NHS LIVERPOOL CLINICAL COMMISSIONING GROUP
PRIMARY CARE COMMISSIONING COMMITTEE
Minutes of meeting held on Tuesday 19TH MARCH 2019 at 10AM
BOARDROOM, THE DEPARTMENT

Present:

Voting Members:

Ken Perry (KP)	Governing Body Lay Member – Patient & Public Involvement (Chair)
Helen Dearden (HD)	Governing Body Lay Member for Governance
Paula Finnerty (PF)	GP – North Locality Chair
Steve Sutcliffe (SS)	GP
Mark Bakewell (MB)	Chief Finance & Contracting Officer
Cheryl Mould (CM)	Primary Care & Community Programme Director

In attendance:

Dr Rosie Kaur (RK)	GP, Primary Care Lead
Peter Johnstone (PJ)	Head of Primary Care Delivery
Colette Morris (CMo)	Primary Care Development Manager
Sarah Thwaites (ST)	Healthwatch
Laura Buckels (LB)	Business Intelligence Team Primary Care Lead
Tom Knight (TK)	Head of Primary Care – Direct Commissioning NHS England
Dr Adit Jain (AJ)	Out of Area GP Advisor
Gemma Melia (GM)	Senior Project Manager, Prescribing
Paula Jones	Committee Secretary

Apologies:

Rob Barnett (RB)	LMC Secretary
Jan Ledward (JLe)	Chief Officer
Jane Lunt (JL)	Director of Quality Outcomes & Improvement/Chief Nurse
Lynn Jones (LJ)	Primary Care Quality Manager
Sandra Davies (SD)	Director of Public Health
Tina Atkins (TA)	Practice Manager

Public: 2

PART 1: INTRODUCTIONS & APOLOGIES

The Chair welcomed everyone to the meeting and introductions were made.

1.1 DECLARATIONS OF INTEREST

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

1.2 MINUTES AND ACTIONS FROM PREVIOUS MEETING ON 16th OCTOBER 2018

The minutes of the 16th October 2018 meeting were approved as an accurate record of the discussions which had taken place subject to the correction of some minor typographical errors passed by HD to Paula Jones.

1.3 MATTERS ARISING NOT ALREADY ON THE AGENDA – Verbal

1.3.1 Action Point One: MB updated that the Estates Strategy and issue had been discussed at the Governing Body Development session and workshops – it would come back to the Primary Care Commissioning Committee in due course.

1.3.2 Action Points Two & Three: it was noted that these actions re a reporting framework for Primary Care were being managed through other committees as part of the governance review within the organisation.

The Primary Care Commissioning Committee:

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

PART 2: UPDATES

2.1 NHS ENGLAND UPDATE – VERBAL

TK updated the Primary Care Commissioning Committee:

- He would be providing an update to PJ later in the day around Primary Care Support Services' services lines:
    - RB had provided a summary of residual practice issues. TK was still seeing pension queries coming through and was meeting with the Practice Managers very soon (he had attended a meeting with the Practice Managers in October last year).
    - Capita had re-organised their Communications & Engagement Team nationally and there was a dedicated manager for CCGs. TK felt encouraged by their engagement with stakeholders.
    - The number of issues coming through directly to TK had decreased.
    - The original transformation timeline had been reviewed and the deadlines extended, for example changes to the GP payment system would happen in 2020 not last year as per the original timescale. It was encouraging that they recognised the requirement for thorough stakeholder engagement around the new services.

- NHS England Team had been asked to produce a Primary Care Strategy for the Cheshire & Mersey Sustainability & Transformation Programme ('STP') with a working draft to be ready by the end of March 2019 setting out the vision for Primary Care across the Cheshire & Mersey STP. This was required because in July 2019 some Primary Care funding would come through the STP. There were four "streams" and a CCG would need to be the "banker":

    - Workforce across Primary Care (not just GPs).
    - Primary Care Networks.
    - Investment.
    - Digital, technology and estates.

  TK stressed that this did not replace local strategies at place level and was merely relating to Sustainability & Transformation Partnership funding. NHS England required a

page summary of what was happening at place (CCG). As mentioned before this did not replace local delivery plans. We needed to embed population health as well as the four "streams". The governance had not yet been worked out, Tony Leo from NHS England was the Senior Responsible Officer for the STP. PJ was part of the working group developing the document and NHS England were providing high level support. In response to a query from KP he confirmed that the funding would be going directly to CCGs. KP asked why this was so late in being requested, TK responded that it had come from the NHS England National Team and the local team had already "kicked back" some of the original deadlines. The working document would be ready for the end of March 2019 and then would be developed further by June 2019.

The Primary Care Commissioning Committee:

- **Noted the verbal update.**

PART 3: STRATEGY & COMMISSIONG

3.1 CONDITIONS FOR WHICH OVER THE COUNTER ITEMS SHOULD NOT ROUTINELY BE PRESCRIBED IN PRIMARY CARE – REPORT NO PCCC 01-19

GM presented a paper to the Primary Care Commissioning Committee which provided an overview of the NHS England guidance for CCGs relating to the prescribing position and the process by which the Medicines Optimisation Committee had considered the guidance and developed its recommendations. The Primary Care Commissioning Committee was asked to approve a period of local patient and public engagement on the proposals to introduce a prescribing policy for self-limiting or minor conditions and items a limited clinical value in line with the recommendations of the Medicines Optimisation Committee.

In December 2017 NHS Clinical Commissioners and NHS England had launched a joint national consultation on commissioning guidance for which over the counter items should not routinely be prescribed in Primary Care and guidance was published in March 2018 which detailed 37 different conditions/items which should not be prescribed in Primary Care.

On 25th September 2018 a task and finish group instructed by the Liverpool Medicines Optimisation Committee ('MOC') met to consider the NHS England guidance and how this could be implemented safely and equitably for the population of Liverpool CCG. The group included representation from the CCG Primary Care Team, CCG Social Value and Engagement Team, CCG Communications Team, NHS England, the Local Medical Committee (LMC), the Local Pharmaceutical Committee (LPC), Healthwatch Liverpool and community pharmacy. The options considered by the Group were 1. Take no action 2. Fully implement the guidance and 3. Implement some of the guidance.

The recommendation of the Medicines Optimisation Committee was to place restrictions on prescribing for 16 of the minor/self-limiting conditions/items of limited clinical value which were:

Acute Sore Throat
Coughs and colds and nasal congestion
Cradle Cap (*except where causing distress or not improving)*
Dandruff
Head Lice
Infant Colic
Infrequent Constipation
Mild Cystitis
Mild Dry Skin/Sunburn
Minor burns and scalds
Mouth ulcers
Prevention of dental caries
Probiotics
Sun Protection *(except ACBS approved indication of photodermatoses)*
Vitamins and minerals *(except a medically diagnosed deficiency, osteoporosis and malnutrition)*
Warts and Verrucae

Liverpool also had the Care At The Chemist Scheme and 22 of the conditions included in this scheme also featured in the NHS England guidance.

- In response to a query from KP it was clarified that the Medicines Optimistion Committee could only make a recommendation to the Primary Care Commissioning Committee. The Primary Care Commissioning Committee needed to approve the recommended proposal to move to public engagement. The Medicines Optimisation Committee noted that Liverpool spent £2.4m in Primary

Care on the the 37 conditions/items listed and £1.3m of the 16 recommended for restriction.

Other CCGs implementing a self-care policy were showing lower than predicted cost savings as it had been difficult to assess numbers of patients who would be exempt. Most CCGs were saving between 10% and 20% on prescribing costs. South Sefton CCG had restricted all 37 conditions but no outcome data was currently available. We estimated that Liverpool would save between £240k and £480k (excluding project costs and cost of public engagement), so savings were minimal. The real benefit lay in starting conversations with the public about self-care and advice.

Appendix 4 to the paper contained the Equality Impact Assessment, the potential ability of certain areas of the public to be able to self-care needed to be taken into consideration. There was also a risk of inequity of application across practices. As the period of 'Purdah' for Local Elections was approaching the consultation could not begin until June this year, ending August with implementation around November 2019.

The Primary Care Commissioning Committee commented as follows:

- SS was concerned that those patients most vulnerable to the effect of the process were least likely to be engaged with and there needed to be assurance that these patients would be reached. He also commented that sometimes the advice provided by other healthcare sources was incorrect and many gave a blanket recommendation to go to visit the GP which was only deferring the issue.

- ST was reassured with the strategy but shared SS's concerns about engaging with the correct patients.

- PF supported the paper but expressed concern that it would impact more on patients in areas of deprivation.

- HD agreed that the most vulnerable of patients were at risk of being affected most and were most likely not to engage and this needed to be taken into consideration when reviewing the results of the engagement. GM responded that the engagement plans were being worked on.

- CM reminded the Primary Care Commissioning Committee that the Medicines Optimisation Committee was a sub-committee of the Primary Care Commissioning Committee.

GM agreed to come back to the Primary Care Commissioning Committee with the formal engagement plan, what was being asked for today was permission to proceed to the next stage. In concluding discussions it was noted that the focus was on promoting self-care rather than the money. MB added that the CCG was continuously challenged to demonstrate that is would utilising its resources as well as it possibly could and we therefore were required to take a measured approach whilst remaining fair and reasonable. SS noted that this same approach needed to be extended around the prescribing of the latest, more expensive "wonder drugs" and that colleagues in Secondary Care needed to be more cost effective in their prescribing as well.

The Primary Care Commissioning Committee:

- **Granted approval for a period of local patient and public engagement to commence on proposals to introduce a prescribing policy for self-limiting or minor conditions and items of limited clinical value, in line with the recommendations of the Medicines Optimisation Committee.**
- **Agreed that the formal Engagement Plan needed to come back to the Committee when ready.**

PART 4: PERFORMANCE

4.1 PRIMARY CARE & PRESCRIBING – BUDGET SETTING METHODOLOGY 2019/20 FINANCIAL YEAR – REPORT NO PCCC 02-19

MB presented a paper to the Primary Care Commissioning Committee to highlight the planning assumptions used during the Primary Care Budget Setting process for the 2019/20 financial year including delegated budget responsibilities from NHS England, Local Quality Improvement Schemes, GP Specification and Prescribing.

The key points were highlighted:

- £80.5m of allocation made to Liverpool CCG for delegated Primary Care Services for 2019/20 (£75m of resource allocation

plus 7.4% of growth i.e. £5.5m). The CCG's resources were 5% under target for delegated budgets. Liverpool CCG did invest from its own programme allocation so Primary Care did not suffer directly (GP Specification).

- Expenditure assumptions for 2019/20 represented substantial changes e.g. Networks funding.

- Local Quality Improvement Schemes (GP Specification) and component parts – for 2018/19 fund the GP Specification at £23.05 per weighted patient plus estimated price increase of 2.7%.

- Local Investment of £11.5m to be added to Primary Care Allocation of £80.5m giving total investment of £92m for 2019/20. For 2018/19 local investment was £13.1m, the difference was due to Network development funding in 2018/19 being superseded by other Network payments (as previously stated).

- Cash Releasing Efficiencies Savings ('CRES') for 2019/20 included H-Pylori and the Minor Surgery Direct Enhanced Scheme.

- Prescribing formed 10% of the overall CCG expenditure, thanks to PJ and the Prescribing Team the budget had been set as per the methodology based on the forecast outturn position at month 9 2018/19 year plus 4% price inflation and estimate of activity growth offset by the CRES target of £2.34m.

- Overall budget for 2019/20 was just under £182m. The Committee was asked to note the risks set out in the paper.

The Primary Care Commissioning Committee commented as follows:

- SS highlighted a discrepancy between the Extended Access Direct Enhanced Service payment stated from the CCG of £1.10 and the British Medical Association of £1.45 and asked which one was correct. MB responded that we could only asked NHS England and TK agreed to take the action to raise this with NHS England.

- ST asked what the risks to prescribing costs of Brexit would be. PJ responded that shortages of various drugs was an existing

issue so did not anticipate much further impact on this from Brexit.

- MB commented around drug expenditure and the increased likelihood of contracts with the trusts being on an Acting As One basis for 2019/20 which was positive, also Liverpool CCG, the Royal and Aintree had agreed a system wide approach which would therefore change the financial perspective. The principle of implemented the Blueteq system had been agreed by the Royal and Aintree but an implementation plan Specialty by Specialty was required.

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 2019-20 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.**

4.2 LIVERPOOL QUALITY IMPROVEMENT SCHEME (GP SPECIFICATION) – FINDINGS FROM EVALUATION – REPORT NO PCCC 03-19 & PRESENTATION

CMo and LB presented an overview of the findings from the evaluation of the Liverpool Quality Improvement Scheme (GP Specification) undertaken as port of the Partner's Priority Programme ('PPP') launched in 2016. The Partners' Priority Programme was developed by National Institute for Health Research Collaboration for Leadership in Applied Health Research and Care North West Coast ('NIHR CLAHRC NWC') in collaboration with NHS and Local Authority partners to address the challenges faced in delivering sustainable, safe and cost effective services which meet the needs of the population. The key objective of the PPP programme was to identify which types of initiatives in general are "most (cost) effective in reducing health inequalities, improving population health and wellbeing and reducing emergency admissions". The overall goal of this programme was to enable partners to develop capacity to embed the evaluation approach as an integral part of the change and transformation process.

The presentation featured the scope of the evaluation, methodology, findings from the quantitative and qualitative research undertaken and recommendations for consideration by the Primary Care Commissioning Committee. They highlighted:

- Contract in place with general practice since April 2011.

- Key aims were to improve health outcomes of patients of Liverpool by:
  - Improvement in quality & consistency of service provision and cost effective use of resources
  - Equalisation of funding across practices
  - Reduction in health inequalities
  - Annual review undertaken

- % funding attached to Key Performance Indicators.

- No formal evaluation of impact of the contract….until now
  - 2016 Partners Priority Programme launched (NIHR CLAHRC/NHS/LA)
  - Facilitated programme of workshops, masterclasses and group learning to design and conduct local level evaluation
  - Evaluation team
    - LCCG Primary Care/Digital/BI/Research
    - University of Liverpool
    - LCC Public Health
    - Public Advisor CLAHRC

Quantitative Findings:

- 'Primary care' A&E attendances had reduced by 15% but we **had not reduced inequality** between most and least deprived areas. This was still higher than the national average. Some practices felt it damaged the relationship with patients result in increased complaints.

- Bowel screening uptake had improved but we had not **reduced inequality** between most and least deprived areas.

- Proportion of people with hypertension whose BP is managed to 150/90 had improved but we **had not reduced inequality** between most and least deprived areas.

- GP workforce had held steady during a time of national decline – 0.6 per 1,000 patients (BMA recommendation was 0.5).

- Asthma review (non-KPI) achievement compared to England had deteriorated. The trend had not been bucked as it was not one of the GP Specification Key Performance Indicators. The finding was that if there was a monetary value attached to something it achieved more attention and focus.

- GP Specification Ambulatory Care Sensitive ('ACS') admissions had reduced by 8% compared to 15% growth nationally.

- In 2016, analysis suggested c15,000 fewer admissions than if Liverpool had behaved like the rest of England.

- Diabetes 8 Key Care Processes – performance had improved when it was a Key Performance Indicator and deteriorated when not, demonstrating again that monetary value increased focus. Also the figures showed that practices in deprived areas were mostly "firefighting" and had to work harder to achieve same performance as practices in more affluent areas.

- Premature Mortality 2010 to 2017 – there was a decrease across all quintiles except for quintile 1. SS observed that respiratory was a key area here and interesting smoking prevalence was higher in more deprived areas.

Qualitative Research Findings:

- One size did not fit all- risk of **widening health inequalities**
- We could generate **target-chasing behaviours** which take focus away from quality / patient
- 'More of the same' **would not** reduce health inequalities
- What had the biggest impact for patients was **not always measurable**
- Simply **commissioning a scheme did not mean it had been successfully implemented** and embedded. It appeared only successful if the specification became a way of working.
- In summary we had improved overall attainment as a city but had not reduced health inequalities and focus followed money.

Recommendations:

- Needed to **focus attention further upstream** of patient journey with a focus on prevention and self-care
- Needed to **avoid organisational complacency** during the lifespan of any scheme commissioned
- Governance processes within CCG needed to **ensure that schemes were objectively designed and assessed – avoid "pet projects".**
- **Embed evaluation** into commissioning process **from the start**
- Needed to **challenge political drivers for unhelpful targets** / measures
- **Targets needed to be based on evidence of best practice** and optimum performance rather than against current city performance
- Incorporate **patient voice** into commissioning decisions
- **Quality improvement and assurance processes had to be in place** and followed regardless of performance against individual targets
- Design of schemes must incorporate **commissioning levers** that reinforce quality assurance
- Changing a scheme / KPI every year could inhibit delivery of intended outcomes
- Schemes needed to be designed in such a way that **good practice was identified and shared**

The Primary Care Commissioning Committee commented:

- KP asked how the recommendations could be taken forward. PJ responded that this would be picked up in the private session around the next iteration of the GP Specification.

- ST asked what would reduce health inequalities if more of the same would not. LB commented that this issue was outside of the scope of the evaluation.

- SS commented on the brilliant outcomes in the GP Specification around reduction in CVD mortality and cancer mortality and better care in diabetes. The fact that Primary Care A&E attendances had reduced showed that investment in Primary Care was good. It was disappointing that the previous format of delivery for vaccinations and immunisations had worked better than the current service which proved that it had been a mistake to move it out of general practice.

- PF picked up on the comment around practices in more deprived areas "firefighting and needing to work harder to achieve targets than practices in more affluent areas.

- SS commented that the GP Specification was funded on a weighted list size, the new contracts would make it an absolute list size which would reduce funding for depressed areas.

The Primary Care Commissioning Committee:

- **Noted the findings from the evaluation undertaken**
- **Considered the recommendations in relation to future commissioning decisions.**

PART 5: GOVERNANCE

5.1 RISK REGISTER – VERBAL

CM updated the Committee that all risks were currently being managed – there was no formal risk register as yet to present to the committee.

The Primary Care Commissioning Committee:

- **Noted the verbal update.**

6. ANY OTHER BUSINESS

6.1 PF voiced concern over the Networks' abilities/expertise to deliver what was required of them.

6.2 RK took the opportunity to thank KP, who was leaving his role as Lay Member for Patient & Public Involvement, for his contribution as Chair to the Primary Care Commissioning Committee.

7. DATE AND TIME OF NEXT MEETING

Tuesday 16TH April Formal Meeting - 10am Boardroom Liverpool CCG