Primary Care Commissioning Committee

Agenda Part 1

Date: 13 February 2018

Time: 15:30 – 16:50

Location: Council Chambers, Hove Town Hall

Item ref	Item description	Action	Lead	Paper	Time
1/18	Welcome and Apologies		Chair		15:30
2/18	Declaration of Conflicts of Interests	Approval	Chair	Paper	15:31
3/18	Minutes from the meeting held on 19 December 2017	Approval	Chair	Paper	15:32
4/18	Action Log	Assurance	Chair	Paper	15:33
	Governance				
5/18	PCCC Orientation Programme	Presentation	Murray King	Presentation	15:35
	Delegated Commissioning of Primary Medical Care				
6/18	Director of Commissioning Update including NHSE Assurance meeting update, Federation Development and Primary Care Strategy update	Assurance	Chris Clark	Verbal	15:45
7/18	Primary Care Commissioning Finance Report for Q4 17/18	Assurance	Alan Beasley	Paper	15:50
8/18	Post-Implementation Review of the Closure of Ridgeway Surgery	Assurance	Murray King	Paper	16:00
9/18	Ireland Lodge Care Home funding request	Approval	Murray King	Paper	16:10
	Report from Sub-Committees				
10/18	Quality and Performance Report/Co-Commissioning Report from the Primary Care Operational Group	Assurance	Murray King	Paper	16:25

	Any other business				
11/18	Any Other Business	Discussion	Chair	Verbal	16:35
	Committee Governance				
12/18	Approve Chair's Report to the Governing Body	Approval	Chair	Verbal	16:36
13/18	Matters to Refer to Another Governing Body Committee	Approval	Chair	Verbal	16:38
14/18	Matters to Escalate to the Risk Registers	Approval	Chair	Verbal	16:40
15/18	Evaluation of Meeting Performance	Discussion	Chair	Verbal	16:42
	Date of the next meeting				
16/18	10 April 2018	Information	Chair	Verbal	16:50

Resolution of Items to be Heard in Private (PCCC Chairman)

In accordance with the provisions of Section 1(2) of the Public Bodies (Admission to Meetings) Act 1960, it is resolved that the representatives of the press and other members of the public are excluded from the second part of the PCCC meeting on the grounds that it is prejudicial to the public interest due to the confidential nature of the business about to be transacted. This section of the meeting will be held in private.

NHS
Brighton and Hove
Clinical Commissioning Group

Primary Care Commissioning Committee Members: Register of Interests – updated 12 January 2018	
Details	**Interest**
Dr Charles Turton, Independent Clinical Member-Secondary Care Clinician and Committee Chairman Start date with CCG: 1 November 2017 Chair of Primary Care Commissioning Committee Member of Quality and Safety Committee Member of Remuneration and Nominations Committee Member of Clinical Investment and Disinvestment Sub-Committee	Trustee and Vice-Chairman of Friends of Brighton and Hove Hospital (charity which supports hospital services). Ambassador for Martlets Hospice.
Wendy Carberry, Managing Director South, Central Sussex Commissioning Alliance Start Date: 1 January 2018 High Weald Lewes Havens CCG Brighton and Hove CCG	No interests declared.
Chris Clark, Director of Commissioning Start date with CCG: 22 May 2017 Member of Finance and Performance Committee Member of Primary Care Commissioning Committee Member of Clinical Investment and Disinvestment Sub-Committee	Director and Sole Shareholder of CW Clark Ltd.

NHS
Brighton and Hove
Clinical Commissioning Group

Primary Care Commissioning Committee Members: Register of Interests – updated 12 Janaury 2018	
Details	**Interest**
Alan Beasley, Chief Finance Officer Start date with CCG: 1 October 2017 Member of Finance and Performance Committee Member of Primary Care Commissioning Committee Member of Clinical Investment and Disinvestment Sub-Committee	Chief Finance Officer at High Weald Lewes Havens CCG.
Lola Banjoko, Director of Performance, Planning and Informatics Start date with CCG: 21 March 2016 Member of Finance and Performance Committee Member of Primary Care Commissioning Committee Member of Quality and Safety Committee Member of Clinical Investment and Disinvestment Sub-Committee	Council Member of the Royal African Society. Volunteer for Global Health. Director of AfricaRecruit and AfricaServe Ltd. Member of NHS International Network.

NHS
Brighton and Hove
Clinical Commissioning Group

Primary Care Commissioning Committee Members: Register of Interests – updated 12 Janaury 2018	
Details	**Interest**
Allison Cannon, Chief Nurse for Sussex and East Surrey STP Commissioners Start date with CCG: 1 July 2017 Member of Finance and Performance Committee Member of Primary Care Commissioning Committee Member of Quality and Safety Committee Member of Clinical Investment and Disinvestment Sub-Committee	Chief Nurse of Hastings and Rother CCG and Eastbourne Hailsham and Seaford CCG. Husband, Director of Primary Care Collaboration, Here Ltd. Father, Chairman, Navigo – social enterprise in Lincolnshire.
Dr Manas Sikdar, Local Member Group GP (East) Start date with CCG: 6 October 2015 Member of Quality and Safety Committee Member of Primary Care Commissioning Committee Member of Clinical Investment and Disinvestment Sub-Committee	GP Principal at Albion Street Surgery. Partner holds a clinical role with Newhaven Downs Rehabilitation Hospital. Partner is a locum GP within Brighton and Hove. Partner is a Member/Shareholder of Here Ltd. Albion Street Surgery has entered discussions with Here Ltd about working collaboratively. Practice (Albion Street Surgery) rents clinical and admin rooms to the Wellbeing Service. The Brighton and Hove Wellbeing Service is a free NHS service for all ages from 4 years and upwards in Brighton and Hove. The service is delivered in partnership by HERE, Sussex Partnership NHS Foundation Trust, MIND in Brighton and Hove and YMCA DownsLink Group. Practice (Albion Street Surgery) provides the substance misuse service LCS with Pavilions. Albion Street Surgery receives an income for providing the service. Dr Sikdar has no direct contact with the services.

NHS
Brighton and Hove
Clinical Commissioning Group

Primary Care Commissioning Committee Members: Register of Interests – updated 12 Janaury 2018	
Details	**Interest**
Dr Jim Graham, Local Cluster Representative Start date with CCG: 1 March 2016 Member of Finance and Performance Committee Member of Primary Care Commissioning Committee Member of Clinical Investment and Disinvestment Sub-Committee	Director of SMC Ltd. Partner at Stanford Medical Centre. Director of Oxymon Ltd. Member/Shareholder of Here Ltd. GP for the Community ENT Service. GP for Intermediate Tier Headache Services (ITHS). Clinical Programme Lead: Access to Primary Care and Urgent Care.
Jonathan Molyneux, Lay Member (Finance) Start date with CCG: 1 June 2017 Chair of Finance and Performance Committee Member of Audit and Risk Committee Member of Primary Care Commissioning Committee Member of Quality and Safety Committee Member of Remuneration and Nominations Committee	No interests declared.

NHS
Brighton and Hove
Clinical Commissioning Group

Primary Care Commissioning Committee Members: Register of Interests – updated 12 Janaury 2018	
Details	**Interest**
Dr Jennifer Oates, Independent Clinical Member - Registered Nurse Start date with CCG: 1 April 2013 Chair of Quality and Safety Committee Member of Primary Care Commissioning Committee Member of Finance and Performance Committee Member of Remuneration and Nominations Committee	Employed by the Care Quality Commission. Employed by Kings College London. Trustee of Brighton Natural Health Centre. Occasional nursing shifts with Sussex Partnership NHS Foundation Trust, outside of Brighton and Hove.
Mike Holdgate, Deputy Chair of the CCG and Lay Member (Patient and Public Participation) Start date with CCG: 1 September 2014 Chair of Clinical Investment and Disinvestment Sub-Committee Member of Audit and Risk Committee Member of Quality and Safety Committee Member of Primary Care Commissioning Committee Member of Remuneration and Nominations Committee	Director of Mike Holdgate Associates.
Rob Persey, Executive Director of Health and Adult Social Care (Brighton and Hove City Council) Start date with CCG: 12 October 2016 Member of Primary Care Commissioning Committee Member of Clinical Investment and Disinvestment Sub-Committee	Employed by Brighton and Hove City Council.

NHS
Brighton and Hove
Clinical Commissioning Group

Primary Care Commissioning Committee Members: Register of Interests – updated 12 Janaury 2018	
Details	**Interest**
Malcolm Dennett, Lay Member (Governance) Start date with CCG: 1 June 2017 Chair of Audit and Risk Committee Member of Primary Care Commissioning Committee Member of Finance and Performance Committee Member of Remuneration and Nominations Committee	Trustee and Vice Chair of Independent Lives (Disability).
Alistair Hill, Acting Director of Public Health (Brighton and Hove City Council) Start date with CCG: 1 November 2017 Member of Primary Care Commissioning Committee Member of Clinical Investment and Disinvestment Sub-Committee	Employed by Brighton and Hove City Council. Partner is a Trustee of Grace Eyre Foundation, local charity for people with learning disabilities and provider of learning disability services.
Murray King, Interim Associate Director of Primary Care Start date with CCG: 1 April 2016 Member of Primary Care Commissioning Committee	Married to East Sussex Tutor for Centre for Postgraduate Pharmacy Education.
Bob Deschene, Director of Healthwatch Brighton and Hove Member of Primary Care Commissioning Committee	No interests declared.

Primary Care Commissioning Committee Members: Register of Interests – updated 12 Janaury 2018	
Details	**Interest**
Jeremy Luke, Medical Director, Surrey and Sussex Local Medical Councils Member of Primary Care Commissioning Committee	Medical Director, Surrey and Sussex Local Medical Councils
Dr Thomas Gayton, Local Cluster Representative Start date with CCG: 9 January 2018 Member of Primary Care Commissioning Committee Member of Clinical Investment and Disinvestment Sub-Committee	Partner at the Montpelier Surgery, Brighton. Wife is a consultant geriatrician at the Royal Sussex County Hospital, Brighton and Sussex University Hospitals NHS Trust.

Primary Care Commissioning Committee

Brighton and Hove Clinical Commissioning Group

Part 1 Minutes

Date: 19 December 2017
Time: 11.30 – 13.00
Location: Jubilee Library, Jubilee Street, Brighton

Summary of resolutions taken at meeting

Proposed resolutions	
Item number	**Resolution**
51/17	The Committee **approved** the declaration of conflicts of interests.
58/17	The Committee **approved** the minutes of 31 October 2017.
59/17	The Committee **approved** the Action Log.
60/17	The Committee **approved** the Practice Support and Performance Policy.

Chair	Dr Charles Turton (CT), Chair, Independent Clinical Member - Secondary Care Clinician	
Present	Alan Beasley (AB), Chief Finance Officer Chris Clark (CC), Director of Commissioning Adam Doyle (AD), Chief Accountable Officer Malcolm Dennett (MD), Lay Member for Governance Bob Deschenne (BD), Healthwatch Dr Jim Graham (JG), GP Local Cluster Representative Sam Harris (SH), NHS England Alistair Hill (AH), Acting Director of Public Health Mike Holdgate (MH), Deputy Chair of CCG and Lay Member for Patient and Public Participation Murray King (MK), Associate Director of Primary Care Jonathan Molyneux (JM), Lay Member for Finance Dr Jennifer Oates (JO), Independent Clinical Member, Registered Nurse Dr Manas Sikdar (MS), LMG Lead (East)	
In attendance	Moosa Patel (MT), Interim Director for Corporate Affairs Vanda Bowles (VB), Interim Governing Body Secretary (Minutes) Sarah Elmaleh (SE), Interim Governing Body Administrator	
Apologies	Lola Banjoko (LB), Director for Performance , Planning and Informatics Allison Cannon (AC), Chief Nurse for Sussex and East Surrey STP Commissioners Dr Jerry Luke (JL), Medical Director, Surrey and Sussex LMCs Rob Persey (RP), Director of Adult Social Care BHCC Peter Wilkinson (PW), Consultant in Public Health, BHCC	

Agenda item	Discussion	Action
56/17	**Welcome and apologies**	
	CT asked everyone to introduce themselves and noted the apologies.	
57/17	**Declaration of any conflicts of interest**	
	No conflicts of interest were noted. The Committee **approved** the declaration of conflicts of interest.	
58/17	**Minutes from the meeting held on 31 October 2017**	
	CT went through the minutes from the meeting held on 31 October 2017 and on page 6, the last sentence of the third paragraph should read: the "policy" and not "police". The Committee **approved** the minutes with the above amendment.	
59/17	**Action Log**	
	CT reviewed the Action Log. All actions were green. The Committee **approved** the Action Log.	
60/17	**PCCC Orientation Programme Presentation**	
	MK gave a presentation on Enhanced Services and full details can be found in the presentation. He explained the difference between National and Locally Enhanced Services and showed what is covered in this CCG. MD asked if there was any indication that NHS England were contemplating further delegation to overcome some of the confusion with NHS England and local authority public health functions. MK did not think this was likely as it has been designed to be a direct relationship between NHSE and the Secretary of State. AD confirmed that it would need legislation to change it and they are not expecting anything at the moment. CT asked about extended hours for GPs which is particularly important in a commuter area. There seems to be some variation in Practices ability to offer this and he asked what the direction of travel was. MK explained that the service had not got off to a good start for political reasons and some Practices decided that it was not worth offering. However, the City has some funding for extended hours which may encourage others to offer this service. It was noted that Practices are under no obligation to offer it.	

	MH asked whether the uptake of the Sunday services had improved and whether there was a communication issue. MK said that the service had not been as well advertised as it could have been but the CCG have been working with Here to promote it. The fact remains that not many people want to see a GP on a Sunday. However, the CCG has worked with 111 to ensure that GP slots are available on a Sunday to avoid sending patients to A&E. MH asked how we knew that patients did not want the service on a Sunday. MK replied that surveys showed this and it has consistently been the lowest uptake of any day of the week. BD commented that this was really an issue of patient choice and it appeared that people did not want to see their GP on a Sunday. MK said that HWLH CCG had recently carried out a survey which showed the same result. CC said that whilst there was a low uptake of patients in primary care on a Sunday, there was a much higher demand in A&E and WIC on a Sunday. This is not something that the CCG is powerless to change and it will continue to work on this mainly through communications and engagement. CT thanked MK for an interesting presentation.	
	Delegated commissioning of primary medical care	
61/17	**Director of Commissioning Update**	
	CC presented the Director of Commissioning Update on the latest developments in Primary Care. The first point that he reported to the Committee was that there had been significant progress in developing the GP Federation. He gave an update at the last Committee where he described what the CCG had asked of the Federation Working Group (FWG) to provide assurance for the CCG to provide financial support. They have made significant progress and are developing a very robust relationship with the FWG. Most importantly the FWG have confirmed that 34 of the 36 GP Practices in Brighton and Hove have given written confirmation of their membership and the remaining 2 Practices have given verbal intent to join. The CCG are looking forward to having a full membership Federation which is very positive for the City. They have developed a road map and agreed how they work towards an operational Federation at which point the CCG can start having discussions with them about the Model of Care, the CCG strategy and services which they may want to deliver or the CCG may want them to deliver. He said that this is a really positive way to end the year and the CCG looks forward to working with the Federation in the New Year.	

	The second point was that significant progress has also been made with the Primary Care Strategy. He thanked Murray King, Katie Stead and all the members who have provided input to this. It is a really important piece of work for the CCG. The focus of the Strategy is to build resilience in primary care. The developed draft of the Strategy will be shared with the Committee and it will be presented to the Governing Body in the public session in January 2018. CC also said that the dispersal of patients from the Ridgeway Practice is ongoing as per the plan agreed by this Committee and no major issues have been encountered. CT then asked for questions and comment. AD commented that the coverage for the Federation is a significant step forward. This time last year it looked very unlikely that a Federation would involve the majority of the General Practices in the City. However, the CCG was very clear that it did not want to offer inequitable services to the population and held firm on a City wide approach. DS, AH and the LMG Representatives worked really hard with the membership on this and deserve credit for the progress that has been made. BD asked if the members made any financial contribution to the Federation. CC replied that they pay 10 pence per patient as an initial starting point to show 'buy in' from the Practices. The Committee was **assured** by the Director's Update.	
62/17	**Primary Care Commissioning Finance Report for Q3 17/18**	
	AB presented the Primary Care Finance Report for Q3 2017/18. He said that the CCG is currently reporting a small underspend of £2,000 against a year to date budget of £24.5m which is therefore a breakeven budget for the year to date. The forecast year end reporting is £538,000 underspend against a total budget of £40.1m. The underspend is against centrally held reserves the CCG is required to hold by NHS England. The money does not go away and is there for investment in future years but is reported in year as an underspend. He wanted to highlight that it had been recognized nationally that there had been an under investment in Primary Care GP Services in the City. In recognition of this the CCG has received a 9.5% uplift to its allocation which is about £2.5m over and above baseline funding which is really good news. This is being utilized by the CCG to support the delivery of the Primary Care Strategy.	

	He also said that LCS (which is the budget for services which are commissioned by the CCG outside of the General Medical Services contract) is currently reporting an in year variance underspend of £300K and a forecast variance of £211K underspend. Table 2 on page 4 of the report shows the position of each of the Locally Commissioned Services that the CCG has commissioned. He apologized that there was an error in the serious mental illness variance but said that the bottom line is correct. He also advised the Committee that he had met with DS because of concerns about the Cancer pilot underspend and Diabetes and Wound Care. Some further analysis is required of those particular LCS's as there is an issue reported from GPs. The feedback is that sometimes access to the fund is onerous and administratively burdensome for General Practices. He has given an undertaking to review these to make sure that the information data requirements from Practices is appropriate to allow the CCG to receive assurance that those services have been provided and can be paid for. He invited questions from the Committee. JM asked if LCS came from the Co-Commissioning budget. AB explained that it is not part of the ring fenced budget but is part of the commissioning baseline budget. JM also asked about where the CCG is in terms of distance from target. AB responded that he would check and come back to him. The 9.5% uplift should have brought the CCG close to its distance from target capitation. He has the allocation for the next 2 years now and will provide a copy of that to JM and that will clarify the distance from target for the next 2 years. **Action:** AB to clarify the CCG distance from target and provide JM with the allocation information for the next 2 years. MD asked whether any underspend in the current year impacts on the national allocation to the CCG going forward. AB replied that it did not. The Primary Care budget is not an area where the CCG is seeking to make savings but rather to invest in developing and implementing the Primary Care Strategy. MH asked if there were any conditions attached to how the additional money can be utilized. AB responded that the only conditions attached will be self-imposed. The CCG will make sure that the money is used for the purpose for which it was intended and will be looking for value for money. They will also look for alignment with delivery of the Primary Care Strategy. JO asked about the areas of concern around the LCS raised earlier for Cancer and Diabetes and how that will be dealt with. AD said that issues would be reviewed by F&PC in as far as performance is concerned and by QASC for quality improvement. The indicators are that the CCG is not doing that well on this and the commissioning model needs to be looked at. He said that the Director of Commissioning should take this forward and provide a plan to the Committees. He accepted that AB has met with the Chair but it has not been resolved what should happen. The resolution should go through the Director of Commissioning to the Management Team and then to the appropriate Committees. CT commended AD and said that it is really important to ensure that the various places where issues are discussed are connected.	**AB**

	MS asked whether the right architecture is in place for the design of LCS. In particular which Committee should it go to if designs need to be changed? AD responded that he did not think that the CCG has a robust plan for Diabetes and Cancer. He would expect the Commissioning Operations Meeting (COM) which is the 'engine room' of our clinicians and managers coming together, to design the best clinical model for these areas. The recovery plan should come from COM and be reported to the Senior Management Team and signed off there. If investment is needed to deliver the Strategy then it would come through this Committee because of its remit. Otherwise it could go to CIDC or F&PC with the quality improvement aspects going to QASC. So in the absence of knowing the overarching plan for Cancer and Diabetes, this should be reviewed by COM and then through relevant parts of the organization going forward. **Action:** CC to develop a Development Plan with COM for Cancer and Diabetes LCS. The Committee was **assured** by the Primary Care Commissioning Finance Report for Q3 17/18.	**CC/COM**
63/17	**Quality and Performance Report and Co-Commissioning Report from Primary Care Operations Group**	
	MK presented the Report from the Primary Care Operations Group (PCOG). He highlighted two points. The first is the impact of a Practice closing particularly at short notice on neighbouring practices in terms of the ability to deliver the Quality and Outcomes Framework. It can take a year for performance to pick up again. Secondly, in terms of good governance he wanted to bring to the Committee's attention the fact that the CCG has received some additional NHSE funding for winter capacity. It is being offered to Practices at short notice as it was only announced recently. JO asked if the PCOG minutes could come to this Committee as many issues were dealt with in more detail there. MK responded that there was no reason in principle not to do this except that they can contain sensitive Practice information but that could be redacted. JM said that there is a summary of points from Committees and that would mean that some could go to the private part of the meeting if necessary. CC agreed and explained that there is a standard format report from Committees that should come from PCOG to this Committee and should contain all the pertinent points. If there is a sensitive issue, it could come to Part 2. The CCG is looking at all the Performance and Quality reporting to make it more consistent and all Committees get a consistent format. AD said that if there is a concern about the quality of the report then more detail can be included. In every other Committee they have agreed to make the sub-committee reports fuller rather than having the minutes. He suggested that it would be worth reviewing what PCCC did delegate to PCOG to assure the Committee that it is getting the information that it needs from the report and if not to change the report.	

	It is important that the general reporting is consistent everywhere and not different for different Committees. However, there is uniqueness with PCCC and PCOG because of the conflicts of interest so there was a need to make sure that that PCOG is reporting to this Committee in the right way. **Action:** Review what was delegated to PCOG and what was not to ensure that it is reporting to the Committee in the right way. MH asked that the Summary sheet contains more information about the work that is being undertaken to engage with the public. It will give the public assurance that they are not being ignored. CIDC have also discussed this. MK agreed with this. MH referred to section 6.3 as that decision was made at CIDC without the GPs as they were potentially conflicted. He asked how that would be managed at this Committee in terms of investment in primary care. MS said that his specific point had been that sometimes an LCS can have a negative impact on Practice income due to the way that the Quality Outcome Framework is set up. This could be why some practices may be reluctant to provide an LCS. He said that it is complex but needs to be discussed somewhere. CC agreed that it is complex but to a Commissioner the two aspects should remain separate based on the needs of the patient rather than finances. This applies to all services but as commissioner for Primary Care the CCG has the responsibility to make sure that there is a sustainable and resilient primary care service for our population. The Primary Care Strategy describes the approach in sustaining primary care and investing in it. Locally Commissioned Services are included in that investment plan. There is within the CCG the opportunity to discuss having a resilient and sustainable primary care offering across the City and at individual practice level. MS said that we need to be aware if we commission something that it can decrease useful activity elsewhere in the system and could lead to worse outcomes for our patients so we should be cautious. AD said that the CCG needs to make sure that it is measuring the impact of everything and not just primary care. There is a commissioning conundrum that the CCG has to face which is if it commissions certain services from providers what the unintended effects may be. The CCG may decide that Primary Care is not the right place to invest for some services depending on the ability to scale up and deliver. These difficult decisions are at Governing Body level. There are choices to be made on where to invest and where not to invest and why based on evidence, track record and ability to deliver. This will be across all services. AH asked about the Quality Assessment Tool. MK explained that it has two indicators from the Quality Outcome Framework and level of exception reporting. This is about health inequalities and although it can be hard work to get some patients in deprived areas in for review the CCG cannot be reconciled to this. It has to work out what needs to be done to support Practices to do this.	**CC**

	The Committee was **assured** by the Report.	
64/17	**Practice Support Toolkit**	
	MK presented the draft Practice Support Toolkit paper. He said that the Committee had seen it before in draft and to put it in context the number one priority is to improve the sustainability and resilience of our practices. The CCG has developed the Quality Assessment Tool to identify vulnerable Practices. The question is what to do when vulnerable Practices have been identified. The Toolkit lists the interventions offered by the CCG and sets out a framework for contributions of the Practice to help it rather than becoming dependent on funding from the CCG. There is no point in propping up an unsustainable Practice. This is a key part of the Strategy. The Toolkit is a starting point for discussion with a Practice about how to move them from where they are to a position of sustainability. It is partly financial, partly clinical and partly operational and works within the context of Primary Care at scale. It could be that some small Practices have to become dependent on other local Practices for resilience. Essentially it is the rules of engagement between the CCG and struggling Practices. JM asked whether the £25,000 was a cap or simply the amount given direct to the Practice and other support could be provided as well. MK responded that this is the financial limit for PCOG. If a Practice needs more than that it needs to go through a fuller process in the CCG, which would be through SMT and then to this Committee for sign off. There has to be proper scrutiny and proper financial and governance processes to put larger sums of money into a Practice. He confirmed that, in such circumstances, PCOG would suggest what else needed to be spent and then come to this Committee to approve it. He also said that what some Practices need to turn them around may not lie within the Practice or the CCG. If the CCG does need to provide outside help then it could make this available to more than one Practice if appropriate. MH said that he was really pleased to see the way this is developing as it is so important that the CCG has a way of responding to Practices in difficulty that helps to alleviate their problems. He asked whether the CCG has the right skills and knowledge and experience in the CCG to assist GPs in this way. He also asked if the CCG was getting feedback from the Practices on how useful they were finding the support and also whether it was assisting patient experience. MK said that outcomes were included in the Assessment Tool. It included FFT and the GP Survey. However, as there was a time lag, there was nothing stopping the CCG from agreeing with the Practice that they would do their own patient survey. We want to avoid Practices thinking that this is being done to them and give them a sense that if they ask for help early, then it can be managed together without drama. This is to encourage them to be pro-active in addressing problems. MH said that patient engagement too often concentrated on the expert patient and patient anger but in his experience there is an enormous wealth of knowledge that the CCG could tap into.	

	JO asked what capacity there was in the CCG to help Practices and whether we could share with some neighbouring CCGs. CC responded that from his perspective as a Commissioner there is a lot of development work and transformation that is needed. It does take a lot of resource when a Practice suddenly develops problems and he wants to share this with other CCGs who have expertise. MK said that they have to move away from firefighting and will not be able to do that without a credible plan. The other place where there is potentially untapped capacity is in the Practices themselves. A lot of them are doing innovative work which could be shared across the City. He would like to develop a bank of specialists who are prepared to help others. He would like incentives for strong Practices to help weaker ones. BD said that one of the key flashpoints for GPs was how the Practice made decisions and if not by consensus how they dealt with disgruntled GPs. MK agreed that this was important and revealed a lot about a Practice. It is one of the issues that the Toolkit addresses. MS urged caution about using the terms strong and weak Practices as this could be misconstrued. He also reminded the Committee that General Practice was provided in a completely different way to any other health services and GPs had invested their own resources which meant that they often saw things differently. This needed to be taken into account. MP asked MK to reconcile the review dates in the document as they were different. MK said that he would do this The Committee was **assured** by the Report.	
65/17	**Any other business**	
	CT asked whether the Committee could resolve the point made by MH about the COPD decision taken at CIDC. MH said that he was happy with AD's answer to this. AD responded that the Governing Body needs to have time in Q4 to look at investment and disinvestment decisions. There is a strong governance model but there is still a question of how to use it to make the right decisions for the 18/19 Operating Plan which will set out decisions on what investments the CCG will and will not make. This is a Governing Body discussion and may then go to Committees for specific areas. MH raised an issue that came up when MK led an engagement session with PPGs over strategy which concerned the closure of the Ridgeway Practice. It was reported that there should have been better communication with the patients of neighbouring practices as rumours spread such as that Rottingdean Practice was closing when it was not. He said that the CCG communicated well with patients at the surgery that was closing but not with the surrounding areas whose patients are also impacted. MK said that he has just started a look back exercise about the closure of the Ridgeway Practice and what can be learned from it.	

	Committee Governance	
66/17	**Revised Committee Terms of Reference**	
	CT outlined the main changes in the Committee Terms of Reference and asked for any comments. BD asked whether the Local Cluster Representatives added at 3.3 meant that there would be more GPs on this Committee. MP clarified that it would not as the LCRs replaced the previous LMG representatives. JM said that he needed to be added to the membership. MH corrected the title error which should be *Patient and Public Participation.* AD asked for agreement that either he would attend the Committee or the Managing Director for the South as this was being discussed at present. This would not need to come back to the Committee again. The Committee **approved** the Terms of References subject to the changes above.	
67/17	**Matters to refer to the Governing Body**	
	How the Governing Body will ensure that policies do not clash particularly in relation to investments and disinvestments.	
68/17	**Matters to refer to another Governing Body Committee**	
	There were no matters to refer to another Governing Body Committee.	
69/17	**Matters to escalate to the Risk Registers**	
	There were no matters to escalate to the Risk Registers.	
70/17	**Evaluation of meeting**	
	CT asked everyone for their evaluations. MH said that he had chaired the meeting very well and others agreed. CC said that it was important that as this was a meeting in public, it was important that it did not start immediately after another meeting. Mr Scott a member of the public said that the room was unsuitable as there was a high volume of low frequency noise coming from the ventilation system. This should either be turned off or another room used. It also had not helped that there were no microphones.	

	CT said that he was sympathetic to the point but the CCG were trying to hold meetings in different parts of the City and there were a limited number of affordable choices. However he appreciated the reminder.	
	Date of next meeting	
	13 February 2018 16.00 – 17.30 Council Chamber – Hove Town Hall CT then closed the public part of the meeting and proceeded to the private part of the meeting.	

	Minute Reference	Committee Paper	Action Required	Due Date	Executive Lead	Comment/ Update	Progress
	62/17	Primary Care Commissioning Finance Report for Q3 17/18	AB to clarify the CCG distance from target and provide JM with the allocation information for the next 2 years.	13/02/2018	AB	This has been circulated.	
	62/17	Primary Care Commissioning Finance Report for Q3 17/18	CC to develop a Development Plan with COM for Cancer and Diabetes LCS.	13/02/2018	CC/COM	This is planned to be completed when we have the year end performance data for the two LCS (Q1 2018/19).	
	63/17	Quality and Performance Report and Co-Commissioning Report from Primary Care Operations Group	CC to review what was delegated to PCOG and what was not to ensure that it is reporting to the Committee in the right way.	13/02/2018	CC	The Committee is now receiving more detailed reports about the work of PCOG. TIAA are undertaking an audit of PCOG and Co-commissioning as part of their planned schedule of reviews for 2017/18. When this is complete, a summary will be brought to PCCC with any appropriate recommendations.	

	Off track
	In hand and on schedule
	Complete

NHS
Commissioning Alliance
Brighton and Hove CCG
Crawley CCG
High Weald Lewes Havens CCG
Horsham and Mid Sussex CCG

7/18: Primary Care Commissioning Finance Report for Q4 17/18

Name of Meeting:	Primary Care Commissioning Committee
Date of Meeting:	13/02/2018
Item Number:	7/18
Recommendation:	
For assurance	
Reviewed at:	
n/a	
Summary	
The Primary Care Commissioning Committee is recommended to note the financial position for the Primary Care budgets. • Detailed Delegated Co-Commissioning budgets reported in Table 1, reflect the position as at month 9 (December). • Performance against Locally Commissioned Services budgets is presented in Table 2 and reflects the position as at Q3, this being the latest period for which sufficient actual data is available following the submission of claims for reimbursement. • The CCG received c5% growth in primary care allocation over and above trend to partly correct a historical -11% funding gap against capitation target. While this does not correct the position completely it provides a source of funds of c£2m to support the delivery of the CCG's Primary Care Strategy for which plans for implementation in 18/19 are currently being developed. This leaves £2.9m of funding for which there is no commitment in 17/18, generating an underspend against reserves for the current financial year.	
Lead Director:	Alan Beasley, Chief Finance Officer
Clinical Lead	Dr Katie Stead - Clinical Lead for Primary Care
Author	Cherry Cozens - Finance Manager
Date of Report:	07/02/2018

Financial Implications
As noted in the report.
Legal or Compliance Implications
In compliance with SFI/SOs
Link to key objective and/or assurance framework risk
n/a
Patient, carer and public engagement
n/a
Equality Impact Assessment
An EIA is not appropriate for this report; however, in assuring delivery of our operating plan and the associated value for money, the equality of access to delivery of healthcare is supported.

Primary Care Finance M9 17/18

1. Co-Commissioning M9 2017/18

Brighton and Hove has historically received approximately 11% less primary care funding than would be anticipated using the national allocation methodology. This is referred to as the distance from target. A 9.5% increase to allocation has been notified which reduces the distance from target to 5%. This equates to £2m which is shown as fully committed to support the implementation of the CCGs Primary Care Strategy which is due to be finalised early in 2018 ready for implementation in 18/19. This leaves £2.9m of funding for which there is no commitment in 17/18, generating an underspend against reserves for the current financial year.

Commissioners are undertaking a detailed review of costs at a practice level to ensure that reported cost are as expected and aligned with contract values, and to identify where practices may have outstanding claims. This will enable detailed year end forecasts to be produced on a practice by practice basis at M10.

2. Table 1: Delegated Co-Commissioning M9 2017/18

B&H CCG – Delegated Commissioning 17/18	Month	9				
Budget Detail	Budget YTD	Actuals YTD	YTD Variance	17/18 Budget	Forecast	Forecast Variance
GMS Contracts	£18,289,910	£18,330,336	£40,426	£24,386,835	£24,386,835	£0
APMS Contracts	£2,075,500	£1,914,027	(£161,474)	£2,767,342	£2,767,342	£0
QOF	£2,213,868	£2,123,486	(£90,382)	£2,952,164	£2,952,164	£0
Premises	£3,312,936	£3,531,682	£218,746	£4,483,760	£4,483,760	£0
Practice Assist	£337,500	£253,490	(£84,011)	£450,000	£450,000	£0
DES	£383,098	£356,807	(£26,291)	£511,029	£511,029	£0
Other GP Earnings	£378,466	£534,954	£156,488	£504,923	£504,923	£0
Misc Costs	£307,850	£302,336	(£5,514)	£410,587	£410,587	£0
GP PCTF	£240,811	£192,649	(£48,162)	£321,279	£321,279	£0
General Reserves	£2,100,000	£0	(£2,100,000)	£2,795,810	£0	(£2,795,810)
General Reserves PMS Premium	£0	£0	£0	£157,271	£153,081	(£4,190)
Contingency	£75,000	£0	(£75,000)	£195,000	£95,000	(£100,000)
Flexibility Reserve	£0	£0	£0	£186,000	£186,000	£0
	£29,714,939	£27,539,766	(£2,175,173)	£40,122,000	£37,222,000	(£2,900,000)

3. Locally Commissioned Services Q3 2017/18

LCS budgets are currently expected to underspend by £226k by the year end.

Forecasts are based on data at Q3, but take into account that there tends to be a higher level of uptake of many of the LCSs in the second half of the year.

4. Table 2: Locally Commissioned Services Q3 2017/18

B&H CCG - Primary Care LCS 17/18	Quarter 3						
	Budget YTD	Actuals YTD	YTD Variance	Comments	17/18 Budget	17/18 Forecast	17/18 variance
LCS							
Ambulatory BP Monitoring	£56,441	57,270	829		£75,255	£76,360	£1,105
Community Alcohol Liaison	£37,690	33,502	(4,188)	started in June not April as planned	£50,253	£41,878	(£8,375)
Cancer Pilot	£255,000	110,619	(144,381)	post-audit payments due Q4	£340,000	£277,313	(£62,687)
Cancer Injectable Medicines	£15,000	13,368	(1,632)		£20,000	£19,324	(£676)
Childrens Health (pilot)	£20,786	5,002	(15,784)		£27,714	£13,669	(£14,045)
COPD	£28,012	30,442	2,430		£37,349	£43,089	£5,740
COPD Enhanced Case-finding	£12,203	614	(11,589)		£16,270	£7,819	(£8,451)
Diabetes	£314,852	250,729	(64,123)		£419,803	£364,306	(£55,497)
Diabetes Access to NDPP	£54,691	28,431	(26,260)	uptake slow	£72,921	£57,908	(£15,013)
Domestic Plebotomy	£6,105	3,534	(2,571)		£8,140	£4,712	(£3,428)
Drug Monitor	£84,041	74,970	(9,071)		£112,054	£104,960	(£7,094)
Palliative Care	£56,558	76,754	20,196	includes retainers (£60k)	£75,410	£92,339	£16,929
Phlebotomy	£229,178	218,854	(10,324)		£305,570	£291,805	(£3,765)
Rabies	£1,145	1,145	(0)		£1,526	£1,526	£0
Serious Mental Illness	£79,517	0		not payable until the end of the year	£106,022	£95,420	(£10,602)
Serious Mental Illness Training	£34,313	12,074	(22,239)		£45,750	£21,098	(£14,652)
Wound Care	£387,447	337,169	(50,278)		£516,596	£469,559	(£30,037)
Young Person's Wellbeing Service	£69,704	0	(69,704)	forecast assume will be invoiced	£92,938	£77,448	(£15,490)
Locally Commissioned Total	**£1,742,683**	**£1,254,477**	**(£408,689)**		**£2,323,571**	**£2,060,534**	**(£226,037)**
DRAFT - Data for 2 practices missing							

Date: 7th February 2018

Lead Director: Alan Beasley – Chief Finance Officer

NHS
Commissioning Alliance
Brighton and Hove CCG
Crawley CCG
High Weald Lewes Havens CCG
Horsham and Mid Sussex CCG

8/18: Post-Implementation Review of the Closure of Ridgeway Surgery

Name of Meeting:	Primary Care Commissioning Committee
Date of Meeting:	13/02/2018
Item Number:	8/18

Recommendation:

PCCC is recommended to receive assurance from the latest position.

The process used should be adopted as the vehicle for achieving the efficient and safe closure of a practice, should that occur, in the future.

Reviewed at:

PCOG

Summary

This paper provides an opportunity to consider the process of closure for Ridgeway Surgery in Woodingdean on the 31st of October 2018.

- Reflection on the execution of the closure process has provided an opportunity to create greater benefit and continual improvement of the process. The project was successfully executed overall with no major issues.
- There is opportunity to further improve the process for any future practice closures and create a toolbox of documentation and information for use in similar circumstances.
- The closure had a clear plan and process with many facets. Patient engagement was undertaken through 2 group events held in the practice, direct engagement in phone calls and Community Works facilitated information and support sessions. This element should be expanded in future, large commissioning projects affecting Brighton and Hove patients.
- Patients were successfully registered with a new a GP practice of their choice via open dispersal. This was done safely and mindfully of those patients identified as vulnerable.
- There were some temporary pressures on relationships with our GP practices caused by operational or third party failures in addition to the pressures of possibly taking on new patients.
- The Eastern side of the City has fewer general practice surgeries which has reduced the future options for patients and increased stresses into an already stretched part of the City. We have to be mindful of these in future commissioning decisions.

Lead Director:	Chris Clark
Clinical Lead	Dr Katie Stead
Author	Hannah Oliver
Date of Report:	31/01/2018

Financial Implications

The costs of implementing this closure are set out in 'Financial Implications' on page 8.

Legal or Compliance Implications

The relevant national guidelines apply to a practice closure including:

NHS General Medical Services Contract Regulations

NHS Primary Medical Services Regulations

NHS Primary Medical Services Policy Book

Link to key objective and/or assurance framework risk

Supporting practices to face relevant challenges and develop both as providers and commissioners of services

Patient, carer and public engagement

Patient, carer and public engagement was carried out during the process of closure but not specifically for the creation of this evaluation paper.

2 x Engagement events at the practice attended by commissioning support manager and the head of patient engagement

2 x Engagement events facilitated by Community Works

3 x Direct mailing communication and updates containing contact details.

Continual feedback via e-mails and patient phone calls

Equality Impact Assessment

AN EIA was carried out as part of the process for affected patients in August 2017.

The assessment identified key groups who needed support in registering with a new practice, in line with the CCG's Policy for Vulnerable Patients.

In particular it identified that there were:

- An above average proportion of older people. 462 registered patients were over the age of 65 and 132 of these were over 80, 22 were nursing home residents and 14 were on the dementia register.
- 17 patients were on the Learning Disability register and/or have Autism Spectrum Condition.
- 14.5% of the registered patients were aged 0-15 years old. 88 children were under five years old and 26 were in receipt of child protection or child in need plans.
- 88 patients were registered as physically disabled.
- 24 patients were housebound.
- Three patients were in their third trimester of pregnancy, or whose wellbeing was of concern.
- 114 adults were on the mental health register for depression. Additionally, there were 21 children and adults with complex mental health needs (2015/16 QOF data)
- It is estimated that 184 patients may have a visual and/or hearing impairment.

To the best of our knowledge, all patients deemed to be vulnerable were supported to register with a new practice.

Post-Implementation Review of the Closure of Ridgeway Surgery

Post Implementation Summary

- Reflection on the execution of the closure process gives an opportunity to create greater benefit and continual improvement of the process. The project was successfully executed and the objectives achieved with some issues along the way.
- The report should recognise what worked well in order to do the same again next time, and what didn't work so well in order to improve the process next time.
- There is opportunity to further improve the process for any future practice closures and create a toolbox of documentation and information for use by another commissioner in similar circumstances.
- The closure had a clear plan and process with many facets that required input from different teams across the CCG, third party suppliers and actions by the practice team.
- There were some temporary pressures on relationships with our GP practices caused by operational or third party failures in addition to the pressures of possibly taking on new patients.
- The Eastern side of the City has fewer general practice surgeries which has reduced the options for patients and increased stresses into an already stretched part of the City. We have to mindful of these in future commissioning decisions.
- Overall patients were provided with clear information and all patients had access to a choice of new general practitioner

Project Summary

The Ridgeway Surgery was a two-handed medical practice comprising of a husband and wife GP team, a part-time regular locum doctor and a practice nurse. There was a practice manager and team of 7 receptionists and administrative staff. The Surgery closed on 31/10/2017 having given the required 6 months' notice to the CCG. The husband and wife team had decided that they wanted to retire early and utilise their surgery premises in a different way. It was a well-considered planned decision and was not primed by any crisis or change in circumstances.

The CCG accepted their resignation and went about a full options appraisal that included patient engagement and the production of an Equality Impact Assessment. A motion for full list dispersal was made at the Primary Care Operational Group (PCOG) based upon the lack of future premises for a primary care medical centre, the relatively low patient list size which was unlikely to attract interest on the open market and the overall capacity in surrounding practices to register new patients. The overall decision for an 'Open dispersal' was made at a previous meeting of this committee (PCCC).

Each of the 2280 patients were informed of their doctor's decision and of the final outcome and were advised to re-register at one of 2 neighbouring surgeries. Overall 1,451 patients went to register at Woodingdean and c400 at Saltdean & Rottingdean Surgery. St Luke's Surgery, a single handed surgery with an already high registered list size, capped their list so that they did not have to register any more patients. The CCG is still able to allocate patients to a practices list in these circumstances and we registered 38 patients to them at patient's request. We expect that around 150 patients are likely to have registered with practices across the City (patients move house but often do not move surgery), being out of area for Woodingdean Surgery and Saltdean and Rottingdean Surgery and c250 of whom remain unregistered or may be 'ghost patients' at the time of IT closure and administrative finalisation. Receiving practices report that they are still receiving the occasional patient but that registration of new patients from Ridgeway surgery has very much declined.

The former GP partners are still working across the healthcare economy, and the building has been granted planning permission for conversion into residential properties.

Resources Allocated

- Hannah Oliver (Lead), Lara Kiziltuna (Project Support), Scott Sweeney (Medicines Management project lead), Kay Batty (Informatics project lead), Anne Smith (Senior Quality and Patient Safety lead)
- Overall the required input was variable over the life of the project. Some weeks required input was very little c2-3 hours, and at other times intensive input was needed c40 hours across the whole project team.
- Whilst not logged, post-project analysis suggests total input time over the project is between 1500 hours and 1750 hours
- Practice closure is a labour intensive process with a high level of responsiveness required.

Background and Applicable Processes

- Brighton and Hove CCG's members voted to have Primary Care Commissioning Services delegated to it from the 1st of April 2017. The contract notice was served by the partners on the 31st of April 2017.
- No local processes were available or had been developed at this fledgling stage of co-commissioning although there were some national processes laid out in the NHS England policy book – "Primary Medical Care Policy and Guidance Manual', that had been recently published and circulated to the CCG.
- This was the first closure solely managed by the CCG. Whilst there have been 7 other closures since 2003, these have been process managed by NHSE with CCG support and input on local issues and knowledge prior to delegated co-commissioning. As such none of the project team had been through a practice closure process before.
- The nationally negotiated GMS Contract contains information on notice period and contractors obligations to patients in the event of giving notice on a contract. This information was supplied to the contractor.

Key Objectives

- Continuation of Care: registration of Patients with a new GP
- Place patients with a GP of their choice
- In the event of an open dispersal, there should be sufficient system capacity to register all the displaced patients.
- Ensure the safe transfer of patients including the placement of vulnerable patients, transfer of medical records and a risk adverse approach to medicines management.
- Equality Impacts: Due consideration and mitigations for groups of patients who would otherwise be adversely impacted.
- Quality and Safety of care: Ensure additional resources allocated as required for receiving practices
- Patient Engagement: Ensuring patients are informed on what is happening and what action they need to take.
- Practice Closure: Assistance to the Ridgeway to secure a smooth transition including:
    - Information and assurances to the GP partners
    - Operational questions and answers with the practice manager
    - Liaison with Primary Care Support England around finances, transfer of medical records etc.
    - In practice visits from, for example, medicines management technicians, information governance facilitators and patient engagement enablers.

Project Timeline and Milestones

01/04/2017 - Co-Commissioning responsibility transferred from NHS E to CCG

28/04/2017 - Notification of intention to close the surgery received (6 months' notice as required for a planned closure).

27/06/2017 – Paper presented to PCOG exploring options to maintain contract / commission new provider / transfer patients to neighbouring practices.

01/08/2017- Equality Impact Assessment presented to PCOG

08/08/2017 - PCCC make decision based on the EIA and available options.

July 2017 onwards- Negotiate with Neighbouring practices, identifying addition resources required to increase list sizes.

05/09/17 - Vulnerable Patients Policy approved by PCOG

11/09/2017 - Start of patient registrations

31/10/2017 -Closure of Surgery to Patients

24/11/2017 -All patient records transferred. Actualised by 21/11

24/11/2017 -Ridgeway IT system shutdown

24/11/2017 -Last day for remaining staff

Summary of Patient Consultation / Satisfaction / Complaints

- All patients received a letter at the beginning of July giving details of the closure of the surgery
- A second letter was sent mid-July inviting feedback or attendance at a drop-in information session. About 12% of the population (c285 individuals) responded to this invitation.
- The CCG commissioned Community Works to provide 3 information sessions to support patients to move to other surgeries on 19th September, 20th September and 26th September.
- 3 Formal concerns were made to the CCG which were satisfactorily resolved with facilitation of re-registration at preferred practices. These patients however remained upset at the closure of their surgery.
- 1 patient's relative contacted the lead directly concerned about how to register when housebound. Receiving practices have in place processes to handle such cases and once the issue was raised to the preferred receiving practice, it was quickly resolved.
- 1 letter from a councillor on behalf of Woodingdean constituents was received; seeking assurances that patients would not be adversely impacted.
- 1 phone call from a councillor was made on behalf of their Rottingdean Coastal constituents seeking similar assurances for their constituents.
- Overall around 400 patients made contact with either the CCG or Community Works with concerns or queries classified as: general upset or concern, requests for help, disfavour to reregistering at the Woodingdean Surgery, wishing to register at St Lukes and failure to understand why a new provider could not be commissioned at the existing premises. This was significantly higher than other practice closures in the city and was not anticipated.
- We allocated 38 patients to St Luke's Surgery as they were not actively receiving new patients.

Process Successes and Challenges

Assessment of success and achievement of objectives

- The closure process was *overall successful*. The core objectives of i) successfully providing patients with a choice of new GP with sufficient system capacity and ii) Support safe transfer of patients including safe transfer of medical records, vulnerable patients and a risk adverse approach to medicines management
- Patients have been able to have a *choice of practices* within a reasonable travel distance and mobilisation of registration was successful overall.

- We were able to gain some support from *surrounding practices*; assign and agree anticipated patient transfer numbers although the conversation and subsequent negotiations were difficult. Following agreement of terms, the practices have then risen to the challenge of registering the new patients, reviewing their diagnoses and prescribed medicines. This has required recruitment of staff in one practice to bolster clinical capacity and that recruitment process was successful with 2 new GP's appointed.
- The practice *administration team* were excellent particularly as they were working towards job redundancy. They worked with all third party providers including medicines management and informatics facilitators who were welcomed into the surgery to support the safe transfer of patients. The project lead spoke almost daily with the practice manager and an effective 2-way dialogue was established during the mobilisation phase.
- *The GP's* proactively followed up tasks and advice from the facilitators in order that patients' records were as good as they could be, particularly with regards to medicines management, ordering blood tests and coding for allergy. Medicines management technicians were not so familiar with their clinical system but this has proved a great learning experience for them.
- The CCG senior pharmacy technician has access to EMIS on his laptop. This meant the practice could grant access to their database and after following IG process, could write the search terms *to identify vulnerable patients* at the CCG. We could actively monitor the number of patients that remained at the surgery with them, and ask the surgery to assign more resource when needed.
- The *IT closedown* went smoothly. The electronic transfer of notes went well (GP to GP transfer) with 100% of notes transferring electronically following registration with a new surgery. The practice manager did learn that if any transfers failed overnight they would generally be successful the following night if fewer were sent. The clinical system providers were reliable and NEL CSU were also reliable, sending in their team to collect IT on two occasions following door closure and on the final day of system shut down. They were also pleased to join our system call and share their learning.
- The usual PCSE *records courier* was helpful and took all the Lloyd George note folders as they accrued. As it was an open dispersal the notes were not removed in one transfer and could be taken away at the usual visits. He provided sufficient bags and was supportive in this process to the practice team.
- The overall success of the closure process was down to involvement of a *full project team representing different teams* in the organisation, who had not facilitated a practice closure previously. This was an example of excellent cross directorate working in the CCG.

Financial Implications

There were financial implications to the CCG for this closure that fall into 3 categories:

1. To receiving Practices
   a. Fee for each new registered patient from Ridgeway Surgery @ £21.34, in line with the CCG's agreed Policy for Supporting Practices in the Event of a Vacant List
   b. QOF achievement in 16/17 underwritten for 1 year within 10%
   c. Prescribing Incentive Scheme achievement underwritten in 16/17 for 1 year
   d. Up to £2,000 for fixtures and fittings for any new recruited staff workstations

   e. Recruitment support in the form of £2,000 towards advertising
   f. Contribution to GP and practice management time to facilitate transition and recruitment
2. To Community Works
   a. For 3 engagement events, support and a report.
3. Other costs
   a. Venue Hire for patient engagement events
   b. Cost of 3rd letter mailing to patients by PCSE £8,000 (our contract with PCSE allows for 2 letters only).

The primary source of savings to the CCG is from the Ridgeway rent and rates reimbursements.

A fuller analysis of the financial impact is set out below.

A secondary source of savings is through non registration of 'Ghost patients'. Around 350 patients have not registered with the local surgeries although up to 150 of these patients may have registered at other practices across the City.

Key learning for future projects

- Allow *sufficient management time* to implement all aspects of the project in the fullest manner, especially given the large number of priorities that the primary care team may be dealing with at any one time.
- The *project team met twice a week*. At the first and latter stages this was obviously needed. During the quieter decision making and governance stages once a week felt sufficient however the project team have fed back that maintaining twice weekly contact was useful to maintain momentum.
- A very *detailed project plan* was kept and updated daily. The document also became a repository for associated information such as stakeholder contact details. This was effective for a small team but one post implementation suggestion is to consider using Kahootz which is a cloud based collaboration tool for wider sharing of documents, plans and message boards.
- A comprehensive issues log was kept within the project containing 24 items.
- Invite *the surgery partners* to take a stronger role in communicating to patients. This could take the form of a direct separate letter or a dual authored letter to patients with the CCG.
- Primary Care Support England *(PCSE)* provided an unreliable and lengthy service for direct letter mailing. Time needs to be dedicated to contact them daily on progress: - "Check, Check and Check again". Nationally NHSE have commissioned 2 letter mailings to patients in a closure. 3 are needed and CCG budget approval is recommended early on.
- Anticipate for a *stronger patient reaction* than expected in any similar projects, have flexible resources available to cope with a possible high level of contact.

- The *emotional burden* for CCG staff was high due to the high number of patient contacts. Patients were upset or angry and training or additional capacity may be needed for this. Staff should be closely supported through this time. We should also consider using third sector organisations such as MIND or community works for patients to get additional help or access to advocacy services.
- The *medicines management* team were successful in getting additional technician support to go into the practice and run medicines searches, add codes and identify higher risk patients. The technician on the ground has provided her findings and this should be passed onto receiving practices as it provides learning opportunities and supports good clinical governance for their new doctors.
- The *information facilitators* provided training to the practice staff on how to undertake GP2GP transfer. Whilst this facility had been enabled at the practice for 12 months +, the practice team did not routinely use the system and were concerned about quantity of information to be transferred from shortly after sending in their resignation. It is recommended that the facilitators are involved from an earlier point in time to reduce anxieties.
- Local *political stakeholders* were informed of the doctors' decision soon after acceptance of notice. These individuals were not known to the project team and in particularly difficult closures it is recommended that senior support is obtained, particularly from those people that may know them or more usually work with them.
- Whilst a *communications* briefing was organised for patients and a briefing memo for media enquiries, a more robust strategy is suggested for future closures to include how to handle media enquiries, patient calls (i.e. a script to support call handlers), and how to handle face to face callers or protests.
- Although there was a dedicated project lead for the closure, the whole of the primary care team needs to be involved and briefed, to provide resilience to cover leave etc.

Improvements that have been implemented or further actions to be taken

- The project was *slow to formally initiate* following the receipt of notice of termination. This is partly because the CCG had only been responsible for co-commissioning for 4 weeks

- when the termination notice arrived and partly because efforts were made to ascertain the reason for the termination before the full closure project was initiated. Recent work on vulnerability and closer engagement with practices is aimed at ensuring a “no surprises” culture for any future terminations.
- This project used National Policies and experiential learning. Creating local policies and toolkit will prove useful for future closures and allow for continual process improvement. *A Closure Toolkit* will include a full selection of documents that can be picked up and utilised. A draft of this will be completed by 31.3.18
- It would be useful to draft a quick reference *timelines* to demonstrate how a closure could be affected during a single-hander closure (3 months’ notice not 6) or a rapid closure under exceptional circumstances.

- Letters to patients inviting them to a consultation meeting were sent out late by PCSE such that letters arrived on the day of the meeting despite all processes being followed well in advance and mailing dates agreed. This was an *SI for PCSE* and the CCG was told it would be investigated in order to make improvements.
- A close watching brief is advised for practices in the *East of Brighton* who have been impacted by this closure. This could be done routinely in the primary care resilience group meeting.
- The *impact of this sort of change* takes years rather than months to be fully absorbed and become business as usual. Extended concern for the surgeries affected should therefore be continued for a minimum of 12 months.
- *Further opportunities for support* should be particularly sought, or applied to, for schemes that will positively support East Brighton practices. In particular this should include opportunities to improve access, build capacity or improve physical ability to provide appointments. This could include the wider multidisciplinary team and those working in the community.

Date: 26/02/2018

Lead Director: Chris Clark, Director of Commissioning

NHS
Commissioning Alliance
Brighton and Hove CCG
Crawley CCG
High Weald Lewes Havens CCG
Horsham and Mid Sussex CCG

Appendix 1:- Financial Overview

The following tables show the total CCG costs and savings that can currently be attributed to this practice closure.

Description of Cost - paid to practices	Price / Calculation	Woodingdean Surgery	Saltdean and Rottingdean	Total
Fee for each new registered patient from Ridgeway Surgery	£21.34 per new patient	£30,964 1,451 patients as at the 23/01/18	£8,536 Approximation of 400 patients	£39,500
QOF achievement in 16/17 underwritten up to10% for 1 year	Stated payment based on 2016/17 point achievement	Was £94,998 TBC	Was £102,904 TBC	£19,000 approx
PIS achievement underwritten in 16/17 for 1 year	Stated payment based on last year's point achievement Practice fee only. Not Cluster fee. The actual cost would be = Last year's fee-£ earnt in 17/18 (if lower)	TBC Last year -£3,057	TBC Last year - £4,449	TBC
Payment for any additional fixtures and fittings up to £2,000	Particularly for new workstations for any new members of staff that may be required.	£1,276 To date	None submitted yet	£1,276
Recruitment support in the form of up to	Full or partial	None submitted yet	None submitted	TBC

£2,000 towards advertising	reimbursement		yet	
6 hours of practice management time to facilitate transition and recruitment @£24.23	6 hours	£145.38	£145.38	£291
				£64,067

Description of Costs – Project Costs		
Community Works and Trust for Developing Communities	2 engagement events and report.	£1,845 £2,500
Letter mailing to patients	Only 2 letters included in national PCSE contract	£7,886
	TOTAL	**£12,331**

Total CCG costs to date	**£76,398 (or £34.73 per patient)**

Description of savings	**The Ridgeway**	**Total**
Annual Rent Reimbursement	£22,800	£22,800
Annual Rates Reimbursement	£11,999.50	£11,999.50
Annual Water and Waste Reimbursement	TBC	TBC
	TOTAL	**£34,799.50**

Balance	**£41,598.50 (or £18.91 per patient)**

If 150 of these are "ghost" patients @ £85.35 per annum (Global Sum), a further £12,802.50 can be deducted from the above, bringing the balance down to £28,796 (or £13.09 per patient).

The capitation and Rent/Rates payments are revenue monies, whereas the payments to the practices are one off, non-recurring payment.

9/18: Primary Care Support to Ireland Lodge Care Home

Name of Meeting:	Primary Care Commissioning Committee
Date of Meeting:	6 February 2018
Item Number:	9/18

Recommendation:

PCCC is requested to agree the following:

That Woodingdean Surgery (G81065) be funded at £19,338 for 12-months to provide care for patients at Ireland Lodge care home.

Reviewed at:

PCOG

Summary

- Following its closure in October 2017, Ridgeway Surgery's patients were dispersed to other neighbouring practices.
- Ridgeway Surgery had provided primary care to the residents of Ireland Lodge care home prior to its closure.
- Negotiations have been taking place with Woodingdean Surgery, located close by, to register Ireland Lodge residents.
- During this period of negotiation residents have been receiving interim primary care services from IC24, arranged by the CCG.
- Woodingdean Surgery has expressed concerns with regard to the additional work that the care of the Ireland Lodge patients might entail, particularly as some residents have complex needs.
- A mutually agreeable proposal with Woodingdean Surgery has been arrived at that will facilitate the registration of these patients and, additionally, will provide a weekly ward round for the home for a 12-month period.
- This cost of this arrangement is £19,338 for one 12-month period.

- A wider piece of work is underway across the Alliance on Care Homes, as part of the overall Clinical Strategy/Out of Hospital Care Model. The Ireland Lodge solution proposed in this report is therefore temporary and will be superseded by this more strategic work, when ready.

Lead Director:	Chris Clark, Head of Commissioning
Clinical Lead	Dr Katie Stead
Author	Jimmy Burke, Deputy Head of Primary Care
Date of Report:	06 February 2018

Financial Implications

The cost of the proposed ward rounds arrangement for Ireland Lodge is £19,338 for 12-months.

This provision is likely to mitigate demand for ambulance conveyance with possible unplanned admission and so, over the course of the year, this proposal could prove better that cost-neutral to the local health system.

Legal or Compliance Implications

The CCG has a legal duty to provide primary care essential services to the population of Brighton and Hove.

Link to key objective and/or assurance framework risk

Leading the development of high quality primary care services and supporting member practices to meet relevant challenges, both as providers and commissioners of services.

Patient, carer and public engagement

Significant patient engagement activity was undertaken as part of the Ridgeway closedown and the dispersal of the practice's patients. Woodingdean surgery is the closest practice to Ireland Lodge and therefore is best placed to provide care to its residents.

Equality Impact Assessment
A comprehensive Equalities Impact Assessment was undertaken as part of the Ridgeway closedown and the dispersal of the practice's patients. Age and Disability are two key protected characteristics relevant to this group of patients. Woodingdean surgery is the closest practice to Ireland Lodge and therefore is best placed to provide care for its residents, taking account of their protected characteristics.

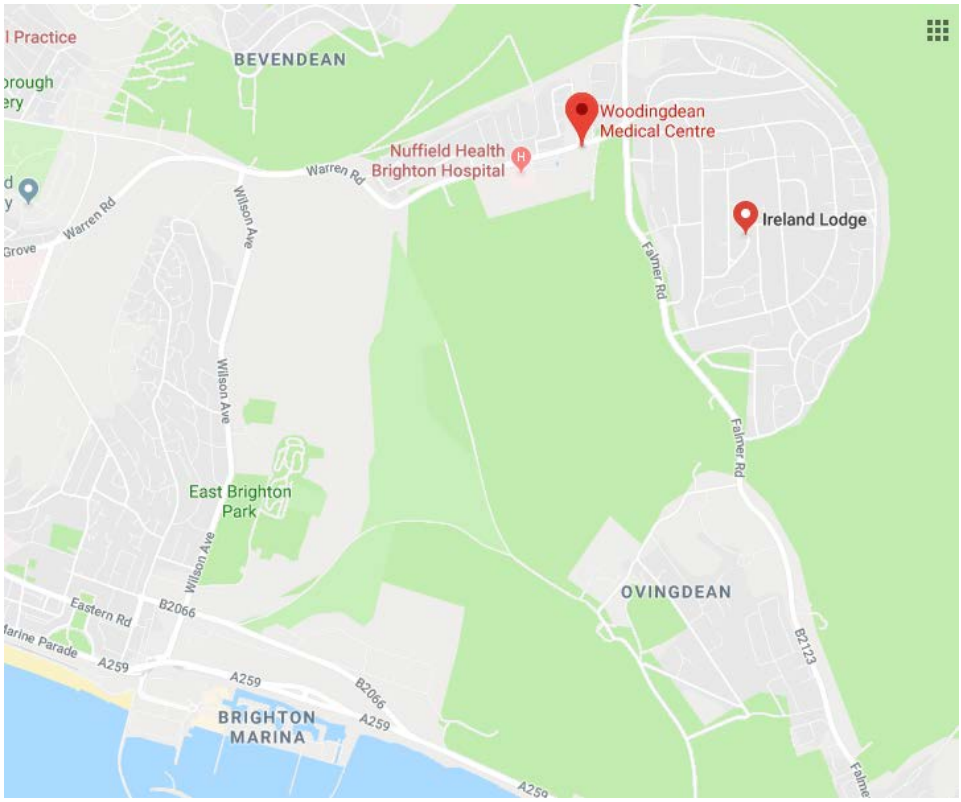
Background information

Following its closure in October 2017, Ridgeway Surgery's patients were dispersed to other neighbouring practices including Woodingdean Surgery and Saltdean/Rottingdean Surgery.

Ridgeway Surgery had provided primary care to the residents of Ireland Lodge care home, situated at Lockwood Crescent, Woodingdean, Brighton BN2 6UH. Ireland Lodge is a residential care home run by Brighton and Hove City Council and offers care to up to 23 older people including those with dementia.

Since Ridgeway Surgery's closure, the CCG has been negotiating with Woodingdean Surgery, located close by, around a proposal to register Ireland Lodge residents. During this period of negotiation residents have been receiving interim primary care services from IC24, arranged by the CCG.

Woodingdean Surgery has expressed concerns with regard to the additional work that the care of the Ireland Lodge patients might entail should they be registered at the practice. This should be seen in the context of the fact that the surgery has already taken on almost 1,500 patients from Ridgeway.



Map illustrating proximity of Woodingdean Surgery to Ireland Lodge Care Home

The Proposal

Through negotiation, a mutually agreeable proposal with Woodingdean Surgery has been arrived at that will facilitate the registration of these patients and, additionally, will provide a weekly ward round for the home for a 12-month period.

This comprises:

IRELAND LODGE PROPOSAL	**52 weeks**
3 hours per week GP time at £100 per hour (CCG set rate)	£15,600
4 hours per week Admin time at £15.47 per hour	£3,218
1 hour per week Practice Manager time at £40 per hour (CCG set rate) for the first 13 weeks	£520
TOTAL COSTS:	**£19,338**

This provision is likely to mitigate demand for ambulance conveyance and possible unplanned admissions. This is because care home staff tend to use emergency services when residents have care needs that cannot be met by ambulatory primary care. Anecdotal evidence suggests that care staff will defer calls to emergency services if they are anticipating imminent visits from clinicians.

The impact of the proposal will be monitored over the year, to establish whether it could prove better that cost-neutral to the local health system.

Date: 31-01-18

Lead Director: Chris Clark, Head of Commissioning

Author: Jimmy Burke, Deputy Head of Primary Care Commissioning

Commissioning Alliance
Brighton and Hove CCG
Crawley CCG
High Weald Lewes Havens CCG
Horsham and Mid Sussex CCG

10/18: Quality and Performance Report/Co-Commissioning Report from the Primary Care Operational Group

Name of Meeting:	Primary Care Commissioning Committee
Date of Meeting:	13.2.18
Item Number:	10/18
Recommendation:	
PCCC is recommended to receive assurance from the work of PCOG	
Reviewed at:	
PCOG, DMT	
Summary	

PCOG is the group that takes responsibility for day to day contract decision making and operational matters under Co-commissioning. Strategic/policy decisions are recommended by PCOG to PCCC, in line with the respective terms of reference of the two groups. This report summarises recent business of the group since the last PCCC meeting.

At its December meeting, PCCC requested a more detailed breakdown of the work of PCOG and that this should be reported to DMT.

This report therefore consists of summaries of the last two meetings of PCOG that have taken place since the December PCCC meeting.

Four specific recommendations for decision have arisen from the PCOG meetings; these are set out in separate papers, one in Part 1 and three in Part 2.

Lead Director:	Chris Clark
Clinical Lead	Katie Stead
Author	Murray King
Date of Report:	6.2.18
Financial Implications	
There are no new financial implications to this report, other than the four decisions that PCCC is asked to make; these are covered in separate papers, for ease of reference.	
Legal or Compliance Implications	
National contract directions apply, under delegation from NHS England.	
Link to key objective and/or assurance framework risk	
Leading the development of high quality primary care services and supporting member practice to meet relevant challenges, both as providers and commissioners of services.	
Patient, carer and public engagement	
The primary care strategy patient reference group is being used as a sounding board for key elements of the emerging strategy and patient/public views will be reflected in these plans as they develop.	
Equality Impact Assessment	
Not required for the business covered by this paper but an EIA is attached to one of the separate decisions covered elsewhere on the agenda.	

Summary of January PCOG

NHS
Commissioning Alliance
Brighton and Hove CCG
Crawley CCG
High Weald Lewes Havens CCG
Horsham and Mid Sussex CCG

Item	Detail	Next Steps
Primary Care Strategy Development		
Report back from Workforce Group	Group is developing proposals for One Year Flexible Salaried staff to work in practices	To be sounded out with membership at February locality meeting. Business case to be developed during March
Proposals for Non-Recurrent Expenditure	Proposals from December locality meeting included possible investment in: • Premises • IT – both business as usual and transformational • OD/Training • Recruitment	Plans to be scoped out and shared with COM/SMT
Preparation for Primary Care strategy element of February Locality Meeting	Suggested areas for focus: • Informatics • Workforce • Proposals for non-recurrent spending	Preparatory work with Andy Hodson, James Simpkin, Katie Stead, David Supple, Ramona Booth, ET
Policy Development		
Maternity leave reimbursement	Inherited NHSE stance on reimbursement for maternity leave is that we pay for weeks 3 – 26. This is consistent with all other CCGs in the south east, as far as we know. LMC is challenging this, on the grounds that the regulations do not specify a limit to the number of weeks reimbursed.	LMC to provide formal challenge by 12.1.18 CCG to consult with other local CCGs and bring back to PCOG February meeting. PCOG to propose a formal stance on this and ask SMT/PCCC to agree it.
Access	New national guidance was issued in late December on Access, including asking CCGs to make a judgement on what practices need to do to meet the “reasonable needs” of their patients for access.	CCG to finalise the position on the single remaining practice that undertakes the Extended Hours DES and has a half day closure. CCG to audit the hours during which

		practices provide what patients consider to be “access”
Quality		
QAT	Review of key practices causing concern. QAT will be tweaked in line with comments from practices at last locality meeting.	4 practices currently being supported under Practice Support Toolkit A further 10 have been actively engaged with during the month.
Resilience Team	Review of 4 practices currently being supported under Practice Support Toolkit. No decisions required at this stage although one practice has applied for financial support.	The request for financial support will be reviewed in the light of CCG investigation into the practice’s overall finances. Any significant proposal will go to SMT and PCCC.
Practice Business		
Clinical Waste Contract managing agent	NHSE are delegating responsibility for the managing agent role for clinical waste collection form practices to CCGs as of 1.4.18. The funding (£10,800) is in CCG’s overall primary care allocation. The Delegated CCGs in the South East are proposing to contract with the current managing agent for 2018/19	PCOG supported the proposal and will ask SMT to agree it. Assuming SMT agreement, HWLH CCG will act as lead CCG for the south east.

MK

9.1.18

Summary of February PCOG

Commissioning Alliance
Brighton and Hove CCG
Crawley CCG
High Weald Lewes Havens CCG
Horsham and Mid Sussex CCG

Item	Detail	Next Steps
Primary Care Strategy Development		
Estates Strategy	Proposed Methodology presented for prioritising estates developments, to support future model of primary care in context of Caring Together	To be presented to patient reference group, cluster/locality meetings, COM, DMT and PCCC over the coming months
Non Recurrent Primary Care Transformation Funding	Ideas from last Locality meeting are being worked up for use of the £768,911 remaining funding	To be presented to COM, Locality meeting (February 20th), DMT and PCCC for final sign off
February Locality meeting	Ideas on how to use the Primary Care strategy slot of the February 20th Locality meeting to progress work on the strategy with member practices	Final agenda for Locality meeting to be agreed with Clinical Chair and Director of Commissioning
Demand Management LCS	Outline of a proposed LCS presented to the meeting for discussion and feedback.	Outline to be worked up in more detail as part of the CCG's QIPP plans for 18/19
Policy Development		
Maternity leave reimbursement	Inherited NHSE stance on reimbursement for maternity leave is that we pay for weeks 3 – 26. This is consistent with all other CCGs in the south east, as far as we know. LMC is challenging this, on the grounds that the regulations do not specify a limit to the number of weeks reimbursed.	LMC has challenged NHS England's stance on this and is awaiting a reply. Until this is resolved, the CCG's current approach will remain.
Access	New national guidance was issued in late December on Access, including asking CCGs to make a judgement on what practices need to do to meet the "reasonable needs" of their patients for access.	CCG is making progress with its data gathering and analysis, with a view to a presentation coming to PCOG's March meeting.
Ridgeway Look Back	Paper summarises lessons learned from the process	To present to PCCC in February and use to update CCG processes

Quality		
QAT	Review of key practices causing concern. QAT has been re-presented in line with comments from practices at last locality meeting to place more emphasis on vulnerability.	5 practices currently being supported under Practice Support Toolkit A further 6 are being actively engaged with.
Resilience Team	Review of 5 practices currently being supported under Practice Support Toolkit. No decisions required at this stage although one practice has applied for financial support.	1 practice has applied to PCOG for funding under the Resilience Toolkit. This decision is covered under a separate item in Part 2 of the agenda.
Practice Business		
Application to open a second site	Care UK have applied to open a second site in the city	This decision is covered under a separate item in Part 2 of the agenda
Funding for support to Care Home in Woodingdean	As a result of the Ridgeway practice closure, a care home in the Woodingdean area is left without medical cover. PCOG supported a proposal to fund clinical time from Woodingdean practice to cover this gap, on a time limited basis.	This decision is covered under a separate item in Part 1 of the agenda
Ardingly Court Procurement	PCOG received an update on progress, with a recommendation to recommend a contract award to PCCC	PCCC will receive a contract award recommendation for the APMS contract.

MK

6.2.18