NHS
East Leicestershire and Rutland
Clinical Commissioning Group

Meeting Title	**Primary Care Commissioning Committee – Public meeting**	**Date**	**Tuesday 6 December 2016**
Meeting No.	**23.**	**Time**	**9:30am – 10:20am**
Chair	**Mr Clive Wood Chair of the Committee and Lay Member**	**Venue / Location**	**Room G52, Leicestershire County Council, County Hall, Glenfield, Leicester, LE3 8TB.**

ITEM	AGENDA ITEM	ACTION	PRESENTER	PAPER	TIMING
PC/16/131	Welcome and Introductions		Clive Wood	**Verbal**	9:30am
PC/16/132	To receive questions from the Public in relation to items on the agenda	To receive	Clive Wood		
PC/16/132	Apologies for Absences: • Dr Girish Purohit	To receive	Clive Wood		
PC/16/133	Declarations of Interest on Agenda items	To receive	Clive Wood		9:35am
PC/16/134	To Approve minutes of the previous meeting of the ELR CCG Primary Care Commissioning Committee held on 1 November 2016	To approve	Clive Wood	**A**	9:40am
PC/16/135	To Receive Actions and Matters Arising following the meetings held in October 2016	To receive	Clive Wood	**B**	
PC/16/136	Notification of Any Other Business	To receive	Clive Wood	**Verbal**	9:45am
QUALITY AND PATIENT SAFETY					
PC/16/137	Care Quality Commission (CQC) Inspections: The Glenfield Surgery	To receive	Salim Isaak	**C**	9:50am
PRIMARY CARE FINANCE REPORT					
PC/16/138	Primary Care Co-Commissioning Finance Report 2016-17: Month 7 (October 2016)	To receive	Donna Enoux	**D**	10:00am

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ITEM	AGENDA ITEM	ACTION	PRESENTER	PAPER	TIMING
ANY OTHER BUSINESS					
PC/16/139		To receive	Clive Wood	**Verbal**	10:10am
DATE OF NEXT MEETING					
PC/16/140	**Date of next meeting:** Tuesday 3 January 2017 at 9:30am, **Framland Committee Room**, ELR CCG, Leicestershire County Council, County Hall, Glenfield, Leicester, LE3 8TB.		Clive Wood		10:15am

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Minutes of the Primary Care Commissioning Committee held on 1 November 2016 at 9.30 a.m., Framland Meeting Room, ELR CCG, County Hall, Glenfield, Leicester, LE3 8TB

Present:

Mr Clive Wood	Lay Member (Chair of Committee)
Dr Tabitha Randell	Secondary Care Clinician
Dr Girish Purohit	GP Locality Lead for Melton, Rutland and Harborough
Dr Vivek Varakantam	GP Locality Lead for Oadby and Wigston
Mr Tim Sacks	Chief Operating Officer
Dr Anne Scott	Deputy Chief Nurse (on behalf of Chief Nurse and Quality Officer)
Ms Preeya Parmar	Primary Care and Non-Acute Accountant (on behalf of Chief Finance Officer)
Dr Chris Hewitt	Local Medical Committee
Ms Sue Staples	Healthwatch, Leicestershire
Ms Jenifer Fenelon	Healthwatch Rutland
Mr Peter Forrester	Business Manager, Empingham Practice (Practice Manager Representative)
Dr Tim Daniel	Public Health Consultant, Public Health

In attendance:

Mr Jamie Barrett	Head of Primary Care
Mrs Daljit K. Bains	Head of Corporate Governance and Legal Affairs
Mrs Caroline Goulding	Senior Contract Manager, NHS England/ELR CCG
Ms Khatja Hajat	Primary Care Contracts Manager (for Items PC/16/125 and PC/16/126 only)
Mr Salim Issak	Primary Care Support Manager
Mrs Julie Cockcroft	Commissioning Collaborative Support Officer, ELR CCG (minutes)

ITEM		LEAD RESPONSIBLE
PC/16/117	**Welcome and Introductions** Mr Wood welcomed all members to the Public meeting of the Primary Care Commissioning Committee (PCCC). This was followed by introductions by all present.	
PC/16/118	**To receive questions from the Public in relation to items on the agenda** There were no questions from the members of the public present.	
PC/16/119	**Apologies received:** • Dr Nick Glover, GP Locality Lead, Blaby & Lutterworth • Mrs Donna Enoux, Chief Finance Officer • Mrs Carmel O'Brien, Chief Nurse and Quality Officer	
PC/16/120	**Declarations of Interest** All GPs present declared an interest in any items relating to commissioning of primary care where a potential conflict may	

ITEM		LEAD RESPONSIBLE
	arise, with particular reference to the following items: • **PC/16/126 – Care Quality Commission (CQC) Inspections** Dr Chris Hewitt declared a conflict of interest as his organisation supports the practices discussed on a pastoral and general level.	
PC/16/121	**To Approve the Minutes of Previous Meeting of the ELR CCG Primary Care Commissioning Committee held on 4 October 2016 (Paper A)** The minutes of the meeting held on 4 October 2016 were accepted as an accurate record of the meeting with the following correction: • To record the meeting was held at 9:30am and not 9:30pm. It was **RESOLVED** to: • **APPROVE** the minutes of the previous meeting.	
PC/16/122	**To Approve the Minutes of Previous Meeting of the ELR CCG Extraordinary Primary Care Commissioning Committee held on 11 October 2016 (Paper B)** The minutes of the meeting held on 11 October 2016 were accepted as an accurate record of the meeting with the following correction: • To record that Dr Vivek Varakantam was present at the meeting. It was **RESOLVED** to: • **APPROVE** the minutes of the previous meeting.	
PC/16/123	**To Receive Matters Arising following the meetings held in October 2016 (Paper C)** The matters arising following the meetings held in October 2016 were received, with the following updates noted: • **PC/16/104 – GP Practice Cover Arrangements: Christmas and New Year 2016/17** It was noted that the deadline for practices to submit their activity returns was 31 October 2016. The returns would be reviewed with a report submitted to NHS England on 5 November 2016.**Action Complete** • **PC/16/106 – Care Quality Commission (CQC) Assurance Reports** With regards to the review of content and the format of future reports and CQC action plans Mrs Goulding reported that progress was being made in this area of	

ITEM		LEAD RESPONSIBLE
	work, and that the report would be reformatted for the next meeting in December 2016. • **PC/16/103 – Conflicts of Interest Guidance and Primary Care Commissioning Committee Terms of Reference** In relation to amending the PCCC terms of reference in line with the new conflicts of interest guidance which requires the PCCC to have a lay vice-chair, Mrs Bains reported that a request for further clarification from the national and local NHS England Teams has been made. Mrs Bains confirmed that clarification is awaited now from the local team following discussion with the national team and agreed to keep the Committee Chair updated. • **PC/16/107 – Primary Care Co-Commissioning Finance Report 2016-17: Month 5, August 2016** It was noted that a review of the reported areas within the Primary Care Co-Commissioning budget and confirmation of overspend and underspend formed part of the Primary Care Co-Commissioning Finance Report 2016-17, Month 6, September 2016 presented to the Committee on 1 November 2016. **Action Complete** It was **RESOLVED** to: • **RECEIVE** the matters arising and note the progress to date.	
PC/16/124	**Notification of Any Other Business** Mr Wood had not received notification of any additional items of business.	
PC/16/125	**Community Based Services Quality Report (Paper D)** Ms Hajat presented this report which provided an update on the following key themes from the 2015-16 Community Based Services (CBS) quality reporting: • CBS reports submitted by GP practices providing secondary care bloods, minor injuries, Gonadorelin, INR and Minor Surgery L5-7 services. • Self-assessment templates submitted by Optometry providers of IOP service. • Self-assessment templates submitted by Pharmacists providing palliative care drugs service. Ms Hajat outlined the process followed by GP providers, Optometry and Pharmacists in completing Quality Schedules and emphasised that all CBS reports submitted by Practices were reviewed by both the Primary Care and Quality teams.	

ITEM		LEAD RESPONSIBLE
	Ms Hajat made reference to the table on page 4 which provides the number of practices rated red, amber or green against each of the 2015-16 quality schedule indicators. It was noted that Long Street Surgery had been excluded as the contract had now been terminated. Ms Hajat confirmed that, at the date of compiling the report, the majority of practices were rated green for the majority of indicators with infection control and minor injuries audit being the indicators where the majority or practices were red. It was noted that the "red" ratings for infection control mainly related to training, which had since been completed and that since compiling the report all CBS reports had now been received with all outstanding actions completed. Ms Hajat explained that Optometry and Pharmacists submitted self-assessment declarations where there were initially a couple of red ratings, but further investigation revealed this related to a misunderstanding of the indicators and confirmed that all indicators were now "green". The Committee was asked to consider what process should be applied for managing the 2016-17 Community Bases Services reporting with the following options detailed: o Continue to adopt a "light touch" approach and adopt the 2015-16 process for all provider groups i.e. self-assessment templates for Pharmacists and Optometrists and annual practice reports to be submitted by GP providers o Adopt 2015-16 process applied to GP practices requesting annual reports from all 3 provider groups o Adopt process of contract monitoring and reviewing provider performance that is used by the CCG contracting team for other providers of NHS services commissioned using the NHS Standard Contract. Mr Wood asked for clarification on red rated indicators and received assurance from Ms Hajat that all practices were green for the safeguarding indicators except for 1 practice. Responding to a question from Dr Scott; Ms Hajat clarified that the issues regarding infection control training were aligned to time constraints rather than problems with gaining access to the training itself. Dr Varakantam asked how the information received regarding safeguarding and infection control was being recorded and triangulated by ELR CCG with CQC information and reports.	

ITEM		LEAD RESPONSIBLE
	Dr Varakantam made reference to the options for managing the services for 2016-17 and asked why there were different processes for General Practice, Optometry and Pharmacists and asked if the Primary Care and Quality Teams felt the current process was robust and provided useful information. Ms Hajat explained that a different process had been agreed for Optometry and Pharmacists as the services they provide were of low volume and were previously considered not to require the same level of scrutiny. Mr Barrett stressed that the same process should be applied for all services regardless of the volume of activity to ensure the same rules apply for all contracts but emphasised the requirement for raising awareness amongst the providers in new ways of reporting. Mr Barrett continued to explain that the full NHS standard monitoring process was detailed and time consuming and it was not necessarily felt that this level of detail was required. It was emphasised that Primary Care and Quality Teams were confident that the current system, developed with General Practices, was robust and appropriate giving a good understanding of the value of assurances gained. Dr Hewitt expressed his support for adopting the same process for all providers and reaffirmed that it was appropriate to be assured on all indicators irrespective of the size or value of the contract. Mr Wood acknowledged the support for continuation of the 2015-16 approach for GP providers and adopting the same process for Pharmacists and Optometrists but stated this would not be in accordance with NHS standards and asked what the associated risks were to the CCG. Mr Barrett explained that locally the decision had been taken to establish the current process as an interpretation of the NHS standards and stressed that the current process offers governance, assurance and control that the services being provided are safe. Mr Barrett informed that adopting the full NHS standards would involve a lot more detail and work and felt the current process was robust. Mr Forrester stated that CQC inspections were part of the assurance process that would provide assurance on the current process undertaken by ELR CCG identifying any associated risks. Mr Forrester suggested it would be helpful to triangulate the process with CQC inspection reports for further assurance rather than change the current process. Ms Hajat confirmed that not all the indicators aligned with CQC inspections but that triangulation	

ITEM		LEAD RESPONSIBLE
	for assurance was carried out. Ms Staples emphasised that CQC inspections review different elements in comparison to the CCG process and stated that the triangulation of the two processes of assurance would ensure that potential areas of risk were not missed. Mrs Goulding emphasised that the majority of Practices had been inspected by CQC with an overview of the recommendations reported to PCCC. Mrs Goulding emphasised the need to establish a supportive process for Community Based Service assurance. In response to a question from Mrs Fenelon; Mr Barrett confirmed that since the report was published signed declarations had been received regarding Minor Injury Audits and confirmed Commissioners assurance that all practices were now rated green. Mr Barrett emphasised that there was a process for CQC inspections that involved sending CQC the practice quality indicators prior to any planned inspection in order that CQC were aware of the CCG assurances regarding quality indicators. Mr Sacks explained that there was a broader issue in that East Leicestershire and Rutland practices tend to have a high number of 'requires improvement' returns from CQC inspections and emphasised that, whilst there were robust processes in place for supporting practices following inspections, these were reactive rather than proactive. Mr Sacks stated that discussions were taking place exploring how the CCG could work with and support Practices where there were issues. Dr Scott explained that discussions had progressed and that a report outlining a review of all CQC reports would be presented at the next meeting. Mr Forrester raised the concern of Practice Managers regarding the inconsistent approach of CQC and requested that the evidence from action reports and CQC reports be incorporated into the report to PCCC Dr Scott confirmed that a review of feedback, action plans and CQC reports was part of the process that aimed to identify emerging themes. Dr Scott confirmed that CQC would be involved in the process with the aim of developing a more consistent approach going forward. Dr Hewitt stated that he attends regional and national CQC meetings and that CQC have been frank regarding inconsistencies amongst some inspectors. Dr Hewitt confirmed that he was campaigning regionally for quality assurance of CQC inspectors to address the issue of inconsistencies across the	

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	patch. It was acknowledged that there needs to be an improvement in CQC inconsistencies and that collating feedback was important. Dr Scott clarified that Practices do have a right to reply to CQC reports, and informed that the CQC had not, to date, received any feedback forms from East Leicestershire and Rutland CCG General Practices. Dr Scott stated that discussions with CQC regarding the challenge of anecdotal feedback were ongoing and formed part of the process outlined above that aims to formalise feedback and challenge. It was acknowledged that feed back nationally was low and that Practices were reluctant to feed back as they felt this would potentially open them up to further scrutiny. It was **RESOLVED** to: • **RECEIVE** the report and assurances given. • **AGREED** that a similar "light touch" be applied for managing the 2016-17 Community Based Services whilst the work on the review of CQC reports is being undertaken. Once the work has been completed by the Quality and Primary Care Team then a further review of the approach will be considered.	**Anne Scott / Jamie Barrett / Khatija Hajat**
PC/16/126	**Care Quality Commission (CQC) Inspections Report (Paper E)** Ms Hajat presented this report which provided an update on the progress Practices have made following the Care Quality Commission (CQC) visits. The following Practices were inspected by the CQC in May 2016: • The Long Clawson Medical Practice; • Enderby Medical Centre Ms Hajat reported that Appendix A outlined the action plan for the Long Clawson Medical Practice and stated that since the initial CQC report was produced the Practice had been working towards improving the situation and had made good progress against the Action Plan. Ms Hajat reported that the Primary Care Contract Manager, Deputy Chief Nursing Officer and a member of NHS England prescribing team had visited the Practice on 28 September 2016 where it was noted that the Practice had implemented a number of actions and were working to improve other areas. Ms Hajat reported that the CCG would await feedback from the CQC re-inspection and arrange a follow-up visit with the Practice if necessary.	

ITEM		LEAD RESPONSIBLE
	Appendix B outlined the Action Plan for Enderby Medical Centre, which had received an inadequate report from CQC following the inspection in May 2016. Ms Hajat reported that CQC had conducted a re-inspection in September 2016 where it was noted that the Practice had implemented the majority of actions and as a consequence the CQC warning letter had been removed. It was noted that a further CQC inspection was scheduled for January 2017 and that the CCG would arrange a follow-up visit with the Practice if necessary. Mr Barrett emphasised that, whilst there have been a number of inadequate CQC inspection reports, there was a robust process in place whereby the CCG and NHS England work with the Practice to identify key issues and actions required to ensure improvement. Mr Barrett expressed thanks to the team for the work undertaken with Enderby Medical Centre to address and improve key areas of concern. Dr Scott emphasised the work of the Practice Managers for both Long Clawson and Enderby Medical Centres in working hard to address the issues and improve the CQC ratings. Mr Forrester agreed to feedback comments to the Practice Managers. Dr Hewitt confirmed that he had received good reports regarding the support provided by the teams within the CCG and wanted to acknowledge the exemplary work undertaken by the CCG. Dr Varakantam raised the concern from a number of Practices that CQC do not always re-inspect in a timely fashion and asked if the CCG had any influence to improve CQC timescales. Mrs Goulding confirmed that the CCG have been working with CQC to improve the timescale for re-inspections and reported that it was improving. It was **RESOLVED** to: • **RECEIVE** the Report.	
PC/16/127	**Primary Care Co-Commissioning Finance Report (Paper F)** Ms Parmar presented the report that outlined the year to date position for the Primary Care budgets based in reporting information available. It was noted that detailed variance reporting for these areas would be available in Month 7 and reported to PCCC on 6 December 2016. Ms Parmar highlighted the following key points: • Appendix 1 outlines the year to date and forecast position for the total Primary Care expenditure areas • Month 6 (Year to date) reports an underspend of £257k with an annual forecast underspend of £430k • Urgent Care Centres report break even for Year to Date (YTD) with a forecast overspend of £51k	

ITEM		LEAD RESPONSIBLE
	• GP Co-Commissioning reports an overspend for YTD of £160k with a forecast overspend of £330k. Ms Parmar explained that discussions were on-going with NHS England regarding this overspend • Expenditure against pharmacists in GP practices, wound clinics and Leicester Asylum Service would be funded from the FDR and PMS monies • Funding for the additional support provided to South Wigston Health Centre has been accounted for in the Month 6 position • Additional pressures for Long Street, Enderby and Limes Medical Centres as well as the Kingsway Long Term Management plan have been noted and would be accounted for in the Month 7 position. Dr Varakantam raised a question with regards to year to date (YTD) underspends. Mr Sacks explained that YTD underspends were not necessarily a prediction of year end underspends as most were committed to be allocated during the last months of the financial year and would therefore not necessarily report an underspend at the end of the year. Dr Varakantam made reference to Prescribing Incentive Scheme that was forecasting an overspend of £76k and GP Federations that was forecasting an overspend of £40k and stated the belief that savings would be made in these areas. Mr Sacks explained that compared to the original budget these annual forecast figures did reflect a saving but that the plan had been revised since the original budget was presented. Ms Parmar agreed to include the original budget lines within future reporting to clarify the position. Mr Sacks reported on recent discussions regarding the overall investment into General Practice and emphasised that taking funding out of General Practice was not something the CCG would do; however Mr Sacks stressed the CCG's current difficult financial position and the need to work closely with Practices and the LMC to identify practical solutions. Dr Purohit made reference to the forecast overspend for Urgent Care Centres and asked; given that Urgent Care centres were not meeting their trajectories, why there was a forecast overspend. Mr Sacks explained that Urgent Care Centres were actually forecast to be significantly underspent and that, rather than report this; the budget had been adjusted and would be reported differently in future months. It was noted that the underspend would contribute to QIPP savings. It was **RESOLVED** to: • **RECEIVE** the Report.	

ITEM		LEAD RESPONSIBLE
PC/16/128	**Primary Care Delivery Group: Summary Reports October 2016 (Paper G)** Mr Barrett presented this report which outlined the key themes from the Primary Care Delivery Group (PCDG). The following key themes were highlighted: • **GP SIP 2016/17** – reviewing Q2 submissions there were some positive trends in practices for areas in the GP SIP. Areas of improvement are Dementia recording and prevalence and also reported avoided admissions in care homes. However the QIPP savings linked to this programme were not delivering in some of the clinical areas. Review and reconciliation was required and to approach practices on a targeted basis to ensure continued delivery. • **INR (anticoagulation service) –** There has been significant movements to re commission the INR service for 2017/18. There are currently 3 clinical models operated by the CCGs. UHL have indicated that this was not sustainable and that a single model was being considered. ELR CCG are behind in the commissioning cycle and therefore need to consider and agree a model to allow for de-commissioning and a new service being in place. • **Primary Care Sustainability Transformation Plan (STP) –** The PCDG will need to be re arranged from its current date in the month as the Primary Care lead GP is now part of the STP planning. Therefore consideration will need to be given to the update that is provided to the PCCC, noting that the updates would be a month behind. It was **RESOLVED** to: • **RECEIVE** the Report.	
PC/16/129	**To RECEIVE Any other Business** There was no other business to discuss.	
Date of next meeting: The date of the next Primary Care Commissioning Committee meeting will be held on **Tuesday 6 December 2016 at 9:30am, Committee Room to be confirmed, County Hall, Glenfield, Leicester, LE3 8TB.**		

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NHS EAST LEICESTERSHIRE AND RUTLAND CLINICAL COMMISSIONING GROUP PRIMARY CARE COMMISSIONING COMMITTE MEETING

ACTION NOTES

Key

Completed	On-Track	No progress made

Minute No.	Meeting	Item	Responsible Officer	Action Required	To be completed by	Progress as at 1 December 2016	Status
PC/16/106	October 2016	**Care Quality Commission (CQC) Assurance Reports**	**Caroline Goulding**	To review the content and format of future reports and CQC action plans presented to the Committee.	~~October – November 2016~~ December 2016	A red, amber and green (RAG) approach has been applied to the report to enable the Committee to identify engagement from Practices to enable the implementation of the recommendations. **ACTION COMPLETE**	**GREEN**
PC/16/103	October 2016	**Conflicts of Interest (CoI) Guidance and Primary Care Commissioning Committee Terms of Reference**	**Daljit Bains / Clive Wood**	To obtain clarification from NHS England in relation to the role of the Secondary Care Clinician as the Vice Chair of the Committee.	October 2016	A response has been received from the national and local NHS England Team and they have confirmed that compliance with the guidance to have a lay vice-chair is a requirement. A discussion has taken place with the CCG Chairman, PCCC Chair and Audit Committee Chair and the consensus is that a lay vice chair will be appointed to the PCCC, and the Secondary Care Clinician will also continue to form part of the membership of the Committee. **ACTION COMPLETE**	**GREEN**

Minute No.	Meeting	Item	Responsible Officer	Action Required	To be completed by	Progress as at 1 December 2016	Status
PC/16/108	October 2016	**Primary Care Delivery Group (PCDG): Summary Report August and September 2016**	**Tim Sacks**	To attend the next meeting of the PCDG in November 2016 to review and consider primary care priorities / future planning of services.	October – November 2016	**Verbal update to be provided at the meeting.**	**AMBER**
PC/16/125	November 2016	**Community Based Services (CBS): Quality Report**	**Anne Scott / Jamie Barrett**	To work on the review of CQC reports to be presented.	December 2016	Report reviewing key themes from CQC reports on the confidential agenda for discussion. **ACTION COMPLETE**	**GREEN**
			Khatija Hajat / Jamie Barrett	Once the work has been completed by the Quality and Primary Care Team then a further review of the approach for CBS contracts will be considered.	January / February 2017	Awaiting completion of the report from the Quality Team.	**AMBER**

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EAST LEICESTERSHIRE AND RUTLAND CLINICAL COMMISSIONING GROUP PRIMARY CARE COMMISSIONING COMMITTEE MEETING

Front Sheet

REPORT TITLE:	Care Quality Commission (CQC) Inspections
MEETING DATE:	6 December 2016
REPORT BY:	Salim Issak, Primary Care Contracts Manager
SPONSORED BY:	Jamie Barrett, Head of Primary Care
PRESENTER:	Salim Issak, Primary Care Contracts Manager

PURPOSE OF THE REPORT
The purpose of this report is to provide the Committee with an update on the progress Glenfield Surgery has made following the Care Quality Commission CQC visit on the 19 May 2016.
RECOMMENDATIONS:
The East Leicestershire and Rutland CCG Primary Care Commissioning Committee are asked to: • **RECEIVE** the report; and note the progress to date.

REPORT SUPPORTS THE FOLLOWING STRATEGIC AIM(S) 2016 – 2017: (tick all that apply)			
Transform services and enhance quality of life for people with long-term conditions		Improve integration of local services between health and social care; and between acute and primary/community care.	
Improve the quality of care – clinical effectiveness, safety and patient experience	✓	Listening to our patients and public – acting on what patients and the public tell us.	
Reduce inequalities in access to healthcare		Living within our means using public money effectively	
Implementing key enablers to support the strategic aims (e.g. constitutional and governance arrangements, communications and patient engagement).			✓

EQUALITY ANALYSIS

An Equality Analysis and due regard to the positive general duties of the Equality Act 2010 has not been undertaken in the development of this report as this is a direct result of an announced CQC inspection.

RISK ANALYSIS AND LINK TO BOARD ASSURANCE FRAMEWORK:

The report highlights the following risks:

- BAF 3 - Quality Primary Care - The quality of care provided by primary care providers does not match commissioner's expectation with respect to quality and safety.

EAST LEICESTERSHIRE AND RUTLAND CLINICAL COMMISSIONING GROUP PRIMARY CARE COMMISSIONING COMMITTEE MEETING

Care Quality Commission (CQC) Inspections

1 December 2016

Background

1. The Care Quality Commission (CQC) is the independent regulator of health and adult social care in England. Their role is to monitor, inspect and regulate services to make sure they meet fundamental standards of quality and safety. They have the power to take appropriate action if care providers fail to meet required standards.

2. Many of the actions identified by CQC links with both the GMS/PMS contract as well as the NHS Standard contract. These are captured within a detailed action plan that sets out the CQC findings, improvements required, the relevant contractual clauses and the remedial actions required by the practice for CCG assurance.

3. Since the last report to the Committee, the following CQC reports have been published and action taken by the CCG:

a) GLENFIED SURGERY

Glenfield Surgery was inspected by CQC on 19 May 2016. The report was published on 12 August 2016 and is available on the CQC website http://www.cqc.org.uk/sites/default/files/new_reports/AAAF3840.pdf
The practice was rated as 'requiring improvement.'

Current Status - Since the initial CQC report was produced, the practice has made progress however further ongoing work is still required.

The Primary Care Contracts Manager and the Head of Nursing from ELR CCG met with the practice on 12 October 2016 to offer support and to seek assurance on the areas identified. The action plan at Appendix A was shared with the practice in advance of the meeting and a remedial action plan agreed.

A follow up meeting will take place on the 18 January 2017 with the practice ELR CCG to monitor progress made against the actions identified for completion in December 2016. ELR CCG will await outcome of CQC re-inspection and arrange a follow-up visit with the practice if necessary.

Recommendations

4. The ELR CCG Primary Care Commissioning Committee are asked to:

- **RECEIVE** the report; and note the progress to date.

Glenfield Surgery: Date of CQC Inspection: 19th May 2016, Date CQC Report Published: 12th August 2016							
CQC Area	**CQC Overall Rating**	**CQC Findings - Examples. Please refer to the full CQC report**	**Improvements Required**	**Link to GMS Contract**	**Link to NHS Standard Contract**	**Assurance required by CCG**	**Engagement and progress to date following ELRCCG Visit on 12 October 2016. Completion of actions to be determined by CQC** **ELR CCG Key:** **GREEN** - Action completed subject to CQC review / approval **AMBER** - Practice engaged and progress made **RED** - Practice engaged and progress yet to be made
Are services safe?	Requires improvement	**The following areas highlighted no issues**: The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse.	N/A	N/A	N/A	N/A	N/A
		Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. However, we found that incidents had occurred that had not been investigated and reported as such as they were non clinical which had not been identified as a significant event.	Practice to have robust processes for reporting, recording, acting on and monitoring significant events, incidents and near misses including non-clinical.	Part 20.1 - Clinical Governance	Indicator 6 - Incident Reporting (including Duty of Candour)	Robust processes for reporting, recording, acting on and monitoring significant events, incidents and near misses including non-clinical.	The Practice has a significant event form which all staff can now complete both clinical and non-clinical staff. There is monthly discussion of the significant events at the Practice Monthly meeting and there is an admin meeting held weekly where any non-clinical significant events are discussed. Actions are discussed and tracked at this meeting to ensure that all are completed.
		Not all risks to patients who used services were assessed such as health and safety and fire and portable electronic equipment had not been checked.	System in place for assessing and monitoring risks including fire safety, health and safety and portable equipment testing.	Part 23.1 - Compliance with Legislation and Guidance		Risk assessment undertaken for fire safety, health and safety and portable equipment testing.	Risk assessments have been completed. Pat testing is booked to be completed in November 2016 and thereafter on an annual programme.
		Not all staff that were available to chaperone had completed the relevant training. Not all staff had a DBS check in place, including those that were chaperoning and no risk assessment had been completed.	All staff acting as chaperone to have the appropriate training. Practice to undertake Disclosure and Barring Service (DBS) checks on staff acting as Chaperones including risk assessment.	Part 20.1 - Clinical Governance		Appropriate training, DBS checks and risk assessment undertaken for all staff acting as Chaperones.	The Practice have 5 members of staff who are chaperones. All staff have chaperoning training as part of their induction. Staff can decline to be a chaperone. Posts are risk assessed regarding the need for DBS.
		Blank prescription pads were securely stored and there were systems in place to monitor their use however as the doors were left unlocked at all times the prescription forms that were left in printers in rooms were not kept secure.	Ensure the prescription forms that were left in printers in rooms are kept secure.	Part 20.1 - Clinical Governance		System in place which ensures all prescription forms are kept secure at all time.	The Practice are in the process of having locks fitted to all doors where there are prescriptions kept.
Are services caring?	Requires improvement	Data from the national GP patient survey showed variable results in respect of several aspects of care. For example, although 89% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 91% and the national average of 89%, only 78% of patients said the last GP they saw or spoke to was good at treating them with care and concern compared to the CCG and the national average of 85%. 71% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 82% and the national average of 82%.	Practice has undertaken a review of the areas identified as needing improvements in the national GP survey with a plan in place for implementation.		Indicator 11 - Patient Experience	Action plan in place to implement improvements identified in the national GP survey.	The practice stated that data used by CQC was out of date. The Practice are continuing to work closely with their PPG and review all data from NHS Choices, Friends and Family Test and the annual GP survey. There is a monthly newsletter produced. Information from the GP survey has been reviewed however there was no overarching action plan discussed at the visit.
		71% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 82% and the national average of 85%.					
		Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment but not all patient survey responses supported these view					
		The following areas highlighted no issues: 1) Information for patients about the services available was easy to understand and accessible. 2) We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.	N/A	N/A	N/A	N/A	N/A
Are services responsive to people's needs?	Requires improvement	Data showed patients consistently rated the practice below others in relation to access to the service and continuity of care. For example 33% of patients said they usually get to see or speak to their preferred GP compared with a CCG average of 60% and the national average of 59%	Practice has undertaken a review of the areas identified as needing improvements in the national GP survey with a plan in place for implementation.		Indicator 11 - Patient Experience	Action plan in place to implement improvements identified in the national GP survey.	The Practice did not provide an overarching action plan against the data in the report and noted that this was old data. The Practice continues to respond to feedback from patient experience data as this is received. The practice highlighted that their list has remained open and they are consistently reviewing demand for appointments against capacity in the practice . The practice has increased it telephone appointments and has activity promoted the use of online services for repeat prescription, booking appointments and the use of Electronic Prescription Services (EPS).
		The following areas highlighted no issues: 1) Practice staff reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group to secure improvements to services where these were identified. 2) The practice had appointments with GP and nurses on Monday evening until 8.30pm. 3) Information about how to complain was available and easy to understand and evidence showed the practice responded quickly to issues raised. 4) The practice had good facilities and was well equipped to treat patients and meet their needs, recent expansion had allowed for increased disabled parking as requested by patients.	N/A	N/A	N/A	N/A	N/A
		Patients said they found it easy to make an appointment in an emergency but it was not always easy to get an appointment with a particular GP in advance.	Review of practice appointment and availability of particular GP patient can book in advance.		Indicator 11 - Patient Experience	Practice has undertaken a review of practice appointment and availability of particular GP patient can book in advance.	The Practice has a system for telephone consultations to enable patients to talk to the GP of their choice and from this call a face to face consultation can be arranged. The use of online appointment booking is increasing and for appointments and prescriptions is around 80%. the demand for telephone consultations is increasing. Patients can only book two weeks in advance and the Practice are looking at ways to ensure that the rationale for this is understood by patients.
Are services well-led?		The practice had an overarching governance framework however it did not fully support the delivery of the strategy and good quality care.	Strategy and good quality care to be provided in line with practices overarching governance framework	Part 20.1 - Clinical Governance		Review undertaken by the practice to ensure its Strategy and good quality care is provided in line with practices overarching governance framework	Monthly and weekly meetings are taking place in the practice to ensure improvements in the quality of care that is provided through review of system and process and implementing change where necessary.
		There was clear leadership and a structure clinically and staff said they felt supported by the partners. However the practice was going through a period of transition which included the implementation of a new management team and these roles were not clearly defined.	Management team in place with clearly defined roles and responsibilities	Part 20.1 - Clinical Governance		Roles and responsibilities clearly defined for the Management team	The Practice has an executive GP lead Dr Chotai and is supported by the Administration Manager and the Operational Manager with clearly defined roles and responsibilities. There is an organisational structure.
		The practice had a number of policies and procedures to govern activity, but some were overdue a review and were not all specific to the practice, for example some had incorrect telephone numbers listed.	Review of policies and procedures in place to ensure up to date and specific for activities undertaken in the practice.	Part 20.1 - Clinical Governance		Practice has undertaken a review of policies and procedures in place to ensure up to date and specific for activities undertaken in the practice.	The Practice has reviewed their policies and has a programme for future reviews. The safeguarding policy highlighted in the CQC report has been updated with the correct telephone number.
		The arrangements for identifying, recording and managing risks, issues and implementing mitigating actions were not robust. We found incidents that had not been recorded and risks assessments had not been completed such as fire risk assessment, health and safety risk assessment and at the time of inspection there had not been an infection control audit completed.	System in place for identifying, recording and managing risks, issues and implementing mitigating actions following fire risk assessment, health and safety risk assessment. Completion of infection control audit.	Part 23.1 - Compliance with Legislation and Guidance		System in place for identifying, recording and managing risks, issues and implementing mitigating actions following fire risk assessment, health and safety risk assessment. Completion of infection control audit.	Infection control audit completed. Fire risk assessment to undertaken in December 2016. Health and safety risk assessment to be undertaken by external organisation in December 2016.
		The following areas highlighted no issues: 1) The practice held meetings including partner meetings, business meetings and practice meetings which were minuted. 2) The practice had sought feedback from patients and the patient participation group was active in surveying patients and looking at ways to improve the practice. 3) There was a focus on continuous learning and improvement at all levels. Part of the future plans had been identified and in the process of development, such as employing an advanced nurse practitioner and recently working with a pharmacist.	N/A	N/A	N/A	N/A	N/A
Are services effective ?	Good	**The practice was rated GOOD in these areas with example of good systems and process as outlined in the CQC report**					

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EAST LEICESTERSHIRE AND RUTLAND CLINICAL COMMISSIONING GROUP PRIMARY CARE COMMISSIONING COMMITTEE MEETING

Front Sheet

REPORT TITLE:	**Primary Care Finance Report Month 7 (October 2016-17)**
MEETING DATE:	**6 December 2016**
REPORT BY:	**Preeya Parmar, Primary Care and Non-Acute Accountant**
SPONSORED BY:	**Donna Enoux, Chief Finance Officer**
PRESENTER:	**Donna Enoux, Chief Finance Officer**

PURPOSE OF THE REPORT:

The purpose of this report is to provide a summary of the financial position to Month 7 (October) of the Primary Care budgets.

RECOMMENDATIONS:

The East Leicestershire and Rutland CCG PCCC is requested to:

- **RECEIVE** the reported variance position against the Primary Care budgets based on reporting information available. Detailed variance reporting for these areas will be available in Month 8.

REPORT SUPPORTS THE FOLLOWING STRATEGIC AIM(S) 2016 – 2017: (tick all that apply)

Transform services and enhance quality of life for people with long-term conditions		Improve integration of local services between health and social care; and between acute and primary/community care.	
Improve the quality of care – clinical effectiveness, safety and patient experience		Listening to our patients and public – acting on what patients and the public tell us.	
Reduce inequalities in access to healthcare		Living within our means using public money effectively	✓
Implementing key enablers to support the strategic aims (e.g. constitutional and governance arrangements, communications and patient engagement).			

EQUALITY ANALYSIS

An Equality Analysis and due regard to the positive general duties of the Equality Act 2010 has not been undertaken in the development of this report as it is judged that it is not required at this point.

RISK ANALYSIS AND LINK TO BOARD ASSURANCE FRAMEWORK:

- Report covers finances for (but not the operational delivery of) Primary Care Budgets that support the delivery of Primary Care Strategy (BAF 6);
- Report supports the appropriate management of Primary Care Budgets and the achievement of financial targets (BAF 10).

EAST LEICESTERSHIRE AND RUTLAND CLINICAL COMMISSIONING GROUP PRIMARY CARE COMMISSIONING COMMITTEE MEETING

Primary Care Finance Report Month 7 (October) 2016-17

6 December 2016

1. Month 7 Year to date and Forecast Position

Appendix 1 contains the year to date and forecast position for the total primary care expenditure areas. Month 7 reporting shows an YTD underspend of -£148k and an annual forecast underspend of -£344k.

Prescribing

For month 7, Prescribing is reporting a YTD underspend of -£365k utilising month 1 to 5 data. Profiling this forward through the year including the current level of projected QIPP, the Prescribing forecast shows an underspend of -£735k. As this remains a volatile area, the information from the PPA will be monitored on a monthly basis against QIPP targets to ensure the provision of a robust positon in the future. The potential impact of QIPP slippage on third party ordering is being evaluated and mitigations are being sought to ensure this position is maintained.

Community Based Services

Community based services are showing a YTD overspend of £10k with £15k relating to Travelling Families where a QIPP had been planned as a result of decommissioning the service early in the year but notice has been served at the end of October. A further £26k overspend relates to Near Patient Testing and £1k relating to Minor Surgery as at month 7. This is offset against a YTD underspend of -£6k for Minor Injury and -£23k for INR Anticoagulation. As at M7, the forecast is reporting an overspend of £72k with the majority relating to INR Anticoagulation of £40k and Near Patient Testing of £44k offset against an underspend -£10k against Minor Injury and -£7k against Minor Surgery. Q2 claims have now been submitted and have been used to provide a more accurate position in M7.

GP Support framework, 7 Day working

The majority have been reported as breakeven due to the availability of robust in year data except Joint Working and End of Life, showing a £2k YTD underspend and £3k annual underspend. 7 Day working is reporting a YTD overspend of £69k due to the continuation of the AVS scheme, final agreement of contract values for this service will see this budget breakeven by the end of the financial year.

Co-commissioning

Appendix 2 contains the reported positions for the primary care co-commissioning expenditure areas. As at month 7, this shows a YTD overspend of £100k and a forecast overspend of £330k.

> Expenditure against pharmacists in GP practices (£466k), wound clinics (£325k) and Leicester Asylum Service (£32.5k) will be funded from the FDR (£165k) and PMS monies (£659k).

Funding for the additional support provided to South Wigston Health Centre of £25k has been accounted for in the M7 position.

Additional pressures of £22k for Long Street support, Premises review of £950 and £8k for Enderby and Limes Medical Centres respectively and additional £3k support against the Kingsway Long Term Management plan has been accounted for in the M7 position.

A full reconciliation between month 6 and month 7 is shown below to highlight where there have been improvements in some areas that are offset by spending pressures in others;

	£'000	£'000
Month 6 Forecast Overspend		330
Improvement in QOF	(49)	
Rents	(2)	
Water rates	(4)	
		(55)
Long Street caretaking costs	22	
Premises review	9	
Kingsway support	4	
Forecast reduction in prescribing fee collection	5	
Other baseline funding revisions, including list size adjustment	15	
		55
Month 7 Forecast		330

Urgent Care Centres

Northern Doctors contract is reporting a forecast overspend of £51k as at M7 due to a reduction in anticipated cross-charging income of £70k offset against increased expected underperformance against the Northern Doctors contract of -£19k.

GP IT

As at month 7, this area is reporting a breakeven forecast with a YTD overspend of £7k.

Primary Care Licences & Other

For month 7 this area is reported as forecasting an annual underspend of -£4k due to payment for DSN nurses covering Q1-3. The YTD underspend is reported as -£1k.

QIPP

Full year QIPP saving of £333k to be identified across primary care services. As at month 7 a £49k reduction in QOF achievement has been realised in comparison to month 6. Further analysis is ongoing to address the remaining gap.

2. Recommendation:

The ELR CCG Primary Care Commissioning Committee is requested to:

- **RECEIVE** the reported variance position against the Primary Care budgets based on reporting information available.

Appendix 1

M7 Primary Care Commissioning Report	YTD Position			Forecast Outturn Position		
	YTD Budget	YTD Actuals	YTD Variance	Annual Budget	Annual Forecast	Annual Variance Over/(Under)
Area	**(£'000s)**	**(£'000s)**	**(£'000s)**	**(£'000s)**	**(£'000s)**	**(£'000s)**
CCG Prescribing						
Scriptswitch	71	45	(26)	121	89	(32)
Central Prescribing	762	690	(72)	1,306	1,205	(102)
High Cost Drugs	564	535	(29)	966	918	(48)
GP Prescribing	27,355	27,117	(238)	45,494	44,941	(553)
Total Practice Prescribing	**28,752**	**28,387**	**(365)**	**47,888**	**47,153**	**(735)**
Enhanced Services						
Community Based Services	1,568	1,578	10	2,687	2,759	72
Total Enhanced Services	**1,568**	**1,578**	**10**	**2,687**	**2,759**	**72**
GP Support Framework						
Care Homes	266	266	0	457	457	0
End of Life	190	188	(2)	325	323	(3)
Prescribing Incentive Scheme	374	374	0	641	625	(16)
Long Term Conditions	17	17	0	103	28	(75)
Joint Working	190	188	(2)	325	323	(3)
Planned Care	0	0	0	0	0	0
GP Federation	95	102	7	135	125	(10)
7 Day Working Better Care Fund	340	409	69	483	483	0
Dementia	380	380	0	651	651	0
Heart Failure	95	95	0	163	163	0
Total GP Support Framework	**1,946**	**2,019**	**72**	**3,282**	**3,176**	**(106)**
Other						
GP Co-Commissioning	23,019	23,119	100	39,498	39,828	330
Urgent Care Centres	860	860	0	1,474	1,525	51
GP IT	400	407	7	650	650	0
Primary Care - Licenses & Other	66	65	(1)	113	109	(4)
QIPP	(194)	(166)	29	(333)	(284)	49
Total Other	**24,150**	**24,285**	**134**	**41,402**	**41,827**	**426**
	0	0	0	0	0	0
Total Primary Care	**56,416**	**56,268**	**(148)**	**95,258**	**94,915**	**(344)**

Primary Care Delegated Budgets analysis **Appendix B9**

	YTD Position			Forecast Outturn Position			
M7 Primary Care Co-commissioning Report	YTD Budget	YTD Actuals	YTD Variance	Annual Budget	Annual Forecast	Annual Variance Over/(Under)	Contract Type
Activity Type	(£'000s)	(£'000s)	(£'000s)	(£'000s)	(£'000s)	(£'000s)	
GMS Global Sum	13,778	13,813	35	23,620	23,727	107	Block with quarterly list size adjustments
MPIG Correction Factor	1,449	1,292	-157	2,201	2,192	-9	Block
PMS reinvestment	220	163	-57	659	469	-190	PMS reinvestment and FDR payment underspend committed to fund wound clinics, Leicester Asylum Service and preactice pharmacists.
FDR Payment	96	0	-96	165	0	-165	
Leicester Asylum Service + South Wigston Support	0	34	34	0	59	59	
Wound Clinics	0	188	188	0	323	323	
	316	385	69	824	850	27	
Total General Practice - GMS	**15,543**	**15,490**	**-53**	**26,644**	**26,770**	**125**	
PMS	151	26	-126	260	124	-135	Block with quarterly list size adjustments
Wigston Central Care taking/Sanctions on LS	0	126	126	0	126	126	N/A
APMS Baseline	0	274	274	0	331	331	N/A
APMS Prof Fees Prescribing	0	1	1	0	2	2	N/A
Staff Cost APMS Contract	0	34	34	0	41	41	N/A
Total General Practice - PMS Long Street Reprovision	**151**	**461**	**310**	**260**	**624**	**364**	
Occupational health	27	27	0	46	46	0	Block - fair share
Travel	1	0	-1	1	1	0	CPC
Locum Adoption/Paternity/Maternity	59	59	0	101	101	0	CPC
Locum Sickness	20	20	0	35	35	0	CPC
Locum suspended doctors	0	0	-0	0	0	-0	CPC - fair share
Seniority	306	271	-35	525	465	-60	Block
Sterile Products	-0	0	0	-0	0	0	CPC - fair share
Statutory Levy	0	0	0	0	0	0	Net nil
Voluntary Levy	0	0	0	0	0	0	Net nil
GP Training	54	46	-8	92	92	0	CPC
PCO Doctors Ret Scheme	0	4	4	0	4	4	N/A
Long Street Dispersal	0	0	0	0	0	0	PMS
Kingsway Management Plan	0	4	4	0	5	5	Pressure badged against Global Sum
Total Other GP Services	**467**	**432**	**-35**	**800**	**749**	**-50**	
QOF Achievement	636	680	44	1,090	1,166	75	CPC
QOF Aspiration	1,591	1,654	63	2,727	2,834	107	Block
Total QOF	**2,227**	**2,334**	**107**	**3,818**	**4,000**	**182**	
DES Extended Hours Access	250	342	92	477	587	110	Block
DES Learning Disability	44	38	-6	75	65	-10	CPC
DES Minor Surgery	394	279	-115	676	479	-197	CPC
DES Unplanned Admissions	526	540	14	901	926	25	Block
DES Violent Patients	27	27	1	46	47	1	Block
DES Minor Surgery - PMS	0	0	0	0	0	0	N/A
LES Extended Hours Access - PMS	0	1	1	0	1	1	N/A
LES Translation Fees	18	34	16	30	58	27	CPC - fair share
Total Enhanced Services	**1,258**	**1,262**	**4**	**2,205**	**2,163**	**-42**	
Dispensing Quality Scheme	64	53	-11	110	90	-19	Block
Prof Fees Dispensing	813	834	20	1,394	1,394	-0	CPC
Prof Fees Prescribing	122	51	-72	210	224	15	CPC
Total Dispensing/Prescribing Drs	**999**	**937**	**-62**	**1,713**	**1,708**	**-5**	
Prescribing charge income	-170	-180	-10	-292	-309	-17	CPC
	-170	**-180**	**-10**	**-292**	**-309**	**-17**	
Prem Actual Rent	862	862	0	1,478	1,478	0	Block
Prem Clinical Waste	67	67	0	115	115	0	CPC - fair share
Prem Cost Rent	158	-10	-168	270	56	-214	Block
Prem Health centre Rates	10	12	3	16	21	5	Block
Prem Health centre Rent	42	56	14	71	96	25	Block
Prem Notional Rent	750	920	170	1,285	1,535	250	Block
Prem Rates	445	435	-10	764	746	-18	Block
Prem Water Rates	36	22	-14	61	38	-23	CPC
Total Premises Cost Reimbursement	**2,369**	**2,365**	**-5**	**4,062**	**4,086**	**24**	
Rent	19	17	-3	33	33	0	CPC
Other premises	2	2	0	3	3	0	CPC
Total Other premises	**21**	**18**	**-3**	**36**	**36**	**0**	
GP Pensions	0	0	0	0	0	0	Net nil
Total Pensions	**0**	**0**	**0**	**0**	**0**	**0**	
Transformation reserves	154	0	-154	252	0	-252	Committed to expenditure
Grand Total	**23,019**	**23,119**	**100**	**39,498**	**39,828**	**330**	