NHS
East Leicestershire and Rutland
Clinical Commissioning Group

Meeting Title	**Primary Care Commissioning Committee – Public meeting**	**Date**	**Tuesday 4 April 2017**
Meeting No.	**26.**	**Time**	**9:30am – 10:30am**
Chair	**Mr Clive Wood Chair of the Committee and Lay Member**	**Venue / Location**	**Room G52, Leicestershire County Council, County Hall, Glenfield, Leicester, LE3 8TB.**

ITEM	AGENDA ITEM	ACTION	PRESENTER	PAPER	TIMING
PC/17/26	Welcome and Introductions		Clive Wood	**Verbal**	9:30am
PC/17/27	To receive questions from the Public in relation to items on the agenda	To receive	Clive Wood		
PC/17/28	Apologies for Absences: • Dr Tabitha Randell	To receive	Clive Wood		
PC/17/29	Declarations of Interest on Agenda items	To receive	Clive Wood		9:35am
PC/17/30	To Approve minutes of the previous meeting of the ELR CCG Primary Care Commissioning Committee held on 7 March 2017	To approve	Clive Wood	**A**	9:40am
PC/17/31	To Receive Actions and Matters Arising following the meetings held on 7 March 2017	To receive	Clive Wood	**B**	
PC/17/32	Notification of Any Other Business	To receive	Clive Wood	**Verbal**	9:45am
GOVERNANCE ARRANGEMENTS					
PC/17/33	Primary Care Delivery Group (PCDG): Updated Terms of Reference	To receive	Tim Sacks	**C**	9:50am
OPERATIONAL ISSUES					
PC/17/34	Agreed Financial Assistance Policy - For Practices Experiencing The Impact of Dispersed List	To receive	Salim Issak	**D**	10:00am

NHS
East Leicestershire and Rutland
Clinical Commissioning Group

ITEM	AGENDA ITEM	ACTION	PRESENTER	PAPER	TIMING
PRIMARY CARE FINANCE REPORT					
PC/17/35	Primary Care Co-Commissioning Finance Report 2016-17: Month 11 (February 2017)	To receive	Donna Enoux	**E**	10:10am
SUB-GROUP REPORTING					
PC/17/36	Primary Care Delivery Group: March 2017	To receive	Caroline Goulding	**F**	10:20am
ANY OTHER BUSINESS					
PC/17/37		To receive	Clive Wood	**Verbal**	10:25am
DATE OF NEXT MEETING					
PC/17/38	**Date of next meeting:** Tuesday 2 May 2017 at 9:30am, **Guthlaxton Committee Room**, ELR CCG, Leicestershire County Council, County Hall, Glenfield, Leicester, LE3 8TB.		Clive Wood	**Verbal**	10:30am

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EAST LEICESTERSHIRE AND RUTLAND CLINICAL COMMISSIONING GROUP

Minutes of the Primary Care Commissioning Committee held on 7 March 2017 at 9.30a.m., Gartree Meeting Room, ELR CCG, County Hall, Glenfield, Leicester, LE3 8TB

Present:

Mr Clive Wood	Lay Member (Chair of Committee)
Mr Tim Sacks	Chief Operating Officer
Dr Vivek Varakantam	GP Locality Lead for Oadby and Wigston
Mrs Chris Bufton	Head of Nursing (on behalf of Chief Nurse and Quality Officer)
Mrs Donna Enoux	Chief Finance Officer
Dr Jane Bethea	Public Health Consultant, Public Health

In attendance:

Mrs Daljit K. Bains	Head of Corporate Governance and Legal Affairs
Mr Jamie Barrett	Head of Primary Care (on behalf of Chief Operating Officer)
Mrs Caroline Goulding	Senior Contract Manager, NHS England/ELR CCG
Dr Nainesh Chotai	Chair of the Leicester, Leicestershire and Rutland Local Medical Committee (LLR LMC)
Mrs Jennifer Fenelon	Healthwatch, Rutland
Mrs Amardip Lealh	Corporate Governance Manager (minutes)

ITEM		LEAD RESPONSIBLE
PC/17/14	**Welcome and Introductions** Mr Wood welcomed all members to the Public meeting of the Primary Care Commissioning Committee (PCCC).	
PC/17/15	**To receive questions from the Public in relation to items on the agenda** There were no questions from the members of the public present.	
PC/17/16	**Apologies received:** • Dr Tabitha Randell Secondary Care Clinician; • Mr Alan Smith, Independent Lay Member (Deputy Chair of the PCCC); • Dr Nick Glover GP Locality Lead, Blaby & Lutterworth; • Dr Girish Purohit GP Locality Lead for Melton, Rutland and Harborough; • Mrs Carmel O'Brien, Chief Nurse and Quality Officer; • Mr Peter Forrester, Practice Manager Representative.	
PC/17/17	**Declarations of Interest** All GPs present declared an interest in any items relating to commissioning of primary care where a potential conflict may arise.	
PC/17/18	**To Approve the Minutes of Previous Meeting of the ELR CCG Primary Care Commissioning Committee held on 7 February 2017**	

ITEM		LEAD RESPONSIBLE
	Mr Wood informed the Committee that a couple of areas within the minutes of the PCCC meeting held in February 2017 were to be reviewed for clarification purposes, however this did not change the overall context of the minutes presented. It was agreed for **Mrs Bains to circulate the revised version of the minutes to members of the Committee in due course.** The minutes of the previous meeting were accepted as an accurate record of the meeting, subject to a review by Mrs Bains and the following amendments: • **Page 1, Present:** Dr Varakantam confirmed he was present at the meeting although had initially sent apologies in advance. It was **RESOLVED** to: • **APPROVE** the minutes of the previous meeting, subject to the above amendment; and a review of the previous minutes for added clarification by Mrs Bains.	**Daljit Bains**
PC/17/19	**To Receive Matters Arising following the meetings held in 7 February 2017 (Paper C)** The matters arising following the meetings held in February 2017 were received, and the following updates noted: • **PC/17/08 – Asylum Dispersal in South Wigston – Update February 2017 and Future Commissioning** Mr Barrett confirmed the Healthwatch Representative for Leicestershire, Ms Staples has been contacted to review the patient feedback received as part of the Asylum service. A meeting is in the process of being arranged. **Action ongoing.** Mr Barrett also confirmed a meeting has been arranged to take place on the 15 March 2017 with Public Health representation to review the health needs of patients accessing this service, and to assess whether their health needs are being met. **Action ongoing.** • **PC/17/10 – Primary Care Co-Commissioning Finance Report 2016-17: Month 9 (December 2016)** Mr Sacks informed the Committee this action related to the potential incorrect coding of activity at Practice level for patients with Dementia. Mr Barrett confirmed this has been reviewed and 10 Practices have confirmed details of the activity provided was accurate, however, the remaining Practices may have further work to undertake. In response to Mrs Enoux's query regarding the number of Practice who could require further work in order for a more actual position,	

ITEM		LEAD RESPONSIBLE
	Mr Barrett confirmed this can be requested from Practices at the next Practice Manager's Forum (week commencing 13 March 2017). As Mrs Enoux confirmed finance reporting for Month 11 will close on 7 March 2017, Mr Barrett was requested to provide high level number of Practices who require (and do not require) further work to be competed. An accurate position can be reported for Month 12. It was noted that the majority of Practices review and ensure claims are submitted by quarter 4 of the financial year; however, some Practices may not be claiming at all. In response to Mr Wood's query whether claims can be carried forward into the next financial year, Mr Sacks confirmed these claims have previously been processed in next financial year as claims can be submitted up until the day of the deadline. In reality, the claim should be submitted and processed within the same financial year, in order to avoid accruals within the financial accounts. Dr Varakantam appreciated the comments made, however, stated it is difficult to Practice to make the claims within a timely manner and felt this may not be the same approach applied by the CCG for other services Providers. It was agreed **Mr Barrett to support Mrs Enoux with the collation of a more accurate reflection of the current position of Practices and dementia activity.** It was **RESOLVED** to: • **RECEIVE** the matters arising and note the progress to date.	**Jamie Barrett**
PC/17/20	**Notification of Any Other Business** Mr Wood had not received notification of any additional items of business.	
PC/17/21	**Primary Care Delivery Group (PCDG) – Governance Arrangements (Paper C)** Mr Wood informed the Committee that following a review of the Terms of Reference for the PCCC and the discussions at its last meeting and at the Governing Body in February 2017 where it was agreed to review the remit of the PCDG, a meeting has taken place between Dr Glover, Mr Barrett, Mrs Bains and Mr Wood to review the options for consideration. Mrs Bains informed the Committee that it is noted that the PCDG provides critical support in the operational matters concerning the primary care, quality and safety. Following the review meeting, Mrs Bains proposed the following next steps: • The terms of reference for the PCDG to be reviewed and	

ITEM		LEAD RESPONSIBLE
	strengthened to reflect the range of responsibilities of the group; • PCDG be formally constituted as a sub-group of the Integrated Governance Committee, subject to discussion with the Integrated Governance Committee chair; • If the PDCG is established with a line of accountability to the Integrated Governance Committee then escalation of quality and safety issues relating to primary care will be considered by the Integrated Governance Committee; • The PCDG will be responsible for escalating primary care related risks and issues to the PCCC, these issues will be pertinent to the remit of the PCCC; • The PCCC will continue to be able to delegate functions that require more detail review and work to the PCDG, and then PCDG would report back to the PCCC; • Updated terms of reference for the PCDG to be received by the Integrated Governance Committee and PCCC in April 2017 for approval and support respectively. It was noted that the above approach has been proposed in line with the Conflicts of Interest guidance provided by NHS England, taking into consideration the issues surrounding a Lay Member to Chair the PCDG. In addition, it was noted that Dr Glover forms part of the PCDG, which is chaired by Mr Barrett; both of whom attend the PCCC. Mr Sacks informed the Committee that he did not entirely agree with the proposed approach as the PCDG should be the driving force behind the GP Five Year Forward View and the various work streams; and quality is part of the primary care agenda. Mr Sacks felt the format of the PCDG needs to be different. In addition, Mr Sacks felt the decision to remove financial authority from the PCCC to the Governing Body was also inappropriate, but noted this was a separate issue. In relation to voting rights by GPs, Mrs Enoux requested confirmation whether GPs could not vote at the PCCC or the Governing Body. Mrs Bains confirmed GPs can be conflicted at both the PCCC and the Governing Body, therefore all conflicts of interest should be declared. In line with the latest Conflicts of Interest guidance from NHS England, GPs on the PCCC do not have voting rights. However, should a GP declare a conflict / declaration of interest at the Governing Body, they are unable to cast a vote for that item of discussion at Governing Body level. In relation to Mr Sacks's comment regarding delegated financial responsibility for the PCCC, Mr Wood informed the Committee that this had been escalated to the Governing Body due to the financial situation of the CCG as a whole. However, delegated financial	

ITEM		LEAD RESPONSIBLE
	accountability will be reinstated from April 2017 and the PCCC will resume its ability to approve financial issues. Mr Wood noted it was unfortunate Mr Sacks had sent apologies for the meeting to review the aforementioned proposals. Mr Sacks suggested the format of the PCDG is reviewed as it deals with a number of difficult issues and proposed quality related issues are reported to the Integrated Governance Committee and primary care issues to the PCCC. It was noted that members of the Committee broadly supported the proposed approach for the future of the PCDG; and agreed for **Mr Barrett to update the Terms of Reference for the Group and ensure this is circulated to members of the PCCC prior to approval at the IGC in April 2017.** It was **RESOLVED** to: • **APPROVE** the proposed approach to strengthen the remit of the Primary Care Delivery Group and update the Terms of Reference accordingly, subject to agreement from the Chair of the Integrated Governance Committee to amend the line of accountability.	**Jamie Barrett**
PC/17/22	**Primary Care Co-Commissioning Finance Report 2016-17: Month 10 – January 2017 (Paper D)** Mrs Enoux presented this report, which provided a summary of the financial position to Month 10 (January 2017) of the Primary Care budgets based in reporting information available. Appendix 1 of the report contained the year to date (YTD) and forecast position for the total primary care expenditure areas. Month 10 shows a year to date underspend of £544k and a forecast outturn underspend of £439k for Primary Care. In addition, the GP Co-Commissioning budget reported a YTD overspend of £140k; and a forecast to reach £337k by the end of the financial year. The main reason for the overspend was linked to the costs associated with the reprovision of the Long Street Surgery. A full breakdown of the Co-commissioning budget was detailed in Appendix 2. Mr Sacks requested clarification in relation to the forecast for prescribing which was stated as *"showing a YTD overspend of £185k"* and should be reported as an underspend as per the previous report presented to the PCCC. Mrs Enoux noted this will reduce to an overspend of £86k as further QIPP savings are delivered within the final quarter of the year, which is being closely monitored. In addition, reductions in Cat M drugs pricing took effect from January 2017, which will provide an anticipated benefit of £90k in year. It was noted this may not have been appropriately	

ITEM		LEAD RESPONSIBLE
	captured within this section as all prescribing activity results in a net overspend. Dr Varakantam requested clarification in relation to the following sections of the report: • **7. GP IT -** Dr Varakantam requested breakdown of the YTD overspend of £61k and a forecast outturn of £82k. Mr Sacks confirmed this includes all areas of GP IT as covered within the Service Level Agreement (SLA) with Leicestershire Health Informatics Services (LHIS). • **8. Primary Care Licenses and Other -** Dr Varakantam queried whether the unfunded MIG licensing costs are to be funded by the CCG or GP Practices. Both Mr Sacks and Mrs Enoux confirmed this will need to be reviewed and documented appropriately. • **9. QIPP –** Dr Varakantam queried whether the achievement of the forecast £333k QIPP target was a financial gain for the CCG in the current financial year. Mrs Enoux confirmed this forms part of 2016-17 following the Post-Payment Verification (PPV) audits of 10 GP Practices, which are to be completed within the next financial year. Given earlier comments regarding the financial accountability of the CCG which is to be reinstated to the PCCC in April 2017, Dr Varakantam queried whether this decision could be revoked, given increased expenditure in 2017-18. It was noted this section should not state the "QIPP target will now be achieved" and PPV to be documented separately. It was **RESOLVED** to: • **RECEIVE** the report.	
PC/16/23	**Primary Care Delivery Group: February 2017** Mr Barrett presented this report, which provided an update on the following key themes from the PCDG meeting in February 2017: • **Practice Based Pharmacists** – Clarity required for the future reference to Practice Pharmacists and employment status; current arrangements to remain in place until end June 2017 and will be reviewed in preparation for the annual update of the SLA in October 2017. • **Complex Wounds Service, Leicestershire Partnership NHS Trust (LPT)** – Poor quality of care concerns over the	

ITEM		LEAD RESPONSIBLE
	waiting times of patient access to complex wound clinics, which has been escalated to LPT to review. • **Pathology Collection** – Conversations have begun to take place with EMPATH, however progress is slow. This has been escalated to the Contract Lead for the University Hospitals of Leicester (UHL) NHS Trust and linked to the CCG's Integrated Governance Committee, which was helpful. Mr Sacks requested clarification in relation to whether GP Practices were required to employ Practice Based Pharmacists from April 2017 as this appears to be an ongoing issue. Mrs Enoux confirmed this was raised at the Financial Turnaround Committee and clarification requested. Dr Varakantam informed the Committee of the increased impact on primary care over waiting times for the complex wounds service, which is similar for other services such as physiotherapy. It was noted the delays were not ideal for both the patient and GPs as health conditions can deteriorate in the absence of treatment at the right time, resulting in additional appointments at GP practices. Mrs Bufton requested GP Practices to report such concerns to the Hosted LLR CCG Patient Safety Team as 'GP Concerns' so these can reviewed and built into themes and trends. With regards to physiotherapy, Mr Wood requested Dr Varakantam to liaise with Mr Barrett separately. It was **RESOLVED** to: • **RECEIVE** the Report.	
PC/17/24	**Any other Business** There was no other business to discuss.	
PC/17/25	**Date of next meeting (Paper F):** Mr Wood presented the schedule of dates for the remaining PCCC meetings in 2017. The date of the next Primary Care Commissioning Committee meeting will be held on **Tuesday 4 April 2017 at 9:30am, Room G52, County Hall, Glenfield, Leicester, LE3 8TB.**	

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

ACTION NOTES

Key

Completed	On-Track	No progress made

Minute No.	Meeting	Item	Responsible Officer	Action Required	To be completed by	Progress as at 30 March 2017	Status
PC/17/08	February 2017	**Asylum Dispersal in South Wigston – Update February 2017 and Future Commissioning**	Jamie Barrett (Jon Holliday)	To liaise with Ms Staples to review how patient feedback could be incorporated to identify lessons learnt as part of this service.	February – March 2017	Work in progress – meeting in the process of being arranged. **Action ongoing.**	**AMBER**
			Jamie Barrett (Jon Holliday)	Mr Barrett to liaise with Public Health to obtain information and data to determine whether the health needs of patients are being met.	February – March 2017	Meeting originally arranged for mid-March 2017, however rearranged to take place on 5 April 2017. **Action ongoing.**	**AMBER**
PC/17/10	February 2017	**Primary Care Co-Commissioning Finance Report 2016-17: Month 9 – December 2016**	Tim Sacks	To review the financial information in detail with the Finance team to ensure accuracy.	February 2017	Financial data reviewed and reconciled with the Finance Team and a more accurate position included within the financial accounts. **Action complete.**	**GREEN**
PC/17/18	March 2017	**Minutes of the meeting held on 7 February 2017**	Daljit Bains	To circulate the revised version of the minutes to members of the Committee in due course.	March 2017	Revised minutes of the PCCC meeting held in February 2017 circulated with papers for next meeting. **Action complete.**	**GREEN**

Minute No.	Meeting	Item	Responsible Officer	Action Required	To be completed by	Progress as at 30 March 2017	Status
PC/17/21	March 2017	**Primary Care Delivery Group (PCDG) – Governance Arrangements**	Jamie Barrett	To update the Terms of Reference for the PCDG and ensure this is circulated to members of the PCCC prior to approval at the Integrated Governance Committee.	March – April 2017	On agenda. **Action complete.**	**GREEN**

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NHS EAST LEICESTERSHIRE AND RUTLAND CCG

Primary Care Delivery Group

Terms of Reference
(v2, draft 1 – March 2017)

1. Purpose

The Primary Care Delivery Group (the 'Group' hereafter) is a sub-group of the Integrated Governance Committee. Its purpose is to design, plan, develop, and deliver the business cases, processes and systems of primary care services as delegated by the Integrated Governance Committee. The Group is not a formal decision-making Group; it will make recommendations to the Primary Care Commissioning Committee for primary care matters and Integrated Governance Committee for any commissioning or quality issues. The Group is also expected to progress ELR CCGs response to the LLR STP and implementation of the GP 5 Year Forward View.

2. Membership

The membership of the Group will consist of:

- Head of Primary Care – chair of the Group
- GP Governing Body members (the Primary Care Lead) – deputy chair
- All GP Governing Body members who do not attend the Primary Care Commissioning Committee
- Practice Manager representatives x 2
- Senior Primary Care Contracts Manager
- Primary Care Implementation and Delivery Manager/Locality Managers
- Head of Medicines Management or representative
- Finance representative

Should members of the Group not be able to attend, nominated deputies may take their place.

A recommendation put to a vote at a meeting shall be determined by a majority of the votes of members present. In the case of an equal vote, the Chair of the Group shall have a second and casting vote.

4. Attendance

The Group may request attendance by other personnel when focussing on particular issues, for example representative from the public health team**.** Other individuals shall be in attendance as required.

5. Quorum

The quorum for the Group will be the following:

- Chair of the Group or Deputy Chair
- A GP governing body member
- A Practice Manager

6. Administration

The administration and minute taking of the Group will be carried out by the Locality Administrator.

7. Frequency of meetings

The Group will meet on a monthly basis and conduct its meeting ensuring adherence to the CCG's Constitution, policies and the Nolan Principles.

8. Duties

The Primary Care Delivery Group will:

a) Plan the delivery and design process and monitoring and performance of primary care services delegated by the Integrated Governance Committee and CCG.

b) Develop business cases on behalf of the Primary Care Commissioning Committee in line with the Primary Care Strategy and following approval of the financial allocations. Make recommendations to the Primary Care Commissioning Committee for approval of business cases and options appraisals (where appropriate).

c) Implementation of the GP 5 Year Forward View across ELR CCG.

d) Act as an advisory group on primary care related matters from service design, operational queries, concerns and local intelligence and information sharing. Escalate areas of commissioning and quality concern to Integrated Governance Committee

e) Develop and recommend service priorities for East Leicestershire and Rutland CCG based on available resources to be communicated to the Primary Care Commissioning Committee.

f) Develop, support and improve primary care services in East Leicestershire and Rutland CCG.

g) Oversee the process for implementing the CCG Quality Framework for primary care services and getting sign off from the appropriate forum.

h) Maintain effective internal and external communication flows that will support development of consistent approaches to service delivery across the whole health economy

i) To act within the groups remit and scope detailed above

9. Reporting responsibilities

The Group will provide a written summary report of the outcomes of the meeting; propose recommendations for to both the Primary Care Commissioning Committee; and detail risks and issues to be escalated to the Primary Care Commissioning Committee and the Integrated Governance Committee. The Integrated Governance Committee update will include escalation of any quality/commissioning concerns. The Primary Care Commissioning Committee update will capture primary care related themes.

10. Review of Terms of Reference

These Terms of Reference will be reviewed annually or sooner if required and recommendations made to the Primary Care Commissioning Committee for approval.

Date of approval:	April 2017
Review Date:	April 2018

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

Front Sheet

REPORT TITLE:	Agreed Financial Assistance Policy - For Practices Experiencing the Impact of Dispersed List
MEETING DATE:	4 April 2017
REPORT BY:	Salim Issak, Primary Care Contracts Manager
SPONSORED BY:	Jamie Barrett Head of Primary Care
PRESENTER:	Salim Issak, Primary Care Contracts Manager

PURPOSE OF THE REPORT

The purpose of the paper is to inform Primary Care Commissioning Committee (PCCC) of the changes made by Leicester City CCG to their policy providing financial assistance to GP practices following list dispersal. ELRCCG PCCC are asked to consider adopting the changes made by Leicester City CCG.

RECOMMENDATIONS:

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

- **RECEIVE** and **NOTE** contents of the report and the changes made by Leicester City CCG to their policy providing financial assistance to GP practices following list dispersal.
- **Recommendation** is to approve Option 2.

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

EQUALITY ANALYSIS (Respond by inserting /completing one of the three statements below, delete the ones that does not apply)

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 not deemed appropriate for this report.

RISK ANALYSIS AND LINK TO BOARD ASSURANCE FRAMEWORK:

The report highlights the following risks:

- BAF 3 - Quality Primary Care - The quality of care provided by primary care providers does not match commissioner's expectation with respect to quality and safety.
- BAF 6 (a) Primary Care Commissioning – ability to perform delegated duties whilst maintaining member relations and Clinical Engagement

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

AGREED FINANCIAL ASSISTANCE POLICY - FOR PRACTICES EXPERIENCING THE IMPACT OF DISPERSED LIST

4 April 2017

Background

1. At the June 2015 ELRCCG Primary Care Commissioning Committee (PCCC) meeting a number of national and local policies in relation to primary medical care services were approved by East Leicestershire and Rutland Clinical Commissioning Group to use in the discharge of its primary medical care co-commissioning responsibilities.

2. It was acknowledged that the national policies could not be amended. However it was agreed that PCCC would receive the local policies for review on an individual basis. The local policy on Agreed Financial Assistance for Practices Experiencing the Impact of Dispersed List was presented to the PCCC in October and December 2015. **Appendix 1 provides the Policy that was approved by the PCCC at its December 2015 meeting.**

3. Following feedback received from GP practices due to the closure of two practices and one branch surgery in the same location, Leicester City CCG undertook a review of their policy providing financial assistance to GP practices following list dispersal for some months with a number of amendments being made with their final revised policy. **Appendix 2 provides LC CCG's GP Practice or Branch Closure Policy - Agreed Financial Assistance for Practices that was being approved at their PCCC meeting in February 2017.**

4. **Table 1 - Changes made by Leicester City CCG**

Changes - Leicester City CCG	Approved by Agreed by West Leicestershire CCG	Recommendation to ELRCCG PCCC
The policy at the moment covers dispersed list, however there are situations whereby a branch closure could have an impact on local practices similar to a dispersed list. It is therefore recommended to include branch closures.	Yes	Agree the change
Removal of the arbitrary % threshold with payments made on the number of patients registered from the closing practice.	Yes	Agree the change
Remove the request for business case to be completed as these can be a lengthy and time	Yes	Agree the change

Changes - Leicester City CCG	Approved by Agreed by West Leicestershire CCG	Recommendation to ELRCCG PCCC
consuming process which could risk practices having their business case rejected after having committed resources. The practice would be required to apply to the CCG providing evidence of the impact of the dispersed list. Propose to undertaken an audit.		
A flat rate fee per patient registered increased from £4.50 to £10. This fee would be increased to £15 in situations where one or more of the following additional circumstances applied; • Where there is more than one closure at the same time, in the same area • Where there are GP IT system compatibility issues • Where there are known performance issues	No - West Leicestershire CCG has approved the following: Increase the flat rate from £4.50 to £5. Pay an additional £5 in situations where one or more of the following additional circumstances applied; • Where there is more than one closure at the same time, in the same area • Where there are GP IT system compatibility issues • Where there are known performance / **quality** issues	Increase in line with West Leicestershire CCG
Paragraph 5 of the revised Leicester City CCG policy states that should dispersed patients register with a practice outside of Leicester City CCG area then the neighbouring CCG would pick up the dispersal payments to be made under the policy. **Please note, core payment funding will transfer as per LLR CCG agreement in line with the agreed set of principles.**	No. This was not mentioned when discussion took place between the three CCGs. No agreement has been reached on this by West Leicestershire CCG. Further discussion needs to take place for an agreement across LLR between the three CCGs.	Not to approve the change and agree that a further discussion needs to take place between the three CCGs.

5. Initial discussion had taken place between Leicester City CCG, East Leicestershire and Rutland CCG and West Leicestershire CCG on the changes proposed by Leicester City CCG.

6. At the time ELRCCG and West Leicestershire CCG informed Leicester City CCG that due to current financial pressures offering the revised payments would not be

affordable and instead proposed that the flat of £4.50 increase to £5 and an additional rate of £5 should only be paid were additional circumstances apply as outlined in Table 1. Increase in funding will need approval from the respective PCCC.

7. Despite the concerns raised by ELRCCG and West Leicestershire CCG, Leicester City CCG made the changes to their policy to reflect local implementation experience and have acknowledged that an LLR wide policy cannot be agreed and have proceeded with a stand-alone policy for LCCCG.

8. Comparison of cost if ELRCCG agrees to increase the payments being made.

Recent Dispersal List Size	**Payment at current rate £4.50**	**New Rate of £5**	**New rate of £10 to be paid in additional circumstances**
2,500	£11,250	£12,500	£25,000

Recommendations

9. The ELR CCG PCCC is requested to:

- **RECEIVE and NOTE** contents of the report and the changes made by Leicester City CCG to their policy providing financial assistance to GP practices following list dispersal;

- **Consider** the options presented.

  Option 1 - Approve all the changes proposed by Leicester City CCG.

  Option 2 – Approve the recommended changes highlighted in table 1. This would be in line with the decision made by West Leicestershire CCG. Have a discussion with Leicester City CCG regarding dispersal payments to be made when patients join neighbouring CCG practices.

  The **Recommendation** is to approve Option 2 and update the policy in line with the recommended changes.

NHS
East Leicestershire and Rutland
Clinical Commissioning Group

Agreed Financial Assistance for Practices Experiencing

The Impact of Dispersed List

Reference number:	ELR Corporate 033
Title:	Agreed Financial Assistance for Practices Experiencing The Impact of Dispersed List
Version number:	Version 1, draft 2 (December 2015)
Policy Approved by:	ELRCCG Primary Care Commissioning Committee
Date of Approval:	1st December 2015
Date Issued:	December 2015
Review Date:	December 2017
Document Author:	Lesley Harrison, Commissioning Lead for Medical and Pharmacy, NHS England - (Central Midlands) Salim Issak, Primary Care Support Manager (GP & Pharmacy) , NHS England,(Central Midlands) On behalf of ELR CCG
Director:	Mr Tim Sacks, Chief Operating Officer, ELR CCG

Version Control

Version number	Approval / Amendments made	Date (Month Year)
Version 1, draft 1	Policy presented to the ELR CCG Primary Care Commissioning Committee – comments / amendments received.	October 2015
Version 1, draft 2	Policy presented to (and approved by) the ELR CCG Primary Care Commissioning Committee – subject to inclusion of the agreed set of principles.	December 2015

DOCUMENT STATUS:
This is a controlled document. Whilst this document may be printed, the electronic version posted on the intranet is the controlled copy. Any printed copies of the document are not controlled.

RELATED DOCUMENTS:
This document will reference additional policies and procedures which will provide additional information

Due Regard

The CCG aims to design and implement services, policies and measures that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others.

All policies and procedures are developed in line with the CCG Equality and Diversity Policy and this policy has been reviewed in relation to paying 'Due Regard' to the general duty of the Equality Act 2010 to eliminate unlawful discrimination, harassment, victimisation, advance equality of opportunity and foster good relations.

The CCG will endeavour to ensure that no one receives less favourable treatment regardless of their race, social exclusion, gender, disability, age, sexual orientation or religion/belief. Where it is identified that statements in this policy have an adverse impact for particular equality groups, this will be raised with ELRCCG Chief Operating Officer and solutions sought.

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East Leicestershire and Rutland Clinical Commissioning Group

Agreed Financial Assistance for Practices Experiencing

The Impact of Dispersed List

1. Introduction

Whilst it is recognised the new registrations will bring additional funding in terms of capitation and some benefit from a shift in the weighted list in the first year, there is an impact from a dispersed list which will vary depending on the circumstances. The impact will be greater where one or more of the factors is relevant.

- the dispersal is undertaken in a short period of time (one day - 3 months)
- the dispersal follows the termination of a contract due to poor performance
- the dispersed list can only be absorbed by a small number of practices and therefore there is a concentration on one practice.

2. Recent Issues experienced by Practices following Dispersal

Recent dispersals have given NHS England, Midland &East (Central Midland) an insight into the real issues faced by the receiving practices. A lack of control or a planned approach will lead to negative impacts. No two situations are identical, but the issues faced can generally be categorised as follows:

- Additional administrative time in registering a large number of patients over a short period of time
- The need to summarise records or check accurate summarising
- The need to run additional GP/Nurse sessions in the short term when immediate demand may be greater
- The longer appointment times needed to deal with complex patients who have not been managed appropriately
- The impact on QOF achievement
- Premises capacity issues, clinical and admin including notes storage

3. Principles to be Established in Supporting a Dispersed List

- The support offered should be in relation to the scale of the issue. This would be based on:
  - the number of dispersed patients in relation to current list size
  - the timeframe in which the list was dispersed
  - any known issues of performance in the dispersed practice.

- The recurrent financial support should reflect the funding mechanisms for the PMS/GMS contract which states that new patients are added at global sum i.e. the prevailing rate or as specifically stated in the PMS/GMS contract.

- The practice can evidence that there has been an immediate and short term exceptional impact of the list growth and the non-recurrent costs involved.

It is therefore proposed that a scale is developed based on the above variables which identify the level of impact, and can be used as a measure of proposed support. Should this indicate that support is required it is proposed that the following is considered.

4. Proposed Assistance

4a Practice list dispersed with no known performer issues

If a practice experiences an increase in demand greater than 1% of the raw list size (patients from the dispersed practice only) for the immediate 3 months after the dispersal date then the practice will be paid £4.50 per patient within the dates agreed specified to assist with administration. A separate list of NHS numbers of new registrations from the dispersed list should be kept for audit purposes.

4b Practice list dispersed with known performance issues (reason for termination)

1. If a practice experiences an increase in demand greater than 1% of the raw list size (patients from the dispersed practice only) for the immediate 3 months after the dispersal date then the practice will be paid £4.50 per patient within the dates agreed specified to assist with administration. A separate list of NHS numbers of new registrations from the dispersed list should be kept for audit purposes.

2. The agreed reasonable cost of additional clinical capacity which can demonstrate the appropriate skill mix to address the exceptional clinical issues identified in the registered patients from the dispersed list. This will need to take account of the ratio of WTE GP: existing patient list of the receiving practice. The assistance offered should not meet existing capacity deficiencies.

3. If a receiving practice can evidence that the registration of a dispersed list will have a negative impact on QOF, assistance will be given to mitigate the impact. The support offered will ensure that QOF achievement will match the minimum of the previous year's achievement.

4c Practice list dispersed with known performance issues (reason for termination). Large number of patients registers with one practice - greater than 10% of the receiving patient list.

1. If a practice experiences an increase in demand greater than 1% of the raw list size (patients from the dispersed practice only) for the immediate 3 months after the dispersal date then the practice will be paid £4.50 per patient within the dates agreed specified to assist with administration. A separate list of NHS numbers of new registrations from the dispersed list should be kept for audit purposes.

2. The agreed reasonable cost of additional clinical capacity which can demonstrate the appropriate skill mix to address the exceptional clinical issues identified in the registered patients from the dispersed list. This will need to take account of the ratio of WTE GP: existing patient list of the receiving practice. The assistance offered should not meet existing capacity deficiencies.

3. If a receiving practice can evidence that the registration of a dispersed list will have a negative impact on QOF, assistance will be given to mitigate the impact. The support offered will ensure that QOF achievement will match the minimum of the previous year's achievement.

4. If premises capacity in delivering additional session is a known issue consider the potential for supporting weekend working for 6 months in addition to any extended hours already undertaken. The additional clinical support will be agreed in relation to the scale of the issues.

5. There may be other financial considerations that the CCG would need to consider beyond those listed above. These would be increased costs incurred by the receiving practice which the CCG will consider if the practice can evidence significant financial detriment. Each case will be looked at on its own merits.

6. Further financial consideration will need to take place in line with the agreed set of principles (Appendix A) for the transfer of Primary Care funding between LLR CCGs when a GP practice list is transferred or dispersed from within the boundary of one CCG to another.

Appendix A - Agreed Set of Principles

1. Where there is a practice transfer, dispersal or merger resulting in a movement of patients between CCG's there should be an appropriate transfer of primary care funding to reflect the movement of costs both in year and the full year impact in the subsequent year. (The full year impact may be zero if the adjustment is incorporated into the national allocation process)

2. CCGs affected by a practice transfer, dispersal or merger are to be notified as soon as is practically possible and before approval.

3. The transfer of primary care funding should reflect the movement in costs/charges and should be calculated on the basis of cost neutrality i.e. no intended gain/loss to either CCG. To achieve this it is recognised that the process of disaggregating the funds will need to be reviewed on a case by case basis taking consideration of the fixed and variable costs movements at the time of the transfer. An initial estimate should be undertaken and agreed prior to approval.

4. Allocation adjustments may be required over a 2 year period to enable the restatement of fixed costs in the subsequent year. Such full year allocation transfers will need to take into consideration national allocation timescales and processes.

5. Both CCGs need to agree the value of the allocation to be transferred. Should a dispute occur, that cannot be resolved through escalation within the respective CCGs, the issue will be referred to NHSE and/or an independent advisor (to be agreed by both parties).

Proposed Funding Transfer Calculations

6. The primary care funds to be transferred should be calculated on the basis of cost neutrality i.e. no gain/loss to either CCG.

7. It should also take into consideration the planned timing of the transfer. Funding transfers can fall within a financial year or planned for the start of a financial year, i.e. 1st April. It is assumed that the national allocation process will deal with the recurrent impact of any practice transfers, assuming information can be provided within stipulated national deadlines.

8. The following outlines areas to be considered in reaching agreement on the value to be transferred. The actual transfer value will need to be reviewed on a case by case basis reflecting the principles agreed.

Income Stream	List Size Related?	Notes	Funding Transfer Required?	Proposed Methodology
GMS – Global Sum	Yes	Costs for CCGs will change once patients have registered. This will be paid on a quarterly basis using the list size information held on NHAIS.	Yes	Monitor the number of patients on a quarterly basis and transfer the budget at Global Sum value. £75.77 per patient + £4.08 per patient (Out of Hours opt out) = £71.69 total per patient.

MPIG	No	Will remain the same irrespective of the number of patients. Will cease.	No	CCG retains this amount
PMS Contract Payments	Yes	Contract value may be adjusted if tolerances have been breached. Receiving practice contract payments will increase.	Yes	Increase in PMS contract value will be transferred to receiving CCG. Use GMS figures for calculating amount, i.e. £75.77 per patient + £4.08 per patient (Out of Hours opt out) = £71.69 total per patient.
FDR Adjustment	No	This will stay the same irrespective of the number of patients on the list.	No	CCG retains this amount.
Enhanced Services	Yes	Claims submitted by the receiving practice will increase. Need to take account of different enhanced services commissioned by different CCGs.	Yes	For activity driven services use % increase in list size against previous quarter's claims. For services based on list size with a standard rate calculate rate X list size. Transfer should only be based on services commissioned in the transferring CCG, i.e. no transfer of resources for services not commissioned by the transferring CCG.
GP IT	No	Not patient level based. The national allocation will change as the total list size changes for each affected CCG. The allocation is reviewed annually and will take account any change in practice list sizes.	No	Unlikely to be significant enough to warrant a transfer of resource in year. Costs currently incurred at practice level which will not change with an increase/decrease in list size. Allocation will catch up the following year.
Premises Costs	No	Costs not allocated based on list size.	No	Transfer of resource not required unless the list size growth is so significant that it warrants an extension/new build – when CCGs prioritisation process/decision making process will start.

QOF	Yes	Practice payments will change in year as the QOF rate per patient is based upon the size of the practice.	Yes	The increase in the receiving CCG's QOF payments to be funded based on the number of patents transferring and the latest QOF achievement, calculated at the nationally agreed rates. NB: QOF is paid on achievement of indicators which have a set value attached to them and the indicators do not apply to all patients, therefore calculations could be skewed if using % increase in list size.
Fees – PCO Admin	No	For locum payments for maternity/sickness/suspension etc. Not patient level driven.	No	Funding for locums to cover the increase in patient numbers will be provided by the Global Sum adjustment.
Fees – Dispensing Services	Yes	The number of dispensing patients is very low. A transfer of patients is unlikely to have a significant impact on the costs incurred, however if this is a full move of a dispensing practice then the funds should follow.	No	Prescribing professional fees or dispensing professional fees should transfer with the patient.

9. An 'In Year' approach will be taken, resulting in the transfer of funding only on a non recurrent basis for that financial year. The full year methodology can then be taken into the next planning round if required.

10. It is assumed that the national allocation process deals with the recurrent impact of any practice transfers, assuming information is provided within stipulated national deadlines.

11. It is assumed that CCGs will be asked to advise on the value of resources to transfer ahead of setting the New Year allocations. Where this is not the case CCGs agree to undertake in year IATs of appropriate costs depending on the timing of the transfer.

Leicester City CCG

GP PRACTICE OR BRANCH CLOSURE POLICY

AGREED FINANCIAL ASSISTANCE FOR PRACTICES

1. Introduction

Whilst it is recognised the new registrations will bring additional funding in terms of capitation and some benefit from a shift in the weighted list in the first year, there is an impact from a dispersed list which will vary depending on the circumstances. The impact will be greater where one or more of the factors is relevant.

- the dispersal is undertaken in a short period of time (one day - 3 months)
- the dispersal follows the termination of a contract due to poor performance
- the dispersed list can only be absorbed by a small number of practice(s) and therefore there is a concentration on one practice or a small number of practices
- the clinical system used by the closing practice is different to the one used by the receiving practice
- the closure of a branch surgery that could potentially have an increase in their list size on the same basis as a dispersed lists

2. Background

Recent Issues experienced by Practices following closure

Recent dispersals had given NHS England and CCG an insight into the real issues faced by the receiving practices. A lack of control or a planned approach will lead to negative impacts. No two situations are identical but the issues faced can generally be categorised as follows.

- Additional administrative time in registering a large number of patients over a short period of time
- The need to summarise records or check accurate summarising
- The need to run additional GP/Nurse sessions in the short term when immediate demand may be greater
- The longer appointment times needed to deal with complex patients who have not been managed appropriately
- The impact on QOF achievement
- Premises capacity issues, clinical and admin including notes storage

3. Principles to be Established in Supporting a Dispersed List

The support offered should be in relation to the scale of the issue. This would be based on;

- the number of dispersed patients in relation to current list size
- the timeframe in which the list was dispersed
- any known issues of performance in the dispersed practice

The recurrent financial support should reflect the funding mechanisms for the PMS/GMS contract which states that new patients are added at global sum i.e. the prevailing rate or as specifically stated in the PMS/GMS contract.

4. Proposed Assistance

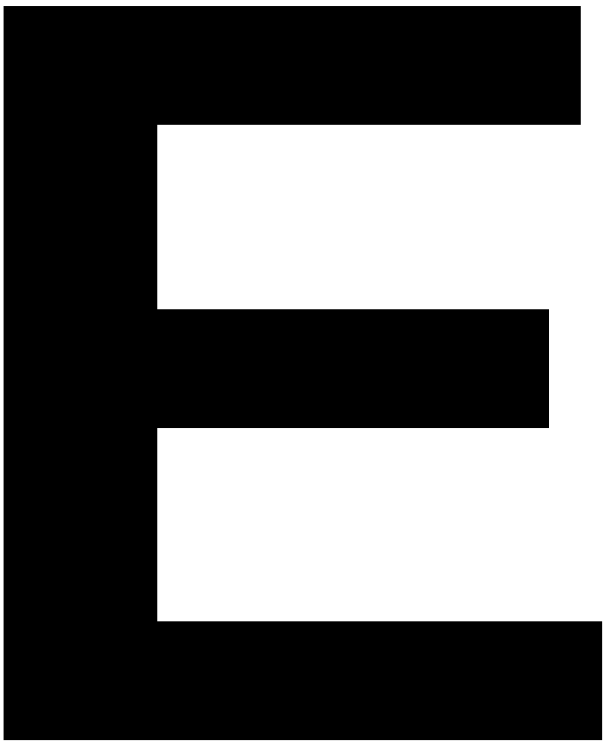
If a practice experiences an increase in their raw list size (i.e. registration of patients previously registered with a practice or branch surgery that closed) for the immediate 3 months after the dispersal the practice will be paid a flat fee per patient registered at £10 per patient they register. This period could be extended depending on the circumstances applicable at the time

This fee would be increased to a minimum of £15 per patient in situations where one or more of the following additional circumstances apply;

- Where there is more than one closure at the same time, in the same area.
- Where there are compatibility issues with the GP IT systems.
- Where there are known performance issues.

5. Closures in Neighbouring CCGs

There may be an impact on practices who are receiving patients from a practice closure within a neighbouring CCG. The impact may be significant or insignificant depending on the location of the closure. The responsibility for making payments to practices rests with their CCG rather than payments being met by the CCG from where the practice closure occurred.



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

Front Sheet

REPORT TITLE:	**Primary Care Finance Report 2016-17 (Month 11: February 2017)**
MEETING DATE:	**4 April 2017**
REPORT BY:	**Richard George, Senior Primary Care and Non-Acute Accountant**
SPONSORED BY:	**Donna Enoux, Chief Finance Officer**
PRESENTER:	**Donna Enoux, Chief Finance Officer**

PURPOSE OF THE REPORT:

The purpose of this report is to provide a summary of the financial position to Month 11 (February 2017) and outturn forecast of the Primary Care budgets.

RECOMMENDATIONS:

The East Leicestershire and Rutland CCG PCCC is requested to:

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

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

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

EQUALITY ANALYSIS

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

RISK ANALYSIS AND LINK TO BOARD ASSURANCE FRAMEWORK:

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

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

Primary Care Finance Report Month 11 (February) 2016-17

4 April 2017

1. Month 11 Year to Date and Forecast Position

As at Month 11, a year to date underspend of £246k and forecast outturn underspend of £325k is being reported for Primary Care. Appendix 1 provides additional detail for all expenditure areas.

2. Prescribing

The forecast for prescribing has been based on PPA data covering months 1-9 and is showing a year to date overspend of £468k with a forecast outturn overspend of £498k. QIPP savings overall are forecast to be delivered with slippage against QIPP2 (reducing waste and promoting self-care) being offset by additional benefits from the reduced cost of Category M drugs. There is a pressure in relation to the prescribing of DOACS where costs have increased significantly during the year in excess of growth built into the budget.

3. Community Based Services

Community based services are showing a year to date underspend of £233k and a forecast outturn underspend of £273k.

Based on the current available information, the main variances to note under this area are:

- INR Anticoagulation – forecast underspend of £199k
- Near Patient Testing – forecast overspend of £60k
- Minor injury – forecast underspend £72k
- PPV audit income – forecast underspend £44k

In addition to this, the CCG has received income of £26k from the Home Office to support the healthcare costs of patients coming to the County under the Syrian Resettlement Programme.

4. GP Support Framework, 7 Day Working

These services are currently showing a year to date underspend of £602k with an outturn forecast underspend of £692k. The majority of areas are forecast to be within budget with the following exceptions:

- Prescribing Incentive Scheme – Forecast outturn underspend of £236k. This position is subject to change pending the outcome of ongoing discussions around incentive payments due to practices.
- Long Term Conditions – Forecast outturn underspend of £102k as QIPP investment monies have not been fully committed.
- Dementia – Forecast outturn underspend of £314k based on claims made by practices in the first 9 months of the financial year. This underspend may be at risk if practices have not been submitting claims but are

planning to submit all claims in the last quarter. Practices have been contacted to confirm.

- GP Federation – Forecast outturn underspend of £35k based on actual expenditure incurred and commitments to the end of the financial year.

5. **GP Co-Commissioning**
   A year to date overspend of £125k is being reported and forecast to reach £161k by the end of the financial year.

   The main reason for this overspend is linked to costs associated with the reprovision of Long Street which are forecast to reach £625k, representing an overspend of £366k.

   The forecast underspends against FDR Payment and PMS Reinvestment are being used to fund Wound Clinics (£323k), Leicester Asylum Service (£34k), additional support to South Wigston Health Centre (£50k) and Practice Pharmacists (£297k).

   A full breakdown of co-commissioning is attached as appendix 2.

6. **Urgent Care Centres**
   The Northern Doctors contract is reporting a year to date underspend of £76k and a forecast outturn underspend of £96k due to activity underperformance.

7. **GP IT**
   At month 11, a year to date overspend of £72k is being reported against this budget area with a forecast outturn overspend of £82k. This is due to the unfunded costs of PRISM software and SMS messaging in practices.

8. **Primary Care Licenses & Other**
   A minor underspend of £2k is being forecast against this area.

9. **QIPP**
   It is forecast that the QIPP target will now be achieved mainly as a result of undertaking additional PPV audits.

10. Recommendation:

The ELR CCG Primary Care Commissioning Committee is requested to:

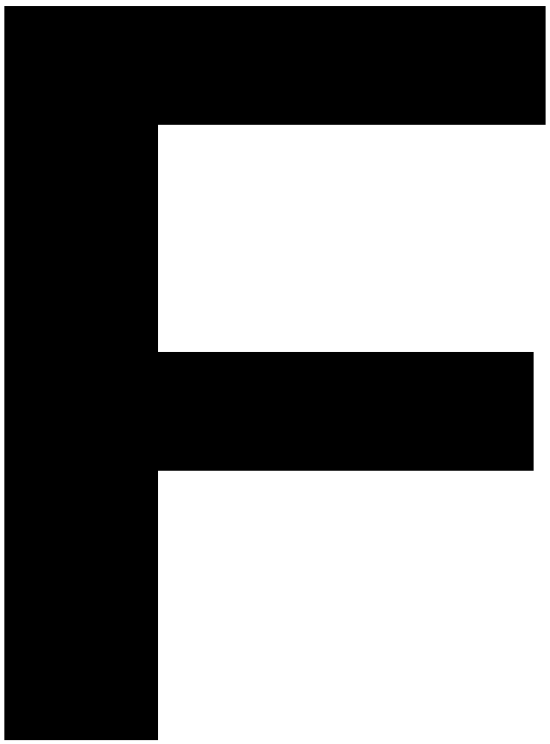
- **RECEIVE** the reported variance position against the Primary Care budgets based on reporting information available.

Appendix 1

	YTD Position			Forecast Outturn Position		
M11 Primary Care Commissioning Report	**YTD Budget**	**YTD Actuals**	**YTD Variance**	**Annual Budget**	**Annual Forecast**	**Annual Variance Over/(Un**
Area	**(£'000s)**	**(£'000s)**	**(£'000s)**	**(£'000s)**	**(£'000s)**	**(£'000s)**
CCG Prescribing						
Scriptswitch	111	81	-31	121	89	-32
Central Prescribing	1,197	1,094	-103	1,306	1,192	-114
High Cost Drugs	886	829	-56	966	904	-62
GP Prescribing	41,823	42,481	658	45,544	46,251	707
Total Practice Prescribing	**44,017**	**44,485**	**468**	**47,938**	**48,436**	**498**
Enhanced Services						
Community Based Services	2,463	2,231	-233	2,687	2,414	-273
Total Enhanced Services	**2,463**	**2,231**	**-233**	**2,687**	**2,414**	**-273**
GP Support Framework						
Care Homes	418	418	0	457	457	0
End of Life	298	296	-3	325	323	-3
Prescribing Incentive Scheme	588	382	-205	641	405	-236
Long Term Conditions	86	1	-85	103	1	-102
Joint Working	298	296	-3	325	323	-3
7 Day Working Better Care Fund	468	468	0	497	497	0
Dementia	596	309	-288	651	337	-314
Heart Failure	149	149	0	163	163	0
GP Federation	202	183	-19	135	181	-35
Total GP Support Framework	**3,103**	**2,501**	**-602**	**3,296**	**2,685**	**-692**
Other						
GP Co-Commissioning	36,228	36,352	125	39,526	39,687	161
Urgent Care Centres	1,461	1,385	-76	1,593	1,498	-96
GP IT	600	672	72	650	732	82
Primary Care - Licenses & Other	103	105	2	113	111	-2
QIPP	-253	-257	-3	-276	-280	-4
Total Other	**38,138**	**38,258**	**120**	**41,605**	**41,748**	**143**
Total Primary Care	**87,721**	**87,475**	**-246**	**95,527**	**95,284**	**-325**

Primary Care Delegated Budgets analysis **Appendix 2**

	YTD Position			Forecast Outturn Position			
M11 Primary Care Co-commissioning Report	**YTD Budget**	**YTD Actuals**	**YTD Variance**	**Annual Budget**	**Annual Forecast**	**Annual Variance Over/(Under)**	**Contract Type**
Activity Type	**(£'000s)**	**(£'000s)**	**(£'000s)**	**(£'000s)**	**(£'000s)**	**(£'000s)**	
GMS Global Sum	21,651	21,785	134	23,620	23,805	185	Block with quarterly list size adjustments
MPIG Correction Factor	2,017	2,014	-3	2,201	2,192	-9	Block
PMS reinvestment	604	87	-516	659	95	-563	PMS reinvestment and FDR payment underspend committed to fund wound clinics, additional support at South Wigston Health Centre, Leicester Asylum Service and practice pharmacists.
FDR Payment	151	0	-151	165	0	-165	
Leicester Asylum Service + South Wigston Support	0	34	34	0	84	84	
Wound Clinics	0	296	296	0	323	323	
Practice Pharmacists	0	260	260	0	297	297	
	755	677	-78	824	799	-25	
Total General Practice - GMS	**24,424**	**24,476**	**52**	**26,644**	**26,796**	**152**	
PMS	238	26	-212	260	101	-159	Block with quarterly list size adjustments
Wigston Central Care taking/Sanctions on LS	0	131	131	0	131	131	N/A
APMS Baseline	0	331	331	0	331	331	N/A
APMS Prof Fees Prescribing	0	2	2	0	2	2	N/A
Redundancy	0	13	13		13	13	N/A
Staff Cost APMS Contract	0	48	48	0	48	48	N/A
Total General Practice - PMS Long Street Reprovision	**238**	**550**	**312**	**260**	**625**	**366**	
Occupational health	42	42	0	46	46	0	Block - fair share
Travel	1	1	0	1	1	0	CPC
Locum Adoption/Paternity/Maternity	93	93	0	101	101	0	CPC
Locum Sickness	32	32	0	35	35	0	CPC
Locum suspended doctors	0	0	-0	0	0	-0	CPC - fair share
Seniority	482	423	-58	525	462	-64	Block
Sterile Products	-0	0	0	-0	0	0	CPC - fair share
Statutory Levy	0	0	0	0	0	0	Net nil
Voluntary Levy	0	0	0	0	0	0	Net nil
GP Training	84	60	-24	92	48	-44	CPC
PCO Doctors Ret Scheme	0	4	4	0	4	4	N/A
Long Street Dispersal	0	4	4	0	4	4	PMS
Kingsway Management Plan	0	-10	-10	0	-11	-11	Pressure badged against Global Sum
Total Other GP Services	**733**	**649**	**-84**	**800**	**689**	**-111**	
QOF Achievement	999	1,069	69	1,090	1,116	25	CPC
QOF Aspiration	2,500	2,598	98	2,727	2,834	107	Block
Total QOF	**3,500**	**3,667**	**167**	**3,818**	**3,950**	**132**	
DES Extended Hours Access	431	538	106	477	587	110	Block
DES Learning Disability	69	60	-9	75	65	-10	CPC
DES Minor Surgery	619	442	-177	676	482	-193	CPC
DES Unplanned Admissions	826	849	23	901	926	25	Block
AUA Old Year 15/16	0	-14	-14	0	-14	-14	N/A
DES Violent Patients	42	43	1	46	47	1	Block
DES Minor Surgery - PMS	0	0	0	0	0	0	N/A
LES Extended Hours Access - PMS	0	0	0	0	0	0	N/A
LES Translation Fees	28	53	25	30	58	28	CPC - fair share
Total Enhanced Services	**2,015**	**1,971**	**-45**	**2,205**	**2,151**	**-54**	
Dispensing Quality Scheme	100	83	-18	110	90	-19	Block
Prof Fees Dispensing	1,278	1,368	90	1,394	1,493	99	CPC
Prof Fees Prescribing	192	211	19	210	231	21	CPC
Total Dispensing/Prescribing Drs	**1,571**	**1,662**	**92**	**1,713**	**1,813**	**100**	
Prescribing charge income	-268	-275	-7	-292	-300	-8	CPC
	-268	**-275**	**-7**	**-292**	**-300**	**-8**	
Prem Actual Rent	1,355	1,355	0	1,478	1,478	0	Block
Prem Clinical Waste	106	106	0	115	115	0	CPC - fair share
Prem Cost Rent	248	-23	-271	270	-25	-295	Block
Prem Health centre Rates	15	19	4	16	21	5	Block
Prem Health centre Rent	65	83	17	71	90	19	Block
Prem Notional Rent	1,178	1,421	242	1,285	1,550	264	Block
Prem Rates	700	621	-79	764	678	-86	Block
Prem Water Rates	56	37	-19	61	40	-21	CPC
Total Premises Cost Reimbursement	**3,723**	**3,619**	**-104**	**4,062**	**3,948**	**-114**	
Rent	31	31	0	33	33	0	CPC
Other premises	3	3	0	3	-18	-21	CPC
Total Other premises	**33**	**33**	**0**	**36**	**15**	**-21**	
GP Pensions	0	0	0	0	0	0	Net nil
Total Pensions	**0**	**0**	**0**	**0**	**0**	**0**	
Transformation reserves	232	0	-232	252	0	-252	Committed to expenditure
Primary Care Transformational Funding	26	0	-26	28	0	-28	Committed to expenditure
Grand Total	**36,228**	**36,352**	**125**	**39,526**	**39,687**	**161**	



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

Front Sheet

REPORT TITLE:	**Primary Care Delivery Group (PCDG): March 2017 Themes**
MEETING DATE:	**4 April 2017**
REPORT BY:	**Jamie Barrett, Head of Primary Care**
SPONSORED BY:	**Tim Sacks, Chief Operating Officer**
PRESENTER:	**Caroline Goulding, Senior Primary Care Contracts Manager**

EXECUTIVE SUMMARY:
To update the Primary Care Commissioning Committee (PCCC) on the key themes from the Primary Care Delivery Group (PCDG). The report contains themes from the March 2017.

RECOMMENDATIONS:
The East Leicestershire and Rutland CCG Primary Care Commissioning Committee is requested to: **NOTE** the contents of the Primary Care Delivery Group for March 2017.

REPORT SUPPORTS THE FOLLOWING STRATEGIC AIM(S) 2017 – 2018:			
Transform services and enhance quality of life for people with long-term conditions		Improve integration of local services between health and social care; and between acute and primary/community care.	
Improve the quality of care – clinical effectiveness, safety and patient experience		Listening to our patients and public – acting on what patients and the public tell us.	
Reduce inequalities in access to healthcare		Living within our means using public money effectively	
Implementing key enablers to support the strategic aims (e.g. constitutional and governance arrangements, communications and patient engagement).			

EQUALITY ANALYSIS
An Equality Analysis and due regard to the positive general duties of the Equality Act 2010 has not been undertaken in respect of this report. The Primary Care Delivery Group will ensure due regard is considered in the consideration of its responsibilities.

RISK ANALYSIS AND LINK TO BOARD ASSURANCE FRAMEWORK:	
The content of the report identifies action(s) to be taken / are being taken to mitigate the following corporate risk(s) as identified in the Board Assurance Framework:	BAF 10 Capacity of Primary Care

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

4 April 2017

Primary Care Delivery Group March 2017 Themes

Primary Care Delivery Group Themes

The below highlights the themes from the March 2017 Meeting:

1. **Practice Based Pharmacists –** Clarity is required for the future with reference to Practice Pharmacists and employment status. Subsequent discussions have clarified that current arrangements can remain in place until the end of June 2017 when we will revisit in preparation for the annual update of the SLA (October 2017). However the issue remains that June is still not long enough and is a continued issue for practices over the directly employed vs contracted route to provide the service. The PM Forum in April will cover all prescribing and meds management schemes for 2017/18 so this will be raised again there.

2. **Pathology Collection** – Dialogue has started with EMPATH but the progress is slow. This has been now escalated to the UHL contract leads to gain some further traction. Only 20 of the 31 practices had expressed a wish for a 2nd collection when a survey went out. It was agreed following actions would be taken:
    - Obtain data of how many bloods are ordered by practice per 1,000
    - Send EMPATH information of how many urgent and how many routine requests are made
    - Obtain a cost from Empath to provide a 2nd collection for the 20 practices who have asked for it.

3. **Use of the CCG Training Budget** – The PCDG confirmed use of the CCG practice training budget would be aligned to commissioned services (CBS/GPSIP areas) to support delivery of these priorities.

Recommendation:

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

- **NOTE** the contents of the Primary Care Delivery Group for March 2017.