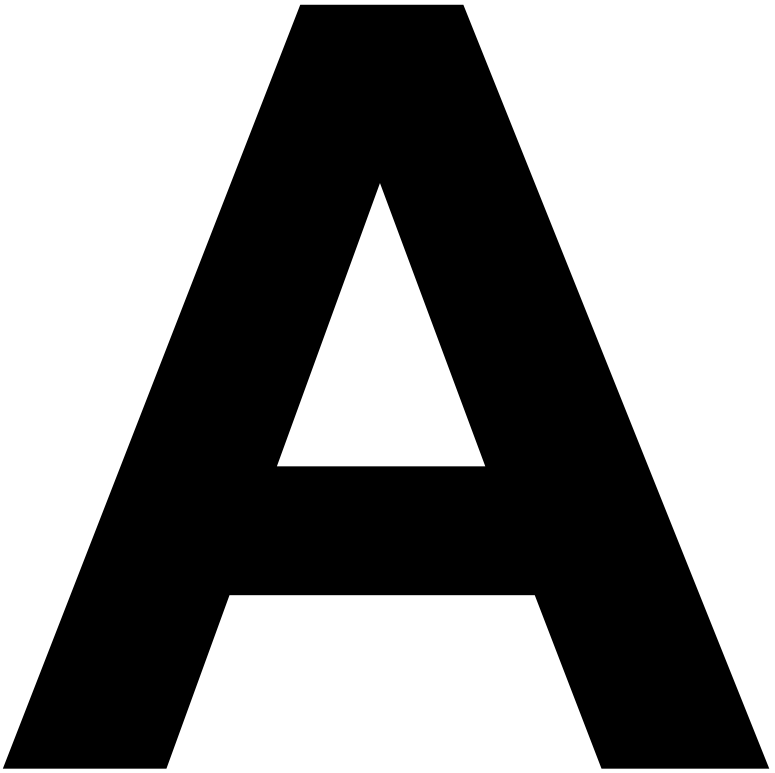
Leicester City Clinical Commissioning Group
West Leicestershire Clinical Commissioning Group
East Leicestershire and Rutland Clinical Commissioning Group

Meeting Title	**Primary Care Commissioning Committees meetings (meetings in common) – held in Public**	**Date**	**Tuesday 6 July 2021**
Meeting no.	**8.**	**Time**	**9.30 am – 10.30am**
Chair	**Ms Gillian Adams** Independent Lay Member (WL CCG)	**Venue / Location**	**Via MS Teams**

REF	AGENDA ITEM	ACTION	PRESENTER	PAPER	TIMING
PCCCs/21/47	Welcome and Introductions		Gillian Adams		9.30am
PCCCs/21/48	Apologies for Absence: **LLR CCGs:** • Caroline Trevithick **East Leicestershire and Rutland CCG:** • Dr Nick Glover **West Leicestershire CCG:** • **Leicester City CCG:** • Dr Gopi Boora	To receive	Gillian Adams	**verbal**	9.30am
PCCCs/21/49	Notification of Any Other Business	To receive	Gillian Adams	**verbal**	9.30am
PCCCs/21/50	Declarations of Interest on Agenda Topics	To receive	Gillian Adams	**verbal**	9.30am
PCCCs/21/51	To receive questions from the Public in relation to items on the agenda only	To receive	Gillian Adams	**verbal**	9.35am
PCCCs/21/52	Minutes of the meetings held in common on 1 June 2021	To approve	Gillian Adams	**A**	9.40am
PCCCs/21/53	Matters arising and actions for the meetings held on 1 June 2021	To receive	Gillian Adams	**B**	9.45am
ITEMS FOR DECISION, ACTION AND ESCALATION					
PCCCs/21/54	Primary Care Networks Configuration Process	To approve	Jamie Barrett	**C**	9.50am
PCCCs/21/55	LLR CCGs Practice List Dispersal - Discretionary Payment Policy (LLR CORPORATE 023)	To approve	Jamie Barrett	**D**	10.00am
PCCCs/21/56	General Practice Quality - High level report	To receive	Wendy Hope	**E**	10.15am
FOR INFORMATION ONLY					
PCCCs/21/57	Items for escalation / information for the Governing Bodies.		Gillian Adams		10.20am
ANY OTHER BUSINESS					
PCCCs/21/58	Items of any other business.	To receive	Gillian Adams	**verbal**	10.25am
The next meeting of the LLR CCGs' Primary Care Commissioning Committee meetings in common will take place on **Tuesday, 3 August 2021, via MSTeams**					



Minutes of the LLR CCGs' Primary Care Commissioning Committees held in common on Tuesday 1 June 2021 at 9.30am
Via MS Teams

Present:

Leicester, Leicestershire and Rutland CCGs

Ms Nicci Briggs	Executive Director of Finance, Contracts and Corporate Governance
Ms Wendy Hope	Head of Quality and Safety (on behalf of Ms Caroline Trevithick)
Ms Sarah Prema	Executive Director of Strategy and Planning
Ms Rachna Vyas	Executive Director of Integration and Transformation

East Leicestershire and Rutland CCG:

Ms Fiona Barber	Deputy Chair and Independent Lay member (Chair for item 21/39)
Mr Clive Wood	Independent Lay Member
Dr Nick Glover	Member Practice Representative
Dr Nikhil Mahatma	Member Practice Representative
Dr Girish Purohit	Member Practice Representative

West Leicestershire CCG:

Ms Gillian Adams	Independent Lay Member (Chair of the meeting)
Dr Geoff Hanlon	Locality Lead North Charnwood
Dr Ash Kothari	Locality Lead

Leicester City CCG:

Mr Nick Carter	Independent Lay Member
Mr Zuffar Haq	Independent Lay Member
Dr Tony Bentley	North and East Health Need Neighbourhood Chair
Professor Azhar Farooqi	Clinical Chair
Dr Avi Prasad	Assistant Clinical Chair

In attendance:

Dr Fahreen Dhanji	Local Medical Committee
Dr Sumit Virmani	Local Medical Committee
Dr Rajiv Wadhwa	Local Medical Committee
Dr Janet Underwood	Healthwatch Rutland (from item 21/39)
Mr Jamie Barrett	Senior Contracts Manager
Ms Laura Norton	Head of Information and Transformation (County and Rutland) (from item 21/39)
Ms Sapna Patel	Contracts Manager
Ms Sarah Shuttlewood	Assistant Director of Contracts, LLR CCGs (from item 21/39)
Ms Sarah Smith	Head of Information and Transformation (City)
Mr Amit Sammi	Head of Strategy and Planning (for item 21/39)
Mr Chris Rowlands	Strategic Estate Consultant (for item 21/39)
Ms Tine Juhlert	International GP Project Manager (for item 21/41)
Mrs Daljit Bains	Head of Corporate Governance
Mrs Clare Mair	Corporate Affairs Officer (Minutes)

Public Gallery
There were no members of the public at the meeting.

ITEM		LEAD RESPONSIBLE
PCCCs/21/32	**Welcome and Introductions** Ms Gilliam Adams welcomed all attendees to the seventh meeting of the Leicester, Leicestershire and Rutland (LLR) Clinical Commissioning Groups' (CCGs) Primary Care Commissioning Committee (PCCC) meetings in common, on behalf of the three PCCC Chairs, reminding members that this meeting was taking place in public and therefore the chat function should not be used and if members wished to make a comment they should use the "raise hand" function.	
PCCCs/21/33	**Apologies for absence:** **LLR CCGs** • Ms Caroline Trevithick, Executive Director of Nursing, Quality and Performance **East Leicestershire and Rutland CCG** • No apologies **Leicester City CCG** • Dr Sulaxni Nainani, South Health Needs Neighbourhood Chair • Dr Raj Than, Left Shift/Integration Lead • Dr Gopi Boora, North and West Health Need Neighbourhood Chair • Mr Jo Johal, Healthwatch, Leicester and Leicestershire **West Leicestershire CCG** • Dr Nil Sanganee, Locality Lead North West Leicestershire • Ms Wendy Kerr, Independent Lay Member The meeting was confirmed to be quorate for East Leicestershire and Rutland Clinical Commissioning Group (ELR CCG) Leicester City CCG (LC CCG) and West Leicestershire CCG (WL CCG).	
PCCCs/21/34	**Notification of Any Other Business** Ms Adams confirmed there were no items of other business.	
PCCCs/21/35	**Declarations of Interest** GP members present declared an interest in items relating to commissioning of primary care where a potential conflict may arise, noting the register of interest contains the current declarations and this is published on the CCGs websites. It was noted that the Local Medical Committee (LMC) representatives may also be conflicted in such matters and as such this will be noted and actioned accordingly.	

Ms Adams noted the following specific declarations:

Paper C – Primary Care Estates Strategy:

- The report is to approve the prioritisation process.
- All GP members, with the exception of Dr Tony Bentley, were directly conflicted in respect of this report as their respective Practices would either benefit from the prioritisation proposal or not.
- It was agreed it would be helpful to gain the views of the GP members in the discussion.
- It was noted that the criteria for prioritisation had been agreed by the CCG Chairs and the PCCC members, and therefore the GPs were not be able to influence this.
- The report was asking for approval of the prioritisation process following on from the review against the criteria. The GP members could therefore potentially influence / introduce bias into the discussion.
- It was agreed that the conflict would be managed by the GP members absenting themselves from this meeting in public following the initial discussion.
- It was noted that Ms Adams is a patient and PPG member at the Loughborough University Medical Practice, and this Practice benefits from the proposal. Therefore Ms Adams would hand over the chairing arrangements to Fiona Barber.
- Ms Bains is registered as a patient at Forest House Medical Centre (ELR) and Ms Vyas is registered as a patient at Evington Medical Centre (LC). No further action would be required in relation to these.
- Committee members declared the practices with whom they were registered; Dr Girish Purohit is a patient at Central Surgery, Wendy Hope is a patient at Central Surgery, Oadby, Sarah Prema is a patient at Birstall Medical Practice, Zuffar Haq is a patient at Al-Waqas Medical Practice, Fiona Barber is a patient at Greengate Medical Centre and Dr Nikhil Mahatma is a patient at one of the Top 20 practices listed in the report.
- Dr Wadhwa declared his practice Highfield Surgery was named in the Top 20 listed practices. Dr Fahreen Dhanji, a partner at Latham House Medical Practice declared this practice was listed in the Top 20 practices in the report.

Paper D – National GMS and Contract changes:

- GPs would be conflicted, with the exception of Dr Tony Bentley, as the report detailed the changes to their GMS contracts.
- However the report was being received for information, highlighting the national requirements.

Paper E – GP International recruitment

- GP members who are supporting the GPs recruited through the programme were asked to highlight their interest during the meeting.
- Dr Girish Purohit has a conflict of interest in this item as his Practice is a training Practice.

	• No further action would be required as the report was to be received. **Paper G - General Practice Quality - High level report** • There was potential for GP members to be conflicted if their practice was identified within the report, however no specific conflicts had been identified on this occasion. It was **RESOLVED** to: • **NOTE** the conflicts of interest declared and the actions to be taken.	
PCCCs/21/36	**To receive questions from the Public in relation to items on the agenda** It was confirmed that no questions had been received from members of the public in advance of the meeting.	
PCCCs/21/37	**Minutes of the previous meeting held on 6 April 2021 (Paper A)** Minutes of the LLR CCGs PCCCs in Common meeting held on 6 April 2021 were received and approved as an accurate record. It was **RESOLVED** to: • **APPROVE** the minutes of the LLR CCGs PCCC meeting held on 6 April 2021.	
PCCCs/21/38	**To Receive Matters Arising and actions for the meeting held on 6 April 2021 (Paper B)** The matters arising following the LLR CCGs meetings in common held on 6 April 2021 were received and it was noted all actions were green/complete. **Matters Arising;** There were no matters arising. It was **RESOLVED** to: • **RECEIVE** the matters arising and the update provided.	
PCCCs/21/39	**Primary Care Estates Strategy (Paper C)** Ms Adams is a patient and PPG member at the Loughborough University Medical Practice and this practice benefits from the proposal. The chairing arrangements for this item only were handed over to Fiona Barber. As agreed under the conflicts of interest section, the conflict would be managed by the GP members absenting themselves from this meeting in public following the initial discussion.	

Ms Prema advised the work on this had commenced over 18 months ago, starting with a survey of premises across LLR to understand the baseline condition of the estate. Housing growth, population growth and demographics and current condition of estate had also been considered, informing the position at practice, PCN and LLR level.

A prioritisation process was then undertaken and the PCCC was supportive of the criteria. Ms Prema advised there were two other components to be developed next; a plan to understand how to turn the information into actions and an investment plan to support identified requirements.

LLR would see an increase of 200,000 homes between the years 2011 to 2050 along with population growth. Some practice premises were too small to manage their current patient numbers and were not suitable for present healthcare delivery. There was also a growth in services at PCN level and that required a workforce to support that growth. Data had also been collected from local authorities on their local development plans, the NHS shape planning tool utilised and costs for construction estimated.

Dr Janet Underwood and Ms Sarah Shuttlewood joined the meeting.

Hot spots for housing development and population growth had been identified, either due to large scale development or a number of developments in one area.

A scoring and weighting process had been established and robustly tested. Three key areas were identified for potential investment into primary care; some practices would be affected by housing growth, some had insufficient space from which to deliver services and some had premises of poor quality/not suitable. For some practices there was a cross-over of these three themes.

A development plan would now be progressed, particularly for those practices identified in the top 20 of need to try and resolve or make headway into the identified issues. If the issues were purely due to housing growth, then a developer contribution route would be followed. Ms Prema advised there was no primary care capital at a national level and the former ETTF (estates and technology transformation fund) scheme had all been committed. Options available were practice self-funding and the CCG meeting the rent reimbursement. There was also scope to look across the combined estate opportunities at PCN level or with partner organisations.

Mr Chris Rowlands and Mr Amit Sammi joined the meeting.

The next steps would be to complete the review of all practices and identify what could be done to support them, identify and agree an investment plan and communicate with practices on the next steps.

Ms Barber thanked Ms Prema for her summary and invited questions and comments.

Dr Glover commented on the impressive work of the task and finish group and the momentum to develop the plans in between meetings. He was in support of the process. He wanted the lack of capital investment available to primary care to be challenged and the system to provide the financial support, perhaps based on PCN footprint. He felt there would be opportunities to repurpose existing estate used or owned by partner organisations.

Ms Briggs advised that whilst the report had been factually correct at the point of writing, the H1 plan from 1 March 2021 to end of October 2021 included capital for the system envelope and it was for the system to determine how capital could be used. LLR had identified £1m for transformation to support delivery of some of the system work and if that was not all required by the system, there could be some funding available from a capital perspective. Ms Briggs added that when the ICS governance had further developed and a finance committee was in place it would be important to have a primary care voice to consider all system spend requirements. Ms Briggs gave an example of her previous employment at Kettering utilising a former department store building for ophthalmology outpatients and that brought 80,000 patients into the city centre which was welcome footfall for nearby businesses. Any fallow space owned or leased by partner organisations could be repurposed for primary care needs.

Dr Prasad spoke of the lack of investment in the primary care estate for many years yet practices continued to deliver good services. He asked that consideration be given to patient consultation if some services were to move to a different location. Dr Prasad noted the increased use of digital contact, triage and consultation and that may result in the existing primary care space being utilised differently.

Dr Wadhwa noted that for larger projects capital could be identified, such as the rebuild of the emergency department at the LRI. He cautioned asking practices to see other patients in their surgeries because most practices in the city were deprived of space and were unlikely to be able to accommodate that request.

Mr Haq noted that more than half of the practices identified as being in need in terms of primary care estate were in the City. He felt the City was limited in accessing Section 106 money because the developments were smaller in scale and had housing of lower value and Section 106 was more of an opportunity for the County. He had seen the increase in availability of vacant property, particularly in city centres and there were now some competitive lease opportunities.

Dr Underwood spoke of the St Georges Barracks Garden Village development in Rutland and she understood that was on hold and the

	2,000 houses might be dispersed across Rutland. Dr Underwood identified a discrepancy in two sets of housing and population growth figures in the report. Dr Mahatma agreed physical estate capacity was stretched but more pertinent was the risk of not being able to recruit staff to deliver those services, regardless of where the estate for that might be. He asked what was meant by the PCN working together to use underutilised space and if practices hosted other services or patients, there would be costs associated with administration and staffing. Dr Mahatma said technically his own practice estate was underutilised because he did not have sufficient staff to provide a service at the branch practice. Dr Mahatma asked to understand the relationship of Leicester LIFT who the CCG had commissioned for the estates review. He noted that for LIFT properties there was no identified maintenance backlog. Ms Prema explained that LIFT (Local Improvement Finance Trust) was a national programme for areas identified as having high need for premises development. This was established at the time of Primary Care Trusts and was a share-holding agreement between PCTs, central NHSE and private finance. When the PCT demised the shares transferred to NHSE. When LIFT was established in Leicester City the LIFTCo was engaged to develop buildings and a 25 year partnership formed as an estates partner that enabled the commissioner, which at the time was the PCT, to work with them on developments. A competitive EU process had been followed and LIFTCo was engaged on a provider framework basis. The LIFT buildings were fully funded for repair and maintenance, both reactive and proactive, so there was no maintenance backlog, as correctly stated in the report. Dr Dhanji firmly felt the system expectations of primary care needed to be supported by an appropriate level of investment. In terms of practices optimising estates utilisation across a PCN, Dr Dhanji was mindful of the considerable geography between some of the rural county practices. Dr Dhanji supported the thinking of using available vacant space in key locations, as had happened in Kettering. In terms of Section 106 money, funding opportunities had not always been taken up in the past and that needed to be maximised going forward. *Ms Laura Norton joined the meeting.* Professor Farooqi expressed his disappointment that there was no national funding for primary care estates but he was confident a solution would be identified. He noted a number of premises on the list were owned by NHS Property Services and buildings identified as being of poor quality needed some investment from them. Whilst there were pressures on primary care to accommodate the left shift work, the remote working opportunities may alleviate some of the estate capacity constraints. Therefore Professor Farooqi asked if the review needed a further evaluation to take into account the impact of technology and total	

	triage. He gave the example of his own practice consulting space usage now being far less than pre-pandemic. Dr Wadhwa was concerned that some contracting arrangements can benefit private companies and he wanted investment to be within the NHS as much as possible. Property improvements would impact on rent reimbursement and it would be useful for practices to understand the implication ahead of any change. Ms Barber summarised some of the points raised; there was support to look at innovative usage of non-NHS premises which would be explored by the task and finish group, patients needed to be involved to understand what changes to service locations they would embrace, to look at getting the best usage out of the estate across each PCN acknowledging how they might be able to work together and potential difficulties, keeping appraised on housing plans and planning processes including maximising Section 106 money, to engage with NHS Property Services and discuss service agreements. Ms Prema would follow up on the pre-assessment notional rent point raised by Dr Wadhwa. Innovation would be required to identify capital at a local system level and national level. Ms Prema was supportive of using business premises for activities that did not require clinical space, otherwise the cost of clinical space was £3,500 to £4,000 per square metre to convert to NHS standards. Some extended roles could be accommodated in non-clinical settings and PCNs could look to those flexibilities and bringing their workforce together. Ms Prema appreciated the point raised that some practices within a PCN were too geographically distant to share space. In terms of planning and Section 106 money, the CCG meets quarterly with each local authority's planning department and was appraised of what developments were coming on stream, what Section 106 money was available and when that needed to be used. Ms Prema was also aware of the Rutland housing situation and that the solution might be different to the planned large-scale development. Ms Prema undertook to come back to Dr Underwood on the differences she had identified in the population and housing numbers in the report. Ms Prema agreed with the point raised by Professor Farooqi that NHS Property Services needed to invest in their own services. *The GPs left the meeting with the exception of Dr Tony Bentley who was not conflicted.* No further questions or comments were raised and Ms Barber went through the recommendations listed in the paper. Ms Barber asked that thanks from the PCCC be passed on by Ms Prema to those who had produced this significant piece of work. Ms Prema undertook to do that and added this would provide a rich source of information to use in all sorts of arenas.	**S Prema**

	It was **RESOLVED** to: • **NOTE** the Baseline Information Document • **APPROVE** the Prioritisation Process • **NOTE** the next steps to set out a Development Plan and supporting Investment Plan. *The GPs returned to the meeting.*	
PCCCs/21/40	**National GMS and Contract Changes 2021/22 (Paper D)** Mr Jamie Barrett presented a report summarising the key changes for the committee and to note key implementation updates locally;. • The learning disability health checks and minor surgery Directed Enhanced services are continuing. • There is an uplift to the Network DES and PCNs • Four new specifications were announced for 2021/22 but have been delayed due to the pandemic. • The access offer for the City and County was being developed, based on this agreement. • The digital offer sets out a number of requirements for primary care access and consultation. • The QOF now includes remote patient reviews, where appropriate. • Uplifts to the value of QOF will be made for the global sum and out of hours adjustment. • A communication will go out to practices this week to remind them of funding arrangements. Dr Prasad questioned whether increased funding was truly new or re-badged. In terms of digital and remote consultation, Dr Prasad asked what support would be offered to GPs in communicating to patients that this was now a standard offer and would practices need additional software and hardware or were their current resources sufficient. Mr Barrett was unable at this point to answer the question about IT resources for practices to enable the digital offer. In response to Dr Prasad's question on additional funding for obesity and weight management, Mr Barrett had no further detail at this stage. This would be added to the action log and reported back to the PCCC by Mr Barrett as more information became available. Ms Vyas made it clear that the changes on digital access and consultation would not be a blanket offer for the population and primary care would continue to provide a range of service offers to ensure patients had equity of access. It was **RESOLVED** to: • **NOTE** the contract changes for 2021/22.	**J Barrett**

PCCCs/21/41	**GP International Recruitment (Paper E)** *Tine Juhlert attended for this item.* Ms Tine Juhlert, International GP Project Manager provided an update on the International GP Recruitment (IGPR) project. The LLR Workforce Plan highlighted an urgent need to recruit GPs across LLR. In September 2018 resources were identified from NHSE to permanently recruit GPs. The LLR CCGs applied to NHSE to deliver an IGPR offer and this was approved in January 2019 and a funding allocation made to support salaries, on-costs, relocation and training costs for 30 IGPRs. The hosted project manager post was also funded. The scheme had a remit to place appropriately qualified GPs with LLR practices. Before Brexit this meant an individual with an EU family doctorship qualification would undergo training to convert to UK general practitioner requirements. Half-way through the recruitment campaigns, Brexit hampered the opportunities to attract the number of candidates envisaged and some of those attracted, due to Covid, decided to continue to practice medicine in their country of origin. Sixteen international GP recruits are now working in LLR and are a permanent resource to practices. There were two cohorts; 14 GPs recruited in cohort 1 and only 2 GPs recruited in cohort 2 for the reasons stated. Six recruits were now fully independent practitioners and by March 2022 the remainder would move to becoming independent practitioners without conditions. The GP recruits are fully funded whilst in training for the first year. Ms Juhlert was in post to support the GPs with social aspects such as finding housing and schooling for their children. The LLR programme would now closedown and Health Education England would support the GPs until they became fully trained and independent. Ms Adams noted a statement in the report about the progress of two individuals on the programme and suggested as the report was in the public domain Ms Juhlert may want to change or redact the wording. Mr Wood appreciated the delicacy but as the report was already in the public domain it should probably remain unchanged. Ms Adams, supported by Dr Bentley and Professor Farooqi, felt on balance it was better to replace or redact as it was personal and private information relating to two GPs. It was agreed that Ms Adams would work with Ms Juhlert on that and a replacement report would be uploaded to the website. It was **RESOLVED** to: • **RECEIVE** the LLR GP International Recruitment update. *Tine Juhlert left the meeting.*	**G Adams** **T Juhlert**

PCCC/21/42	**Risk Share and CQC Inspections 2020/21 (Paper F)** Ms Wendy Hope provided a report on the key activities of the risk share group and CQC inspections undertaken in 2020/21. With regard to the Risk Share Group (RSG), the three CCG RSG's had started to come together to share information on practices of concern. The LLR CCG's RSG is chaired by the Deputy Director of Nursing and Quality. The RSG shares information on risks of quality and safety of care being provided, generally for matters that were more widespread and prolonged rather than limited in cause and scope. The RSK has a level of challenge from an Independent Lay Member and GP. Practitioner performance is the responsibility of NHSE. The risk log held by the RSG is reviewed at each meeting. 13 general practices had been on the risk log from across the LLR CCGs and 6 CQC inspection reports had been published, 2 of which were for the same practice. The 5 practices came from different PCNs. Each practice had previously been inspected with a rating of inadequate and placed in special measures. All practices had improved over the intervening period by which time the CQC carried out a reinspection. Key themes of the CQC inspections were: • Infection prevention and control and safeguarding process and procedures • Management of MHRA and other alerts • Medicines optimisation • Vulnerable patients and application of Accessible Information Standards • Oversight and governance arrangements Ms Hope commented it was noticeable that practices who performed well in the safeguarding domain had completed the safeguarding toolkit. The CCGs would work with the safeguarding team to roll that out to practices. During the last 12 months no breach notices had been issued by the CCGs. The CCGs continue to work with the practices on their improvement plans. Ms Hope noted the significant work put in by practices to make the required improvements. Dr Underwood asked whether practices of concern were monitored by the LLR CCGs according to that footprint or for all practices where LLR patients were registered. Healthwatch was receiving a number of approaches from patients who lived in LLR but were registered to a practice in Stamford. Ms Norton commented this was a difficult area as the CCG did not have commissioner jurisdiction but wanted LLR residents to have good access to services. Assurance was given that the CCGs were working with colleagues in Lincolnshire to understand their actions. The CCGs would be presenting to the Rutland Health and Wellbeing Board next week and would cover this issue. Dr Underwood	

	was further concerned by the pressure this would put on the Empingham practice as patients chose to register there as a nearby alternative practice. Ms Norton advised the list sizes were routinely monitored and the practice had directly raised a similar concern. The issue would be put onto the action log. It was **RESOLVED** to: • **RECEIVE** the report for information	**L Norton**
PCCCs/21/43	**General Practice Quality – High Level report (Paper G)** Ms Wendy Hope provided a high-level report on newly published CQC reports for LLR general practices. No new CQC reports had been issued since the last PCCC meeting in March 2021. Ten practices were receiving increased support and monitoring and/or additional monitoring and oversight from CCG teams. A practice had been newly added to the risk log and three practices had been removed. Various teams in the CCGs continued to support practices with the actions arising. Ms Hope advised the risk log was undergoing a review and the format of what was presented to the PCCC might therefore change going forward. It was **RESOLVED** to: • **RECEIVE** and note the report for information.	
PCCCs/21/44	**GP IM&T Update** The paper was received for information, providing an update on the IM&T Work Programme across LLR which supports the delivery of the Local Digital Roadmap and implementation of GP 5 Year Forward View (5YFV) requirements. Dr Prasad had raised a question under item 21/40, National GMS and Contract Changes 2021/22 regarding IT and if that necessitated additional equipment requirements. That would be added to the action log. Dr Prasad asked that practices receive support from the CCG to communicate the digital offer to patients. Mr Haq commented that drop-in clinics had been well received and a mixed offer going forward would deliver advantages. Ms Adams added that some patients had digital access but no transport access. Dr Underwood was aware of some patients who had digital access but could not find e-consult on their practice website or download it and having completed the e-consult registration form, had not been contacted by their practice. Ms Vyas responded that was within Ms Alice McGee's list of responsibilities and she undertook to feed back the points raised by Dr Underwood. It was **RESOLVED** to:	**J Barrett** **R Vyas**

	• **RECEIVE** the report for information.	
PCCCs/21/45	**Items for escalation / information for the Governing Bodies** There were no specific items for escalation to the Governing Body. **I**t was agreed through the summary report the Governing Body would be informed of; 21/39 – Primary Care Estates Strategy 21/41 – a short update on GP International Recruit 21/44 – IM&T update specifically the balance of e-consultation and face to face patient contact in primary care. Ms Hope advised the Risk Sharing Group report would be received by the Quality and Performance Committee.	
PCCCs/21/46	**Any other business** Ms Adams confirmed that there were no items to discuss. The meeting concluded at 11.15am.	
	Date of next meeting The date of the next LLR Primary Care Commissioning Committee meetings will be held on **Tuesday 6 July 2021 at 9:30am, via MS Teams.**	

B

LEICESTER, LEICESTERSHIRE AND RUTLAND CLINICAL COMMISSIONING GROUPS
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 July 2021	Status
PCCCs /20/38	6 October 2020	**General Practice Quality – High level report**	Caroline Trevithick	Mrs Trevithick to present the report detailing specific issues in GP Practices at the next PCCC meeting.	~~December 2020~~ June 2020	Risk Share Group Annual Report was received by the PCCC in June 2020 **ACTION COMPLETE**	**GREEN**
PCCCs /21/39	1 June 2021	**Primary Care Estates Strategy**	Sarah Prema	Discrepancy pointed out by Dr Underwood in population and housing numbers in two different sections of the report. Ms Prema to check and respond directly.	July 2021	Additional clarity and detail had been provided to Dr Underwood. **ACTION COMPLETE**	**GREEN**
PCCCs /21/40	1 June 2021	**National GMS and Contract Changes 2021/22**	Jamie Barrett	The information was not yet available, but in due course, Mr Barrett would respond; • Extent of IT resources to enable to digital offer from practices to patients • Obesity and weight management service – check the funding is a new stream coming into primary care.	August 2021		**AMBER**

Minute No.	Meeting	Item	Responsible Officer	Action Required	To be completed by	Progress as at July 2021	Status
PCCCs /21/41	1 June 2021	**GP International Recruitment**	Tine Juhlert Gillian Adams	The wording regarding the progress of two individuals on the programme to be changed or redacted. Clare Mair to be advised when a replacement report ready for upload to the website.	July 2021	Revised wording awaited.	**AMBER**

Minute No.	Meeting	Item	Responsible Officer	Action Required	To be completed by	Progress as at July 2021	Status
PCCCs /21/42	1 June 2021	**Risk Share and CQC Inspections 2020/21**	Laura Norton	Issues regarding a practice in Stamford are affecting some LLR patients near the boarder who are registered there and more patients are transferring to the Empingham practice. Update on the situation to be provided.	July 2021	LLR CCGs have been made aware of concerns from Rutland patients around services provided by Lakeside Healthcare in Stamford. As this practice is in Lincolnshire, not Rutland, the commissioning responsibility and contract management sits with Lincolnshire CCG. LLR CCGs recognise the impact however, that disruption at this practice is having on Rutland residents and practices and we are working with Lincolnshire to ensure we are involved and aware of the action they are taking with Lakeside Healthcare to make improvements. **ACTION COMPLETE**	**GREEN**

Minute No.	Meeting	Item	Responsible Officer	Action Required	To be completed by	Progress as at July 2021	Status
PCCCs /21/44	1 June 2021	**GP IM&T Update**	Rachna Vyas Alice McGee	Ms McGee to be asked to look into and respond to questions raised regarding e-consult/digital GP access; • Availability/download of e-consult from practice websites. • Having completed the e-consult registration form, no follow up from their practice.	July 2021	2 solutions are available for practices to use within LLR. AccuRx and Engage Consult. Solutions however are not currently mandated under the GP Contract. Where practices are adopting, these are made available on their websites. For the patient who had no follow up on online consultation, this issue occurred at a non-LLR practice and therefore no follow up can be made. **ACTION COMPLETE**	**GREEN**

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

Name of meeting:	LLR CCGs' Primary Care Commissioning Committee Public ✓ | Confidential	**Date:**	6 July 2021	**Paper:**	**C**
Report title:	**Primary Care Networks Configuration Process**				
Presented by:	Jamie Barrett (Senior Contracts Manager – primary care)				
Report author:	Priya Pandya (Contracts Manager)				
Executive lead:	Rachna Vyas – Executive Director of Integration & Transformation Nicci Briggs - Executive Director of Finance, Contracting and Governance				
Action required:	**Receive for information only:**	-	**Progress update:**	-	
	For assurance:	-	**For approval / decision:**	✓	
Executive summary:	Following on the re configuration of Leicester City Central PCN the learning from this has been adapted to the formation of a process in case it is required for the future. The purpose of this report is for PCCC to approve the proposed process for managing any PCN changes in year.				
Appendices:	Appendix 1 – Draft process				
Recommendations:	The LLR CCGs' Primary Care Commissioning Committees are asked to: **APPROVE** the process PCN configuration process developed.				
Report history and prior review:	N/A				

Aligned to Strategic Objectives		
Leicester City CCG	**West Leicestershire CCG**	**East Leicestershire and Rutland CCG**
✓	✓	✓

Implications	
a) Conflicts of interest:	All Board GPs are conflicted as this could apply to their own practice however for the purpose of the report and policy it will be appropriate for GP Board members to receive and comment on the process.
b) Alignment to Board Assurance Framework	LLR BAF 05 - Quality of care provided by primary care LLR BAF 12 - Impact on Primary Care Resilience – workforce, estates, IT and PPE
c) Resource and financial implications	There are no resource and financial implications.
d) Quality and patient safety implications	Not applicable for the purpose of the report.

e)	**Patient and public involvement**	Not applicable for the purpose of the report.
f)	**Equality analysis and due regard**	Not applicable for the purpose of the report.

Please complete the table below to start next section:

CCG Primary Care Delegated Functions Assurance Checklist	Additional Related Evidence
· the relevant section of the Policy Guidance Manual	Numerous references to the Network Contract DES however section 3.9 provides information on relevance of the DES.
· NHSE statutory duties listed within the Delegation Agreement and also in the Policy Guidance Manual have been addressed and action taken. This could include cross references to the Quality Impact Assessments (QIA) and the Equality Impact Assessments (EIA	Management of DES services are included in the delegation agreement.
· engagement with patients and stakeholders	Not applicable
· that procurement rules have been considered and action taken where applicable	Not applicable
· any needs assessment relevant to the decision.	Not applicable

Primary Care Networks configuration process

6 July 2021

Context

1. Primary Care Networks (PCNs) were initially formed in July 2019 with all practices signed up to the Network Contract Directed Enhanced Service (DES). Following the initial sign up of the DES practices are automatically opted into the Network Contract DES based on the previous financial years PCN configuration.

2. Under the terms of the DES practices do not have the ability to change PCNs *in year* for any other reason other than the reasons listed in the Network Contract DES. Under the current contract arrangements, the CCG is unable to support any other local changes other than what is prescribed in the DES as any changes has direct impact on national funding flows, current and future service delivery requirements. Locally the CCG does not have any authority to go against the terms of the Network Contract DES.

3. The purpose of this report is for PCCC to approve the proposed process for managing any PCN changes in year subject to any further comments from committee members and the Local Medical Committee.

Current situation

4. The CCG has recently overseen a transfer of a practice to become a member practice of another PCN. By undergoing this process and seeking guidance from NHS England what became apparent that a process had to be developed to:

    - Provide practices and PCNs with a clear steer on what is possible with PCN changes
    - Support Clinical Directors on managing internal PCN issues effectively
    - Raise awareness of the importance of collaborative working internally and externally against the DES
    - Offer solutions to practices where there may be a potential issue within a PCN.

5. The process has been developed with input from NHS England and GP Board members that support the primary care contracts team.

6. The draft process developed sets out the following:

    - Background
    - When changes can be made
    - Sets out interventions that the CCG would need to do to support all parties
    - Practice allocation process where applicable
    - The governance routes and role of PCCC.

7. By managing the transfer of a practice to another PCN, standard operating procedures are currently being developed to support CCG and practices teams to manage any transitional arrangements.

Conclusion

8. In summary by overseeing a transfer of a practice to another PCN, it was clear that a process had to be developed to manage any future potential changes for PCN configurations.

9. The process developed demonstrates that the process does involve a collaborative approach from the LMC, practices, Clinical Directors and internally within the CCG.

Next steps:

10 If the committee approve the proposed process, it will need to be shared with a range of stakeholders including practices, PCNs, Clinical Directors and the LMC for implementation and use.

Recommendations:

The LLR CCGs' Primary Care Commissioning Committees are asked to:

APPROVE the process PCN configuration process developed.

PCN Configuration process for Leicester, Leicestershire and Rutland (LLR) Clinical Commissioning Groups Clinical Directors

Network DES contract requirements

This communication is for PCNs and practices to read in conjunction with the Network Contract DES and related guidance.

Primary Care Networks (PCNs) were initially formed in July 2019 with all practices signed up to the Network Contract Directed Enhanced Service (DES). Following the initial sign up of the DES practices are automatically opted into the Network Contract DES based on the previous financial years PCN configuration. For this financial year practice's sign-up would be based on financial year 2020/21 PCN configurations, please note this is an automatic opt in process to the service.

Within the DES, paragraph 4.9.7 sets out when member practices are able to change membership, examples include:

Example	Governance route and action
Expiry or termination of the contract	PCCC In line with Primary Medical Care Policy and Guidance Manual (PGM) (v3)
There was an irreparable breakdown with the PCN	PCCC See below and detail in Network Contract DES
The commissioner has approved a merger or split	PCCC In line with Primary Medical Care Policy and Guidance Manual (PGM) (v3)
The commissioner determines that the core network's participation in the network contract DES should cease in line with paragraph 9 of the DES.	PCCC See below and detail in Network Contract DES In line with Primary Medical Care Policy and Guidance Manual (PGM) (v3)

PCN membership

Under the terms of the DES practices do not have the ability to change PCNs *in year* for any other reason other than the reasons listed above. The automatic opt in confirms the practice's inclusion for that financial year. Under the current contract arrangements the CCG is unable to support any other local changes other than the above as this has direct impact on national funding flows, current and future service delivery requirements.

Practices should note that the decision to change PCN should not be taken lightly and it is encouraged that commissioners are included in early discussions to identify potential solutions; practices are also encouraged to approach the LMC for advice and guidance early on. Practices looking to change PCN in year need to identify a new PCN taking into consideration the requirements of the DES.

Irreparable breakdown

Where it is identified that a practice or a group of practices are unable to operate as part of their existing PCN the following locally developed process should take place, please note that the process would need to be adapted based on the circumstances however the following principles will be applied:

Steps	Action	Attendance rquired
1	Initial meeting to take place with the *practice or group of practices that no longer* want to continue with their PCN. Purpose of the meeting would be to understand what the issues are and whether they can be resolved.	• Senior member of integration and transformation directorate • LMC • Practice(s) • Contracts manager
2	A follow up meeting to take place with the *other practices* in the PCN. Purpose of the meeting would be to understand what the issues are and whether they can be resolved.	• Senior member of integration and transformation directorate • LMC • Practice(s) • Contracts manager
3	If steps 1 and 2 fails to resolve the inherent issues a joint mediation meeting will take place. Meeting to be led by a LLR CCG clinical chair (conflict of interest issue to be considered).	• Executive Director/Deputy Director of integration and transformation directorate • LLR CCG clinical chair • LMC • All PCN practices • Contracts manager
4	If step 3 does not lead to a resolution practices are to take part in regional mediation.	• Executive Director/Deputy Director of integration and transformation directorate • LLR CCG clinical chair • LMC • PCN Clinical Director and practice(s) wanting to leave the PCN • Contracts manager • LLR CCG clinical chair • CCG senior member of integration and transformation directorate • NHS England PCN Leads (Director, GMAST team and regional lead)
5	If step 4 does not lead to a resolution mediation would need to take place at a national level which will include British Medical Association (BMA)	• LMC • PCN Clinical Director and practice(s) wanting to leave the PCN • LLR CCG clinical chair • Contracts manager • CCG senior member of integration and transformation directorate • NHS England PCN Leads (Director, GMAST team and regional lead)

		BMA clinical lead
All meetings will be documented and shared with meeting attendees for transparency.		

Practice Allocation

The current DES does not provide guidance on what should happen where a practice is unable to secure PCN membership, this may apply in the following situations:

- The practice has served notice on their PCN in line with the PCN's network contract agreement
- Where a practice has been removed by a PCN due to 'irreparable breakdown'.
- Where a practice wishes to leave due to immediate 'irreparable breakdown' concerns.

All of the above scenarios would need to be considered on a case by case basis by commissioners, guidance and advice would be sought from NHS England with input from the LMC.

Where a practice finds itself with no PCN membership the commissioner with support from the LMC have a responsibility in ensuring that the practice is part of a PCN to enable patients to receive through the Network Contract DES as an example. In this situation the following would need to take place:

- Approach PCNs to check whether they are able to include a practice that maybe an appropriate fit taking into consideration geography and patient populations
- If a practice still hasn't found a new PCN, commissioners would undergo an expressions of interest process to find a new PCN for that practice
- If that does not lead to a practice finding a new PCN, the CCG may need to allocate a practice to a PCN where the practice may have to forfeit the right to be part of the decision making process or access to any funding under the DES.
- In some instances, a MOU would need to be in place to ensure that all parties are clear on expectations and that service delivery continues for patients.

Governance

Regular and timely reports/updates are to be provided at CCG Primary Care Commissioning Committee (PCCC).

PCCC will be asked to make endorse any PCN changes in line with the DES only.

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Name of meeting:	LLR CCGs' Primary Care Commissioning Committee meetings in common Public ✓ | Confidential		**Date:**	6 July 2021	**Paper:**	**D**
Report title:	**LLR CCGs Practice List Dispersal - Discretionary Payment Policy (LLR CORPORATE 023)**					
Presented by:	Jamie Barrett, Senior Contracts Manager – Primary Care					
Report author:	Amardip Lealh, Senior Contracts Officer – Primary Care					
Executive lead:	Nicci Briggs, Executive Director of Finance, Contracts and Corporate Governance					
Action required:	**Receive for information only:**		**Progress update:**			
	For assurance:		**For approval / decision:**	✓		
Executive summary:	The Leicester, Leicestershire and Rutland (LLR) CCGs are in the process of reviewing all relevant documentation to ensure consistency in decision making processes across the CCGs; and that these are fully reflective of the delegated commissioning arrangements of primary care services. In March 2021, internal auditors carried out a review as part of the Primary Medical Care Services (PMCS) Contract Oversight and Management Functions audit. It was identified that current primary care policies and procedures do not reflect current working arrangements across LLR; and it was recommended these should be reviewed and reflected to meet current working arrangements. In light of the above, the Primary Care Contracting Team have developed a robust programme for the review of all their policies and procedures in order of priority. Based on the recent closure of the Westcotes Medical Practice in Leicester City CCG and the learning identified, the Primary Care Contracting Team prioritised the review of the **Practice List Dispersal – Discretionary Payment Policy (Appendix 1).** This includes an amalgamation of existing documents; evidences any best practice and previous learning; a formal structure with defined roles and responsibilities; and feedback from the LLR CCG Clinical Leads and Directorates, as well as the LLR Local Medical Committee (LMC). The Committee is requested to note the following key changes and approve the Policy: • The removal of a percentage increase in the raw list size as this was not reflective of the process or payment attached; • A defined timeframe for implementation of this Policy (i.e. the date the practice list dispersal is agreed by the PCCC, or when officially advertised by the Practice to patients, whichever is sooner; and remain in situ for 3 calendar months after the date of the practice closure);					

	• A refined 2-Tiered Financial Support system with proposed criteria for Practices to receive a set amount of funding relevant to the particular circumstances of the dispersal (i.e. £10 - £20 maximum).
Appendices:	Appendix 1 - LLR CCG Practice List Dispersal Policy (v1, d4 June 2021)
Recommendations:	The LLR CCGs' Primary Care Commissioning Committees are asked to: • **RECEIVE and APPROVE** the latest policy for managing a dispersed patient list at Appendix 1 (LLR CCGs Practice List Dispersal – Discretionary Payment Policy). • **NOTE** that once approved, this will replace the current local procedures in place.
Report history and prior review:	• New report

Aligned to Strategic Objectives		
Leicester City CCG	**West Leicestershire CCG**	**East Leicestershire and Rutland CCG**
✓	✓	✓

Implications	
a) Conflicts of interest:	All GP Board members are conflicted who may benefit from any potential list dispersals however, for the purpose of the report, GPs should receive the report and policy for comment.
b) Alignment to Board Assurance Framework (BAF)	LLR BAF 05 - Quality of care provided by primary care LLR BAF 12 - Impact on Primary Care Resilience – workforce, estates, IT and PPE
c) Resource and financial implications	As the nature of the list dispersals are ad hoc, it is not possible to plan for the resource / financial impact this could have on the LLR CCGs. However, any future costs that are agreed will be absorbed into the CCG Primary Care budgets as and when they arise.
d) Quality and patient safety implications	Not applicable.
e) Patient and public involvement	Not applicable.
f) Equality analysis and due regard	Included within paragraphs 6 and 7 of the attached Policy.

CCG Primary Care Delegated Functions Assurance Checklist	Additional Related Evidence
· the relevant section of the Policy Guidance Manual (PGM)	Part C, section 2.5 - Key steps in the case of a list dispersal.'
· NHSE statutory duties listed within the Delegation Agreement and also in the PGM have been addressed and action taken. This could include cross references to the Quality Impact Assessments (QIA) and the Equality Impact Assessments (EIA).	See Policy sections on 'Legal Compliance' and 'Due Regard.'
· engagement with patients and stakeholders	Not applicable.
· that procurement rules have been considered and action taken where applicable	Not applicable.
· any needs assessment relevant to the decision.	Not applicable.

LLR CCGs Practice List Dispersal - Discretionary Payment Policy
(LLR CORPORATE 023)

Introduction

1. In March 2021, internal auditors carried out a review as part of the Primary Medical Care Services (PMCS) Contract Oversight and Management Functions audit. It was identified that current primary care policies and procedures do not reflect current working arrangements across LLR; and it was recommended these should be reviewed and reflected to meet current working arrangements.

2. In light of the above, the Primary Care Contracting Team have implemented a robust process to currently review all primary care policies and procedures in order of priority. The aim of the review is to ensure:

   a) adherence to the requirements of delegated commissioning arrangements for primary care services;
   b) they meet contractual requirements and regulations;
   c) consistency in the decision making / application of processes across LLR CCGs;
   d) they reflect current ways of working.

3. Based on the recent closure of the Westcotes Medical Practice in Leicester City CCG and the learning identified, the Primary Care Contracting Team prioritised the review of the **LLR CCGs Practice List Dispersal – Discretionary Payment Policy (Appendix 1).** This includes feedback from the LLR CCG Clinical Leads and other Directorates and the Local Medical Committee (LMC).

Background

4. The LLR CCGs have a statutory duty to follow GP contract regulations, which may result in the termination of a contract for a variety of reasons (e.g. death of a sole practitioner; voluntary closure; action from the Care Quality Commission). In the event of a planned or unplanned termination of a contract, patients will voluntarily move (or be allocated) to another Practice to ensure they continue to receive primary medical care.

5. Across the LLR CCGs, the following policies currently exist for management of list dispersals; however, they are different as outlined in the table below:

CCG / Policy in place:	Last updated:	Dispersal fee per registered patient:
LC CCG GP Practice or Branch Surgery Closure Policy	February 2018	Initial - £10 Additional - £5
WL CCG Discretionary Financial Assistance for Practices Experiencing the Impact of Dispersed List - Local Financial Support for General Practices	July 2018	Initial - £5 Additional - £5
ELR CCG Agreed Financial Assistance for Practices Experiencing the Impact of Dispersed List (ELR CORPORATE 033)	September 2019 – September 2020 (v2)	One-off payment £4.50

Progress to date – Review of other dispersal policies

6. Over the last few months, a scoping exercise was undertaken across other CCGs to review current practice. The review showed that all practice list dispersals are processed in line with the national PGM, however, there was a difference in the payment process and amount. For example:

    - A one-off payment per registered patient where the practice experienced an increase in the list size of 3-5% at £17.50, or more than 5% at £35;

    - A 2-step financial framework of various elements depending on the circumstances of the dispersing practice. This included the following per registered patient:

        - up to £10: administration, notes summarisation / coding / queries etc;
        - up to £10 - £15; upon application to the CCG for clinical / locum time to address clinical issues / additional appointments / health checks etc);
        - maximum payment varied from £20-£25.

7. The above documents were amalgamated in line with the LLR CCGs policy template to include best practice; a formal structure; and a revised financial model that is now equitable for GP Practices across LLR.

Lessons Learnt

8. It also includes the lessons learnt following the closure of the Westcotes Medical Practice, which were recently presented to the Committee. For example:

    - Regular reporting to and/or approval by the Committee in a timely manner to avoid delays in the process, with clarity and explicit detail, language and terminology to aid understanding

    - Paragraph 18 – the closing practice to ensure the patient list size is as close to zero before the actual closedown; and the immediate allocation of registered patients 2.5 weeks prior to the practice closing down;

Current position

9. The revised **LLR CCGs Practice List Dispersal - Discretionary Payment Policy (LLR CORPORATE 023)** at Appendix 1 has been shared with the GP Board members and NHS England for review and comment. Comments and views have also been incorporated from the LLR Local Medical Committee and the wider CCG Directorates (e.g. Finance, Contracting and Corporate Governance; Integration and Transformation).

10. The following key changes have been made to the policy:

    - The removal of a percentage increase in the raw list size as this was not reflective of the process or payment attached;

    - The inclusion of a defined timeframe for the implementation and duration of this Policy (i.e. the date the practice list dispersal is agreed by the PCCC, or when officially advertised by the Practice to patients, whichever is sooner; and remain in situ for 3 calendar months after the date of the practice closure)

- A refined 2-tiered financial support system with proposed criteria for Practices to receive a set amount of funding relevant to the particular circumstances of the list dispersal.

Recommendations

The LLR CCGs' Primary Care Commissioning Committees are asked to:

- **RECEIVE and APPROVE** the latest policy for managing a dispersed patient list at Appendix 1 (LLR CCGs Practice List Dispersal – Discretionary Payment Policy).

- **NOTE** that once approved, this will replace the current local procedures in place.

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

Practice List Dispersal - Discretionary Payment Policy

Reference number:	LLR CORPORATE 023
Title:	Practice List Dispersal - Discretionary Payment Policy
Version number:	Version 2 draft 4 (June 2021)
Policy Approved by:	LLR CCG's Primary Care Commissioning Committee (PCCC)
Date of Approval:	6 July 2021
Date Issued:	July 2021
Review Date:	June 2022
Document Author:	LLR CCGs Primary Care Team
Executive Lead:	Ms Nicci Briggs Executive Director of Finance, Contracting and Governance, LLR CCG's

Version Control

Version number	Approval / Amendments made	Date (Month Year)
Version 1	Individual policies / procedures held by each LLR CCG: • LC CCG – GP Practice or Branch Surgery Closure Policy • WL CCG – List Dispersal Discretionary Payment Policy • ELR CCG – Agreed Financial Assistance for Practice Experiencing the Impact of Dispersed List	February 2018 July 2018 September 2019 (v2)
Version 2, draft 1	Realignment of the previous policies and procedures across the LLR CCGs to ensure a consistent process is in place, which includes recommendations from the LLR CCG wide primary care audit completed in March 2021.	May 2021
Version 2, draft 2	Policy presented to, and comments included from: • LLR CCG Primary Care Team • LLR CCG Clinical Leads	w/c 17 May 2021
Version 2, draft 3	Comments / feedback included from LLR CCG Clinical Leads / Finance, Contracting and Corporate Governance Directorate; NHS England; and the LLR Local Medical Committee (LMC)	June 2021
Version 2, draft 4	Policy to be presented to, and approved by the LLR CCG's PCCC.	July 2021

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

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

All policies can be provided in large print or Braille formats upon request. An interpreting service, including sign language, is also available.

Contents Page

Policy Statement

1. NHS East Leicestershire and Rutland Clinical Commissioning Group, NHS Leicester City Clinical Commissioning Group and NHS West Leicestershire Clinical Commissioning Group (hereafter referred to as the 'LLR CCGs' or 'the CCG') have an individual statutory duty to follow national GP contract regulations. This may result in the termination of a contract and dispersal of the practice list due to the following examples:

    - Death or retirement of a sole practitioner
    - Mutual agreement between the provider and the CCG to terminate the contract;
    - Cancellation of the provider's registration with the Care Quality Commission (CQC), or non-compliance against CQC actions;
    - The end of a time limited contractual agreement;
    - Performance issues / contract regulation breach leading to termination of the contract.

2. The LLR CCGs have experience of managing patient list dispersals and understand the impact this may have on practices and patients. A joint policy for the LLR CCGs will therefore:

    a) ensure a robust and transparent process is applied consistently across the region when dispersing a practice list near to where the patient lives;
    b) outline the additional resources available to both the closing (and receiving) practices, including potential financial support;
    c) be applied following approval by the CCG's Primary Care Commissioning Committee, together with consultation and engagement with the member practices, patients and key stakeholders including the Local Medical Committee.

Scope of the Policy

3. This policy applies to all members of staff and others who are authorised to undertake work on behalf of the LLR CCGs, as well as all Practices that hold the following contracts with the LLR CCGs for the provision of NHS health care and associated services:

    - APMS – Alternative Primary Medical Services
    - GMS – General Medical Services
    - PMS – Primary Medical Services

4. This policy **does not apply** where:

    a) an agreement has been made between the CCG and a Practice (or between practices) to merge a list; or whereby the registered patients are part of a planned expansion or an existing practice or patient transfer;
    b) changes occur due to New Models of Care work streams as separate contractual arrangements for the transfer of care will need to be in place in such eventuality.

Legal Compliance

5. The national **Primary Medical Care Policy and Guidance Manual (PGM) (v3) issued by NHS England in January 2021** includes a section on 'Key steps in the case of a list dispersal' (Part C, section 2.5), which states:

   - *'Commissioners should adopt the same approach as that set out in paragraphs 39 and 40 of Schedule 3, Part 4 'Assignment of patients to lists' of the **GMS Contract Regulations (2015)** or paragraphs 38 and 39 of Schedule 2, Part 4 of the **PMS Agreements Regulations (2015).'***

   - *'Allocations should however have regard to paragraphs 23 to 31 of Schedule 3, Part 2 of the **2015 GMS Regulations**, and paragraphs 22 to 30 of Schedule 2, Part 2 of the **2015 PMS Regulations**, in relation to the removal of patients.'*

   GMS Regulations 2015 - https://www.legislation.gov.uk/uksi/2015/1862/contents/made

   PMS Regulations 2015 - https://www.legislation.gov.uk/uksi/2015/1879/contents/made

6. All users of this policy are required to review the aforementioned guidance prior to its implementation.

Due Regard

7. The LLR CCGs aim to design and implement services, policies and measures that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others. All policies and procedures are developed in line with the LLR CCGs Equality and Diversity Policy and need to consider the diverse needs of the community that is served.

8. The LLR CCGs will endeavour to make sure this policy:

   a) supports its diverse workforce look after the information the organisation needs to conduct its business;
   b) endeavours to make sure that this information is protected on behalf of patients regardless of race, social exclusion, gender, disability, age, sexual orientation or religion/belief.

   Where it is identified that statements in this policy have an adverse impact for particular equality groups, this will be raised with the LLR CCG's Senior Contracts Manager for Primary Care.

Governance

9. The LLR CCGs Contracts and Procurement Team will establish the principles in supporting the practice list dispersal in conjunction with the Finance Team.

10. The CCGs Primary Care Commissioning Committee (PCCC) will be responsible for ensuring patient safety and associated risks are managed appropriately throughout the practice list dispersal process. Final assessments / outcomes will be shared with the CCG representatives, as required, and with the dispersing practice.

11. Accountability and Key Responsibilities

12. The **LLR CCGs Chief Executive (Accountable Officer)** has overall accountability across the LLR CCG for ensuring there are effective systems and process in place.

13. The **LLR CCGs Executive Director for Finance, Contracting and Corporate Governance** has overall responsibility to:

    a) Be accountable for financial probity; effective contracting, use of financial resource to drive change and the capital interface with local NHS providers;
    b) Be accountable for, and provide expert advice on, overall financial management, including financial planning and financial risk management, corporate finance, financial efficiency, outcomes-based contracting and corporate Governance;
    c) Provide strategic financial leadership at both CCG and system level, providing expert knowledge to support decisions made by the Governing Bodies and by the LLR System Leadership Team (SLT).

14. **LLR CCGs Assistant Director of Contracts and Procurement** and the **LLR CCGs Head of Contracts and Procurement** has overall responsibility for escalation on any complex issues and oversight.

15. The **LLR CCGs Senior Contracts Manager for Primary Care** and the **LLR CCGs Contracts Managers for Primary Care** are responsible for ensuring a smooth process is applied during this process; and presenting reports / updates to the relative Board / Committee meetings with supporting information in a timely manner.

16. The **LLR CCG Primary Care Team** are responsible for:

    a) engaging with the dispersing practice to clarify any issues which may arise;
    b) providing advice / guidance to ensure patient safety and quality of service for the continuation of care on an ongoing basis during this process;
    c) assessing the levels of clinical risk with a Clinical Lead or clinician on the Governing Body, if required;
    d) Ensuring the regular reporting and/or approvals required are presented to and received from the relevant Committee in a timely manner to avoid future delays in the process;
    e) Providing the PCCC with clarity on the approach to the closure options, including explicit detail and considering language and terminology to aid understanding;
    f) setting up and leading an Exit Plan meeting with members of the dispersing practice;
    g) setting up and leading a Task and Finish Group which involves representatives from Finance, Corporate Governance, Nursing and Quality, Medicines Optimisation / Quality Team, Communications, Leicestershire Health Informative Service (LHIS);
    h) obtaining / reviewing patient level data from a variety of sources in a timely manner, which meet current information governance and information security policies and procedures;
    i) reviewing / resolving any areas of dispute / concerns with stakeholders involved;
    j) lead the immediate allocation of patients still registered with the Practice 2.5 weeks prior to the closedown, which is to be made clear in the patient communication;
    k) ensuring this policy and procedure are completed in line with national guidance / legislation.

17. **Primary Care Support England (PCSE)** provides key services and support to GPs, GP Locums and GP Practices, which includes medical records, patient registrations (and

deductions), practice closures. Some of these services may incur a fee. Further information available - https://pcse.england.nhs.uk/services/

18. The **dispersing Practice** is responsible for:

    a) engaging with the LLR CCGs to ensure the patient list size is as close to zero before the actual closedown;
    b) liaising with LHIS to ensure the clinical system has been appropriately and satisfactorily cleared of all tasks and information, prior to it being authorised for obsolete.

19. The **LLR CCGs Primary Care Commissioning Committee (PCCC)** has responsibility for monitoring the GP contracts, taking contractual action (including removing a contract), making decisions on discretionary payments, and managing the budget for the commissioning of primary medical care services in each of the respective CCG areas.

Principles to be established in supporting a dispersed practice list

20. **Previous list dispersals** have given NHS England and CCG's an insight into the real issues faced by the receiving practices. A lack of control or a planned approach will lead to negative impacts. No two situations are identical, but the issues faced by receiving practices could experience the following issues:

    - The need to summarise records or check accurate summarising;
    - Additional administrative time in registering a large number of patients over a short period of time (including new patient registration checks)
    - Premises capacity issues, clinical, infrastructure and administration including notes storage
    - The need to run additional GP/Nurse sessions in the short term, when immediate demand may be greater;
    - The longer appointment times needed to deal with complex patients who have not been managed appropriately;
    - The impact on Quality and Outcomes Framework (QOF) achievement / enhanced services.
    - Managing any language and cultural issues
    - Managing patient expectations

21. The support offered should be in relation to the scale of the issue and based on:

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

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

    - the dispersal is undertaken in a short period of time (one day - 3 months);
    - the dispersal follows the termination of a contract due to poor performance;

- the dispersed list can only be absorbed by a small number of practice(s) and therefore there is a concentration on one or a small number of practices;
- the clinical system used by the closing practice is different to the one used by the receiving practice;
- the approval for the closure of a branch surgery that could potentially impact on local practices.

23. The practice can evidence that there has been an immediate and short-term exceptional impact of the list growth and the non-recurrent costs involved. It is therefore proposed that a scale is developed based on the above variables, which identifies the level of impact and can be used as a measure of proposed support (i.e. financial and non-financial).

24. If during the process, further risk to patient safety is identified, then the receiving practice has the right to request a review of the level of financial and non-financial support originally agreed. **See 'Financial Support Tiers' for further information when this would apply.**

Dispersal affecting neighbouring CCGs (outside the LLR boundary)

25. There may be an impact on practices outside of the LLR CCG who are receiving patients from a list dispersal, which may be significant or insignificant to them, depending on the location of the practice closure and the factors identified above.

    The CCG is required to consult with the relative CCG before making any decision to disperse a patient list. Possible impact to these practices and an agreement of the transfer of global funding should also be identified at this point. CCGs affected by the dispersal of patients are to be notified as soon as is practically possible and ideally prior to PCCC approval.

26. The responsibility for supporting these practices with any financial reimbursement via this policy will remain the responsibility of the relative PCCC approving the list dispersal in line with the terms of this policy.

27. Should a dispute occur, that cannot be resolved through escalation within the respective CCGs, the issue will be referred to NHS England and/or an independent advisor agreed by both parties, if required.

Registration of patients subject to dispersal

28. As per the registration process, all patients would be required to confirm whether they live within the practice boundary of the receiving practice. This can be done through the practice website, or by contacting them direct. Once confirmed, each patient will need to complete the GP registration form and national GMS1 form. Most practices would invite patients for a health check to establish their health needs.

29. Dependent on the electronic transfer of medical records via GP2GP, most clinical records should be summarised and up to date. However, where the medical notes are not summarised, the practice would need to facilitate this in a timely manner. In addition, notes transferred between different clinical systems, Practices should recognise there will be degradation of data quality, including summarisation that could incur additional time.

30. When a practice closes, they are required to agree a final cut-off date with LHIS who will inform the relevant clinical system providers of the closure and facilitate an appropriate timeframe for all electronic transfer of medical records to take place. A timeframe of 3 to 6 months should be allowed to ensure all registrations and associated system tasks have been completed.

Discretional Additional Financial Support

31. Where there is a practice closure resulting in a movement of patients due to a practice list dispersal, there should be an appropriate transfer of primary care funding to reflect this, both in year and the full year impact in the subsequent year.

32. The primary care funds to be transferred should be calculated on the basis of cost neutrality i.e. no intended gain/loss to either CCG**. Appendix 1 outlines the areas to be considered in reaching an agreement on the value to be transferred, which will need to be reviewed on a case by case basis.**

33. The planned timing of the transfer should also be taken into consideration, which can be the start of (or fall within) a financial year. It is assumed that the national allocation process will deal with the recurrent impact of any practice transfers, assuming information can be provided within stipulated national deadlines.

34. To achieve this, it is recognised that the process of disaggregating the funds will need to be reviewed on a case by case basis, taking into consideration of the fixed and variable cost movements at the time of the transfer. An initial estimate should be undertaken by NHS England / GMAST (General Medical Advice and Support Team) and agreed prior to approval. Allocation adjustments may be required over a 2 to 5-year period to take into consideration national allocation timescales and processes.

35. The recurrent global financial support should reflect the funding mechanisms for the GP contracts, which state that new patients are added at global sum (i.e. the prevailing rate or as specifically stated in the relative GP contract).

36. Please refer to NHS England / GMAST for further information.

Financial Support Tiers

37. If a practice experiences an increase in their raw list size (i.e. the registration of patients from the dispersed practice only), they will receive financial support in line with the following 2-Tiered system:

    These Tiers will**:**

    a) apply **from** the date the practice list dispersal is agreed by the relative PCCC or when officially advertised by the practice to patients, whichever is sooner; and

    b) remain in situ for 3 calendar months after the date of the practice closure.
    This period of should be reviewed by the relative PCCC and could be amended depending on the circumstances applicable at the time, subject to their agreement.

TIER:	CRITERIA:	FINANCIAL PAYMENT:
	Global sum provides 0.46 x Prevailing Global Sum rate per patient x Number of new registrations (GMS Contract)	
Tier 1	One-off payment in recognition of the need for the following, which may be required within a relatively short period of time: • Clinical time / Locum costs to address quality issues, additional review appointments / health checks; • Administration costs; • Notes summarisation; • Data quality checks	**£10.00 per registered patient following dispersal.**
Tier 2	Additional payment in recognition of further administration / clinical resources, which may be required due to the following **examples**: • Known performance issues prior to the dispersal / supporting evidence from the practice • Care Quality Commission (CQC) registration cancellation / close down • Contract cancelled by Contractor • Compatibility issues with the GP IT systems • Multiple dispersal lists within the same area / timeframe • Registrations completed towards the end of the financial year (i.e. January – March) **Practices receiving this payment will need to apply to the CCG with evidence of the impact of the dispersed list, in order to receive the additional payment, which is subject to PCCC agreement.**	**A) £5.00 per registered patient for up to TWO issues from the criteria.** **AND** **B) An additional £5.00 per registered patient for THREE or more issues from the criteria.**
	Maximum fee per registered patient	**£20.00**

38. There is no minimal threshold to trigger payments as these will be made per patient transferred as a result of the list dispersal, not per patients on the list.

39. Practices will be expected to provide a local patient identifier (i.e. NHS number) for each patient registered as a result of the list dispersal. It is therefore recommended that each practice and the CCG maintain a separate list of NHS numbers of all new registrations from the dispersed list for audit purposes.

40. Where concessions to QOF are made, manual payment to be agreed (where appropriate) and made by the CCG.

41. The dispersing CCG will obtain monthly reports from PCSE in relation to patient movement from the dispersing practice to all receiving practices in order for the Finance Team to make payments following successful registration. Payments should commence 1 calendar month after the dispersal process has been instigated.

Non-Financial Support

42. The LLR CCGs Primary Care Team will provide advice and guidance to ensure patient safety and quality of service for the continuation of care to all practices involved during this process. This is also within the remit of the devolved responsibilities of the CCG under delegated commissioning arrangements.

43. Non-financial support may include, but is not limited to, assistance from:

- Medicines Optimisation / Quality Team for medication reviews and identification of active review date;
- LHIS for ensuring IT solutions are current and efficient, such as GP2 GP note transfer;
- PCSE team in terms of data quality to ensure processes are established to track patients through the system, in particular, those who are considered vulnerable and/or for patient safety and practice payment purposes;
- Communication and Engagement Team to:
  a) ensure consistency of communication to existing and transferring patients and all practices (e.g. websites and social media platforms);
  b) to support patients further to understand the need to register with a GP through improved / additional engagement and communication methods, addressing language barriers;
- Practices to support with notes summarising and coding e.g. subdivided past medical history significant / active problems highlighted.

Monitoring and appeals

41. The LLR CCGs Primary Care Team will:

a) review this policy on an annual basis, and in accordance with the following as and when required:
   - legislative changes;
   - good practice guidance;
   - significant incidents reported;
   - new vulnerabilities; and
   - changes to organisational infrastructure.

b) Ensure that is supports all parties involved in accordance with this policy.

42. In situations where a practice appeals the process undertaken through this policy, or queries the discretionary payments made or not made, they can do so via the local dispute resolution in line with NHS England.

Distribution and Implementation

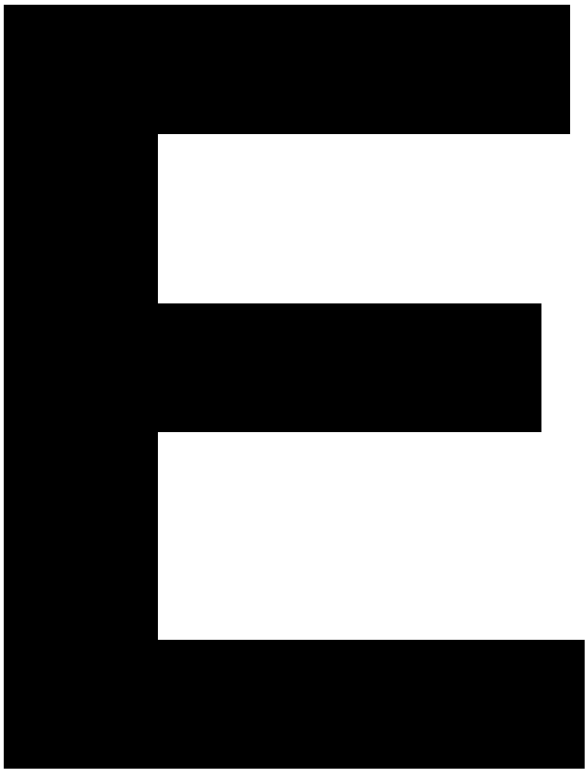
43. This policy will be:

a) made available to all LLR CCG GP Practices via email and shared with the LLR LMC for their information;
b) implemented in line with national guidance / legislation as stipulated above, following ratification from the relative PCCC.

Appendix 1: Proposed funding transfer considerations

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

Income stream	Notes	Funding Transfer Required?	Proposed Methodology
List size related:			
GMS – Global Sum	Costs for CCGs will change once patients have registered. This will be paid on a quarterly basis using the list size information held on NHAIS.	Yes	Monitor the number of patients on a quarterly basis and transfer the budget at Global Sum value. £75.77 per patient + £4.08 per patient (Out of Hours opt out) = £79.85 total per patient.
PMS Contract Payments	Contract value may be adjusted if tolerances have been breached. Receiving practice contract payments will increase.	Yes *(1 PMS contract remains in Leicester City CCG)*	Increase in PMS contract value will be transferred to receiving CCG. Use GMS figures for calculating amount above.
List size possibly related:			
Enhanced Services / Community Based Services (CBS)	Claims submitted by the receiving practice may increase.	No	Taking into account different enhanced services commissioned by different CCGs and the difficulty in evidencing if the dispersed list is responsible for the activity transfer calculations would be difficult.
List size not related:			
FDR Adjustment	This will stay the same irrespective of the number of patients on the list.	No	CCG retains this amount.
GP IT	Not patient level based. The national allocation will change as the total list size changes for each affected CCG. The allocation is reviewed annually and will		Unlikely to be significant enough to warrant a transfer of resource in year. Costs currently incurred at practice level which will not change with an increase/decrease in list size. Allocation will catch up the following year.
MPIG	Will remain the same irrespective of the number of patients. Will cease.		CCG retains this amount



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

Name of meeting:	Primary Care Commissioning Committee in Common Public ✓ | Confidential	**Date:**	6 July 2021	**Paper:**	**E**
Report title:	**General Practice Quality - High level report**				
Presented by:	Wendy Hope, Head of Quality & Safety				
Report author:	Wendy Hope, Head of Quality & Safety Amy Walker, Primary Care Quality Manager				
Executive lead(s):	Caroline Trevithick, Executive Director of Nursing, Quality and Performance				
Action required:	**Receive for information only:**	✓	**Progress update:**		
	For assurance:		**For approval / decision:**		
Executive summary:	This report aims to provide the Primary Care Commissioning Committee with a high-level report informing the committee of: • Overview information on newly published CQC reports for LLR general practices. ○ Three CQC reports have been published since the last meeting in March 2021: Spirit Beaumont Leys, Spirit Asquith, and Ar-Razi Medical Centre • The number of practices who are receiving increased support and monitoring and/or additional monitoring and oversight from CCG teams is seven.				
Appendices:	• None				
Recommendations:	The LLR CCGs' PCCC are asked to: • **RECEIVE** and note the information contained in the report.				
Report history and prior review:	• n/a				

Aligned to Strategic Objectives		
Leicester City CCG	**West Leicestershire CCG**	**East Leicestershire and Rutland CCG**
✓	✓	✓

Implications	
a) Conflicts of interest:	General Practitioners could be conflicted if their General Practice or Primary Care Network is mentioned within the report.

b) Alignment to Board Assurance Framework	Yes
c) Resource and financial implications	None
d) Quality and patient safety implications	As indicated within the report
e) Patient and public involvement	N/A for purpose of the report
f) Equality analysis and due regard	None

General Practice Quality Highlight Report

Introduction

1. This report aims to provide the Primary Care Commissioning Committee (PCCC) with information on newly published Care Quality Commission (CQC) reports and high-level aggregated information of general practice quality concerns as discussed at the CCGs Risk Sharing Groups.

2. The report represents a point in time as there may be changes in circumstances between the writing of the report and the PCCC meeting.

3. General practices receiving additional or enhanced support or where intelligence suggests there may be a concern, are discussed at the Risk Sharing Groups and other forums. From a quality perspective the Risk Sharing Group will monitor and follow up on agreed actions for practices it discusses.

4. Whilst this report is high level, specific practice information is discussed within confidential sections of Primary Care Commissioning Committee as required.

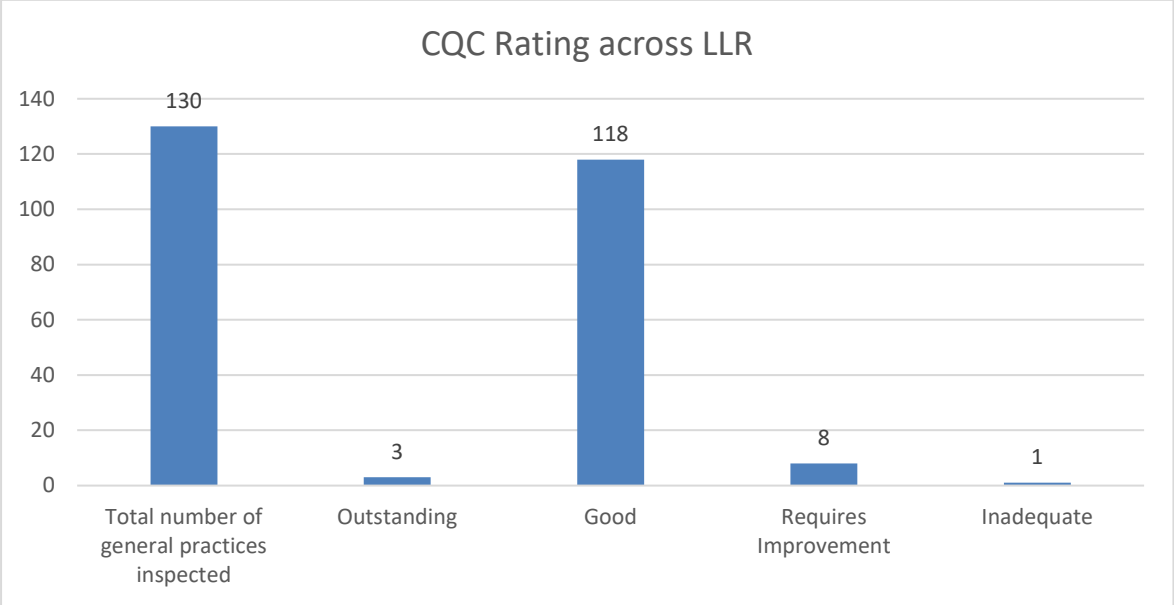
Care Quality Commission

5. At the time of writing three CQC inspection reports have been published since the last Primary Care Commissioning Committee in common meeting as summarised below.

Practice Name	**Spirit Beaumont Leys (Leicester City)**	**Spirit Asquith Surgery (Leicester City)**	**Ar-Razi Medical Centre (Leicester City)**
Date of inspection	05/05/2021	24/05/2021	22/04/2021
Date of Report	27/05/2021	07/06/2021	17/06/2021
Overall rating	**Good**	**Good**	**Inadequate – Special Measures**
Are services safe?	Requires Improvement	Good	Inadequate
Are services effective?	Good	Good	Inadequate
Are services caring?	Good	Good	not inspected
Are services responsive?	Good	Good	not inspected
Are services well-led?	Good	Good	Inadequate

6. A specific improvement and support plan has been initiated with Ar-Razi Medical Centre.

7. A total of 130 LLR General Practices have now received a CQC inspection. This number represents the latest reports that are available on the CQC website. The number, which includes any changes to practice locations, is not static and does fluctuate as practices are re-inspected and/or reports are archived. The overall CQC rating is indicated below.



8. The CCG teams will work with practices that require additional support to enable them to make the required improvements.

Aggregated General Practice Information

9. The tables below summarise the numbers of practices who are receiving additional / enhanced support and/or increased monitoring from the LLR Risk Share Group. This support can be long term as it covers a period of time to ensure any changes have been embedded into the practice.

10. There are currently 7 General Practices on the LLR GP Risk Log receiving enhanced monitoring and/or support or increased monitoring:

2020/21	**June 2021**
New this month	1
Closed this month	3
Total number of practices on LLR Risk Log	7

11. Key areas in which support, and monitoring are taking place are around:
    a. Service delivery including quality
    b. Patient experience
    c. Workforce
    d. CQC improvements

12. The CCG continues to support and monitor practices with actions arising from: CQC inspection reports and known intelligence, escalation of concerns from LLR General Practice Quality Operational Group and any other quality concerns or risks identified.

13. Any high-risk concerns reported to the LLR Risk Sharing Group and where required, are escalated to the Primary Care Commissioning Committee.

Recommendations

The Primary Care Commissioning Committee is asked to:

RECEIVE and **NOTE** the information contained in the paper.