update for Noting Report No: PCCC 06-18 - JH

JH presented an updated report to the Primary Care Commissioning Committee following on from the report presented to the March 2018 meeting at which the Primary Care Commissioning Committee had requested additional clarity around the pilot status and to this end a paragraph had been added on page two of the report in red.

SS re-iterated his concern that there would not be any financial impact of the scheme. It was badged as a "proof of concept" but there were already 80 practices in Liverpool delivering on the HbA1c target. There had been mention of the scheme supporting these practices to deliver their Quality Outcome Framework ('QOF') targets. He had no problem with improving diabetic care in Liverpool, some practices might be experiencing difficulty in hitting the target due to circumstances outside of their control such as demographic/cultural mix but others simply because there was more they could do. JH responded that there would not be financial savings. He understood the concerns raised by SS but we could improve patient outcomes by the use of this project. With reference to QOF points/rewarding practices for not doing the work, a qualitative and quantitative review would be carried out.

RB felt that there was a great deal of inequity in the project across practices, he was not particularly fond of commercial sponsorship but if it helped to improve patient care it should not be dismissed. As regards QOF, SS was correct and the CCG would need to look at this.

JLe commented that we needed to see the learning from working closely with a pharmaceutical company, QOF points were not the issue, this issue was around quality of care for the patient, not income for the practice. JH agreed that the learning needed to come back to the Primary Care Commissioning Committee.

PF had declared her interest in the agenda item at the beginning of the meeting has her practice was one of those selected for the scheme. She stated that more often than not the practice not hitting the required targets was due to the practice demographic. It would be interesting to see the results of the scheme and think about what could be done differently.

RK endorsed the point made by SS, patient behaviour had a great deal of influence here and it would be good to learn how practices might need to change their approach. JH agreed that the project would provide answers to SS's questions and the results brought back to the committee. CM noted that a framework for

decision making on projects such as this had been discussed and would be brought to the next formal meeting.

KP summed up the mood of the meeting by saying that this was not perfect and that the Primary Care Commissioning Committee would like to see the questions raised built into the outcomes report for the project. JH agreed that as soon as the Project was over he would come back to the Primary Care Commissioning Committee to update.

1.3.2 Action Point One: TK updated that he had not yet attended a practice managers' meeting to brief on Primary Care Support Services/Capita but that this was in hand.

1.3.3 Action Point Two: it was noted that RB and JLe had met to discuss solutions and escalation process re Capita and Primary Care Support Services.

1.3.4 Action Point Three: it was confirmed that the language around timescales for practice groupings within the Liverpool Quality Improvement Scheme 2018/19 had been softened.

1.3.5 Action Point Four: it was noted that RB working with JLe on the correct determinant for diabetes prevalence was ongoing.

1.3.6 Action Point Five: it was noted that the Update on the Diabetes Therapy Optimisation Service Proposal was on the agenda.

1.3.7 Action Point Six: it was noted that the outcome of the North West Collaboration for Leadership in Applied Health Research and Care CLAHRC academic evaluation of the Local Quality Improvement Scheme 2011 to 2016/17 would be brought to the Primary Care Commissioning Committee when available.

1.3.8 Action Point Seven: KP was involved in the group looking at GP Survey results in more detail and the output of this would feature in the Performance Report coming to the June 2018 meeting.

1.3.9 Action Point Eight: it was noted that full year end report and planning for the next two years re General Practice Forward View would be brought to the June 2018 meeting rather than May 2018.

1.3.10 Action Point Nine: re Action Point Eight above it was noted that the report on the General Practice Forward View summary of measures being taken and a delivery action plan for the Governing Body would be presented to the May 2018 Governing Body as part of the Operational Plan. RK commented on the order of the two GP Forward View reports with the full year end report and planning for the next two years going to the Primary Care Commissioning Committee AFTER the delivery action plan going to the May 2018 Governing Body. CM confirmed that this was correct.

1.3.11 Action Point Ten: from matters arising it was noted that there was a Task & Finish Group working on the Seven Day Access Working Model and Specification with the Report coming back to the August 2018 Primary Care Commissioning Committee and then the September 2018 Governing Body.

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:
  - Concerns had been raised regarding payments, communication and feedback.
  - This had been reported to the Cheshire & Mersey Quality Surveillance Group, the response would be shared with the committee when available.
  - TK was to meet with the Practice Managers to update them.

- Winter 2018/19 Planning – specific Primary Care Guidance received as yet but were looking at Pharmacy and urgent Dental rotas. The A&E Delivery Board would be asking for the first draft of Winter Plans by the end of April 2018.

- Primary Care Network Transformation Funding Programme:

  - ✓ This was yet to be confirmed re the rollout.

  - ✓ NHS England wanted to focus funding through the Primary Care Network and ensure alignment between the Primary Care Network and the Cheshire & Mersey Health & Social Care Partnership Funding.

  - ✓ The Network would serve a population of 30,000 to 50,000. Practices could work together either without a structure or using the GP Federation, this was not prescriptive.

  - ✓ The final offer was yet to be confirmed.

  - ✓ There would be a bidding process which would be kept as simple as possible using an application form to be assessed by a panel.

  - ✓ It was possible that a communication would be sent out by either 7th May 2018 or week commencing 14th May 2018 with a briefing, with an 8th June 2018 application with a possible notification to bidders by 3rd July 2018.

RB informed the Primary Care Commissioning Committee that performance had deteriorated further with Primary Care Support Services and that this was damaging GPs. With regard to Primary Care Network Funding it was not possible to assess if it would be of any benefit without knowing the amounts involved. TK responded that this would be millions of pounds across Cheshire & Mersey.

JLe responded to RB that the CCG did care about GPs and that she had written to Graham Urwin, Director of Commissioning Operations NHS England to raise the issue of Primary Care Support Services and ask what the escalation process was. With regard to the opportunity for money to support the Primary Care Network, she asked TK how this would work with Place Based Business Plans. TK responded that the Selection Panel would have representation from CCGs, the Sustainability & Transformation Plan and NHS

England. CM confirmed her willingness to be part of the Cheshire & Mersey Panel.

SS commented that with regards to the Primary Care Networks there should be equity in the system, in a bidding process not every submission would be successful which would result in inequalities.

TK agreed to feed all these comments back to NHS England.

The Primary Care Commissioning Committee:

- **Noted the verbal update.**

PART 3: STRATEGY & COMMISSIONG

3.1 PRIMARY CARE & PRESCRIBING – BUDGET SETTING METHODOLOGY 2018/19 FINANCIAL YEAR – REPORT NO: PCCC 07-18

MB presented a paper to the Primary Care Commissioning Committee which highlighted the planning assumptions used during the Primary Care Budget Setting process for the 2018/19 financial year, including delegated budget responsibilities from NHS England, Local Quality Improvement Schemes, GP Specification and Prescribing for 2018/19. The CCG had a growth allocation of £2.492m for 2018/19 (3.44%) which resulted in a resource allocation of £75m for the year. The distance from target between funding allocation actually received and the target allocations for Liverpool CCG for 2018/19 was -4.92% (gap between £75m actual allocation and £78.9m target allocation) which would carry through to 2019/20. This related to Primary Care budgets not the CCG as a whole. Adding in Liverpool CCG's Local Investment in 2018/19 of £13.4m to the actual allocation of £75m gave a total investment of £88.4m which compared to the target allocation of £78.9m gave an investment above target of £9.5m.

Forecast expenditure for 2018/19 was detailed in the paper by area, most of which were showing at month 11 a 1% uplift.

Local Quality Improvement Scheme Memorandum of Understanding – 2018/19 Weighted List Sizes had been uplifted by using the 2017/18 quarterly growth trends with a value of £2 per patient but this was still under discussion with NHS England and the Local Medical Committee.

General Practice Forward View:

- **Practice Transformational Support** - CCGs to spend approximately £3 per head in 2017/18 and 2018/19 as set out in the General Practice Forward View. This was funded in full in 2017/18 therefore has not been included in 2018/19 budgets, however the CCG has set aside an additional £2 per patient as per MOU section above.

  CCG Implications – Fulfilled in full in 2017/18 therefore no further provision has been included within assumptions

- **Online general practice consultation software systems** – CCGs to receive a share of £15m funding between 2017/18 and 2019/20 based on their registered population as set out in the General Practice Forward View. Liverpool CCG did not receive any funding in 2017/18 but would receive £126,318 in 2018/19 and £260,405 in 2019/20.

  CCG Implications – **Not currently** included within resource / expenditure assumptions, budgets would be adjusted upon receipt of allocations.

- **Training care navigators and medical assistants for all practices** - CCGs to receive a share of £10m funding between 2016/17 and 2020/21 based on their registered population as set out in the General Practice Forward View. Liverpool CCG will receive £86,972 in 2018/19, £86,523 in 2019/20 and £86,081 in 2020/21 in addition to the £131,361 received and spent to date.

  CCG Implications – **Not currently** included within resource / expenditure assumptions, budgets will be adjusted upon receipt of allocations.

- **Funding to improve access to general practice services** - This funding was targeted at those areas of England which had successful pilot sites in 2015/16, known as the “Prime Minister’s Challenge Fund” or “General Practice Access Fund” sites in 2017/18.

  In 2018/19 Liverpool CCG would receive an allocation of £1,977,150 (£3.34 per head based on an estimated Weighted Population BY NHSE). The funding would increase to £6 per head in 2019/20.

CCG Implications – **Not currently** included within resource / expenditure assumptions, budgets would be adjusted upon receipt of allocations.

Risks:

The budgets where expenditure could fluctuate within the financial year were:

- List size adjustments – noting that 2018/19 budgets had been adjusted to include expected growth on list size (weighted and raw) on all areas of expenditure where funding was based on list size. These areas were at risk of overspending if the local population increased by more than previous years' trends.

- QOF – dependent on the level of achievement by practices

- Local Quality Improvement Schemes – dependent on activity undertaken; trends of 2017/18 as at M11 might not be indicative of the trends for 2018/19

- Premises - rent reviews and rate increases that might occur mid-year

- Locums – locum services required randomly throughout the year

Prescribing: the budgets for 2017/18 had been challenging such as No Cheaper Stock Option and this area could add an additional £4m of pressure with overall pressure for the 2017/18 financial year of £3.2m. 2018/19 would therefore be challenging.

Budget Setting Methodology:

It was noted that the reference to £'000s was incorrect and it was actual numbers recorded. The total budget for 2018/19 was: £90.49m BSA Prescribing, £1.16m from FP47 Prescribing, £7.7k charges from the Commissioning Support Unit and £227k from computer software/Licenses giving a total of £91.88m.

Prescribing Cost Reduction Plan 2018/19 – a cost reduction target of £1m had been identified which was an additional challenge for the prescribing team.

Financial Risks – 'flu' vaccine costs and generic price increases for drugs. No Cheaper Stock Options pressure might also continue.

RB referred to the CCG's allocations and asked if any increase from the Review Body on Doctor's and Dentists' Remuneration ('DDRB') to the Global Sum would need to be absorbed by the CCG or would additional funding be available. MB responded that as far as we were aware the CCG would need to absorb.

SS commented that more often than not prescribing costs were driven from Secondary Care so an option was required for GPs to make prescribing savings. JH responded that the whole prescribing system was being looked at.

The Primary Care Commissioning Committee:

- **Noted the resource allocation made to the CCG in respect of the delegated primary care co-commissioned budget**
- **Noted the budget setting methodology used for primary care and prescribing budgets in sections 3 to 5 for the 2018-19 financial year and as summarised in section 6**
- **Noted the financial risks and key issues set out in Section 4.4 and Section 5.5 that may impact the delivery of financial balance.**

3.2 CCG LOCAL QUALITY IMPROVEMENT SCHEMES (LQIS) – REPORT NO: PCCC 08-18

SA presented a paper to the Primary Care Commissioning Committee to seek approval for the commissioning of Local Quality Improvement Schemes from 1st April 2018 until 31st March 2019. These were:

- Ankle-Brachial Pressure Index (ABPI)
- Helicobacter Urea Breath Testing (H Pylori)
- Prostate Hormone Injections
- Impaired Glucose Regulation and Gestational Diabetes
- Near Patient Testing
- Homeless
- Traveling Community
- Asylum Seekers and Refugees
- Resettlement Programme

Minor Surgery was still in negotiation and therefore not part of the list.

Local Quality Improvement Schemes have been designed by NHS Liverpool CCG to facilitate the improvement and delivery of high quality services provided by general practice.

The annual review of the specifications had been undertaken by the CCG Clinical Lead, Commissioning Manager, Local Authority Public Health Team and the Primary Care Programme Group. The CCG had also engaged with the Local Medical Committee.

- Appendix one details the outcome of the reviews
- Appendix two lists each of the specifications

The following were highlighted:

- ABPI – there was evidence that 25% of referrals to vascular surgeons did not require secondary care intervention, this pathway allowed for patients with claudication symptoms to be tested first in primary care.
- H Pylori - upated and review to include Gastro-oesophageal reflux in line with NICE Guidance.
- Prostate hormone injections – now available closer to home.
- Impaired Glucose Regulation – would identify those at risk of developing diabetes.
- Near Patient Testing – working closely with Secondary Care trusts on shared care agreements.
- Homelessness
- Travelling Community
- Asylum Seekers and Refugees.
- Resettlement Programme for Syrian Vulnerable Person launched by the Home Office in January 2014 and extended to all those fleeing Syria, claim of £2,600 per person to be made within one year of arrival. Liverpool CCG proposed a one off payment of £113.56 per patient to be allocated to General Practice for each patient allocated via the Scheme. The CCG could claim any additional spend within Secondary Care via the Home Office but without providing patient identifiable information.

The Primary Care Commissioning Committee commented as follows:

- HD commented that she would like to know what the benefits were from the schemes so that an informed decision could be made on whether or not they represented value for money. RK responded that the Primary Care Programme Group had already discussed the clinical specification in detail. We would struggle to quantify the benefits other than a better service for patients. SA added that the cost of the H Pylori testing in Primary Care was lower than in Secondary Care and also the referral to Secondary might well be inappropriate. RB added

that there would be several years' worth of data required before we could provide this type of analysis, however outpatient referrals in Liverpool was lower than in the rest of the country and no doubt saved the CCG a lot of time and money but this in itself was not a definitive answer. RK agreed that the benefits were not always financial.

- JLe felt that there need to be a retrospective assessment of the outcomes of the Scheme. SP responded that there was a retrospective evaluation being carried out to be brought back to the Primary Care Commissioning Committee which would answer these quantitative and qualitative issues.

The Primary Care Commissioning Committee:

- **Noted the content of the paper.**
- **Approved the commissioning of the specifications until March 2018**
- **Approved the approach to monitoring and review of specifications in line with placed based commissioning priorities.**

PART 4: PERFORMANCE

4.1 PRIMARY CARE & PRESCRIBING – DRAFT YEAR END FINANCIAL POSITION 2017/18 FINANCIAL YEAR – REPORT NO: PCCC 09-18

MB presented a paper to the Primary Care Commissioning Committee to indicate the draft year-end financial position for Primary Care and Prescribing Budgets as at Month 12 of the 2017/18 financial year (subject to audit). The draft year end accounts for the organisation were being finalised the following week. In summary the total annual budget was £173m and we had spent £175.7m which left a variance of £2.7m.

The total year to date variance for Local Enhanced Services was £184k underspent. CM took the opportunity to thank JH and PJ for all their hard work with the prescribing budget bringing it in at a 3.65% overspend in the face of the challenges.

Primary Care Cash Releasing Efficiency Savings ('CRES') target in month 1 had been identified at £2m to underachieve by £1.5m due to

the requirement to fund £1.5m of GP Out Of Hours deductions against the GP Contract value. The shortfall did not have an impact on the Primary Care budget as this had been funded from reserves resulting in an unidentified CRES.

The minor surgery CRES target of £200k was reporting an over-delivery of £116k based on Quarter one to Quarter 3 data. The scheme was expected to achieve planned savings for Quarter 4 with the over delivery from Quarter 1 to 3 expected to continue as a trend for the remainder of the scheme.

The Primary Care Commissioning Committee:

- **Noted the indicative year-end financial position against budget of the specific Primary Care and Prescribing budgets highlighted above for 2017/18.**
- **Noted the indicative achievement against CRES targets set for 2017/18.**
- **Noted the financial position reported is still being finalised and is subject to external audit review, variations will be reported at a later date if applicable.**

PART 5: GOVERNANCE

5.1 PRIMARY CARE COMMISSINING RISK REGISTER APRIL 2018 – REPORT NO: PCCC 10-18

The Primary Care Commissioning Committee had received the Risk Register in advance of the meeting. RK noted that there were 13 risks not 12.

The question was asked of the benefit realisation of the Local Quality Improvement Scheme needed to be added to the Risk Register

The Primary Care Commissioning Committee:

- **Noted the contents of this report and review of risks for the commissioning of General Practice**
- **Considered current control measures and whether action plans provide sufficient assurance on mitigating actions.**

- **Agreed that the risk scores accurately reflect the level of risk that the CCG is exposed to given current controls and assurances.**

6. ANY OTHER BUSINESS

None

7. DATE AND TIME OF NEXT MEETING

Tuesday 19th June Formal Meeting - 10am Boardroom LCCG