NHS
Liverpool
Clinical Commissioning Group

PRIMARY CARE COMMISSIONING COMMITTEE
TUESDAY 18TH JUNE 2019 AT 10AM TO 12PM
BOARDROOM THE DEPARTMENT

A G E N D A

Part 1: Introductions and Apologies

1.1	Declarations of Interest	***All***
1.2	Minutes and actions from previous meeting on 21st May 2019	**All**
1.3	Matters Arising:	

Part 2: Updates

2.1	NHS England Update	**Verbal** **Tom Knight**

Part 3: Strategy & Commissioning

3.1	Liverpool Quality Improvement Scheme (GP Spec 2019/21)	**PCCC 07-19** **Peter Johnstone**

Part 4: Performance

Part 5: Governance

5.1	MIAA Primary Care Commissioning Committee Governance Review and Work Plan 2019/20	**PCCC 08-19** **Helen Dearden**
5.2	Primary Care Commissioning Risk Register May 2019	**PCCC 09-19** **Cheryl Mould**
5.3	Primary Care Network – Sign Off	**Verbal** **Peter Johnstone**
6.	Any Other Business	**ALL**
7.	Date and time of next meeting: Tuesday 20th August 2019 Formal Meeting, Boardroom, The Department	

NHS
Liverpool
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Report no: PCCC 07-19

NHS LIVERPOOL CLINICAL COMMISSIONING GROUP
PRIMARY CARE COMMMISSIONING COMMITTEE

TUESDAY 18th JUNE 2019

Title of Report	Liverpool Quality Improvement Scheme (GP Specification) 2019-21
Lead Governor	Jan Ledward Chief Officer
Senior Management Team Lead	Mark Bakewell Chief Finance Officer
Report Author	Jacqui Waterhouse Primary Care Development Manager
Summary	The purpose of this paper is to seek approval for the Liverpool Quality Improvement Scheme 2019-21 (GP Specification)
Recommendations	That Liverpool CCG Primary Care Commissioning Committee: ➢ Approves the Liverpool Quality Improvement Scheme (GP Specification) 2019 – 2021 ➢ Notes and approves the proposed monitoring arrangements
Relevant standards/targets	This scheme has been developed to support practices to deliver high quality primary care services and ensure general practice plays in part in realising the CCG vision to improve health outcomes for the people of Liverpool. • To improve health outcomes

	• To maximise value from our financial resources and focus on interventions that will make a major difference • To build successful partnerships which promote system working and integrated service delivery • To hold providers of commissioned services to account for the quality of services delivered • To ensure continuous improvement in primary care services

LIVERPOOL QUALITY IMPROVEMENT SCHEME
(GP SPECIFICATION) 2019 - 2021

1. PURPOSE

The purpose of this paper is to seek approval for the Liverpool Quality Improvement Scheme 2019-21 (GP Specification)

2. RECOMMENDATIONS

That Liverpool CCG Primary Care Commissioning Committee:

- Approves the Liverpool Quality Improvement Scheme (GP Specification) 2019 – 2021
- Notes and approves the proposed monitoring arrangements

3. BACKGROUND

The Liverpool Quality Improvement Scheme for General Practice has been in place since April 2011. The quality scheme aims to improve the quality and consistency of the services offered by General Practice across the city. The Liverpool Quality Scheme specification (known as GP Specification) outlined a set of key performance indicators and quality standards to be met by practices in order to improve the health of patients, reduce inequalities and variation and ensure most cost effective use of resources. In addition, it aims to reduce the variation in general practice in Liverpool and health outcomes. The GP Specification has been updated each year to reflect updated clinical guidance and ensure that is aligned with the CCG priorities.

Each year the specification has been reviewed, with some KPIs withdrawn and others added, to support improvement across a range of therapeutic areas and outcomes.

The 2019-21 specification is being introduced at a time of major change for general practice. The direction of travel is for the CCG to commission systems to deliver outcomes, rather than individual providers and as Primary Care Networks and the Provider Alliance are in development stages the targets continue to be set at practice level.

A commissioned review of previous versions of the specification identified that the specification did foster improvements in services and

outcomes for the city, but also widened the gap between the most and least deprived parts of Liverpool. The 2019-21 specification takes on board the learning from the review, particularly through the target setting approach, which considers variation between deprivation quintiles, the workload involved in delivering a service, and the benefit for Liverpool patients.

Although there has been significant improvement in performance in the Quality Standards and Key performance indicators it is clear that there is more to do so the CCG proposes a continued focus this year on CCG Access, Ambulatory Care Sensitive ('ACS') admissions, reduce inappropriate outpatient referrals and improve quality of prescribing.

5. MONITORING ARRANGEMENTS

In order to open dialogue with individual practices and networks around performance achievement and mitigation, improvement trajectories are in development and the CCG will publish KPI data monthly to identify where practices are not on trajectory. Practices will have access to the same data and be expected to review it regularly. To be considered for exceptional circumstances, the practice will need to formally raise the potential for non-achievement before the end of Q2 2020-21, and demonstrate what measures have been put in place already before the end of Q2 2020-21, although this should have been under discussion once the issue is recognised.

The CCG and practice will agree an action plan, based upon what other practices have put in place and the support available from the wider network. Implementation reports will be reviewed monthly.

6. STATUTORY REQUIREMENTS (only applicable to strategy & commissioning papers)

6.1 Does this require public engagement or has public engagement been carried out? Yes / No

i. If no explain why

ii. If yes attach either the engagement plan or the engagement report as an appendix. Summarise key engagement issues/learning and how responded to.

Not applicable

6.2 Does the public sector equality duty apply? Yes/no.

iii. If no please state why

iv. If yes summarise equalities issues, action taken/to be taken and attach engagement EIA (or separate EIA if no engagement required). If completed state how EIA is/has affected final proposal.

Not applicable

6.3 Explain how you have/will maximise social value in the proposal: describe the impact on each of the following areas showing how this is constructed to achieve the most:

a) Economic wellbeing

b) Social wellbeing

c) Environmental wellbeing

Not applicable

6.4 Taking the above into account, describe the impact on improving health outcomes and reducing inequalities

Not applicable

7. DESCRIBE HOW THIS PROMOTES FINANCIAL SUSTAINABILITY

Delivery of the Liverpool Quality Improvement Scheme will contribute to the demand management plan for Liverpool CCG as it addresses avoidable demand on hospital services and on prescribing costs.

8. CONCLUSION

The Liverpool Quality Improvement Scheme was developed to improve the quality and consistency of General Practice across the city, in order to improve the health of patients, reduce inequalities and variation ensure most cost effective use of resources.
The Primary Care Committee are requested to approve the content of the specification for 2019-2021 and its monitoring arrangements.

Jacqui Waterhouse
Primary care Development Manager

LIVERPOOL QUALITY IMPROVEMENT SCHEME 2019-21

Introduction

The Liverpool Quality Improvement Scheme (GP Specification) has been in place since 2011. The specification was developed to improve the quality and consistency of General Practice across the city, in order to improve the health of patients, reduce inequalities, and ensure most cost effective use of resources. Also, through additional investment, it aimed to reduce the variation in service provision across general practice in Liverpool.

Key principles

An evaluation of the previous iterations of the GP specification was carried out in partnership with the National Institute for Health Research Collaboration for Leadership in Applied Health Research, and Care North West Coast

This showed that, although the specification supported Liverpool in improving services, it didn't reduce variation between the better off and the more deprived parts of the city, and may have contributed to widening inequalities as practices in less challenging areas were able to improve quicker.

The 2019-21 specification recognises the difference in the needs of the population across the city, and targets are tailored according. A number of target setting methodologies were considered, based on practices' Index of Multiple Deprivation scores and the CCG has applied the method that delivers the best combination of: reduction in variation between populations, an even spread of workload, and an improvement for the population although, for KPI3, improving all three was not possible.

More detail is given in the KPI Technical Specification in Appendix 1.

The KPIs included in this specification make up only part of the work of general practice. Other areas may be supported through funding mechanisms such as QOF, whilst others are considered to be good general practice.

The CCG is reviewing a range of indicators to define quality in general practice and allow the ongoing monitoring of delivery. Practices are expected

to engage with this process and consider how best to maintain standards and deliver improvements in areas that are not included as KPIs.

Timetable

The 2019-21 GP specification will run from July 2019 until 31st March 2021.

The CCG recognises that general practice is undertaking a major reorganisation, with a focus on development of Primary Care Networks (PCN), and taking its place in the Provider Alliance. This will occupy a lot of practice time and attention, particularly during the early phases of that development and, therefore, the specification covers a two-year period, with practices expected to have achieved their targets by March 2021.

Monitoring and validation

To avoid the need for an onerous validation process at the end of the second year, all key performance indicators can be collected and monitored by the CCG. Data will be refreshed monthly, and feedback on delivery and trajectories will be provided to practices, to allow an ongoing conversation between provider and commissioner.

For some indicators, work needs to be done on data quality and practices are expected to engage with this process. This will happen over the early part of the life of the specification, and practices will not be assessed until, and unless, robust data quality is achieved. This will particularly apply to KPI 5.

Definition of patients to be covered by the service

All patients registered with a Liverpool practice.

Network development

The CCG supports the development of robust Primary Care Networks, but recognises that most PCNs are not yet ready to take on collective responsibility for the delivery of services. Therefore, targets are set for individual practices. As PCNs develop, the networks may wish to consider how they work together to achieve each practice's targets as patients are more frequently seen outside of their own practice.

It is expected that this will be the final practice-focused specification. From 2021 the CCG will seek to commission services, and hold providers to account, on a collective basis.

Outcomes

The specification will continue to act as an enabler to ensure general practice is sustainable, being a mechanism to bring substantial funding, to practices. This level of funding means that there will need to be a focus on delivery and that practices will ensure there is no decline in performance, particularly for aspects of the specification that are not included as key performance indicators

The specification will not claw back monies previously paid. Instead, the routine monthly payment will be reduced from October 2020 and then a final balancing payment made at the end of the year. This gives practices certainty around their minimum income across the two-year period, and ongoing monitoring from the start of the specification will flag where there is potential to not meet the target.

The CCG position is that the indicators in the specification are within the capability of general practice, along with the support of the wider primary care network, to deliver. The CCG recognises that admission rates are subject to a number of influences, but expects a collaborative approach across networks and including community, wider primary care and third sector services to support delivery.

Indicator trajectories will be monitored monthly and the risk of non-delivery raised with the practice, who will be expected to put appropriate measures in place. However, the CCG recognises that there may be a need to consider cases where a practice has experienced exceptional circumstances which impact on its ability to achieve the target:

- The practice experiences a sustained (over three months) and significant reduction in the whole time equivalent of relevant staff within year two of the specification, which directly results in a trajectory that was previously expected to achieve the KPI no longer being on track

- The practice takes on a material and rapid increase in patients in the last 9 months of the specification. This recognises that practices may be

reluctant to take on practices in the event of a closure unless the impact on KPIs is recognised.

- The practice has a very low (or high, as appropriate) baseline and is unable to make further gains after delivering an action plan that was agreed with the CCG. The CCG would consider the position against achievement in other practices with a similar baseline and similar demographic.

The CCG will publish KPI data monthly, and will identify where practices are not on trajectory in order to open dialogue with individual practices and networks around performance achievement and mitigation. Practices will have access to the same data and are expected to review it regularly.

Although the potential for non-achievement should have been under discussion from the point that it was recognised, to be considered for exceptional circumstances, the practice needs to formally raise the potential for non-achievement, and provide an action plan that demonstrates the impact of measures that have been put in place already, and sets out further planned mitigation. This plan will need to be agreed by the CCG.

2. Key performance indicators

Most of the key performance indicators are based on existing targets in the 2017-19 version of the specification, but cross referenced, to avoid duplication, against the new GMS framework which covers many of Liverpool's top priorities, either in work streams that will deliver in the next couple of years, or through the new Quality and Outcomes Framework.

KPI 1: Proportion of those aged 65+ (excluding those already diagnosed with AF) who have received a manual pulse check in the previous 12 months

This indicator is important for detecting undiagnosed AF and therefore preventing strokes as the number of patients identified with AF remains below the expected prevalence. This aligns with the One Liverpool aim of reducing premature mortality from CVD and the intention to 'Make Every Contact Count'.

KPI 2a: The proportion of people whose alcohol consumption has been recorded in the last 3 years
And
KPI 2b: The proportion of people whose alcohol consumption (recorded in last 3 years) is above recommended levels who have been offered a brief intervention

Liverpool has high rates of alcohol specific admissions and admissions of conditions where alcohol is a contributor, recording of alcohol consumption enables identification of people drinking over recommended levels. Alcohol Brief Interventions have a strong evidence base and will contribute to the One Liverpool aim of reducing alcohol related hospital admissions.

KPI 3: The proportion of people on the hypertension register who have had their physical activity levels recorded in the last 12 months

CVD is one of the biggest causes of mortality and premature mortality in Liverpool. Physical activity has been shown to reduce hypertension and reduce the potential contribution of hypertension to cardiovascular risk. This indicator therefore contributes to the One Liverpool outcome ambitions to reduce levels of physical inactivity and premature mortality from CVD.

KPI 4: The proportion of people on the SMI register who have received a physical health check in the previous 12 months

People living with serious mental illness die 15-20 years earlier than the rest of the population, largely due to preventable or treatable physical health problems.

This indicator contributes to One Liverpool outcome ambition to improve the physical health of people with a mental health condition, and the Mental Health Five Year Forward View aim to reduce premature mortality in people with SMI.

QOF for 2019/20, asks practices to record BMI and BP for SMI patients, but does not cover the wider aspects of a health check

KPI 5: The number of minutes of appointment (of any type) available per week with the following clinician types: GPs, clinical pharmacists,

advanced nurse practitioners / nurse practitioners, physicians associates, paramedics, physiotherapists

Patients consistently tell us that they are unable to get appointments when they need one, this is thought to contribute to patients seeking treatment at inappropriate settings**.** This indicator aims to ensure that all patients have the same opportunity to consult with a health care professional.

This indicator considers all aspects of patient contact, including face to face, telephone and digital that are provided by the practice. It does not include extended access or other services.

KPI 6a: The rate per 1000 ASTRO PU of broad spectrum anti-bacterials prescribed in the previous 12 months

KPI 6b: The rate per 1000 ASTRO PU of all anti-bacterials prescribed in the previous 12 months

KPI 6c: The proportion of antibacterial issues linked to a diagnosis code

General practice prescribing rates have been falling year on year in Liverpool, but total volumes remain high and a national five-year strategy has been published which reiterates the importance of further reductions. This indicator requires a reduction in both total and broad spectrum antibiotics

Ensuring that prescriptions are linked to diagnoses enables audit at city level. In addition, it will support practices with the CQC requirement to audit their antibiotic prescribing.

KPI 7a: The rate per 1000 weighted patients of GP-referred first outpatient appointments for the selected specialties
And
KPI 7b: The number of Advice & Guidance requests made as a proportion of GP-referred first appointments in selected specialties

Liverpool continues to have a significantly higher rate of outpatient first-attendances resulting from GP referrals than both England and our Peer CCGs, despite having reduced rates over the last 5 years.

The CCG recognises the tension between reducing demand and ensuring appropriate referrals, and this is an area that the Provider Alliance are looking to address.

The use of Advice & Guidance is a key element of the CCGs demand management strategy. There are still practices that are not using A&G at all and this indicator is intended to encourage uptake of this service.

KPI 8: The percentage of bowel cancer screening non-responders sent a letter by the practice within 42 days of the practice receiving the non-responder notification

Bowel and cervical screening were both included in the previous specification and cervical screening is now a QOF indicator. Liverpool screening uptake has increased greater than England / peers since 2010/11. However, the city is still significantly lower than both and inequalities within the city have not reduced since 2010/11

KPI 9: The rate per 1000 weighted patients of selected non-elective admissions

By March 2021, practices will have achieved a minimum standard in two therapeutic areas that align to the One Liverpool Plan priorities and where there is wide variation and inequality across the city. These will be linked to neighbourhood population needs, as described in the neighbourhood data packs. Practices within the same network will be required to select the same areas upon which to focus.

Although these are set as practice targets, delivering improved outcomes is complex and involves the wider primary care network, with NHS and council community and the third sector having important roles.

Aspects of achieving this KPI may also include, implementing the CCG's primary care digital strategy, changes resulting from urgent care review and having a process to refer patients to social prescribing support.

Details for the KPIs are shown in the Technical Specification in Appendix 1.

3. Targets and payment

The targets will be set based on a two-year trajectory (i.e. to be achieved by end of March 2021) but monitored on a regular basis from July 2019.

Practices will receive the full annual payment of £23.67 per weighted head of population in the 2019/20 financial year (including a 2.7% increase that is in line with Acting as One contract agreements with other providers commissioned by NHS Liverpool CCG). Payments will be made monthly, and the population size recalculated quarterly.

Where practices do not achieve targets, a proportion of the 2020-21 funding will be retained by the CCG. This will be up to 20% of one year's specification funding (equivalent to approximately 3.9% of practice core funding).

This proportion will be spread across all the indicators according to the weighting below.

Key Performance Indicator weighting

Manual pulse checks	5%
Alcohol consumption recording and brief intervention	10%
Physical activity recording for people with Hypertension	10%
SMI Health Checks	10%
Appointments Per 1000 (reliant on APEX roll out)	10%
All antibiotic prescribing	5%
Broad spectrum antibiotic prescribing	5%
Recording diagnosis code for antibiotics	5%
OP First attendances and advice and guidance	15%
Bowel screening	10%
Non-elective admissions	15%

Payment schedule

The 2018-19 specification applied until the end of June 2019. From the start of July a monthly payment will be made that transfers ¾ of the 2019-20 funding (the other ¼ being paid as part of the previous specification).

The full annual funding of £23.67 per head (weighted population) will be made to all practices in 2019-20 through the two schemes.

For 2020-21, a routine monthly payment of 1/12 of the annual payment will be made for the first six months. From October 2020, the regular monthly payment will be reduced so that the guaranteed income, 80% of the total funding for 2020-21, is received by the end of March 2021.

This will be topped up by the appropriate payment for the indicators that are on trajectory and a final balancing payment will be made at the end of the year for other indicators that are achieved by that point.

A worked example is shown in Appendix 2.

Monitoring

In order to open dialogue with individual practices and networks around performance achievement and mitigation, improvement trajectories are in development and the CCG will publish KPI data monthly to identify where practices are not on trajectory. Practices will have access to the same data and be expected to review it regularly. To be considered for exceptional circumstances, the practice will need to formally raise the potential for non-achievement before the end of Q2 2020-21, and demonstrate what measures have been put in place already before the end of Q2 2020-21, although this should have been under discussion once the issue is recognised.

The CCG and practice will agree an action plan, based upon what other practices have put in place and the support available from the wider network. Implementation reports will be reviewed monthly.

Appendix 1

General Practice Quality Schedule 2019/21

Technical Specification of Payment KPIs

Contents

Deprivation Quintiles

A detailed evaluation of the previous iterations of the Liverpool Quality Improvement Scheme (GP Specification) clearly highlighted that universal targets cause a disproportionate burden of work for practices with high levels of deprivation in their registered populations.

To address this, wherever practical, targeting setting methods were assessed to ensure they did not create an uneven distribution of work. To inform the process, practices were assigned to one of five Liverpool deprivation quintiles based on their nationally published practice IMD (index of multiple deprivation) score[1]. The outcome of this process was that some targets will be dependent on the deprivation quintile of the practice.

A list of practices along with their assigned deprivation quintile is shown overleaf. Quintile 1 is the area of greatest deprivation (in Liverpool), Quintile 5 is the area of least deprivation.

[1] https://fingertips.phe.org.uk/profile/general-practice/data#page/1/gid/2000005/pat/152/par/E38000101/ati/7/are/N82xxx

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Practice	Deprivation Quintile
N82001	3
N82002	3
N82003	3
N82004	4
N82009	5
N82011	1
N82014	5
N82018	2
N82019	2
N82022	1
N82024	5
N82026	5
N82033	2
N82034	4
N82035	5
N82036	2
N82037	4
N82039	5
N82041	4
N82046	4
N82048	2
N82049	1
N82050	4
N82052	2
N82053	4
N82054	3
N82058	3
N82059	5
N82062	5
N82065	2
N82066	5
N82067	1

Practice	Deprivation Quintile
N82070	3
N82073	5
N82074	3
N82076	1
N82077	2
N82078	1
N82079	5
N82081	2
N82082	3
N82083	4
N82084	5
N82086	3
N82087	3
N82089	2
N82090	3
N82091	2
N82092	5
N82093	4
N82094	4
N82095	1
N82097	3
N82099	1
N82101	1
N82103	1
N82104	4
N82106	5
N82107	5
N82108	5
N82109	3
N82110	3
N82113	1
N82115	1

Practice	Deprivation Quintile
N82116	4
N82117	4
N82617	4
N82621	2
N82633	3
N82641	4
N82645	1
N82646	2
N82648	4
N82650	2
N82651	1
N82655	3
N82662	2
N82663	4
N82664	5
N82668	2
N82669	1
N82670	2
N82671	1
N82676	5
N82678	3
Y00110	1

KPI 1:

Proportion of those aged 65+ (excluding those already diagnosed with AF) who have received a manual pulse check in the previous 12 months

Target Achievement:	40th centile – 78.1%
Methodology used to derive target and rationale:	A practices are required to reach the 40th centile of the city.
Numerator:	The number of currently registered people aged 65+ (not already diagnosed with Atrial Fibrillation) who have received a manual pulse check in the previous 12 months
Denominator:	The number of currently registered people aged 65+ not already diagnosed with Atrial Fibrillation
Calculation:	$\frac{Numerator}{Denominator}$
Expressed As:	Percentage (%)
Data Source:	EMIS Enterprise aggregate searches
Read Codes:	Code / Term **2431** O/E- pulse rhythm regular **2432** O/E- pulse irregularly irregular **2433** O/E- pulse regularly irregular **242%** O/E- pulse rate **G573%** Atrial fibrillation and flutter (excluded)

KPI 2:

The proportion of people whose alcohol consumption has been recorded in the last 3 years.

Target Achievement:	Statistically significant increase on practice baseline achievement.
Methodology used to derive target and rationale:	Statistically significant increase (based on 95% confidence intervals). Statistically significant change is the most appropriate target as this delivers an overall improvement whilst also reducing the inequality gap and also ensuring work is evenly distributed across practices.
Numerator:	The number of currently registered people aged 18+ with alcohol consumption recorded in the last 3 years
Denominator:	The number of currently registered people aged 18+
Calculation:	$\frac{Numerator}{Denominator}$
Expressed As:	Percentage (%)
Data Source:	EMIS Enterprise aggregate searches
Read Codes:	<table><tr><th>Code</th><th>Term</th></tr><tr><td>**136%**</td><td>Alcohol consumption</td></tr><tr><td>**388u**</td><td>FAST alcohol screening test</td></tr><tr><td>**9k15**</td><td>Alcohol screen- Audit completed</td></tr><tr><td>**9k16**</td><td>Alcohol screen- Fast alcohol screening test completed</td></tr><tr><td>**38D3**</td><td>Alcohol use disorders identification test</td></tr><tr><td>**38D4**</td><td>Alcohol use disorder identification test con question</td></tr></table>

KPI 2b:

The proportion of people whose alcohol consumption (recorded in last 3 years) is above recommended levels who have been offered a brief intervention.

Target Achievement:	90%.
Methodology used to derive target and rationale:	This maintains the current proportion of brief interventions delivered to those patients who are drinking over recommended levels.
Numerator:	The number of currently registered people aged 18+ with alcohol consumption of more than 14 units per week recorded offered brief intervention
Denominator:	The number of currently registered people aged 18+ with alcohol consumption of more than 14 units per week recorded in the last 3 years
Calculation:	$\frac{Numerator}{Denominator}$
Expressed As:	Percentage (%)
Data Source:	EMIS Enterprise aggregate searches
Read Codes:	Code – Term **9k1A** – Brief intervention for excessive alcohol consumption completed **67A5** – Pregnancy alcohol advice **8CAM** – Patient advised about alcohol **6792** – Health ed. – alcohol **67H0** – Lifestyle advice regarding alcohol

In order to achieve KPI 2, practices are required to deliver both consumption recording and brief intervention

KPI 3:
The proportion of people on the hypertension register who have had their physical activity levels recorded in the last 12 months

Target Achievement:	Quintile 1: 37.5% Quintile 2: 48.2% Quintile 3: 56.8% Quintile 4: 63.1% Quintile 5: 67.1%
Methodology used to derive target and rationale:	Achievement centiles were derived based on baseline practice performance. Practices in the most deprived areas (quintile 1) are required to reach the 40th centile of the city, moving up the centiles as deprivation decreases so that practices in the least deprived areas (quintile 5) are required to reach the 80th centile of the city. This methodology delivers an improvement in overall achievement, whilst ensuring that a greater burden of work does not fall upon the practices in the most deprived areas.
Numerator:	The number of currently registered people on the Hypertension register who have had their physical activity level recorded in the previous 12 months
Denominator:	The number of currently registered people on the Hypertension register
Calculation:	$\frac{Numerator}{Denominator}$
Expressed As:	Percentage (%)
Data Source:	EMIS Enterprise aggregate searches

Read Codes:

Code	Term
G20%	Essential hypertension
G24%	Secondary hypertension
G25%	Stage 1 hypertension
G26	Severe hypertension
G28	Stage 2 hypertension
G2y	Other specified hypertensive disease
G2z	Hypertensive disease NOS
G2	Hypertensive disease
Gyu2	[X] Hypertensive disease
Gyu20	[X] Other secondary hypertension
EMISNQNU32	Number of days per week of mod intensity phys act
EMISNQAV4	Ave duration of mod inten phys acti per day
EMISNQNU33	Number of minutes of moderate intensity physical activity per week
1381	Exercise physically impossible

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KPI 4:
The proportion of people on the SMI register who have received a physical health check in the previous 12 months

Target Achievement:	60%
Methodology used to derive target and rationale:	60% is national standard which Liverpool is required to meet in 19/20 and applies to all practices, regardless of quintile
Numerator:	The number of currently registered people on the SMI register who have received a physical health check including BMI, blood glucose/HbA1c, cholesterol, BP, alcohol consumption and smoking status in the previous 12 months
Denominator:	The number of currently registered people on the SMI register
Calculation:	$\frac{Numerator}{Denominator}$
Expressed As:	Percentage (%)
Data Source:	EMIS Enterprise aggregate searches
Read Codes:	

Code	Term
E10%	Schizophrenic disorders
E110%	Manic disorder single episode
E111%	Recurrent manic episodes
E1124	Single major depressive severe + psychosis
E1134	Recurrent major depressive + psychosis
E114%	Bipolar affective now manic
E115%	Bipolar affective now depressive
E116%	Mixed bipolar affective disorder
E117%	Unspecified bipolar affective disorder
E11y%	Oher manic depressive psychosis
E11z	Other unspecified affective psychosis
E11z0	Unspecified affective psychosis NOS
E11zz	Other affective psychosis NOS
E12%	Paranoid states
E13%	Other nonorganic psychoses
E2122	Schizotypal personality

	Eu2%	[X] Schizophrenic schizotypal delusion
	Eu30%	[X] Manic episode
	Eu31%	[X] Bipolar affective disorder
	Eu323	[X] Severe depressive episode with psychotic symptoms
	Eu333	[X] Recurrent depressive disorder, current episode severe with psychotic symptoms
	Eu328	Major depression, severe, with psychotic symptoms
	Omit the following from hierarchy or E11y%:	
	E11y2	Atypical depressive disorder
	Omit the following from the hierarchy of E13%	
	E135	Agitated depression
	Exclude the following:	
	E1005	Schizophrenia in remission
	E1015	Hebephrenic schizophrenia in remission
	E1025	Catatonic schizophrenia in remission
	E1035	Paranoid schizophrenia in remission
	E1055	Latent schizophrenia in remission
	E1075	Schizo-affective schizophrenia in remission
	E1106	Single manic episode, in full remission
	E1116	Bipolar affective disorder, currently in remission
	E1146	Bipolar affective disorder, now depressed, in full remission
	E1156	[X] Bipolar affective disorder, currently in remission
	Eu317	Mixed bipolar affective disorder, in full remission
	E1166	Unspecified bipolar affective disorder in full remission
	E1176	Single major depressive episode, severe, with psychosis, in remission
	Eu329	Recurrent major depressive episodes severe with psychosis, in remission
	Eu32A	
	Eu26	[X] Nonorganic psychosis in remission
	Eu223	[X] Paranoid state in remission

The definition chosen mirrors the NHS England technical definition required for national monitoring submissions.

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KPI 5:
The number of minutes of appointment (of any type) available per week with the following clinician types: GPs, doctors including GP trainees and F2, clinical pharmacists, advanced nurse practitioners and qualified physicians associates, paramedics, physiotherapists.

Target Achievement:	X minutes per 1000 GMS weighted patients per week- **to be agreed for year two.**
Methodology used to derive target and rationale:	Maintains the previous level of appointments commissioned whilst at the same time ensuring that practices who offer 15 minute appointments are not disadvantaged.
Numerator:	The number of minutes of appointment time with the specified clinician types made available per week
Denominator:	The number of GMS weighted patients
Calculation:	$\frac{Numerator}{Denominator}\ x\ 1000$
Expressed As:	Rate per 1000
Data Source:	TBC- Intended to be APEX (enterprise view currently in development, NHS E purchasing 1 license per CCG).
Read Codes:	N/A

Measuring minutes available per thousand patients avoids penalising practices who are offering appointments of 15 minutes or longer. Practices will be required to work with the CCG in year one, to ensure that monitoring systems are in place and tested before measurement of the indicator commences in year two. GMS Weighting is designed to reflect work generated in general practice so is the most appropriate weighting to use for this calculation

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KPI 6a.
The rate per 1000 ASTRO PU of broad spectrum anti-bacterials prescribed in the previous 12 months

Target Achievement:	A statistically significant reduction in practice baseline prescribing rate
Methodology used to derive target and rationale:	Statistically significant reduction (based on 99% confidence intervals). Statistically significant reduction is the most appropriate target due to public health imperative to reduce antibiotic prescribing.
Numerator:	The number of items of BNF 5.1.1.3 (sub-section co-amoxiclav), BNF 5.1.2.1 (cephalosporins) and BNF 5.1.12 (quinolones) dispensed in the previous 12 months.
Denominator:	2013 Item-based ASTRO PU (2013 refers to the year the weighting method was developed)
Calculation:	$\frac{Numerator}{Denominator}\ x\ 1000$
Expressed As:	Rate per 1000 ASTRO PU
Data Source:	EPACT2 (NHS Business Services Authority system that contains details of all prescriptions dispensed).
Read Codes:	N/A

The CCG is held to account for levels of antibiotic prescribing by our practices and therefore the drugs included in this definition match those specified for the CCG.

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KPI 6b.
The rate per 1000 ASTRO PU of all anti-bacterials prescribed in the previous 12 months

Target Achievement:	A statistically significant reduction in practice baseline prescribing rate.
Methodology used to derive target and rationale:	Statistically significant reduction (based on 99% confidence intervals). Statistically significant reduction is the most appropriate target due to public health imperative to reduce antibiotic prescribing.
Numerator:	The number of all antibacterial items dispensed in the previous rolling 12 months
Denominator:	2013 Item-based ASTRO PU (2013 refers to the year the weighting method was developed)
Calculation:	$\frac{Numerator}{Denominator}\ x\ 1000$
Expressed As:	Rate per 1000 ASTRO PU
Data Source:	EPACT2 (NHS Business Services Authority system that contains details of all prescriptions dispensed).
Read Codes:	N/A

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KPI 6c.
The proportion of antibacterial issues linked to a diagnosis code

Target Achievement:	95%
Methodology used to derive target and rationale:	The Five year national action plan on antimicrobial resistance will require all infection consultations to record an appropriate diagnostic code, and be subject to audit
Numerator:	The number of issues of antibacterial items made in the previous rolling 12 months which have a linked diagnosis code
Denominator:	The number of issues of antibacterial items made in the previous rolling 12 months
Calculation:	$\frac{Numerator}{Denominator}$
Expressed As:	Percentage (%)
Data Source:	EMIS Monthly general practice patient-level dataset
Read Codes:	N/A

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KPI 7a.
The rate per 1000 weighted patients of GP-referred first outpatient appointments for the selected specialties

Target Achievement:	Reduce to xx per 1000 HCHS weighted patients of the city or maintain current rate.
Methodology used to derive target and rationale:	Equates to 50th centile of the city. This methodology delivers a reduction in specialties where Liverpool benchmarks as high, whilst also reducing the inequality gap between the highest and lowest referring quintiles.
Numerator:	The number of first outpatient attendances in the following specialties resulting from GP-referral: Dermatology Cardiology ENT Gastroenterology Gynaecology *(excluding ToP, colposcopy and male infertility)* Respiratory Rheumatology Urology Vascular Surgery (The above includes both adults and paediatrics)
Denominator:	HCHS Weighted Population
Calculation:	$\frac{Numerator}{Denominator}\ x\ 1000$
Expressed As:	Rate per 1000 HCHS Weighted Population
Data Source:	SUS Outpatients Dataset
Codes:	First attendance codes: 01, 03 Source of referral code: 03 Treatment Function codes: 101, 107, 110, 120, 211, 214, 215, 251, 257, 258, 262, 301, 320, 321, 330, 340, 410, 502 https://www.datadictionary.nhs.uk/data_dictionary

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KPI 7b.
The number of Advice & Guidance requests made as a proportion of GP-referred first appointments in selected specialties

Target Achievement:	10%
Methodology used to derive target and rationale:	
Numerator:	The number of Advice & Guidance requests made during the previous 12 months to the selected specialties
Denominator:	The total number of GP referrals made during the previous 12 months to the selected specialties in 7a
Calculation:	$\frac{Numerator}{Denominator}$
Expressed As:	Percentage (%)
Data Source:	eReferral system
Read Codes:	N/A

In order to achieve KPI 7, practices are required to deliver both the reduction in referrals and target use of advice and guidance

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KPI 8.
The percentage of bowel cancer screening non-responders who are contacted via an appropriate method by the practice within 42 days of the practice receiving the non-responder notification

Target Achievement:	75%
Methodology used to derive target and rationale:	Blanket target across the city as practice ability to send letter is not influenced by population characteristics.
Numerator:	The number of people coded with 'No response to bowel cancer screening programme invitation' in the last 12 months, who were sent a letter reminding them about screening within 42 days of the non-responder code being added to their record, the reminder letter being coded as 'Bowel cancer screening programme invitation letter sent'.
Denominator:	The number of people coded with 'No response to bowel cancer screening programme invitation' within the last 12 months.
Calculation:	$\frac{Numerator}{Denominator}$
Expressed As:	Percentage (%)
Data Source:	EMIS Enterprise aggregate searches
Read Codes:	Code: **9Ow2** — No response to bowel cancer screening programme invitation Code: **9Ow5** — Bowel cancer screening programme invitation letter sent (should be used for all communication methods)

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KPI 9.
The rate per 1000 weighted patients of selected non-elective admissions

Target Achievement:	Achieve 50th centile of city baseline, or maintain current achievement if already below for areas selected from a pick list. Practices within the same network will be required to select the same areas upon which to focus.
Methodology used to derive target and rationale:	This methodology delivers a reduction in areas where Liverpool benchmarks as high, whilst also reducing the inequality gap between the quintiles with the highest and lowest admission rates and ensuring an even distribution of work across deprivation quintiles.
Numerator:	The number of non-elective admissions in the previous twelve months that are in the practices' chosen therapeutic area
Denominator:	HCHS weighted population
Calculation:	$\frac{Numerator}{Denominator}\ x\ 1000$
Expressed As:	Rate per 1000 HCHS weighted population
Data Source:	SUS Admitted Patient Dataset
Codes:	Dependent on chosen therapeutic area

Liverpool Quality Improvement Scheme 2019 – 21

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Appendix 2: Worked Example of Payment Schedule

Worked Example of Tapered Payments In Year 2

Payments will changein 20/21 from month 16 of the contract onwards, depending on practice forecast achievement

Average Practice GMS List 6929

GP Spec Per GMS Patient £23.67

£123,007 Total for year 1 of spec (9 months)

£164,009 Total for year 12 of spec (12 months)

Year 2 split of guaranteed money & money dependent on achievement

£131,208 (Guaranteed) £32,802 (Dependent on Achievement) £164,009 (Total)

	Already paid under old specification- not included in calculations			Year 1 (19/20)									Year 2 (20/21)												Total received in year 2	Proportion of Year 2 GP Spec Money Received By Practice	Proportion of Year 1 & 2 GP Spec Money Received By Practice
Scenario 1: Practice Not Meeting Any Thresholds				M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12	M13	M14	M15	M16	M17	M18	M19	M20	M21			
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar			
	£13,667	£13,667	£13,667	£13,667	£13,667	£13,667	£13,667	£13,667	£13,667	£13,667	£13,667	£13,667	£13,667	£13,667	£13,667	£13,667	£13,667	£13,667	£8,200	£8,200	£8,200	£8,200	£8,200	£8,200			
													Guaranteed level of income for 6 months (50% of year 2 money)						Further 30% only						£131,208	80%	88.6%
Scenario 2: Practice Meeting All Thresholds Apart From OP/ACS	Already paid under old specification- not included in calculations			Year 1 (19/20)									Year 2 (20/21)														
				M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12	M13	M14	M15	M16	M17	M18	M19	M20	M21			
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar			
	£13,667	£13,667	£13,667	£13,667	£13,667	£13,667	£13,667	£13,667	£13,667	£13,667	£13,667	£13,667	£13,667	£13,667	£13,667	£13,667	£13,667	£13,667	£12,027	£12,027	£12,027	£12,027	£12,027	£12,027			
													Guaranteed level of income for 6 months (50% of year 2 money)						Further 30% plus 70% of the achievement money						£154,169	94%	96.6%
Scenario 3: Practice Meeting All Thresholds	Already paid under old specification- not included in calculations			Year 1 (19/20)									Year 2 (20/21)														
				M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12	M13	M14	M15	M16	M17	M18	M19	M20	M21			
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar			
	£13,667	£13,667	£13,667	£13,667	£13,667	£13,667	£13,667	£13,667	£13,667	£13,667	£13,667	£13,667	£13,667	£13,667	£13,667	£13,667	£13,667	£13,667	£13,667	£13,667	£13,667	£13,667	£13,667	£13,667			
													Guaranteed level of income for 6 months (50% of year 2 money)						Further 30% plus 100% of the achievement money						£164,009	100%	100.0%

NHS Liverpool Clinical Commissioning Group

Report no: PCCC 08-19

NHS LIVERPOOL CLINICAL COMMISSIONING GROUP
PRIMARY CARE COMMISSIONING COMMITTEE

TUESDAY 18th JUNE 2019

Title of Report	Primary Care Commissioning Committee and Governance Review
Lead Governor	Jan Ledward, Chief Officer
Senior Management Team Lead	Cheryl Mould, Programme Director Provider Alliance
Report Author	Jacqui Waterhouse, Primary Care Development Manager
Summary	The purpose of this paper is to update Primary Care Commissioning Committee on the progress of the action plan to address the report from Merseyside Internal Audit Agency and to review the proposed work plan for the committee
Recommendation	That the Primary Care Commissioning Committee: ➢ Notes the progress of the action plan ➢ Approves both the action plan and work plan
Relevant standards/targets	The Health and Social Care Act states that: *"The main function of the governing body will be to ensure that CCGs have appropriate arrangements in place to ensure they exercise their functions effectively, efficiently and economically and in accordance with any generally accepted principles of good governance that are relevant to it."*

PRIMARY CARE COMMISSIONING RISK REGISTER JUNE 2019

1. PURPOSE

The purpose of this paper is to update the Primary Care Commissioning Committee on the progress of the action plan to address the report from Merseyside Internal Audit Agency as presented in May 2019 and to review the proposed work plan for the committee.

2. RECOMMENDATIONS

That the Primary Care Commissioning Committee:

- Notes the progress of the action plan
- Approves both the action plan and work plan

3. BACKGROUND

Liverpool Clinical Commissioning Group Primary Care Commissioning Committee received an action plan in May 2019 in response to a review of governance of the committee by the Merseyside Internal Audit Agency during 2018/19.

Attached (Appendix 1) is the status of the actions as agreed by the committee in May including project end dates.

4. KEY UPDATES

<u>Reporting arrangements in PCCC Terms of Reference</u>

A members' event is planned for July 2019 which will include a review of the constitution and committee structures. Once agreed a draft terms of reference for the PCCC will be presented to the committee in August.

<u>Oversight of performance and risk</u>

A work plan for the presentation to and oversight of performance and risk papers is presented in appendix 2. This will inform the agenda for the next 12 months.

Risk register

The draft risk register for Primary Care Commissioning is presented to the Committee today for sign off and will be updated and presented to the committee in accordance with the work plan.

Primary Care Scheme reporting

Progress reports and trajectories for primary care schemes such as local and directed enhanced services and prescribing projects are added to the work plan to be presented on a 6 monthly basis.

All recommendations including actions have been allocated across the relevant officers and dates for completion of actions agreed as per the content of the full report attached.

5. STATUTORY REQUIREMENTS (only applicable to strategy & commissioning papers)

5.1 Does this require public engagement or has public engagement been carried out?

Not Applicable

5.2 Does the public sector equality duty apply?

Not Applicable

5.3 Explain how you have/will maximise social value in the proposal: describe the impact on each of the following areas showing how this is constructed to achieve the most:

a) Economic wellbeing
b) Social wellbeing
c) Environmental wellbeing

Not Applicable

5.4 Taking the above into account, describe the impact on improving health outcomes and reducing inequalities

5. DESCRIBE HOW THIS PROMOTES FINANCIAL SUSTAINABILITY

Not applicable

7. CONCLUSION

The Primary Care Commissioning Committee is in receipt of an update to the action plan to address the recommendations following the MIAA review of its governance. The Committee will continue to receive updates on the actions monthly as per the PCCC work plan.

This review forms part of an internal audit cycle and follow up to ensure actions are conducted and embedded is recommended in 6 months' time to provide evidence of progress to substantial or full assurance.

Jacqui Waterhouse
Primary Care Development Manager

Ends

MIAA PCCC Gove		
June 2019		
Theme	**Issue description**	**Project Lead**
Reporting Processes of Committees and Sub-Committees	The Reporting Arrangements section of the Primary Care Commissioning Committee Terms of Reference does not identify any Sub-Committees/Groups that are required to report into it	Peter Johnstone
Committee Duties	The Committee have not had regular oversight of the risk register, performance reporting and updates from relevant subcommittes	Peter Johnstone
Committee Duties/Primary Care Risk Register	Risk register not updated with risks reviewed, added or removed for 6 months, therefore the CCG cannot be sure that risk in relation to Primary care have been approriately identified, monitored and escalated in accordance with the TOR	Jacqui Waterhouse
Patient Engagement	The CCG does not have a Patient Engagment and Involvment Plan relating to Primary Care Commissioning activity this could lead to decisions being made without being informed by patient engagement	Sarah Dewar
Committee Duties	The committee may not receive sufficient information to enable it to exercise it's managment functions in relation to primary care services and finances and to make effective and informed decsions	Scott Aldridge
One Liverpool Primary Care	Progress reports on implementation of primary care	

One Liverpool Primary Care Schemes	Progress reports on implementation of primary care quality schemes not reported to the PCCC for scrutiny	Peter Johnstone
Statutory Requirements Section of Committee Papers	Review of papers identified that the statutory duties sections where not always conisdered for completion	Peter Johnstone

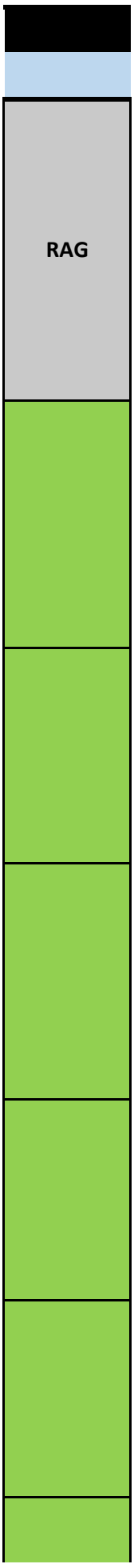
rnance Review Action Plan

Project Start	Project End	Assurance stage
		1 - Initiation 2 - Development 3 - Implementation 4 - Benefits Realisation
May-19	Dependent on action 1	Initiation
May-19	Jun-19	Initiation
May-19	Jun-19	Development
Jun-19	Aug-19	Initiation
Apr-19	May-19	Implementation

May-19	Aug-19	Initiation
May-19	May-19	Implementation

Key deliverables
1) Review of constitution, committee and sub committee structures and reporting
2) Draft revised TOR, including frequency
3) Board sign off of TOR
1) Draft annual work plan that specifies the items that the Committee will undertake throughout the financial year and informs the agenda
2) Plan to be confirmed by PCCC June 19
1) Draft risk register in agreed CCG fomat and naming conventions to PCCC for amendments 21/5/19
2) PCCC sign off of risk register June 19
3) Monthly update on risks presented to PCCC and includes clear responsibilties for the mitigating actions
1) Update on CCG involvement strategy to be presented to the August PCCC
1) Primary Care Performance and Finance Report to be presented to the PCCC in accordance with the annual work plan
1) Monthly progress reports to Planning and Performance Group on an exception basis
2) Twice yearly report to PCCC as per work plan

1) Committe secretary and committee management officer to remind paper authors to ensure statutory sections are completed approriately and review prior to dissemination of paper pack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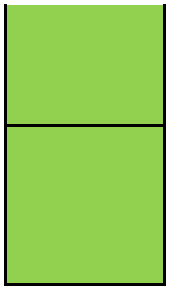

COMMENTS
Members event scheduled for 10th July 19 to consider revised constitution
Complete
First report presneted to PCCC May 19

Primary Care Commissioning Committee (PCCC) Work Plan 2019/20

Agenda Items / Issues	Frequency	April - CANCELLED	May	June	Aug	Oct	Dec -	Feb
PERFORMANCE								
Contract & Finance Report	Each meeting	x	x		x	x	x	x
LES, DES, Prescribing Projects Report	6 monthly				x			x
STRATEGY AND COMMISSIONING								
Budget setting	Annual	x						
APMS Options (PB only GPs excluded	When required							
Approval of Local Quality Improvement Schemes	Annual	x						
Approval of practice mergers, boundary changes	When required							
GOVERNANCE								
Risk Register	Each meeting	x	x	x	x	x	x	x
UPDATES								
NHS England Updates	Each meeting (Verbal)	x	x	x	x	x	x	x

NHS Liverpool Clinical Commissioning Group

Report no: PCCC 09-19

NHS LIVERPOOL CLINICAL COMMISSIONING GROUP
PRIMARY CARE COMMISSIONING COMMITTEE

TUESDAY 18th JUNE 2019

Title of Report	Primary Care Commissioning Risk Register June 2019
Lead Governor	Jan Ledward, Chief Officer
Senior Management Team Lead	Cheryl Mould, Programme Director Provider Alliance
Report Author	Jacqui Waterhouse, Primary Care Development Manager
Summary	The purpose of this paper is to update the Primary Care Commissioning Committee on the Primary Care Commissioning Committee Risk Register for 2019-20 financial year as at June 2019
Recommendation	That the Primary Care Commissioning Committee: ➢ Notes the contents and updates of risks for the commissioning of General Practice ➢ Considers current control measures and whether action plans provide sufficient assurance on mitigating actions. ➢ Agrees that the risk scores accurately reflect the level of risk that the CCG is exposed to given current controls and assurances.
Relevant standards/targets	The Health and Social Care Act states that: *"The main function of the governing body will be to ensure that CCGs have appropriate arrangements in place to*

	ensure they exercise their functions effectively, efficiently and economically and in accordance with any generally accepted principles of good governance that are relevant to it."

PRIMARY CARE COMMISSIONING RISK REGISTER MAY 2019

1. PURPOSE

The purpose of this paper is to update the Primary Care Commissioning Committee as to status of the risk on the Primary Care Commissioning Risk Register for 2019-20 financial year for June 2019.

2. RECOMMENDATIONS

That the Primary Care Commissioning Committee:

- Notes the contents and updates of risks for the commissioning of General Practice
- Considers current control measures, existing mitigating action and planned actions provide sufficient assurance to mitigate the risk
- Agrees that the risk scores accurately reflect the level of risk that the CCG is exposed to given current controls and assurances.
- Agrees the frequency of updates to the Committee

3. BACKGROUND

NHS Liverpool CCG has a statutory commitment to effectively monitor risks associated with its commissioning activities against its strategic objectives including General Practice via effective and robust risk management procedures.

The Primary Care Risk Register is a structured framework underpinned by governance arrangements and internal controls that enable the identification and management of acceptable and unacceptable risks. Where the risk score cannot be reduced escalation should be considered to the Governing Body Corporate Risk Register.

JUNE UPDATE

As per the actions from the May review of the register by the Primary Care Commissioning Committee an additional risk for Primary Care Finance has been added**.**

There have otherwise been no significant updates or changes to the risk register since that presented in May with those agreed actions having deadlines at the end June on target.

The Risk Register attached as appendix 1 therefore reflects the risks, current controls, assurance and action plans associated with the CCG objectives as delegated to the Primary Care Commissioning Committee as at June 2019.

4. STATUTORY REQUIREMENTS (only applicable to strategy & commissioning papers)

4.1 Does this require public engagement or has public engagement been carried out?

Not Applicable

4.2 Does the public sector equality duty apply?

Not Applicable

4.3 Explain how you have/will maximise social value in the proposal: describe the impact on each of the following areas showing how this is constructed to achieve the most:

a) Economic wellbeing
b) Social wellbeing
c) Environmental wellbeing

Not Applicable

4.4 Taking the above into account, describe the impact on improving health outcomes and reducing inequalities

5. DESCRIBE HOW THIS PROMOTES FINANCIAL SUSTAINABILITY

Effective risk management arrangements are essential to ensure the mitigation of identified risks to the organisation from commissioned services and ultimately safety of services commissioned for the residents of Liverpool.

6. OVERVIEW OF THE PRIMARY CARE RISK REGISTER

The CCG's risk profile (low – extreme) is summarised below:

Risk Category	Score Range	Total Risks	Change +/-
Extreme	15-25	**2**	
High	8-12	**5**	
Moderate	4-6	**4**	
Low	1-3	**1**	

7. CONCLUSION

The Primary Care Commissioning Committee Risk Register updates will be presented monthly with any escalated risk reported through the Corporate Risk Register to the Governing Body as appropriate.

Jacqui Waterhouse
Primary Care Development Manager

Ends

LIVERPOOL CCG: PCCC Draft Risk Register June 2019 **Version: V3**

Risk Ref (includes date added to CRR)	Relevant CCG Objective	Risk Description Risk Owner Lead Committee	Cause and potential impact/consequence of risk (Why could this risk occur and what would be the effects if the risk materialised?)	L	C	Inherent Risk Score (without controls)	Existing Mitigation/Controls (How are we managing this risk? What are the key controls in place to prevent this risk from occuring?)	Assurance/Evidence (Who/where can we gain evidence that these controls are working effectively? All assurances are 'positive' unless stated otherwise. I = Internal E= External)	L	C	Residual Risk Score (Current)	Trend (Movement since last update & date last reviewed)	Planned Actions (Is this action to address a gap in **Control** (C) **or** a gap in **Assurance** (A) Must include 'Action Owner' ***and*** Implementation Date)	Progress On Actions (What stage are planned current actions at? Are Implementation Dates on track? How will this impact on Residual Risk?)	L	C	Target Risk Score (risk tolerance)
PCCC 0.1	Commission for better health outcomes	Required contribution to improved health outcomes from Local Quality Improvement Schemes (inc GP spec and LD DES) not achieved Chair Of PCCC	Voluntary sign up - practices might not feel they have the competence and or capacity (due to competing demands) to deliver leading to inequality of delivery of services commissioned to address local and national health needs.	4	4	16	Regular review of specifications and expected standards to ensure they are meeting local need and are evidence based. Monitoring of ongoing delivery and action plans if not on trajectory.	PCCC to Governing Body (I)	3	4	12	New	Consider network delivery to cover populations not covered. © Action Owner PJ Imp date August 19 Agree perfomance trajectories for the GP spec and other schemes. (A) Action owner PJ/SA Imp date August 19		2	4	8
PCCC 0.2	Ensure maximum value for money from available resources	Les than 100% of the population covered by the network specifications if a practices is not part of a network Chair Of PCCC	Networks are at various stages of maturity and will develop at differing rates they need to be fit for purpose to deliver the requirements of the DES including extended hours.	3	3	9	Networks have received the relevant documentation from the CCG including a check list to guide them through the registration process. Network footprints approval via non conflicted PCCC members following which consultation will take place with other stakeholders eg community providers and STP. Network of networks meetings and structures.	Reporting to PCCC as part of the Finance and Performance Report bimonthly (I) Escalation to Governing Body on an exception basis (I)	2	3	6	New	Ensure all guidance for specifications is available to networks for implementation and that delivery is monitored when avaible (A) Action owner JW Imp date when available from NHSE		2	3	6
PCCC 0.3	Commission for better health outcomes	Not all patients have access to General Practice services should a practice or large scale provider close/fail Chair Of PCCC	Pressure on other practices staff and premises to provide services for dispersed lists if a provider closes due to, for example, CQC closure, contract issue, financial issue, succession planning failure. Loss of continuity of care for vulnerable patients.	3	4	12	Support for providers including regular contract reviews. Interim provider policy in place	Triangulation of risk by Quality and Safety Assurance Group.(I) Escalation to Quality and Safety Outcomes Committee.(I)	2	4	8	New	Develop mobilisation check list for new providers and closures. © Action owner RH Imp date June 19 Development of a CCG system for early warning system and structure for trangulation of issues to be established. (C) PJ Imp date July 19 Clarify roles and responsibilties of provider and commissioner during practice closure (C) PJ Imp date Aug 19 Quality monitoring for early identification of deteriorating performance frameowrk. LJ July 19		2	3	6

LIVERPOOL CCG: PCCC Draft Risk Register June 2019 **Version: V3**

Risk Ref (includes date added to CRR)	Relevant CCG Objective	Risk Description / Risk Owner / Lead Committee	Cause and potential impact/consequence of risk (Why could this risk occur and what would be the effects if the risk materialised?)	L	C	Inherent Risk Score (without controls)	Existing Mitigation/Controls (How are we managing this risk? What are the key controls in place to prevent this risk from occuring?)	Assurance/Evidence (Who/where can we gain evidence that these controls are working effectively? All assurances are 'positive' unless stated otherwise. I = Internal E= External)	L	C	Residual Risk Score (Current)	Trend (Movement since last update & date last reviewed)	Planned Actions (Is this action to address a gap in Control (C) or a gap in Assurance (A). Must include 'Action Owner' *and* Implementation Date)	Progress On Actions (What stage are planned current actions at? Are Implementation Dates on track? How will this impact on Residual Risk?)	L	C	Target Risk Score (risk tolerance)
PCCC 0.4	Ensure maximum value from available resources	The CCG is unable to deliver its financial plan for 2019/20. Chief Finance Officer (MB)	Lack of robust budgetary control and uncertainty of expenditure fluctuations in the delegated Primary Care budget could affect delivery of the CCG Financial Plan, resulting in failure to meet NHS England Business Rules at year-end.	3	3	9	• Financial assumptions include contingency of 0.5% for operational pressures and variation away from planned expenditure levels • CRES plan in place (set at £13.8m at start of 2019/20 financial year & within the CCG's Operational Plan). • SoRD details budget holder and SMT lead delegated limits by cost centre. • Budget Holder involvement and engagement in budget setting / sign-off. •Robust financial monitoring via formal monthly budget holder meetings - maintained throughout the year (forecast outturn is regularly updated in line with known issues) with plans for mitigation included • Financial position is reviewed at each Finance, Procurement and Contracting meeting and reported on a monthly basis. • Financial position is reviewed every second month at the Primary Care Co-Commissioning Committee • Proposed CRES schemes explicitly risk assessed for qualitative and quantitative impact of proposed changes and associated outcomes	• Financial Plan approved/signed off by Governing Body in March 2019 (In). • FPCC review 'monthly reporting packs' - committee is made aware of cost pressures on a timely basis (In) • Primary Care Co-Commissioning Committee review financial position every second month - committee is made aware of cost pressures on a timely basis (In) • Finance Update Report is standing agenda item at each Governing Body meeting summarising budget and forecast figures (In) • Internal Audit review of 5 areas of Financial Sytems and Process including Budgetary Control in 2018/19 resulted in 'High Assurance' rating - validation of CCG systems and processes in place. (Ex) • Internal Audit review of delegated Clinical Commissioning Groups gives assurance on financial controls and processes and identifies areas of improvement (Ex)	2	3	6		1. Number of Identified actions outlined to mitigate operational pressures (as per FPCC reporting) © Action Owner - Chief Finance Officer Deadline - As per individual mitigation action plans 2. Implement Actions from Internal Audit Recommendations with regards to Financial Management & CRES to improve systems and processes (A) Action Owner - Chief Finance Officer Deadline - As per Audit Recommendation milestones 3. Implement Actions from Internal Audit Recommendations with regards to delegated Clinical Commissioning Groups (A) Action Owner - Chief Finance Officer	1. Ongoing review with Budget Managers/ Programme Leads re mitigating actions Actions being undertaken, will support delivery of overall position and reduce residual risk as year progresses. 2. Follow up review currently being undertaken by Internal Audit to assess implementation of recommendations Actions have been implemented in line with recommendations and will improve 'grip' on financial monitoring which will support reduction in residual risk 2018/19 Internal Audit Report ratings in relation financial management and financial have resulted in 'high' assurance ratings	1	3	3

Updates to existing risks in 'blue'

* denotes new risk

- **Risk Unchanged**
- **Risk increased**
- **Risk decreased**

Risk scoring = likelihood x consequence (L x C)

	Likelihood				
Consequence Score	1	2	3	4	5
	Rare	Unlikely	Possible	Likely	Almost certain
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5

For grading risk, the scores obtained from the risk matrix are assigned grades as follows:

1 – 3 Low risk

4 – 6 Moderate Risk