NHS
Calderdale
Clinical Commissioning Group

Commissioning Primary Medical Services Committee Meeting
Held on Thursday, 9th January, 2020
at the Elsie Whiteley Innovation Centre, Hopwood Lane, Halifax HX1 5ER

FINAL MINUTES

Present	John Mallalieu	(JM)	Governing Body – Lay Member (Chair of the Committee)
	Dr Rob Atkinson	(RA)	Governing Body - Secondary Care Specialist
	Dr Steven Cleasby	(SC)	Governing Body - GP Member (CCG Chair)
	Dr James Gray	(HD)	Governing Body - GP Member
	Neil Smurthwaite	(NS)	Chief Finance Officer/Deputy Chief Officer
In attendance			
	Neil Coulter	(NC)	Senior Primary Care Manager - NHS England/Improvement
	Emma Bownas	(EB)	Senior Primary Care Manager
	Helen Hunter	(HH)	Chief Executive, Health Watch, Kirklees and Calderdale
	Debbie Robinson	(DR)	Head of Primary Care Quality & Improvement
	Martin Pursey	(MP)	Head of Contracting and Procurement
	Lesley Stokey	(LS)	Head of Finance
	Frances O'Sullivan	(FO)	APMS Project Manager
	Penny Woodhead	(PW)	Chief Quality and Nursing Officer
	Andrew O'Connor	(AO)	Corporate Governance Officer (Minutes)

There was one member of the public in attendance.

01/20 APOLOGIES FOR ABSENCE AND DECLARATIONS OF INTEREST **ACTION**

JM welcomed those in attendance. He explained the purpose of the meeting and reminded members of the public that whilst the meeting was being held in public, so they could observe the business of the committee, they would not be able to participate in the discussions, voting or put their own views to members of the committee. He thanked the public for their cooperation.

Apologies were received from: Helen Davies (GP Governing Body Member); Matt Walsh (Chief Officer) and Cllr Tim Swift (Representative of Calderdale Health and Wellbeing Board).

Committee members were invited to declare any interests relevant to items on the agenda.

SC and JG declared a **direct financial interest** in relation to Items 5 and 6 (public section) as general practice contract holders in Calderdale who may at some point benefit or be negatively affected by the proposals. Recognising that SC and JG would bring beneficial clinical input and insight to the discussions, JM proposed that they take part in the initial deliberations but not in the decision making and that they be asked to move their chairs back from the table at the relevant point to signal their withdrawal from the proceedings. Both SC and JG had received the meeting papers. The committee was content with the proposed arrangements for managing the declared conflicts of interest.

SC and JG declared a **direct financial interest** in relation to item 1 (private section) as general practice contract holders in Calderdale who may at some point benefit of be negatively affected by the proposals referenced in the minutes of the Private Section of the committee meeting held on 7 November 2019. JM proposed that SC

and JG be asked the leave the room for this item noting that they had not received a copy of the minutes with their papers. The committee was content with the proposed arrangements for managing the declared conflicts of interest.

The Register of Interests can be obtained from the CCG's website: https://www.calderdal ccg.nhs.uk/key-documents/#registerofinterests or from the CCG's headquarters.

02/20 MINUTES OF THE OF COMMISSIONING PRIMARY MEDICAL SERVICES COMMITTEE MEETING HELD ON 7 NOVEMBER 2019

DECISION

The minutes of the committee meeting held on 7 November 2019 were **RECEIVED** and **ADOPTED** as a correct record.

Matters arising

- **Action 40/19** – EB confirmed the action was complete and could be closed.
- **Action 38/19** - NS confirmed that a committee decision was not required. The request did not constitute a new request and was within the delegated limits of managers. The action was closed.
- **Action 11/19** – DR confirmed that the committee Terms of Reference would not be amended and that clinical leads involved in the development of proposals would be made clearer in reports with lead clinicians attending meetings as required. The action was closed.

03/19 QUESTIONS FROM THE PUBLIC

There were no questions from the public

04/19 APMS POST CONSULTATION DELIBERATION

DR in presenting the report explained that it provided a summary of the consultation process undertaken, the outcomes of the consultation and proposed next steps. She also explained that information additional to that in the circulated report would be provided in the form of an accompanying presentation and that MP would provide a verbal proposal and recommendation concerning a separate solution for patients in the Upper Calder Valley at Todmorden.

JM drew the committee's attention to the four recommendations as set out which they would need to consider during this agenda item.

PW explained the information presented constituted the final stage in what had been an ongoing deliberation process that had preceded and extended beyond formal consultation and that emerging findings and potential mitigations had been discussed with stakeholders, such Adults, Health and Overview and Scrutiny Board, as part of the process. Detailed discussions had also regularly taken place with the CCG's Senior Management Team throughout.

Findings from the Consultation

- The consultation took place over a six week period from 28 October to 6 December 2019 building on pre-consultation engagement activity and targeting identified stakeholders.

- The response to the consultation had been good. More people had taken part than during the pre-consultation engagement. 832 surveys had been received and 5 drop-ins had taken placed attended by 167 people. The CCG's Engagement Champions had helped to address gaps that had emerged during the pre-consultation engagement.
- Overall finding and themes had been consistent throughout all consultation and engagement activities. These included concerns about returning to a practice where patients had previously been registered (for a variety of reasons); availability of appointments and capacity at other GP practices; travel and transport; continuity of care and good quality care (particularly among vulnerable people including those with complex health needs); anxiety about change and next steps.

The committee confirmed it was in agreement with the main findings and themes set out in the report.

- Equalities themes which had emerged were reviewed and considered throughout the process with additional activities put in place in areas with low response rates, particularly in Park Ward. Engagement Champions had helped support targeted activities. Calderdale Adults, Health and Overview and Scrutiny Board considered the consultation to have been comprehensive and robust. Several areas of underrepresentation persisted and steps had been taken to address these where it was possible. The Equality Impact Assessment (EIA) was noted to propose further mitigations for protected groups.

MP addressed the matter of a separate solution for patients in the Upper Calder Valley at Todmorden. He explained that, following the committee's decision in September 2019 to explore an alternative option for Todmorden, a market test had taken place. The response from the market had been very limited. As such, the view was that a competitive procurement process was not suitable option. Work exploring the impacts of reallocation had resulted in there being concerns about capacity and resilience at the co-located practice should patients be dispersed to it. This concurred with the concerns of local people who had expressed a preference for an alternative proposal. Consequently, Locala had been asked to re-consider its position and had subsequently agreed to continue to provide a service in Todmorden. To allow this, the contract would be varied to exclude Park Community Centre for the rest of the contract (two years). The boundary would also be changed so that it coincides with the Upper Calder Valley Primary Care Network (PCN) boundary. The cost of the contract would reflect reimbursement for the full cost of delivery of services. The benefits of commissioning Primary Care from Locala for Todmorden were said to include:

- Continuity of service provision delivered by the current provider;
- A degree of stability in the short term while PCNs are developed;
- Based on an existing working relationship with Locala;
- Continuation of capacity benefits other practices in the PCN;
- Provided and retained required capacity.

MP went on to report that the proposal would be compliant with procurement rules and that the Adults, Health and Social Care Overview and Scrutiny Board agreed that it would help resolve the situation in terms of access to service in the short term.

In terms of disadvantages, a longer term solution would still be required; the cost of the service would continue to be comparatively expensive; and it would not resolve staff recruitment and retention issues.

In conclusion MP asked that the committee note the proposal and approve the

variation to the contract held with Locala to enable their continued provision of primary care in Todmorden.

JM asked that the committee address the provision of primary care for Todmorden. He explained that he had given his consent to the proposal not being set out in the report as conservations were still ongoing at the time of publication.

Comments and questions were invited from the committee.

- NS noted that the proposal responded to what people had said during the consultation and engagement activities and provided the time that would be required to put in place a longer term solution for the Upper Calder Valley.
- PW reported that the Adults, Health and Social Care Overview and Scrutiny Board was concerned about the quality of primary medical services in the Upper Valley overall and was waiting for a meeting with the CCG and partners to discuss improvements.
- In response to a question, MP confirmed that proposal was financially viable but the services were at a premium. However, taken as part of the wider changes, the overall cost to the CCG was lower. LS added that the reserves to support the cost were available in the five year plan but not necessarily in the long term.
- In response to a question, MP confirmed that new patients would be able to register at the practice.
- SC recognised the proposal was right for patients in the short term and reflected the CCG's understanding of the value of investment in access to general practice. However, he also recognised this would not resolve access issues for all patients in the Upper Valley and that serious efforts would need to be made by the system to find a longer term sustainable solution over the course of the two years including the creation of a geography that could attract and can retain, not only GPs, but the wider primary care and community workforce. He suggested that looking to address and change demand may help practices become more resilient.
- JM summarised that the market had been tested without sufficient response; the public's concerns about capacity had been listened to and confirmed with the co-located practice; and that the proposal provided a pragmatic solution in the short term while a longer term suitable proposal was developed for the Upper Calder Valley as a whole.

The committee confirmed that it understood the proposed model and was comfortable with the proposal.

Moving on to the first part of the presentation concerning the engagement and consultation work undertaken, JM recognised the flexibility with which the work had been undertaken in order to listen to people's views. He also recognised that there was more work to be done in response to the findings which would be addressed during the mitigations element of the presentation.

Comments and questions were invited.

- HH raised a concern regarding people from minority communities being asked to attend another practice when they had originally been encouraged to attend a particular practice by organisations who support refugees and asylum seekers (Park Community Practice). She was concerned there may be a disproportionate impact on those patients due to the loss of established relationships with physicians and the impression that the practice had been better placed to meet their needs and was more accessible to them. There were several responses recognising that whilst high level mitigations were in place and the patients would be captured under the mitigations for vulnerable people and groups, the CCG

needed to ensure that the providers engage with one another to share knowledge and skills and that the provider receiving patients engages with support groups to draw on their expertise and help manage the changeover. The offer of help and support from support organisations working directly with the patients in question was welcomed. EB to progress. It was also noted that patients would benefit from greater continuity in terms of care and contacts as a result of reallocation as staffing at the existing providers had fluctuated. **EB**

DR presented to the committee how the impacts of reallocation would be mitigated noting the quality of the communications would be key. Mitigations reported were as follows:

- Patients would receive letters explaining the practices they could register with if they wanted to change from their reallocated practice.
- Practices would receive appropriate funding to provide the required resource as per the CCG's Policy for Discretionary Financial Assistance to General Practices Impacted as a Result of a List Dispersal.
- Patients would be reallocated to the practice nearest to them geographically. Discussions had taken place with the Local Medical Committee (LMC) and patient lists and numbers had been provided to the practices.
- The possible use of existing sites in Sowerby Bridge and Elland to assist with capacity were being explored.
- A co-ordinated needs assessment would be carried out for vulnerable patients.
- An ongoing communications plan was in place.

The following themes and feedback from practices were highlighted:

- **Workforce** – Investment would be made via the policy as described above.
- **Estates** - Consideration would need to be given to investment in premises to increase capacity.
- **Quality and Outcomes Framework (QOF)** - Practices had been advised that patients who move within last three months of the financial year could be exempted from QOF.
- **Boundaries** – There was willingness to expand practice boundaries but with an expectation that they would not need to undertake the full process. Work undertaken by the CCG in the form of Equality Impact Assessment would be able to be used by the practices to support this process.
- **Reallocation approach** - A preference for a phased approach to reallocation.
- **Patient records** - Concerns about the quality of patient records.

Questions and Comments were invited:

- In response to a question, it was confirmed that people had the right to ask to register at any practice but that boundaries could be used by practices as a reasons to refuse an application.
- In response to a question, it was confirmed that the existing properties being considered for use to provided additional car parking and clinical space were owned by NHS Property Services.
- PW confirmed that a Task and Finish Group would have oversight of mitigating actions and work plans as set out in Quality and Equality Impact Assessments with any emerging issues being brought to the attention of the committee via the committee's operational group. The committee confirmed it would like to be kept informed of risks and progress made via future Lead Officer reports. **DR**
- In response to a question, NS confirmed that the concern about patient records arose due to issues that had arisen during a previous dispersal. He confirmed all patient records would be electronic and there was not an expectation of similar problems. He also confirmed there was an ongoing offer of support available for

practices in term of records management via the CCG's Data Quality Team. JM clarified that practices had expressed a concern but that was all it was to date.

- In response to a question, DR confirmed that the phased reallocation must have taken place by the 31 March 2020 (commencing at the end of January 2020). FO confirmed that the rate practices registered patients was at the discretion of the practice.
- HH volunteered her support in terms of reviewing communication materials which were welcomed EB to liaise with HH. **EB**

In concluding the discussions and presentation, DR summarised the next steps as follows:

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- Supporting funding for allocated patients, workforce and recruitment, premises upgrade and securing current premises solutions.
- The phased reallocation of patients.
- Ongoing support and direction by the CCG's Senior Management Team.

At this point in the meeting SC and JG pushed their chairs back from the table to indicate their withdrawal from the proceedings.

DECISION

The Committee;

1. **RECEIVED** and **DISCUSSED** the draft Consultation Report (Appendix 1).
2. **NOTED** the consultation process undertaken and **CONFIRMED** their confidence that the impact upon patients has been captured and mitigations recognised in the recommendations.
3. **APPROVED** the recommendation for a separate solution for patients in the Upper Calder Valley at Todmorden, specifically the variation to the Locala contract to enable its continued provision of primary care in Todmorden for a period of two years.
4. **ENDORSED** the agreed recommendation for the locally managed allocation of the patients registered at the following sites; Park, Ovenden, Elland and Sowerby Bridge

NS asked the committee to note the significant amount of work that taken place across and between teams to date.

In response to a question, NS confirmed that the Lead Officers would now need to address the work that would be required to deliver a longer term solution for the Upper Calder Valley.

SC and JG re-joined the meeting.

05/19 **PRIMARY MEDICAL SERVICES – NON-RECURRENT SPENDING PLAN 2019/20**

DR in presenting the report explained that it provided an update to the committee on proposals to invest non-recurrent funding from the delegated budget and sought approval for additional investment for the General Practice additional on the day appointments scheme. The scheme had already been agreed in principle by the committee at its meeting in September 2019, with part of the investment provided from Primary Medical Services (PMS) premium funding. The paper presented requested the remainder of the required funding of £155k from non-recurrent underspends.

Noting the previous decisions and the clinical leads that had been involved

(Appendix 1), JM invited questions and comments.

- In response to a question about direct bookable appointments being available to A&E, EB confirmed that the IT system would not be in place for the start of the pilot but assured the committee that the ambition was in place. SC added that the ability to direct book was already available to a limited extent but usage was low which needed to be addressed.

At this point SC and JG moved their chairs back from the table to indicate their withdrawal from the proceedings.

DECISION

The Committee:

1. **NOTED** the prioritisation of the plans that took place between august and November 2019.
2. **NOTED** the level of Clinical Leadership invested in developing the plans.
3. **NOTED** the plans for investment of non-recurrent funding.
4. **APPROVED** the investment for General Practice Additional on the day Appointments scheme.

NS asked the committee note of a risk emerging through the A&E Delivery Board. Concerns had been raised regarding the capacity of GPs to cover commissioned activity and he asked the committee note that the decision taken may have an unintentional impact. Conversations were taking place with the Local Medical Committee. DR assured the committee that the PCN Clinical Directors were confident they could deliver what had been proposed. EB added that the shift to allow Prescribing Clinicians to provide the appointments had been useful but that during the pilot the impact on out-of-hours would need to be monitored. NS concurred emphasising that it need to monitor the impact with and on the wider system. The committee was in agreement. SC added that there was a need for a holistic system approach to manage demand. LS confirmed that £3.1m would be invested over the next three years to provide additional roles in Calderdale which would help to build capacity and support delivery of the required system wide changes.

06/19 Date and time of next meetings in public

The Committee **NOTED** that the next meeting would take place on:

Thursday 23rd April 2020, 11am – 1:30pm at the Elsie Whitely Innovation Centre, Hopwood Lane, Halifax. HX1 5ER

07/19 EXCLUSION OF THE PUBLIC

DECISION:

The CPMS Committee **AGREED** that representatives of the press and other members of the public be excluded from the remainder of the meeting, having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.

Commissioning Primary Medical Services Committee Meeting 9th January 2019 – Action Sheet

Agenda item	Minute No.	Action required	Lead	Current Status	Comments/ Completion Date
5	**04/20**	Via the Task & Finish Group's communication and engagement plan, CCG to ensure that the providers engage with one another to share knowledge and skills to support vulnerable patients and that the providers receiving patients engage with support groups to draw on their expertise and help manage the changeover.	**EB**	**Complete**	**14/01/2020**
5	**04/20**	The committee confirmed it would like to be kept informed of risks and progress made arising from ongoing mitigations activity via future Lead Officer reports.	**DR**	**Ongoing**	**23/04/2020**
1	**04/20**	Prior to circulation, EB to share and review Easy Read letter with HH.	**EB**	**Complete**	**06/02/2020**

Commissioning Primary Medical Services Committee Meeting 9th January 2019 – Action Sheet

Agenda item		Minute No.	Action required	Lead	Current Status	Comments/ Completion Date
5	APMS Post Consultation Deliberation	04/20	Via the Task & Finish Group's communication and engagement plan, CCG to ensure that the providers engage with one another to share knowledge and skills to support vulnerable patients and that the providers receiving patients engage with support groups to draw on their expertise and help manage the changeover.	EB	Complete	14/01/2020
			The committee confirmed it would like to be kept informed of risks and progress made arising from ongoing mitigation activity via future Lead Officer reports.	DR	Ongoing	23/04/2020
			Prior to circulation, EB to share and review Easy Read letter with HH.	EB	Complete	06/02/2020

NHS
Calderdale
Clinical Commissioning Group

Calderdale Primary Medical Service Committee
Decision Notice
Circulated 21 April 2020 (by email)

Due to the COVID 19 public health emergency the meeting in public due to take place on 23 April was stood down.

A virtual Committee meeting was help with a single paper circulated for decision by the committee members via email.

DECISION NOTICE

Member Recipients			
	Neil Smurthwaite	NS	Chief Finance Officer/Deputy Chief Officer
	John Mallalieu	JM	Deputy Chair, Lay Member, Finance and Performance
	Rob Atkinson	RA	Secondary Care Specialist
	Alison MacDonald	AM	Lay Member, Patient and Public Engagement
	Prof Rob McSherry	RM	Registered Nurse
Other recipients	Debbie Robinson	DR	Head of Primary Care, Quality and Improvement
	Lesley Stokey	LS	Head of Finance

Action

1. CONFLICTS OF INTEREST

The GP committee members were declared to have a **direct financial interest** in the decision and therefore were not provided with the paper.

The Register of Interests can be obtained from the CCG's website: https://www.calderdaleccg.nhs.uk/key-documents/#registerofinterests or from the CCG's headquarters.

2. SPRING HALL GROUP PRACTICE - APPLICATION FOR NOVATION OF GMS CONTRACT

The paper recommended to approve the incorporation and was consistent with a previous application for merger which the committee had approved on 7th November 2019. It followed the agreed process for assessing such applications. The paper was circulated electronically inviting questions and comments. Committee members' responses were recorded and are held centrally by the Corporate Governance Team.

The Committee noted that there had been some valuable learning from processing these applications and requested that;

- the key learning points identified be presented in the next contracting report, these will focus on processing the applications and the benefits definitions,
- an update on the Joint Patient Participation Group within the next Head of Primary

Care Report.

In response to a question raised as to whether officers had included in the novation agreement a restriction or a need to seek approval from the commissioner on transfer of shares, it was confirmed that the novation agreement contained the following:

> *In consideration of the Commissioner agreeing to the novation of the Partnership's rights, obligations and liabilities under the Contract to the New Contractor, the New Contractor agrees that for a period of five (5) years commencing from the Effective Date, no shares in the New Contractor shall be transferred, sold or otherwise assigned without the prior consent of the Commissioner, such consent not to be unreasonably withheld or delayed.*

DECISION:

As of 1 May 2020, the Committee:

- **RECEIVED** and **NOTED** the content of the report.
- **APPROVED** officers of the CCG to proceed to complete the novation of contract upon receipt of the required evidence of assurance.
- **APPROVED** the request for the incorporation and novation of contract

The decision was supported by all committee members who were in receipt of the paper. Responses received via email had achieved the required quoracy for decision making as set out in the committee's Terms of Reference.

3. DATE AND TIME OF THE NEXT MEETING IN PUBLIC:

Thursday 23 July 2020, 11.00am Elsie Whitely Innovation Centre
(venue subject to confirmation)

NHS
Calderdale
Clinical Commissioning Group

Name of Meeting	Commissioning Primary Medical Services Committee	**Meeting Date**	23/07/2020
Title of Report	**Head of Primary Care Report**	**Agenda Item No.**	5
Report Author	Debbie Robinson, Head of Primary Care, Quality and Improvement Emma Bownas, Senior Primary Care Quality and Improvement Manager	**Public / Private Item**	Public

GB/ Clinical Lead	Mr Neil Smurthwaite, Interim Accountable Officer	**Responsible Officer**	Debbie Robinson, Head of Primary Care, Quality and Improvement

Executive Summary								
Please include a brief summary of the purpose of the report	General Practice in Calderdale has had to rapidly adopt a different operating model in order to respond to the Covid 19 pandemic. This paper intends to summarise the decisions and processes implemented and as we enter the next phase of the response it is timely to update members of the Committee on the response to date.							
Previous consideration	**Name of meeting**	none	**Meeting Date**	Click here to enter a date.				
	Name of meeting	none	**Meeting Date**	Click here to enter a date.				
Recommendation (s)	The Committee is asked to note the content of the paper.							
Decision	☐	**Assurance**	☒	**Discussion**	☐	**Other**	Click here to enter text.	

Implications							
Quality & Safety implications	Detailed within the paper						
Engagement & Equality implications (including whether an equality impact assessment has been completed)	A Rapid Impact Assessment was completed for the development of Green Sites. For both the green sites and the face to face sites a travel implication was indicated and this was mitigated through the provision of a transport service booked by the GP Practice on behalf of the patient.						
Resources / Finance implications (including Staffing/Workforce considerations)	Detailed within the paper						
Has a Data Protection Impact Assessment (DPIA) been completed? (Please select)	**Yes**		**No**		**N/A**	x	

Strategic Objectives (which of the CCG objectives does this relate to?	• Achieving the agreed strategic direction for Calderdale. • Improving Quality • Improving value	**Risk** (include risk number and a brief description of the risk)	Risk are detailed within the paper
Legal / CCG Constitutional Implications	• Obligation to provide primary medical services to the local population.	**Conflicts of Interest** (include detail of any identified/potential conflicts)	Any conflicts of interest will be managed in line with the CCG's policy for managing Conflicts of Interest.

1.0 Introduction

1.1 General Practice in Calderdale has had to rapidly adopt a different operating model in order to respond to the Covid 19 pandemic. This paper intends to summarise the processes implemented and acknowledge some of the operational decisions that have taken place to facilitate safe working for staff and patients.

2.0 Detail

2.1 NHS England (NHSE) has led the central communication of messages to general practice to ensure a consistent approach to managing the epidemic across England. This has taken place through a regular production of letters, briefings, standard operating procedures and weekly webinars.

2.2 A key letter was issued on 19 March 2020, which very much shifted the way general practice operated through the specific guidance below:

- **Move to a total triage system** (whether by phone or online)
- **Agree locally with your CCG which practice premises and teams should be used to manage essential face-to-face services**
- **Undertake all care that can be done remotely via appropriate channels**
- **Prepare for the significant increase in home visiting** as a result of social distancing, home isolation and the need to discharge all patients who do not need to be in hospital
- **Prioritise support for particular groups of patients at high risk**
- **Help staff to stay safe and at work, building cross-practice resilience** across primary care networks, and confirming business continuity plans.

2.3 There was also a clear message regarding funding which confirmed that GP practices in 2020/21 continue to be paid at rates that assume they would have continued to perform at the same levels from the beginning of the outbreak as they had done previously, including for the purposes of the Quality Outcomes Framework (QOF), Directed Enhanced Service Specification (DES) and Local Enhanced Service Specification (LES) payments.

2.4 On the 29th April, the government announced the move to the second phase of the outbreak response. For primary care this meant:

- Ensuring patients have clear information on how to access primary care services and are confident about making appointments (virtual or if appropriate, face-to-face) for current concerns.
- Completing work on implementing digital and video consultations, so that all patients and practices can benefit.
- Given the reduction of face-to-face visits, stratify and proactively contact their high-risk patients with ongoing care needs, to ensure appropriate ongoing care and support plans are delivered through multidisciplinary teams.
- In particular, proactively contact all those in the 'shielding' cohort of patients who are clinically extremely vulnerable to Covid-19, ensure they know how to access care, are receiving their medications, and provide safe home visiting wherever clinically necessary.
- To further support care homes, the NHS will bring forward a package of support to care homes drawing on key components of the Enhanced Care in Care Homes service

and delivered as collaboration between community and general practice teams. This should include a weekly virtual 'care home round' of residents needing clinical support.
- Make two-week wait cancer, urgent and routine referrals to secondary care as normal, using 'advice and guidance' options where appropriate.
- Deliver as much routine and preventative work as can be provided safely including vaccinations immunisations, and screening.

2.5 On 1st May, primary care was instructed to build on existing work, to further support care homes with community services. Practices and community providers were asked to ensure:

- Timely access to clinical advice for care home staff and residents.
- proactive support for people living in care homes, including through personalised care and support planning as appropriate.
- care home residents with suspected or confirmed COVID-19 are supported through remote monitoring – and face-to-face assessment where clinically appropriate – by a multidisciplinary team (MDT) where practically possible (including those for whom monitoring is needed following discharge from either an acute or step-down bed).
- sensitive and collaborative decisions around hospital admissions for care home residents if they are likely to benefit.

2.6 On the 9th of June, " The Minimising Nosocomial Infection letter" was issued by NHSE, this contained details of the Test and Trace Service and advice on what to do if a staff member tests positive for COVID-19 and how to apply the rules of test and trace, including identifying and isolating contacts. In order to mitigate the risk of an outbreak the letter states that "*Ongoing and Consistent Implementation of National Infection Prevention and Control guidance must take place in all health care settings, including adhering to social distancing and wearing appropriate PPE*"

In addition to ensuring workplaces and practices are COVID secure, NHS Employers published guidance for NHS organisations to take appropriate measures to mitigate the risk of COVID-19, including taking ethnicity and age into account alongside other factors, through completion of risk assessments to ensure staff safety.

3.0 Calderdale Position

3.1 Throughout the pandemic a General Practice focused group was established to oversee the General Practice response. The group is made up of CCG and Local Medical Committee (LMC) Colleagues along with the Clinical Director (CD) for each Primary Care Network (PCN). The group initially met 3 times per week, which is now reduced to a weekly meeting. Some key features of the response overseen by the group are:

- Establishing a new operating model for General Practice for implementation from the 30th March 2020
- Establishing situation reports (sitrep) from every practice; monitoring the staffing levels at practice but also the overall Operational Pressures Escalation Levels (OPEL) score to help determine where additional support may be required and whether the situation is currently manageable.
- 100% availability of online and video consultations (starting from a low baseline at the beginning of March of just 7/21 practices live with online consultations and zero practices live with video consultations). The CCG has not yet received any utilisation reports so there may be some variation in offer and utilisation amongst practices.
- Co-ordinated central communications through a 'Key Messages' daily briefing, providing

a Calderdale response to nationally released guidance and opportunity for general practice to raise concerns. Direct support to practices ensuring emergency supplies of Personal Protective Equipment (PPE) (represented as part of a district wide specific group for PPE through the Local Resilience Forums (LRFs) in conjunction with the Local Authority).

- Mobilising IT solutions to allow for working at a Primary Care Network level. This included the acceleration of GP Connect allowing clinicians to have access to patient records for consultations at the face to face site, laptops and network access to enable safe working and remote working where possible, an increase of hardware into the face to face sites.
- Worked with Voluntary Action Calderdale to provide a patient transport service for those patients that needed a face to face appointment but were unable to travel to the face to face site. Weekly evaluations have been received from those receiving the service and the feedback has been mostly positive.
- With support from the Calderdale CCG Communications Team, a suite of communications have been developed for stakeholders and the general public to inform them and reassure them that General Practice is still open. These have included traditional press releases and social media films and messaging.

3.2 Calderdale General Practice should be commended for their positive response to managing the situation, with rapidly changing guidance. Practices and PCNs with the positive support from the LMC and CCG have been able to mobilise services from the implementation of video consultations to the identification of face to face sites to keep patients and staff safe.

3.3 Local 'best practice' guidance has also been issued to support practices manage patients during Covid. This includes a regular general practice key messages bulletin initially sent to practices on a daily basis but now issued twice weekly, following feedback from practices. The bulletin signposts national and local guidance to our practices. The key messages bulletin and associated guidance is posted onto the Calderdale LMC website.

3.4 Support was provided to practices and PCNs to implement a new operating model from the 30th of March 2020 in order to continue to provide safe and effective care for the registered population in Calderdale and to ensure resilience in delivery of primary medical services. This was supported by operational guidance developed locally by CCG GP leads, Clinical Directors and the Local Medical Committee in line with national guidance the model included:

- Each individual practice operating remote triage, online, telephone and video consultations to their registered population. The majority of patient's needs have been met at this stage. Some of the essential routine work has been changed to remote consultations where appropriate enabling this to continue through the first wave.

- Two options made available where a patient requires a physical examination comprising of a face to face appointment at a surgery or a home visit. The GP practices within the PCN worked together to provide face to face appointments at one site during core hours. An acute home visiting service has been extended across Calderdale having previously been available in two of the five Primary Care Networks. It was recognised that for palliative patients requiring visits, continuity of care was important and therefore for these patients, visits would be undertaken by their own registered practice.

3.5 The model was further developed through April 2020 with work undertaken to develop green sites for baby and childhood immunisations and baby checks. This was developed in partnership by the Primary Care Networks (Nurses, GPs and Practice Managers) and Locala Health Visitors and School Nurses, supported by the CCG Primary Care Team. This allowed parents and children to attend for immunisations and vaccinations in a site without the need to mix with other patients. A detailed Standard Operating Procedure was developed and a rapid impact assessment completed, alongside comprehensive training to ensure staff were competent. Locala colleagues are returning to their usual duties from mid- July 2020 however conversations are beginning to understand how we can build on the learning from this and improve the experience for parents and children in the first 6-8 weeks of life.

3.6 In respect of the bank holiday arrangements, nationally practices were directed to open at both the Easter and May (VE) Bank holidays. All Calderdale Practices complied with this request and continued to provide services for their patients.

3.7 As part of the second phase response it was stated that elements of the Primary Care Network (PCN) Directed Enhanced Service (DES) would be brought forward to May, further details of what those requirements are were published in the COVID-19- response-primary-care-and-community-health-support-care-home-residents document that was dated the 1st May 2020.

3.8 As a level of work had already taken place to begin to develop delivery of the Care Home Support element of the PCN DES , an enhanced care home planning meeting was re-established with the Clinical Directors of the PCNs , the Quest Team, South West Yorkshire Mental Health Trust and the Local Authority. The existing community services that support care homes have been flexible and increased their team numbers to ensure that the requirements were responded to and people and staff in care homes were appropriately supported. The learning from this work is being used to shape the model for care home support and deliver the DES.

3.9 To assist practices in ensuring they have considered the latest guidance relating to **Safe Working Practices** and also **safety of staff**, a summary of helpful links has been provided, this includes individual risk assessment templates, a draft risk assessment for the working environment and for a link to the RCGP Business Continuity Template. In addition to this, a question and answer session has been delivered for Practice Managers and staff, with support from the wider CCG team and a representative from the Local Authority Infection, Prevention and Control team. Practices have been asked to provide a self-declaration to provide assurance that they have;

- reviewed their existing Business Continuity Plans.
- undertaken COVID-19 Secure Workplace Risk Assessment, and
- undertaken Risk Assessments for all staff (ensuring this includes high risk staff including BAME)

The CCG has received responses from all 21 practices. The 21 practices that have responded have provided positive assurance against all three elements requested, with 3 stating that they are currently strengthening their business continuity plan and one indicating that staff risk assessments are underway but incomplete.

Engagement regarding experiences of health and care during this period of the covid pandemic has been carried out by Healthwatch and also some specific work in Calderdale with BAME communities. The themes of this are still being considered however one of the insights has raised an issue with remote triage and consultation where English is not a person's first language. Work needs to be undertaken within General Practice to ensure that where digital

solutions do not work alternatives are easily accessible. This needs to be considered and addressed by General Practice as these ways of working continue in order to ensure that inequalities are not widened further.

4.0 Arrangements to Free Up Capacity and Protect Income

4.1 Work has been undertaken both nationally and locally to free up practice capacity to prioritise workload to both prepare for and manage the COVID-19 outbreak. All routine CQC inspections have been cancelled and advice was issued on suspension of appraisal and revalidation activities.

4.2 All practices have been asked to consider stopping any private work they are doing to help free up capacity.

4.3 To ensure that funding does not influence clinical decision making all GP practices in 2020/21 will continue to be paid at rates that assume they would have continued to perform at the same levels from the beginning of the outbreak as they had done previously, including for the purposes of the Quality and Outcomes Framework (QOF) Directed Enhanced Services (DES) and Local Enhanced Services (LES) payments.

5.0 Medicines Management

5.1 The CCGs Medicines Management Team (MMT) has been supporting the Covid - 19 response by providing answers to medicines supply and administration queries to help GP practices continue to provide safe and effective care. This includes signposting local and national guidance within the regular primary care bulletin and maintaining and updating a prescribing support document with answers to FAQs e.g. changes to drug monitoring schedules.

5.2 The MMT has engaged closely with local providers to support issues relating to End of Life (EOL) care. This has included updating EPACCS and other templates, providing advice to clinicians on prescribing issues and supporting concerns around access to end of life medicines.

5.3 The MMT has engaged with other WY Heads of Medicines Management to improve access to EOL medicines, working with NHSE local team to amend and enhance the current palliative care pharmacy scheme and improve assurance around the availability of EOL medicines in these pharmacies. The team has made a weekly phone call to these pharmacies and issued a weekly update to our community providers to increase awareness of any stock concerns and reduce delays for patients accessing these medicines.

5.4 The CCG re-deployed the commissioned practice pharmacy team away from planned cost effective prescribing work to support practices with increasing the uptake of electronic repeat dispensing and 28 day prescription supply in line with NHSE guidance. The team were also supporting practices with other tasks such as medicines reconciliation and prescription queries. The external practice pharmacy team have returned to their commissioned work plan on the 1st July.

5.5 The MMT was also re-deployed on a part time basis to support the uptake of electronic repeat dispensing and medicines reconciliation in Calderdale practices requesting support. The team returned to CCG work in mid-June.

5.6 The MMT have been co-ordinating the nationally mandated pharmacy response to support care homes during Covid. This has involved working with Clinical Directors and the PCN Clinical Pharmacists and the existing QUEST Pharmacist to deliver more proactive support to our care homes around medicines. This continues to be a work in progress which will lead towards the delivery of the DES for Enhanced Care in Care Homes in October.

5.7 The MMT has offered support to the CDs and the PGPA to assist with the recruitment and induction of new PCN clinical pharmacists.

6.0 Next Steps

6.1 Support will continue to be given to practices and PCNs as we move to the next phase of Covid.

7.0 Financial Implications

7.1 The CCG confirmed with PCNs the availability of Covid support funding to support practices, via their PCNs with reasonable costs that have been incurred to date. This was established as an initial payment to acknowledge the need for set up costs with a claim form for practices to submit further costs.

7.2 To date, a total of circa £491k has been paid in respect of general practice costs. This can be broken down as follows:

PCN Face to Face set up costs - Leadership	£45k
PCN Face to Face set up costs – non pay	£50k
Bank Holiday staff costs	£197,375
GP Information Technology	£42,389
Acute Visiting Service	£156,370
TOTAL	£491,134

All the costs relating to Covid-19 will be reclaimed through the national reimbursement scheme, however it should be noted that that the there is a risk that the costs will not be reimbursed to the CCG.

In response to COVID-19, a temporary financial regime has been put in place by NHS England and Improvement to cover the period 1st April 2020 to 31st July 2020.

The revised financial regime and service changes in response to COVID-19 will have an impact on individual CCG financial positions and affordability of positions against allocations.

The re-deployment of the external practice pharmacy team has reduced the potential planned QIPP savings from primary care prescribing which impact on the prescribing will spend in 2020/21. As a result the team did not deliver any QIPP in Q1 2020/21.

8.0 Establishing the 'new normal'

8.1 There is a need to learn and progress from what's been achieved during the COVID-19 outbreak and establish a 'new normal' for General Practice, this could mean:

- Empowering people to continue to look after their own health e.g. by increasing or encouraging the use of technology to support long term condition management
- Maintaining reductions in footfall seen in all settings by continuing and expanding the digital first approach across services (e.g. EPS, eRD, virtual clinics etc.)
- Encouraging and enabling agile working for a wider workforce potentially enabling a more effective utilisation of estate
- Using technology to deliver training/engagement/meetings virtually giving people back valuable time lost to traveling
- Harnessing the leadership that has been shown to coproduce
- Aspects of Care Home support in response to COVID-19 will remain for the foreseeable future
- Engaging effectively within networks, with acute providers, community providers and the Local Authority to find new ways to deliver socially distanced primary health care. Two examples of this are the work underway to deliver the care home requirements of the PCN DES and also the conversations to build on the baby vaccinations, immunisations and baby check work
- Embedding a Population Health management approach across the district. This is about looking at population groups who have similar needs and using existing skills and resources differently, including those of the individual, to improve population outcomes, reduce inequalities and the way we develop and deliver services.

8.2 As part of supporting the approach to "the new normal" the CCG has worked with the Calderdale LMC to source and provide some external facilitation for each practice (individually in the first instance) to focus on the following:

- Reviewing their experiences of recent service and care delivery
- Identifying their successes and best practice
- Agreeing what specific practises they want to embed as BAU (business as usual)
- Discussing additional service innovation they want to adopt
- Creating a robust implementation plan and patient communication plan
- Identifying potential obstacles or blockages to the plan and developing solutions or responses

8.3 In addition, the CCG has engaged with the National Association of Primary Care to support the use of a population health management approach as fundamental to the development of the PCNs. They have been funded to provide support to Calderdale PCNs over the next 12 months with the delivery of the following proposed programme outcomes:

- Development of individual bespoke PCN action plans with recognition of individual progress to date and future development needs
- Support PCNs with practical approach of turning population health management into action plans to identify quality initiatives across 5 PCNs
- Support from small team derived from NAPC National Faculty members over 12 months utilising NAPC PCH approach to develop maturity of PCN through delivery identified projects / initiatives against action plans.

The aim is that once the NAPC support concludes, there is a legacy of skills within Calderdale and the approach is embedded. This work supports the wider Care Closer to Home work and starts to develop wider locality working, including with the voluntary sector

and communities.

9.0 Risks

9.1 There is a risk of increased spend within the primary care prescribing budget due to increased prescribing as a result of Covid 19 patient demand and due to delays in delivery of the MM QIPP plan.

9.2 There is a risk to the delivery of previous medicines management quality work including safer opioid prescribing work stream and antimicrobial audits due to delays in implementation as a result of Covid 19.

9.3 There is a risk to the delivery of the pharmacy response to enhanced care for care homes due to pharmacist capacity within our PCNs to support this work.

9.4 There is an emerging risk, seen through engagement work undertaken during this period of time, that some communities (particularly BAME) are finding it difficult to access General Practice due to the change of model and introduction of remote triage and consultation being the access route.

9.5 There is a risk that the covid costs will not be reimbursed to the CCG which will have a direct impact on the Primary Care delegated budget and the investment in activities that support the progress of the strategy for Primary Care.

10.0 Legal / CCG Constitutional Implications

10.1 The CCG will apply appropriate governance, follow procurement policy and ensure sound financial management in doing so.

11.0 Conflicts of Interest

11.1 Any interests will be managed in line with the CCG's policy for managing Conflicts of Interest.

12.0 Recommendations

12.1 The Committee is asked to **NOTE** the content of the paper.

Name of Meeting	Commissioning Primary Medical Services Committee	**Meeting Date**	23/07/2020
Title of Report	**Contracting Update**	**Agenda Item No.**	6
Report Author	Suzanne Howarth, Senior Contract Manager – Primary Care	**Public / Private Item**	Public
GB / Clinical Lead	Dr Majid Azeb, Primary Care Lead	**Responsible Officer**	Martin Pursey Head of Contracting & Procurement

Executive Summary							
Please include a brief summary of the purpose of the report	This paper provides an update to the Committee in respect of a number of contracting issues where it is felt that the Committee should know or be aware of.						
Previous consideration	**Name of meeting**		**Meeting Date**	Click here to enter a date.			
	Name of meeting		**Meeting Date**	Click here to enter a date.			
Recommendation (s)	It is recommended that the Committee: **RECEVIES** and **NOTES** the content of this report						
Decision	☐	**Assurance**	☒	**Discussion**	☐	**Other**	Click here to enter text.

Implications							
Quality & Safety implications	The paper is for information purposes and is not requiring a decision by the Committee						
Engagement & Equality implications (including whether an equality impact assessment has been completed)	The paper is for information purposes and is not requiring a decision by the Committee						
Resources / Finance implications (including Staffing/Workforce considerations)	The paper is for information purposes and is not requiring a decision by the Committee						
Has a Data Protection Impact Assessment (DPIA) been completed? (Please select)	**Yes**		**No**		**N/A**	X	
Strategic Objectives (which of the CCG objectives does this relate to?)	Achieving the agreed strategic direction for Calderdale ▪ Improving quality ▪ Improving value	**Risk** (include risk number and a brief description of the risk)					
Legal / CCG Constitutional Implications	The CCG will apply appropriate governance, follow procurement policy and ensure sound financial management in doing so	**Conflicts of Interest** (include detail of any identified/potential conflicts)		Any interests will be managed in line with the CCG's policy for managing conflicts of Interest			

1.0 Introduction

This paper provides an update to the Committee in respect of a number of contracting issues where it is felt that the Committee should know or be aware of.

2.0 Detail

2.1 GP Online Consultations Software

2.1.1 Following a joint procurement process with North Kirklees CCG the contract for GP On-line Consultations was awarded to Engage Health Systems Ltd. The original contract was awarded for one year with an option to extend by a further one year.

2.1.2 The commencement of the roll out of the software to practices was delayed with only one practice using a live system by July 2019. The CCG was invoiced for two year software licences for each practice so to ensure the CCG received value for money the original start date of the contract was revised to July 2019.

2.1.3 The expiry date of the original contract was 30th June 2020. On 5th June 2020 a decision paper was taken to the SMT meeting to obtain approval to invoke the one year extension option. The SMT supported this request and a letter was sent to Engage Health to seek their views on the proposal. Engage Health responded positively and accepted the extension period.

2.1.4 Engage Health is developing a video consultation model as an addition to the existing provision. They have assured the CCG there will be no additional costs during the length of the contract. Several practices have volunteered to be pilot sites to test out the functionality pending wider roll out across Calderdale, North Kirklees and Wakefield.

2.2 NHS England DES Participation 2020/21

2.2.1 NHS England commissions the national Directed Enhanced Services for the following schemes;

Learning Disabilities Health Checks (21);
Minor Surgery level 2 (18) and
GP Choice Out of Area Registration (9)

2.2.2 Each practice was asked to indicate which schemes they would be delivering during 2020/21 and the deadline for returning the notifications was the end of June. All 21 practices have returned their sign up documents and the numbers in brackets above indicate how many practices are signed up to each scheme.

2.2.3 As part of the annual negotiations between the NHS and the BMA the above schemes were extended for an additional year with no increases to the fees in place during 2019/20.

2.3 Network Contract DES 2020/21

2.3.1 Each PCN has previously indicated their commitment to the Network Contract DES. It is a contractual requirement for the DES to be varied into each individual practices' core GMS/PMS/APMS contract. The contract variations (CV) have been issued by the contracting team and all 5 PCNs have returned their confirmation of sign up to this DES.

2.4 Incorporation Applications – Update

2.4.1 The Boulevard Medical Practice has provided written assurance of the conditions sought by the CPMSC to support the Novation of the GMS Contract to the new entity.

2.4.2 The new entity has elected the 1st October 2020 as the date the Novation will formally take place. The Novation Agreement has been signed off and a copy returned for their records.

2.4.3 Spring Hall Group Practice (SHGP) has provided written assurance of the conditions sought by the CPMSC to support the Novation of the GMS Contract to the new entity.

2.4.4 Since the original application the partners of SHGP have requested a change to the name of the new entity. As due diligence was performed on Spring Hall Halifax Limited this process will be repeated for the new company called Spring Hall Group Practice Limited. This company was formed specifically for the Novation Agreement and is already registered with Companies House.

2.5 Benefits and Lessons Learnt from Incorporation Applications

2.5.1 A request from the last CPMSC meeting was to include lessons learnt from processing incorporation applications from practices and review the benefits these bring to general practice in general terms.

Benefits

2.5.2 Incorporation offers a GP practice increased flexibility when dealing with a change in shareholders. The process for changing a GP partnership under the traditional GP partnership model requires a contract variation to be signed by each party. There are other partner organisations such as NHSE and PCSE who are also involved in this process which takes a considerable amount of time to conclude. By comparison a change to a shareholder would be less labour intensive and potentially free up some of the available resource.

2.5.3 A wider range of pension arrangements are available to shareholders compared to the existing opportunities within a traditional GP partnership. Shareholders may also pay themselves dividends which attract lower rates of tax and are not subject to NI. The pension and financial benefits that incorporation offers may encourage and retain GP's to stay in Calderdale. This will hopefully improve GP retention in the area.

2.5.4 Recruitment of Primary Care Staff remains a significant challenge in Calderdale, along with the difficulty of attracting new partners. There is a recognition that practices need to diversify their workforce and skill mix. An incorporated structure can offer GPs and other multi-disciplinary staff, a salaried model of employment making it easier to recruit and retain staff. With a greater range of clinicians, practices will be better placed to innovate and take on a broader range of services by moving a range of hospital services out into the community.

2.5.5 As an incorporated entity practices will be able to link the surgery premises to the incorporating structure, ensuring the introduction of new "partners" does not result in significant renegotiation of the borrowing facility and transfers in the property. This is a major issue when trying to attract partners as opposed to salaried clinicians. This is largely due to the high level of financial commitment for the incoming clinician. As a result this will attract new partners and better position the practice to invest into the premises to better meet the CCG's objectives as outlined in the Primary Care Strategy and GPFV.

2.5.6 With a commissioning strategy aimed at commissioning an integrated approach, practices will be in a better position to take on more innovative services. Potentially they could take a lead

on projects involving Primary Care Networks under a more robust providing structure that a company vehicle offers.

Lessons Learnt

2.5.7 Early involvement of LMC – at the earliest opportunity the LMC are informed an application to incorporate has been received. This allows discussions to be held to identify any issues and to enable professional advice to be available should a practice seek LMC support. The LMC are able to see the wider impact of multiple applications across Calderdale.

2.5.8 Early engagement across key teams within the CCG – expert advice and input may be required from other teams to ensure the application progresses smoothly. This may be more appropriate for practice merger or boundary change applications than incorporation applications but making sure other teams are aware and may be required at some stage is important.

2.5.9 Expert advice and support to practices – early awareness allows all involved to be able to plan for the impact relating to the application. Practices have required input from CCG teams to develop their applications to a suitable standard in the past.

2.5.10 A multi-functional team has been established which meets bi-monthly, following the CPMSC Operational Group meetings, to discuss any primary care applications relating to general practice. Dependent upon the stage of the application will determine whether the whole group meets or is function specific. This enables the CCG to deal promptly with the applications and by having the meetings already in diaries the required staff are available.

3.0 Recommendations

3.1 It is recommended that the Committee RECEIVES and NOTES the content of this report.

Name of Meeting	Commissioning Primary Medical Services Committee (CPMSC)	**Meeting Date**	23/07/2020
Title of Report	**Risk Register Position Statement Risk Cycle 2 2020-21 (18 May to 8 June 2020) for CPMS**	**Agenda Item No.**	7
Report Author	Rob Gibson, Risk, Health & Safety Manager	**Public / Private Item**	Public
GB / Clinical Lead	Dr Steven Cleasby, Chair Calderdale CCG	**Responsible Officer**	Neil Smurthwaite, Interim Accountable Office

Executive Summary							
Please include a brief summary of the purpose of the report	CCG Risk Register currently contains a total of 43 risks. There are 11 risks marked for closure this risk cycle meaning that 32 risks are open. 8 of total CCG risks (19%) fall for consideration by the Commissioning Primary Medical Services Committee. Of these three are marked for closure meaning there are 5 open risks at the end of risk cycle 2. Among the 8 CPMS risks: • 3 open risks scoring 12 • 4 new risks • 3 risks marked for closure						
Previous consideration	**Name of meeting**	Quality, Finance & Performance Committee	**Meeting Date**	25/06/20			
	Name of meeting	SMT	**Meeting Date**	08/06/20			
Recommendation (s)	It is recommended that the Committee: 1. Reviews the CPMS Risk Register and the management of CPMS risks. Approves the CPMS Risk Register for reporting to Governing Body, subject to any amendments requested.						
Decision	☒	**Assurance**	☒	**Discussion**	☐	**Other**	Click here to enter text.

Implications						
Quality & Safety implications	There are no quality & safety implications.					
Engagement & Equality implications (including whether an equality impact assessment has been completed)	No engagement has been undertaken.					
Resources / Finance implications (including Staffing/Workforce considerations)	There are no resources / finance implications.					
Has a Data Protection Impact Assessment (DPIA) been completed? (Please select)	**Yes**		**No**		**N/A**	x

Strategic Objectives (which of the CCG objectives does this relate to?	Improving value	**Risk** (include risk number and a brief description of the risk)	Risk is managed in line with the CCG's Integrated Risk Management Framework. Risks are captured on the Corporate Risk Register or the Governing Body's Assurance Framework (GBAF) as appropriate.
Legal / CCG Constitutional Implications	There are no legal / CCG Constitutional implications	**Conflicts of Interest** (include detail of any identified/potential conflicts)	Any conflicts of interest arising from this paper will be managed in line with the CCG's Management of Conflicts of Interest Policy.

1.0 Introduction

1.1 The CCG's approach to the management of risks is set out in the Integrated Risk Management Framework. All CPMS risks on the CCG's corporate risk register are the responsibility of the CPMSC and all risks are submitted for review to each of the Committee meetings.

1.2 Assurance is provided to the Governing Body that all risks are being effectively managed and a risk report is provided at each Governing Body meeting setting the detail of risks scoring 15 (serious) or more.

1.3 Although a comprehensive review of risks by their respective risk owners and senior managers for risk cycle 1 of 2020-21 took place during February and March 2020, the risk register was not presented at Committees or to the Governing Body at their meetings during this period. Due to Covid19 the focus of these specific meetings evolved to primarily decision making rather than routine assurance or discussion items. This is not to say that the assurance work wasn't happening, but rather seeking to reduce the burden on staff writing routine papers for committees detailing this. This was to ensure that CCG staff were able to focus on the COVID-19 response and supporting the NHS frontline.

1.4 This report has been prepared with consideration to any significant movement of CPMS risks that also took place during risk cycle 1 of 2020-21.

2.0 Detail

2.1 CPMS risks have been categorised as separate risks on the corporate risk register since risk cycle 4 of 2017-18.

2.2 During risk cycle 2 of 2020-21 the CCG Risk Register had a total of 43 risks. There were 8 CPMS risks, of which 5 are open:

2.3 Open risks

Risk ID	Risk summary	Risk score	Risk movement
1617	The medicines management QIPP plan will not deliver the expected savings of £750k from the primary care prescribing budget due to focus of the support from the NECS teams being focussed on supporting the covid-19 pandemic work resulting in an additional financial pressure to the CCG.	12	New
1564	A risk of delay in access to end of life medicines due to supply issues for pharmacies for some of these medicines. This may result in poor symptom control for patients at the end of life (EOL) and distress for patients, carers and families. It may also result in additional workload for healthcare staff and carers when trying to source these medicines on prescription.	12	New
1560	GP practices who have received patients as a result of the closure of APMS practices will have additional work to align the care of the patients with their standards and approaches due to the information received through the clinical records. This may result in: 1) the receiving practices requiring increased clinical capacity to review the patients and ensure that they are receiving appropriate care and treatment 2) additional work in order to ensure QOF achievement is met, both	12	New

	of which may impact the income of practices and therefore result in further requests for reimbursement		
1561	Following the closure of APMS practices and the registration of patients at new practices that the patients may be dissatisfied and not able to understand clearly any changes made to care and treatment following review due to variation in clinical practice and updated medication reviews. This may result in an increase in complaints for particular practices and negatively impact the reputation of the CCG and primary care within Calderdale.	9	New
1434	The quality of and access to commissioned primary medical services in Calderdale is compromised due to local and national workforce shortages, resulting in the inability to attract, develop and retain people to work in general practice roles.	8	Reduced from 12 due to collaborative work with CHFT

2.4 There were 3 risks closed during risk cycle 2:

Risk ID	Risk summary	Risk score	Reason for closure
1563	100% of the practices not being live on GP Online Consultations in line with the contractual requirements resulting in additional capacity being focussed in this area at a time of increased demand due to COVID-19 and also potential reputational damage	12	This risk has become a reality
1435	Not all practices will implement online consultations by March 2020 due to the significant demand on practices to undertake a number of digital changes at the same time and of equal priority resulting in some practices not meeting their contractual obligations on 1 April 2020.	12	Closed due to all practices meeting target
1432	The end of the APMS contract Terms in March 2020 may result in a negative impact on the reputation of the CCG due to public concern in relation to access to primary medical services.	8	Reached tolerance

3.0 Recommendations

3.1 It is recommended that the CPMS Committee **CONFIRMS** that it is **ASSURED** that the Risk Register represents a fair reflection of the risks relating to the commissioning of primary medical services for risk cycle2 2020-21.

4.0 Next Steps

4.1 The CCG's corporate risk register will be updated accordingly and the risk register report will be reported to the next Governing Body meeting on 23 July 2020.

5.0 Appendices

- CPMS risk register showing all risks during risk cycle 2 2020-21

Risk register of all CPMS risks for CPMS Committee meeting 23 July 2020

Risk ID	Date Created	Risk Type	Risk Category	Risk Rating	Risk Score	Target Risk Rating	Target Score	Senior Manager	Principal Risk	Key Controls	Key Control Gaps	Assurance Controls	Positive Assurance	Assurance Gaps	Risk Status
1617	19/06/2020	Commissioning Primary Medical Services Committee	F&P - Financial	12	(I3xL4)	4	(I3xL4)	Debbie Robinson	There is a risk that the medicines management QIPP plan will not deliver the expected savings of £750k from the primary care prescribing budget due to focus of the support from the NECS teams being focussed on supporting the covid-19 pandemic work resulting in an additional financial pressure to the CCG.	Action plan developed for 2020/21 and approved by Medicines Advisory Group NECS commissioned to deliver action plan in Calderdale practices	NECS were redeployed in quarter 1 of 2020/21 to support practices with non QIPP work during Covid pandemic Work on the action plan delayed until quarter 2 2020/21 which will result in a shortfall on delivery Revised QIPP target of £580k in year based on delayed delivery of the plan	monthly medicines financial monitoring meetings scheduled at CCG with finance, primary care, Business Intelligence and Medicines Management in attendance quarterly contract monitoring meetings with NECS and CCG	Agreement to re-start QIPP plan from CDs and LMC at GP resilience meeting June 11th 2020 PMAG June meeting supportive of re-start in practices	NECS ability to deliver depends on early approval of action plan work plan in each practice. This needs to take place in next few weeks to allow delivery from start of July	New
1564	26/05/2020	Commissioning Primary Medical Services Committee	Q - Medicines Management	12	(I3xL4)	6	(I3xL4)	Debbie Robinson	There is a risk of delay in access to end of life medicines due to supply issues for pharmacies for some of these medicines. This may result in poor symptom control for patients at the end of life (EOL) and distress for patients, carers and families. It may also result in additional workload for healthcare staff and carers when trying to source these medicines on prescription.	NHSE WY area team commission a palliative care medicines service from a number of community pharmacies in West Yorkshire to maintain stocks of key end of life medicines. There are 7 pharmacies in Calderdale who are commissioned to provide this service. Other pharmacies not commissioned to provide this service can also obtain these medicines from their wholesalers same day or next day but may not keep them in stock for urgent prescriptions. NHSE WY area team have issued a contract variation 22nd May 2020 requiring the palliative care pharmacies to provide a bi- weekly stock assurance and to increase their stock of some EOL medicines	There have been national supply problems with some of these medicines which has meant the palliative care pharmacies have not had all the required medicines in stock resulting in delays in obtaining prescriptions.. There has been no mechanism in place for the commissioned pharmacies to let CCG or providers know when these medicines are out of stock. Not all the commissioned pharmacies are open extended hours in the week or after Saturday lunchtime meaning reduced geographical provision in some areas of Calderdale.	NHSE are responsible for contract monitoring and are working to provide bi weekly assurance to CCGs on stock availability for these medicines. This is expected to start week beginning 1st June 2020	Medicines Management Team are currently doing a weekly call to confirm EOL medicine stocks with the 7 palliative care pharmacies	Stock shortages in wholesalers being reported on weekly calls by some pharmacies	New
1563	26/05/2020	Commissioning Primary Medical Services Committee	F&P - Contracting	12	(I4xL3)	4	(I4xL3)	Debbie Robinson	There is a risk to the CCG of 100% of the practices not being live on GP Online Consultations in line with the contractual requirements resulting in additional capacity being focussed in this area at a time of increased demand due to COVID-19 and also potential reputational damage	Development of a regional team to oversee delivery and understand implementation and engagement Support for roll out of 10 high impact actions Procurement concluded and provider in place Regular project reports Updates provided monthly to LMC Weekly meeting with NHSD/E to discuss position Contractual Requirement	Potential use of contractual sanctions	Monthly report to LMC that shows progress Report from GPOC weekly call with NHSD/E	Monthly and weekly reports have shown significant progress in compliance through March and April 2020. Project manager and primary care team link report engagement with three remaining practices	3 practices outstanding and time limited actions have been agreed with the remaining practices	Closed - This risk has become a reality
1560	22/05/2020	Commissioning Primary Medical Services Committee	CPMS - F&P	12	(I4xL3)	4	(I4xL3)	Debbie Robinson	There is a risk that GP practices who have received patients as a result of the closure of APMS practices will have additional work to align the care of the patients with their standards and approaches due to the information received through the clinical records. This may result in: 1) the receiving practices requiring increased clinical capacity to review the patients and ensure that they are receiving appropriate care and treatment 2) additional work in order to ensure QOF achievement is met, both of which may impact the income of practices and therefore result in further requests for reimbursement	Additional reimbursement has been agreed with LMC in excess of the agreed amount within the CCG Policy QOF payment was not affected for the financial year ending 2020/21 Receiving practices have a full 12 months to ensure appropriate reviews are undertaken in relation to QOF	None	Agreement through LMC of additional financial payment to practices above that agreed within policy CPMSC performance report detailing QOF achievement Datix reporting in relation to quality of care	Evidence of additional payment issued to receiving practices through Primary Care Budget	The amount of additional work required for patients transferring is not quantified as practices are still working through the patient reviews	New

1435	25/11/2019	Commissioning Primary Medical Services Committee	CPMS - F&P	12	(I4xL3)	4	(I4xL3)	Debbie Robinson	There is a risk that not all practices will implement online consultations by March 2020 due to the significant demand on practices to undertake a number of digital changes at the same time and of equal priority resulting in some practices not meeting their contractual obligations on 1 April 2020.	Development of a regional team to oversee delivery and understand implementation and engagement Support for roll out of 10 high impact actions Procurement concluded and provider in place Regular project reports against progress Updates provided monthly to LMC	Ability to understand appetite for implementation and engagement	Regular project updates and meetings	Update into CPMSC Operational Group - notes WY&H Care Partnership Digital Project Board has oversight of all CCGs across West Yorkshire and Harrogate Regular progress report to LMC	Number of practices at go live remain low	Closed - Merged with another risk (please link to merged risk)
1561	22/05/2020	Commissioning Primary Medical Services Committee	CPMS - Q	9	(I3xL3)	3	(I3xL3)	Debbie Robinson	There is a risk that following the closure of APMS practices and the registration of patients at new practices that the patients may be dissatisfied and not able to understand clearly any changes made to care and treatment following review due to variation in clinical practice and updated medication reviews. This may result in an increase in complaints for particular practices and negatively impact the reputation of the CCG and primary care within Calderdale.	Medication reviews will be undertaken in line with Calderdale CCG guidance and recommended practice Receiving practices have agreed to undertake reviews based on clinical priority Compliance with accessible information standard	Accessible information standard was incomplete for one of the closing practices	Complaints information available by practice from NHSE and can be requested through the CPMSC operational group	None	None	New
1434	25/11/2019	Commissioning Primary Medical Services Committee	CPMS - F&P	8	(I4xL2)	4	(I4xL2)	Debbie Robinson	There is a risk that the quality of and access to commissioned primary medical services in Calderdale is compromised due to local and national workforce shortages, resulting in the inability to attract, develop and retain people to work in general practice roles.	1. Calderdale is part of the international GP recruitment programme 2. LWAB funding has been secured to commission the development of a Calderdale workforce strategy, including stocktake of current available workforce and forecasted requirement for the future. 3. Primary care workforce group is established 4. Primary Care network contract supporting development of workforce plans 5. Additional roles funding available through PCNs at 100% reimbursement from April 2020 6. Role out of Apex Insight tool to practices to understand capacity and demand 7. New national contractual requirements on workforce from April 2020 8. Investment to support local delivery of GP career plus, ACP Career Plus made for 2020/21	1.Gaps exist in relation to current workforce data 2.Calderdale Workforce Plan (in development) 3.Infancy of PCNs with no coherent workforce strategy or plan at present (expected End of June 2020)	1. Central reporting requirements including progress against additional roles 2.Quarterly Dashboard reports to Quality Committee & Commissioning Primary Medical Services Committee 3. CQC programme for assurance	1.CQC Inspection reports. 2.CPMSC minutes	CQC routine inspections have been suspended during covid-19 Pandemic	Decreasing
1432	22/11/2019	Commissioning Primary Medical Services Committee	CPMS - Q	8	(I4xL2)	8	(I4xL2)	Debbie Robinson	There is a risk that the end of the APMS contract Terms in March 2020 may result in a negative impact on the reputation of the CCG due to public concern in relation to access to primary medical services.	Clear Communication, engagement ad consultation plan. Monitoring of response rates and adjusting consultation methods as appropriate in order to reach protected groups Engaged with Local Councillors Meeting with Calderdale Overview and Scrutiny Board Press Briefings Dedicated consultation Telephone line Regular updates to LMC	None identified	Established operational Task and finish Group Weekly updates to SMT Commissioning primary Medical Services Committee Oversight All queries received through the telephone line have been dealt with to conclusion. All complaints and counsellor queries have been responded to	Paper to Overview and Scrutiny Board Pre-consultation Engagement report SMT notes Weekly Task and Finish Group Notes	Final Consultation report	Closed - Reached tolerance

CPMSC WORK PLAN - 2020-21							
	Lead	**Purpose**	**Frequency**	**April**	**July**	**Oct**	**Jan**
Contracting							
Park & Calder & Meadow Dale APMS extension to contract	MP	For decision	As required				
Contracting Report	MP	For assurance	Monthly	C	√	√	√
Ongoing management and performance of GMS, PMS and APMS contracts	MP		Monthly				
Commissioning of primary medical services	MP		As required				
Approve GMS, PMS and APMS contract branch/remedial notices and removing a contract	MP		As required				
Consideration of a request for branch closure	MP		As required				
Consideration of a request for branch merger	MP		As required				
Practice list closure	MP		As required				
Consideration of contract end dates	MP		As required				
Discretionary payments	MP		As required				
Boundary Change Request (Options paper)	MP	For decision	As required				
Practice resilience - strategic update	MP		As required				
Application for Rent reimbursement - Spring Hall	MP	For decision	As required				
Enhanced surveillance	MP		As required				
•e.g. mergers	MP		As required				
Finance							
Finance Report	NS	For assurance	Monthly	C	√	√	√
Draft Finance Plan	LS	For assurance	As required	C			
Assurance Reports							
Primary Care Assurance cover paper & report - to be replace with National Dashboard	*DR*	*For assurance*	*tbc*				
Head of Primary Care Report	DR	For assurance	Monthly	C	√	√	√
PCN Development/Maturity Matrix Action Plan/timeline	DR	For assurance					
Risk Management							
CPMS Risk Review	RG	For assurance	As required	C	√	√	√
GBAF Review	RG	For assurance	Bi-annually			√	
Annual Risk Report	RG	For assurance	Annually (date tbc)				
Policies & Procedures							
PGM - via paper to Committee, confirm the CCGs default position to use the revised manual unless there is a local procedure in place that supersedes it.	MP	For assurance	As required				
Review Policy for discretionary financial assistance as a result of a list dispersal **(Septembe 2021)**	MP	For decision	As required				
Additional items in year relating to areas of potential high risk or priority							
GP Access Incentive Scheme – Commitment to a recurrent level of PMS funding for future investment subject to the provision of appropriate evaluation report	EB	For decision	As required		√		
Contract Variations							
Spring Hall Group Practice - Application for novation of GMS contract	MP	For decision		√			
Conduct of Committee & Development							
Review work plan	DR	For assurance	Monthly	C	√	√	√
Agree CPMSC Draft Annual Report to include a review of terms of reference and output from self-assessment	DR/JM	For assurance	Annually				√
Internal Audit Report	JS	For assurance	As required				√

	Lead	Purpose	Frequency	April	July	Oct	Jan
Follow up development session to review PCN Support and to progress recommendations and further establish/plan requirements in relation to the wider integration agendas. Establish the areas of contractual governance that fall solely within the responsibility of the committee	DR	For asurance	TBC				

C= cancelled

Name of Meeting	Commissioning Primary Medical Services Committee	**Meeting Date**	23/07/2020
Title of Report	**Finance Report**	**Agenda Item No.**	9
Report Author	Lesley Stokey - Interim Chief Finance Officer	**Public / Private Item**	Public
GB / Clinical Lead	Neil Smurthwaite, Interim Chief Officer	**Responsible Officer**	Neil Smurthwaite, Interim Chief Officer

Executive Summary							
Please include a brief summary of the purpose of the report	Key messages for the committee to note at Month 2 are: ▪ The Primary Medical Services delegated budget had an initial plan for 2020/21 of £31.5m. Due to COVID -19 a new temporary finance regime has overwritten previous plans for 2020/21. ▪ The CCG has received allocations for the period April-July 2020/21 which are less than the original plan. ▪ The CCG fully spent its allocation in 2019/20.						
Previous consideration	**Name of meeting**	N/A		**Meeting Date**	N/A		
	Name of meeting	N/A		**Meeting Date**	N/A		
Recommendation (s)	It is recommended that the Committee: 1. **NOTES** the financial position on Primary Medical Services delegated budgets for 2019/20. 2. **APPROVES** the proposed financial plan for April – July 2020 3. **APPROVES** putting on hold discretionary investments until further guidance received.						
Decision	☒	**Assurance**	☒	**Discussion**	☐	**Other**	Click here to enter text.

Implications			
Quality & Safety implications (including Equality & Diversity considerations e.g. EqIA)	N/A		
Public / Patient / Other Engagement	N/A		
Resources / Finance implications (including Staffing/Workforce considerations)	N/A		
Strategic Objectives (which of the CCG objectives does this relate to – delete as applicable)	▪ Improving value	**Risk** (include link to risks)	N/A
Legal / CCG Constitution Implications	N/A	**Conflicts of Interest** (include detail of any identified/potential conflicts)	Any conflicts of interest will be managed in line with the CCG's policy for managing Conflicts of Interest.

1.0 Key Messages

The purpose of this report is to update the Commissioning Primary Medical Services Committee on the financial position of primary care co-commissioned delegated budgets for 2019/20 and to present the proposed budgets for the period April to July 2020 in line with financial guidance following Covid-19.

The CCG had developed a plan for the financial year 2020/21 and this was submitted to NHS England and Improvement in January 2020, however due to the impact of COVID-19 a new temporary financial regime has been put in place for the period April to July 2020. The CCG has received less than originally planned for the period April-July 2020.

Guidance is due to be published on the financial arrangements for the period August 2020 to end of March 2021.

2.0 Financial Performance 2019/20 – Delegated Budgets

A summary of the final Month 12 delegated budgets and expenditure is shown in the table below:

Centre Code	Annual	In Month (£)			Year To Date (£)		
Name	Budget	Budget	Actual	Variance	Budget	Actual	Variance
	£000	£000	£000	£000	£000	£000	£000
GMS	15,644	1,304	1,291	(12)	15,644	15,688	44
PMS	3,052	254	266	11	3,052	2,975	(77)
APMS	1,729	144	190	46	1,729	2,283	554
QOF	2,844	237	338	101	2,844	2,819	(25)
PCN	778	65	83	18	778	725	(53)
Enhanced Services	633	53	111	59	633	677	44
Premises - Reimbursed Costs	2,861	238	895	656	2,861	3,545	684
Premises - Other	636	53	(20)	(73)	636	407	(229)
Prof Fees Prescribing & Dispensing	201	17	24	8	201	174	(27)
Collaborative Payments	0	0	0	0	0	0	0
Other GP Services (inc. PCO)	512	43	166	124	512	626	114
Other Non GP Services	588	49	(202)	(251)	588	392	(195)
Pensions	0	0	0	0	0	0	0
Reserves - 19-20	676	58	(618)	(676)	676	0	(676)
Reserves - Contingency	156	13	0	(13)	156	0	(156)
Total Primary Care Medical	**30,310**	**2,528**	**2,526**	**(2)**	**30,310**	**30,310**	**0**

The CCG remained within its delegated budget of £30.3m and has not, as planned, used any slippage from delegated budgets to support core CCG allocations.

- The CCG has taken a prudent approach enhanced services accruals so this has shown an increase of £44k funded from contingency.
- Premises costs in total have overspent by £445k due to inclusion of some provisional costs for dilapidations.
- APMS final overspend of £554k funded from reserves
- The contingency of £156k and reserves balance of £676k have been released to fund the pressures as noted above.

3.0 Delegated Primary Medical Services Pre-COVID Plan for 2020-21

The CCG had initially been notified of a recurrent allocation for 2020-21 of £31,522k. In addition, the CCG would be able to access additional roles funding (to the maximum level) on top of the amount included in the baseline as staff are recruited.

However under the temporary finance regime in response to COVID-19, the CCG has had its allocations reversed for 2020/21 and been given an allocation based on 2019/20 spend uplifted for inflation and only for a four month period April to July 2020.

NHS England has established a process that CCG's can report pressures against this allocation and they will consider the pressures on a case by case basis and adjust allocations accordingly.

The allocation received is £10,380k for the period April-July 2020. The equivalent budget based on our original plan would be £10,507k (excluding additional allocations) leaving a potential shortfall of at least £127k against the original plan. This is shown in the table below.

PRIMARY CARE SERVICES:	Pre-Covid		Covid	
Calderdale CCG	2021/21 plan	M1-4 Pro rata budget	Revised Budget M1-4	Variance to original plan M1-4
	£000	£000	£000	£000
GMS	18,282	6,094	5,379	-715
PMS	1,742	581	1,012	431
APMS	1,041	347	782	435
QOF	2,803	934	927	-7
Enhanced Services	317	106	106	0
Premises - Reimbursed Costs	2,966	989	990	1
Premises - Other	625	208	159	-49
Prof Fees Prescribing & Dispensing	155	52	56	4
Collaborative Payments	-	-	-	-
Other GP Services (inc. PCO)	365	122	172	50
Other Non GP Services	615	205	222	17
Pensions		-	-	-
PCN	2,086	695	345	-350
Reserves	367	122	177	55
Reserves - Contingency	158	53	53	0
Total Primary Care Medical	**31,522**	**10,507**	**10,380**	**(127)**

The Committee is asked to approve the budgets as notified by NHSE. The CCG will report any pressures against this budget accordingly.

Guidance is due to be published on the financial arrangements for the period August 2020 to end of March 2021.

It should be noted that due to the uncertain nature of allocations and also as a result of the significant value of COVID related expenditure, **it is recommended** that any discretionary investments should be suspended until further guidance is received.

4.0 Equitable Funding / PMS Premium Update

As previously agreed in committee, the CCG is intending to introduce equitable funding from October 2020. This means the PMS and GMS practice will receive the same core per patient payment from October 2020.

The PMS premium adjustments have been recalculated based on 2020/21 actual payments and the table below shows the latest values.

	In year changes	PMS Premium Budget
19/20	£0	£493,730
20/21	£86,286	£580,016
21/22	£86,286	£666,303

As the adjustment was agreed to be implemented from October 2020, there will be a half year impact of £86k in 2020/21 giving a PMS premium budget of £580k and the full year adjustment will be available from 2021/2 with a budget of £666k.

5.0 New GP Contract Investments 2020/21

As part of the original financial plan budgets were set to reflect the updates to the new GP contract agreement 2020/21-2023/24.

The table below shows the breakdown of the £2.1m included within the CCG baseline for these investments.

PCN Payments	**2020-21**
Additional Roles Reimbursement	£976,349
Clinical Lead	£160,337
Extended Hours Access DES	£322,007
Investment and Impact Fund	£148,790
Network Participation	£394,273
Care Homes	£84,600
Total CCG Plan	**£2,086,356**
Aditional Roles Reimbursement held by NHSE (max amount)	£623,865

With respect to the funding available for additional roles, this funding is split between the amount included in CCG baselines (£976k) and an amount held centrally by NHSE (£624k) giving a total maximum of £1,615k. The funding for additional roles will only be made available to PCNs if they have well developed plans to spend the allocated amount. In the initial guidance, there was an expectation that plans should be developed by PCNs by end of June and shared with NHS England by end of July.

6.0 Risk/Opportunities

- **Risk -** The CCG does not receive the planned allocation in full.
- **Risk -** The CCG is not able to make discretionary investments.

- **Risk -** The CCG does not fully spend additional roles allocations and funds may be redistributed.

7.0 Recommendations

7.1 It is recommended that the Committee:

1) **NOTES** the 2019/20 financial position on Primary Medical Services delegated budgets.
2) **APPROVES** the proposed budgets for 2020/21 April to July.
3) **APPROVES** withholding discretionary investments until further guidance received.

NHS
Calderdale
Clinical Commissioning Group

Name of Meeting	Commissioning Primary Medical Services Committee	**Meeting Date**	23/07/2020
Title of Report	**Approval of Branch Surgery for Bankfield Surgery**	**Agenda Item No.**	10
Report Author	Debbie Robinson, Head of Primary Care, Quality and Improvement	**Public / Private Item**	Public
GB / Clinical Lead	Mr Neil Smurthwaite Interim Accountable Officer	**Responsible Officer**	Debbie Robinson Head of Primary Care, Quality and Improvement

Executive Summary							
Please include a brief summary of the purpose of the report	The report reminds the committee of the APMS post consultation deliberation paper considered at the Commissioning Primary Medical Services Committee on 9th January 2020 which drew to the attention of the committee that as part of the mitigations against the impact upon patients of reduced GP capacity, travel, parking and access the CCG was exploring the potential use of the Rosemount premises following the closure of the Meadowdale APMS practice. The report details the financial requirements for the term of the 3 year lease.						
Previous consideration	**Name of meeting**	CPMSC Committee	**Meeting Date**	09/01/2020			
	Name of meeting		**Meeting Date**	Click here to enter a date.			
Recommendation (s)	It is recommended that the Committee: 1. Note the content of the paper 2. Formally approve the establishment of a branch surgery at Rosemont House, Elland 3. Determine any further requirements or conditions as part of the approval						
Decision	☒	**Assurance**	☐	**Discussion**	☐	**Other**	Click here to enter text.

Implications							
Quality & Safety implications	The surgery is need to provide patients with access to high quality services closer to home						
Engagement & Equality implications (including whether an equality impact assessment has been completed)	The CCG is committed to monitoring the compliance with the Equality duty of the providers from whom we commission services. This is done through the quality and contracting process.						
Resources / Finance implications (including Staffing/Workforce considerations)	Recurrent CCG revenue costs for additional rent and rates as detailed in the report						
Has a Data Protection Impact Assessment (DPIA) been completed? (Please select)	**Yes**	X	**No**		**N/A**		
Strategic Objectives (which of the CCG objectives does this relate to?	1. Achieving the agreed strategic direction for Calderdale. 2. Improving Quality 3. Improving value	**Risk** (include risk number and a brief description of the risk)	Risk 1432 Reputational risk linked to public concern re access to primary medical services.				

Legal / CCG Constitutional Implications	Obligation to provide primary medical services to the local population.	**Conflicts of Interest** (include detail of any identified/potential conflicts)	Any conflicts of interest will be managed in line with the CCG's policy for managing Conflicts of Interest.

1.0 Introduction

1.1 When Calderdale CCG took on delegated authority for primary care commissioning in April 2015 the CCG became responsible for decision making regarding the primary care estate across the district, as well as for determining new primary care priorities and ensuring that sufficient primary care provision is commissioned to meet the needs of the local population.

1.2 The CCG's responsibilities, with regard to premises, are mostly set out in the National Health Service (General Medical Services Premises Costs) Directions 2013, and include:-

- Managing the rents reimbursed to practices for the provision of general medical services in buildings owned by Practices or another body, where the Practice is a tenant and is charged a lease;
- Managing the reimbursement of business rates for the provision of general medical services in buildings owned by Practices or another body, where the Practice is a tenant and is charged a lease;
- Determining improvement grant priorities- the NHS is able to provide some funding to help surgeries improve, or extend their building in line with the directions;
- Determining new primary care premises priorities;
- Consideration of funding new premises annual revenue requirements as a result of additional/ new rent reimbursement requirements of new premises, subject to funding being available (although note that capital funding requirements are not delegated to the CCG and NHS England approval is still required).

1.3 This paper seeks approval for the establishment of leasehold Branch Surgery at Rosemount House Elland.

2.0 Practice Background

2.1 Bankfield Surgery is based in Elland on Huddersfield Road, HX5 9BA and is currently a single site practice. The practice has a list size of 10,377 (source NHS Digital - April 2020 Raw) and is part of the Calder & Ryburn Primary Care Network (PCN) (42,442 – April 2020).

2.1.1 The practice has seen a higher than average increase in their list size over recent years, particularly following the closures of Burley Street Surgery in 2018 and the Rosemount House site of Meadow Dale Group Practice in 2020, both of which were located in the Town of Elland.

2.1.2 There was very little increase in patient list size (+519) over the 5 years from April 2013 to April 2018 which was in line with other practices across Calderdale. However, since April 2018 there has been a significant increase of 2,077 patients.

2.1.3 Comparing this increase to other practices across Calderdale, Bankfield Surgery has seen the highest (+33%) list size increase at a single practice since 2013 (excluding practices that have merged).

2.2 <u>Focus on Elland</u>

2.2.1 Population

The 2011 census gave the population size of Elland as 11,676 which increased to 12,423 in the mid-2018 population estimates. (Source ONS publication 25th October 2019)

When the surgery was built in 1991 the population of Elland was around 11,330 (guestimate based on the ONS Calderdale population size of circa. 194k in 1990).

The Public Health data sets from the Local Authority show that Elland has just under 1 in 3 households with no car or van and the deprivation level is 24.9, slightly below the Calderdale average of 26.4. The practice is 2.3 miles away from A&E with one regular bus service.

There have been a number of housing developments in the Elland area which has meant increases to the population locally.

In Elland patients historically had a choice historically of registering at 4 local practices, in June 2018 this became 3 and in March 2020 with the closure of a further practice this has reduced to 2 practices, the other being situated in Stainland.

2.2.2 Current Surgery Premises

The current premises, Bankfield Surgery, was purpose built in 1991 and is in a prime location in the heart of Elland, with on-site parking available for patients and staff. The practice became a training practice in February 2020 unfortunately there are no spare rooms to accommodate a GP registrar

The 6-facet survey carried out in 2016 rated the condition as 'fair'. It highlighted that work was needed internally but the premises were in good condition externally.

Space Utilisation was rated as F - Fully Occupied based on their list size of 8201 in July 2016. compared to 10,377 in April 2020.

2.3 Patient Views

The practice had previously discussed expanding the Bankfield Surgery Site with their Patient Reference Group (PRG) in February 2019 who were supportive.

At the a further meeting in February 2020, a further discussion took place with their PRG that the practice were looking into the possibility of using the Rosemount House premises, to support the increased patient numbers following the Meadow Dale Group Practice closure. No objections or concerns were raised. Due to the Covid Pandemic, the group has not met since.

2.4 Premises Development Request

Initially, the practice approached the CCG in late 2019 to explore the possible redevelopment of the existing Bankfield Surgery with the intention of extending their current premises to support a potential increased list size, increasing staffing levels and to support the new role requirements as part of the Primary Care Network Directed Enhanced Service.

The practice was in the process of completing a Project Initiation Document (PID), with support from the NHSEs Strategic Estates Advisor, in preparation for formal submission to the CCG. During this time, plans were being made to close down four APMS premises, which resulted in patients being allocated to practices across Calderdale.

In view of this, the premises development request was put on hold and the practice were offered the option of using Rosemount House as either a temporary or permanent site to support their more immediate needs following the allocation of patients.

The APMS post consultation deliberation paper considered at the Commissioning Primary Medical Services Committee on 9th January 2020 drew to the attention of the committee that as part of the mitigations against the impact upon patients of reduced GP capacity, travel, parking and access the CCG was exploring the potential use of the Rosemount premises.

3.0 Branch Site at Rosemount House

3.1 The current lease with NHS Property Services (NHSPS) is due to expire in October 2020 and the CCG is liable for the void costs between April and October 2020.

3.2 Negotiations commenced with NHSPS with the intention of a Tenancy at Will (TaW) arrangement, between Bankfield Surgery and NHSPS from the 2nd week in April 2020.

3.3 Bankfield Surgery also explored a new lease arrangement directly with the proprietor from November 2020, but due to the Covid-19 pandemic and the change to standard operating model for general practice the immediate occupation arrangements were paused.

3.4 The District Valuer was asked to provide and independent Value for Money (VFM) report on the proposed new lease and potential rent on Rosemount House. Recommendation from the was that the reimbursement rent figure and other associated lease terms represent Value for Money to Calderdale CCG

3.5 The table below gives an indication of the reimbursement impact on the delegated budget. Due to the type of APMS contract, we are unable to give a direct comparison between these costs and those included in the contract of the former practice. However, we have been able to obtain the rates and water rates figures from NHSPS:

Item	**Rent £**	**Information**
Current Market Rent (CMR) Value	31,764	
Sinking Fund (Practice to invest in Repairs & Insurance Rent with remaining into a Sinking Fund)	7.5%	Sinking fund is 7.5% of CMR
	2,382	(no VAT)
Sub-total Rent Reimbursement	34,150	
+VAT @ 20%	6,353	VAT on £31,764 (VAT is not payable on the sink fund)
Total Rent Reimbursement	**40,500**	Per Annum for 3 years
Impact over term of lease	121,500	Over 3 years as a minimum

Other considerations:

Water	220	Per annum
	44	VAT@ 20% on £220
Rates	13,572	Per annum (no VAT)
Total Reimbursement	**54,336**	**Per annum**
Potential impact over term of lease	*163,008	Over 3 years as a minimum

3.6 There is an expectation that the revenue is available to invest as planned, a result of the end of the APMS contracts, if we get our allocations as promised, there should be some reserves available. However, we do recognise the potential risk given the current revised funding arrangements as detailed in the Finance update.

3.7 We recognise that whilst we may have resource available we need to put a clear process and strategy in place to ensure any resource meets the priorities identified and expectations

4.0 Future Considerations

4.1 The new lease would be for a period of 3 years with a 2 year break clause requiring 6 months' notice.

4.2 It is still the intention of the practice to develop the Bankfield site long term and using Rosemount House as a branch site is seen as a temporary measure to give immediate support.

5.0 Conflicts of Interest

5.1 Any interests will be managed in line with the CCG's policy for managing Conflicts of Interest.

6.0 Recommendations

6.1 It is recommended that the Committee:

- **Notes** the content of the paper
- **Approves** the establishment of a branch surgery at Rosemont House, Elland
- **Determines** any further requirements or conditions as part of the approval

Name of Meeting	Commissioning Primary Medical Services Committee	**Meeting Date**	23/07/2020
Title of Report	**Establishment of an Estates Sub Group**	**Agenda Item No.**	11
Report Author	Debbie Robinson Head of Primary Care, Quality and Improvement	**Public / Private Item**	Public
GB / Clinical Lead	Mr Neil Smurthwaite Interim Accountable Officer	**Responsible Officer**	Debbie Robinson Head of Primary Care, Quality and Improvement

Executive Summary								
Please include a brief summary of the purpose of the report	This paper advises the committee about the number of premises investments applications that have been submitted to the CCG for consideration. The Committee should recognise that having an estates strategy for the CCG is a gap and acknowledge the steps being taken to help make these decisions and this is step in that direction. The Committee is reminded about its duties in relations to the delegation agreement with NHSE. The paper asks that the formation of a time-limited estates sub group is established to help more this agenda forward and put the CCG on a firmer footing with its estates plans.							
Previous consideration	**Name of meeting**	none	**Meeting Date**	Click here to enter a date.				
	Name of meeting	none	**Meeting Date**	Click here to enter a date.				
Recommendation (s)	It is recommended that the Committee: Considers the proposal to the formation of a time-limited Estates Sub Group as detailed in section 3.							
Decision	☒	**Assurance**	☐	**Discussion**	☐	**Other**	Click here to enter text.	

Implications							
Quality & Safety implications	None at this time						
Engagement & Equality implications (including whether an equality impact assessment has been completed)	None at this time						
Resources / Finance implications (including Staffing/Workforce considerations)	None at this time						
Has a Data Protection Impact Assessment (DPIA) been completed? (Please select)	**Yes**		**No**		**N/A**	x	
Strategic Objectives (which of the CCG objectives does this relate to?	▪ Achieving the agreed strategic direction for Calderdale	**Risk** (include risk number and a brief description of the risk)	Reputational Risk – if there is an inability to describe and operate a clear process around the development of Primary Care premises.				

Legal / CCG Constitutional Implications	None at this time	**Conflicts of Interest** (include detail of any identified/potential conflicts)	GP members of the Committee will be conflicted; conflicts to be managed in line with CCG's Conflicts of Interest Policy.

1.0 Introduction

1.1 As part of the CCG's Delegated Commissioning responsibilities, it is required to ensure delivery of delegated functions in respect of Premises and Estates, premises cost directions functions, premises and strategic estates planning. The relevant extracts from the NHSE/CCG Delegation Agreement are attached at Appendix A.

1.2 The Committee will recognise that the CCG has limited skills and capabilities in this area and as such finds itself with a number of propositions it needs to consider and at the same time help develop its strategy so we are clear on process and priorities for the committee and its practices.

1.3 In addition to this the CCG is looking to gain external support to set and present a formal estates strategy for the committee and its partners, so we are clear on roles and priorities for Calderdale.

2.0 Background

2.1 The current provision of general practice is based on our 21 practices delivering Services across 33 sites. Local transformation through the establishment of PCNs and Collaborative Community working has seen a growing model of community provision, care closer to home delivered by an expanding workforce.

2.2 The 33 sites are a combination of practice owned or privately leased sites with a Number of practices in Third Party Private Investment or NHS Property Services (NHSPS) sites. All are eligible for reimbursement through NHS (GMS Premises Costs) Directions 2013.

2.3 In accordance with the National Health Service(General Medical Services Premises Costs) Directions 2013, where a contractor has a proposal for :

a) The building of new premises to be used for providing primary medical services
b) The purchase of premises to be used for providing primary medical services
c) The development of premises are used or to be used for providing primary medical services
d) The sale and lease back of premises to be used for providing primary medical services
e) The increase of the existing floor area of premises to be used for providing primary medical services which would increase the payment made to the contractor in der the directions, or
f) Premises improvements, which are to be the subject of a premises improvement grant application and,

the contractor puts the proposal to the CCG (as the delegated commissioner) as part of an application for financial assistance, the CCG must consider the application and in appropriate cases (having regard amongst other matters, to the budgetary targets it has set itself), grant the application.

2.4 At the present time the CCG has received xx uninvited applications for premises investment, the proposed schemes are made up as follows:

Proposal	Number of Applications
New Branch Surgery	1
Extension of Existing premises	3
New Premises	1
Other developments of existing premises	3
Revised Lease Arrangements	3
TOTAL	**11**

2.5 All proposed primary care schemes will need to go through the same assessment process. This includes any requests to NHS England for one off investment and schemes with ongoing revenue implications in the form of reimbursements under the Premises Cost Directions 2013.

3.0 Next Steps

3.1 The CCG does not currently have a formal process for receiving estate proposals from practices. It is therefore proposed that a time limited sub group of the Committee is formed to consider the principles and criteria against which, premises development bids could be prioritised should funding become available.

3.2 It is further proposed, in light of the potential conflicts of interest, the sub group is made up of the following:

- The Committee Chair
- The Governing Body Lay Adviser *
- The Acting Chief Officer
- The Acting Chief Finance Officer
- The Head of Primary Care
- The Primary Care Project Manager
- Supported as required by the NHSE/I Strategic Estates Adviser for the CCG.

*It is proposed, that the Lay Member for Patient and Public Involvement is not part of the sub group. This is to enable her to provide a more objective focus on the consequences of decisions on patients, at the point that the committee considers any formal applications for investment.

4.0 Conflicts of Interest

4.1 GP members of the Committee will be conflicted; conflicts to be managed in line with CCG's Conflicts of Interest Policy.

5.0 Recommendations

5.1 It is recommended that the Committee considers the proposal to the formation of a time-limited Estates Sub Group as detailed in section 3.

6.0 Appendices

6.1 Appendix A - Relevant Extracts from the NHSE / CCG Delegation Agreement

Appendix A

Relevant Extracts from the NHSE / CCG Delegation Agreement

Section A – Terms and Conditions

6.0 Performance of the Delegated Functions

6.1. The role of the CCG will be to exercise the Delegated Functions in the Area.

6.2. The Delegated Functions are the functions set out in Schedule 1of the Delegation and being:

6.2.7. Premises Costs Directions Functions;

Section C. Functions reserved to NHS England

8.0 Performance of the Reserved Functions

8.1. The role of NHS England will be to exercise the Reserved Functions.

8.2. Subject to clause 8.3, the Reserved Functions are all of NHS England's functions relating to primary medical services other than the Delegated Functions and including those functions set out in Schedule 2 of the Delegation and being:

8.2.4. Capital Expenditure Functions;

Schedule 2 – Delegated Functions
Part 1: Delegated Functions: Specific Obligations

7.0 Premises Costs Directions Functions

7.1. The CCG must comply with the Premises Costs Directions and will be responsible for making decisions in relation to the Premises Costs Directions Functions.

7.2. In particular, but without limiting the generality of paragraph 7.1, the CCG shall make decisions concerning:

7.2.1. Applications for new payments under the Premises Costs Directions (whether such payments are to be made by way of grants or in respect of recurring premises costs); and

7.2.2. Revisions to existing payments being made under the Premises Costs Directions.

7.3. The CCG must comply with any decision-making limits set out in Schedule 5 (Financial Provisions and Decision Making Limits) when taking decisions in relation to the Premises Costs Directions Functions.

7.4. The CCG will comply with any guidance issued by the Secretary of State or NHS England in relation to the Premises Costs Directions, including the Principles of Best Practice, and any other Guidance in relation to the Premises Costs Directions.

7.5. The CCG must work cooperatively with other CCGs to manage premises and strategic estates planning.

7.6. The CCG must liaise where appropriate with NHS Property Services Limited and Community Health Partnerships Limited in relation to the Premises Costs Directions Functions.

Schedule 3 – Reserved Functions

6.0 Capital Expenditure Functions

6.1. In accordance with clauses 13.13 to 13.16, NHS England retains the Capital Expenditure Functions and will be responsible for taking decisions in relation to the Capital Expenditure Functions.