NHS
Liverpool
Clinical Commissioning Group

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

Report to:	**Governing Body**
Meeting Date:	

MINUTES OF THE MEETING OF

Primary Care Commissioning Committee

Date:	17 August 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 LCCG
Jane Lunt (JLU)	Director of Quality, Outcomes & Improvement (Chief Nurse)
Cathy Maddaford (CMA)	Non-Executive Nurse
Carol Rogers (CRO)	Lay Member for Patient & Public Involvement
In Attendance:	
Scott Aldridge (SAL)	Senior Performance Manager
Hayley Barker (HBA)	Administrator, LCCG
Rob Barnett (RBA)	LMC Secretary
Kellie Connor (KCO)	Senior Contracts Manager
Paula Finnerty (PFI)	GP Director
Stephanie Gallard (SGA)	GP Director
Paula Guest (PGU)	Head of Planning and Delivery – Out of Hospital
Stephen Hendry (SHE)	Head of Governance and Corporate Services
Dave Horsfield (DHO)	Director of Transformation Planning & Performance
Lindsay Humphreys (LHU) (for item B2)	Clinical Quality and Safety Manager
Peter Johnstone (PJO)	Head of Medicines Optimisation
Fiona Lemmens (FLE)	Chair LCCG
Cheryl Mould (CMO)	Director Provider Alliance
David O'Hagan (DOH)	GP Director
Jacqui Waterhouse (JWA)	Senior Programme Delivery Manager, Provider Alliance
Amanda Williams (AWI)	Deputy Director of Quality, Outcomes & Improvement
Debbie Richardson	Committee Secretary, Liverpool CCG
Apologies Received:	
Val Attwood (VAT)	Deputy Chief Contracting Officer

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.

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 RBA and FLE commented that as GP partners it was possible that items may be discussed which they 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. This was true of other GP members in attendance too whether they were partners or employees.

A4 MINUTES OF THE MEETING HELD ON 15 JUNE 2021.

4. The minutes of the previous meeting held on 15 June 2021 were accepted as an accurate record subject to the following amendment:
    1) Section E2 point 53 be revised to read "…a local 8th requirement which would be in two parts…"

A5 ACTION LOG

5. The action log was discussed with the following points made:
    - Item 1 – NHS England Updates, seek clarification from Tony Leo who may be the NHSE contact for the committee. DHO reported that he had contacted both Tom Knight and Tony Leo with no response to date. it was agreed that RBA would pick this up and report back to the next meeting. Item ongoing.
    - Item 2 – Primary Care Commissioning Committee Risk Register, Include flu vaccine risks within committee risk register. Completed, item closed.
    - Item 3 – Primary Care Commissioning Committee Risk Register, Consider patient engagement within risk register actions at Primary Care Recovery meeting. DHO stated that the primary care recovery meeting did not have a risk register however this would be discussed within the group. Item ongoing.
    - Item 4 - Process for assignment of an 'orphan' practice to a primary care network, explore dispute process with attention to concurrent or subsequent appeal submission. KCO reported that this had been discussed and it had been agreed to continue with the process with the concurrent approach being tested with a view to reviewing this approach should any issues arise. Item closed.
    - Item 5 - Process for assignment of an 'orphan' practice to a primary care network, clarify reference to Primary Care Network (PCN) Direct Enhanced Service (DES) specification within document. Complete, item closed.
    - Item 6 - Process for assignment of an 'orphan' practice to a primary care network, consider flow chart of process to accompany document. The flow chart was in progress and would be brought to the next meeting. Item ongoing.
    - Item 7 - Primary Care Commissioning Committee Performance Quality and Contracts Report, reflect on introducing a RAG rating system on appendix 2 of the report. Complete, item closed.

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

6. DHO presented the committee work plan for noting commenting that no changes had been made to the plan since the last meeting.
7. RBA highlighted the forthcoming transition to an Integrated Care System (ICS) asking about the impact this change could have on the work plan of the committee in its last two quarters if at all. JLE responded that discussions were underway to form a transition board and it would be the CCGs responsibility to ensure the ICS was in a fit state to take on its responsibilities from 1st April 2022. There was a need to assure Governing Body that everything was in place to transfer the functions across when the time came. Primary Care had been identified as a specific workstream within the transition process and work was underway preparing data ensuring all systems and processes were logged and recorded with negotiations continuing with the ICS team on the scale and scope of the functions with challenges around roles and responsibilities which it was hoped would be clarified shortly. It was hoped that Diane Johnson would be the programme director for the transition process with Accountable Officers from the CCGs taking a lead in a number of areas.
8. RBA queried whether there would be support from Primary Care to which JLE responded that there would be along with colleagues from NHS England (NHSE).

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

B UPDATES

B1 NHS ENGLAND UPDATES

9. As discussed within A5 - Action Log above.

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

B2 HEALTHWATCH REPORTING THEMES

10. LHU delivered a presentation on feedback received from Healthwatch to Liverpool CCGs quality team outlining the following:
11. LCCG Quality team hold quarterly meetings with Healthwatch to discuss feedback received and to triangulate information regarding commissioned providers and this included primary care. LCCG quality team also received ad hoc information and feedback from other health professionals and providers regarding Primary Care via other meetings or reported incidents.
12. LCCG quality team monitor significant event audits (SEA's) requested by NHS England and NHS Improvement (NHSE/I) following receipt of complaint(s) regarding a GP practice.
13. Complaint themes have usually been around access, care and treatment, admin and registration, and COVID-19 vaccination with access being the main cause of complaints received.
14. LHU went on to provide examples of feedback received from quarter 4 for each theme as listed here:

- ACCESS
- Many months on we are still having problems contacting x medical centre. We, my husband and I, have filled in forms on their website, they tell us to ring the surgery as we need to speak to a doctor. We ring the surgery wait on hold for half an hour then they cut us off! We have not had contact with our surgery for many months now. This is just not good enough. Can you help?
- Access to x surgery is also proving tricky particularly for those who work, as a patients told appointments cannot be given out after 3:00 PM and the online booking system has been disabled. We hear a lot about how difficult it can be to access this surgery and the difficulties disabling the Patient Access App has led to.
- A patient of x medical centre shared similar concerns as they have repeatedly tried to access a GP and being told to attend A&E or collect a blood form and have bloods taken .
- Two Farsi speaking patients of x health centre who both have ongoing health issues and have been unable to communicate with the GP practice. Both clients are in extreme pain/distress and having difficulties navigating the GP phone lines as they keep being cut off and when they are able to speak with staff, no interpreting services are offered. Both patients have been trying to speak with their GP unsuccessfully for several months and have presented at A&E with these issues and have both been referred back to the GP for further care.
- CARE AND TREATMENT
- The locum that spoke did not put on fresh gloves immediately before internally examining me. He had the same gloves on from when he collected me from the waiting area. He spoke to me, used a computer keyboard, explained what would happen and then physically examined me before checking me internally. I wish to make a complaint about this, it is not right and in the current climate of things it has me incredibly distressed.
- Patients advised to go to A&E for minor concerns and difficulties in requesting a physical exam from the doctor. The patient here had a period of trying to be seen by a GP for 18 weeks where several courses of treatment had been prescribed but failed to work. The family of the patient had difficulties arranging a home visit when the patient was discharged from hospital. The patient required blood tests/monitoring, medication and possibly a referral from the GP to assist with a blood transfusion but the family had many difficulties contacting the practice and accessing the care the family member needed at the time which led to significant delays in the patient getting the treatment they needed, the family member passed away at Aintree University Hospital in January.
- ADMIN AND REGISTRATION
- A couple of enquirers have advised about difficulties registering with the GP practice with no access to POA documents/ID being cited as a factor for these refusals despite guidance dictating these are not essential, some practices are asking for up to three forms of ID. This is being particularly problematic for those new to the UK who do not have bills in their names/POA.
- We have heard from a couple of families new to the area and students also inquiring about how they can access GP services in and around the city. There seems to be a lack of information for those coming from outside of the UK about where, when and how to register with a GP.
- Issues reported with delays in the transferring of medical records when patients have registered with a new GP, potentially another delay due to

COVID-19 as being heard more frequently and worrying for those shielding*/vulnerable who have been advised to register elsewhere during the pandemic as the new GP has no medical history*.

15. Many examples had been received with just a few shared here. PPE seemed to be a concern earlier in the pandemic although recently appeared less so with patients becoming more familiar with PPE. Patients expressed concern at being prescribed antibiotics without being seen by a GP.
16. When considering the complaints regarding the COVID-19 vaccinations the issues were largely outside the control of PCNs as the vaccination programme was operating under national guidance and so these were not included.
17. Healthwatch were asking practices to consider access for their patient population and to consider if the mode of access was right for the practice's patient cohort.
18. RBA commented that it was interesting and important to hear the view of patients using the service but there was no ability to respond as he was only hearing half the story and the other half was crucially important to understand. He would like to share some of this information with practices so they knew what was being said. Some of the comments needed to be followed up to understand if they were real or perceived issues. LHU responded that she understood RBAs comments and that's some of the complaints were being followed up. GGR commented that it was a good suggestion to share the feedback with practices.
19. DHO stated that the CCG was bringing themes through to the committee to give members an awareness of what Healthwatch were seeing, just to highlight the context. Access was the key concern coming through and this had been noted at the Primary Care Recovery Group which was looking at what the model needed to be.
20. JLU reported that Healthwatch were members of a number of CCG committees and their role was to undertake research publishing their findings on the Healthwatch website which the CCG looked at when considering the overall quality. As the system was in a world of change and with the development of PCNs moving into becoming more provider focussed links could be made with the Liverpool Network Alliance (LNA) to gather patient experiences to get a rounded perspective enabling the opportunity to explore ways to connect differently to gain more patient experience.
21. SGA noted that sometimes patients mentioned crushing chest pain as though it were a minor irritation and GPs frequently filtered out serious health concerns from those the patient dismissed. Also, sometimes going straight to A&E was the only medically safe option for the patient.
22. HDE noted that even if themes were perceived it was a concern as the perception was real to the person raising the concern.

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

C GOVERNANCE

C1 PRIMARY CARE COMMISSIONING COMMITTEE RISK REGISTER

23. DHO presented the Primary Care Commissioning Committee (PCCC) Risk Register (RR) reporting that a new risk had been added 0.13 which related to flu. There were no significant changes otherwise.
24. The new risk looked at a shortage of supply of product from the manufacture, more information would be included in future versions of the RR and new guidance became available recently about the flu programme and some mitigations were in place.
25. CMO noted that a decision was to be made on whether the Flu and COVID-19 vaccine

programmes should be brought together as a risk given the amount of overlap and duplication. This was for consideration at a future meeting.

Action	Lead	Timescale	Status
Recommendations approved by the committee, namely: The Committee is asked to: • 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; approve the recommendation to step down risk. • 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: • None identified			

C2 PRIMARY CARE COMMISSIONING COMMITTEE TERMS OF REFERENCE REVIEW

26. DHO presented the Primary Care Commissioning Committee (PCCC) Terms of Reference (TOR) noting that there was a minor change to a job title to be made. No other changes had been made.
27. MBA suggested section 2.7 which discussed scope would benefit from a discussion around estates noting that this committee was a good place to start those conversations. After a difficult period recently the Cheshire and Merseyside (C&M) strategic estates group (SEG) had been reestablished.
28. There were significant challenges and opportunities for the Primary Care estate and a forum was needed to start bringing items through for an audit trail and governance.
29. This could be added into the TOR.

Action	Lead	Timescale	Status
Recommendations approved by the committee, namely: The Committee is asked to: • Note the Terms of Reference			
Further actions required: • Revisit section 7 to include SEG outcomes.	D Horsfield / M Bakewell	Oct 21	On Oct 21 PCCC agenda.

D PERFORMANCE

D1 PRIMARY CARE COMMISSIONING COMMITTEE PERFORMANCE QUALITY AND CONTRACTS REPORT

30. DHO delivered the performance report noting that some Calculating Quality Reporting System (CQRS) data remained outstanding. The expectation was that this would come through as the months progressed however some of the data was from March. A more up to date position would be reported at the next meeting.
31. There was no massive change to Primary Care key performance indices (KPIs) for learning disability (LD) and severe mental illness (SMI) and this would be monitored. Contact had been made with practices so the CCG and the practice was aware of its performance and

how practices were progressing. The performance team was trying to support practices early in the cycle to avoid issues later in the year.

32. PCN DES requirements were not income protected. Monthly monitoring gave practices an opportunity to check more frequently as the year progressed. There was not a lot of data to support July KPI achievements and this would be populated as the year progressed.
33. The subcommittee had highlighted concerns around care home practices not clarifying responsibilities and there was a request to write to PCNs regarding their responsibilities which would be followed up outside the committee.
34. The Additional Roles Reimbursement Scheme (ARRS) had spent around £750,000 of £2.5M budget up to July and further claims were to be processed from Aintree PCN. This was a significant shortfall which was being monitored. There were no other major changes to note.
35. JLU drew members attention to two incidents that had been reported to StEIS (Transfer of Strategic Executive Information System). Work was underway with the relevant teams to understand the learning from the incidents to feedback into the COVID-19 programme with Public Health England (PHE) screening and immunisations teams.
36. Work was also underway with Primary Care teams following recent quality visits to utilize support where it was required which had been paused during the pandemic. The intention was to resurrect the programme more formally to support primary care teams.
37. CMA referred to the issue around safeguarding asking if there was any progress on the safeguarding appointment within the CCG and was informed that there had been no progress as yet with the post being advertised three times. The CCG was trying to be innovative in its approach to the recruitment and it was noted that safeguarding was not always obvious to GPs despite being rewarding and consideration was being given to the possibility of sharing the role across more than one GP.
38. RBA commented that the CCG may need to review what it was asking for and what the remuneration was noting that the role may not be as attractive as it might have been. RBA went on to state that another role was to be advertised shortly although the CCG would not be responsible for it. The role was for a Medical Examiner and the change in regulation regarding confirmation of death needed to be considered.
39. DHO drew members attention to the report, specifically the enhanced access service which had a utilization rate per 1000 population noting that high or low utilization were both of equal concern. The report showed low utilization rates for the last few months and feedback from practices was that utilization was not low and this appeared to be an anomaly within the data and was being investigated. KCO commented that discussions were underway with PC24 and that patients who required support with an interpreter were given a double appointment which appeared as if the resource was under-utilized and this needed to be factored in going forward.
40. RBA commented that it would be helpful if the report gave an indication of the number of practices not using the enhanced access service and that it would be interesting to see who used the interpreter service clarifying that the flu vaccine information included referred to the 2020-21 financial year.
41. CMO reported that a task and finish group had been set up to understand the DES requirements within care homes which included colleagues from Liverpool City Council, Mersey Care Foundation Trust (MCFT) and care home GP leads. The practice was happening but may not always be recorded and so the data was not there.

Action	Lead	Timescale	Status
Recommendations approved by the committee, namely: The Committee is asked to: • Note the performance of the practices in delivery of the Primary Care KPI performance.			

• Note the performance of the CCG in delivery of Primary Care Medical commissioned services.			
Further actions required: • None identified			

D2 PRIMARY CARE COMMISSIONING COMMITTEE FINANCE REPORT

42. MBA presented the finance report for Month 3 up to June recognising the different environment of H1 and H2. The report covered three key areas: delegated primary care, prescribing, and other primary care budgets.
43. As it was early in the financial year there was little data to report on. Key position for delegated primary care was a balanced position at that time. There was some variation in the budget year to date allocation with an overall balanced position and the team was working through the variation to understand the trend.
44. Section 4 included a potential overspend in prescribing. Colleagues were preparing the figures for month four reporting and an update would be provided to the next committee noting that the overspend was normal for this point in the year.
45. ARRS remained a potential area of volatility as the funding could only pay for roles that were in place as it was a reimbursement scheme. A workplace return was due at the end of August and it was assumed that the approach taken last year would be in place again this year. The scope and number of roles had expanded this year and further clarity was being sought.

Action	Lead	Timescale	Status
Recommendations approved by the committee, namely: The Committee is recommended to: • Note the contents of the report and the H1 forecast financial position for 2021/22 as at June 2021 (Month 3).			
Further actions required: • None identified.			

D3 PRIMARY CARE SERVICES RECOVERY

46. DHO delivered an update on Primary Care Services Recovery noting that the Primary Care Services Recovery Group had met that morning with colleagues from Liverpool University Hospital Foundation Trust (LUHFT) and MCFT. The data presented to the group was taken from the CIPHA (Combined Intelligence for Public Health Action) database and was rightly challenged. Work was underway to investigate the data further. The data showed that Liverpool had performed well from a primary care perspective with the number and type of appointments almost identical across Cheshire and Merseyside and Liverpool was not an outlier. The only area where Liverpool was an outlier was in that it had performed particularly well in the number of appointments provided within 7 days over the last 12 months. This was a good result.
47. The group was looking at what was the target operating model in general terms for primary care to recover back to. Previously it was approximately an 80:20 split between face to face and telephone/online/remote activity. This was not where we wanted to recover back to in terms of access types for balance however access was an important topic for patients and practices and there was no right answer here as each practice had to respond to its own population needs and wants. The data had shown that when the number of face-to-face appointments were reduced the number of appointments available within 7 days increased. It was difficult to find the right balance and the group was meeting to consider the data for Liverpool.
48. JWA confirmed that she had been supporting the work around access in general practice

and after engaging with NHSE's access improvement programme at least half of the practices in Liverpool were also actively involved on the programme, looking to see what the impact was. NHSE had been very accommodating holding a specific event for Liverpool practices which was encouraging. Those practices not able to join the Liverpool event were encouraged to access national programmes.

49. DOH commented that he supported the work on understanding the data at a granular level noting that it would add quality to the data.
50. DHO stated that this was a good point and it had been drilled home at the Primary Care Services Recovery Group meeting that morning. He went on to say that the group would be trying to understand the efficiency of the service from looking at the data. There was no easy answer and he was trying to get to a position where some support could be provided to practices to enable them to respond to patient needs.
51. PFI agreed saying it was interesting and tallied nicely with the Healthwatch feedback discussed earlier. PFI suggested it would be useful to have an update at the next meeting and she was happy to be involved in the group. DHO responded that there was a need for more clinicians on the group as they would offer another perspective on the data. SGA and DOH volunteered to be involved too.
52. JLE suggested asking the practices involved if they had patient groups and could they be involved too in order to understand the patient perspective.

Action	Lead	Timescale	Status
Recommendations approved by the committee, namely: • Note the update.			
Further actions required: • Expand the membership of the group as discussed.	D Horsfield	ASAP	On PCCC Oct 21 agenda.

E STRATEGY AND COMMISSIONING

E1 LQIS, DES, PRESCRIBING PROJECTS REPORT

- **GP INCOME FOR LES & GP SPEC FOR QUARTERS 3&4 2021-22**

53. PGU delivered an update on GP income for Local Enhanced Services (LES) and GP Specification for quarters 3 and 4 2021-22 noting that in May 2021, partway through quarter two, the committee approved a proposal reviewing LES and GP Specifications.
54. Payment by results had been reintroduced for the LES's as agreed however it was not felt to be the right time to introduce the GP specifications given the pressures primary care was under at the time. The GP specification had been aligned to the seven national priorities since the start of COVID-19. Operational pressures continued and two new DES's had been introduced around weight management and long covid. There was also the joint vaccination programme due to be introduced for flu and COVID-19 boosters.
55. For that reason the CCG felt it was not appropriate to introduce the new LES specifications in September and this had been agreed and if they could not be introduced by September then they would not be introduced for the rest of the year.
56. A group had been working on some metrics that could be introduced over an 18-month period for the GP specification. As contractual guidance and budget details were not yet available contract negotiations had not proceeded and the CCG wished to remain with funding allied to the seven priorities for the rest of the year. Should any additional priorities be introduced in the planning guidance these would be added into the matrix.
57. This would give practices a degree of protected income and it would support practices during the transition to the integrated care system.
58. RBA thanked PGU for the paper and comments noting that there was a lot going on in Primary Care at that point with a lot of pressures being faced by practices around ways of working and with continuing changes as well as the demands on practices regarding COVID-19 vaccinations. in addition, practices had just had the 12- to 15-year-old

vaccination programme added as well as the ongoing COVID-19 booster programme and the flu programme and it was unclear how these would operate together. As the system moved towards 2022 work needed to begin on introducing what changes the ICS wanted to introduce so that practices were aware of the proposed changes.

59. FLE supported the pragmatic approach asking what would happen with the move towards an ICS and how did it feed into the work accountable officers were doing to ensure the benefits of GP specifications were not lost. JLE responded that it was the responsibility of the ICS to ensure the benefits were not lost and the more time that could be given to practices to prepare earlier in the process the better; the concern about the urgency of the work to be undertaken had been expressed to the ICS and this had become time critical; there would be a combination of learning from all CCGs and what was required of primary care.
60. DOH commented that one saving grace of the bill was that it did not request anything of primary care and gave the ICS the opportunity to set out models which would work for primary care and it also gave the opportunity to destabilise what had worked. There was a need to keep as much stability as possible within primary care while acknowledging the desire for neighbourhood working with primary care led health services that worked for patients which would be a difficult challenge.
61. Members agreed to the proposal to delay implementation of the new LES service specifications until 2022-23; to retain the matrix of indicators associated with the CCG's GP specification, to support practices in recovery of service and protect this element of their income.
62. It was noted that guidance on planning and funding for 2022-23 had not yet been received, with this in mind it was anticipated that a Liverpool GP specification would be offered however the form and funding of this remained unclear.

Action	Lead	Timescale	Status
Recommendations approved by the committee, namely: The Committee is asked to: • Approve the proposal to delay implementation of the new LES service specifications until 2022-23. • Approve the proposal to retain the matrix of indicators associated with the CCG's GP specification, to support practices in recovery of service and protect this element of their income. • Note that guidance on planning and funding for 2022-23 has not yet been received. Whilst it is anticipated that a Liverpool GP specification will be offered, the form and funding of this remains unclear.			
Further actions required: • None identified.			

- **PCN PRESCRIBING CRES PROGRAMME**

63. MBA delivered an update on the PCN prescribing CRES programme noting that a paper had been presented to the committee previously regarding prescribing for PCNs however due to the pandemic the CCG had not been able to progress the scheme as it had originally intended.
64. Indications were that there would be an increase in CRES from H2 onwards and this was an area of opportunity as well as challenge to ensure the right incentives were in place and that there was capacity to make this happen.
65. The paper reiterated the scope of the structure and there was further work to be done to

reengage with the PCNs. The committee was being asked to reconfirm its support for the approach.

66. PJO referred to the previous conversation regarding primary care and GP capacity commenting that the CCG had a list of projects it wished to run over a number of years and it would discuss these with PCNs. It was aware that adding something too onerous would not be achievable at this time and this approach was hoping to achieve a lot with not too much impact.
67. RBA stated that while he was aware of the plans he expressed concern regarding the effect this would have on practice workloads noting that in theory with more pharmacists in place there would be the workforce to help support but everyone was still stretched. If the approach was adhered to there shouldn't be too many problems.
68. Members supported the programme.

Action	Lead	Timescale	Status
Recommendations approved by the committee, namely: The Committee is asked to: • To confirm support for a Primary Care Network CRES programme.			
Further actions required: • None identified.			

E2 HOMELESS HEALTH LES UPDATE

69. DHO delivered an update on Homeless Health noting that a previous local enhanced service (LES) in place was not sufficient to support what needed to happen to deliver a more rounded service for the city. Homeless health was a joint arrangement between the local authority and multiple organisations both in the community and acute along with primary care.
70. Work had been underway for some time to deliver a joined-up pathway for homeless people and there was still work to be done. A request was made via senior leadership team to continue with the existing LES while work on the pathway continued in order to maintain funding and services while moving towards more streamlined services. The proposal included a slight increase in costs which was listed within the outline business case.
71. RBA reported that he was aware of what had taken place and the current position commenting that it had been very difficult for the practices providing the services. The CCG had not gained any glory which the system would note during the transition to an ICS and this was due to the effects the discussions and changes had on practices delivering the services.
72. FLE asked what had the CCG learnt from the process and would the learning be transferred into the new organisation. DHO responded that a lot had been learnt with goalposts moving too much over the period and the CCG had expected to get to this point much quicker. This stage had been reached by the combined efforts of the group working together, there was no intention to criticise any practices approach and a lot of different players had been involved. A more robust conversation needed to happen looking at where the process began and how some of those involved had started at different points. It was in a better place now to move forward while not underestimating the task ahead. This was important to keep on the agenda as the organisation moved towards an ICS arrangement; there was a drive to maintain pace with a better understanding of what had to happen and where it was heading.
73. DOH suggested this was a flagship for a segmentation model and it was important to do what was possible here noting there was not much mention of the local authority within the paper asking how did the CCG contract for or describe within the provision how it expected services to work together as this may become more possible with the health care act and it would be good to plan for this. The paper did not mention quantity and it needed to be

accessible.

74. GGR asked how the proposal fed into the housing first initiative to which JLE responded that the local authority would be the organisation that could answer that question.
75. DHO commented that more points were discussed and he would share those outside the meeting.
76. JLE thanked colleagues for their input stating that it demonstrated that the CCG could listen and the learning should be shared across the other CCGs after reflection on what was needed next and what changed through the process to help others understand why things had changed. It may be a project that needed to take time to be considered.
77. CMO referred to the focus on homelessness within the vaccination programme noting the approach and numbers highlighted across Cheshire and Merseyside and the challenge of getting the population vaccinated. Reflection on how invested in these areas the services were would help with this.

Action	Lead	Timescale	Status
Recommendations approved by the committee, namely: The Committee is asked to: • Note the progress towards an equitable and integrated service response in primary care for the homeless health/complex lives patient cohort • Note the need for a stepped change in relation to delivery, and to joint commissioning, in order to ensure the continuation of safe services.			
Further actions required: • None identified.			

F FOR NOTING

78. No items.

G ANY OTHER BUSINESS

G1 SUMMARY OF BUSINESS/RISK REVIEW

79. GGR summarized the business of the committee. There were no items for escalation.

G2 ITEMS SHARED ACROSS COMMITTEES FOR NOTING

80. No items.

G3 ANY OTHER BUSINESS

81. No other items of business were discussed. The meeting closed.
82. The next meeting will be held on Tuesday 19th October at 10.00am. Papers due by 8th October.