**NHS LIVERPOOL CLINICAL COMMISSIONING GROUP**
**PRIMARY CARE COMMISSIONING COMMITTEE**
**Minutes of meeting held on Tuesday 19th JUNE 2018 at 10AM**
**BOARDROOM, THE DEPARTMENT**

**Present:**

**Voting Members:**

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| Ken Perry (KP) | Governing Body Lay Member – Patient & Public Involvement (Chair) |
| Jan Ledward (JLe) | Chief Officer |
| Cheryl Mould (CM) | Primary Care Programme Director |
| Paula Finnerty (PF) | GP – North Locality Chair |
| Mark Bakewell (MB) | Acting Chief Finance Officer |
| Jane Lunt (JL) | Chief Nurse/Head of Quality |

**In attendance:**

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| Rob Barnett (RB) | LMC Secretary |
| Dr Rosie Kaur (RK) | GP, Primary Care Lead |
| Colette Morris (CMo) | Primary Care Development Manager |
| Dr Jamie Hampson (JH) | GP – Prescribing Clinical Lead |
| Peter Johnstone (PJ) | Primary Care Development Manager |
| Jacqui Waterhouse (JW) | Primary Care Development Manager |
| Victoria Houghton (VH) | Primary Care Accountant |
| Ben Kennedy (BH) | Senior Finance Manager (VH Maternity Leave cover) |
| 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 Nurse Transformation & Workforce Lead |
| Scott Aldridge (SA) | Contracts Manager |
| Lynn Jones (LJ) | Primary Care Quality Manager |
| Tina Atkins (TA) | Practice Manager |
| Sarah Thwaites (ST) | Healthwatch |
| Sandra Davies (SD) | Director of Public Health |
| Sarah Stephen (SSt) | Prescribing Project Manager |
| Paula Jones | Committee Secretary |

**Apologies:**

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| Steve Sutcliffe (SS) | GP |
| Helen Dearden (HD) | Governing Body Lay for Governance |

## PART 1: INTRODUCTIONS & APOLOGIES

The Chair welcomed everyone to the meeting and introductions were made. It was agreed that item 3.1 which was a presentation and discussion around the Primary Care Framework Deliverables for the year and planning for the next two years would be taken last on the agenda.

### 1.1 DECLARATIONS OF INTEREST

There were no declarations of interest made specific to the agenda.

### 1.2 MINUTES AND ACTIONS FROM PREVIOUS MEETING ON 17TH APRIL 2018

The minutes of the 17th April 2018 were approved as an accurate record of the discussions which had taken place subject to the following amendments:

- Correction of typographical error on page 8 second paragraph with the word "with" to be inserted prior to Place Based Business Plans.

### 1.3 MATTERS ARISING NOT ALREADY ON THE AGENDA – Verbal

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

1.3.2 Action Point Two: CM updated that she and KP had met with the CCG Primary Care Team and ST/Healthwatch to pull together the GP survey results and Healthwatch survey information with a view to enhanced access and to triangulate their data. A presentation would be brought to the August meeting in the new format.

1.3.3 Action Points Four and Five: JH updated the Primary Care Commissioning Committee on the Diabetes Therapy Optimisation Service Proposal as requested:

a. Programme would last two months in total, dealing with 16 patients per day.
b. HBA1C testing to be carried out, lifestyle advice given and tutorials on injection technique – therefore an intensive assessment.
c. GP and Nurse would provide educational improvement.
d. Clinical assessment would take 8 weeks to complete in all practices.
e. ICS would produce an initial report but could not offer repeat HBA1C testing, however they would assess whether interventions had been effective and see if any changes needed to be made.

The question was raised by members on how this differed from what was already offered in practices, noting that what was difficult to alter was patient behaviour. JH responded that this would be more intensive and proactive.

PJ referred to the whole issue of commercial sponsorship and that a lengthy process was under way to put together a framework to ensure that we got we wanted to from these initiatives and have a correct process in place. He agreed to bring a report back to the September 2018 meeting. JH noted that this referred to the whole of the CCG, not just prescribing.

1.3.4 Action Point Six: TK noted that he would provide an update on Primary Care Support Services in his update from NHS England. RB asked if JLe had received a response from Graham Urwin at NHS England re the CCG concerns as mentioned in the minutes of the previous meeting. JLe responded that she had not received a response. TK added that he was involved in drafting the response and that the regional team had also escalated its own issues.

**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/Capita:

✓ Response received from the Service Engagement Team at Capita who he had written to in April 2018.

✓ Internal Audit review had been carried out for each service line concerned (Customer Support Centre and Complaints) and action plans agreed with Capita.

✓ Pension Payments – an action plan was being discussed with NHS Pensions. (RB highlighted how serious an issue this was for practices).

✓ A new liaison manager was in post for the North West for the Engagement Team (Jonathon Gore) who had been offered a hotdesk with NHS England and had agreed. There were concerns over his capacity as he also dealt with Midlands and the North West.

✓ Concerns were being reported to the Cheshire & Merseyside Quality Surveillance Group (escalating to the Contract Team).

✓ TK had met with the Practice Managers in Liverpool and had fed back their concerns to the Contract Team.

- Primary Care Network Development Fund – final submissions date was 12pm on 9th July 2018. National guidance was coming around pharmacy involvement, RB had met with TK and the Local Pharmacy Committee to talk about this and an event was set up for 18th July 2018 involving community pharmacy, the Local Pharmacy Committee, Local Medical Committee and GPs. It would therefore be good for the Network application to include community pharmacy, this funding was about transforming services not continuing with the status quo and he would be happy to input/support in this.

- He had attended a positive meeting with PJ re the Clinical Pharmacy Programme and was keen to have this as a citywide scheme.

- Pharmacy Integration Fund – Wirral CCG was the lead CCG and this Care Homes/Medicines Optimisation scheme – Wirral CCG had a list of pharmacists in Care Homes, the aim was to get community pharmacy in one place for oversight. There would be a bid led by Wirral CCG re Care Homes.

- For 2018/19 NHS England were to provide additional funding for Primary Care Delivery, different to the GP Forward View CCGs could pick deliverables and expectations, he could pick this up with colleagues afterwards.

CM referred to the development of GP Networks established in the GP Specification and was happy to inform the Primary Care Commissioning Committee that nine networks had been confirmed in Liverpool with a Memorandum of Understanding signed, with two more expected. We were not expecting any practice to be left out and all would be part of a Network. Each Network would be assigned an NHS England buddy as part of the Primary Care Network Fund process. The Networks to date had all been approved as geographically viable by NHS England.

**The Primary Care Commissioning Committee:**

- **Noted the verbal update.**

## PART 3: STRATEGY & COMMISSIONG

## 3.1 PRIMARY CARE FRAMEWORK DELIVERABLES FOR YEAR AND PLANNING FOR NEXT TWO YEARS – PRESENTATION

Before the presentation was made CM asked the question “Does the Primary Care Commissioning Committee fulfil its role and how does governance work in the organisation”.

- JL felt that quality could be managed better than at present. LJ was now working closely with the Quality Team but all strands of Primary Care needed to feed in to quality and tie up with the internal governance structures.

- MB stressed the need to work with the resources we had available.

During the course of the presentation the following issues were raised:

- KP felt that financial sizing would be useful and also asked about patient and public involvement. RK noted that we had worked closely with Healthwatch on enhanced access discussions but now needed to work with other stakeholders, not just patients, with outcomes and measurables.

- KP wondered how engaged practices were in scale and pace of change. PF noted the drive from NHS England to develop GP Practice Networks had started practices to get together and collaborate to deliver “at scale”, however it was too early to tell how this would deliver.

- RB highlighted the differing views of various groups of patients on how they wanted Primary Care to be delivered: some wanted the continuity of seeing the same GP each time, others wanted immediate access to have this delivered by a variety of clinicians at a variety of venues.

- MB commented that the paper was missing two items:

  - Where did we want to be, what was the ambition of the programme – the positives were GP Specification and Estates but how did this stack up with quality issues, we needed to be realistic.

  - Wider Place – there were system pressures in the acute sector and how could we be more preventative and futureproof?

- RB felt there were a number of problems:
  - Premises
  - Independent Contractor versus salaried model.
  - GPs did not feel valued for what they did.
  - The system kept changing.

- If we were to start completely from scratch with a blank canvas we would never devise the current system, however there was commitment to maintain the list-based format.

- It was felt that the GP Forward View monies were very prescriptive in how they could be spent and a wide range of

requirements needed to be met before they were available to spend. JLe felt that the CCG needed to demonstrate what model it wanted and how it wanted to achieve and ask for the money to fulfil this rather than wait for funding to be announced and attached to national initiatives.

- MB commented that a lot of money was spent on void estates costs (55% of space not utilised) and this could be released back into frontline care.

KP pulled the discussion to a close commenting that the discussion showed that the meeting was in "leadership mode" rather than "management mode". Every £1 spent running the system meant £1 less to spend elsewhere. CM suggested looking at the informal session dates and using these for more discussions along the lines of this discussion, looking at the key issues. She suggested using the September 2018 Informal Session to look at workforce issues. KP suggested changing the name of these sessions to "Strategic Development" with more time being given to thought with less papers to be read.

KP summarised the requirements from the Primary Care Commissioning Committee as being:

- More financial information required.
- Need to get patients and public more involved.
- Committee meetings to be used more appropriately to look at our own model of change (KP to take this action on board).

**The Primary Care Commissioning Committee:**

- **Noted the presentation and ensuing discussion.**

## 3.2 REQUEST TO REDUCE PRACTICE BOUNDARY – ST JAMES' HEALTH CENTRE (DR PRASAD & PARTNERS) – REPORT NO: PCCC 12-18

SA presented a paper to the Primary Care Commissioning Committee to inform it of an application from St James's Health Centre (Dr Prasad) to reduce the practice's inner and outer boundaries. Under the previous partner the boundary was extremely large covering an area from Bootle to Speke, when this partner left

the remaining partners felt that the geographical area was too large for them to provide home visits and had therefore requested the reduction of the boundary outlined in the paper to a more manageable size. The practice was required to engage and inform patients of any changes, no out of area registered patients would be removed but they would not register new patients from outside the boundary. There had been no opposition from local practices and therefore the Primary Care Commissioning Committee was being asked for its approval.

JLe expressed a concern that we needed to ensure that all patients had a choice, she also wondered why the paper stated that engagement with patients was required and yet under the statutory requirement information section of the paper the area of engagement was marked as not applicable. She wondered if the format of the papers needed to be changed.

KP summarised that we needed to learn the lessons raised around clarity of process but that the consensus of the Primary Care Commissioning Committee was to approve the boundary change.

**The Primary Care Commissioning Committee:**

- **Approved the application to reduce the practice boundary.**

## 3.3 DIRECT PATIENT ORDERING POST PILOT EQUALITY IMPACT ASSESSMENT – REPORT NO: PCCC 13-18

JH presented a paper to the Primary Care Commissioning Committee to share the post pilot Equality Impact Assessment for Direct Patient Ordering highlighting the risks and mitigating actions in relation to citywide rollout.

The pilot had been carried out last year in the "WAGGA" Neighbourhoods (Woolton, Aigburth Garston, Gateacre, Allerton) and had performed very well. A full report had gone to the Governing Body for approval for rollout as part of the Operational Plan:

- There had been a 3.3% reduction in prescribing in the pilot sites which translated in potential savings of £2m to £3m.

- No negative feedback had been received from practices.

- The rollout was happening, the purpose of bringing the paper here was to provide assurance that all areas of potential risk had been considered and mitigating action taken.

The Primary Care Commissioning Committee commented as follows:

- KP felt that the paper was extremely comprehensive.

- ST raised concerns around patients considered as vulnerable/with mental health conditions and how confident we could be that they were identified correctly in order to retain the ability to telephone for their repeat prescription. She gave examples of an elderly couple where the husband might run the risk of not being identified as vulnerable but the fact that he could not leave his invalid wife, did not have computer access/photo ID meant that they would need to come together in taxi to the surgery when they were low income. JL agreed that this was an issue which needed to be addressed, bearing in mind that other city neighbourhoods were a very different demographic to WAGGA. JH was confident that this would be addressed correctly at practice level/community pharmacy level.

- RK wanted to know how feedback could be gathered on a formal basis, such as using forums like the Practice Managers Forum, Patient Forums, formal feedback from receptionists and clinicians. The reduction in workload in dealing with prescribing queries could be offset against the additional workload in identifying and supporting vulnerable patients. KP asked for feedback to come to the December 2018 meeting.

- AJ noted that Knowsley CCG had already rolled this out very successfully and could liaise with Liverpool CCG.

- SSt added that as part of the pilot evaluation there had been a helpline set up for patients to call.

**The Primary Care Commissioning Committee:**

- **Noted the post pilot Equality Impact Assessment for the Direct Patient Ordering project.**
- **Received assurance that the mitigating actions provided against the highlighted risks have been incorporated into the city wide roll out project plans.**
- **Requested an update on identification of vulnerable patients be brought back to the December 2018 meeting.**

## PART 4: PERFORMANCE

### 4.1 CCG PRIMARY CARE COMMISSIONING COMMITTEE CONTRACTING AND FINANCE REPORT – REPORT NO: PCCC 14-18

SA and MB presented a paper to the Primary Care Commissioning Committee to report on key aspects of the CCG's Primary Care Contracting and Finance position for 2018/19 as at 31st May 2018. He highlighted:

- Contracts: there were 74 GMS contracts, 5 PMS contracts and 13 APMS contracts (to reduce to11 by 14th September 2018. Of the 5 PMS, 3 had requested to switch to GMS but the process was not completed, the requested had been submitted to NHS England Primary Care Support in February and March 2017 but the national systems had not yet updated. From the 4 APMS contracts to cease 11,000 patients were at risk, 610 needed to be dispersed to new practices across the city.

- Friends and Family test data, 29 of the 92 Liverpool GP practices failed to formally responded and submit their responses for the April 2018 return.

- Contract Sanctions – one practice received a remedial notice regarding failure to deliver a GP on one working day, clinical support was provided by a neighbouring practice working from the same provider.

- Contract visits programme – all 92 practices had completed their reviews and a paper would be presented to the Finance Procurement & Contracting Committee regarding the future of the visits programme.

- Delegated Commissioning – it was early on in the year, a forecast overspend had been calculated for one GP Retention Scheme currently in place for £12.3k, the scheme had not been know at budget setting. The total Month 2 forecast variance was £23.7k being made up of the £12.3k GP Retention Scheme and the prior year (2017/18) amount of £11.4k.

- Local Enhanced Services – forecast position as at Month 2 was £13.147m (underspend of 0.3%) against the planned figure of

£13.182m. Activity up to month 2 had caused a variance of (£35.7k).

- Prescribing - difference between assumptions at the end of previous year and month 2 performance resulted in the goods new of an underspend of £378.5k.

The Primary Care Commissioning Committee commented as follows:

- RB referred to the PMS to GMS contract change requested dating back to February and March 2018 and felt that this was unacceptable. TK agreed with him and noted that he would chase this up immediately.

- JL referred to the Friends & Family Test data and felt that is was disappointing that so many practices had failed to submit the April 2018 data. JL also asked if patients were aware of how to access data on their practices and should this be more in the public domain. She felt that the report did not contain adequate assurance. RB responded that the reason practices had not submitted the Friends & Family data for April 2018 was due to systems issue which were one off and which practices had not been notified of in advance. RK wondered if the 29 practices in question were different in this instance to the other practices who had not submitted data and if they were the same was there another vehicle for reporting on this, i.e. to the Quality and Safety Assurance Group or the Quality Safety & Outcomes Committee. CM responded to the issue of insufficient assurance in the document noting that the aim had been to keep papers shorter and more manageable, the information was available and thought needed to be given on the format and how to provide the requisite assurance/detail. KP agreed that the practice data needed to be readily available in the public domain but felt that a committee paper was not the area in which to deliver this, it would be better to have this easily locatable on the CCG website.

**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 was still being finalised and is subject to external audit review, variations will be reported at a later date if applicable.**

## PART 5: GOVERNANCE

No items

## 6. ANY OTHER BUSINESS

None

## 7. DATE AND TIME OF NEXT MEETING

Tuesday 21st August 2018 Formal Meeting - 10am Boardroom LCCG