NHS LIVERPOOL CLINICAL COMMISSIONING GROUP
PRIMARY CARE COMMISSIONING COMMITTEE
Minutes of meeting held on Tuesday 21ST JUNE 2016 at 10am
BOARDROOM, THE DEPARTMENT

Present:

Voting Members:

Dave Antrobus (DA)	Governing Body Lay Member – Patient Engagement (Chair)
Prof Maureen Williams (MW)	Lay Member for Governance/Deputy Chair of Governing Body
Dr Rosie Kaur (RK)	GP Governing Body Member/Vice Chair
Katherine Sheerin (KS)	Chief Officer
Simon Bowers (SB)	GP/Governing Body Member
Cheryl Mould (CM)	Primary Care Programme Director
Nadim Fazlani (NF)	GP Governing Body Chair
Paula Finnerty (PF)	GP – North Locality Chair

Non voting Members:

Moira Cain (MC)	Practice Nurse Governing Body Member
Tina Atkins (TA)	Governing Body Practice Manager Co-Opted Member

In attendance:

Tom Knight (TK)	Head of Primary Care – Direct Commissioning NHS England
Dr Adit Jain (AJ)	Out of Area GP Advisor
Peter Johnstone (PJ)	Transformational Change Manager – Prescribing
Colette Morris (CMo)	Locality Development Manager
Paula Jones	PA/NoteTaker

Apologies:

Tom Jackson (TJ)	Chief Finance Officer
Jane Lunt (JL)	Chief Nurse/Head of Quality
Rob Barnett (RB)	LMC Secretary
Sandra Davies (SD)	Director of Public Health
Sarah Thwaites (ST)	Healthwatch

Public: 2

PART 1: INTRODUCTIONS & APOLOGIES

The Chair welcomed everyone to the meeting and introductions were made. It was highlighted that the public were in attendance but any questions they wished to raise needed to be done via the public Governing Body meeting in writing. It was agreed that item 5.1 being the revised Terms of Reference for the Primary Care Commissioning Committee would be discussed as the first item on the agenda after the minutes and matters arising.

1.1 DECLARATIONS OF INTEREST

There were no declarations of interest raised specific to the agenda.

1.2 MINUTES AND ACTIONS FROM PREVIOUS MEETING ON 17TH MAY 2016

The minutes of the 17th May 2016 were approved as accurate records of the discussions which had taken place subject to the following changes:

- DA requested clarification on the title of Dr Arvind Madan who was mentioned in the GP Practice Forward View. It was noted that the minutes would be amended to include his title of GP Director of Primary Care, NHS England.

1.3 MATTERS ARISING NOT ALREADY ON THE AGENDA – Verbal

1.3.1 Action Point One – it was noted the Service Level Agreement with NHS England would be ready for the next meeting of the Primary Care Commissioning Committee.

1.3.2 Action Point Two – it was noted that the action around the ICE system being reviewed to ensure transfer of key tests to support the delivery of key performance indicators was ongoing.

1.3.3 Action Point Three – TK noted that recovery plan and timescales re Primary Care Support Services were to be discussed verbally on the agenda and he had slides that he could send through.

1.3.4 Action Point Four – it was noted that CM and RB had sent a communication out to practices on Primary Care Support Services.

1.3.5 Action Point Five – it was noted that the Primary Care Strategy would be shared in a couple of months.

The Primary Care Commissioning Committee:

- **Noted the issues raised under matters arising.**

PART 2: UPDATES

2.1 PRIMARY CARE SUPPORT SERVICES – VERBAL

TK updated the Primary Care Commissioning Committee as promised at the last meeting:

- Locally TK was in contact with RB on a regular basis, there were still local issues re the ordering of medical supplies and other operational matters which had been escalated. He had spoken to the Practice Managers relating to the issues, particularly around medical records, ordering of supplies, and confirmed these concerns had been escalated to Capita and NHS England Central Management Team. Communications had been sent out to practices noting that there had been improvements nationally but he noted that there were still significant local issues.

- Capita had submitted an improvement plan on 9th June 2016 to the Stakeholder Forum which included supplies and ophthalmic payments.

- The Medical Records pilot in West Yorkshire was ongoing. Of the 23 indicators 19 had now been met so the pilot was nearing completion. Contingency had been put in place with Citysprint and as at 9th June 2016 954,000 records were being transported/moving in the system and 464,000 were in progress which showed improvement.

- With regards to the movement of medical supplies Citysprint were now dealing with the backlog so there was some improvement.

- With regards to stock forecasting Capita now had the information they did not have prior to contract being put in place.

- There were 12 potential information governance issues/breaches which had occurred.

- Opthalmic payments – this was a national issue which was being looked at.

- Nationally improvements were being seen in delivery across all key areas. 90% of calls were being answered under two minutes nationally.

- TK was now responding to RB's queries and escalating them to the Regional Manager.

TA re-iterated concerns about movements of records/transfer of records given the changes to the student population over the summer and start of the new term in the autumn. The problem with the GMS1 forms was now resolved.

NF noted that the spreadsheet now sent to practices around finances/rent/reinvestment was extremely complicated and wondered if this was the same as with other Primary Care contractors. TK responded that the finance process was complicated and the Finance Team had had to work through the process with Capita.

KS raised queries over the governance structure within NHS England for the contract with Capita. TK responded that Capital met regularly with NHS England but the only point of involvement for CCG members was via the Stakeholder Forum, there were no end users on the Board. He agreed to circulate the slides from the meeting with Capita. KS noted that Capita needed to be aware of the feedback from practices first hand. TA noted that Capita did attend the National Student Health Association meetings where Liverpool CCG had representation so could feed this back to the Primary Care Commissioning Committee.

CM noted that RB had asked her to mention delays in acquiring NHS numbers for patients. TK assured that the pilot system would become the permanent system and would be a good and effective system.

The Primary Care Commissioning Committee:

- **Noted the verbal update.**

2.2 FEEDBACK FROM SUB-COMMITTEES – REPORT NO: PCCC 13-16

- **Medicines Optimisation Sub-Committee – PCCC 13a-16**

PJ fedback to the Primary Care Commissioning Committee from the Medicines Optimisation Sub-Committee on 10th June 2016 as it had now been agreed under the amended Terms of Reference that this sub-committee would report into Primary Care Commissioning Committee:

- ✓ Due to changes in demographics and Long Term Conditions management, 5 Year Projections indicated there would be a 6% increase which would impact severely on the CCG's finances therefore the sub-committee was looking at ways to take out inappropriate prescribing and costs. The 5 Year Plan had been received favourably at the Governing Body Development Session. Changes would be communicated at the marketplace event and shared with practices.

- ✓ Concerns over Secondary Care Prescribing – NOAC prescribing was higher than the guidelines laid out by NICE and costs passed on to Primary Care at discharge were substantially higher. The Clinical Leads were to raise this with the secondary care consultants.

- ✓ The Minor Ailments Scheme was to be re-designed.

- ✓ The Sub-Committee was looking at the supply of appliances, blood glucose monitoring and sip feeds through general practice via FP10 with the aim to eliminate inappropriate costs. SB asked if podiatrist prescribing had been considered and PJ noted that the cost involved did not justify the focus. KS noted the need for engagement with trusts and asked if the Area Medicines Management Committee could be of help, PJ noted that he was close to the Area Medicines Management Committee and there was a strong position supported by NICE Guidance. NF added that NICE Guidance was not binding and it was the clinical pathway that needed to be scrutinised. Possibly a risk share agreement was required. CM agreed to ensure that PJ was tied in to the discussions taking place locally around the re-design of long term conditions.

The Primary Care Commissioning Committee:

- **Considered the report and recommendations from the Sub-Committees**

PART 3: STRATEGY & COMMISSIONG

3.1 LIVERPOOL QUALITY IMPROVEMENT SCHEME 2016/17 (GP SPECIFICATION) DELIVERY AND MONITORING PLANS – REPORT NO: PCCC 14-16

CMo presented a paper to the Primary Care Commissioning Committee which provided a summary of the key themes from the GP Specification Practice Implementation Plans for 2016/17 and which presented the monitoring arrangements to ensure delivery of the specification. In November 2015 the Primary Care Commissioning Committee had received a paper on the changes and proposed additional investment in the GP Specification. This had subsequently been approved by the Governing Body in February 2016. All practices had then been asked to submit their plans for how they would approach the GP Specification and their implementation of the additional investment and identification of their requirements for delivery. The Practice Implementation Plans were referred to in section 5 of the paper. 54 practices were planning to improve access by increasing the number of sessions delivered by a GP. To deliver vaccinations and immunisations staff were to be fully trained, systems to be put in place to monitor uptake rates and there needed to be access to historical records through EMS to reconcile records. This was a new area for General Practice.

The GP Specification was about improving quality in Primary Care therefore there would be a series of quarterly workshops from July 2016 for each of the three Localities.

Monitoring would be on two levels: requirement at practice level to monitor performance against the GP Specification and at CCG level from the Primary Care Quality Team with a focus monthly on the priority areas of access, ACS, prescribing and Outpatient attendances. Quarterly all Primary Care Quality Framework indicators would be reviewed and an update report would be brought quarterly to the Primary Care Commissioning Committee.

TK asked how this would fit with the workforce challenges of the General Practice Forward View. NF responded that at a future meeting CM would be bringing our response to the General Practice Forward View particularly relating to workforce which

would be looking at initiatives such as the Physician's Associate etc.

KS commented that this was an excellent paper. £5.6m was lot of money and it was good to focus on access and outpatients. She asked what lessons had been learnt. CMo responded that this was still very early on in the process however it had been noted that practices looking at their telephone triage systems and processes had come across similar issues although there was no one universal process to be adopted.

MC noted that there was still variation between practices/staffing and practices could not be forced to follow a particular format. KS responded that the Specification was designed on outcomes rather than inputs. RK added that it was important to use the existing skill mix in a different way.

CM updated the Primary Care Commissioning Committee that the CCG was working with the GP Provider Organisation and the Local Medical Committee looking at the issue of workforce and that there was a Members' event taking place on 13th July 2016 dedicated to workforce and new ways of working/utilising skill mix. RK stressed that a solution needed to be in place before the end of the year and that we needed to be pro active rather than reactive.

MW asked what sanctions could be utilised and noted that the process needed to be more robust. She also noted that the Appeals process was not mentioned which was required and referred to variation within practices around vaccinations and immunisations. CM responded to MW's comments, noting that this was part of the validation process and this process would be formalised in a few months' time.

PF commented that a template for practices to complete the quality information would be helpful, CM responded that a template would be pre-populated as a great deal of information was already available.

KS commented that it would be useful to look back now and gather intelligence from the last 5 years and identify themes and trends.

The Primary Care Commissioning Committee:

- **Notes the content of this paper**

- **Supported the approach to monitoring arrangements put in place to ensure delivery of the GP specification 2016/17**
- **Noted that quarterly updates would be brought to the Primary Care Commissioning Committee on outcomes.**

3.2 7 DAY WORKING UPDATE –VERBAL

RK gave a verbal update to the Primary Care Commissioning Committee on 7 Day Working:

- Extended access to Primary Care 7 days a week 8am to 8pm.
- Footprint identified of practices pilot with two sites one in city centre and one in the North of the city.
- Members' event had been held in May.
- To go live 25th July 2016 for the practices included in the pilot.
- Focus on the practices in the vicinity of Mersey View which was closing in July.
- Weekly operational meetings were taking place focussing on the implementation (including UC24 and Liverpool Community Health).

TA asked how many practices had been included in the pilot? She noted the City Centre Neighbourhood's concerns also. The reply was that 38 had been invited and 8 had signed up.

The Primary Care Commissioning Committee:

- **Noted the verbal update.**

PART 4: PERFORMANCE

4.1 PRIMARY CARE COMMISSIONING COMMITTEE PERFORMANCE REPORT - REPORT NO: PCCC 15-16

RK presented the key aspects of the CCG's performance in delivery of Primary Care Medical Services quality, performance and financial targets for 2015/16. She highlighted:

- Local Quality Premium (different for 2015/16 to 2016/17 but would remain on the work programmes to reduce variation across the city):

    - Physical Health Checks for people with mental health conditions, the target was for the bottom 25 practices to be delivering 40.7% but final year achievement was 29.3%. City wide there had been improvement from 39% to 40% and was only 300 patients short so next year should see an improvement. It was also noted that this was a composite indicator and blood tests appeared to be an issue due to location. The indicator needed to be reviewed for the current year with this being taken into consideration.

    - Patients with Diabetes who have had all 9 Care Processes in the previous 12 months – the target was for the bottom quartile practices to be delivering 63.8% and the final year achievement was 43.8%. Overall performance had improved from 57% to 64%. As with physical health checks this was a composite indicator and let down by issues over urine bottles' delivery and coding.

- There had been a slight improvement in in hour A&E attendances and the rate of ACS admissions had decreased slightly in 2015/16.

- GP Specification outpatient referrals – these had reduced year on year since the start of the GP Specification but had remained static 2015/16.

- Alcohol Brief Interventions – at the end of May 2016 the proportion of patients drinking over recommended levels who had been offered a brief intervention had decreased slightly to 89.48% from the baseline of 90.75%. DA noted that this was rated as yellow and yet had been red in the previous report on Delivery and Monitoring of the Local Quality Improvement Scheme (GP Specification) for 2016/17. CM explained that this was due to the baseline and available data. SB observed that this was due in part to correct monitoring and assessment of patients paying dividends.

NF referred to Liverpool's performance with A&E attendances and noted that Liverpool was performing better than the rest of the country in that the levels were flat compared to increases elsewhere. In response to a query from KS re the need for

assurances around delivery of the GP Specification given the additional investment, CM noted that best practice needed to be shared and practices needed to work more collaboratively with other providers in order to achieve targets.

PJ continued to talk about prescribing performance:

- Antibiotic prescribing was improving (15% reduction) which showed the messages were being received in practices.

- Key Performance Indicators not being achieved included reducing numbers of dementia patients prescribed anti-psychotic drugs which was linked to consultant prescribing and required clinical discussion with the patient in general practice.

- MC observed that there were 69 Non Medical Prescribers in Liverpool compared with 3 in Sefton and they regularly reviewed antibiotic prescribing via the evidence available.

CM continued to talk about the Care Quality Commission inspection of General Practice reports and contract performance:

- In July a report would be pulled together for the Primary Care Quality Sub-Committee looking at all the practices inspected and identifying key themes.

- A small number of practices did not have Patient Participation Groups and were failing to submit their Friends & Family Test figures. The Primary Care Team were offering support to practices, also re Friends & Family there were possible coding issues and the CCG was liaising with the Local Medical Committee to contact practices. The approach to contract monitoring was to be referred to the Finance Procurement & Contracting Committee.

KS noted that this was a good report. She referred to the Bandings which varied in percentages of practices as they were updated from the previous year which made it more difficult for practices to achieve Band A in areas such as prevalence. RK responded that prevalence had been discussed at the Long Term Conditions meeting. CM noted that bandings across all the key performance indicators were being discussed at the GP Specification meetings.

The Primary Care Commissioning Committee:

- **Noted the performance of the CCG in delivery of Primary Care Medical commissioned services and the recovery actions taken to improve performance**

PART 5: GOVERNANCE

5.1 AMENDED TERMS OF REFERENCE FOR PRIMARY CARE COMMISSIONING COMMMITTEE - REPORT NO: PCCC 16-16

This item was discussed first on the agenda after the minutes and matters arising. CM noted that these needed to be approved first and if approved it would enable the Medicines Optimisation Sub-Committee to report to the Primary Care Commissioning Committee. This was the key amendment. MW reminded the Primary Care Commissioning Committee that the revised, approved Terms of Reference would need to included in the update given to the Governing Body on this meeting. DA referred to the frequency of meetings which had been changed following feedback from Mersey Internal Audit Agency. It was agreed that the proposed wording be changed "meeting as and when necessary but a minimum of six times over the 12 month period".

The Primary Care Commissioning Committee:

- **Approved the revised Terms of Reference subject to the alternation of the frequency of meetings to as and when necessary but a minimum of six times over the 12 month period.**

5.2 PRIMARY CARE COMMISSIONING COMMITTEE RISK REGISTER UPDATE JUNE 2016 - REPORT NO: PCCC 17-16

DA referred to the update paper on changes to the Risk Register for June 2016 and noted that it was now easier to understand. CM noted that she had met the previous week with the Corporate Services Manager and had discussed the APMS procurement risk which should be removed from the Primary Care Risk Register but had been left in for the time being. MW felt that it should remain on the Risk Register to maintain awareness of how it was being managed and dealt with and to note that it was being referred to the Finance Procurement & Contracting Committee risk register and was also on the Corporate Risk Register.

DA referred to risks Co-Com 20 and 21 which were red under current risk accepted but had in fact been accepted and this was confirmed by CM.

TA referred to the safe transfer of medical records and CM confirmed that all risks around Primary Care Support Services had been amalgamated into the one risk.

The Primary Care Commissioning Committee:

- **Noted the content of the report and the mitigating actions.**

6. ANY OTHER BUSINESS

None

7. DATE AND TIME OF NEXT MEETING

The next meeting was scheduled for Tuesday 19th July 2016 – 10am to 12pm Boardroom The Department, however this clashed with the Validation Committee and so as most people would be unavailable it would be cancelled and the next meeting would take place on 16th August 2016.