Wirral Clinical Commissioning Group
Primary Care Co-Commissioning Committee (PMCCC) Minutes

Date: 14th March 2017
Time: 3pm – 5pm
Location: Duncan Room, Old Market House

Members:

Linda Roberts (Chair)	Lay Member, Quality & Outcomes – Wirral CCG
Alan Whittle	Lay Member- Audit & Governance, Wirral CCG
Mike Treharne	Chief Finance Officer, Wirral CCG
Carla Sutton	Senior Contract Manager, NHS England (Cheshire & Merseyside)
Graham Hodkinson	Director of Adult Social Services, Wirral Council/Health and Wellbeing Board representative
Dr Simon Delaney	GP/Primary Care Clinical Lead
Dr James Sowery	GP/Members Council Chair
Iain Stewart	Assistant Director of Primary Care Commissioning, Wirral CCG
Martyn Kent	Head of Primary Care Transformation, Wirral CCG
Alison Scullion (Admin)	Admin Support, Wirral CCG
Oliver Stewart (Admin)	Admin Support, Wirral CCG

Item No.	Agenda Item	Actions
1	**Preliminary Business**	
1.1	**Apologies for Absence**: Apologies were noted from Nesta Hawker, John Adams and Tom Knight.	
1.2	**Chair's Announcements**	
1.3	**Declarations of Interest**	
1.4	**Previous Minutes/Action Points** Re: NHSE Question	
1.5	**Action Log** (**IS**) CCG will compile a report for the Chair to submit to the committee. **ACTION** No. 18 - on the agenda and being actioned. No. 19 - No. 20 - Close No. 21 -	**IS**
2	Items For Discussion	
2.1	**Primary Care Transformational Plan** (**IS**) updated the committee on the Primary Care	

	Transformational Plan. Informed the committee that members had been updated at the January Members Meeting and had been asked to provide feedback. Some of the feedback called for greater emphasis to be placed on plans for investing in service level issues at practices. Due to many of the members having been present in January it was decided that no update would be provided at February's Members Meeting. Instead, it was agreed with LMC that there was a need for an evening meeting to discuss GPFV and the transformational plan. NHSE feedback has been received. General theme was that the plan was "Okay, but needs to be more descriptive" i.e. how we are going to implement the plan and by when? Going forward we will need to give more precise metrics and should be encouraged to incorporate the positives from the current plan, which is coming to an end. Peter Groggins will be the main link for GPFV programme going forward. **Q.** (**GH**) What is NHSE's offer to Wirral? **A.** (**IS**) Offer is to provide support for issues in terms of maximising uptake etc. (**MT**) Need to be aware that we need to be more self-initiating to satisfy NHSE targets. We will have failed if GP members can't describe exactly what they're going to get out of this. Need to think of a Comms strategy, a simple message that GPs can own. (**IS**) Agreed, and welcomed LMC's involvement. Will utilise practice visits to reinforce themes.	
2.2	**PCQS 2017 – 19. Practice Standards and Clawback Terms** (**MK**) Informed the group that last committee approved PCQS over the next 2 years. Updated the group on the progress of the Enhanced Primary Care in Care homes pilot. Described to the committee how the Highlight Report showed that there had been 430 fewer referrals during the time period and a fairly small saving has been apportioned to it.	

	Q. (**AW**) noticed a small amendment to be made to the highlight report. Moving the practice at the top of quartile 2 back into quartile 1. **A.** (**MK**) Agreed. (**MK**) was optimistic and sees us as being in a favourable position, if the Right Care data is correct. (**MK**) CCG Ops Group has been placing the focus on reducing non-elective admission ahead of all others. **Q.** (**JS**) enquired as to how the % savings were agreed. **A.** (**MK**) Use of Business Intelligence input and committee discussion. Admittedly, not an exact science but is flexible. (**JS**) pointed out that admissions were high and he wasn't sure where the savings could be made. (**MK**) Right Care data suggests there is scope to reduce non-elective admissions further. Agrees with the point but pointed out the need to link Primary Care measures with A&E attendances. How can we better educate people? May be a need for better signposting. Described various systems that have been used in other parts of the country such as IT systems that divert patients to more appropriate care channels. Notes (**JS**) point and keen not to unduly penalise GPs for things beyond their control but believes more can be done in practices. (**JS**) stressed the need for pathways to come online quickly in order it to positively affect this. (**SD**) Only so much GP's can do to prevent non-elective admissions. Multiple factors such as, social deprivation, education and patients who present late on. Important to have the familiarity between GP and patients in order to prevent unnecessary admissions being made by locums and GPs who are unfamiliar with certain patient's conditions, for example. Important to note that A&E attendances are not the same as admissions. (**MT**) Need to do more to incentivise admission prevention. (**SD**) RTT has escalated. For example, Orthopaedics is currently a 20 week wait, which impacts upon data collection. (**MT**) Important to be aware of the difficulties of data	

	validation. (**AW**) Roughly half of the financial savings to be drawn from approximately 25% of practices. Rather disproportionate. Is there a compromise to be made on a baseline number for referrals that spreads the load across practices? May not necessarily be fair but may be more achievable. (**MK**) Very subjective exercise but committee has scope to readjust and react to appeals from practices. (**AW**) There's a risk that we're putting off practices by setting the bar too high and making it an unattractive proposition. (**MT**) If we weren't running a deficit it might be the situation that budgets were devolved to practices entirely and the incentive would be that savings would go back into the practices themselves. Steps towards this are being taken (e.g. around prescribing etc.) but not there yet. (**AW**) Not arguing with the science or how the savings figures were reached but concerned by practicality of placing too much pressure to make savings on too few practices. (**MT**) Might be that money needs to be staggered as the early steps of making savings are often easier than the latter steps. Build in a phased approach and be more flexible with non-elective Right Care targets. **ACTION:** (**MK**) and (**MT**) to meet outside of the committee to review the figure of £3.9 Mil. (**MK**) keen to work with finance on this. (**MT**) Would perhaps need to run past NHSE as it would benefit GPs but would not have been agreed at committee. Will therefore need to present to PMCCC first to get it signed off. (**SD**) Re: Meds Management – **Q.** if repeat re-ordering pilot comes back as having made no savings, will it be scrapped? Bearing in mind it will take several months for results to be gathered. (**MK**) **A.** Unlikely to be scrapped but likely to be revised. (**SD**) **Re: e-learning for anti-biotics**. All prescribing leads should complete this training and other clinicians given the option to complete it if they wish.	**MK** & **MT**
2.3	**PCQS 2016/17 – March 2017** (**MK**) Regarding area 4, possibility of appeal from Primary Care.	

	Will be doing a year-end review but not yet as everything is currently 2/3 months behind. (**AW**) Are we setting ourselves up to fail in terms of prescribing? (**GH**) Massive variance in performance despite savings. (**MK**) Need to investigate why some practices have done so well and why some have done poorly. (**SD**) Important to compare practices that are similar in terms of list size and demographics etc. (**JS**) Use of practice visits is vital to share best practice. (**MT**) described practices that use referral review meetings after morning surgeries as an example of good practice.	
2.4	**Estates Technology and Transformation Fund (ETTF)** (**IS**) 2 out of 4 PIDs were asked to be refined by NHSE. Meeting to be agreed between Riverside, Sunlight Group and Parkfield to discuss possibility of a super centre in New Ferry area. Caveat with Marine Lake and Civic MC PIDs. Marine Lake wants to raise capital with a 3rd party developer. However, no NHS contribution if using a 3rd party or private provider. If practices partnered with an NHS property company for example, there may be scope for funding to be released. Both PIDs have gone in; one involves a 3rd party developer and the other is GP capital. Practices going this route won't get capital funds from NHS. Project Phoenix – a consideration to allocate funds for increased rent for new builds. £180K secured for technology pilot.	
2.5	**GP Access HUBS** (**MK**) Some funding has been provided, approx. £14K. Need confirmation of delivery sites (approximately 12 so far). Would like support from committee on where Access Hubs sprout up and how many.	

	Query over whether CQC registration has been factored into timeframe.	
2.6	**PCSE**	
	Risk Register (**MT**) Can Estates (3.1) be improved to a 12? 1 & 2 can be removed. (**IS**) Transformation plan should stay at the score it currently is. (**AW**) Suggested adjusting the scores for 1 & 2 but leaving them on as evidence. Worth doing a comparison between this and the risk registers of other committees. (**IS**) PCQS addition to the risk register is to be discussed outside the meeting. **ACTION**	**IS**
	A.O.B. (**IS**) Asked for a meeting in May rather than waiting until June to get the logic of the Prescribing budget scheme together.	
	Date & Time of Next Meeting: 13th June 2017 14:00 – 16:00, Duncan Room OMH	