A meeting of the Primary Care Commissioning Committees of the Eastbourne, Hailsham and Seaford (EHS) and Hastings and Rother (HR) Clinical Commissioning Groups to be held together on Wednesday 26 October 2016 from 11.00am in the Wiltshire Room, Kings Centre, Edison Road, Eastbourne, East Sussex, BN23 6PT

Voting Members

**Eastbourne, Hailsham and Seaford CCG**
- Frances Hasler, Lay member, Patient and Public Involvement (Chair – and meeting Chair) (FH)
- Allison Cannon, Chief Nurse (AC)
- Graham Dodge, Independent member, Secondary Care Doctor (GD)
- Rose Durban, Lay member (RDu)
- Karen Keane, Independent member, Registered Nurse (KK)
- John O’Sullivan, Chief Finance Officer (JOS)
- Amanda Philpott, Chief Officer (ALP)
- Julia Rudrum, Lay member, Governance (Vice Chair) (JR)

**Hastings and Rother CCG**
- Barbara Beaton, Lay member, Patient and Public Involvement (Chair) (BB)
- Allison Cannon, Chief Nurse (AC)
- Rajeev Dhar, Independent member, Secondary Care Doctor (RD)
- Rose Durban, Lay member (RDu)
- Karen Keane, Independent member, Registered Nurse (KK)
- John O’Sullivan, Chief Finance Officer (JOS)
- Amanda Philpott, Chief Officer (ALP)
- Alan Rummins, Lay member, Governance (Vice Chair) (AR)

Non-voting members
- Tim Caroe, GP member (TC)
- Julie Fitzgerald, Executive Director, East Sussex Community Voice (JF)
- Dr Ian Harper, Medical Director, East Sussex Local Medical Committee (IH)
- Stephen Ingram, Head of Primary Care, NHS England South East (SJl)
- Susan Rae, GP member (SR)

In Attendance
- Jessica Britton, Chief Operating Officer (JEB)
- Zoe Holter, Governance and Corporate Services Officer (*minutes*) (ZH)
- Fiona Kellett, Head of Finance and Primary Care Commissioning (FK)
- Clive Mellor, Head of Governance and Business Planning (CM)

Members of the Public

**AGENDA**

Questions from the public will be taken prior to the formal opening of the Primary Care Commissioning Committees’ meeting. There will also be the opportunity for members of the public to ask questions after the meeting has finished, in response to any items discussed. A record of these discussions will be appended to the minutes of the meeting.

<table>
<thead>
<tr>
<th>Item No</th>
<th>Item</th>
<th>Action</th>
<th>Lead</th>
<th>Paper Attached</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>49/16</td>
<td>Welcome and apologies for absence</td>
<td>Note</td>
<td>FH</td>
<td>Verbal</td>
<td>11.10</td>
</tr>
<tr>
<td>50/16</td>
<td>Declaration of interests</td>
<td>Note</td>
<td>FH</td>
<td>Verbal</td>
<td></td>
</tr>
<tr>
<td>51/16</td>
<td>Minutes of the previous meeting</td>
<td>Approve</td>
<td>FH</td>
<td>Yes</td>
<td></td>
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<tr>
<td>52/16</td>
<td>Action Log</td>
<td>Approve</td>
<td>FH</td>
<td>Yes</td>
<td></td>
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<tr>
<td>53/16</td>
<td>Committee Chairs’ opening remarks</td>
<td>Note</td>
<td>FH/BB</td>
<td>Verbal</td>
<td></td>
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| **Section 1 – Governance of the Committees**
| 54/16 | Information Update: *(i)* General Practice Resilience Programme | Note | SJI | Yes | 11.20 |
| 55/16 | Conflict of Interest and GP voting *(i)* Revised Terms of Reference | Ratify | CM | Yes | 11.25 |
| 56/16 | Managing General Practice Performance and Quality under Delegated Commissioning Responsibilities Policy 2016 | Ratify | JOS | Yes | 11:30 |
| 57/16 | Workplan review – Item to follow shortly | Note | FK | Yes | 11:35 |
| 58/16 | Risk Register | Note | JOS | Yes | 11:45 |
| **Section 2 – Quality, Performance and Delivery**
| 59/16 | General Practice Forward View: an update on the implementation of the programme to support sustainability in Primary Care: *(i)* Workload *(ii)* Workforce *(iii)* Information Management and Technology (IM&T) *(iv)* Premises | Note | FK | Yes | 11.55 |
| 60/16 | Finance: Primary Care Delegated Commissioning Budget 2016-17 | Note | FK | Yes |
| 61/16 | Monitoring Performance in Primary Care 2016 - 2017 – Quarter 2 (July 2016 – September 2016) | Note | FK | Yes |
| 62/16 | Quality | Note | AC | Yes |
| 63/16 | Primary Care Commissioning Operational Group (PCCOG) update | Note | JOS | Yes |
| **Section 3 – For information**
| 64/16 | Patient Participation Group (PPG) mid-year update | Note | JF | Yes | 12:20 |
| 65/16 | Any Other Business | Note | FH | Verbal |

Public reflection or feedback on the discussions of the Committee during the meeting will be taken prior to the formal closing of the meeting. A record of these discussions will be appended to the minutes of the meeting.  

To consider a motion: “That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest”. (Section 1(2) Public Bodies (Admissions to Meetings Act 1960)).

**Freedom of Information Act:** Those present at the meeting should be aware that their names and designation will be listed in the minutes of this Meeting which may be released to members of the public on request.

**Conduct of meetings in relation to attendance by members of the public:** Members of the public are asked to note that meetings of the Eastbourne, Hailsham and Seaford and Hastings and Rother Clinical Commissioning Groups' Primary Care Commissioning Committees are meetings of the Committees held in public. They are not ‘public meetings’ where members of the public can speak at any point. Agendas identify when the Chair will receive questions and comments from the public. For all other agenda items speaking rights are reserved to Committee members and agreed representatives sitting at the table; members of the public should not speak or intervene in proceedings unless invited to do so. In all matters the Chair’s decision is final. The introduction by the public or press representatives of recording, transmitting, video or similar apparatus into meetings of

NHS Eastbourne, Hailsham and Seaford Clinical Commissioning Group
NHS Hastings and Rother Clinical Commissioning Group
Eastbourne, Hailsham and Seaford and Hastings and Rother Clinical Commissioning Groups together is not permitted.

**Written questions from the public:** Any questions relating to Committee meeting papers which are received in writing three or more days in advance of the meeting will receive a verbal response at the meeting. A written reply will also be sent after the meeting, and the minuted question and response will be appended to the minutes of the meeting. Please send your question, along with a contact telephone number or e-mail address, to: Zoe Holter, 36-38 Friars Walk, Lewes, East Sussex, BN7 2PB, or zoe.holter@nhs.net If your question includes personal information about you or someone else we may contact you about safeguarding such information.

**Committee papers:** Eastbourne, Hailsham and Seaford Clinical Commissioning Group Committee papers are held on the website and can be accessed through the following web page link: [http://www.eastbournehailshamandseafordccg.nhs.uk/](http://www.eastbournehailshamandseafordccg.nhs.uk/)

Hastings and Rother Clinical Commissioning Group Committee papers are held on the website and can be accessed through the following web page link: [http://www.hastingsandrotherccg.nhs.uk/](http://www.hastingsandrotherccg.nhs.uk/)
DRAFT Minutes of a meeting of the Primary Care Commissioning Committees (PCCCs) of the Eastbourne, Hailsham and Seaford (EHS) and Hastings and Rother (HR) Clinical Commissioning Groups (CCGs) held together on Wednesday 29 June 2016 from 11.00am in Manor Barn, 4 De La Warr Road, Bexhill on Sea, East Sussex, TN40 2JA

Present
(Voting Members):

**Eastbourne, Hailsham and Seaford CCG**
Frances Hasler, Lay member, Patient and Public Involvement (PPI) (Chair) (Chairing meeting) (FH)
Allison Cannon, Chief Nurse (AC)
Tim Caroe, GP member (TC)
Karen Keane, Independent member, Registered Nurse (KK)
John O’Sullivan, Chief Finance Officer (JOS)
Amanda Philpott, Chief Officer (ALP)
Julia Rudrum, Lay member, Governance (Vice Chair) (JR)

**Hastings and Rother CCG**
Barbara Beaton, Lay member, Patient and Public Involvement (PPI) (Chair) (BB)
Allison Cannon, Chief Nurse (AC)
Rajeev Dhar, Independent member, Secondary Care Doctor (RD)
Karen Keane, Independent member, Registered Nurse (KK)
John O’Sullivan, Chief Finance Officer (JOS)
Amanda Philpott, Chief Officer (ALP)
Susan Rae, GP member (SR)
Alan Rummins, Lay member, Governance (Vice Chair) (AR)

Present
(Non-voting members):

Julie Fitzgerald, Executive Director, East Sussex Community Voice (JF)
Stephen Ingram, Head of Primary Care, NHS England South East (SJI)

In Attendance

Jessica Britton, Chief Operating Officer (JEB)
Fiona Kellett, Head of Finance and Primary Care Commissioning (FK)
Clive Mellor, Head of Governance and Business Planning (CM)
Sally Robson, Risk and Business Planning Manager (observing) (SR)
Kerry Smith, Governance and Corporate Services Officer (minutes) (KS)

Members of the Public

Questions from the public were taken prior to the formal opening of the meeting. A record of the discussion is appended to these minutes – please see Appendix A.

<table>
<thead>
<tr>
<th>Item No.</th>
<th>Item</th>
<th>Action</th>
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<tbody>
<tr>
<td>36/16</td>
<td>Welcome and apologies for absence</td>
<td>Frances Hasler welcomed those present. Graham Dodge, Independent member, Secondary Care Doctor, EHS CCG and Dr Ian Harper, Medical Director, East Sussex Local Medical Committee (LMC) were noted as absent.</td>
</tr>
<tr>
<td>37/16</td>
<td>Declarations of interests</td>
<td>Julie Fitzgerald declared an interest related to the East Sussex Better Together (ESBT) award of contract to support Patient Participation Groups (PPGs). Tim Caroe declared an interest related to his involvement with a communications</td>
</tr>
</tbody>
</table>
company to create software.

There were no new declarations of interest considered prejudicial to any of the agenda items.

### 38/16 Minutes of the previous meeting

The minutes of the 27 April 2016 meeting of the PCCCs of the EHS and HR CCGs were **approved** as an accurate record of the meeting.

### 39/16 Action Log

#### 26/16 Finance

John O’Sullivan confirmed that action to raise the sessional rate of reimbursement for locums in the 2016/17 budget for discussion by the Primary Care Commissioning Operational Group (PCCOG) is in progress. This is being considered as part of discussions about establishing a locum bank. NHS England (NHSE) may set a capped rate for GP locums which will be picked up as part of this.

All other actions were reported as complete.

### 40/16 Committee Chairs’ opening remarks

Frances Hasler remarked that it was the Committees’ first meeting since the United Kingdom’s (UK) decision to leave the European Union (EU). Our job as Committees is the same today as it was before; to concentrate on overseeing the best GP service for the people of East Sussex including building up the Primary Care workforce and working to transfer resource into the system in accordance with our long-term plan.

Barbara Beaton echoed these remarks.

The Committee noted the Chair’s opening remarks.

### 41/16 Informal orientation

**i An update on changes to General Medical Services contract for 2016/17**

Stephen Ingram presented a paper providing the Committees with an update on the contractual changes that will come into effect in 2016/17.

The Committees heard that the national General Medical Services (GMS) contract is subject to annual change by the British Medical Association (BMA) and NHS Employers on behalf of NHSE and the Department of Health. The global sum per weighted patient has increased from £75.77 to £80.59 resulting from the 1% uplift on pay. Practices will receive the increase as a proportion of their income to ensure sustainability.

During discussion Tim Caroe commented that we need to encourage practices to implement and manage online access but recognised this creates a huge amount of work.

Stephen Ingram confirmed that there is an obligation in GMS and Primary Medical Services (PMS) Contracts for practices to have a PPG. He also confirmed that collaborative working between practices is not built into contracts.

The Committees noted the report.

**Action:** Stephen Ingram will establish whether there will be consistency in definitions around data extraction from the Access to GP services survey.  

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**SI 26/10/16**
**Overview of Primary Medical Services Contracts**

Stephen Ingram presented a paper providing an overview of PMS contracts.

The Committees heard that the new GMS contract commenced in 2004. It seeks to give practices more flexibility and control. Before 2004 GPs were responsible for their own Out of Hours (OOH) provision. It is the responsibility of commissioners to operate OOH services for GPs that opted out after 2004. The new contract also allows GPs to choose to provide one or more of the following additional services: cervical screening services; contraceptive services; vaccines and immunisations; childhood vaccines and immunisations; child health surveillance services; maternity medical services; and minor surgery. The GMS contract requires GP practices to provide all ‘essential services’ throughout ‘core hours’ as appropriate to meet the needs of its patients. Core hours are defined as the period beginning at 8am and ending at 6.30pm on any day from Monday to Friday excluding Bank Holidays. If GP practice premises are closed at any point during the core hours the practice must provide a means for patients to see a duty Doctor. Stephen Ingram suggested that the CCGs might wish to consider a patient offer to define ‘reasonable need’.

PMS contracts were piloted between 1998 and 2004. GMS contracts have a strong influence on the content of PMS contracts and allow participation in the Quality Outcomes Framework (QOF) scheme. NHS England South is conducting a review to create more equity between GMS and PMS contracts, in particular the level of funding associated with them.

Alternative Provider Medical Services (APMS) contracts were introduced in 2006 to create competition, procurement law and principles. One GP must be a signatory to the contract. An APMS contract cannot be held by a single entity.

During discussion Stephen Ingram confirmed that APMS contracts are locally negotiated and tend to be more expensive than GMS and PMS contracts.

The Committees noted the report.

**Governance of the Committees**

42/16 **Primary Care Operational Group Terms of Reference**

John O’Sullivan presented the Terms of Reference for the PCCOG, a sub-group of the PCCCs.

Frances Hasler commented that we need to remind ourselves as part of general communication that patients directly affected by decisions made need to be communicated with.

The Committees ratified the Terms of Reference for the PCCOG.

**Quality, Performance and Delivery**

43/16 **Sustainability of Primary Care**

i **Progress Report**

Fiona Kellett presented an update report on progress on sustainability in Primary Care.

The Committees heard that work around sustainability of Primary Care is being managed in four specific workstreams: workforce developments; premises developments; Information Management and Technology (IM&T) developments; and Patient and Stakeholder engagement. Two General Practice summits will be held to review the work undertaken on this to date and to shape the directions and priorities for future work. At the first summit on 28 June 2016 streamlining
processes with East Sussex Healthcare NHS Trust (ESHT) was raised and a presentation on how practices can merge was given.

During discussion Tim Caroe raised how we will feed ideas from the GP Summits back into our overall plans.

John O’Sullivan stated that at the summit there was a recognition that we need to share data and protocols.

Fiona Kellett confirmed that invitations to the GP summits are sent to all practice staff. Senior Nurses will have the opportunity to be involved at summits.

John O’Sullivan confirmed that federations are to be determined. It is anticipated that these will be established groups of GPs working in partnership rather than as sole practitioners. They do not need to be a merged single partnership.

Fiona Kellett added that EHS has one federation and HR has three federations. The Primary Care team meets regularly with federations to make sure their thinking is in line with the CCGs’ direction. It is our intention that federations will help with issues such as recruitment and retention.

Amanda Philpott stated that we should be looking at large scale federation in order to gain best benefit for both practices and patients.

The Committees noted the progress on the initiatives supporting sustainability in Primary Care.

ii Information Management and Technology (IM&T)

Fiona Kellett presented a report which provided an update on progress made on each of the commitments within the GMS contract during 2015/16 across the two CCGs.

The Committees heard that the CCGs have received three bids for the Information Technology Fund, two of which will be recommended to go forward to the next PCCOG meeting.

During discussion Jessica Britton confirmed that:
- she will have a conversation with Julie Fitzgerald about support to our PPGs to underpin priorities for practices;
- John O’Sullivan and Jessica Britton will pick up a formalised programme of Patient and Public Engagement (PPE) around Primary Care; and
- CCGs have to comply with the Accessible Information Standard, we have reviewed compliance for the CCGs and are considering if there is a shared approach that can support Primary Care with this.

Frances Hasler raised the need for information about how we benchmark our progress against other CCGs at national and Sussex-wide levels.

The Committees noted the progress on IM&T developments in EHS and HR CCGs.

iii Workforce

Fiona Kellett presented a Workforce Plan update as at June 2016.

The Committees heard that ESHT is supportive of a joint recruitment programme with the CCGs for Junior Doctors or recently registered GPs.

Amanda Philpott commended this new and innovative way of attracting the upcoming workforce and noted it as a good test case and that it bodes well for the
iv Premises

Fiona Kellett presented an update report on Primary Care premises.

The Committees noted the update.

The Committees heard that the CCGs will bid for major transformational premises developments ranging from extensions to existing Primary Care facilities to refurbishment of premises to implementation of IT systems. The CCGs anticipate a final decision on which bids are successful by the end of August 2016. CCG officers are holding regular meetings with representatives from each of the local District and Borough Councils to ensure Primary Care plans take account of any planned or anticipated housing growth. There will also be an opportunity for minor improvement grants later in the year. The CCGs have discussed with ESHT about who holds the head lease for buildings and how the Trust might be the vehicle for that. As part of general sustainability work we have gathered case studies across East Sussex to see what is applicable to each of the workstreams issues locally.

During discussion John O’Sullivan commented that we need to progress premises development regardless of whether or not bids are successful.

The Committees noted the formation of a Primary Care Premises and IM&T action group and the progress to date on inviting bids for premises and IM&T developments.

44/16 Finance

John O’Sullivan presented a Finance update on Primary Care Delegated Commissioning Budgets 2016/17.

The Committees heard that detailed budgets have been received from NHSE. The 2016/17 allocation for Primary Care delegated commissioning for EHS CCG is £25m comprising £23.6m budget brought forward and £1.3m growth funding for the last year of delegated commissioning. In HR the allocation is £26m. In accordance with NHSE business rules the budgets set in each CCG include a 0.5% contingency reserve and a 1% uncommitted reserve. There is no requirement in 2016/17 to deliver a 1% surplus against the Primary Care allocation. Changes to the global GMS contract and the Locally Commissioned Services (LCS) budget for 2016/17 have been built into the Primary Care delegated commissioning budget for 2016/17. With effect from 2016/17 the CCGs have agreed to uplift all LCS prices annually in line with the global sum uplift. In addition, all LCS specifications are being reviewed to ensure they are current and consistent across both CCGs and we will follow up with the LMC on this.

During discussion John O’Sullivan confirmed that it is likely that the East Surrey and Sussex Sustainability and Transformation Plan (STP) will determine how the 1% uncommitted reserve will get used. We do not have the experience to assure that the 0.5% contingency reserve will be sufficient as in some ways this is the first year of test. 2015/16 budgets came out managing this risk. We need to have contingency plans to manage this in 2016/17.

The Committees approved the 2016/17 Primary Care delegated commissioning budgets and LCS budgets.

45/16 Performance

The Committees heard that the CCGs’ Primary Care Co-commissioning team continues to support practices routinely and particularly when issues are flagged to them. The team would welcome support of GP Board member colleagues. Two HR practices are in special measures and the team is working closely with them around their remedial action plan (RAP).

The Committee noted the progress made.

46/16 **Quality**

Allison Cannon presented an update on Quality in General Practice. She stated that she supports Tim Caroe’s request for availability of clinical colleagues to attend practice visits.

Allison Cannon highlighted the introduction of the Preceptorship Framework, supporting Nurse revalidation and Competency Framework development. It has been agreed that ESHT will advise each GP in writing around the status of their patients should they be required to be reviewed in line with 104 day cancer treatment delay breach requirements. A champions/lead Infection Control programme is being hosted by the CCGs.

During discussion Fiona Kellett confirmed that practice visits include a contractual element and if there are performance issues they are discussed with the Quality Team and a joint response is made. Allison Cannon added that learning is shared to reduce the risk of harm to patients.

The Committees noted the report.

47/16 **Primary Care Commissioning Operational Group (PCCOG) update**

John O’Sullivan presented an update on the PCCOG.

The Committees heard that the CCGs have submitted a request for an extension to the Walk in Centre contracts to NHSE to align to reprocurement of the Urgent Care pathway by April 2018. A communication has been sent out to all practices across both CCGs to clarify the process for making list closures and confirming that there is no formal process for capping of lists.

**Action:** John O’Sullivan will bring a draft risk register for areas covered by the PCCCs to their meeting on 26 October 2016.

The Committees noted the update.

48/16 **Any Other Business**

There was no further business.

The Committees considered and agreed the motion “that representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest”. (Section 1(2) Public Bodies (Admissions to Meetings Act 1960)) and moved to the confidential part of this meeting.

**Appendix A – Questions from the Public taken prior to the formal opening of the meeting**

There were no questions from the public taken prior to the formal opening of the meeting.

**Appendix B – Reflections from the Public following the meeting**

Liz Walke, Chair, Save the DGH Campaign reflected that the area forums and some PPG meetings have not taken place for a year. She stated that she is happy to coordinate these. It was confirmed at
the April 2016 PCCC meeting that Healthwatch is supporting the CCGs with PPG development but nothing has been seen to be done. There are issues in Primary Care and it is important that patients are heard.

Julia Fitzgerald confirmed that Healthwatch signed the contract in the week commencing 20 July 2016 and will make sure this happens quickly.

Frances Hasler apologised for the length of time it has taken to get more PPG development underway.

Liz Walke reflected that she agrees with Tim Caroe’s comment on the importance of online access and that she is pleased about this as a way forward.

Liz Walke reflected that she is also pleased with discussion around GP specialisation across the CCGs and ESHT.

Liz Walke congratulated the Committees on innovative ways of working which benefit patients, public, GPs and consultants.
<table>
<thead>
<tr>
<th>Date</th>
<th>Agenda Item</th>
<th>Item Title</th>
<th>Initial Action Required</th>
<th>Staff to Action</th>
<th>Action Due</th>
<th>Action Complete</th>
<th>Further Actions/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>24/02/2016</td>
<td>11/16</td>
<td>Quality and Performance update</td>
<td>Allison Cannon and Tim Caroe agreed to provide a paper on any issues reported regarding electronic prescribing and assurance on incomplete take up of prescribing reviews.</td>
<td>Allison Cannon</td>
<td>27/04/2016</td>
<td>Complete</td>
<td>Allison Cannon confirmed that this will be included in the next report to the Committee</td>
</tr>
<tr>
<td>24/02/2016</td>
<td>13/16</td>
<td>Any other business</td>
<td>John O'Sullivan agreed to request that the PCCOG consider the new contracts and locum rates for doctors. A summary of the changes and their implications in real terms would be discussed at the PCCOG.</td>
<td>John O'Sullivan</td>
<td>27/04/2016</td>
<td>Complete</td>
<td>Update October 2016: John O'Sullivan confirmed that a locum bank has been set up as the first step to employing our own floating GPs to reduce the reliance on and cost of locums</td>
</tr>
<tr>
<td>29/06/2016</td>
<td>41-16 i</td>
<td>An update on changes to General Medical Services contract for 2016/17</td>
<td>Stephen Ingram will establish whether there will be consistency in definitions around data extraction from the access survey to GP services.</td>
<td>Stephen Ingram</td>
<td>26/10/2016</td>
<td>Complete</td>
<td>Stephen Ingram will provide a verbal update to Committees at the October 2016 meeting.</td>
</tr>
<tr>
<td>29/06/2016</td>
<td>47/16</td>
<td>Primary Care Commissioning Operational Group (PCCOG) update</td>
<td>John O'Sullivan will bring a draft risk register for areas covered by the PCCCs to their meeting on 26 October 2016.</td>
<td>John O'Sullivan</td>
<td>26/10/2016</td>
<td>Complete</td>
<td>John O'Sullivan confirmed this as a agenda item for October 2016.</td>
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Status as of: 19.10.2016
The Primary Care Commissioning Committees of Eastbourne, Hailsham and Seaford CCG and Hastings and Rother CCG meeting together
Date of meeting: 26 October 2016

Title of report: NHS England (NHSE) General Practice Resilience Programme

Recommendation: The Committees are recommended to note the guidance and summary report.

Summary:

The attached guidance describes how the NHSE General Practice Resilience Programme (GPRP) will operate to deliver the commitment set out in the General Practice Forward View (GPFV). This programme aims to deliver a menu of support that will help practices to become more sustainable and resilient, better placed to tackle the challenges they face now and into the future, thereby securing continuing high quality care for patients.

The Committees should note that the GPRP is a specific Reserved Function in terms of delegated co-commissioning responsibility. This means that the commissioning and accountability for the programme sit with NHSE. However the NHSE Local Regional Office will work closely with all CCGs in delivering this programme.

It should be noted that some of the programme milestones have been revised to enable practices to self-refer since the publication of the guidance. The key points to note are:

- Directory of Local Regional Office arrangements – 03 October 2016.
- Practices to be given the opportunity to self-refer into the scheme – 07 October 2016.
- Local Regional Office teams of NHS England to confirm list of practices to be offered support – 18 October 2016.

At the time of writing this report the vast majority of CCGs, including both Eastbourne, Hailsham and Seaford CCG and Hastings & Rother CCG, had submitted their assessment for their member practices. CCGs were asked to risk assess each practice in terms of the need for support and the extent to which practices would benefit from support against a template provided by NHSE.

The financial allocations that are to be made to NHS England South East are as follows:

- 2016/17 - £1,315,623
- 2017/18 - £657,812
Practices that are prioritised for support from the GPRP will be contacted shortly.

**Committee sponsor:** Stephen Ingram, Head of Primary Care, NHS England

**Author(s):** Stephen Ingram, Head of Primary Care, NHS England  
**Date of report:** 13/10/16

**Review by other committees:** None

**Health impact:**
The programme is designed to support a number of GP practices to become more resilient and sustainable. This will be an important step in ensuring that local people continue to have access to GP services.

**Financial implications:**
There are no revenue implications to the CCGs regarding this programme.

**Legal or compliance implications:**
The GPRP is a Reserved Function in terms of delegated co-commissioning. Consequently there are no legal or compliance issues associated with the programme that the CCG is responsible for.

GP practices may find support from the programme helpful in terms of their own compliance issues with regards to Care Quality Commission (CQC) ratings and in terms of delivering services in accordance with the Regulations that underpin their contracts.

**Link to key objective and/or principal risks:**
The programme will only be able to support a specific number of practices that are prioritised for support. The risk is that some practices may not receive support from the programme and this may result in them experiencing ongoing operational issues. The risks are therefore risks relating to service delivery and a demand for support from other sources.

**Link to East Sussex Better Together (ESBT) programme:** A resilient primary care

**How has the patient and public engagement informed this work:**
This is one of the national programmes which form part of the General Practice Forward View.

**Equality Analysis (EA) Process - outcome:**
- Negative Impact: ☐
- Neutral Impact: ☐
- Positive Impact: ☒
- No Impact: ☐
- Not required for report: ☒

**Privacy Impact Assessment (PIA) – outcome:**
- No personal data used: ☒
- Data processes sufficient: ☐
- Actions required: ☐
General Practice Resilience Programme
This guidance describes how the General Practice Resilience Programme (GPFV) will operate to deliver the commitment set out in the General Practice Forward view. This programme aims to deliver a menu of support that will help practices to become more sustainable and resilient, better placed to tackle the challenges they face now and into the future, and securing continuing high quality care for patients.
General Practice Resilience Programme

Operational Guidance

Version number: 1.0

First published: 28 July 2016

Prepared by: Primary Care Commissioning Team, Medical Directorate

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As a controlled document, this document should not be saved onto local or network drives but should always be accessed from the intranet.
1 Summary

This guidance document describes how the new General Practice Resilience Programme (GPRP) will operate to deliver the commitment set out in the General Practice Forward View1 to invest £40m over the next four years to support struggling practices.

This programme aims to deliver a menu of support that will help practices to become more sustainable and resilient, better placed to tackle the challenges they face now and into the future, and securing continuing high quality care for patients.

The intended audience for this guidance is:

- NHS England local teams working under Directors of Commissioning Operations who will lead delivery of this programme.
- Clinical Commissioning Groups and local provider GPs and their Local Medical Committee (LMC) representatives and Royal College of GPs (RCGP) Faculties and Regional Ambassadors who will work in close collaboration with local teams to support this programme.

As part of agreed devolution arrangements, Greater Manchester has been allocated a transformation fund which includes an appropriate share of NHS England funding for primary medical care initiatives. It will be for Greater Manchester to determine how it is spent in the local area.

Promoting equality and addressing health inequalities are at the heart of NHS England’s values. Throughout the development of the policies and processes cited in this document, we have:

- Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and
- Given regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities.

2 Introduction

Rising GP workload pressures are widely recognised in England. Managing GP services that are at or beyond capacity risks locking those practices into responding reactively and inhibits effective strategic leadership and practice management. Recruitment challenges exacerbate these difficulties. In addition, practices do not exist in isolation and the impact of these pressures can have a ‘domino effect’ in local areas. One or two local problems can quickly impact on otherwise functioning and stable practices.

1 https://www.england.nhs.uk/ourwork/gpfv/
NHS England is committed to supporting GP practices to improve their sustainability and resilience; securing operational stability; developing more effective ways of working and helping practices to explore new care models.

Two national programmes are currently operating to offer turnaround support to those GP practices where there is the greatest need to improve sustainability and resilience:

- £10m investment in externally facilitated support – the Vulnerable Practice Programme\(^2\), and,
- RCGP Peer Support Programme\(^3\) providing support to practices entering CQC special measures.

We have worked with the RCGP, British Medical Association (BMA) General Practitioners Committee (GPC) and NHS ClinicalCommissioners (NHS CC) to consider how best to offer further support.

This guidance sets out how the GPRP will be delivered and confirms:

- Operational and funding arrangements at NHS England local team level
- Practices (individual or groups) will be identified for support using existing national criteria
- A menu of support will be offered by local teams, ranging from support to stabilise practice operations where there is a risk of closure, through to more transformational support that will secure resilience in to the future.
- Local teams will tailor this support and decide how to deliver this in view of local practice needs working in conjunction with CCGs, provider GPs, LMCs representatives and RCGP Faculties and Regional Ambassadors (referred hereafter as 'key partners').
- We will work nationally to quality assure support by enabling learning and sharing of best practice, working with RCGP to maximise learning from local peer support and through the roll out of regional events.

In 2016/17 the GPRP will operate in addition to existing national programmes of turnaround support. This means the additional funding from GPRP can be used to support even more GP practices this year.

### 3 Funding

NHS England is committed to investing £40m in the GPRP over the next four years.

In 2016/17 there is £16m available to be invested in support to help practices become more sustainable and resilient, with £8m available per year thereafter until March 2020.


This means local teams will be able to invest in support arrangements over the medium term, giving greater certainty and continuity in the support offer available to GP practices over the lifetime of the GPRP (notwithstanding local ambitions to ensure support continues to be responsive and evolving with local practice needs).

The funds will be transferred direct to local teams. Fair shares at this footprint have been calculated on a registered patient population basis. Local teams will work with key partners to ensure the funding is used to target support at areas of greatest need and will work in line with the processes set out in this guidance to deliver support to practices.

GPRP allocations for 2016/17 will be made to local teams by end of July 2016 and future years will be made at the start of each financial year. Annex A provides details of funding allocations for each NHS England local team and region.

4 Menu of support

There are many definitions of struggling practices in need of support to become more sustainable and resilient. This means there is a wide range of support needed.

We have identified a menu of support for which the GPRP funding should be used to secure this at a local level. This will include the provision of immediate help to practices facing urgent operational pressures, to transformation support to move to more resilient care models. The menu of support comprises:

- **Diagnostic services to quickly identify areas for improvement support.**
  For example, seven practices in London were put forward for a diagnostic assessment from chosen suppliers (a local GP alliance and a non-local GP federation). This has helped identify some common themes to target support including lack of practice direction following significant personnel changes (a need to develop practice vision) and scope to improve operational efficiency (leading to redesign of practice processes improving both practice responsiveness and efficiency).

- **Specialist advice and guidance – e.g. Operational HR, IT, Management, and Finance**
  For example, a small number of practices in Cumbria & North East local team wanted to take ‘working together’ to the next stage and agreed in principle on a merger. The limiting factor to making progress had been limited local practice capacity and expert advice to assist with proposals. These were addressed through programme funded support.

  The programme funding can be used to secure expert advice and support on delivering any operational changes (e.g. help with demand and capacity planning, effective use of operational systems and processes including help to release capacity).
- **Coaching / Supervision / Mentorship as appropriate to identified needs**
  For example, South Central local team secured support from a multi-professional team helping a practice conduct a detailed review of safeguarding arrangements. The scheme supported training for all staff, as well as support and advice on developing an approach to clinical audit, and help and advice to individual GPs, through appraisal and access to occupational health support.

- **Practice management capacity support**
  For example, South Central local team has provided cover for practice manager sick leave, using an experienced business manager to help provide stability, support a practice diagnostic review and help to develop a practice action plan.

- **Rapid intervention and management support for practices at risk of closure**
  For example, the Central Midlands local team works with CCGs to offer assistance with practices that receive poor CQC ratings (in addition to the RCGP Special Measures peer support programme) to maximise prospects for turnaround.

  This element of the menu of support is not just about working with practices with poor CQC ratings and we recognise there are many definitions where practices may need rapid intervention support to prevent closure e.g. following sudden critical vacancies. One of the key concerns has been the ability to provide support quickly to practices to help coordinate key activities. This means the funding can be used to deliver rapid support including help to secure any immediate clinical capacity needs, assuring and supporting continuing operations and coordinating additional improvement needs to help with operational delivery and effectiveness.

- **Coordinated support to help practices struggling with workforce issues**
  For example South Central local team helped a practice secure capacity for a practice nurse home visiting service for non-urgent chronic disease management for 3-months. This was to inform development of the practices skill mix and provide additional short-term capacity.

  This element of the menu of support has been included as it is recognised that maintaining clinical sessions is a priority for practices struggling with workforce issues (e.g. sudden critical vacancies, sickness, and long term vacancies) and increasing competition for a diminishing workforce can escalate workforce challenges in local areas.

  The funding can be used flexibly to secure practical workforce support. For example, local teams can create a local pool of expert peer support by funding key elements of GP costs (e.g. General Medical Council, Medical Defence Organisation and appraisal toolkit fees) in return for securing a minimum clinical commitment (e.g. 2 sessions per week) to work to support practices. This would be a portfolio career choice, targeting experienced GPs who may have recently retired or who can offer additional clinical commitments,
supporting GP retention/returners locally. Salary costs would remain practice responsibility. Alternatively, it can be used to establish post(s) in local teams with responsibility for (and attached to) a locality, working with practices to help plan, coordinate and match their recruitment needs and opportunities. This could also include leading on developing pragmatic solutions for practices where short term barriers exist (e.g. help to support skill mix alternatives to GP recruitment during periods of maternity leave).

- **Change management and improvement support to individual practices or group of practices**

  For example, South West local team identified through local provider GPs and other local stakeholders a strong need for change management resource to support practices in thinking about and delivering future resilience. Support to practices was underpinned by a Project Management Office approach with project/change managers linking with practices to plan and deliver across 4 main work streams (new care models, infrastructure, working at scale and provider development).

  The emphasis here is on providing dedicated project or change management support available to practice to help plan, develop proposals and implement changes. The GPRP funding can be used to target support at groups of practices including support for local strategic planning, future vision and review of practice business models, help to identify and realise opportunities to working at scale, succession planning, facilitating premises improvements or better use on IM&T etc.

  Much of this initial menu of support should already be in place and being delivered as a consequence of the existing national programmes of turnaround support but we want to ensure the GPRP improves accessibility by developing local capacity and capability to deliver a wider range of practice support to practices and in a more agile and responsive way.

  Greatest impact should be achieved under the GPRP by local teams tailoring the menu of support to the assessed needs of practices in local areas. It is recognised there may be different views locally on the emphasis of practice needs, for example, whether investment boost this year should be used to prioritise help to practices with workforce issues or whether greater benefit would be achieved from targeting groups of practices at a scale to provide more upstream support.

  Local teams will consult on their proposals for how this menu of support is to be delivered with their key partners. For example GPRP funding can be used to fund:

  - **Additional local team capacity and capabilities to provide support directly** – for example ‘local resilience teams’, as established in some areas already, provide a resource with capacity to work with practices. Examples to date have included NHS England or CCG employed staff.

  - **Contracted third party Supplier(s) to work with practices** – including GP Federation or other at scale providers. Suppliers can provide specialist aspects of the menu and there is also potential to extend to delivery of local resilience teams.
• **Backfill (or other costs) for individual GPs and other practice team members** – to work to provide peer support to practices locally, providing ‘sender’ practices have additional capacity to offer such support.

• **Section 96 Support and Financial Assistance** – where there are opportunities to support practices directly in delivering the menu of support.

Where existing support teams or equivalent arrangements apply, the GPRP funds can be used to deliver support further and faster to practices. Local teams are encouraged to consider how they can build on the foundations of the work they have started with the Vulnerable Practices Programme although the GPRP remains a separate programme. However, the emphasis on how this menu of support is delivered is on local flexibility.

**Personal resilience training**

There is also the human dimension to supporting practice sustainability and resilience. Personal resilience is widely recognised and evidenced as an important factor in organisational resilience which is recognised in the GPRP.

In parallel to the GPRP, NHS England is working to introduce the NHS GP Health service, a new treatment service providing GPs suffering stress and burnout access to mental health support from December 2016 and the procurement[^4] for this service is underway.

Local teams will recognise the upstream benefits of supporting GPs and practices team members to develop personal resilience skills and will consider with their key partners whether access to personal resilience training would be a helpful facet of the local GPRP support.

### 5 Identifying practices to support

In view of the continuing operation of the Vulnerable Practice Programme[^5] in 2016/17 the same national criteria applied here will be used by local teams to identify practices for support under the GPRP. Resources under the GPRP will allow support to be made available to even more practices, including providing ‘upstream’ support i.e. practices at the tipping point who may be struggling with workload but who are otherwise operationally stable, and retain the lessons learned from the implementation of the Vulnerable Practices Programme.

Local teams will have the flexibility to quickly identify practices for support under the GPRP by selecting:

• Practices assessed initially but not subsequently prioritised for support.

[^4]: [https://www.contractsfinder.service.gov.uk/Notice/325d71bd-ebfd-4068-819c-6ff0b911b546](https://www.contractsfinder.service.gov.uk/Notice/325d71bd-ebfd-4068-819c-6ff0b911b546)

• Practices offered support but who did not take up the offer.
• Groups of practices where practice based assessments identify a need in a particular locality or place (e.g. support offered to a group of 5 practices in a locality because 3 practices are struggling and there is a risk of domino effect impacting other practices unless support targeted at scale).

Decisions and thresholds set locally should be made on the basis of local intelligence and decisions as to where the greatest impact can be achieved using the available resources. Local teams will again need to work in conjunction with key partners here.

Local teams will need to keep assessments under regular review, updated as a minimum on a 6-monthly basis, and should ensure there are clear opportunities for practices to self-refer for assessment for improvement support under the GPRP. This will include making available a named local team contact for practice enquiries that can be included in local communications.

To support ongoing assessment and prioritisation of support we have refreshed the national criteria (annex B), to better reflect a practices’ needs in developing their sustainability and resilience.

Local NHS England teams will need to be able to confirm details of those GP practices they have agreed to support. Further details will follow on the national reporting arrangements which will support accountability and oversight of the delivery of GPRP.

6 Practice commitment

Support to GP practices will be conditional on matched commitment from practices, evidenced through an agreed action plan which will need to include clear milestones for exiting support. Practices will not be required to match-fund the support.

GP practices selected to receive support under the GPRP will be expected to enter into a non-legally binding Memorandum of Understanding (MOU) with NHS England. A template MOU will be published as part of this guidance within which local teams and practices can record local arrangements, including objectives and responsibilities in respect of any support or funding provided. It is anticipated the template MOU will be available by 16th August for adaption by local teams.

GPRP funding should not be used where there is no identifiable exit strategy for support and where there is no engagement with the local primary care strategy.

7 National support

Local teams will be aware we are already working to deliver for October 2016 a sustainability and resilience procurement framework for primary care6. This will speed up local ability to secure support from a range of providers. Use of the

6 https://www.contractsfinder.service.gov.uk/Notice/a2337154-494f-4202-a4ef-b39528028229
framework will not be mandatory given flexibilities in the local approach as to how support may be delivered under the GPRP.

Sharing learning and best practice under the programme will be important. We intend to work with key partners to secure and embed learning locally, including from RCGP peer support teams supporting practices in CQC special measures and to ensure local teams do not act in isolation of others approaches.

We are planning a series of regional learning events, to be led by RCGP peer support teams, to engage with local teams and other key partners. The timing of these will be confirmed but the first events are expected by end of November this year.

NHS England has introduced monthly monitoring to ensure that all the funding for the £10m Vulnerable Practices Programme is reaching practices, and is setting a deadline of 31st October for this funding to be fully committed for individual and groups of practices. Monthly monitoring will also be established for the GPRP so progress can be reviewed.

8 Key milestones

NHS England is committed to moving forward with the delivery of this programme rapidly and to ensure decision making is not protracted. The following milestones apply:

- **By 19 August:** NHS England local teams to share proposals for delivering the menu of support with their key partners.

- **By 23 September:** NHS England local teams will confirm to NHS England central team how they will deliver the menu of support, including single point of contact for practices. NHS England central team will publish these details nationally so there is clarity for all GP practices on the support arrangements in place. This will be in addition to local communications.

- **By 30 September:** NHS England local teams will confirm to the NHS England central team list of practices selected to receive support in 2016/17 (notwithstanding practices who may be subsequently assessed for support, including practices who self-refer) and that support offers have been made to practices listed. Offers will be followed up with agreed MOUs.

- **By 14 October:** where any practices have been identified in need of urgent support due to risk of closure, and are not already receiving support under the existing national programme, NHS England local teams will need to confirm to NHS England central team, that practices are now in receipt of practical support.
• **By 30 December:** local teams to confirm £16m investment support in GPRP (expenditure and/or evidence of investment being fully committed to named practices).

For any questions on the programme which you would like to raise which are not covered by the information in this guidance please send an email to england.primarycareops@nhs.net including in the subject heading ‘GPRP Question’.

We will be producing and maintaining a separate frequently asked questions (FAQs) document to accompany this guidance and will ensure these reflect key themes on issues raised.
9 Annex A – Indicative Funding allocations

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<td>North Region Total</td>
<td>13,111,378</td>
<td>£ 3,640,040</td>
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<td>£ 9,100,103</td>
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<td>£ 358,431</td>
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<td>£ 358,431</td>
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<td>£ 451,757</td>
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<td>Lancashire</td>
<td>1,533,553</td>
<td>£ 425,752</td>
<td>£ 212,876</td>
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<td>£ 212,876</td>
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<td>Yorkshire and the Humber</td>
<td>5,741,254</td>
<td>£ 1,593,913</td>
<td>£ 796,957</td>
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<td>£ 3,984,784</td>
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<td>Midlands &amp; East Region Total</td>
<td>17,427,264</td>
<td>£ 4,838,238</td>
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<td>£ 2,419,119</td>
<td>£ 2,419,119</td>
<td>£ 12,095,595</td>
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<td>Central Midlands</td>
<td>4,817,045</td>
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<td>£ 668,665</td>
<td>£ 668,665</td>
<td>£ 668,665</td>
<td>£ 3,343,325</td>
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<td>£ 619,144</td>
<td>£ 619,144</td>
<td>£ 3,095,720</td>
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<td>North Midlands</td>
<td>3,716,823</td>
<td>£ 1,031,882</td>
<td>£ 515,941</td>
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<td>£ 515,941</td>
<td>£ 2,579,705</td>
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<td>West Midlands</td>
<td>4,433,101</td>
<td>£ 1,230,738</td>
<td>£ 615,369</td>
<td>£ 615,369</td>
<td>£ 615,369</td>
<td>£ 3,076,845</td>
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<td>London Region Total</td>
<td>9,443,052</td>
<td>£ 2,621,625</td>
<td>£ 1,310,812</td>
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<td>£ 1,310,812</td>
<td>£ 6,554,061</td>
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<td>North West London</td>
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<td>£ 646,770</td>
<td>£ 323,385</td>
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<td>£ 323,385</td>
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<td>South London</td>
<td>3,495,265</td>
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<td>£ 485,186</td>
<td>£ 2,425,930</td>
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<td>South Region Total</td>
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<td>£ 10,190,995</td>
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<td>South Central</td>
<td>3,793,820</td>
<td>£ 1,053,258</td>
<td>£ 526,629</td>
<td>£ 526,629</td>
<td>£ 526,629</td>
<td>£ 2,633,145</td>
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<td>South East</td>
<td>4,738,857</td>
<td>£ 1,315,623</td>
<td>£ 657,812</td>
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<td>£ 657,812</td>
<td>£ 3,289,059</td>
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<td>South West</td>
<td>3,302,555</td>
<td>£ 916,871</td>
<td>£ 458,435</td>
<td>£ 458,435</td>
<td>£ 458,435</td>
<td>£ 2,292,176</td>
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<td>Wessex</td>
<td>2,847,896</td>
<td>£ 790,646</td>
<td>£ 395,323</td>
<td>£ 395,323</td>
<td>£ 395,323</td>
<td>£ 1,976,615</td>
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<tr>
<td>Greater Manchester**</td>
<td>2,966,954</td>
<td>£ 823,699</td>
<td>£ 411,850</td>
<td>£ 411,850</td>
<td>£ 411,850</td>
<td>£ 2,059,249</td>
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<td>England Total</td>
<td>57,631,776</td>
<td>£ 16,000,000</td>
<td>£ 8,000,001</td>
<td>£ 8,000,001</td>
<td>£ 8,000,001</td>
<td>£ 40,000,003</td>
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*Indicative allocations as calculation will be subject to latest available registered population data.

**These amounts represent the proportion of the total allocations attributable to Greater Manchester based on the latest available population data. Primary Care Transformation funding has been made available for the Greater Manchester Strategic Partnership sufficient to cover the indicative amounts listed above.
10 Annex B - National Criteria

Identifying General Practice sustainability and resilience needs is challenging. There are elements of any assessment which are subjective and deciding on the nature, severity or weight of issues facing individual practices are even more problematic to measure. These criteria (as previous) seek to chart a middle route between those aspects that are measurable and those less tangible issues which can help identify and prioritise practices sustainability and resilience needs. The nature of the issues facing a practice can be grouped generally as follows; demand, capacity and internal issues.

The range of criteria identified below can be used as a screening tool by local commissioners to guide their assessment with local stakeholders on offers of support to improve sustainability and resilience. Based on this assessment local teams should use the support matrix (effectively rating the need and impact of support). This can be used to prioritise practices for support within a given organisational or geographical area as well as to target support between areas where there is likely to be greatest benefit.

It is suggested that local teams will utilise their judgement when completing the assessment working with their key partners. It should be noted that the criteria overlap in some cases, for example a practice with a high vacancy level may also seek to close their list to new registrations.

Considerations

Patient safety is paramount - when undertaking the assessment if it becomes evident that safety could be compromised, commissioners should be alert to the need for escalation through the appropriate channels, whilst recognising the need for continuing support.
<table>
<thead>
<tr>
<th>Domain</th>
<th>Criteria</th>
<th>Description and rationale for inclusion</th>
</tr>
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<tbody>
<tr>
<td><strong>Safety</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.</td>
<td>CQC rating – inadequate</td>
<td>Practices rated as inadequate by the CQC are already directed to the RCGP peer support scheme. It is not proposed that this is changed but is included within the criteria for the sake of completeness and recognising practices moving out of special measures may still need additional ‘upstream’ support.</td>
</tr>
<tr>
<td>2.</td>
<td>CQC rating - requires improvement</td>
<td>Practice rated as requiring improvement where there is greatest need for support are already directed to the vulnerable practice programme. It is not proposed that this is changed but is included within the criteria for the sake of completeness and recognising additional ‘upstream’ support may still be needed. FAQs provide further guidance.</td>
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<tr>
<td>3.</td>
<td>Individual professional performance issues</td>
<td>This reflects that sometimes the overall operations of the practice can impact on or be impacted by professional performance issues.</td>
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<tr>
<td><strong>Workforce</strong></td>
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<td>4.</td>
<td>Number of patients per WTE GP and/or WTE Practice Nurse</td>
<td>These criteria help detect significant workload facing a practice in comparison to other practices. Neither criteria are an indicator of the need for support in themselves but they may indicate opportunities for improvement support, including skill mix.</td>
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<tr>
<td>5.</td>
<td>Vacancies (include long term illness)</td>
<td>This is a key local indicator of a practices sustainability and resilience. It is a crude ‘measure’ however in that long term or sudden critical vacancies may impact on operations of the practice in different ways. It will be important to consider the nature of the vacancies. The proportion of staff in the practice aged 55 and over may also be an important consideration given potential for early retirements.</td>
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<tr>
<td><strong>External Perspective</strong></td>
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<td>6.</td>
<td>Other external perspectives not covered in the above criteria, for example significant support from LMC, CCG or NHS England local team.</td>
<td><strong>This is a key criteria.</strong> The level of support increases dependent upon how many local external bodies have significant concerns. Practices self-referring for support may also be considered here.</td>
</tr>
<tr>
<td>7.</td>
<td>Primary Care Web Tool</td>
<td>Using this tool and in particular those practices that trigger 5/6 or more outlier indicators provides an indication of some issues in a practice that may require support.</td>
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<tr>
<td><strong>Organisational Issues</strong></td>
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<td>8.</td>
<td>Practice leadership issues (partner relationships)</td>
<td>This is a key area where practices may need support but it is difficult to define so will be for local commissioners to reflect and justify.</td>
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<tr>
<td>Domain</td>
<td>Criteria</td>
<td>Description and rationale for inclusion</td>
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<td></td>
<td>9. Significant practice changes</td>
<td>It is self-evident that this increases the need for support for individual or groups of practices. Practice mergers may make local practices stronger and more resilient, practice splits less so but still requiring support to ensure sustainable operations.</td>
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<tr>
<td></td>
<td>10. Professional isolation</td>
<td>This is a self-evident criteria, but there are many resilient single handed practices that continue to operate successfully. However by definition a single handed practice has less resilience than a larger practice. Again it would be for local commissioners to reflect a risk rating against this.</td>
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<tr>
<td>Efficiency</td>
<td>11. QOF % achievement</td>
<td>This is often used as a short hand measure of how well a practice is operating. The vast majority of practices score well above 90% with average 94% achievement. Just 500 practices score under 80% achievement, 100 practices score under 65% achievement. 21 practices achieve a score which is half of England average achievement (47%). Significant changes in achievement could also evidence changes in operations in need of support.</td>
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<tr>
<td></td>
<td>12. Referral or prescribing performance</td>
<td>It is proposed that this is flagged where a practice is a clear outlier (e.g. top / bottom 5%) for aggregate prescribing or referral rates compared to the CCG average.</td>
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<tr>
<td>Patient Experience/ access</td>
<td>13. List closure (including application to</td>
<td>This is a key indicator and is akin to the practice self-declaring that they need support. It is a crude ‘measure’ in that the practice may need support to meet an increase in demand or it may need support to better manage its current demand. It will be important to consider the reasons for list closure. It will be important for local commissioners to also reflect here on practices with refused applications or practices bordering onto a closed list practice.</td>
</tr>
<tr>
<td></td>
<td>close list)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>14. GP Patient Survey - Would you recommend</td>
<td>This is one of a set of patient experience criteria that could be usefully included. Patient advocacy is known to correlate with good quality care.</td>
</tr>
<tr>
<td></td>
<td>your GP surgery to someone who has just</td>
<td></td>
</tr>
<tr>
<td></td>
<td>moved to your local area? (% no).</td>
<td></td>
</tr>
<tr>
<td></td>
<td>15. GP Patient Survey – ease of getting</td>
<td>Could be usefully included in that it provides an early indication where practices may be supported to better match or manage capacity and demand issues.</td>
</tr>
<tr>
<td></td>
<td>through by phone (% not at all easy).</td>
<td></td>
</tr>
<tr>
<td></td>
<td>16. GP Patient Survey - ability to get an</td>
<td>Could also be usefully included in that it provides an early indication where practices may be supported to better match or manage capacity and demand issues.</td>
</tr>
<tr>
<td></td>
<td>appointment to see or speak to someone (% no)</td>
<td></td>
</tr>
</tbody>
</table>
**Sustainability and Resilience Support Matrix**

Following an assessment of the criteria above local NHS England teams should decide where individual practices should be placed on the support matrix below.

Placement should be scored between 1-5 for both scope for support and impact of support. Descriptions for scoring are also provided.

Local NHS England teams will need to ensure there is a record justifying placement based on their assessment of the criteria and demonstrating a consistent approach to the assessment of practices.

<table>
<thead>
<tr>
<th>Impact of support</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very high - 5</td>
<td>A</td>
<td>A/G</td>
<td>G</td>
<td>G</td>
<td>G</td>
</tr>
<tr>
<td>High - 4</td>
<td>A</td>
<td>A</td>
<td>A/G</td>
<td>A/G</td>
<td>G</td>
</tr>
<tr>
<td>Moderate - 3</td>
<td>A/R</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A/G</td>
</tr>
<tr>
<td>Low - 2</td>
<td>R</td>
<td>A/R</td>
<td>A/R</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>Very low - 1</td>
<td>B</td>
<td>R</td>
<td>R</td>
<td>R</td>
<td>R</td>
</tr>
</tbody>
</table>

**Scope for support**

1. Rare
2. Unlikely
3. Possible
4. Likely
5. Very likely
### Description: Scope for support

<table>
<thead>
<tr>
<th>Descriptor</th>
<th>1: Rare</th>
<th>2: Unlikely</th>
<th>3: Possible</th>
<th>4: Likely</th>
<th>5: Very Likely</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequency / What is the scope for support the practice?</td>
<td>There is no evidence that support is needed</td>
<td>Do not expect it to need support, but it is possible it may do so in the future</td>
<td>Might need support on basis of evidence presented</td>
<td>Likely need support because of specific issues/circumstances but not expected to persist</td>
<td>Very likely to need support because of persisting local issues or circumstances.</td>
</tr>
</tbody>
</table>

### Description: impact scoring

<table>
<thead>
<tr>
<th>Descriptor</th>
<th>1: Rare</th>
<th>2: Unlikely</th>
<th>3: Possible</th>
<th>4: Likely</th>
<th>5: Very Likely</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequency / What is the scope for support the practice?</td>
<td>Very minor support needs</td>
<td>Single support issue</td>
<td>Moderate impact of support for practice, staff and for multiple patients</td>
<td>Significant effect for practice and staff if support provided, and moderate impact for patients</td>
<td>Very significant impact for practice, staff and patients if support provided</td>
</tr>
</tbody>
</table>
The Primary Care Commissioning Committees of Eastbourne, Hailsham and Seaford CCG and Hastings and Rother CCG meeting together  
Date of meeting: 26 October 2016

<table>
<thead>
<tr>
<th>Title of report:</th>
<th>Primary Care Commissioning Committee Terms of Reference (TOR)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recommendation:</td>
<td>The Committees are recommended to <strong>approve</strong> their revised terms of reference.</td>
</tr>
</tbody>
</table>
| Summary:         | As part of the governance structures of the CCGs, the individual Governing Bodies have established a small number of sub-committees and have delegated certain duties to them. Where a CCG has commissioning of primary medical care (GP practices) delegated to it by NHS England, those duties cannot be held by the CCG Governing Body (which may have a GP majority). Instead it is a statutory requirement for the CCG to establish a Primary Care Commissioning Committee (PCCC) to which these duties must be delegated. Each CCG has its own PCCC which meets in public. These committees meet together in order that the richest discussion may take place on shared subjects with a minimum of duplication of effort. During these meetings each committee retains its sovereignty and they may make different decisions. These documents have been reviewed and amended as follows:  
  - to align with the strengthened national guidance on Conflicts of Interest from NHS England in June 2016, principally removing the voting rights of GPs on the committees;  
  - re-formatted to conform to CCG guidelines and updating of staff job titles;  
  - updated to reflect NHS England entitlement to attend meetings at their discretion;  
  - considerations when conflicts of interest impact on the quoracy of the Committee; and  
  - updated regarding the reporting procedure. |

**Committee sponsors:** Barbara Beaton, Lay member, Patient and Public Involvement (HR) and Frances Hasler Lay member, Patient and Public Involvement (EHS)

**Author:** Clive Mellor, Head of Governance and Business Planning

**Date of report:** 11/10/16

**Review by other committees:** The PCCC revised Terms of Reference have been ratified by the individual Governing Bodies (September 2016).
**Health impact:** There is no direct health impact from these TOR. Decisions by the committees will have health impacts.

**Financial implications:** There is no direct financial impact from these TOR. Decisions by the committees will have financial implications.

**Legal or compliance implications:** Under the delegation from NHS England of commissioning of primary medical care each CCG is required to have a PCCC.

**Link to key objective and/or principal risks:** These documents provide a framework in support of the key objectives, though there is no direct link to any individual objective.

**Link to East Sussex Better Together (ESBT) programme:** These documents provide a framework in support of the Primary Care aspects of ESBT.

**How has the patient and public engagement informed this work:** These governance arrangements follow statutory requirements and good practice. They have not been subject to patient or public engagement.

**Equality Analysis (EA) Process - outcome:**

<table>
<thead>
<tr>
<th>Negative Impact</th>
<th>Neutral Impact</th>
<th>Positive Impact</th>
<th>No Impact</th>
<th>Not required for report</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☒</td>
</tr>
</tbody>
</table>

**EA Summary:** No analysis is required of these terms of reference.

**Privacy Impact Assessment (PIA) – outcome:**

<table>
<thead>
<tr>
<th>No personal data used</th>
<th>Data processes sufficient</th>
<th>Actions required</th>
</tr>
</thead>
<tbody>
<tr>
<td>☒</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

**Actions:** None.
1. Constitution (Introduction)

The Clinical Commissioning Group's (CCG) Governing Body hereby resolves to establish a Committee of the Governing Body known as the Primary Care Commissioning Committee (known as the P3C or ‘the Committee’) in accordance with Schedule 1A of the National Health Service Act 2006 (as amended) (“the NHS Act”).

The Committee is established in accordance with the CCG’s constitution and the delegation by NHS England (also known as ‘the NHS Commissioning Board’ or ‘the Board’) under section 13Z of the NHS Act (set out in schedule 1). These Terms of Reference set out the membership, remit, responsibilities and reporting arrangements of the Committee and shall have effect as if incorporated into the CCG’s constitution.

2. Statutory Framework

NHS England has delegated to the CCG authority to exercise the primary care commissioning functions set out in Schedule 2 in accordance with section 13Z of the NHS Act.

Arrangements made under section 13Z may be on such terms and conditions (including terms as to payment) as may be agreed between the Board (NHS England) and the CCG.

Arrangements made under section 13Z do not affect the liability of NHS England for the exercise of any of its functions. However, the CCG acknowledges that in exercising its functions (including those delegated to it), it must comply with the statutory duties set out in Chapter A2 of the NHS Act and including:

- Management of conflicts of interest (section 14O).
- Duty to promote the NHS Constitution (section 14P).
- Duty to exercise its functions effectively, efficiently and economically (section 14Q).
- Duty as to improvement in quality of services (section 14R).
- Duty in relation to quality of primary medical services (section 14S).
- Duties as to reducing inequalities (section 14T).
- Duty to promote the involvement of each patient (section 14U).
- Duty as to patient choice (section 14V).
- Duty as to promoting integration (section 14Z1).
- Public involvement and consultation (section 14Z2).

The CCG will also need to specifically, in respect of the delegated functions from NHS England, exercise those set out below:
3. **Purpose (Role)**

The Committee has been established in accordance with the above statutory provisions to enable the members to make collective decisions on the review, planning and procurement of primary care services in Hastings and Rother, under delegated authority from NHS England.

In performing its role the Committee will exercise its management of the functions in accordance with the agreement entered into between NHS England and NHS Hastings and Rother CCG, which will sit alongside the delegation and Terms of Reference.

The Committee function (as a corporate decision-making body for the management of the delegated functions and the exercise of the delegated functions set out in Schedule 2 in accordance with section 13Z of the NHS Act) shall be to carry out the functions relating to the commissioning of primary medical services under section 83 of the NHS Act.

The Committee is subject to any directions made by NHS England or by the Secretary of State.

4. **Responsibilities**

The Committee will make collective decisions on the review, planning and procurement of primary care services in Hastings and Rother, under delegated authority from NHS England. This includes the following activities:

- General Medical Services (GMS), Personal Medical Services (PMS) and Alternative Provider Medical Services (APMS) contracts (including the design of PMS and APMS contracts, monitoring of contracts, taking contractual action such as issuing branch/remedial notices, and removing a contract);
- Newly designed enhanced services ("Local Enhanced Services" and "Directed Enhanced Services") where relevant and appropriate;
- Design of local incentive schemes as an alternative to the Quality Outcomes Framework (QOF);
- Decision making on whether to establish new GP practices in an area;
- Approving practice mergers; and
- Making decisions on ‘discretionary’ payment (e.g., returner/retainer schemes).

The CCG will also carry out the following activities:

- To ensure that the work of the committee aligns with the strategic intentions of the East Sussex Better Together programme;
- To plan, including needs assessment, primary medical care services in Hastings and Rother;
- To undertake reviews of primary medical care services in Hastings and Rother;
- To co-ordinate a common approach to the commissioning of primary care services generally; and
• To provide oversight of the financial planning for the commissioning of primary medical care services in Hastings and Rother.

5. Membership

The voting membership committee shall consist of:

• Two Lay Members of the Governing Body
• The Independent Clinician (Registered Nurse) and/or the Independent Clinician (Secondary Care Doctor) member of the Governing Body
• The Chief Officer (or deputy)
• The Chief Financial Officer (or deputy)
• The Chief Nurse (or deputy)

The committee chair and vice chair will be Lay members.

In addition the following non-voting members shall be invited to all meetings:

• A General Practitioner Member of the Governing Body
• A representative from the local Health and Wellbeing Board
• A representative from Healthwatch
• A representative from the Local Medical Committee

Other representatives will be invited from time to time from:

• NHS England will be invited to attend all meetings and NHS England will be entitled to attend at their discretion
• Senior manager from the CCG
• Other stakeholders.

6. Quorum

A quorum shall be three members to include one Lay member, one independent clinician and the Chief Officer or deputy. The Committee may consider the use of independent clinicians from other CCGs where conflicts of interest impact on the quoracy of the Committee.

7. Attendance

Members of the public may attend the meetings, subject to the conditions in section 12 below.

8. Meetings and Voting

The Committee will operate in accordance with the CCG’s Standing Orders. The Corporate Services team will be responsible for giving notice of meetings. This will be accompanied by an agenda and supporting papers and sent to each member representative no later than 7 days before the date of the meeting. When the Chair of the Committee deems it necessary in light of the urgent circumstances to call a meeting at short notice, the notice period shall be such as s/he shall specify.
Each voting member of the Committee shall have one vote. The Committee shall reach decisions by a simple majority of members present, but with the Chair having a second and deciding vote, if necessary. However, the aim of the Committee will be to achieve consensus decision-making wherever possible.

9. Reporting

The minutes of this Committee shall be formally recorded. Minutes, signed by the Chair (or otherwise approved), are retained by the secretary to the Committee.

The Committee will produce a summary report which will be presented to the CCG Governing Body for information, including the minutes of any sub-committees to which responsibilities are delegated. This can also be provided to NHS England South (South East).

The CCG will also comply with any reporting requirements set out in its constitution.

The Chair of the Committee shall draw to the attention of the Governing Body any issues that require disclosure to the Governing Body or exception items requiring action by Governing Body of NHS Hastings and Rother CCG.

10. Administration

Secretarial support will be provided to the Committee.

11. Frequency

Meetings shall be held not less than five times a year and more frequently as required.

12. Conduct of the Committee

The Committee shall conduct its business in public (subject to the subsequent paragraph) in accordance with national guidance and relevant codes of practice including the Nolan Principles and the Conflict of Interests policy. Members of the Committee shall respect confidentiality requirements as set out in the CCG’s Constitution and relevant policies.

The Committee may resolve to exclude the public from a meeting that is open to the public (whether during the whole or part of the proceedings) whenever publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution and arising from the nature of that business or of the proceedings or for any other reason permitted by the Public Bodies (Admission to Meetings) Act 1960 as amended or succeeded from time to time.

Members of the Committee have a collective responsibility for the operation of the Committee. They will participate in discussion, review evidence and provide objective expert input to the best of their knowledge and ability, and endeavour to reach a collective view.

The Committee may delegate tasks to such individuals, sub-committees or individual members as it shall see fit, provided that any such delegations are consistent with the parties’ relevant governance arrangements, are recorded in a scheme of delegation, are governed by
terms of reference as appropriate and reflect appropriate arrangements for the management of conflicts of interest.

The Committee may call additional experts to attend meetings on an ad hoc basis to inform discussions.

13. Review

These Terms of Reference will be reviewed on an annual basis or sooner if required with recommendations made to the CCG Governing Body and the Sub-regional Team of NHS England South (South East) for approval.

<table>
<thead>
<tr>
<th>Author</th>
<th>C Mellor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date approved</td>
<td>October 2016</td>
</tr>
<tr>
<td>Review date</td>
<td>June 2017</td>
</tr>
<tr>
<td>Version</td>
<td>V0.1</td>
</tr>
</tbody>
</table>

**Accountability of the Committee**
For the avoidance of doubt, in the event of any conflict between the terms of the Scheme of Delegation, these Terms of Reference and the Standing Orders or Standing Financial Instructions of any of the members, the latter will prevail.

**Procurement of Agreed Services**
The detailed arrangements regarding procurement will be set out in the delegation agreement.

[Schedule 1 – Delegation - to be added when final arrangements confirmed]
[Schedule 2 – Delegated functions - to be added when final arrangements confirmed]
[Schedule 3 – List of Members - to be added when confirmed]

<table>
<thead>
<tr>
<th>Last approved by Committee</th>
<th>27 April 2016</th>
<th>19/16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last approved by Governing Body</td>
<td>28 September 2016</td>
<td>108/16 iii</td>
</tr>
</tbody>
</table>
Primary Care Commissioning Committee
Draft Terms of Reference

1. Constitution (Introduction)

The Clinical Commissioning Group’s (CCG) Governing Body hereby resolves to establish a
committee of the Governing Body known as the Primary Care Commissioning Committee
(known as the P3C or ‘the Committee’) in accordance with Schedule 1A of the National
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  14Q);
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- Duty to promote the involvement of each patient (section 14U);
- Duty as to patient choice (section 14V);
- Duty as to promoting integration (section 14Z1);
- Public involvement and consultation (section 14Z2).
The CCG will also need to specifically, in respect of the delegated functions from NHS England, exercise those set out below:

- Duty to have regard to impact on services in certain areas (section 13O);
- Duty as respects variation in provision of health services (section 13P).

3. Purpose (Role)

The Committee has been established in accordance with the above statutory provisions to enable the members to make collective decisions on the review, planning and procurement of primary care services in Eastbourne, Hailsham and Seaford, under delegated authority from NHS England.

In performing its role the Committee will exercise its management of the functions in accordance with the agreement entered into between NHS England and NHS Eastbourne, Hailsham and Seaford CCG, which will sit alongside the delegation and Terms of Reference.

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- To ensure that the work of the committee aligns with the strategic intentions of the East Sussex Better Together programme;
- To plan, including needs assessment, primary medical care services in Eastbourne, Hailsham and Seaford;
- To undertake reviews of primary medical care services in Eastbourne, Hailsham and Seaford;
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The Committee will produce a summary report which will be presented to the CCG Governing Body for information, including the minutes of any sub-committees to which responsibilities are delegated. This can also be provided to NHS England South (South East).

The CCG will also comply with any reporting requirements set out in its constitution.

The Chair of the committee shall draw to the attention of the Governing Body any issues that require disclosure to the Governing Body or exception items requiring action by Governing Body of NHS Eastbourne, Hailsham and Seaford CCG.

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Secretarial support will be provided to the Committee.

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Members of the Committee have a collective responsibility for the operation of the Committee. They will participate in discussion, review evidence and provide objective expert input to the best of their knowledge and ability, and endeavour to reach a collective view.

The Committee may delegate tasks to such individuals, sub-committees or individual members as it shall see fit, provided that any such delegations are consistent with the parties’ relevant governance arrangements, are recorded in a scheme of delegation, are governed by terms of reference as appropriate and reflect appropriate arrangements for the management of conflicts of interest.

The Committee may call additional experts to attend meetings on an ad hoc basis to inform discussions.

13. Review

These terms of reference will be reviewed on an annual basis or sooner if required with recommendations made to the CCG Governing Body and the Sub-regional Team of NHS England South (South East) for approval.

Author: C Mellor
Date approved: October 2016
Review date: June 2017
Version: V2.0

Accountability of the Committee

For the avoidance of doubt, in the event of any conflict between the terms of the Scheme of Delegation, these Terms of Reference and the Standing Orders or Standing Financial Instructions of any of the members, the latter will prevail.

Procurement of Agreed Services

The detailed arrangements regarding procurement will be set out in the delegation agreement.

[Schedule 1 – Delegation - to be added when final arrangements confirmed]
[Schedule 2 – Delegated functions - to be added when final arrangements confirmed]
[Schedule 3 – List of Members - to be added when confirmed]
The Primary Care Commissioning Committees of Eastbourne, Hailsham and Seaford and Hastings and Rother CCGs meeting together

Date of meeting: 26 October 2016 56/16

Title of report:
Managing General Practice Performance and Quality under Delegated Commissioning Responsibilities Policy 2016

Recommendation:
The Committees are recommended to ratify the Policy.

Summary:
The attached policy has been reviewed in line with annual monitoring requirements, and conforms to current legislation and good practice. The policy has been reviewed by the CCGs’ Governance and Policy Officer, the Primary Care Co Commissioning Strategic Manager and the Chief Nurse.

There has been a general review of formatting to ensure the policy conforms to CCG guidelines and staff job titles have been updated where appropriate. A references section has been added to the policy, containing links to relevant legislation and organisations, along with standard sections on Equality and Review.

Mention of the Quality Assessment Tool (QAT) has been updated to the Primary Care Performance Dashboard.

Committee sponsor: Allison Cannon, Chief Nurse

Author(s): Angela Groom, Governance and Policy Officer  Date of report: 26/09/16

Review by other committees: None

Health impact: Whilst there is no direct health impact, there may be indirect benefits from financial, legal and quality improvements.

Financial implications: The policy enables the CCGs to have a uniform and fair approach to managing practice performance across each CCG.

Legal or compliance implications: CCGs have a statutory responsibility to commission
services to the highest level of quality within available resources. The CCGs have delegated responsibility to commission primary medical services and to ensure general practices achieve the highest possible quality of primary care service provision.

This policy is an agreed statement on how the CCGs, under delegated commissioning responsibilities, will manage and improve contract performance and quality of general practice service provision across the CCGs.

**Link to key objective and/or principal risks:** Non-compliance with this policy would lay the CCGs open to the risk of challenge to the quality of its primary medical services.

**Link to East Sussex Better Together (ESBT) programme:**
The primary objective of this policy is to ensure transparency and openness in all dealings, helping to deliver ESBT objectives.

**How has the patient and public engagement informed this work:** There are no implications as these are support services.

**Equality Analysis (EA) Process - outcome:**

<table>
<thead>
<tr>
<th>Negative Impact</th>
<th>Neutral Impact</th>
<th>Positive Impact</th>
<th>No Impact</th>
<th>Not required for report</th>
</tr>
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<tbody>
<tr>
<td>☐</td>
<td>☒</td>
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<td>☐</td>
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</tr>
</tbody>
</table>

**EA Summary:**
The policy is a requirement applying equally to all affected staff. There is no evidence of disproportionate impact on any groups sharing a particular personal characteristic.

**Privacy Impact Assessment (PIA) – outcome: TBC**

<table>
<thead>
<tr>
<th>No personal data used</th>
<th>Data processes sufficient</th>
<th>Actions required</th>
</tr>
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</table>

**Actions:** There is no personal data used in this specific report but an updated PIA is currently being processed and assessed for this policy and process. This will ensure the robust and sufficient management of the data processes.
Managing General Practice Performance and Quality under Delegated Commissioning Responsibilities Policy

APPROVED BY:  To be approved by Primary Care Commissioning Committee October 2016
EFFECTIVE FROM:  October 2016
REVIEW DATE:  October 2018
AUTHORS: Nicola Hone, Primary Care co-commissioning Strategic Manager and Allison Cannon, Chief Nurse

This policy must be read in conjunction with the following policies:
Safeguarding Adults Policy
Safeguarding Children Policy
Version Control

Policy Category: Primary care
Relevant to: All Staff (including temporary staff, contractors and seconded staff)

Version History

<table>
<thead>
<tr>
<th>Version No.</th>
<th>Date</th>
<th>Changes Made</th>
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<tr>
<td>0.1</td>
<td>2015</td>
<td>Policy developed by the Chief Nurse</td>
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<td>0.1</td>
<td>October 2015</td>
<td>Approved by Primary Care Commissioning Operational Group</td>
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<td>0.1</td>
<td>October 2015</td>
<td>Adopted by Eastbourne, Hailsham and Seaford PCCC</td>
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<tr>
<td>0.1</td>
<td>April 2016</td>
<td>Adopted by Hastings and Rother PCCC with a view to creating a joint polity for the two CCGs at the next review</td>
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<tr>
<td>0.2</td>
<td>August 2016</td>
<td>Reviewed by Governance and Policy Officer</td>
</tr>
<tr>
<td>0.3</td>
<td>September 2016</td>
<td>Reviewed by Primary Care Co Commissioning Strategic Manager</td>
</tr>
<tr>
<td>0.4</td>
<td>September 2016</td>
<td>Reviewed by Chief Nurse</td>
</tr>
<tr>
<td>0.5</td>
<td>September 2016</td>
<td>Reviewed by Chief Finance Officer</td>
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<tr>
<td>1</td>
<td>October 2016</td>
<td>To be approved by Joint Primary Care Commissioning Committee</td>
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1. **STAFF QUICK REFERENCE GUIDE**

1.1. Eastbourne, Hailsham and Seaford Clinical Commissioning Group (CCG) and Hastings and Rother CCG have a joint staff structure. This policy covers both organisations and they are referred to jointly as ‘the CCG’.

1.2. This policy is an agreed statement on how the CCG, under delegated commissioning responsibilities, will manage and improve contract performance and quality of General Practice service provision across the CCG.

1.3. The purpose of this Policy is to ensure that a uniform and fair approach is taken to managing practice performance across the CCG.

1.4. The CCG will use national and local measures and indicators to measure the quality of performance of its General Practices.

1.5. Failure to address a remedial notice would constitute cause to issue a breach notice. Failure to address a breach notice may cause termination of contract.

1.6. The CCG will adopt “NHS England Policy for Contract breaches, sanctions and terminations for primary medical services”:


2. **INTRODUCTION**

2.1. The CCG will use all appropriate and necessary means to ensure it complies with best practice when it is discharging its responsibility for managing General Practice Performance and Quality.

2.2. CCGs have a statutory responsibility to commission services to the highest level of quality within available resources. The CCG has delegated responsibility to commission primary medical services and to ensure general practices achieve the highest possible quality of primary care service provision. This should support a firm foundation of primary care services upon which to build successful, clinically-led commissioning and the future of primary care provision.

2.3. Managing the performance of those on the GP Performers List remains the responsibility of NHS England.

3. **PURPOSE**

3.1. This Policy sets out the CCG’s position regarding the performance management and quality improvement of general practice in the CCG.

3.2. The purpose of this Policy is to ensure that a uniform and fair approach is taken to managing practice performance across the CCG. The attached procedures address the CCG’s approach to:

   - **Defining Quality**.
   - **Measuring Quality**.
   - **Monitoring Performance**.
   - **Managing Performance**.
4. **SCOPE**

4.1. This policy applies to practice performance management of all general practices in the CCG and all staff involved in managing practice performance will adhere to this policy.

4.2. **Complaints**

The overall responsibility for dealing with patient complaints remains with NHS England. NHS England will share trends and concerns with the CCG and these will inform the performance and quality monitoring of General Practices.

5. **RESPONSIBILITIES**

5.1. **The Primary Care Commissioning Committee (PCCC).**

Responsible for:

- Ratification of this policy.
- Setting the strategic direction.
- Receiving assurance on all performance management visits and action plans.

A quality report will be received every quarter, see section 5.3 for more detail.

5.2. **Quality and Governance Committee**

Responsible for:

- Seeking assurance on the wider quality trends across the whole healthcare system including Primary Care.
- Agreeing action where appropriate.

5.3. **Primary Care Co-Commissioning Operational Group (PCCOG)**

Responsible for:

- Reviewing the collated data.
- Agreeing which practices are to receive a performance management visit.
- Reviewing the detail of practice visits.
- Agreeing and setting actions.
- Sharing good practice.

The Primary Care Performance Dashboard provides an overview of practice performance against identified quality measures. It is reviewed quarterly and informs the quality report taken to the PCCC. See **Appendix 2** for more details.

5.4. **The Quality Team**

Responsible for:

- Supporting the Primary Care Co-commissioning Team in all aspects of quality monitoring.
- Providing practices with support as required.
5.5. The Primary Care Co-commissioning Team
Responsible for:

- Ensuring that contract performance of practices under delegated commissioning is managed in line with policy.

5.6. The Practice Support Group (PSG)
Responsible for:

- Performance Management agenda with practices to be visited:
  - Co-ordinating quality visits to practices.
  - Agreeing appropriate action plans.
  - Monitoring progress of the action plan and reporting back to the PCCOG making appropriate recommendations to PCCOG.

Practice Support Group membership consists of:
  - GP Governing Body Lead for Quality.
  - Chief Nurse, Quality Directorate.
  - Primary Care Co-Commissioning Strategic Manager.
  - Quality Team member as required dependent on issues to be addressed.
  - Medicines Management team member.
  - Governance Lead.

6. EQUALITY
6.1. In applying this policy, the CCG will have due regard for the need to eliminate unlawful discrimination, promote equality of opportunity and provide for good relations between people of diverse groups, in particular on the grounds of the following characteristics protected by the Equality Act (2010); age, disability, gender, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, and sexual orientation, in addition to offending background, trade union membership, or any other personal characteristic.

7. RATIFICATION AND REVIEW
7.1. This policy will be reviewed every two years. Where review is necessary due to legislative change, this will happen immediately.

7.2. An Equality Analysis Initial Assessment has been carried out on this policy. As a result, there is no anticipated detrimental impact on any equality group.

8. REFERENCES
- Calculating Quality Reporting Service
digital.nhs.uk/article/3570/Calculating-Quality-Reporting-Service-CQRS-questions

- Clinical Alert System
www.england.nhs.uk/patientsafety/psa/
• Darzi NHS Next Stage Review  

• The five key areas assessed through Care Quality Commission (CQC) inspections  
  www.cqc.org.uk/content/five-key-questions-we-ask

• Framework for responding to CQC inspections of GP practices  
  www.england.nhs.uk/resources/resources-for-ccgs/#cqc

• National Institute of Health and Clinical Excellence  
  www.nice.org.uk/

• National Primary Care Web Tool  
  www.primarycare.nhs.uk/

• NHS Choices  
  www.nhs.uk/pages/home.aspx

• NHS England Policy for Contract breaches, sanctions and terminations for primary medical services”  

• NHS England – National Performers List  
  www.performer.england.nhs.uk/

• NHS England regional Quality Surveillance Group  
  www.england.nhs.uk/2013/01/nqb/

• NHS GP Practices and GP out-of-hours services Provider handbook  
  www.cqc.org.uk/content/gp-practices-and-out-hours-service-providers

• NHS Outcome Framework  

NHS England regional Quality Surveillance Group  
www.england.nhs.uk/2013/01/nqb/
Appendix 1: Procedure on Performance and Quality visits

1.1. A performance and quality visit to each practice will take place on an annual basis as part of an integrated approach to regular performance monitoring.

1.2. A proactive visit will take place outside the planned review cycle if required. Issues to be discussed at pro-active visits include:
   - Contractual Obligations.
   - Quality issues.
   - CQC Domains.

1.3. These visits will focus on:
   - Improving patient outcomes.
   - Supporting quality improvement.
   - Enabling the sharing and development of good practice and action plans as required.

1.4. Issues that would indicate the need for a re-active visit would include:
   - A CQC overall assessment of “Requires Improvement”.
   - Deteriorating Performance Dashboard scores.
   - An excess of, or a trend of, significant events.
   - An excess of, or a trend of, significant complaints.
   - Whistleblowing issues of significant importance.

1.5. Safeguarding Children and Adults
   The CCG will seek assurance that all GP practices comply with the safeguarding accountability framework which includes an annual general practice self-assessment declaration.

1.6. National Guidance
   The CCG will seek assurance that all GP practices have mechanisms in place for the review and incorporation of all relevant national guidelines (including those issued by the National Institute of Health and Clinical Excellence) into services provided to patients.

1.7. Clinical Alert System (CAS)
   The CCG will seek assurance that all GP practices have mechanisms in place for the review and incorporation of CAS alerts into services provided to patients.
Appendix 2: Managing Practice Performance

1.1. **Defining Quality**
   The Darzi NHS Next Stage Review (Department of Health, 2008) defined quality in the NHS in terms of three core areas:
   - Patient safety.
   - Clinical effectiveness
   - Experience of patients.

1.2. The quality agenda has been developed further with the introduction of the NHS Outcome Framework:

2.1. **Measuring Quality**
   The CCG will use national and local measures and indicators to measure the quality of performance of its General Practices.

2.2. **Tools to Measure Performance and Quality**
   The Primary Care Quality Assessment Tool (QAT) has been used in East Sussex since 2010 to provide an overview of practice performance against identified quality measures. Its impact has been linked to the level of ownership achieved amongst practices. The QAT has now been reviewed and is called the Primary Care Performance Dashboard. The CCG will work with General Practice to ensure there is ownership of any quality issues to be addressed and support General Practice to improve the quality of services provided.

2.3. **The Primary Care Performance Dashboard**:
   - Is aligned to the five key areas assessed through the Care Quality Commission (CQC) inspections ensuring practices are Safe, Caring, Responsive, Effective and Well Led (see Table 1, below).
   - Attaches a score to each outcome and a total score is calculated resulting in outliers being identified.
- Is updated quarterly and reviewed at the following Primary Care Co-Commissioning Operational Group (PCCOG) to identify practices which may need support from the Practice Support Group. This may include specialised Quality Team input i.e. infection control, safeguarding; practice visit; supporting education and training. A quarterly quality report is made to the Primary Care Co-Commissioning Committee.

2.4. The CCG will use the following national resources as a minimum:
- CQC information will be triangulated with known issues and other forms of intelligence.
- The CCG will respond to issues raised in line with NHS England national guidance.¹
- National Primary Care Web Tool.
- NHS Choices.
- Calculating Quality Reporting Service (CQRS).

Table 1²:

<table>
<thead>
<tr>
<th>Safe</th>
<th>By safe, we mean that people are protected from abuse and avoidable harm.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Effective</td>
<td>By effective, we mean that people’s care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.</td>
</tr>
<tr>
<td>Caring</td>
<td>By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.</td>
</tr>
<tr>
<td>Responsive</td>
<td>By responsive, we mean that services are organised so that they meet people’s needs.</td>
</tr>
<tr>
<td>Well-led</td>
<td>By well-led, we mean that the leadership, management and governance of the organisation assures the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.</td>
</tr>
</tbody>
</table>

3.1. Monitoring Performance
Local and national data will be collated and analysed by the Primary Care Commissioning and Quality teams and will be presented to both the PCCOG and Quality and Governance Committee for review and agreement on outlying performance issues.

4.1. Managing Performance
The Primary Care Co-Commissioning team will send letters of congratulation to practices who have improved their performance as highlighted by the Primary Care Performance Dashboard.

4.2. Practices performing below the agreed standards will be offered a supportive visit from the CCG Practice Support Group (PSG).

¹ “Framework for responding to CQC inspections of GP practices” (NHS England, October 2014)
² “NHS GP Practices and GP out-of-hours services Provider handbook www.cqc.org.uk/content/gp-practices-and-out-hours-service-providers
4.3. An agenda will be drafted and agreed between the PSG and practice prior to the visit identifying areas for discussion and required attendees.

4.4. The visit should be seen initially as supportive allowing the practice time for reflection.

4.5. An action plan will be developed by the PSG and agreed with the practice with identified areas and timescales for improvement.

4.6. The CCG will offer support to practices that are performing below the agreed minimum standards through the following actions:
   - Mentoring.
   - Clinical Leadership and Support.
   - Agreement of an action plan.
   - CCG and practice review of the action plan at follow up visit.

4.7. The process for contractual escalation is outlined below:
   - Supportive processes established as outlined within this document.
   - At review of action plan any outstanding issues may result in issue of a contract remedial notice.
   - Failure to address a remedial notice would constitute cause to issue a breach notice.
   - Failure to address a breach notice may cause termination of contract.

4.8. Given that any decision to issue a breach or remedial notice, apply sanctions or terminate a contract or agreement can be challenged by the contractor under appeal, it is essential that the CCG follows (and can demonstrate that it has followed) due process in investigating, communicating and implementing actions in this respect and that the CCG has acted fairly and reasonably throughout. Consideration of issues raised will also take place at the NHS England regional Quality Surveillance Group.

4.9. The CCG will adopt “NHS England Policy for contract breaches, sanctions and terminations for primary medical services”:
The Primary Care Commissioning Committees of Eastbourne, Hailsham and Seaford CCG and Hastings and Rother CCG meeting together  
Date of meeting: 26 October 2016  

<table>
<thead>
<tr>
<th>Title of report:</th>
<th>Work plan 2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Recommendation:</strong></td>
<td>The Committees are recommended to <strong>note</strong> the work plan.</td>
</tr>
<tr>
<td><strong>Summary:</strong></td>
<td>As part of the assurance and governance work of the CCGs, a work plan is proposed for the Primary Care Commissioning Committees to ensure appropriate planning for the work of the committees that meets their terms of reference and enables assurance with regard to the delegated responsibility for the commissioning of primary medical services to be provided to the Governing Bodies.</td>
</tr>
<tr>
<td><strong>Committee sponsor:</strong></td>
<td>John O’Sullivan, Chief Finance Officer.</td>
</tr>
<tr>
<td><strong>Author(s):</strong></td>
<td>Fiona Kellett, Head of Finance and Primary Care Commissioning</td>
</tr>
<tr>
<td><strong>Review by other committees:</strong></td>
<td>The work plan has not been reviewed by any other committees</td>
</tr>
<tr>
<td><strong>Financial implications:</strong></td>
<td>An agreed work plan will assist the CCGs to manage within the delegated budget</td>
</tr>
<tr>
<td><strong>Legal or compliance implications:</strong></td>
<td>An agreed work plan will ensure that the committees meet their statutory obligations</td>
</tr>
<tr>
<td><strong>Link to key objective and/or principal risks:</strong></td>
<td>An agreed work plan is a key element in the assurance and governance of the CCGs.</td>
</tr>
<tr>
<td><strong>Link to East Sussex Better Together (ESBT) programme:</strong></td>
<td>Sustainable primary care is a key platform for the delivery of the ESBT transformation programme</td>
</tr>
<tr>
<td><strong>How has the patient and public engagement informed this work:</strong></td>
<td>External scrutiny of the work plan is undertaken by NHS England, Healthwatch and a representative from the Health and Wellbeing board</td>
</tr>
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**EA Summary:** n/a

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<th>Privacy Impact Assessment (PIA) – outcome:</th>
<th>No personal data used</th>
<th>Data processes sufficient</th>
<th>Actions required</th>
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</table>

**Actions:** n/a.
The Primary Care Commissioning Committees of Eastbourne, Hailsham and Seaford CCG and Hastings and Rother CCG meeting together
Date of meeting: 26 October 2016

| Item Number: 58/16 |

| Title of report: | Primary Care Risk Register |

| Recommendation: | The Primary Care Commissioning Committees (PCCC) are recommended to review the attached information and decide whether or not this information: |
| | • adequately identifies all high level Primary Care risks to the Key Objectives; and |
| | • details sufficient actions to manage the risks. |

| Summary: | This report includes relevant information from the CCGs’ Risk Management System in order to further support the Primary Care Commissioning Committees in their work. |
| | This report and appendices detail risks from the September 2016 Committee and Governing Body reports in the area of Primary Care Commissioning. They provide details of the impacts upon the Governing Bodies’ Key Objectives and of the actions being taken to manage the risks. |

| Committee sponsor: | Jessica Britton, Chief Operating Officer |

| Author(s): Clive Mellor, Head of Governance and Business Planning | Date of report: 13/10/16 |

| Review by other committees: | Individual corporate risks are scrutinised at each meeting of the Quality and Governance Committees. The Assurance Framework is submitted to each meeting of the Governing Bodies. The system of risk management is scrutinised by the Audit Committees. |

| Health impact: | Individual risks may have health impact. This will be indicated within the detailed information about the risk. |

| Financial implications: | Individual risks may have financial implications. This will be indicated within the detailed information about the risk. |

| Legal or compliance implications: | The CCGs are required to have a robust system of risk, the effectiveness of which forms part of its annual governance statement. |
**Link to key objective and/or principal risks:** The Assurance Framework details the Principal Risks to the Key Objectives upon which they impact.

**Link to East Sussex Better Together (ESBT) programme:** A number of risks arise from or may impact upon the ESBT programme. This is detailed within the individual risks.

**How has the patient and public engagement informed this work:** The Assurance Framework of Principal Risks is in the public domain.

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</table>

**EA Summary:** The Risk Management Strategy and Policy have been Equality Assessed and have neutral impact.

<table>
<thead>
<tr>
<th>Privacy Impact Assessment (PIA) – outcome:</th>
<th>No personal data used</th>
<th>Data processes sufficient</th>
<th>Actions required</th>
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</table>

**Actions:** Nil.
CCG Risks and the Primary Care Commissioning Committee

1. **Summary**

1.1 In order to further support the Primary Care Commissioning Committees in their work this paper includes relevant information from the CCGs’ Risk Management System.

1.2 Attached are:

- Relevant risks extracted from the Corporate Risk Register (Appendix A).
- Relevant information from the Assurance Framework containing levels of assurance for Key Objectives impacted by Primary Care Risks (Appendix B).

1.3 This information indicates risks in the area of Primary Care Commissioning from the September 2016 reports. It provides details of the impacts upon the Governing Bodies’ Key Objectives and of the actions being taken to manage the risks.

2. **Assurance on the System**

2.1 The CCGs have a Corporate System of Risk that has been regularly audited. Auditors have reported ‘Substantial Assurance’ (the highest of the 4 levels of audit assurance) on the system.

2.2 Risks may be raised anywhere within the CCGs. They are then assessed against a national scoring system (from 1 to 5 in terms of likelihood and from 1 to 5 in terms of their potential impact – with 5 being the highest level in each case – the two scores are multiplied to give a total score from 1 to 25).

2.3 Lower scoring risks (scores totalling below 10) are managed within local teams (directorates). Higher scoring risks (scores totalling 10 or above) are deemed ‘corporate risks’. These are entered on the Corporate Risk Register (CRR) and have a member of the senior management team allocated as the risk owner. The highest level risks (scores totalling 15 and above) are also added to the Governing Body Assurance Framework (AF) where they are mapped against the Governing Bodies’ Annual Objectives.

3. **Activity to mitigate risk**

3.1 Each risk has an allocated manager who sets actions to mitigate the risk, thus reducing either the likelihood or the potential impact. When a risk is sufficiently mitigated the relevant score may be reduced.

3.2 Risks are reviewed at least bi-monthly by their owners. Risks on the CRR and AF are scrutinised at each meeting of the CCGs’ Quality and Governance Committees. Risk owners may be requested to provide further assurance or take further action to mitigate a risk. The CCGs’ Audit Committees receive assurance at each meeting that the risk
processes are being robustly applied. The CCG Governing Bodies receive the AF and a narrative report at each meeting.

3.3 As part of the delegation of the commissioning of primary medical care from NHS England to the CCGs, each CCG Governing Body has established a Primary Care Commissioning Committee (PCCC). These meet in public to oversee the delegated functions and duties, in the same way as the Governing Bodies oversee the other CCG functions and duties.

3.4 The Primary Care Commissioning Committees’ agenda for October 2016 includes reports and actions that support the mitigation of key risks. This includes:
- General Practice forward view introduction and update on workload and workforce

4. Recommendations
4.1 The Primary Care Commissioning Committees are recommended to review the attached information and decide whether or not it:
- adequately identifies all high level Primary Care risks to the Key Objectives; and
- details sufficient actions to manage the risks.

Clive Mellor
Head of Governance and Business Planning
13 October 2016
## Corporate Risk Register – Primary Care Risks

### EHS CCG And HR CCG

**Report date:** 13/09/2016

<table>
<thead>
<tr>
<th>Risk Number</th>
<th>Risk Impact Date</th>
<th>Link to Business Plan Objective</th>
<th>Risk Type</th>
<th>Risk Description</th>
<th>Severity (Impact)</th>
<th>Likelihood</th>
<th>Total (Risk Rating)</th>
</tr>
</thead>
<tbody>
<tr>
<td>747</td>
<td>18/12/2015</td>
<td></td>
<td></td>
<td>There is a risk that the GP Out of Hours service available in its current configuration due to instability to recruit to a range of clinician roles and in the required amount of clinical hours to meet demand.</td>
<td>4</td>
<td>4</td>
<td>16 (Risk Rating)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Patient safety will be compromised and patients will not be seen returned within required timeframes. The wider urgent care system may be compromised due to additional pressure from overflow of primary care.</td>
<td>4</td>
<td>4</td>
<td>16 (Risk Rating)</td>
</tr>
<tr>
<td></td>
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<td></td>
<td>4. Options around OOH base location and sustainable delivery model to safely meet demand for duration of working contract delivered. Remitad actions monitored via weekly performance reports and by the system resilience group.</td>
<td>4</td>
<td>4</td>
<td>16 (Risk Rating)</td>
</tr>
<tr>
<td></td>
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<td></td>
<td></td>
<td>5. Developing sustainable 24/7 urgent primary care model under the EHS Urgent Care Re-design Programme: County-wide and CCG-wide working groups with SP locality access to county-wide primary care model.</td>
<td>4</td>
<td>4</td>
<td>16 (Risk Rating)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Action Matrix/Target date for remanuell Action Target Date Action Computed date Residual Risk Rating Responsibility Date of Last Review</td>
<td>4</td>
<td>4</td>
<td>16 (Risk Rating)</td>
</tr>
<tr>
<td>790</td>
<td>31/12/2016</td>
<td></td>
<td></td>
<td>There is a risk there is insufficient workforce across the locality of primary care to meet the needs of the population. This may result in a lack of resilience within primary care and impact upon patient care.</td>
<td>4</td>
<td>4</td>
<td>16 (Risk Rating)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Objective not met, instability in primary care.</td>
<td>4</td>
<td>4</td>
<td>16 (Risk Rating)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1. Implement the 2016/17 workforce actions within the Primary Care Strategy.</td>
<td>4</td>
<td>4</td>
<td>16 (Risk Rating)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2. Workforce Steering Group is place to oversee implementation of the South West Workforce programme.</td>
<td>4</td>
<td>4</td>
<td>16 (Risk Rating)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3. CCG to work closely with Health Education England to ensure that the CCG commissions the workforce needed for the future.</td>
<td>4</td>
<td>4</td>
<td>16 (Risk Rating)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>4. Use extended learning time for GPs to address training needs.</td>
<td>4</td>
<td>4</td>
<td>16 (Risk Rating)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>5. Implement sufficiently impactful plans to support new roles and practices across the whole patch.</td>
<td>4</td>
<td>4</td>
<td>16 (Risk Rating)</td>
</tr>
<tr>
<td></td>
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<td></td>
<td>6. HR CCG only: Use funding from the resiliency fund reallocated programme to support the merger of single-handed practices in order to increase medical cover and patient waiting opportunities.</td>
<td>4</td>
<td>4</td>
<td>16 (Risk Rating)</td>
</tr>
<tr>
<td></td>
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<td></td>
<td>7. GP summit to engage with Primary care on short and longer-term strategies.</td>
<td>4</td>
<td>4</td>
<td>16 (Risk Rating)</td>
</tr>
<tr>
<td></td>
<td></td>
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<td></td>
<td>Community Education Renewal Network (CERN) governance packs to be signed off by the CERN Delivery Board.</td>
<td>4</td>
<td>4</td>
<td>16 (Risk Rating)</td>
</tr>
</tbody>
</table>
**Levels of Assurance for Objectives impacted by Primary Care Risks (September 2016)**

<table>
<thead>
<tr>
<th>Risks</th>
<th>Current</th>
<th>Mitigation</th>
<th>Residual</th>
<th>1</th>
<th>3</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk 747 - There is a risk that the GP Out of Hours (OOH) service is unsustainable in its current configuration due to inability to recruit to a range of clinical roles and fill the required amount of clinical hours to meet demand.</td>
<td>4x4=16</td>
<td>Reduce likelihood from 4 to 2</td>
<td>4x2=8</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Risk 790 - There is a risk that there is insufficient workforce within primary care to meet the needs of the population. This may result in a lack of resilience within primary care and impact upon patient care.</td>
<td>4x4=16</td>
<td>Reduce likelihood from 4 to 2</td>
<td>4x2=8</td>
<td>Y</td>
<td>N</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
</tbody>
</table>

Total score of all aligned principal risks: 114

Total residual score of all aligned principal risks: 75

**Level of assurance**

<table>
<thead>
<tr>
<th>Substantial Assurance</th>
<th>Reasonable Assurance</th>
<th>Limited Assurance</th>
<th>No Assurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>There is a robust series of suitably designed internal controls in place upon which the CCG relies to manage the risk of failure of the continuous and effective achievement of the objectives of the process, which at the time of review were being consistently applied.</td>
<td>There is a series of controls in place however there are potential risks that they may not be sufficient to ensure that the individual objectives of the process are achieved in a continuous and effective manner. Improvements are required to enhance the adequacy and effectiveness of the controls to mitigate these risks.</td>
<td>The controls in place are not sufficient to ensure that the CCG can rely upon them to manage the risks to the continuous and effective achievement of the objectives of the process. Significant improvements are required to improve the adequacy and effectiveness of the controls.</td>
<td>There is a fundamental breakdown or absence of core internal controls such that the CCG cannot rely upon them to manage the risks to the continuous and effective achievement the objectives of the process. Immediate action is required to improve the adequacy and effectiveness of controls.</td>
</tr>
</tbody>
</table>

**Governing Body Key Objectives 2016/17**

<table>
<thead>
<tr>
<th>ESBT</th>
<th>NHS Constitutional Standards</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Deliver the ESBT work stream objectives for 2016/17</td>
<td>6. Ensure our contract and performance mechanisms deliver on trajectories</td>
</tr>
<tr>
<td>2. Deliver the next stages on the journey to new models of (accountable) care.</td>
<td>7. Deliver financial plans in-year and provide significant evidence of good use of resources.</td>
</tr>
<tr>
<td>3. Deliver the 2016/17 Commissioning Intentions, including the re-commissioning of support services.</td>
<td>8. Evidence measurable improvements in the quality and safety of commissioned services.</td>
</tr>
<tr>
<td>4. Deliver integrated CCG and Social Care Engagement and Communications Strategy.</td>
<td>9. Agree the profile for delivering the nine &quot;must dos&quot; for all local health systems in 2016/17, taking into account any agreed improvement trajectories.</td>
</tr>
<tr>
<td>5. Deliver the in-year plans to address Health Inequalities.</td>
<td></td>
</tr>
</tbody>
</table>
The Eastbourne, Hailsham and Seaford CCG and Hastings and Rother CCG Primary Care Commissioning Committees, meeting together

Date of meeting: 26 October 2016

<table>
<thead>
<tr>
<th><strong>Title of report:</strong></th>
<th>General Practice Forward View: an update on the implementation of the programme to support sustainability in Primary Care</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Recommendation:</strong></td>
<td>The Committees are recommended to note the progress on the implementation of the General Practice Forward View to support sustainability in Primary Care</td>
</tr>
</tbody>
</table>
| **Summary:**          | The report summarises the actions and plans outlined by the General Practice Forward View (GPFV) published in April 2016 to support the sustainability of General Practice through a number of key areas.  
                        | The report includes details on the local implementation of these initiatives specifically covering General Practice workload, workforce and infrastructure plans and an update on future developments.  
                        | The report highlights the actions that have now been implemented such as the locum bank, physician associate training, information and data sharing agreements and the development of portfolio roles for GPs jointly with East Sussex Healthcare Trust. |
| **Committee sponsor:**| John O’Sullivan, Chief Finance Officer |
| **Author:**           | Fiona Kellett, Head of Finance and Primary Care Commissioning |
| **Date of report:**   | 07/10/16 |
| **Review by other committees:** | Reviewed by the CCGs’ Primary Care Commissioning Operational Group (PCCOG). |
| **Health impact:**    | Improved access to services. |
| **Financial implications:** | Sustainable Primary Care is critical to ensuring financial balance. |
| **Legal or compliance implications:** | None. |
| **Link to key objective and/or principal risks:** | National priority – Sustainability and Quality of General Practice and delivery of ESBT |
| **How has the patient and public engagement informed this work:** | Patient and public engagement plans are built into each work programme. |
### Equality Analysis (EA) Process - outcome:

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<th>Impact</th>
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<th>☐</th>
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</thead>
<tbody>
<tr>
<td>Negative Impact</td>
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<tr>
<td>Neutral Impact</td>
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<tr>
<td>Positive Impact</td>
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<tr>
<td>No Impact</td>
<td></td>
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<td></td>
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<tr>
<td>Not required for report</td>
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</table>

**EA summary:** N/A.

### Privacy Impact Assessment (PIA) – outcome:

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</thead>
<tbody>
<tr>
<td>No personal data used</td>
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</tr>
<tr>
<td>Data processes sufficient</td>
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<td></td>
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<tr>
<td>Actions required</td>
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</table>

**Actions:** N/A.
Update on General Practice Forward View

1. Introduction
1.1 The General Practice Forward View (GPFV) was published by NHS England in April 2016 and sets out how general practice workload pressures will be addressed. It refers to specific programmes to address investment, workforce, workload, infrastructure and care redesign as follows:

2. Investment
2.1 Nationally, a further £2.4bn a year is to be invested into general practice services by 2020/21 which represents a 14% real terms increase. This is double the 8% real terms increase for the rest of the NHS.
2.2 This funding is likely to increase as CCGs build community services and new care models in line with the Five Year Forward View (FYFV).
2.3 This includes capital investment of £900m nationally over the next five years which will be managed through the Estates and Technology Transformation Programme.
2.4 This will be supplemented by a Sustainability and Transformation package totalling half a billion over the next five years to support struggling practices, develop the workforce, tackle workload and stimulate care redesign.
2.5 A new funding formula to better reflect practice workload including deprivation and rurality is being developed.
2.6 CCGs will now able to use Better Care Fund monies to jointly commission expanded services including: additional nurses in GP settings to co-ordinate care for patients with long term conditions; GPs providing services in care and nursing home settings; providing a mental health professional and a social worker in a GP setting.

3. Workforce
3.1 Increase in GP training recruitment by 1,200 each year to support overall net growth of 5,000 extra doctors compared with 2014.
3.2 Major recruitment campaign in England to attract doctors to become GPs and major international recruitment campaign to attract 500 trained and qualified doctors from overseas.
3.3 Targeted £20k bursaries in the areas that have found it hardest to recruit into GP training.
3.4 250 new fellowships to provide further training opportunities in areas of poorest GP recruitment.

3.5 Measures to attract and retain at least 500 GPs back into English general practice through simplifying the return to work routes and targeted financial incentives.

3.6 A minimum of 5,000 other staff working in general practice by 2020/21 to include mental health therapists, (one for every 2-3 typical sized GP practice); extension of the programme to pilot clinical pharmacists in practices (one pharmacist per 30,000 population) and introduction of a new pharmacy integration fund.

3.7 A general practice nurse development strategy improving training capacity in general practice, increases in the number of pre-registration nurse placements and measures to improve retention and return to work schemes.

3.8 National investment to support the training of reception and clerical staff to play a greater role in navigation of patients and handling clinical paperwork to free up GP time.

3.9 Investment in the training of 1,000 physician associates to support general practice and pilots for new medical assistant roles.

3.10 A £6m investment in practice manager development alongside access to a new national development programme.

3.11 A £3.5m investment in multi-disciplinary training hubs to support the development of the wider workforce within general practice.

3.12 £16m extra investment in specialist mental health services to support GPs.

4. Workload
4.1 This programme will offer support for general practice with the management of demand, diversion of unnecessary work, reduction in bureaucracy and more integration with the wider health and care system including:

4.2 “Releasing time for Patients” programme to help release capacity in general practice;

4.3 New standard contract measures for hospitals to stop work shifting at the hospital / GP interface;

4.4 New “Practice Resilience Programme”;

4.5 A move to five yearly intervals of CQC inspections for practices rated good and outstanding and a simplified system across NHS England, CQC and GMC; and streamlining of payment processes for practices and automation of common tasks.
5. Infrastructure
5.1 Investment for practice estates and infrastructure to reach £900m over the next five years and measures to speed up delivery of capital projects.

5.2 New rules on premises costs to enable NHS England to fund up to 100% of the costs for premises developments (previously 66%).

5.3 New offer to fund stamp duty land tax for practices who are tenants of NHS Property Services and who are signing new leases between May 2016 and October 2017.

5.4 New funding routes for transitional funding support for practices seeing significant rises in facilities management costs in leases held with NHS Property Services.

5.5 Greater use of technology to enhance patient care and experience as well as streamlined practice processes.

5.6 Programme to stimulate uptake of on-line consultations and online access for patients to accredited clinical triage systems.

5.7 Development of an approved on-line Apps library and measures to support practices to offer more on-line self-care and self-management services.

5.8 Actions to make it easier for practices to work collaboratively including full interoperability across IT systems.

5.9 Funding for the hardware, implementation and service costs for Wi Fi services in GP practices for staff and patients from April 2017.

5.10 A number of initiatives to improve procurement processes for IT products and services and work with supplier market to create a wider and more innovative choice of digital services for general practice.

5.11 Completion of the roll out of access to the summary care record to community pharmacies by March 2017.

6. Care redesign
6.1 Commissioning and funding of services to provide extra Primary Care capacity across every part of England.

6.2 Integration of extended access with out of hours (OOH) and Urgent Care services, including reformed 111 and local clinical hubs.

6.3 A new national three year “Releasing Time for Patients” programme to reach every practice in the country to free up 10% of GP time. This will spread the best innovations from across the country, fund local collaborations to support practices in
implementing new ways of working and provide free training and coaching for clinicians and managers to support practice redesign.

7. Local Implementation
7.1 The plans set out in the GPFV are being implemented locally in three main areas as follows:

- Workload;
- Workforce; and
- Infrastructure (Premises and IT).

The care redesign work is being covered within all three areas as appropriate and as part of the wider ESBT transformation programme.

7.2 The three work streams are each supported by an action group that meets monthly and reports into the GPFV Implementation Group. This group has members from each of the action groups, the lead Director for Primary Care, the governing body GP quality leads and the clinical director of the ESBT transformation programme and is chaired by one of the CCGs’ Lay members.

7.3 A summary of the work completed to date in each main area is reported below.

8. Primary Care Workload – Update
8.1 The General Practice Forward View (GPFV) requires CCGs to develop plans to ensure the sustainability of Primary Care. An implementation group has been formed, and the programme is being managed within three main areas:

- Workload
- Workforce
- Infrastructure

8.2 The plans to address Workload reflect the more immediate actions that can be taken to ensure sustainability of primary care while allowing practices the time and headspace to develop longer term plans to address workforce and capacity issues.

8.3 Plans agreed and in place:

8.4 The CCGs have supported Integrated Family Healthcare Ltd (the federation of Hastings practices) and South Downs Health and Care Ltd (the federation of Eastbourne, Hailsham and Seaford practices) to recruit some interim GPs for a period of up to one year. This project is designed to support practices that have had particular difficulties in recruiting either partner or salaried GPs. The first of the interims took up post in early October and feedback is that the role is very well received and is proving effective at relieving pressure within the practice.

8.5 The CCGs have commenced a pilot scheme to support practices who are hosting a Physician Associate trainee. This is a new role and the local area has been
fortunate to secure two trainees in each CCG from the first cohort of students in this new programme. The pilot practices will be evaluating the best way to use this role and it is hoped that the trainees may decide to remain in the local area at the end of their official training.

8.6 Work with colleagues from ESHT is on-going to review the arrangements in place when patients are discharged from hospital to ensure that the exchange of information between secondary and primary care is as streamlined as possible. This will also ensure that patients are clear which health professional they need to contact to receive feedback on tests, request prescriptions etc.

8.7 A pilot programme is in place in four Eastbourne practices where a care navigator role is being used to work with a cohort of patients who can benefit from signposting to alternative appropriate services within the primary and community care setting.

8.8 A forum for practice managers has been established in Hastings to offer support and development to local practice managers and to facilitate the sharing of best practice and expertise in the use of systems and processes.

8.9 CCG officers are working with colleagues from ESHT to develop some joint roles where a GP can work part time in general practice and part time in a specialty area. This is designed to appeal to GPs who are not sure they want to commit full time to a general practice role whilst also embedding specialist skills in the primary care setting.

8.10 The CCG have agreed a plan to support the training of administrative staff to extend their roles to reduce the workload of clinicians in the practice, specifically in relation to clinical coding.

8.11 The CCG is supporting the development of centralised data extraction templates to free up management time.

8.12 The CCG is piloting a project with practices who may wish to work together to utilise the clinical systems to facilitate remote consultations. This will enable struggling practices to be linked with GPs in a position to offer some capacity and resource remotely.

8.13 The CCG is informing practices of alternative technological solutions to support their workforce e.g. encouraging patients to use the on-line resources within clinical systems.

8.14 Next steps:
The next stage of the programme will include the following schemes which are currently being worked up:

- Plans for recruitment and retention initiatives targeted at GPs.
- Plans for bursaries for GPs and student nurses.
- Review of work model for GPs close to retirement.
- Consideration of role of practice based pharmacists.
9. Primary Care Workforce – Update

9.1 To enable accurate workforce planning it is essential the CCG has up-to-date information on the current workforce. The CCG has agreed to resource practices to collate and submit their Primary Care Workforce Data as part of the GP Support Scheme. This will ensure the CCG has the most accurate data possible to undertake workforce development and planning within the ESBT workforce. To enable this to happen:

- The CCG is resourcing practices to enable them to submit quarterly workforce data via the Health Education England Workforce tool
- An ESBT Workforce Information Analyst has been appointed to build on initial reports on workforce planning and vacancy gaps

9.2 With recruitment and retention in primary care a national problem it is imperative that the current workforce is used efficiently. The CCG has agreed a plan to support the development of the current workforce ensuring that individuals’ skills are applied and used in the most appropriate way. This currently includes:

- Facilitating and resourcing administration training to enable admin teams in practices to be fully trained to code clinical correspondence. It is reported that this change in process can result in saving a GP 40 minutes a day.

9.3 The CCG is committed to encouraging people to come and work in the area through:

- Attendance at two national careers fairs in London to promote primary care and the opportunities offered in the local area through our ESBT transformation programme
- Local engagement opportunities alongside EHST and the vocational training scheme supporting new doctors to the area
- Using public relations tools to promote the opportunities in the local area and demonstrate that the area is an attractive place to work

9.4 New roles are being developed to integrate secondary and primary care:

- Four practices are being resourced to mentor Physicians Associates in Primary Care
- Practices are being supported in integrating Paramedic Practitioners and Clinical Pharmacists through mentorship funding
- The CCG Primary Care Workforce Tutor is working with the Health Education Institute and local practices to identify nursing gaps and to inform the future education curriculum. This will ensure the delivery of an appropriate nursing workforce is incorporated in workforce plans.
9.5 Next steps:
The next stage of the programme will include the following schemes which are currently being worked up:

- Plans to utilise a “Golden Hello” for newly qualified GPs committed to working locally
- Resourcing of a “redesign fund” enabling practices to re-design their workforces
- Commissioning of Educational Pharmacists pathways
- Engage with ESHT on overseas recruitment

10. Primary Care Infrastructure - Premises Update
10.1 The CCGs submitted bids to NHSE on behalf of practices for the Estates and Technology Transformation Fund (ETTF) by 30 June 2016. Following submission, CCG officers attended a meeting with NHSE colleagues to provide further detail on each of the bids and specifically to confirm how each bid would be able to support the delivery of major transformational change.

10.2 Further additional information was requested to support the submission including an indication of the expected timescale for completion. This was returned by the due date with no change in the CCG priorities. CCGs were contacted by NHSE in early October 2016 and asked to re-confirm their top three priorities which remain unchanged.

10.3 CCG officers are working with practices to ensure that where possible they seek alternative methods of financing any planned developments in the event that bids are not successful.

10.4 CCG officers continue to meet regularly with representatives from each of the local district and borough councils. This is to ensure primary care plans take account of any planned or anticipated housing growth and the CCGs are kept updated with regard to the timings of any significant developments.

10.5 The CCG are engaging with ESBT partners to ensure that any primary care estates requirements are considered within the context of the ESBT footprint and all opportunities for collaborative working are fully explored.

10.6 A Primary Care Action Group meets monthly to review all premises and estates issues and will consider applications for minor improvement grants.

10.7 Next Steps:
- NHSE are now reviewing and moderating the bids submitted by CCGs and we are expecting notification of when a decision will be made that can be communicated to practices.
• Estates and premises planning will be discussed in detail at locality level at the next round of locality meetings in December 2016.

11. Primary Care Infrastructure – IM&T Update

11.1 All practices have been upgraded to Windows 7

11.2 All practices now have wireless installed

11.3 All practices in Hastings & Rother are using EMIS Web as their Clinical System. With the exception of one practice, all Eastbourne, Hailsham & Seaford practices are either currently using EMIS Web or have a migration date in the next six months.

11.4 All practices in both CCGs are now live with the core Summary Care Record (SCR). In addition all practices are now able to create, with explicit patient consent, SCRs with additional information which, in addition to the core information includes: significant medical history, reason for medication, anticipatory care information, communication preferences, end of life care information and Immunisations.

11.5 All practices in both CCGs offer patients the opportunity to book appointments, order repeat medication and view summary record information online. The GMS contract requires that practices aim for a minimum 10% of their list to be registered for online services by 31 March 2017. The IM&T Team are working with practices to achieve this with the numbers of patient registrations increasing steadily.

11.6 Currently 95% of practices in EHS and 70% practices in H&R are now live with the Electronic Prescription Service. Most of the non-live practices are dispensing practices. An opt-out has been negotiated for these practices until dispensing systems are able to process scripts via EPS.

11.7 The CCGs are working closely with ESHT to get NHS E-Referral system rolled out. Currently only the Respiratory Medicine service is live with NHS E – Referrals but five surgical specialities will be ready to go-live 30 November 2016. These services will include Ear, Nose and Throat (ENT), General Surgery, Urology, Vascular and Ophthalmology.

11.8 DXS is a standardised pathway and referral management system and provides referral forms, pathways and clinical guidance to GPs linked to their clinical system. We are continuing to update and improve DXS content in response to feedback from GPs.

11.9 We are about to implement the EMIS remote consultation tool at pilot sites in both CCGs to provide additional capacity across localities.

11.10 Next Steps
• Move Practices onto Single Domain – We have applied for funding to enable practices to migrate onto a single domain infrastructure. This will enable the
existing file servers to be remotely hosted and allow greater flexibility for cross site working which will be a key enabler for sharing extending access coverage.

- Managed Print Service - we will investigate and offer alternative solutions to practices looking to reducing printing costs. This work will start once a new IT provider is in place from 1 November 2016.

- SMS – use of bi-directional messaging – we will offer practices a two way SMS messaging platform to allow more intelligent communication with patients. This will allow patients to auto cancel appointments and allow practices to offer flu invitations and other services via this method.

- Expansion of Wireless Provision – we will look to expand the current wireless networking infrastructure into additional care settings particularly where mobile coverage is poor. This could range from care homes, to village halls or any particular area patients are seen.

- Patient Note Storage – we have applied for funding to introduce off-site storage solutions for practices where there is limited space. This ranges from an off-site and call in service to a fully off-site and detailed scanning service.

- Single Sign-On – we are working with our IT provider to deploy a single sign on solution for GP practices which will remove the requirement to type in multiple usernames and passwords on a daily basis. Technology is available to link this process to the current smartcards.

- Common 3rd party add-ons – as practices look to collaborate and work closer together we will work with groups of practices to investigate solutions which are common within those areas.

Fiona Kellett
Head of Finance and Primary Care Commissioning

October 7th 2016
Title of report:  
Finance Update: Primary Care Delegated Commissioning Budgets 2016/17

Recommendation:  
The Committees are recommended to approve the 2016/17 Primary Care delegated commissioning budgets and Locally Commissioned Services (LCS) budgets at M5 (August 2016).

Summary:  
- The 2016/17 allocation for Primary Care Delegated Commissioning for Eastbourne, Hailsham and Seaford (EHS) CCG is £24.821m. For the first year of delegated commissioning in Hastings and Rother (HR) CCG the allocation is £26.206m.

- In accordance with NHS England (NHSE) business rules the budgets set in each CCG include a 0.5% contingency reserve and a 1% uncommitted reserve.

- The LCS budget for EHS CCG is £5.198m and for HR CCG £5.022m.

- The year to date (YTD) position and forecast outturn at August 2016 is breakeven for both CCGs’ delegated budgets.

- There are plans for the full amount of the Over 75’s allocation to be committed during 2016/17.

- NHSE have confirmed that there will be a Minor Improvement Grant for practices to bid for this year; further details are expected in autumn 2016.

Committee sponsor: John O’Sullivan, Chief Finance Officer

Author(s): Fiona Kellett, Head of Finance  
Date of report: 10/10/16

Review by other committees: None

Health impact: Ensuring a sustainable financial position best enables the CCG to meet the current and future needs of the population.

Financial implications: The CCG has a statutory responsibility to live within its means.

Legal or compliance implications: Compliance with financial objectives and duties.
<table>
<thead>
<tr>
<th>Link to key objective and/or principal risks: Financial balance.</th>
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</thead>
<tbody>
<tr>
<td>How has the patient and public engagement informed this work: Not applicable</td>
</tr>
<tr>
<td>Privacy Impact Assessment (PIA) – outcome:</td>
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<td>No personal data used</td>
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</table>
Finance Report: Primary Care Delegated Commissioning Budgets 2016/17

1. Introduction

1.1 The Primary Care Committees (PCCC) approved the delegated commissioning budgets and Locally Commissioned Services (LCS) budgets at the June 2016 meeting.

1.2 The M5 year to date position and forecast outturn for the delegated commissioning budget in each CCG is shown at appendix 1. The overall forecast position on the delegated co-commissioning budgets is a breakeven although there is a year to date underspend against the General Practice Information Technology (GPIT) budget in both CCGs.

1.3 NHSE have confirmed that a there will be a Minor Improvement Grant for practices to bid for this year; further details are expected in autumn 2016.

2. NHSE Allocation and financial business rules compliance

2.1 The 2016/17 allocation for Primary Care Delegated Commissioning for Eastbourne, Hailsham and Seaford (EHS) CCG is £24.821m. For the first year of delegated commissioning in Hastings and Rother (HR) CCG the allocation is £26.206m.

2.2 A technical accounting adjustment has been applied to budget of £33k for EHS and £25k for HR which has been moved from the Primary Care Co-commissioning budget to Corporate Commissioning budget to support the implementation of GP Forward View (GPFV).

2.3 Both CCGs continue to meet the NHSE business rules:
   • Establish a 0.5% contingency reserve – set at £123k for EHS and £129k for HR.
   • Set aside a 1% uncommitted reserve which must be held as part of wider health system contingency arrangements and which can only be released or utilised with formal approval from NHSE - set at £250k for EHS and £260k for HR.

2.4 There is no requirement in 2016/17 to deliver a 1% surplus against the Primary Care allocation. The requirement is “statutory breakeven”.

3. Summary of budgets for 2016/17

3.1 Since the start of the year work has continued with NHSE to understand the current commitments against the delegated budget, the financial risks at individual budget area level and the level of any uncommitted reserve. NHSE and the CCGs had agreed a staged handover with NHSE continuing to make payments until June and the CCGs taking over full responsibility from July 2016. This timetable has now slipped as NHSE are not yet in a position to complete the detailed analysis.
necessary for complete handover to CCGs. The revised timetable is expected shortly.

3.2 The LCS budget for EHS CCG is £5.198m and for HR CCG £5.022m. The detail is shown at appendix 2. With effect from 2016/17 the CCGs have agreed to uplift all LCS prices annually in line with the global sum uplift. In addition, all LCS specifications are being reviewed to ensure they remain in line with current clinical pathways and this will include a review of the pricing for each scheme.

4. Position to the end of August 2016

- The overall forecast position on the delegated co-commissioning budgets is a breakeven although there is a year to date underspend against GPIT in both CCGs. NHSE are in the process of transferring the operational management of the budgets to the CCGs at which point more detailed information will be available.

- The position of LCS against budget is shown at appendix 2. The forecast is for both LCS & the Over 75’s to break even at year end.

- An uplift of 1% has been applied to the rates paid for LCS schemes with effect from 1 April 2016; this is in line with the nationally agreed uplift to the Global Sum. CCG staff are working with local medical committee (LMC) colleagues to review all current LCS specifications to ensure that they continue to reflect clinical best practice, locally agreed clinical pathways and that the pricing is appropriate.

5. Key Financial Risks

5.1 The detailed knowledge of the primary care budgets and associated risks currently sits within NHSE, but there is an on-going process to transfer this knowledge to CCG staff. At this stage in the process, the level of financial risk of an overspend against the total budget appears to be small. The budgets where expenditure can change in-year are:

- Premises - rent reviews and rate increases that occur mid-year
- Enhanced services – dependent on activity undertaken
- Other GP services – locum services required throughout the year
- List size adjustments
- QOF – dependent on the level of achievement by practices

5.2 The CCGs continue in dialogue with NHSE to assess the risk and to determine whether the 0.5% contingency reserve is sufficient to cover likely pressures.
6. Recommendation

6.1 The Primary Care Commissioning Committees are asked to approve the M5 year to date and forecast position for Primary Care delegated commissioning budgets and LCS budgets for EHS and HR CCGs [set out in Appendix 1 and Appendix 2].

John O’Sullivan
Chief Finance Officer
10 October 2016
### Appendix 1

#### Eastbourne Hailsham and Seaford CCG 2016-17 Primary Care Commissioning Budget August 2016

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The Primary Care Commissioning Committees of Eastbourne, Hailsham and Seaford CCG and Hastings and Rother CCG meeting together

Date of meeting: 26 October 2016

Title of report:
Update on the progress of monitoring performance in Primary Care – Quarter 2 2016 - 2017 (July 2016 – September 2016)

Recommendation:
The Committees are recommended to note the progress made in relation to the Practice Support Visits being conducted to date

Summary:

- In October 2015 the PCCC ratified the Managing General Practice Performance and Quality under Delegated Commissioning Responsibilities Policy. The policy was reviewed in September 2016 and is to be ratified at this meeting. This paper provides the PCCC with an update on the process identified in the policy.

- Practices have been prioritised for Practice Support Visits using criteria as detailed in the policy. At the time of this report three EHS practices and nine H&R practices were visited between July 2016 and September 2016. All practices yet to be visited have dates scheduled between October 2016 and January 2017.

- Following initial revision of the meeting format the visits have continued to be conducted using the new format as reported previously. Practices continue to report the support visits as a useful exercise.

- The main outcomes from the visits remain as per previous visits:
  - Infection control audits are being conducted to support Care Quality Commission (CQC) visits.
  - Training matrices are being shared for staff mandatory training.
  - Discussions are being held with practices to develop their administration and management teams as well as their clinical teams.
  - Workforce and premises issues are discussed at every meeting and CCG plans around ESBT are shared with practices.
  - Communication and relationship building is acknowledged as a positive outcome from the meetings.
  - Feedback from practices following a review of the locality meeting structure and content has been positive.

- The Performance Reporting tool (previously known as the QAT) has been revised following discussions at PCCOG and Practice Operational Forums. The latest Quality and Outcome Framework (QOF) data is not yet available but will be presented to the Committee in December 2016 once shared with practices.
NHSE have started to develop a performance reporting tool which will be assessed and utilised where appropriate.

- The support visits are also structured to discuss preparation for, or the outcome of, practice CQC visits. (Appendices 1 and 2). Detailed information of individual practice CQC visits is included in the Primary Care Quality update being presented to this committee.

- The Practice Support team have a meeting scheduled for November 2016 to review the structure and outcome of the visits conducted to date. A report on the review of the process will be presented to the PCCC in December 2016 along with recommendations for future visits.

Committee sponsor: John O’Sullivan, Chief Financial Officer

Author(s): Nicola Hone, Primary Care Co-Commissioning Strategic Manager. Date of report: 07/10/16

Review by other committees: Reviewed by the CCGs’ Primary Care Co-Commissioning Operational Group (PCCOG)

Health impact: Improving the quality of Primary Care is essential for improving the quality and health outcomes for the residents who use these services

Financial implications: Where residents do not achieve optimal health outcomes and quality there are inherent additional costs to the health system.

Legal or compliance implications: GP practices are required to comply with the Care Quality Commissions Fundamental Standards of Quality and Safety.

Link to key objective and/or principal risks: Improving Quality and Safety and Supporting Practices

How has the patient and public engagement informed this work: Sources of patient experience feedback and engagement information features within the Quality Assessment Tool referred to in this report.


Privacy Impact Assessment (PIA) – outcome: No personal data used Data processes sufficient Actions required ☒ ☐ ☐
1. **Introduction**

This paper provides an update following the paper on managing quality and performance in Primary Care which was submitted to the Primary Care Co-Commissioning Committee (PCCC) in July 2015 and the subsequent policy which was ratified by the PCCC in October 2015. The reviewed policy is for adoption at the October 2016 PCCC meeting. A record of CQC and practice visits conducted is attached in Appendices 1 and 2.

2. **Progress to date**

2.1 The CCG Practice Support Visit team has remained consistent and members are:

- Primary Care Co-Commissioning representative
- Quality Directorate representative
- GP Board Member
- Medicines Management representative
- Finance representative
- Any other CCG member who may wish to discuss specific issues

2.2 Practices to receive a support visit are identified using agreed criteria:

- Outliers identified on the CCG Performance Reporting Dashboard
- A CQC visit resulting in improvements required
- A trend of significant events and/or patient complaints
- Practice request
- Highlighted GP contractual issues

2.3 12 Practice Support visits have been undertaken with practices in EHS and HR CCG throughout April to June 2016. A total of 34 practice visits have been conducted (73%) this year.

3. **Outcomes**

3.1 All practices have individual issues to be addressed which are documented in the practice’s post visit report and action plan.

3.2 Common themes which have arisen:

- Infection control audits are being conducted to support CQC
- Training matrices are being shared for staff mandatory training
- Discussion and agreements are being had with practices to develop their administration and management staff as well as their clinical teams. Two practices have agreed to undergo key staff development to support reduction of administration for GPs.
- Workforce and premises are key at every meeting and sharing with the practices the CCG plans is received well.
- Communication and relationship building is felt as a real positive outcome from the meetings.
Feedback from practices following a review of the locality meeting structure and content has been positive.

3.3 Practices continue to report the support visits as a useful exercise.

3.4 The Performance Reporting Tool (previously QAT) has been reviewed following much engagement with member practices, PCCOG and PCCC.

3.5 The support visits are also structured to discuss preparation for, or the outcome of, practice CQC visits. (Appendices 1 and 2). Detailed information of individual practice CQC visits is included in the Primary Care Quality update being presented to this committee.

4. **Summary**

4.1 Following individual practice feedback at each visit no further changes to the format of the meetings have been deemed as necessary for the remainder of this programme of visits.

4.2 The Practice Support team have a meeting scheduled for November 2016 to review the structure and outcome of the visits. A report on the review of the process will be presented to the PCCC in January 2017 along with recommendations for future visits.

5. **Recommendations**

5.1 The Committees are recommended to note the progress made in relation to the Practice Support Visits being conducted to date.

Nicola Hone, Primary Care Co-Commissioning Strategic Manager.
Report date: 07 October 2016
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<th>Practice Name &amp; Address</th>
<th>CQC Visit</th>
<th>CQC Outcome</th>
<th>Practice Support Visit</th>
<th>Code, Status &amp; Clinical System</th>
<th>List Closure in place Yes / No</th>
<th>List Closure or capping applied for Yes/ No</th>
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<tr>
<td>PRIORY ROAD HOUSE SURGERY</td>
<td></td>
<td></td>
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<tr>
<td>ROEBUCK HOUSE SURGERY</td>
<td>27.10.2015</td>
<td>Special Measures</td>
<td>14.4.2016</td>
<td>GB11651</td>
<td>Yes</td>
<td>Recent change in partnership requested</td>
<td></td>
</tr>
<tr>
<td>Guesting Surgery</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>THE STATION PRACTICE</td>
<td>15.4.2016</td>
<td>Good</td>
<td>To be rescheduled - practice request</td>
<td>GB11058</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>ST LEONARDS LOCALITY</strong></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>CARISBROOKE SURGERY</td>
<td>10.11.2016</td>
<td>Good</td>
<td>27.7.2016</td>
<td>GB11048</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CHURCHWOOD MEDICAL PRACTICE</td>
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<td>Good</td>
<td>14.10.2016</td>
<td>GB11055</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HIGH GLADES MEDICAL CENTRE</td>
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<td>26.3.2016</td>
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<tr>
<td>SEDLESCOMBE HOUSE SURGERY</td>
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<td>Good</td>
<td>15.11.16</td>
<td>GB11026</td>
<td></td>
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<tr>
<td>SILVER SPRINGS MEDICAL PRACTICE</td>
<td>No</td>
<td></td>
<td>3.8.2016</td>
<td>GB11033</td>
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<td>SOUTH SAXON HOUSE SURGERY</td>
<td>2.2.2016</td>
<td>Good</td>
<td>8.11.2016</td>
<td>GB11089</td>
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<td></td>
<td>To be re-inspected by CQC at new premises</td>
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<tr>
<td>WARRIOR SQUARE SURGERY</td>
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<td>Good</td>
<td>21.4.2016</td>
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<tr>
<td>CORNWALLIS Plaza SURGERY</td>
<td>9.2.2016</td>
<td>Requires Improvement</td>
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<td>Cornwills Plaza Contract</td>
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<tr>
<td>SHANKILL SURGERY (G81662)</td>
<td>24.09.2014</td>
<td>Old Grading System</td>
<td>19.4.2016</td>
<td>G81013</td>
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<td></td>
<td></td>
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<tr>
<td>ESSENDEN ROAD SURGERY (G81064)</td>
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<td></td>
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<tr>
<td>LITTLE RIDGE SURGERY (G81643)</td>
<td>No</td>
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<td></td>
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</tbody>
</table>

*Practice operated by Integrated Care 24 (IC24)
**Title of report:**
Quality In General Practice (Update)

**Recommendation:**
The Committees are recommended to note the content of this report.

**Summary:**
The key points of this report include:

- Given the limited availability of CCG clinical (i.e. GP) staff to undertake Primary Care Eastbourne, Hailsham and Seaford CCG contract visits it is recommended that extra consideration is given as to how this can be supported. The PCCC is asked to consider how GP representation can be improved at these visits. There continued to be good clinical representation at the GP Practice visits that took place in HR CCG;
- Improvement in GP feedback regarding the “One Click” system;
- Development of the Infection Control Champion programme including examples of learning from June 2016 and July 2016 events;
- Key objectives supporting the educational development of the Primary Care nursing workforce;
- The Lighthouse Practice was reviewed and subsequently rated as “Outstanding” by the CQC. The CCG Quality team will identify key learning points and disseminate to the wider GP community; and
- There has been one GP CQC inspection report published since September 2016 at the time of writing. This report relates to the Ferry Road Health Centre in Rye where a rating of “good” was recorded.

**Governing Body sponsor:** Dr Tim Caroe, Governing Body GP member

**Author(s):** Allison Cannon, CCG Chief Nurse

**Date of report:** 10/10/16

**Review by other committees:** Reviewed by the CCGs’ Quality and Governance Committees

**Health impact:** Underperformance in the areas highlighted in the paper has the potential to impact on the quality and health outcomes for the residents using those services.

**Financial implications:** Where residents do not achieve optimal health outcomes and quality from the commissioned services there are inherent additional costs to the health system. These can be related to on-going health needs and/or as a consequence of residents suffering avoidable harm associated with healthcare.
**Legal or compliance implications:** NHS Trusts are required to comply with the Care Quality Commission (CQC) Essential Standards of Quality and Safety. Any non-compliance is reported as part of the attached document.

**Link to key objective and/or principal risks:** Risks associated with the duty to provide quality and improve health outcomes for residents within the Eastbourne, Hailsham and Seaford and the Hastings and Rother geographical areas.

**How has the patient and public engagement informed this work:** All available sources of patient experience feedback and engagement information are triangulated by the CCG alongside the safety and clinical effectiveness to understand the quality of commissioned services.

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<table>
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<tr>
<th>Privacy Impact Assessment (PIA) – outcome:</th>
<th>No personal data used</th>
<th>Data processes sufficient</th>
<th>Actions required</th>
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</thead>
<tbody>
<tr>
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</table>
Quality in General Practice (Update)

1. Introduction

1.1 From 01 April 2015 Eastbourne, Hailsham and Seaford (EHS) Clinical Commissioning Group (CCG) agreed to undertake the commissioning of General Practice (GP) medical services under primary care co-commissioning arrangements.

1.2 From 01 April 2016 Hastings and Rother (HR) Clinical Commissioning Group (CCG) agreed to undertake the commissioning of General Practice (GP) medical services under primary care co-commissioning arrangements.

1.3 Prior to the agreement of co-commissioning arrangements, the responsibilities for commissioning GP services lay with NHS England (NHSE).

1.4 The CCG has developed a robust, clinically focussed and proactive approach to improving quality across all GP services. This process incorporates the principles of Patient Safety, Patient Experience and Clinical Effectiveness.

1.5 The purpose of this paper is to provide an update on progress to date relating to priority areas on the Quality agenda.

2.0 Practice Support Visits (Key points since last update)

2.1 The programme of Practice support visits continues to take place.

2.2 Given the limited availability of clinical (i.e., GP) staff to undertake these visits it is recommended that extra consideration is given as to how this can be improved in relation to EHS CCG. The PCCC is asked to consider how GP representation can be improved at these visits. There continues to be good clinical representation at the GP Practice visits that took place in HR CCG.

2.3 There is a requirement for the CCG to review the progress of the joint quality and contract visits. Further areas for review also include how to share learning and best practice better across the GP community and ensure that CCG resources are being utilised in effectively.

3.0 Soft Intelligence, General Practice and East Sussex Healthcare NHS Trust (ESHT)

3.1 The CCG Quality team receives as copy a template letter designed by the Local Medical Committee (LMC) for GPs to feed back to Providers areas of care which should be undertaken by secondary care rather than themselves, or areas of quality of care which they feel should be addressed.¹

3.2 The CCG Quality team has undertaken a review of returns which are outlined below. The key themes include the following and will be raised with the Trust to seek assurance.

¹ This is part of the LMC’s approach to improving the quality of care provided to patients and reducing the workload burden for GPs.
• ESHT request to ask GP to organise investigations that should be arranged by the hospital doctor caring for this patient
• ESHT request to ask GP to obtain/act upon the results of investigations/diagnostic procedures undertaken by the hospital doctor, whose responsibility this is; and
• ESHT request for GP to organise procedure at a future date.

3.3 The majority of the returns relate to the Conquest hospital. The reason for this is that the LMC improving quality mechanism is largely utilised in a small number of HR CCG practices only. The use of this template is not mandatory and is a voluntary initiative. Further information is required around how the LMC will be promoting this function and what they are doing with responses.

3.4 Following the drive to improve the visibility of “One Click” during August 2016 over 70 comments were posted which is significantly more than previous months. This brings the total number per CCG to the end of August 2016 as:
  • EHS CCG (177 comments);
  • HR CCG (250 comments); and
  • CCG Back Office (86 comments).

3.5 The key themes identified via One Click relating to East Sussex Healthcare NHS Trust (ESHT) include the following:
  • Administration (16 comments);
  • Communication (16 comments); and
  • Quality of care (12 comments).

3.6 The themes noted above are consistent with those noted during earlier analysis on previous occasions and comments have been forwarded to the ESHT Governance team for review.

3.7 The findings of this improvement drive were fed back to the GP population at the September Membership Engagement and Learning Events (MELE) during September 2016.

4. Infection Control (Primary Care Champions)

4.1 The latest update regarding the infection control champion programme can be found below:
  • The Primary Care Champions course is being held bi-annually. The first courses were held during June and July 2016. Further courses will be held during February 2017;
  • The areas to be covered include the Health and Social Care Act (2008) and requirements for Primary care. From February 2017 the course will also include water management and control of Legionella;
  • Areas identified as concerns during the June and July 2016 events included Occupational Health provision within East Sussex. The CCG infection control lead nurse is as a result in discussion with NHS England regarding the services required by Practices;
• A voluntary infection control accreditation programme\(^2\) is in development where practices provide commissioners with evidence of accomplishment of mandatory training, environmental audits and promotion of infection control, for example; and

• An Infection Control audit has been piloted within one GP practice. The audit tool will be cascaded to all practices by the end of October 2016. This a supportive rather than mandatory tool for practices to standardise their approach to infection control.

5. **Practice Nursing**

5.1 Student nurse practice placements preparation audits

At the time of writing in EHS CCG, 76% of practices are audited in readiness to host student nurses and have 27 up to date mentors within their teams. In HR CCG 33% of practices are audited and there are 37 up to date mentors. The uptake of practices hosting students remains inconsistent; this is largely due to time pressures, perceived low remuneration and resources.\(^3\)

5.1.1 Four final placement students have been hosted between the two CCGs from October 2016. It is envisaged that this will lead to direct employment into General Practice from registration.

5.1.2 The importance has been noted regarding the employment of Primary Care nurse leads in continuing to change culture and make hosting learners a standard part of the Practice Nurse role.

5.1.3 Practice Nurses, Nurse Practitioners, Support Workers, Pharmacists, Paramedics and the newly emerging Physician Associate, Nurse Associate and Care-navigator roles will all require support mechanisms with adequate mentorship made available.

5.2 **Key practice nurse lead objectives (2015/17)**

The below objectives comprise the essential aims that the practice nurse leads expect to deliver regarding educational improvement and standards of Primary Care nursing staff:

• **Objective One:** All nurses and healthcare assistants (HCA) are clear about their responsibility and accountability. This will give assurance around patient safety.

  **Mechanism for achievement:** Educate workforce on Duty of Candour and incident reporting. The outcome will be an increased awareness, as well as an increase in the recording of incidents in Primary Care. Improvement in patient experience will be evidenced within the patient satisfaction survey and promote a workforce fit for 2020.

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\(^2\) Levels of attainment include bronze, silver and gold.

\(^3\) The Queen’s Nursing Institute Survey (2015) on General Practice Nursing also found levels nationally to be disappointing and concerning that such a limited number of practices offer the opportunity for placement learning to nursing students. It emphasised that if students are introduced to the diversity and challenge of work in a GP practice and the rewards its brings, it will help support the succession planning and inspire the next generation of Graduate Registered Nurses to select a career in Primary Care.
• **Objective Two**: Continue to develop nurse mentors, sign off mentors and practice teachers through the support and delivery of academic learning and in-house educational updates.

  **Mechanism for achievement**: Increase nurse mentors by seven in practices yet to audit over EHS and HR CCGs. This will increase capacity from 48% to 60% by June 2017.

• **Objective Three**: Develop a competency framework for all non-medical workforce bands 1-9 by March 2017.

  **Mechanism for achievement**: This will build on the band 1-4 document and support the progression of all appropriate roles within bands 5-9, ensuring a balanced skill mix within General Practice promoting timely and safe patient care.

• **Objective Four**: Promote professional development by improving education capability and capacity in Primary Care for all non-medical workforce this financial year. This will maintain our nurse expertise, support revalidation requirements and ultimately the quality and safety patients expect.

  **Mechanism for achievement**: Deliver updates appropriate to experience and expertise, manage continuous professional development budget allocation based on needs analysis and look inventively at ways to increase income through multi-professional sharing of education and working at scale to improve economy.

6. **Medicines Management**

6.1 Prescribing Support Scheme (Repeat prescribing)

6.1.1 This year’s Prescribing Support Scheme for GPs aims to improve repeat prescribing processes both in terms of patient safety and reduced medicines waste. All practices\(^4\) have had their repeat prescribing processes mapped by a member of the medicines management team and individual action plans drafted to improve their repeat prescribing process.

6.1.2 Individual action plans to improve the safety of the process and promote clinical review of prescriptions are agreed with each practice. 156 practice administration staff have attended training on how to recognise risks and improve a practice repeat prescribing process.

6.1.3 EHS CCG was highlighted as one of the top five CCGs in England for uptake of the Electronic Prescribing Service (EPS), sending 64% of items by EPS and this year are working on the roll out of electronic Repeat Dispensing (eRD).

6.1.4 From 01 October 2016 the CCG has commissioned an innovative Locally Commissioned Service (LCS) from community pharmacists to

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\(^4\) Except the three HR CCG practices that did not sign up to the scheme
identify and prepare appropriate patients for eRD, support them with adherence and communicate to their GP electronically using a web-based tool called PharmOutcomes.

6.1.5 The CCG has engaged with patient forums in both CCGs on the issues of Medicines waste and their opinions have informed the development of our repeat dispensing service and will inform a public campaign which we are planning for Quarter 3 this year.

6.1.6 Training on the management of polypharmacy has been delivered to GPs, nurses and Community pharmacists across both CCGs. We have commissioned a Medicines Optimisation Service in care homes that will support the delivery of in-depth medication reviews for residents in care homes. The frailty nurses are reviewing medicines in their weekly virtual ward rounds with a geriatrician.

7. Care Quality Commission (CQC)

7.1 The CQC is continuing to review GP premises as part of the regulatory process to ensure providers meet the Fundamental Standards of Care.

7.2 Key themes arising from previous visits include:
- The need to ensure all mandatory training is planned, undertaken and accounted for;
- The need to ensure that all infection protocols are in place and relevant audits are undertaken;
- The need to ensure that patient care plans are fully completed;
- The need to ensure that Legionella checks are undertaken by an accredited professional;
- The need to ensure that “cold chain” protocols are observed in relation to medicines and fridges;
- The need to ensure that fire drills are taking place and that these have been documented;
- The need to ensure that GP meetings are minuted;
- The need to ensure that all staff are aware of who the safeguarding leads are for the practice and that all staff are trained to the relevant level;
- The need to ensure that all staff folders are complete with references, job descriptions and employee photographic documentation; and
- The need to ensure that all staff have Disclosure and Barring Service (DBS) checks relevant to their role.

7.3 Please see Appendix One for further information around CQC GP visit outcomes from April 2015 to latest publication of reports at time of writing.

8. Conclusion

8.1 The Committees are asked to note the content of this update.

Allison Cannon, Chief Nurse
Report date: 10 October 2016
Appendix One: EHS and HR CCG GPs published CQC inspection reports

**EHS GPs**
The following GP premises have been reviewed by the CQC with reports published since April 2015:

<table>
<thead>
<tr>
<th>Practice</th>
<th>Review Date</th>
<th>Rating</th>
<th>Link to report</th>
</tr>
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<tbody>
<tr>
<td>Bolton House</td>
<td>April 2015</td>
<td>Good</td>
<td><a href="http://www.cqc.org.uk/location/1-559622542">http://www.cqc.org.uk/location/1-559622542</a></td>
</tr>
<tr>
<td>Bridgeside Surgery</td>
<td>January 2016</td>
<td>Good</td>
<td><a href="http://www.cqc.org.uk/location/1-543128957/reports">http://www.cqc.org.uk/location/1-543128957/reports</a></td>
</tr>
<tr>
<td>Seaford Farm</td>
<td>October 2015</td>
<td>Requires Improvement</td>
<td><a href="http://www.cqc.org.uk/location/1-569893082/reports">http://www.cqc.org.uk/location/1-569893082/reports</a></td>
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</tbody>
</table>

**HR GPs**
The following GP premises have been reviewed by the CQC with reports published since April 2015:

<table>
<thead>
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<th>Practice</th>
<th>Review Date</th>
<th>Rating</th>
<th>Link to report</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beaconsfield Road Surgery</td>
<td>December 2015</td>
<td>Requires Improvement</td>
<td><a href="http://www.cqc.org.uk/location/1-544158982/reports">http://www.cqc.org.uk/location/1-544158982/reports</a></td>
</tr>
<tr>
<td>Practice Name</td>
<td>Date</td>
<td>Rating</td>
<td>Report URL</td>
</tr>
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<td>--------------------------------------------------</td>
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<td>-----------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Priory Road Surgery</td>
<td>December 2015</td>
<td>Inadequate</td>
<td><a href="http://www.cqc.org.uk/location/1-496144059/reports">http://www.cqc.org.uk/location/1-496144059/reports</a></td>
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<tr>
<td>Please note: this organisation has been placed in “Special Measures”</td>
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</tr>
<tr>
<td>Dr Elias and Partners (Seabourne Road)</td>
<td>December 2015</td>
<td>Good</td>
<td><a href="http://www.cqc.org.uk/sites/default/files/new_reports/AAAE6647.pdf">http://www.cqc.org.uk/sites/default/files/new_reports/AAAE6647.pdf</a></td>
</tr>
<tr>
<td>Roebuck House - Practice 3 (a.k.a Dr Chopra)</td>
<td>January 2016</td>
<td>Inadequate</td>
<td><a href="http://www.cqc.org.uk/sites/default/files/new_reports/AAAE6067.pdf">http://www.cqc.org.uk/sites/default/files/new_reports/AAAE6067.pdf</a></td>
</tr>
<tr>
<td>Please note: this organisation has been placed in “Special Measures”</td>
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<tr>
<td>Dr Dewhurst &amp; Partners</td>
<td>January 2016</td>
<td>Good</td>
<td><a href="http://www.cqc.org.uk/location/1-541820741/reports">http://www.cqc.org.uk/location/1-541820741/reports</a></td>
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<tr>
<td>Martins Oak</td>
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<td>Requires Improvement</td>
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<tr>
<td>South Saxenbury House</td>
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<tr>
<td>High Glades Medical Practice</td>
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<td>Ninfield Surgery</td>
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<td>Good</td>
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<tr>
<td>Roebuck House - Practice 3 (a.k.a Dr Chopra)</td>
<td>March 2016</td>
<td>Inadequate</td>
<td><a href="http://www.cqc.org.uk/sites/default/files/new_reports/AAAF1518.pdf">http://www.cqc.org.uk/sites/default/files/new_reports/AAAF1518.pdf</a></td>
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<tr>
<td>Please note: this organisation remains in “Special Measures”</td>
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<tr>
<td>Ferry Road Health Centre</td>
<td>August 2016</td>
<td>Good</td>
<td><a href="http://www.cqc.org.uk/location/1-1521099912">http://www.cqc.org.uk/location/1-1521099912</a></td>
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The Primary Care Commissioning Committees of Eastbourne, Hailsham and Seaford CCG and Hastings and Rother CCG meeting together

Date of meeting: 26 October 2016

<table>
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<tr>
<th>Title of report:</th>
<th>Primary Care Commissioning Operational Group (PCCOG) Summary update – October 2016.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recommendation:</td>
<td>The Committees are recommended to <strong>note</strong> the summary update.</td>
</tr>
<tr>
<td>Summary:</td>
<td>1. PCCOG discusses a number of issues that are the subject of other reports to this committee. These issues include: Finance, Workforce, Premises, Information Management and Technology (IM&amp;T), Performance and Quality reports.</td>
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<tr>
<td></td>
<td>2. This summary report provides an update on key issues and decisions considered by PCCOG.</td>
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**Update on key issues and decisions:**

3. The Primary Care and Quality Teams have continued to support the two Hastings and Rother (HR) practices placed in Care Quality Commission (CQC) special measures earlier this year. Both practices have had follow up CQC visits and finalised reports are awaited. Key issues from the CQC reports have been around management and leadership. Management and leadership support have been offered by HR CCG with one of the managers commencing a management diploma.

4. The practice support visits continue to be well received. Detail on the process is included in the performance report.

5. Workload and workforce pressures within practices have led to various considerations being made to attempt to manage the pressures:
   - Practice Mergers – some practices are merging their contracts whilst others are merging management structures with a view to a full merger in time. The CCG is supporting these mergers.
   - Practices are requesting list closures which allow them to cease registering patients for an agreed period of time. Before a list closure is granted PCCOG review each application individually and liaise with the localities to ensure there is adequate local
provision of services. One six month list closure has been granted in Hailsham. Three others have been deferred across the CCGs. Other options to manage the pressures are being discussed with these practices: e.g. skill mix and appropriate re-direction of patients.

- Practices are requesting boundary changes. Each practice has a practice boundary and patients living inside the boundary are able to register with the practice. One application has been granted as there was minimal impact on the surrounding practices and two have been deferred. Other options such as ‘skills mix’ are being discussed.

- The CCGs continue to work with localities, federations and the Local Medical Committee to ensure there is a wider view taken of list closures, list capping and practice boundaries so that patients are able to access appropriate primary care services.

- Where patients are having problems registering, the practice gives them contact details for the CCG’s primary care team to help them register with a practice. This information is also on the CCG websites.

6. The application to extend the walk in centre contracts (WIC) was approved. The contracts now run to March 2018. Over the next year PCCOG will work with providers and stakeholders to ascertain what Primary Care Provision should be commissioned following the end of the WIC contract. This process will take into account the current Urgent Care system review.

7. Each year the CCG runs a Primary Care scheme where practices receive £1.00 per registered patient per annum to support commissioning in Primary Care. The scheme changes each year depending on the CCG priorities. This year practices are being asked to submit workforce information and also participate in central data extraction to support future workforce planning.

8. On 1 September 2015 Primary Care Support England (PCSE) took on responsibility for the delivery of NHSE Primary Care support services. This includes patient registration, medical records, GP payments and pensions, performers list and supplies support. There have been some significant issues in the performance of the new service which NHS England is resolving nationally. The Primary Care team are working with NHSE to resolve local issues.

Committee Sponsor: John O’Sullivan, Chief Finance Officer

Author(s): Nicola Hone, Primary Care Co-Commissioning Strategic Manager

Date of report: 07/10/16

Review by other committees:
Reviewed by the CCGs’ Primary Care Commissioning Operational Group

Health impact:
Ensuring a sustainable primary care estate best enables the CCGs to meet the current and future needs of the population.
### Financial implications:
The CCGs have a statutory duty to maintain financial balance

### Legal or compliance implications:
Compliance with statutory duties.

### Link to key objective and/or principal risks:
Sustainability of Primary Care.

### Link to East Sussex Better Together (ESBT) programme:
Ensuring a sustainable primary care estate best enables the CCGs to meet the current and future needs of the population

### How has the patient and public engagement informed this work:
N/A

#### Equality Analysis (EA) Process - outcome:
- Negative Impact
- Neutral Impact
- Positive Impact
- No Impact
- Not required for report

**EA Summary:**
- ☒

#### Privacy Impact Assessment (PIA) – outcome:
- No personal data used
- Data processes sufficient
- Actions required

**Actions:** N/A
Title of report:
Patient Participation Group (PPG) Development Project update report
01/06/2016 - 30/09/2016

Recommendation:
The Committees are recommended to note the progress of the project to date.

Summary:
The CCGs (together with High Weald Lewes Havens CCG (HWLH)) commissioned a one year project to support PPG development across East Sussex (June 2016 - May 2017).

The role of the PPG Development Worker is as follows:
- To provide support to GP practices and/or patients with either setting up a PPG or dealing with any challenges it may be facing with its PPG.
- To facilitate a PPG network in order to: facilitate PPG peer support; identify common themes; share good practice; and work collaboratively to overcome challenges.
- In order to develop the potential of PPGs, to facilitate GP practice patients in understanding and engaging with the aims and objectives of changes in health and care and in new developments in service provision parts of East Sussex Better Together (ESBT).
- To support PPGs in raising awareness of Healthwatch to other patients and therefore to facilitate patient feedback. This will in turn influence future commissioning and provision.

Committee sponsors: Julie Fitzgerald, Executive Director, East Sussex Community Voice (ESCV) and Jessica Britton, Chief Operating Officer, Eastbourne, Hailsham and Seaford CCG and Hastings and Rother CCG (EHS and HR CCG).

Author(s): Kate Richmond ; PPG Development Worker
East Sussex Community Voice

Date of report: 17/10/16
**Review by other committees:** Reviewed by the CCGs’ Primary Care Commissioning Committee (PCCC).

**Health impact:**
PPG members are fully informed of services to support wellbeing, prevention strategies and appropriate local services.

**Financial implications:** As agreed in the contract for this project.

**Legal or compliance implications:**
PPG Development Role supports GP practices to meet their obligations as stated in the General Medical Services (GMS) contract and Care Quality Commission (CQC) requirements.

**Link to key objective:**
1) Supports GP Practices to comply with GMS & CQC requirements.
2) Optimises patient involvement with their PPGs.

**Link to East Sussex Better Together (ESBT) programme:**
PPG development supports PPGs to raise awareness amongst other patients about activities and organisations which could: a) contribute to their health and wellbeing; b) support self-management of their long term health conditions; and c) optimise their use of medicines. This is achieved by making links with appropriate professionals and leaders of community groups who can engage with PPGs either individually or at forum and development events.

**How has the patient and public engagement informed this work:**
The PPG Development Role has patient and public engagement at its core. PPG representatives initially approached Healthwatch in 2014 requesting support to reach other groups. East Sussex Community Voice (ESCV) responded by funding a one year pilot role in 2015-16. The outcomes of this were reported to East Sussex CCGS who then jointly commissioned work for a further year, 2016-17. The PPG Development Worker engages with individual practices according to expressed need, as well as undertaking PPG awareness raising at public venues and events. Examples this quarter are the Healthwatch Red Bus Tour, and ESBT events. This has resulted in; a) constructive communication with PPGs across all CCG areas; and b) increase in PPGs communicating with and supporting each other. The PPG Development Worker has facilitated contact both between individual groups and through a PPG Forum where representatives from several PPGs in the local area meet, discuss and agree actions.

**Equality Analysis (EA) Process - outcome:**

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<th>Negative Impact</th>
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<th>Positive Impact</th>
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**EA Summary:**

**Privacy Impact Assessment (PIA) – outcome:**

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<th>No personal data used</th>
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**Actions**
PPG Development Report

Key deliverables (in bold) achieved between June 2016 – September 2016 are listed as follows:

- **PPG Development Support**: This was provided to three PPGs in Eastbourne, Hailsham and Seaford CCG (EHS CCG) and two in Hastings and Rother CCG (HR CCG).

  1) Support was provided to a GP Practice in Hailsham where a re-launch of its PPG is in progress. The practice has mergers in progress. Despite energetic attempts at recruitment, very few patients have expressed interest in becoming involved. The group has met twice and will require continued support in the coming months to develop its structure and activities. The objective is to support the group to become self-sustaining by spring 2017.

  2) Support provided to a small PPG in Polegate to organise and publicise a Macmillan coffee morning in a local church hall. A PPG Development Worker hosted a Healthwatch and PPG information table. Health and wellbeing information from both the practice and other organisations, such as Community Pharmacy and Care for the Carers, was made available on all tables as well as individual stalls. The event had full support of the Practice Manager and another staff member who attended and helped with greeting and serving guests. The PPG event achieved excellent attendance of approximately 100 people and raised £400 for Macmillan.

  3) Initial meeting in Hailsham with a GP Practice which has undergone some significant re-structuring and a change of senior management. The Practice needs support to re-launch their PPG and the PPG Development Worker is awaiting a meeting with the recently appointed Practice Manager in order to proceed.

  4) Follow up support provided to PPG in Hastings which was set up in May 2016 with support from the prototype ESCV PPG Development contract (May 2015 - May 2016). The PPG reports that their group is working well and will be attending the next Hastings and Rother (HR) PPG forum in November 2016.

  5) Follow up contact was attempted with a GP practice in Hastings which has been in the process of several mergers in 2015 and 2016. No reply to contact was received, but an invitation to the HR PPG Forum was forwarded to a patient who subsequently attended the event. Further contact with the patient representative of the Practice is planned before next PPG Forum.

- **Patient Participation Forum (PPF or PPG Forum)**

  The project worker organised and serviced two PPG forum meetings held in September 2016; one each in EHS CCG and HR CCG areas. A maximum of two patient representatives from each PPG in a CCG area can attend a PPG Forum. The aim of forum is to facilitate a mutually supportive group that can inform the work of the CCG as well as support their own practices. These were attended by patient representatives from seven practices in EHS CCG with a total attendance of nine representatives. In the HR CCG area nineteen patient representatives from eleven practices attended. The next forums are planned for end November/early December 2016.
• **Healthwatch East Sussex feedback materials to all CCG GP Practices**

Healthwatch feedback materials have been delivered to 50 out of 76 GP sites in the EHS CCG and HR CCG areas (includes branch practices). A number of small branches were closed at the time of the visit. Outstanding practices will be supplied with materials before the end of December 2016.

This work supports the message to PPGs that they are well placed to encourage the practice population to feedback to Healthwatch about all the health and social care services they and their families use, for example; home care packages, nursing and care homes, community occupational and physiotherapy services amongst others.

**Recommendation**
The Committees are recommended to note the progress of the project to date.

Kate Richmond
Report date: 17 October 2016