NHS
Liverpool
Clinical Commissioning Group

Status of these minutes *(check one box)*:	
Draft for Approval:	☐
Formally Approved:	☒

Report to:	Governing Body
Meeting Date:	8 September 2020

MINUTES OF THE MEETING OF

Primary Care Commissioning Committee

Date:	26 May 2020	Time:	10.00am
Venue:	Skype Conference Call		

Name	Job Title (Division/ Organisation*) *if not Liverpool CCG
Present:	
Gerry Gray (GGR)	Lay Member for Finance
Mark Bakewell (MBA)	Chief Finance & Contracting Officer
Helen Dearden (HDE)	Lay Member for Governance
Jan Ledward (JLE)	Chief Officer
Jane Lunt (JLU)	Director of Quality, Outcomes & Improvement (Chief Nurse)
Cathy Maddaford (CMA)	Non-Executive Nurse
Cheryl Mould (CMO)	Programme Director Provider Alliance
Carol Rogers (CRO)	Lay Member for Patient & Public Involvement
In Attendance:	
Scott Aldridge (SAL)	Senior Performance Manager
Rob Barnett (RBA)	LMC Secretary
Kellie Connor (KCO)	Senior Contracts Manager
Paula Finnerty (PFI)	GP Director
Victoria Horton (VHO)	Finance Manager
Sam James (SJA)	Director of Planning, Performance & Delivery
Peter Johnstone (PJO)	Head of Medicines Optimisation
Fiona Lemmens (FLE)	Chair LCCG
Maurice Smith (MSM)	GP Director
Rebecca Tunstall (RTU)	Deputy Chief finance Officer
Jacqui Waterhouse (JWA)	Senior Programme Delivery Manager
Debbie Richardson	Committee Secretary, Liverpool CCG
Apologies Received:	
Tom Knight	

ISSUES CONSIDERED

2020

A1 WELCOME

1. GGR welcomed all those present to the meeting noting that business would be conducted on the assumption that members had read all papers ahead of the meeting. This was the first Primary Care Commissioning Committee meeting to meet in the revised CCG format with GGR assuming the role of Chair. Members introduced themselves and their roles within the CCG and how their roles serviced the committee.

A2 APOLOGIES FOR ABSENCE

2. The apologies for absence received for this meeting are detailed above.

A3 DECLARATIONS OF INTEREST

3. There were no additional declarations reported for noting at the meeting other than those already listed on the LCCG register. None of those listed on the register were pertinent to the discussions at the meeting. However MSM informed members that he was a GP in a Liverpool practice and an independent specialist member of the NHS Digitals' I Guard panel which considered data requests. RBA was secretary of Liverpool Medical Council (LMC) and FLE was also a local GP which was a member of a Primary Care Network (PCN). PFI was also a locum GP.

A4 MINUTES OF THE MEETING HELD ON 18 FEBRUARY 2020.

4. The minutes of the previous meeting held on 18 February 2020 were accepted as an accurate record subject to the following amendments:
    a) Item 5.1 Questions & Comments section refers to LMA to be amended to LNA (Liverpool Network Alliance); Reference to LMC to be amended to FPCC.
    b) Item 1.1 to be amended to remove the reference to finance colleagues being perceived as conflicted;
5. Discussion took place regarding items contained in the previous meeting minutes which had subsequently changed due to the pandemic. These would be discussed in the meeting.
6. MSM enquired about the medicines management project process which would entail having several projects running concurrently and whether this was feasible and the response was that this was normal practice however due to the pandemic some projects had since paused temporarily.
7. MSM also enquired why interventions made in prescribing were not listed as recurrent savings and the response was that any savings made here were absorbed as practices or drugs changed.
8. RBA commented that at the time of the previous meeting LMC was concerned with the direction of travel the CCG was heading towards as it felt the CCG was moving from being a supportive organisation to one that treated GP practices similar to Trusts in sending out remedial and breach notices which the LMC found disappointing. This had halted since the pandemic. JLE responded that the CCG had set out for some time to have a consistent and fair approach to all providers. Any provider who was not achieving expectations were sent breach or remedial notices accordingly. In the beginning the CCG was criticized for interfering with primary care and there is a balance to be struck. JLE noted that she would be happy to discuss this further with the LMC which RBA commented would be helpful.

Action	Lead	Timescale	Status
Recommendations approved by the committee, namely: • Approve the minutes of the previous meeting			
Further actions required: • Update minutes in line with discussions	D Richardson	ASAP	Completed

A5 ACTION LOG

9. The action log was discussed and it was noted that progress on the items listed had paused due to the pandemic.
10. It was agreed to bring the point back to the next meeting with updates on progress.

Action	Lead	Timescale	Status
Recommendations approved by the committee, namely: • Note the verbal update			
Further actions required: • Update action log in line with discussion	D Richardson	June 2020	On Agenda for June PCCC meeting

B UPDATES

11. There were no updates for discussion that were not included on the agenda.

C GOVERNANCE

C1 PRIMARY CARE COMMISSIONING RISK REGISTER

12. CMO updated members on the primary care commissioning risk register which had been revisited and updated to reflect the impact of Covid19 where services had been paused and where they has increased. The risk had been carried over with completion dates revised due to the resource being redeployed to manage the pandemic.
13. A new risk had been added around general practice Covid-19 and the response to this.
14. RTU commented that risk number PCCC0.4 could be closed as the CCG financial position had been achieved.
15. MSM commented that when rolling risks over should the risk be spelt out in terms of what was the risk for primary care and the subsequent risk for the CCG.
16. JLE commented that the risk register was prepared from a commissioner perspective and not in terms of provider delivery primary care and had been developed in conjunction with the Lay Member for Governance over the last 6-8 months working with SLT.
17. CMO reported that the risk register was the responsibility of several members of SLT and the Provider Alliance team and they would be happy to discuss the journey it had undergone outside the meeting. The Risk Register was a live document which was constantly being developed and updated.
18. HDU asked if actions were being suspended should the risk rating be reconsidered. Members agreed to take this away and discuss and will feed back to the next meeting.

Action	Lead	Timescale	Status
Recommendations approved by the committee, namely: • Note the contents and updates of risks for the commissioning of General Practice • Consider current control measures and whether action plans provide sufficient assurance on mitigating actions Review the mitigations and progress • Agree that the risk scores accurately reflect the level of risk that the CCG is exposed to given current controls and assurances			

Further actions required: • Revisit the risk scores to ensure that they accurately reflect the level of risk that the CCG is exposed to given current controls and assurances with particular regard to Covid19.	C Mould	June 2020	On June 2020 PCCC Agenda

D PERFORMANCE

D1 PRIMARY CARE COMMISSIONING COMMITTEE CONTRACTING AND FINANCE REPORT

D2 GP SPECIFICATION PERFORMANCE REPORT

19. Both the Primary Care Commissioning Committee contracting and Finance Report and the GP Specification Performance Report were noted with no updates due to the Covid-19 situation.

D3 PRIMARY CARE COVID19 RESPONSE

20. JWA presented the Primary Care Covid-19 response highlighting that general practices had received guidance which included a Standard Operating Procedure (SOP) on 6th April 2020 which gave information about how to perform under the new regulations. The guidance was quite specific in requesting 100% triage, remote consultations, and the separation of Covid-19 and non Covid-19 patients.
21. The paper described the support offered in the Primary Care Team of the Provider Alliance team for work to be carried out safety in Primary Care Network s.
22. The work was carried out on a geographical footprint understanding staffing to enable awareness and offer support if necessary if staffing was likely to fall over and what contingencies plans were; support with PPE shortages; and support to enable homeworking.
23. The Provider Alliance team refocused to give the support required with daily contact with team members and CCG colleagues.
24. Reports were sent to NHS England regarding compliance with the SOP and working with clinical directors on communications and care homes with Mersey Care to ensure support is given where it is needed.
25. The implementation of hubs was supported with buddying arrangements where hubs were not in place. Infection Control support and training was delivered where necessary.
26. Nothing had been published as yet however the team was moving toward recovery with the non-clinical Primary Care Network leads looking at which services could be stood back up. Cheshire and Merseyside heads of primary care and Public Health England were looking to re-establish screening programmes for cancer and other services.
27. The team was also looking at what was good about what had taken place with some things instigated swiftly which may have taken considerably longer prior to the pandemic. The intention was to capitalize on the learning of the leadership team and ensure the benefits could be maximized.
28. MSM asked if the extended hours situation would be standardised to ensure equity across networks which he felt would be beneficial. In addition MSM commented that the work undertaken by the team during the pandemic was phenomenal and it would be helpful not to be constrained by regulations if possible in future.
29. CMO responded that a standardised approach to extended hours would benefit all and that was the approach the CCG would be promoting.
30. CMA enquired if there was a mechanism for practices to record incidences which had resulted in an adverse impact when accessing urgent and routine care for patients who had not attended the practice because they couldn't or perhaps were frightened.
31. SJA responded that work was ongoing with colleagues in secondary care to collate and monitor data on incidences where there could have been potential harm. There has been a drop off in people attending appointments which was believed to be due to patients being afraid of infection and there was a concern about cancer referrals.
32. Best practice is also being captured and work was ongoing to build a digital platform to record the positive and negative data.
33. RBA commented that Covid-19 gave the potential to widen the health inequalities with

particular concern for patients who did not have access to a smart phone or internet access.

34. FLE acknowledged the work of the Primary Care Team who had done a fantastic job supporting practices and supporting the system and primary care response. The role of the LNA was also acknowledged with the really impressive teamwork.
35. PFI asked if any practices did fall over during Covid-19 and was there a date for when the recovery phase was due to start. PFI also commented that it was difficult to encourage patients to come in for appointments and if they are recommended to attend hospital they are extremely reluctant to attend and it was very difficult to persuade them otherwise.
36. JWA confirmed that 100% of practices in Liverpool remained open throughout the pandemic and were still open. No date has been suggested for a recovery phase but it had become the natural next phase both in terms of how things had progressed and the language of the guidance being delivered.
37. CMO commented that very early on buddying arrangements were put in place for smaller practices who might have staff shortages and this was utilized a couple of times. SJA is leading a piece of work with each of the organisation to discuss recovery as part of the wider system and the CCG will have an input.
38. MSM asked why a hub was not created in the north of Liverpool and suggested canvassing practices for themes in relation to learning from the pandemic.
39. CMO reported that a SOP was in place ready to be mobiised if necessary for a hub in north Liverpool but it was felt that practices were managing and the numbers were low so it was not needed at the time.
40. FLE added that the experience of trying to set up a centralized hot hub in the north highlighted the large number of small practices and the poor quality of the estate. This is a challenge to take forward to enable the practices to work more collaboratively.
41. JLE commented that consideration was needed regarding how to collect information from individual practices regarding harm JLU is considering this.
42. PFI asked if the PC24 Covid-19 response was going to be stood down and if guidance would be available to practices when this happened as all Covid-19 patients had been directed there and practices were unclear what to tell patients.
43. CMO responded that the assessment centre was taken down dome time ago. RBA stated that it was the job of GPs to treat patients in the community. There is a process for Covid-19 patients via 111 and a follow up process via GPs.
44. JLU reported that the process of SEAs is being expanded in general practice with a degree of proportionality. This is about capturing the learning from the situation whatever it may be and possibly mobiise better should there be another surge.

Action	Lead	Timescale	Status
Recommendations approved by the committee, namely: • Note the activity delivery model for General Practice during the pandemic			
Further actions required: • **No action required**			

E STRATEGY AND COMMISSIONING

E1 PRIMARY CARE NETWORK MERGER
E2 PRIMARY CARE NETWORK DES 2020/21

45. The approval of the merger was agreed in a virtual meeting earlier in the year. Of the issues highlighted in the paper one PCN had since sent in the necessary documentation and so all 10 networks were agreed to participate in the DES requirements for 2020/21.
46. One practice which was part of the Childwall and Wavertree network had chosen not to be part of the network this year. In line with guidance the CCG was now responsible for making alternative arrangements to ensure the local population were not disadvantaged by this and still had access to services developed by the PCNs.
47. The paper included contractual and financial requirements for 2020/21 which were quite complex.
48. Members agreed to formally ratify the decision made virtually earlier in the year.

49. MBA commented that regarding Rocky Lane conversations were underway to resolve the issues with SJA reporting that there was a process to follow which included the practice writing to the CCG formally and the CCG notifying the practice of the potential income loss which would occur as a result of this. The CCG was in the process of outlining the implications of the decision and further information will come to the committee in subsequent meetings. It was noted that timelines were short and must be adhered to as there would be implications the committee would need to consider if the issue was not resolved before mid-July. A PCN needed to be found which would host the arrangements.
50. HDE asked for clarity on how the DES sat with regard to the emergency measures that were in place. The response was that the DES requirements were due to be fulfilled by 31st May as normal however NHSE were anticipating that responses would be tailored to meet Covid-19 responses.
51. For example patients in care homes were expected to have had access to primary care and the DES return must show how this had been achieved. Work was underway to develop a plan to support care homes in delivering this.
52. Elements of the DES are being brought forward. The national requirements are still eligible with no changes received regarding expectations. Clarification is still expected regarding standardised enhanced hours from NHSE and what they were expecting would be delivered throughout 2020/21.
53. The DES had been tailored due to the circumstances and regular reporting to NHSE continued.
54. CRO enquired about patient consultation with regard to Rocky Lane Medical Centre in parallel with the PCN discussion and the response was that this would be picked up once there was more clarify regarding options.
55. RBA informed members that a communication had been sent to practices that day informing them of the consequences of not signing up to the DES and further responses may follow. With regard to care homes NHSE is expecting particular things to be delivered now which impacts on any patients Rocky Lane may have in a care homes and this could not wait.
56. JLE commented that the awakening of government to the perilous state of some of the care home market partially due to Covid-19 but also partially due to the death rates in care homes and their ability to respond. They had brought forward a lot of the ask around the DES for general practice and they had also required plans to be put in place by the end of May for infection control etc. Some of this is NHSE responding to the crisis unfolding which could have been recognized earlier with more local control. It was NHSE reacting rather than planning. There is a need to assess the risk in terms of general practice to understand their position.
57. Members supported the proposal.

Action	Lead	Timescale	Status
Recommendations approved by the committee, namely: • Approves the application from the member practices of Croxteth/Norris Green and Walton Primary Care Network s to become North Liverpool Network (subject to receiving formal written support from Mersey Care and Liverpool City Council) • To note the PCN DES requirements in 2019-20; • To note the PCN DES requirements for 2020-21 and the process followed to formalise the arrangements; • To note the changes in 2020-21 to the previously approved PCN's in 2019; • To note the contractual and financial overview of the PCN DES in 2020-21; • To note the next steps in formalising			

the PCN's participation for 2020-21;			
Further actions required: • None identified			

E3 PMS – GMS CONTRACT

58. KCO presented a request from Albion Street practice requesting a change from a PMS to a GMS contract. This is a right of the practice and in line with national guidance falls within the up to 3 month notice period required. The practice had requested that the changeover be made from April and after discussion it was agreed to bring to this committee for agreement.
59. MBA commented that discussions had taken place over time and given the financial implication the compromise was reasonable.
60. Members agreed to approve the request.

Action	Lead	Timescale	Status
Recommendations approved by the committee, namely: • Note the notification received from N820 to change to GMS from PMS Primary Care Contract; • Note the PMS Contractor's Right to a GMS Contract and confirm the GMS Contract start date for (N82095) of 1st June 2020.			
Further actions required: •			

G ANY OTHER BUSINESS

61. The Terms of Reference (TOR) for the committee were for members to consider.
62. MSM commented that it was unusual to have GPs attending not as members. JLE responded that the TOR had been under consideration for 6 months and they had been signed off at Governing Body. The committee TOR reflected good practice in line with NHSE guidance for good decision making. The TOR would be reviewed annually however if the merger went ahead they were subject to change in the revised structure. If members wished to discuss any items either from the meeting or from the TOR they were invited to contact CMO.
63. No other items of business were discussed. The meeting closed.