Meeting of the Primary Care Commissioning Committee Part I

4th Floor Unex Tower, 5 Station Street, London E15 1DA

30th October 2016 3pm – 4.30pm
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**AGENDA**

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<td>Welcome, Introductions, Apologies and Declarations of Interest</td>
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<td>Primary Care Access offer- NHC Proposal</td>
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<td>Referral Management Scheme - development and outline of proposed programme</td>
<td>Decision</td>
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<td>Decision</td>
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<td>Risk Register</td>
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<td>Forward Plan</td>
<td>Information</td>
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<td>Chair</td>
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Statement of advice on declaring interests at NCCG meetings

Guidance

- All attendees are asked to declare any interest they have in any agenda item before it is discussed or as soon as it becomes apparent before or at the meeting. If during the course of a meeting an interest not previously declared is identified, this must be declared at that time.
- The record of a declared interest is the interest declared verbally at the meeting. An attendee cannot refer to interests already declared on the register of interests or an interest already declared at a previous meeting. There is no such thing as an “ongoing” interest.
- The minutes of the meeting will detail all declarations made and any relevant responses and/or action taken.

Direct Financial Interest

- If you have a direct financial interest in any matter on the agenda you must not participate in any discussion or vote on that matter. If you do so you may be committing a criminal offence, as well as a Breach of the Conflict of Interest Policy and the CCG Code of Conduct. The individual should leave the meeting (including any public seating area) during consideration of the matter.

Indirect Financial Interest

- You are required to make a verbal declaration of the existence and nature of any Indirect Financial Interest. Any Member who does not declare these interests in any matter when they apply may be in breach of the Policy and Code of Conduct.

Other Interest

- You are required to declare an interest where a decision in relation to the business of the meeting might reasonably be regarded as affecting your well-being or financial standing, or a member of your family, or a person with whom you have a close association with to a greater extent than it would affect the majority of the GPs or other Board Members.

If in doubt you should assume that a potential conflict of interest exists.

Action upon declaration of an interest at a meeting

- For direct financial interests you must leave the meeting for that item
- For indirect financial interests and for other interests the action required will vary dependent upon the interpretation of the extent and influence of the interest and may involve;
  - leaving the meeting,
  - remaining at the meeting and not voting or speaking,
  - remaining at the meeting and both speaking and voting

Chairs ruling

- For the avoidance of doubt the Chairs decision on a declaration of interest and its management is final
Voting members present:

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
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<tbody>
<tr>
<td>Andrea Lippett (Acting Chair)</td>
<td>Lay Member Remuneration NCCG</td>
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<td>Dr A Gopinathan</td>
<td>GP Board Member NCCG</td>
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<td>Steve Gilvin</td>
<td>Chief Officer NCCG</td>
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<td>Chad Whitton</td>
<td>Chief Finance Officer NCCG</td>
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Non-voting members present:

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<th>Name</th>
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<tr>
<td>Clive Furness</td>
<td>Local Authority Member LBN</td>
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<td>Meradin Peachey</td>
<td>Public Health Member LBN</td>
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<td>Dr Chandrakant Patel</td>
<td>LMC Member</td>
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<td>Alison Goodlad</td>
<td>NHSE Member</td>
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<td>Dr Ashwin Shah</td>
<td>GP Member</td>
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In Attendance:

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<th>Name</th>
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<tr>
<td>Mike Sims</td>
<td>Board Secretary NCCG</td>
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<tr>
<td>Neil Hamer</td>
<td>Associate Director Primary Care NCCG</td>
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1. Welcome, Introduction, Apologies for Absence & Declarations of Interest

1.1 Welcome
The Chair welcomed the members to the meeting.

1.2 Apologies were received from the following members:
- Wayne Farah Lay Member Patient & Public Engagement NCCG
- Fiona Smith Registered Nurse NCCG
- Greg Cairns LMC Member

1.3 Declarations of interest.
There were no declarations of interest

2. Minutes of the Part I meeting 28 September 2016

2.1 Minutes
- Approved as accurate record of the meeting

2.2 Action Log
- 63 - Primary Care Strategy - add to forward plan for November - completed
- 64 - Review of Language Services contract in primary care - add to forward plan - completed
- 65 - Commence a dialogue with LMC on where any scope to develop any items of local agreement on GMS/PMS notwithstanding the London wide position – discussion has commenced at least on a NEL basis on what might be agreeable in common
- 66 - Risk Register - Provide cover report for future items - completed
- 67 - Provide report on COI rationale at PCCC meetings for October meeting – deferred until November meeting

### 3 Strategic Items

#### 3.1 Standard Operating Procedure

**Comments**
- Clarified that all other London CCGs have agreed to adopt the procedure already

**Actions**
- None

**Decisions**

The Committee adopted the document “A consistent approach to responding to Care Quality Commission ‘Requires Improvement’ notifications “ as its Standard Operating Procedure

#### 3.2 CEPN – Annual Report

**Comments**
- Noted that the achievements on a limited budget were impressive
- Clarified that the 70 support workers referred to across health and local care were already in post
- Key issue identified as how the programme would be mainstreamed going forward and secured given its assistance in delivering STP objectives which would require discussion with HENCEL and consideration of merging fully or partially elements of the CEPNs across NEL
- Committee made it clear that the Newham CEPN was a key driving force in achieving the sustainable workforce objectives of STP and every effort should be made to explore the options that could secure the continuation of the programme

**Actions**
- Report back on progress on identifying future arrangements at the January 2017 meeting (Action: L Delauney)

**Decisions**
- The Report was noted

#### 3.3 Newham Primary Care Finance Report

**Comments**
- Reported that a balanced position was still projected
- Will provide a deep dive analysis on the use of reserves for next meeting
3.4 PCCC Risk Register

**Comments**
- PCCC02 – Financial Risks from 14/15 outturn - now downgraded
- PCCC07 - Failure to ensure the provision of sufficient resources to deliver the CCGs Primary Care Strategy impacting on increasing patient population – now not expecting the same level as funding as previously reported, although a clearer position should emerge in early November when a response on GP Forward view funding is expected. The ETTF submission to NHSE will be made 27/10/16. A “Plan B” on funding may be that schemes are eligible for improvement grant but if not then alternative sources would need to be secured

**Actions**
- None

**Decisions**
- The Report was noted

4. Information Items

4.1 Six month progress report on PCCC April – Sept 2016

**Comments**
- Noted that COI guidance in respect of primary care had been complied with
- Recognised that going forward a requirement to focus on;
  - STP and Primary Care
  - Primary care’s role in signposting into health lifestyles
  - IT issues as they relate to Primary Care

**Actions**
- Timetable a briefing report for early 2017 on proposals to consider these items going forward *(Action: N Hamer)*

**Decisions**
- The Report was noted

4.2 Forward Plan

**Comments**
- None

**Actions**
- Chair delegated to review *(Action: W Farah)*

**Decisions**
- The Report was noted
<table>
<thead>
<tr>
<th>Action reference</th>
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<tr>
<td>PCCC65</td>
<td>28/09/2016</td>
<td>Commence a dialogue with LMC on where any scope to develop any items of local agreement on GMS/ PMS notwithstanding the London wide position</td>
<td>N Hamer</td>
<td>None</td>
<td>Discussion has commenced at least on a NEL basis on what might be agreeable in common</td>
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<td>PCCC67</td>
<td>28/09/2016</td>
<td>Provide report on COI rationale at PCCC meetings for October meeting</td>
<td>M Sims</td>
<td>October</td>
<td>Completed for November meeting</td>
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<tr>
<td>PCCC68</td>
<td>26/10/2016</td>
<td>Report back on progress on identifying future mainstreaming arrangements for CEPN at the January 2017 meeting</td>
<td>L Delauney</td>
<td>January</td>
<td>Added to forward plan - completed</td>
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<tr>
<td>PCCC69</td>
<td>26/10/2016</td>
<td>Provide briefing report to Jan 17 meeting on Primary care issues and - STP, Self care , ITN</td>
<td>N Hamer</td>
<td>January</td>
<td>Added to forward plan - completed</td>
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### Primary Care Commissioning Committee (PCCC)

#### 30th November 2016

<table>
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<tr>
<th>Title:</th>
<th>Newham CCG – NHC Proposal for 8-8 Access scheme 6m Pilot</th>
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<tr>
<td>Agenda item</td>
<td>4</td>
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<tr>
<td>Author:</td>
<td>NHC and GP Co-Op (via external consultant)</td>
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<tr>
<td>Presented by:</td>
<td>Neil Hamer – Associate Director - Primary Care Commissioning</td>
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<tr>
<td>Contact for further information:</td>
<td>Neil Hamer – Associate Director of Primary Care</td>
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<td>This Paper is for:</td>
<td>Decision</td>
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| Action required: | The PCCC members are asked to consider the approach proposed and:  
- To agree the proposed period and format for the 8-8 Access scheme pilot as proposed.  
- To approve the funding requested be allocated to the pilot scheme |
| Purpose of the Pilot: |  
- Provide improved access whilst the CCG continues to work on a longer term plan to deliver Newham-wide 8-8 Access 7 days a week for all Newham patients in line with the national criteria.  
- Establish the optimum locations for sites, hours provided at locations and clinical capacity required to transition toward a longer term version of the 8-8 scheme in April 2017. |
| Supporting papers: | Primary Care access Proposal and STP plan |
| How does this fit with Newham CCG Strategy: | Values: Accountability and responsibility  
Aims: Reducing inequalities and improving quality of general practice provided to patients and residents of Newham. |
| Where has the paper been already presented? | n/a |
### Risk:
The Additional Hours capacity scheme came to an end on September 30th 2016. If an alternative service is not secured the likelihood is that there would be increased pressure on General practice and potentially an increase in higher cost activity generated by patients attending A&E who could otherwise be seen in a Primary Care setting.
Failure to deliver an 8-8 7-day programme would also put the CCG at risk of losing the funding associated with the Londonwide programme which has been allocated on the basis of STP delivery plans already submitted to NHS London – see appendix.

### Equality Impact:
As part of the development process an EIA will be conducted.

### Stakeholder engagement:
Extensive Stakeholder engagement has taken place on the GPFV and the delivery of 8-8 Access which has now become national policy.

### Financial Implications
The funding required for the scheme over the 6 month period is £436k of which on-going costs are £407k and one off costs are £29k. Further review with the CCG’s Finance Directorate may lead to an adjustment of where the costs fall. There may need to be a review where certain costs have been allocated e.g. IM&T has been identified as an on-going cost and there is an element of equipment included in SPA costs.

The above funding will be met from an earmarked allocation made by NHSE following an earlier submission by Newham CCG which initially requested funding of £554k of funding split between non recurrent funding of £154k and recurrent cost of £400k.

This figure has subsequently been reduced as Londonwide funding has subsequently been top sliced by 6%. The Finance team have confirmed that the funding requested is affordable within the allocation made available to the CCG.

An additional consideration is that supporting elements for phone technology improvement for 2017/8 may in part be funded through a successful ETTF bid for telephony.
1. Background – National Guidance and Newham CCG Framework for Extended Access

1.1 The CCG has discussed with Newham Health Collaborative the scheme and the following sets out the requirements of the scheme set by the CCG in line with the national conditions attached to the allocation;

1.) The CCG have requested Newham Health Collaborative (NHC) to submit a pilot proposal relating to providing Access to a GP appointment 8-8 seven days a week. The logic behind asking the NHC to provide the pilot proposal is the desire for NCCG to move to borough-wide provision of services on a population basis that is closely integrated with in-hours primary care provision.
2.) Communication will be done via a single point of contact at NHC who will act as the project coordinator.
3.) NHC is expected to be the lead provider and the pilot co-ordinator whilst delegating a number of functions for this pilot work to the Newham GP Co-operative.
4.) A key objective for the CCG is to ensure a simpler form of delivery that avoids a variation of service provided to different practice populations. The CCG is seeking a delivery model that covers the whole population with a similar service offer.
5.) The CCG asked for the pilot to look at how a top-up model can be delivered, i.e. providing cover between 6.30 pm and 8 pm in the evenings Monday to Friday and from 8am to 8pm on Saturdays and Sundays.
6.) This Pilot proposal was submitted to the CCG by 11th November to enable the first phase, i.e. the 6.30 pm to 8 pm Monday to Friday offer to be delivered starting from December 1st.
7.) In the initial 8 weeks the CCG require NHC to provide access to the registered patients of Newham (along with those unregistered who require an appointment) on a similar basis to that of the Additional hours scheme using the Newham GP Co-operative as the provider of the infrastructure.
8.) The funding for the initial 8 week period from Oct 1st – Dec1st (see 7) will be made available from the CCG to NHC based on the previous EPCS and Newham GP Co-operative Additional hours scheme levels so that there is no deterioration in access availability during the proposal development phase. This funding will be distributed by NHC who will take on the responsibility of payment to providers who are supporting the NCCG Pilot*
9.) The funding available for the Scheme the Pilot is replacing was Additional Hours Total cost - £139,425 for 6m = £23,237.50 per month. In addition there was funding from the EPCS for Additional hours delivering 300 appointments.
10.) The CCG have an overall funding envelope of approximately £465k which includes an element of non-recurrent capital funding of £154k.
11.) The PCCC have agreed the principle that as part of the overall access strategy the CCG move to an area wide commissioning of access using a Hub model with equitable access for the whole population of Newham. The CCG expect to see a Pilot which provides equitable access.
12.) NHC will confirm that suitable governance between the organisation and the Newham GP Co-operative are in place and specified appointment booking arrangements can be in place by Nov 30th, the Pilot proposal preparation period.
13.) There should be full access to medical records
   a. By the hub – Hub requires the ability to see all patient records irrespective of which practice they come from
   b. Hub must be able to update the medical record
   c. Practice must be able to see the update made by the Hub
14.) Appointments must provide face to face access and can be complimented by additional methods e.g. telephone, on-line.
15.) Appointments must be pre-bookable via the practice, online and NHS 111, and there should be a mixed model of slot availability (i.e. pre-bookable, unscheduled, booked via 111 or online etc.)
16.) Appointments must not conflict or duplicate with any other contractual access commitments and must be clearly identified (so that DES and Contractual hours e.g. under APMS can be looked at separately from appointments under the Pilot).
17.) All patients in the Newham area must have access
18.) The hubs need to demonstrate reasonableness of access for patients in the area
     (appropriate to the locality – i.e. how many hubs are required will be dependent on size and
     transport links of borough)
19.) Patients will be able to access routine appointments with a primary health care
     professional via all practices 8am – 6.30pm Monday to Friday – the service will be built
     around this premise as a top up
20.) If possible the patient would be able to dial into a practice and be seamlessly
     transferred through to the Hub for an appointment (current systems permitting) – please
     confirm the process and numbers planned to be used.
21.) The 6.30-8pm appointments can be delivered via a Hub model – the CCG have
     indicated at least 6 hubs would be available Monday to Friday but is open to proposals on this
     quantity with two hubs to be available at weekends covering the Saturday to Sunday 8-8
     period.

*Some funding has already passed direct to the Co-op which will need to be deducted from the
overall payment

The Pilot proposal must show a breakdown over the 6 months indicating in monthly slots how the
costs build up with Oct and Nov being pre-set as per the above. The Pilot plan also needs to show
how the existing information provided has been utilised in the proposed solution:

- Contract type PMS/GMS/APMS and existing access commitments which impact on the 6.30-
  8pm coverage or week - ends
- Any specific requirements under contract i.e. PMS = 2 sessions 1 early 1 late or any
  combination = 2
- Any specific clinical access requirement i.e. PMS = 16.5 hrs. per 1000*
- Opening Hours by practice e.g. PMS = 52.5 per week*
- Clinical hours by practice Estimated*
- Practice list sizes
- Estimated capacity/appointments per 1000 in hours
- Extended Hours already delivered by practice
- Population density/mapping showing specific areas for Hub location plans
- Historical data relating to Additional Hours Demand/Capacity
- Any relevant Referral data

*Consider for April 2017 in final model

A large quantity of information has been provided - sufficient to allow the Pilot proposal to be as
accurate as possible and enable a detailed demand model and business plan to be produced.

Limited funding is available from which to cover both delivery and any start-up costs – both have
been identified. This Pilot is seen as an opportunity for NCCG to take the lead as one of the early
adopters of 8-8 outside of the CCGs with Prime Ministers Challenge Fund practices.
2. Summary of the Access guidance

2.1. Overall access – what is being done

**We are improving access in a number of ways**

The following 7 descriptions are the access aims of the Strategic Commissioning Framework:

<table>
<thead>
<tr>
<th>Access Specifications (SCF)</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A1 Patient choice</td>
<td>Patients will be given a choice of access options and should be able to decide on the consultation most appropriate to their needs.</td>
</tr>
<tr>
<td>A2 Contacting the practice</td>
<td>Patients will be required to only make one call, click or contact in order to make an appointment. Primary care teams will maximise the use of technology and actively promote online services to patients including appointment booking, prescription ordering, viewing medical records and email consultations.</td>
</tr>
<tr>
<td>A3 Routine opening hours</td>
<td>Patients will be able to access pre-bookable routine appointments with a primary health care professional (see ‘workforce implications’ for the proposed primary care team) at all practices 8am – 6.30pm Monday to Friday and 8am to 12 noon on Saturdays. An alternative equivalent patient offer may be provided where there is a clear, evidenced local need.</td>
</tr>
<tr>
<td>A4 Extended opening hours</td>
<td>Patients will be able to access a GP or other primary care health professional seven days per week. 12 hours per day (8am to 8pm and an alternative equivalent offer based on local need) in their local area, for pre-bookable and unscheduled care appointments</td>
</tr>
<tr>
<td>A5 Same day access</td>
<td>Patients who want to be seen the same day will be able to have a consultation with a GP or appropriately skilled nurse on the same day within routine surgery hours at the practice at which they are registered (see Specification A3: Routine opening hours).</td>
</tr>
<tr>
<td>A6 Urgent and emergency care</td>
<td>Patients with urgent or emergency needs will need to be clinically assessed rapidly. Practices should have systems in place and skilled staff to ensure these patients are effectively identified and responded to appropriately.</td>
</tr>
<tr>
<td>A7 Continuity of care</td>
<td>All patients will be registered with a named GP who is responsible for providing an ongoing relationship for care coordination and care continuity. Practices will provide flexible appointment lengths as appropriate</td>
</tr>
</tbody>
</table>

**Using the wrap around model**

### Standards for access to routine primary care

Patients will be able to access routine appointments with a primary healthcare professional at all practices 8am – 6.30pm Monday to Friday, and could be delivered at home from 8am to 12 noon on Saturdays.

**Minimum standards:**
- Appointments must be pre-bookable via the practice, online and NHS 111, and should be a mixed model of slot availability (i.e. pre-bookable, unscheduled, booked via 111 or online etc.)
- Must have access to patients records

Extended opening hours must apply the same minimum standards, in addition the TPC Board have agreed with CCGs that:
- All patients in the area have access
- UCC/VCIs (i.e. existing capacity) could not be reloaded as meeting this extended access specification, unless it met with the minimum standards and provided additional capacity
- The hubs do not necessarily have a specified ‘top-up’ for patients in the area (appropriate to the locality – i.e. how many hubs are required will be dependent on size and transport links of borough)

**“Top up” primary care hubs**

Some local areas are providing patients with access to primary care from 8am – 8pm by providing extended hours at a host practice from 8:30 – 8pm on a weekend, and then 8-4pm on a weekend.

The hubs can access the patient’s records, and are pre-bookable as well as providing unscheduled care.

This enables the network/federation to use existing facilities to provide additional hours.

**“Stand alone” primary care hubs**

Stand alone hubs provide 12 hours a day of additional primary care to the local area.

The hubs can access the patient’s records, and are pre-bookable as well as providing unscheduled care.

These hubs have the benefit that they can be used as an overflow option during peak hours for local practices, as well as being able to receive referrals from A&E.

*Financial modelling has been provided to each CCG to enable them to understand how much it would cost for them to deliver extended access in their local area, through either a top up hub or a stand alone hub.*
The must do elements of an 8-8 Access plan

Extended access is a key component

The SCF has several descriptions of improved access; one of which is that General Practice services should be available in the evenings and weekends – the requirements for areas to consider this delivered are

To provide general practice services which are available:

<table>
<thead>
<tr>
<th>London specification</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓ 8am to 8pm Monday to Friday (e.g. ‘top up’ the services 6.30 – 8pm or provide additional services for the full 12 hours)</td>
</tr>
<tr>
<td>✓ 8am to 8pm Saturday and Sunday</td>
</tr>
<tr>
<td>✓ Offer pre-bookable and same day appointments</td>
</tr>
<tr>
<td>✓ Open to all registered population in the area</td>
</tr>
<tr>
<td>✓ Has access to medical records</td>
</tr>
<tr>
<td>✓ Accessible via multiple routes including 111, online and via the practice</td>
</tr>
</tbody>
</table>

In addition to delivering the above specification, London understands it is important to:

<table>
<thead>
<tr>
<th>Challenge</th>
<th>Actions to date</th>
<th>Next steps</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measure usage/understand need</td>
<td>Areas have monitored demand and where required (GPAF) reported this</td>
<td>Lessons learnt/ best practice from current GPAF areas to be discussed/ shared at workshop (19 Sept)</td>
</tr>
<tr>
<td>Make route clear to patients and maximise utilisation</td>
<td>CCGs have aimed to make access routes clear to patients, e.g. some have done this through practices so their known route of access is maintained</td>
<td>GPAF supplemented access team to consider how to maximise/deliver most effectively across London</td>
</tr>
<tr>
<td>Support channel shift of patients to reduce demand in other areas</td>
<td>‘hubs’ which are available have been part of Primary Care response over holidays/ strikes etc</td>
<td></td>
</tr>
<tr>
<td>Maximise use of digital channels (see section 2)</td>
<td>Primary Care response to North Mid challenge has been to set up hubs and provide indirect support</td>
<td></td>
</tr>
</tbody>
</table>

3. What does the NHC model provide

3.1 Patients will access the service via the existing out of hours contact number. 4 GP’s will be on duty Monday to Friday each providing approximately 7 face to face and 2 telephone appointments.

Phase 1 from 1st December 2016

Bookable appointments available 6.30pm – 8pm from 6 hubs on rotation 2 open each evening

- Plashet Medical Centre
- Woodgrange
- Westbury Road
- Dr Bhadras Surgery
- The Summit Practice
- Glen Road MC

Phase 2 from Jan 1st

Saturday 320 FtF appointments and 77 telephone
Sunday 175 FtF and 42 phone
The above with the addition of Saturday and Sunday opening 8 am - 8 pm at
- Plashet MC
- Glen Road Medical Centre

All appointments will be bookable and meet the specification laid down with access to medical records via hubs and the ability to update medical records from the hubs with visibility of those changes at practice level and other locations.

Calls will be taken via a single point of access and will be subject to triage. Patients may be dealt with via a telephone consultation where appropriate. A mix of face to face and telephone appointments will be available.

The scheme will complement and not duplicate the extended hours already delivered by GP practices under the DES and will be for all patients both registered and non-registered.

It is expected that to meet demand the number of appointments made available will need to increase from April 17 although this will be reviewed using the learning from the pilot.

### 4.0 Monitoring

#### 4.1 The following measures will be used to monitor the effectiveness of the service:
- The number of patients attending from each practice
- Number of unregistered patients booked to these appointments
- Peak volumes measured in terms of volume of access and access preferences
- Use and success of telephone consultations
- Usage of each hub
- Patient satisfaction levels
- Use of other urgent care services (subject to data availability)

Monthly monitoring from January will take place and a summary of the outcomes prepared with a view to shaping the long term plans for 8-8 access.

### 5.0 Next Steps

The PCCC are asked to approve the Pilot project proceeding and identify any requests for additional information.

STP discussions about different models of Access being trialled will be shared across the area.

A proposal will be developed for submission to PCC in early 2017 for a longer term solution including investment in non-recurrent infrastructure such as EMIS connectivity, phone systems and automatic call forwarding to 8-8 providers.

Up grading phone systems to Digital has been estimated as approx. £270k and phone systems are being evaluated as part of the ETTF funding available to the CCG.
Single Point of Access
Appointments Pilot

November 2016
1. Introduction

This service proposal has been developed in response to a request from NHS Newham CCG. Newham Health Collaborative (NHC) have been asked to design a ‘minimal cost wrap around service’ to provide Newham patients with nominal access to bookable GP appointments between the hours of 8am and 8pm, seven days a week.

This pilot will supersede and expand upon the current Additional Capacity service which provides a seven-day service for 44 of the 60 practices in Newham, to address insufficient primary care capacity. The new pilot will provide services for patients from all Newham GP practices, as well as any unregistered patients.

This pilot will be provided only until April 2017, when funding will be available to enable the development of a comprehensive 8-8 service.

2. Governance structure

Under instruction from NHS Newham CCG, the contract for this service will be held by NHC, with Newham GP Cooperative being sub-contracted to provide all services. A Memorandum of Understanding is currently being agreed between the two organisations.

3. Pilot Stage 1

Stage one of the pilot will commence from 1st December 2016, providing bookable GP appointments to all Newham patients via a single point of access (SPA) call centre until 8pm Monday to Friday.

   **Phone number:** 0207 540 9949

The GP appointments themselves will be available from a number of the Cooperative’s existing hubs to ensure the project remains within the cost envelope and mobilisation timescales. The appointments will consist of:

- 30 face-to-face and 8 telephone GP appointments on each of Monday, Tuesday, Wednesday and Fridays (equivalent of 6 GP hours).
- 45 face-to-face and 11 telephone GP appointments on Thursdays due to circa 26 GP practices being closed on Thursday afternoons (equivalent of 9 GP hours).

4. Stage 2

Stage two of the pilot will commence from 1st January 2017, providing bookable GP appointments per stage 1, between 8.00am and 8pm Saturday and Sunday.

The GP appointments themselves will be available from a number of the Cooperative’s existing hubs to ensure the project remains within the cost envelope and mobilisation timescales.

Based on experience of the split of demand on Saturdays and Sundays, the following will be made available:
5. Appointment provision

During stage two of the pilot, the service will be providing 1,054 face-to-face and telephone consultations. This is approximately 2.15 appointments per 1,000 registered patients per week, or 13 appointments per week for an average sized Newham practice (circa 6,000 list). Based on the known GP capacity problems in Newham, and the Cooperative’s experience of access patterns through the additional capacity service, this level of provision is not considered sufficient to enable demand to be satisfactorily met.

Newham’s estimated 80,000 unregistered patients will also be able to access this service in the same way as registered patients. However, experience shows that these patients are often directed to the service via the GP streamer service.

Demand will be monitored throughout the pilot to inform when/where additional capacity will be required from April 2017, when further funding is available. The appointment pattern has also taken in to account data provided by NCCG concerning current provision of routine GMS, Extended Hours and Additional Capacity appointments by all practices.

6. Bookings

Telephone access

To access the service during the pilot period, patients/practices will be required to call the SPA directly. The SPA will be open from 8am to 8pm daily.

It is currently not possible to have patients automatically transferred to the SPA by phone due to the out-dated telephone systems within many GP practices. It is estimated that approximately 60% of Newham practices (circa 40 practices) would need to be upgraded to digital systems to enable automatic transfer.

A recent quote from Premier Choice Telephone Systems put the cost of upgrading practices at around £6,500 per practice (circa £269,000). This places the project firmly outside the scope of the core pilot funding.

*Data provided by Neil Hamer in document entitled “Access Database version 1.4”*
**Booking systems**

In the first instance, patients/practices/111 must contact the SPA directly by telephone to make appointments.

A quote has been sought from EMIS to enable GP practices to book appointments directly into the SPA’s appointment system, while providing the SPA with some control over the number of appointments booked by individual practices. This functionality will require training to be provided to reception staff within each local practice and it is therefore unlikely to be available for stage 1 of the pilot.

The cost of this functionality and training is likely to be in the region of £8,000 and discussion regarding timescales are on-going with EMIS.

### 7. Access to Medical Records

The Cooperative has access to the majority of medical records from Newham GP practices through the EMIS clinical system. Contemporaneous records will be maintained throughout all consultations within the patient’s medical notes, which will be seen by each practice.

The established hubs already have the EMIS facility in place and in use across the established Additional Capacity Scheme group of practices. It will be necessary to increase the EMIS connectivity to include all Newham practices.

A block data sharing agreement will need to be put in place to ensure a clearly documented understanding of how merged records should be managed. Timescales will depend upon speed of agreement/response from the individual practices involved.

### 8. Hubs

As requested by the CCG, weekday services will be provided from up to six hub locations throughout the week, and weekend services from at least two hubs, ensuring equitable access across the geography of Newham.

To enable swift and cost-effective mobilisation, existing hubs agreed with the CCG as part of the additional capacity service will be used.

With four GPs on duty Mon-Fri, the Cooperative will open two hubs each evening, on a rota basis to ensure provision from up to six hubs throughout the week. In the first instance, the hubs are likely to include:

1. Plashet Medical Centre
2. Woodgrange Medical Centre
3. Westbury Road Medical Centre
4. Dr Bhandra’s Surgery
5. The Summit Practice
6. Glen Road Medical Centre
At least two hubs will be open on a Saturday and Sunday. These are likely to be the same each week:

1. Plashet Medical Centre
2. Glen Road medical Centre

The above hubs are subject to change depending upon availability and patient demand. Demand and patient satisfaction will be monitored at each hub, with hubs being changed as appropriate in liaison with patients and practices to maximise patient convenience and minimise (and where possible eliminate) potential DNA’s.

9. Mobilisation

The Cooperative currently provides an Additional Capacity Scheme to 44 practices locally. This SPA pilot will benefit from the infrastructure in place for this service, but will require the service to be significantly up-scaled to accommodate patients from all 60 practices. The current service operates at capacity and recruitment and service expansion will therefore be required.

The Collaborative are confident that the timescales for stage 1 and 2, though challenging, can be met if agreement to proceed is received by 18th November 2016.

A mobilisation plan is attached as Appendix 1.

10. Monitoring metrics

Throughout the pilot, the Cooperative will report on a monthly basis to the Collaborative Board on:

- Number of patients attending from each of the Newham GP Practices
- Number of unregistered patients booked to these appointments
- Peak access times and access preferences for patients
- Usage and success of telephone consultations
- Usage of each of the hubs
- Patient satisfaction
- Use of other urgent care services (where data is available)

Data will be used to inform future service design and configuration. Key Performance Indicators (KPIs) attached to the contract will not be related to performance/outcomes due to the minimal nature of the service being funded.

11. Financial Model

Core pilot costs

The table below sets out the core service costs involved in mobilising and providing the SPA pilot scheme.
### Core pilot costs

<table>
<thead>
<tr>
<th>Description</th>
<th>One-off/set-up costs</th>
<th>Ongoing costs</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>October and November Additional Capacity payments to cooperative</td>
<td></td>
<td>£51,425</td>
<td>£51,425</td>
</tr>
<tr>
<td>Stage 1: 33 GP hours per week for 4.5 weeks</td>
<td></td>
<td>£22,275</td>
<td>£22,275</td>
</tr>
<tr>
<td>Local average hourly rate (including Xmas and NY premiums)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stage 2: 132 GP hours per week for 13 weeks</td>
<td></td>
<td>£188,760</td>
<td>£188,760</td>
</tr>
<tr>
<td>Local average hourly rate (including New Year premium)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Continuation of Sat &amp; Sun Additional Capacity Scheme for 44 practices</td>
<td></td>
<td>£20,250</td>
<td>£20,250</td>
</tr>
<tr>
<td>December (30 GP hours per weekend for 4.5 weeks with Xmas and New Year premiums)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SPA (including recruitment, staffing, training and equipment)</td>
<td>£14,000</td>
<td>£38,000</td>
<td>£52,000</td>
</tr>
<tr>
<td>Duty Director (on call 8-8 x7), Service Coordinator, and governance/audit systems</td>
<td>£10,000</td>
<td>£41,000</td>
<td>£51,000</td>
</tr>
<tr>
<td>IM&amp;T</td>
<td></td>
<td>£20,000</td>
<td>£20,000</td>
</tr>
<tr>
<td>Premises and Facilities Management</td>
<td></td>
<td>£10,000</td>
<td>£10,000</td>
</tr>
<tr>
<td>General consumables</td>
<td></td>
<td>£7,000</td>
<td>£7,000</td>
</tr>
<tr>
<td>Marketing/communications (inc. printed service leaflet)</td>
<td>£5,000</td>
<td></td>
<td>£5,000</td>
</tr>
<tr>
<td>Newham Health Collaborative Board</td>
<td></td>
<td>£8,554</td>
<td>£8,554</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>£29,000</strong></td>
<td><strong>£407,264</strong></td>
<td><strong>£436,264</strong></td>
</tr>
</tbody>
</table>

These costs have been subject to significant negotiation with the CCG to enable a service to be provided within the limited financial envelope available until end March 2017.

Costings include no allocation for contingency/surplus, and the Cooperative fully expect the cost of the service to exceed agreed funding. In recognition of this significant financial risk, the Cooperative require that the savings applied to the pilot’s management and SPA costs (£32,000\(^2\)) are formally accepted as the Cooperative’s total contribution to the current “Value for Money Review” (VFMR) process. This will need to be formally agreed with Julie van Bussel (CCG AD) prior to commencement of stage 1 of the pilot.

**Future investment requirements**

The budget available for the pilot does not enable some important elements of a full 8-8 service to be incorporated as per other nationally recognised and evaluated schemes such as those funded by the Prime Minister’s Challenge Fund. Given additional funding from April 2017, the following components would significantly improve the service offering.

---

\(^2\) £29,000 reduction to Duty Director and Management costs and £3,000 reduction to SPA costs
Set-up cost | Ongoing cost
---|---
Telephony to enable direct call transfer. Circa 40 practices to be upgraded to digital phone systems. | £269,000
Additional SPA capacity (1WTE) at 8am related to direct call transfer and subsequent peak in demand at 8am | £30,000 per annum
Video conferencing and video consultation facilities and training | £20,000
EMIS/Adastra enabled laptops to enable remote working and provide resilience during periods of high/unexpected demand | £28,000
WebGP | £ TBA
Mobile App development and maintenance | £ TBA

Although not financially viable as part of the pilot, the Collaborative are keen to consider use of a specialist call management software such as “WebGP”. WebGP is a patient platform that links from a GP practice’s existing website to a suite of online offers including:

- Symptom checkers and condition finders, so patients can ensure they are using general practice appropriately
- Self-help guides and videos, so a proportion of demand can be top-sliced as patients are given the information to self-manage
- Sign-posting to alternate local services, e.g. pharmacy, so patients are aware of the range of resources available that might help with their issue

It is also proposed to develop a mobile phone app to allow patients to access services and clinicians via their mobile phone. Nationally, a number of these are currently being reviewed and are looking very promising in terms of improving patient satisfaction.

**Invoicing**

For the continuation of the additional capacity service during October and November 2016, invoices will be raised per the Cooperative’s previous agreement for this service with the CCG.

For stage one and two of the pilot, services will be paid by the CCG quarterly in advance following an invoice from the Collaborative on the first working day of the month, as below.

<table>
<thead>
<tr>
<th>Invoice date</th>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>1/12/2016</td>
<td>SPA Stage 1 (Mon – Fri only) Continuation of Sat &amp; Sun Additional Capacity scheme for 44 practices ¾ of overhead costs</td>
<td>£73,664</td>
</tr>
<tr>
<td>1/12/2016</td>
<td>Set-up costs</td>
<td>£29,000</td>
</tr>
<tr>
<td>2/1/2017</td>
<td>SPA stage 2 for 60 practices ¾ of recurrent overhead costs</td>
<td>£282,176</td>
</tr>
</tbody>
</table>
Payments will be made directly to the Cooperative’s bank account (details on invoice), and the Cooperative will forward NHC Board costs directly to NHC.

For cash-flow purposes, all invoices must be paid within 14 days.
# Appendix 1: Mobilisation Plan

<table>
<thead>
<tr>
<th>Task</th>
<th>MILESTONES</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Service</strong></td>
<td></td>
</tr>
<tr>
<td>Stage 1 - Mon-Fri</td>
<td>Stage 1 implemented</td>
</tr>
<tr>
<td>Stage 2 - 7 days a week</td>
<td>Stage 2 implemented</td>
</tr>
<tr>
<td><strong>Personnel</strong></td>
<td></td>
</tr>
<tr>
<td>Recruit/appoint Service Manager on temporary contract</td>
<td>Person Appointed</td>
</tr>
<tr>
<td>Recruit/appoint additional call handlers</td>
<td>Person Appointed</td>
</tr>
<tr>
<td>Source additional GP hours</td>
<td>Month 1 rota filled</td>
</tr>
<tr>
<td>Consult additional capacity staff on changes to role, and provide required training</td>
<td>Person Appointed</td>
</tr>
<tr>
<td>Identify any further support from project members</td>
<td>Support identified</td>
</tr>
<tr>
<td>Employment / contractual issues for staff that will work for the service</td>
<td>All issues sorted out</td>
</tr>
<tr>
<td>Agree Rotas</td>
<td>Rotas agreed</td>
</tr>
<tr>
<td><strong>Project Board</strong></td>
<td></td>
</tr>
<tr>
<td>Agree Memorandum of Understanding between NHC and the Cooperative</td>
<td>MOU signed</td>
</tr>
<tr>
<td>Terms of Agreement for Implementation Team</td>
<td>Terms agreed</td>
</tr>
<tr>
<td>Confirm Implementation Team Members</td>
<td>Members appointed</td>
</tr>
<tr>
<td>Set meeting dates for Implementation Team</td>
<td>Meetings diarised</td>
</tr>
<tr>
<td>Regular monthly meetings of the Implementation Team</td>
<td>Monthly meetings happen</td>
</tr>
<tr>
<td><strong>Systems</strong></td>
<td></td>
</tr>
<tr>
<td>Agree EMIS data sharing agreements with all Newham practices</td>
<td>Data sharing agreements signed by all practices</td>
</tr>
<tr>
<td>Set up systems and provide training to all practices to enable appointment booking via EMIS</td>
<td>All GP practice receptionists received training</td>
</tr>
<tr>
<td>Ensure all EMIS links are in place and able to deal with the extended service</td>
<td>EMIS testers (and works) for the service</td>
</tr>
<tr>
<td>Ensure all telephone links for telephone consultations are in place</td>
<td>Telephone links in place</td>
</tr>
<tr>
<td><strong>Training</strong></td>
<td></td>
</tr>
<tr>
<td>Staff training for telephone consultations</td>
<td>Training Complete</td>
</tr>
<tr>
<td>Staff training to be able to direct / inform patients about the new extended service</td>
<td>Training Complete</td>
</tr>
<tr>
<td><strong>Marketing</strong></td>
<td></td>
</tr>
<tr>
<td>Website</td>
<td>Website Live</td>
</tr>
<tr>
<td>Service leaflet produced and distributed to all practices</td>
<td>Leaflets created and handed-out</td>
</tr>
<tr>
<td><strong>Data</strong></td>
<td></td>
</tr>
<tr>
<td>Data gathering, methods, tools and systems approved</td>
<td>Tools and systems approved</td>
</tr>
<tr>
<td>Template created tested to present the data to the Collaborative and Commissioners</td>
<td>Template approved</td>
</tr>
<tr>
<td>Evaluate data</td>
<td>Data evaluated</td>
</tr>
<tr>
<td><strong>Title:</strong></td>
<td>Referral Management Scheme - development and outline of proposed programme</td>
</tr>
<tr>
<td>------------</td>
<td>-------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Agenda item:</strong></td>
<td>5</td>
</tr>
<tr>
<td><strong>Author:</strong></td>
<td>Chad Whitton, Chief Finance Officer Newham CCG</td>
</tr>
<tr>
<td><strong>Presented by:</strong></td>
<td>Chad Whitton, Chief Finance Officer Newham CCG</td>
</tr>
</tbody>
</table>
| **Contact for further information:** | Chad Whitton, Chief Finance Officer Newham CCG  
  Chad.Whitton@newhamccg.nhs.uk  
  0203 688 2328  
  Lei Wei, Deputy Chief Finance Officer Newham CCG  
  Lei.Wei@newhamccg.nhs.uk  
  0203 688 2334 |
| **This Paper is for:** | Decision |
| **Action required:** | The Primary Care Commissioning Committee are asked to  
  • Note and approved development of the outline proposals for referral management as outlined below, as supplemented by the update as reviewed by the Members Practice Council of 25th November (to be circulated). |
Referral Management – Newham CCG Scheme Outline – Update for PCCC

Summary
This paper arises from the ‘in principle’ CCG Board approval of a referral management implementation plan as part of an approved additional savings package. The PCCC is requested to review and agree development of the options for implementation to maximise the plan impact in 2016/17 and future years, identifying any specific requirements relating to implementation and engagement with stakeholders, patients and the general public.

Background
The CCG faces a significant financial challenge from increased levels of acute activity. Outpatient referrals have risen by over 5% in a year and the projected 2016/17 overspend on acute budgets is above £8m. There is also a significant pressure on the prescribing budget. The current acute spend trajectory would, if continued, require community and primary care budgets to be reduced or cut in 2017/18 as the spend on PBR driven acute activity would make such funding unaffordable.

Noting that current levels of growth in activity are financially unsustainable, at its Part 2 Board Meeting on 9th November the CCG approved a package of additional savings measures targeted at delivering at least £2.4 million additional savings in 2016/17.

A key component in the plan both for this year and, more importantly, in 2017/18 and 2018/19 is the implementation of referral management measures aimed at ensuring the appropriateness of outpatient referrals and, ultimately, elective activity. The Board approved the plan in principle but requested further investigation and a report to the Executive Committee.

The referral management plan is the first stage of a CCG strategy targeted to minimise unnecessary entry into the acute sector through:

• Effective referral management
• GP led triage at all other acute system entry points
• Risk-based targeting of patient cohorts to enable effective non-acute management of conditions
• Highly effective early response and intervention to minimise crises requiring acute treatment

Referral Management Components
Currently there are three components to the referral management implementation plan

1 Providing information and advice directly to practices and implementing practice led support
   a. A letter will be sent out to all GPs and other system referrers providing details of the financial pressures, rate of activity growth and CCG plans,
and requesting GP support in ensuring only appropriate referrals and prescribing are undertaken. A number of measures to support GPs in this process including development of clear CCG/HWBB policy guidelines, information to patients and the public and professional support options will also be developed.

b. Senior Practice GPs will be supported to assist the referral and prescribing practice of locums and less experienced GPs to improve consistency and effective use of the directory of services. The scheme will support practices combining and will also utilise the specialised knowledge of clinical leads, consultants and others where available and appropriate.

2. Enhancing the existing Cluster benchmarking, scrutiny and support systems to assist practices to peer review delivery. This will be supported by development of a targeted dashboard and comparative data as well as direct input by clinical leads where relevant.

3. A specific referral management scheme targeted at high impact areas will be developed with a view to implementation in April 2017 if deemed helpful by practices. Details of the scheme (and potential options for consideration) are being developed for further discussion with the Board, Executive Committee and GP leads.

**Next Steps**

The intention is to introduce the scheme a speed to maximise the impact in 2016/17 as well as 2017/18. The scheme will focus on maximum impact/minimum workload. However, although the financial position is very constrained in 2016/17 the intention is to reflect the additional workloads in the 2017/18 EPCS/LIS budgets.

The approval process has been developed as follows:

Consideration and agreement to proceed was given at the Executive Committee a presentation.

A presentation outlining the above will be made for review and approval to the Members Practice Council on 25th November. This will then be circulated for consideration with this report to this Committee on 30th November.

Subject to the response of the Members Practice Council and the PCCC the plan will form part of a savings and QIPP update included in the 14th December Board Finance Report.

As implementation is rolled out updates will be provided to all the above Committees to ensure the process remains scrutinised and assured.

**Supporting papers:**

Further paper to be circulated following review at the MPC 25th November.
<table>
<thead>
<tr>
<th><strong>How does this fit with Newham CCG Strategy:</strong></th>
<th>Accountability and Responsibility - Requirement to meet target surplus.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Where has the paper been already presented?</strong></td>
<td>N/a</td>
</tr>
<tr>
<td><strong>Risk:</strong></td>
<td>Failure to implement effective control of referrals and prescribing jeopardise the achievement of the 2016/17 surplus target and a balanced 2017/18 Operating Plan.</td>
</tr>
<tr>
<td><strong>Equality Impact:</strong></td>
<td>Effective delivery of the scheme will support the CCG in achieving its duty to reduce inequality of health provision and outcomes for the residents of Newham by ensuring improved consistency and appropriateness of referral.</td>
</tr>
<tr>
<td><strong>Stakeholder engagement:</strong></td>
<td>This report has been subject to no specific prior consultation but reflects any comments from CCG Executive Committee</td>
</tr>
<tr>
<td><strong>Integrated Care Impact</strong></td>
<td>Effective referral will maximise the benefits offered through the integrated care service structure currently in place.</td>
</tr>
<tr>
<td><strong>Financial Implications</strong></td>
<td>The report outlines schemes to deliver savings as outlined in the report to the November Board.</td>
</tr>
</tbody>
</table>
### Title:
Management of Conflicts of Interest at Primary Care Commissioning Committee

### Agenda item
6

### Author:
Mike Sims Board Secretary Newham CCG

### Presented by:
Mike Sims Board Secretary Newham CCG

### Contact for further information:
Mike Sims Board Secretary Newham CCG

### This Paper is for:
Decision

### Action required:
Consider whether or not a general protocol for the management of conflicts of interests for GP members at Primary Care Commissioning Committee Meetings should be adopted and review arrangements for clinical membership

### Executive summary:
Newham's PCCC has the delegated authority to make a range of decisions about individual or groups of practices within the borough as the commissioner of primary care service. Newham GPs on the committee may have direct or indirect conflicts of interest in relation to the decisions the Committee has to make. The report asks the Committee to consider whether it is appropriate to adopt a protocol that would readily advise the Chair and officers who are preparing items for decision at the meetings on automatically being excluded from participating in particular decision. The report looks at alternative clinical membership options which may assist the CCG to manage conflicts in primary care decision making.

### Supporting papers:
None
| How does this fit with Newham CCG Strategy: | Values:  
Transparency  
Accountability  
Aims:  
Reducing quality variation |
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Where has the paper been already presented?</td>
<td>No previous presentation to any meeting.</td>
</tr>
</tbody>
</table>
| Risk: | 1. Failure to consider how to proactively manage conflicts would mean the CCG is not compliant with best practice in terms of statutory guidance recommended to CCGs published in June 2016  
2. The adoption of a policy which excludes GPs from involvement in decision making carries the risk of inadequate clinical input into primary care decision making |
| Equality Impact: | There is the possibility that the adoption of a protocol which excluded GPs from decision making would have an adverse impact on the Committee in relation to those groups covered by the 9 protected characteristics that are covered by the Equality Act 2010 and our Equality Duties. |
| Stakeholder engagement: | None |
| Integrated Care Impact | No explicit impact on Integrated Care. |
| Financial Implications | No explicit financial implications. |
1. **Introduction and Background**

1.1 NHSE provided CCGs with revised guidance on managing conflicts of interest in June 2016. The guidance now places a duty on a CCG to be proactive and not reactive in relation to anticipating and evaluating whether conflicts of interest in decision making may arise.

The membership of the Primary Care Commissioning Committee in Newham has one voting Board GP member and two non-voting non Board GP members. Additionally in Newham the attending non-voting LMC member is often a Newham GP member as well.

There are no quorum requirements of the committee that require a GP member to be present for a decision to be taken.

2. **Guidance on the management of conflicts of interests**

2.1 Revised guidance on the management of conflicts of interest stops short of stating that GP members should be excluded from all primary care decision making and refers to the CCG having a responsibility to manage those potential conflicts.

Having said this, the guidance has broadened the scope of what issues the CCG should consider in terms of a definition of appropriate management. In general terms the guidance now refers to:

- **Financial interests** – Direct financial interests e.g. Director or shareholder in a private or plc likely to do business in Health &Social Care
- **Non-Financial professional interests** – increasing personal or professional status e.g. advocate for particular patients, GPSI, CQC Adviser
- **Non-Financial Personal interests** – Professional benefits e.g. voluntary sector champion or member of a board
- **Indirect interests** – close-association with an individual e.g. spouse, close relative, close friend
- **Secondary Employment interests** – the guidance now refers to a range of circumstances where conflict may occur as the member is employed by a provider.

3. **Potential trigger areas for conflicts of interests**

3.1 The Committee makes a range of decisions where direct or indirect financial and non-financial decisions may occur including decisions regarding:

- Contract approvals and terminations
- Mergers
- Partnership decisions
- Temporary arrangements
- Breach notice approvals
- Remedial action approvals
- Support package approvals
- Estates funding and investment decisions
- Remuneration for contracted or additionally contracted services (LIS, EPCS, other)
- GP Federation

4. **Newham Health Collaborative (NHC)**
All GP members of PCCC are members of NHC, the newly formed Newham GP Federation either directly through their Practice or a Company. The Committee will need to take a view on the association of Committee membership with Federation membership and whether GP members may reasonably be expected to or, as importantly, be perceived to be able to maintain impartiality in relation to a range of decision making responsibilities whilst being members of a provider organisation.

### Summary of types of decision

<table>
<thead>
<tr>
<th>Type of decision report</th>
<th>Conflicted / Not Conflicted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary care strategic reports and financial/anonymous performance monitoring reports</td>
<td>Not conflicted</td>
</tr>
</tbody>
</table>
| Changes in remuneration for all services | Conflicted  
Newham GPs have a direct financial interest in the remuneration Practices receive for their services |
| Decisions relating to a specific practice or group of Practices the GP is a member of | Conflicted  
Newham GPs have a direct interest in the decision involving a Practice they are a member of e.g. the service of a notice or the termination of a contract |
| Decisions relating to a practice or group of Practices the GP is not a member of  
   a) Conflicted if has declared a close association with an individual  
   b) May be conflicted by virtue of membership of same GP Federation | Committee will need to take a view on  
   b) – is membership of the same provider organisation in itself sufficient to suggest there will always be the risk of a perceived interest |

### Summary of options on Committee composition

<p>| Composition | Conflicts would be managed on an ad hoc basis or on the basis of an agreed protocol which was shared and understood. If there is a view that existing GPs are conflicted on decisions relating to a practice or group of Practices the GP is not a member of by virtue of membership of NHC then its arguable the GP members would be so conflicted as to not be able to reasonably contribute to the Part II decisions |
| Change the GP Membership to include some or only independent GP members | GP members would no longer be conflicted but the Committee would lose the experience of localism and factors specific only to Newham. The STP agenda may also mean that independent advice may need to be sought from outside of the North East London Area. A model which expanded membership to include independents whilst retaining local GPs could be adopted although this would mean the local GPs would play hardly any role in part II meetings. In practice the Committee would end up with different clinical memberships for Part I and II meetings | required and suggest their membership is not feasible |</p>
<table>
<thead>
<tr>
<th><strong>Title:</strong></th>
<th>Quality Dashboard</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Agenda item:</strong></td>
<td>7</td>
</tr>
<tr>
<td><strong>Author:</strong></td>
<td>Saem Ahmed, Newham CCG, Head of Quality and Development</td>
</tr>
<tr>
<td><strong>Presented by:</strong></td>
<td>Chetan Vyas, Newham CCG, Director of Quality and Development</td>
</tr>
<tr>
<td><strong>Contact for further information:</strong></td>
<td>Chetan Vyas, Newham CCG, Director of Quality and Development, <a href="mailto:Chetan.Vyas@newhamccg.nhs.uk">Chetan.Vyas@newhamccg.nhs.uk</a>, 0203 688 2316</td>
</tr>
<tr>
<td><strong>This Paper is for:</strong></td>
<td>Decision</td>
</tr>
<tr>
<td><strong>Action required:</strong></td>
<td>Approve the new process of triggers using the Quality Dashboard.</td>
</tr>
<tr>
<td><strong>Executive summary:</strong></td>
<td>The report asks Committee to:</td>
</tr>
<tr>
<td></td>
<td>• Note the Quality Dashboard could not be updated due to delay in data</td>
</tr>
<tr>
<td></td>
<td>• Note the CQC Outcome Dashboard (Appendix A)</td>
</tr>
<tr>
<td></td>
<td>• Approve the trigger process of the Quality Dashboard.</td>
</tr>
<tr>
<td><strong>Supporting papers:</strong></td>
<td>• Appendix A – CQC Outcome Dashboard</td>
</tr>
<tr>
<td><strong>How does this fit with Newham CCG Strategy:</strong></td>
<td><strong>Values:</strong></td>
</tr>
<tr>
<td></td>
<td>Accountability and responsibility</td>
</tr>
<tr>
<td></td>
<td>Caring culture and behaviour</td>
</tr>
<tr>
<td></td>
<td>Working with our partners to improve health outcomes</td>
</tr>
<tr>
<td></td>
<td><strong>Aims:</strong></td>
</tr>
<tr>
<td></td>
<td>Reducing quality variation</td>
</tr>
<tr>
<td><strong>Where has the paper been already presented?</strong></td>
<td>No previous presentation to any meeting.</td>
</tr>
<tr>
<td>Risk:</td>
<td>Failure to comply with the recommendations of the report may result in the absence of a proactive mechanism to review quality in general practice</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Equality Impact:</td>
<td>This document relates to all Newham residents in the 9 protected characteristics that are covered by the Equality Act 2010 and our Equality Duties.</td>
</tr>
<tr>
<td>Stakeholder engagement:</td>
<td>Quality Committee and Primary Care Commissioning Committee which both have a wide ranging membership consisting of Public Health, Healthwatch, London wide LMC, NHSE.</td>
</tr>
<tr>
<td>Integrated Care Impact</td>
<td>No explicit impact on Integrated Care.</td>
</tr>
<tr>
<td>Financial Implications</td>
<td>No explicit financial implications.</td>
</tr>
</tbody>
</table>
1. **Introduction and Background**

1.1 This paper is to:
- Update the committee on the Quality Dashboard
- Provide analysis of CQC outcomes for Newham practices
- Recommend new trigger indicators process from the Quality Dashboard

2. **Quality Dashboard & CQC Outcomes**

2.1 At the time of authoring this report, the data on the Quality Dashboard had not been updated centrally, and therefore an updated dashboard could not be provided.

However an analysis of the CQC inspections outcomes between 1 January 2016 and 10 November 2016 has been provided.

In summary the following overall ratings are:
- 15 practices rated good
- 5 practices rated requires improvement
- 3 practices rated inadequate
- 17 Requirement Notices were issued across 12 practices.
- 8 Enforcement Actions were issues across 3 practices.

Please refer to Appendix A for further detailed information.

3. **Trigger indicators process from the Quality Dashboard**

3.1 A proposal was recommended to the Committee on the 27th January around trigger indicators from the dashboard. The paper recommended that practices which have 17 total outlier indicators and above will be provided development support as a priority.

However, since the paper the CCG Quality Team have developed a risk scoring mechanism in order to be smarter in identifying practices as a priority.

The rationale for change is using total number outlier methodology (17 outliers and above) may not always highlight indicators which are of high risk and therefore missing the opportunity to take urgent improvement action of practices.

Therefore the table below suggests trigger indicators by level of risk:

<table>
<thead>
<tr>
<th>Risk</th>
<th>Triggers</th>
<th>Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>High Risk</td>
<td>• Outliers in safety indicators</td>
<td>• Triggers in OF Domain 1 (Premature Mortality)</td>
</tr>
<tr>
<td></td>
<td>• Soft intelligence</td>
<td>• Triggers in OF Domain 5 (Patient safety)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• <em>Consider effectiveness indicators</em></td>
</tr>
<tr>
<td>Medium Risks</td>
<td>• Outliers in well-led indicators</td>
<td>• CQC indicators</td>
</tr>
<tr>
<td></td>
<td>• Outliers in effectiveness</td>
<td>• Triggers in OF Domain 2 (Long Term Conditions)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Triggers in OF Domain 3 (Recovery</td>
</tr>
<tr>
<td>Low Risks</td>
<td>Indicators</td>
<td>National Patient Experience Survey</td>
</tr>
<tr>
<td>-----------</td>
<td>------------</td>
<td>------------------------------------</td>
</tr>
<tr>
<td>• Outliers in national patient experience indicators</td>
<td>• Soft intelligence</td>
<td>• Triggers in OF Domain 4 (Patient Experience)</td>
</tr>
</tbody>
</table>

The committee are asked to approve this new process.
Appendix A

Care Quality Commission (CQC) Outcome Dashboard

Newham CCG Practices visited between 1 January and 10 November 2016

14 November 2016
Saem Ahmed - Head Quality & Development
# Newham General Practice Headline of CQC Rating Outcomes

<table>
<thead>
<tr>
<th>Rating</th>
<th>Safe</th>
<th>Effective</th>
<th>Caring</th>
<th>Responsive</th>
<th>Well Led</th>
<th>Overall</th>
<th>Requirement Notices</th>
<th>Enforcement Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Good</td>
<td>9</td>
<td>16</td>
<td>19</td>
<td>17</td>
<td>17</td>
<td>15</td>
<td>17 Requirement Notices were issued across 12 practices.</td>
<td></td>
</tr>
<tr>
<td>Requires Improvement</td>
<td>10</td>
<td>5</td>
<td>3</td>
<td>5</td>
<td>2</td>
<td>5</td>
<td>8 Enforcement Actions were issued across 3 practices.</td>
<td></td>
</tr>
<tr>
<td>Inadequate</td>
<td>4</td>
<td>2</td>
<td>1</td>
<td>4</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Rating                 |      | Older people | People with long term conditions | Families, children and young people | Working age people (including those recently retired and students) | People whose circumstances may make them vulnerable | People experiencing poor mental health (including people with dementia) |
|------------------------|------|---------------|----------------------------------|-------------------------------------|---------------------------------------------------------------|---------------------------------------------------------------------|
| Outstanding            | 0    | 0             | 1                                | 0                                   | 0                                                             | 0                                                                  |
| Good                   | 14   | 15            | 12                               | 15                                  | 15                                                            | 15                                                                 |
| Requires Improvement   | 6    | 6             | 7                                | 5                                   | 5                                                             | 5                                                                  |
| Inadequate             | 3    | 2             | 3                                | 3                                   | 3                                                             | 3                                                                  |

**Re-inspection Outcomes**

<table>
<thead>
<tr>
<th>Rating</th>
<th>Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Worse</td>
<td>At the time of authoring this report no CQC reports published to suggest rating has declined upon re-inspection.</td>
</tr>
<tr>
<td>Same</td>
<td>At the time of authoring this report no CQC reports published to suggest rating has remained the same upon re-inspection.</td>
</tr>
<tr>
<td>Better</td>
<td>1 Practice re-inspected was originally rated as Requires Improvement. However after re-inspection has now been rated as good which is reflected in the dashboard.</td>
</tr>
<tr>
<td>GP Practice</td>
<td>Date report published</td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>-----------------------</td>
</tr>
<tr>
<td>Glen Road Medical Centre (Dr Rao)</td>
<td>24/03/2016</td>
</tr>
<tr>
<td>Leytonstone Medical Practice (Dr Kohli)</td>
<td>06/05/2016</td>
</tr>
<tr>
<td>Upper Road Medical Centre (Dr Zakaria)</td>
<td>02/06/2016</td>
</tr>
<tr>
<td>Stratford Village Surgery (Dr Shah)</td>
<td>08/06/2016</td>
</tr>
<tr>
<td>Latham Medical Centre (Dr Reena Patel)</td>
<td>15/06/2016</td>
</tr>
<tr>
<td>Royal Docks Medical Centre (Dr Lawrie)</td>
<td>15/06/2016</td>
</tr>
<tr>
<td>The Shrewsbury Surgery (Dr Sri-Ganeshan)</td>
<td>30/06/2016</td>
</tr>
<tr>
<td>Lord Lister Health Centre (Dr Driver)</td>
<td>25/07/2016</td>
</tr>
<tr>
<td>Lord Lister Health Centre (Dr Swedan)</td>
<td>03/08/2016</td>
</tr>
<tr>
<td>Lord Lister Health Centre (Dr Abiola)</td>
<td>23/09/2016</td>
</tr>
<tr>
<td>West Ham Medical Practice (Dr Bhowmik)</td>
<td>26/09/2016</td>
</tr>
<tr>
<td>St Bartholomew Surgery (Barking Road, Dr Bash)</td>
<td>28/09/2016</td>
</tr>
<tr>
<td>Essex Lodge (Dr Higgins)</td>
<td>28/09/2016</td>
</tr>
<tr>
<td>Esk Road Medical Practice (Dr Venugopal)</td>
<td>28/09/2016</td>
</tr>
<tr>
<td>Star Lane Medical Centre (Dr Fang)</td>
<td>28/09/2016</td>
</tr>
<tr>
<td>Tollgate Health Centre (Dr Watt)</td>
<td>28/09/2016</td>
</tr>
<tr>
<td>Greengate Medical Practice (Dr Kathoro)</td>
<td>04/10/2016</td>
</tr>
<tr>
<td>E12 Medical Practice (Dr Kugapala)</td>
<td>24/10/2016</td>
</tr>
<tr>
<td>Dr Ruiz – St Lukes Medical Centre (Dr Ruiz)</td>
<td>25/10/2016</td>
</tr>
<tr>
<td>Cumberland Road Medical Practice (Dr Gonsai)</td>
<td>02/11/2016</td>
</tr>
<tr>
<td>East Ham Medical Centre</td>
<td>03/11/2016</td>
</tr>
<tr>
<td>Manor Park Medical Centre (Dr Dharwal)</td>
<td>03/11/2016</td>
</tr>
<tr>
<td>Sangam Surgery (Dr P Chandra)</td>
<td>10/11/2016</td>
</tr>
</tbody>
</table>
## CQC Ratings by specific service areas

<table>
<thead>
<tr>
<th>GP Practice</th>
<th>Date report published</th>
<th>Older people</th>
<th>People with long term conditions</th>
<th>Families, children and young people</th>
<th>Working age people (including those recently retired and people whose circumstances may make them vulnerable)</th>
<th>People experiencing poor mental health (including people with Requirement Notices)</th>
<th>Enforcement Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Glen Road Medical Centre (Dr Rao)</td>
<td>24/03/2016</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>0</td>
</tr>
<tr>
<td>Leytonstone Medical Practice (Dr Kohli)</td>
<td>06/05/2016</td>
<td>Requires Improvement</td>
<td>Good</td>
<td>Good</td>
<td>Requires Improvement</td>
<td>Requires Improvement</td>
<td>1</td>
</tr>
<tr>
<td>Upper Road Medical Centre (Dr Zakaria)</td>
<td>02/06/2016</td>
<td>Requires Improvement</td>
<td>Requires Improvement</td>
<td>Requires Improvement</td>
<td>Requires Improvement</td>
<td>Requires Improvement</td>
<td>1</td>
</tr>
<tr>
<td>Stratford Village Surgery (Dr Shah)</td>
<td>08/06/2016</td>
<td>Good</td>
<td>Requires Improvement</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>1</td>
</tr>
<tr>
<td>Latham Medical Centre (Dr Reena Patel)</td>
<td>15/06/2016</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>1</td>
</tr>
<tr>
<td>Royal Docks Medical Centre (Dr Lawrie)</td>
<td>15/06/2016</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>1</td>
</tr>
<tr>
<td>The Shrewsbury Surgery (Dr Sn Ganeshan)</td>
<td>30/06/2016</td>
<td>Requires Improvement</td>
<td>Requires Improvement</td>
<td>Requires Improvement</td>
<td>Requires Improvement</td>
<td>Requires Improvement</td>
<td>2</td>
</tr>
<tr>
<td>Lord Lister Health Centre (Dr Driver)</td>
<td>25/07/2016</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>0</td>
</tr>
<tr>
<td>Lord Lister Health Centre (Dr Swedan)</td>
<td>03/08/2016</td>
<td>Inadequate</td>
<td>Inadequate</td>
<td>Inadequate</td>
<td>Inadequate</td>
<td>Inadequate</td>
<td>2</td>
</tr>
<tr>
<td>Lord Lister Health Centre (Dr Abiola)</td>
<td>23/09/2016</td>
<td>Good</td>
<td>Requires Improvement</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>1</td>
</tr>
<tr>
<td>West Ham Medical Practice (Dr Bhowmik)</td>
<td>26/09/2016</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>0</td>
</tr>
<tr>
<td>St Bartholomew Surgery (Barking Road, Dr Patel)</td>
<td>28/09/2016</td>
<td>Requires Improvement</td>
<td>Requires Improvement</td>
<td>Requires Improvement</td>
<td>Requires Improvement</td>
<td>Requires Improvement</td>
<td>2</td>
</tr>
<tr>
<td>Essex Lodge (Dr Higgins)</td>
<td>28/09/2016</td>
<td>Requires Improvement</td>
<td>Requires Improvement</td>
<td>Requires Improvement</td>
<td>Requires Improvement</td>
<td>Requires Improvement</td>
<td>2</td>
</tr>
<tr>
<td>Esk Road Medical Practice (Dr Venugopal)</td>
<td>28/09/2016</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>0</td>
</tr>
<tr>
<td>Star Lane Medical Centre (Dr Fang)</td>
<td>28/09/2016</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>1</td>
</tr>
<tr>
<td>Tollgate Health Centre (Dr Watt)</td>
<td>28/09/2016</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>0</td>
</tr>
<tr>
<td>Greengate Medical Practice (Dr Kailoro)</td>
<td>04/10/2016</td>
<td>Requires Improvement</td>
<td>Requires Improvement</td>
<td>Requires Improvement</td>
<td>Requires Improvement</td>
<td>Requires Improvement</td>
<td>2</td>
</tr>
<tr>
<td>E12 Medical Practice (Dr Kugapala)</td>
<td>24/10/2016</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>0</td>
</tr>
<tr>
<td>Dr Ruiz – St Lukes Medical Centre (Dr Ruiz)</td>
<td>25/10/2016</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>0</td>
</tr>
<tr>
<td>Cumberland Road Medical Practice (Dr Gonsai)</td>
<td>02/11/2016</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>0</td>
</tr>
<tr>
<td>East Ham Medical Centre</td>
<td>03/11/2016</td>
<td>Inadequate</td>
<td>Inadequate</td>
<td>Inadequate</td>
<td>Inadequate</td>
<td>Inadequate</td>
<td>0</td>
</tr>
<tr>
<td>Manor Park Medical Centre (Dr Dharwal)</td>
<td>03/11/2016</td>
<td>Inadequate</td>
<td>Inadequate</td>
<td>Inadequate</td>
<td>Inadequate</td>
<td>Inadequate</td>
<td>0</td>
</tr>
<tr>
<td>Sangam Surgery (Dr P Chandra)</td>
<td>10/11/2016</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>0</td>
</tr>
</tbody>
</table>
Primary Care Commissioning Committee (PCCC)

30th November 2016

<table>
<thead>
<tr>
<th>Title:</th>
<th>Newham CCG - Practice Quality and Improvement Group (PQIG)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agenda item</td>
<td>8</td>
</tr>
</tbody>
</table>
| Author: | Saem Ahmed – Head of Quality  
Palak Joshi – Primary Care Commissioning Manager |
| Presented by: | Neil Hamer – Associate Director - Primary Care Commissioning |
| Contact for further information: | Neil Hamer – Associate Director of Primary Care  
Saem Ahmed – Head of Quality  
Palak Joshi – Primary Care Commissioning Manager |
| This Paper is for: | Decision |
| Action required: | The PCCC members are asked to consider the approach proposed:  
• To agree a step-by-step pathway for supporting the practices identified by the quality dashboard.  
• That the proposed next steps meet the expectations of the CCG PCCC Board and NHSE as co-commissioners. |
"Practice Quality and Improvement Group" (PQIG) consisting of the CCG primary care, CCG quality and NHSE (London) primary care teams. The purpose is to improve resilience and sustainability over the long term to apply preventative action sufficiently early on so that a reactive approach can be avoided by:

1) Following up on practices identified in the dashboard
2) Act on intelligence which might trigger an ‘immediate visit or action’ i.e. high risk situation that indicates an action
3) Initiate and review Practice improvement and development plans
4) Recommend a course of action to the PCCC.
5) Provide regular feedback on progress to PCCC

There are several bodies covering different areas related to activity and performance of GP practices. The main tool of the group will be the “practice improvement and development plan” which will triangulate the different data sources from NHSE, CCG’s primary care and Quality teams and other services such as NHS choices by using a single data tool (quality dashboard) to gain a holistic understanding of practice status.

This practice improvement and development plan will enable the group to work consistently with practices to agree an action plan.

Supporting papers:
- Development Session February 2016
- Previous presentation at the PCCC (November 2015)

How does this fit with Newham CCG Strategy:
- Values: Accountability and responsibility
- Aims: Reducing inequalities and improving quality of general practice provided to patients and residents of Newham.

Where has the paper been already presented?
- This paper follows on from earlier submissions made relating to the Quality dashboard made in November 2015
<table>
<thead>
<tr>
<th><strong>Risk:</strong></th>
<th>The key risk relates to the safe and effective care and treatment of patients if there is no improvement in the quality of care provided by the identified GP practices. There is a further risk more drastic action being taken by the CQC (as regulator), and referral of practitioners to the GMC if an effective process of improvement is not put into place.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Failure to improve quality of primary care with the recommendations of the report risks the practices not achieving NHS standards or meeting the obligations as a NHS contract holder. This potentially may result in increased oversight and assurance being required by the commissioners (NHSE &amp; Newham CCG).</td>
<td></td>
</tr>
<tr>
<td>At present, this risk is managed in house via close relationships between the practices, Primary Care team, NHSE London and the Quality team. As a level 3 commissioner with delegated responsibilities the CCG now feel this process requires formalisation with appropriate oversight.</td>
<td></td>
</tr>
<tr>
<td><strong>Equality Impact:</strong></td>
<td>As part of the development process an EIA will be conducted should there be any significant change from the existing approach to performance management.</td>
</tr>
<tr>
<td><strong>Stakeholder engagement:</strong></td>
<td>This report outlines the scope, which if approved, will be shared and discussed via engagement with CCG Board, cluster leads and practices, the LMC, the CCG Quality team and co-commissioners at the NHS as well as Healthwatch and PPG colleagues.</td>
</tr>
</tbody>
</table>
| **Financial Implications** | Poor performance if not dealt with in a timely effective manner leads to inefficiency, patient risk and threatens practice sustainability which can have a significant impact on funding where alternative providers or retrospective rectification of unresolved issues is required. In 2015/16 diverting patients from 2 failing practices and sourcing interim providers cost the CCG in excess of £500k.  
Where practices are identified for RCGP support following a CQC rating of Inadequate a potential commitment of £10k per practice exists and if training, financial or diagnostic support is required this will reach similar sums for each practice concerned. NCCG has in the region of 15 practices currently categorised as vulnerable  
The CCG has just received funding to support Vulnerable practices and under the GPFV monies for Resilience funding £TBC which will be used to support in delivering turn around packages of support to practices who need it most. |
1. Introduction and Background

1.1 In April 2015, NCCG took responsibility for the co-commissioning of primary medical services and to manage this accountability the CCG implemented new governance structures and recruited a dedicated Primary Care Team which now serves the population of Newham CCG.

This new responsibility brings new challenges for the CCG including the responsibility for issuing of breach and remedial notices to practices on performance issues, those not meeting contractual targets and those placed under “special measures” or assessed as requires improvement by the CQC. The CCG work closely with NHSE on practice closures, mergers, temporary closures, CQC remedial action plans and a range of performance issues. The CCG Primary Care team conduct regular quarterly practice support visits, review quality and practice performance dashboards to identify outliers and trends. There is a need for the CCG to have an established holistic governance process around practice support to ensure the CCG meets its legal requirements while simultaneously patient safety and quality of care is maintained.

At the PCCC Nov. 2015, establishment of “Practice Quality and Improvement Group” was requested and the group tasked with producing a process of response to concerns raised by the quality dashboard. This plan describes when, how and by whom action will be taken to improve practice performance based on the intelligence gathered. The action outcomes will form the basis of an Assurance Report provided to the PCCC. (see appendix 1)

**Figure 1**

The actions and improvements recommended by the PQIG will be reflected in the CCG spend on...
the Vulnerable practices and National GP Resilience Programme (GPRP) which supports General Practice in improving sustainability and resilience as part of GPFV; securing operational stability; developing more effective ways of working, and working towards future sustainability, including helping practices explore new care models. GPRP will provide support to primary care general practices over next four years through £40m CCG funding over the next 4 years. Newham CCG has received notification of its allocation of Resilience Programme funding of £170,000 covering the following GP Forward View initiatives: Vulnerable Practices programme, Practice Resilience Programme and Practice Development programme. These resources will be available for the CCG to support the identified practices.

<table>
<thead>
<tr>
<th>2</th>
<th>Responsibilities of Practice Quality and Improvement Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1</td>
<td>As agreed by the PCCC in November 2015, the Quality dashboard will be used as a benchmarking tool to help initial identification of practices potentially in need of support. Members of the Practice Quality and Improvement group have access to a wide range of data sources and soft intelligence. The CCG’s primary care dashboard combined with NHSE’s GP high-level indicators dashboard (covering finance, workforce and quality outcomes) along with the soft intelligence the CCG receives will provide the group with detailed understanding of quality and performance of a particular practice (see below figure 2).</td>
</tr>
</tbody>
</table>

Key responsibilities of the group include:

- Investigating further the practices identified by the “quality dashboard”. Direct reporting of issues relating to practice performance
- Review evidence / supporting materials / best practice
- Ensure arrangements are in place for practice visits to discuss and develop “practice improvement and development plans”, agree outcomes and actions with timelines
- Monitor performance improvements and practice actions.
- Identifying the need for practice support, the type of support and the appropriate partner to deliver the support
- Obtain advice from CCG’s finance team where required, for example additional funding for staffing, diagnostics, RCGP, efficiency improvement, leadership training.
- Report to the PCCC on monthly basis with update on practice improvements v plan.
- Agree recommendations made to the PCCC on actions the commissioner should take to address issues identified

(for detailed information on process flow see – Appendix 2)

<table>
<thead>
<tr>
<th>3</th>
<th>Process – Practice Quality and Improvement Group (PQIG)</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1</td>
<td>The PQIG will meet monthly and will:</td>
</tr>
<tr>
<td></td>
<td>• Ensure everyone who needs to be is informed relating to an issue identified is involved</td>
</tr>
<tr>
<td></td>
<td>• Potentially calling on the following to join the review team on request*:</td>
</tr>
<tr>
<td></td>
<td>• Medicines Management, Infection Control</td>
</tr>
<tr>
<td></td>
<td>• Medical Directorate, LMC , Public Health</td>
</tr>
<tr>
<td></td>
<td>• LBN, Clinical leads , CQC , NHSE, HR lead</td>
</tr>
</tbody>
</table>
PQIG must ensure all parties have the same understanding of issues
Provide continuity via the 4 stage process – Appendix 1
Provide a rolling monthly record to the PCCC of actions
Provide accountability in the form of a record showing the group has followed an agreed procedure, made appropriate decisions and providing a contemporaneous account should it be required for formal action.

PQIG will make recommendations
- on breach or remedial notices for approval to PCCC
- on actions relating to practice closures/mergers/ list dispersals for approval to PCCC.

The PQIG expect issues to fall into one of the following categories:
- Contractual issues with options as per Fig 2 leading ultimately to financial penalty or Breach
- Clinical practice, CQC, patient safety concerns
- Performance issues
- Health & Safety or Infection Control issues Workforce/ recruitment /partnership problems/skills or development need
- Financial management or cash flow management
- Practice efficiency problems/ Perfect Practice or QI requirements
- Patient engagement / complaints

See further detail in Figure 3

Below is a flow chart of GP contracts and course of action taken at each stage.
Below is an example of how the CCG will work with a practice identified by the quality dashboard. For the step-by-step process (see Appendix 1):

**Stage 1: Identify a practice**

1) Identify a practice for further review based on quality dashboard/risk matrix
2) PQIG undertake a desktop review of the information on the practice triangulating the quality dashboard, CCG’s primary care team and NHSE’s primary care team’s data reports and soft intelligence.
3) Group will look at other data sources including NHS Choices, GP patient survey, CQC history and ratings for a holistic approach.
4) Based on the outcome of desktop review the group will decide whether a practice requires a visit to determine if a “practice development and improvement plan” is required.

Stage 2 applies if practice “does not require an improvement and development plan” e.g. where the practice has struggled over a period of time to recruit permanent staff or there has been a leadership development requirement identified

**Stage 3: Requires “practice improvement and development plan”**

1) The group review the data and agree that following a practice visit that the practice requires improvement.
2) Group holds a practice improvement and development meeting with the practice. CCG primary care team will facilitate this meeting. (potential templates to be developed for scenarios/root cause analysis)
3) Investigation will follow a process to analyse causal factors for the issues identified but will also be expected to probe for other non-immediately identifiable problems
4) The plan will have SMART objectives and milestones, clear timelines and outcome measures and evidence of achievement clearly defined when assessing completion.

**Stage 2: No “practice improvement and development plan” required**

1) Depending on the practice performance and outcomes triangulation and desktop review, the group decide there are other factors causing the practice to appear as an outlier which either need no further action (earlier circumstances which are a legacy and the practice is working their way out of them) or issues which can be rectified through other means such as a leadership development programme or extra phone lines or physical space for clinical delivery
2) Group may agree ‘no improvement required’ and put the practice under surveillance for 3 months.
3) At the end of 3 months surveillance, the group re-look at practice performance. Practice will be removed from the list if there are no further issues identified and practice has made sufficient progress against issues initially identified in the first report.
4) If at the end of three months there are any further issues identified or the practice fails to make sufficient improvement (from the 1st report) then the practice will move to “Stage 3”.
5) During the discussions it may emerge that further diagnostics are required or a specific development plan required e.g. a QI development to deliver efficiency improvement or a Practice Manager skills Dev. Programme to rectify shortcomings.

6) At the meeting a clear exit strategy will be developed for any support package and the consequence of any failure to act on a development plan will be made clear.

7) Practice will be given a period of 3 months to work on the plan unless a specific time is established for a programme e.g. Admin staff training on rotation over 6 months.

8) The Primary Care team will monitor progress v plan and improvements made. Practices will be able to discuss other non-immediately identified issues and seek external support.

9) A review meeting after 3 months will be arranged at the time when the plan is agreed.

10) If the practice achieves v the improvement and development plan and can evidence resolution of the problems that the improvements are made then no further actions will be taken. The Practice will remain under surveillance for a further 3m to ensure it’s on course for recovery to a satisfactory position.

   - If at the review meeting the group identifies that the practice has not managed to achieve against the practice improvement and development plan or shows no progress, depending on one of the following, the group will escalate this to the PCCC with recommendations. (see Appendix 1)

   - The Risk rating/urgency of the problem
   - How long the problem has existed, is it a cumulative issue
   - Whether the practice recognises the severity of the issue
   - Whether the practice will engage in putting it right.

The PQIG will identify any actions which cannot wait for the next PCCC and seek Chairs action where appropriate. Where patient safety issues and an immediate action needs taking the approval of the CO or DCO would be sought in the event that the Chair of the PCCC is unavailable.

Below are some of the examples based on historical review:

<table>
<thead>
<tr>
<th>At organisation level</th>
<th>At individual level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Workforce / capacity issues</td>
<td>Clinical issues (i.e. numbers of unrecorded SUIs)</td>
</tr>
<tr>
<td>Clinical issues (i.e. out of date drugs)</td>
<td>Access to a specific GP</td>
</tr>
<tr>
<td>Management issues, Failure to adhere or implement procedure</td>
<td></td>
</tr>
<tr>
<td>Policies and Procedures (i.e safe handling of clinical waste policy)</td>
<td>CQC registration issues</td>
</tr>
<tr>
<td>Infection control (i.e. maintenance of cold chain)</td>
<td>Performance issue</td>
</tr>
<tr>
<td>Premises</td>
<td>Patient safety</td>
</tr>
<tr>
<td>CQC related</td>
<td>CQC related</td>
</tr>
<tr>
<td>Patient complaints</td>
<td>Patient complaints</td>
</tr>
</tbody>
</table>
4.0 Next steps

4.1 The board is asked to

- Comment on and approve the process and governance for the PQIG
- Approve the establishment of the group and the development of a proposal as to membership and ToR
- Keep the PCCC informed of any relevant national changes to policies and procedures
- The group will present a regular review and outcome report to the PCCC as part of the assurance process. Initially monthly
- Lessons learnt and best practice will be shared via cluster meetings, practice council and various other CCG forums.

Appendix 1

1. Process

In order to identify a practice for further review, we will use following risk scoring mechanism.

<table>
<thead>
<tr>
<th>Risk</th>
<th>Triggers</th>
<th>Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>High Risk</td>
<td>• Outliers in safety indicators</td>
<td>• Triggers in OF Domain 1 (Premature Mortality)</td>
</tr>
<tr>
<td></td>
<td>• Soft intelligence</td>
<td>• Triggers in OF Domain 5 (Patient safety)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Consider effectiveness indicators</td>
</tr>
<tr>
<td>Medium Risks</td>
<td>• Outliers in well-led indicators</td>
<td>• CQC indicators</td>
</tr>
<tr>
<td></td>
<td>• Outliers in effectiveness indicators</td>
<td>• Triggers in OF Domain 2 (Long Term Conditions)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Triggers in OF Domain 3 (Recovery from</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| Stage 1 | 1. Identify practices for further review based on the quality dashboard using the Risk Matrix above.  
2. Undertake a desktop review based on all intelligence available to understand the quality of the general practice.  
3. Based on the data and intelligence decide on whether further improvement work is required. |
| Stage 2 | 4. If further improvement is not required, the practice will be put under surveillance for 3 months.  
5. If the group decide the practice does require improvement, a Quality Improvement Visit will be undertaken.  
6. Based on the Quality Improvement Visit and the data and intelligence a development plan will be developed with the practice.  
7. The practice will be responsible for delivering against the development plan support will be available (refer to section 2). |
| Stage 3 | 8. If Quality Improvement Group is assured that improvements have been made there will be no further action, and the practice will return to the cycle.  
9. If the Quality Improvement Group is not assured, this will be escalated to the PCCC for further action. |
| Stage 4 | 10. If there is no improvement various escalation process available as described below. |
Practice Quality Improvement Group identify practice for review

Practice Quality Improvement Group undertakes a desktop review of practice triangulating the Quality Dashboard, Primary Care Team and NHS England

Improvement required?

Yes

Undertake a Quality Improvement Visit

Practice and Practice Quality Improvement Group develop an improvement development plan

General practice delivers against the improvement development plan supported by support programmes available, a re-visit is undertaken to monitor progress against development plan.

Improvement made?

Yes

No further action required

Immediate actions taken on High Risk

Practice Quality Improvement Group makes recommendation to PCCC

No

Practice under surveillance for 3 months

Issues identified

Yes

No

STAGE 4 – 5 options available for action at this stage (refer to section 5 escalation options available)

Support through:
- Building General Practice Resilience
- The General Practice Development Programme
- Perfect Practice Programme
- Quality Improvement Academy
2. **Quality Improvement Visit**

The Quality Improvement Visit will be undertaken by a multi-disciplinary team and will include the following:

- Clinical Member
- CCG Quality and Development Team Member
- CCG Primary Care Commissioning Team Member
- NHS England Representative
- Subject Matter Experts (as required)

3. **Support available for practices**

The support offered to practices around development will be embedded with programmes currently available for practices in the General Practice Forward View, such as:

- Building General Practice Resilience
- The General Practice Development Programme
- Perfect Practice Programme
- Quality Improvement Academy

4. **Governance & Membership**

![Diagram of governance and membership structure]

**Primary Care Commissioning Committee**

- Primary Care Commissioning Committee will be a point of escalation. Decision for further action and approval will be the responsibility of this committee.
- This committee will be required to at Stage 3 of the process.
Quality Committee
• The Quality Committee has responsibility to assure the Board of the quality of services delivered to the population of Newham, and therefore will be seeking assurances from the Primary Care Commissioning Committee.

Practice Quality Improvement Group
Responsibility
• This group will be responsible to undertake the activity described in Stage 1 and Stage 2 of the process.
• The aim of this group is to identify practices that trigger a review, undertake the review and recommend next steps.

Membership
• This group will consist of core membership and other subject matter experts as members as and when required.
• The group will be chaired by a clinical lead, or a deputy chair.

<table>
<thead>
<tr>
<th>Core Membership</th>
<th>Subject Matter Experts</th>
</tr>
</thead>
<tbody>
<tr>
<td>• NHSE representative</td>
<td>• CCG Medicine Management Team</td>
</tr>
<tr>
<td>• CCG Quality and Development Team member</td>
<td>• CCG Long Term Conditions Team</td>
</tr>
<tr>
<td>• CCG Primary Care Commissioning Team members</td>
<td>• CCG Patient and Public Engagement Team</td>
</tr>
<tr>
<td>• NHS England representatives</td>
<td>• NHSE subject matter experts</td>
</tr>
<tr>
<td>• Senior representative from CCG Primary Care Commissioning and Quality and Development Teams as required (Deputy Chairs)</td>
<td>• LMC</td>
</tr>
<tr>
<td>• Clinical representative (Chair)</td>
<td>• Care Quality Commission</td>
</tr>
<tr>
<td>• CCG Medicine Management Team</td>
<td>• Healthwatch</td>
</tr>
<tr>
<td>• CCG Long Term Conditions Team</td>
<td>• Safeguarding</td>
</tr>
<tr>
<td>• CCG Patient and Public Engagement Team</td>
<td>• Any other subject matter experts</td>
</tr>
<tr>
<td>• NHSE representative</td>
<td></td>
</tr>
<tr>
<td>• CCG Quality and Development Team member</td>
<td></td>
</tr>
<tr>
<td>• CCG Primary Care Commissioning Team members</td>
<td></td>
</tr>
<tr>
<td>• NHS England representatives</td>
<td></td>
</tr>
<tr>
<td>• Senior representative from CCG Primary Care Commissioning and Quality and Development Teams as required (Deputy Chairs)</td>
<td></td>
</tr>
<tr>
<td>• Clinical representative (Chair)</td>
<td></td>
</tr>
<tr>
<td>• CCG Medicine Management Team</td>
<td></td>
</tr>
<tr>
<td>• CCG Long Term Conditions Team</td>
<td></td>
</tr>
<tr>
<td>• CCG Patient and Public Engagement Team</td>
<td></td>
</tr>
<tr>
<td>• NHSE subject matter experts</td>
<td></td>
</tr>
<tr>
<td>• LMC</td>
<td></td>
</tr>
<tr>
<td>• Care Quality Commission</td>
<td></td>
</tr>
<tr>
<td>• Healthwatch</td>
<td></td>
</tr>
<tr>
<td>• Safeguarding</td>
<td></td>
</tr>
<tr>
<td>• Any other subject matter experts</td>
<td></td>
</tr>
</tbody>
</table>

5. Escalation options
At Stage 4, the escalation stage there is 5 options for the CCG and/or the Primary Care Commissioning to consider which are set out in the table below.

<table>
<thead>
<tr>
<th>Option</th>
<th>Action</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Intensive support</td>
<td>The PCCC may consider a support team to work with the practice for a specific period for quality improvement. This team could be a multi-disciplinary team including CCG, NHSE, RCGP or external support as appropriate.</td>
</tr>
<tr>
<td>2</td>
<td>Alternative support plans</td>
<td>Practice can be supported through potential mergers / co-location/ succession planning or inclusion of new partner to drive the quality improvement.</td>
</tr>
<tr>
<td>3</td>
<td>Contract breaches &amp; Remedial notices</td>
<td>The contract regulations make a clear distinction between breaches that are capable of remedy and those that are not.</td>
</tr>
</tbody>
</table>
Breaches may occur as a result of actual failure to deliver the contract in relation to mandatory or locally agreed clauses, behaviour that gives cause for concern, which may (or may not) lead to a failure to deliver a contract, and which might include professional misconduct, inappropriate clinical behaviour or fraud.

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>4</strong></td>
<td><strong>Referral to the NCAS/Medical Directorate/GMC/CQC</strong></td>
</tr>
<tr>
<td></td>
<td>if there are serious patient safety concerns, clinical issues for example SUIs, infection control breach, PCCC will advise NHSE to refer the practice / contract holder / GP to one of these committees. This may result in practice put under temporary measures.</td>
</tr>
<tr>
<td><strong>5</strong></td>
<td><strong>A termination of contract or agreement</strong></td>
</tr>
<tr>
<td></td>
<td>Termination is a very significant action to take both on the part of commissioners and on the part of the contractor and is an area of high risk for both parties in respect of financial impact and continuity of services. It is, therefore, essential that the PCCC via CCG &amp; NHSE maintain thorough and accurate records of all communications and discussions in respect of all notices under this policy and have, where appropriate, followed all other possible contractual routes to resolve the matter. The termination can be temporary or permanent.</td>
</tr>
</tbody>
</table>
Appendix 2

Data Sources:

1. **Newham CCG Quality and Development Team** - The CCG Quality dashboard indicates rating the CCG may wish to investigate or review further in order to understand the performance and quality of a practice, it does not suggest that a practice is not performing or is clinically unsafe.
   - **Quality dashboard indicators** - Each indicator is aligned to a domain of quality, the 46 indicators should be used as triggers to review, deep dive or investigate an area or domain of quality.

2. **Newham CCG Primary Care Commissioning Team** - The Primary Care Team use a range of templates at quarterly practice support visits.
   - **Practice Profile** – This provides in depth information of a practice. Performance for clinical domains is benchmark against cluster, CCG and where available WEL and national averages. The practice profile covers range of dataset from practice workforce information to practice population and age distribution of the practice and any other intelligence known to the Primary Care Team
   - **Practice Action Plan** – Practices on quarterly basis submit action plans to the CCG following their practice support visit.
   - **EPCS and LIS dashboards** – Practices receive quarterly update at cluster meetings and in form of a dashboards on activity and performance against all EPCS and LIS clinical and non-clinical indicators. Practices not achieving or struggling to achieve are visited by the primary care team.

3. **NHS England Primary Care Team** - NHSE Intelligence Monitoring tool provides a fuller all-encompassing Development Framework for a Practice. This data includes NHS choices patient rating, GP patient survey and other NHS indicators.

Combined Recommendations and Actions Log – Timeline for review

Example of Practice Development Plan
Appendix 3

GP Practice Improvement & Development Plan

<table>
<thead>
<tr>
<th>Practice Name:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Practice Code:</td>
<td></td>
</tr>
<tr>
<td>Name of practice GP Lead:</td>
<td></td>
</tr>
<tr>
<td>Date submitted:</td>
<td></td>
</tr>
</tbody>
</table>

The practice retains ownership of the document. The practice improvement and development plan will be used as a measurement / achievement tool against actions identified at the meeting with practice staff.

All sections should be completed, please use “not applicable” where appropriate
<table>
<thead>
<tr>
<th>Services</th>
<th>Priority</th>
<th>Issues (examples)</th>
<th>Aims and objectives (examples)</th>
<th>How will this be done?</th>
<th>Named Lead</th>
<th>Time Scale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access &amp; Patient Engagement</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Access</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient Engagement</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Practice Developments</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>e.g. New clinical services</td>
<td></td>
<td>National Clinical priorities</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Teaching and training</td>
<td></td>
<td>Local priorities</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Collaborative arrangements (cluster or federation)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical performance issues (i.e. missed diagnosis, SUIs not recorded)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical Domains</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>--------------------------------------</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Planned Care:- Referral management and care pathways</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unplanned care</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Workforce</th>
</tr>
</thead>
<tbody>
<tr>
<td>Issue</td>
</tr>
<tr>
<td>-----------</td>
</tr>
<tr>
<td>IT &amp; Estate</td>
</tr>
<tr>
<td>Issue</td>
</tr>
</tbody>
</table>

| GP performance issues | |

| Why? | What will be done? | How will this be done? | Named Lead | Time Scale |

| Why? | What will be done? | How will this be done? | Named Lead | Time Scale |

| Why? | What will be done? | How will this be done? | Named Lead | Time Scale |
**Primary Care Commissioning Committee (PCCC)**

**30\(^\text{th}\) November 2016**

<table>
<thead>
<tr>
<th>Title:</th>
<th>Primary Care Medical Finance Report – Month 7 Update on 2016/17 Budget</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agenda item</td>
<td>9</td>
</tr>
<tr>
<td>Author:</td>
<td>Chad Whitton, Chief Finance Officer Newham CCG</td>
</tr>
<tr>
<td>Presented by:</td>
<td>Chad Whitton, Chief Finance Officer Newham CCG</td>
</tr>
</tbody>
</table>
| Contact for further information: | Chad Whitton, Chief Finance Officer Newham CCG  
Chad.Whitton@newhamccg.nhs.uk  
0203 688 2328  
Lei Wei, Deputy Chief Finance Officer Newham CCG  
Lei.Wei@newhamccg.nhs.uk  
0203 688 2334 |
| This Paper is for: | Monitor |
| Action required: | The Primary Care Commissioning Committee are asked to  
• Note the summary Primary Care allocation and projected spend (Appendix 1)  
• Note the risk and innovation reserve (Annex A) |
| Executive summary: | The CCG identified the 5 year allocations in the May report.  

It has received indicative allocations at a practice level and these are in the ledger.  

A Primary Care risk and innovation reserve of £2m was established by the CCG. All additional primary care funding in 2016/17 must be contained within this cash envelope. The reserve is reported monthly and a formal quarterly risk assessment is presented to the PCCC to ensure risk is appropriately monitored.  

The 2016/17 delegated budget is currently forecasting a breakeven position. |
| Supporting papers: | Appendix 1 – Primary Care Delegated Budgets – Updated Position  
Annex A – Primary Care Risk and Innovation Reserve |
<table>
<thead>
<tr>
<th><strong>How does this fit with Newham CCG Strategy:</strong></th>
<th>Accountability and Responsibility - Requirement to meet target surplus.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Where has the paper been already presented?</strong></td>
<td>N/a</td>
</tr>
<tr>
<td><strong>Risk:</strong></td>
<td>The Primary Care delegated budget financial plan as identified in the CCG Finance and Activity Plan is an essential component in identifying and managing financial risk and ensuring the CCG delivers its financial requirements.</td>
</tr>
<tr>
<td><strong>Equality Impact:</strong></td>
<td>Effective delivery of the financial plan will support the CCG in achieving its duty to reduce inequality of health provision and outcomes for the residents of Newham.</td>
</tr>
<tr>
<td><strong>Stakeholder engagement:</strong></td>
<td>This report has been subject to no specific prior consultation but reflects any comments from NHSE assurance processes and any comments, queries or suggestions raised by CCG members in relation to earlier reports.</td>
</tr>
<tr>
<td><strong>Integrated Care Impact</strong></td>
<td>Effective financial planning, monitoring and control delivering value for money enables effective targeting of resources to support delivery and continuous improvement of high quality services for patients.</td>
</tr>
<tr>
<td><strong>Financial Implications</strong></td>
<td>The report provides a high level view of the CCG’s Primary Care Medical financial performance at Month 7 2016/17</td>
</tr>
</tbody>
</table>
Primary Care Delegated Budgets – Updated Position – 30th November 2016

**Expenditure**
The month 7 year to date position for delegated co-commissioning was £33.4k and is currently maintaining a forecast of a breakeven position. The expenditure year to date has been adjusted to reflect the changes of lease and rent agreements received by NHSE within October.

Table 1

<table>
<thead>
<tr>
<th>Practice Type</th>
<th>Annual Budget</th>
<th>YTD Budget</th>
<th>YTD Actual</th>
<th>YTD Variance Over/(Under)</th>
</tr>
</thead>
<tbody>
<tr>
<td>APMS</td>
<td>7,105,216</td>
<td>4,144,467</td>
<td>4,095,752</td>
<td>(48,715)</td>
</tr>
<tr>
<td>GMS</td>
<td>10,052,957</td>
<td>5,863,597</td>
<td>5,839,249</td>
<td>(24,348)</td>
</tr>
<tr>
<td>PMS</td>
<td>33,159,572</td>
<td>19,342,165</td>
<td>19,295,789</td>
<td>(46,376)</td>
</tr>
<tr>
<td></td>
<td>50,317,745</td>
<td>29,350,229</td>
<td>29,230,790</td>
<td>(119,439)</td>
</tr>
<tr>
<td>Net Savings Requirement</td>
<td>(62,745)</td>
<td>(137,231)</td>
<td>15,563</td>
<td>152,794</td>
</tr>
<tr>
<td></td>
<td>50,255,000</td>
<td>29,212,998</td>
<td>29,246,353</td>
<td>33,355</td>
</tr>
</tbody>
</table>

Included in the month 7 position is a non-recurrent benefit relating to the premises revaluation provision; held locally.

**Risk and Reserves**
At this point the CCG is holding a Risk and Innovation reserve of £2m for primary care. Details of the identified risk and proposed innovation commitments are attached as Annex A.
From the initial £2m reserve identified in April, £1.32m was committed to Innovation Schemes, of which £0.35m relates to schemes that remain unconfirmed. In addition £0.68m of the initial risk reserve has been committed to schemes to reduce clinical risk. It is understood that financial support maybe required by practices going through transitional periods (i.e. cessation of caretaking contracts / new contract holders commencing). Discussions relating to practices going through transition are ongoing and the Risk Reserve listing will be updated accordingly.

Newham CCG has been aware by NHSE of a possible pressure relating to prior year activity that is yet to be claimed by practices. Work is ongoing to determine the full potential exposure of these additional claims. An update will be provided in the month 8 briefing when work has been completed.

**Conclusion**
This report updates PCCC members on the financial position based on Month 7 data. Currently spend is expected to break-even against the allocation. The report also lists the risk and innovation reserves in Appendix A. The CCG will need to continue to seek to put effective measures in place to control spend in primary care budgets and maximise the funding available for initiatives that reflect the CCG and TST priorities.
Primary Care Reserves Analysis

The CCG has established a Primary Care Risk and Innovation Reserve from which all Primary Care risks and innovation not met within the delegated budget, EPCS contracts or other contracts rolled over from 2015/16 must be met. Reserves will be utilised over the year with monthly transfers to budget lines.

<table>
<thead>
<tr>
<th>Newham Primary Care Reserve</th>
<th>Indicative</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>Total</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£</td>
<td>£</td>
<td>£</td>
<td>£</td>
<td>£</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Primary Care Risk Reserve Application</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Current additional spend (Managed practices)</td>
<td>657,627</td>
<td>0</td>
<td>0</td>
<td>117,000</td>
<td>0</td>
<td>117,000</td>
<td>EMC, NMC, DMC and Sinha (estimate)</td>
</tr>
<tr>
<td>Likely additional spend</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>60,000</td>
<td>60,000</td>
<td>120,000</td>
<td>Assumes 1 practice per quarter (6 Month input)</td>
</tr>
<tr>
<td>Impact over/understatement of uplift</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>Currently anticipated to balance</td>
</tr>
<tr>
<td>Addnl prem devel/estate costs</td>
<td>0</td>
<td>tbd</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Addnl CQC costs</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>For additional support - No current provision</td>
</tr>
<tr>
<td>PMS Review</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>To be determined as discussions develop</td>
</tr>
<tr>
<td>Potential costs of GP Forward View</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Projected Current Risk Support</strong></td>
<td>657,627</td>
<td>0</td>
<td>0</td>
<td>177,000</td>
<td>60,000</td>
<td>237,000</td>
<td>Currently assumed all funded from CCG or STF</td>
</tr>
<tr>
<td>Vulnerable practice reviews</td>
<td>15,000</td>
<td>0</td>
<td>15,000</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acute medicines management services</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>13,250</td>
<td>32,750</td>
<td>46,000</td>
<td>Committed for Acute Medicine Management Service from CSU</td>
</tr>
<tr>
<td>Phlebotomy service</td>
<td>0</td>
<td>0</td>
<td>26,000</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Practice Nurse Facilitator support</td>
<td>0</td>
<td>0</td>
<td>4,000</td>
<td>4,000</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Risk reserve balance</td>
<td>7,373</td>
<td>0</td>
<td>107,000</td>
<td>182,000</td>
<td>289,000</td>
<td>Not committed at present</td>
<td></td>
</tr>
<tr>
<td><strong>Primary Care Reserve</strong></td>
<td>680,000</td>
<td>0</td>
<td>0</td>
<td>342,250</td>
<td>274,750</td>
<td>617,000</td>
<td></td>
</tr>
</tbody>
</table>

**Primary Care Innovation**

<table>
<thead>
<tr>
<th></th>
<th>£</th>
<th>£</th>
<th>£</th>
<th>£</th>
<th>£</th>
<th>£</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHSE GP development programme</td>
<td>0</td>
<td>33,000</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>33,000 NHSE ringfenced funding - reception and clerical training</td>
</tr>
<tr>
<td>ETTF (draft small scale local approvals)</td>
<td>170,000</td>
<td>0</td>
<td>100,000</td>
<td></td>
<td></td>
<td></td>
<td>100,000 Local small developments.</td>
</tr>
<tr>
<td>GP federation additional support</td>
<td>500,000</td>
<td>0</td>
<td>100,000</td>
<td>100,000</td>
<td>200,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Additional Appts Scheme</td>
<td>300,000</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>300,000</td>
<td>Agreed to September- New scheme to be reviewed</td>
</tr>
<tr>
<td>Addnl Capacity support</td>
<td>250,000</td>
<td>250,000</td>
<td>250,000</td>
<td></td>
<td></td>
<td></td>
<td>To be confirmed</td>
</tr>
<tr>
<td>GMS Equalisation</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>To be confirmed</td>
</tr>
<tr>
<td>Quality Initiatives (UCLP)</td>
<td>50,000</td>
<td>20,000</td>
<td>30,000</td>
<td></td>
<td></td>
<td></td>
<td>50,000 Under discussion</td>
</tr>
<tr>
<td>Workforce initiative development</td>
<td>50,000</td>
<td>20,000</td>
<td>30,000</td>
<td>50,000</td>
<td></td>
<td></td>
<td>50,000 Under discussion</td>
</tr>
<tr>
<td>Pontoon Dock support</td>
<td>15,000</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Support AFO Initiatives</td>
<td>50,000</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

**Sub-Total - Non-delegated**

<table>
<thead>
<tr>
<th></th>
<th>£</th>
<th>£</th>
<th>£</th>
<th>£</th>
<th>£</th>
<th>£</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1,320,000</td>
<td>0</td>
<td>0</td>
<td>305,000</td>
<td>443,000</td>
<td>748,000</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Total**

<table>
<thead>
<tr>
<th></th>
<th>£</th>
<th>£</th>
<th>£</th>
<th>£</th>
<th>£</th>
<th>£</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>2,000,000</td>
<td>0</td>
<td>0</td>
<td>647,250</td>
<td>717,750</td>
<td>1,365,000</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Availability**

<table>
<thead>
<tr>
<th></th>
<th>£</th>
<th>£</th>
<th>£</th>
<th>£</th>
<th>£</th>
<th>£</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1,360,000</td>
<td>0</td>
<td>0</td>
<td>623,000</td>
<td>742,000</td>
<td>1,365,000</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

In Month 7 the CCG released £144K in relation to additional spend reducing the overall reserves to £1.365 million. This is in line with planned release of reserves.
Standing Notes:
Where reserves for specific items are deemed to be no longer required initially they will be transferred to contingency within the overall Primary Care Reserve. The CCG financial position requires all unapplied reserves to be held pending development of measures currently in place to guarantee financial balance. However, until the end of Quarter 3 any unallocated reserves will remain held in the Primary Care Reserve schedule and may be used as a first call on any unavoidable costs that may yet emerge in Primary Care. A decision on any transfer out of Primary Care will be made in the new calendar year as part of a report to the Board following consultation with the Primary Care Committee. However, it should be noted that all available contingency has already been applied to emerging primary care commitments.

Additional funding is due to be received from the successful bid for Access funding and to support practice resilience. Details of the funding will be reported when received and will initially held in reserves pending roll-out of the initiative.

The reserve will be updated on a monthly basis with a formal quarterly review that will be shared with the Chair of the PCCC and the CCG Executive Committee.
Primary Care Commissioning Committee (PCCC)

30 November 2016

<table>
<thead>
<tr>
<th>Title:</th>
<th>Primary Care Risk Register</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agenda item</td>
<td>10</td>
</tr>
<tr>
<td>Author:</td>
<td>Joseph Lee, Newham CCG, Primary Care Commissioning Manager</td>
</tr>
<tr>
<td>Presented by:</td>
<td>Neil Hamer, Assistant Director of Primary Care NCCG</td>
</tr>
<tr>
<td>This Paper is for:</td>
<td>Monitor</td>
</tr>
<tr>
<td>Action required:</td>
<td>Note the report</td>
</tr>
<tr>
<td>Executive summary:</td>
<td>Newham CCG is a level 3 delegated commissioner and as part of the governance and oversight within the Primary Care Commissioning Committee, the Primary Care Team have produced a risk register to identify key risks and mitigating actions associated with the CCG’s delegated functions of commissioning primary care services.</td>
</tr>
</tbody>
</table>
| Supporting papers: | • Appendix A – Primary Care Risk Register  
                          • Appendix B – Primary Care Risk Register Summary  
                          • Appendix C – Primary Care Risk Register Trend Summary |
| How does this fit with Newham CCG Strategy: | Explain which single value and single aim the report best fits – delete others as appropriate.  

**Values:**  
Effective & collaborative communication  
Transparency with our decision-making and leadership  
Accountability and responsibility  

**Aims:**  
Improving health outcomes through developing models of integrated care and focusing on prevention  
Reducing inequalities and improving accessibility  
Reducing quality variation  
Ensuring equity of Health and Wellbeing outcomes |
<p>| Where has the paper been already presented? | Previous version of the risk register has been submitted to Primary Care Commissioning Committees |</p>
<table>
<thead>
<tr>
<th><strong>Risk:</strong></th>
<th>Failure to comply with the recommendations of the report risks</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Equality Impact:</strong></td>
<td>There are no identified equality issues associated with this paper and therefore no equality impact conducted.</td>
</tr>
<tr>
<td><strong>Stakeholder engagement:</strong></td>
<td>There has been no engagement regarding the current risks within primary care, however other CCG colleagues, such as finance, provide information which contributes to the assessment if the current risks.</td>
</tr>
<tr>
<td><strong>Financial Implications</strong></td>
<td>There are no financial implications associated with this report other than those identified within the specific risks and actions.</td>
</tr>
</tbody>
</table>
1. Introduction and Background

1.1 Primary Care Risk Register

1.1.1 Risk management is the recognition and effective management of all threats and opportunities that may have an impact on NHS England’s reputation, its ability to deliver its statutory responsibilities and the achievement of its objectives and values.

1.1.2 Newham CCG became a Level 3, fully delegated, commissioner on 1 April 2015 and took on the responsibility of commissioning GP services for the residents of Newham.

1.1.3 As part of these functions and in line with transparency of decision making and to ensure that the Primary Care Commissioning Committee has overall accountability and responsibility of the decisions taken with these delegated functions, a primary care risk register has been developed to highlight the current status of risks identified along with the current proposed mitigating actions.

2. Risk Summary Updates

2.1 Updates of note

PCCC.04, 05, 09

Risk Register Update

PCCC.02 – Financial impact of month 12 14/15 primary care finances not yet agreed. There is a risk that the liability the CCG may have against this unknown amount may create financial difficulties if NHS England has not accrued sufficient for this. May also have an impact on QIPP and future budget projections.

Update

There has been no update since the last report

2.2 PCCC.03 - Failure to deliver against 0.97% of annual CCG QIPP target. £1.19m for Newham, including Primary Care list size (PC), Minor ailments transfer to NHS E (PC) and prescribing (Quality). Failure to meet this would impact on the budget for 16/17. It should be noted that this QIPP targets are not within the control of primary care and prescribing is currently within the quality directorate.

Update

There has been no update since the last report

2.3 PCCC.04 - There is a risk that performance actions by the CCG under the new commissioning arrangements may impact on the relationship of the CCG with its member practices. Due to the CCG taking on the performance management of practices we need to emphasise the work being implemented to help develop practice support to foster and improve relationships with GPs as a way of maintaining relationships and improving quality for patients.

Update

There has been no update since the last report - The primary care team continue to engage with practices and are about to review the practice visit process to ensure maximum benefits are realised for practices.

2.4 PCCC.05 - Failure to develop Practice Federation may lead to lack of development around new models of care and commissioning across the CCG. A strong federation bidding for cross cluster contracts will assist with population health management and equity of services across
| 2.4.1 | the CCG. Some services tendered in future will not be possible to commission at practice level and therefore a developed federation will be key to delivery of the CCGs plans |
| **Update** | There has been no update since the last report - HC are in the process of appointing a permanent CEO although the lack of back office functions does remain a concern |

| 2.5 | PCCC.06 - Failure to deliver increased appointment availability will put an increased burden on existing GP provision and may impact on the quality of services such as QOF, LTC, and EPCCS. This may also lead to poor patient satisfaction and not allow the CCG to deliver the elements within STP which require transfer of services to primary care. This may also lead to increased A&E attendance which will have a financial impact. |
| **Update** | There has been no update since the last report - the discussion are ongoing regarding this service and the planned pilot for 8-8 services |

| 2.6 | PCCC.07 - Failure to ensure the provision of sufficient resources to deliver the CCGs Primary Care Strategy will impact on the increasing patient population. A lack of resources (infrastructure, estates and workforce) will impact on the quality of care and ability to deliver expected outcomes in line with national and local programmes. |
| **Update** | There has been no update since the last report |

| 2.7 | PCCC.08 - Failure to maintain a strategic approach to delivering the primary care strategy. PCCC members may become too focused on detail and not the strategic focus of the strategy. Primary care team may not have the capacity or capability to deliver the requirements along BAU |
| **Update** | There has been no update since the last report - the CCG continues to work in collaboration with WEL colleagues to ensure an STP approach to major commissioning decisions |

| 2.8 | PCCC.09 - Failure to agree equalisation process for GP contracts (including PMS renegotiations) will continue the inequity of funding for GP contracts and could result in more radical implications for current PMS practices if a new national contract is introduced. Failure to equalise the offer may also lead to continued inequity of offer and quality for patients. |
| **Update** | No change since last report - The negations have been passed back to CCGs for local determination - Newham is working with WEL colleagues to try and unify the approach and where possible the PMS offer |
Appendix A – Primary Care Risk Register

PCCCTemplate Risk Register November.xlsx
## Risk Scoring Matrix

### Likelihood

<table>
<thead>
<tr>
<th>Impact</th>
<th>Rare (1)</th>
<th>Unlikely (2)</th>
<th>Possible (3)</th>
<th>Likely (4)</th>
<th>Certain (5)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Severe (5)</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Major (4)</td>
<td></td>
<td></td>
<td></td>
<td>PCCC.03, PCCC.04, PCCC.06,</td>
<td>PCCC.09</td>
</tr>
<tr>
<td>Moderate (3)</td>
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<td></td>
<td>PCCC.05</td>
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<tr>
<td>Minor (2)</td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>Insignificant (1)</td>
<td></td>
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</table>
### Appendix C – Primary Care Risk Register Trend Summary

<table>
<thead>
<tr>
<th>Risk</th>
<th>Risk Summary</th>
<th>Previous Score</th>
<th>Current Score</th>
<th>Trend</th>
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<tbody>
<tr>
<td>PCCC.02</td>
<td>Financial impact on 14/15 finances</td>
<td>6</td>
<td>6</td>
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<tr>
<td>PCCC.03</td>
<td>Failure to deliver on QIPP</td>
<td>12</td>
<td>12</td>
<td>▲</td>
</tr>
<tr>
<td>PCCC.04</td>
<td>Impact of performance actions by CCG on relationships with practices</td>
<td>12</td>
<td>12</td>
<td>▲</td>
</tr>
<tr>
<td>PCCC.05</td>
<td>Failure to sufficiently develop the practice federation</td>
<td>3</td>
<td>3</td>
<td>▲</td>
</tr>
<tr>
<td>PCCC.06</td>
<td>Failure to deliver increased appointment access</td>
<td>12</td>
<td>12</td>
<td>▲</td>
</tr>
<tr>
<td>PCCC.07</td>
<td>Failure to ensure sufficient provision to deliver strategy</td>
<td>12</td>
<td>12</td>
<td>▲</td>
</tr>
<tr>
<td>PCCC.08</td>
<td>Failure to maintain a strategic approach to strategy</td>
<td>6</td>
<td>6</td>
<td>▲</td>
</tr>
<tr>
<td>PCCC.09</td>
<td>Failure to deliver equalisation across GP contracts</td>
<td>16</td>
<td>16</td>
<td>▲</td>
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<tr>
<td>Risk ID</td>
<td>Risk Description</td>
<td>Objective/Measure</td>
<td>CQC Risk/ID</td>
<td>Risk Priority</td>
</tr>
<tr>
<td>--------</td>
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<tr>
<td>P3.C3.</td>
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<td>P3.C9.</td>
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<tr>
<td>P3.C16.</td>
<td></td>
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<td>P3.C17.</td>
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<td>P3.C18.</td>
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<tr>
<td><strong>Title:</strong></td>
<td>Newham CCG – Premises development update – NHS E Estates and Technology Transformation Fund Submissions (ETTF) and Improvement Grant Funding: London Borough of Newham Section 106 CIL funding</td>
<td></td>
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<td><strong>Agenda item:</strong></td>
<td>12</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| **Author:** | Jason Kelder, NCCG, Head of Finance - Property  
Bev Norton, NCCG, Premises Project Support |
| **Presented by:** | Jason Kelder, NCCG, Head of Finance - Property |
| **Contact for further information:** | Jason Kelder, NCCG, Head of Finance - Property  
Bev Norton, NCCG, Premises Project Support |
| **This Paper is for:** | Information |
| **Action required:** | Note the report |
| **Executive summary:** | NCCG has been working with clusters and practices to identify what premises funding is needed to ensure the development set out in the Strategic Estates Plan (SEP) in December 2015 can be taken forward.  
The CCG submitted proposals to NHS E for funding under the Estates and Technology Transformation Fund (ETTF) in June 2016 and for Improvement Grant (IG) funding for 2016-7 and 2017-8. Applications have been made to London Borough of Newham to access section 106 and community infrastructure levy funding (CIL)  
This paper provides an update of the schemes that are being progressed and the funding streams. |
| **Supporting papers:** | Attachment 1: Strategic Plan – ETTF – IG schemes and progress |

**How does this fit with Newham CCG Strategy:**

**Values:**  
Transparency with our decision-making and leadership

**Aims:**  
Reducing inequalities and improving accessibility
<table>
<thead>
<tr>
<th>Where has the paper been already presented?</th>
<th>This paper updates previous plans set out for the PCCC in the NCCG’s SEP June 2016 and the ETTF paper June 2016.</th>
</tr>
</thead>
</table>
| Risk: | Failure to understand and make recommendations of the report risks the CCG:  
- Not meeting DH requirements to deliver an estates strategy and prioritised applications through the Estates and Technology Transformation Funding – primary care (ETTF)  
- Not being able to make timely decisions that will secure appropriate modern health care facilities and accommodation to meet the needs of the growing and aging population of Newham under the regeneration and third party development programmes |
| Equality Impact: | The development and implementation of the strategic estates plan will ensure that the CCG can secure the necessary health care facilities, through effective processes, that will offer the population more equitable access to a wider range of primary care and community services in improved facilities. |
| Stakeholder engagement: | Discussions have been held with key stakeholders through the Estates Strategy Group, through two patient and public meetings, through the GP cluster meetings (November 2015 and April 2016), with the London Borough of Newham Regeneration Team, with third party developers, landlords and associated practices, where developments are planned or have an impact. |
| Financial Implications | The CCG has taken a view to request maximum funding for developments or where practices have submitted proposals to increase capacity. Any capital funding will have an impact in reducing the recurrent rental costs vs the practices funding the developments directly.  

The CCG is seeking to maximise all opportunities to increase capital funding and reduce the financial impact. A more detailed budget forecast will be prepared once all proposals have been reviewed and decisions made on funding methods.  

Proposals will not be supported if they do not meet the criteria as set out in the Strategic Estates Plan. |

### Introduction and Background

1.1 In 2015/16, NHS England began a multi-year £1 billion investment programme to support primary care and general practice to make improvements across a range of areas, including in premises and in technology, linked to estates strategies and digital roadmaps for the NHS in local areas. This programme includes both capital and revenue funding.  

1.2 In June the CCG submitted eight major schemes through the Estates and Technology Transformation Programme. These were scrutinised and prioritised by an internal and an
1.3 external team to ensure transparency in decision making.

In October 2016 NHS E requested that the total of 63 schemes were reviewed and prioritised at a NEL level.

NHS E advised the CCGs of schemes with agreed funding, those for which funding might become available (dependent on the delivery of higher prioritised schemes nationally) and those not agreed.

Applications have been made by practices for improvement grant funding, several schemes have requested both ETTF and IG monies

The AO and estates team are meeting regularly with LBN regeneration team and councillors to develop a shared vision for healthcare developments in Newham.

2. Key Considerations

2.1 The outcomes of the CCG’s applications and funding requests are set out in attachment 1: Strategic Plan – ETTF – IG schemes and progress

The CCG has assisted practices in securing funding under each of the schemes as follows;

Improvement Grant 2016/17 - £2,726,542

Estates and Technology Fund - £1,065,500

S106 (in process of approval) - £1,570,094

Total Project costs - £5,362,136
Newham CCG - Improvement Grants and ETTF Schemes

<table>
<thead>
<tr>
<th>Practice</th>
<th>Scheme Details</th>
<th>Funding Scheme</th>
<th>Project Cost</th>
<th>Documentation required</th>
<th>Project Approval Status</th>
<th>Planned completion date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Froud Development</td>
<td>Fees only to get to Business Case. The Manor Park Care Group has formed into a single practice through a merger of four small practices. One surgery has closed but three other inadequate premises remain in operation, whilst the new development is undertaken. The practice is working with Aston Mansfield Charitable trust to develop a new premises co-located with a community facility. AMCT will fund capital build</td>
<td>ETTF 2016/17</td>
<td>£ 224,000.00</td>
<td>PID/OBC/FBC</td>
<td>NHSE have approved the scheme for fees only. Need to provide 3 quotes by 9th December - CCG is leading on this on behalf of Manor Park Care Group. Quotes received evidence fees are £189k, NHSE have approved to full funding of fees to maximum £224k</td>
<td>Apr-18</td>
</tr>
<tr>
<td>Royal Wharf (Pontoon Docks)</td>
<td>Build mezzanine floor and fit out costs to bring building in condition B. Cost includes professional fees, F&amp;F, IT etc</td>
<td>ETTF 2016/17</td>
<td>£ 841,500.00</td>
<td>PID/OBC/FBC</td>
<td>NHSE have approved scheme to fund fees to deliver Business Case and for 100% funding of GP practice area</td>
<td>Autumn 2017</td>
</tr>
<tr>
<td></td>
<td>Build Payment to Developer. - New Build provided shell and core from Developes. Relocation of existing practice from Britannia. To accommodate the increase in population based development, circa 20k increase in population</td>
<td>S106</td>
<td>£ 1,570,094.00</td>
<td>LBN template</td>
<td>Request S106 to make bullet payment to developer to reduce the recurrent rental value to ensure scheme is affordable</td>
<td></td>
</tr>
<tr>
<td>Canning Town (New River Place)</td>
<td>New build to accommodate regeneration plans around Canning Town. Scheme is supported on the relocation of primary care facilities at St Lukes Health Centre. This is a reprovision and not commissioning of new practices</td>
<td>ETTF 2016/17</td>
<td>£ 3,300,000.00</td>
<td>PID/OBC/FBC</td>
<td>Scheme has not progressed to next stage of ETTF funding. Remains in pipeline for funding if other national projects fall away</td>
<td></td>
</tr>
<tr>
<td>Star Lane Medical Centre</td>
<td>Redesign part of the existing building to improve the use of clinical space, Provide improved patient waiting accommodation, Upgrade the current lift and install a second lift for improved DDA Build a two storey extension with additional multipurpose clinical consulting room on the first floor</td>
<td>ETTF 2016/17</td>
<td>£ 1,191,600.00</td>
<td>PID/OBC/FBC</td>
<td>Scheme has not progressed to next stage of ETTF funding. Remains in pipeline for funding if other national projects fall away</td>
<td></td>
</tr>
<tr>
<td>St Bartholomew's Surgery</td>
<td>This opportunity would provide 2 additional consulting rooms and 2 fully equipped nurse treatment rooms as well as an extended waiting room, training room and staff areas.</td>
<td>ETTF 2016/17</td>
<td>£ 600,000.00</td>
<td>PID/OBC/FBC</td>
<td>Scheme has not progressed to next stage of ETTF funding. Remains in pipeline for funding if other national projects fall away</td>
<td></td>
</tr>
<tr>
<td>Practice</td>
<td>Description</td>
<td>Funding Year</td>
<td>Funding Amount</td>
<td>Scheme Status</td>
<td>Response Date</td>
<td></td>
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<tr>
<td><strong>Boleyn Medical Practice</strong></td>
<td>This proposal is to refurbish and reconfigure the existing surgery at 162 Boleyn Road and redevelop the adjoining premises at 185 Neville Road, so as to provide an enlarged facility, 750-950 NIA M2, to meet current NHS standards and co-locate practices creating a facility that can potentially serve a list size to 20,000 population with additional GP provided services.</td>
<td>ETTF 2016/17</td>
<td>£ 2,475,000.00</td>
<td>Scheme has not progressed to next stage of ETTF funding. Remains in pipeline for funding if other national projects fall away</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Brampton Park (Rainbow Centre)</strong></td>
<td>New Build on the Brampton School premises, lack of primary care facilities in this area, relocation of existing practice, not commissioning of new GP, must have childrens services as part of the offer</td>
<td>ETTF 2016/17</td>
<td>£ 1,973,000.00</td>
<td>Scheme has not progressed to next stage of ETTF funding. Remains in pipeline for funding if other national projects fall away</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Westbury Road Practice</strong></td>
<td>New build to replace existing site as per CQC recommendations</td>
<td>Premises Directions</td>
<td>£ 185,000.00</td>
<td>Fully approved and in process of build</td>
<td>Apr-18</td>
<td></td>
</tr>
<tr>
<td><strong>Woodgrange Medical Practice</strong></td>
<td>Construction of extension to create additional consulting rooms, admin areas and toilets complies with Para 8(a). Refurbishment of garage is not eligible for funding.</td>
<td>Improvement Grant 2016/17</td>
<td>£ 600,000.00</td>
<td>Formal approval has been given by NHSE. Practice needs to contract with supplier by the 9th of December. Build and design fees only and based on 66% as per Premises Direction</td>
<td>Apr-18</td>
<td></td>
</tr>
<tr>
<td><strong>Essex Lodge</strong></td>
<td>Works to build an extension to provide additional clinical space complies with Para 8(a) however the proposal to purchase the land required to facilitate this is not eligible for funding as per Para 9(b)</td>
<td>Improvement Grant 2016/17</td>
<td>£ 1,918,636.00</td>
<td>Formal approval has been given by NHSE. Practice needs to contract with supplier by the 9th of December. No funding approved for land purchase, build and design fees only and based on 66% as per Premises Direction</td>
<td>Apr-18</td>
<td></td>
</tr>
<tr>
<td><strong>Claremont Clinic</strong></td>
<td>Installation of Equality Act compliant reception desk complies with Para 8(b). Fixed waiting room seating complies with Para 8(g). Installation of infection control compliant sink units and splashbacks in clinical areas comply with Para 8(j).</td>
<td>Improvement Grant 2016/17</td>
<td>£ 22,906.00</td>
<td>Formal approval has been provided, practice is required to contract with supplier by the 9th of December. Funding based on 66% as per Premises Directions</td>
<td>2016-17</td>
<td></td>
</tr>
<tr>
<td><strong>East End Medical Centre</strong></td>
<td>Works to reception desk to improve staff safety comply with Para 8(g). Upgrades to disabled toilet including an alarm complies with Para 8(b).</td>
<td>Improvement Grant 2016/17</td>
<td>£ 3,918.00</td>
<td>NHSE in process of due diligence - waiting for formal approval to progress with scheme</td>
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</tbody>
</table>

Response from NHS not yet received Completion date dependent on approval
<table>
<thead>
<tr>
<th>Location</th>
<th>Project Description</th>
<th>Funding Details</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Custom House Surgery</td>
<td>As part of the redevelopment of Custom House locality the London Borough of Newham (LBN) are proposing to demolish the existing Custom House surgery. This will require the practice/LBN to negotiate an alternative site. In addition to a 'like for like' replacement NCCG will be working with LBN and the developers to increase the footprint to provide accommodation for the planned increased population and potential colocation of Dr Lwin's practice.</td>
<td>ETTF 2016/17 £1,650,000.00 PID/OBC/FBC</td>
<td>Scheme has not progressed to next stage of ETTF funding. Remains on pipeline in case other projects fall away</td>
</tr>
<tr>
<td>Star Lane Medical Centre</td>
<td>Redesign part of the existing building to improve the use of clinical space, provide improved patient waiting accommodation, upgrade the current lift and install a second lift for improved DDA, build a two storey extension with additional multipurpose clinical consulting room on the first floor.</td>
<td>Improvement Grant 2017/18 £1,191,600.00 PID</td>
<td>Star Lane has resubmitted this scheme under the IG 2017/18 application as well as ETTF and IG 2016-7</td>
</tr>
<tr>
<td>St Bartholomew’s Surgery</td>
<td>Ceiling fans in reception and waiting areas comply with Para 8(c). Fixed seating for the elderly or infirm complies with Para 8(f). Hearing loop and automatic entrance doors comply with Para 8(b). Installation of compliant sinks and taps in clinical rooms complies with Para 8(j).</td>
<td>Improvement Grant 2016/17 £12,740.00 PID</td>
<td>NHSE in process of due diligence - waiting for formal approval to progress with scheme</td>
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<td>This opportunity would provide 2 additional consulting rooms and 2 fully equipped nurse treatment rooms as well as an extended waiting room, training room and staff areas.</td>
<td>Improvement Grant 2017/18 £700,000.00 PID</td>
<td>Response from NHS not yet received. Completion date dependent on approval</td>
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<tr>
<td>Custom House Surgery</td>
<td>Automatic reception doors, upgrade existing wheelchair access to ensure DDA compliant, upgrade secondary patient access route for DDA compliance, existing reception desk to be made DDA compliant, replace flooring to waiting area.</td>
<td>Improvement Grant 2017/18 £22,000.00 PID</td>
<td>CCG has approved this request to ensure all urgent H&amp;S and DDA compliance is being adhered too, no commitment for any development/refurb works to take place as practice needs to relocate. Flooring may not be eligible hence CCG part support</td>
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<tr>
<td>E12 Medical Centre</td>
<td>Automatic doors for entrance, Canopy for entrance, Pram and mobility scooter parking, Privacy curtains for clinic rooms, Air conditioning for premises, Disability toilet for patients, Replace existing seating in waiting room, Installation of electric bollard to parking facility</td>
<td>Improvement Grant 2017/18</td>
<td>£ 56,800.00</td>
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<td>Month</td>
<td>Administration &amp; Updates</td>
<td>Strategic Items</td>
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<td>27 April</td>
<td>Apologies</td>
<td>OOH Review</td>
<td>Outcomes of Ctee development discussions</td>
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<td>• Declarations of interests</td>
<td>PMS Review</td>
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<td>• Minutes of the last meeting</td>
<td>Risk Register</td>
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<td>25 May</td>
<td>Apologies</td>
<td>Risk Register</td>
<td>Quality Dashboard</td>
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<td>• Declarations of interests</td>
<td>Estates infrastructure</td>
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<td>• Minutes of the last meeting</td>
<td>Report back from Primary Care WEL Advisory Group</td>
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<td>• Action log</td>
<td>Review of OOH service</td>
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<td>• Chairs Actions</td>
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<td>29 June</td>
<td>Apologies</td>
<td>Primary Care Strategy – Review including business continuity</td>
<td>NCCG Finance Report</td>
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<td>• Declarations of interests</td>
<td>Estates Review</td>
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<td>• Minutes of the last meeting</td>
<td>EPSCS proposals 16-17</td>
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<td>• Action log</td>
<td>GP Federation – operational preparedness</td>
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<td>• Chairs Actions</td>
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<td>27 July</td>
<td>Apologies</td>
<td>Risk Register</td>
<td>NCCG Finance Report</td>
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<td>• Declarations of interests</td>
<td>Primary Care access offer</td>
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<td>• Minutes of the last meeting</td>
<td>Workforce, Capacity and Development – report from CEPN</td>
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<td>31 August</td>
<td>Apologies</td>
<td>Risk Register</td>
<td>NCCG Finance Report</td>
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<td>• Declarations of interests</td>
<td>Primary Care Access Offer</td>
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<td>• GP Federation – Business</td>
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<td>• Minutes of the last meeting&lt;br&gt;• Action log&lt;br&gt;• Chairs Actions</td>
<td>Plan (part II)</td>
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<td>28 September</td>
<td>• Apologies&lt;br&gt;• Declarations of interests&lt;br&gt;• Minutes of the last meeting&lt;br&gt;• Action log&lt;br&gt;• Chairs Actions</td>
<td>• Risk Register&lt;br&gt;• Primary Care Strategy&lt;br&gt;• Review of progress on NCCG Patient Engagement Strategy - Primary Care&lt;br&gt;• Review of Roma Community access to Primary Care&lt;br&gt;• Primary Care Access Offer - update&lt;br&gt;• GP Federation – Business Plan (part II)</td>
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<td>26 October</td>
<td>• Apologies&lt;br&gt;• Declarations of interests&lt;br&gt;• Minutes of the last meeting&lt;br&gt;• Action log&lt;br&gt;• Chairs Actions</td>
<td>• Risk Register&lt;br&gt;• Workforce, Capacity and Development – report from CEPN&lt;br&gt;• Standard Operating Procedure (SOP): A Consistent Approach to Issuing Breach &amp; Remedial Notices&lt;br&gt;• Review of effectiveness of PCCC</td>
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<td>30 November</td>
<td>• Apologies&lt;br&gt;• Declarations of interests&lt;br&gt;• Minutes of the last meeting&lt;br&gt;• Action log&lt;br&gt;• Chairs Actions</td>
<td>• Risk Register&lt;br&gt;• Management of Conflicts&lt;br&gt;• Primary Care Strategy Refresh&lt;br&gt;• Estates AFO Proposal (Part II)&lt;br&gt;• Primary Care Access offer-NHC Proposal&lt;br&gt;• Referral Management Model</td>
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<td>21 December</td>
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<td>• Risk Register</td>
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<td>25 January</td>
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<td>•Risk Register</td>
<td>• Review of Language Services contract</td>
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<td>• Apologies</td>
<td>• Roma Community Update – verbal</td>
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<td>• Declarations of interests</td>
<td>• CEPN - mainstreaming proposals</td>
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<td>• Minutes of the last meeting</td>
<td>• Briefing report – STP / Self-care signposting / Primary Care IT</td>
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<td>22 February</td>
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<td>• Risk Register</td>
<td>• 17-18 Delivery Plan – Primary Care objective setting – draft</td>
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<td>• Apologies</td>
<td>• Review of Patient Engagement in primary Care</td>
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<td>29 March</td>
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<td>• Workforce, Capacity and Development – report from CEPN</td>
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<td>• 17-18 Delivery Plan – Primary Care objective setting - final</td>
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