NHS
Calderdale
Clinical Commissioning Group

Minutes of the Commissioning Primary Medical Services Committee Meeting held on 23 July 2020, 11am, via video conference

Due to the COVID 19 public health emergency this meeting was not held in public.

DRAFT 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)
	Neil Smurthwaite	(NS)	Interim Accountable 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
	Cllr Tim Swift	(TS)	Representative of Calderdale Health and Wellbeing Board
	Debbie Robinson	(DR)	Head of Primary Care Quality & Improvement
	Martin Pursey	(MP)	Head of Contracting and Procurement
	Lesley Stokey	(LS)	Interim Chief Finance Officer
	Penny Woodhead	(PW)	Chief Quality and Nursing Officer
	Dr Majid Azeb	(MA)	Clinical Lead for Primary Care (Item 5 only)
	Zoe Akesson	(ZA)	Senior Administrator

There was no public in attendance.

08/20 APOLOGIES FOR ABSENCE **ACTION**

Apologies were received from Dr James Gray, Governing Body - GP Member.

JM welcomed members of the committee and reminded them that the meeting was not accessible to the public. The Committee was politely asked to adhere to the virtual meeting etiquette.

09/20 DECLARATIONS OF INTEREST

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

GP members were declared to have an interest in items 9, 10 and 11. It was noted that MA was only attending for item 5 'Head of Primary Care report'. JM described how the conflicts would be managed as below;

- Item 9 'Finance Report'; asked for a decision around the suspension of the discretionary budget and the acceptance of the first 4 months of the delegated budget. Both GPs had a direct financial interest and non-financial professional interest. They received the paper however it was agreed SC could stay for the discussion but would leave prior to the decision making.

- Item 10 'Branch Surgery Approval for Bankfield'; asked for a decision on the use of the Rosemount premises following the closure of the Meadowdale APMS practice. As a partner of Bankfield surgery, JG had both a professional (reputation amongst partners) and financial interest in this item. SC had a financial interest. JG and SC did not receive the paper and would not take part in

the discussion or decision.

- Item 11 'Establishment of an Estates Sub-Group'; the GPs had a direct financial interest in this item as decisions around GP estate could impact on their income It was also acknowledged the conflict would become greater when decisions are made against the principles the group establishes. The two conflicted individuals did not receive the paper and it was agreed they would not be involved in the discussion or decision.

There were no further declarations of interest.

The Committee agreed with the management of the conflicts.

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

10/20 QUESTIONS FROM THE PUBLIC

There were no questions from the public.

11/20 MINUTES OF THE OF COMMISSIONING PRIMARY MEDICAL SERVICES COMMITTEE MEETING HELD ON 9 JANUARY 2020

The minutes of the committee meeting held in public on 9 January 2020 were approved electronically and were received for information.

Actions and Matters Arising

There was one outstanding action (04/20) to keep the Committee informed of risks and progress made arising from ongoing APMS mitigations activity from the Committee's task & finish group. The action was recorded as closed, as this is included in the Lead Officer's report and would be going forwards.

12/20 DECISION NOTICE 1 MAY 2020 - SPRING HALL GROUP PRACTICE APPLICATION FOR NOVATION OF GMS CONTRACT

Due to April's committee meeting being stood down, a paper on the novation of contract for Spring Hall Group practice was circulated to those committee members that were not conflicted for a decision. The novation of the contract was approved and the decision notice was received for information.

13/20 HEAD OF PRIMARY CARE REPORT

Committee was provided with a paper on the Calderdale General Practice response to the COVID pandemic.

In presenting the report, DR highlighted that the pandemic had accelerated immense change in the way that General Practice was delivered in Calderdale. In order to respond to the pandemic, General practice had to rapidly adopt a different operating model and the practices and PCNs should be commended for their positive response to managing the situation as it both emerged and progressed. The challenging yet positive partnership approach between the Local Medical Committee, the PCN

Clinical Directors and the CCG should not be underestimated and was a significant factor in how the changes were adopted so quickly in Calderdale.

The paper summarised some of the key national guidance documents and expectations up to June 2020 and described some of the decisions, processes and actions that were implemented in Calderdale to respond to the pandemic and to meet NHSE expectations. Some of the additional COVID costs that have been claimed by PCNs were also included in the paper.

In the paper DR described the learning and "the new normal" for General Practice and what this could mean. It highlighted some of the work that had been funded by the CCG to support practice transition into the next phases, including the engagement of the National Association of Primary Care to help PCNs gain a better understanding of population health management approaches, which were fundamental to the development of the PCNs and their vital role in improving local health outcomes for the future.

The paper concluded with some identified risks and work to mitigate these and the Committee was asked to note the content.

Comments and questions were invited.

- The Committee recognised the huge efforts from the whole of the primary care system in responding to COVID. It was highlighted that amongst adapting to the rapid changes, an OPEL type system was set up. This highlighted a couple of practices that would have struggled but due to working as PCNs all surgeries in Calderdale remained open, for all the population.

- A comment was made that although this was an incredible achievement in responding in such a short period of time, public perception and communication around accessing services was questioned. The Healthwatch survey signalled that some patients were struggling to contact their practices as they were closed or patients perceived them to be closed. It was unclear if this was due to COVID or APMS dispersal. HH was asked to investigate.

ACTION: HH to establish reason why patients were unable to contact their surgery during the pandemic and feedback to DR. **HH**

- TS added this was also reflective of the feedback received by CMBC. Again he recognised the huge amount of work and change that had taken place across the system but now his concerns were around staff being able to refresh before the onset of winter.

- A question was raised around the utilisation of video consultations during the pandemic and how it would be developed as part of the online offer. DR confirmed that every practice had the facility and the CCG was working on gaining access to utilisation information to see if it was being used effectively. When the information becomes available it would be included in the Lead Officer's report.

The conversation continued during which the following points were made around establishing a "new normal";

- PW reminded the Committee there would be more challenges ahead working and living in the new COVID world. In relation to the quality and safety of patients, there needs to be clear communication on what is available, how this can be accessed, embedding quality assurances through our 'reset' plans and using the

information gathered by Healthwatch to gain a better understanding of the utilisation of services through different lenses.

- There was a short discussion on the GP offer. The following points were raised;
  - Although there were different options available to access services, it was clear that some patients were still defaulting to telephoning the surgery rather than using the GP online service. A system approach from all partners was required to help communicate messages around access to the public.
  - HH reminded the Committee about the perception of messages being received by the public and to be mindful in that although there was a limitation as to what could be offered people's safety is paramount and an inclusive approach needs to be built into so people feel like they have access.
  - TS echoed the importance of system messaging but also added that there was a need to establish a way of measuring how these changes have improved people's lives.
  - In order to adapt and use new technology there was a need to understand how to utilise this to deliver something better.
  - In relation to access to care going forwards, there was a need to consider the balance. Being mindful that some patients may find video consultations difficult compared to telephone conversations and while we need not throw away some of the old system we need to keep in mind the BAME population /workforce and to ensure they too are protected.
  - Be aware of other service developments in the system such as '*Talk before you Walk'*, that could impact on Primary Care.

In conclusion, there was gratitude and an acknowledgement from the Committee to parties who have moved Primary Care forward. It was acknowledged there was a significant piece of work to do on understanding the access, utilisation and prioritisation of the GP offer going forwards.

DECISION

The Committee **RECEIVED** the paper and was **ASSURED** with the content, noting the significant activity undertaken in Primary Care.

MA left the meeting

14/20 CONTRACTING REPORT

In presenting the report, MP highlighted the GP online consultation software contract, informing the Committee of the uptake of the provision in the contract which was extended for a further year.

It was noted that all 21 practices had returned their sign-up documents in relation to their participation in the elements of the NHSE DES and confirmation had been received that all PCNs had signed-up to Network DES 2020-21. The report also included an update on incorporation decisions made by the Committee and both novation agreements had been signed and returned to relevant parties.

The second part of the paper was a request from the Committee to give an indication of the benefits and reasons why some practices wanted to seek incorporation. These were as follows;

- Risk of liability
- Ability to encourage people to join practices without having to join partnerships that might have significant financial liability.
- Task benefits for individuals

- Lessons learned would be for early engagement so that issues commissioners may face when considering incorporations can be discussed.
- It was also noted that the novations had been agreed subject to a number of caveats in the Calderdale, Greater Huddersfield and north Kirklees CCGs, this brought consistency in the legal advice that was sought and standardisation in the documentation with regards to the caveats and clauses.

Questions and comments were invited.

- MP was asked to share the lessons learned with practices considering incorporation, to enable future applications to progress quickly.

- MP was asked to include a benefits statement in future incorporation application papers which would provide context for decision making by the Committee**.**

There were no further comments.

DECISION

The Committee **RECEIVED** and **NOTED** the content of the report.

15/20 CPMS RISK REVIEW 2020-21 (18 May to 8 June 2020)

RG reported that there were 8 CPMSC risks for consideration. There were no risks above 12 but of the 5 open risks, 3 were new for risk cycle 2.

JM invited questions and comments from the Committee.

- DR stated that risks 1561 and 1564 would be moved to Quality, Finance and Performance Committee (QFPC) for review, as they were currently not in the delegated responsibilities of this Committee. Following a short discussion around the clarity around risks for delegated duties, it was agreed that the formal risk review of risks outside of delegated primary medical services but that had a bearing on those services would take place at the Quality, Finance and Performance Committee (QFPC) and that the Lead Officer would highlight in her report any risks that would impact on the business of this committee.

- In relation to risk 1561, JM asked if the CCG was monitoring the dissatisfaction following closure of APMS, as this would change over time. RG was asked to review the scoring.

ACTION: RG to reduce the risk score of R1561. **RG**

SC left the meeting

DECISION

The Committee **AFFIRMED** it would review risks in relation to its delegated responsibilities only and any wider Primary Care risks that impact on the Committee would be raised in the Lead Officer's report.

The Committee **REVIEWED** the register and the management of the CPMSC risks.

The Committee **APPROVED** the risk register for reporting to Governing Body.

16/20 MEETING TIME AND WORK PLAN

There were no changes to the work plan. The Committee was content with the format.

JM raised the timing of the meetings as they fall on the same day as the Governing Body meeting in public, putting demands on both Governing Body and most importantly staff in preparing for 2 large formal meetings. JM asked the Committee if they would be interested in pursuing a move to another Thursday.

Comments and questions were invited;

- All agreed it would be more helpful to move the meeting dates. Members asked to inform JM of any further limitations to this arrangement outside the meeting. A preference for afternoons was noted.

ACTIONS: To work on finding alternative Thursday (pm) for future meetings. **ZA/JM/DR**

17/20 FINANCE REPORT

In presenting the paper LS highlighted the key points from the report;

- For 2019-20, the CCG delivered a break even budget against its allocation of £33.3m. The main overspend areas were APMS and premises, which were managed through releasing contingency reserves. It was noted that provisions were put into premises around dilapidations on APMS properties, which did not feature in the last finance report.

- For 2020-21, the plans submitted to NHSE in January were not implemented and a new finance regime was put in place due to COVID. The CCG was issued a part year allocation for 4 months (April - July) of £10.4m. Overspends against this, could be claimed against additional COVID monies. The CCG had been asked by NHSE to approve the initial budget for the 4 month period. LS pointed out that this had been the same for all budgets, which have been approved through QFPC. The Committee was asked to approve the delegated budget on this basis.

- With regards to the financial arrangements from August onwards, LS advised the Committee to remain prudent and not to approve any discretionary spend or plans until the planning guidance had been received. It was noted that this proposal excluded the decision that was to be considered on agenda item 10. It was agreed that work around developing plans should progress so the CCG was ready to take them through a governance process as soon as clarity was received.

- Presented in a paper last year, the CCG was intending to introduce equitable funding from 01/10/20. The PMS premium spending would be on a consistent basis across Calderdale. The CCG did commit to recalculating each financial year and the report included the values of what the budget would be with an additional £87K coming into the budget this year.

- The paper provided a high level outline of additional investments under the GP contracts. Additional roles reimbursement had increased significantly. NHSE were holding the additional funding and this could only be accessed if PCNs had 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 NHSE by the end of July, this deadline had now been moved The

CCG developed a tool kit to understand these plans and was now starting to receive plans back from the PCNs. The profile will increase significantly again into the following year, so there was a need to make sure the PCNs make best use of this.

There were no further comments or questions from the Committee.

DECISION

The Committee **NOTED** the 2019-20 budget.

The Committee **APPROVED** the given budget and **ENDORSED** the non-investment of spend approach until the budget for the remainder of the year is known. Noting an exclusion to this being any decision under item 10 on the agenda.

18/20 APPROVAL OF BRANCH SURGERY FOR BANKFIELD SURGERY

It was noted that the conflicted individuals were not present for this item.

DR presented a paper that sought approval from the Committee for the establishment of a branch surgery for Bankfield surgery practice in Elland.

The Committee was reminded that due to the closure of 2 surgeries in Elland, Bankfield Surgery has had a higher than average increase in their list size over the last 2 years. Also as part of the APMS post consultation deliberations meeting in January 2020, the establishment of a branch surgery was part of the mitigating actions to secure access and capacity and it was noted that one of the next steps was to secure a current premises solution.

The paper requested approval for a 3-year funding arrangement to cover rent and rates, whilst the CCGs long term estate strategy was being confirmed.

The paper contained information in relation to the responsibilities placed upon the Committee under delegated commissioning arrangements with NHSE and the responsibilities the CCG had with regards to premises which are set out in the National Health Service (General Medical Service's premises costs) directions 2013. The paper referenced the fact that the practice had an initial conversation with its patient representative group who were supportive but due to the recent pandemic further meetings have not taken place. The paper also reference that the CCG had ongoing financial commitments to NHS Property Services until the current lease at Rosemount expired at the end of October 2020.

Comments and questions were invited.

- For clarification, DR confirmed to the Committee that the branch surgery would be available for the whole of the Bankfield registered patients list.
- In order to manage population expectations, it needs to be clear in communications that this is an interim solution and be about timeframes.
- In response to question on operating hours, branch would be the same as surgery with the exception that it would close at 6pm.
- The PCN may offer other services from this location, as it is existing general practice not additional estate.

DECISION

The Committee **NOTED** the content of the paper and formally **APPROVED** the

establishment of an interim branch surgery at Rosemount House, Elland for 3 years.

There were no further requirements or conditions as part of the approval.

19/20 ESTABLISHMENT OF AN ESTATES SUB-GROUP

It was noted that the conflicted individuals were not present for this item.

The paper proposed the establishment of a time limited estates sub-group to consider the principles and criteria against which applications for premises investment can be assessed. The paper advises the committee that there had been a number of requests for premises investments submitted to the CCG for consideration. Included in the paper was high level information in respect of the number of practices and the number of sites from which services were provided. The committee was reminded that it had responsibility for making decisions on premises investment under the delegation arrangements with NHSE and the specific elements of the delegation agreement were detailed in the appendix to the paper.

The paper highlighted that the CCG had very limited skills and capabilities in estates development and that there was a need to develop the estate strategy and the associated processes and criteria to enable the CCG to establish clear priorities for investment.

Due to potential conflicts of interest the membership of the subgroup excluded GPs. It was proposed that the lay member for patient and public involvement and secondary care specialist were not part of the subgroup in order to provide a more objective focus on the impact on patients as a consequence of decisions that were made on any formal applications.

Comments and questions were invited.

- In relation to the exclusion of the Lay Member from the sub-group, PW would pick up the principles around the quality and safety of patients with DR.
- Denise Cheng-Carter, the CCG's Lay Advisor would be part of the group to provide challenge along with other committee members.
- NS emphasised the need to produce a high level strategy that recognised priorities, direction of travel and working at scale which would give a clear outline for our expectations around any bids..
- Output from the sub-group to be presented at October's CPMSC.

JM concluded that by creating a small sub-group it would help the CCG manage estate applications. The group would set principles and these would come back to this committee, excluding GPs from the discussions, for validation and approval.

DECISION

The Committee **AGREED** for the time-limited Estates sub-group to be created.

21/20 DATE AND TIME OF NEXT MEETINGS IN PUBLIC

The Committee **NOTED** that the next meeting would take place on:
Thursday 22 October 2020, 11am – 1:30pm, MS Teams

Commissioning Primary Medical Services Committee Meeting wef 23 July 2020 – Action Sheet

Agenda item	Minute No.	Action Required	Lead	Current Status	Comments/ Completion Date
APMS Post Consultation Deliberation	**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. It is now included in the Lead Officer's report and would be going forwards.	**DR**	**Closed**	It is now included in the Lead Officer's report going forwards.
Head of Primary Care Report	**13/20**	To establish the reason why patients were unable to contact their surgery during the pandemic and feedback to DR/EB	**HH**	**Open**	
CPMS Risk Review	**15/20**	To review and reduce risk score for R1561	**RG**	**Closed**	RG raised with owner and agreed to close.
Work Plan	**16/20**	To work on finding alternative Thursday (pm) for future meetings.	**ZA/JM/DR**	**Closed**	Dates confirmed, diaries updated.

NHS
Calderdale
Clinical Commissioning Group

Calderdale Primary Medical Service Committee
Decision Notice

Report circulated 3 September 2020

Due to the COVID 19 public health emergency this single item meeting did not take place in public.

A virtual committee meeting was help with a single paper circulated on 3 September 2020 for decision by the committee members via email.

DECISION NOTICE

Member Recipients	Neil Smurthwaite	NS	Interim Accountable Officer
	John Mallalieu	JM	Committee Chair, Lay Member, Finance and Performance
	Lesley Stokey	LS	Interim Chief Finance Officer
	Alison MacDonald	AM	Lay Member, Patient and Public Engagement
	Dr Rob Atkinson	RA	Secondary Care Specialist
	Prof Rob McSherry	RM	Registered Nurse
	Dr Steven Cleasby	SC	GP Member
	Dr James Gray	JG	GP Member
Other recipients	Debbie Robinson	DR	Head of Primary Care, Quality and Improvement
	Emma Bownas	EB	Senior Primary Care Manager
	Neil Coulter	NC	Senior Primary Care Manager– NHS England/Improvement
	Tim Swift	TS	Council Leader and Chair of the Calderdale Health and Well Being Board
	Rob Gibson	RG	Corporate Systems Manager
	Helen Hunter	HH	Chief Executive, Health Watch, Kirklees and Calderdale
	Martin Pursey	MP	Head of Contracting & Procurement
	Penny Woodhead	PW	Chief Quality & Nursing Officer

Action

1. CONFLICTS OF INTEREST

There were no conflicts of interest declared.

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. PROCESS FOR URGENT DECISIONS

The paper circulated proposed the establishment of urgent decision making arrangements for matters relating to COVID-19 that could not wait until the next scheduled committee meeting for decision.

In their responses, committee members were supportive of the proposal to establish the urgent decision making process and underlying rationale for the process being put in place. They recognised the reporting plan to the full committee and public, the intention to utilise the full committee where timing allowed and the intention to review the arrangements in three months' time.

DECISION:

That the Committee **approve** the urgent decision making process.

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

Thursday 15 October 2020, 3.00pm, Video Conference

Name of Meeting	Commissioning Primary Medical Services Committee	**Meeting Date**	15/10/2020
Title of Report	**Head of Primary Care Report**	**Agenda Item No.**	5
Report Author	Debbie Robinson, Head of Primary Care, Quality and Improvement	**Public / Private Item**	Public
GB/ Clinical Lead	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 report provides an update to the committee on: 1. Flu campaign for 2020/21 2. Progress on the development of PCNs 3. Details of the Internal Audit Planning Brief for the "Review of Commissioning and Procurement of Primary Medical Services"							
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)	Detailed within the paper						
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 Update on Flu Campaign 2020/21

1.1 There is a significant national focus on delivering a successful flu campaign this year due to concerns around the potential impact of influenza infection on top of existing and growing Covid 19 pressures this winter. West Yorkshire and Harrogate ICS have established a Flu Board which is receiving bi-weekly updates from CCGs on their flu plans.

1.2 The national aspiration is to deliver 75% uptake of flu vaccination to all existing patient cohorts:

a) Over 65 year olds
b) At risk under 65
c) Pregnant women
d) Pre-school children aged 2 and 3
e) School children reception to year 7

1.3 A further target this year is to offer 100% of frontline health and social care workers a vaccine this year.

In addition to this, household contacts of people on the NHS Shielded Patient list will be offered the vaccine opportunistically, with the aim to offer to all identified. Calderdale has set up a local flu group to share good practice and identify concerns around delivery of the flu campaign to aid plans for mitigating risks and improve system understanding. The group has met 3 times since August and has representation from GP practices, community nursing, school immunisation team, midwifery, public health team from Calderdale MBC, community pharmacy, PHE Screening and Immunisation Team. Calderdale CCG is represented by the Flu Lead, Medicines Optimisation Team, Quality team and the Communications Team.

1.4 Additional work is being done with the local authority street engagement team and neighbourhood teams in areas of high BAME population and where there are wider health inequalities e.g. North Halifax.

1.5 Calderdale practices have been asked to share their flu plans with the CCG so the group is able to have oversight of delivery against expected trajectories and understand our ability to meet the expected targets. About half of practices have provided an overview of their plans which includes provision of additional flu clinic dates than previous years.

1.6 The LMC and Community Pharmacy West Yorkshire have issued a joint statement to practices and pharmacies encouraging collaborative working between both providers to deliver a successful flu campaign. This may include signposting to each other where vaccines supplies are low or using prescription messages promoting vaccination for harder to reach cohorts such as the at risk under 65s.

1.7 The CCG is maintaining a live flu plan for the Calderdale system, which is used to track progress on delivery and record risks as they are identified. This is used to update the WY&H ICS Flu Group. Calderdale CCG Senior Management Team receives a biweekly update on flu uptake using information from practices clinical system. This allows tracking of progress in delivery for each patient cohort.

1.8 The programme may be further extended in November and December to include those in the 50-64 year old age group subject to vaccine supply and after existing eligible groups have been prioritised.

2.0 Primary Care Network (PCN) Development

2.1 PCN Workforce Additional Roles Reimbursement Scheme

2.1.1 As set out in the Additional Roles Reimbursement Scheme (ARRS) guidance 2019/20, from April 2020 each PCN will be allocated an Additional Roles Reimbursement Sum, which will be based upon the PCN's weighted population.

2.1.2 PCNs will be able to recruit the reimbursable roles as they are required to support delivery of the Network Contract DES. For the average PCN this means around an additional seven full time equivalent staff. The additional roles that are included in the ARRS are:

- clinical pharmacists,
- social prescribing link workers,
- physician associates,
- first contact physiotherapists,
- pharmacy technicians,
- health and wellbeing coaches,
- care co-ordinators,
- occupational therapists,
- dietitians, and
- podiatrists.
- From 2021/22 community paramedics and mental health practitioners will also be added to the scheme.

2.1.3 The CCG has been supporting the PCNs to look at their PCN workforce strategy and complete their plans. Further work is required to progress these in more detail for 2021/22 and beyond to ensure we maximise the funding available to deliver improved services and outcomes for our population.

2.1.4 To date the CCG has worked with the PCNs to understand local aggregated plans and any potential ARRS underspend. It is worth noting that any underspend can only be spent on ARRS salary costs; and underspend has to remain within the CCG footprint.

2.1.5 In the update to the GP Contract Agreement 2020/21-2023/24 it was announced the funding for additional roles was to increase significantly and that roles would be fully reimbursed (within agreed limits) rather than partially reimbursed. However, NHSE have retained the additional funding centrally and CCGs can only access these funds if the amount delegated to CCGs has been spent in full. For Calderdale CCG indicatively the fund available to Calderdale CCG and therefore PCNs in 2020/21 is £1.615m, however only £0.976m is sitting within the CCG allocation and the balance £0.639m is with NHSE.

2.1.6 A meeting took place on the 28th of September to agree plans with NHSE/I Regional Team to enable PCNs to draw down as much of their share of ARRS funding for 2020/21 as possible. PCNs have plans in place to fully spend the funding sat within the CCG allocation and part of the funding retained centrally by NHSE. Further work is ongoing to clarify the process for drawing down the additional committed elements. Further detail and associated risks are detailed within the finance report.

2.1.7 PCNs have been encouraged to take full advantage of their guaranteed funding, recruiting as soon as possible. Where recruitment has been delayed due to the initial pandemic response, PCNs are entitled to 'over recruit' for the final months of the year (i.e. beyond the average 7-8 staff) in order to use their full funding allocation, recognising the potential delays in recruitment due to COVID.

2.1.8 The position of the 5 PCNs in Calderdale can been found at appendix A.

2.1.9 Two new risks (1628 and 1629) have been added to the risk register regarding this scheme and are detailed in the risk report at item 10.

2.2 Primary Care Network Development Funding - 2020/21 Update

2.2.1 Recently NHSE/I have confirmed that each ICS/STP will receive further PCN development funding in 2020/21. The exact amount has not yet been confirmed. The development support recognises the significant change and new roles ongoing in General Practice and reflects the need to support PCNs to manage and maximise the opportunities.

2.2.2 The ICS Primary and Community Care Programme Board will assume responsibility for the allocation/commitment of this funding and will want to maximise the funding available to further progress development across West Yorkshire PCNs, supporting PCNs in delivering the Long Term Plan commitments and the GP Contract requirements.

2.2.3 The Programme Board will explore with key partners and PCN Clinical Directors how the 2020/21 budget should be used to deliver the PCN development priorities for 2020/21. These priorities include recruiting, embedding and retaining new roles, enhancing integration, continuing to improve access and reducing health inequalities.

2.2.4 It is expected that a discussion will take place at the October Programme Board, which will reflect on the review of the 19/20 funding and the opportunities for the 20/21 funding.

2.2.5 A further update paper will be provided to the Committee with a spending plan proposal, once the details are known.

3.0 Digital Update

3.1 GP Online and Video Consultations

3.1.1 Calderdale CCG procured the Engage Consult solution, along with North Kirklees CCG, as part of the General Practice Forward View (GPFV) funded programme for GP Online Consultations, which is due to expire on 30th June 2021.

3.1.2 During Covid-19, NHS Digital centrally contracted with AccuRX for the provision of Video Consultations, which is due to expire on 31st March 2021. More details on this and any subsequent procurement are provided in the contracting report. Access to accurate usage data remains a challenge.

3.2 111 Direct Booking via GP Connect & CCAS

3.2.1 All 21 practices in Calderdale have been live with NHS 111 Direct Booking via GP Connect since the early part of this year. Following support needed during Covid-19, this was extended to incorporate the Covid-19 Clinical Assessment Service (CCAS) appointments.

3.2.2 The COVID Clinical Assessment Service (CCAS) was set up to ensure that patients contacting NHS 111 and presenting with COVID-19 symptoms receive appropriate, fast and streamlined care.

3.2.3 Previously, practices were required to make one appointment per 3,000 registered patients per day available for direct booking by NHS 111 this has been superseded and all practices in England must make **1 appointment per 500 registered patients per day available** for direct booking by NHS 111. This contractual requirement was extended until 30th September 2020, as detailed in the General Practice SOP. At the time of writing this report, the CCG is not aware whether the requirement for direct booking appointments will continue at the current level or revert back to the original contract from October 2020. However it is clearly the national direction of travel for there to be direct booking via 111.

3.3 **Apex Insight**

3.3.1 Apex Insight offers practices a comprehensive workload analysis and workforce planning capability (software and support) to make informed decisions about the future. Practice-level information can be consolidated at PCN, Federation, CCG and STP level to inform strategic planning and system-wide solutions to these challenges.

3.3.2 NHSE, during 2018-19 procured the APEX Insight workforce planning tool for all GP practices. Due to delays in confirming there were no encryption issues in managing data the software roll out was delayed. This was eventually resolved and 20 Calderdale practices have now had the software enabled.

3.3.3 In January of this year, the current licence period for the Apex Insight workload and workforce planning tools, originally funded by NHSE North Region, was extended to 31st August 2020. NHSE regional teams confirmed that extensions of the software licence period would be a local decision and therefore funded and contracted at ICS or CCG level (or possibly PCN level).

3.3.4 The CCG consulted with the LMC, PCN Clinical Directors and Practices for feedback on the tool and whilst the response was mixed, it was recognised that the tool itself was valuable and usage likely impacted due to Covid-19. It is recognised this tool with be useful to ensure the maximisation of the new roles being invested in and reported in section 2.1 above.

3.3.5 Funding for the extension of the contract with Apex Insight for a further 12 months has been agreed by the CCG, at a cost of £38,835 + VAT for Calderdale practices. This provision includes:

- Extending the licences for the 20 deployed practices
- Provide both licence and deployment support for the 1 remaining practice (Y02572 Calder Community Practice – postponed due to APMS)
- Provide the Enterprise licence and deployment support that enables PCNs to share data and create consolidated views across their member practices.

3.3.6 There is a risk that not all practices will have the capacity and capability to maximise use of the tool and the data provided. The CCG intends to develop plans with the LMC and the PCNs to support practices to maximise the use of this tool over the coming months.

4.0 Assurance - Internal Audit Planning Brief

4.1 As part of the internal audit plan for 2020/21 work is underway for commencing the primary care commissioning review. This is to start in October 2020 and the specific area of review for this year will be Commissioning and Procurement of Primary Medical Services. The following is in scope:

i. planning the provision of primary medical care services in the area, including carrying out needs assessments and consulting with the public and other relevant agencies as necessary
ii. the processes adopted in the procurement of primary medical care services, including decisions to extend existing contracts
iii. the involvement of patients / public in those commissioning and procurement decisions
iv. the effective commissioning of Directed Enhanced Services and any Local Incentive Schemes (including the design of such schemes)
v. commissioning response to urgent GP practice closures or disruption to service provision

4.2 The overall objective of the review is to provide assurance on the management of delegated primary medical care commissioning arrangements with regards to Primary Medical Care Commissioning and Contracting, and the associated governance arrangements. The outcome of the review will be reported to the CCGs Audit Committee and shared with this committee for information.

5.0 Recommendations

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

Appendix A

	2020/21											
Suumary by Role 2020/21	Calder & Ryburn		Central Halifax		Lower Valley		North Halifax		Upper Calder Valley		Total	
	WTE	£	WTE	£	WTE	£	WTE	£	WTE	£	WTE	£
Clinical pharmacist	2.27	£113,744	3.00	£122,699	1.42	£79,260	1.91	£106,482	1.58	£88,144	10.19	£510,329
Social prescribing link worker	2.05	£71,043	1.85	£61,068	1.09	£38,662	1.58	£55,885	2.29	£81,129	8.87	£307,789
Physiotherapist	1.50	£69,588	0.00	£83,505	2.00	£111,340	1.00	£55,670	1.67	£92,783	6.17	£412,886
Physician associate	0.00	£0	0.00	£13,431	0.25	£13,431	0.00	£0	0.00	£0	0.25	£26,862
Paramedic	0.00	£0	0.00	£0	0.00	£0	0.00	£0	0.00	£0	0.00	£0
Pharmacy technician	1.00	£14,745	0.00	£0	0.54	£19,056	0.00	£0	0.00	£0	1.54	£33,801
Occupational therapists	0.00	£0	0.00	£17,908	0.00	£0	0.25	£13,431	0.00	£0	0.25	£31,339
Dieticians	0.00	£0	0.00	£0	0.00	£0	0.00	£0	0.00	£0	0.00	£0
Chiropadist/podiatrists	0.00	£0	0.00	£0	0.00	£0	0.00	£0	0.00	£0	0.00	£0
Health and Wellbeing coach	0.00	£0	0.00	£0	0.00	£0	0.00	£0	0.00	£0	0.00	£0
Care co-ordinator	1.00	£16,585	0.00	£17,668	0.42	£12,140	0.63	£18,209	0.61	£17,668	2.65	£82,269
Mental Health Practitioner	0.00	£0	0.00	£0	0.00	£0	0.00	£0	0.00	£0	0.00	£0
Total	**7.82**	**£285,705**	**4.85**	**£316,279**	**5.72**	**£273,888**	**5.37**	**£249,677**	**6.15**	**£279,725**	**29.91**	**£1,405,274**
Budget		**£298,864**		**£378,845**		**£318,128**		**£334,034**		**£270,343**		**£1,600,214**
Variance		**-£13,159**		**-£62,566**		**-£44,240**		**-£84,357**		**£9,381**		**-£194,940**

Name of Meeting	Commissioning Primary Medical Services Committee	**Meeting Date**	15/10/2020
Title of Report	**Contracting Report**	**Agenda Item No.**	6
Report Author	Suzanne Howarth, Senior Contracts Manager – Primary Care	**Public / Private Item**	Public
GB / Clinical Lead	Dr Majid Azeb	**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: 1) the Committee **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. 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. Detail

2.1 GP Online and Video Consultations

2.1.1 Calderdale CCG procured the Engage Consult solution, along with North Kirklees CCG, as part of the GPFV funded programme for GP Online Consultations, which is due to expire on 30th June 2021.

2.1.2 During Covid-19, NHS Digital centrally contracted with AccuRX for the provision of Video Consultations, which is due to expire on 31st March 2021.

2.1.3 NHS Digital is in the process of aligning their procurement frameworks, the Dynamic Purchasing System (DPS) and GPIT Futures, to align the buying routes for both Online Consultations and Video Consultations. As a result, CCGs have been advised not to enter into any new procurement during 2020 until the new framework is released around January 2021.

2.1.4 Whilst funding has been confirmed until 2022/23 for Online Consultation, CCGs have also been informed that there will be no separate funding provision for Video Consultation. National advice is to procure both Online and Video Consultations jointly. However, timelines for these contracts do not currently align.

2.1.5 To support discussions across the West Yorkshire & Harrogate Health & Care Partnership (WY&H HCP) footprint, the digital programme team are currently gathering feedback from practices via an online survey on existing suppliers. These results, combined with a review of the new products on the market and clinical input, will support both the WY&H HCP and CCGs when considering future procurement needs.

2.2 Revised Specification Network Contract DES 2020/21

2.2.1 Following discussion and agreement with GPC England, NHS England and NHS Improvement has published an amendment to the Network Contract Directed Enhanced Service for 2020/21. The amended DES updates the terms of the 2020/21 Network Contract DES, and applies from 1 October 2020 to all practices that are signed up to the DES.

2.2.2 The amended DES introduces three substantive changes to the 2020/21 Network Contract DES:

2.2.2.1 flexibility for the clinical lead under the Enhanced Health in Care Homes service requirements to be a non-GP;

2.2.2.2 the introduction of two new reimbursable roles under the Additional Roles Reimbursement Scheme (ARRS); and

2.2.2.3 the introduction of an Investment and Impact Fund worth £24.25m.

2.2.3 Since April 2020 new ‘auto-enrolment’ provisions have been included in the DES, which mean that practices and PCNs do not need to submit any further information to the CCG to confirm their acceptance of these revised terms and future years’ specifications.

2.2.4 If a practice does not wish to accept the revised terms, and wishes to opt out of the Network Contract DES as a result, it must inform the CCG of its decision to opt out by **17th October** and the terms of the Network Contract DES will no longer apply to the practice from 18th October.

2.3 **Incorporation Applications – Update**

2.3.1 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.

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

2.3.3 The practice had made enquiries about closing the branch surgery at Horne Street. An email has been sent to the partners to remind them of the CPMSC approving the incorporation on the condition of both surgeries remaining open. This situation will continue to be monitored by the Contracting team.

2.3.3 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.

2.3.4 The new entity has elected the 1st August 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 **National Medical Performer List Applications – for assurance**

2.4.1 Medical performers wishing to provide medical services in primary care within the NHS must be included in the national medical performers list. Primary Care Support England (PCSE) is responsible for administering entry and status changes to the National Performers Lists on behalf of NHS England. The decision to admit applicants to the National Performers List is the responsibility of NHS England.

2.4.2 PCSE sets out the process to be followed to ensure a consistent approach is followed for processing applications for inclusion in NHS England's national medical performers lists in accordance with the National Health Service (Performers Lists) (England) Regulations 2013.

2.4.3 The aim of the procedure is to enable NHS England to make informed decisions about applications for inclusion in the national medical performers lists and assure itself of the suitability of NHS primary care medical performers it includes.

2.4.4 Approval of the application rests with the medical directors/ROs or nominated deputies within NHS England's teams, where an application is straight forward and without concerns or where mandatory refusal is required.

2.4.5 If the medical director/RO has any concerns, a meeting of the performance advisory group (PAG) will be arranged to consider the application. If a decision regarding conditional inclusion or refusal is required the application will then be passed to the performers list decision panel (PLDP) for consideration.

2.4.6 Once a performer has been included in the national performers lists and the performer changes the area or practice where he or she carries out the majority of his or her work, the performer is responsible for notifying the NHS England team where they will be working, as soon as practical.

2.4.7 The process to be followed by PCSE for each application includes the following steps:

- Receipt of an application form for inclusion in the national medical performers list.
- Submission of the application pack to the relevant NHS England medical director/RO with a summary of information provided and any information of note flagged.
- Notifying the applicant of the decision.
- Completing entries on the payments system and primary care information system (PCIS). This includes locums.
- Administering changes to the performers list regarding change of circumstance/ status and transfer between teams.

2.4.8 PCSE notify NHS England (NHSE) of any changes to status of existing medical practitioners with the local CCG which may require a contract variation to the core GMS Contract or PMS Agreement. This may be when a new partner joins or leaves one of the local GP practices.

2.4.9 NHSE requires the GP partnership to complete an Application to Vary form to enact this sort of change. This provides details of the incoming or outgoing GP and the effective date of the proposed change.

2.4.10 The CCG's Contracting Team is contacted to make sure there are no local circumstances which would prevent the proposed change going ahead. The Contracting Team liaise with the Primary Care Development and Support Team before advising NHSE of their decision.

2.4.11 NHSE prepare the contract variation document for completion by the partnership which is signed off by the CCG Chief Finance Officer or his delegated representative. The final stage of the process is carried out at the practice where all partners sign to confirm their agreement to the proposed change.

2.5 **Friends and Family Test (FFT) Update**

2.5.1 The Friends and Family Test (FFT) is an important feedback tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience. Listening to the views of patients and staff helps identify what is working well, what can be improved and how.

2.5.2 The FFT asks people if they would recommend the services they have used and offers a range of responses. From April 2020, a new question replaced the original FFT question about whether people would recommend the service they used to their friends and family.

2.5.3 The replacement question invites feedback on the overall experience of using the service. When combined with supplementary follow-up questions, the FFT provides a mechanism to highlight both good and poor patient experience.

2.5.4 There will be delays in some services being able to implement the new guidance in full due to the impact of the coronavirus on services.

2.5.5 Reporting from GP practices has been suspended since March. Acute Trusts and Community providers have been advised to restart reporting from December with a restart expected for Primary Care in early 2021.

3. Recommendations

It is recommended that the Committee:

1. Receives and notes the content of this report

Name of Meeting	Commissioning Primary Medical Services Committee	**Meeting Date**	15/10/2020
Title of Report	**Finance Report**	**Agenda Item No.**	7
Report Author	Lesley Stokey - Interim Chief Finance Officer	**Public / Private Item**	Public
GB / Clinical Lead	Neil Smurthwaite, Interim Accountable Officer	**Responsible Officer**	Neil Smurthwaite, Interim Accountable Officer

Executive Summary							
Please include a brief summary of the purpose of the report	Key messages for the committee to note at Month 5 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-September 2020/21 and indicative allocations for October 2020 to March 2021.						
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 2020/21 financial position on Primary Medical Services delegated budgets. 2. **NOTES** the indicative allocations for 2020/21October to March. 3. **APPROVES** setting up an additional virtual meeting in private with non-conflicted members to approve any discretionary investment proposals.						
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)	N/A

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 the financial year 2020/21 and to update the Committee on the latest position in relation to 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. This regime was rolled over for the period August to September 2020.

Although the CCG has received less than originally planned for the period April-September 2020, there has been a process of retrospective allocations put in place to ensure that a breakeven position is achieved.

Financial guidance and allocations have been published during September for the period October 2020 to March 2021. Within this guidance the CCG has been notified of indicative allocations for delegated primary care which indicate that there is a clear alignment with the initial financial plan for 2020/21.

ICS level plans are due to be finalised by 5th October.

2.0 Financial Performance April – August 2020

High Level Forecast position M1-M6	Delegated Primary Medical Services Budgets £'000
Initial Allocation - Covid Regime	-15,570
Latest Forecast for M6	15,919
Net overspend	349
Covid costs to date M1-M5	0
Other pressures (forecast M1-M6)	349
Total variance	349
Allocation adjustment M5	-232
Net position	117

For the first 6 months of the year the CCG received an allocation of £15,570k for delegated primary medical services. This was slightly less than the original plan for the same period. In Month 5 the CCG is reporting a forecast overspend of £349k to the end of September. The CCG has received retrospective allocation adjustments for the period April to July of £232k, leaving a forecast overspend of £117k. This forecast position will continue to be assessed by NHS England and Improvement as part of their review of expenditure and will likely receive a retrospective allocation adjustment in the same way as the period April to July.

Calderdale CCG Delegated Primary Medical Services Summary at 31st August 2020

PRIMARY CARE SERVICES:	6 Months	In month			Year To Date (£)			Forecast	
Name	Budget	Budget	Actual	Variance	Budget	Actual	Variance	Outturn	Variance
	£000	£000	£000	£000	£000	£000	£000	£000	£000
GMS	8,068	1,345	1,540	195	6,723	7,638	915	9,177	1,110
PMS	1,518	253	143	(110)	1,265	713	(552)	856	(662)
APMS	1,173	195	63	(132)	977	317	(660)	381	(792)
QOF	1,390	232	226	(6)	1,159	1,131	(28)	1,357	(33)
Enhanced Services	159	26	27	0	132	130	(3)	156	(2)
Premises - Reimbursed Costs	1,485	248	272	24	1,238	1,331	93	1,597	112
Premises - Other	239	40	9	(31)	199	79	(120)	95	(144)
Prof Fees Prescribing & Dispensing	84	14	2	(12)	70	17	(53)	27	(57)
Collaborative Payments	0	0	0	0	0	0	0	0	0
Other GP Services (inc. PCO)	258	43	66	23	215	191	(24)	213	(45)
Other Non GP Services	333	56	56	0	278	281	4	338	4
Pensions	0	0	0	0	0	0	0	0	0
PCN	518	86	176	89	432	835	404	1,011	493
Reserves	498	94		(94)	454	602	148	710	212
Reserves - Contingency	80	13	72	59	66	0	(66)	0	(80)
Total Primary Care Medical	**15,802**	**2,645**	**2,653**	**8**	**13,207**	**13,265**	**58**	**15,919**	**116**

The more detailed analysis of the forecast in the table above shows a breakdown of the expenditure by category. Budgets have been set here based on 2019/20 outturn as per NHS England guidance under the temporary covid finance regime.

The most significant variances are as follows:

- GMS – is showing a forecast overspend – due in part to the end of the APMS contract and also in part due to some practice mergers which saw some practices move from PMS contracts to a new merged GMS contract.
- PMS – is showing an underspend due to some practice mergers where some PMS practices have moved onto a single merged GMS contract.
- APMS - is showing an underspend due to the ending of an APMS contract at the end of 2019/20.
- PCN is showing an overspend as the budget was set at 2019/20 levels and PCN planned expenditure is significantly higher in 2020/21 due to development set out within the national GP Framework.
- Reserves are showing over as this assumes that reserves are spent and also that underspends elsewhere are spend in year.

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 with a further £315k to be allocated separately. 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 separate allocations for the period April to September and has been given indicative allocations for the period October to March. The CCG and ICS are to submit plans for the period October to March on the 5th October so no plan has been formally agreed at the time of writing this paper.

The summary below shows that the indicative allocations for the period M7 to M12 , when combined with the allocations received for M1-6 give a total of £31,758k. This compares well

with the original plan of £31,837k. The recent financial guidance indicates that the additional roles funding in excess of the baseline amount can still be accessed separately and is not included in the allocations below.

Allocations Summary	Pre-Covid	M1-6	M7-12	Total
	£'000	£'000	£'000	£'000
Annual Resource Allocation	31,522	15,570	15,761	31,331
Additional allocations anticipated:	315		195	195
Retrospective allocations received		232		232
Retrospective allocations anticipated				-
Total	**31,837**	**15,802**	**15,956**	**31,758**

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.

Plans have been developed to spend this budget in 2020/21 as outlined in a separate report to the Committee.

5.0 New Investments 2020/21

As can be seen in the forecast, the CCG has a reserves balance of £710k for the period April to September. As indicative allocations have been issued for the remainder of the financial year, there is now more certainty that the original financial plan can be delivered.

There is therefore an opportunity to look at investing these funds to improve capacity and respond to pressures caused by Covid and also to plan for winter related pressures.

In order to facilitate a timely approval of any proposed investments it is recommended that an additional virtual meeting in private of non-conflicted committee members be set up to sign-off any proposed schemes and that the outcome is reported to the next formal committee meeting.

6.0 Risk/Opportunities

- **Risk -** The CCG is not able to make discretionary investments in a timely manner.

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

- **Opportunities –** the CCG has funding in reserves available for investment.

7.0 Recommendations

It is recommended that the Committee:

1) **NOTES** the 2020/21 financial position on Primary Medical Services delegated budgets.
2) **NOTES** the indicative allocations for 2020/21October to March.
3) **APPROVES** setting up an additional virtual meeting in private with non-conflicted members to approve any discretionary investment proposals.

Name of Meeting	Commissioning Primary Medical Services Committee	**Meeting Date**	15/10/2020
Title of Report	**Estates Report**	**Agenda Item No.**	8
Report Author	Debbie Robinson Head of Primary Care Quality and Improvement	**Public / Private Item**	Public

GB / Clinical Lead	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 sets out some proposed Golden Rules, principles that all submissions for premises development proposals in Calderdale must meet before being considered for investment support. In addition, the paper also sets out new guidance to PCNs to commence work on estates in conjunction with workforce planning						
Previous consideration	**Name of meeting**	CPMSC		**Meeting Date**	23rd July 2020		
	Name of meeting			**Meeting Date**	Click here to enter a		
Recommendation (s)	The Commissioning Primary Medical Services Committee is asked to: 1. Note the content of the report and the requirements of PCNs, Clinical Directors, and the CCG (as part of the wider system) to commence work to ensure there is sufficient accommodation for professionals recruited under the Additional Roles Reimbursement Scheme. This involves workforce and estates planning. 2. **Approve** the "Golden Rules"						
Decision	☒	**Assurance**	☐	**Discussion**	☒	**Other**	Click here to enter text.

Implications	
Quality & Safety implications	1. Sustainable delivery of Primary Care services to the local population from suitable estate; 2. Ensuring patients are not unduly compromised in their experience of care as a result of premises; 3. Ensuring primary care estate is suitable and fit for purpose

Engagement & Equality implications (including whether an equality impact assessment has been completed)	Not applicable

Resources / Finance implications (including Staffing/Workforce considerations)		Not applicable					
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)			N/A		
Legal / CCG Constitutional 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		

1.0 Purpose

1.1 The purpose of this paper is to set out a set of proposed Golden Rules, a small set of principles that all submissions for premises development proposals in Calderdale must meet before being considered for investment support. In addition, the paper looks at the requirements of PCNs to work within the wider system to support estate works and helps to set out next steps.

2.0 Introduction

2.1 All CCGs were individually required to produce Estates Strategy documents in 2016 and in the main, these were produced by NHS Property Services and do not reflect the current challenges faced by General Practice. Around the time of this work, most CCGs also had '6 Facet Surveys' completed which described the condition of the local general practice estate and some of the pressures within specific buildings.

2.2 The pressures facing General Practice such as increased workload, an ageing population and the need to extend access to primary medical services often put a significant strain on existing infrastructure and premises are no exception to this.

2.3 The most recent challenge has arisen with the introduction of Primary Care Networks and the Additional Roles Reimbursement Scheme (ARRS) which is incentivising a rapid expansion of the workforce able to support primary care and the wider localities.

2.4 The 'Update to the GP Contract Agreement 2020/21 – 2023/24' (published 6th February 2020) makes reference to ensuring sufficient space is available for additional staff employed under the ARRS. In this guidance, NHS England & NHS Improvement also set out the intention to revise the Premises Cost Directions (PCDs) to allow greater investment in GP practices. This would see the removal of a long- standing restriction on commissioner contribution to premises improvements and the allowance of up to 100% of the project value (currently 66%). Revised Premises Cost Directions have not yet been published.

3.0 Advice Note & Supplementary Guidance

3.1 NHS England have recently published an 'advice note' and supplementary guidance to support PCNs, Clinical Directors and CCGs to take the next steps to ensure there is sufficient space to accommodate professionals employed under the ARRS and to guide them to develop workforce plans to determine estate need and then begin to form estate strategy.

3.2 The advice note and supplementary guidance are attached at Appendix B and Appendix C respectively.

3.3 The letters set out the steps to be followed at PCN level:

3.3.1 **Step 1** - Build a picture of current services & set out the workforce strategy

3.3.2 **Step 2** - Outline future health and care models (population health approach) and assess estate needs. This would include a stocktake of the PCN estate

3.3.3 **Step 3** - Produce key elements to begin to form an estate strategy including a gap analysis,

3.4 The guidance suggests that the basis of an estate strategy should now be discussed with commissioners, STP and ICS partners to agree alignment with wider service strategies and to help inform a comprehensive local primary care estates strategy as part of the broader System-wide estates work and investment strategy.

4.0 Calderdale Primary Care Estates "Golden Rules"

4.1 At its meeting on the 23rd of July2020 the Committee agreed to the establishment of a small sub- group to develop overriding principles that would be used to support the CCGs in responding to requests for premises developments and reviewing Project Initiation Document (PID) applications, from GP practices, for both minor and major works. In the main, these requests are then directed to capital funding resources held by NHSE .The group has now met and the proposed 'Golden Rules" can be found at appendix A of this report. The Committee is asked to consider these for approval.

4.2 It is important to remember that CCGs do not hold capital funds and are not constituted to be able to do so. However, any impact to the changes in premises which impact on the size, rent, rates, clinical waste and water which arise from a change in premises falls to the CCG as recurrent revenue consequence and would be within the remit of Commissioning Primary Medical Services Committee.

5.0 Next Steps

5.1 The CCGs Primary Care Operational Group will develop further criteria to support prioritisation and guidance for GP Practices with regards to the submission of applications for premises developments. This will include key messages about the need to meet the Golden Rules from the outset.

5.2 CCG officer will work with PCNs to support them to develop a comprehensive Estates Strategy bringing together relevant stakeholders across Calderdale. This will strengthen the CCGs ability for decision making when strategically assessing complex estates applications. This work will be in line with the recent Advice Note and Supplementary Guidance detailed above.

6.0 Recommendations

6.1 The Commissioning Primary Medical Services Committee is asked to:

I. Note the content of the report and the requirements of PCNs, Clinical Directors, and the CCG (as part of the wider system) to commence work to ensure there is sufficient accommodation for professionals recruited under the Additional Roles Reimbursement Scheme. This involves workforce and estates planning.

II. **Approve** the "Golden Rules"

7.0 Appendices

Appendix A – Proposed Golden Rules
Appendix B – Estates Advice Note for PCNs – June 2020
Appendix C – Estates Supplementary Guidance for PCNs – August 2020

Appendix A

Proposed 5 Golden Rules

All submissions for premises development proposals must meet the 5 high level golden rules before being considered and practices would need to ensure that their application meets the rules before being submitted to the CCG.

In additional schemes must be affordable to the CCG and the submission needs to clearly quantify the:

- Impact on revenue costs (rent and rates reimbursements)
- technology considerations and the potential impact on the GPIT funding stream

Golden Rules

1. **ACCESS**
    - Enable better overall access to primary care services to ensure patients are supported proactively in the community and out of hospital in line with Care Closer to Home and in line with the re-configuration of acute hospital plans
2. **PLACE**
    - Meets the needs of the local population – "Needs" assessment of their population
    - Applications should always involve the wider system in first instance, involving their local PCN and locality to avoid receiving multiple bids from the practices within a PCN.
    - *Enables the CCG to utilise our estate to deliver our Strategy for Care Closer to Home and the drive towards joined up services within a defined localities model.* Adding in strategy and objectives for *'Calderdale the place'*
    - Improvement to physical environment and compliance (DDA)
3. **PCN NETWORK**

- PCN collaboration and support
    - Undertake an options appraisal and agreed a best solution
    - what supported the decision on the solution putting forward

4. **STRATEGIC ALIGNMENT YES/NO**
    - Increased Capacity of clinical service out of hospital (care closer to home) YES/NO
    - It enables the CCG to utilise our estate to deliver our Strategy for Care Closer to Home and the drive towards joined up services within a defined localities model
    - Enabling access to wider services, as set out in commissioning intentions, to reduce unplanned admissions to hospital.
5. **TECHNOLOGY**
    - Supports use of technology and digital solution to deliver of care in different ways which maximises estate.

Appendix B

ADVICE NOTE FOR PCN CLINICAL DIRECTORS:
Accommodating additional Multi-Disciplinary Team (MDT) staff appointed under the Network Contract DES
June 2020

Introduction

i. The Network Contract Directed Enhanced Service (DES) Contract Specification 2020/21 – PCN Entitlements and Requirements ('the Contract') paves the way for around seven additional new full-time clinical support staff for an average PCN in 2020/21. This figure rises to 20 full-time staff by April 2024. It is predicted that the introduction of these new staff, under the Additional Roles Reimbursement Scheme (ARRS), will transform service delivery for patients, and ease the mounting pressures on existing clinical staff, including GPs and practice nurses.

ii. The 'Update to the GP Contract Agreement 2020/21 – 2023/24' (published 6th February 2020) makes reference to ensuring sufficient space is available for additional staff employed under the ARRS (paragraph 1.34).

iii. This advice note sets out pertinent considerations for Networks facing potential challenges in terms of estate. It should be read in conjunction with NHS England & NHS Improvement good practice guidance **Supplementary guidance: Accommodating additional Multi-Disciplinary Team (MDT) staff appointed through the Network Contract DES**[1],

Advice

1. New MDT support staff will provide a service across a PCN, and in some cases may work across several sites, and / or across multiple PCNs. In terms of estates, this does not mean that every clinician will require a permanent, dedicated room at every (or any) site.

2. It is important for PCNs to fully understand their existing estate and any capacity within it (both in physical terms and in terms of vacancy of room occupation across a given day / week). An assessment of current estate, workforce and service provision delivered to the PCN population is key to developing a viable plan, before testing future options with PCN partners. The scope of this assessment must include general practice, mental health, primary, community and secondary care alongside social care and the voluntary sector.

3. The effective use of technology will enhance service delivery and has the potential to offset the need for future physical space requirements across the PCN. Recent responses to COVID-19 across the Health system introduced new ways of working which may now offer unique opportunities to deliver future MDT services in different and innovative ways.

[1] Further advice and guidance can be found on the 'PCN Frequently Asked Questions' page of the NHS England website: https://www.england.nhs.uk/primary-care/primary-care-networks/pcn-faqs/

Appendix C

ADVICE NOTE FOR PCN CLINICAL DIRECTORS:
Accommodating additional Multi-Disciplinary Team (MDT) staff appointed under the Network Contract DES
June 2020

4. Not all new services will need to be delivered from existing GP estate. Consideration must be given as to the most appropriate setting for each service, linked to the service model and care pathway being offered. For example, clinical pharmacy staff could undertake telephone consultations from home or may be best located within local Pharmacies, with access to patient consultation rooms to undertake Medication Reviews. Use of Local Authority (Council) buildings or other NHS estate may be appropriate2; social prescribing activity could take place in the local library or delivered from Voluntary Sector service locations, for instance. Other Primary Care providers - such as dentists and optometrists - may also present opportunities for shared working and benefits. Mobile solutions should also be considered, particularly in rural PCNs where distances between patients and practices are significant.

5. Duplication and inefficiency should be minimised across a PCN. Where multiple practices have come together to form a PCN, it is likely that they will each have the same number of staff meeting rooms, conference and group rooms and other staff related ancillary accommodation functions. Consideration could be given in the medium- and long-term to consolidating and sharing conference or group room facilities to free up space and create additional clinical or admin space to host for MDT hubs, for example. These could be given over to operational clinical floor space to accommodate new MDT staff, for example.

6. Steps to address the need for additional capacity may include:

    a. Consideration of 'Digital First' solutions at every stage of service delivery with a view to reducing the volume of patient footfall where alternative service delivery is more appropriate;

    b. Identifying space across a PCN footprint freed up as a result of the digitisation of Lloyd George Records national programme;

    c. Promotion of flexible / home working for Clinical and MDT staff to reduce pressure on the estate;

    d. Accessing the estate of all PCN partners, relieving the pressure on GP practice premises;

    e. Creation of telephony or digital 'pods' in an under-utilised patient waiting room, or an existing oversized clinical consulting room or staff meeting room to support online consultations and free up clinical space;

    f. Consolidation of estate where sharing arrangements could be developed;

2 In these instances, a licence agreement for use by MDT staff may be a required.

g. In addition to accessing clinical rooms during lunchtime closures in surgeries, MDT staff could utilise the full floor space of GP practices into the evenings, at weekends or during other periods of inactivity – this, potentially, could create more than 30 hours of additional capacity per room and provide an immediate solution[3];

h. PCNs should critically assess their sessional occupation of clinical rooms on a regular basis. A consultation room, for example, could be utilised by members of the MDT team in between morning and afternoon GP sessions, or on GP non-working days. Administration and other non-patient facing tasks can be undertaken from a central back office, a GP-breakout or admin room, or even off-site to free up clinical rooms to effect full time and extended use;

i. Reconfiguration of existing floor space which requires capital investment is a last resort and should only be considered where all other options have been considered and exhausted;

7. Notwithstanding any of the above, it is acknowledged that the success of estate solutions will depend on strong working relationships, collective understanding and the effective sharing of knowledge, information, and data across all PCN partners. GP Practices should not consider this to be a problem they must address in isolation.

NHS England and Improvement
Primary Care Estates Team

For further advice and guidance on estates and PCNs, please access the PCN estates network by following the steps below:

- Go to www.networks.nhs.uk;
- Click 'register' (in the top right hand corner);
- Once you are registered, click onto the link https://www.networks.nhs.uk/nhs-networks/pcn-estates-network/view and select 'join this network'. You will then receive a confirmation from NHS Networks.

[3] Assuming an additional 2 hours per evening, 5 days a week, totalling 10 hours; an additional 20 hours spread across Saturday and Sunday, and; any additional utilisation within the core hours – for example, between morning and afternoon surgeries.

SUPPLEMENTARY GUIDANCE: Accommodating additional Multi-Disciplinary Team (MDT) staff appointed under the Network Contract DES
August 2020

Introduction

1. This guidance has been prepared for PCN Clinical Directors and their constituent practices to identify estates and other opportunities across your network to deliver the additional staffing opportunities set out in the Network Contract DES. It should be read in conjunction with **ADVICE NOTE FOR PCN CLINICAL DIRECTORS: Accommodating additional Multi-Disciplinary Team (MDT) staff appointed under the Network Contract DES**. The guidance note provides steps in the process of identifying, assessing and addressing potential estates requirements driven by the Additional Roles Reimbursement Scheme (ARRS) under the DES.

The PCN contract

2. The Network Contract Directed Enhanced Service (DES) Contract Specification 2020/21 – PCN Entitlements and Requirements ('the Contract') paves the way for around seven additional new full-time clinical support staff for an average PCN in 2020/21. This figure rises to 20 full-time staff by April 2024. The Contract makes no direct provision (financial or otherwise) for estate expansion or redevelopment. Networks are expected to accommodate the additional MDT staff within the PCN estate assets[1]. This note sets out pertinent considerations for Networks facing potential challenges in terms of estate.

PCN Activity – Key Steps in developing a local estates strategy:
Assessing future estate needs with partners crucial to success of PCNs

3. The infrastructure implications of developing PCNs to meet the NHS Long Term Plan ambitions have the potential to be significant. PCNs will be keen to ensure that use of the estate is maximised, costs managed, waste eradicated, and funding released to develop transformational projects. In order to achieve this, networks should always seek to bring stakeholders to the table across the wider system to collectively consider proposal and look to avoid planning in isolation.

4. The NHS Long Term Plan places technology at the centre of several of its commitments. It sets out that every patient will have the right to be offered digital-first primary care by 2023/24, where they can easily access advice, support and treatment using digital and online tools. The digital agenda will lead to major change in service delivery. Response to the COVID-19 pandemic has already accelerated our use of digital in primary, community and secondary care service provision. Much of this change will remain and form the basis of further development of, and improvement in, services.

[1] NB: PCN estate assets include GP premises, secondary and tertiary care premises, Local Authority and voluntary sector buildings, etc.

5. To achieve this, the GP contract has laid out a number of digital primary care requirements, including:

    - All practices will ensure at least 25 percent of appointments are available for online booking. Practices are encouraging online consultations and offering non-triage appointments online including those available for direct booking by patients on the phone or in person;
    - All patients will have the right to online consultations by April 2020 and video consultation by April 2021.

6. These principles can easily be applied to the extended workforce under the PCN DES contract, with a move to use technology to develop and enhance the service offering.

Step 1 - Build a picture of current services

7. In order to test need and explore options, there is a need to map the baseline in terms of current service provision. Across the PCN membership, all practices should list the services provided, and in building a full picture PCNs should capture what else is provided in their locality, from where and by whom. This may require some local research and CCG leads and provider contacts should help in drawing together relevant information. The SHAPE asset mapping tool would serve as a useful storage solution (see para 23)

8. The recently published NHSE-supported National Association of Primary Care (NAPC) estate guide (March 2020), 'Primary Care Networks – Critical thinking in developing an estates strategy', provides helpful information and case studies and may help to guide PCN teams through the process.

9. National investment in feasibility studies at such an early stage of PCN maturity is not planned and may not be appropriate but PCNs may consider that this is a key step in the local assessment process and opt to self-fund such work.

Set out your Workforce Strategy

10. Estates requirements will ultimately be driven by recruitment decisions made by PCNs, which will depend on their priorities.

11. To provide some context, a PCN with a population of around 30k patients – to provide an illustrative example – could engage around 3 WTE clinical pharmacists, 1.5 WTE social prescribing link workers, 0.5 WTE physiotherapists and 0.5 WTE physician associates from 2020/21.

12. The employment model of new staff is key to understanding how these staff will operate within the PCN and if they are required to spend at their base if employed by a Trust or another organisation, for which the PCN holds a sub-contract. These

conversations should take place before the new staff member has been taken on by the PCN.

Suggested actions required across the PCN membership organisations:

- Calculate the hours the new workforce will provide to the network;
- Assess when and where these individual services may be best delivered – clinical or non-clinical setting, GP surgery base (all, or some), for example;
- Identify where these services are typically delivered from other (non- GP surgery) sites, and consider if it is possible that other non-clinical premises could be considered suitable;
- Assess whether more flexible working arrangements across all staffing groups may be attractive and improve recruitment & retention and relieve pressure in crowded premises;
- Determine if flexible working could be established which sees the extended team in particular, providing services outside of core GMS contracted hours, for at least for part of the week;
- Consider if flexible working arrangements be agreed which provide for home or remote working for at least some of the working week.

Step 2 - Outline future health and care models (population health approach) and assess estate needs

13. Once the current provision is mapped, the next step will see the PCN stakeholders considering the responses to key questions:

i. *In terms of commissioning, which services are specific to local health need and patient demographics?*
ii. *What does the PCN population require in terms of services?*
iii. *Does the PCN have data to evidence this?*
iv. *What services do 'core-'and 'non-core' PCN members already provide?*
v. *Is that service provision considered sufficient?*
vi. *Is the service under pressure?*
vii. *Will the service change as a result of the extended workforce, or for another reason – for example, advancements and improvements in systems and processes made under the digital agenda?*
viii. *What other extended services outside of the core GMS contract provision are provided across the wider PCN area?*
ix. *Could the extended workforce be better aligned to those teams – mental health, pharmacy, for example?*
x. *What opportunities exist for enhanced PCN integration and working?*
xi. *What is the best way to integrate the new workforce with the existing, and link the Network together with the wider system Providers?*
xii. *Does this integration require physical co-location, or can it be affected in some other way?*
xiii. *What time could the services be delivered - 'in core hours' or 'outside of core hours'?*

xiv. How do we ensure that lone working risks are avoided, and staff are not isolated?

Stocktake of the PCN estate

14. This next phase will require the PCN members to take stock of all available estate within the PCN boundaries, including everything from community services to third sector estates. Recognition of estate which sits just outside the boundaries of the PCN, but which could serve the PCN population well, should also be considered.

15. Agreement of a service delivery plan and sites to be used should be agreed with your commissioners.

16. When considering the use of premises, a range of questions should be asked:

- *What do we know about the current use of the building?*
- *Do the buildings have vacant or void space or an element of capacity?*
- *Are the buildings to be leased or owned? By whom?*
- *Is it possible to secure new licence / lease agreements?*
- *Who will take the risk of the licence / lease commitment?*
- *What do we know about the connectivity and information technology systems at each of the sites (broadband connection, WiFi, telephone line, digital health etc.) – how easy would it be to use this space?*
- *What are the opening hours of each site?*
- *Are there restrictions on use of the building – explore the User clause, planning permission, for example*
- *What is the condition of the building?*
- *Does it meet the standards required by the NHS and CQC?*
- *Are capital works required to bring the building to standard?*
- *What are the funding options for capital works?*
- *How long would the works take to deliver suitable premises?*

17. PCN members should consider the advantages of finding a solution collectively. Benefits include:
    - *Helping to improve the quality of one or more patient services*
    - *Sharing of staff can bring about significant cost savings*
    - *Improved patient access*
    - *Provides flexible arrangements between practices and providers*

SHAPE mapping tool

18. A useful resource for PCNs is the SHAPE mapping tool – Strategic Health Asset Planning and Evaluation - a web enabled, evidence-based application that informs and supports the strategic planning of services and assets across a whole health economy. The SHAPE Place Atlas is free to NHS professionals and Local Authority

Professionals with a role in Public Health or Social Care. Access to the application is by formal registration and licence agreement.

19. The primary aim of the application is to facilitate scenario planning and option appraisal in support of STPs. Specifically, the SHAPE Place Atlas helps organisations consider the evaluation of the impact of service configuration on populations, and to assess the optimum location of services.

    The SHAPE tool provides:

    - an accessible online tool for STP stakeholders;
    - key indicators and data about an area to STP level, with a focus on health inequalities and equity of service;
    - flexible geographies including STP, CCG, LA, ward and Lower Layer Super Output Areas (LSOA);
    - a comprehensive overview of the STP's NHS estate;
    - functionality to enable users to flexibly evaluate and test the impact of plans;
    - Support for GP Primary Care Networks.

20. Clinical Directors and other strategic planning staff should consider the use of SHAPE to support the workforce and estates audit across a PCN.

21. NHS England & NHS Improvement is launching a Primary Care Data Collection programme in 2020. As data is collated, it will be added to the SHAPE tool to further inform local service and estate planning.

Step 3 - Produce key elements to begin to form an estate strategy

Gap Analysis

22. Using this information, a basic level overview should now be available to drive local discussions around which options exist to address any demand for additional space.

23. Any consideration for additional space will undoubtedly require commissioner support where financial assistance is expected under the Premises Costs Directions (2013). No formal agreements should be entered into unless Commissioners have been formally consulted on any proposed changes, has had the ability to consider the application and have formally confirmed approval for any underwriting or commitment to funding new / additional space.

24. The basis of an estate strategy should now be discussed with commissioners, STP and ICS partners to agree alignment with wider service strategies and to help inform a comprehensive local primary care estates strategy as part of the broader System-wide estates workbook and investment strategy.

Governance considerations

25. Where extra space is required, governance arrangements for approving additional space should be considered and agreed. There is no change to the current arrangements in that the GP Contractor is accessing rights under the GMS (PMS) contract for financial assistance in respect of premises costs in line with the Premises Costs Directions (2013).

26. The GP contractor is required to make a formal application to the commissioner. This may be on behalf of a PCN by a 'host' practice and the application should provide necessary detail and evidence of support from all member practices of the PCN and any agreements reached in terms of hosting, running costs, liability, risk etc. The host practice will need to confirm that it is willing to take the risks, liabilities and commitments associated with any financial assistance provided by NHSE.

27. Where leases or licences are to be entered into, the PCN / host practice should present the draft Terms to the commissioner for assessment. Standard lease terms can be shared by NHSE to guide negotiations. No lease or licence should be entered into prior to written commissioner approval – to do so would place the contractor at risk.

28. Commissioners are required to undertake a formal due diligence process, testing and reviewing any application for financial assistance, seeking professional advice from the District Valuer Service (DVS) and other advisers as necessary. Typically, all applications are expected to be considered by the Commissioning Primary Medical Services Committee as a minimum, but larger, complex or contentious applications may require review by more senior committees.

29. The PCN / practice should not take any steps to formally secure additional accommodation where it is reliant on NHS funding, unless it has been given the express and formal approval by the appropriate commissioner. To do so without formal approval being in place, will place the practice / PCN at risk and commissioners will not be obliged to support such costs.

Practical Implementation

30. The current PCDs allow for the hosting of additional employees as set out in the Network Contract DES; this is because the additional staff should be considered as the extended team delivering services under General Medical Services Contracts. It is assumed NHS England will cover the costs of hosting the additional PCN support staff, typically within the current level of approved GMS space and in new space, only where an application has been made, considered and supported by the commissioner.

31. Where it can be evidenced that despite the testing of the estate capacity and wider system solutions as described in this guide, a demand for additional accommodation exists, commissioners will expect to receive a formal application, as set out in the governance considerations above.

Holding the Lease or Licence

32. Where new estate is to be occupied, the PCN will need to agree which party will hold the lease or licence for external space. Where the NHS is asked to take on property commitments, we will rely on partners such as NHS Property Services Ltd as commissioners cannot hold operational property or enter into lease commitments for this type of asset. Where such proposals are being considered, NHSPS will be entitled to undertake its own due diligence and assess the application in accordance with its own commercial judgment. However, NHS commitment to a lease has an impact on NHS national capital budgets and is subject to formal agreement and prior planning.

Agreeing & Regulating the use of ‘new’ or additional space

33. It is important to ‘track changes’ to premises. Where PCN services are being delivered and these are being hosted by a PCN member organisation, or are delivered at an alternative location, the site should be recorded within the formal PCN Network Agreement, including any charges to be levied (see below) and any advice on licence agreements. The GMS/PCN contract needs to be updated to include relevant detail of sites used; CQC registration may also be required.

34. Use of existing primary care floor space which has already been designated as GMS space, will be covered by the existing GMS contract terms and the Premises Costs Directions. Where charges are to be levied, these will be considered under the PCDs and deductions made to reimbursement payments accordingly. Ultimately, the aim is to ensure occupants should not receive more than 100% of the reimbursable costs.

35. Where a PCN looks to utilise external (perhaps NHSPS, community or hospital accommodation) floor space which is not currently deemed GMS approved space, an application to the CCG to include this space as GMS approved accommodation is required, as set out in the Governance considerations above.

36. Occupation should be secured by way of negotiation and recorded in a licence (short term/less than 12 months & no exclusive use) or lease (longer term / more than 12 months and/or exclusive use of space). Shorter term arrangements may be preferred initially to provide flexibility and change over time should further service changes be anticipated.

Charging for accommodation or utility / running costs

37. A PCN extended roles staff member is deemed to be a GMS service provider and the extended workforce should be considered an expansion of the GMS workforce where significant unseen benefits are available to staff, patients and the system. These teams should not be considered to have a negative impact on the practice costs.

38. A thorough assessment of all accommodation options should be undertaken, as detailed above and consideration given to the impact on commissioner budgets. A cost-effective solution should be proposed, ensuring appropriate use of public funds and best use of existing accommodation is achieved.

39. In terms of charging a contribution towards costs – where the NHS is already reimbursing costs against that accommodation, these cannot be re-charged to sub-tenants/service providers, to avoid the potential for double-charging.

40. Where hosting arrangements are agreed across a PCN, an agreement may be required between the parties where other members share the burden of any additional costs which the host practice/provider may suffer. Unless the services are delivered out of hours though, where specific additional running costs may be created, it is expected these staff will create little impact on running costs. The creation of bureaucratic recharging deals between parties should be avoided and perhaps, quid pro quo arrangements considered instead, where possible.

41. Where PCN services are delivered in community spaces (typically paid for by local Trusts), conversations will need to be had regarding contributions towards running and rental costs, as a new commitment for a GP practice/PCN.

42. The process for securing reimbursable costs is set out above in governance considerations; non-reimbursable costs will be subject to negotiation and agreement between the landlord and PCN members on a case by case basis.

NHS England and
Improvement Primary Care
Estates Team

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- Go to www.networks.nhs.uk;
- Click 'register' (in the top right-hand corner);
- Once you are registered, click onto the link https://www.networks.nhs.uk/nhs-networks/pcn-estates-network/view and select 'join this network'. You will then receive a confirmation from NHS Networks.

Name of Meeting	Commissioning Primary Medical Services Committee (CPMSC)	**Meeting Date**	15/10/2020
Title of Report	**Risk Register Position Statement Risk Cycle 2 2020-21 (17 Aug to 2 Sep 2020) for CPMS**	**Agenda Item No.**	10
Report Author	Rob Gibson, Corporate Systems Manager	**Public / Private Item**	Public
GB / Clinical Lead	Dr Steven Cleasby	**Responsible Officer**	Neil Smurthwaite, Interim Accountable Officer

Executive Summary							
Please include a brief summary of the purpose of the report	CCG Risk Register currently contains a total of 38 risks. There are 6 risks marked for closure this risk cycle meaning that 32 risks are open. 7 of total CCG risks (18%) fall for consideration by the Commissioning Primary Medical Services Committee. Of these one is marked for closure meaning there are 6 open risks at the end of risk cycle 3. Among the 7 CPMS risks: • 4 open risks scoring 12 • 4 new risks • 1 risk marked for closure						
Previous consideration	**Name of meeting**	Quality, Finance & Performance Committee	**Meeting Date**	24/09/20			
	Name of meeting	SMT	**Meeting Date**	08/09/20			
Recommendation (s)	It is recommended that the Committee: 1. Reviews the CPMS Risk Register and the management of CPMS risks. 2. 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)	There are no conflicts of interest.

1. 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.

2. 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 3 of 2020-21 the CCG Risk Register had a total of 38 risks. There were 7 CPMS risks, of which 6 are open:

2.3 Open risks

Risk ID	Risk summary	Risk score	Risk movement
1631	That patients will not have access to extended primary medical services when the current contract expires on the 31st March 2021, this is due to the delay in publishing NHSE commissioning intentions for 2021/22 resulting in a reduced offer to patients and a negative impact on the reputation of the CCG.	12	New
1630	The Calderdale population will not be adequately vaccinated against influenza during the 2020 flu campaign due to the impact of the COVID-19 pandemic resulting in increased risk of illness, hospitalisation, mortality and additional pressures on primary and secondary medical services over the winter period.	12	New
1629	The additional roles being introduced within General Practice will not be utilised to their maximum benefit, will compromise the safe delivery of care and intervention for patients and be asked to practice outside of their scope of competency, due to limited professional and clinical experience in general practice of these roles resulting in the potential for harm to patients, poor retention and recruitment rates and a lost opportunity for general practice to maximise the roles and support the GP workforce effectively.	12	New
1628	The full amount of Funding for the Additional Roles Reimbursement Scheme available to General Practice in Calderdale is not able to be claimed resulting in Calderdale losing investment into General Practice and directly impacting on patient outcomes and pressure on the healthcare system across Calderdale.	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 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	8	Decreasing (from 12 to 8) The elements of income protection

	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		due to covid have reduced the risk further.
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	Static for 1 archive

2.4 There was 1 risk closed during risk cycle 3:

Risk ID	Risk summary	Risk score	Reason for closure
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.	3	Reached tolerance

3. Recommendations

It is recommended that the CPMS Committee:

1. Reviews the CPMS Risk Register and the management of CPMS risks.

2. Approves the CPMS Risk Register for reporting to Governing Body, subject to any amendments requested.

4. 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 22 October 2020.

5. Appendices

- CPMS risk register showing all risks during risk cycle 3 2020-21

Risk register of CPMS risks for risk cycle 3

Risk ID	Date Created	Risk Type	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
1631	21/08/2020	Commissioning Primary Medical Services Committee	12	(I4xL3)	8	(I4xL2)	Debbie Robinson	There is a risk that patient will not have access to extended primary medical services when the current contract expires on the 31st March 2021, this is due to the delay in publishing NHSE commissioning intentions for 2021/22 resulting in a reduced offer to patients and a negative impact on the reputation of the CCG	Existing contract in place. Exploration of potential to extend the contract for a fixed period Raise by primary Care Leads with NHSE at each meeting for several months	Financial implications need to be quantified and reported Position statement to be included in Contracting to CPMSC	Contract meeting with existing provider.	none identified	Appears to be no ability to influence NHSE to make the postion know	New - Open
1630	21/08/2020	Commissioning Primary Medical Services Committee	12	(I4xL3)	4	(I2xL2)	Debbie Robinson	There is a risk that the Calderdale population will not be adequately vaccinated against influenza during the 2020 flu campaign due to the impact of the COVID-19 pandemic . Resulting in increased risk of illness, hospitalisation, mortality and additional pressures on primary and secondary medical services over the winter period.	Key providers have delivery plans in place to vaccinate the patients in line with NHSE ambitions and guidance as advised in first and second flu letters. Calderdale CCG has coordinated system meetings with all providers and commissioners to develop a locality plan and identify risks and mitigations to delivery The WYH ICS have set up a Flu board to seek assurance from all places around flu plans, the CCG is attending these meetings to represent Calderdale	the community pharmacy service specification has not yet been published impacting on development of this sectors plans and collaborative working between providers	The Calderdale flu group has met twice in July and August and a third meeting planned to look at draft Calderdale plan first week in september	16/21 Calderdale practices have returned a flu questionnaire to the CCG which identifies their progress with flu plans, the majority are expressing reasonable confidence in their plans to deliver to existing flu cohorts	Details of the NHSE extended vaccination programme to wider cohorts from November are as yet unknown limiting meaningful planning by providers.	New - Open
1629	20/08/2020	Commissioning Primary Medical Services Committee	12	(I4xL3)	4	(I4xL1)	Debbie Robinson	There is a risk that the additional roles being introduced within General Practice will not be utilised to their maximum benefit, will compromise the safe delivery of care and intervention for patients and be asked to practise outside of their scope of competency, due to limited professional and clinical experience in general practice of these roles resulting in the potential for harm to patients, poor retention and recruitment rates and a lost opportunity for general practice to maximise the roles and support the GP workforce effectively.	Employment models for some of the new roles that include professional leadership and clinical governance for the individuals from an established provider of those roles GP mentorship in place for the new professionally qualified roles Registered Professionals must work within their code of conduct	The clinical pharmacist role has not got established professional leadership and governance across PCNs This is similar for care co-ordinators and Social Prescribing link Workers No overall PCN Additional Roles governance framework in place for adoption locally - being discussed through Primary Care School at ICS level	Working within the governance systems already in place and compliant with the CQC in General Practice Where employed by a host organisation strong professional and clinical leadership and training exists PCN nursing leadership role in place in 4/5 PCNs	None	Retention has been a challenge for Social Prescribing link workers and clinical pharmacists	New - Open
1628	20/08/2020	Commissioning Primary Medical Services Committee	12	(I4xL3)	4	(I4xL1)	Debbie Robinson	There is a risk that the full amount of Funding for the Additional Roles Reimbursement Scheme available to General Practice in Calderdale is not able to be claimed resulting in Calderdale losing investment into General Practice and directly impacting on patient outcomes and pressure on the healthcare system across Calderdale	Reporting deadlines in place as outlined in the PCN Contract Directly Enhanced Scheme Reporting of position agreed into the monthly LMC/CD/CCG meeting in order to understand the current position, any slippage to plan and agree other plans to ensure spend. (CCG Finance and Primary Care Colleagues are sighted on this)	None	Detailed spreadsheet by month of expected spend to review against actual Current position shared and approach agreed with CCG/LMC and PCNs around management	Initial plans have been received from each PCN and progress made to date on recruitment	Detailed submission of each PCN plan awaited to increase CCG assurance that forecasted spend will become actual	New - Open

1560	22/05/2020	Commissioning Primary Medical Services Committee	8	(I4xL2)	4	(I4xL1)	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 Due to changes in contractual requirements as a result of COVID-19 there is income protection in place for practices relating to elements of 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	Decreasing
1434	25/11/2019	Commissioning Primary Medical Services Committee	8	(I4xL2)	4	(I4xL1)	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 and support from national PCN DES relating to GP and GPN Fellowship	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 - plans developed in relation to the Additional Roles Funding however longer term strategy needs addressing at PCN level	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	Static - 1 Archive(s)
1561	22/05/2020	Commissioning Primary Medical Services Committee	3	(I3xL1)	3	(I3xL1)	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 A dedicated line was available at the CCG and the primary care team have worked through queries and concersn that were raised - all of these have been dealt with	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	No further queries are coming through to the CCG and all existing ones have been closed. No open complaints or MP correspondence relating to the closure of these practices	None	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			
PMS Premium Investment 2020/21	DR	For decision	As required			√	
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	√	√	√
Feedback from Estates Sub Group		For assurance	Monthly			√	
PCN Development/Maturity Matrix Action Plan/timeline	DR	For assurance					
Risk Management							
CPMS Risk Review	RG	For decision	As required	C	√	√	√
GBAF Review	RG	For decision	Bi-annually				
Annual Risk Report	RG	For decision	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				√
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
Additional meetings held on :

NHS
Calderdale
Clinical Commissioning Group

Name of Meeting	Commissioning Primary Medical Services Committee	**Meeting Date**	15/10/2020
Title of Report	**PMS Premium Investment 2020/21**	**Agenda Item No.**	9
Report Author	Debbie Robinson, Head of Primary Care, Quality and Improvement	**Public / Private Item**	Public
GB/ Clinical Lead	Lesley Stokey Acting Chief Finance 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 report makes a recommendation to the Committee for the need to invest the PMS premium funding in 2020/21 and makes a proposal for such investment at PCN level. It is proposed that PCNs determine themselves how best to invest this funding to meet the following overarching objectives: • Reducing inequalities to accessing general practice services • Managing and meeting all on the day demand • Ensuring practices as part of PCNs are able to remain resilient over winter • Target acute care, prevention and screening of those who's physical and mental health is most at risk							
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; I. Note the content of this report II. Approve the proposal for investment of the PMS premium funding for 2020/21 as detailed in the report.							
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)	Detailed within the paper
Resources / Finance implications (including Staffing/Workforce considerations)	This is a budget of £589k for 2020/21 and follows national guidance. Further detail is within the report. Additional top up funding from delegated services of £77,285 is also detailed.

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 Background

1.1 As part of the delegated commissioning budget for 2020/21 £589k is included for PMS premium monies. National guidance is clear that any decisions relating to the future use of PMS funding should be agreed by the CCG, as part of delegated commissioning, in consultation with the LMC. Any freed up resources should always be invested in General Practice services and should be redeployed within the current CCG.

1.2 In previous years, the CCG has invested the premium funding available in schemes to improve Access to General Practice, and last year included funding to support additional prescribing clinician capacity during winter. Whilst these schemes have been very useful in establishing clear expectations and baselines they are also limiting in terms of enabling practices to flex their access offers. This year there is a need to adapt the Commissioning approach to consider additional capacity beyond prescribing clinicians and for it to be informed by the needs of the Practices/PCNs.

1.3 Primary Care saw 850,000 patients every day in England during 2019; 70,231 of these patients attended A&E departments, of which 13,400 were admitted to hospital.[1] These figures demonstrate the importance of primary care in preventing the NHS from being overwhelmed this winter.

1.4 General Practices and their services have and continued to change as a result of COVID-19, with reduced face to face consultations and increased access via digital solutions, it is being asked to target acute care, prevention and screening of those who's physical and mental health is most at risk.

1.5 As the NHS continues to focus on restarting routine services with the ongoing risk of outbreaks, General Practice will be put under additional strain by delayed presentations, investigations, and treatment; poorly controlled long term conditions; a rise in mental illness; the need to deliver the largest flu vaccination campaign to date; the effects of "long covid"; and widened socioeconomic inequalities due to covid-19 and the associated response. [2] In addition there is concern from practices about the roll out of NHS 111 First from December 2020 and the impact that this may have on access and capacity in General Practice. At this time this has not been quantified.

1.6 Appropriate resourcing of General Practice can protect the rest of the health and social care system. Many practices will struggle with resources over the winter; they are likely to face workforce shortages as staff have to shield, intermittently self-isolate, or fall sick. Careful consideration must be given to General Practice resourcing to ensure practices remain well-resourced throughout the winter.

2.0 Proposal

2.1 It is therefore proposed that PMS premium monies are distributed to practices via PCNs based on weighted list size at the 1st April 2020.

[1] House of Commons Library (2020). *NHS Key Statistics: England, February 2020.* https://commonslibrary.parliament.uk/research-briefings/cbp-7281/

[2] Greater London Authority. Socio-economic impact of COVID-19. 14 August 2020. Greenhalgh T, Knight M, A'Court C, Buxton M, Husain L . *Management of post-acute covid-19 in primary care.*

The table below shows the proposed distribution of monies by PCN:

PCN	Weighted List Size	PMS Premium Amount per PCN
Calder & Ryburn	41,910	£109,967.31
Central Halifax	53,126	£139,396.57
Lower Valley	44,612	£117,055.70
North Halifax	46,843	£122,908.25
Upper Calder Valley	37,911	£99,473.17
	224,402	**£588,801**

It is also proposed that the Premium funding is topped up from delegated reserves to £666,285 this will make available the equivalent of £3 per head of population to PCNs for investment. This will then be a similar level to the recurrent premium amount from 2021/22 onwards

2.2 It is recommended that PCNs determine themselves how best to invest this funding to meet the following overarching objectives:

- Reducing inequalities to accessing general practice services
- Managing and meeting all on the day demand
- Ensuring practices as part of PCNs are able to remain resilient over winter
- to target acute care, prevention and screening of those who's physical and mental health is most at risk

A condition of this funding would be that all practices continue to build on the relationship with secondary care providers, in particular A&E teams continuing as a minimum with dedicated "staff only" telephone lines into their practices, lines manned during practice opening hours; 8.00am – 6:30pm Monday to Friday and where the presentation at A&E is deemed inappropriate the practice as a minimum offer the patient a telephone consultation.

3.0 Reporting

In light of the continued pressures on the system it is proposed that reporting expectations are kept to minimum and that PCNs be asked to report by the 15th of May on the totality of:

- investment made across the PCN,
- the alignment to the overarching objectives,(including some for patient experience of access), and
- Capture and share any learning that could inform future investment decisions.

4.0 Conflicts of Interest

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

5.0 Recommendations

5.1 It is recommended that the Committee

I. Note the content of this report
II. Approves the proposal for investment of the PMS premium funding for 2020/21 as detailed in the report.