NHS
Liverpool
Clinical Commissioning Group

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Draft for Approval:	☐
Formally Approved:	☒

Report to:	**Governing Body**
Meeting Date:	**13 July 2021**

MINUTES OF THE MEETING OF

Primary Care Commissioning Committee

Date:	20 April 2021	Time:	10.00am
Venue:	MS Teams		

Name	Job Title (Division/ Organisation*) *if not Liverpool CCG
Present:	
Gerry Gray (GGR)	Lay Member for Finance - Chair
Mark Bakewell (MBA)	Chief Finance & Contracting Officer
Helen Dearden (HDE)	Lay Member for Governance
Jan Ledward (JLE)	Chief Officer
Fiona Lemmens (FLE)	Chair LCCG
Cathy Maddaford (CMA)	Non-Executive Nurse
Cheryl Mould (CMO)	Director Provider Alliance
In Attendance:	
Scott Aldridge (SAL)	Senior Performance Manager
Val Attwood (VAT)	Deputy Chief Contracting Officer
Kellie Connor (KCO)	Senior Contracts Manager
Paula Finnerty (PFI)	GP Director
Stephen Hendry (SHE)	Head of Governance and Corporate Services
Dave Horsfield (DHO)	Head of Transformation & Programmes
Richard Houghton (RHO)	Corporate Services and Governance Manager
Peter Johnstone (PJO)	Head of Medicines Optimisation
Jane Lunt (JLU)	Director of Quality, Outcomes & Improvement (Chief Nurse)
Ian Pawson (IPA) (for item B1)	Medical Director, LNA
Carol Rogers (CRO)	Lay Member for Patient & Public Involvement
Maurice Smith (MSM)	GP Director
Adrienne Taylor (ATA) (for item B1)	Managing Director of LNA
Jacqui Waterhouse (JWA)	Senior Programme Delivery Manager
Debbie Richardson	Committee Secretary, Liverpool CCG
Apologies Received:	
Rob Barnett (RBA)	LMC Secretary
Victoria Horton (VHO)	Primary Care Accountant
David O'Hagan (DOH)	GP Director

ISSUES CONSIDERED
2021

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. Adrienne Taylor and Ian Pawson from the Liverpool Networks Alliance (LNA) were also welcomed to the meeting.

A2 APOLOGIES FOR ABSENCE

2. The apologies for absence received for this meeting were as detailed above.

A3 DECLARATIONS OF INTEREST

3. In addition to the declarations already listed on the LCCG register FLE commented that as a GP it was possible that items may be discussed which she may declare an interest in as they arose. Members agreed that a clinical perspective would be valued, and items would be discussed on an individual basis with any conflicts dealt with as they arose. All GPs present declared an interest in the LQIS and ARRS schemes with MSM having a particular interest in the Mather Avenue Surgery which was to be discussed within partnership changes.

A4 MINUTES OF THE MEETING HELD ON 16 FEBRUARY 2021.

4. The minutes of the previous meeting held on 16 February 2021 were accepted as an accurate record.

A5 ACTION LOG

1. The action log was discussed with the following points made:
    a. Item 1 – Review of Primary Care Networks (PCNs) with maturity matrix in year-end review. The item was the responsibility of the Liverpool Networks Alliance (LNA) and required tidying up. DHO to discuss the item offline and report back. Item ongoing.
    b. Item 2 – Primary Care Commissioning Committee Risk Register, risk number 8, the risk had been fully reviewed and was on the meeting agenda within the risk register. Item closed.
    c. Item 3 – Medicines Optimisation Committee (MOC) guide. The guide had been written and was to be shared with Performance and Quality Committee (PQC); Clinical Effectiveness Committee (CEC); and Primary Care Commissioning Committee (PCCC) prior to their next meetings. Item closed.
    d. Item 4 - Mental and physical health checks. This item had been picked up and discussed by the relevant groups. Any updates would come back to the committee as appropriate. There was some overlap between PQC and PCCC which would be monitored. Commissioning issues were for discussion at PCCC and performance issues to be discussed at PQC. Item closed.
    e. Item 5 - searches for assurance regarding extraction data. The CCG had previously had difficulty running searches via EMIS enterprise and had arranged that practices could run searches they needed which gave them more timely information than the national data they previously received. This should enable more information to be available to the committee. It was known that some practices had run the searches, but it was not yet known if all practices had run the searches as yet. Item ongoing.

Action	Lead	Timescale	Status
Recommendations approved by the committee, namely: • Note the progress with previous action points.			
Further actions required: • Update the action log in line with discussions.	D Richardson	ASAP	Completed

A6 COMMITTEE WORK PLAN

2. DHO presented the committee work plan which had been reviewed with the changes made being:
3. Performance quality and contracts and Finance report reflect what is included within the report; report titles refreshed; LQIS approvals moved from April to February in line with financial deadlines; CQC and performance and quality referrals moved to be more prominent; and the annual review by Mersey Internal Audit Agency (MIAA) had been moved back to December.
4. CMA sought clarity regarding where the annual report was fed back to as it was not on the MIAA plan. DHO responded that the intention was that it would be an annual review of the committee for Audit and Risk Committee (ARC) and to maintain the progress made on the MIAA review.
5. JLE noted the reference to APMS (alternative provider medical services) options asking did this refer to the APMS timetable or the decisions on procurement outcomes suggesting this was made clearer on the work plan. JLE also asked if it included boundary changes to which DHO stated that it did to which VAT concurred. VAT reported that regarding APMS it would be reported as and when necessary for recommissioning or to consider new APMS when contracts ended mid-year.
6. CMO suggested formally requesting NHS England (NHSE) representation at the committee as this was a statutory committee and there had been no representation in recent months. DHO reported that he had been in touch with NHSE and initiated that conversation and would report back in due course.
7. HDE noted the need to include an annual review of the committees' terms of reference (TOR).

Action	Lead	Timescale	Status
Recommendations approved by the committee, namely: • Note the committee work plan			
Further actions required: • Update committee work plan in line with discussions.	D Horsfield	June 21	On June 21 agenda.

B UPDATES

B1 LNA DELIVERY OVERVIEW

8. IPA and ATA delivered a presentation around progress to date with LNA delivery outlining the plans for 2021-22. The presentation highlighted the following:
    a. LNA had been to PCCC three times, the last time being in August 2020.
    b. The CCGs role was to support the LNA into becoming an organisation that worked with General Practices.
    c. General Practise was the keystone for community delivery for patients and should remain at the centre of all care delivered outside hospitals.
    d. Priorities included:
    e. The development of PCN leadership;
    f. Establishing a voice for GPs within the healthcare system;
    g. Further developing the stand-alone organisation;
    h. Developing relationships with system partners to deliver more effective healthcare in Liverpool;
    i. LNA aimed to do this by being a strong voice for General Practice across the healthcare system;
    j. Supporting PCNs in their journey;
    k. Maximising the impact of PCNs on population health;
    l. Creating General Practice provision at scale while being an advocate and key

delivery partner for the One Liverpool plan and championing quality.

m. The operational plan included:
n. PCN recovery and reset plans post COVID19;
o. Secure hosting to become an independent organisation;
p. Developing access that met the needs of the population for primary and community care integration;
q. Workforce planning to maximise the available PCN resources;
r. System leadership DES specification delivery;
s. Winter planning for the social model of health;
t. New model of care tackling health inequalities.
u. To date the LNA had achieved:
v. A coordinated effective collective GP response to COVID-19;
w. Secured and was delivering a leadership development programme for PCNs;
x. Established systemwide GP presence which was now viewed as necessary;
y. Led integrated care home approach and facilitated care home allocation;
z. Delivery of the COVID-19 vaccination programme;
aa. Learned from COVID-19 innovation to develop a new model of care to tackle health inequalities;
bb. Secured £270,000 extra resources for GPs.
cc. The presentation listed progress made in the last 18 months and the direction it wished to take next with he challenges it faced along with what had been learnt on the journey.

9. SAL referred to supporting PCNs with workforce recruitment asking if there was a plan to support those that had struggled in the last year and did the support for DES delivery include supporting the development of searches for practices and the performance management of the DES requirements. The CCG offered DES support for care homes and would networks be developed to support practices or would this still sit within the CCG.
10. IPA responded that there was a variability in supporting ARRS recruitment which was sometimes due to PCN capacity particularly with the COVID19 response and the vaccine programme roll out. This made it difficult to plan despite the best efforts of the LNA. The intention was that the LNA would continue to support where it could under the constraints it operated under. Regarding supporting the DES requirements this was not for the LNA to answer although it was happy to support the conversation around it, it did not have the capacity to take on more analysis work. CMO commented that this work was for internal teams and work needed to be done on how to work together with teams to discuss collectively how to work together. ATA added that from a digital perspective regular discussions were held with task groups established to progress areas of work with membership from relevant teams including iMerseyside to address the needs of PCNs.
11. MBA commented that the presentation demonstrated the building blocks being laid for the future asking what the sustainability of the LNA was moving forward. Recognising the journey had been made with the CCG how did the LNA envisage being sustainable as a business as it starts to emerge as a standalone organisation.
12. ATA responded that from an LNA perspective a key part of the organisational development was to make sure the LNA became fit for purpose and self-sustaining so that it could provide support to PCNs. The challenge was that as the LNA comes out of PCNs it was difficult to enable PCNs to continue to support strategy themselves.
13. IPA commented that it was tricky not knowing what was happening in the system as this was key to what to look for going forward. The LNA had anticipated it would have moved on further than it had by this point however due to COVID19 there had not been the opportunity and the whole landscape looked very different as a result. There may be opportunities where the LNA had greater influence by being a system partner and it was about balance noting that when the LNA was set up it was equally inward and outward facing. Over time PCNs were much more able to stand on their own feet requiring less support to be sustainable and the ask of GP's to be involved in the system had ballooned and the expectation was that this would continue although it was not clear what it would

look like in the future. There was a need to be involved to support opportunities for the emerging landscape of the future looking at how manage this and this was the challenge the LNA was grappling with as it moved into the next phase.

14. JLE stated that if she were to give the LNA some advice it would be that it needed to convince the PCNs in Liverpool that they needed the LNA and the visibility of PCNs was clear in the ICS however the LNAs value was not clearly shown despite it being there. The LNA was doing a fantastic job and if the CCG stayed it would continue to encourage the LNA however the LNA had to put plans in place to thrive as they had an important role.
15. DHO thanked the LNA members for the presentation stating that it was good to see the progress made recognizing the pressure and struggles the team had been under. DHO commented that he would welcome sight of future plans and how they were to be resourced with consideration of what could be achieved with the capacity it had. Innovative thinking needed to happen, prioritizing items that could be worked through quickly with the CCG while it was there as the pressure was not likely to go away.
16. MSM referred to a previous federation that had taken on too much and lost its way through trying to do too much suggesting the LNA kept to its strategic focus as it had done a fantastic job so far. MSM noted that there was a danger in comparing a small team with an organisation and there was a role for the CCG to shape the LNA as it goes forward. ATA responded that work was underway on organisational development plans although there was nothing to report yet. IPA welcomed the feedback noting the challenge around the focus of the organisation stating that the team would take the comments on board.
17. KCO asked how the LNA measured the impact of what it did asking what success looked like for the LNA to which IPA responded that it depended upon the level and from a PCN level all PCNs in Liverpool standing on their own delivering against contract requirements focused on tackling health inequalities would be deemed a successful outcome for the LNA. A success story would be when there was little to no role for the LNA to be involved. GGR asked if views would be different if COVID19 had not happened. IPA responded that because of COVID19 PCNs do talk between themselves a lot more and have developed better stronger relationships; they have WhatsApp groups sharing ideas which had facilitated the ability for PCNs to develop much further much faster. The impact of this will be long lasting and the learning from this will be widely shared.
18. PFI voiced concerns about sustainability and capacity noting that from the discussion everyone wants something from the networks and there was a system wide need for input. IPA had mentioned the continual refocus on areas and everything was essential at the time. Maintaining a dialogue with the CCG was important and conversations needed to continue outside the meeting to discuss how Liverpool will be served.

Action	Lead	Timescale	Status
Recommendations approved by the committee, namely: • Note the LNA delivery presentation.			
Further actions required: • None identified			

B2 LQIS PHLEBOTOMY UPDATE

19. DHO delivered and update on LQIS Phlebotomy following the original proposal which came to the committee in August 2020. Phlebotomy had been an important part of the system as it maintained capacity with the scheme increasing capacity by 1500 blood tests per month. Senior Leadership Team (SLT) had looked at extending the programme in quarter one of 2021-22 as it was important that capacity remained in the system and so approval was being sought from the committee for this. The cost would be just over £26,000 to continue to offer the service.
20. HDE enquired if the costs could be recovered via the COVID19 recovery funding and was informed that it would come from the general CCG allocation.

21. Members agreed to support the continuation of the service for quarter one of 2021-22.

Action	Lead	Timescale	Status
Recommendations approved by the committee, namely: • Note the LQIS Phlebotomy update.			
Further actions required: • None identified.			

B3 PCN CARE HOME BED ALIGNMENT

22. VAT updated members on the changes made to the alignment of care homes to Primary Care Networks, in support of Enhance Health in Care Homes, which was previously reported the Committee in August 2021 and to agree the starting position for the 21/22 contract year.
23. Under the PCN DES, there was a requirement for Care Homes in the local area to be aligned to a specific PCN to support delivery of the Enhanced Health in Care Homes element of the DES. Each PCN was paid £120 per care home bed, per year to undertake this, regardless of bed occupancy.
24. In August 2020, a report was presented to the committee to outline the position on the alignment of care homes and to confirm the funding arrangements for the last half of 2020/21. Since this point, there had been a period of revision with the PCNs to ensure the most optimum alignment and to reflect changes in the numbers of beds at specific care homes.
25. The Provider Alliance team of the CCG had kept a log of all the changes to the original care home alignment and the impact of the changes across all care homes / PCNs for 2021/22 could be summarised as beds approved at PCCC in August 2020 totaled 3182. A bed review in March 2021 amounted to 3301, resulting in an additional 122 beds and subsequent financial increase of £14,640. This was not a material change for the CCG.
26. The changes would result in 4 PCN's receiving a lower level of funding and 6 PCN's receiving increased funding in 2021/22.
27. HDE referred to challenges made when the application was submitted originally regarding the allocation of beds to which VAT responded that this was true, and the provider alliance team had worked to address this stating that concerns had been raised that the number of beds PCNs paid for did not reflect actual numbers as they changed over time. There may be requests for retrospective funding as this related to 2021/22 and some changes had taken place in 2020/21. CMO confirmed that discussions had been facilitated between relevant PCNs when the concerns were raised the previous year however no concerns had been raised at this point.

Action	Lead	Timescale	Status
Recommendations approved by the committee, namely: • Note the change in alignment of care homes between different primary care networks. • Note the Standard Contract requirements for the Enhanced Health Care Homes under the DES. • Note the additional beds which also now need to be paid.			
Further actions required: • None identified			

C GOVERNANCE

C1 PRIMARY CARE COMMISSIONING COMMITTEE RISK REGISTER

28. DHO presented the Primary Care Commissioning Committee (PCCC) Risk Register (RR) reporting that it had been fully reviewed thanking RHO for the work involved here.
29. There were 4 key points to note:
    a. Risk number 0.1 had the controls updated. As a result of this the risk rating had been adjusted from 12 to 8 and the target risk score had been adjusted. There is more that could be done following the evaluation to manage the risk.
    b. Risk number 0.4 had been published for 6 months and been updated.
    c. Risk number 0.8 was recommended for removal as the risk no longer existed. The item concerned a lack of availability of medication and the issue had been resolved.
    d. Risk number 0.9 was likely to be superseded with the delivery of the COVID19 standard operation procedure (SOP) as this would progress the status to business as usual. It was unclear when the guidance would arrive.
30. CMA referred to the care home update regarding the vaccination uptake and the vaccine uptake from care home staff for which Liverpool was listed as 2nd from bottom asking was this a risk for PCCC or elsewhere. CMO responded that the vaccination programme was listed as a separate risk and not specific. Work was ongoing with PCNs to increase the uptake of vaccines amongst care home residents and staff and a 10-point plan was in place with PCNs as it was felt different initiatives were needed to make this work.
31. MSM asked about any anticipated changes to the infection prevention and control (IPC) regime in place and commented that perhaps the flu vaccine risk could be taken off the risk register as the season was over. DHO responded that nothing had been received regarding IPC changes and the expectation was that things would continue as they were however if anything changed then colleagues would be consulted. Flu planning was left on the risk register as planning happened early in the year and it helped to maintain focus by having the mechanism already in place. GGR suggested it be managed by changing the scoring to reflect the time of year.
32. PFI asked about networks not continuing with the vaccination programme for COVID19 to ensure patients were not put at risk. CMO informed members that SWAGGA and Care Enterprise had opted out and so arrangements had been made with LUHFT for any patients who wished to receive the vaccination to attend there by appointment as they had agreed to offer a service to these patients. In addition, there was the vaccination bus and clinics would be scheduled for communities which were harder to access.
33. MSM noted that there were multiple sites for people to book using the national booking system.

Action	Lead	Timescale	Status
Recommendations approved by the committee, namely: The Committee is asked to: • 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, Review the mitigations and progress. • Agrees that the risk scores accurately reflect the level of risk that the CCG is exposed to given current controls and assurances.			
Further actions required: • None identified			

D PERFORMANCE

D1 PRIMARY CARE COMMISSIONING COMMITTEE PERFORMANCE QUALITY AND CONTRACTS REPORT

34. SAL delivered the performance report noting that the report format had been revised to highlight risks at the beginning of the report with the detail held within the appendix.
35. Section 2.1.1 listed the temporary changes to GP contracts under the pandemic regulations which were in place until 30 June 2021. Section 2.2 showed the areas of high risk with Annual Health Checks for People with a LD at 67% with a target of 75%. Engagement with practices with zero achievement had been undertaken and it was noted that 70% had completed a learning disability review with the data only recording those who had undergone a full review i.e., 6.3% had not had a urine test and 29.5% had not had a cholesterol test.
36. 64.7% of people had undergone cervical screening and data from NHSE showed which practices had no screening activity. The CCG was engaging with practices to ensure screening continued. A meeting had been scheduled with Mersey Care Foundation Trust (MCFT) to progress learning disability reviews.
37. A Directed Enhanced Services (DES) paper to Performance and Quality Committee (PQC) showed the level of care homes reviews undertaken. The CCG engaged with the LNA and sent information to all practices to highlight the correct coding to be used. The CCG then ran an audit to identify what had taken place within the year.
38. Section 2.6 highlighted two outstanding Significant Event Analysis (SEA) which the quality team had constantly been engaging with. The next step would be to write to the practices formally asking for a response prior to issuing a contract query notice. The March position for Enhanced Access Service (EAS) was 86.9% with PC24 reverting to full delivery of service.
39. VAT noted that a contract query notice was not a formal element of the contract process and there was an error in the document as there were 3 partnership changes not 9 as listed.
40. MSM commented that one of the SEAs referred to an IG breach which was not mentioned at the IG committee and he requested that the information be sent to him. SAL agreed to forward the information on.

Action	Lead	Timescale	Status
Recommendations approved by the committee, namely: The Committee is asked to: • Notes the performance of the practices in delivery of the Primary Care performance. • Notes the performance of the CCG in delivery of Primary Care Medical commissioned services.			
Further actions required: • Forward IG breach information to MSM.	S Aldridge	ASAP	On June 21 agenda.

D2 PRIMARY CARE COMMISSIONING COMMITTEE FINANCE REPORT

41. MBA presented the finance report commenting that key changes and movements from the M9 report to highlight included: no or minimal change in most other areas:
    a. Delegated:
    - £298k additional COVID funding received/expenditure for PCN Clinical Director sessional increase from 0.25wte to 1.0wte for Jan-Mar 21.
    - Reduction in FOT for Core Contract payments (global sum etc.) due to Q4 list sizes being received lower than planned quarterly growth.

- (£196k) slippage against Other Costs, predominantly Interpretation costs in general practice during the first 6 months of the financial year with activity being significantly lower than in previous years.
- (£364k) slippage against the CCG Allocation of ARRS funding following confirmation of recruitment intentions and COVID19 overtime from PCN's for the final months of the year –during March PCNs had advised the CCG of revised plans/submitted higher claims and therefore the CCG anticipated the M12 position to report a near break-even position but still anticipate NHSE funding would not be required/lost.

b. LES
- £1,475k additional COVID19 funding for the Supporting General Practice fund – funds had been available to practices since January 21.
- (£206k) slippage against the Phlebotomy LQIS as practice sign up and activity was much lower than the levels expected upon the commencement of the LQIS earlier in the financial year.

c. Prescribing
- Minimal change but further slippage of approx. £100k between M9 and M11 identified predominantly against practice high volume vaccine prescribing.

d. List Size Growth (for information)
- added section 4.4 to highlight the averages used in setting financial planning growth assumptions by age group compared with the actual 20/21 growth.
- Main variance in terms of patient numbers is in 15-44 age group (could be assumed students but not stated in the paper).
- In context of Global Sum value, the lower growth was an annual reduction of approx. £500k. Any other costs based on list sizes could also be affected.

42. No or minimal change in most other areas.
43. MSM sought clarification on prescribing and high-volume vaccines listed in the report. Following the meeting this explanation was given:
    a. High Volume Vaccines - certain high-volume personally administered vaccines can be claimed by practices on an FP34D appendix form (influenza, typhoid, hepatitis A, hepatitis B, Pneumococcal and Meningococcal). The vaccines are generally administered over 3-4 winter months of the year with low activity in the remaining months of the year, the costs form part of the overall prescribing BSA position but we tend to report on them separately due to the seasonal trends in the data.
44. PJO responded that high volume vaccines were usually flu and large-scale vaccines (FP34D) and benefits were being shown from the catheter service managing the costs. There was quite a lot of 3 month prescribing in March which was a benefit in the financial year, and it was not replicated month on month. The downside was that across various aspects of activity people had not been in contact with their GP as an outcome of COVID19 and this was not necessarily a good thing, particularly for those with long term health conditions.
45. CMA asked if the posts recruited via the ARRS scheme were temporary posts to support during the pandemic or if they were additional posts managed through the scheme. MBA responded that the rules around the scheme meant that only specific posts could be charged to the programme and people had tried to be flexible in this through the year with severe rebuttals. SAL reported that there had been some additional capacity for short term agency staff in the last 3 months of the year. PCNs had recruited care navigators to support the vaccination programme with NHSE support.

Action	Lead	Timescale	Status
Recommendations approved by the committee, namely: The Committee is recommended to:			

• Note the contents of the report and the forecast financial position for 2020/21 as at February 2021 (Month 11)			
Further actions required: • None identified.			

E STRATEGY AND COMMISSIONING

46. No items.

F ANY OTHER BUSINESS

47. No other items of business were discussed. The meeting closed.
48. The next meeting will be held on Tuesday 15th June at 10.00am. Papers due by 4th June.