NHS
Stockport
Clinical Commissioning Group

PRIMARY CARE COMMISSIONING COMMITTEE
Public Meeting
Agenda

Date of Meeting:	**21st October 2020**	**Time**	**From**	**To**
			15:00	**16:30**
Venue:	**Virtual Meeting via Microsoft Teams**			

Item No	Agenda Item	Papers	Action required	Lead	Time
1.	Welcome and apologies		Note	Chair	15:00
2.	Notification of Items of Any Other Business		Note	Chair	
3.	Declarations of Interest: (any interest on any issue arising at the meeting that may conflict with agenda items)		Note	Chair	
4.	Minutes from previous meeting held on 19th August 2020	Attached	Approval	Chair	
5.	Matters Arising / Actions from previous meeting	Attached	Approval	Chair	
Standing Items					
6.	Update report: Issues affecting Primary Care - Hot clinic	Verbal	Assurance	GM	15:15
7.	Notification of any regular GM or national reporting programmes	Verbal	Assurance	GM representative	15:30
Primary Care Development					
8.	Primary Care Contractual Changes Update 2020/21	Report	Information	GE	15.40

Quoracy requirements – three members of the Committee which must include: The chair or vice-chair of the Primary Committee; The Chief Nursing Officer or Chief Finance Officer; and another Lay Member

Membership – 3 x lay members; Executive Nurse; Chief Finance Officer; Stockport Healthwatch; LMC representative; and NHSE representative.

9.	Practice Merger Vernon Park Surgery and The Surgery 1	Report	Decision	GE	15.50
10a. **10b**	Delegated Commissioning Internal Audit Review Final Report Contract Management and Oversight Benchmarking Report	Report Report	Assurance Information	GE DD	16.00
Performance					
11.	Finance Report Month 6	Report	Assurance	MC/DD	16.10
Any Other Business:					
12.	Any Other Business	Verbal	To note	Chair	
Date and time of next meeting:					
	16th December 2020 at 3.00 pm, Virtual Microsoft Teams				

Quoracy requirements – three members of the Committee which must include: The chair or vice-chair of the Primary Committee; The Chief Nursing Officer or Chief Finance Officer; and another Lay Member

Membership – 3 x lay members; Executive Nurse; Chief Finance Officer; Stockport Healthwatch; LMC representative; and NHSE representative.

NHS
Stockport
Clinical Commissioning Group

Primary Care Commissioning Committee
MINUTES of the Public meeting held on 19th August 2020
Virtual Meeting via Microsoft Teams

Present:

Peter Riley	Lay Member for Primary Care Commissioning, **CHAIR**
Michael Cullen	Chief Finance Officer
Ben Squires	NHSE
Don Phillips	Lay Member for PPI, NHS Stockport CCG
Anita Rolfe	Chief Nurse
Paul Stevens	Local Medical Council (LMC)

In attendance:

Paul Lewis-Grundy	Deputy Director of Corporate Affairs
Gale Edwards	Commissioning Lead, Primary Care
David Dolman	Deputy Chief Finance Officer
Emma Ince	Director of Integrated Commissioning
Dr Simon Woodworth	Chief Medical Officer, NHS Stockport CCG
Lindsay Smith	Corporate Administrator (Minute Taker)

Apologies:

Philip Winrow	Lay Member for Audit and Governance
Dianne Oldfield	Senior Management Accountant, NHS Stockport CCG
Gillian Miller	Associate Director of Commissioning
Gail Henshaw	NHSE

Minute	Action
1. Welcome & Apologies	
The Chair welcomed all to the meeting and the apologies were noted as detailed above. Introductions were made by Ben Squires, Head of Primary Care for Greater Manchester, Health and Social Care Partnership who was the representative from NHSE on behalf of Gail Henshaw. The Chair confirmed the meeting was quorate and the meeting commenced.	
2. Notification of any other Business	
No other items to note.	

3. Declarations of Interest	
The Chair asked the committee members to declare any interest they may have at the meeting which might conflict with the business of NHS Stockport Clinical Commissioning Group. SW and PS declared their interest in General Practice related items. The Chair confirmed that where a conflict arose they could be involved in the discussion but would not be involved in any decision making.	
4. Minutes of the Previous Meeting	
The minutes of the meeting held on 17th June 2020 were reviewed for accuracy. The following amendments were noted:- ➢ Page 3 change to Mr Paul Stevens and not Dr Paul Stevens. **Resolved that PCCC approved the minutes from the meeting held 17th June 2020 as true and accurate record based on the amendment as listed above.**	
5. Matters Arising / Actions from previous meeting	
029/4.12.19 AR confirmed she and GM have not met since last meeting and this item will be carried forward. Agreed for a revised date of September 2020 to be made as the due date. 030/4.12.19 AR confirmed this item could be taken off as completed. 036/19.02.20 DD confirmed that there had been a SEG meeting 2 weeks ago and that the agenda focussed on A&E campus around Stepping Hill. He confirmed he would report back anything relevant from SEG going forward. 044/17.06.20 Action completed paper received on that. **Resolved that PCCC NOTED the updates provided for the action log.**	
6. Update report: **Issues affecting Primary Care**	
SW provided a verbal update to PCCC members on the issues affecting primary care. The key points were noted and summarised below. **Flu Programme for 20/21** ➢ Significantly larger programme than previous years with an increase in those eligible for the flu vaccine. ➢ Flu vaccinations will be carried out in context of COVID 19 pandemic and will have the added pressure of public interest in carrying out the	

vaccinations. This will create a bit more of an issue for practices in carrying out the vaccinations in line with the COVID 19 guidelines.

- Potentially there could be a vaccine supply issue as practices ordered last year.
- Work is taking place in practices on how they prioritise and liaison/involvement/discussion has taken place with Dr David Baxter, Flu Lead in how to prioritise vaccinations.
- For age groups 50-64, they will be vaccinated from November onwards which is the National recommendation.

COVID hot clinics

- Mastercall and Viaduct are providing clinic assessments and home visit assessments which has been really successful and meant that primary care has seen limited COVID patients in practices.
- This scheme has been extended to October and there have recently been some tweaking around home visit capacity.
- Primary Care has its workforce intact and continues to deliver a good service.

Issues for Practices

- Practices are struggling with volume of patients and they are busier than last year.
- Remote working is not always efficient for the practices as increased appointment time needs to be allowed to ensure all the safety aspects are covered and the consultation is safe and next steps for the patient understood.

A question was asked from DP as to whether additional staff has had to be taken on to cope with the additional flu workload?
SW advised that this has not been budgeted for therefore practices cannot afford to do that.

The Chair indicated that potentially there may be reduced exposure to flu due to COVID which would hopefully be realised.

BS referred to the challenge around infection control and PPE with the expectation that this would slow down carrying out the flu vaccination. He confirmed that there would be revised guidance issued shortly that would significantly support the PPE requirements.

BS also responded to the question around capacity raised by DP and the increase in cohort. He advised that this year flu vaccinations will be paid at an item of service so an increase of numbers of patients vaccinated will increase payment for practices. BS acknowledged that it was difficult for practices to plan for in terms of extra expense in order to take on additional resources to manage the capacity. He highlighted the importance of making use of community pharmacy and shared working across practices.

PS said that the demand for flu vaccinations will mean there is a need to

prioritise the giving of vaccinations which will impose additional amount of work on practices and engagement with patients. He said it was important to not under estimate how difficult this years' flu campaign will be to deliver and that there was a level of concern around resource and of a need to look to deliver the level of flu vaccinations as required. **Resolved that PCCC NOTED the verbal update as provided and commented as detailed above.**	
7. Notification of any regular GM or national reporting programmes	
BS introduced the item and gave a verbal update on the GM and National reporting programmes. PCCC were informed of the key points listed below:- ➢ Capacity and demand on primary care is being looked at as it is a key part of healthcare provision and noted that Primary Care was not there to pick up overspill from secondary care. ➢ Higher levels of remote consultation are positively being received by patients however this means that on some occasion patients are taking up 2 or 3 appointments as they are having telephone triage and video consultation and then face to face appointments. ➢ Plan of recovery is being managed across GM with recovery of services, capacity and demand on primary Care being reviewed. ➢ Acknowledged that Winter period was being entered into and the pressures surrounding that. **Resolved that PCCC NOTED the verbal update provided and thanks were given to BS.**	
8. Primary Care Development	
GE brought to the attention of PCCC members the following updates:- **8. Practice Merger Update** ➢ No merger applications at the moment however there is likely to be a contractual change request being presented at the October PCCC meeting due to one GP retiring and another practice taking over that contract. GE said that the aim would ultimately be the merging of the two contracts as one. PCCC were informed that the GP that had retired had been a GP in Stockport for over 31 years and that the practice was one of the high performing practices in Stockport and as such this would be a great loss to Stockport and the patients. **8.1 PCN DES Enhanced Health in Care Homes 2020/21** GE informed PCCC that the purpose of the report was to provide the Primary	

Care Commissioning Committee with an update and assurance on the work taking place to support networks and practices in their delivery of the Care Home element of the Primary Care Network DES. GE also stated that there was a plan to align the local commissioned schemes for care homes to the national DES for 2020/21. PCCC were made aware that the requirements as set out in the EHCH (Enhanced Health in Care Home) network and DES timeframes had been fully met in July 2020 by Stockport CCG and the PCN. They also noted that Stockport CCG had fully met the requirement to implement as an interim to the EHCH Des a model of support for enhanced care home residents to support the response to COVID 19 (which were detailed in the NHS letters of May 2020). GE did say that post producing the report there had been a slight amendment from Cheshire CCG that will be followed through and brought to PCCC in October. PCCC were advised that this was a key piece of work looking at how we deliver the enhanced care home framework and of the need to review national requirement to local requirement and as such a task and finish group had been set up to do that. PCCC were also informed by GE that no local commissioned services should be decommissioned until 1 October and any local commissioned service funding needed to remain in primary care. GE concluded that there would be challenges expected with this collaborative approach. The Chair asked PCCC to raise any questions or raise comments and the following was recorded:- DP asked what examples of challenges were anticipated. He was informed that it was around community nursing as it would be a new ask for them in an already highly stretched team. AR asked for the following to be clarified for the minutes. She said that learning disability homes had not been excluded or treated differently and that the learning disability homes ethos was for those from the homes should be out in the community leading a full and active life. AR explained therefore, that those patients would have access to Primary Care as per everyone else in the community. DP enquired if this was incremental money this year and whether it would be there in subsequent years? GE informed PCCC that it was a 5 year scheme started in 2019 until 2023/24 with funding of care home beds of £120 per year. She said that as this scheme was starting half way through the year the cost would £60. PS informed PCCC that the £60 stretches over 8 months which equates to £2 per week per bed (approximately).	

The Chair raised a question from PW that asked whether this would mean adjustments to the PCN funding and if so what would be the distribution and scale of gains and losses? He also asked if this would give any PCN/Provider an issue. GE confirmed that it was alignment of two schemes under review and changes of funding would remain in primary care and any other proposals would be brought back to PCCC for consideration. The Chair also asked on behalf of PW, how does the payment for 2020/21 compare to the budgeted position and will the additional costs be covered by the Covid 19 reclaim? GE clarified that the DES is new monies and there is already a local scheme in the budget at the CCG. PW submitted a question that asked what were the local adjustments for Tame Valley and Heaton's and whether they were sustainable in future? EI confirmed that the adjustments related to the intermediate care beds that fall under separate contracts. In terms of overpayments, VFM and the "normal" occupancy rates, PCCC were informed that the local authority has had to subsidise care homes generally in order to maintain service and as we enter into Winter this would continue. GE reiterated that this scheme was nationally mandated per bed and not occupancy. **RESOLVED that;** **PCCC noted the content of the report outlining the national and local position of the EHCH element of the PCN DES 2020/21 in Stockport.** **PCCC noted that Stockport CCG had fully met the requirements implementing the interim model of support to for enhanced support for care home residents as set out in the NHS letters of May 2020.** **PCCC noted that Stockport CCG had fully met the July 2020 requirements of the enhanced health in care home element of the PCN DES.** **PCCC noted and approved the next steps.** **8.2 PCN DES Additional Roles Reimbursement Scheme 2020/21** PCCC were informed that the purpose of the report was to provide the Primary Care Commissioning Committee with an update on the implementation of the national PCN DES in relation to the additional roles reimbursement scheme (ARRS). GE advised that the additional roles reimbursement scheme (ARRS) as part of the PCN DES was to grow additional capacity in general practice through new roles, and by doing so, help to solve the current workforce shortages	

and support growing workload demands. She said the ARRS funding was a significant part of the DES with a value of over £2.2m in 20/21 in Stockport increasing year on year with an investment available to PCN's of over £7m by 2023/24 and that the available funding under the DES would be lost at the end of each year if not fully utilised. PCCC were informed that NHS England are recommending PCN's over recruit over the next 6/9 months to fully utilised available funding. PCCC were highlighted to the point that for 2020/21 Stockport PCNs workforce plans included employing additional first contact physiotherapist (FCP), additional pharmacist and pharmacy technicians however the number of WTE proposed exceeded the national limits permitted. GE advised however that she doesn't know why limits have been placed on those. In 2021/22 GE confirmed that there were two new roles that formed part of the ARRS scheme; mental health practitioners and paramedics and that this allowed Stockport PCN's the option of using slippage monies to recruit to next year's additional roles. PCCC noted that CCG were asked to do a baseline assessment and plan for 23/24 which could mean as many as 7 practitioners. EI informed PCCC that the next steps for the CCG would be to approve the waiving of the limit to the number of roles, however there was a need to understand what that would mean in terms of the benefits to the population as a result of releasing capacity in primary care and as such there was a piece of work which would be done to quantify that as part of next steps. The Chair enquired if the additional roles would be to take some pressure away from GPs? SW confirmed that it was about diversifying the workforce and allowing non conditional roles to deliver some of PCN DES and workforce planning along with alleviating some of the issues. The Chair advised that PW was supportive of the proposal however there was a need to ensure that waiving limits do not shift funding burden outside (onto CCG) of the ring fenced sum and can be afforded in future years. GE confirmed that this was until 23/24 however there had been the suggestion that might fall part of GP contract in future years. PW asked for assurance around the recruitment timescales as to whether there as confidence in the roles suggested are part of the future workforce planning and of the practices producing the right information for forward planning. SW clarified that it was the networks and not practices that had carried out the forward planning and that they had carried out project planning identifying what they might require when they are trying to recruit to the roles. A question was asked around if the proposed individuals were out there in the market to be recruited into these roles? PCCC were advised that there is national evidence for the practitioner roles and that the CCG was confident	

that they will be able to recruit the right people at the right place at the right time. EI also confirmed that Viaduct had been part of the recruitment process and they had not identified any issues. The Chair referred to table 2.6 which was confusing as it seemed to suggest 4.84 sought against 7 permitted states limit exceeded by 2.47 but 7 allowed. GE answered that table 2.6 was for one PCN only, Bramhall PCN and not for all 7. **RESOLVED that PCCC;** **Noted the content of the report outlining the national recommendations by NHS England to fully utilise the available funding.** **Noted that requirements of the national DES in relation to additionality had been fully met** **Noted and approve the PCN's proposed workforce plans for 2020/21.** **Noted and approved the proposal for the earlier recruitment of mental health practitioners and paramedic roles in 2020/21, in advance of the national directive, using any available ARRS slippage funding.** **Noted and approved the next steps.**	
9. Current issues and outputs from Primary Care Quality Board	
This item was introduced by AR who explained that this was a verbal update highlighting the current issues and outputs from the Primary Care Quality Board. PCCC noted that the key points as listed below. ➢ Sandra Walker, Quality Lead was developing a quality oversight paper which will be submitted to the Quality and Governance Committee meetings. ➢ Quality oversight will look at patient experience, safeguarding along with celebrating good practice and how we demonstrate the good practice across primary care. ➢ Information will be brought together in one place and primary care will be treated like a commissioner like all other providers. ➢ A workshop will be in place from early September to pull information together. The Chair enquired if this would add to other pressures or impact on work? AR advised that it does add another layer of complexity in trying to get to back to where we were. **Resolved that PCCC noted the verbal update had been provided and thanks were given to AR.**	

10. Finance	
10.1 Finance Report Month 4 DD introduced the report which provided the Financial regime update along with the forecast outturn against budget for the period 1 April 2020 to 31 July 2020 as well as the income protection arrangements for general practices in 2020/21. The report detailed that the temporary financial regime NHSE/I had put in place covering the period 1 April 2020 to 31 July 2020 in response to Covid19 emergency had been extended until 30 September. The principle for this approach was that CCG's would receive retrospective allocations to enable a breakeven position which would be reported on an in year basis until 30 September 2020. PCCC were informed that £1.7m will be funded from a retrospective allocation and that the difference reported was down to difference costs in general practice in relation to COVID and costs in terms of alterations needed to general practice premises in line with the guidance in terms of COVID. The Chair raised a comment from PW who emphasised the need to forecast and have decisions on how we will land year end of budget and whether the period April to September will be balanced by the additional funds for COVID or whether this, using Month 11 sums as baseline, was still unaffordable within the 20/21 budget. MC clarified the point stating that the submitted month 4 figure and the retrospective payment is made in arrears. The retrospective payment for month 1, 2 and 3 has enabled a balanced position. He said that adjustments are seen to be reasonable within the financial regime and that he would expect the period up to September to be balanced by retrospective adjustments. MC confirmed that the key issue would be for months 7 – 12 with regard anticipated COVID expenditure and of the work that taking place at local and regional level. MC gave assurance that months 1-6 will be balanced and that guidance was still awaited whether allocation received for months 7 -12 will be equal to allocated run rates. **RESOLVED that PCCC;** **Noted that the CCG is reporting a forecast over spend of £1.706m for 2020/21 for month 1 to month 4 which will be funded by a retrospective non recurrent allocation adjustment to enable an in-year breakeven position to be reported**.	

10.2 General Practice COVID 19 Support Fund

MC gave background and informed the committee that on the 4 August 2020 NHSE/I published guidance confirming that additional government funding would be available for practices to submit claims to their CCG for reasonable expenditure in response to Covid-19. PCCC were advised that the report issued provided a summary of the published guidance and the CCG's response to the guidance.

The key points in the report referenced;

- Bank holiday opening (Easter & May)
- Backfill for COVID-19 related absences between 23 March – 31 July
- Additional capacity required between 23 March – 31 July
- Other COVID-19 related costs
- Practices must complete and sign a declaration form with all claims
- Practices have six weeks from the 4 August to submit claims.

PCCC noted that the CCG had received claims totalling £0.584m and had made payments totalling £0.406m.

MC referenced that the CCG had been awaiting guidance and recognised that it had taken until 4 August to receive it before processing had started. MC advised that about 70% of claims submitted had been paid. He also stated that there was an intention of the claims in line with the guidance to be paid as quickly as possible.

The Chair asked if any of the Stockport GP practices had suffered financially due to COVID? MC confirmed that the practices have incurred additional costs and one of the frustrations was due to the time taken for the guidance to come out. SW concurred and said speed of payment had been disappointing and created some pressures for practices. He said however that most practices were financially well governed.

The Chair also asked a question around whether the CCG felt confident that if a practice was struggling in terms of cash flow would they reach out to the CCG and ask for support? MC advised that if any practice needed short term support that would be something that the CCG would consider to do within powers as a CCG. He said the CCG was fully aware of the part primary care plays in the healthcare system and economy and the CCG wouldn't want any practice to be put at risk as a result of cash flow issues.

The Chair delved further and asked if the CCG felt there was a substantial relationship in place with the practices and CCG. SW said that he would hope that any issues relating to this would come through the LMC. It was agreed therefore for PS and MC to have a discussion meeting outside of PCCC.

Resolved that PCCC;

Noted the content of this report and the CCG's response to the

guidance. **Action: PS and MC to have a discussion meeting outside of PCCC.**	**MC/PS**
11. Annual Workplan	
The annual workplan for the year was brought to the attention of PCCC for their information. EI referred to the work plan stating that she was happy for any PCCC members to pick up queries outside of the meeting. The Chair highlighted a question raised by PW about the exclusions under schedule 2, and whether PCCC or Governing Body get updates on the local position and any issues arising for the CCG? BS advised that should there be any explicit Stockport matters then NHSE I would look to ensure that the CCG was fully aware and abreast of any matters. He also said that he would hope that Part 2 PCCC would be made aware of any implications and performance management and that the lead Executives/Management Team or Primary Care Leads etc. in the CCG would take forward those through the appropriate governance route ensure other colleagues in the CCG were fully aware. BS explained that once that route had been followed then NHSE I could produce exception reports. AR mentioned that unless there was something major to highlight/discuss she was reluctant to bring any quality information about a named GP or practitioner to PCCC and that the most appropriate route would be for an exception report or summary report of any issues or anything to report on a 6 monthly basis. The Chair agreed and said it was more of a level of assurance of circumstances that was needed. **Action: AR and SW to pull together a summary document of issues they have actioned and bring to PCCC. PS asked to be a part of those discussions too, if appropriate.** **Resolved that PCCC noted the workplan that had been issued for their information and review.**	**AR/SW/PS**
Any other Business	
The Chair closed the public meeting 4.40 pm.	

Primary Care Commissioning Committee
Action Log

Action Number	Date Agreed	Action	Owner	Due Date	Revised Due Date	Comments
029/4.12.19	04/12/2019	Review the CCG policy re practice closures in line with national and local specifications and to report back to the Committee	GM	19/02/2020	Sep-20	This is in draft and is awaiting approval to come to PCCC. AR and GM on how to take forward, update to be given on 19.08.20. 19.08.20 AR and GM to meet, discuss and revised date of September agreed. Update to be provided at the meeting on 21.10.20
045/19.08.20	19/08/20	General Practice Covid 19 Support Fund – PS and MC to pick up any discussions surrounding this or views from LMC outside of the Committee meeting	MC	21/10/20		
046/19.08.20	19/08/20	Annual Workplan - AR & SW to pull together a 6 monthly summary report on any issues that PCCC needed to be aware of in relation to GP's or practitioners. PS to be included in any discussions as appropriate.	AR	01/02/21		

Primary Care Contractual Changes Update 2020/21

Report To (Meeting):	Primary Care Commissioning Committee		
Report From (Executive Lead)	Emma Ince / Gillian Miller		
Report From (Author):	Gale Edwards		
Date:	21st October 2020	**Agenda Item No:**	8
Previously Considered by:	Not previously considered		

Decision		**Assurance**		**Information**	**X**

Conflicts of Interests	
Potential Conflicts of Interest:	Any attendees of the meeting that are associated with general practice or a member practice within the CCG

Purpose of the report:

The purpose of the attached report is to provide the Primary Care Commissioning Committee with an update on the contractual changes in relation to the PCN DES and GMS/PMS core general practice services contract.

Key points (Executive Summary):

To reflect the impact of COVID-19 on general practice NHS England and NHS Improvements have recently published some guidance on changes to the GMS/PMS contract including QOF and PCN DES changes for 2020/21

These changes are due to the recognition that practices will need to reprioritise aspects of care not related to COVID-19 and also help release capacity in general practice to focus on COVID-19 recovery.

For the next 6 months over 50% of the QOF indicators will fall within income protection arrangements subject to the care delivery to specified focuses groups and to support recovery plans.

Recruitment to additional roles as part of the DES ARRS remains priority for PCN's. The

introduction of the Investment and Impact fund started in October giving PCN's the opportunity to achieve investment payments based on performance of the 6 indicators

The primary care commissioning committee were presented with a paper at the August meeting and agreed to approve the earlier recruitment of mental health practitioners and paramedic roles in 2020/21 based on the information at the time. The recent changes do not propose any additional flexibility outside of the twelve permitted roles for utilisation of the additional roles reimbursements. Although there was initial enquiries from PCN's the recruitment to these roles has not taken place. The recommendation to the committee will be to reconsider the previous decision and adopt the national timelines as per guidance starting in April 2021.

Recommendation:

It is recommended that the Primary Care Commissioning Committee

a. Note the content of this report outlining the national contractual changes to the GMS/PMS contract and the PCN DES

b. Note that the PCN DES service specifications are now in the delivery phase as from 1st October 2020

c. Reconsider the decision taken in August 2020 agreeing the earlier recruitment of mental health practitioners and paramedics in 2020/21 and adopt the same timeline set out in the national guidance

d. Note the next steps

Aims and Objectives:	
Which Corporate aim(s) is / are supported by this report:	Start well ,Live well , Age well , Die well and lead well
Which corporate objective(s) is / are supported by this report:	Improve quality & safety of care Support people to remain healthy and independent as long as possible Improve early identification of health conditions Reduce health inequalities faster Empower people to live well & proactively manage long-term conditions Support people to remain healthy and independent as long as possible Ensure people can access safe, high quality care when necessary Improve quality & safety of care Financial balance across the system Patients and their families will receive high quality support at the end of life

Risk and Assurance:	
List all strategic and high level risks relevant to this paper	None identified

Consultation and Engagement:	
Patient and Public Involvement:	*[N/A]*

1.0 INTRODUCTION

1.1 This paper is to update the Primary Care Commissioning Committee on the recent contractual changes to the GMS/PMS contract and the PCN DES

1.2 On the 4th September NHS England and NHS Improvements published revised Quality and Outcomes Framework (QOF) guidance for the remainder of 2020/21

1.3 Further changes to the GP contract was published in a letter of the 30th September. These changes are effective from the 1st October 2020

1.4 On the 17th September 2020 NHS England and NHS Improvements issued an updated version on the PCN Directed Enhanced Service guidance for 2020/21 applying from the 1st October 2020 for all practices that have signed up to the DES.

1.5 Also published on the 17th September was the service specification for the structured medication reviews and investment and impact fund guidance that form part of the PCN DES requirements.

.

2.0 CONTRACTUAL CHANGES TO GMS/PMS CONTRACT

2..1. The Revised Quality and Outcomes Framework (QOF) guidance for the remainder of 2020/21.

2..1.1. The aims of this revision is to release capacity within general practice to focus efforts upon the identification and prioritisation of people at risk of poor health and those who experience health inequalities for proactive review.

2..1.2. The changes also aim to support practices to restore vital care delivery in areas such as screening, implementation of early cancer diagnosis and care for patients with a learning disability, with a specific focus upon proactive health checks and seasonal influenza vaccination.

2..2. The changes are :

2..2.1. Some indicators (310/567 points) will be subject to income protection arrangements subject to the delivery of revised and simplified requirements that focuses upon care delivery to:

- patients at greatest risk of harm from COVID-19,
- patients with uncontrolled long term condition parameters
- patients with a history of missing reviews.

2..2.2. Income protection payments will be based on historic achievements. To be eligible practices will need to agree a plan for QOF population stratification with the CCG during October and November 2020.

2..2.3. To support recovery plans there are some changes to points and payments for cervical screening and flu indicators

2..2.4. Some indicators will continue to be paid on the basis of practice performance however some points have doubled to proactively target and support vulnerable groups.

2..2.5. The refocused requirements for the Quality Improvement domain in order to support the restoration of key services to people with a learning disability and early cancer diagnosis;

2.2 Other key changes to the GP contract effective from the 1st October 2020 include:

2.2.1 A new contractual requirement for practices to participate in the Appointments in General Practice data collection. Practices will be required to record appointments in their appointments book in line with guidance NHS England jointly published with the BMA in August 2020.

2.2.2 There are also new and amended regulations in relation to:

2.2.2.1 An amendment to allow onward subcontracting of clinical services provided under the Network Contract DES

2.2.2.2 In response to the phase 3 implementation letter and health inequalities practices are asked to proactively review and ensure the completeness of patient ethnicity data by no later than 31 December .

2.2.3 The extension of changes implemented during the pandemic that will continue until the 31st March 2021 include:

2.2.3.1 A continuation of the temporary increase in the number of appointment slots that practices must make available for direct booking by 111 to 1 slot per 500 patients per day.

2.2.3.2 NHS England have asked GP practices to make sufficient slots available for NHS 111 to refer into and assess the use of the slots each day and adjust the number to meet demand. This could be fewer than 1 in 500.

2.2.3.3 The suspension of the requirement that practices report to commissioners about the Friends and Family Test returns;

2.2.3.4 A temporary suspension of the requirement for individual patient consent in certain circumstances, in order to encourage increased use of electronic repeat dispensing

3.0 CONTRACTUAL CHANGES TO PCN DES

3.1 As set out in the guidance document, the amended DES introduces three substantive changes to the 2020/21 Network Contract DES.

3.1.1 Flexibility in the enhanced Health in Care homes clinical leads

3.1.2 Introduction of two new additional reimbursable roles within the additional roles reimbursement scheme (ARRS)

3.1.3 The introduction of the Investment and Impact fund (IIF)

3.2 Enhanced Health in care homes

3.2.1 The amended DES has removed the requirement for the clinical lead under the Enhanced Health in Care Homes service to be a GP .The clinical lead may now be a non-GP clinician with appropriate experience of working with care homes, provided this is agreed by the practices in the PCN, the CCG and the relevant community provider.

3.3 The additional roles reimbursement scheme (ARRS).

Two new additional reimbursable roles were added from the 1st October 2020 and include:

3.3.1 Nursing associates

3.3.2 Trainee nursing associates

3.3.3 The addition of these roles takes the total number of reimbursable roles via the ARRS this year to 12. NHSEI have indicated that they remain committed' to introducing mental health practitioners and community paramedics as reimbursable roles in 2021/22, while it will 'continue to consider' the introduction of advanced nursing roles.

3.3.4 The primary care commissioning committee were presented with a paper at the August meeting and agreed the earlier recruitment of mental health practitioners and paramedic roles in 2020/21 based on the information at the time. The recent changes do not propose any additional flexibility outside of the twelve permitted roles for utilisation of the additional roles reimbursements. Although there was initial enquiries from PCN's the recruitment to these roles has not taken place.

3.3.5 The recommendation to the committee is to adopt the national timelines for these roles as per guidance starting in April 2021.

3.4 Introduction of the Investment and Impact Fund (IIF)

The IIF will operate in a similar way to QOF, based on specific indicators with points attached to each indicator

3.4.1 The previous network contract DES guidance published indicated the postponement of the introduction of the Investment and Impact Fund (IIF) until 1 October. Of the £40.5 million national funding originally earmarked for the IIF, £16.25 million has already been recycled into a PCNs support payment on the basis of a PCN's weighted population at 27p per weighted patient for the six month period to 31 September 2020.

3.4.2 This amended DES introduces the remaining £24.25 million national funding, which will be available for PCNs to earn through the new IIF.

Payment to PCN will be based on performance of the points achieved within the six indicators for 2020/21.

3.4.3 For 2020/21, each IIF point will be worth £111 and there will be a total of 194 points available to each PCN. Payments to PCNs will be proportional to points earned, with an adjustment for list size and (where relevant) prevalence.

3.4.4 The six indicators fall within four areas/domains and include:

3.4.4.1 Prevention based on flu achievement of between 70-77% for the over 65 cohort of patients

3.4.4.2 Tackling Health inequalities based on the learning disability annual health check achievements

3.4.4.3 Personalised care based on the percentage of patients referred to social prescribing services.

3.4.4.4 Three medicines safety indicators

3.4.5 To be eligible to receive a total achievement payment, a PCN must commit in writing to the CCG that it will reinvest the total achievement payment into additional workforce and/or primary medical services.

4.0 STRUCTURED MEDICATION REVIEWS AND MEDICINE OPTIMISATION GUIDANCE

4.1 The guidance outlines how each PCN will identify and prioritise patients who would benefit from a SMR, including those:

4.1.1 in care homes

4.1.2 with complex and problematic polypharmacy, specifically those on ten or more medications

4.1.3 on medicines commonly associated with medication errors

4.1.4 with severe frailty, who are particularly isolated or housebound or who have had recent hospital admissions and/or fall

4.1.5 using potentially addictive pain management medication.

4.2 The guidance advises PCNs to consider offering a SMR to any other patients they think would benefit from a SMR including those prescribed multiple but fewer than 10 medications, and other potentially addictive medication.

4.3 PCNs have also been asked by NHS England to be alert to the needs of communities at particular risk of COVID-19 (e.g. BAME), including by considering how complex prescribing regimens may be rationalised to improve their safety**.**

4.4 The number of SMRs that a PCN is required to offer will be determined and limited by their clinical pharmacist capacity.

4.5 PCNs and CCG's must discuss and agree a reasonable volume of SMRs based on the Pharmacist workforce aligned to PCN's

4.6 In estimating available capacity, CCGs and PCNs should acknowledge that clinical pharmacists have a variety of responsibilities and not all of their hours should be spent on SMRs.

5.0 RECOMMENDATIONS

It is recommended that the Primary Care Commissioning Committee

5.1 Note the content of this report outlining the national contractual changes to the GMS/PMS contract and the PCN DES

5.2 Note that the PCN DES service specifications are now in the delivery phase as from 1st October 2020

5.3 Reconsider the decision taken in August 2020 agreeing the earlier recruitment of mental health practitioners and paramedics in 2020/21 and adopt the same timeline set out in the national guidance.

5.4 Note the next steps

6.0 NEXT STEPS

6.1 Establish and agree with PCN's a reasonable volume of SMRs based on pharmacist recruited within the ARRS reimbursements

6.2 Practices and CCG's to agree a plan for QOF by 30th November 2020 for income protection payments.

8.0 POTENTIAL IMPLICATIONS

Potential Implications:								
Financial Impact:	Non-Recurrent Expenditure	Nil						
	Recurrent Expenditure	Detailed in the paper						
	Expenditure included within CCG Financial Plan	Yes	X	No		N/A		
Performance Impact:	*[N/A]*							
Quality and Safety Impact:	*[N/A]*							
Compliance and/or Legal Impact:	National Contracts							
Equality and Diversity:	General Statement:							
	Has an equality impact assessment been completed?	Yes		No		N/A	X	
	If Not Applicable please explain why	Not required						

NHS
Stockport
Clinical Commissioning Group

Practice Merger of Vernon Park Surgery and The Surgery 1

Report To (Meeting):	Primary Care Commissioning Committee		
Report From (Executive Lead)	Emma Ince / Gillian Miller		
Report From (Author):	Gale Edwards		
Date:	21st October 2020	**Agenda Item No:**	9
Previously Considered by:	Not previously considered		

Decision	**X**	**Assurance**		**Information**	**X**

Conflicts of Interests	
Potential Conflicts of Interest:	Any attendees of the meeting that are associated with general practice or a member practice within the CCG

Purpose of the report:

The purpose of the attached report is to request approval from the committee for a merger application received by Stockport CCG in accordance with the NHS General Medical Services (GMS) regulations and NHSE Primary Medical Services (PMS) policy and guidance.

Key points (Executive Summary):

An application has been received by NHS Stockport CCG for the merger of two practices in Brinnington to form one General Medical Services (GMS) contract .The two practices currently are member practices within the Tame Valley Primary Care Network.

The merger of the two single hander GMS contracts to create one partnership operating under one contract, with a single registered list of patients. This will require amending the practice boundary to incorporate the boundaries of both practices, and reflecting the change of name to Vernon Park Surgery.

The CCG have followed the processes as set out NHS England Primary Medical Care – Policy and Guidance Manual (PGM) in considering this merger and have assurance that there will be a positive impact for patients and services with all financial aspects considered by the

commissioner and the contractors.

The LMC and the member practices of Tame Valley Primary Care network are fully supportive of the merger.

Recommendation:

It is recommended that the Primary Care Commissioning Committee

1. Review the content of this report outlining the merger application of the two practices
2. Note that the CCG has assurance that the procedures for the merger application have been fully met.
3. Note and approve the contractual merger of the two practices onto one GMS contract**.**
4. Note and approve the next steps

Aims and Objectives:	
Which Corporate aim(s) is / are supported by this report:	Start well , Live well , Age well , Die well and lead well
Which corporate objective(s) is / are supported by this report:	Improve quality & safety of care Support people to remain healthy and independent as long as possible Improve early identification of health conditions Reduce health inequalities faster Empower people to live well & proactively manage long-term conditions Support people to remain healthy and independent as long as possible Ensure people can access safe, high quality care when necessary Improve quality & safety of care Financial balance across the system Patients and their families will receive high quality support at the end of life

Risk and Assurance:	
List all strategic and high level risks relevant to this paper	Merging practices is a time consuming process, with the alignment of clinical systems and merging patient records being some of the IT processes which need to be completed. The merger of clinical systems is a service which needs to be booked, and the lead-in time for this is around 3 months. To meet deadlines and increased demand on services during winter months it is important for the CCG to escalate this process as soon as possible.

Consultation and Engagement:	
Patient and Public Involvement:	The practice have engaged with patient of both practice via a patient survey via texts and on the practice websites – details are included below

INTRODUCTION

This paper is to inform the Primary Care Commissioning Committee of an application received by Stockport CCG to merge the GMS contracts of two practices, Vernon Park Surgery and The Surgery 1 who are both member practices within the Tame Valley primary care network.

After a long period of illness the partner of The Surgery1 decided to take retirement in July/August 2020 .The original plan was to merge the practices before the GP retirement but due to the priorities of the pandemic this was not possible. To retain the GMS contract and avoid an unnecessary dispersal of patients during that time NHS E approved an additional partner to the Surgery1 contract. Following retirement the partner of Vernon Park surgery became the sole holder of both GMS contracts.

The practices believe the merger will ensure long-term sustainability for services in the area providing an equitable service offer across both practices. Working with separate clinical systems and databases, separate phone systems and different processes are adding to the challenges of the increasing demand in the practices and there is an urgent need to merge the two contracts.

The details of the two practices are listed below:

	Vernon Park Surgery	The Surgery1
No of partners	1	1
Registered Population as at 1st July 2020	1523	1750
Contract type	GMS	GMS
Practice Address	32 Brinnington Road Stockport SK1 2EX	30 Brinnington Road Stockport SK1 2EX
Practice Code	P88615	P88600
CQC rating	Good	Good Prior to contract changes Reregistered 5th October 2020 – no inspection to date

1.0 **PROPOSAL**

2.1 It is proposed that there will be a formal merger of the two GMS contracts, which will create one partnership operating under one contract, with a single registered list of patients.

2.2 This will be possible as a result of:

2.2.1 the simultaneous termination of the Surgery contract
2.2.2 the variation of Vernon Park surgery contract to incorporate the Surgery contract,
2.2.3 amending the practice boundary to incorporate the boundaries of both practices,
2.2.4 Reflecting the change of name to Vernon Park Surgery.

2.3 The merged practice will have two GP's and additional clinic support from practice nursing and other clinicians.

2.4 All current staffing will be retained to form one workforce

2.5 The merged practice will continue working from two sites in the short term with the plans to merge the two adjoining sites into one larger site in the near future

2.0 CCG RESPONSIBILITIES

The NHS England Primary Medical Care – Policy and Guidance Manual (PGM) sets out the process that should be followed when considering a merger:

Where a practice merger requires amendments to the practice contracts, the final commissioning decision on whether contracts should be amended to effect the proposed merger, lies with the Commissioner and there are a number of important issues that would need to be considered, prior to giving consent".

The following are highlighted as items which should be considered by the CCG

Benefit to Patients	Comments
Patients access to a single service.	The merged practice will continue to operate from the 2 existing sites until renovation to the two sites can take place to make this a single site. Patients will be able to book appointments or visit both sites. Telephony currently will be via two separate numbers with a planned new single telephony service to be installed over the coming months.
Assurances that all patients will access a single service with consistency across provision i.e. home visits, booking appointments, essential and additional services, opening hours, extended hours, and so on, single IT and phone system.	The practices have provided assurance that there will be a merged clinical system and a single point of access for patients. The new merged practice will adopt the same access model and opening times. The merged practice will offer a consistent offer to all registered patients including home visits, booking of all appointments and provision of enhanced services including extended hours with no detrimental impact on patient or a reduction in services.

What would the practice boundary be (inner and outer).	The merged practice boundary will include the inner and outer boundary of both practices to form a new boundary. Boundary details for both practices are shown in (Appendix 2)
Premises arrangements and accessibility to those premises to patients.	The merged practice will continue to operate from the two existing sites who will maintain their current opening hours. There are plans in place to develop the two premises into a single larger facility
Proposed arrangements for involving patients about the proposed changes, communicating the change to patients and ensuring patient choice throughout.	Both practices have undertaken a full patient consultation via a patient survey. A summary of this and outcomes is shown below. The merger will not limit patient choice as patients will retain the choice to register with other practices within the locality.
The impact on health inequalities and patient choice	An Equality Impact Assessment has been completed (Appendix 1) and does not reveal any significant impact on any protected groups. The merged practice will provide access to both male and female clinicians that were not available previously on site.

Financial Impacts	**Comments**
Financial arrangements – the impact of Directions under the Statement of Financial Entitlements, or any specific terms included in the individual contracts.	The SFE is a national directive which underpins the way payments are made to practices. Financial arrangements for the merged practice would remain in line with the SFE and would be equitable with other practices within the CCG. There are no adverse financial implications for either the practice or the CCG that we are aware of.
Premises reimbursements	The newly merged practice would continue to operate from the existing two premises. Rent reimbursement and reimbursable costs are expected to remain the same and continue to be based upon the current levels paid by the CCG
Locally commissioned services and out of hours opt-outs/improved access arrangements.	It is anticipated that additional services and extended hours will continue in line with current arrangements.
Enhanced services.	It is the responsibility of the 2 practice to consider the impact on payments for the merged practice in relation to QOF, enhanced services etc. However, the CCG expectation is that current commissioning arrangements will include provision of all enhanced services that are provided within Vernon Park surgery and patients will be able to access a greater range of services including minor surgery and nurse appointments. The merged practice will be expected to maintain membership of the Tame Valley PCN and responsible for its delivery of the service specifications required as part of the PCN DES.
IM & T cost to merge data bases	The cost of the database merges are approximately around £3k and is usually met by the CCG.

3.0 PATIENT SURVEY

3.1 Due to the current Covid-19 situation, there were limitations on the patient engagement processes that could be carried out on the proposed merger, however the practices carried out a survey via the website and via text messaging. The survey was sent to all the registered patients over a period of 4 weeks in August /September 2020

3.2 A total **of** 129 (5%) responses were returned across the practices with 87.5% positive responses and in agreement with the merger and 12.5% with concerns and against the merger. Those that responded against the merger had concerns about the increased patient list size, not being able to see their regular GP and the impact on access and waiting times.

3.3 The practice responded to all the patients who raised concerns providing the necessary assurances and highlighting the benefits of the merged services including the ability to see the GP of choice and improved access with a bigger team to support service delivery.

4.0 RECOMMENDATIONS

It is recommended that the Primary Care Commissioning Committee

4.1 Review the content of this report outlining the merger application of the two practices, Vernon Park surgery and The Surgery1.

4.2 Note that the CCG has assurance that the procedures for the merger application have been fully met.

4.3 Note and approve the contractual merger of the two practices onto one GMS contract**.**

4.4 Note and approve the next steps

5.0 NEXT STEPS

5.1 Inform the practice on the outcome of the committees decision

5.2 Inform GM shared services and the CCG IM &T on the outcome of the PCCC decision

5.3 Inform the PCN of the outcome of the PCCC decision in order to update their network agreement

8.0 POTENTIAL IMPLICATIONS

<table>
<tr><td colspan="8">Potential Implications:</td></tr>
<tr><td rowspan="3">Financial Impact:</td><td colspan="2">Non-Recurrent Expenditure</td><td colspan="5">£3k</td></tr>
<tr><td colspan="2">Recurrent Expenditure</td><td colspan="5">Detailed in the paper</td></tr>
<tr><td colspan="2">Expenditure included within CCG Financial Plan</td><td>Yes</td><td>X</td><td>No</td><td></td><td>N/A</td><td></td></tr>
<tr><td>Performance Impact:</td><td colspan="7">[N/A]</td></tr>
<tr><td>Quality and Safety Impact:</td><td colspan="7">[N/A]</td></tr>
<tr><td>Compliance and/or Legal Impact:</td><td colspan="7">Contractual change – NHSE</td></tr>
<tr><td rowspan="3">Equality and Diversity:</td><td colspan="7">General Statement:</td></tr>
<tr><td>Has an equality impact assessment been completed?</td><td>Yes</td><td>X</td><td>No</td><td></td><td>N/A</td><td></td></tr>
<tr><td>If Not Applicable please explain why</td><td colspan="6">attached</td></tr>
</table>

APPENDIX 1 EQUALITY IMPACT ASSESSMENT

Equality Impact Assessment		NHS Stockport Clinical Commissioning Group
1.	**Name of the Strategy / Policy / Service / Project**	The merger of GMS contracts of Vernon Park Surgery and The Surgery1
2.	**Champion / Responsible Lead**	Emma Ince
3.	**What are the main aims?**	It is proposed that there will be a formal merger of the two GMS contracts, which will create one partnership operating under a single contract, with a single registered list of patients.
4.	List the main activities of the project:	• Review of merger business case • Review of patient engagement • Review and assurance of NHS guidance procedures • Assessment of Equality impact • Request CCG approval through Primary care Commissioning • LMC and PCN approval sought • Commission GMSS to carry out merger with CCG IM & T support
5.	What are the intended outcomes?	To provide an improved and equitable service to patients in both practices. To increase the viability and sustainability of the practice. To reduce the burden of the practice teams by having to operate different clinical systems and processes.
	IMPACT ON SERVICE USERS	
6.	**Who currently uses this service?**	Joint practice registered population of 3,273
7.	**Are there any clear gaps in access to this service?** (e.g. low access by ethnic minority groups)	None identified.
8.	**Are there currently any barriers to certain groups accessing this service?** (e.g. no disabled parking / canteen doesn't offer Kosher food / no hearing loop)	None identified
9.	**How will this project change the service NHS Stockport offers?** (is it likely to cut any services?)	There number of GP practices in Stockport will reduce from 37 to 36 practices. There will be no cut to any services
10.	**If you are going to cut any services, who currently uses those**	N/A no loss to existing services

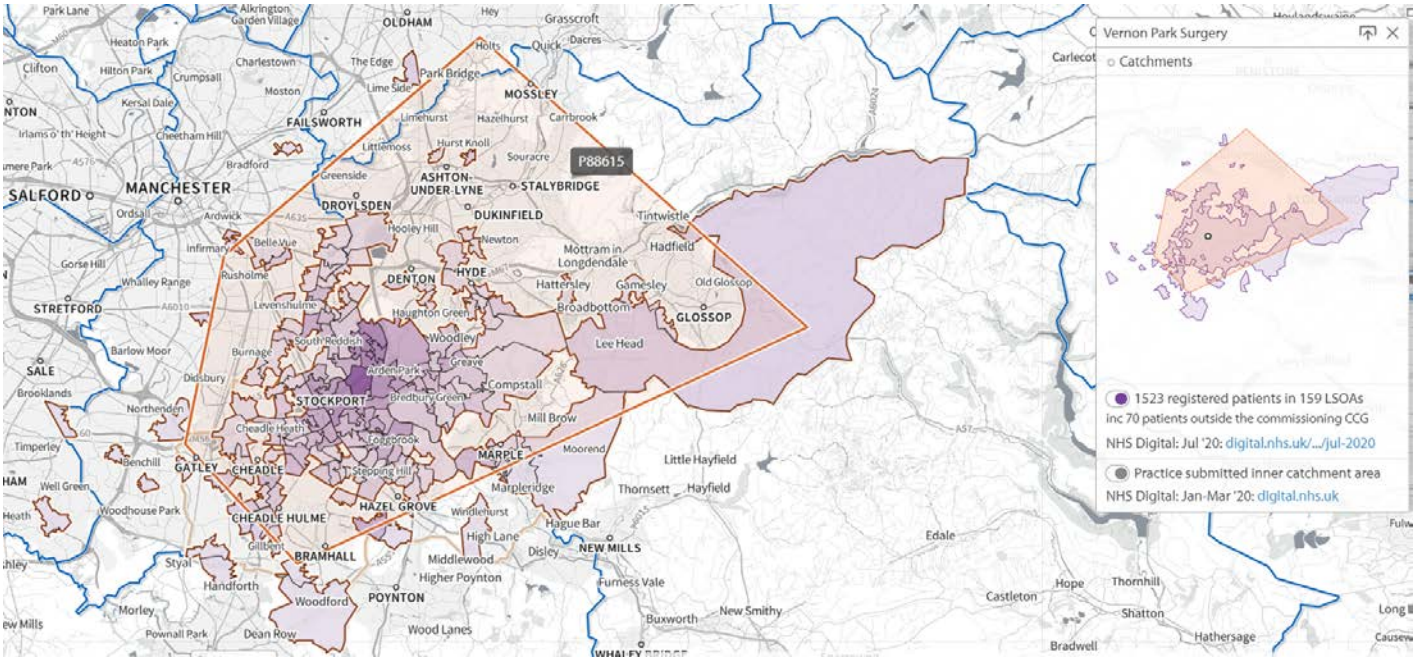
	services? (Will any equality group be more likely to lose their existing services?)		
11.	**If you are creating any new services, who most likely to benefit from them?** (Will any equality group be more ore less likely to benefit from the changes?)	All the patients of The Surgery1 will be able to access additional enhanced services such as nursing appointments for long term condition management, minor surgery and access to first contact practitioners. All patients will have on site access to both male and female appointments. Both patient cohorts will benefit from the proposed increased clinical capacity	
12.	**How will you communicate the changes to your service?** (What communications methods will you use to ensure this message reaches all community groups?)	The practice carried out a patient survey on the proposed merger including all patients of the two practices in July and August 2020 via text messaging and practice website surveys links. Further communications will be done via the practice website and practice notices in both sites.	
13.	**What have the public and patients said about the proposed changes?** (Is this project responding to local needs?)	A total **of** 129 (5%) responses were returned across the practices with 87.5% positive responses and in agreement with the merger and 12.5% with concerns and against the merger. Those that responded against the merger had concerns about the increased patient list size, not being able to see their regular GP and the impact on access and waiting times. The practice responded to all the patients who raised concerns providing the necessary assurances and highlighting the benefits of the merged services including the ability to see the GP of choice and improved access with a bigger team to support service delivery.	
14.	**Is this plan likely to have a different impact on any protected group?** (Can you justify this differential impact? If not, what actions will you add into the plan to mitigate any negative impacts on equality groups?)	**IMPACT**	**MITIGATION**
	Age	None	
	Carers	None	
	Disability	*No negative impact expected, however the following actions provide for mitigation should the need arise:*	Both practices offer learning disability annual health checks and this will continue in the merged practice Both GP sites are DDA compliant and have provision for Accessible Information Standard (AIS) needs. Information will be made available on transportation routes.

			The full medical record will be transferred with patients as part of the merger to ensure new merged practice have access to the full patient history and are able to fully support patients on-going health needs. Other mitigating factors will include patient engagement and communications including patient notices within the practices and on website
	Gender Reassignment	*No negative impact expected*	
	Marriage / Civil Partnership	*No negative impact expected*	
	Pregnancy & Maternity	*No negative impact expected*	There would be no change for on-going pregnancy support services and support for parents with children
	Race	No negative impact expected	Patients will continue to be supported with language/interpreter support as required. Information would be available to patients to meet their language needs.
	Religion & Belief	No negative impact expected	
	Sex	No negative impact expected	
	Sexual Orientation	No negative impact expected	
	Other	No negative impact expected	

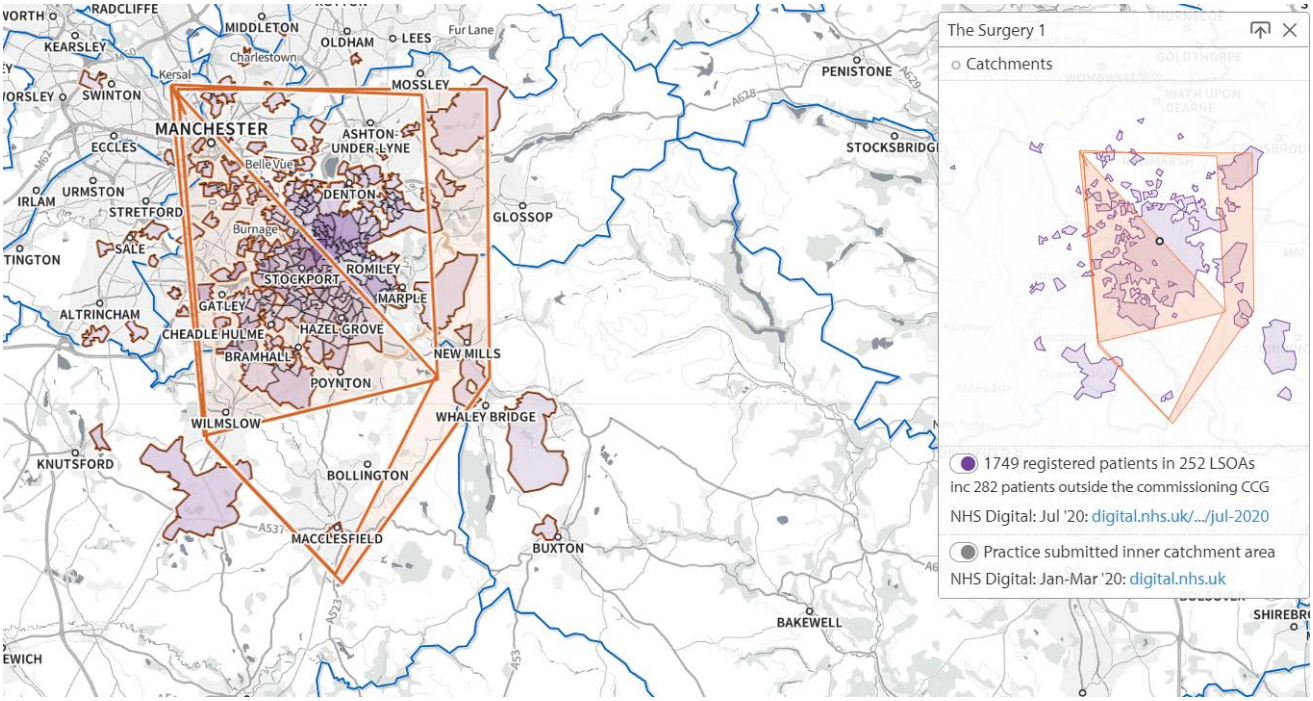
IMPACT ON STAFF			
15.	**How many staff work for the current service?**	Not known but the plan is to increase the Clinician capacity and join all the existing staffing roles in both practices	
16.	**What is the potential impact on these employees?** (including potential redundancies, role changes, reduced hours, changes in terms and conditions, locality moves)	None all staff to be TUPE into new merged contract	
17.	**Is the potential impact on staff likely to be felt more by any protected group? If so, can you justify this difference? If not, what actions have you put in place to reduce the differential impact?**	**IMPACT**	**MITIGATION**

	Age	N/A	
	Carers	N/A	
	Disability	N/A	
	Gender Reassignment	N/A	
	Marriage / Civil Partnership	N/A	
	Pregnancy & Maternity	N/A	
	Race	N/A	
	Religion & Belief	N/A	
	Sex	N/A	
	Sexual Orientation	N/A	
18.	**What communication has been undertaken with staff?**	Staff have been informed of the proposal to merge the two practices	
19.	**Do all affected workers have genuinely equal opportunities for retraining or redeployment?**	N/A	
IMPACT ON STAKEHOLDERS			
20.	**Who are the stakeholders for the service?**	• PCN member practices • LMC • CCG • Community services teams • SMBC	
21.	**What is the potential impact on these stakeholders?**	None identified	
22.	**What communication has been undertaken with stakeholders?**	Stakeholders to be informed via the usual CCG communication channels.	
23.	**What support is being offered to frontline staff to communicate this message with service users / family / carers?**	N/A	
24.	**How will you monitor the impact of this project on equality groups?**	All Providers are asked to monitor access to their services by protected groups. The impact on service access will be monitored through the CCG and providers' annual equality publications.	
EIA SIGN OFF			
25.	*EIAs should be signed off by your Director and attached to policy / strategy documents sent to Governing Body.* *Your completed EIA should be sent to the corporate services team for publication:*		

APPENDIX 2
VERNON PARK SURGERY BOUNDARY MAP



THE SURGERY1 BOUNDARY MAP



NHS England

6 – Application for consideration of a contractual merger

(Please add additional pages if you have insufficient room to complete fully)

Practice stamp

DR S CHATTERJEE, DLO, MRCGP
VERNON PARK SURGERY,
32 BRINNINGTON ROAD,
STOCKPORT SK1 2EX
01614802724

Please complete the following:

1. Details of the two contractual agreements you are proposing to merge

Name and Address Practice A	**Name and Address Practice B**
Vernon Park Surgery 32 Brinnington Road Stockport SK1 2EX	The Surgery 30 Brinnington Road Stockport SK1 2EX
Practice Code	**Practice Code**
P88615	P88600
GMS/PMS	**GMS/PMS**
GMS	GMS
Number GPs	**Number GPs**
1	1
WTE GP's	**WTE GP's**
1	1
Premises: Owned/Leased/NHS Property	**Premises: Owned/Leased/NHS Property**
Owned	Leased
Patient List Size	**Patient List Size**
1350	1750

Premises Arrangements

2. Indicate whether you intend to operate from two premises No

a. If yes, which premises will be considered the main and which is to be considered the branch (if applicable):

b. If no, which premises do you intend to practice from:

Because these are adjoining Properties, we intend to make it into one single property linked by a newly constructed Extension at the back of the Surgeries.

c. Do the proposed premises have the capacity and infrastructure to accommodate the additional patients and services?

It will have fantastic capacity and infrastructure with the newly Constructed Extension.

d. Details of the distances between the 2 practices

Adjoining properties separated by a wall.

e. Details of car parking arrangements currently in place at both practices

Off Road Parking for patients and dedicated parking for Doctors.

f. Details of access to Public Transport to proposed site

Bus, rail, road.

g. Details of the current practice boundary (inner/outer if outer agreed) Practice A:

All over Stockport, Manchester, Tameside and Glossop

h. Details of the current practice boundary (inner/outer if outer agreed) Practice B:

Stockport, Manchester, Cheshire, Tameside & Glossop

Please indicate the practice boundary for the proposed merged practice

To remain the same

I.T. Information

NHS England

3. Indicate which IT systems are currently in use at each practice

Practice A	**Practice B**	
EMIS Web	EMIS Web	
Has IT been consulted to assess if the 2 systems are compatible to be merged		Yes
Has IT confirmed the costs of the IT systems merger		**No**
Has IT confirmed the timescale of merging the databases		**2-3 months?**
Have the costs been approved by the CCG		**Unknown**
Additional Comments **IT and Telephony needs to be Urgently sorted. This is because I use Technology to a very massive extent- there are Documents and Templates that I use at Vernon Park Surgery, that are missing at The Surgery EMIS. I am then wasting time exporting these documents to my desktop and importing them to The Surgery EMIS. This time can be better utilised on other patient care issues.** **Also I use MJOG/ EMIS in-built SMS technology to automatically communicate about results with patients. This technology is missing at The Surgery- hence an early merge of IT systems will ensure better and safe patient care.**		

4. Provide full details of the benefits you feel your registered patients will receive as a result of this proposed merger.

- **Practice B has never had services from a Practice Nurse or Health Care Assistant. Therefore services to patients will improve vastly as chronic disease management is extremely efficiently rendered by our Practice Nurse/ HCA.**
- **Efficient co-ordination of services- at the moment I have to deal with 2 clinical systems each day for tasks/ medication queries, searches, etc etc. This involves substantial wasting time logging in and out of clinical systems. The Clinical systems have different configurations with Practice B not having up to date documents, templates and searches. Patient safety can be improved vastly if the 2 IT systems merge**
- **Substantial modernisation of Premises can be undertaken to deliver safe care to patients in a Covid world..**
- **Economies of scale will enable increased/ extended patient access.**
- **Sharing administrative burden.**
- **I am an Undergraduate Medical Tutor and have gone from strength to strength over the years. I have started with Years 1,2 and 3 in 2009 and have progressed to Year 5 students currently. I have had several Gold awards from the University in the last few years for quality teaching. I wish to carry this even further by having**

Graduated Medical student placements and then GP Registrars as well. This will enable a more skilled workforce that will sustain the future needs of our patients.

- A one GP Practice will become a 2 GP Practice, enabling reduction of workload pressures.
- By having bigger and extended premises we can offer services from the extended workforce like Pharmacists doing medication reviews and other functions from the Practice itself. Other newer roles can be sited in the Premises offering their services to the patients.
- We would be able to offer greater training functions to develop a more skilled workforce- this will help patients have even better and easier access.
- Administrative burden of 2 NHS Contracts will be minimised.

Services Currently Provided

5. Details of services currently provided Practice A

Home Visits	Booking Appointments
Yes	Yes
Opening Hours	**Extended Hours**
0800-1830	Yes
Single IT and Phone System	**Premises facilities**
Yes	Good, but in need of updating
Additional Services Yes	**Enhanced Services** DES- LD, Immunisations, Smears, Extended hours etc through PCNs.

Details of services currently provided by Practice B

Home Visits	Booking Appointments
Yes	Yes
Opening Hours	**Extended Hours**
0800-1830	Yes
Single IT and Phone System	**Premises facilities**
?Yes	In need of updating to be Covid secure.
Additional Services **Yes**	**Enhanced Services** Yes

6 Please provide as much detail as possible as to how the current registered

Patients from the existing practices will access a single service

Home Visits	Booking Appointments
By normal means- telephoning a single merged Telephony number to request Home visit.	Patients will still be able to book appointments at both sites. Online appointments pre-bookable by Patient access or booked on the day, Online Consultations via EMIS Web, Telephone on the day for on the day for same day appointments, pre book appointments via Telephone.
Opening Hours	**Extended Hours**
0800-1830	Hours to be calculated and Prebookable appointments via online/ Telephone means
Single IT and Phone System	**Premises facilities**
Telephony- plans are in place already for X-On to provide single Telephony access.	Premises will be modernised and Extended to provide modern, crisp services with Disabled

EMIS Web to be merged across the 2 Practices	access to the site to see GPs, Nurses, Health care assistants, First Contact Physio, Trainees, Pharmacists.
Additional Services	**Enhanced Services**
Will be provided as signed up to via a single merged EMIS Web.	To be provided by GPs, Practice Nurse and HCAs through rigorous Searches in EMIS Web.

7. How do you propose to consult with your patients about this proposal, communicate actual change to patients and ensure patient choice throughout: We would Consult patients

1) through both our Websites via Patient survey to gain their views- advertise the proposal via this means as well.

2) MJOG- able to send bulk messages to all patients who have a mobile number- again a Patient survey

3) Patients who are housebound/ elderly/ don't have a mobile phone will be sent the Patient survey by Mail.

4) Patient Participation Group Consultations.

To be signed by all parties to both contracts being proposed for merger

Signed: Suvajit Chatterjee

Print: DR SUVAJIT CHATTERJEE

Date: 14/8/2020

Please continue on a separate sheet if necessary

***Please note: NHS England Greater Manchester Area Team advise each party to seek their own financial advice in respect of areas such as superannuable earnings under each contract and a recommendation for the parties to have a formal partnership deed prepared to underpin the arrangements.**

Any changes to any partnership will require a new registration with CQC

Note: this application does not impose any obligation on the NHS CB to agree to this request.

Delegated Commissioning Internal Audit Review Final Report

Report To (Meeting):	Primary Care Commissioning Committee		
Report From (Executive Lead)	Emma Ince / Gillian Miller		
Report From (Author):	Gale Edwards		
Date:	21st October 2020	**Agenda Item No:**	10a
Previously Considered by:	Draft report previously reported to PCCC April 2020		

Decision		**Assurance**		**Information**	**X**

Conflicts of Interests	
Potential Conflicts of Interest:	Any attendees of the meeting that are associated with general practice or a member practice within the CCG

Purpose of the report:

The purpose of the attached report is to provide the Primary Care Commissioning Committee with the final report of the audit undertaken by MIAA assurance internal auditors including action to be implemented and timelines.

Key points (Executive Summary):

The function of the MIAA audit is to gain assurance that the NHSE's statutory primary medical care functions are being carried out effectively, and in turn to provide aggregate assurance to NHSE and facilitate NHSE's engagement with CCGs to support improvement. The audit was undertaken as part of the 2019/20 internal audit plan with the focus on the Contract Oversight and Management function requirements

Stockport CCG has provided '**Substantial assurance'** of compliance to the requirements

The review confirmed that the CCG has arrangements in place to exercise its primary medical care commissioning function and in accordance with the NHS England Delegation Agreement; The report makes recommendations and timescales for actions to be implemented.

The draft report was presented to the Primary Care Commissioning Committee in April 2020.

The final report was issued later following a meeting with the CCG and MIAA auditors agreeing the actions required and timescales to address the recommendations.

.

Recommendations are that:

1. The CCG undertake a review of the agenda items along with the membership including the consideration of a Quality Assurance dashboard to identify performance issues.
2. The CCG ensures that there is appropriate monitoring and performance of primary care with systematic processes to ensure delivery of high standards across Stockport.
3. The CCG reviews the Governance Structure to ensure that there are appropriate governance arrangements in place for Primary Care
4. A review of the Terms of Reference for the PCCC should be undertaken to ensure that there is an appropriate sub-group / committee reporting into it and that the regularity of meetings are defined.
5. The CCG ensures there is an appropriate rolling program of visits undertaken by the different teams to ensure visits are being completed on a cyclical basis.
6. The CCG formalises an agreed process that will address any conflicts between the CCG and the practices
7. The CCG should include the completed agreed Equality Impact Assessment for contractual changes business cases at the PCCC.

Recommendation:

It is recommended that the Primary Care Commissioning Committee

a. Note the content of this report outlining the actions required and the agreed implementation timescales

b. Note that Stockport CCG has provided 'Substantial assurance' of compliance to the requirements for the Contract Oversight and Management function in discharging NHSE's statutory primary medical care functions effectively.

Aims and Objectives:	
Which Corporate aim(s) is / are supported by this report:	Start well ,Live well , Age well , Die well and lead well
Which corporate objective(s) is / are supported by this report:	Improve quality & safety of care Support people to remain healthy and independent as long as possible Improve early identification of health conditions Reduce health inequalities faster Empower people to live well & proactively manage long-term conditions Support people to remain healthy and independent as long as possible Ensure people can access safe, high quality care when

	necessary Improve quality & safety of care Financial balance across the system Patients and their families will receive high quality support at the end of life

Risk and Assurance:	
List all strategic and high level risks relevant to this paper	None identified

Consultation and Engagement:	
Patient and Public Involvement:	*[N/A]*

Primary Medical Care Commissioning and Contracting: Contract Oversight & Management Functions Review

Draft Assignment Report 2019/20

NHS Stockport CCG

MIAA ASSURANCE

Contents

1. Introduction and Background

NHS England (NHSE) became responsible for the direct commissioning of primary medical care services on 1 April 2013. Since then, following changes set out in the NHS Five Year Forward View, primary care co-commissioning has seen the Clinical Commissioning Groups (CCGs) invited to take on greater responsibility for general practice commissioning, including full responsibility under delegated commissioning arrangements.

In 2017/18, 84% of CCGs had delegated commissioning arrangements (82% - £6,247.6 million – of the primary medical care budget, with the remainder being spent directly by NHSE local teams). In 2018/19 this has increased to 96% with 178 CCGs now fully delegated.

In agreement with NHSE Audit and Risk Assurance Committee, NHSE will be requiring the following from 2018/19:

Internal audit of delegated CCGs primary medical care commissioning arrangements. The purpose of this is to provide information to CCGs that they are discharging NHSE's statutory primary medical care functions effectively, and in turn to provide aggregate assurance to NHSE and facilitate NHSE's engagement with CCGs to support improvement.

The Primary Medical Care Commissioning and Contracting Internal Audit Framework for Delegated CCGs was issued in August 2018. This document provides a framework for delegated CCGs to undertake an internal audit of their primary medical care commissioning arrangements.

The audit framework is to be delivered as a 3-4 year programme of work to ensure this scope is subject to annual audit in a managed way within existing internal audit budgets. This will focus on the following areas:

- Commissioning and procurement of services
- Contract Oversight and Management Function
- Primary Care Finance
- Governance (common to each of the areas)

For 2019/2020, the review of **Contract Oversight & Management Functions** has been undertaken. The remaining reviews will be incorporated into the planning cycle for the internal audit plan.

2. Objective

The overall objective was to evaluate the effectiveness of the arrangements put in place by the CCG to exercise the primary care medical care commissioning function **(Contract Oversight & Management Functions)** of NHS England as set out in the Delegation Agreement.

3. Executive Summary

The controls in place do not adequately address one or more risks to the successful achievement of objectives and/or one or more controls tested are not operating effectively, resulting in unnecessary exposure to risk.

Substantial Assurance

The overall assurance rating is provided as per the NHSE guidance. A comparison of NHSE and MIAA assurance ratings is at Appendix B.

Overall Summary

The review confirmed that the CCG has arrangements in place to exercise its primary medical care commissioning function and in accordance with the NHS England Delegation Agreement, although it is acknowledged that primary governance arrangements and structures need addressing and work is currently in progress with regards to this.

The overarching governance committee is the Primary Care Commissioning Committee (PCCC) which has oversight of primary care through its monitoring of the safety and quality infrastructure, receiving updates at each meeting either verbally or with a paper presented. This will be enhanced with identified improvements with the Primary Care Quality Group.

In addition to the standard NHS GP Contract requirements that includes Quality Outcome Framework standards, the CCG has the Enhanced Primary Care Framework, which are additional requirements with incentives for GP practices to achieve additional safety and quality standards. The GP Practices are assessed for quality, safety and performance through a range of methodologies, with governance arrangements including soft intelligence and data received through the Tableau information system. Where quality visits identify areas for improvement or following a CQC inspection where practices require improvements, the CCG provides support in ensuring action plans are completed. The CCG has regular contact with the local inspector for CQC who is also a member of the Primary Care Quality Group, with CQC an agenda item.

The CCG has a formal process in place for approving contractual changes including the closure and mergers of practices. Standardised business case templates are used which include engagement, consultation with stakeholders, potential options and rationale for the favoured option and any implications of the merger / closure being proposed. Consideration should be given to ensure a more formal equality impact assessment is undertaken.

Stockport CCG currently does not have its own targeted programme for list maintenance. Maintenance is carried out by Primary Care Support England (PCSE) on behalf of all Greater Manchester CCGs.

Historically, the GP practice annual self-declaration (eDec) have not been shared with the CCG, with the review being undertaken by Greater Manchester Health and Social Care Partnership. The information was shared with the CCG in February 2020 for the first time and is currently being reviewed by Business Intelligence. Appropriate arrangements and controls

were in place for GP opening hours of practices along with boundary changes and if required, closure of patient lists at practices.

To further strengthen the control environment we have made recommendations including:

- To review and update the Local Dispute and Appeals Policy;
- Equality impact assessment to formalise and standardise the process of monitoring and recording of visits across the CCG and to update their performance framework for GP practices.
- To undertake a review of the Primary Care Quality Group governance and reporting arrangements including a refresh of agenda and Terms of Reference, to ensure appropriate sub-committee support to the PCCC.

The CCG are aware that some enhancements are required which would improve the CCG's oversight and governance arrangements.

The following provides a summary of the key themes.

Elements	Key Themes
GP Practice Opening Times and Sub Contracted Arrangements	Guidance states that all GP practices have contracts in place and should be compliant with the contractual opening hours of 8am – 6.30pm Monday to Friday with any extended opening hours contracted via the Primary Care Network Directed Enhanced Service (PCN DES) where they will receive additional payments. GP practices declare their opening hours as part of the General Practice Annual Electronic Self-declaration (eDec) questionnaire also required by the CCG's Enhanced Primary Care Framework. Also, there is a requirement for the 36 practices that have signed up to the Enhanced Primary Care Framework (one practice opting out). A sample of six of the 37 practice opening hours were checked to the '8am – 6.30pm agreement' and found to be compliant, with arrangements in place when required for half day closing. Procedures are in place for practice development and training requirements. Internal audit was informed that there is no sub – contracting undertaken via the CCG, with any sub-contracting being undertaken by Viaduct Care (GP Federation) or the use of the out of hours provider Mastercall.
Managing Patient Lists and Registration Issues	The CCG advised they do not hold the personal details of patients and therefore are unable to undertake a

Elements	Key Themes
	programme of targeted list maintenance at GP practices. This is consistent with the position across Greater Manchester. NHS England has a statutory duty to maintain patients' lists through the National Health Applications and Infrastructure Service. There has been identified evidence of practices requesting to close their patients' lists in the last 30 months. A formalised process is in place using NHSE guidance and template letters and any actions would require approval by the PCCC. In their annual 'eDec' declaration, GP practices state whether they are taking patients out of area within the contractual boundaries. The CCG has the facility to identify practices taking patients outside the boundary at patient level. Where boundary changes have occurred, appropriate processes and arrangements are in place, including contacting relevant practices within the CCG and other CGG's as required, on the proposed changes with approval being received from the PCCC. Clarification was provided by Greater Manchester Health and Social Care Partnership in November 2018, regarding patients that register out of area with regards to home visits and access to homecare. Arrangements are in place for patients requiring access to the Special Allocation Scheme (SAS), including risk assessments and the processes for new patients. There is evidence of update being provided through the Primary Care Quality Group and the PCCC. At the time of review there are currently nine patients on the SAS scheme.
Contract review of Practices	Currently, the CCG does not have access to review the annual self-declarations (eDec) of GP Practices. The review is undertaken by Greater Manchester Health and Social Care Partnership. The data relating to 2019 was made available to the CCG in February 2020 and is being reviewed by the Business Intelligence team. The CCG, from the information received including soft intelligence, is expected to have a robust assurance management programme in place to identify and share

Elements	Key Themes
	best practice, identify where additional management is required and when processes are going wrong. The CCG has produced a Performance Framework for GP Practices to ensure performance is being monitored and to identify when support is required. A review of the framework is being undertaken to identify the most appropriate methodologies to ensure standards are achieved **Recommendation 1 Medium** The CCG uses a number of sources and measures to identify GP practices (including local and national data) with access to data through the Tableau system and the Quality Outcomes Framework. This includes practice visit reports, data received from practices including their returns and governance meetings. It is acknowledged that the Primary Care Quality Group has not been as effective in 2019, with a number of meetings being cancelled, changes in personnel and limited reporting to the PCCC. It has been identified by the CCG that the Primary Care Quality Group needs a refresh to ensure it delivers its objectives. There is a limited amount of performance information provided in quality meeting discussions and it is recommended that a quality assurance dashboard is included within the governance arrangements. **Recommendation 2 Medium** It has been recognised by the CCG that there is no formal group reporting into the PCCC as its Terms of Reference do not have the Primary Care Quality Group feeding into the committee. This being reviewed along with the governance structure by the CCG. **Recommendation 3 Medium** The CCG undertake quality visits to the GP Practices, however, the CCG acknowledges the need to enhance and formalise the coordination of visits to ensure the process is more systematic. **Recommendation 4 Medium** Issues identified from quality visits are addressed informally. Where required the Medical Director and Chief Operating Officer visit the practice and review the contractual issue. There was evidence to confirm that the LMC are also are informed of any issues. The PCCC

Elements	Key Themes
	are notified of any issues and provided with respective updates regarding completion of any action plans. KPIs to monitor performance for GP practices are specified within the national contract. The CCG has specified additional KPI's as part of the Stockport CCG Enhanced Primary Care Framework, and GP practices receive additional payments for meeting the criteria. There are also specific KPIs in place for Care Homes Medical Practice, to cover their unique role outside the national contract. All but one practices have signed to the Enhanced Primary Care Framework. There are processes in place at the CCG to verify performance and support payments for enhanced services through data entered by GP practices into the 'Tableau" System', which identifies outlier performance. In the case of flu injections updates of performance are reported to the PCCC. For minor surgery claims the CCG have expected numbers identified and if required, additional data is requested. We have identified no instances of conflict resolution being required between the CCG and a GP practice. We have been advised however that the CCG would utilise national guidance if needed. The CCG also requires local procedures to handle conflicts between any CCG and the practice, including locally commissioned services, which fall under primary care services. **Recommendation 5 Low**
Management of poorly performing GP practices	At the time of the review none of the CCG's practices were rated as "inadequate" or "requires improvement". A standing item for the PCCC is GP practice compliance regarding CQC inspection, together with any CQC updates. On reviewing the minutes there are occasions when the CQC report has been attached and details of the findings are presented. There is regular contact with the CQC inspector (monthly) to share intelligence and any areas of concern, potentially before an issue occurs. The CQC inspector is also a member of the Primary Care Quality Group, with CQC an agenda item.

Elements	Key Themes
	Following an adverse report NHSE prepare the specific remedial action plan with the practice as they reference parts of the contract with which they may be in breach. . Where the outcome of the CQC inspection is “requires improvement”, the CCG offers support to the practice with a meeting undertaken with the GP practice. In the case reviewed as part of this audit, it was confirmed that a senior manager and CCG Director have visited the practice and reviewed the implementation of the action plan.
Practice Mergers and Closures	The CCG has processes in place regarding proposed closures and mergers. A standard template business case is used which includes details of engagement undertaken with patients and stakeholders including, LMC, local GP practices and other health/ interest groups impacted by the decision. Responses from the consultation are identified as part of the process with the PCCC agreement to the option being put forward. Testing included review of papers relating to the proposed closure for practice P88010 presented to the PCCC in June 2017. Mergers of practices P88026 and P88028 presented to the PCCC in January 2018, P88026 and P88617 presented to the PCCC in February 2019 and P88624 and P88625 presented to the PCCC in September 2019. NHSE guidance states that as part of the decision making process for closures and mergers an Equality Impact Assessment should be undertaken. From review of the testing no formalised equality impact assessment was undertaken, to ensure that no protected characteristics are being adversely effected. Although the business cases did focus on the disability access, it is recommended that the CCG Diversity and Inclusion Lead has oversight of the assessment. **Recommendation 6, Low.**

4. Findings, Recommendations and Action Plan

The review findings are provided on a prioritised, exception basis, identifying the management responses to address issues raised through the review.

To aid management focus in respect of addressing findings and related recommendations, the classifications provided in Appendix B have been applied. The table below summarises the prioritisation of recommendations in respect of this review.

Core Elements	Critical	High	Medium	Low	Total
GP Practice Opening Times and Sub Contracted Arrangements	0	0	0	0	0
Managing Patient Lists and Registration Issues	0	0	0	0	0
Contract review of Practices	0	0	3	2	5
Management of Poorly Performing GP Practices	0	0	0	0	0
Practice Mergers and Closures	0	0	0	1	1

Recommendations are set out below in Section 5.

5. Recommendations

Management of Poorly Performing GP Practices	
1. Performance Framework for GP Practices	**Risk Rating: Medium**
Control design	
Issue Identified – CCG's are expected to have a robust assurance management programme in place to identify where support and assistance is required along with additional action required to support the practice. The CCG received information through a number of sources including soft intelligence, and data through the Tableau system. Additionally, the CCG now receive the annual self-declarations (eDec) of GP Practices and the changes incurring at national and local level. In order to bring all available information and resources together the CCG have produced a Performance Framework for GP Practices. The framework was presented to the Primary Care Quality Group in October 2017, although the framework is yet to be implemented. There needs to be a process that identifies the process to be adopted by the CCG to ensure that there is appropriate monitoring and performance of primary care with systematic processes to ensure delivery of high standards across Stockport.	
Specific Risk – Failure to address the Performance of GP Practices	
Recommendation – To review the Performance Framework for GP Practices to ensure it meets the requirements of the CCG's operational and governance arrangements and delivers high standards across all GP practices and also identifies processes to support GP practices when required.	
Management Response (Remedial Action Agreed) – Agreed. Updates will be made in line with the new GP contract arrangements being introduced and will also linked with the CGG's Performance Committee.	
Responsibility for Action – Gale Edwards, Business Manger	
Deadline for Action – 31st March 2021	

Contract Review of Practices	
2. Primary Care Quality Group	**Risk Rating: Medium**
Operational Control	
Issue Identified – There has been a number of changes in personnel in the last year with responsibility for Primary Care. As a consequence, meetings of the Primary Care Quality Group have been infrequent during 2019. The Terms of Reference for the group are in the process of being developed and a work plan is being proposed for the group to enable full scope of the primary care at GP Practices to be reviewed. On reviewing the agenda at the meetings in November 2019 and February 2020, it was noted that some additional items could be considered for inclusion: • Actions outstanding • No performance information being provided including dashboards • RAG rating the position with CQC inspections • Visits undertaken • Safeguarding • Contractual issues • To receive a copy of the Quality Assurance Framework, benchmarking performance across the various criteria Membership, attendance and apologies have impacted on the functionality of the group, and review identified whether there is sufficient cross section of members and attendees. Possible additions could include: • Mastercall and Viaduct Care • Local Medical Committee representative • Contracting representative • Finance representative From a review of the agenda and minutes, there is not a formal process in place for presenting available data including a Quality Framework dashboard of performance against agreed criteria.	
Specific Risk – Governance and oversite arrangement not review and monitoring quality issue within the GP practices	

Recommendation – As part of the review of the Terms of Reference for the Primary Care Quality Commissioning Group a review of the required agenda of the Group should be carried out to ensure it meets its stated objectives To undertake a review of the agenda items along with the membership including the consideration of a Quality Assurance dashboard to identify performance issues.
Management Response (Remedial Action Agreed) – Agreed. A review will be undertaken of the governance arrangements for quality and performance including the Terms of Reference and role of the Primary Care Quality Committee. Will include having discussions and the involvement of the Chair of the PCCC
Responsibility for Action – Gillian Miller, Director of Quality & Provider Management
Deadline for Action – 31st October 2020

Contract Review of Practices	
3. The CCG'S Quality Governance arrangements	**Risk Rating: Medium**
Operating effectiveness	
Issue Identified – There needs to be clarification of the governance structure in relation to the primary care quality. The Primary Care Quality Group has operated under a number of different names in the report to the PCCC, including Quality Board and Primary Care Committee. As an example, it was recorded in the minutes of the Primary Care Commissioning Committee October 2019, *the Quality Board which is a sub-committee of the PCCC has not met since February 2019. There are plans for the first one to be held in November, to report to the PCCC in December. A primary Care Workplan and Primary Care Quality Committee will be established*." Updates were being provided to the PCCC regarding primary care quality although not by a supporting group / sub- committee, rather being that of updates provided by management. The Terms of reference for the PCCC does not include having a sub-committee which was identified at the Primary Care Quality Group in November 2019.	
Specific Risk – No oversight and governance arrangements of quality and performance in the CCG.	
Recommendation – A review the Governance Structure for the CCG should take place to ensure that there is are appropriate governance arrangements in place for Primary Care (including quality). Additionally, a review of the Terms of Reference for the PCCC should	

take place to ensure that there is an appropriate sub-group / committee reporting into it and that the regularity of meetings is defined.
Management Response (Remedial Action Agreed) – Agreed. A review will be undertaken of the governance arrangements for quality and performance and governance arrangements. Will include having discussions and the involvement of the Chair of the PCCC.
Responsibility for Action – Gillian Miller, Director of Quality & Provider Management
Deadline for Action – 31st October 2020

Contract Review of Practice	
4. Rolling Programme of GP Practice visits	**Risk Rating: Medium**
Operating effectiveness	
Issue Identified –The CCG has a statutory duty to conduct reviews of all GP Practices, ensuring all have a contract review at least every three years, to ensure compliance with quality and safety standards. Visits are undertaken to the GP practices by a number of different teams within the CCG, with different responsibilities for reviewing performance, quality and safety. Although the CCG undertake a rolling programme of quality visits to the GP Practices, they need to enhance and formalise the coordination of visits to ensure the process is more systematic.	
Specific Risk –. Failure to undertake reviews of all GP practices in a consistent manner	
Recommendation – To ensure there is an appropriate rolling program of visits undertaken by the different teams to ensure visits are being completed cyclical basis.	
Management Response (Remedial Action Agreed) – Dr Simon Woodworth, Medical Director and the clinical lead for primary care along with the Executive Nurse and the Quality Team are to establish a quality oversight programme with practices. The rolling programme of visits is impractical currently during COVID 19, and is unlikely to occur during 20/21. The virtual quality oversight programme will be monitored via the CCG Quality and Governance Committee.	
Responsibility for Action – Dr Simon Woodworth, Medical Director and Anita Rolfe Executive Nurse	
Deadline for Action – Routine Reporting to Quality and Governance Committee by 31st March 2021	

Contract Review of Practice	
5. Local Dispute and Appeals Policy	**Risk Rating: Low**
Operating effectiveness	
Issue Identified — Issues regarding delegated primary care contracts would be referred to the NHS dispute resolution service. The CCG does not have a Local Dispute and Appeals Process for primary Care Service that will manage any conflicts between the CCG and the practices.	
Specific Risk – Failure to have an agreed process in place to address any local disputes and appeals if to arise.	
Recommendation – To formalise an agreed process that will address any conflicts between the CCG and the practices.	
Management Response (Remedial Action Agreed) – Agreed. Will ensure that the arrangements we do have are in place and formalised.	
Responsibility for Action – Gale Edwards, Business Manager	
Deadline for Action – 31st October 2020	

Practice mergers and closures	
6. Equality Impact Assessments	**Risk Rating: Low**
Operational Control	
Issue Identified – As part of the decision making process for closures and mergers an equality impact assessment (equality analysis) is required to be completed as set out within NHSE guidance. From review of the testing, no formalised equality impact assessment was undertaken, to ensure that protected characteristics are being adversely effected. Although the business cases did include focus on the disability access, this was not formalised through CCGs Diversity and Inclusion Lead.	
Specific Risk – Decisions are made without all of the relevant equality impact assessment	
Recommendation – The CCG should include the completed Equality Impact Assessment as part of the presentation of the business case at the PCCC. They should also ensure that the Equality Impact Assessment Screening forms have been approved and agreed by the CCGs Diversity and Inclusion Lead.	

Management Response (Remedial Action Agreed) – Agreed Will commence including the equality impact assessment in future mergers and closures.
Responsibility for Action – Gale Edwards, Business Manager
Deadline for Action – 31st October 2020

Follow-up

In light of the findings of this audit we would recommend that follow-up work to confirm the implementation of agreed management actions is conducted within the next 12 months.

Appendix A: Terms of Reference

The overall objective was to evaluate the effectiveness of the arrangements put in place by the CCG to exercise the primary care medical care commissioning function **(Contract Oversight & Management Functions)** of NHS England as set out in the Delegation Agreement.

Limitations inherent to the internal auditor's work

We have undertaken the review subject to the following limitations.

Internal control

Internal control, no matter how well designed and operated, can provide only reasonable and not absolute assurance regarding achievement of an organisation's objectives. The likelihood of achievement is affected by limitations inherent in all internal control systems. These include the possibility of poor judgement in decision-making, human error, control processes being deliberately circumvented by employees and others, management overriding controls and the occurrence of unforeseeable circumstances.

Future periods

The assessment is that at February 2020. Historic evaluation of effectiveness is not always relevant to future periods due to the risk that:

The design of controls may become inadequate because of changes in the operating environment, law, regulation or other; or

The degree of compliance with policies and procedures may deteriorate.

Responsibilities of management and internal auditors

It is management's responsibility to develop and maintain sound systems of risk management, internal control and governance and for the prevention and detection of irregularities and fraud. Internal audit work should not be seen as a substitute for management's responsibilities for the design and operation of these systems.

We shall endeavour to plan our work so that we have a reasonable expectation of detecting significant control weaknesses and, if detected, we shall carry out additional work directed towards identification of consequent fraud or other irregularities. However, internal audit procedures alone, even when carried out with due professional care, do not guarantee that fraud will be detected. The organisation's Local Counter Fraud Officer should provide support for these processes.

Appendix B: Assurance Definitions and Risk Classifications

MIAA Definitions		NHSE Definitions	
Level of Assurance	**Description**	**Level of Assurance**	**Description**
High	There is a strong system of internal control which has been effectively designed to meet the system objectives, and that controls are consistently applied in all areas reviewed.	Full	The controls in place adequately address the risks to the successful achievement of objectives; and, The controls tested are operating effectively.
Substantial	There is a good system of internal control designed to meet the system objectives, and that controls are generally being applied consistently.	Substantial	The controls in place do not adequately address one or more risks to the successful achievement of objectives; and / or, One or more controls tested are not operating effectively, resulting in unnecessary exposure to risk.
Moderate	There is an adequate system of internal control, however, in some areas weaknesses in design and/or inconsistent application of controls puts the achievement of some aspects of the system objectives at risk.		
Limited	There is a compromised system of internal control as weaknesses in the design and/or inconsistent application of controls puts the achievement of the system objectives at risk.	Limited	The controls in place do not adequately address multiple significant risks to the successful achievement of objectives; and / or, A number of controls tested are not operating effectively, resulting in exposure to a high level of risk.
No	There is an inadequate system of internal control as weaknesses in control, and/or consistent non-compliance with controls could/has resulted in failure to achieve the system objectives.	No	The controls in place do not adequately address several significant risks leaving the system open to significant error or abuse; and / or, The controls tested are wholly ineffective, resulting in an unacceptably high level of risk to the successful achievement of objectives.

Risk Rating	Assessment Rationale
Critical	Control weakness that could have a significant impact upon, not only the system, function or process objectives but also the achievement of the organisation's objectives in relation to: • the efficient and effective use of resources • the safeguarding of assets • the preparation of reliable financial and operational information • compliance with laws and regulations.
High	Control weakness that has or could have a significant impact upon the achievement of key system, function or process objectives. This weakness, whilst high impact for the system, function or process does not have a significant impact on the achievement of the overall organisation objectives.
Medium	Control weakness that: • has a low impact on the achievement of the key system, function or process objectives; • has exposed the system, function or process to a key risk, however the likelihood of this risk occurring is low.
Low	Control weakness that does not impact upon the achievement of key system, function or process objectives; however implementation of the recommendation would improve overall control.

Appendix C: Report Distribution

Name	Title	Report Distribution
Gillian Miller	Director of Quality & Provider Management	Draft & Final
Gale Edwards	Business Manager	Draft & Final
Anita Rolfe	Executive Nurse	Draft & Final
Dr. Simon Woodworth	Medical Director	Final
Diane Jones	Director of Corporate Affairs	Draft & Final
Paul Lewis-Grundy	Deputy Director of Corporate Affairs	Final
Fiona Smith	Corporate Affairs Manager	Draft & Final
Michael Cullen	Chief Finance Officer	Final
David Dolman	Deputy Chief Finance Officer	Draft & Final

Review prepared on behalf of MIAA by

Name	Lyndon Wiles
Title	Principal auditor
☎	07552 261251
✉	Lyndon.wiles@miaa.nhs.uk

Name	Andrew Rothwell
Title	Internal Audit Manager / Engagement Manager
☎	07554 333641
✉	Andrew.rothwell@miaa.nhs.uk

Acknowledgement and Further Information

MIAA would like to thank all staff for their co-operation and assistance in completing this review.

This report has been prepared as commissioned by the organisation, and is for your sole use. If you have any queries regarding this review please contact the Audit Manager. To discuss any other issues then please contact the Director.

MIAA would be grateful if you could complete a short survey using the link below to provide us with valuable feedback to support us in continuing to provide the best service to you. https://www.surveymonkey.com/r/MIAA_Client_Feedback_Survey

NHS
Stockport
Clinical Commissioning Group

Primary Care Contract Management and Oversight Benchmarking

Report To (Meeting):	Primary Care Commissioning Committee		
Report From (Executive Lead)	Michael Cullen		
Report From (Author):	David Dolman		
Date:	21 October 2020	**Agenda Item No:**	10b
Previously Considered by:	The report is being presented for the first time		

Decision		**Assurance**		**Information**	✓

Conflicts of Interests	
Potential Conflicts of Interest:	Non identified

Purpose of the report:

In 2019/20 MIAA undertook the 'Contract Oversight and Management' audit review. This benchmarking document summarises the key themes identified from these reviews across their CCG client base. It provides information to support organisations in understanding how their approach to the Primary Care Contract Oversight and Management compares to others. It is intended to prompt and inform discussion.

Key points (Executive Summary):

The most common recommendation theme across the Manchester CCGs was that of assurance processes with the majority of CCGs receiving a recommendation in this area. No other common themes were identified in the region.

The distribution of recommendations by framework area broadly corresponds to the distribution of recommendations at a North West level.

The CCG received obtain substantive assurance for the Primary Care Contract Management Oversight review with 3 Medium and 3 Low level recommendations made. The recommendations were made in the following areas:

- Contract review of practices - 5 recommendations (3 medium and 2 low)

- Practice Mergers and Closures – 1 Recommendation (low)

Recommendation:

The Committee:

- Asked to comment on the report

Aims and Objectives:	
Which Corporate aim(s) is / are supported by this report:	Lead Well
Which corporate objective(s) is / are supported by this report:	Improve quality and safety of care

Risk and Assurance:	
List all strategic and high level risks relevant to this paper	

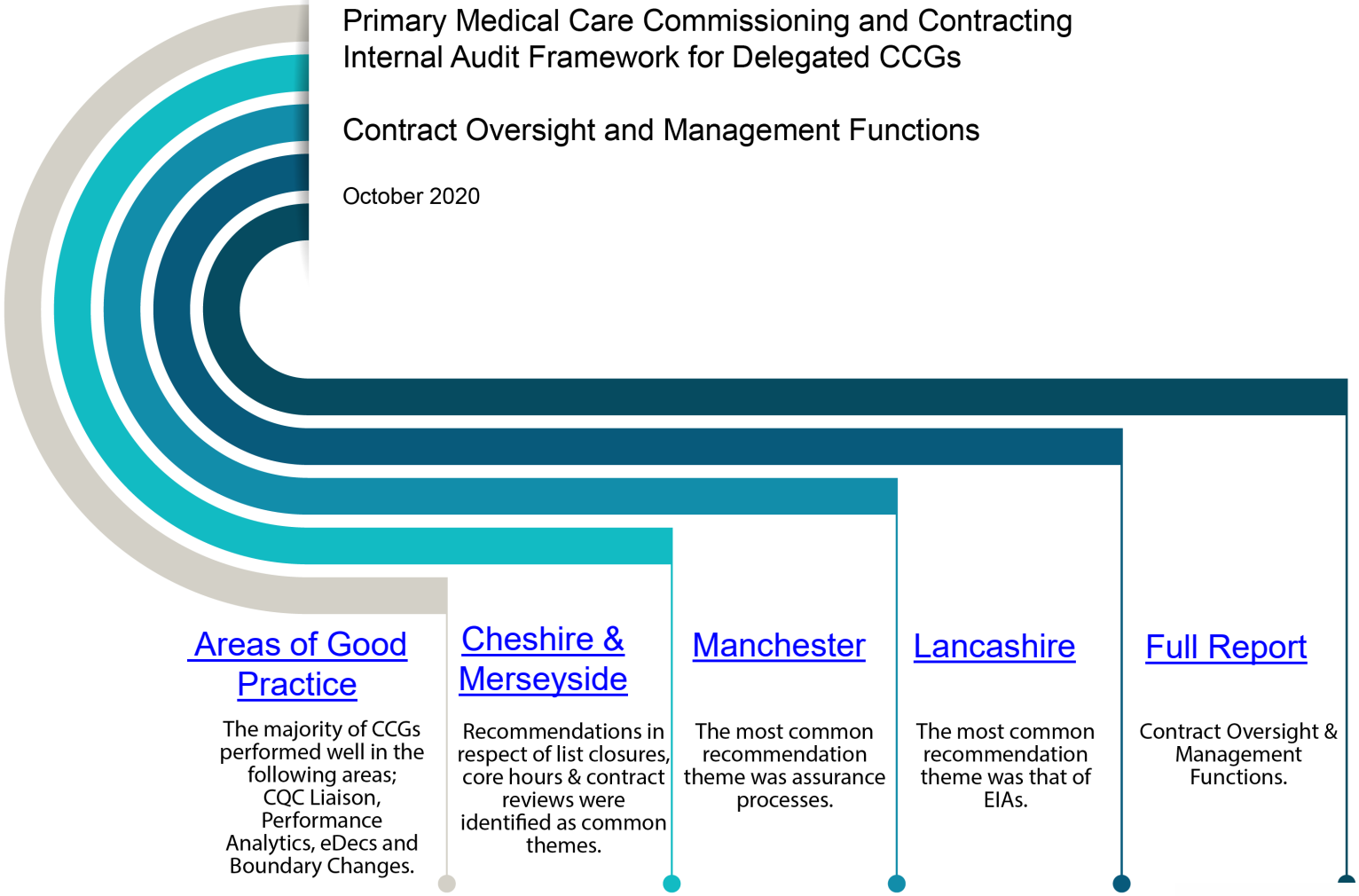
Consultation and Engagement:							
Patient and Public Involvement:	Not Applicable						
Clinical Engagement:	Not Applicable						
Potential Implications:							
Financial Impact:	Non-Recurrent Expenditure						
	Recurrent Expenditure	£8k - £10k to be incorporated into financial plans 21/22					
	Expenditure included within CCG Financial Plan	Yes		No		N/A	
Performance Impact:	Supports the strategy to provide more service in the community and out of hospital as well as providing accommodation for PCN workforce						
Quality and Safety Impact:	Premises will be DDA compliant and provide improved access for disabled and elderly patients						
Compliance and/or Legal Impact:	N/A						
Equality and Diversity:	General Statement:						
	Has an equality impact assessment been completed?	Yes		No	✓	N/A	
	If Not Applicable please explain why						

MIAA Benchmarking Series 2020

Primary Medical Care Commissioning and Contracting
Internal Audit Framework for Delegated CCGs

Contract Oversight and Management Functions

October 2020



MIAA ASSURANCE

NHS
Stockport
Clinical Commissioning Group

PCCC Finance Report for the period ending 30th September 2020 - Month 6

Report To (Meeting):	Primary Care Commissioning Committee		
Report From (Executive Lead)	Michael Cullen		
Report From (Author):	Dianne Oldfield		
Date:	21 October 2020	**Agenda Item No:**	11
Previously Considered by:	This is the first time the report has been presented		

Decision		**Assurance**	✓	**Information**	✓

Conflicts of Interests	
Potential Conflicts of Interest:	Any attendees of the meeting that are associated with general practice or a member practice within the CCG

Purpose of the report:

The purpose of the report is to provide an overview of:

- Financial performance as at 30 September 2020
- Financial regime 1 October 2020 to 31 March 2021

Key points (Executive Summary):

In response to COVID-19 emergency, NHSE/I have put in place a temporary financial regime covering the period 1 April 2020 to 31 July 2020 which has been extended to September 2020. The principle approach is that CCG's will receive retrospective allocations for reasonable additional expenditure to enable an in-year breakeven position to be reported to 30 September 2020.

Contracts and payment guidance together with the Greater Manchester system funding envelope for the period 1 October 2020 to 31 March 2021 was published on 15 September 2020.

Retrospective non-recurrent allocations will no longer be available after M6 with the financial regime based on working at a system (Greater Manchester) level with systems issued with fixed funding envelopes
Recommendation:
(i) **Note** that a breakeven position is being reported year-to-date for the period 1 April 2020 to 30 September 2020. (ii) **Note** that retrospective non-recurrent allocations will no longer be available after M6 with the financial regime based with systems issued with fixed funding envelope.

Aims and Objectives:	
Which Corporate aim(s) is / are supported by this report:	Lead Well
Which corporate objective(s) is / are supported by this report:	Ensure financial balance across the system

Risk and Assurance:	
List all strategic and high level risks relevant to this paper	Failure to manage costs within the delegated allocation may result in the CCG failing to deliver financial targets and consequently impact the CCG annual assessment.

Consultation and Engagement:	
Patient and Public Involvement:	Not Applicable
Clinical Engagement:	Not Applicable

1.0 Introduction

This report provides an overview of the CCG's performance in context of the temporary financial regime that NHSE/I have put in place during the period 1 April 2020 to 30 September 2020 in response to COVID-19. The report also details the financial regime 1 October 2020 to 31 March 2021.

2.0 Financial performance as at 30 September 2020

The financial position as at month 6 is summarised in Appendix 1. It should be noted that the YTD variances are to the NHSE/I prescribed budget.

Under the financial regime 1 April 2020 to 30 September 2020 the CCG has received non-recurrent retrospective allocations totalling £1.962m and is anticipating receiving a further retrospective non-recurrent allocation of £0.538m for the Primary Care delegated budgets and is therefore able to report a breakeven position.

Please refer to appendix 1 which the following significant variances to budget are detailed:

PMS Contracts – £0.162m adverse variance due to patient list size increases.

Quality and Outcomes Framework (QOF) – £0.495m adverse variance is due to the budget calculated by NHSE/I did not take into account that 30% of the QOF achievement is accrued in month 12.

Primary Care Network Payments – £0.843m adverse variance is due to an increase in PCN DES payments including the full year effect of posts funded by the Additional Roles Reimbursement scheme (ARR) and additional services in line with the new GP contract.

Non Delegated PRC Schemes - £0.896m adverse variance is due to additional costs incurred in response to COVID-19. Costs include £0.345m for General Practice opening on Good Friday, Easter Monday and early May bank holiday, £0.348m reimbursing Practice's for additional reasonable PPE, equipment and staff costs and £0.130m relating to premises improvement and alteration works costing less than five thousand pounds to ensure COVID-19 risks to staff and patients are mitigated when attending the practice premises.

3.0 Financial Regime in response to COVID-19

Contracts and payment guidance together with the Greater Manchester system funding envelope for the period 1 October 2020 to 31 March 2021 was published on 15 September with further details and clarifications still being received.

Retrospective non-recurrent allocations will no longer be available after M6 with the financial regime based on working at a system (Greater Manchester) level with systems issued with **fixed** funding envelopes.

The expenditure baseline (against which the expenditure expectation has been developed) for CCG delegated primary care allocations for M7-12 have been updated from 2019/20 M11 to 2019/20 M12. No specific COVID-19 support fund for general practice has been proved for M7-12.

4.0 Next Steps

The CCG will continue to implement national guidance as and when it is published.

5.0 POTENTIAL IMPLICATIONS

Potential Implications:							
Financial Impact:	Non-Recurrent Expenditure						
	Recurrent Expenditure	The finance implications are identified in the paper					
	Expenditure included within CCG Financial Plan	Yes	✓	No		N/A	
Performance Impact:	Reporting a breakeven position in accordance with national guidance.						
Quality and Safety Impact:	*N/A*						
Compliance and/or Legal Impact:	Reporting in compliance with national guidance in response to Covid19 pandemic						
Equality and Diversity:	General Statement:						
	Has an equality impact assessment been completed?	Yes		No		N/A	✓
	If Not Applicable please explain why						

Appendix 1 – Financial Summary

YTD Financial Position as at 30-Sep-20		YTD budget £m	YTD Actual £m	YTD Variance £m
Revenue Resource Limit (RRL)				
Confirmed Allocations		(£20.356)	(£20.356)	£0.000
Retrospective Allocation Received		(£1.962)	(£1.962)	£0.000
Total RRL		**(£22.318)**	**(£22.318)**	**£0.000**
Net Expenditure				
General Practice - GMS				
	Global Sum	£5.751	£5.790	£0.039
	MPIG Correction Factor	£0.026	£0.000	(£0.026)
General Practice - PMS				
	Contract Value	£7.967	£8.129	£0.163
	Baseline Adjustment	£0.001	£0.000	(£0.001)
QOF				
	QOF Aspiration	£1.632	£1.599	(£0.034)
	QOF Achievement	£0.096	£0.625	£0.529
Enhanced services				
	DES- Individual Practice Payments			
	Learn Dsblty Hlth Chk	£0.051	£0.061	£0.009
	Minor Surgery	£0.182	£0.191	£0.008
	Violent Patients	£0.026	£0.054	£0.028
	PCN-Participation	£0.280	£0.274	(£0.007)
	Primary Care Network DES Payments			
	PCN-Extended Hours Access	£0.256	£0.229	(£0.027)
	PCN-Clinical Director	£0.081	£0.114	£0.034
	PCN Support Payment	£0.000	£0.106	£0.106
	PCN DES Care Home Premium	£0.000	£0.068	£0.068
	PCN-Clinical Pharmacist	£0.180	£0.626	£0.446
	PCN DES Pharmacy technicians	£0.000	£0.014	£0.014
	PCN-Physiotherapist	£0.000	£0.209	£0.209
Premises Cost Reimbursement				
	Prem Clinical Waste	£0.021	£0.031	£0.009
	Prem Notional Rent	£0.543	£0.554	£0.011
	Prem Rates	£0.195	£0.208	£0.013
	Prem Water Rates	£0.015	£0.035	£0.020
	Prem Healthcentre Rent	£0.796	£0.811	£0.015
	Prem Actual Rent	£0.161	£0.161	(£0.000)
Other Premises Cost				
	Prem Other	£0.003	£0.003	£0.000
Dispensing/Prescribing Drs				
	Prof Fees Prescribing	£0.157	£0.088	(£0.069)
Other GP Services				
	PCO Seniority	£0.089	£0.000	(£0.089)
	Legal / Prof Fees	£0.005	£0.010	£0.004
	CQC	£0.098	£0.096	(£0.003)
	PCO Locum Adop/Pat/Mat	£0.116	£0.219	£0.103
	PCO Locum Sickness	£0.085	£0.044	(£0.041)
	PCO Locum Susp Drs	£0.000	£0.000	£0.000
	Sterile Products	£0.002	£0.002	(£0.000)
	PCO Doctors Ret Scheme	£0.014	£0.035	£0.021
	Translation Fees	£0.033	£0.039	£0.006
	Healthcare Foundation Trust	£0.000	£0.005	£0.005
	Indemnity	£0.000	£0.004	£0.004
Void & Subsidy				
	NHS Property Services	£0.446	£0.482	£0.036
Reserves				
	Business Rules / General Reserves	£1.962	£0.000	(£1.962)
	Primary Care Investments	£0.000	£0.000	£0.000
Non-Delegated PRC Schemes		£1.047	£1.120	£0.073
Non-Delegated PRC Schemes Covid-19		£0.000	£0.823	£0.823
Total Net Expenditure		**£22.318**	**£22.856**	**£0.538**
(Surplus) / Deficit before anticipated retrospective allocation		**£0.000**	**£0.538**	**£0.538**
Retrospective allocation anticipated		£0.000	(£0.538)	(£0.538)
(Surplus) / Deficit after anticipated retrospective allocation		**£0.000**	**£0.000**	**£0.000**