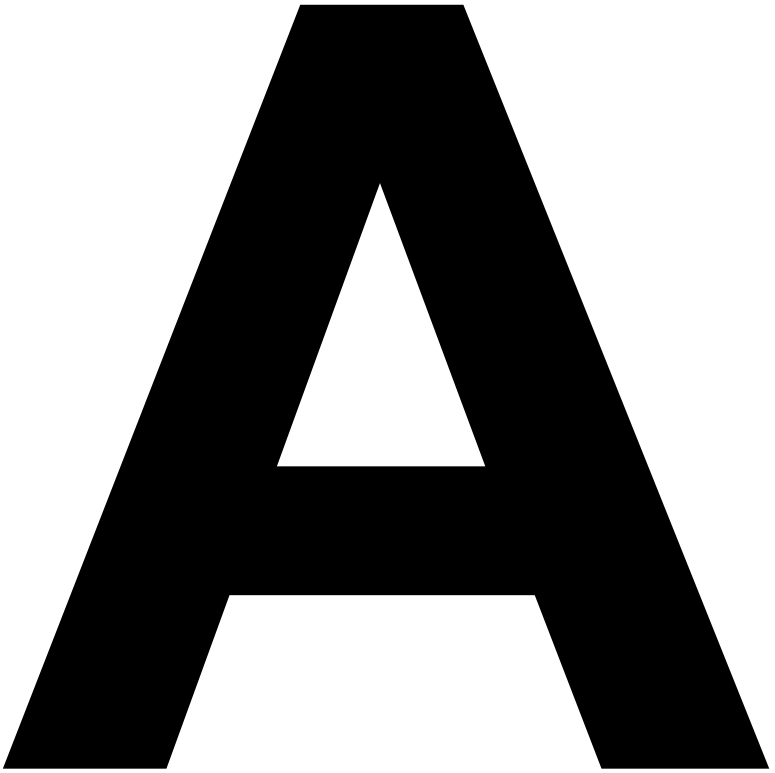
Leicester City Clinical Commissioning Group
West Leicestershire Clinical Commissioning Group
East Leicestershire and Rutland Clinical Commissioning Group

Meeting Title	**Primary Care Commissioning Committees meetings (meetings in common) – held in Public**	**Date**	**Tuesday 3 August 2021**
Meeting no.	**9.**	**Time**	**9.30am – 10.20am**
Chair	**Mr Nick Carter** Independent Lay Member (LC CCG)	**Venue / Location**	**Via MS Teams**

REF	AGENDA ITEM	ACTION	PRESENTER	PAPER	TIMING
PCCCs/21/ 59	Welcome and Introductions		Nick Carter		9.30am
PCCCs/21/ 60	Apologies for Absence: **LLR CCGs:** • Caroline Trevithick **East Leicestershire and Rutland CCG:** • Dr Nick Glover **West Leicestershire CCG:** • Gillian Adams • Dr Nil Sanganee **Leicester City CCG:** • Professor Azhar Farooqi • Dr Sulaxni Nainani	To receive	Nick Carter	**verbal**	9.30am
PCCCs/21/ 61	Notification of Any Other Business	To receive	Nick Carter	**verbal**	9.30am
PCCCs/21/ 62	Declarations of Interest on Agenda Topics	To receive	Nick Carter	**verbal**	9.30am
PCCCs/21/ 63	To receive questions from the Public in relation to items on the agenda only	To receive	Nick Carter	**verbal**	9.35am
PCCCs/21/ 64	Minutes of the meetings held in common on 6 July 2021	To approve	Nick Carter	**A**	9.40am
PCCCs/21/ 65	Matters arising and actions for the meetings held on 6 July 2021	To receive	Nick Carter	**B**	9.45am
ITEMS FOR DECISION, ACTION AND ESCALATION					
PCCCs/21/ 66	Practice Boundary Change – LLR Standard Operating Procedure	To approve	Priya Pandya Amardip Lealh	**C**	9.50am
PCCCs/21/ 67	General Practice Quality - High level report	To receive	Wendy Hope	**D**	10.05am
FOR INFORMATION ONLY					
PCCCs/21/ 68	Items for escalation / information for the Governing Bodies.		Nick Carter		10.15am
ANY OTHER BUSINESS					
PCCCs/21/ 69	Items of any other business.	To receive	Nick Carter	**verbal**	10.20am
The next meeting of the LLR CCGs' Primary Care Commissioning Committee meetings in common will take place on **Tuesday, 7 September 2021, via MSTeams**					



Minutes of the LLR CCGs' Primary Care Commissioning Committees held in common on Tuesday 6 July 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
Mr Clive Wood	Independent Lay Member
Dr Nikhil Mahatma	Member Practice Representative

West Leicestershire CCG:

Ms Gillian Adams	Independent Lay Member (Chair of the meeting)
Dr Ash Kothari	Locality Lead
Dr Nil Sanganee	Locality Lead North West Leicestershire

Leicester City CCG:

Mr Nick Carter	Independent Lay Member
Dr Tony Bentley	North and East Health Need Neighbourhood Chair
Professor Azhar Farooqi	Clinical Chair
Dr Avi Prasad	Assistant Clinical Chair
Dr Sulaxni Nainani	South Health Needs Neighbourhood Chair

In attendance:

Dr Fahreen Dhanji	Local Medical Committee
Dr Sumit Virmani	Local Medical Committee
Dr Rajiv Wadhwa	Local Medical Committee
Ms Harsha Kotecha	Chair, Healthwatch Leicester and Leicestershire (from item 21/53 onwards)
Mr Jamie Barrett	Senior Contracts Manager
Jo McKenna	Head of Contracts and Procurement (attending for Sarah Shuttlewood) (until item 21/55)
Ms Laura Norton	Head of Information and Transformation (County and Rutland)
Ms Sarah Smith	Head of Information and Transformation (City)
Ms Amy Walker	Primary Care Quality Manager
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/21/47	**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/21/48	**Apologies for absence:** **LLR CCGs** • Ms Caroline Trevithick, Executive Director of Nursing, Quality and Performance • Ms Sarah Shuttlewood, Assistant Director of Contracts **East Leicestershire and Rutland CCG** • Dr Nick Glover, Member Practice Representative • Dr Girish Purohit, Member Practice Representative • Dr Janet Underwood, Healthwatch Rutland Chair **Leicester City CCG** • Mr Zuffar Haq, Independent Lay Member • 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 Geoff Hanlon, Locality Lead North Charnwood • 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/21/49	**Notification of Any Other Business** Ms Adams confirmed there were no items of other business.	
PCCCs/21/50	**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 A – minutes** • Members conflicted with the relevant sections of the minutes were asked to refrain from commenting on the content of the minutes unless there was a point of accuracy. **Paper C – Primary Care Networks Configuration Process** • The report was asking PCCC members to approve the process. • All GP members, with the exception of Dr Tony Bentley, are directly conflicted in respect of this report as their respective Practices belong to a PCN. • However it would be helpful to gain the views of the GP members in the discussion. It was agreed that GPs would absent themselves for the decision making element, with the exception of Dr Tony Bentley. **Paper D – Practice List Dispersal Policy** • The report was asking PCCC members to approve the policy. • All GP members, with the exception of Dr Tony Bentley, are directly conflicted in respect of this report as their respective Practices may financially benefit from future list dispersals. • However, it would be helpful to gain the views of the GP members in the discussion and for GPs to absent themselves for the decision making element, with the exception of Dr Tony Bentley. **Paper E - General Practice Quality - High level report** • It was noted that potentially GP members could 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/21/51	**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/21/52	**Minutes of the previous meeting held on 1 June 2021 (Paper A)** Minutes of the LLR CCGs PCCCs in Common meeting held on 1 June 2021 were received and approved as an accurate record. **21/39 – Primary Care Estates Strategy** Page 6 of the minutes, Dr R Wadhwa clarified for the notes his point related to capital usually being made available for large projects however for primary care projects the message often conveyed was	

	that no capital was available. He had asked for a system approach to be taken to finding capital to support primary care projects. *Ms Harsha Kotecha joined the meeting.* It was **RESOLVED** to: • **APPROVE** the minutes of the LLR CCGs PCCC meeting held on 1 June 2021.	
PCCCs/21/53	**To Receive Matters Arising and actions for the meeting held on 1 June 2021 (Paper B)** The matters arising following the LLR CCGs meetings in common held on 1 June 2021 were received and updates received: **21/40 – National GMS and Contract Changes 2021/22** Whilst this item was not due for completion until August 2021, Mr Barrett was able to report the detail of the obesity and weight management enhanced service had now been received and new money was attached for this specification. Mr Barrett advised GMAST had sent the documents for sign up. Detail on the additional IT money was awaited and would be reported on at the August PCCC meeting. **21/39 – Primary Care Estates Strategy** Dr Wadhwa asked for actions on the Estates report to be added to the action log, such as mechanisms of rent review. Mr Barrett undertook to pick that up. **Matters Arising;** There were no matters arising. It was **RESOLVED** to: • **RECEIVE** the matters arising and the update provided.	**J Barrett**
PCCCs/21/54	**Primary Care Networks Configuration Process (Paper C)** For this item it was noted that GPs members, with the exception of Dr Tony Bentley, were directly conflicted. They would remain for the discussion and then leave for the decision. Mr Barrett advised following the reconfiguration of Leicester City Central PCN, learning from that had been adapted into a process in case it was required for the future. The purpose of the report was for PCCC to approve the proposed process for managing any PCN changes in year. Mr Barrett explained no prior process had been in place and nothing had been described in the network DES to support PCN reconfiguration requests. Working with NHSE, the primary care	

contracting team had put together a number of steps to be worked through before deciding if a PCN would change its membership. Due to extenuating circumstances there may be an entry point along those steps, recognising each case would be different.

Mr Barrett had received comments from the LMC on the process and asked for any comments or to be advised of further required amendments.

Dr Dhanji noted most PCN network schedules had a 6-month notice period but this paper stated the changes would be considered annually. Dr Dhanji asked that requests be expedited if they fell close to the start of a new financial year. Dr Dhanji further asked that the impact on patient care and sources of intelligence be taken into account when considering PCN membership changes.

Mr Barrett advised NHSE had been very clear that changes would not take place in-year due to unpicking the flow of finances. The process would make it clear to practices who may otherwise assume the changes could take place at any point during the year.

Dr Mahatma welcomed the paper and having a framework and process to follow however, he was surprised that a number of practices may want to move PCN and as the ICS would rely on place based and neighbourhood delivery, he asked if this was a risk that needed capturing and managing. Dr Mahatma noted the impact the changes would have on PCN stability and if more than one practice wanted to remove itself from a PCN, the PCN as a proposition could become less attractive. He further asked what would happen if a practice did not want to be part of a PCN. Mr Barrett reported it was an expectation of NHSE that practices would sign up to the PCN DES and the CCG as commissioners would strongly advise all practices were part of a PCN otherwise they would be left behind in some of the work.

Dr Nainani agreed with Dr Mahatma's point on PCNs having stability and time to mature. One practice move could have a knock on effect of subsequent requests being made.

In terms of the risk, Mr Barrett advised the Risk Sharing Group was in place and a PCN element will be established, either as an extension to the Risk Sharing Group or as a separate meeting.

In terms of practices that did not want to be part of a PCN, Ms Vyas reported these were known nationally as orphan practices and NHSE have suggested there should be no orphan practices across the country. There were five nationally the last time that Ms Vyas had seen this data.

Dr Bentley commented that the report was fine for routine changes but for irretrievable breakdowns there needed to be the facility for urgent

changes or else patients might be affected.

Ms Barber reflected on the purpose of establishing PCNs; to strengthen primary care delivery, offer better outcomes to patients, share resources across a group of practices with geographical adjacency and she asked if this paper would ensure that would continue to be provided as a result of a PCN membership change. Ms Barber also asked for patient views to be considered. The paper noted PCCC would endorse any PCN membership changes and Ms Barber asked whether the PCCC had real influence in this process.

Mr Carter noted there was potential for a PCN membership request to take considerable time to conclude and asked if a time limit would be set by which practices and PCNs could work to.

Mr Barrett undertook to clarify the matter of timescales and conclusion in the process. Regarding geography and access, that was reflected in the network DES and agreement and he would ensure there was read-across in this process. Mr Barrett also agreed to add something on patient engagement being undertaken, when relevant to the potential issue.

Dr Wadhwa spoke of occasions when relationships within a PCN declined to such a point that the function of the PCN and ergo the patient care was affected. Therefore, timescales and resolution were important. A PCN affected by these things would feel a process of six to twelve months was too long. Dr Wadhwa and Dr Nainani were in support of practices having an opportunity to review their PCN membership and make a one-time case for moving to another PCN. Professor Farooqi commented that the move to PCNs two years ago had been enacted quite quickly. Particularly in the city, some PCNs did not align to local authority or LPT configurations or the vision for geographic neighbourhoods and therefore now may be the time to rethink the PCN membership.

Ms Vyas advised NHSE had made it clear that outside of exceptional circumstances PCN configuration changes would not be allowed in-year. However, Ms Vyas agreed there was a need in the city to look again at PCN configuration and to check if county colleagues also had a similar desire.

Ms McKenna left the meeting.

The GPs left the meeting, with the exception of Dr Tony Bentley, whilst the PCCC considered the recommendations.

Ms Adams asked the PCCC members if, given the points raised, they would want to approve the process or defer the decision. Mr Carter was in support of reworking the paper to add the fundamental points made, particularly around timescales.

	Mr Barrett commented a paper like this was difficult to frame, when a new process was being designed and there were bigger questions around PCN configuration and the wider context of the work being done around PCNs. Mr Barrett considered the paper might not come back to PCCC until the wider PCN work had been done. Taking account of the changes required, it was agreed this had been a good paper and had generated some useful discussion. Ms Vyas reiterated the NHSE stipulated timescales of PCN configuration changes only being accepted annually in March and the expectations around changes from practices and PCNs needed to be managed. Ms Norton noted the wider issues of risk and the need to separately articulate how that would be taken forward. Ms Barber asked if the PCNs had or were to be legislated in the ICS structure, and the need to be aware of how that could impact this process. It was **RESOLVED** to: • **DEFER** approval of the process of PCN configuration process pending further development of the paper taking into account geographical adjacency and timescales to support practices through mediation and resolution or enact a PCN reorganisation in line with NHSE parameters and extenuating circumstances. The paper would come back to PCCC once the wider issues around PCN configuration and risk, particularly in the City, had been worked through. *The GPs returned to the meeting and were advised of the decision and rationale.*	**J Barrett**
PCCCs/21/56	**General Practice Quality – High Level report (Paper E)** Ms Wendy Hope provided a high-level report on newly published CQC reports for LLR general practices. Three CQC reports had been published since the last meeting in April 2021: Spirit Beaumont Leys, Spirit Asquith, and Ar-Razi Medical Centre. One practice had been placed in special measures and that practice was being supported by the CCG. The number of practices who are receiving increased support and monitoring and/or additional monitoring and oversight from CCG teams is seven. Seven practices were on the risk log with movement being; three risks had been closed and a new risk opened.	

	It was **RESOLVED** to: • **RECEIVE** and note the report for information.	
PCCCs/21/55	**LLR CCGs Practice List Dispersal - Discretionary Payment Policy (LLR CORPORATE 023) (Paper D)** For this item it was noted that GPs members, with the exception of Dr Tony Bentley, were directly conflicted. They would remain for the discussion and then leave for the decision. Mr Barrett advised the Leicester, Leicestershire and Rutland (LLR) CCGs were in the process of reviewing all relevant documentation to ensure consistency in decision making processes across the CCGs and that these were fully reflective of the delegated commissioning arrangements of primary care services. Based on the recent closure of the Westcotes Medical Practice in Leicester City CCG and the learning identified, the Primary Care Contracting Team prioritised a review of the Practice List Dispersal – Discretionary Payment Policy, circulated as Appendix 1. This included an amalgamation of existing documents; evidenced 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 PCCC was requested to note the following key changes for 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 two-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). Dr Dhanji noted the increased workload if a practice was moving from one IT system to another, such as Sytmone to EMIS. Mr Barrett advised that had been taken into account through providing the additional £5 grant. Mr Wood noted the different policy starting positions for each CCG and was pleased to see an LLR-wide approach, which for some CCGs had resulted in a greater uplift. He asked from a financial view whether the CCG was assured it could afford the uplift in payments. Ms Briggs responded that in considering the alternative of caretaking	

	arrangements this was preferable and this seemed a sensible approach when no other arrangements were in place. Benchmarking against other areas had been done. Dr Bentley noted for ELR this was a subsequent uplift but for LC CCG it was broadly the same. His view was that this should look to ensure the right level of fee for the work being done rather than the affordability. *The GPs left the meeting, with the exception of Dr Tony Bentley, whilst the PCCC considered the recommendations.* There were no further comments or discussion and the meeting moved to the resolution. It was **RESOLVED** 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 policy would replace the current local procedures in place. *The GPs did not return to the meeting.*	
PCCCs/21/57	**Items for escalation / information for the Governing Bodies** Prior to the GPs leaving the meeting due to the above conflict of interest, it had been determined there were no specific items for escalation to the Governing Body and the summary report would provide a brief sentence on each of the items discussed today.	
PCCCs/21/58	**Any other business** Prior to the GPs leaving the meeting due to the above conflict of interest, it had been determined by Ms Adams that there were no other items to be discussed. The meeting concluded at 11.31am.	
	Date of next meeting The date of the next LLR Primary Care Commissioning Committee meetings will be held on **Tuesday 3 August 2021 at 9:30am, via MS Teams.** Meeting to be chaired by Nick Carter. Apologies were noted in advance from Gillian Adams and Dr Nick Glover.	

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 August 2021	Status
PCCCs/ 21/39	1 June 2021	Primary Care Estates Review	~~Jamie Barrett~~ Sarah Prema Amit Sammi	From the discussion, ~~PC~~ S&P team to explore; • Utilisation of partner organisation premises and vacant commercial space opportunities, for providing 'high street' health care services		This will be picked up as part of the next stage of the Primary Care Estates Strategy: Development Plan when potential solutions are explored with practices/PCNs (slide 12 of the slide deck presented at July PCCC). **ACTION COMPLETE**	**GREEN**

Minute No.	Meeting	Item	Responsible Officer	Action Required	To be completed by	Progress as at August 2021	Status
				• Lack of capital investment at system level to be challenged		There is currently no national capital regime for primary care, further national guidance on this position is awaited. The next stage of the PCES is to develop an investment plan that potentially allocates some of our primary care funding to support increases in reimbursable costs as a consequence of individual practice developments. **ACTION COMPLETE**	**GREEN**
				• Changing nature of primary care delivery due to more IT and virtual options and the impact that would have on primary care space		This will be picked up as part of the next stage of the Primary Care Estates Strategy: Development Plan when potential solutions are explored with practices/PCNs and better understand the type of estate need and possible solutions. **ACTION COMPLETE**	**GREEN**

Minute No.	Meeting	Item	Responsible Officer	Action Required	To be completed by	Progress as at August 2021	Status
			Lou Young	• Managing the risk of having available staff to support expanded services		Acknowledged as a valid point but outside the scope of the PCES which focuses on Estates provision. Action assigned to Lou Young from a workforce perspective.	**AMBER**
				• Addressing the maintenance backlog on NHS Property Services premises		The S&P team are planning to work with NHS PS to develop a premises improvement plan as part of the wider estate development plan. Some of the NHS PS premises appear in our 'top 20s' and these will be prioritised as part of our investment planning, but we will also discuss the wider backlog maintenance challenge with NHS PS. **ACTION COMPLETE**	**GREEN**

Minute No.	Meeting	Item	Responsible Officer	Action Required	To be completed by	Progress as at August 2021	Status
				• Keeping appraised of housing plans to maximise usage of S106 money.		Regular quarterly meetings are in place with colleagues from district planning departments to keep appraised of new housing plans, S106 developer contributions. These meetings include representation from across CCG directorates (I&T, contracts, strategy and planning). Equally, regular communication with the City Council to make sure that provision of funding for health services is included in their planned new Community Infrastructure Levy Policy. **ACTION COMPLETE**	**GREEN**

Minute No.	Meeting	Item	Responsible Officer	Action Required	To be completed by	Progress as at August 2021	Status
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	OLC solutions, Engage Consult and AccuRx have been already been commissioned and there is existing funding supporting these but no additional funding at present. Detail of the obesity and weight management specification had now been received. **ACTION COMPLETE**	**GREEN**
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 received and updated on the websites. **ACTION COMPLETE**	**GREEN**
PCCCs/ 21/54	July 2021	Primary Care Networks Configuration Process	Jamie Barrett	The paper was not approved and would be revised to take into account comments made on timescales and geography. Wider issues around PCN membership and risk would be addressed prior to the process coming back to the PCCC.	September 2021	In progress for update in September 2021.	**AMBER**

C

Name of meeting:	LLR CCGs' Primary Care Commissioning Committee meetings in common Public ✓ | Confidential	**Date:**	3 August 2021	**Paper:**	**C**
Report title:	**Practice Boundary Change – LLR Standard Operating Procedure**				
Presented by:	Priya Pandya, Contracts Manager Amardip Lealh, Senior Contracts Officer – Primary Care.				
Report author:	Fayaaz Hussein, Senior Contracts Assistant – 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:

In July 2021, the LLR PCCC was informed that the internal auditors carried out a review as part of the Primary Medical Care Services (PMCS) of Contract Oversight and Management Functions audit in March 2021, which identified that current primary care policies aligned to the delegated co commissioning functions do not reflect current working arrangements across LLR.

The auditors recommended the policies should be reviewed to reflect the current working arrangements (alignment across the 3 LLR CCGs with a forward view to ICS working arrangements). In line with the above, the Contracts Team have implemented a programme to review all of the policies and procedures in order of priority. As part of this work area at the July 2021 committee the list dispersal policy was received and approved by the committee. This programme of work is to ensure that there is:

- Consistency in decision making and processes going forward across LLR
- These are fully reflective of the delegated commissioning arrangements of primary care services.

The Practice Boundary Change SOP Appendix 1 has been reviewed and updated to provide guidance to practices that want to vary their existing practice boundary (i.e., inner, and outer boundary). The new SOP has been developed with the following in mind:

a) An amalgamation of existing SOP documents (i.e., ELR CCG June 2018 and LC CCG February 2019)
b) Evidence of any best practice and previous learning
c) Specified the roles and responsibilities from previous applications
d) Links to relevant documents / national guidance and areas of discussion to support the process.

The aim of the Practice Boundary Change SOP is to guide and support both practices and the CCGs to engage in open communication and involve parties, as required, in a consistent manner. The approved SOP will be communicated and implemented with immediate effect.

	To develop the SOP feedback was sought from the LLR CCG Clinical Leads in July 2021 who have provided comments which have been incorporated in the SOP. The Contracts and Procurement team will continue to review policies and procedures that will be used across the LLR, the next polices to be reviewed are as follows: - Emergency Caretaking – September 2021 - Contract review process – September 2021 - Practice merger process – October 2021
Appendices:	Appendix 1 - Practice Boundary Change - Standard Operating Procedure (SOP)
Recommendations:	The **LLR CCGs'** Primary Care Commissioning Committees are asked to: • **APPROVE** the Practice Boundary Change – Standard Operating Procedure (SOP). • **NOTE** that once approved, this will replace the current local procedures that are in place with immediate effect.
Report history and prior review:	First 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 practice boundary change, however, for the purpose of the report, GPs should receive the SOP for comment.
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	As the nature of practice boundary changes are ad hoc, it is not possible to plan for the resource / financial impact this could have on the LLR CCGs, but the likely impact is the potential movement of current funds across practices when a boundary changes.
d) Quality and patient safety implications	Not applicable but consideration will be given as per the implementation of the SOP.

e) Patient and public involvement	Not applicable but consideration will be given as per the implementation of the SOP.
f) Equality analysis and due regard	As the nature of practice boundary changes are ad hoc, an equality analysis will be conducted as part of the actual practice boundary change process where applicable.

CCG Primary Care Delegated Functions Assurance Checklist	Additional Related Evidence
· the relevant section of the Policy Guidance Manual (PGM)	7.14 PGM 2021/22 https://www.england.nhs.uk/publication/primary-medical-care-policy-and-guidance-manual-pgm/
· 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).	Please refer to section about EIA.
· 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.

7.14 Boundary Changes

Stage 1

Practice initiates contact with ***Commissioner*** via:

primarycare@leicestercityccg.nhs.uk

with intent of changing practice boundary (main and/or outer boundary)

Time-frame: N/A

Stage 2

Commissioner to provide ***Practice*** with Annex 13A of PGM 21/22 (see **Resources**)

Time-frame: 7 calendar days

Stage 3

Practice to complete **Template Application to Change the Practice Area** (Annex 13A of PGM 21/22) *(as per 7.14.4 PGM 21/22)* and return to:

primarycare@leicestercityccg.nhs.uk

Time-frame: 14 calendar days

Stage 4

Practice and ***Commissioner*** must engage in open dialogue. Discussion areas to consider:

- Proposed boundary
- Reasons for boundary change
- Implications of increase/decrease in practice list size
- Financial implications of boundary change
- Considerations for alternatives
- Why this particular area
- 'Patient choice' - would this change affect the patients' ability choose which practice they want to register at?
- Impact on care homes in this area
- Patient demographics
- Positive impact for patients / other local providers
- Other providers boundaries
- PPG comments/views

This is not an exhaustive list, please consider any/all relevant information.

Arrange a meeting at earliest convenience to initiate dialogue, and maintain regular contact (via email/telephone) to fully consider all area's.

Involve Finance, I&T and/or S&P where necessary for input and advice.

Time-frame: N/A

Stage 5

Commissioner to share completed Annex 13A with relevant stakeholders (e.g. LMC, nearby practices likely to be affected by changes in boundaries).

Time-frame: 14 calendar days (extended as appropriate; to be discussed with Commissioner).

Any changes to the practice area (main and outer boundary) that are approved must be considered a variation to the contract and the definitions of these areas amended under a variation notice.

Stage 6

Commissioner to collate stakeholder comments and share with ***Practice*** for feedback/response.

Time-frame: 14 calendar days

Stage 7

PCCC Paper - Areas to consider:

- Practice background
- NHS England Policy on Boundary Changes
- CCG Principles on Boundary Changes
- Application Reasons / Justification
- CURRENT / PROPOSED boundaries
- Care homes
- Equality Impact Assessment
- Stakeholder comments (e.g. LMC, nearby practices) & Practice feedback
- CCG strategy for area (include 'Patient choice of practice')
- Premises
- Other relevant information
- Options / Recommendations

This is not an exhaustive list, please consider any/all relevant information.

Time-frame: for the next anticipated PCCC Meeting

Outcome of PCCC decision to be communicated using **Acknowledgement of Application to Change the Practice Area** (see **Resources**)

BOUNDARY CHANGE APPROVED

Formal letter from ***Commissioner*** to ***Practice*** detailing:

- Acceptance of proposal (with any conditions)
- Date changes will take effect from
- Notify NHS England of change in boundary
- Requirement for practice to update website/leaflets

Patients who subsequently fall outside of the new agreed area, but who are within the original practice area (main and outer boundary) can only be removed from the list if one or more of the provisions of the relevant regulations/directions that relate to removal of patients from the practice's patient list apply *(as per 7.14.10 of PGM 21/22).*

Time-frame: as soon as possible following PCCC Meeting

BOUNDARY CHANGE REJECTED

Formal letter from ***Commissioner*** to ***Practice*** detailing:

- Reasons for rejection
- Right to appeal (**within 28 calendar days**)
- New application to vary practice area will **not** be considered for a set period *(as per 7.14.9 PGM 21/22)*.

Time-frame: as soon as possible following PCCC Meeting

RESOURCES

Primary Medical Care Policy and Guidance Manual (PGM)
https://www.england.nhs.uk/publication/primary-medical-care-policy-and-guidance-manual-pgm/

ANNEX 13A: Template Application to Change the Practice Area
https://www.england.nhs.uk/publication/primary-medical-care-policy-and-guidance-manual-financial-changes-statement-of-financial-entitlements-annexes/

ANNEX 13B: Acknowledgement of Application to Change the Practice Area
https://www.england.nhs.uk/publication/primary-medical-care-policy-and-guidance-manual-financial-changes-statement-of-financial-entitlements-annexes/

Version Control	
July 2021	v1.0
July 2021	REVIEW

D

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		**Date:**	3 August 2021	**Paper:**	**D**
	Public ✓	Confidential				
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.
	  ○ Two CQC reports have been published since the last meeting
	  ▪ Spirit Rushey Mead Health Centre – overall rating Good
	  ▪ Maples Family Medical Practice – overall rating of good
	• The number of practices who are receiving increased support and monitoring and/or additional monitoring and oversight from CCG teams is five.					

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
August 2021

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

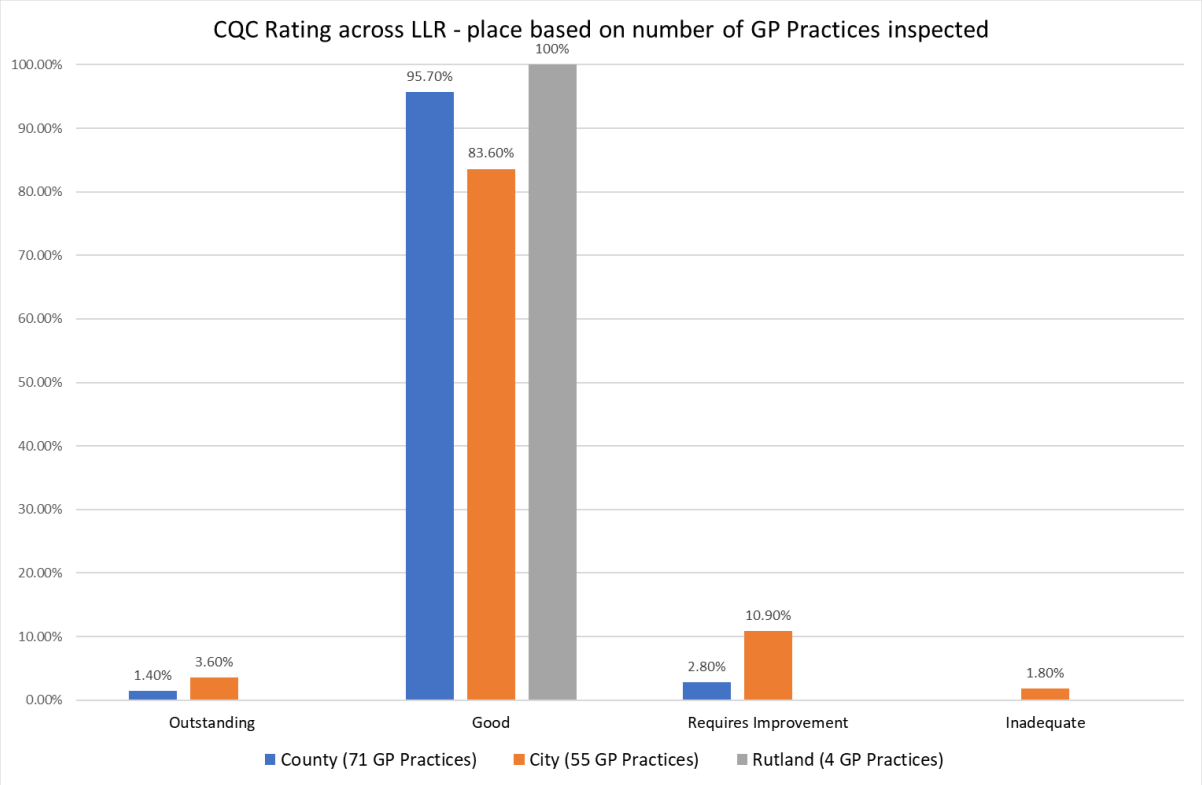
5. At the time of writing two CQC inspection report have been published since the last Primary Care Commissioning Committee in common meeting as summarised below.

Practice Name	Spirit Rushey Mead Health Centre	Maples Family Medical Practice
Date of inspection	31/05/2021	20/05/2021
Date of Report	24/06/2021	09/07/2021
Overall rating	Good	Good
Are services safe?	Requires Improvement	Good
Are services effective?	Good	Good
Are services caring?	Good	Good
Are services responsive?	Good	Good
Are services well-led?	Good	Good

6. Rushey Mead Health Centre: Desktop follow up inspection focussed on the breaches of regulations following an inspection in October 2019. The breaches of regulation were met, the practice remains requires improvement for safe services as they need to improve the records kept for health and safety and ensure actions identified are addressed. Support will be provided as required and monitored via the GP Quality Operational Group.

7. Maples Family Medical Practice: The practice had previously received a comprehensive inspection in October 2019 when it received an overall rating of requires improvement. The practice is now rated as good for providing safe, effective, caring, responsive and well-led services. All population groups were rated as good.

8. 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, at place level is indicated below.



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

Aggregated General Practice Information

10. 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.

11. There are currently 5 General Practices on the LLR GP Risk Log receiving enhanced monitoring and/or support or increased monitoring:

2020/21	**July 2021**
New this month	0
Closed this month	2
Total number of practices on LLR Risk Log	5

12. 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

13. 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.

14. 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.