NHS
East Leicestershire and Rutland
Clinical Commissioning Group

Meeting Title	**Primary Care Commissioning Committee**	**Date**	**Tuesday 5 January 2016**
Meeting No.	**11.**	**Time**	**2:00pm – 3:00pm**
Chair	**Mr Clive Wood Chair of the Committee**	**Venue / Location**	**Board Room, ELR CCG, Units 2 – 3, Bridge Business Park, 674 Melton Road, Thurmaston, Leicester, LE4 8BL.**

ITEM	AGENDA ITEM	ACTION	PRESENTER	PAPER	TIMING
PC/15/127	Welcome and Introductions		Clive Wood		2:00pm
PC/15/128	To receive questions from the Public in relation to items on the agenda	To receive	Clive Wood		
PC/15/129	Apologies for Absences	To receive	Clive Wood		
PC/15/130	Declarations of Interest on Agenda items	To receive	Clive Wood		2:05pm
PC/15/131	To Approve minutes of the previous meeting of the ELR CCG Primary Care Commissioning Committee held on 1 December 2015	To approve	Clive Wood	**A**	2:10pm
PC/15/132	To Receive Actions and Matters Arising following the meeting held on 1 December 2015	To receive	Clive Wood	**B**	
REPORTS					
PC/15/133	Options Appraisal for Reinvestment of Primary Medical Services (PMS) / Funding Differential Review (FDR) Premium	To receive	Jamie Barrett	**C**	2:15pm
PC/15/134	7-Day Working in Primary Care	To receive	Jamie Barrett	**D**	2:30pm
PC/15/135	Any other Business	To receive	Clive Wood	**Verbal**	2:45pm
DATE OF NEXT MEETING					
PC/15/136	**Date of next meeting:** Tuesday 2 February 2016 at 2:00pm, ELR CCG office, Board Room.				

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EAST LEICESTERSHIRE AND RUTLAND CLINICAL COMMISSIONING GROUP

Minutes of the Primary Care Commissioning Committee held on Tuesday 1 December 2015 at 2:00pm in Boardroom, ELR CCG, Units 2 & 3, Bridge Business Park, 674 Melton Road, Thurmaston, Leicester, LE4 8BL

Present:

Mr Tim Sacks	Chief Operating Officer (Deputy Chair of the Committee, ELR CCG)
Ms Diane Eden	Deputy Chief Operating Officer (on behalf of Chief Operating Officer)
Mrs Donna Enoux	Chief Finance Officer
Dr Anne Scott	Deputy Chief Nurse (on behalf of Chief Nurse and Quality Officer)
Dr Andy Ker	Clinical Vice Chair
Dr Vivek Varakantam	GP, Oadby and Wigston Locality Lead

In attendance:

Mr Jamie Barrett	Head of Primary Care
Mrs Daljit K. Bains	Head of Corporate Governance and Legal Affairs, ELR CCG
Mrs Amanda Anderson	Medical and Pharmacy Contract Manager, NHS England - Central Midlands
Ms Lesley Harrison	Commissioning Lead for Medical and Pharmacy, NHS England – Central Midlands
Mr Salim Issak	Primary Care Support Manager (GP & Pharmacy)
Ms Kiran Loi	Public Health Specialty Registrar (on behalf of Mike Sandys representative from Health and Wellbeing Boards Leicestershire and Rutland).
Ms Sue Staples	Healthwatch Leicestershire
Dr Saqib Anwar	Medical Secretary, Leicester, Leicestershire and Rutland Local Medical Committee
Mr Chris Parnell	Care Maker (Student Nurse, UHL and LPT)
Mrs Amardip Lealh	Corporate Governance Manager, ELR CCG (minutes)

ITEM	DISCUSSION	LEAD RESPONSIBLE
PC/15/112	**Welcome and Introductions** Mr Tim Sacks welcomed all members to the Public meeting of the Primary Care Commissioning Committee (PCCC), in particular: • Ms Diane Eden, Deputy Chief Operating Officer who was shadowing Mr Sacks following recent appointment to the CCG and attending as his formal deputy; • Mr Chris Parnell who was shadowing Dr Anne Scott as part of NHS Care Maker Project.	

ITEM	DISCUSSION	LEAD RESPONSIBLE
	This was followed by introductions by the Committee.	
PC/15/113	**To receive questions from the Public in relation to items on the agenda** There were no questions received from members of the public present.	
PC/15/114	**Apologies for Absence:** • Mr Clive Wood, Lay Member; • Mrs Carmel O'Brien, Chief Nurse and Quality Officer; • Dr Nick Glover, GP, Blaby and Lutterworth Locality Lead; • Mrs Jennifer Fenelon, Healthwatch Rutland.	
PC/15/115	**Declarations of Interest** All GPs present declared an interest in any items relating to commissioning of primary care where a potential conflict may arise, with particular reference to the following items on the agenda: • **PC/15/120: Primary Care Community Based Services (CBS) 2014 – 15: Quality Report Summary Update** due to previous conflicts declared; • **PC/15/122: Options Appraisal for Reinvestment of Primary Medical Services (PMS) / Funding Differential Review (FDR) Premium** due to previous conflicts declared.	
PC/15/116	**To Approve minutes of the previous meeting of the ELR CCG Primary Care Commissioning Committee held on 3 November 2015 (Paper A)** The minutes of the meeting held on Tuesday 3 November 2015 were approved, subject to the following amendments: • **Page 5 (PC/15/107: Primary Care Community Based Services (CBS) 2014 – 15: Quality Report Summary –** The action for Mr Jamie Barrett to re-evaluate the information presented for CAS alerts to be added to the action log. Mr Barrett confirmed this has been included within the update to be presented (Item PC/15/120). Dr Andy Ker confirmed CAS alerts were highlighted within their Practice meeting, which states the	

ITEM	DISCUSSION	LEAD RESPONSIBLE
	dissemination of these alerts is working, if set up appropriately. • **Page 9 (PC/15/109: ELR CCG GP Federation High Level Plan) -** 1st paragraph, last sentence: Dr Vivek Varakantam requested the following paragraph to be amended as follows (in italics): "Mr Sacks informed the Committee that funding has been made available for 2 years (until the end of 2016 - 17); however, it was considered that at this stage, multiple applications may weaken the ability to develop *as a viable and sustainable federation* as the funding may not be adequate to support more than one Federation structure." It was **RESOLVED** to: • **APPROVE** the minutes of the previous meeting, subject to the above amendments.	
PC/15/117	**To Receive Matters Arising following the meeting held on 3 November 2015 (Paper B)** The revised matters arising following the meeting held on Tuesday 3 November 2015 were received, with the following updates noted: • **PC/15/90: Primary Care Estates Review** Mr Sacks confirmed an update in relation to the process and criteria for undertaking the primary care estates review will be providing under agenda Item PC/15/118. **Action complete.** It was **RESOLVED** to: • **RECEIVE** the matters arising.	
PC/15/118	**Primary Care Estates Review (Verbal)** Mrs Amanda Anderson informed the Committee that following discussions at previous PCCC meetings, correspondence has been disseminated to GP Practices, providing details of the process to be undertaken for a review of all Primary Care Estates. Practices have been requested to complete and submit a self-assessment by 4 December 2015. Following this, all issues identified will be reviewed and a plan of action	

ITEM	DISCUSSION	LEAD RESPONSIBLE
	proposed. Mrs Anderson advised the Committee that a formal report will be presented at the next meeting in January 2015. In response to Dr Anwar's query in relation to the number of submissions received so far, Mrs Anderson confirmed 8 responses had been received to date. Dr Anwar suggested further communication is required in order to increase Practice engagement as some may not be able to meet the current deadline. **Dr Anwar suggested informing the Advisory Clinic at the LMC to provide an opportunity to improve GP premises and support nationally. The Committee welcomed support from Dr Anwar and the LMC.** Dr Ker stated that previous experience of completing online questionnaires in relation to property have not proven successful and queried what other formats the self-assessment is available in. Mrs Anderson confirmed Practices will be reminded (both orally, and in writing) and can be supported to complete the self-assessment, which is very simple and consists of 8 straight forward questions. It should be noted this is an assessment of the current premises, and not a bid for new premises. It was noted that the information collated as part of the self-assessment for Primary Care Estates will support the next element of Primary Care Transformation Fund for which the bid is to be submitted by 16 February 2016. Mr Sacks stressed the importance of completing a self-assessment at this stage as no extra funding will be available to the CCG from NHS England so all additional funding will need to come from within existing CCG commissioning budgets. It was **RESOLVED** to: • **RECEIVE** the update and progress to date.	
PC/15/119	**List Dispersal Policy (Paper C)** Ms Lesley Harrison presented this report, which provided an updated List Dispersal Policy for ELR CCG, following presentation and comments received from the meeting held in October 2015. Ms Harrison stated the Policy has been updated in the following areas: • Page 2 – 'Due Regard' statement and reference to	

ITEM	DISCUSSION	LEAD RESPONSIBLE
	the Equality Act 2010; • Page 6, Section 6 (highlighted in yellow) – the Policy has been updated to include reference to the agreed set of principles between the three LLR CCGs for the transfer of Primary Care funding when a GP practice list is transferred or dispersed from within the boundary of one CCG to another. In response to Dr Ker's query around the agreed principles, Mrs Daljit Bains stated these could be appended to the Policy. **Ms Harrison to ensure the agreed set of principles are appended to the Policy.** Dr Saqib Anwar queried whether this Policy had an impact on boundary changes, to which Ms Harrison confirmed this is included within the Boundary Change Policy. **It was RESOLVED to:** • **APPROVE** the List Dispersal Policy, subject to the inclusion of the agreed set of principles as an Appendix.	**Lesley Harrison**
PC/15/120	**Primary Care Community Based Services (CBS) 2014 – 15: Quality Report Summary Update (Paper D)** Mr Jamie Barrett presented this report, which provided a brief update in relation to the management of the CBS Contracts for 2014 – 15 that were outlined as follows: • Contracts Management The NHS Standard Contract was used for contracting CBS, which must be used by CCGs and NHS England for all NHS funded services; and made up of the following Parts: 1. Service Conditions 2. General Conditions 3. Contract Particulars It was noted that Parts 1 and 2 are nationally set and cannot be amended; and Part 3 is populated with Provider and Commissioner details via a national template. • Quality Monitoring Mr Barrett referred to the following Quality Schedules which were developed by the Quality Team and include a set of generic indicators for all provider	

ITEM	DISCUSSION	LEAD RESPONSIBLE
	groups; with specific indicators for each too: - Appendix A: GPs Practices completed a reporting template and provide evidence of compliance. - Appendix B: Pharmacists The Primary Care Contracts and Provider Performance Manager visited Pharmacies with a CCG representative, where possible, to establish contract, provide guidance and support. - Appendix C: Opticians Same process applied as for Pharmacists. Performance for these Providers has been collated and RAG rated against each of the Quality Schedules above and feedback reports issued with actions as illustrated in Appendices D, E and F. • Role of Primary Care Development Group (PCDG) This Group is responsible for: - overseeing the commissioning and development of primary care CBS; - developing and recommending service priorities based on available resources; and - developing, supporting, improving and monitoring primary care services. Mrs Bains referred to Section 4.1, which states the PCDG sub-group of the Board, and queried where this Group reports to, as it is not a sub-group of the Governing Body. Mr Sacks confirmed the PCDG would report to the PCCC for formal sign-off / approval. Dr Saqib Anwar queried whether the quality monitoring aspects align to the Quality dashboard. Mr Barrett confirmed specific quality services that align to the Quality dashboard are cross referenced; however, there is not a huge link. In addition, Mr Sacks stated the quality indicators link to individual Practice Profiles to ensure they will need to add more value. **Mr Barrett to ensure these indicators are added to the Practice Profiles.** It was **RESOLVED** to: • **RECEIVE** the report and the progress to date.	**Jamie Barrett**

ITEM	DISCUSSION	LEAD RESPONSIBLE
PC/15/121	**Community Based Services (CBS) Audit Reviews: Pre-Payment Verification Visits (Paper E)** Mr Sacks informed the Committee that this report is to be presented under the 'Confidential' section, due to the detailed information presented within the appendices; and has been removed from the CCGs website. Mr Sacks apologised for the oversight. It was **RESOLVED** to: • **RECEIVE** the report in the Confidential section of the PCCC meeting.	
PC/15/122	**Options Appraisal for Reinvestment of Primary Medical Services (PMS) / Funding Differential Review (FDR) Premium (Verbal)** Mr Sacks confirmed that following the detailed report and scoring matrix presented to the Committee at the last meeting whereby Option 3 (CCG Priority Workstreams) was approved to take the PMS / FDR proposal forward, the timescales have slipped slightly. **A report will be presented at the next meeting in January 2016.** It was **RESOLVED** to: • **RECEIVE** the update.	**Tim Sacks / Jamie Barrett**
PC/15/123	**ELR CCG GP Federation: Update (Verbal)** Mr Barrett reminded the Committee that following attendance from representatives of the Federation at the last meeting, feedback has been obtained in order to understand the comments made at the meeting, which have been reviewed and reflected within a detailed plan. At the PLT in November 2015, GP Practices were requested to confirm their preference of opting in to (or out of) the GP Federation by end November 2015. As of 1 December 2015, 100% of Practices have signed up as part of the Federation at its current stage. As this is an evolving process, **Mr Barrett to present the detailed plan written by the Federation at the next meeting in January 2016.** Mr Sacks also informed the Committee that the CCGs Governing Body is also engaged and up to date with the proposed plans for the GP Federation; with a presentation at the last Governing Body in November 2015. GP Federations have also been featured in the media recently,	**Jamie Barrett**

ITEM	DISCUSSION	LEAD RESPONSIBLE
	acknowledging GPs working together. Ms Sue Staples queried whether the progress made to date was in line with neighbouring CCGs in Leicester and Leicestershire. Mr Sacks confirmed these have been up and running for West Leicestershire CCG since last year; however, the arrangements / rationale for ELR CCG is slightly different in terms of reinvestment, as ELR CCG has incorporated planned care and working more closely with community services. It was **RESOLVED** to: • **RECEIVE** the update.	
PC/15/124	**Co-Commissioning Staffing Model (Paper F)** Ms Lesley Harrison presented this report, which provided details of the staffing model agreed between NHS England and ELR CCG to deliver the primary care commission and contracting delegated functions. Ms Harrison provided the following overview: • 1 April – 30 September 2015: an informal arrangement in place between the CCG and NHS England; • CCG about to enter into a formal memorandum of understanding (MoU) with NHS England and a proposed MoU included in Appendix 1; • In the Co-commissioning delegation agreement, the CCG has the following options: - Option 1: Assignment (funded by NHS England): NHS England staff remain in the current roles and locations and provider services to the CCG under a Service Level Agreement (SLA). - Option 2: Secondment (funded by NHS England): NHS England staff are seconded to (and based within) the CCG (but remain employees of NHS England) from 1 January 2016 – 31 March 2017. A Secondment Agreement was included in Appendix 2). - Option 3: Direct Employment (funded by CCG):	

ITEM	DISCUSSION	LEAD RESPONSIBLE
	CCG may create and employ staff directly within the CCG providing it first offers these posts to existing NHS England staff with an opportunity to apply. In response to Dr Ker's query regarding the location of GP Dispensing, as this is stated as not part of the delegated functions (Page 3, 2nd paragraph, last sentence), Ms Harrison confirmed this is included within Community Pharmacy and remains the responsibility of NHS England, until further notice. Dr Varakantam queried whether the proposed number of staff for the CCG was adequate for the amount of work involved. It was noted that the number of staff proposed for the CCG was more than those employed by NHS England. It was noted that a combination of Options 1 and 2 would be most suitable for the CCG. Mr Sacks formally thanked the Local Area Team at NHS England for its extra support and advice in assisting the CCG to be fully set up and successful with its delegated arrangements. It was **RESOLVED** to: • **APPROVE** Options 1 and 2.	
PC/15/125	**Any other Business** • **7-day Working in Primary Care Pilot** Dr Varakantam declared a conflict of interest in this item as his Practice (The Croft Medical Centre) was involved in the pilot; and Dr Anwar also declared a conflict of interest as he has been involved in the debates for 7-day working. Mr Barrett informed the Committee that following the dissemination of the updated '7-Day Working Practice Guide' to GP Practices since the meeting in October 2015, Practices were advised to submit their Expressions of Interest by 16 November 2015; with a reminder on 30 November 2015. To date, submissions have been received from the following Practices:	

ITEM	DISCUSSION	LEAD RESPONSIBLE
	- Latham House Medical Practice - The Central Surgery, Oadby - Forest House Medical Centre, Leicester Forest East - The Croft Medical Centre - The Glenfield Surgery A few queries have also been received from Practices in relation to the provision of primary care services across the Localities and the use of various clinical systems, which have been addressed. In addition, the demographics of the patient population were also queried as this varies too. It was proposed Dr Varakantam and Ms Kiran Loi review the issues raised with Mr Barrett and provide individual level of advice and expertise in preparation for a formal update in January 2016**.**	
PC/15/126	**Date of Next Meeting** Tuesday 5 January 2016 at 2:00pm – 5:00pm in the Board Room, ELR CCG office, Unit 2-3 (Ground Floor), 674 Melton Road, Thurmaston, Leicester, LE4 8BL.	

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

ACTION NOTES

Key

Completed	On-Track	No progress made

Minute No.	Meeting	Item	Responsible Officer	Action Required	To be completed by	Progress as at 29 December 2015	Status
PC/15/14	14 April 2015	**Strategic Planner / Work Programme 2015 - 16**	Tim Sacks	**Medicines Optimisation and Dispensing Strategy** Initial plan to be developed and presented to the Committee in July 2015.	February 2016	Progress update required. **Action ongoing.**	**AMBER**
PC/15/119	1 December 2015	**List Dispersal Policy**	Lesley Harrison	To ensure the agreed set of principles to be appended to the revised Policy.	December 2015	**Action complete.**	**GREEN**
PC/15/120	1 December 2015	**Primary Care CBS 2014-15: Quality Report Summary Update**	Jamie Barrett	To ensure the Quality indicators are included within the Practice Profiles.	December 2015	Quality indicators included on Practice Profiles – to review and update on a quarterly basis. **Action complete.**	**GREEN**
PC/15/122	1 December 2015	**Options Appraisal for Reinvestment of PMS / FDR Premium**	Tim Sacks / Jamie Barrett	Updated report to be presented to the next meeting, following recent slippage in timescales.	January 2016	On agenda. **Action complete.**	**GREEN**

Minute No.	Meeting	Item	Responsible Officer	Action Required	To be completed by	Progress as at 29 December 2015	Status
PC/15/123	1 December 2015	**ELR CCG GP Federation: Update**	Jamie Barrett	To present the detailed plan written by the GP Federation at the next meeting.	January 2016	On PCCC Confidential agenda. **Action complete.**	**GREEN**

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EAST LEICESTERSHIRE & RUTLAND CLINICAL COMMISSIONING GROUP
PRIMARY CARE COMMISSIONING COMMITTEE

Front Sheet

MEETING DATE:	5 January 2016
REPORT TITLE:	Primary Medical Services Premium and Funding Differential Review Reinvestment Options 2016/17
SPONSOR:	Tim Sacks, Chief Operating Officer
PRESENTER:	Jamie Barrett, Head of Primary Care

EXECUTIVE SUMMARY

The purpose of this report is to consider funding options for the use of PMS premium and Funding Differential Review monies for 2016/17. Following the decision made at the November 2015 PCCC meeting the option was to scope a number of options related to investing this money into primary care. This paper outlines some suggested options for the use of this money.

RECOMMENDATION

The Primary Care Commissioning Committee is requested to:

AGREE a reinvestment option for the 2016/17 financial year to be scoped fully for February PCCC approval.

EAST LEICESTERSHIRE & RUTLAND CLINICAL COMMISSIONING GROUP
PRIMARY CARE COMMISSIONING COMMITTEE
5 January 2016

Primary Medical Services (PMS) Premium and Funding Differential Review (FDR) Reinvestment Options 2016/17

INTRODUCTION

1. In April 2015 the PCCC of ELR CCG signed of the criteria and methodology for the reinvestment of PMS and FDR monies. The purpose of this paper is to refresh the PCCC of the rules and methodology and put forward options for how this funding can be reinvested back into primary care from 2016/17 onwards

BACKGROUND

Primary Medical Services Premium review

2. The national data collection exercise identified that the premium element of PMS expenditure nationally is £325 million. That is the value of how far PMS expenditure exceeds the equivalent items of GMS expenditure. This means that NHS England pays, on average, a premium of £13.52 for patients registered with PMS practices. The premium will reduce to around £235 million over the seven years to 2021/22, as the GMS Minimum Practice Income Guarantee (MPIG) is gradually phased out. This reduces the average premium per registered PMS patient to £9.80.

3. A purpose of the national review was to seek to secure best value from future investment of the 'premium' element of PMS funding by ensuring available resources for investment are deployed in line with the re-investment criteria which have been agreed between the area team and the CCGs as part of the co-commissioning arrangements. In principle these criteria are that any additional investment in general practice services that go beyond core national requirements should

4. A task and finish group was set up to establish the process and options for the PMS review and to develop a framework for reinvestment. The membership of the group covered Leicestershire and Lincolnshire and consisted of representatives from the Local Medical Committees, all CCGs and Area Team representatives from primary care commissioning and finance.

5. As part of this process, fourteen out of fifteen ELR CCG PMS Practices opted to revert to a GMS Contract and access transitional support over a period of 6 years starting in 2015/16. The target contract value at the end of the period will

be the equivalent to the GMS contract value without any MPIG (the seven-year endpoint).

6. Financial Differential Review (FDR) Funding consideration in light of PMS review decisions

In 2010 Leicester City and County PCTs along with the LMC undertook an initiative to ensure that all practices regardless of the contract type received a minimum of £74.21 per patient (2013/2014). This was achieved by County PMS practices relinquishing 8% of their PMS premium and the PCT investing an additional £800,000 into primary medical care. The FDR payment was intended to erode as the global sum increased, therefore FDR would have come to an end in Mar 2014. However it was not envisaged that the global sum would increase by moving funding from elsewhere in the contract. Therefore in May 2014 the Area Team agreed the following option for the reinvestment into FDR practices:

'Recycled' FDR monies (net of new money i.e. excluding any Enhanced Services and QOF funding) will be reinvested on a similar basis to the original FDR non-recurrently to align with the PMS Review. Where the practice can evidence that funding has been used to employ practice staff and this has demonstrable improvement in access and/or clinical outcomes for patients. Where a practice cannot evidence the above then the funding will be removed from 17th November 2014.

It was also agreed that practices would continue to receive full FDR funding until 17th November 2014 when the new arrangements commence. This option was approved on the basis that the funding was re-invested on a non-recurrent basis and reviewed in line with the timeframe for PMS Reviews.

7. Transition Offer

The PCCC of ELR CCG agreed in March 2015 that in 15/16 the net deduction from all PMS practices choosing to move to GMS will be reinvested back into the practices that have had a reduction of income. The net deduction is made up of the funds released due to a reduction in PMS premium funding less any increase in Global Sum payment. The reinvestment will be non-recurrent in 15/16 meaning in 16/17 practices will have a 2 year reduction i.e. 2/6th of the PMS premium less 2 years increase in global sum.

In light of the PMS review decision it was confirmed that FDR funding will continue until 31st March 2016 and that its redeployment would follow the PMS review key principle.

8. Principles for Reinvestment

Based on the prior agreement that the reinvestment funding is available from 2016/17, the methodology for reinvestment was approved at the April 2015 PCCC

- That re-investment of PMS premium funding will be targeted to support general practice services that respond to the health and care needs of local people in line with the Primary Care Strategy/ framework and local CCG priorities
- That we will work to ensure that PMS premium funding remains within Primary Medical Care in the CCG area
- Reinvestment of the PMS premium will be targeted to support direct patient care
- Secure services or outcomes that go beyond what is expected of core general practice or improve primary care premises; this would be supported by a case by case review of all affected practices
- Help reduce health inequalities
- Give equality of opportunity to all GP Practices
- Support fairer distribution of funding at a CCG level
- Innovation in use of skill mix/ service delivery to create capacity

a) Improve Clinical Outcomes

- Innovative use of skill mix – workforce
- Innovative use of technology

b) Integrated Working – primary care at scale

- Support a more integrated approach to delivering community-based services
- Integration for a specific medical condition or group of conditions
- Integration across a wide range of conditions around a specific geography
- Co-location and merger of practices where cost-effective premises improvements are secured and choice is preserved.
- Creative use of primary care with public sector and community services in more rural locations
  - Federation agreements to jointly deliver core services whilst preserving individual contractual arrangements.
  - Use of specialist GPs for targeted populations where evidence suggest better outcomes would be achieved
  - Aligns to Better Care Together or LHAC programmes.

c) Reducing Inequalities

- Deprivation factor where Carr-Hill formula does not adequately reflect population demographics
- Funding for specific populations

9. Reinvestment funding

The funding available for reinvestment is recurrent and will come in phases from 2016/17

Year	FDR	PMS Premium
2016/17	£210k	£658K
2017/18		£329K
2018/19		£329K
2019/20		£329K
2012/21		£329K
TOTAL	£210k	£1.97m

For 2016/17 £321k has already been allocated for practice wound service. This was signed of at the July 2015 PCCC. This leaves a balance for 2016/17 of £547k

10. Options for reinvestment

Following the agreed principles, four options had been put forward for a decision at the November 2015 PCCC these were:

- Option 1 - Fair Share reinvestment
- Option 2 - Funding Differential
- Options 3 – CCG Priority Work streams
- Option 4 – Innovation and Transformation

The PCCC agreed to option 3 to prioritise linked to CCG Work Streams. Appendix 1 details suggestions of targeted areas where the resource could be allocated.

RECOMMENDATION

AGREE a reinvestment option for the 2016/17 financial year to be scoped fully for February PCCC approval.

PMS FDR Options 2016/17

Option	Scheme Description	Outcomes	Delivery Model	Costs	Benefits	Risks
Acute Visiting Service across the entirety of ELR.	The Acute Visiting Service (AVS) and Clinical Response Team (CRT) provides a rapid response from ECPs, supporting Primary Medical Care Providers, to patients with urgent health needs who are vulnerable to admission.	The schemes aim to reduce the number of in hour's emergency admissions and attendances at the emergency department (ED) and to maximise the use of other care pathways.	Commissioned service initially weekday and potentially at weekends for complex vulnerable patients.	£91k for the Jan-March Pilot Period. This covers only a proportion of the CCG patients. Full role out is estimated to be £750k	Supports complex patients, reduces admissions, assist with urgent care needs and much needed capacity to support primary care. Assists with Primary Care QIPP	All practices may not use this service fully. Full evidence of impact needed to seek learning from WL CCG and define future model of delivery
Direct Pharmacy Service in General Practice	Resource allocated for practice medicines optimisation support. Service designed following review of current 3 HUB pilots and adapted to maximise benefits for all ELR CCG practices	This option puts pharmacists directly in general practice providing capacity to manage patients, free up GP and nurse time, improve quality outcomes and reduce cost, enabling reinvestment back into General Practice through incentives.	Practices or Federation directly commission or employs additional Meds Optimisation input.	The results of the pilot review will support the decision of the scale necessary. Estimates are between £810k per annum to £1.1m Based on one pharmacist and a technician per hub size ranging from 2 per 35k population to 2 per 25k population	Allows for increase in capacity for patient care Supports the whole Meds Optimisation in primary care for polypharmacy, MUR's, Switching /Reconciliation and overall Prescribing budget monitoring and integrated Stakeholder working	Defining a set criteria and additional approval/monitoring process

PMS FDR Options 2016/17

Option	Scheme Description	Outcomes	Delivery Model	Costs	Benefits	Risks
Integrated Access Service	Single hub based evening and weekend service. This integration of urgent care centres, Out of hours services and GP extended hours into a single service will provide greater continuity, improved access and ability to manage complex patients	Increased access, support for complex patients, reduced duplication services, improved outcomes through treatment in the community and lower unplanned admissions	Joint contract between ELRUC (the UCC provider) GPs and the ELR Federation	The duplication that currently takes place would cease and release funding to improve the service and this, plus the FDR PMs funding would be invested in addition	Assist with broader Primary Care capacity and a more seamless primary care offer for patients. Supports GP Operating Framework ambitions and also to link with ELR GP Federation in its aims and ambitions	This is not 7DW by another route and more the formal integration of existing commissioned services.
Support to Clinical Priorities (BTC LTC Management)	Resource allocated for the delivery of LTC/Complex patient management across practices or groups of Practices delivering the BCT priorities	This option will allow for practices to focus on their LTC/Complex Patients in line with the BCT clinical priorities.	A worked up business case relating to each clinic area would need to be made operational in agreed timescales	A suggestion would be to allocate the 2016/17 monies on a fair share locality basis to allow options for a locality based solution or a practice based option	Allows for potential innovation of delivery Delivers elements of the BCT LTC Plan.	Increased practice time in delivery seen as additional work not a supporting enabler. Defining a set criteria and additional approval/monitoring process

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EAST LEICESTERSHIRE AND RUTLAND CLINICAL COMMISSIONING GROUP
PRIMARY CARE COMISSIONING COMMITTEE

Front Sheet

REPORT TITLE:	**7 Day Services in Primary Care Pilots – Update Jan 2016**
MEETING DATE:	**5 January 2016**
REPORT BY:	**Sharon Rose, Locality Lead Manager**
SPONSORED BY:	**Jamie Barrett, Head of Primary Care**
PRESENTER:	**Jamie Barrett, Head of Primary Care** **Vivek Varakantam, GP Board Member**

PURPOSE OF THE REPORT:
To update the Primary Care Commissioning Committee on the progress of ELR CCG's 7 Day Working pilot, Practice Expressions of Interest.

RECOMMENDATIONS:
The East Leicestershire and Rutland CCG Primary Care Commissioning Committee is requested to: **NOTE** progress to date and commencement date of service.

REPORT SUPPORTS THE FOLLOWING STRATEGIC AIM(S) 2015 – 2016:			
Transform services and enhance quality of life for people with long-term conditions	Y	Improve integration of local services between health and social care; and between acute and primary/community care.	Y
Improve the quality of care – clinical effectiveness, safety and patient experience		Listening to our patients and public – acting on what patients and the public tell us.	
Reduce inequalities in access to healthcare		Living within our means using public money effectively	Y
Implementing key enablers to support the strategic aims (e.g. constitutional and governance arrangements, communications and patient engagement).			

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

EAST LEICESTERSHIRE AND RUTLAND CLINICAL COMMISSIONING GROUP
PRIMARY CARE COMMISSING COMMITTEE

7 Day Services in Primary Care Pilots

1 Introduction and Background

Clinical stakeholders have told NHS England that the current service offer at weekends impacts directly and negatively on the delivery of improvements across all five domains of the NHS Outcomes Framework and particularly on the domains of Reducing Mortality, Patient Safety and Patient Experience.

The 5 day model no longer meets justifiable user expectations of a convenient, compassionate and responsive service. We now lead 24/7 lives, and one consequence is that we expect services to be available on demand. NHS England's ambition for the NHS should be that primary care GPs can meet those expectations. 7 day services have the potential to drive up clinical outcomes and improve patient experience through reducing the risk of morbidity and excess mortality following weekend admission in a range of specialties.

During November 2015 GP practices across East Leicestershire and Rutland CCG were asked to submit their expressions of interest to undertake the second wave of 7 Day Services pilot based on the original pilot undertaken by The Croft Medical Centre.

Pilot Model

The Croft and Central surgeries offered an extended service to their most '***complex***' patients whom require continuity and a more cohesive approach to care.

This was run exclusively by experienced local GPs, and the service was available both as a service to patients, but also other OOH providers as a resource to ensure that patient care was delivered closer to home and patient appropriate.

- Weekend Saturday and Sunday service 9am – 4pm
- Coverage 17,000
- GP ran
- Run by experienced local GPs who know patients
- Remote access and visits if necessary.
- Defined cohort (2% vulnerable care homes, palliative patients, those at risk of admission).

4 Practices responded and have submitted their interest to take part in the second wave of the pilot, these practices are:

- The Croft Medical Centre – Approx Population 8,500
- Oadby Central Surgery – Approx Population 8,500

- Latham House Medical Practice – Approx Population 35,000
- Glenfield Surgery – Approx Population 14,000

This equates to 66,000 (21%) of the CCG Population and covers all localities.

2 7 Day Pilot services

The 7 day working pilot is not a replication of existing OOH provision. The services across the three sites will look to target those individuals at highest risk of admission their 'Complex Patients'.

There are many definitions for 'complex patients'. For the purposes of this pilot it is the practices have stated that the focus will be for their 'High Risk Unplanned Admission populations' but this will include:

- 2% of most vulnerable older people > 75years on the list for both practices (Identified using risk stratification tool)
- High risk patients (Special Handover Patients)
- Patients needing end of life care
- Patients who are at risk of unplanned admission to hospital. Typically 1% of the practice's adult population (aged 75 and older.(For discussion with other OOH provides for admission avoidance)
- Care Home Patients

Full details of each practices plan to deliver the model is in the attached table (Appendix A) but all practices have stated they will focus on their Top 2/3% of patients.

All three pilot sites will operate a rota system for the GPs and will operate the service between the hours of 8am and 4pm Saturdays and Sundays via telephone and home visiting. All sites will need laptops and mobile phones to commence the 7 day working.

Croft Medical Centre was the only one of the three practices who has expressed an interest to work with other practices in the surrounding area to improve the cohort range and target a higher 'At Risk Population'. Following further talks within the locality area it is hoped that The Croft Medical Centre and Central Surgery Oadby will be able to work on this pilot together.

The proposal is that this second wave of pilots runs for 6 months Jan - June 2016.

Monitoring

Each of the pilot practices will need to monitor their activity / patient contacts over the weekends / bank holidays and submit their activity to the CCG on a monthly basis.

During the original pilot with The Croft Medical Centre an excel template was developed to capture the outcome of the patient contact.

Two of the required fields 'Category of Caller' and 'Reported outcomes' are set choice fields which will ensure consistent outcome reporting from all three pilot sites and will provide consistency throughout the pilot

Date	Time	Category of Caller	Reported Outcome	Comments	Admitted	Diagnosis	Notes

Caller Category	Reported Outcome
Residential Home	Visit no further action
2% Patient	Telephone Advice
Palliative Care	Telephone Contact " All Well"
Special Handover	Admission Avoided
District Nurse	Surgery Attendance / Prescription Contacts
OOH Call	Admitted
Phone Call	
Own Home	
Other	

In addition to the monthly the monthly reporting, a patient survey will take place to gather feedback on the service the patients have received and further evaluation work will be undertaken by Public Health to access impact of the admissions avoided.

SLA

SLA's are to be signed prior to commencement of services in January 2016.

Costings and assumptions

There is approximately £320k available to continue/expand the model across the CCG. The Pilots will be expected to commence from: 16th January 2016 until 19th June 2016 (23 weekends)

Pilot costings:

Practice	Clinical Costs	Other Costs	Total
The Croft Medical Centre and Central Surgery Oadby	£61,600	£6,000	£67,600
Glenfield Surgery	£61,600	£6,000	£67,600
Latham House	£61,600	£7,000	£68,600
Total			£203,800

(Other Costs = Admin, IT Set up and VPN)

This gives a proposed pilot costing of £204K across the 3 sites for a 23 week period (6 months) including bank holidays.

Scale and impact.

The current sites would provide a population scale of 66,000.Using the 3% patient case mix as per the original pilot would equate to a caseload of 1980 patients across the three sites, which equates to almost 1% of the CCG population.

On average the pilot 'saved' between 10-12 admissions per month. To extrapolate this across these 3 sites would save between 30-36 admissions per month and an annual figure 360-432 admissions per year. The financial impact for the CCG based on an average admission cost of £1800 would be around £350k for 6 months in saved admissions for the cost of investment of £204k. This is already in the QIPP for 2015/16.

The Profiling of impact will be explored with BCF leads in January 2016. Trajectories are to be confirmed.

There is also scope to involve / include the development of the AVS scheme alongside these pilots, where applicable.

Conclusion

These pilot practices would enable us to test the model at a larger scale covering a wide population. By starting the pilot in mid-January the practices will be able to provide extra support to their complex high risk patients over some of the most demanding winter months and will help provide evidence to show if the model works within different GP practices and at a larger scale.

Recommendation:

The East Leicestershire and Rutland Primary Care Commissioning Committee are requested to:

NOTE progress to date and commencement date of the service.

Appendix A - 7DW Pilot Information						
	Communications / buy in	**Patient Cohort selected / size**	**Communications to patients / partners**	**IM&T**	**Rota / Standard Operating Procedure**	**Monitoring**
Croft / Oadby Central	Croft Medical Centre has successfully delivered a 7 day pilot project for which it was nominated for a national award. The practice was able to significantly reduce admissions targeting the 3% risk group within its own surgery along with (for the purposes of the pilot) Central Surgery Patients, and has a proven model that has been shown to reduce admissions at A +E. With our experience, and CCG support, we are confident that neighbouring practices will have the sufficient buy-in required to support us in delivering a 7 day model for their patients. Currently we anticipate that it will be the Croft Surgery GP's who will be running this project therefore there will be very little buy in required from host GP's. Through the improvements delivered from our model, we would feel there is a strong case to shape the national requirements of 7 day provision that is safe, effective and does not compromise the quality of offering the 7 day service in a suitably sustainable manner	This Pilot will be for The Croft Medical Centre and Central Surgery Oadby	All patients will be communicated with via SMS, PPG and or letter arranged mutually between practices involved. Other services will be informed also such as LPT, EMAS, OOH GP services. The 3% group will be given a special access number. Partners taking part in the pilot as hosts will have a factsheet to all the Partners to ensure they understand how the service will work and have the opportunity to ask us questions if required. Consultations and tasks will be sent to GP's concerned (at host practices) to communicate work done with any patient that presents to the service. An end of day audit of all patients accessed at the host practice will be sent for the colleagues at the host site to follow up any patients seen over the weekend as deemed necessary. All community service dialogue will occur in the same way as routine and recorded in the consultation notes in the usual manner. This ensures consistency of working is familiar to all those involved during weekday surgeries.	VPN access and necessary consents will be in place to ensure governance aspects are covered with respect to patient data handling, and confidentiality and security between practices and also external community services where appropriate. Patients will be made fully aware by clinicians how their records will be used if it is deemed necessary to refer them on to other services, and for admission purposes. We have previously delivered the pilot using different clinical system to ours (Croft have S1 and host practice at the time had Emis Web), therefore we will have no issues in interoperability with either same or different Clinical systems. We will work with LHIS to ensure that all local arrangements are adhered to in a robust manner.	We would apply a similar rota system as done previously amongst our clinicians to cover the weekends on a 1 in every 5 or 6 week basis. There will be sufficient arrangements for holiday and sickness cover as contingency plans. As each GP will have access to divert function should any mobile phone fail so the service can continue to run even if primary communication methods fail. The duty GP will go through a round robin of the 3% risk group at each host practice to ensure all clinical flags are covered and respond to any issues (including any handover arrangements to OOH). All of our Doctor's bag contents are validated against our checklist and will have agreed contents relevant to the cohort of patients within the 3%. There is an emergency bag available for anything that presents on site. This is checked on a regular basis to ensure that the contents are present for each week the bag will be used for the duration of the project. Our Business Manager will ensure there is adequate staffing arrangements in place such that we are able to offer face to face services as appropriate to the needs of the 3% cohort where required.	The pilot will collect the following information for audit purposes in spreadsheets already built from the previous pilot:- • Number of patients using the service. • Agencies contacting the service. • Type of response required by the doctor. e.g. telephone, visit, referral, prescription etc. • Number of admissions - this will be reviewed for appropriateness of the admission. • Admissions avoided - and how the service impacted on this. • Patient/Carer Satisfaction • Response time for the problem being dealt with. We will work with the CCG on any other monitoring arrangements that may be required. Our Business Manager will ensure that monitoring arrangements are adhered to through timely submissions to CCG as required.
Latham House	"The Practice believes that it should be at the forefront of Primary Care in ELRCCG to offer their most at-risk patients access to a primary care GP over 7 days. This will be achieved by means of expanding access to GPs on Saturdays and Sundays in a 3 month pilot period. Access to a primary care clinician will ensure that patients most at risk will have a clinician known to them to enable their care planning needs to be met consistently (with the help of other services) over a 7 day period, this will help reduce the risk of morbidity and excess mortality following weekend admissions in a range of specialities. By undertaking this pilot, the practice will be able to evidence of reducing avoidable admissions, which is part of the overall LLR health economy target/trajectory. This pilot is not for CORE GMS work. This pilot is not for the whole population covered by Latham House Medical Practice. This pilot is to prevent admissions for the at-risk population identified by LHMP.	The patient cohort will be pulled from the 3% most at risk of emergency admissions, whom have care plans in place (usually 2% of our population). Aprox 700 patients	The Doctors working at Latham House Medical Practice will be asked to opt in to work on the 7 day pilot. The current nurse co-ordinator employed by the practice, Mon – Fri, will be instrumental to sharing the pilot ethos and roles to patients with care plans/their carers/ the nursing and residential homes/the extended community staff, with support from doctors and managers. The Patient Services Manager will inform and engage with the Practices PRG in all matters relating to the pilot. The Practice Manager will get ELRCCG support for the pilot. The Practice Manager and colleagues will be responsible for all communications and feedback to ELRCCG in relation to the pilot. The Patient Services Manager will manage all incidents/complaints in relation to the pilot, and report these separately to the usual practice mandatory returns.	The Practice will appropriate from HIS two practice laptops and two mobile phones for the duration of the pilot.	Time of working: 8:00am – 1:00pm to receive telephone calls, and other home visits as appropriate to patients with care plans/liaise with other services. 1:00pm – 4:00pm to receive telephone calls and complete all associated paperwork from case load that day – including informing usual accountable GP of contacts made/alerting nurse co-ordinator as required. The Practice can undertake the pilot on dates identified, as have already arranged their holiday absences 18 months in advance of the pilot starting, and this is the period of time when the health economy is most stressed with emergency admissions to secondary care. We believe this will be the most effective period of time to test the GP Pilot, and the wider services ability to respond to caring for patients at most risk, safely in their usual place of residence. The Practice will utilise laptops and mobile phones to undertake the pilot duties. The Practice will inform the relevant population about the pilot, via agreed communication methods. - Letters to patients/carers residing in their own homes.	The Practice will agree with ELRCCG the monitoring and reporting requirements during December 2015, prior to the pilot starting in January 2016. The Practice and the ELRCCG will evaluate the results in APRIL 2016 and re-discuss any future extension to the pilot at that point/whether the federation should be encouraged to undertake such services etc.

					- Meetings with residential and nursing home managers for patients residing in nursing/residential homes. The Practices nurse coordinator will place patients requiring review – as known to her on a Friday night – onto the list for the 7-day Doctor. The 7-day Doctor will contact those patients, and all nursing and residential homes between the hours 8:00am – 1:00pm, to plan and prioritise cases, and to undertake home visits as and when required.	
Glenfield Surgery	We would look to provide extended service to our most 500 of our most complex patients via remote linking via laptop. Proposal documents suggest providing services on weekend from 8-4pm however the practice would consider providing services up to 8pm Monday - Friday given the resources to do so.	The practice already has an unplanned admissions regsitered to 268 patients which includes patients on our GFS register, patients in care homes and patients deemed to get high risk covered admission. We would look to estend this list to at least 500 patients at high risk of admission upon CCG tools.	Communicaiton to patients would be using the appendix letters guide provided. We would also seek to advise EMAS, the out of Hours Providers, Walk-in-Centres and any other agencies that may be contacted by patients during the period of 8-4pm on weekends and bank holidays.	The practice will need support in terms of its administration costs, IMT and GP costs the summary of which includes: Laptops with licence for one year Mobile phones	The rota would be monitored and controlled by the lead GP (Dr N Chotai), following the initial GP Guide Outlined by the CCG.	We would complete a monitoring schedule as per CCG recommendation/guide