### AGENDA

<table>
<thead>
<tr>
<th>Item No: 14</th>
<th>Agenda Item</th>
<th>Member Responsible</th>
<th>Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>PUBLIC PARTICIPATION</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>1.</td>
<td>Chair’s Welcome</td>
<td>Mr Graham Burgess</td>
<td>Verbal</td>
</tr>
<tr>
<td>2.</td>
<td>Apologies for Absence and Confirmation of Quoracy</td>
<td>Mr Graham Burgess</td>
<td>Verbal</td>
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<td></td>
<td>Mr Peter Sellars</td>
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<td>3.</td>
<td>Declarations of Interest</td>
<td>Mr Graham Burgess</td>
<td>Verbal</td>
</tr>
<tr>
<td>4.</td>
<td>Questions from Members of the Public</td>
<td>Mr Graham Burgess</td>
<td>Verbal</td>
</tr>
<tr>
<td></td>
<td>Please note that questions must be submitted in advance of the meeting, in line with the protocol which can be found on the CCG website.</td>
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</tbody>
</table>

### BUSINESS

| | | | |
| 5. | Draft minutes of the meeting held on 31st May 2016 | Mr Graham Burgess | Attached |
| 6. | Action Matrix Matters Arising | Mr Graham Burgess | Attached |
| 7. | Primary Care Update Report | Dr Malcolm Ridgway | Attached |
| 8. | Draft version of the Primary Care Strategy | Dr Malcolm Ridgway | Attached |
| 9. | Blackburn with Darwen Estates Strategy | Dr Stephen Gunn | Attached |
| 10. | Chair’s Action North Locality Estates Bid | Dr Stephen Gunn | Attached |
| 11. | CCG Assurance Framework 2016/17 Delegated Functions - Self-certification Q1 | Dr Malcolm Ridgway | Attached |

### FOR INFORMATION

| | | |
| 12. | Primary Care Services – Financial Summary | Mr Roger Parr | Attached |
| 13. | Any Other Business | All | |

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<table>
<thead>
<tr>
<th>Item</th>
<th>Agenda Item</th>
<th>Member Responsible</th>
<th>Report</th>
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<tbody>
<tr>
<td>PART 2</td>
<td></td>
<td></td>
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<tr>
<td>A/3.</td>
<td>Draft minutes of:</td>
<td>Mr Graham Burgess</td>
<td>Attached</td>
</tr>
<tr>
<td>A/3.1</td>
<td>Part 2 of the meeting held on 15&lt;sup&gt;th&lt;/sup&gt; March 2016</td>
<td>Mr Graham Burgess</td>
<td>Attached</td>
</tr>
<tr>
<td>A/3.2</td>
<td>Part 2 of the meeting held on 31&lt;sup&gt;st&lt;/sup&gt; May 2016</td>
<td>Mr Graham Burgess</td>
<td>Attached</td>
</tr>
<tr>
<td>B/3</td>
<td>Action Matrix</td>
<td>Mr Graham Burgess</td>
<td>Attached</td>
</tr>
<tr>
<td>C/3.</td>
<td>General Practice Report</td>
<td>Dr Malcolm Ridgway</td>
<td>Verbal</td>
</tr>
<tr>
<td>D/3</td>
<td>P81607 (The Montague Practice) transfer of PMS to GMS</td>
<td>Dr Malcolm Ridgway</td>
<td>Attached</td>
</tr>
<tr>
<td>E/3</td>
<td>Report from the Quality Performance and Effectiveness Committee (QPEC) Chair – Contractual Issues</td>
<td>Dr Nigel Horsfield</td>
<td>Verbal</td>
</tr>
<tr>
<td>F/3</td>
<td>Any Other Business</td>
<td>Mr Graham Burgess</td>
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Item 5

CLINICAL COMMISSIONING GROUP (CCG)

Minutes of the Primary Care Commissioning Committee (PCCC) held on
Tuesday 31st May 2016
in Meeting Rooms 1 & 2
Kings Court, 33 King Street, Blackburn, BB2 2EF

PRESENT:
Mr Graham Burgess Lay Member (Chair)
Dr Malcolm Ridgway Clinical Director for Quality and Effectiveness
Mr Roger Parr Chief Finance Officer
Mrs Anne Asher Lay Member – Nurse Representative
Mr Paul Hinnigan Lay Member - Governance
Dr Nigel Horsfield Lay Member - Secondary Care Doctor (Retired)

IN ATTENDANCE:
Mrs Sarah Danson NHS England
Mr Stephen Gough NHS England
Mr Mark Rasburn Blackburn with Darwen Healthwatch
Mr Ian Grimshaw Lay Person Representative
Mr Joe Slater Lay Person Representative
Mr Duncan McGrath Local Medical Committee
Mrs Julie Kenyon Senior Operating Officer – Primary Care and Medicines Commissioning
Mrs Hannah Sellers CCG Development Officer (minutes)

<table>
<thead>
<tr>
<th>Min No:</th>
<th>Description</th>
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<tbody>
<tr>
<td>7.01</td>
<td>Chair’s Welcome</td>
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</table>

The Chair welcomed everyone to the meeting and gave a short brief with regards to the content of the agenda and housekeeping.

| 7.02    | Attendance at Part 2 of the Meeting |

The Chair summarised the discussions which had taken place during the meeting on 15th March around attendance at Part 2 of the meeting and clarified that after further looking into the governance and Term of Reference of the group, it would be most appropriate for voting members only to remain for Part 2 of the Meeting. Mr Roger Parr confirmed that voting members of the committee are CCG Officers and CCG Lay Members. Other members of the committee will be asked to leave after Part 1, however they will be asked to attend on an exception basis, dependent on the content of the meeting.

RESOLVED: That attendees at Part 2 of the meeting will be limited to voting members only.

| 7.03    | Apologies for Absence and Confirmation of Quoracy |

Apologies for absence were received in respect of:

Mrs Debbie Nixon Chief Operating Officer
Dr Stephen Gunn  Clinical Lead for Primary Care
Mr Peter Sellars  Primary Care Transformation Manager
Dr Gifford Kerr  Public Health
Ms Sally McIvor  Health and Wellbeing Board

The meeting was confirmed as quorate.

### 7.04 Declarations of Interest

There were no declarations of interest.

The Chair reminded those present that if during the course of discussions, any further conflicts of interest became apparent, they should be declared at that point.

### 7.05 Minutes of the Meeting held on 15th March 2016

The minutes of the previous meeting were reviewed and accepted as an accurate record.

**RESOLVED:** That the Minutes of the Meeting held on 15th March 2016 were approved as an accurate record.

### 7.06 Election of the Vice Chair

The Chair notified members of the requirement for a Vice Chair of the Committee who is required to be a CCG Lay Member. The Chair asked for suggestions and members proposed Dr Nigel Horsfield as a suitable candidate.

**RESOLVED:** That Dr Nigel Horsfield was elected as Vice Chair of the PCCC.

### 7.07 Action Matrix / Matters Arising

There were no matters arising.

The action matrix was reviewed and completed actions were accepted as such by the committee.

Mrs Sarah Danson provided an update on the action points relating to minute 6.11.

Mrs Danson confirmed that a remedial notice had been issued to the practice who had failed to submit their electronic declaration (EDEC). The practice has now submitted their EDEC.

Mrs Danson also reported that the 13 practices who had submitted negative responses on their EDEC have been written to and a review will be carried out when the responses have been clarified by practices. NHS England (NHS E) will advise the CCG of any action required as appropriate.

Questions and answers followed.

Mr Joe Slater queried the action relating to minute 6.06 and asked whether the telephone triage evaluation had been carried out as yet. Mr Roger Parr explained that the evaluation had not yet commenced but is expected to within the coming months. Mr Slater reported that he had received soft data indicating that some patients were not satisfied with the new procedure and may have left the practice as a consequence. Mr Slater asked whether information could be captured as part of the evaluation to provide further insight into this. Mr Parr agreed to investigate whether patients had left the practice as a result of the triage system being introduced and clarify the reasons for this. It was highlighted that the benefits of telephone triage could encourage patients to join the practice so perhaps the overall list size...
would be a good measure as it would indicate a significant change in registered patients.

**ACTION:** Mr Parr to confirm patient list for the practice trialling telephone triage to highlight any recent changes. Mr Parr to also confirm why patients may have left the practice due to the introduction of telephone triage and clarify the reasons for this.

### 7.08 General Practice Forward View (GPFV) Presentation

Dr Malcolm Ridgway provided members with a presentation on the recently released GPFV. Dr Ridgway highlighted that the plan had been developed to address the pressures in Primary Care and the requirement for an increased focus on General Practice in order to address the current issues. The key points were noted as follows:

- There is a lack of new GPs entering General Practice, in contrast to the increased number of consultants entering the field.
- A breakdown of the monies being invested into Primary Care and where these will be focused. Areas include sustainability and transformation, care closer to home, indemnity costs and capital investment.
- The focus on workforce through the GPFV, highlighting, recruitment, retention and return to practice schemes. Dr Ridgway also drew members’ attention to new roles, including Mental Health Therapists, Clinical Pharmacists and Physician Associates, which aim to reduce the burden on GP’s workload.
- The aim to reduce General Practice workload through new schemes and programmes which include support for struggling practices, simplified systems (to reduce bureaucracy) and health and wellbeing support for GP staff.
- The introduction of infrastructure schemes which include new rules that allow up to 100% reimbursement of premises development for practices and funding for technological development.
- The ambition to redesign care, including the Multi-speciality Community Provider (MCP) model which meets the requirement to deliver large scale integrated services in the community.

Dr Ridgway concluded the presentation by providing an overview of what the GPFV means for Blackburn with Darwen. Dr Ridgway highlighted how the GPFV resonates with the Quality and Outcomes Enhanced Service Transformation (QOEST) scheme and the requirements to develop Primary Care at scale.

Questions and answers followed.

There was a discussion around aligning the GPFV to the Primary Care Strategy and Dr Ridgway confirmed that the Primary Care Strategy was being updated to reflect the new requirements. The Chair asked that the Primary Care Strategy is presented to the PCCC, prior to circulation and actions will be agreed which will be aligned to the strategy and the wider Pennine Lancashire work.

**ACTION:** Dr Ridgway to present the updated Primary Care Strategy to the PCCC and upon approval, share the updated strategy with GP colleagues.

**RESOLVED:** That the PCCC noted the content of the presentation.

### 7.09 Primary Care Update

Dr Ridgway presented the report and members noted updates in the following areas:

- The CQC inspection regime will commence during June 2016 and the CCG will be working with practices throughout the process.
The Blackburn West Primary Care Transformation Fund Bid for estates development is due to be submitted to NHS E for evaluation on 2nd June 2016.

A fixed term Project Manager has been employed across six Lancashire CCGs to support practices in the implementation of the Care Certificate in Primary Care; the Practice Manager is employed utilising funding from Health Education England (HEE).

East Lancashire Hospital Trust (ELHT) has confirmed, in principle, their support for the development of the Primary Care Access Centre (PCAC).

The locality spokes continue to operate seven days per week; recently some appointments were offered to Accident and Emergency at ELHT to assist with pressures on the system.

A trial is due to launch within the next six to eight weeks, which aims to reduce unnecessary demand in General Practice by working collaboratively with local pharmacies to support patients with diagnosis and the issuing of Prescription Only Medications (POMs).

Questions and answers followed.

Following a question regarding the recent dip in the utilisation of locality appointments, the PCCC requested that appointment utilisation is monitored over the next month. If there is no improvement, the PCCC requested that an explanatory paragraph is included in the next report.

**ACTION:** Mr Parr to work with the Prime Minister’s Challenge Fund (PMCF) team to monitor locality spoke appointment utilisation over the next month and if no improvement is made, provide a brief report for the PCCC at the next meeting.

**RESOLVED:** That the PCCC noted the content of the report

### 7.10 Primary Care Quality Report

Dr Ridgway presented the report and provided an explanation to the PCCC around the various data sources available for monitoring quality in Primary Care and how this is managed, with appropriate information fed to various groups and committees. Dr Ridgway explained that currently all quality information is monitored by the Primary Care Group (PCG) and by the Quality, Performance and Effectiveness Committee (QPEC), whereas reduced information is presented to the Governing Body (GB) and PCCC.

Dr Ridgway reported on current quality issues, highlighting that there are currently four practices in BwD with six or more outlying parameters; this will be discussed with practices during the CCG Quality Visits. Dr Ridgway also reported on the Friends and Family Test stating that there is a generally low return overall across the CCG; however some practices have a much higher return than others. Dr Ridgway confirmed that the scheme to reduce prescription of unwarranted antibiotics has been successful to date.

Dr Ridgway provided a brief update on the Vulnerable Practice Programme, explaining that there can be numerous reasons for a practice being identified as vulnerable. At present, five practices in Blackburn with Darwen have been identified and the support programme to be offered to practices is currently being reviewed by NHS E.

Questions and answers followed.

Mr Stephen Gough brought the PCCC’s attention to the Quality Forum which has been introduced to triangulate the various sources of quality information available. A Quality Dashboard is currently under development at NHS E, being facilitated by the Commissioning Support Unit (CSU) and Mr Gough suggested that the committee and officers may wish to contribute ideas regarding what could be included.
ACTION: PCCC members and CCG officers to feed any suggestions for the NHS E Quality Dashboard to Mr Gough.

Following a discussion regarding the quality information discussed at each CCG committee and sub-group, Dr Ridgway agreed to review the decision making remit of PCCC to ensure that only the relevant information is provided.

ACTION: Dr Ridgway to review the decision making remit of the PCCC to ensure that Quality Reports provide only the relevant information.

RESOLVED: That the PCCC noted the content of the report

7.11 Support Framework For Vulnerable Practices

Dr Ridgway presented the report, providing a brief reminder of what the Vulnerable Practice Programme entails. Dr Ridgway highlighted to the PCCC that it does not mean a practice is underperforming if they are identified as vulnerable.

Dr Ridgway explained that practices identified as vulnerable will be offered a support package which is currently being developed by NHS E. If a practice declines the offer of support then the practice will be continue to be monitored and should issues develop or persist, normal contractual procedures apply.

RESOLVED: That the PCCC noted the content of the report

7.12 CCG Assurance Framework 2015/16 Delegated Functions – Self Certification Q4

Dr Ridgway presented the quarter four Delegated Functions Self Certification for information; the PCCC were advised that the submission had already been approved by the Audit Committee Chair and CCG Clinical Chief Officer.

RESOLVED: That the PCCC noted and approved the submission.

7.13 Primary Care Infrastructure Fund (PCIF), Revenue Consequences

Dr Ridgway presented the report and provided a brief background to the PCIF, explaining that the fund exists to support improvement requests from Primary Care, which aim to enhance the service delivered to patients. Dr Ridgway described the assessment process and why notional rent increase occurs.

Dr Ridgway reported to members regarding the notional rent increase for Pringle Street Surgery, whose bid to the PCIF was approved by NHS E, prior to the CCG taking full delegated responsibility for Primary Care.

Questions and answers followed.

Dr Ridgway provided assurance that any future bids will need to be aligned to the local estates strategy and bids that do not support the overall estates plan and Primary Care Strategy will be challenged.

RESOLVED: That the PCCC agreed to support the increase in notional rent payments for Pringle Street Surgery.

7.14 Primary Care Services – Financial Summary

Mr Parr presented the Primary Care Services Financial Summary for information and drew
members’ attention to the year-end position, highlighting a slight overspend driven by prescribing.

Mr Parr highlighted expenditure now being incurred as part of Primary Care running costs. The running costs were transferred to the CCG when full delegated responsibility for Primary Care commenced and as a result unforeseen costs are now impacting on the CCG’s budget. Mr Parr explained that this has been raised with NHS E but made the PCCC aware that this may affect the budget going forward.

Mr Gough agreed to escalate the issue with the Head of Primary Care at NHS E and report back.

**ACTION:** Mr Gough to raise the issues running costs with the Head of Primary Care at NHS E and report to the committee.

If the situation is not resolved, the Chair requested that Mr Parr draft a letter from the Clinical Chief Officer and Chair of the CCG, escalating the issue with NHS E.

**RESOLVED:** That the PCCC noted the content of the report.

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<thead>
<tr>
<th>7.15</th>
<th>Any Other Business</th>
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<tbody>
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<td>There were no items of Any Other Business.</td>
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<table>
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<tr>
<th>7.16</th>
<th>Date and Time of Next Meeting</th>
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<tr>
<td>The next meeting will be held on 19th July 2016 at 12.30pm in Meeting Rooms 1 &amp; 2 Kings Court, 33 King Street, Blackburn, BB2 2EF</td>
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### PRIMARY CARE CO-COMMISSIONING COMMITTEE (PCCC) - ACTION MATRIX

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<th>Action</th>
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<tr>
<td>7.07</td>
<td>Mr Roger Parr to confirm patient list for the practice trialling telephone triage to highlight any recent changes. Mr Parr to also confirm why patients may have left the practice due to the introduction of telephone triage and clarify the reasons for this.</td>
<td>RP</td>
<td>July 2016</td>
<td>ONGOING Information requested from the LPC</td>
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<tr>
<td>7.08</td>
<td>Dr Malcolm Ridgway to present the updated Primary Care Strategy to the PCCC and upon approval, share the updated strategy with GP colleagues.</td>
<td>MR</td>
<td>July 2016</td>
<td>COMPLETED Primary Care Strategy on PCCC agenda for 19th July 2016.</td>
</tr>
<tr>
<td>7.09</td>
<td>Mr Parr to work with the Prime Minister’s Challenge Fund (PMCF) team to monitor locality spoke appointment utilisation over the next month and if no improvement is made, provide a brief report for the PCCC at the next meeting.</td>
<td>RP</td>
<td>July 2016</td>
<td>COMPLETED Ongoing evaluation. Utilisation has improved.</td>
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<tr>
<td>7.10</td>
<td>PCCC members and CCG officers to feed any suggestions for the NHS E Quality Dashboard to Mr Gough.</td>
<td>All</td>
<td>As soon as possible</td>
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<tr>
<td>7.14</td>
<td>Mr Stephen Gough to raise the issues running costs with the Head of Primary Care at NHS E and report to the committee. If the situation is not resolved, the Chair requested that Mr Parr draft a letter from the Clinical Chief Officer and Chair of the CCG, escalating the issue with NHS E.</td>
<td>SG</td>
<td>July 2016</td>
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### Primary Care Update Report

| Date of Meeting | 19th July 2016 | Agenda Item | 7. |

#### CCG Corporate Objectives

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<th>Objective</th>
<th>Status</th>
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<tr>
<td>Through better commissioning, improve local health outcomes by addressing poor outcomes and inequalities</td>
<td>Y</td>
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<tr>
<td>To work collaboratively to create safe, high quality health care services</td>
<td></td>
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<tr>
<td>To maintain financial balance and improve efficiency and productivity</td>
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<tr>
<td>To deliver a step change in the NHS preventing ill health and supporting people to live healthier lives</td>
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<tr>
<td>To maintain and improve performance against core standards and statutory requirements</td>
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<tr>
<td>To commission improved out of hospital care</td>
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#### CCG High Impact Changes

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<tr>
<td>Delivering high quality Primary Care at scale and improving access</td>
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<tr>
<td>Self-Care and Early Intervention</td>
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<td>Enhanced and Integrated Primary Care and Better Care Fund</td>
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<td>Access to Re-ablement and Intermediate Care</td>
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<td>Improved hospital discharge and reduced length of stay</td>
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<td>Community based ambulatory care for specific conditions</td>
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<td>Access to high quality Urgent and Emergency Care</td>
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<td>Scheduled Care</td>
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<td>Quality</td>
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#### Clinical Lead:

Dr Malcolm Ridgway

#### Senior Lead Manager

Mr Peter Sellars

#### Finance Manager

Ms Linda Ring

#### Equality Impact and Risk Assessment completed:

n/a

#### Patient and Public Engagement completed:

n/a

#### Financial Implications

n/a

#### Risk Identified

n/a

Report authorised by Senior Manager:

#### Decision Recommendations

The Primary Care Co-commissioning Committee (PCCC) is asked to receive this report and note the items as detailed.
Primary Care Update Report

July 2016

1. Introduction

1.1. This report provides the PCCC with an update on national and local Primary Care news and information, highlighting areas not covered elsewhere on the agenda.

2. Primary Care Workforce Development

2.1 Health Education England (HEE) has released their Workforce Transformation Offer for 2016/17 which includes support for new roles, upskilling existing staff and new ways of working. The CCG will be linking with HEE North West (NW) and with Primary Care Providers to promote Advanced Practitioner training, Assistant Practitioner training, apprenticeships for Medical Assistants and non-medical prescribing qualifications, which are all part of the 2016/17 offer. In addition, the CCG continue to support the Physician Associate Pilot Programme and members of the GP federation continue to attend the Population Centric Workforce Model Development Programme.

2.2 On 4th July 2016, the CCG participated in a Careers Day, as part of the East Lancashire Careers Hub, funded by HEE NW. The event was hosted by East Lancashire Hospital Trust (ELHT) and was attended by approximately 80 students from local schools, between the ages of 11 and 14. The event aimed to promote the variety of careers available in Primary Care and students appeared to engage with sessions provided. A report compiled from student evaluations will be available to the committee once received.

3. General Practice

3.1 All member practices have now signed up for the plans element of the Quality and Outcomes Enhanced Service Transformation Scheme (QOEST) to be delivered by the GP federation, Local Primary Care. Development work will now commence, with the first draft of the plans being due in October 2016.

4. Update from the Primary Care Group

4.1 The CCG has submitted three bids against the Estates and Technology Transformation Fund (ETTF) these being both the North and West Locality individual Health Centre development, in addition to the Primary Care Access Centre (Prime Minister’s Challenge Fund) based on the Royal Blackburn Hospital site. The bids had to be uploaded to a central NHS England Portal by 30th June 2016 and will now go through several layers of assessment over the next few months. Successful submissions will require the production of a full business case upon approval.

5. Prime Minister’s Challenge Fund (PMCF)

5.1 Primary Care Access Centre (PCAC)

BwD CCG and the East Lancashire Hospital Trust’s (ELHT) Board have recently confirmed their support, in principle, to the development of the PCAC. However discussions need to continue around how the system risks are managed and ensure this continues to be aligned to the Primary Care Strategy.
5.2 **Locality Spokes**

The PMCF continues to provide additional access at three hubs across Blackburn with Darwen between Monday and Friday. Weekend access is available for all practices on Saturday and Sunday, operated from Barbara Castle Way Health Centre. The project team has been undertaking regular reviews of the existing model and has concluded that the additional access is not being utilised effectively. The model has therefore been refined and includes a telephone consultation service. The model has received support from stakeholders and is ready to mobilise. The GP federation continues to work with East Lancashire Medical Service (ELMS) to trial an enhanced GP service at weekends. Patients who access the out of hours service are offered an appointment at the Locality Spokes if this is more convenient for them. This increases the capacity in the system and improves patient choice. This is well utilised and is offering resilience.

5.3 **Telephone Triage – Patient Signposting**

Supporting patients to access services in a different way is critical to supporting practices to manage patient need and improve access. Funding has been made available to practices to help them introduce triage systems, allowing patients to be seen by the appropriate clinician at the appropriate time, based on their presentation. General uptake from the practices has been very low, even after two rounds of expressions of interest. The view is that any scheme requires a commitment in practice time, both clinical and managerial.

We do appreciate that practices already have significant workloads, so finding time for new initiatives will always be a challenge. The project team is looking at other initiatives to support practices.

5.4 **Pharmacy Scheme – Accessing Health Care**

As with item 5.3, this proposal will help reduce unnecessary demand at practice level and improve access. A review of clinical presentations at the Locality Spokes has identified that over 30% of patients presented with symptoms/conditions that could have been appropriately managed by a pharmacist.

Since the last update considerable progress has been made. A service specification has been developed around the conditions groups and the level of support to be offered by pharmacists has been agreed. The project team is looking to launch a trial in the Darwen Locality and local practices and pharmacists are currently being consulted. The vision for the scheme will see patients who present at practice with one of the defined conditions signposted to an approved pharmacy. The pharmacist will manage the entire episode. It is envisaged the trial will launch in the summer.

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**Dr Malcolm Ridgway**  
Clinical Director for Quality and Primary Care Transformation  
July 2016
APPENDIX 1

<table>
<thead>
<tr>
<th>Date</th>
<th>Darwen</th>
<th>East/West</th>
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Primary Care Co-Commissioning Committee

Primary Care Strategy Update

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<th>19th July 2016</th>
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**CCG Corporate Objectives**

- Through better commissioning, improve local health outcomes by addressing poor outcomes and inequalities: Y
- To work collaboratively to create safe, high quality health care services: Y
- To maintain financial balance and improve efficiency and productivity: Y
- To deliver a step change in the NHS preventing ill health and supporting people to live healthier lives: Y
- To maintain and improve performance against core standards and statutory requirements: Y
- To commission improved out of hospital care: Y

**CCG High Impact Changes**

- Delivering high quality Primary Care at scale and improving access: Y
- Self-Care and Early Intervention
- Enhanced and Integrated Primary Care and Better Care Fund: Y
- Access to Re-ablement and Intermediate Care
- Improved hospital discharge and reduced length of stay
- Community based ambulatory care for specific conditions
- Access to high quality Urgent and Emergency Care: Y
- Scheduled Care: Y
- Quality: Y

**Clinical Lead:** Dr Stephen Gunn

**Senior Lead Manager:** Mr Peter Sellars

**Finance Manager:** Mrs Linda Ring

**Equality Impact and Risk Assessment completed:**

- Yes for Original strategy. Will need further assessments depending on schemes within the strategy

**Patient and Public Engagement completed:**

- Yes for Original strategy. Will need further assessments depending on schemes within the strategy

**Financial Implications:**

- Will need further assessments depending on schemes within the strategy

**Risk Identified:**

- If Strategy not agreed then transformation of primary care will be limited

**Report authorised by Senior Manager:** Dr Malcolm Ridgway

**Decision Recommendations**

Members to receive the paper and to approve the strategic direction
**Introduction**

Blackburn with Darwen Clinical Commissioning Group (CCG) is committed to improving the health and quality of care for the local population as explicitly stated in its mission statement:

“To deliver effective, efficient, high quality, safe, integrated care. This will improve the health and wellbeing of the population of Blackburn with Darwen and help people live better for longer, reducing health inequalities and improving outcomes in the borough.”

Primary care and, in particular, General Practice as the cornerstone of NHS provision, providing the bulk of interactions with the NHS yet receiving a relatively small and reducing proportion of the total NHS budget. Primary care is also considered key to improving productivity and cost effectiveness of the health and care system given the financial challenges facing the NHS.

**Primary Care Vision**

General Practice is recognised as the foundation of NHS provision, providing the first point of access to advice, diagnosis and treatment together with on-going support and disease management. Blackburn with Darwen’s primary care vision is to commission a service that;

- Preserves the best of traditional General Practice i.e. continuity, holistic and family based care
- Provides continuous quality improvement and reduced variation
- Is cost effective
- Is accessible to patients
- Reduces reliance on secondary care
- Sustains and prospers into the future
- Is attractive to new and existing GPs

To achieve this vision it is imperative that General Practice changes from its current fragmented model of small independent units, to an integrated high quality service provider, having collective responsibility for the health of the population.

General Practice will provide care to a registered list of patients throughout their lifetime whilst retaining its “gatekeeper” role. GPs also have a key role in managing people out of hospital whenever possible. This will mean GPs having to prevent, diagnose and treat illnesses better to manage increasingly complex multi-morbidity, both for ongoing care and exacerbations. To free up capacity to do this, GPs will have to...
delegate tasks to others such as administration, dealing with minor ailments, routing chronic disease management and paperwork. For this change to be informed, transformational and sustainable it needs to be driven by GPs.

Case for Change

General Practice is under pressure from an increasing range of supply, demand and other factors as identified by both NHS England’s 5 Year Forward View and the General Practice Forward View, these being:-

- An ageing population with multiple co-morbidities and increased frailty
- Increasing patient expectations
- Increasing pressure on NHS financial resources
- Growing dissatisfaction with access to services (the GP Patient Survey continues to show reduced satisfaction with access, both for in-hours and out-of-hours services, particularly in certain parts of the town).
- Increasing workforce pressures, including recruitment and retention of GPs and nurses both locally and nationally.

There are increasing demands on GPs themselves to do work outside of the practice such as CCG clinical lead roles or working in urgent primary care (GP Out of Hours, Acute Visiting Service, Prime Minister’s Challenge Fund etc). Bureaucracy in practices has also increased with CQC inspections, revalidation, requests for reports and information etc. Complaints and litigation are now more widespread with increased scrutiny from the GMC and the press further increasing pressures on GPs.

There is also evidence of variability in access and clinical outcomes between practices and localities which must be addressed. Centrally there is a political imperative to widen access to General Practice to 8am-8pm, 7 days per week, improve patient’s experience of services and reduce unwarranted variation. All the above are resulting in General Practice struggling and becoming unsustainable.

Local Challenges

In Blackburn with Darwen the current business model for many practices is based around relatively small organisations working independently. The greatest potential for Primary Care could be reached by General Practice working more closely together. The shift of care to out-of-hospital settings is a significant opportunity for General Practice, yet the ability to undertake this is compromised by the small, fragmented organisational form, together with variability in service provision, premises and workforce issues.

Current Plans

Integrated teams based in localities are now operational but requires further development. The multi-disciplinary integrated teams are coterminous with the 4 established localities of North, East, West Blackburn and Darwen, and are providing care for the registered population of the practices in those localities. An Intensive support at home programme and a directory of services/navigation hub has also been introduced to further support care based in the community. This will require expansion if the numbers
of patients requiring hospital admission are to be reduced, either by admission avoidance or by supporting earlier discharge.

Blackburn with Darwen CCG has developed a quality scheme - the Quality and Outcomes Enhanced Services Transformation (QOEST) scheme. This scheme amalgamates and simplifies the existing Local Improvement Schemes (LIS’s), rationalising the payment system and requiring the production of Quality, Access and Sustainability plans. The scheme will encourage practices to work together, improve outcomes, reduce the bureaucratic burden and improve work life balance.

A Blackburn with Darwen GP Federation has now been established and is in the process of providing both clinical and management support for the delivery of QOEST on behalf and in collaboration with the practices.

Service delivery vision

Blackburn with Darwen CCG’s vision is for Primary Care to function within an integrated health and social care system, with providers working together and supporting each other for the benefit of patients and staff. This is likely to include primary and secondary care, social care and the voluntary sector and will be enabled by integrated IT, aligned incentives and contracts and a change in culture (staff and the public) to provide high quality cost effective services.

In addition to developing General Practice, GPs will need to work with other professionals (community nursing, social care, community mental health, third sector) as part of locality based integrated multidisciplinary teams working together to prevent illness, promote healthy living, diagnose illness early, treat safely in line with best evidence and educate the public in self-care and early recognition of illness. GPs will manage complex multi-morbidity and treat illness and exacerbations in the community whenever possible. To free up the capacity to undertake this expanded role, other duties such as care of minor ailments, routine QoF, Chronic Disease Management and practice bureaucracy (including administrating the practice, checking results etc.) must be undertaken by other members of the primary health care team. This will require / necessitate a greater skill mix and development of new roles within practices including medical assistants, clinical practice pharmacists, physician’s associates, advanced nurse practitioners etc.

Delivery of these services will be close to home, where safe to do so within modern, fit for purpose premises based on a hub and spoke configuration (i.e. larger facilities with satellite surgeries to provide local care depending on need), or in the patients home when required. Community bed provision may be required depending on the ultimate model of care. Primary Care will be accessible on a 24/7 basis through core, extended and out of hours services, utilising the best in digital communication to improve access and convenience. Improvements in IT will include access to patients’ own records, ordering prescriptions, making appointments and accessing medical advice and information on line.

This vision will create the foundation of an Accountable Care System, with General Practice at the centre and operating at scale through the development of larger practice groups commissioned via a Multi-Speciality Community Provider (MCP) contract. In this system there will be a reduced reliance on hospital based care with more care (and thus resources) in the community.

This ‘new’ form of Primary Care delivery, will provide the best of General Practice as well as offering a greater range of services through working with other community based services, the third sector, consultant colleagues etc. Staff will again want to work in Primary Care due to improved job satisfaction, career prospects and work life balance.

The CCG will involve practices to collaboratively develop this vision with patients and other partner organisations.

Primary Care Co-Commissioning Committee
Page 4 of 6
What needs to be done?

In understanding the current pressures and aspirations both from the Government and the public to improve Primary Care, it will be necessary to jointly develop sustainable organisational solutions. These will need to be sufficiently radical and innovative to improve both quality of care and access along with attracting high quality staff in an environment of increasing demand and constrained resources.

General Practice is at a tipping point and has the opportunity to proactively develop new models of care provision, working with colleagues and other partners to deliver improved population health and patient experience whilst remaining within current and anticipated future financial resources. This is supported by the 5 Year forward View, the General Practice Forward View and facilitated by the Blackburn with Darwen CCG QOEST scheme.

How will this be achieved?

This strategy sets out the CCG’s aspiration to work with General Practice in developing the vision for an improved Primary Care Service. This will be a key part of the wider system changes needed to improve outcomes, meet demand, achieve financial balance and make the local NHS locally attractive to work. This will require a programme of work, using the QOEST scheme as an enabler, to engage with General Practice and the community, to develop the overall strategic vision with a plan for implementation over the next 5 years.

The CCG will help and support the facilitation of new GP “Champions” and leaders, creating time to design and plan the new model of care. The planning will always be GP/clinically driven, providing a ground up solution that patients and staff can feel involved in and support.

The CCG will commission this via the full delegated arrangements of Co Commissioning Primary Care (General Practice) working with NHS England. It will facilitate the necessary engagement with practices, the public, other provider colleagues and stakeholders such that a mutually agreeable solution is developed.

Estate and Infrastructure

Recognising that major service change and delivery will inevitably require appropriate high quality estate and supportive infrastructure such as Information Technology, the Estates strategy has been refreshed to reflect future requirements.

Any estate development will naturally be driven by the service delivery model, the expectation being through larger “hub” sites, whilst continuing to support development of the smaller “spoke” surgeries closer to people’s homes within each of the 4 localities.

Integrated electronic care records will enable improved, safer care across the system and better communication between services. Social media and other forms of electronic communication will play an increasing role in educating and caring for people in convenient and accessible formats. Telemedicine will facilitate consultations and monitoring of patients, with tele-care increasingly supporting peoples' independence in the community.

Workforce

Blackburn with Darwen (BwD) CCG has a high proportion of GPs and Practice Nurses who are nearing retirement age. In addition there is lack of new GPs entering General Practice within BwD and as such, innovative solutions are required in order to create a sustainable model for the future.
There is opportunity for improved skill mix across General Practice in BwD, utilising some of the emerging Primary Care roles to ease the pressures on GPs and release some of their time. BwD CCG is working closely with Health Education England to ensure that schemes and resources available to Primary Care colleagues are appropriately promoted and implemented. The emerging roles in Primary Care are listed as follows:

- Care navigation
- Health coaching
- Prescribing Clerk
- Medical Assistant
- Assistant Practitioner
- Pharmacy Technician
- Associate Nurse (in consultation)
- Community Specialist Paramedic (temporary project)
- Pharmacist ("practice-based" or "clinical")
- Advanced Practitioner
- Physician Associate

Although certain initiatives are already underway within General Practice, there is a requirement to progress this work to ensure effective skill mix across the entire BwD footprint. Integrated working across practices, including shared staff, could help practices to utilise these new roles in the most effective manner.

The CCG, together with General Practice and the wider NHS, needs to create an attractive working environment to attract the best doctors, nurses and other staff to work in Blackburn with Darwen. There is an opportunity to link with the wider health economy and create portfolio careers for new GPs and other healthcare professionals. Portfolio working has been highlighted as something that General Practice currently lacks. There will also be a strong emphasis on training and development. In the short term, work will be undertaken to help Practice Managers promote new roles within their practices, think innovatively about replacing and plan for future workforce.

**Conclusion**

There is an opportunity for General Practice in Blackburn with Darwen to redefine primary and community care services for the benefit of patients and the local population. The approach suggested within this strategy is to support provider development and enabling clinical provider led transformation and innovation. This will ensure that the future of General Practice and Primary Care is sustainable, delivering high quality and accessible services to the local population as close to home as possible.

Peter Sellars
Primary Care Transformation Lead
June 2016
## Blackburn with Darwen Estates Strategy

### Date of Meeting
19th July 2016

### Agenda Item
9.

### CCG Corporate Objectives

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### Decision Recommendations

The PCCC are asked to approve the Estates Strategy

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**Clinical Lead:**
Dr Stephen Gunn

**Senior Lead Manager:**
Mr Peter Sellars

**Finance Manager:**
Mrs Linda Ring

**Equality Impact and Risk Assessment completed:**
To be determined dependant on Scheme

**Patient and Public Engagement completed:**
To be determined dependant on Scheme

**Financial Implications:**
To be determined dependant on Scheme

**Risk Identified:**
To be determined dependant on Scheme

**Report authorised by Senior Manager:**
Dr Malcolm Ridgeway
Introduction

Blackburn with Darwen CCG has undertaken a review of the Primary Care estates in the CCG’s area in order to align the future estate with commissioning service requirements. This will deliver both clinical and financial benefits, though a more accessible service model and increased utilisation of existing estate. Pennine Lancashire Strategic Estates Group has set savings targets, with each of its two CCGs (East Lancashire and Blackburn with Darwen) developing their own strategic estates plans. The estates plan will be service led and as such, any estate development will naturally be driven by the service delivery model, the expectation being through larger “hub” sites, whilst continuing to support development of the smaller “spoke” surgeries closer to where people live, within each of the four localities. The estates plan adopts a system wide view, reinforcing the importance of integrated services within any future Primary Care estates development. It is also critical that new estates are fit for the future and able to provide services within a new model of care.

Population Overview

At midyear 2010 the resident population of Blackburn with Darwen was estimated to be 140,000, with 170,000 patients registered with a GP in Blackburn with Darwen. Over the last five years the population of the borough has remained relatively stable. From a population size of 139,900 in 2006 there has been a small increase of 0.1%.

30.3% of residents in the borough area aged 0 to 19. This is the highest proportion of young people in England and Wales, on a par with Newham in London. Only 12.9% of residents in Blackburn with Darwen are aged 65 and over, compared to 16.7% in the North West and 16.6% in England and Wales as a whole. The 2010 Index of Multiple Deprivation ranks the borough as the 17th most deprived authority in England (on the rank of average score). With a third of residents living in areas classified as being in the most 10% deprived in England.

Data from the 2001 Census highlighted that 22.1% of the borough’s population were from Black and Minority Ethnic groups. More recent the Office of National Statistics (ONS) data estimates suggest that this figure has not changed significantly.

In 2010 around 880 foreign national adults living in the borough applied for National Insurance Numbers, 200 were from Pakistan, 170 Poland and 120 India.

Health

Life expectancy in the borough for both men (74.8 years) and women (79.6 years) is one of the worst of all local authorities in England, ranking 320 of the 326 local authorities. Within the borough, life expectancy in the most deprived 10% of the borough is 12.4 years lower for men and 7.1 years lower for women compared to the least deprived 10% of Blackburn with Darwen.

Over the last 10 years, all-cause mortality rates have fallen, along with early deaths from cancer and from heart disease and stroke, but remain worse than the England average.

Estates within a National Context

The NHS is facing extremely challenging times. Demand for services is rising faster than funding. The cost of drugs and new medical technology continue to rise. The population is changing, with an increasing number of older people, often with greater health and social care needs. The traditional approach of targeted service improvements and contract variations has in the main been successful to date. However it is now necessary to find new, transformational solutions to meet this unprecedented challenge.

In October 2014 NHS England’s Five Year Forward View was published setting out a clear direction for the NHS in respect of whole system integration of services, implementation of alternative care delivery models, a greater emphasis on prevention and self-management, and improving the quality of services by using its resources more effectively. The ‘Forward View’ clearly set out the financial challenge facing the NHS and
the actions required. In addition, NHS England’s ‘Everyone Counts: Planning for Patients 2014/15 – 2018/19 identifies GPs and other Primary Care providers being at the heart of integrated care. As the NHS works to redesign the delivery of services in response to the Forward View, high quality local estates planning is crucial and will require all parts of the NHS to work together to enable system wide transformation. It will be necessary for the estate to be reconfigured to accommodate the associated increase of services in the community and to provide opportunities for greater integration. Although the benefits for patients, and the NHS as a whole may be clear, implementation of the Forward View will inevitably place additional pressure on existing primary and community services and the estate from which they operate. The NHS estate is therefore both a key enabler and risk to the delivery of the objectives set out in the Forward View through its impact on quality and patient experience and its potential to deliver efficiencies.

In June 2015, the Department of Health (DH) issued guidance on the development of Strategic Estates Plans. A substantial improvement in the management of the NHS owned and occupied estate is required to respond to the challenges of the NHS Five Year Forward View. The NHS Constitution (Department of Health 2012) includes a requirement for health services to be delivered in fit for purpose, accessible, clean, and safe environments protected from risks associated with unsuitable and unsafe premises.

**Estates Overview**

Across the Blackburn with Darwen CCG area there are 27 GP practices covering a total registered patient population of approximately 170,000. GP practices and community providers operate from a mixture of old and new properties in varying conditions. Space utilisation is often perceived as an issue with many providers across the patch reporting a lack of space having an impact on their ability to effectively deliver services. A significant number of GP practices operate from premises that they own, often in converted domestic properties; others are located in rented accommodation, often in NHS health centres. Geographical access to GP practices across the area is generally good. However the population across the CCG district is set to rise over the next few years. In addition plans to increase the local housing stock will add significant pressure to existing health and local authority services with an inevitable impact on the estate.

**Overview of Existing Estate and Providers**

The reorganisation of the NHS has seen the ownership of the NHS Estate change over the past year. Property is now owned by Community Providers, NHS Property Services, Community Health Partnerships or Acute Trusts. The challenge faced by the system is to ensure that the NHS Estate responds to the needs of the local population and is used to support providers to deliver services that are accessible to patients and service users.

**Principles of the Pennine Lancashire Strategic Estates Group**

- Have a high quality, value for money, well utilised estate.
- Make system-wide savings, reducing estates costs by 15% over 5 years across the Pennine Lancashire Health economy - £8.85m.
- Adopt the One Public Estates principles, collaboratively using space across the public and wider voluntary sector.
- Enable delivery of the Five Year Forward View, ensuring the estate (and its management) is responsive and flexible to meet the changing needs of healthcare.

**Alignment of the Estates Plan to the Primary Care Strategy**
Blackburn with Darwen CCG’s vision for Primary Care is to function within an integrated health and social care system, with providers working together and supporting each other for the benefit of patients and staff. This is likely to include primary and secondary care, social care, community nursing and the voluntary sector and will be enabled by integrated IT, aligned incentives and contracts and a change in culture (staff and the public) to provide high quality, cost effective services.

In addition to developing General Practice, GPs will need to work with other professionals as part of locality based integrated multidisciplinary teams working together to prevent illness, promote healthy living, diagnose illness early, treat safely in line with best evidence and educate the public in self-care and early recognition of illness.

Delivery of these services will be close to home, where safe to do so within modern fit for purpose premises based on a hub and spoke configuration (ie larger facilities with satellite surgeries to provide local care depending on need), or in the patients home when required. Community bed provision may be required depending on the ultimate model of care. Primary Care will be accessible on a 24/7 basis through core, extended and out of hours services, utilising the best in digital communication to improve access and convenience. Improvements in IT will include access to patients’ own records, ordering prescriptions, making appointments and accessing medical advice and information on line.

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This ‘new’ form of Primary Care delivery, will provide the best of General Practice as well as offering a greater range of services through working with other community based services, the third sector, consultant colleagues etc. Staff will again want to work in Primary Care due to improved job satisfaction, career prospects and work life balance.

The CCG will involve practices to collaboratively develop this vision together with patients and other partner organisations.

Intenions of the Estates Plan

Primary Care Development

- New GP and community care facility in Blackburn West – three GP practices to be relocated.
- New GP and community care facility in the North locality 6 practices relocating.
- Federation development and expansion
- Multi-speciality Community Provider/s development through MCP contracting
- Prime Minister’s Challenge Fund – primary care access centre located at Royal Blackburn Hospital (RBH) site.
- 7 Day Access expanded through locality spoke developments

Integrated Locality Teams (ILT) Co-location

- Co-location of four health and social care teams across health and Local Authority estates in each of the four localities.

Potential Lancashire Care Foundation Trust (LCFT) Mental Health Facility

- New mental health facility proposed on land adjacent to Royal Blackburn Hospital.

Intermediate Care

- Feasibility into how intermediate care requirements of the CCG’s emerging strategy can be delivered through best use of existing land and assets.
**Healthier Lancashire and Combined Authority may change the future landscape for health and social care across the CCG patch – our strategy must be mindful of this moving forward.**

**Acute Hospital Master-planning**
- Options to re-purpose land/buildings at East Lancashire Hospital Trust (ELHT) acute site to help deliver the strategic visions of the Trust, CCG and wider health and social care economy.

**Drivers for Change**

Within this draft strategy a number of drivers for change in terms of strategic plans, changing populations and associated housing developments and clinical capacity requirements have been identified. An initial Gap Analysis has been undertaken based on core strategies, commissioning plans and the most recent surveys of current estate, and each CCG has identified priorities for change. The analysis will be further developed to inform more detailed proposals and longer term strategy.

**Stakeholder Engagement and Partnership Working**

The CCG has developed strong clinical relationships and local partnerships as the foundation for successful redesign of clinical pathways and is focussed on developing closer clinical engagement and integration between primary care, secondary care, community services, social care and voluntary sector. The CCG has a communication and engagement strategy which details the locally agreed approach with patients, public and local partners. The values, strategic objectives, local plans and priorities evolve from listening to patients, the public, partners and other stakeholders. The CCG has established patient fora which include representatives from each GP Practice’s Patient Participation Group. In addition to engaging with patients and carers, the CCG work with local stakeholders including the Borough Councils, healthcare providers and voluntary sector members. In developing plans, the CCG reflects the priorities detailed in the Health & Wellbeing Strategy and Better Care Fund Plans. All draft plans are consulted on with internal committees and external stakeholders. Every opportunity is taken to work collaboratively with local partners and providers to redesign and integrate care pathways and improve outcomes. The CCG will continue to engage with all stakeholders on all plans and on each specific proposal regarding changes to the estate.

**Financial Summary**

The CCG is developing a summary of the capital resources required to implement the strategy, including revenue consequences and any potential revenue savings associated with improving the estate. These will be included in the CCGs’ financial plans going forward.

**Risk Management**

The property landscape in the NHS has changed considerably since the last re-organisation when the Health and Social Care Act 2012 came into force. CCGs have no ownership or operational responsibility for premises which fall within the remit of a number of different bodies including NHS Property Services, Community Health Partnerships or NHS acute and community providers and GP practices. This complex picture of property ownership presents a number of issues, including the availability of good quality data and financial information on which to base the identification of priorities and ultimately decisions. This presents a very real barrier to progress and risk to benefits realisation. The CCG will develop a risk management framework for the strategy that will highlight the critical dependencies and major barriers or risks to implementation. It will include a risk register, the cumulative risk exposure, and the overall risk management strategy.
Conclusion

The Local Estates Strategy will be fully aligned with commissioning plans for the area, including the Health & Wellbeing Strategy, CCG priorities and local health needs.

The CCG will take a strategic overview of the planning of the estate in consultation with various local stakeholders, to set the future direction for development, investment and disinvestment. The Local Estates Strategy has an important role to play in enabling change, delivering savings, reducing running costs and ensuring that all investment, including the Estates Technology Transformation Fund (ETTF) (formally PCTF) is properly targeted.

This draft initial Strategic Estates Plan outlines the development of the vision for the estate, based on the Five Year Forward View and commissioning plans. The CCG has identified two critical Primary Care schemes to ensure development and sustainability of primary care service delivery. The strategy has shown commitment to maximising utilisation of premises, improving integration wherever possible and using gap analysis to identify initial priorities for change.

The strategy will continue to evolve over the coming months to include risk management, implementation plans and financial modelling. It will articulate how the existing estate needs to change to meet the future health and social care requirements in the local area.

Peter Sellars  
Primary Care Transformation Lead  
June 2016
## Appendix A: Commissioning Overview

<table>
<thead>
<tr>
<th>Drivers for Change</th>
<th>Estates Impact</th>
</tr>
</thead>
</table>
| **Blackburn with Darwen CCG Strategic Estates Plan** | • In order to enable delivery of the Strategic Plan, a more strategic approach to estates and property management is required.  
• The Strategic Estates Group has started to work more collaboratively and this system wide approach should allow greater efficiencies to be made to benefit the health and social care economies moving forward.  
• Ensure estate aligned to locality model (4 localities). |
| **Primary Care Strategy** | • Estates are key to aiding the transformation and development of primary care, with significant investment required to deliver Blackburn with Darwen’s Primary Care Strategy.  
• Enable the development of Multi-Speciality Community Provider (MCP)  
• Improve quality and capacity of the primary care estates.  
• Further the development of the Federation and collaboration of GP practices  
• Creation of community and service care hubs across Blackburn with Darwen CCG – locality model.  
• Relocation of services from multiple locations to the hub model (e.g. ILTs)  
• Relocate services from an acute to a community setting – identify space following utilisation studies. |
| **Transformation of health care services across Blackburn with Darwen CCG.** | |
| **Reduce estates costs** | • Increase utilisation to make core estate more efficient and allow consolidation of services.  
• Consolidate accommodation where possible, preventing duplication. |
<table>
<thead>
<tr>
<th>2015/16</th>
<th>2016/17</th>
<th>2017/18</th>
<th>2018/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complete property database for property – to include partners’ information.</td>
<td>Confirm PCTF applications</td>
<td>Finalisation of master planning for Royal Blackburn Hospital - ELHT</td>
<td>Complete PCTF Blackburn North GP practices Scheme and mobilise new build</td>
</tr>
<tr>
<td>Develop Blackburn with Darwen CCG Estates Plan in more detail.</td>
<td>Finalise estates strategy</td>
<td>Blackburn West GP practices Scheme and mobilise new build</td>
<td>Reduce un-utilised space across the LIFT portfolio by 60%</td>
</tr>
<tr>
<td>Undertake utilisation studies of LIFT portfolio, identify opportunities for better utilisation.</td>
<td>Develop and finalise scheme for Blackburn West GP / Community Scheme</td>
<td>Identify option for further rationalisation/consolidation of services.</td>
<td></td>
</tr>
<tr>
<td>Finalise lease negotiations for new lease on Fusion House, BwD CCG HQ.</td>
<td>Develop scheme and bid for GP development in North locality.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Undertake review of primary care estate – pending funding.</td>
<td>Master planning of Royal Blackburn Hospital - ELHT</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Move ILT team into Darwen Health Centre.</td>
<td>Implement key projects identified as a result of utilisation reviews.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>PCMF capital development Royal Blackburn Hospital.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Maximise use of Everybody Centre, Barbara Castle Way Health Centre.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Maximise use of Everybody Centre.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Complete co-location of ILT teams.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Review investment requirements.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix C: Estates Map
## Primary Care Co-Commissioning Committee

### Chairs Action North Locality Estates bid

<table>
<thead>
<tr>
<th>Date of Meeting</th>
<th>Agenda Item</th>
</tr>
</thead>
<tbody>
<tr>
<td>19th July 2016</td>
<td>10.</td>
</tr>
</tbody>
</table>

### CCG Corporate Objectives

- Through better commissioning, improve local health outcomes by addressing poor outcomes and inequalities
- To work collaboratively to create safe, high quality health care services
- To maintain financial balance and improve efficiency and productivity
- To deliver a step change in the NHS preventing ill health and supporting people to live healthier lives
- To maintain and improve performance against core standards and statutory requirements
- To commission improved out of hospital care

### CCG High Impact Changes

- Delivering high quality Primary Care at scale and improving access
- Self-Care and Early Intervention
- Enhanced and Integrated Primary Care and Better Care Fund
- Access to Re-ablement and Intermediate Care
- Improved hospital discharge and reduced length of stay
- Community based ambulatory care for specific conditions
- Access to high quality Urgent and Emergency Care
- Scheduled Care
- Quality

### Clinical Lead:

Dr Stephen Gunn

### Senior Lead Manager

Mr Peter Sellars

### Finance Manager

Mrs Linda Ring

### Equality Impact and Risk Assessment completed:

Not at this stage

### Patient and Public Engagement completed:

Not at this stage

### Financial Implications

Not at this stage Further work to undertake subject to bid progression

### Risk Identified

Not at this stage

### Report authorised by Senior Manager:

Dr Malcolm Ridgway

### Decision Recommendations

To ratify the PCCC chairs action to support the North Locality bid for a new Health Centre development.
Chairs Action North Locality Estates bid  
July 2016

1.0 Background

1.1 The Estates and Technology Infrastructure Fund (ETTF) was announced to CCGs earlier this year for them to bid against this fund to assist developing the primary care estate

1.2 The CCG was informed in May that an electronic submission portal would be operational from June 3rd until the 30th and all bids must be submitted via the portal within that time frame.

2.0 Schemes

2.1 Blackburn with Darwen has three major schemes that fit with both the Primary Care and Estates strategies, these being the West locality development, the Primary Care Access Centre (Prime Ministers Challenge Fund. PMCF) and the North locality development which is a new scheme (appendix1).

2.2 The West Scheme and the PCAC have previously been approved to progress by the PCCC however given the rapidity of the submission process the North Scheme has not been to the PCCC to date. The Executive Team have reviewed the bid and the Chair of the Primary Care Co Commissioning Committee has agreed to support the scheme in principle.

3.0 Recommendation

The Committee is asked to:

Ratify the PCCC chair’s action to support the North Locality development.

Peter Sellars  
Primary Care Lead  
June 2016
## CCG Assurance Framework 2016/17 Delegated Functions - Self-certification Q1

| Date of Meeting | 19th July 2016 | Agenda Item | 11. |

### CCG Corporate Objectives
- Through better commissioning, improve local health outcomes by addressing poor outcomes and inequalities  
- To work collaboratively to create safe, high quality health care services  
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### CCG High Impact Changes
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- Access to high quality Urgent and Emergency Care
- Scheduled Care
- Quality

### Clinical Lead:
- Dr Stephen Gunn

### Senior Lead Manager
- Mr Peter Sellars

### Finance Manager
- Mrs Linda Ring

### Equality Impact and Risk Assessment completed:
- Not Applicable

### Patient and Public Engagement completed:
- Not Applicable

### Financial Implications
- Not Applicable

### Risk Identified
- Not Applicable

### Report authorised by Senior Manager:
- Dr Malcolm Ridgway

### Decision Recommendations

The PCCC are asked to note the content of the submission which has been approved by the Clinical Chief Officer and Chair of the Audit Committee.
CCG Assurance Framework 2016/17
Delegated Functions - Self-certification

Annex A

Blackburn with Darwen CCG

Quarter/year to which certification applies  |  Quarter 1 2016/17

1. Assurance Level

To support ongoing dialogue, CCGs are asked to provide a self-assessment of their level of assurance for each Delegated Function (as appropriate).

<table>
<thead>
<tr>
<th>Delegated commissioning</th>
<th>Assured as good</th>
<th>Change since last period</th>
<th>Not applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>OOH commissioning</td>
<td>Assured as good</td>
<td>Change since last period</td>
<td>Not applicable</td>
</tr>
</tbody>
</table>

2. Outcomes

Briefly describe progress in last quarter towards the objectives and benefits the CCG set out in taking on delegated functions, in particular the benefits for all groups of patients

<maximum 200 words>

Summary of benefits

- The Local Quality Incentive Scheme (QOEST) is now finalised 100% of practices have signed up to the scheme and has commenced implementation.
- Practices through the locality structure continue to be supported and encouraged to identify innovative solutions to deliver improvement through new models of care, these groups have now become QOEST delivery groups.
- The CCG is continuing to pilot additional locality based patient appointments through the GP Federation Prime Minister’s Challenge Fund (PMCF). This service is now operational 7 days per week.
- The Alternative Provider Medical Service (APMS) contract procurement is ongoing with the mobilisation date set for October 2016.
- The CCG and practices in the West and North localities have designed 2 bids to be submitted against the Estates and Technology Transformation Fund (ETTF).
- The CCG is fully involved in workforce development which includes the CCG investing in developing the Physician’s Associate role and re-looking at developing the Pharmacist role in practice.
- The programme of Practice Quality visits continues.
- Streamlining OOH and Urgent care pathways to enable appropriate, timely and responsive patient care and supported through accurate and intelligent NHS 111 DOS Pathways.
3. Governance and the management of potential conflicts of interest in relation to primary care co-commissioning (this section should be completed by those CCGs which undertake joint commissioning with NHS England as well as those that have delegated commissioning arrangements)

<table>
<thead>
<tr>
<th>Have any conflicts or potential conflicts of interest arisen during the last quarter?</th>
<th>Co-commissioning</th>
<th>OOH commissioning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>If so has the published register been updated?</th>
<th>Not Applicable</th>
<th>No</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Is there a record in each case of how the conflict of interest has or is planned to be managed?</th>
<th>Not Applicable</th>
<th>Not Applicable</th>
</tr>
</thead>
</table>

Please provide brief details below and include details of any exceptions during the last quarter where conflicts of interest have not been appropriately managed

<maximum 200 words>

n/a

4. Procurement and expiry of contracts

Briefly describe any completed procurement or contract expiry activity during the last quarter in relation to the Delegated Functions and how the CCG used these to improve services for patients (and if and how patients were engaged).

<maximum 250 words per Delegated Function>

There have been no further procurements during this quarter of 2016/17, other than progressing the APMS procurement

The Personal Medical Services (PMS) premium withdrawal and a plan for reinvestment back into primary care via the Local Quality Scheme (QOEST) commenced in April 2016

No procurements during this quarter of 16/17 for OOH commissioning.

Local Incentive Schemes

<table>
<thead>
<tr>
<th>Is the CCG offering any Local Incentive Schemes to GP practices?</th>
<th>Yes</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Was the Local Medical Committee consulted on each new scheme?</th>
<th>Yes</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>If any of those schemes could be described as novel or contentious did the CCG seek input from any other commissioner, including NHS England, before introducing?</th>
<th>Not Applicable</th>
</tr>
</thead>
</table>

| Do the offered Local Incentives Schemes include alternatives to national QOF or DES? If yes, are participating GP practices still providing national data sets? | No | Yes |
What evidence could be submitted (if requested) to demonstrate how each scheme offered will improve outcomes, reduce inequalities and provide value for money?

<maximum 250 words for each Delegated Function>

Local incentive schemes are now in the General Practice Quality and Outcomes Enhanced Services Transformation (QOEST) and this can be submitted as now ratified by the Primary Care Commissioning Committee.

5. Availability of services

Briefly describe any issues raised during the last quarter impacting on availability of services to patients (include if and how patients were engaged).

<maximum 250 words for each Delegated Function>

No issues raised during the last quarter

<table>
<thead>
<tr>
<th></th>
<th>Delegated commissioning</th>
<th>OOH commissioning</th>
</tr>
</thead>
<tbody>
<tr>
<td>How many providers are currently identified by the CCG for review for contractual underperformance?</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>And of those providers, how many have been reviewed and there is action being taken to address underperformance?</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>During the last quarter were any providers placed into special measures following CQC assessment?</td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>

If yes, please provide brief details of each case and how the CCG is supporting remediation of providers in special measures

<maximum 50 words per case>

In the last 12 months has the CCG published benchmarked results of providers OOH performance (including Patient experience)

No

If yes, please provide link to published results:

6. Internal audit recommendations

<table>
<thead>
<tr>
<th></th>
<th>Co-commissioning</th>
<th>OOH commissioning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has internal audit reviewed your processes for completing this self-certification since the last return?</td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>

If so, what was their conclusion and recommendations for improvement?

<maximum 200 words for each Delegated Function>

N/A
Use this space to detail any other issues or highlight any exemplar practice supporting assurance as outstanding

N/A

7. CCG declaration

I hereby confirm that the CCG has completed this self-certification accurately using the most up-to-date information available and the CCG has not knowingly withheld any information or misreported any content that would otherwise be relevant to NHS England assurance of the Delegated Functions undertaken by the CCG.

I confirm that the primary medical services commissioning committee remains constituted in line with statutory guidance.

I additionally confirm that the CCG has in place robust conflicts of interest procedures which comply with the CCG’s statutory duties set out in the NHS Act 2006 (as amended by the Health and Social Care Act 2012), and the NHS England statutory guidance on managing conflicts of interest.

Signed by CCG Accountable Officer

Name: Dr Chris Clayton
Position: Clinical Chief Officer
Date:

Signed by Audit Committee Chair

Name: Mr Paul Hinnigan
Position: Audit Committee Chair
Date:

Please submit this self-certification to your local NHS England team and copy to england.primarycareops@nhs.net using the email subject ‘Delegated functions self-certification.’
### Primary Care Finance Report

**Date of Meeting** | 19th July 2016 | **Agenda Item** | 12.

### CCG Corporate Objectives

| Through better commissioning, improve local health outcomes by addressing poor outcomes and inequalities |
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### CCG High Impact Changes

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| Improved hospital discharge and reduced length of stay |
| Community based ambulatory care for specific conditions |
| Access to high quality Urgent and Emergency Care |
| Scheduled Care |
| Quality |

### Clinical Lead:

- Dr Malcolm Ridgway

### Senior Lead Manager

- Mr Roger Parr

### Finance Manager

- Mrs Linda Ring

### Equality Impact and Risk Assessment completed:

- N/A

### Patient and Public Engagement completed:

- N/A

### Financial Implications

- None

### Risk Identified

- Yes

### Report authorised by Senior Manager: Mr Roger Parr

### Decision Recommendations

It is recommended that the Primary Care Commissioning Committee note the contents of this financial summary and the overall position at the end of May 2016, noting the risk.
### Primary Care Services - Financial Summary

**Month 2 – Period Ending 31st May 2016**

<table>
<thead>
<tr>
<th></th>
<th>Year to Date</th>
<th></th>
<th>Full year forecast</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Budget £000</td>
<td>Actual £000</td>
<td>Variance £000</td>
<td>Budget £000</td>
</tr>
<tr>
<td>Funds Available</td>
<td>8,845</td>
<td>8,845</td>
<td>0</td>
<td>55,087</td>
</tr>
<tr>
<td>PC Co-Commissioning</td>
<td>3,507</td>
<td>3,503</td>
<td>4</td>
<td>22,726</td>
</tr>
<tr>
<td>Prescribing</td>
<td>4,596</td>
<td>4,596</td>
<td>0</td>
<td>27,575</td>
</tr>
<tr>
<td>Enhanced Services</td>
<td>185</td>
<td>203</td>
<td>(18)</td>
<td>1,115</td>
</tr>
<tr>
<td>Home Oxygen Therapy</td>
<td>22</td>
<td>22</td>
<td>0</td>
<td>130</td>
</tr>
<tr>
<td>Resilience Partnerships</td>
<td>109</td>
<td>109</td>
<td>0</td>
<td>655</td>
</tr>
<tr>
<td>Medicines Management</td>
<td>69</td>
<td>69</td>
<td>0</td>
<td>413</td>
</tr>
<tr>
<td>PM Challenge Fund</td>
<td>28</td>
<td>28</td>
<td>0</td>
<td>500</td>
</tr>
<tr>
<td><strong>Balance</strong></td>
<td><strong>8,845</strong></td>
<td><strong>8,859</strong></td>
<td><strong>(14)</strong></td>
<td><strong>55,087</strong></td>
</tr>
</tbody>
</table>

**Summary Financial Position** – At month 2, Primary Care Services are reporting a small overspend of £14k and a year-end breakeven position is forecast.

- **Income and Expenditure**
  
  Primary care co-commissioning is reporting a small YTD underspend of £4k. A year-end breakeven position is forecast.

  Prescribing is reporting a breakeven position at this time of the financial year. At May, no figures have been received from the NHS Business Services Authority and expenditure has therefore been estimated for April and May.

  Enhanced Services are reporting a small overspend at May and a year-end breakeven position is forecast. Enhanced Services now includes expenditure on the Quality Outcomes Enhanced Service Transformation scheme which started in April 2016.

- **Risks**
  
  Prescribing expenditure is volatile and is monitored closely by the Medicines Management Team.

- **Capital**
  
  The CCG is anticipating GPIT capital expenditure of £143k and is awaiting confirmation of the allocation from NHS England.

**Recommendation** - It is recommended that the Primary Care Commissioning Committee note the contents of this financial summary and the overall position at the end of May 2016, noting the risk.