NHS
East Leicestershire and Rutland
Clinical Commissioning Group

Meeting Title	**Primary Care Commissioning Committee – meeting in public**	**Date**	**Tuesday 6 March 2018**
Meeting No.	**35.**	**Time**	**9:30am – 10:30am**
Chair	**Mr Clive Wood (Deputy Chair of the CCG and Independent Lay Member)**	**Venue / Location**	**Gartree Committee Room, Leicestershire County Council, County Hall, Glenfield, Leicester, LE3 8TB.**

ITEM	AGENDA ITEM	ACTION	PRESENTER	PAPER	TIMING
PC/18/15	Welcome and Introductions		Clive Wood	**Verbal**	9:30am
PC/18/16	To receive questions from the Public in relation to items on the agenda	To receive	Clive Wood	**Verbal**	9:30am
PC/18/17	Apologies for Absences:	To receive	Clive Wood	**Verbal**	9:35am
PC/18/18	Notification of Any Other Business	To receive	Clive Wood	**Verbal**	9:35am
PC/18/19	Declarations of Interest on Agenda items	To receive	Clive Wood	**Verbal**	9:40am
PC/18/20	To Approve minutes of the previous meeting of the ELR CCG Primary Care Commissioning Committee held on 6 February 2018	To approve	Alan Smith	**A**	9:40am
PC/18/21	To Receive Actions and Matters Arising following the meeting held on 6 February 2018	To receive	Alan Smith	**B**	9:45am
OPERATIONAL ISSUES					
PC/18/22	GP5FV - Sustainability and Transformational Partnership (STP): GP Work stream	To receive	Tim Sacks	**C**	9:50am
PC/18/23	Paper Switch Off (PSO): update	To receive	Jamie Barrett	**D**	10:00am

NHS
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Clinical Commissioning Group

ITEM	AGENDA ITEM	ACTION	PRESENTER	PAPER	TIMING
PRIMARY CARE FINANCE REPORT					
PC/18/24	Primary Care Co-Commissioning Finance Report 2017-18: Month 10 (January 2018)	To receive	Donna Enoux	**E**	10:10am
ANY OTHER BUSINESS					
PC/18/25		To receive	Clive Wood	**Verbal**	10:20am
DATE OF NEXT MEETING					
PC/18/26	**Date of next meeting:** **Tuesday 3 April 2018 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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Minutes of the Primary Care Commissioning Committee held on Tuesday 6 February at 9:30am in Gartree Committee Room, ELR CCG, County Hall, Glenfield, Leicester, LE3 8TB

Present:

Mr Alan Smith	Independent Lay Member (and Deputy Chair of the Committee)
Dr Vivek Varakantam	GP Locality Lead for Oadby and Wigston
Dr Girish Purohit	GP Locality Lead, Melton, Rutland and Harborough
Mr Tim Sacks	Chief Operating Officer
Dr Anne Scott	Deputy Chief Nurse (on behalf of Chief Nurse and Quality Officer)
Mrs Daljit Bains	Head of Corporate Governance and Legal Affairs (on behalf of Chief Finance Officer)
Mr Colin Thompson	Public Health Consultant

In attendance:

Mr Jamie Barrett	Head of Primary Care
Mrs Seema Gaj	Primary Care Contracts Manager
Mrs Hayley Moore	Primary Care Contracts Manager (for item PC/18/08 only)
Dr Nainesh Chotai	Chair of the Leicester, Leicestershire and Rutland Local Medical Committee
Mrs Jennifer Fenelon	Healthwatch Rutland
Mrs Amardip Lealh	Corporate Governance Manager (Minutes)

ITEM		LEAD RESPONSIBLE
PC/18/01	**Welcome and Introductions** Mr Smith welcomed all members to the Primary Care Commissioning Committee (PCCC) meeting, in particular, Mrs Moore, which was followed by a series of introductions.	
PC/18/02	**To receive questions from the Public in relation to items on the agenda** There were no questions from members of the public.	
PC/18/03	**Apologies for absence:** • Mr Clive Wood, Deputy Chair and Independent Lay Member (Chair of the Committee) • Dr Tabitha Randell, Secondary Care Clinician • Dr Nick Glover, GP Locality Lead, Blaby and Lutterworth • Mrs Carmel O'Brien, Chief Nurse and Quality Officer • Ms Donna Enoux, Chief Finance Officer – • Ms Sue Staples, Healthwatch Leicestershire Mrs Bains informed that she is deputising for Ms Enoux, however if there is a decision to be made where there is significant financial expenditure for approval this may need to be reverted to Ms Enoux given the financial challenges faced by the CCG.	

ITEM		LEAD RESPONSIBLE
PC/18/04	**Notification of Any Other Business** Mr Smith had not received notification of any other business.	
PC/18/05	**Declarations of Interest** All GPs present declared an interest in items relating to commissioning of primary care where a potential conflict may arise, in particular: • **PC/18/08 – Asylum Centre, Kennedy House in South Wigston: Update on Inclusion Healthcare's Proposal to relocate the Main Surgery -** Dr Varakantam declared a conflict of interest as the Practice falls within his locality. It was agreed for Dr Varakantam to remain within the meeting as this report was a progress update. It was **RESOLVED** to: • **RECEIVE** the conflicts of interest declared.	
PC/18/06	**To Approve the Minutes of Previous Meeting of the ELR CCG Primary Care Commissioning Committee held on 5 December 2017 (Paper A)** The minutes of the meeting held in December 2017 were accepted as an accurate record of the meeting. It was **RESOLVED** to: • **APPROVE** the minutes of the previous meeting.	
PC/18/07	**To Receive Matters Arising following the meeting held on 5 December 2017 (Paper B)** The matters arising following the meeting held in December 2017 were received, and noted as 'complete.' It was **RESOLVED** to: • **RECEIVE** the matters arising and note the progress to date.	
PC/18/08	**Asylum Centre, Kennedy House in South Wigston: Update on Inclusion Healthcare's Proposal to relocate the Main Surgery (Paper C)** Mrs Moore presented this report, which provided a progress update in relation to the service provision for asylum seekers in Leicester City and Kennedy House, which falls within ELR CCG. The Committee were reminded that the Practice had undertaken a	

ITEM		LEAD RESPONSIBLE
	60-day patient consultation on 7 November 2017 in relation to the proposed option to relocate services for the Leicester City ASSIST Practice from Clyde Street to Charles Berry House (Headquarters for Inclusion Healthcare who also provide GP services for Leicester Homeless Services from this site too). Patients registered with the Leicester City ASSIST Practice and the Leicester Homeless GP Service were invited to take part in the consultation, and were asked the following questions: • *Do you support the proposal to move the ASSIST Practice to Charles Berry House?* • *Please tell us why:* - *If the move goes ahead, please tell us any way which this may impact on you;* - *Is there anything else you think could help us to make a decision on the proposal?* It was noted that a total of 161 questionnaires were completed out of 2,414 patients registered at the practice; and reported that the majority of patients either supported or did not mind the proposal to move from the ASSIST Practice to Charles Berry House. This was a positive outcome for ELR CCG patients residing at Kennedy House due to direct public transport from Wigston to Charles Berry House. Appendix 1 of the report provided the Patient Consultation Report from Inclusion Healthcare. Mrs Moore informed the Committee that the proposed move is scheduled to take effect on 11 April 2018, subject to development of the reception area which could delay the move until May 2018. It was noted Charles Berry House is more suitable and has better accommodation, which will mean better service provision for patients. Dr Varakantam queried whether the proposed move was open to challenge from other Providers in terms of the contract. Mrs Gaj informed that there was the potential for challenge, however the CCG has sought legal advice and due process has been followed. Mr Smith thanked Mrs Moore for the update. It was **RESOLVED** to: • **RECEIVE** the report and **NOTE** the progress to date. *Mrs Moore left the meeting.*	
PC/18/09	**Paper Switch Off (PSO) Programme: Update (Paper D)** Mr Barrett presented this report, which provided an update on the	

ITEM		LEAD RESPONSIBLE
	changes that the Hospital Trusts in Leicestershire need to implement during 2018 to meet national requirements provided by NHS England and NHS Digital to improve use of electronic referrals from primary care into secondary care to achieve PSO. In 2017-18, the NHS Standard Contract introduced a CQUIN for the e-Referral Service (e-RS) to make services available on e-RS and reduce appointment slot issues. It was noted that the NHS Standard Contract for 2018-19 stipulates that, from 1 October 2018, all referrals from primary care into secondary care for first led clinics are to be sent via e-RS, as they will not be funded for activity associated with such referral routes. In essence, this means that hospitals do not have to accept referrals for first consultant led clinics from GPs through any other means (e.g. post, fax or email). NHS Digital have provided all NHS Hospital Trusts with dedicated support in order to achieve PSO and have allocated an interim implementation date of 1 April 2018 for the following: • University Hospitals of Leicester (UHL) NHS Trust • Community Hospitals • Leicester, Leicestershire and Rutland (LLR) In light of the above, a Project Group has been formed which is accountable to UHL's Executive Performance Board and reports to LLR Planned, Care, IM&T e-Communications Board and UHL Outpatients Programme Board. In addition, a Joint Communication Strategy has been formulated; and Business Continuity Strategy is in the process of being drafted in the event of system unavailability. Members of the Committee raised concern in relation to the proposed timescales for LLR; Mr Barrett agreed and confirmed that it may be possible for a soft launch in April 2018, however, this may be delayed due to the logistics and other electronic systems issues, for instance appointment slot issues, and therefore a cleansing exercise will be required. Mr Smith referred to section 20 of the report which stated around two thirds of referrals are sent to UHL and Community Hospitals; and queried what happens to the remaining third of referrals. Mr Barrett stated referral activity varies from speciality to speciality as some Practices use the Choose and Book referral system; and this may not apply to some services, such as same day clinics and fracture clinics for example. Mr Barret advised that Practices need to be advised of the change and a contingency plan is in place. Dr Chotai stated GPs are willing to work with NHS Digital to implement the PSO Programme, however queried the process regarding communication from secondary care to primary care, which can be received in both paper and electronic format, and	

ITEM		LEAD RESPONSIBLE
	duplicated in some cases. It was noted this would also support the Programme. Mr Barrett confirmed this has previously been raised by Practice Managers and fed back to UHL for their internal processes to be reviewed. In response to whether a formal timeline of events has been identified, Mr Barrett confirmed no official timeline has been disseminated to date, and will need to be defined. In addition, Dr Varakantam informed the Committee that the issue has also been raised via the LLR CCG IM&T Clinical Lead and through the IM&T Board. In response to Dr Scott's query in relation to the issue to be resolved, Dr Varakantam provided an example of a referral sent to UHL and cancelled with no response sent to the referring Practice or Patient; and on follow-up, noted to be added to the system one month after initial referral. Members of the Committee felt the LLR CCGs were a little late in informing Practices of the Programme and action required, however, noted Practices will be able to manage the process as they have been urged to move towards electronic systems. In addition, there was significant concern in relation to how UHL will manage and implement the Programme by April 2018; however, it was helpful to note concerns raised have been fed back to UHL. In addition to communicating with Practices, Mrs Fenelon stated it would be helpful to also inform patients and the public, including details of the timescales. It was agreed for **Mr Barrett to obtain further assurance and a progress update of the PSO Programme, including timescales, and an update to be provided to the Committee at its next meeting.** Mr Smith stated it would be helpful for an update to be provided over the next few months, and post implementation in April 2018. It was **RESOLVED** to: • **RECEIVE** the report and **NOTE** the progress to date.	**Jamie Barrett**
PC/18/10	**GP5YFV - Sustainability and Transformational Plan (STP): GP Work stream– GP Programme Update (Paper E)** Mr Sacks presented this report, which provided an update on the work programme for the STP GP Programme Board and included the following: • Appendix A – GP Programme Board Tracker; • Appendix B – approved minutes of the GP Programme Board held in December 2017; • Workforce overview update. Mr Sacks drew the Committee's attention to the following sections of the report, which were discussed in further detail:	

ITEM		LEAD RESPONSIBLE
	• **International Recruitment -** it was noted that a workshop was held on 25 January 2018 to provide updates and increase interest, which was well attended and presentations provided from NHS England and the GP Lead. In addition, it was noted that two Commissioning Support Units (CSUs) have been commissioned to support with providing educational support to the clinicians as part of this process and the CCGs to support Practices with recruitment. It was noted that initiative is progressing well and Practices are being supported. • **LLR General Workforce Plan -** the LLR General Workforce Plan was initially submitted in November 2017, with a revised version submitted in January 2018 following a request from NHS England to include a section on the wider workforce, including non-clinical staff. LLR STP has been set a target of 1508 Whole Time Equivalent (WTE) non-GP staff, including Pharmacists, Nurses and Administration staff that is currently being exceeded. A new chapter is being developed for the Plan to reflect the target and the wider workforce. In addition, Mr Sacks informed the Committee of recent correspondence received from NHS England's LLR STP Senior Responsible Officer for GP Workforce. It was noted the correspondence received is requesting LLR revise LLR CCGs' Plan to meet the targets set for both GPs and non-clinical staff by 2020. Mr Sacks requested comments and advice from the Committee in relation to the latest correspondence received as it was felt that if the target set is not met this would be seen as non-compliance; however, if we agree to meet the target, the LLR CCGs will be held to account for delivery against a target which is not achievable. It was proposed a formal letter of response is submitted to NHS England. Mr Smith suggested that the letter be sent from the Chairs of the LLR CCGs. Dr Scott was in support of this and informed that this issue was also discussed at the Health Education meeting and felt the response to NHS England should include information and evidence base available at national level as this is a national issue which is also described by the BMA, RCGP and the GMC. Therefore, it was felt the targets set would not be delivered at a national level. GPs present stated that significant time is taken to train other GPs and agreed this would increase efficiency and provision of services; however, it was felt that additional influence was required from local establishments in order to support primary care as a whole and to address the issues. It was also noted that it would be helpful for a formal and system wide response to be sent, including information and evidence available nationally as described.	

ITEM		LEAD RESPONSIBLE
	In response to the number of locums in use, Mr Sacks confirmed this cohort has been included within the GP numbers provided within the Plan; and the correspondence has been forwarded to the LLR CCGs. **It was agreed for a formal response to be submitted to NHS England taking into account national information and evidence; and obtaining input from LC CCG and WL CCG for a system-wide approach; and escalated to the Chairs of the LLR CCGs.** Mr Sacks thanked members of the Committee for their comments, views and advice; noting NHS England has requested a response by 8 February 2018. It was **RESOLVED** to: • **RECEIVE** the report and **note** the progress to date.	**Tim Sacks**
PC/18/11	**Narborough Health Centre (NHC): Update leading to NHC Closure (Paper F)** Mrs Gaj presented this report, which provided an update leading up to the closure of the NHC following approval by Leicester City CCG to transfer (and subsequently merge) services from the NHC (ELR CCG) to 193 Narborough Road (LC CCG). Mrs Gaj summarised the report as follows: • regular meetings are held with the Practice to establish key exit planning actions required and a detailed 'Exit Plan' in place, which is monitored by the CCG and on track; • key stakeholders including UHL, Pharmacists, nearby Practices and the Primary Care Support England (PCSE) for example, have been notified as part of the Plan; • the Practice plans to offer its last clinical session at NHC on 29 March 2018, following which, all IT equipment will be removed as this belongs to ELR CCG; • the Practice have been advised to consider contacting vulnerable patients and/or their carers to inform them of the closure and to maintain continuity of care; • the Practice's Care Quality Commission (CQC) registration to be updated accordingly, including their website and NHS Choices. Mrs Gaj informed the Committee that in addition to the above, the Primary Care Team informed NHS Digital of the change in membership from ELR CCG to LC CCG and were subsequently	

ITEM		LEAD RESPONSIBLE
	advised to review the business process for completing GP Practice CCG membership changes and to contact the Assurance Manager at NHS England. The Primary Care Team has been informed that Practice moves between CCGs are subject to constitutional change that has to be approved by the Regional Operations and Delivery Director as per national guidance on an annual basis. It was noted that the deadline for approving constitutional changes was June each year in order to be effective from April the following year. In light of the above, the Committee were informed that an informal arrangement has been agreed between the CCGs involved, as the NHC will continue to appear on ELR CCG's records until April 2019, if approved, and can be amended locally. This arrangement will include a local financial arrangement detailing the transfer of funding from ELR CCG to LC CCG. Mrs Bains informed the Committee that CCGs are required to follow and implement the rules and regulations stipulated by NHS England, however, both CCGs were not entirely sure of the intentions of the Practice back in June 2017. In addition, it would not have been possible to submit such an application to NHS England prior to the outcome of the patient consultation process. Therefore, the actions and decisions taken by both CCGs have been based on existing policies and procedures in place; as well as the outcome of the public consultation. However, Mrs Bains strongly advised the Primary Care Team to submit the application to NHS England as a matter of urgency and offered to support with the process. It was agreed for **Mr Sacks and Mrs Gaj to review the application required by NHS England with Mrs Bains; and ensure this is submitted as soon as possible.** In response to Mr Smith's request for clarification in relation to section 23 of the report which stated *'…the proposed practice move can't be authorised,'* Mrs Gaj confirmed NHS England are unable to formally authorise the transfer of membership in the absence of formal documentation and approval. Mr Barrett queried whether it was possible to raise the flexibility of meeting deadlines set by NHS England at the next quarterly Checkpoint meeting as this can cause additional problems or issues as noted above. Mr Sacks agreed to raise at the next assurance meeting with NHS England as having only one opportunity in the year to submit a formal application was proving difficult. In the absence of the formal change in membership, Mr Smith queried who the CQC would contact if an issue arose, for example. Mr Barrett confirmed the CQC would contact the ELR CCG however, they have been informed of the change of membership and this has been noted at the Risk Sharing Group too. It was **RESOLVED** to:	**Tim Sacks / Seema Gaj/ Daljit Bains**

ITEM		LEAD RESPONSIBLE
	• **RECEIVE** the report and **AGREE** the Constitutional changes required.	
PC/18/12	**Primary Care Co-Commissioning Finance Report 2017-18: Month 9, December 2017 (Paper G)** In the absence of Ms Enoux, Mrs Bains presented this report, which provided the year to date and forecast outturn for Primary Care Services as at Month 9, December 2017. The report was taken as 'read'. Members of the Committee did not raise any queries or issues at the meeting. Mrs Bains advised should there be any queries for these to be emailed to Mrs Enoux. It was **RESOLVED** to: • **RECEIVE** the report and the update provided.	
PC/18/13	**Any other Business** There was no other business to discuss.	
PC/18/14	**Date of next meeting:** The date of the next Primary Care Commissioning Committee meeting will be held on **Tuesday 6 March 2018 at 9:30am, Gartree Committee Room, County Hall, Glenfield, Leicester, LE3 8TB.**	

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NHS EAST LEICESTERSHIRE AND RUTLAND CLINICAL COMMISSIONI NG 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 28 February 2018	Status
PC/18/09	February 2018	**Paper Switch Off (PSO) Programme: Update**	Jamie Barrett	To obtain further assurance and a progress update of the PSO Programme, including timescales; update to be provided to the Committee at the next meeting.	March 2018	Item on the agenda for March 2018. **ACTION COMPLETE**	**GREEN**
PC/18/10	February 2018	**GP5YFV - Sustainability and Transformational Plan (STP): GP Work stream– GP Programme Update**	Tim Sacks	**LLR General Workforce Plan** A formal response to be submitted to NHS England following receipt of correspondence in relation to meeting workforce targets set; taking into account national information / guidance.	February 2018	Formal response sent from Chief Operating Officer to NHS England on 12 February 2018 in relation to Workforce Doctor numbers; item on the agenda (PC/18/22) for March 2018. **ACTION COMPLETE.**	**GREEN**
PC/18/11	February 2018	**Narborough Health Centre (NHC): Update leading to NHC Closure**	Tim Sacks / Seema Gaj / Daljit Bains	To review the application required by NHS England to change the constitutional membership.	February 2018	Meeting arranged to be held on 5 March 2018; verbal update to be provided at the meeting.	**AMBER**

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

Front Sheet

REPORT TITLE:	**Sustainability and Transformational Plan (STP): GP Programme Update**
MEETING DATE:	**6 March 2018**
REPORT BY:	**Tim Sacks, Chief Operating Officer** **Sharon Rose, Locality Lead Manager & STP GP Programme Lead** **Sue Price, Operations Team Support Officer**
SPONSORED BY:	**Tim Sacks, Chief Operating Officer**
PRESENTER:	**Tim Sacks, Chief Operating Officer**

EXECUTIVE SUMMARY:

This Paper provides an update on the Work Programme for the STP General Practice Programme Board.

The documents included are:

- The tracker for the GP Programme board (appendix A)
- Letter from Chief Operating Officer to NHS England dated 12 February 2018 regarding GP workforce numbers (Appendix B)
- Meeting notes from the Extended GP PB (Appendix C)

RECOMMENDATIONS:

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

- **RECEIVE** the report.

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).			

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

General Practice Five Year Forward View (GP5YFV)

6 March 2018

Introduction

1. The Aim of the programme is to deliver the GP Five Year Forward View strategy that was published in April 2016. 7 Key priority areas with 14 Key projects have been identified for 17/18.The key areas of focus are;
    - Access to GP Services 7 days per week
    - Workforce
    - Workload
    - IM&T/Estates
    - Care Model re-design
    - Finance recurrent/transformational non-recurrent
    - Communications and Engagement

Workforce Progress

2. Last month we reported that a submission was made to NHSE regarding how LLR will achieve its GP workforce number. This was rejected with a specific request to show how LLR will achieve the full target GP workforce number. A revised submission has now been made for the full target numbers of GPs. A letter to accompany the return has been sent, on behalf of the GP workforce group indicting that NHSE need to provide the resources to support.

3. The GP Workforce Group has agreed its priority areas for 18-19, work is now underway to agree actions and implementation plans. Some of these areas are a continuation of 17-18 priorities.

IM&T progress

4. We have received late confirmation of funding for E consultations. A project manager is now in place and work progressing towards identifying pilot sites and software solutions across LLR.

5. A piece of work is being progressed to update and future proof the contract with LHIS incorporating the elements of the GPIT Framework ahead of the termination of the AGEM contract on the 31st March.

GP Programme Board

6. Following an extended GP Programme Board in January 2018, the group have agreed its mission and priorities for 18-19. To assist with communicating Message as around the GPFV and its main objective, the group will know be known as the GP Resilience Programme Board.

7. The 5 priority areas for 18-19 for GP resilience are;
    - Workforce
    - Models of Care
    - IMT and estates
    - Funding and contracts and,
    - Workload/demand.

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

    - **RECEIVE** the report.

LLR STP General Practice Delivery Plan 17-18 Priorities

No.	Work stream	Priority Area	Overview of project	Managerial Lead	Clinical Lead	Project Lead	Delivery Group	Funding £	Funding Source (GP5FV / CCG)	PID Submitted	EIA	QIA	Date of Next Critcal Milestone	Current RAG status	Decisions required/items for escalation
1	**Communication & Engagement**	Communications Plan	Visionary event to define the vision and inform the plan. • Formulation and agreement of a single vision for all LLR parties and stakeholders for STP and public. • Communication plan in place and implemented.	Tim Sacks	Dr Azhar Farooqi	Richard Morris / Melanie Shilton	GP Programme Board		CCG				Mar-18	amber	
2	**Workforce**	Workforce Mapping	• Produce a comprehensive baseline of current workforce numbers and skills in General Practice to show current and projected workforce gaps and to map future supply of trainees, informing reporting tool development. • Map the future workforce needs in line with the proposed new models of care in General Practice	Tim Sacks		Bridget Roberts	GP Workforce Group	£50K	HEEM	Workforce Delivery PID			Jan-18	Green	
3		Clinical Pharmacists	• Increase clinical pharmacists in general practice through national and local funding • Coordinate bids for funding to employ pharmacists within General Practice across LLR as part of Wave 3 of the national funding programme, Clinical Pharmacists within General practice to increase the numbers of clinical pharmacists working in primary care	John Nicholls	TBC	James Watkins	GP Workforce Group	60% yr 1 40% yr2 20% yr 3	NHSE	Clinical Pharmacists PID			Feb-18	amber	
4		International recruitment	The General Practice Forward View (GPFV) included a commitment to deliver a major international recruitment drive to attract up to 500 appropriately trained and qualified GPs from overseas by 2020. NHS England's general practice workforce team has been engaging with regional and local colleagues, Health Education England, RCGP and the BMA to agree an approach for delivering the commitment. It is recognised that across LLR there is a shortage of GPs which is compounded substantial difficulties with recruitment both of qualified GPs and GP trainees, with local training places unfilled. This project aims to deliver a sustainable general practice across LLR by successfully recruiting international GPs to work within LLR. August 2017 NHS England has announced it is embarking on a £100m international recruitment drive to boost the number of GPs, and contracts have been offered to agencies to help NHS England achieve its goal of recruiting 5,000 extra doctors by 2020.	Tim Sacks	Dr Nil Sanagee	Sharon Rose	GP Workforce Group	£36,000 per new recruit (£2500 to CCG for training)	NHSE	Int Recruitment PID			Feb-18	Green	
5		Care Navigators	• Active Signposting and Correspondence Management Training to upskill admin staff and release GP time • Organise and coordinate CLAP courses, incorporating active signposting and social prescribing.	Ian Potter	TBC	Daniel Nerini	GP Workforce Group	£665K 2017-2020	NHSE	Receptionists Training PID			Mar-18	Amber	
6	**Access**	7 day Access	• An integrated service that provides at least 45 minutes of GP services per 1000 population in evenings and weekends across LLR • An integrated home visiting service available 24/7 for urgent and complex patients across LLR	Julia Cory Paula Vaughan David Muir	Dr Prasad Dr G Purohit Dr G Hanlon		Strand 1 UEC	£3.69M 18/19 £6.62M 19/20 onwards	NHSE	to CCG PCCC			Mar-18	Amber	
7	**Workload**	Transferring Care Safely (TCS)	• Implement a clinical integration group across LLR • Development of new common reporting pathways for both operational and quality concerns • Development of a guide book	Amy Linnett	Dr Nick Pullman		GP Programme Board						Mar-18	Green	
8		10 High Impact Actions (HIA)	• Collaborative learning in action programme for practices, targeting HIAs 1)active signposting & 8) Social prescribing. • Work with NHS England to reach agreement, structure and content of offer to practices. • Key learning outcomes agreed across LLR.	Ian Potter			GP Programme Board						Aug-17	Green	
9	**Models & Contracts**	Toolkit for new models of care delivery	• Modelling delivery of complex / non-complex pathways • Develop new ways of joint working / contracting to deliver sustainable models • Development of a toolkit for practices.	Julia Cory	TBC	James Watkins	GP Programme Board			Models and Contracts PID			Mar-18	Green	

No.	Work stream	Priority Area	Overview of project	Managerial Lead	Clinical Lead	Project Lead	Delivery Group	Funding £	Funding Source (GP5FV / CCG)	PID Submitted	EIA	QIA	Date of Next Critcal Milestone	Current RAG status	Decisions required/items for escalation
10	**IM&T**	Online consultations	• Online General Practice Consultation Software Systems, development of online consultation systems with a view to improving access and making the best use of clinical time • Pilot online General Practice Consultation Systems in 3 areas during 2017/18 as part of a range of initiatives to improve access and make best use of clinical time to identify the appropriate IT solution for LLR in line with national guidance once available.	Tim Sacks	Dr Tony Bentley		STP GP IM&T Group	£820K 2017-2020	NHSE	Online Consultations Project Plan Jul-17 E consultation PID			Feb-18	red	Following a number of delays, guidance was released by NHSE 30th October 2017. Awaiting outcome of LLR bid.
11		System Migration and Interoperability	• Support practices to migrate as part of the local transition towards a footprint wide clinical system estate towards a single interoperable platform in line with GPSoC • Develop plans for expression of interest.	Tim Sacks	Dr Tony Bentley	Jennie Caukwell	STP GP IM&T Group	£550K 17/18	ETTF	GP Programme Migrations PID.docx			Jan-18	Amber	
12	**Finance**	Transformation and models of funding	• ELR CCG Funding to support groups of General Practices to come together in line with the proposed new care models • WL CCG outcome based federation level QIPP scheme. closely aligned to our strategic priorities which include the sustainability of general practice primary care at scale • LC CCG - through the four city Health Needs Neighbourhoods(HNNs) which encompass all of LC CCG practices. Consider transformational opportunities of practices working together to free-up capacity and enable resources to be redirected to the areas of greatest need.	Tim Sacks / Ian Potter / Richard Morris	TBC		GP Programme Board	£3.28M 17/18 and 2018/19	CCG Baseline	3 CCGs PCCCs			Sep-17	Amber	CCGs to complete transformation plans

12th February 2018

Dear Dave

RE: Workforce Doctor Numbers

Thank you for your letter dated 2nd February in response to the resubmission of the LLR General Practice workforce plan.

The CCGs, other health care partners and NHSE workforce leads collaborated to deliver a very detailed and realistic plan that outlined the real issues and risks that face our General Practice workforce and the proposed actions and priorities to support recruitment and retention. This was formally signed off through the STP General Practice Programme Board and the LWAB.

Our plan clearly outlines that in the last 2 years there are 5% fewer WTE GP sessions being delivered in LLR. This mirrors the national picture and is corroborated by the RCGP and BMA. This is a real concern to our member practices and the whole health care system.

The LLR workforce plan illustrates that there are three key issues facing General Practice

1. **Retention:** More and more GPs are leaving, retiring early, reducing their sessions or working as Locums due to workload pressures, want for more flexibility or due to the pension rules creating a disincentive to work much beyond 50.

2. **Recruitment:** Simply there are not enough Doctors who wish to be General Practitioners in LLR. The reason for this is multi-factorial, but specifically not enough training places and the poor reputation of General Practice as a career.

3. **Funding:** The NHS is facing unprecedented demand and the expectation of QIPP delivery and financial pressures is making it increasingly difficult to retain current levels of funding into General Practice, when there is a real need for an increase.

The task of meeting the LLR share of the GP5YFV target for General Practitioners and other health professionals therefore is going to be a real challenge, even taking into consideration all of the LLR General Practice workforce initiatives that are taking place.

The purpose of this letter is to confirm that the resubmission of the trajectory for General Practitioner numbers will be for the full target of 639 WTE GPs by 2020.

Whilst the funding for international recruitment and managerial support are most welcome, achieving more funding for primary and community care also needs to be part of the LLR STP financial Plan. We therefore assume, in the acceptance of the GP recruitment target, that NHSE will seek assurance of enhanced funding for general practice and community care when it considers signing off the STP plan.

The LLR health system will work hard to deliver this as best as it can within the constraints previously set out, but seek greater support from NHS England in ensuring the appropriate training places and funding is available to the system.

Kind Regards

Prof. Azhar Farooqi
Chair of LCCCG
Chair of STP GP Programme Board

Dr Peter Miller
CEO of LPT
Chair of LWAB

Mr T Sacks
COO of ELRCCG
Chair of GPWG

Meeting	STP GP Programme Board	**Date & Time**	Tuesday 30th January 2018
Chair	Azhar Farooqi	**Notes**	Sue Price (SP)

Name	Organisation	Initials	Name	Organisation	Initials
Azhar Farooqi	LCCCG	AF	Nainesh Chotai	LLR LMC	NC
Julia Cory	LCCCG	JC	Ian Potter	WLCCG	IP
James Watkins	ELR GP Fed	JW	Tony Bentley	LCCCG	AJJB
Tim Sacks	ELRCCG	TS	Tabitha Randell	ELRCCG	TR
Sue Lock	LCCCG	SL	Anuj Chahal	ELRCCG	AC
Andy Ker	ELRCCG	AK	David Shepherd	LCCCG	DS
Beverley Fall	WL Federations	BF	Sulaxi Nainani	LCCCG	SN
Chris Barlow	WLCCG	CB	Hilary Fox	ELRCCG	HF
Raj Than	LCCCG	RT	Girish Purohit	ELRCCG	GP
Nil Sanganee	WLCCG	NL	Vivek Varakantam	ELRCCG	VV
Sharon Rose	ELRCCG	SR	Richard Morris	**Apologies**	
Melanie Shilton	LCCCG	MS	Rysz Bietzk		
Nick Glover	ELRCCG	NG	Jennifer Fenelon		
Ursula Montgomery	UHL	UM	Paul Hanlon		

Notes

As chair of the GPPB and STP, AF welcomed all to this meeting of the extended Programme board as an update to Governing Bodies on the work which is at varying stages of development. The 2nd part of the meeting will take a workshop format to help shape and progress work going forwards.

The group were reminded of the Vision and Priorities as per the slide presentation and invited to take a look in more detail at the Workforce Plan and the detailed Tracker (provided as handouts).

The **GPFV Plan**, submitted just over a year ago, was rated a good plan by NHSE subject to 6 monthly assurance meetings. Our first assurance meeting took place in October; this received a positive response as we are meeting expectations.
The **GP Workforce Plan** provides for the first time, some real granularity on our GP workforce. We now need to understand where the gaps are in terms of our Clinical, Non-clinical and administrative staff and determine what areas we should focus on. A further submission to the Plan, a chapter on the non-clinical workforce is due to be submitted to NHSE this week.

International recruitment – NS, as Clinical lead for International GP Recruitment provided an update on where we are with the scheme. Initially NHSE promised 500 additional GPs through International Recruitment, this was increased to 2000 to be procured over 5 waves. For LLR there has been significant engagement with Practices resulting in Expressions of Interest from 22 Practices. As a result a wave 3 bid was submitted for 24.5 International recruits. The application has been approved in principle and we are waiting to hear what this means in terms of numbers. There has been significant interest Nationally in the scheme with more applications than funding.
Recently published timelines for wave 2 have given an indication of the likely time frame for wave 3 recruits. It could be winter next year before the recruits hit practices; this long lead in time, may lead to attrition and we need to manage this. A request was made to the meeting attendees to help maintain the interest in the scheme.

Practice Toolkit – the toolkit was developed to help Practices wanting to work together; to help address the sustainability and resilience challenge. The basic template was already there and has been developed further containing decision making tools, examples of joint working from informal joint working to full mergers and "How to" Guidance. It contains detail around MCPs and what they look like as well as Primary care home and examples from across the Country. It is hoped it will provide options for practices.
The document has been shared (with CQC amongst others) and feedback incorporated. It will be an evolving document, flexible to pick up changes. More local examples are needed.

On-line Consultations – one off Funding over 3 years is promised with this year's funding only recently being notified. The money equates to 24p per patient and with most off the shelf packages on the market being 65p+ per patient solution options are limited.
The idea is to pilot different solutions across a number of practices using this year's funding and to look for a Project Manager. Some practices are already using on line consultation packages. A survey has already been undertaken with Practices in LLR and if we get the go ahead from NHSE, further engagement with Practices and patients will be undertaken.

Care navigator – 2 elements to this, Active Signposting and Correspondence Management. Increased focus on self-care to reduce workload. One practice has freed up 11% of appointments through signposting; this is not clinical triage. Locally we are using a collaborative approach, learning from what practices are doing already. A second cohort is due to start and we are keen to get City Practices on board. Correspondence management is about training administrative staff to manage some of the correspondence instead of the GP.

Extended Access – LCCCG are compliant having benefitted from PM Challenge funding and are sharing their learning with others.
East and West are in similar positions; compliant in 5 out of the 7 areas. From April 2019 all Practices must be able to book directly into the UCC. There are some pilots taking place across LLR and with the significant amount of recurrent money available we need to make sure it is appropriate for General Practice.

Communications and Engagement – LCCCG Comms team are looking to address the sporadic communication around GP5YFV and bring all practices up to a shared understanding. Hoping to do this through specific branding and sharing success stories. For patients – need to effectively communicate the patient journey and reinforce the new ways of working. Patient engagement needs to happen in a way that doesn't compromise patient satisfaction. The suggestion was made that this communication needs to happen now, before change takes place, to avoid landing on negative perception.
Discussions around the challenges and risks and in particular the falling patient satisfaction rates. CQC focus remains on quality and so when we are faced with joint working/ joint delivery of services to support practice resilience, how do we support the practice to demonstrate quality. Working at scale may not be reflected positively in patient satisfaction surveys.

IM&T - AJJB gave an update on the current programmes of work.
Interoperability and Record Sharing. The challenges are the large number of different systems in use across LLR. Sharing of records through the Care Plan and SCR V2.1 continues to be the focus. Phase 3 will involve sharing information with Social care and is a work in progress. LPT are on SystmOne and can see records. For UHL only admitted and A&E have access.
Flagging will look to standardise the process of flagging across the STP to introduce consistency.
The ideal situation would be to have all on the same system. We are slowly making progress with Migrations from EMIS to SystmOne (S1) in general practice but it should be recognised that GP System of Choice (GPSOC) still exists. Within the system, there is lots of movement onto S1 which should bring with it huge efficiencies.
Self-Care/Apps – we are at the very early stages of this work stream
System optimisation is training in the competent use of the systems available to maximise the output.
Recently issued a Practice Survey that we would like everyone to complete to help with a refresh of the HIS SLA.
The LLR IM&T group has very good working relationships and is held to account through the steering group.

RT expressed concern regarding the low numbers of individuals consented to SCR. The priority has to be complex patients first of all and that is why consent is built into the template care plan. More work is needed to get UHL to use this system. Active communications and engagement is needed to promote further.
GPu asked what can be done to influence paper switch off. TS and AF to take to John Adler.

GP5YFV Staffing/ Capacity to deliver
It was reported that NHSE are providing staff to support the delivery of the 5YFV. Need to explore further the detail regarding what needs to be done and get the right people in place to support.

QUESTIONS/COMMENTS

GP Workforce/IGPR – if the applications are assessed and awarded at STP level, how will recruits be allocated? The GP Workforce plan suggests the greatest need is in the City. Applications have been received from across the 3 CCGs and the majority are from City Practices, if we do not get 24.5 recruits, we will have to prioritise placement but the process involves an element of 'speed dating' which it is hoped will successfully match GPs to practices.
How will the 2000 GPs be sourced? Lincolnshire only managed to recruit 29 although not all yet in post? The Lincolnshire pilot has been evaluated and the process has changed for waves 2 onwards. In Lincolnshire, the LMC were instrumental in the process and had to recruit the individuals themselves, this element will now be facilitated Nationally. Recruitment companies have been appointed to a Framework and a company will be assigned to an STP area to recruit GPs.
What is the language test they will have to satisfy? All recruits will need to attain an ILT at level 7. There will also be a two stage interview process and I&R training; this will determine whether simulated surgery is required.
It was suggested that this is not good use of NHS money and that the Practices in need of more GPs are not able to provide the support that an international recruit will need. The group are looking to hub and spoke models and possibly federated practices to support the ongoing needs of these individuals to ensure that programme is a success. TS responded that £100m has been made available by NHSE for IGPR and we need to make maximum use of the opportunity presented. We know we have issues with GP retention and Locum use, our job is to determine what we can do to make it right. We know our GP retention scheme is underutilised and these need to be promoted. All the workforce schemes are ongoing but Locums and Retention should feature highly in the work programme for 2018-19.
The suggestions was made that a defined education programme/set of teaching sessions for GPs might take some of the burden away and help with retention.
Are UHL included in the workforce dialogue? Yes they are represented on the Local Workforce Action Group who looks at joint solutions to our workforce problems.
CB added that the complex patient's take up more GP time, with many reducing their number of clinical sessions to accommodate this increase in work.

Correspondence Management – AJJB accepts this with reluctance noting that this work programme could take away some of the positive and nicer elements of the work; the good news that a patient is ok - leaving the GP to deal with only the negative.
Care navigation – Is a Centralised DOS part of this work? Yes, building on what is in existence in the County in the form of First Contact Plus and incorporating similar for City and Rutland.

Online consultations – a query was received in respect of the differing views of defence organisations and the liabilities and indemnities. The LMC have advised that this will be addressed from April 2019 when Crown indemnity will apply to all NHS activity including GPs. It is thought that this will also be retrospective.

Toolkit – it is good that we have consulted the CQC on the toolkit. How do we develop the toolkit further? How do we commission from GP? WLCCG are working on Resilience Planning; how practices can support one another. How do we develop differently as Hubs/ federations and localities?

Nursing – how do we get increased exposure of student nurses in Primary care? The curriculum is heavily influenced by LPT and UHL? The suggestion was made to include Primary care into the rotation programme for post graduate nurses. Needs the STP to take a different view.
The DMU course for Nurse prescribers is too prescriptive; they insist that a Nurse has obtained a degree over 3 years. Practices are sending Nurses elsewhere for this training where Nursing degree is obtained over 5 years.

BREAK

Open discussion regarding Joint working, what works and what are the barriers and how we enable practices to jointly deliver both core and non-core general Practice to support resilience and sustainability.

- Frustration that commissioned services dictate how work will be done; would like sub localities to determine what is needed for groups of practices. Influence and control at locality level will increase resilience.
- Use relationships to influence what needs to be done along with contract.
- Strict criteria that are inflexible such as won't see a 64 ½ year old because the service is for over 65s
- Secondary Care strictly adheres to what is in the contract. Control should be groups of individuals not just one organisation; General Practice understands the needs of patients. Locus of Control.
- CQC will continue to look at quality of care for patients and the patients remain on the practice registered list whoever delivers the service. Therefore there is a need for a better specification for local services.
- Design and delivery could be different. Delivery could be locality based. Can it be loosely worded to enable more control at locality level?
- Opportunity to use transformation funding for more intelligent use of resources/staff. May have more influence as a group of practices rather than individual.
- Some of our providers need to be more flexible otherwise they may lose out. Why are GPs still doing bloods in Nursing homes?
- How do CCGs work together? This group is a good example of CCGs working together.
- What about Hubs, HNN and Federation level? There is some interesting work already taking place. How do we support failing practices? What are the benefits for otherwise 'secure' practices?
- West 4Fed seeing practices change their opinion on Federated working. Previously negative, they are receiving some benefit/support which has changed their opinion. But there are other ways of receiving this support, for example, partnerships.
- What is not working well; LPT not engaged with the ILT. 800 LPT staff support general Practice; need a framework to enable delivery and provision at locality level.
- Services commissioned to support General Practice are the Home Visiting Service and the Hubs. Physio/ Mental Health and Nursing services could be provided through a Federation. What happens to those practices that are not engaged through a federation? Do CCGs continue to fund?
- Providers will have difficulty with 138 contracts need to identify commonality across the system
- Massive opportunities with MCPs with money for community. If we make this work better we get benefits at scale. And if we don't support our failing practices we pick up the pieces anyway.
- Need to design a structure that works and take a step away from the fire fighting.
- No rigid solutions. There are a number of different ways of addressing things dependant on the problems. The toolkit will help with the logistics.
- Patients like General Practice, it is local, and this needs preserving but enhancing.

AF closed the meeting, thanking everyone for their valued input, and noting there is lots to build upon to support core General Practice and the work that goes with it.

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

Front Sheet

REPORT TITLE:	**Paper Switch Off (PSO) Programme: Update**
MEETING DATE:	**6 March 2018**
REPORT BY:	**Jennie Caukwell, Delivery Manager, WL CCG**
SPONSORED BY:	**Tim Sacks, Chief Operating Officer, ELR CCG** **Dr Tony Bentley, LC CCG**
PRESENTER:	**Jamie Barrett, Head of Primary Care, ELR CCG** **Jennie Caukwell, Delivery Manager, WL CCG**

PURPOSE OF THE REPORT:
The purpose of this report is to provide Primary Care Commissioning Committee with an update on the progress that has been made by the Hospital Trusts in Leicestershire to implement the national requirements that have been dictated by NHS England and NHS Digital to improve the utilisation of electronic referrals from primary care into secondary care to achieve paper switch off (PSO) following the paper that was presented on 6th February 2018.

RECOMMENDATIONS:
The ELR CCG Primary Care Commissioning Committee is requested to: • **RECEIVE** and **NOTE** the contents of the report.

REPORT SUPPORTS THE FOLLOWING STRATEGIC AIM(S) 2017 – 2018: (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 been undertaken in the development of this report and is open to all. This completes the due regard required.

Leicester City Clinical Commissioning Group
West Leicestershire Clinical Commissioning Group
East Leicestershire and Rutland Clinical Commissioning Group

Name of meeting	Primary Care Commissioning Committee (Public)	**Date**	2nd March 2018	**Paper**	
Report title	**Paperswitch Off Programme**				
Lead Director	Tim Sacks (IM&T SRO)	**Tel/Email**	Tim.Sacks@EastLeicestershireandRutlanddccg.nhs.uk		
Report Author	Jennie Caukwell	**Tel/Email**	Jennie.caukwell@westleicestershireccg.nhs.uk		
Clinical Lead	Dr Tony Bentley	**Tel/Email**	AJJ.Bentley@gp-c82030.nhs.uk		
Links to CCG strategic objectives	☒ Through better commissioning, improve local and national health outcomes, particularly by addressing poor outcomes and inequalities; ☒ Help create the safest, highest quality health and care services; ☒ Balance the NHS budget and improve efficiency and productivity; ☐ Lead a step change in the NHS in preventing ill health and supporting people to live healthier lives; ☒ Maintain and improve performance against core standards; ☒ Improve out-of-hospital care; ☐ Support research, innovation and growth.				
Purpose	**Note**	X	**Discuss and recommend**		**Approve**	
Report summary	The purpose of this report is to provide Primary Care Commissioning Committee with an update on the progress that has been made by the Hospital Trusts in Leicestershire to implement the national requirements that have been dictated by NHS England and NHS Digital to improve the utilisation of electronic referrals from primary care into secondary care to achieve paper switch off (PSO) following the paper that was presented on 6th February 2018.				
Identified risks and risk management actions	• Unavailability of electronic systems – business continuity strategy being defined • Primary care and secondary care dis-interest and compliance with this process – communication strategy defined and commenced, learning from all parties being obtained and addressed				
Resource and financial implications	Staff to support this project have been identified from within current organisations resources. The financial implications for this project will impact on the Hospital Trusts in Leicestershire, from the 1st October 2018 if PSO is not achieved and referrals for first consultant led clinics are not received via e-Referrals (e-RS), then they will not receive payment for services delivered.				
Conflicts of interest	None				
Engagement and/or consultation considered?	No formal consultation needs to be completed, however engagement has been completed with the Local Medical Council (LMC) to gain their support on the project and direction of travel to delivery PSO. A joint communication strategy has been defined and this has commenced which is being undertaken across all relevant organisations including, University Hospital of				

	Leicester, Community Hospitals and Primary Care.
Clinical input assurance	Dr Tony Bentley, as the LLR CCG Information Management & Technology (IM&T) Clinical Lead.
Due regard/equality considerations?	This is open to all.
Report history (audit trail)	
Appendices	Paper Switch Off February Update (Appendix 1)
Recommendation	The Primary Care Commissioning Committee is asked to: **RECEIVE** and **NOTE** the contents of the report.

PURPOSE

1. The purpose of this report is to provide Primary Care Commissioning Committee with an update on the progress that has been made by the Hospital Trusts in Leicestershire to implement the national requirements that have been dictated by NHS England and NHS Digital to improve the utilisation of electronic referrals from primary care into secondary care to achieve paper switch off (PSO) following the paper that was presented on 6th February 2018.

CURRENT POSITION

2. The current position for referrals being sent into UHL and the Community Hospitals from primary care continues to show an increase via NHS e-Referrals (e-RS) which is detailed in the table below.

For Referrals	Oct 2017	Nov 2017	Dec 2017	Jan 2018
NHS EAST LEICESTERSHIRE AND RUTLAND CCG	65.29%	66.46%	66.52%	67.81%
NHS LEICESTER CITY CCG	66.31%	66.28%	67.26%	68.75%
NHS WEST LEICESTERSHIRE CCG	66.29%	69.33%	68.98%	70.21%
All LLR CCGs	**66.00%**	**67.33%**	**67.58%**	**68.95%**

3. We have agreed with NHS England and NHS Digital that the PSO implementation date of the 9th April 2018 will be a soft launch.

4. A task and finish group has been formed which includes representation from University Hospitals of Leicester (UHL), Alliance, CCGs and the IM&T Practice Manager Kieran Mann, who are determining what the business as usual process will be so that a recommendation can be made to the PSO Project Group.

5. This process will support practices as UHL and the Community Hospitals will continue to accept and process any referrals received outside of e-RS during a brief soft launch process which will not go beyond June 2018.

6. The soft launch period will be used to educate the relevant practice staff including clinicians who have been identified as not referred using e-RS. Additional upskilling on e-RS will be arranged as required.

7. The practice level performance information continues to be shared by UHL with the three CCGs, each CCG is making contact with practices asking them to review their referrals so that we can understand how they manage these and any issues they experience so that we can share this intelligence with UHL for rectification.

8. Communications are on-going with practices through practice manager and locality meeting. A list of out of county providers implementation dates has been provided to practices during February 2018 (these are summarised in Appendix 1 on Slide 2).CCGs will also need to ensure that OOH or other commissioned services send referrals via ERS.

CONCLUSION

9. UHL and the Community Hospitals continue to work towards PSO, undertaking all actions that were referenced in the 6th February Paper (this is summarised in Appendix 1 on Slide 3).

RECOMMENDATIONS
The Primary care Commissioning Committee is asked to:-
RECEIVE and NOTE the contents of this report.

Paper Switch Off Programme
April 2018

Paper Switch Off (PSO) Programme Key Dates

- ALL referrals from GPs to first consultant led outpatients clinics will need to be sent via e-RS.
- Hospitals will not accept referrals from GPs through any other means (e.g. post, fax, email), as they will not be funded for activity associated with such referral routes.
- NHSD have dictated when Hospital Trusts implement PSO which will be at different points during 2018, snapshot provided below of local providers in the East Midlands:-
  - Derby – 22nd February
  - Nottingham – March
  - Peterborough/Stamford – March
  - Burton – 1st April
  - **UHL/Alliance – 9th April**
  - Lincolnshire – June
  - George Eliot – August

Full list of dates available from:- https://digital.nhs.uk/e-Referral-Service/Future-Service/Paper-switch-off-dates

NHS e-Referral Service

Actions being undertaken by UHL

- University Hospital of Leicester (UHL) and Community Hospitals know they have a way to go and are continuing to work towards PSO:-
  - Reviewing all their services, identifying gaps where new services need to be created.
  - Reviewing appointment slots to ensure they are linked to relevant services on e-RS, with maximum capacity being made available for GP referrals.
  - Updating the Directory of Services (information provided on e-RS about a clinic, conditions treated, service exclusions, suggested investigations).
  - Identifying services that are excluded from PSO (e.g. same day clinics).
  - Defining a business continuity strategy for times of system unavailability.
  - Clinics with potential e-RS coding issues are being identified for rectification.
  - Checking that all relevant staff know their responsibilities, have access to Smartcards and appropriate permissions.
  - Working through prompts on PRISM if service is on e-RS and vice versa.

UHL and the Alliance are sharing regular performance information with all their specialities.

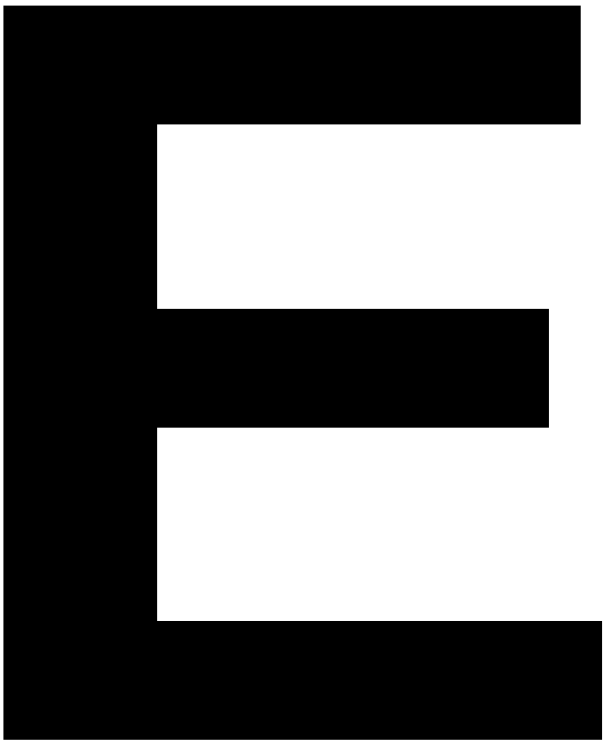
Paper Switch Off Programme

- UHL and Community Hospitals have agreed:-
  - if no slots are available on e-RS, please use the “Defer to Provider” option. This will be counted as an e-RS referral
- For those occasions where we have a system unavailable, business continuity will be invoked, for UHL this will be similar to the current 2WW process, finalised plan to be shared
- We now have local practice performance from UHL/Alliance which we believe is not reflective, we will be looking to work with practices to understand this

For Referrals	Oct 2017	Nov 2017	Dec 2017
NHS EAST LEICESTERSHIRE AND RUTLAND CCG	65.29%	66.46%	66.52%
NHS LEICESTER CITY CCG	66.31%	66.28%	67.26%
NHS WEST LEICESTERSHIRE CCG	66.29%	69.33%	68.98%
All LLR CCGs	**66.00%**	**67.33%**	**67.58%**

- We are also reviewing how providers communicate back (outpatients/inpatients) with practices as we want to support with moving these to electronic process too

Further updates will be provided to practices as we move towards April 2018



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

Front Sheet

REPORT TITLE:	**Primary Care Finance Report 2017/18 (Month 10, January 2018)**
MEETING DATE:	**6 March 2018**
REPORT BY:	**Richard George, Senior Primary Care and Non-Acute Commissioning 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 2017/18 year to date and forecast outturn position for Primary Care services.

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) 2017 – 2018: (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 2017/18 (Month 10, January 2018)

6 March 2018

1. Month 10 Year to Date and Forecast Position

The 2017/18 annual budget for Primary Care services totals £98.1m. At month 10 (January 2018) a year to date underspend of £865k and an outturn underspend of £1,769k is being forecast. Appendices 1 and 2 provide further analysis of all service areas.

2. Primary Care Prescribing

Based on Month 8 PPA data, the forecast outturn position (including high cost drugs and central prescribing) is an underspend of £562k.

It is forecast that the QIPP programme for prescribing will over deliver at £2.82m against a target of £1.5m. In addition to this there is a £685k benefit following the expiration of the pregabalin patent.

The forecast includes a £1.6m cost pressure in relation to NCSO drugs. The number of drugs being added to the list has started to reduce in recent months. This risk, and the impact it may have on the outturn position will continue to be monitored closely.

3. Community Based Services

Based on activity data for quarters 1 to 3, a year to date underspend of £102k and forecast outturn underspend of £49k is being forecast. This underspend mainly relates to anti coagulation monitoring as more patients transfer to DOACS.

4. GP Co Commissioning

The year to date position for co commissioning is an overspend of £36k and a forecast outturn overspend of £109k.

There are a number of pressures in this area, the main ones including:

- Global sum payments reflecting the continuing increase in practice list sizes.
- Locum costs following changes to rules around practice reimbursement for sickness cover and maternity / paternity leave.
- Indemnity insurance payments to practices. This comes out of the GP Five Year Forward view that practices would be reimbursed for this cost at a rate of £0.516 per patient. In 2016/17 this was funded by NHSE England, however for 2017/18 it has become the CCGs responsibility.

To partially offset overspending areas, a £406k benefit is included in the forecast in relation to business rates reimbursements where local authority billing to gp practices has been challenged.

In addition to this, there is an underspend against PMS / FDR reinvestment of £106k. This budget will be reinstated in the 2018/19 financial plan.

5. GP Support Framework

Costs for the majority of GP support framework areas are forecast to be in line with the budgeted values.

There is however an underspend of £200k being reported against the Primary Care Transformational Support Funding budget where the only expenditure to be incurred this year is in relation to the GP Federation. An equivalent amount of funding will be built into the 2018/19 financial plan to ensure the CCG meets the GP Forward View requirement to invest £3/patient on transformational support.

6. **GP IT**

As at month 10 this area is forecast to overspend by £90k. The main reasons for this include:

- Funding transferred from NHSE following the devolvement of N3 network charges does not cover the cost and the CCG has inherited a £60k cost pressure
- Unfunded equipment purchases following the extension of a practice.

7. **Primary Care Licenses & Other**

This budget area is forecast to underspend by £871k. There are a number of variances that make up this value:

- -£86k – GP Workforce training. The CCG has received funding for supporting GP workforce development. This underspend relates to the elements of work that will be undertaken during 2018/19 and built into the financial plan accordingly

- -£30k – International GP Recruitment. Funding received from HEEM has not been committed until 2018/19.

- -£22k – Funding received from the Home Office to support the cost of health care for families who have moved to the area under the Syrian Refugee Resettlement Programme

- -£30k – Winter pressures funding. The CCG has been awarded £50k from NHSE to support winter pressures. £20k of this has been specifically allocated to DHU for the provision of additional out of hours care, with the remaining £30k being used to offset against cost pressures within existing contractual arrangements.

- -£500k – Allocation from NHSE to support existing pressures in Primary Care

- -£200k – GPFV GP Online Consultation. In month 10, the CCG received an allocation of £275k following the submission of a bid for GPFV funding. Funding will not be fully spent in 2017/18 and slippage will be built into the 2018/19 financial plan.

8. **Urgent Care Centres**

Urgent Care Centre activity is in line with expectations and no additional payments beyond the core contract value are being forecast. However, there are ongoing discussions with the Provider who has requested additional funding in relation to inflation and premises costs backdated to 2016/17 which presents a financial risk to the CCG.

As at month 10 an outturn underspend of £273k is being forecast. This is the net benefit to the CCG in relation to the cross charging of urgent care centre activity.

9. 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		
M10 Primary Care Commissioning Report	**YTD Budget**	**YTD Actuals**	**YTD Variance**	**Annual Budget**	**Annual Forecast**	**Annual Variance Over/ (Under)**
Area	**(£'000s)**	**(£'000s)**	**(£'000s)**	**(£'000s)**	**(£'000s)**	**(£'000s)**
CCG Prescribing						
OptimiseRX	76	76	-	91	91	-
Central Prescribing	1,050	988	-62	1,256	1,182	-74
High Cost Drugs	792	750	-42	947	897	-50
GP Prescribing	38,828	38,854	26	46,435	46,057	-378
Prescribing Incentive Scheme	576	525	-50	691	630	-60
Total Practice Prescribing	**41,322**	**41,194**	**-128**	**49,420**	**48,858**	**-562**
Enhanced Services						
Community Based Services	2,176	2,074	-102	2,611	2,563	-49
Total Enhanced Services	**2,176**	**2,074**	**-102**	**2,611**	**2,563**	**-49**
Co Commissioning	**33,763**	**33,799**	**36**	**40,516**	**40,625**	**109**
GP Support Framework						
Care Homes	403	390	-13	484	471	-13
End of Life	273	273	0	327	327	
Long Term Conditions	545	545	0	655	655	0
Demand Mangement	273	273	0	327	327	0
Dementia	136	136	0	164	164	0
Primary Care Transformation Fund	273	106	-167	327	127	-200
Total GP Support Framework	**1,903**	**1,723**	**-180**	**2,284**	**2,070**	**-213**
Other						
GP IT	811	886	75	974	1,063	90
Primary Care - Licenses & Other	433	94	-338	519	-352	-871
7 Day Working BCF	0	1	1	0	1	1
Urgent Care Centres	1,495	1,267	-227	1,794	1,521	-273
Total Other	**2,739**	**2,248**	**-490**	**3,287**	**2,233**	**-1,054**
Total Primary Care	**81,903**	**81,038**	**-865**	**98,118**	**96,348**	**-1,769**

Appendix 2

Month 10 Primary Care Co-Commissioning	Year-to-Date Position			Forecast Outturn Position		
	Budget	Actual	Variance (Under)/ Over	Budget	Forecast	Variance (Under)/ Over
	£000's	£000's	£000's	£000's	£000's	£000's
GMS Global Sum	21,321	21,431	110	25,585	25,744	159
MPIG Correction Factor	1,370	1,370	0	1,644	1,644	-0
PMS Reinvestment	4	0	-4	5	0	-5
FDR Payment	69	0	-69	83	0	-83
Ear Irrigation	68	68	0	82	82	-0
Wound Clinics	273	273	0	327	327	0
SLA Pharmacists	545	531	-15	655	637	-18
Subtotal PMS & FDR Reinvestment	960	872	-88	1,152	1,046	-106
Total General Practice - GMS	**23,651**	**23,672**	**22**	**28,381**	**28,434**	**53**
Occupational Health	39	39	-1	47	47	0
Locum Adoption/Paternity/Maternity	117	82	-35	140	100	-40
Locum Sickness	17	92	75	20	111	91
Locum Suspended Doctors	0	0	0	0	0	0
Seniority	391	298	-93	469	398	-71
Sterile Products	0	0	0	0	0	0
GP Training	79	79	0	95	95	0
PCO Doctors Ret Scheme	17	17	0	20	20	0
Kingsway Management Plan	88	98	9	106	117	11
CQC Registration	126	129	3	151	155	4
Total Other GP Services	**873**	**833**	**-41**	**1,048**	**1,043**	**-5**
QOF Achievement	990	1,031	41	1,188	1,237	49
QOF Aspiration	2,310	2,405	95	2,772	2,886	114
Total QOF	**3,300**	**3,436**	**136**	**3,960**	**4,123**	**163**
DES Extended Hours Access	489	514	25	587	613	26
DES Learning Disability	65	65	0	78	78	0
DES Violent Patients	39	39	0	47	47	0
DES Minor Surgery	425	391	-34	510	468	-42
DES TPP QRisk	0	0	0	0	0	0
Avoiding Unplanned Admissions	0	0	0	0	0	0
LES Translation Fees	42	42	0	50	50	0
Imdemnity Insurance	0	142	142	0	170	170
Leicester Asylum Service	27	20	-7	33	24	-9
Total Enhanced Services	**1,086**	**1,212**	**126**	**1,303**	**1,449**	**146**
Dispensing Quality Scheme	79	79	0	95	95	0
Prof Fees Dispensing	1,250	1,250	-0	1,500	1,500	0
Prof Fees Prescribing	183	183	0	220	220	0
Prescribing Charge Income	-250	-250	0	-300	-300	0
Total Dispensing/Prescribing Drs	**1,262**	**1,262**	**0**	**1,515**	**1,515**	**0**
Premises Actual Rent	1,417	1,300	-117	1,700	1,559	-141
Premises Clinical Waste	125	125	0	150	150	0
Premises Cost Rent	25	0	-25	30	0	-30
Premises Health Centre Rates	18	18	0	22	22	0
Premises Health Centre Rent	79	113	34	95	139	44
Premises Notional Rent	1,250	1,316	66	1,500	1,579	79
Premises Rates	592	748	156	710	897	187
NHSE / GL Hearn Rent Rebates	0	-338	-338	0	-406	-406
Premises Water Rates	52	42	-10	62	50	-12
Other premises	33	60	27	40	70	30
Total Premises Cost Reimbursement	**3,591**	**3,383**	**-208**	**4,309**	**4,061**	**-248**
GRAND TOTAL - Co-Commissioning	**33,763**	**33,799**	**36**	**40,516**	**40,625**	**109**