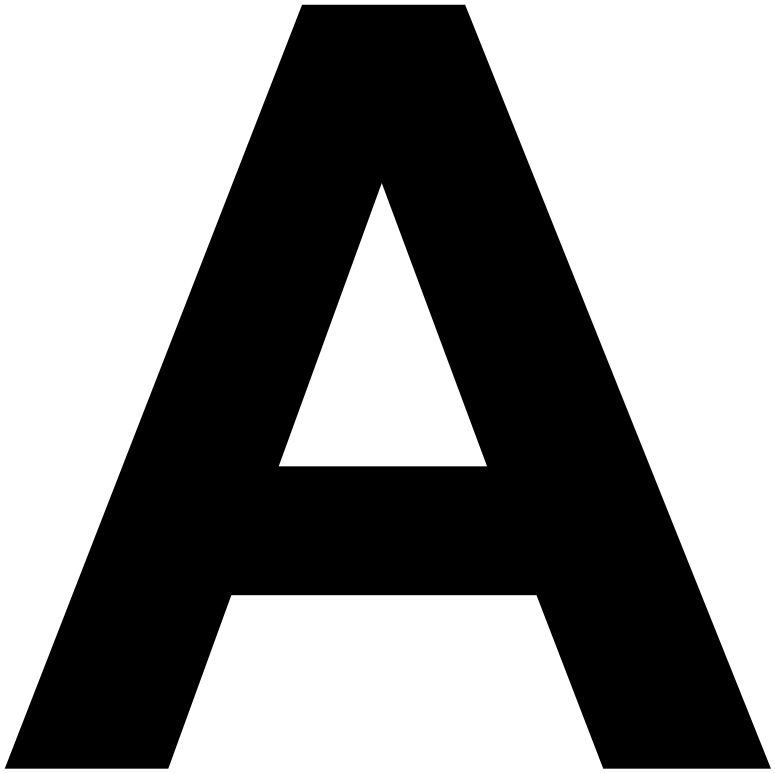
NHS
East Leicestershire and Rutland
Clinical Commissioning Group

Meeting Title	**Primary Care Commissioning Committee – meeting in public**	**Date**	**Tuesday 5 March 2019**
Meeting No.	**45.**	**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/19/01	Welcome and Introductions		Clive Wood	**Verbal**	9:30am
PC/19/02	To receive questions from the Public in relation to items on the agenda	To receive	Clive Wood	**Verbal**	9:30am
PC/19/03	Apologies for Absences: •	To receive	Clive Wood	**Verbal**	9:30am
PC/19/04	Notification of Any Other Business	To receive	Clive Wood	**Verbal**	9:35am
PC/19/05	Declarations of Interest on Agenda items	To receive	Clive Wood	**Verbal**	9:35am
PC/19/06	To Approve minutes of the previous meeting of the ELR CCG Primary Care Commissioning Committee held on 4 December 2018	To approve	Clive Wood	**A**	9:40am
PC/19/07	To Receive Actions and Matters Arising following the meeting held on 5 February 2019	To receive	Clive Wood	**B**	9:40am
PRIMARY CARE FINANCE REPORT					
PC/19/08	Primary Care Finance Report 2018/19 (Month 10, January 2019)	To receive	Donna Enoux	**C**	9:45am
OPERATIONAL ISSUES					
PC/19/09	LLR GP Information Management and Technology (IM&T): Work Programme Update	To receive	Tim Sacks	**D**	9:55am

ITEM	AGENDA ITEM	ACTION	PRESENTER	PAPER	TIMING
PC/19/10	Investment and evolution: A five-year framework for GP contract reform to implement The NHS Long Term Plan (31 January 2019)	To receive	Jamie Barrett	**E**	10:05am
PC/19/11	Development of Primary Care Networks (PCNs) in Leicester, Leicestershire and Rutland (LLR)	To receive	Tim Sacks	**F**	10:15am
ANY OTHER BUSINESS					
PC/19/12		To receive	Clive Wood	**Verbal**	10:25am
DATE OF NEXT MEETING					
PC/19/13	**Tuesday 2 April 2019 at 9:30am – 12:30pm, Room 173**, ELR CCG, Leicestershire County Council, County Hall, Glenfield, Leicester, LE3 8TB.		Clive Wood		10:30am



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Minutes of the Primary Care Commissioning Committee held on Tuesday 4 December 2018 at 9:30am in the Gartree Committee Room, ELR CCG, County Hall, Glenfield, Leicester, LE3 8TB

Present:

Mr Clive Wood	Deputy Chair of the CCG and Independent Lay Member (Chair)
Mr Alan Smith	Independent Lay Member
Dr Nick Glover	GP Locality Lead, South Blaby and Lutterworth
Dr Girish Purohit	GP Locality Lead, Melton, Rutland and Harborough
Dr Vivek Varakantam	GP Locality Lead, Oadby and Wigston (from item PC/18/142 onwards)
Mr Tim Sacks	Chief Operating Officer
Ms Donna Enoux	Chief Finance Officer
Mrs Amanda Bland	Interim Deputy Chief Nurse (on behalf of the Interim Chief Nurse and Quality Officer)
Dr Katherine Packham	Public Health Consultant
Dr Tim Daniel	Public Health Consultant (from item PC/18/136 onwards)

In attendance:

Mr Jamie Barrett	Head of Primary Care
Mrs Seema Gaj	Primary Care Contracts Manager
Ms Charlotte Woods	Office Manager, Leicester, Leicestershire and Rutland Local Medical Committee (LLR LMC)
Mr Tom Bailey	Senior Primary Care Contracts Manager, NHS England
Mrs Amardip Lealh	Corporate Governance Manager (Minutes)

Public Gallery

Ms Taruna Masani	Practice Manager, Forest House Medical Centre

ITEM		LEAD RESPONSIBLE
PC/18/132	**Welcome and Introductions** Mr Wood welcomed all members to the Primary Care Commissioning Committee (PCCC) meeting, in particular, Ms Woods, Mr Bailey and Ms Masani, which was followed by a series of introductions.	
PC/18/133	**To receive questions from the Public in relation to items on the agenda** There was one member of the public present at the meeting, however, no questions raised or received.	
PC/18/134	**Apologies for absence:** • Mrs Tracy Burton, Interim Chief Nurse and Quality Officer; • Mrs Daljit Bains, Head of Corporate Governance and Legal Affairs; • Dr Nainesh Chotai, Chair of the LLR LMC; • Ms Amy Linnett, Quality Lead;	

ITEM		LEAD RESPONSIBLE
	• Ms Kate Holt, Healthwatch Rutland.	
PC/18/135	**Notification of Any Other Business** Mr Wood had not received notification of any other business.	
PC/18/136	**Declarations of Interest** GPs present declared an interest in items relating to commissioning of primary care where a potential conflict may arise, no further action was required on this occasion. It was **RESOLVED** to: • **NOTE** the conflicts of interest declared. *Dr Tim Daniel joined the meeting.*	
PC/18/137	**To Approve minutes of the previous meeting of the ELR CCG Primary Care Commissioning Committee held on 6 November 2018 (Paper A)** The minutes of the meeting held in November 2018 were accepted as an accurate record of the meeting, subject to the following amendment: • **PC/18/126 – Primary Care Finance Report 2018-19 (Month 6, September 2018)** Ms Enoux confirmed the third bullet under this section relating to 'Co-commissioning' requires amending; Ms Enoux to provide Mrs Lealh with the amendment. It was **RESOLVED** to: • **APPROVE** the minutes of the previous meeting, subject to the above amendment.	
PC/18/138	**To Receive Matters Arising following the meeting held on 6 November 2018 (Paper B)** The matters arising following the meeting held in November 2018 were received, and noted as 'complete.' It was **RESOLVED** to: • **RECEIVE** the matters arising.	
PC/18/139	**Primary Care Finance Report 2018-19 (Month 6, September 2018 (Paper C)**	

ITEM		LEAD RESPONSIBLE
	Ms Enoux presented this report, which was taken as 'read,' as there were no changes since the previous report to the Committee. However, in comparison to Month 6, there is a £10k improvement in the forecast outturn, for which movements were summarised in the table on page 2 of the report, that related to: - prescribing - Community Based Services - Co-commissioning - GP Support Framework - Other Primary Care Appendices 1 and 2 of the report provided further analysis of all service areas. It was **RESOLVED** to: • **RECEIVE** the report and **NOTE** the update.	
PC/18/142	**Boundary Change Principles – Guidelines update (Paper D)** Mrs Gaj presented this report, which provided an updated version of the Leicester, Leicestershire and Rutland (LLR) Boundary Principles for approval. Mrs Gaj reminded the Committee that the previous Boundary Principles were presented to the Committee in February 2016, which was approved for the LLR CCGs. However, in August 2018, Leicester City (LC) CCG received a request from one of their Practices to cease registering new County patients from Care Homes following a boundary change, and have requested for section 3 and 4 of the current Boundary Change Principles at appendix 1 to be amended accordingly. Therefore, the purpose of the report is to inform the Committee that the scope of the Boundary Change Principles has been amended to cover ELR CCG and West Leicestershire CCG only. Mr Barrett confirmed that following consultation with Practices and the LLR CCGs in light of the amendment requested, both ELR CCG and West Leicestershire (WL) CCG did not agree to the proposed change. This was subsequently noted by LC CCG as 'not supported' by both ELR CCG and WL CCG. Mr Wood thanked both Mrs Gaj and Mr Barrett for bringing this to the attention of the Committee and noted it was unfortunate that a consistent approach has not been agreed across Leicester, Leicestershire and Rutland (LLR) CCGs. Dr Glover noted that the localities covered by each of the LLR	

ITEM		LEAD RESPONSIBLE
	CCGs is not necessarily known to patients and/or within Care Homes, however, agreed the three LLR CCGs should work together in order to provide a collaborative function across LLR. Mr Sacks stated his disappointment in the response from LC CCG following feedback from one of their Practices, and agreed a single policy and process should be implemented across the LLR CCGs. It was suggested whether a formal response from NHS England was required to obtain clarification whether it was appropriate to manage policies and procedures across organisations in this manner. *Dr Vivek Varakantam joined the meeting.* Following concerns raised by members of the Committee in relation to lack of collaborative and joined up working across GP Practices in LLR, it was agreed that it would not be possible for the Committee to approve the updated Boundary Changes Principles. However, it was agreed for **Mr Wood to formally write to LC CCG raising concerns in relation to the proposed amendments required to the current Boundary Changes Principles.** It was **RESOLVED** to: • **RECEIVE** the report.	**Clive Wood / Jamie Barrett**
PC/18/141	**Sustainability and Transformational Partnership (STP): GP Programme Update (Paper E)** Mr Sacks presented this report, which provided an update on the Work Programme for the STP General Practice Programme Board (GPPB) that included the following supporting documents: - the minutes of the STP GP resilience Programme Board at appendix A; - GP Programme Board tracker at appendix B; - LLR STP: GP Forward View GP – GP Programme Board Review at appendix C. Mr Sacks reminded the Committee that the aim of the programme is to deliver the GP Five Year Forward View Strategy that was published in April 2016. For 2018-19, the following five priority areas have been identified within NHS England for GP Resilience: 1. Workforce 2. Models of Care 3. IM&T and Estates 4. Funding and Contracts 5. Workload / Demand.	

ITEM		LEAD RESPONSIBLE
	In addition, it was noted that progress made against the GPFV has been positive and was presented at appendix C, which will be further supplemented with quantitative data and a financial overview. Dr Glover formally thanked the Primary Care Team within ELR CCG and the Committee for supporting the work undertaken to date, which has proved beneficial within Practices who are working well together across Localities and have built cohesive working relationships, which was positive. Mr Sacks provided a brief overview in relation to the following: • **Clinical pharmacists** - NHS England have approved the CCG's bid to part fund this initiative, which will be developed as part of the future workforce section; • **GP International Recruitment** – 15 clinicians are being trained in Walsall who will be relocating to LLR once training has been completed. In response to Dr Glover's query as to costs associated per GP recruited, Mr Sacks confirmed this equates to around £40k per GP, which forms part of their salary and settlement costs. Mr Wood recalled from a previous PCCC meeting that a target had been identified by NHS England for CCGs to recruit a set number of GP via this scheme. Mr Sacks confirmed that NHS England had set a target of 99 Whole Time Equivalent (WTEs) to be recruited across LLR. It was noted the process to recruit and train international clinicians is lengthy; however, 15 of the 24 applications for ELR CCG have been approved. Dr Varakantam queried which CCG the 15 applications had been assigned to. Mr Sacks confirmed this information had not been provided to date, however, confirmed the decision to locate the clinicians is made by the GP Programme Board. All receiving Practices are required to fully support the clinicians in their development. • **Practice Manager's Academy** – a significant number of Practices involved and NHS England has received positive feedback in relation to the process to date. Dr Purohit declared a conflict of interest in relation to this work undertaken by the Practice Manager's Academy, as his Practice Manager has been involved who agreed this	

ITEM		LEAD RESPONSIBLE
	was helpful and supportive. • **Care Navigation** – a good proportion of training has been cascaded to Practices which has proved to be valuable and supportive. • **Online consultations** – funding has been provided from NHE England for which online consultations can be provided in varying forms at Practice level, which has also proved beneficial as this freed up clinical capacity. It was **RESOLVED** to: • **RECEIVE** the report and **NOTE** the progress to date.	
PC/18/140	**Uppingham Surgery: Ketton Closure Update (Paper F)** Mr Barrett presented this report, which provided an update following the approval by the Committee to close their branch surgery in Ketton. The Committee were reminded that following its support with the Practice's application to close the Ketton branch surgery, the Primary Care Team have been working closely with the Practice on an Exit Plan (at appendix 1) to ensure a smooth transition with minimal disruption to patient services. It was noted that the CCG has also sought assurances on mitigating actions identified post-consultation, which included: • Transport (including public transport) • Parking • Other branch surgery may be at risk • Distance to Uppingham Surgery • Growing population of Ketton • Home visits • Dispensing services • Impact monitoring on the 9 protected characteristics of the Equality Act 2010. Mr Barrett informed the Committee that the Uppingham Surgery's application to close their Ketton branch was submitted to NHS England and a contract variation signed by all parties; the branch surgery was closed on Friday 16 November 2018. It was noted that the Exit Plan has been completed, and the one 'amber' section relating to the change of address has been notified to the Care Quality Commission (CQC), which will be reviewed in January 2019.	

ITEM		LEAD RESPONSIBLE
	Mr Sacks declared a conflict of interest with this agenda item as a resident within Uppingham. It was agreed for Mr Sacks to remain part of the discussion. Mr Sacks confirmed concerns were previously raised in relation to the proposed closure, which has deteriorated significantly since approval and the process implemented thereafter. Mr Wood thanked Mr Barrett for the update and the Primary Care Team who fully supported the Practice with their proposal in line with the process required by NHS England, which was undertaken in a very professional manner and to a great level of detail. It was agreed for **Mr Barrett / Mrs Gaj to provide a light touch progress update to the Committee regarding the Uppingham Surgery in due course as part of the assurance process.** Mr Sacks agreed with comments made by Mr Wood and confirmed a meeting has also been held with the Practice in order to gain feedback and learning, which will be taken into consideration. In response to Mr Smith's query whether the CCG could write to NHS England in relation to the lengthy process for one area of primary care, which can be very difficult if all areas were to be completed at this scale, Mr Sacks confirmed the CCG followed due process, which ensured a reduction in legal challenge to the CCG. It was **RESOLVED** to: • **RECEIVE** the report and **NOTE** the progress to date.	**Jamie Barrett / Seema Gaj**
PC/18/143	**Any other business** There was no other business to discuss.	
PC/18/144	**Date of next meeting** The date of the next Primary Care Commissioning Committee meeting will be held on **Tuesday 5 February 2019 at 9:30am – 12:30pm, Room 173, County Hall, Glenfield, Leicester, LE3 8TB.** Mr Wood thanked all members of the Committee for their hard work during the year; and wished them all a happy Christmas and a happy new year.	

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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 5 March 2019	Status
PC/18/142	December 2018	**Boundary Change Principles – Guidelines update**	Jamie Barrett / Clive Wood	Mr Wood to formally write to LC CCG raising concerns in relation to the proposed amendments required to the current Boundary Changes Principles.	December 2018	Letter from Mr Wood, Chair of the PCCC sent to LC CCG in December 2019; LLR CCGs Heads of Primary Care to review and resolve the issues identified. **Action complete.**	**GREEN**
PC/18/86	December 2018	**Uppingham Surgery: Ketton Closure Update**	Jamie Barrett / Seema Gaj	To provide a light touch progress update to the Committee regarding the Uppingham Surgery in due course as part of the assurance process.	June 2019	Work in progress; **action ongoing.**	**AMBER**

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

Front Sheet

REPORT TITLE:	**Primary Care Finance Report 2018/19 (Month 10, January 2019)**
MEETING DATE:	**5 March 2019**
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 2018/19 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) 2018 – 2019: (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 2018/19 (Month 10, January 2019)

5 March 2019

1. Month 10 Year to Date and Forecast Outturn Position

The 2018/19 annual budget for Primary Care services totals £95.6m. At month 10 a year to date overspend of £3.3m and an outturn overspend of £4.2m is being forecast.

In summary the main variances include; £1.9m prescribing overspend for the NCSO and Category M drug pressures, £301k underspend against community based services, £1.2m co-commissioning overspend where year on year expenditure increases exceed the CCG's funding allocation, £0.2m prior year expenditure relating to LLR urgent care centre activity recharges, £1.7m under delivery of primary care QIPP and a net £0.5m underspend against GPIT and other primary care commissioning budgets.

In comparison to month 9 there is a £32k improvement in the primary care position. Movements across services are summarised in the table below:

Area	**Month 9 Forecast Outturn Variance £'000**	**Month 10 Forecast Outturn Variance £'000**	**Movement in Position £'000**	**Explanation of key movements**
Prescribing	1,768	1,941	173	Continued increasing costs of NCSO and reduction in delivery of OTC / LCV QIPP
Community Based Services	-84	-301	-217	Reduced activity, in particular INR anticoagulation and minor injury
Co-Commissioning	1,129	1,180	51	Increased costs of locum expenditure for GP sickness & maternity / paternity
GP Support Framework	-32	-32	0	
Other Primary Care	1,409	1,368	-41	Increased costs of Acute Access offset by slippage in the procurement of on-line consultation.
Total	**4,188**	**4,156**	**-32**	

Appendices 1 and 2 provide further analysis of all service areas.

2. Delegated Co-Commissioning

As previously reported to the Committee, there is a significant cost pressure against this budget area as costs will exceed the funding allocation.

Nationally, the outcome of GMS contract negotiations has resulted in a 3.4% cost increase in 2018/19. Locally however, as the CCG is deemed to be over funded, the co-commissioning allocation has only increased by 2.4% (£1.0m). Increases in Global Sum payments to practices were estimated to cost £1.1m leaving a £919k shortfall of funding for other inflationary and demographic cost pressures.

The financial position for co-commissioning has worsened this month and a £1.18m overspend is now being reported. This is an adverse movement of £51k and is due to the continually increasing cost of locum cover.

Cost pressures totalling £1.806m against this budget include:

- £336k - GPFV. Out of the co-commissioning allocation, CCGs were required to set this funding aside for indemnity insurance. This has since been reallocated to fund GPFV commitments including GP Receptionist Training, On Line consultation and an element of Extended Access Funding.

- £50k - CQC registration fees where costs have increased by (33%) following a change in the methodology by which practice charges are calculated.

- £57k - Doctor's retention scheme where costs are exceeding the £20k included in the co-commissioning allocation.

- £400k – Global Sum payments

- £376k – Recurrent pressure from 2017/18 due to increases in costs not being met by allocation.

- £383k - cost pressure relating to premises costs where rent reviews have resulted in a number of practices receiving increased payments, and a significant amount of prior year expenditure claimed by practices going back a number of years, in particular clinical waste and water rates.

- £142k – increased costs of locum expenditure where employed by practices to cover maternity / paternity leave and sickness.

- £36k – prescribing fees

- £26k - other minor overspends

Overspends are partially offset by:

- £(135k) underspend against seniority payments as it had been identified that one practice in 2017/18 had been overpaid. This has been rectified in 2018/19.

- £(491k) underspend against PMS Reinvestment. This is as a result of how Acute Access expenditure is recorded in the financial ledger (we have to show this spend on a separate code), but the PMS Reinvestment funds have been used to support Acute Access payments. This is therefore not funding available to carry forward into 2019/20.

3. GP Prescribing

A £1.941m forecast outturn overspend is being reported within the prescribing area based on PPA data received for months 1 to 8.

The main reasons for the overspend position are:

- NCSO drugs continues to be a cost pressure to the budget as the number of drugs being added to the list has not reduced as anticipated. In addition to this, there are a number of NCSO drugs that have reverted back to tariff at a higher price. The total cost to the CCG is forecast to reach £1.5m of which £400k was identified as part of the 2018/19 planning process, resulting in an overspend of £1.1m There doesn't appear to be any reduction in the quantity of drugs being added to the NCSO list and there is a risk that this cost pressure will to continue to rise for the remainder of the financial year.

- From August 2018 the prices of Category M drugs increased which has resulted in additional costs to the CCG of £0.7m. In addition to this, prices have dropped in November 2018, which is estimated to reduce prescribing costs by £0.3m. Guidance from NHSE recommends that CCGs treat this latest reduction as a non-recurrent benefit in 2018/19 only. The reported net cost pressure relating to Category M drug price changes this financial year therefore is £0.4m.

- In 2017/18, the outturn positon included a challenge of £525k to NHSE for recharging influenza vaccines to address inconsistencies in practice across the region which left LLR CCGs with a cost pressure. This challenge has been unsuccessful and has resulted in a prior year cost pressure. In addition to this there is also a £300k QIPP target for 2018/19 of which only £125k will be delivered. The impact of these two issues is a further cost pressure of £700k.

- Other demand growth being less than anticipated and QIPP over delivery -£259k

Based on the current information available, the £3m GP prescribing QIPP target is forecast to deliver in full although there is a high level of risk associated with this assumption.

4. Community Based Services

Community based services expenditure in 2018/19 is forecast to underspend by £301k. This is mainly as a result of the continued reduction in INR / Anticoagulation testing as more patients transfer to DOACS and reduced minor injury activity.

5. GP Support Framework

It is forecast that the GP support framework expenditure will underspend by £32k. This is an assumption, based on previous years' schemes, that there will be a certain level of under achievement by practices.

6. Primary Care QIPP stretch

As part of the 2018/19 financial planning process, a £2m QIPP stretch target was allocated to primary care services. Work has taken place to identify a range of options to deliver against this. The majority of the options that are being progressed are linked to contracts and only partial delivery is anticipated in 2018/19 resulting in a £1.7m overspend.

7. GP IT

At month 10 a £61k forecast outturn overspend is being reported. This is a presentational issue linked to a QIPP scheme for the recommissioning of primary care strategic IM&T (previously provided by Arden GEM CSU) and is offset by an underspend in the CCG's Corporate function.

8. Primary Care Licenses & Other

An underspend of £608k is being forecast against other primary care commissioning budgets and is being used to offset pressures elsewhere within the service area. The reasons for this underspend are:

- -£189k – Likely underspending against Acute Access plans (GPFV Extended Access allocation).

- -£251k - An underspend in relation to GP On-Line consultation where procurement delays will mean that the 2017/18 carry forward will not be required in 2018/19. It is the intention to build this continued slippage into the 2019/20 financial plan.

- -£114k – Income received for practice pharmacist schemes where the expenditure will not be incurred until 2019/20. The ongoing commitment (2018/19 underspend) will be reinstated into the 2019/20 financial plan.

- -£39k – Income received from the Home Office for patients who have arrived in the UK under the Government's Syrian Resettlement Programme. Expenditure is incurred elsewhere within the CCG budget lines.

- -£15k – other minor underspends against this budget area.

9. Urgent Care Centres

The urgent care centre budget is forecast to overspend by £218k. £33k of this is as a result of backdated inflationary payments agreed with the service provider and net contract over performance. The remainder is linked to 2017/18 recharges for ELR patients attending West Leicestershire CCG commissioned urgent care centres.

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 and the main risks identified to delivery to date.

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	83	7	91	99	8
Central Prescribing	1,037	1,073	36	1,240	1,284	43
High Cost Drugs	786	770	-17	940	920	-20
Home Oxygen	346	372	26	415	447	32
GP Prescribing	36,396	38,166	1,769	43,521	45,464	1,943
Prescribing Incentive Scheme	552	498	-54	662	597	-65
Total Practice Prescribing	**39,194**	**40,961**	**1,768**	**46,870**	**48,811**	**1,941**
Enhanced Services						
Community Based Services	2,146	1,894	-253	2,576	2,274	-301
Total Enhanced Services	**2,146**	**1,894**	**-253**	**2,576**	**2,274**	**-301**
Co Commissioning	**33,943**	**34,949**	**1,005**	**40,732**	**41,912**	**1,180**
GP Support Framework						
Care Homes	408	408	0	489	489	0
End of Life	276	276	0	331	331	0
Long Term Conditions	579	579	0	695	695	0
Demand Management	276	249	-27	331	299	-32
Dementia	110	110	0	132	132	0
Primary Care Transformation Fund	707	707	0	848	848	0
Total GP Support Framework	**2,355**	**2,328**	**-27**	**2,827**	**2,794**	**-32**
Other						
Primary Care QIPP Stretch	-1,280	-169	1,111	-1,866	-169	1,697
GP IT	767	814	47	920	981	61
Primary Care - Licenses & Other	1,397	779	-618	1,776	1,169	-608
Urgent Care Centres	1,489	1,711	222	1,786	2,004	218
Total Other	**2,372**	**3,134**	**762**	**2,616**	**3,985**	**1,368**
Total Primary Care	**80,011**	**83,266**	**3,255**	**95,620**	**99,776**	**4,156**

Appendix 2

Month 10 Primary Care Co-Commissioning	Year-to-Date Position			Forecast Outturn Position		
	Budget	Actual	Variance	Budget	Forecast	Variance (Under)/ Over
	£000's	£000's	£000's	£000's	£000's	£000's
GMS Global Sum	22,365	22,620	255	26,838	27,166	328
MPIG Correction Factor	913	913	-0	1,096	1,096	0
PMS Reinvestment	0	0	0	0	0	0
FDR Payment	62	0	-62	75	0	-75
Ear Irrigation	69	69	-0	83	82	-1
Wound Clinics	276	274	-2	331	329	-2
Acute Access	345	0	-345	414	0	-414
SLA Pharmacists	552	552	0	662	662	0
Subtotal PMS & FDR Reinvestment	1,303	894	-409	1,564	1,073	-491
Total General Practice - GMS	**24,582**	**24,427**	**-155**	**29,498**	**29,335**	**-164**
Occupational Health	39	37	-1	46	45	-1
Locum Adoption/Paternity/Maternity	89	138	49	107	143	36
Locum Sickness	125	243	118	150	256	106
Locum Suspended Doctors	0	0	-0	0	0	0
Seniority	333	219	-114	400	265	-135
Sterile Products	0	0	0	0	0	0
GP Training	79	79	0	95	95	0
PCO Doctors Ret Scheme	58	69	10	70	81	11
CQC Registration	170	170	0	204	204	0
Narborough HC Dispersal Costs	0	1	1	0	1	1
Total Other GP Services	**894**	**957**	**63**	**1,072**	**1,090**	**18**
QOF Achievement	953	953	-0	1,144	1,144	-0
QOF Aspiration	2,522	2,522	0	3,026	3,026	0
Total QOF	**3,475**	**3,475**	**0**	**4,170**	**4,170**	**0**
DES Extended Hours Access	488	494	5	586	592	6
DES Learning Disability	73	73	0	87	87	0
DES Violent Patients	39	39	0	47	47	0
DES Minor Surgery	425	418	-7	510	501	-9
LES Translation Fees	48	41	-8	58	49	-9
Leicester Asylum Service	17	17	0	20	20	0
Total Enhanced Services	**1,090**	**1,080**	**-10**	**1,307**	**1,296**	**-12**
Dispensing Quality Scheme	77	77	0	92	93	1
Prof Fees Dispensing	1,262	1,266	4	1,514	1,519	5
Prof Fees Prescribing	157	189	31	189	227	38
Prescribing Charge Income	-243	-249	-6	-291	-299	-8
Total Dispensing/Prescribing Drs	**1,253**	**1,283**	**30**	**1,504**	**1,540**	**36**
Premises Actual Rent	1,275	1,614	339	1,530	1,927	397
Premises Health Centre Rent	106	34	-72	128	41	-87
Premises Notional Rent	1,350	1,261	-89	1,620	1,532	-88
Premises Clinical Waste	137	244	107	164	294	130
Premises Health Centre Rates	9	7	-2	10	8	-2
Premises Rates	500	500	0	600	600	0
NHSE / GL Hearn Rates Rebates	0	0	0	0	0	0
Premises Water Rates	26	54	28	31	65	34
Other premises	13	13	0	15	15	0
Total Premises Cost Reimbursement	**3,415**	**3,727**	**311**	**4,098**	**4,481**	**383**
In Year Cost Pressure	-766	0	766	-919	0	919
GRAND TOTAL - Co-Commissioning	**33,943**	**34,949**	**1,005**	**40,732**	**41,912**	**1,180**

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EAST LEICESTERSHIRE AND RUTLAND CLINICAL COMMISSIONING GROUP

PRIMARY CARE COMMISSIONING COMMITTEE MEETING

Front Sheet

REPORT TITLE:	**LLR GP Information Management and Technology (IM&T): Work Programme Update**
MEETING DATE:	**5 March 2019**
REPORT BY:	**Kirsty Tite, IM&T Work Stream Manager for LLR**
SPONSORED BY:	**Tim Sacks, Chief Operating Officer**
PRESENTER:	**Tim Sacks, Chief Operating Officer**

EXECUTIVE SUMMARY:

This paper provides an update on the IM&T Work Programme across LLR which supports the delivery of the Local Digital Roadmap and implementation of GP 5YFV requirements.

RECOMMENDATIONS:

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

- **RECEIVE** the report for information.

REPORT SUPPORTS THE FOLLOWING STRATEGIC AIM(S) 2018 – 2019:			
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

LLR GP Information Management and Technology (IM&T): Work Programme update

5 March 2019

Introduction

1. The aim of the GP IM&T work programme is to deliver the IM&T initiatives which support the GP Five Year Forward View (GP5FV) and the Leicester, Leicestershire and Rutland Local Digital Road Map, overseen by the GP IM&T Steering Group. The Steering Group are also the forum to discuss any emerging initiative or development that will impact on GP IT.

IM&T Work Programme

2. Within the programme there are 7 key initiatives which are being delivered in response to national NHS E GP IT framework mandates, GP5FV or those locally defined_strategic objectives_of the LDR (Record sharing, Supporting pathways, Digital self-care and Business Intelligence (BI) & research).

    a. Online Consultations
    b. GP Clinical System Migration
    c. Electronic Record Sharing
    d. Flagging and notifications
    e. Clinical System Optimisation
    f. Patient WIFI
    g. Self-care and mobile apps

3. Progress updates and current position are given for each project on the IM&T tracker (appendix b) and key points for information covered in the items for escalation to PCCC section of this paper.

Items for information from the LLR GP IM&T Steering Group 14th February 2019

Work Stream Update

4. **eConsultations.** Approval to award the contract for Online Consultations is yet to be agreed by WL and LC PCCC. Discussions will take place at the March PCCC's. NHSE are concerned with the lack of movement around eConsultations across the DCO and have flagged this as a high risk. CCG's may be required to explain non movement.

5. **System Migration.** 2 practices in ELR have committed to migrate and a further 3 have expressed interest. 2 practices within WL have also expressed interest in migrating system. It is unlikely that 18/19 funding can be carried

forward. ELR and WL CCG's have submitted bids for 19/20 funding for four practices each.

6. **Electronic Record Sharing.** The Summary Care Record into Adult Social Care in LLR is progressing. Local Authorities met recently to finalise the protocols and have begun training for staff involved in the Proof of Concept. Numbers for the RA elements and users are being finalised.

Estates and Technology Fund (ETTF)

7. **NHS NOW App**. An event was held on the 30th January 2019 consisting of two workshops with the morning session being attended by PPG representatives and the afternoon session by healthcare professionals and external partners. Feedback from these sessions will be incorporated into the development.

8. **Mobile Working.** Funding for the Mobile Working programme has been received. The laptops have been purchased and will be distributed as part of the rolling replacement programme across LLR.

9. **Electronic Record Sharing.** The Alliance SystmOne unit has now gone live and practices notified to add this to their white list to enable sharing.

10. **Skype**. NHSE have approved the LLR bid for Skype implementation in General Practice. Work is now underway to move this forward.

Primary Care Enabling Service (PCES) Update

11. Contracts need to be in place by 1 April 2019 for delivering email, Registration Authority (RA), Information Governance (IG) support for General Practices. A PCES paper was presented at the LLR CCG Joint Management Team (JMT) meeting recently and the members were supportive of the work. Conversations are being held with Midlands and Lancashire Commissioning Support Unit (ML CSU) and HIS for the 2019/20 arrangements.

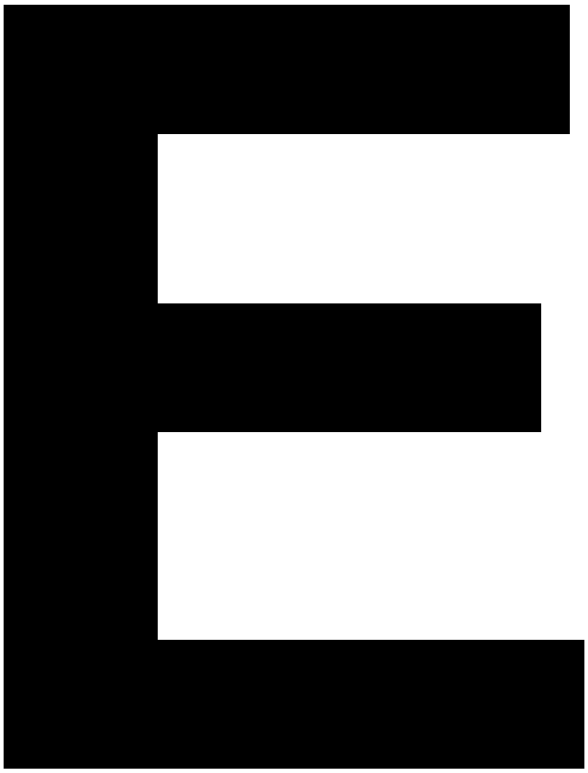
Primary Care Networks (PCN) / 10 Year plan

12. Discussions have commenced regarding the IM&T requirements for PCN development and operation. A draft paper of expected IT needs and solutions is being collated by the LLR IT team. A further iteration of the paper is expected to be shared with PCCCs in April before being shared with PCN Clinical Directors when they are known.

RECOMMENDATIONS

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

- **RECEIVE** the report for information.



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

Front Sheet

REPORT TITLE:	**Investment and evolution: A five-year framework for GP contract reform to implement The NHS Long Term Plan (31 January 2019)**
MEETING DATE:	**5 March 2019**
REPORT BY:	**Seema Gaj, Senior Primary Care Contract Manager**
SPONSORED BY:	**Jamie Barrett, Head of Primary Care**
PRESENTER:	**Jamie Barrett, Head of Primary Care**

EXECUTIVE SUMMARY:

On 31st January 2019, NHS England published the Investment and evolution: A five-year framework for GP contract reform to implement the NHS Long Term Plan. This agreement between NHS England and the BMA General Practitioners Committee (GPC) in England, and supported by Government, translates commitments in The NHS Long Term Plan into a five-year framework for the GP services contract.

The purpose of this report is to provide the Primary Care Commissioning Committee with a summary of this report and key considerations for the CCG.

RECOMMENDATIONS:

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

- **RECEIVE** the report;
- **NOTE** NHS England guidance on the Long Term Plan which outlines key developments of the Primary Care Networks which are to be implemented by July 2019.

REPORT SUPPORTS THE FOLLOWING STRATEGIC AIM(S) 2018 – 2019:			
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 proportionate on the basis that this is a proposal stage.

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 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

Investment and evolution: A five-year framework for GP contract reform to implement The NHS Long Term Plan (31 January 2019)

5 March 2019

Introduction on Long Term Plan January 2019

1. The purpose of this report is to provide the Primary Care Commissioning Committee with a summary of the recently published NHS England Long Term Plan and GP Contract 2019.

2. Under the CCGs delegated responsibility of Primary Care Contract national guidance and implementations are to be considered as part of the co-commissioning agenda. This paper provides the CCG with guidelines on what changes are to be expected for the next five years.

3. Health Care providers came together to develop the Long Term Plan to make the NHS fit for the future, and to get the most value for patients. The plan has been drawn by frontline health and care staff, patient groups and other experts.

4. This report provides a summary of the key ambitions of the NHS Long Term Plan over the next ten years, the NHS Long Term Plan also sets out how these challenges overcome as staff shortages and growing demand for services, by;

    a. **Doing things differently**: give people more control over their own health and the care they receive, encourage collaboration between GPs, teams and community services, as ‘primary care networks’, increase services they can provide jointly, and increase the focus on ‘Integrated Care Systems’, to plan and deliver services which meet the needs of their communities.

    b. **Preventing illness and tackling health inequalities**: NHS will increase its contribution in tackling ill health such as smoking, drinking problems and avoiding Type 2 diabetes, with a particular focus on the communities and groups of people most affected by these problems.

    c. **Backing our workforce**: increase the NHS workforce by training and recruiting more professionals to make better use of their skills and experience for patients.

    d. **Making better use of data and digital technology**: provide more convenient access to services and health information for patients, with the new NHS App as a digital ‘front door’, better access to digital tools and patient records for staff, and improvements to the planning and delivery of services based on the analysis of patient and population data.

e. **Getting the most out of taxpayers' investment in the NHS**: identify ways to reduce duplication in how clinical services are delivered, make better use of the NHS' combined buying power to get commonly-used products for cheaper, and reduce spend on administration.

A five-year framework for GP contract reform to implement The NHS Long Term Plan (31 January 2019)

5. At the end of January 2019, NHS England published a five-year framework for GP services agreed with the British Medical Association (BMA) General Practitioners Committee (GPC) in England and supported by Government. It implements commitments in the NHS Long Term Plan for changes to the GP contract and sets the direction for primary care for the next five years and summarised as follows;

- Core general practice funding will increase by £978 million per year by 2023/24;
- Primary Care Network (PCN) contract will be introduced from 1st July 2019.
- By 2023/24, the PCN contract is expected to invest £1.799 billion, or £1.47 million per typical network covering 50,000 people.
- All patients will have the right to digital-first primary care, including web and video consultations by 2021; and
- All practices will be offering electronic re-ordering of repeat prescriptions from April 2019 and patients will have digital access to their full medical records from 2020.

6. **The Seeks to address workload issues resulting from workforce shortfall**. Through a new Additional Roles Reimbursement Scheme, Primary Care Networks (PCNs) will be guaranteed funding for an up to estimated 20,000+ additional staff by 2023/24. The scheme will meet a recurrent 70% of the costs of additional clinical pharmacists, physician associates, first contact physiotherapists, and first contact community paramedics; and 100% of the costs of additional social prescribing link workers. By 2023/24, the reimbursement available to networks amounts to £891 million of new annual investment.

7. **Brings a permanent solution to indemnity costs and coverage**. The new and centrally-funded Clinical Negligence Scheme for General Practice will start from April 2019. All of general practice will be covered, including out-of-hours and all staff groups.

8. **Improves the Quality and Outcomes Framework (QOF).** 28 indicators are being retired from April 2019. 74 points created for the Quality Improvement domain, for 2019/20 these are prescribing safety and end-of-life care. 101 points will be used for 15 more indicators, mainly on diabetes, blood pressure control and cervical screening. The current system of exception reporting will be replaced by the more precise approach of the Personalised Care Adjustment.

9. **Introduces automatic entitlement to a new Primary Care Network Contract**. In The NHS Long Term Plan, Primary Care Networks are an essential building

block of every Integrated Care System, and under the Network Contract Directed Enhanced Service (DES), general practice takes the leading role in every PCN. If every network takes up 100% of the national Network Entitlements we intend, including a recurrent £1.50/patient support, plus a new contribution to clinical leadership, £1.799 billion would flow nationally through the Network Contract DES by 2023/24. NHSE expect 100% geographical coverage of the Network Contract DES by July 2019. Each network must have a named accountable Clinical Director and a Network Agreement setting out the collaboration between its members. A new Primary Care Network development programme will be centrally funded and delivered through Integrated Care Systems.

10. **Helps join-up urgent care services.** The NHS Long Term Plan envisages Primary Care Networks joining up the delivery of urgent care in the community. Funding and responsibility for providing the current CCG-commissioned enhanced access services transfers to the Network Contract DES by April 2021 latest. From July 2019, the Extended Hours DES requirements are introduced across every network, until March 2021.

11. **Enables practices and patients to benefit from digital technologies**. NHS England will continue to ensure and fund IT infrastructure. Additional national funding will also give Primary Care Networks access to digital-first support from April 2021

12. **Delivers new services to achieve NHS Long Term Plan commitments**. Seven Long Term Plan specifications will be developed with GPC England, April 2020 include structured medication reviews, enhanced health in care homes, anticipatory care (with community services), personalised care and supporting early cancer diagnosis. April 2021 include cardio-vascular disease case-finding and locally agreed action to tackle inequalities.

13. **Gives five-year funding clarity and certainty for practices**. Resources for primary medical and community services increase by over £4.5 billion by 2023/24, and rise as a share of the overall NHS budget.

14. **Tests future contract changes prior to introduction**. A new testbed programme will be established to provide real-world assessment. Testing is likely to include rapid cycle evaluation, with assessment of costs and benefits. Each cluster will be commissioned nationally, topic by topic, normally through open calls for practice or network participation. Network participation in research will also be encouraged from 2020/21, given the proven link to better quality care.

Next Steps

15. The Primary Care Teams across LLR will consider these future plans and attend National and Local events which provide strategy and guidance for implementations.

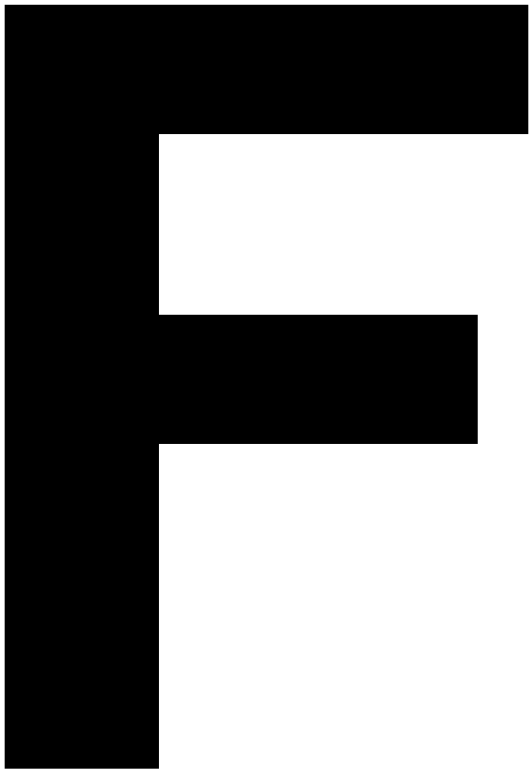
16. Primary Care Networks are to be implemented by July 2019 and the CCG will work with GP practices to facilitate the process.

17. For ELRCCG this will be described in part through our investment scheme for next year which will require Governing Body approval.

Recommendations

The ELR CCG Primary Care Commissioning is asked to:

- **RECEIVE** the report;
- **NOTE** NHS England guidance on the Long Term Plan which outlines key developments of the Primary Care Networks which are to be implemented by July 2019.



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

Front Sheet

REPORT TITLE:	**Development of Primary Care Networks (PCNs) in Leicester, Leicestershire and Rutland (LLR)**
MEETING DATE:	**5 March 2019**
REPORT BY:	**Tim Sacks, Chief Operating Officer**
SPONSORED BY:	**Tim Sacks, Chief Operating Officer**
PRESENTER:	**Tim Sacks, Chief Operating Officer**

EXECUTIVE SUMMARY:

The development of Primary Care Networks (PCNs) is a pre-requisite of the new General Practice 5 year contract. These need to cover the entire population of LLR and are broadly in the region of 30,000 - 50,000 patients. The deadline for practices to agree their structures and clinical leads is 15 May 2019.

PCNs will form the neighbourhood structure of the LLR ICS and as such it is crucial that they have a robust infrastructure.

The aim of this paper is to set out the development of PCNs and for the three CCGs to agree a set of principles so that the PCN structures are aligned enough in geography and infrastructure to meet the NHSE rules and enable the ICs to develop with a robust delivery model.

RECOMMENDATIONS:

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

- **APPROVE** the approach to developing PCNs in LLR.

REPORT SUPPORTS THE FOLLOWING STRATEGIC AIM(S) 2018 – 2019:			
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

Development of Primary Care Networks in LLR

5 March 2019

Background

1. The development of Primary care at scale is not a new concept within the NHS nationally or locally within LLR. The idea of primary care networks in one form or another has been reshaped over several decades. There is a clear provenance dating back to fund holding, total purchasing pilots and practice based commissioning, with a resurgence evident within the NHS five year plan The most recent national direction dates back to the Primary Care Home concept, which was launched by the National Association of Primary Care in 2016 whereby, localities / groups of practices have been working to develop further "right size" primary care networks for their populations, bringing in the key themes of integration of services, population health management.

2. In late 2016 the GP Five Year Forward view was launched, which strongly advocated scale working and new models of care, but it wasn't until late 2017 that the concept of Primary Care Networks was formally launched.

3. The concept was that CCGs around the country should encourage all GP practices to become part of a local Primary Care Network (PCN), based around a GP registered list of approximately 30,000 – 50,000 patients, encompassing general practice and other partners in community and social care. These networks offer care on a scale which is small enough for patients to get the continuous and personalised care they value, but large enough – in their partnership with others in the local health and care system – to be resilient.

4. The direction signalled within the GP5YFV in 2016 and the expectation that CCGs put forward £3 per patient across 2017-2019 for transformation of General Practice led to PCN development becoming NHSE policy, with all practices expected to be informally within a PCN by October 2018.

5. This policy direction, compared to the new care models set out in the Five Year Forward View of multispecialty community providers and primary and acute care systems is more focused on informal networks developed through more organic growth. This suggests that major contracting changes for general practice are unlikely, but there needs to be a pathway for governance and financial apparatus to develop around networks. The next stages of PCN development were outlined within the NHS Long Term plan, published by NHSE in January 2019.

6. In early February 2019 a detailed 5 year contract for General Practice was published with clear drive to design and deliver future healthcare through PCNs by driving practices to work together with community, social care and voluntary sector. The contract includes new funding for Core contracts, integration of

urgent care services and £1bn for new clinical staff. The deadline is that all practices are signed up to a formal PCN by 15 May 2019.

PCNs within an Integrated Care system

7. The NHS England view is that Primary Care at scale has a significant role to play within an Integrated Care System with local delivery being at neighbourhood level, built around primary care networks; places, integrating care between local hospitals and local authorities; and systems, which undertake strategic planning, allocate resources, and deliver some specialised services.

   Primary care will be expected to play a crucial role at all of these levels:

   - Primary care networks will deliver integrated services to people in neighbourhoods, as the foundation of an effective health system;

   - In places, primary care will interact with hospitals and local authorities, working together to meet the population's needs (In some systems, federations could operate at the place level to support primary care networks);

   - At the system level, primary care as a provider will increasingly participate in system decision making. Networks create an opportunity for primary care to have a greater voice in both the design and delivery of 'place' based care with hospitals and local authorities, than may have been feasible historically in arrangement of individual separate practices.

The Function of a PCN

8. NHSE have signalled their intentions for transformation of "Out of Hospital Care" with a commitment to increase funding in real terms of £4.5bn into primary medical and community health services by 2023/24.

9. The direction is that Primary care networks support groups of practices to come together locally, in partnership with community services, social care and other providers of health and care services, delivering greater provision of proactive, personalised, coordinated and more integrated health and social care.

10. According to the NHSE Draft guidance on PCNs, these Primary care networks covering geographically contiguous populations should build on the core values and strengths of general practice. They involve staff from practices and other local health and social care providers working in close partnership, as one team. The aim should not be to reorganise for the sake of it, but to design and implement ways of providing services collectively, that meets the health and care needs of their local population.

11. Most care will continue to be based around the general practice unit holding primary responsibility for a registered patient's needs. Additional services that are too big to be in every practice but which don't need to be delivered from a hospital should be delivered at the network level, allowing networks of practices to have a stronger prevention and population focus. Networks of practices can

also have a greater voice in service redesign that reaches beyond traditional general practice, and ability to share a larger pool of resources for their local communities.

12. Collaboration and integration should be the core characteristic of a network, with a number of ways people can access services, tailored to different population groups. This should include more effective ways of using technology and supported self-care models, and be firmly rooted in multi-professional, multi-service delivery with general practice acting as the primary care management centre ensuring that patients receive the right care from the right professional at the right time using the right channel (or channels) for their particular issue (online, by phone or in person).

13. The core characteristics of a Primary care network are:

- Practices working together and with other local health and care providers, around natural local communities that make sense geographically, to provide coordinated care through integrated teams;

- Providing care in different ways to match different people's needs, including flexible access to advice and support for 'healthier' sections of the population, and joined up multidisciplinary care for those with more complex conditions;

- Focus on prevention, patient choice, and self-care, supporting patients to make choices about their care and look after their own health, by connecting them with the full range of statutory and voluntary services;

- Use of data and technology to assess population health needs and health inequalities, to inform, design and deliver practice and population scale care models; support clinical decision making, and monitor performance and variation to inform continuous service improvement;

- Making best use of collective resources across practices and other local health and care providers to allow greater resilience, more sustainable workload and access to a larger range of professional groups.

National Direction for PCN Development

14. The ten year plan set out a number of steps towards the formation of PCNs, which shows the direction for design and development. Further guidance is expected from NHSE in the coming months, but these directives point towards General Practice at the centre of population health management, with PCN level contracts for more than just General Practice services, with accountability for delivery and a vested interest in their financial benefits

    These are specifically:

- **NETWORK CONTRACTS**

Individual practices in a local area will enter into a network contract, as an extension of their current contract. This will require a designated single fund through which all network resources flow. CCGs will use this arrangement for local contracts CBS etc. (Not Core).

- **NEIGHBOURHOOD TEAMS**
  Expanded neighbourhood teams will comprise a range of staff such as GPs, pharmacists, district nurses, community geriatricians, dementia workers and AHPs such as physiotherapists and podiatrists/chiropodists, joined by social care and the voluntary sector. In many parts of the country, functions such as district nursing are already configured on network footprints and this will now become the required norm.

- **CLINICAL LEADERSHIP**
  A named accountable Clinical Director of each primary care network.

- **SHARED SAVINGS PCN**
  'Shared savings' scheme so that they can benefit from actions to reduce avoidable A&E attendances, admissions and delayed discharge, streamlining patient pathways to reduce avoidable outpatient visits and over-medication through pharmacist review.

- **POPULATION HEALTH MANAGEMENT**
  Primary care networks will from 2020/21 assess their local population by risk of unwarranted health outcomes and, working with local community services, make support available to people where it is most needed. Using a proactive population health approach, people identified as having the greatest risks and needs will be offered targeted support for both their physical and mental health needs.

- **Quality and Outcomes Framework (QOF)**
  To support this new way of working, there will be significant changes to the GP QOF, which will include a new Quality Improvement (QI) element. The revised QOF will also support more personalised care.

15. These are key enablers to focus the design of the PCN structures. The 10 year plan also sets out a clear set of clinical priorities that PCNs will be expected to be at the forefront of delivery. The CCGs in LLR will need to consider how to align incentives and funding to enable primary care networks to be able to deliver improvements in the following:

- Care homes
- Carers
- Social Prescribing
- End Of life care
- Diabetes
- CVD
- COPD

This list forms only a fraction of the clinical areas that will require the CCGs to redesign and realign around the PCNs

Next steps for PCN Development in LLR

16. There has been significant progress across LLR in developing informal and formal networks across General Practice. This has come in the form of Federations, Localities and Health Needs Neighbourhoods. Any further development of PCNs is therefore based on a solid foundation. In October 2018 NHSE asked all CCGs to undertake a state of readiness / PCN maturity assessment. This was based on very loose guidance, but provided an opportunity to provide a baseline. The outcome of this exercise illustrated that each CCG has approached this differently and although all meet the basic standards, there is work to do to develop and deliver this. The most recent guidance from the 10 year plan shows that there will need to be significant development jointly across LLR to ensure that there is a consistency of PCN structures.

17. Since the new contract guidance was published on the 31 January 2019 there has been greater clarity on the development and design of PCNs. The view across LLR is that there needs to be significant engagement with practices across the 3 CCGs and develop a clear set of guidance and support offer so that the PCNs within LLR are built using a system wide set of rules that delivers against the NHSE guidance. This will support the PCNs to be strong organisations from which to commission services as the Neighbourhood of the LLR ICS.

18. The timescales for this are that by 15 May 2019 all PCNs are formed and agreed locally to be signed off by the CCGs and LLR. This is detailed in the table below:

Date	Action
Jan-Apr 2019	PCNs prepare to meet the Network Contract DES registration requirements
By 29 Mar 2019	NHS England and GPC England jointly issue the Network Agreement and 2019/20 Network Contract DES
By 15 May 2019	**All Primary Care Networks submit registration information to their CCG**
By 31 May 2019	**CCGs confirm network coverage and approve variation to GMS, PMS and APMS contracts**
Early Jun	NHS England and GPC England jointly work with CCGs and LMCs to resolve any issues
1 Jul 2019	**Network Contract DES goes live across 100% of the country**
Jul 2019-Mar 2020	National entitlements under the 2019/20 Network Contract start: • year 1 of the additional workforce reimbursement scheme • ongoing support funding for the Clinical Director • ongoing £1.50/head from CCG allocations
Apr 2020 onwards	National Network Services start under the 2020/21 Network Contract DES

19. To achieve this there has been engagement with the LMC executive, the Clinical chairs of the CCG and the joint CCG Executive Management team, as well as member practice locality meetings and listening events. The aim is to agree a common set of principles and support to develop and deliver PCNs.

20. These five principles for forming PCNs are set out in **Appendix 1** with suggested direction and actions that will need to be taken. The PCCCs of all three CCGs are asked to consider each principle and approve them to set the direction for the development of PCNs in LLR. The PCCCs need to be cognoscente that this is a direction of travel based on the most up to date guidance, but there is expected to be updated information from NHSE in the coming weeks and months that may supersede this.

Conclusion

21. This paper has set out the background, direction of travel and some key objectives and decisions that will need to be made to establish PCNs across LLR as the delivery model for the ICS.

22. A working group will be set up as a sub group of the Primary Care Board building on existing STP and CCG governance structures to drive forward the PCNs to deliver this national and local strategy.

Recommendation:

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

- **APPROVE** the Approach to developing PCNs in LLR.

Appendix 1: Primary Care Networks- Potential Options and Action to deliver a Framework by 15 May 2019

Key Areas for Decision	Risks / Questions	Proposed Direction (based on views of JMT/ CCG Chairs and LMC)	ACTIONS
1. PCN Structures- Practice alignment By 15 May 2019, each PCN will need to have completed a registration form detailed the names and ODS codes of its member practices. A decision needs to be made by each practice (supported by its CCG) of the PCN structure and membership but must fit with: • The PCN guidance (including size and geographical contiguity) • The configuration (present or future) of community / Local Authority services	-Some potential PCNs exceed 50,000 (max in LLR 69k). If Self determined and agreed by practices, will these meet the rules? Risks that practices could wish to move away from traditional CCG boundaries -Risks that in the short term the LPT teams can't match the new PCN structure -Year 1 funding for New Roles is based on 30k patients then doubles at 100k, creating perversity to be smaller PCN. Reverts to per capita in year 2 onwards. Does this require mitigation?	**- Provide clear guidance on the rules for developing PCN footprint and support practices to make their own decisions** **- Ensure Practices are aware, when agreeing their PCN footprint that the CCG has a responsibility to ensure ALL PCNs meet the national rules prior to final sign off by NHSE in June.** **-Continue engagement with practise through locality meetings and PLTs. Hold a joint LLR development session for practices in late April 2019 to support transition**	**-Provide PCN guidance document to LLR practices** **-Need clarity from all PCNs of structure by 1st April to enable support and negotiation if rules not met to achieve 15th May deadline** **-Work closely with Providers, especially LPT and Local Authorities to support mapping of service for 2019/20 onwards** **-Clarify with NHSE whether the PCN boundaries can change in the future**
2. Nominated Practice OR Provider By15 May 2019, PCNs are asked to define the nominated practice or provider which will receive the funding on behalf of the PCN. The CCG will have no direct influence over this decision, which each PCN determine. It is expected that this designated organisation will become the host employer for the New clinical Roles. **Options** 1. A practice within a PCN 2. Another locality-based organisation e.g. Federation, PCL or another provider 3. The formation of a PCN Community Interest Company (CIC)	-Employing organisation needs to be CQC registered and have the governance structures in place -Although the decision on employment of the New roles through the DES are exclusively for individual PCNs to agree, if CCG commissions community nursing / therapies etc at PCN footprint the micro scale could create fragmentation and workforce issues. -Risk that practices do not have an adequately mature relationship within a PCN to designate one practice within such short timescales.	**-Enable practices to self-determine whether they wish to have a Lead Practice / Federation or Community Interest Company as the lead provider for holding finance and employment for their PCN if these meet the PCN rules.**	**-Develop guidance on Community Interest Companies to support practices to be able to consider every option for formal joint working** **-Support Practices with Legal advice and/or draft MOU documents for practices, if using the lead Practice model of PCNs (rather than CIC or Federation) for finance and staff employment**
3. Accountable Clinical Director (ACD) By 15 May 2019, PCNs are asked to agree and appoint an ACD. Funding for the ACD is provided at £0.69p/pt. This is proportional to network list size. For a 50,000 PCN, this is a full year funding of £34,500. This equates to approximately one working day per week for a Partner GP. The formal process for appointment is yet to be published by NHSE.	-Without clear guidance on roles and responsibilities, potential ACDs may be difficult to appoint. -Risk of conflicts of interest if the ACD is a board or federation GP lead -CCGs need to give guidance ASAP, but cognoscente that the national guidance may be very prescriptive	**-19/20 should be seen as a transition year, with short timescales and lack of NHSE process. This will require a flexible approach, which could include temporary appointments or secondments.** **-The ACD will be the lead for a provider organisation; therefore to reduce conflicts of interest the CCG employed GP board members may not be able to hold the role of ACD and GP Board member.** **-It is a PCN decision who they appoint as ACD, as long as a recognised and fair process has been followed to elect / appoint the individual.**	**-Work with HR teams to develop;** **1) ACD Competency framework** **2)Clear appointment process that practices within PCNs can adopt to support decision making** **3)Develop and maximise Local OD and Leadership opportunities to support the ACD development** **-Plan through 2019/20 the impact of the PCNs and CCG changes on the role of the Elected GP Board member and the extent that this impacts on CCG organisational structure**

Key Areas for Decision	Risks / Questions	Proposed Direction (based on views of JMT / CCG Chairs and LMC)	ACTIONS
4. Network Financial Entitlement PCNs will be guaranteed a cash payment of £1.50 per registered patient as a contribution towards network effectiveness. This is funded by general CCG allocations (not primary care allocations) . There is no definition of network effectiveness, but CCGs should consider the developmental needs of their PCNs. If PCN network funding and its use is for PCNs to decide individually. CCGs should consider how they advise PCNs to direct this funding in the most positively impactful way for patients, aligned to the PCN vision of the CCG.	- Clarity needed on rules as BMA guidance states that this funding is for general administration of PCNs and is up to each PCN to decide. This is not specifically stated in the NHSE guidance	-**Award funding to PCNs, but with clear stipulations to develop network effectiveness which will enable each PCN to be a functioning "neighbourhood" from which CCGs can commission services** **-Real need for strong, robust structures and guidance will need to be provided on what framework will enable future commissioning from PCNs.**	**-Define what it is to be an effective PCN / Neighbourhood to support the development of strong structures** **-Develop clear outcomes framework and potential commissioning levers that could be used e.g. CBS/ Community nursing etc**
5. CCG Support in Kind In a reciprocal style agreement with PCNs, CCGs should consider the developmental needs of their localities/PCNs and put this in context of a defined CCG "support in kind" for PCN development. This support could be a description of the support currently offered or take a transformation approach dependant on the skill set and capacity within the CCG team. In the context of this decision, CCGs should consider the current and future role of the CCG primary care team and how these roles do and could crossover with the earlier PCN functions funded via the PCN network financial entitlement.	- Need to understand the following if primary care and medicines staff are given as support in kind; • Can the CCGs sustain services if staff in PCNs • What are the HR implications • Would staff moving support the running cost allocation reduction (become programme costs)	**-No direct seconding of staff in 2019/20 to PCNs, but support with BI, data, enhanced / more aligned support from CCG staff** **-**	**-Define and deliver clear offer of support to all PCNs** **-CCGs to build an offer in 2019/20 to work through how restructuring could support the development and longevity of PCNs** **-This work will be supported by the commissioning capabilities framework**