**ELR GP Federation Ltd**

**Chief Operating Officer Report – January 2019**

1. **LLR Federations joint working**

* A positive joint LLR Federations meeting was held on 20th December 2018.
* Notes from the November meeting are attached at **appendix 1**

1. **Business plan for FY19/20**

* JW/HP will table an updated income and expenditure forecast at the Board meeting and present the associated business plan assumptions.

1. **Localities & transformation fund update**

* Ongoing support to Localities in implementing their transformation fund projects
* The Federation is now holding the following contracts on behalf of practices.

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| **Locality** | **Contractor** | **Project** | **Duration** |
| Harborough | Jamie Bell Physiotherapy Ltd | First Contact Physio | 6 months |
| O&W | Jamie Bell Physiotherapy Ltd | First Contact Physio | 6 months |
| SLAM | DHU | ECP | 6 months |
| All | Clarity Informatics | GPTeamNet | 12 months |
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* We are working on an ECP contract for Rutland with DHU – although DHU have expressed concern regarding their capacity to deliver this.
* The First Contact Physio contracts are progressing well and GP time is being saved.
* Federation fee arrangements are summarised at **appendix 2**

1. **Urgent Care / extended primary care**

* Weekly implementation meetings have been set up – see terms of reference @ **appendix 3**
* The JV Board will now be set up; following the model established in the City and West Leicestershire
* The Federation’s fixed fee will be @ £48K and that there will be a profit share above a capped level; so that the Federation is not exposed to the risk of sharing a negative surplus.
* **The next key task for the Federation Board is to assist the DHU/ELR GP Fed JV to recruit GPs / ANPs to fill the shifts.** An induction evening will be scheduled for late January 2019.
* O&W Locality, LHMP and MHMP have expressed an interest in contributing to the service delivery.

1. **Community services re-design**

* RB will verbally update.

1. **Winter Access scheme** 
   * Jamie Barrett has indicated that there may be fund available but this is yet to be confirmed.
2. **NHS England; Clinical pharmacists in general practice Project**

* See action plan @ **appendix 4**
* NHS E have confirmed that we can proceed with two pharmacists in the first instance.
* Awaiting NHS E confirmation that we can proceed with patient population @ just under 60,000
* LMC Law will then be asked to review the PSS contracts; costs to be shared.
* PSS have been acquired by McKesson UK.

1. **Community Based Services**

* HP is confirming with our sub-contracting practices their schedule of fitters and their evidence to practice and indemnity certificates.

1. **Correspondence management**

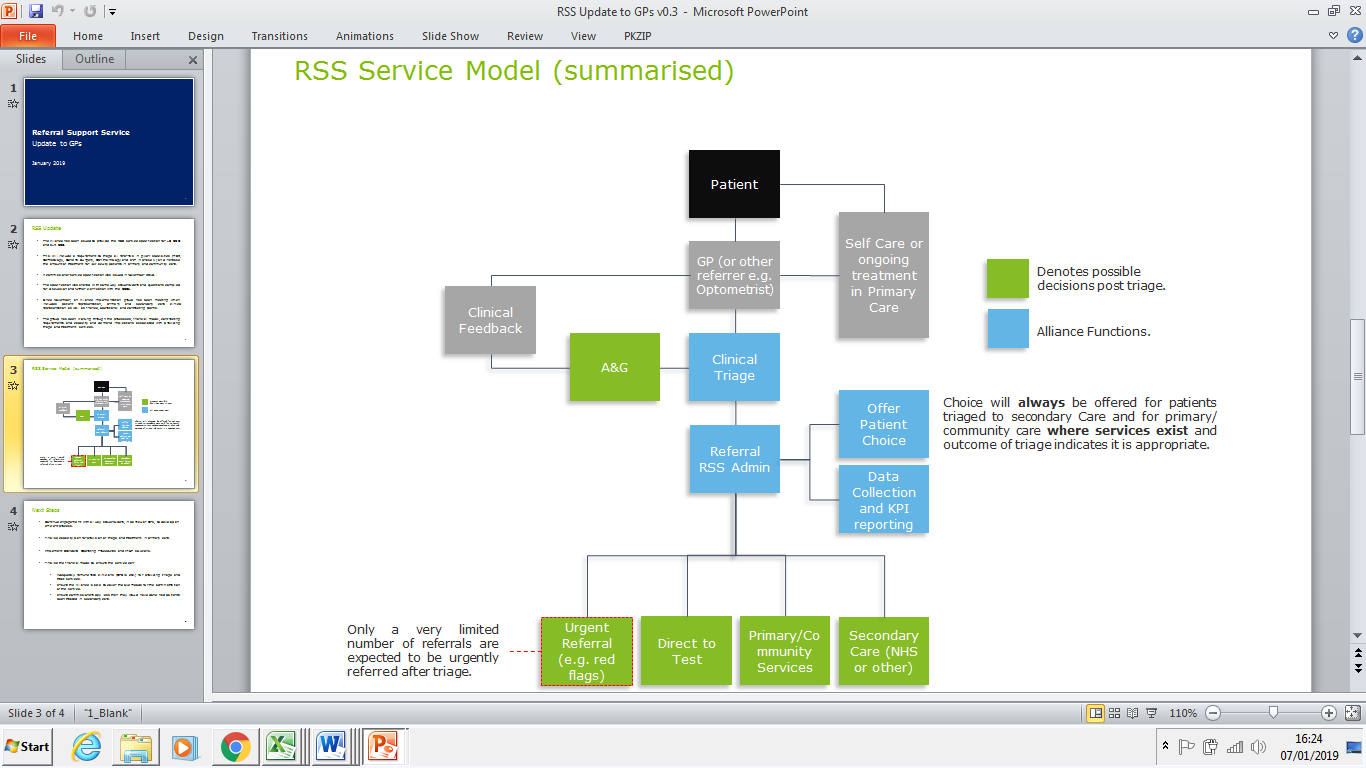
* Our contract provides a further 15 months of support from Practice Unbound.
* We will arrange quarterly support / review sessions with our participating practices – next meeting has been scheduled for 9th January 2019.

1. **Demand Management**

* Practices have returned referral information for the month of October 2018 for the specialties identified;
* RB has completed reports for each Locality – identifying key trends and areas for further investigation / training / service development (see example @ **Paper C**)
* There has been an observable reduction in overall referrals across ELR
* We need to secure CCG funding to continue the Demand Management project into FY19/20

1. **Referral support service (RSS)**

* Rysz, James and Kirsty have met with Helen Mather and Simon Carr to progress the next steps for the RSS
* ELR and City CCGs have agreed to work with the Alliance to develop a model (see diagramme below) to shift more activity into the community in the following specialties;
* ENT
* Dermatology
* General Surgery
* Orthopaedics
* Rheumatology
* An Alliance implementation group has been meeting which includes patient representation, primary and secondary care clinical representation as well as finance, operational and contracting teams.
* The group has been working through the processes, financial model, contracting requirements and capacity and demand implications associated with providing triage and treatment services.



* The Alliance will hold the contract; who could sub-contract to PCL / Federations.
* This is an opportunity for ELR GP Federation to manage the provision of both the triage and treatment elements of the model.
* JW has asked practices to identify skills / GPSIs in ELR. The responses so far are shown in the table below.

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| **Specialty** | **Name** | **Practice** |
| ENT | Dr Gareth Chidlow  Dr Fahreen Dhanji  Dr Liz Loughridge | County  LHMP  LHMP |
| Rheumatology | Dr Hugh Delargy | MHMP |
| Dermatology | Dr Sach Hirani  Dr Tom Blake  Dr Nigel Stollery  Dr Juliet Dover | LHMP  MHMP  Kibworth  Severn |
| Opthamology | Dr Geetisha Hirani  Dr Mark Yates | LHMP  MHMP |
| MSK | Dr Paul Atkinson | LHMP |
| Gastro / Surgery | Dr Bash Miri | LHMP |

* **Next steps;**
* Alliance / CCGs to finalise the capacity plan for provision of triage and treatment in primary care.
* Alliance / CCGs to finalise the financial model to ensure that there are sufficient resources to fund the triage and treatment package offer
* Ensure commissioners pay less than they would have done had patients been treated in secondary care.
* EOI to be sought to provide the triage and treatment services
* Orthopaedic specs likely to be released in Jan/Feb; and will be followed by dermatology
* Federation to prepare to respond to the specs

1. **Diabetes nurse specialists**

* Three DSNs continue to provide a valuable support to identified LLR practices.
* West Leicestershire CCG , who commission the service on behalf of NHS E, are pleased with the progress that has been made.
* GC/JW have met to develop a clinical governance process to assure this scheme. JW now needs to write up the approach for Board consideration.

1. **Rutland Patient App project (VitruCare)**

* Three care homes and >90 patients have signed up to trial / use the product
* There has been a glitch with the system which will result in an extension to the contract.

1. **GP TeamNet**

* All six Localities have signed up to the GPTeamNet project utilizing Transformation Funds.
* The Federation has finalised a contract with Clarity Informatics.
* A project implementation team has been put in place which includes a lead from each Locality, JW and Kati Makepeace from Clarity Informatics.
* 5 introductory workshops have been held.
* The Locality leads will meet with Clarity Informatics on 17th January 2019 to determine how to use the tool to facilitate Locality and ELR wide working.

1. **H Pylori**

* The majority of Practices have decided to provide an H Pylori service as a sub-contractor to the Federation.
* Q3 returns are now been collated.

1. **Locum service**

At the annual shareholders meeting it was suggested that a ‘Locum Agency’ solution would be well received by practices and could generate useful revenue for the Federation. Options include; Primary Care Exchange and GPTeamNet - JW will progress this.

1. **GDPR – DPO service**
   * The majority of the Practices have now signed up.
   * Practices now need chasing to complete the self-survey.
   * Hinckley & Bosworth Federation have expressed an interest in using the DPO service.
   * We need to determine the best approach for our practices for FY19/20.
2. **Fracture Liaison Service (FLS) project**
   * The proposal is to trial a locality based ‘fracture liaison service’ to help prevent further fractures in the identified risk group.
   * **The updated business case is attached at Paper D.**
3. **Communications update**

* The Transformation Fund pilot scheme to develop hub level web portal, integrated with social media and e-marketing approaches with Rutland Healthcare is progressing well.
* The new Rutland hub has now been launched.

1. **INR STAR**

* The CCG will cease funding INR STAR wef April 2019.
* The Federation will identify the best provider and negotiate the best deal on behalf of practices

1. **Second blood collection**

* 19 practices have indicated that they wish to procure a second blood collection
* JW / Tracey Knight have met with UHL
* UHL advised that there is compelling evidence that the lack of a second collection is resulting in many unnecessary referrals to ED etc
* Therefore, before negotiating for a discrete service, UHL will clarify whether the CCGs will pay for a second collection.

**Appendix 1**

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| **Meeting** | LLR Federations Collaborative | **Date** | Friday 16th November 2018 |
| **Time** | 12:30 – 14:30 |
| **Chair** | Dr D Jackson | **Location** | Syston Health Centre |

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| **Attendees** | |
| North West Leicestershire GP Federation  Charnwood GP Network  Hinckley & Bosworth Medical Alliance  East Leicestershire & Rutland GP Federation  Leicester City Health | Dr Kirk Moore (KM), Melanie Arnold (MA)  Dr Anu Rao (AR), Helen Rose (HR)  Dr Darren Jackson (DJ), Beverley Vizard (BV)  Dr Ryszard Bietzk (RB)  Dr Rajiv Wadhwa (RW) |
| **Apologies** | |
| East Leicestershire & Rutland GP Federation | Dr James Watkins |
| **In Attendance** | |
| Minute Taker | Samantha Hayes, NWL GP Federation |

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|  |  | **Actions** |
| 1. | **Welcome and Apologies**  DJ welcomed everybody to the meeting and delivered the apologies as noted above. |  |
| 2. | **Introductions and Purpose of the Group**  Everybody introduced themselves around the table and DJ advised that the purpose of the group was to explore the possibilities of all of the City, East and West Federations working together on future projects. |  |
| 3. | **Federation Updates**  Each Federation gave an update on their structure, journey, opportunities and threats.  **WEST LEICESTERSHIRE**  Three Federations – practices were allocated based on their history of working closely together geographically.  ***Charnwood GP Network*** *(formally the North and South Charnwood Federations who merged to create one Federation).*  22 practices, 8 board members, admin support.  Clinical Chair – Anu Rao, Director – Helen Rose, Finance – Paul Hanlon.  Training Hub – Lead: Dr Borrill, Manager: Laura Norton.  Have a very good relationship with both the GP Practices and the CCG.  Currently hold contracts for Anticoagulation, H-Pylori, Teaching Medical Students and QIPP. Facilitate inter-practice referrals in Contraception.  Caretaking one GP practice at present as part of the sustainability offer to practices. Ideally would like to keep practices within West therefore encourage practices to go to them for support as a first port of call.  Opportunities – pushing back discretionary services by providing costs to the CCG. QIPP to continue next year. Development of Primary Care Networks.  Threats – General Practice need to be able to lead the changes in Primary Care.  ***North West Leicestershire GP Federation***  13 practices, 13 board members, 1 PM Director  Clinical Chair: Dr K Moore  Federation Manager: Melanie Arnold  During the first two years the main focus was getting engagement from practices. Successfully moved from two, to twelve practices using the same clinical system (SystmOne). This allows the Federation to organise services at scale and provide across the locality, one example being inter-practice referrals (currently available for dermatology, minor surgery, contraception, joint injections).  Practices work very closely together and the Federation is the vehicle that facilitates this.  ***Hinckley & Bosworth Medical Alliance***  13 practices  Clinical Chair – Dr D Jackson  Federation Manager – Beverley Vizard  Have a similar back-story to NWL & Charnwood.  Also provide Workflow Optimisation for up to 6 practices  ***4Fed***  Collaboration of all three (previously 4) Federations to bridge the gap that is being created by the CCG. This gives the Federations more of a role in challenging decisions made by the CCG and also have input when new services are being designed. Have the influence of all 48 practices in West therefore they are more representative of General Practice.  4Fed have developed a good trust between themselves and the CCG.  Have a joint venture with DHU to deliver the Extended Access and Urgent Care contracts.  Some work is operated at 4Fed level however if it can remain with practices it will. It works on an escalation basis, i.e. Practice > Federation > 4Fed  Would like to become involved in LLR wide opportunities therefore coming together with City and East Federations would be useful.  **LEICESTER CITY**  Initially 3 Federations but two merged. Some practices still do not belong to a Federation for various reasons. This is currently the biggest challenge as all new services have to go to procurement due to this.  ***Millennium*** (not represented today)  7-8 Surgeries (50,000 population)  No current contracts  ***Leicester City Health***  18 GP practices  Well established board – new elections to take place in January. All board members take lead roles.  Venture with DHU to provide 4 Clinical Hubs across Leicester.  Two large APMS practices  Pilot site for Clinical Pharmacists in General Practice – Lead: Dr Garcia  Received Transformation Funding £1.50 pp/per year (guaranteed 2 years) and practices can select their own areas of focus  Main focus over the last year has been procurement  Threats - Interested in providing a sexual health inter-practice referral service however finding it difficult to progress. The bid was accepted however there is no support in providing the service.  H-pylori contract cannot be held by the Federation as there are multiple as well as some non-federated practices. This means that practices are currently not being paid to provide the service. Concerned that another provider will gain control of this.  **EAST LEICESTERSHIRE**  ***East Leicestershire and Rutland GP Federation***  30 practices, population 330,000  Initially one Federation. Transformation fund used to create 6 geographically appropriate localities.  Has a good relationship with the CCG which is improving.  Hold contracts for Physio (from Harborough and Oakham), GP Net (all practices signed up).  Demand management – the Federation review the referral processes for each practice and compare these to create a plan for each practice going forward.  Going to look at pathology/diagnostic services which will be contracted by CCG (instead of QIPP).  QIPP is still practice based however the Federation offer support and therefore take a management fee.  GDPR – the Federation provide a Data Protection Officer Service that the Practices can register for.  Opportunities – won the tender to run Extended Access with DHU. Localities are able to provide this within the Practices. ECPs cover afternoon visits.  Threats – Acute Access monies have been removed as these hours are already offered by the CCG funded Hubs. This money has been deemed as CCG savings.  No current funding from Practices however this may change in the future.  All agreed that having the CCG on board is essential to succeeding. Leicester City Health has some concerns about challenging them as previously the CCG have not been receptive to this and they do not want to compromise their relationship. AR advised that any challenges can be done via the LMC so as to safeguard existing relationships. |  |
| 4. | **What is our Vision for:**  **Community Based Services**  There are 3 early implementers in East and the County Council are on board.  Everyone was asked what their individual appetites are with regards to the LPT contract. There is definitely an appetite in East. A meeting was facilitated for all nurses (practice and district), and the difference since has been palpable.  AR advised that LPT are currently under staffed which has meant that there has been little or no attendance at meetings in West. The response is that they are unable to accommodate all practices. LPT were offered the chance to change meeting dates to suit their availability, but there has still been no engagement.  In the City, DNs don’t come to practices. A practice based Paediatric Phlebotomy Service has already been introduced for ages 12+. Waiting lists are so long that admissions are being made for blood taking. RW feels that the DNs are interested but are just too busy. MDTs are managed by the Nurses who sit in the health centre and allocate slots for practices to attend. This occasionally works however it is the practices that lack engagement.  KM feels that LPT are disengaging in West. They don’t attend IPMF, rarely attend MDT and never ILT. He is encouraged to hear they are engaging in other areas but his feeling is that control needs to be regained.  H&B want to start their early implementer pilot but there is currently no care coordinator available and no funding available. This has been started in the City whose care coordinators are mainly social workers, not nurses.  There was a joint concern that losing the DNs to a private company will be detrimental and the feeling in the room is that control needs to be taken. There is a keen desire to have ALL nursing contracts and to not separate the various teams/companies. Mental health is separate entirely. LPT are known to move resource within the various contracts so some areas are being propped up by others making it difficult to ‘cherry pick’.  AR will share the spreadsheet that shows the various services. HR advised that the budget is for the entire population, not line-by-line services.  BV asked about the latest on the CCG merge. Options are being presented by January but there is not timescale for completion at this time.  It was agreed that having a joint stance between Federations is good as this will improve negotiating abilities and prevent the CCG from playing them off against each other.  **Diagnostic Hubs & Alliance Opportunities**  MA & KM have attended two meetings with the Alliance. They are trying to move services out of secondary care and are currently in the stage of understanding what is already being provided by Practices.  They are currently looking at 3 models which may need to differ by area depending on activity levels; 1) Practice based [west], 2) community hospitals [East], 3) Hub model [City].  Practices in West can see the funding opportunities and are actively getting involved as FDR will end in 2 years. UHL is tariff based therefore services can be offered below tariff in practices. The Alliance is happy to support all federations.  DJ feels that CSR is too big to take individually therefore a collaborative approach from all 6 federations would be ideal. Diagnostic Hubs however, would be better offered individually as all of the federations have vastly differing activity.  MA advised that the Alliance is under pressure as they have not currently met their target to shift activity out of UHL. Their interest in talking to the west federations has now increased. Keeping money and skills in primary care will provide protection and resilience to practices and it will also make the Alliance sustainable. They receive a 15% saving per patient shifted.  There is currently not much happening in the City since H-pylori has ended. HR advised that PCL is a governance vehicle and that contracts could still come through federations (subcontracting).  AR encouraged City to explore the options with the Alliance since contact has already been made with East and West.  KM is having discussions with Helen Mather as there is currently £600k worth of joint injections in UHL. These are mainly performed under imaging, costing £400+ per case. This work can easily be done in primary care under tariff. HM is looking at the activity and a possible tariff – will be dependent on skills required etc. so tariffs for each procedure/service will vary and she is confident that the money will follow. Offering these services will also provide capacity in primary care.  It was agreed that this group need to quickly establish a collaborative working model going forward. They can actively look for services to provide as a group, however delivery can then be decided at local level.  **RSS**  East & City – CCGs agreed Alliance approach. This is not yet in place as still in discussion stages.  East have been criticised for not getting this off the ground yet. The plan is to employ a GPwSI to triage the referrals. DJ queried how this will this be covered by £6pp? RB advised that it will be tagged onto work that they are already doing.  City – unsure of their current progress.  West – CCG agreed a federated working model. The specification has been written for the Alliance model therefore the Federations need to come up with their own. MA reminded everyone that this is still in a pilot phase therefore the specification can be worked on. Unfortunately due to short turnaround times there has not yet been a discussion with practices about this.  **GPFV Implementation**  If areas can be delivered at practice level then this should be the first port of call. These can then be scaled up as required.  STP Board – currently represented by CCG GPs. LMC do have a seat but have not attended yet. Discussion as to whether Federations can get on board as providers? This group (LLR Federation Collaborative) would most likely be able to as they would be representative of the whole of LLR. | AR |
| 5. | **Integrated Community Board**  AR explained the purpose and structure of this board and confirmed that she will be representing 4FED. This is a strategic group and the main ethos is shifting services from UHL into the community (integrated working, not planned care).  Going forward AR will send the meeting papers to all 6 federations. She will happily take any views and will feedback. | AR |
| 6. | **Any Other Business**  None raised.  Everybody agreed that today’s meeting was very useful.  Plan going forward: Short term - Meetings to continue (3rd Friday of Month) Medium term - Terms of reference and MOU required if going to be formalised. Governance to be considered. (Discuss at next meeting) Long term – potential legal entity. For further discussion.  It was agreed that the admin for meetings will be rotated between all.  It was agreed by all that it would be helpful to invite Helen Mather to a meeting in the new year and that it would also be useful to send a message to the three CCGs to say that the Federations have met and are planning on working together going forward. MA encouraged everybody to invite other representatives to future meetings. |  |
| **Date of next meeting:** Friday 21st December 2018 (will be arranged by ELR Federation) | | |

**Appendix 2 – Federation Transformation Fund fees**



**Appendix 3**

**ELR IUC Mobilisation Committee Terms of Reference**

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| 1. **Constitution** | The DHU Urgent Care (LLR) CIC Board hereby resolves to establish a sub group of the Board to be known as the ELR IUC Mobilisation Board (the Committee) | |
| 1. **Membership** | Simon Harris (Chair)  Rob Haines (Vice Chair)  Saurabh Johri  Rhonda Pickering  James Watkins  Donna McDonnell  Sonia Gale  Nat Pearson  Kaye Kirkhope  Joanne Horton  Joanna Clinton  Julie Bryan | Managing Director (DHU)  Head of Operations (DHU)  Clinical Director (DHU)  Head of Clinical Services (DHU)  Chief Operating Officer (ELR GP Federation)  Workforce Manager (DHU)  HR Business Partner (DHU)  Head of IT (DHU)  Head of Integrated Governance (DHU)  PA to Managing Director (DHU)  Head of Contracts and Provider Performance (WLCCG)  Senior Contract and Provider Performance Manager (WLCCG) |
| 1. **Frequency** | Weekly until one month post mobilisation or more frequently should an identified need arise | |
| 1. **Authority** | The Committee is authorised by the LLR Board to carry out any activity within its Terms of Reference. | |
| 1. **Purpose** | The Committee is empowered to mobilise the contract known as the ELR IUC Services. | |
| 1. **Objectives** | The overall objective of the committee is to safely mobilise the contract working with the ELR GP Federation as a Joint Venture partner. Specific objectives prescribed in the service specification are:   1. To ensure all patients regardless of ethnicity, age, disability, sex, gender reassignment, religious belief or sexual orientation can receive urgent care including appropriate translation services. 2. To provide urgent care services responsive to local demand in primary and community care settings. 3. To prevent and reduce the number of patients avoidably attending an ED with emphasis on providing maximum convenience for patients and best value for money. 4. To ensure that patients are treated and discharged within the national standard of four hours of presentation with the locally agreed target of achieving a two hour maximum wait for all patients. 5. To provide an extended local urgent care offering as part of wider community services ensuring continuity and least disruption to families as a result of acute illness. 6. To provide a service that is integrated operationally and strategically with other urgent care services in the wider health economy and, thereby, reduces the number of patients having an avoidable attendance and/or admission in an acute hospital. 7. To assist the patient or carer in self-management of an acute episode with the ability to access community support services if needed. 8. To increase patient and carer understanding of self-limiting illness and steps to minimise the impact of illness. 9. To ensure that patients have a seamless transition into and out of the service and that it promotes appropriate sharing of information to optimise the outcomes of care. 10. To ensure that patients, carers and parents of young children are supported to access the right urgent care treatment and where necessary, be referred to the appropriate health care service for on-going management. 11. To support unregistered patients to register with a GP. 12. To support the CCG to deliver routine out of hours primary care capacity as part of the NHS England five year forward view core requirements. 13. Ensure all locations as per appendix 1 are ready for go live working in partnership with the CCGs. | |
| 1. **Duties** | 1. Map the predicted demand of presentations that will be seen in the ELR IUC Services. 2. Develop rotas to meet the demand. 3. Provide an appropriate skill mix to meet the patient presentations. 4. Work with the CCGs to review, establish and implement pathways to enhance patient care and meet the service and patient needs. 5. Develop an action that will be the work programme for this committee. | |
| 1. **Quorum** | No business shall be transacted at the meeting unless at least 4 members of the Committee are present one of which must be the chair or vice chair. | |
| 1. **Attendance** | The committee may co-opt such other members, as may be required dependent on the agenda items for discussion. | |
| 1. **Reporting** | The committee shall report to the LLR Board monthly until the committee is dissolved. | |

Appendix 1

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| **ELR Locality** | **Site** | **Mon – Fri** | **Sat, Sun & BH** | **Minimum Staffing** |
| Harborough | St Luke’s | 18:30 – 21:00 | 09:00 – 19:00 | Prescribing ANP & Receptionist |
| Syston, Melton & Long Clawson | Melton Hos | 18:30 – 21:00 | 09:00 – 19:00 | Prescribing ANP & Receptionist |
| Rutland | Rutland Memorial Hos | 18:30 – 21:00 | 09:00 – 19:00 | GP & Nurse / Receptionist |
| Oadby & Wigston | Oadby UCC | 08:00 – 21:00 | 08:00 – 20:00 | GP, Prescribing ANP & Receptionist |
| South Blaby | Lutterworth | Not Open | 09:00 – 19:00 | GP & Receptionist |
| North Blaby | Enderby Leisure Centre | 18:30 – 21:00 | 09:00 – 19:00 | Prescribing ANP plus Receptionist |

**Appendix 4 - ELR GP Federation Pharmacists in Practice – Implementation Plan @ December 2018**

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| **Area** | **Task** | **Lead** | **When** | **Status** |
| **Practices** | Practices confirmed;   * Oakham (Lead), MOSS, Empingham, * County (Lead), Rosemead, Croft, Billesdon * This equates to **59,855** patients * Oakham and County will be the Lead Practices * Identify practices for the third pharmacist | JW  JW | Dec 18  Jan 19 | Done  TBC |
| **NHS England / portal** | * Check that we can proceed @ 59,855 population * Update NHS E portal | JW  JW | Jan 19  Jan 19 | Email to Salim Issak |
| **Contract** | Complete contract documentation – in conjunction with LMC law;   * Enhanced Service Agreement between NHS England and the lead practices * SLA between PSS and lead practices * SLA between PSS and participating practices * Framework ‘call off’ agreement | IY (PSS) / JW / LMC Law | Jan 19 | TBC |
| **Staff** | Recruit staffing to ensure availability of 2 WTE. Ensure that appropriate DBS checks are completed and that HR documentation is in place. Provide confirmation of indemnity insurance. | IY (PSS) | Feb 19 (TBC) |  |
| **IT system** | Ensure that staff have access to the practice systems and have received the appropriate training | PMs | Feb 19 |  |
| **Induction** | Prepare an induction programme for each practice | PMs | Feb 19 |  |
| **KPIs** | PSS to implement a process for delivering the NHS E KPIs | IY (PSS) | Feb 19 |  |

**Appendix 1 - Costings**

