NHS Liverpool Clinical Commissioning Group

NHS LIVERPOOL CLINICAL COMMISSIONING GROUP
PRIMARY CARE COMMISSIONING COMMITTEE
TUESDAY 20th DECEMBER 2016 AT 10AM to 12PM
BOARDROOM THE DEPARTMENT

A G E N D A

Part 1: Introductions and Apologies

1.1	Declarations of Interest	***All***
1.2	Minutes and actions from previous meeting on 18th October 2016	**All**
1.3	Matters Arising	

Part 2: Updates

2.1	Primary Care Support Services	**Verbal Tom Knight/Glenn Coleman**
2.2	Feedback from Sub-Committees:	**PCCC 30-16**
	• Medicines Optimisation Sub-Committee November/December 2016	**PCCC 30a-16 Peter Johnstone**
	• Primary Care Quality Sub-Committee (25.10.16)	**PCCC 30b-16 Jacqui Waterhouse**

Part 3: Strategy & Commissioning

3.1	No items	

Part 4: Performance

4.1	Primary Care Performance Report	**PCCC 31-16 Rosie Kaur/ Cheryl Mould**

Part 5: Governance

5.1	Risk Register	**PCCC 32-16 Cheryl Mould**

6. Any Other Business **ALL**

7. Date and time of next meeting:

Tuesday 17th January 2017 Informal Meeting – Boardroom The Department
Tuesday 21st February 2017 Formal Meeting - Boardroom The Department

NHS
Liverpool
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Report no: PCCC 30-16

NHS LIVERPOOL CLINICAL COMMISSIONING GROUP
PRIMARY CARE COMMISSIONING COMMITTEE

TUESDAY 20TH DECEMBER 2016

Title of Report	Feedback from Sub-Committees
Lead Governor	Rosie Kaur
Senior Management Team Lead	Cheryl Mould, Primary Care Programme Director
Report Author(s)	Cheryl Mould, Primary Care Programme Director Peter Johnstone, Primary Care Development Manager
Summary	The purpose of this paper is to present the key issues discussed, risks identified and mitigating actions agreed at the sub-committees reporting to the Primary Care Commissioning Committee This will ensure that the Primary Care Commissioning Committee is fully engaged with the work of sib-committees, and reflects sound governance and decision making arrangements for the CCG.
Recommendation	That Liverpool CCG Primary Care Commissioning Committee: ➢ Considers the report and recommendations from the Sub-Committees
Relevant Standards or targets	

LIVERPOOL CCG CORPORATE GOVERNANCE TEMPLATE – SUB-COMMITTEE MINUTES

Sub-Committee: Medicines Optimisation	**Meeting Date**: 4th November 2016	**Chair:** Dr Shamim Rose
Key issues:	**Risks Identified:**	**Mitigating Actions:**
1. Prescribing – effective use of resources.	Effective delivery of phase 1 – rapid savings	• Annualised savings of £2M in place • Estimated in year savings of £1M • Further savings plan agreed for Nov / Dec 2016
	Prescribing of drugs not included in drug tariff – high cost products being issued	• MMT changing prescriptions retrospectively and implementing OptimiseRx interventions • MOC working with LPC to agree appropriate actions
2. Transfer of prescribing from secondary care	Multiple requests for GPs to prescribe Irrigation Pumps – outside GP experience and competence	• MOC guidance to all practices not to prescribe • MOC to write to gastroenterology / urology requesting pumps are supplied by trusts if considered necessary

Recommendations to NHS Liverpool CCG Primary Care Commissioning Committee:
1. To note the key issues and risks.

LIVERPOOL CCG CORPORATE GOVERNANCE TEMPLATE – SUB-COMMITTEE MINUTES

Sub-Committee: Medicines Optimisation	**Meeting Date**: 2nd December 2016	**Chair:** Dr Jamie Hampson
Key issues:	**Risks Identified:**	**Mitigating Actions:**
1. Prescribing – effective use of resources.	In year delivery of prescribing budget	• Phase 1 (rapid savings project) extended until end of March 2017 • Wave 1 and 2 savings reviewed to ensure maximum impact • Wave 3 savings plan in development for delivery from January • High impact rebates put in place
	Long term / sustainable savings project	• Implementation of Phase 2 moved back from January • 3 of 9 pilot sites to go ahead
	Delivery of prescribing KPI for GP specification	• Focus area for January locality meeting • Guidance on review & withdrawal in development
2. Non-medical prescribers	Governance of LCH non-medical prescribers	• Detail of LCH NMP governance process presented to MOC - Monthly audit of data - Challenger to outliers and unusual prescribing - Monitoring of controlled drugs - Use of TARGET toolkit for antibiotic prescribing

Recommendations to NHS Liverpool CCG Primary Care Commissioning Committee:
1. To note the key issues and risks.

Committee: Primary Care Quality Sub-Committee	**Meeting Date**: **25th October 2016**	**Chair:** Dr Nadim Fazlani

Key issues:	**Risks Identified:**	**Mitigating Actions:**
1. Locality Clinical Workshops – addresses variation and improving quality.	• That the CCG Practice Leads do not attend/feedback to their practice members.	• Workshops provide an update from the CCG, any relevant service re-design and clear focus on clinical areas. • Information and presentation are sent to all CCG Practice Leads to disseminate to practice staff.
2. Liverpool Quality Improvement Scheme – Minor Surgery	• That the clinical model does not align with dermatology re-design. • That the clinical model does not manage the increased demand.	• A full review of the current scheme is undertaken and ensure there is no duplication in the dermatology pathway. • Local Enhanced Services Group oversee the clinical model.
3. Digital Roadmap – Primary Care Transformation	• That the Primary Care Digital Transformation outcomes are not realised.	• A Clear plan is provided as part of the GP Practice Forward View plans describing the aims and outcomes of digital transformation

Recommendations to NHS Liverpool CCG Primary Care Commissioning Committee:
1. To note the key issues and risks.

NHS
Liverpool
Clinical Commissioning Group

Report no: PCCC 31-16

NHS LIVERPOOL CLINICAL COMMISSIONING GROUP
PRIMARY CARE COMMMISSIONING COMMITTEE

TUESDAY 20TH DECEMBER 2016

Title of Report	CCG Primary Care Commissioning Committee Performance report
Lead Governor	Katherine Sheerin, Chief Officer
Senior Management Team Lead	Cheryl Mould, Primary Care Programme Director
Report Author	Jacqui Waterhouse, Locality Manager
Summary	The purpose of this paper is to report to the Primary Care Commissioning Committee key aspects of the CCG's performance in delivery of Primary Care Medical services quality, performance and financial targets for 2016/17.
Recommendation	That the Primary Care Commissioning Committee: ➢ Notes the performance of the CCG in delivery of Primary Care Medical commissioned services and the recovery actions taken to improve performance
Relevant standards/targets	NHS Outcomes Framework 2015/16; The *Forward View* Into Action: Planning for 2015/16; CCG Assurance Framework 2015/16

LIVERPOOL CCG PRIMARY CARE COMMISSIONING COMMITTEE PERFORMANCE REPORT

1. PURPOSE

The purpose of this paper is to report to the Primary Care Commissioning Committee key aspects of the CCG's performance in delivery of Primary Care Medical services quality, performance and financial targets for 2016/17.

2. RECOMMENDATIONS

That Liverpool CCG Primary Care Commissioning Committee:

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

3. BACKGROUND

The CCG is held to account by NHS England for performance and delivery of Primary Care Medical services. Since 1st April 2015 the CCG took delegated commissioning responsibilities for Primary Care Medical Services. The delegated agreement sets out the functions that have been delegated and included the commissioning of local quality improvement schemes, delivery and commissioning of Directed Enhanced Services, delegated funds and premises.

The CCG has established robust governance processes and committee structures in order to monitor performance and provide assurance to the Governing Body that key risks to the organisation are being identified and effectively managed.

The Performance Report for the financial year 2016/17 will report on all aspects of Primary Care Medical Services to assure the committee and Governing Body that the services we commission are delivering the required quality standards and that any risks and issues relating to service quality and patient safety are identified, with positive action taken to rectify.

The report details the assurance measures to deliver the national performance measures detailed in the Governing Body reports, core

contract requirements and locally commissioned Primary Care Medical services.

The report is based on the published and validated data available as at the end of October 2016 and will be refreshed bi-monthly.

4. REPORT OUTCOME

This report provides performance information against the following areas:

Area	Target	Current Performance
National Performance Measures		
Local Quality Premium – Overall experience of making a GP appointment:	Either achieve 85% respondents who said they had a good experience of making an appointment or 3% increase on percentage of respondents who said they had a good experience	**Red** 77% (Jan-March 16 data, published July 16)
Local Quality Premium – Increase in the proportion of GP referrals made by e-referrals: either 80% by March 2017 and year on year increase or March 2017 performance to exceed March 2016 by 20%	Either 80% by March 2017 and year on year increase or March 2017 performance to exceed March 2016 by 20%	**Red** 56% Down (decrease in performance) by 2% on September report
Local Quality Premium – **Antimicrobial resistance (AMR) Improving antibiotic prescribing in primary care:** Part 1		**Green** 1.223 Down

4% reduction on 1314 in the number of antibiotics prescribed in primary care Target less than 1.264 per STAR PU (items)		(improvement in performance) from 1.239
Local Quality Premium – Part 2 number of co-amoxiclav, cephalosporins and quinolones as a proportion of the total number of antibiotics prescribed to be equal to or lower than 10%		**Green** 8.60% Down (improvement in performance from 8.70%)
Local Quality Improvement Schemes – GP Specification		
The delivery of 80 appointments per 1,000 weighted practice population		78 Practices are delivering 80 appointments per 1,000 weighted practice population
GP Specification ACS Admissions	Band A <7.30 rate per 1,000 weighted population	Current: 8.33 Baseline: 8.24
GP Specification Outpatients Referrals	Band A <63.48 rate per 1,000 weighted population	Current: 68.53 Baseline: 67.65
The percentage of patients aged 18 years and over who have had the alcohol consumption recorded in the last 3 years	Band A 67%	Current: 64.65% Baseline: 63.23%
The percentage of patients who are 18+ who have alcohol intake recorded over indicated levels who have been offered brief interventions	Band A 96.5%	Current: 92.64% Baseline: 93.57%

Early detection: Percentage of registered patients aged 40+ on the CHD register	Band A greater than 6.84%	Current: 7.68% Baseline: 7.65%
Early detection: Percentage of registered patients aged 40+ on the Heart Failure register	Band A greater than 1.10%	Current: 1.88% Baseline: 1.82%
Early detection: Percentage of registered patients aged 40+ on the Stroke register	Band A greater than 2.89%	Current: 3.83% Baseline: 3.76%
Early detection: Percentage of registered patients aged 40+ on the Atrial Fibrillation register	Band A greater than 2.29%	Current: 3.73% Baseline: 3.59%
Early detection: Percentage of registered patients aged 40+ on the Hypertension register	Band A greater than 24.16%	Current: 29.16% Baseline: 28.85%
Early detection: Percentage of registered patients aged 40+ on the COPD register	Band A greater than 4.22%	Current: 6.90% Baseline: 6.68%
Early detection: Percentage of registered patients aged 40+ on the Diabetes register	Band A greater than 7.89%	Current: 10.55% Baseline: 9.93%
Combined percentage achievement for DTaP/IPV/Hib at 1 year, MMR1, PCV booster, Hib/MenC at 2 years	Band A 95%	Current: 92.32% Baseline: 92.96%
Combined percentage achievement for MMR2 at 5 years and DTaP/IPV preschool booster	Band A 95%	Current: 88.85% Baseline: 88.91%
Medicines Management the percentage of patients on Warfarin who have had an INR result in the last 4 months	Greater than or equal to 90%	Current: 94.77% Baseline: 96.33%

Medicines Management the percentage of patients on Lithium who have had their Lithium levels recorded in the last 4 months	Greater than or equal to 90%	Current: 80.09% Baseline: 92.08%
Medicines Management the percentage of patients on Lithium prescribed a Thiazide	Less than or equals to 1.5%	Current: 1.02% Baseline: 1.40%
Medicines Management the percentage of Dementia patients prescribed an Anti-psychotic	Less than or equals to 5%	Current: 12.61% Baseline: 11.09%
Medicines Management the percentage of Asthma patients prescribed a non-cardio specific beta blocker	Less than or equals to 0.2%	Current: 0.83% Baseline: 0.73%
Medicines Management the percentage of Addison disease patients prescribed a Thiazide	Less than or equals to 1%	Current: 1.43% Baseline: 1.46%
Medicines Management Antibiotic Prescribing: 5% reduction against the practice's 2015-16 baseline or achievement of national average	National average 48.54	Current: 50.19 Baseline: 51.18
A target of 5% reduction in costs for a combination of pregabalin/oxycodone/buprenorphine patches/fentanyl	£3, 029.06	Current: £3,322.21 Baseline: £3,188.00
Core Contract Requirements		
GP contractual requirement – Practices having a Patient Participation Group	100% of practices to achieve by March 2016	Informally all practices have and continue to have a PPG as per the minimum requirements. This is report via e-dec closing

		date for which is the 23rd Dec 16.
GP contractual requirement - GP Friends and Family Test	100% of practices to submit each month	At the end of September 28 practices failed to submit their figures by the deadline, this is an increase from the 27 practices who failed to submit in the last reporting period.
GP contractual requirement – Patients to have access to their electronic medical records	100% of practices to activate by March 2016	All practices achieved this.
GP contractual requirement – Practices to publish the average earnings of GPs onto their website or NHS Choices	100% of practices to activate by March 2016	All practices completed this contractual requirement.
Finance		
Finance Budget	Achieve balanced budget	The current 2016/17 position as at the 30th September 2016 in respect of delegated Primary Care budgets was an overspend of £2.1m on a total budget of £61.7m. Prescribing budget was an

		overspend of £2.1m on a total budget of £87.5m

5. NATIONAL PERFORMANCE MEASURES

NHS Liverpool CCG is committed to ensuring that patient rights under the NHS Constitution are consistently upheld. National Performance Measures are reflective of the key priority areas detailed in the NHS Outcomes Framework 2015/16 and include measurements against Quality (including Safety, Effectiveness and Patient Experience) and Resources (including Finance, Capability and Capacity). In addition to analysing local performance against these indicators, CCGs are expected to achieve improvements against indicators across the five domains as detailed in the NHS Outcomes Framework and NHS Operational Planning Measures 2015/16 which represent the high-level national outcomes the NHS is expected to be aiming to improve. Each month the Governing Body are provided with an updated Performance Report.

5.1 NHS Constitution – Experience of General Practice

5.1.1 General Practice Patient Survey

Indicator	Narrative
Overall experience of making a GP appointment: either achieve 85% respondents who said they had a good experience of making an appointment or 3% increase on percentage of respondents who said they had a good experience	**Red** 77% No update during this period
There has been a slight increase between the January 2016 (76%) report and the latest report published July 16. Since the last patient survey report LCCG has increased the number of appointments that practices provide per 1,000 weighted patients each week. This is an extra 5,708 appointments per week, 296,830 annually.	

Access to General Practice is considered to be a key ingredient of high quality healthcare and its importance to the public is recognised and reflected in the national patient survey. During 2014/15 LCCG practices took part in a programme of 'insight' work which identified the following common issues:

- Inability to make appointments in advance;
- No continuity of seeing the same GP (especially for patients with long term conditions);
- Having to telephone multiple times to get through to practice staff;
- Same day appointments all booked once able to get through;
- Inability to book online;
- Wanting to be seen within 48hrs;
- Uncomfortable with describing symptoms to non-clinician

Analysis of the above common themes resulted in a number of recommendations for practices to implement and improve the patient experience of making a GP appointment (for example, sharing the learning from better performing practices on how systems and staff are organised, reduction of DNAs and reviews telephony infrastructure). Some of these recommendations were (at that time) attached to specific practices although moving forward for 2016/17 and 2017/18 the aim is to have a 'suite' of proposed initiatives and examples of good practice to roll out to all LCCG practices. In terms of short-term actions, practice staff are able to access the 'Practice Manager and Administration Development Programme' which includes face-to-face and online modules specifically relating to good customer care. So far around 15 delegates have completed the online course (or at least registered) with a further six delegates attending the workshop. This builds upon the customer care training offered at a previous Primary Care Market Place Event in 2015.

5.2 Increase in the proportion of GP referrals made by e-referrals

Indicator	Narrative
Increase in the proportion of GP referrals made by e-referrals: either 80% by March 2017 and year on year increase or March 2017 performance to exceed March 2016 by 20%	**Red** 56%

The planned care team have contacted The Royal, Liverpool Heart and Chest, Alder Hey, Aintree and Spire Liverpool and have established the base line and identified the next steps for the coming quarter.

The providers need to carry out capacity and demand modelling or share results with the CCG if this has already been carried out. We are looking to increase capacity and reduce ASIs (appointment slot issues) which has a negative impact on the CCGs utilisation if the providers book the ASIs outside of the e-Referrals system as these don't count towards the quality premium as they are not classed as a direct booking.

Providers will be reviewing each speciality/service DOS (directory of services) ensuring that GPs can clearly identify the appropriate services for their patients, which will also reduce the number of referrals rejected or redirected. We are also looking to implement Advice and Guidance which will reduce the number of first outpatient appointments enabling capacity to be shifted to areas where the providers are struggling to meet demand.

The national team (NHS Digital) Implementation Manager for NHS e-Referrals is also supporting the CCG to meet the requirements of the Quality Premium.

In order for the GPs utilisation to increase we need to get the provider to do the above, however the planned care team are working with the business intelligence team to identify practices whose utilisation is low and will be contacting them directly to advise on best practice and identify any training needs.

5.3 Antibiotic Prescribing

Indicator	Narrative
Antimicrobial resistance (AMR) Improving antibiotic prescribing in primary care: Part 1 4% reduction on 1314 in the number of antibiotics prescribed in primary care Target less than 1.264 per STAR PU (items)	**Green** 1.223

Indicator	Narrative
Part 2 number of co-amoxiclav, cephalosporins and quinolones as a proportion of the total number of antibiotics prescribed to be equal to or lower than 10%	**Green** 8.60

6. LOCAL QUALITY IMPROVEMENT SCHEMES

6.1 Liverpool Quality Improvement Scheme (GP Specification) position at the end of July 2016

6.1.1 The Provision of 80 appointments per 1,000 weighted practice population

Indicator	Narrative
The provision of 80 appointments per 1,000 weighted practice population per week.	**Band** / **Numbers Achieving** **A** / **78**
Assurance on CCG control measures Primary Care Commissioning Committee Paper PCCC14-16 outlined the process for the Primary Care Team to undertake a quarterly review of booking and access audit, identify areas for improvement and take action and to compare this to the Practice Implementation plans. This has been completed in line with the requirements; however, it has not been possible to automatically collect the GP appointment data from the EMIS clinical system. Therefore, the Primary Care Team have called all practices in the City to establish their numbers of appointments offered per week and to remind practices that the achievement of the KPI is for the average number of appointments to be 80 per 1,000 over the 12-month period. The business intelligence team is in conversation with EMIS to test an EMIS web module in six practice over the next two months which will automate the appointment count. Following evaluation of the module, roll out to all practices will take place as soon as practicable in the following month.	

In the meantime, practices have submitted manual data and this will be analysed and published on the Aristotle Portal on the 20th December, a detailed update will be provided in the next performance report

6.1.2 GP Specification ACS Admissions

<table>
<tr><th>Indicator</th><th>Narrative</th></tr>
<tr><td>ACS Admissions

Rate per 1000 hospital weighted population for admissions for a selection of ACS conditions (Angina, Asthma, COPD and Influenza & Pneumonia as primary diagnosis.)

(NB: Note change to definition for 16/17)

AMBER 8.33

Band A 7.30</td><td>There has been an increase of around 50 admissions in the most recent 12 months compared to the baseline of 15/16.

The rate of ACS admission has increased slightly since the baseline position of 8.24 to 8.33 per 1000 weighted patients. The numbers achieving band A has reduced from 37 in September report.

<table><tr><th>Band</th><th>Numbers Achieving</th></tr><tr><td>A</td><td>31</td></tr></table></td></tr>
<tr><td colspan="2">Assurance on CCG control measures

Blood Pressure - review of data last month over a 3 month period (July 16 to September 16) identified 8 practices currently less than 60% (threshold >75.28%). All practices were contacted / visited to discuss performance. Performance as reported in November shows improvement in 7 of the 8 practices over the last month

COPD - Pulmonary Rehab referrals in two practices following Primary Care team intervention have increased from – Storrsdale Oct data 20.00% Nov data 100% Yewtree Oct data 9.80% Nov data 97.62%

Flu - The Merseyside Flu Task Group met in July and the Liverpool group was convened at the beginning of August. Practices have been identified across all cohorts that require specific support and a range of tools and resources (template letters, promotional materials etc) are being collated for circulation once the PGD is published nationally. The group includes CCG Primary Care staff (quality manager, nursing and practice management representation), Local Authority Public Health, PHE and LMC.</td></tr>
</table>

Asthma – 53 practices attended the October locality GP workshops, actions to be taken:-

- Collate learning from the events and share
- Lead nurses to meet and agree approach to education for nurses
- Lead PMs to meet and agree feedback at PMs meetings
- Produce a resources pack including searches and audits
- Re send ACS audit tool and amend to include RCP 3 questions
- Primary Care Team Asthma action plan to be drawn up and agreed with clinicians and transformational change manager
- Markers of success improvements in PCQF asthma indicators
- Facilitate links between secondary care and general practice clinicians
- Review of access to clinical pathways following closure of MoM
- Promotion of Flo in self-management of asthma
- Asthma leads to be identified in each practice (this could be a PN)
- Training needs to be identified and close working with Liv Asthma support delivery
- Practices encouraged to target asthma patients for flu vaccination
- Asthma action plans in for under and over 11s in development, once have been through Alder hey processes to be shared

The December 8th Citywide Nurse event has the same agenda items as the locality GP meeting.

6.1.3 GP Specification Outpatient Referrals

Indicator	Narrative
Outpatient Referrals Rate per 1000 hospital weighted population for GP referred first Outpatient attendances to certain specialities (Dermatology, ENT, Rheumatology, Gynaecology, Urology, Vascular Surgery) **(NB: Note change to definition for 16/17)** **AMBER 68.53**	Since the start of the GP Specification outpatient referrals have reduced year on year with a 17.10% reduction. The rate of first GP-referred OP appointments has seen an increase from the baseline of 67.65 to 68.56 per 1000 HCHS weighted population. The number of practices achieving band A has increased on September report of 30.

Band A 63.48	<table><tr><th>Band</th><th>Numbers Achieving</th></tr><tr><td>A</td><td>33</td></tr></table>

Assurance on CCG control measures

Against the baseline dermatology has decreased by 170 referrals whist other areas including gynea and ENT have seen slight increases.

Gynae masterclass took place 16/11. Gynae pathways being reviewed. Planned care team looking into the care pathway for access to gynae physio as currently counts as a secondary care referral. Actions plan agreed and once completed learning to be shared with all practices including presentation of audit results via planned care clinical lead GP to the NBH clinical leads at their January meeting.

December NBH clinical leads meeting discussed options for peer review and advice and guidance

ENT masterclass in planning for January

Commencement of the tele dermatology pilot delayed due to EMIS functionality issues.

6.1.4 Alcohol Consumption

Indicator	Narrative
Alcohol Consumption The percentage of patients who are 18+ who have alcohol intake recorded over the past three years YELLOW: 64.65% Band A 67%	The proportion of patients who have had their alcohol consumption recorded has increased from the baseline of 63.23% to 64.65%. The number of practices achieving band A has increased since September report of 34. <table><tr><th>Band</th><th>Numbers Achieving</th></tr><tr><td>A</td><td>39</td></tr></table>

Assurance on CCG control measures

There are now no practices under 30% and the number of practices that have not achieved this indicator has reduced from 71 to 49.
All practices have been contacted to encourage recording and a top tips guide has been circulated.

6.1.5 Alcohol Brief Interventions

<table>
<tr><th>Indicator</th><th>Narrative</th></tr>
<tr><td>Alcohol Brief Interventions

The percentage of patients who are 18+ who have alcohol intake recorded over indicated levels who have been offered brief intervention

YELLOW

Band A 96.5%</td><td>The proportion of patients drinking over recommended levels who had been offered a brief intervention had decreased to 92.64% compared to the baseline 93.57%. The number of practices achieving band A has increased from the September report of 28.

<table><tr><th>Band</th><th>Numbers Achieving</th></tr><tr><td>A</td><td>36</td></tr></table></td></tr>
<tr><td colspan="2">Assurance on CCG control measures

LCAS training offer has been well received however those who have not yet booked on will have to wait until January for the training as the service have all available dates booked till then.

A 1 day RCGP accredited training programme took place on 6th September with 27 people in attendance. 10 (out of maximum number of 30 places) places remain on an additionally planned session in February 2017. Practices with either high admission rates or high prescribing rates for alcohol abuse will be targeted for this training.</td></tr>
</table>

6.1.6 Early Identification

Indicator	Narrative
Early detection: Percentage of registered patients aged 40+ on the CHD register Band A greater than 6.84%	At the end of Oct the CCG achievement was 7.68% Number at Band A: 71

Early detection: Percentage of registered patients aged 40+ on the Heart Failure register Band A greater than 1.10%	At the end of Oct the CCG achievement was 1.88% Number at Band A: 90
Early detection: Percentage of registered patients aged 40+ on the Stroke register Band A greater than 2.89%	At the end of Oct the CCG achievement was 3.83% Number at Band A: 81
Early detection: Percentage of registered patients aged 40+ on the Atrial Fibrillation register Band A greater than 2.29%	At the end of Oct the CCG achievement was 3.73% Number at Band A: 85
Early detection: Percentage of registered patients aged 40+ on the Hypertension register Band A greater than 24.16%	At the end of Oct the CCG achievement was 29.16% Number at Band A: 87
Early detection: Percentage of registered patients aged 40+ on the COPD register Band A greater than 4.22%	At the end of Oct the CCG achievement was 6.90% Number at Band A: 83
Early detection: Percentage of registered patients aged 40+ on the Diabetes register Band A greater than 7.89% ALL GREEN	At the end of July the CCG achievement was 10.55% Number at Band A: 87
Assurance on CCG control measures Case finding tool sent all practices and targeted e-mails to four practices that have younger populations and struggle to meet expected prevalence. With the exception of CHD all indicators have risen since the September report.	

6.1.7 Exception Reporting

Indicator	Narrative
Quality and Outcomes Framework exception reporting. The percentage of exception reporting against register size on the key registers of CHD, Heart Failure, Stroke, Atrial Fibrillation, Hypertension, COPD and Diabetes Band A less than 7.29% **GREEN**	At the end of March the CCG achievement was 4.48% This indicator is only updated annually once the QOF indicators are published Number at Band A: 75
Assurance on CCG control measures This indicator is only updated annually once the QOF indicators are published	

6.1.8 Palliative Care

Indicator	Narrative
Practices are required to demonstrate adherence to the Gold Standards Framework	All practices achieve this indicator in 2015/16
Assurance on CCG control measures Practices only submit their evidence at year end.	

6.1.9 Dementia

Indicator	Narrative
Practice to establish a process to complete annual reviews for patients diagnosed with Mild Cognitive Impairment	All practices achieve this indicator in 2015/16

Assurance on CCG control measures
The validation proforma is currently being reviewed with regards to suggested evidence and will be sent to practices once agreed by the GP spec development group by the LMC

6.1.10 Children's Vaccinations and Immunisations

Indicator	Narrative
Combined percentage achievement for DTaP/IPV/Hib at 1 year, MMR1, PCV booster, Hib/MenC at 2 years Band A 95% **AMBER: 92.32%**	At the end of Oct 16 the CCG achievement has decreased to 92.32% compared to the baseline position of 92.96% Number at Band A: 32
Combined percentage achievement for MMR2 at 5 years and DTaP/IPV preschool booster Band A 95% **AMBER: 88.85%**	At the end of Oct 16 the CCG achievement has decreased to 88.85% compared to the baseline position of 88.91% Number at Band A: 21
Assurance on CCG control measures Project manager (CNS) in place and reporting to Immunisation Transition and operations group. Consideration is taking place with regards to the continuation of the CNS post, with possible funding from PHE for 17/18 as it is felt by the imms and vacs team and LMC that continued support for a further year is needed. Coverage analysed monthly and contact made with practices with low coverage and action plan put in place. Practices with queues being worked with and visited to understand the immunisation capacity need to clear. Continuing and considerable input is required at this stage to recover uptake including cleansing of data, queue management, follow up with Active Patient Management Team, domiciliary visits.	

6.1.11 Medicines Management

Indicator	Target	Current Achievement	Number of practice at band A
Medicines Management the percentage of patients on Warfarin who have had an INR result in the last 4 months	Greater than or equal to 90%	At the end of Oct the CCG achievement was 94.77% **Achieved**	76
Medicines Management the percentage of patients on Lithium who have had their Lithium levels recorded in the last 4 months	Greater than or equal to 90%	At the end of Oct the CCG achievement was 80.09% **Not Achieved**	29
Medicines Management the percentage of patients on Lithium prescribed a Thiazide	Less than or equals to 1.5%	At the end of Oct the CCG achievement was 1.02% **Achieved**	81
Medicines Management the percentage of Dementia patients prescribed an Anti-psychotic	Less than or equals to 5%	At the end of Oct the CCG achievement was 12.61% **Not Achieved**	22
Medicines Management the percentage of Asthma patients prescribed a non-cardio specific beta blocker	Less than or equals to 0.2%	At the end of Oct the CCG achievement was 0.83% **Not Achieved**	18
Medicines Management the percentage of Addison disease patients prescribed a Thiazide	Less than or equals to	At the end of Oct the CCG achievement	70

	1%	was 1.43% **Not Achieved**	
Medicines Management Antibiotic Prescribing: 5% reduction against the practice's 2015-16 baseline or achievement of national average	National average 48.54	At the end of Oct the CCG achievement was 50.19 **Not Achieved**	57
Prescribing for type 2 diabetes should avoid risk of hypoglycaemia - T2D on insulin with 2 or more hypo in 12 months - T2D on SU with 2 or more hypo in 12 months Resulting in a hospital admission			
A target of 5% reduction in costs for a combination of pregabalin/oxycodone/buprenorphine patches/fentanyl	£3029.06	At the end of Oct the CCG achievement was £3322.21	6

Antibiotics

The MOC has a rolling programme to review the GP specification. Practices with increasing prescribing volumes were contacted in November to alert them to the KPI position and recommend review of prescribing. The presentation of the KPI data on Aristotle is being amended to make it clearer.

Safety indicators

The MOC has a rolling programme to review the GP specification. In December, practices not meeting the safety indicators KPI will be contacted to advise that appropriate monitoring is being carried out.

Review of the analgesia data will be the focus in January, particularly through the locality education meetings. The presentation of the analgesia KPI data on Aristotle is being amended to make it clearer.

6.1.11 Significant Event Analysis

Indicator	Narrative
Practices with a list size less than 3,500 (weighted) to complete 3 clinical significant events Practices with a list size less than 3,500 (weighted) to complete 5 clinical significant events	Evidence submitted was variable in quality
Assurance on CCG control measures The Primary Care Team have offered support to all practices to establish processes to embed SEA reviews into practice.	

7. CQC REPORTS

Where providers are not meeting essential standards, the CQC has a range of enforcement powers to protect the health, safety and welfare of people who use the service (and others, where appropriate). When the CQC propose to take enforcement action, the decision is open to challenge by the provider through a range of internal and external appeal processes. The following updates are provided in relation to recent CQC inspection activity locally:

7.1 CQC Inspections of Liverpool GP Practices

Since the last reporting period a total of 13 Liverpool practices reports or re inspection reports have been published:

7.1.1 Old Swan Health Centre– Overall Rating 'Good'

An announced comprehensive inspection was carried out at Old Swan Health Centre on 30th June 2016. Overall the practice was rated as 'Good'. The practice required improvement on being Safe but rated Good

for all other areas of inspection. Key findings across the areas inspected are as follows.

- Patient needs were assessed and care was planned and delivered in line with current legislation.
- Staff worked well together as a team and all felt supported to carry out their roles
- The practice was aware of and had systems in place to ensure compliance with the requirements of the duty of candour.
- The provider must ensure appropriate checks are carried out for all their staff.
- The provider to have monitoring systems in place for use of prescription pads.

The full inspection report can be downloaded from the CQC website:
http://www.cqc.org.uk/sites/default/files/new reports/AAAF4046

Moss way Medical Centre – Overall 'Good' (re-inspection following initial inspection 7th March 2016)

The CQC carried out an announced comprehensive inspection at the practice on the 7th March 2016 and at the time the practice was rated as 'Good'. However, there was a breach of legal requirement Regulation 12 Safe, Care and Treatment. A focused review of Moss Way was conducted on 4th July 2016 to check whether the practice had completed the improvement identified. Key findings across the focussed areas inspected are as follows

- Risk assessments for health and safety had been carried out and action has been taken against the risks identified such as gas, electrical and fire safety.
- The practice had oxygen for use in medical emergencies.
- The practice had updated business contingency plans

The full inspection report can be downloaded from the CQC website:
http://www.cqc.org.uk/sites/default/files/new reports/AAAF6206

Margaret Thompson Medical Centre – Overall 'Good' (re-inspection following initial inspection 03/03/16)

The CQC carried out an announced comprehensive inspection at the practice on the 3rd March 2016 and at the time the practice was rated as 'Good' However, there was breach of legal requirement Regulation 18 Staffing. A focused review of Margaret Thompson was conducted on the

5th July 2016 to check whether the practice had completed the improvement identified. Key finding across the focussed areas inspected are as follows.

- A staff training matrix which outlined details of when staff had received or when they were due to complete their training. Training included Safeguarding, Infection Control, Fire Safety Awareness.
- New induction checklists for clinicians and administration staff. Training at induction included health and safety and fire safety.
- A list of staff who had completed their annual appraisals and invites for those staff that were due to receive their appraisal later in the year.

The full inspection report can be downloaded from the CQC website:
http://www.cqc.org.uk/sites/default/files/new reports/AAAF6342

Valley Medical Centre – Overall Rating 'Good'

An announced comprehensive CQC inspection was carried out at Valley Medical Centre on 6th July 2016 which resulted in an overall rating of 'Good'. The key findings of the inspection are summarised below

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses.
- The practice used innovative and proactive methods to improve patient outcomes, working with local providers to share best practice.
- The practice had a clear vision which had quality and safety as its top priority.
- The practice had strong and visible clinical and managerial leadership and governance arrangements
- The practice needs to develop a protocol or procedure for the safe transport, storage and administration of vaccines in the community setting

The full inspection report can be downloaded from the CQC website:
http://www.cqc.uk/sites/default/files/new reports/AAAF5693

Priory Medical Centre – Overall 'Good' (re-inspection following initial inspection 10th December 2015)

The CQC carried out an announced comprehensive inspection at the practice on 10th December 2015 and at the time the practice was rated as 'Good'. However, there were breaches of legal requirement Regulation 19 – Fit and Proper Persons Employed and Regulation 12 –

Safe Care & Treatment. A focused review of Priory Medical Centre was conducted on 8th July 2016 to check whether the practice had completed the improvement identified. Key findings across the focussed areas inspected are as follows:

- The practice had address the issues identified during the previous inspection. Disclosure and Barring Service checks and professional registrations had been completed for all necessary staff.
- The practice had updated its fire risk assessment and carried out health and safety risk assessments

The full inspection report can be downloaded from the CQC website:
http://www.cqc.org.uk/sites/default/files/new reports/AAAF6345

Poulter Road – Outcome 'Good' (re-inspection from initial inspection October 2014)

The CQC carried out an announced comprehensive inspection at the practice on 14th October 2014 and at the time the practice was rated as 'Good'. However, there were breaches of legal requirement Regulation 21 of the Health and Social Care Act 2008 and Regulation 19 of the Health and Social Care Act 2008. A focused review of Poulter Road was conducted on 14th July 2016 to check whether the practice had completed the improvements identified. Key findings across the focussed areas inspected are as follows

- Practice submitted evidence to show that all staff had a completed DBS in December 2014.
- The practice has purchased emergency equipment such Oxygen and Pulse Oximeter.
- Evidence was submitted to show the practice had completed PAT testing after the inspection and systems had been put into place to ensure this was routinely monitored.
- Practice had completed a disabled access audit in 23 June 2015

The full inspection report can be downloaded from the CQC website:
http://www.cqc.org.uk/sites/default/files/new reports/AAAF7305

Dovecot Health Centre – Outcome Good

The CQC carried out an announced inspection at Dovecot Health Centre on 15th July 2016 and rated the practice as 'Good'. Key findings across all areas inspected are as follows

- The practice was aware of and had systems in place to ensure compliance with the requirements of the duty of candour
- Patient's needs were assessed and care was planned and delivered in line with current legislation
- Patients felt they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available. The practice sought patient views about improvements that could be made to the service including having a PPG and acted, where possible on feedback.
- Many of the staff had worked at the practice for a long time and knew the patients well. Staff worked well together as a team and all felt supported to carry out their roles.

The full inspection report can be downloaded from the CQC website:
http://www.cqc.org.uk/sites/default/new reports/AAAF7008

Walton Medical Centre – Outcome 'Good'
The CQC carried out an announced inspection at Walton Medical Centre on 10th August 2016 and rated the practice as 'Good'. Key findings across all areas inspected are as follows:

- Staff understood their responsibilities to raise concerns and report incidents and near misses.
- The practice used innovative and proactive methods to improve patient's outcomes, working with other local providers to share best practice.
- The practice worked closely with other organisations and with the local community in planning how services were provided to ensure that they meet patient's needs.
- There are strong and visible clinical and managerial leadership and governance arrangements.
- Maintain proof of identity of staff by having a recent photograph on the staff file

The full inspection report can be downloaded from the CQC website:
http://www.cqc.org.uk/sites/default/files/new reports/AAAF7247

Lance Lane Medical Centre – Outcome Good (re- inspection following initial inspection 03/12/15)

The CQC carried out an announced comprehensive inspection at the practice on 3rd December 2015 and at the time the practice was rated as 'Good'. However there were breaches of legal requirement Regulation 19 of the Health and Social Care Act 2008. A focused review of Lance Lane Medical Centre was carried out on 22nd August 2016 to check whether the practice had completed the improvements identified. Key findings across the focussed areas inspected are as follows:

- The practice had addressed all of the issues identified during the previous inspection.
- The process for recording significant events and incidents were reviewed
- New policy was set up for staff and this included tools to use to improve recording of significant events
- Risk assessment for legionella had taken place
- Safeguarding training for vulnerable adults and children was available.

The full inspection report can be downloaded from the CQC website:
http://www.cqc.org.uk/sites/default/files/new reports/AAAF7951

Speke Health Centre (Dr Mangarai) – Outcome 'Good'

The CQC carried out an announced inspection at Dr Mangarai – Speak Health Centre on 14th September 2016 and rated the practice as 'Good'. Key findings across all areas inspected are as follows

- Patient's needs were assessed and care was planned and delivered following best practice guidance.
- The practice actively reviewed complaints and how they were managed and responded to, and made improvements as a result
- The practice needs a system in place to monitor and improve quality and identify risk.
- The practice is required to develop a system for the receipt of NICE guidelines

The full inspection report can be downloaded from the CQC website:
http://www.cqc.org.uk/sites/default/files/new reports/AAAF2852

Edge Lane Medical Centre – Outcome 'Good'

The CQC carried out an announced inspection at– Edge Lane Medical Centre on 21st September 2016 and rated the practice as 'Good'. Key findings across all areas inspected are as follows

- Safeguarding vulnerable adults, children and young people was given sufficient priority. Staff took a proactive approach to safeguarding and focus on early identification.
- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses and they were fully supported when they did.
- Monitoring and reviewing activities enabled staff to understand risks and gave a clear, accurate and current picture of safety.
- Complaints and concerns were taken seriously, responded to in a timely way and listened to.
- There were systems in place to monitor and improve quality and identify risk

The full inspection report can be downloaded from the CQC website:
http://www.cqc.org.uk/sites/default/files/new reports/AAAF7100

Rock Court Medical Centre – Outcome 'Good'
The CQC carried out an announced inspection at– Rock Court Medical Centre on 28th September 2016 and rated the practice as 'Good'. Key findings across all areas inspected are as follows:

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses.
- The practice used innovative and proactive methods to improve patient outcomes, working with other local providers to share best practice.
- The practice had a clear vision which had quality and safety as its top priority.
- A system should be put in place to enable the practice nurse to receive appropriate clinical supervision and support.
- The practice should develop a business continuity plan for major incidents such as power failure or building damage.

The full inspection report can be downloaded from the CQC website:
http:/www.cqc.org.uk/sites/default/files/new reports/AAAF3015

Lance Lane Medical Centre – Outcome Good (re- inspection following initial inspection 03/12/15)

The CQC carried out an announced comprehensive inspection at the practice on 3rd December 2015 and at the time the practice was rated as 'Good'. However there were breaches of legal requirement Regulation 19 of the Health and Social Care Act 2008. A focused review of Lance Lane Medical Centre was carried out on 22nd August 2016 to check whether the practice had completed the improvements identified. Key findings across the focussed areas inspected are as follows:

- The practice had addressed all of the issues identified during the previous inspection.
- The process for recording significant events and incidents were reviewed after inspection
- The practice manager submitted information to show that a risk assessment for legionella had taken place.
- Safeguarding training was available and provided for all staff in regard to vulnerable adults and children.
- The practice developed a new complaints management policy with supporting complaints information for patients.

The full inspection report can be downloaded from the CQC website:
http://www.cqc.org.uk/sites/default/files/new reports/AAAF7951

8. GMS/PMS/APMS CONTRACTS

Each of the 92 Liverpool GP practices hold either a General Medical Services (GMS), Personal Medical Services (PMS) or an Alternative Provider Medical Services (APMS) contract.

There are:

- GMS 74 contracts.
- PMS 5 contracts.
- APMS 5 contracts
- GMS time limited 8

8.1 Contract Requirements

8.1.1 Patient Participation Groups

Practices are required to declare in the annual electronic practice self-declaration (eDEC) that they have fulfilled these requirements. This

submission window is still open therefore an update will be available at the next report.

8.1.2 Friends and Family Test

It is a requirement that each month GP practices submit their previous months Friends and Family Test results onto CQRS by the 12th working day of the following month.

The latest published data[1] is for September 2016. This shows that for the September return, 28 of the 92 Liverpool GP practices failed to formally respond and submit their responses. This report also indicates that there were 10 practices who have now failed to submit a response for the 3 latest returns.

The Primary Care team have now begun formal contract visits with all Liverpool GP practices and have identified this requirement as a standing agenda item to discuss to ensure full compliance.

Assurance on CCG control measures

The Primary Care Team have been following the national guidance and have been reminding practices of their requirements. The primary care team have also provided to practices a list of the dates that the submissions have to be entered onto the CQRS system. Delivery of this core contract requirement will be discussed at the annual core contract meetings.

8.1.3 Patients having Access to their Medical Records

No update for this reporting period

8.1.4 Publication of GP Incomes

From 1st April 2015 it is a contractual requirement for practices to publish, on their practice website by the end of the financial year (i.e. 31st March 2016), the mean earnings for all GPs in their practice relating to the previous financial year (2014/15). The submission for publication of mean earnings during 2015/16 will be due on or before 31st March 2017.

[1] https://www.england.nhs.uk/ourwork/pe/fft/friends-and-family-test-data/

The Primary Care team are currently holding formal contract meetings with all GP providers and as part of that process are ensuring that all practices are submitting their mean earnings.

8.2 Contract Variations

8.2.1 Contract Extensions

No requests during this period

8.2.2 Interim Providers

No update for this period

8.2.3 Partnership Changes

Since September 2016 the CCG has received seven requests for contract variation for new partnership joining contracts. There have been seven contract variations for practices when a partner has left.

8.2.4 Boundary Changes

No update for this reporting period

8.2.5 Practice Mergers

No updates during this period.

8.3 Contract Sanctions

No update for this reporting period.
Contractor visits are planned to start in December 2016, all contractors to be visited each year.

8.4 Practices asking to close list size

No practices have requested to close their list.

8.5 Practices asking to close

No update for this reporting period

9. COMPLAINTS

General Practice complaints have not transferred from NHS England to the CCG as part of the transitional programme; therefore, there is nothing to report at the time of this report.

10. FINANCE

The current 2016/17 position as at the 30th November 2016 in respect of delegated Primary Care budgets was an overspend of £2,405,465 on a total budget of £61.7m.

Primary Care Delegated Budget Position as at 30th Nov 2016:

Description	YTD Budget £'000	YTD Actual £'000	YTD Variance £'000	Annual Budget £'000	Forecast Outturn £'000	Forecast Variance £'000
Enhanced Services	1,222,276	1,437,192	214,916	1,833,416	2,154,602	321,186
General Practice - GMS	23,811,828	25,454,906	1,643,078	35,717,744	38,174,109	2,456,365
General Practice - PMS	2,102,835	1,590,529	-512,306	3,154,255	2,385,794	-768,461
Other - GP Services	1,359,124	1,191,566	-167,558	2,038,688	1,810,890	-227,798
Other List-Based Services (APMS ind.)	3,431,857	4,391,319	959,462	5,147,785	6,586,981	1,439,196
Other Premises costs	512,936	502,951	-9,985	769,408	754,427	-14,981
Premises cost reimbursements	1,431,152	1,797,369	366,217	2,146,728	2,205,185	58,457
Primary Care NHS Property Services Costs - GP	2,918,958	2,818,270	-100,688	4,378,434	4,171,072	-207,362
QOF	4,404,568	4,416,898	12,330	6,606,852	6,625,345	18,493
Total	**41,195,534**	**43,600,999**	**2,405,465**	**61,793,310**	**64,868,404**	**3,075,094**

The CCG's prescribing financial performance position as at November 2016 is currently showing a £2.1m year to date overspend based on actual prescribing information received until the end of September and estimated costs for the months of October and November.

The table below shows the budgeted and actual expenditure as at November 2016:

	Annual Budget	Year to Date Budget	Year to Date Actual Expenditure	Variance Over / (Under)
Prescribing Expenditure	£87,543,000	£58,363,808	£60,527,964	£2,164,156

The forecast outturn position currently stands at £1.2m over performance against planned levels at the end of the financial year. The forecast position takes into account a range of anticipated savings, some of which have already commenced as part of the Finance and Effectiveness Plan, with a greater emphasis placed on prescribing savings as per the CCG's Financial Recovery Plan that has been developed during quarter 2 and 3.

The table below shows the budgeted and actual expenditure at the end of the financial year:

	Annual Budget	Forecast Expenditure	Forecast Variance Over / (Under)
Prescribing Expenditure	£87,543,000	£88,782,650	£1,239,650

The year end position is based on actual costs incurred for period as per above, but due to the impact of the financial savings developed, the forecast position has been developed using an average of quarter 2's prescribing expenditure with further adjustments as per the financial recovery plan assumptions that have been developed by the CCG.

Detailed monitoring is taking place to monitor these assumptions and the additional prescribing intelligence that is received on a monthly basis will help to ensure a robust year end forecast position which will be reviewed at the end of quarter 3.

11. STATUTORY REQUIREMENTS (only applicable to strategy & commissioning papers)

11.1 Does this require public engagement or has public engagement been carried out? N/A

11.2 Does the public sector equality duty apply? N/A

11.3 Explain how you have/will maximise social value in the proposal: describe the impact on each of the following areas showing how this is constructed to achieve the most:

a) Economic wellbeing
b) Social wellbeing
c) Environmental wellbeing

11.4 Taking the above into account, describe the impact on improving health outcomes and reducing inequalities

11.5 DESCRIBE HOW THIS PROMOTES FINANCIAL SUSTAINABILITY

12. CONCLUSION

The ongoing focus will be on use of resources mainly ACS, OPD and prescribing. Practices who are statistical outliers will be visited and support offered.

Primary Care Senior Managers will be now be attending monthly neighbourhood meetings to ensure the focus is on delivery of the GP specification.

13. RECOMMENDATIONS

That Liverpool CCG Primary Care Commissioning Committee:

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

NHS
Liverpool
Clinical Commissioning Group

Report no: PCCC 32-16

NHS LIVERPOOL CLINICAL COMMISSIONING GROUP

PRIMARY CARE COMMISSIONING COMMITTEE

TUESDAY 20TH DECEMBER 2016

Title of Report	Primary Care Commissioning Risk Register Update December 2016
Lead Governor	Dave Antrobus
Senior Management Team Lead	Cheryl Mould, Primary Care Programme Director
Report Author	Cheryl Mould, Primary Care Programme Director
Summary	The purpose of this paper is to update the Primary Care Commissioning Committee on the changes to the Risk Register for December 2016
Recommendation	That the Primary Care Commissioning Committee: ➢ Notes the content of the report and the mitigating actions
Relevant standards/targets	The Health and Social Care Act states that: *"The main function of the governing body will be to ensure that CCGs have appropriate arrangements in place to ensure they exercise their functions effectively, efficiently and economically and in accordance with any generally accepted principles of good governance that are relevant to it."*

Primary Care Commissioning Risk Register Update December 2016

1. PURPOSE

The purpose of this paper is to update the Primary Care Commissioning Committee on the changes to the Risk Register for December 2016.

2. RECOMMENDATIONS

That the Primary Care Commissioning Committee:

- Notes the content of the report and the mitigating actions

3. BACKGROUND

NHS Liverpool CCG aims to achieve its overall objectives, ambitions and maintain its reputation via effective and robust risk management procedures. As a public body, the CCG has a statutory commitment to manage any risks that affect the safety of its employees, patients and its commissioned, financial and business services by adopting a proactive approach to the management of risk.

The Risk Register is a structured framework underpinned by concepts of effective governance and other systems of internal control that enable the identification and management of acceptable and unacceptable risks. Opportunities for improvement in controls and assurances are translated into action plans under specific named lead/managerial control so that monitoring, tracking and reporting can be supported, with clear target dates and milestones identified where appropriate.

4. OVERVIEW OF THE PRIMARY CARE RISK REGISTER

As at 1st December there have been no new risks added or risk removed. All changes made have been minor updates.

The CCG's risk profile (low – extreme) is summarised below:

Risk Category	Score Range	Total Risks	Change +/-
Extreme	15-25	**2**	**+2**
High	8-12	**7**	**-2**
Moderate	4-6	**5**	**-1**
Low	1-3	**0**	**0**

5. STATUTORY REQUIREMENTS (only applicable to strategy & commissioning papers)

Not applicable

5.1 Does this require public engagement or has public engagement been carried out? Yes / No

i. If no explain why

ii. If yes attach either the engagement plan or the engagement report as an appendix. Summarise key engagement issues/learning and how responded to.

5.2 Does the public sector equality duty apply? Yes/no.

i. If no please state why

ii. If yes summarise equalities issues, action taken/to be taken and attach engagement EIA (or separate EIA if no engagement required). If completed state how EIA is/has affected final proposal.

5.3 Explain how you have/will maximise social value in the proposal: describe the impact on each of the following areas showing how this is constructed to achieve the most:

a) Economic wellbeing
b) Social wellbeing
c) Environmental wellbeing

5.4 Taking the above into account, describe the impact on improving health outcomes and reducing inequalities

6. DESCRIBE HOW THIS PROMOTES FINANCIAL SUSTAINABILITY – Not applicable.

7. CONCLUSION

The Primary Care Risk Register continues to be monitored on a monthly basis. Action plans put in place against each risk identified are reviewed monthly by the appropriate lead.

Cheryl Mould
Primary Care Programme Director
20th December 2016

Ends

LIVERPOOL CCG: Head of Primary Quality and Improvement

Ref	Organisational goal	Date Entered	Objective	Description of Risks	Current Controls	Assurance in Controls	L	C	Current Risk (score)	Current risk accepted	Management Actions re gaps in controls and assurance or unacceptable risk rating	L	C	Residual Risk (score)	Lead Officer	Completion Date	Review Date	Progress	Reviewed by lead
Co-Com 01		01/06/2015	Effective Provision of commissioning of Primary Care services - Transitional Plan	Transfer of services from NHS England to NHS Liverpool Clinical Commissioning Group is not safe and CCG is not able to fulfil its statutory functions.	Regular monthly meetings were established and monitoring of the transfer has been managed by NHS Liverpool CCG and NHS England.	Transitional plan is regularly monitored and reports directly to The Primary Care Commissioning Committee.	2	2	4		Senior NHS England Primary Care Commissioning and Finance Managers along side Senior NHS Liverpool CCG monitor compliance. Issues highlighted for Premises	1	2	3	CM / DR	Ongoing	08/12/2015	The transitional group met on the 2/09/15. All actions are on target. Risks still remain on premises, Primary Care Support Services Out of Scope and staffing model. 08/12/15 The only outstanding issues are CQRS which is a national issue, Premises and the national staffing model. It has been agreed that the process will be signed off by March 2016.	
Co-Com 02		01/06/2015	APMS Procurement	14 Practices will require a full procurement exercise to be completed, to ensure continuity of provision, with 8 requiring an Interim Provider from April 2016	Interim provider policy is being presented to the Primary Care Commissioning Committee to establish a process should a situation occur.	The interim provider policy has been agreed, assessment criteria established and local procurement interest has begun	3	4	12		Project plan devised with additional reviewers being identified due to the increased number of bids. In January there will be a weekly development group to monitor the progress of the procurement.	3	4	12	CM / DR	Mar-16	01/02/2017	There have been weekly development group meetings occurring since 6th January 2016. Procurement papers have been developed for the Finance, Procurement and Contracting Committee and the Primary Care Commissioning Committee for sign off, before being reviewed by the Governing Body. This was now being managed and dealt with at the Finance Procurement & Contracting Committee	
Co-Com 03		01/06/2015	Staffing Model	It is a requirement that all delegated commissioning CCGs and NHS England must agree a staffing model by October 2015. There is currently no national staffing model available.	Transitional Group is reviewing this on a monthly basis and will convenient additional meetings should this be required.	Transitional plan is regularly monitored and reports directly to The Primary Care Commissioning Committee.	4	1	4		The Primary Care Co-Commissioning Steering Group has been working jointly for this across the region.	3	1	3	CM / DR	Feb-16		The regional steering group and NHS England agreed to share resources across the region for services such as Premises. Liverpool CCG has completed the recruitment of staff.	
Co-Com 04		01/06/2015	Finance	Practice switching from PMS to GMS and the impact on the CCG finance.	Monthly monitoring of the budget occurs. There is a FOT of £113,000 for 2015/16		4	3	12		CCG and NHS E Finance Managers are working together to identify each of the payment lines and how they are being placed into the CCG account.	4	3	12	AO		01/02/2017	As at the 31st August 2016, the year to date position for the Delegated Primary Care budget is a £1,525,000 overspent, with a forecast full year position is a balanced budget. This underspend has already been committed to fund the 2016/17 increase in the Liverpool Quality Improvement Scheme (LQIS).	
Co-Com 05	High Quality General Practice	01/04/2014	To improve quality and reduce variation in General Practice	Lack of capacity and skills within practice teams to deliver improvements to quality and reduce variation.	As a result of training needs analysis programmes for clinical and nursing staff have been developed and are being delivered. Regular locality PN and PM meetings throughout the year to share best practice. Weekly advice and resources on the practice/CCG bulletin. Quarterly locality based GP workshops focused on key clinical GP spec delivery specialities.	Monitoring of the practice implementation plans for GP spec. Monthly monitoring of Aristotle and early warning system put in place to identify practices where additional support might be needed in order to accelerate practices achievement of GP spec KPI. Primary Care Quality Team (including	3	3	9		Reviewed by Primary Care Quality Sub Committee on a quarterly basis.	2	3	6	JW	Ongoing	Monthly	Each month performance and variation is reviewed by the primary care team. The primary care performance dashboard is shared at the start of each month by business intelligence and discussed at the monthly primary care & quality team senior managers meeting. Priority area's and actions are agreed going forward, using a cycle of improvement methodology so that learning, intelligence and feedback is triangulated and best practice can be shared widely. This internal review process acts as an early warning to highlight when performance is deteriorating or variation widening so that understanding, early action and support is timely. Action plans have been developed for the GP spec indicators and other priority areas on PCQF and these are reviewed by quarterly meetings of the Primary Care Quality Team.	y
Co-Com 07		01/06/2015	GP Service Provision	Potential for retirement of a number of single handed contract holders, which could result in a number of contract terminations.	Develop of Interim Provider Policy for terminations that require without notice. Localities to work with members regarding succession planning.	The interim provider policy has been agreed, assessment criteria established and local procurement interest has begun	3	4	12		The implementation of the Interim Provider Policy and support from SBS.	3	4	12	SA	Ongoing	Jul-16	The Interim Provider Policy was approved in June 2015 and has seen the procurement of 9 Interim Providers. The policy is due for review in July 2016.	
Co-Com 09	Maximise value from resources		Prescribing - financial effectiveness plan - Primary Care driven prescribing	Unable to reduce costs. 1. Increased demand on primary care prescribing from improved LTC treatment. 2. Increased demand from hospital initiated drugs - see PC009	Monthly review by MOC of cost drivers	Monthly review by MMC. Reporting to PCCC	5	4	20		Finance & effectiveness plan developed. Q1 - Phase 1 - rapid delivery savings. Q2-4 - Phase 2 & 3 - systems & process redesign. Q2-4 Phase 4- commissioning savings projects in development Q1 2017 - Phase 5 - self care / NHS funding guidance	2	4	8	PJ	Phase 1 - December 2016 Phase 2 - June 2017 Phase 3 - April 2018 Phase 4 - April 2017 Phase 5 - April 2017	Quarterly	Phase 1 - Short term cost reduction plan agreed and under implementation. Phase 2 - Consulting on systems & process redesign, for discussion by governing body development session. Phase 4 - Commissioning savings projects in development - under discussion with potential providers Phase 5 - consultation / engagement being worked up by engagement team	y
Co-Com 10	Maximise value from resources		Prescribing within budget - specialist driven prescribing	1. Increased initiation of NOACs by secondary / tertiary care, driven by NICE guidance (Full year effect on prescribing & monitoring costs up to £2.4M) 2. Initiation of new class heart failure drugs by secondary / tertiary care, driven by NICE guidance (full year effect on costs rising from £400k to £2M+). MMT not able to challenge prescriptions for appropriateness 3. NHSE budget drugs and PbR excluded drugs invoiced to CCG (approximate full year costs £400,000 with 15% growth nationally)	1. Monitoring of prescribing cost growth 2. Monthly monitoring of primary care prescribing spend. Reporting to PCCC 3. Costs collated by CSU. Project to describe, quantify and manage costs in place, to deliver report by December 2016	Monthly review by MOC. Quarterly reporting to PCCC. Exception report to governing body	5	4	20		1&2. Risk raised with governing body Five year growth projections included in prescribing cost plan 3. Dedicated MMT resource engaged to identify and quantify current and future costs and develop systems to link hospital prescribing with diagnosis	5	4	20	PJ	Apr-17	Quarterly	1. NOAC initiation service as part of LAS service under consideration 2. Treatment pathways agreed with specialist services 3. System to monitor secondary care prescribing according to appropriate indication (BlueTeq) being put in place by NHS England for Specialist Commissioning drugs. CCG support to develop management process at risk as post holder leaving LCH - Score returned to 20 until resolved	y
Co-Com 11	High quality general practice		Prescribing outcomes	Increased volume of prescribing for LTCs not resulting in improved achievement of clinical indicators and substantial variation across practices	Prescribing quality / risk dashboard. Quality indicators in PCQS.	Quarterly review by MMC. Report to locality leadership boards and PCQC	3	4	12		Development of further indicators linked to risk and outcomes. Publication of benchmarking data. Feedback to lowest quartile practices	2	3	6	PJ	Sep-16	Quarterly	Indicators agreed and system of managing data into intelligence and action completed. Case finding and long term conditions searches to be owned by LTC group.	**y**
Co-Com 12	High Quality General Practice	09/04/2015	Ensure practices are fit for purpose to be assessed by CQC	Practices in danger of being ranked as special Messages. Reputation of CCG at risk	Pre CQC visits offered to practices to support them. Post inspection visits carried out to support practices with actions required	Report to Primary Care Commissioning Committee and Governing Body	3	3	9		Protocols available that practices can adapt for their own practice. Guidance and advice offered regarding all aspects of a CQC inspection	2	3	6	LJ	Apr-17	Monthly	Assurance report submitted to the Primary Care Quality Sub Committee outlining the support provided to practices prior and following on from CQC visits.	**y**
Co-Com 13	High Quality General Practice	25/08/2015	Out of Area Patients	Willing providers not all in prime locations., coverage is not universal across the City.	8 practices across the City have signed up to the DES and one practice is willing to extended beyond. Discussions to be had with all members to ask if assess if sign up for the scheme can be increased.	Issue to be reported to the Primary Care Commissioning Committee	3	4	12		We have a number of practices who have signed up to the scheme with NHS England. This needs to be sense checked and engagement with the LMC to review the need for coverage in every neighbourhood.	3	4	12	**SA**	ongoing		Only 5 practices have signed up for this scheme for 2016/17. The CCG has a gap in service if patients need home visits who have a GP outside of the city. There was only 1 person who requested support for LCH during 2015/16. No patients have requested to use this service in 2016/17.	**y**
Co-Com 14	High Quality General Practice	13/10/2015	Maintain safe & effective Vaccination & immunisation provision for local patients	Transfer of Vaccination & Immunisation provision to General Practice could lead to reduced uptake across the city as not all General Practice staff are adequately trained or prepared to access transfer. There is also a risk that "queues" of patients build up as a result of capacity issues within the practices post transition.	Standing agenda item on Primary Care Quality Committee, oversight conducted by PCCC Primary Care Quality Team continuing to work with Locality/N'hood teams to quantify risk and establish capacity gap. Fortnightly monitoring meetings with PHE, CCG, LCH, LCC and LMC to discuss and oversee progress Training packages for nursing/admin staff, mentoring/shadowing opportunities with HV team, PNDT support to practices without a nurse all available to practices and this support continues to be available.	Exception reporting from PCCC to Governing Body Audit of General Practice preparedness is now complete. Delivery of childhood V&I to be included within GP spec from 1st April 2016 to ensure city wide delivery of routine vaccination programme and support uptake rates to achieve national target of 95%	5	3	15		Practices contracted to deliver from 1st April 2016 (via the GP Spec and core contract) so failure to deliver would mean a re-negotiation of practice funds associated with this scheme of work. As at 1st April 16, the transition is technically complete although the resilience of practices in delivering sustainably is yet to be realised. The Active Patient Management Team (APMT) continues to be commissioned and there is some project support in place to monitor queues etc. As at 1st April 16, the APMT plus project support is in place. Group meetings are monthly with continued support from PHE & NHSE **(Update from AW 01/04/2016)**	2	3	6	JW	on-going though full transition should be complete by end of March 2016 Monitoring will continue throughout 2016/17	Feb-17	Provision of childhood vaccinations is occuring in all 93 practices across the CCG. Current 2 year old vaccination rates are 92.32% and 5 year old vaccines are 88.85%.	**y**
Co-Com 15	High Quality General Practice	13/10/2015	To ensure patients currently accessing the service at Merseyview Equitable Access Centre have suitable alternatives available from July 2016.	Contract for Merseyview ends 31st July 2016 without an alternative service being in place to accommodate patient groups utilising the walk in service. No comms or engagement to notify patients of change to service.	Patients can access other walk in services in the city. Patients attending Merseyview who have a registered GP can attend their own practice and encouraged to do so. Monitoring of access within GP spec in place. OSC assured of plans to improve access once Merseyview contract ceases.	Exception reporting to PCCC	4	2	8		Practices within 3 mile radius prioritised for visits to ensure patients able to access services in a timely manner. Model for 7 day access to GP developed and mobilisation is underway for go live July 2016. Comms & engagement started May 2016.	3	2	6	ColM	Jul-16	Jul-16	Merseyview contract ceased 31st July. Patients signposted back to own GP practice & arrangements in place to manage other patients attending Everton Rd HC. Monitoring of impact will continue for 3 months and reviewed in Oct 16. Proof of concept for 7 day go live postponed pending confirmation of model across primary and urgent care. **Updated 050916 ColM**	**y**
Co-Com 16	High Quality General Practice	13/10/2015	To ensure an enhanced level of access to general practice through GP spec	Non-recurrent funding for winter scheme ends 31/3/16 and practices unable to deliver increased access to 80/1000 appointments from April 16.	Spec for 16/17 in development, discussed with LMC and city wide members event planned for 22/10/15	GP spec working group met fortnightly now monthly	3	2	6		Monthly feedback to Primary Care Quality Committee.	3	2	6	ColM	End January 2016	Jan-16	Clinical model and direction of travel approved at PCCC Nov 2015. Investment proposal shared with SMT prior to FPCC 22/12 and Governing Body 13/1/16. At this stage, likelihood remains 3 until the investment proposal has been through CCG governance processes. The Governing Body agreed the specification in February **I think this can be removed now as GP spec 16/17 now in place. ColM 050916**	**y**

LIVERPOOL CCG: Head of Primary Quality and Improvement

Ref	Organisational goal	Date Entered	Objective	Description of Risks	Current Controls	Assurance in Controls	L	C	Current Risk (score)	Current risk accepted	Management Actions re gaps in controls and assurance or unacceptable risk rating	L	C	Residual Risk (score)	Lead Officer	Completion Date	Review Date	Progress	Reviewed by lead
Co-Com 17		15/12/2015	The safe transfer of Medical Records	Local PCS services have been procured nationally for a period of 7 years. There will be significant change in the processing of Medical Record transfers.	National pilot service took place in February 2016 and a local training programme is taking place on the 9th March 2016.	Regional steering group has been establish and invited local PM lead.	3	4	12		NHS England are managing the contract regarding PCS. However, the new transfer of medical records begins on the 29th March 2016. Practice have been given sample kits and were asked to participate in the pilot using the courier service. There is no details about which practices completed the pilot test.	3	4	16			Apr-16	Communication has been circulated to all practices and Capita attended a Practice Managers session on the 9th March to detail their new system. 55 practices attended the meeting and the remaining practices will be contacted to ensure that they are fully aware of the process. NHS England will be performance manging the Capita contract nationally, with a local stake group established within Cheshire and Merseyside.	
Co-Com 18	High Quality General Practice	15/12/2015	The achievement of the GP Specification	Practices failing to deliver the GP Specification resulting in financial reclaims.	Each practice is contacted via the Primary Care Team to ensure they are focused on the GP Specification. If necessary a visit with a clinical lead is undertaken to establish implementation plans	Monthly reviews of the achievements and support to practices.	4	3	12		Practices receive a supportive contact from the Primary Care Team to establish if there are any underlying issues that we need to be aware of. If the trend continues thoughout the year then the offer of a supportive visit from a clinical lead is provided.	3	3	9	LJ	Ongoing	Feb-17	From June monthly meetings have been set up with the Locality Manager/Primary Care Quality Manager and Clinical Advisor to review the PCQF. Practices are contacted and offered support were required. Update: Next Locality Leadership meetings have a targeted approach for treatment of asthma.	
Co-Com 19	High quality general practice	22/03/2016	To meet Quality Premium Target to reduce antibiotic prescribing	QP data includes prescribing by out-of-hours services, walk in centres and community nurses. Measures to reduce GP prescribing are succesful and, based on these, CCG would meet QP requirements. Inclusion of prescribing in other organisations puts QP acheivement at risk. OOH figures include prescribing for Knowsley patients	Antibiotic lead GP to meet with UC24 and LCH non-medical prescribers to discuss antibiotic reduction strategies		3	3	9			2	3	6	PJ	Quarterly	01/03/2017		y
Co-Com 20	To maximise value from our financial resources and focus on interventions that will make a major difference. To hold providers of commissioned services to account for the quality of services delivered	27/01/2015	To accept from NHS England delegated responsibility for the commissioning of primary care medical services	That the CCG acceptance of delegated authority to commission primary care medical services progresses without a full and proper due diligence exercise to assess the potential risks including financial, staffing and any pre-existing liabilities to the detriment of the CCG.	Transition Group in place with approved Terms of Reference and meeting on weekly basis. Primary Care Co-Commissioning Manager in post	Exception reporting to the Governing Body through Transition Group and Primary Care Commissioning Committee CCG has signed the Scheme of Delegation with NHS England and confirmation assurances from the Director of Finance, NHS England Cheshire & Merseyside Sub-Regional team that there is sufficient resource.	4	4	16	g	The Primary Care Commissioning Committee is fully established and has formally convened twice in Q1. Process and guidance in relation to delegated commissioning responsibilities continues to evolve. Risk will be re-assessed in Nov 2015. Issue that remains is NHS England resources. Service Level Agreement to be developed ready for April 2016 confirming responsibility and assurance of the remaining risks / issues. Further detail to be developed for each of the delegated functions ready for next Primary Care Committee. Budget has been confirmed and presented at PCCC. (Update from CM 30/03/2016)	2	4	8	KS / TJ	Ongoing	Feb-17	▶ MIAA completed reivew. SLA to be developed with clarity of responsibilities for each of the delegated functions.	
Co-Com 21	To hold providers of commissioned services to account for the quality of services delivered	16/04/2015	To accept from NHS England delegated responsibility for the commissioning of primary care medical services	Acceptance of delegated authority to commission primary care medical services potentially does not allow for necessary timescales for re-procurement of 12 Liverpool APMS practices (current provider SSP) once contract expires on 31st March 2016. Risks are that decision to either extend or cease the contract without full and proper consultation could impact negatively on service delivery to patients	Standing agenda item on Primary Care Commissioning Committee Interim Provider Policy has been developed approved by the Primary Care Commissioning Committee (June 2015). 5 practices being extended until April 2017. 7 practices require interim provider by April 2016 and plans are in place to ensure robust provider in place by that date.	Exception reporting from PCCC to Governing Body Practice contracts continue to be monitored via normal reporting processes Interim provider policy successfully implanted for 7 practices which evidences strength of control measure and level of assurance	5	4	20		Interim providers appointed for all practices. Mobilisation Plans in place (service commencement from 01/04/2016). APMS full procurement commenced and on target for 2016/17 completion. (Update from AP 30/03/2016 and CM **30/03/2016)**	2	4	8	CM/DR	on-going	Feb-17	Procurement exercise is on track to meet the requirements to have new providers in palce by 1/6/17.	
Co-Com 22	To hold providers of commissioned services to account for the quality of services delivered	27/01/2015	Effective provision of commissioning support services to the CCG and primary care contractors.	National outsourcing of primary care support services from 1st July 2015 will leave a gap in provision which is detrimental to the CCG and local primary care contractors with regard to delegated commissioning of primary care medical services.	Standing agenda item for Finance, Procurement & Contracting Committee and Primary Care Commissioning Committee Primary Care Team and Finance Team strengthened in anticipation of increased workload. Formal meetings in place between LCCG Finance and NHS England Finance Teams to discuss provision of financial data	Limited assurance on control measures due to uncertainty in terms of gaps. Minutes of committee meetings & exception reporting to Governing Body NHS England awarded contract (22 Jun 2015) to Capita to establish a 'single provider framework' for primary care administrative support functions LMC, Head of Primary Care Quality and Improvement	3	3	9		Transformation timetable has been produced by Capita demonstrating significant challenges to delivery of services post April 2016. Additional representation sought from healthwatch and member practices to attend local stakeholder forum to ensure local issues are raised at a national level. Capita Regional Manager attended Practice Manager City Wide Event. LMC circulate communications, outlines changes and support. Liverpool Office remains fully operational (until end of May 2016) for all services apart from requesting and ordering supplies. Payments are being made to practices although issues concerning aspects of PCSS service delivery have been raised by practices and the LMC. NHS England have escalated delivery issues to Capita and will present briefing paper to Primary Care Commissioning Committee on 17/05/2017	5	3	15	TK / CM	Ongoing	Feb-17	The Primary Care Commissioning Committee has written to NHS England North to outline our concerns with the delivery of the service from Primary Care Support Services (CAPITA). The committee is not assured that the issues highlighted from practice members have been addressed either locally or nationally. No formal update from NHS England since September 2016.	
Co-com 23	High quality general practice		Prescribing risk	Mortality, morbidity and hospital admissions due to adverse effects of medication and drug interactions	MMT previously audited higher risk drugs. Drugs requiring therapeutic monitoring included in prescribing KPI.	MMT review. Identified adverse events due to medication recorded on Datix and reported to MOC governance meeting.	4	4	16	4	Very high risk drugs included in Prescribing Quality / Risk searches. MOC to publish data to effected practices and follow up actions monthly	2	4	8	PJ	Dec-16	Monthly	New addition to the risk register	

▼ Risk reduced

▶ Risk unchanged

▲ Risk increased

Updated by Scott 07/06/16

Risk scoring = likelihood x consequence (L x C)

Consequence Score	Likelihood 1	2	3	4	5
	Rare	Unlikely	Possible	Likely	Almost certain
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5

For grading risk, the scores obtained from the risk matrix are assigned grades as follows:

1 – 3	Low risk
4 – 6	Moderate Risk
8 – 12	High Risk
15 – 25	Extreme Risk