NHS LIVERPOOL CLINICAL COMMISSIONING GROUP
PRIMARY CARE COMMISSIONING COMMITTEE
Minutes of meeting held on Tuesday 27th August 2019 at 2PM
MEETING ROOM 1, THE DEPARTMENT

Present:

Voting Members:

Cathy Maddaford (CMa)	Governing Body Registered Nurse (Chair)
Helen Dearden (HD)	Governing Body Lay Member for Governance
Dr Monica Khuraijam (MK)	Governing Body GP
Dr Steve Sutcliffe (SS)	GP
Jan Ledward	Chief Officer
Mark Bakewell	Chief Finance & Contracting Officer

In attendance:

Dr Rob Barnett (RB)	Secretary LMC
Peter Johnstone (PJ)	Head of Primary Care Delivery
Samson James (SJ)	Director of Planning, Performance & Delivery
Sarah Thwaites (ST)	Healthwatch
Laura Buckels (LB)	Business Intelligence Team Primary Care Lead
Jacqui Waterhouse (JW)	Primary Care Development Manager
Victoria Horton (VH)	Primary Care Accountant
Paula Jones	Committee Secretary (minutes)

Apologies:

Dr Paula Finnerty (PF)	GP – North Locality Chair
Dr Janet Bliss (JB)	GP
Dr Rosie Kaur (RK)	GP
Jane Lunt (JL)	Director of Quality Outcomes & Improvement/Chief Nurse
Cheryl Mould (CM)	Programme Director, Liverpool Provider Alliance
Colette Morris (CMo)	Primary Care Development Manager
Dr Adit Jain (AJ)	Out of Area GP Advisor
Dr Sandra Davies (SD)	Director of Public Health, Liverpool City Council
Tom Knight (TK)	Head of Primary Care – Direct Commissioning NHS England
Lynn Jones (LJ)	Primary Care Quality Manager
Sarah Stephen (SSt)	Project Manager - Prescribing

Public: 0

PART 1: INTRODUCTIONS & APOLOGIES

The Chair CMa welcomed everyone to the meeting and introductions were made. She requested that the order in which the papers were discussed should be changed to facilitate ease of discussion, this would be 3.3 Primary Care Contract, Performance & Quality, 3.1 Primary Care Commissioning Committee Contracting & Finance Report, 4.2 Local Quality Improvement Schemes and then 3.2 Prescribing Projects Savings Updates.

1.1 DECLARATIONS OF INTEREST

All GPs present declared an interest in the items around the GP Specification, it was noted that their input was required for the discussions and was relevant, should any decisions be required they would not vote.

1.2 MINUTES AND ACTIONS FROM PREVIOUS MEETING ON 18TH JUNE 2019

The minutes of the previous meeting held on the 18th June 2019 were agreed as a true and accurate record of the discussions which had taken place.

1.2.1 Action Point One - it was noted that the minutes from the May 2019 meeting had been amended as requested.

1.2.2 Action Point Two – it was noted that the Contracting and Finance Report was on the agenda for the August 2019 meeting.

1.2.3 Action Point Three – it was noted that the August 2019 agenda contained information on savings from prescribing initiatives in the last twelve months,

1.2.4 Action Point Four – it was noted that the workplan had been updated – this was for quarterly feedback on schemes/decisions taken at the Primary Care Commissioning Committee.

1.2.5 Action Point Five – it was noted that PJ had fed back to NHS England where their data was incorrect re workstream delivery timescales.

1.2.6 Action Point Six – it was noted that the Audit Risk & Scrutiny Committee had received an update on 2nd July 2019 on the Committee's response to the governance review carried out by Mersey Internal Audit Agency and this was a regular agenda item for the Primary Care Commissioning and on the agenda for today.

1.2.7 Action Point Seven – it was noted that the Risk Register was on the agenda and included a risk on the clarity/quality of developing Primary Care Networks.

1.2.8 Action Point Eight – it was noted that the process for Primary Care delivery was on the August 2019 agenda.

1.2.9 Action Point Nine – it was noted that there was an update on Primary Care Networks on the August 2019 agenda.

1.3 MATTERS ARISING

1.3.1 PJ provided a verbal update to the Primary Care Commissioning Committee on a previous issue raised about access under the GP Specification. The Key Performance Indicator ('KPI') number 5 referred to same day access and the decision had been taken by the previous meeting of the Committee not to include F2/Registrar GPs and nursing staff but this was now being queried re the need for the Key Performance Indicator not to exclude these staff which had been raised by training and non-training practices alike. There were various comments/observations made:

- RB felt that access needed to be a team approach or we ran the risk of labelling certain clinicians as "not counting".

- HD commented that from the patient's perspective what was wanted was access to a GP rather than "healthcare". PJ reminded the committee that the KPI was around access to the appropriate clinician to treat the patient. JLe noted that people wanted to see their own GP so there was a larger piece of work around finding out what patients actually wanted.

- SS warned that as funding for training staff might mean that if coding was not dealt with there would be an element of paying twice for certain clinicians' time as some F2/Registrars were funded from Primary Care through the CCG as well as the Faculty.

- There should be a practice minimum to deliver same day access which could be added to as required. He also noted that we did not know what the landscape would be following the review of urgent care.

- CMa wondered if a working group should be established to consider this KPI as the issue was wider than simply the inclusion of trainee GPs.

- With reference to what patients wanted JW referred to the National Patient Survey results available every 6 months.

In summary the Primary Care Commissioning Committee agreed that F2 and GP Registrars would be part of the Key Performance Indicator, the issue of including nursing staff was part of the wider issue and would continue to be monitored.

PART 2: UPDATES

2.1 NHS ENGLAND UPDATE – VERBAL

As there was no one present from NHS England there was no verbal update

PART 3: STRATEGY & COMMISSIONG

3.1 CCG PRIMARY CARE COMMISSIONING COMMITTEE CONTRACTING & FINANCE REPORT – REPORT NO: PCCC 11-19

PJ introduced a paper to the Primary Care Commissioning Committee to report on key aspects of the CCG's Primary Care Contracting and Finance position for 2019/20 as at July 2019 (Month 4). The CCG was held to account by NHS England for the performance and delivery of Primary Care Medical Services.

JW highlighted:

- 14 indicators in the spreadsheet.
- 24/86 practices had failed on one.
- 5/86 practices had failed on four.
- 2/86 practices had failed on five.

This could be used as a basis for deciding on the prioritisation of support to practices/issue of remedial notices based on the numbers rather than hitting contractual targets. RB observed that some of the targets were historic and some in year, for those targets not required to be achieved until 2020 marking practices down on them now would be unreasonable. JLe agreed that we needed to be careful around how performance was measured and when, there needed to be a different approach to combine contract quality performance as well as financial performance. PJ commented that the Quality & Safety Assurance Group would have the view of this and report to Primary Care Commissioning Committee. MB added that there would be more escalation and explanation going forward unlike this report which was initially setting out all the detail. We needed to get better at this and asked for the Committee to be patient.

JW observed that the Primary Care Team were using trajectory progress to reflect where we expected practices to be at various times in the year.

HD was concerned that there might be delays in being aware that practices were "in difficulty". MB responded that there was a prioritisation of data processing and practices would have access to the data on a monthly basis and would be monitoring performance themselves. RB observed that the problem with data was that it was a snapshot in time not a rolling process so for this reason was comfortable with the proposal to wait for two months' of non-performance. SJ noted that the Quality Outcomes Framework was out of synchronisation with the Core GP Specification.

PJ commented on the prescribing overspend which currently was due to the change in cost of category M drugs.

MB referred to issues such as the APMS contract which had an effect on the Primary Care budget. RB referred to the physical cost to practices around such issues as shortage of drugs for example the current shortage of HRT and acknowledge this. JLe wondered if the Risk Register should be amended to take into account Brexit and supplies to practices of drugs and other items. It was noted that the Governing Body would require a report on Brexit anyway.

The Primary Care Commissioning Committee:

- **Noted the performance of the CCG in delivery of Primary Care Medical commissioned services.**
- **Determined if the levels of assurance given are adequate in terms of mitigating actions**
- **Noted the forecast financial positon for 2019/20 as at July 2019 (Month 4) including key issues that have been factored into reporting assumptions**

3.2 PRESCRIBING PROJECTS SAVINGS UPDATE – REPORT NO: PCCC 12-19

PJ presented a paper to the Primary Care Commissioning Committee which provided an update on the impact of three schemes previously agreed by the Primary Care Commissioning Committee, supporting improvements in prescribing activities for the CCG: (1) Direct Patient Ordering, (2) Blood Glucose Meter Upgrade Project and (3) Do Not Dispense.

(1) Direct Patient Ordering

There had been a reduction in cost and number of items dispensed, Sefton CCG had carried this out previously and had not sustained the savings.

(2) Blood Glucose Meter Upgrade
This was an initiative to reduce variation in the use of blood glucose meters. There had been pharmaceutical involvement in this, the Diabetes Partnership withdrew support and estimated savings were only £37k; it was not considered to be a reasonable basis to extend across all practices and the project was discontinued

(3) Do Not Dispense

Commissioning pharmacies (for additional payment) would identify if a patient did not require an item on their repeat medication list and would deliver reasonable savings. RB was of the opinion that pharmacies should be doing this anyway, PJ however noted that the responsibility to authorise a repeat prescription lay firmly with the practice.

SS asked about the review of efficiency of diabetes treatment in practices which had been approved. PJ was not aware of the scheme being implemented and it was agreed that the Committee Secretary would check when this had been approved.

ST noted that some patients had mobility issues in getting to a practice to order repeat scripts/review medication and were not good at describing over the telephone what they required. RB noted that some patients preferred 3-monthly repeat prescriptions if they paid for their scripts and did not have a pre-payment certificate.

The Primary Care Commissioning Committee:

- **Noted the position of each of the projects referred to within this paper**

3.3 PRIMARY CARE CONTRACT, PERFORMANCE AND QUALITY – REPORT NO: PCCC 13-19

PJ presented a paper to the Primary Care Commissioning Committee which proposed the Liverpool CCG approach to the contract, performance and quality management of Primary Care Medical Services in Liverpool. Historically the CCG had not had a consistent and systematic approach to what had been done and what it was going to do. This paper looked at a contractual process, with the increasing requirements of the Primary Care Networks going forward this would ramp up for 2020/21. SJ added that the Quality and Safety Assurance Group would be used to review and gain assurance, feeding back to the Primary Care Commissioning Committee on the assurance which in turn fed back to the Governing Body. This was a more formal way of managing performance, in a similar in which the other trust providers were managed.

PJ observed that there were contractual matters which were of clinical importance and those which were merely contractual; for example should compliance with Friends and Family Test be given the same importance as Frailty Assessments.

JLe observed that the Primary Care Commissioning Committee was under delegation from NHS England, normally there would be a report directly to the Governing Body. Audit Risk & Scrutiny would be sighted on the process and what came to the Primary Care Commissioning Committee was more around assurance that what needed to be done had been done.

RB felt strongly that the practices needed to be aware of the process. It was agreed that this report would come to each Primary Care Commissioning Committee meeting.

The Primary Care Commissioning Committee:

- **Noted the performance of the CCG in delivery of Primary Care Medical commissioned services.**
- **Approved the recommended approach to the management of GP contracts.**
- **Noted that the report would come to each meeting.**

PART 4: PERFORMANCE

4.1 PRIMARY CARE NETWORKS – REPORT NO: PCCC 14-19

PJ presented a paper to the Primary Care Commissioning Committee which provided the state of play with regard to the establishment of Primary Care Networks and the expectations through 2019 and onwards:

- There were eleven Primary Care Networks with all practices on board.

- Two networks were around the 100,000 patients size and had therefore divided into two separate delivery groups.

- Each Network had a Clinical Director although one had resigned and was looking to appoint a replacement

- Networks were required to deliver Extended Hours (outside of core of hours) this year.

- JW had an oversight spreadsheet and the systems were in place to support the operation of Primary Care Networks which were currently:

    - Receiving notification of a changes of Primary Care Network ('PCN' Clinical Director
    - Reviewing and approving, as appropriate, within 28 days, changes in membership (leaving, joining and expulsion) and sub-contracting arrangements – this may require virtual meetings of the Primary Care Commissioning Committee
    - Systems to sign off PCN QOF peer review meetings for prescribing and end of life for payments – These will be reviewed by the Medicines Optimisation Committee and the end of life commissioner prior to approval
    - A route for practices to submit claims via Tradeshift for payment - managed by the finance team
    - A process for payment verification and validation, and an audit that claims for new staff meet additionality criteria
    - Ensuring that the specifics of the extended hours access are being met

RB was not sure if all the Primary Care Networks were stable. JLe noted that this initiative had been handed down by NHS England; the Terms of Reference of the Primary Care Commissioning Committee needed to be reviewed as they currently did not include Primary Care Network responsibility. As a designated committee under the NHS England's delegation to the CCG the Terms of Reference needed to be part of the CCG's Constitution so changes needed to go to NHS England for approval and the Constitution amended.

Regarding the second recommendation in the paper to agree the frequency and content for the Primary Care Network Oversight Reports, CMa felt that we were not yet able to do that.

The Primary Care Commissioning Committee:

- **Noted the contents of this report.**
- **Was not able to agree the frequency and content for PCN oversight reports.**

4.2 LOCAL QUALITY IMPROVEMENT SCHEMES – REPORT NO: PCCC 15-19

PJ presented a paper which provided the key aspects of the CCG's position regarding the Local Quality Improvement Schemes to the Primary Care Commissioning Committee. He highlighted:

- Only a small number of practices provided the Asylum Seeker/Refugee service as patients were clustered in specific parts of the city.

- Rather than have each practice being commissioned to provide all services, future commissioned services may use a Networks/small footprint. This made best use of expertise and reduced variation across the city.

RB felt that this did not reduce variation for patients and it was necessary to challenge what was commissioned at practice level and at Primary Care Network level. Also the services commissioned by the Local Authority such as sexual health were missing, the CCG needed to have a handle on all services not just the ones it commissioned. JLe responded that the Local Authority commissioning would be addressed by the bringing together of many commissioning functions.

JLe asked what happened to patients whose practice did not offer minor surgery. PJ explained that the practice would then refer the patient to a practice who did. MK explained further that this would happen via the Choice Team who had clinically led criteria for access to the service. JLe was concerned that patients might be at a disadvantage even at a Network/Neighbourhood level with the service not being offered at all but MK reassured that minor surgery had been equitable in uptake across the patch, unlike other services such as ABPI where there was more limited coverage. JLe asked for evidence rather than assumptions.

CMa noted that the Primary Care Commissioning Committee were being asked to note the paper and approve the six monthly clinical audit to be undertaken in September 2019. She asked that the results of the clinical audit come back to the Committee

The Primary Care Commissioning Committee:

- **Noted the content of the paper**
- **Approved the six monthly clinical audit review.**

PART 5: GOVERNANCE

5.1 MIAA PRIMARY CARE COMMISSIONING COMMITTEE & GOVERNANCE REVIEW – REPORT NO: PCCC 16-19

JW presented a paper which updated on the progress of the action plan to address the report from Mersey Internal Audit Agency on the Primary Care Commissioning Committee and highlighted:

- This report would come to each meeting.
- Patient & Public Engagement – a link was required with the CCG's Public & Patient Forum so a flow chart was attached which showed the engagement process.
- Primary Care Scheme Reporting – a report on the progress of prescribing projects had already been discussed today, reporting of other schemes would be considered for future meetings and a worked up paper would be brought to the next meeting.

ST asked how the Engagement Plan fitted with Primary Care and how did schemes become a Form 0 or a Form1. PJ commented that all new schemes went through the Form 0/Form 1 process. Equality Impact Assessments were done whenever the schemes recommended this.

JLe noted that the CCG was changing the way it carried out engagement and we needed to make use of soft intelligence and link into Healthwatch. There was an Engagement Committee in the new structure, our current systems and processes were not as good as they could be. The Engagement Team were looking at how we engaged with the practices' Patient Participation Forum.

The Primary Care Commissioning Committee:

- **Noted the progress of the action plan**

5.2 PRIMARY CARE COMMISSIONING RISK REGISTER – REPORT NO: PCCC 17-19

JW presented the updated Risk Register to the Primary Care Commissioning Committee. As all practices had been successfully

included in a Primary Care Network the risk around not achieving this had been retired. There was a new risk added regarding the delivery of the Network requirements including the 7 national specifications. Otherwise there were no significant changes.

MB suggested that frailty should be added and JLe suggested supply of drugs. CMa noted RB's comment about the instability of the Primary Care Networks and that this should be added.

CMa suggested that at future meetings the Governance section should be discussed first to give more time to matters such as the Risk Register.

The Primary Care Commissioning Committee:

- **Noted the contents and updates of risks for the commissioning of General Practice**
- **Considered current control measures and whether action plans provide sufficient assurance on mitigating actions.**
- **Agreed that the risk scores accurately reflected the level of risk that the CCG is exposed to given current controls and assurances.**

6. ANY OTHER BUSINESS

SS raised the matter of a request to close list size which he had wished to bring to the Primary Care Commissioning Committee and declared his interest as the Lead GP Partner in the practice concerned. It was noted that there was a process to be followed and the matter would be brought to the next meeting pending that process being followed, held in public with SS excluded at that point due to his conflict of interest.

7. DATE AND TIME OF NEXT MEETING

Tuesday 15th October 2019 Formal Meeting - 10am
Boardroom Liverpool CCG