NHS
Calderdale
Clinical Commissioning Group

Minutes of the Commissioning Primary Medical Services Committee Meeting held on 15th October 2020, 3pm, Held virtually by Microsoft Teams

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

FINAL MINUTES

Present	John Mallalieu	(JM)	Governing Body - Lay Member (Chair of the Committee)
	Alison MacDonald	(AM)	Governing Body - Lay Member (Patient & Public Involvement)
	Dr Rob Atkinson	(RA)	Governing Body - Secondary Care Specialist
	Dr Steven Cleasby	(SC)	Governing Body - GP Member (CCG Chair)
	Dr James Gray	(JG)	Governing Body - GP
	Neil Smurthwaite	(NS)	Interim Accountable Officer
	Lesley Stokey	(LS)	Interim Chief Finance 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, Healthwatch, 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
	Penny Woodhead	(PW)	Chief Quality and Nursing Officer
	Zoe Akesson	(ZA)	Senior Administrator

There was no public in attendance.

22/20 APOLOGIES FOR ABSENCE — ACTION

There were no apologies received.

23/20 DECLARATIONS OF INTEREST

The Chair informed the meeting that GP members had conflicts of interest in items 7, 8 and 12. The proposed approaches for managing these conflicts were set out below;

Item 7 - the Finance paper asked for agreement to set up an additional virtual meeting in private with non-conflicted members to approve any discretionary investment proposals. JG and SC had a **direct financial interest** in the item as general practice contract holders in Calderdale. The Chair felt the GPs contributions to the finance paper were valuable and proposed that they take part in discussion but did not take part in the decision making.

Item 8 - the Estates paper set out some proposed principles referred to as 'Golden Rules' that all submissions for premises development proposals in Calderdale must meet before being considered for investment support. JG and SC had a **direct financial interest,** as practices could be impacted positively or negatively by the proposed gateway principles. Again, it was felt that contribution to the conversation would be helpful but the GPs were asked not participate in the decision.

Item 12 - the PMS premium funding investment for 2020-21 paper asked for agreement to a proposal for investing the funding at PCN level. JG and SC have a **direct financial interest,** as their practices would potentially receive funds via the proposal. The GPs had not received the paper, would be asked to leave the meeting at this point and would not take part 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.

24/20 QUESTIONS FROM THE PUBLIC

There were no questions from the public.

25/20 MINUTES OF THE OF COMMISSIONING PRIMARY MEDICAL SERVICES COMMITTEE MEETING HELD ON 23rd JULY 2020

The Committee reviewed the minutes of the last meeting on 23rd July 2020 and **APPROVED** these as an accurate record of the meeting.

26/20 ACTIONS AND MATTERS ARISING 23rd JULY 2020

The Committee reviewed the action log. There was one outstanding action (13/20) for HH to establish the reason why patients believed they were unable to contact their surgery during the pandemic. Since the last meeting Healthwatch had prepared and shared a report on Calderdale's response to the pandemic, to which the CCG was preparing a formal response. The action was closed.

27/20 DECISION NOTICES

A Notice of Decisions from July's Committee was made available to the public via the website. The Committee **APPROVED** the notice.

The Chair informed the Committee that a single item meeting took place with core committee members with regards to establishing a process for urgent decision making. The Committee approved the urgent decision making process on 3rd September 2020 and the note reflecting the decision made at that point was made available to the public via the website.

28/20 HEAD OF PRIMARY CARE REPORT

In presenting the update DR highlighted the following key points.

There is a significant national and local 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. A West Yorkshire and Harrogate Flu Board has been established which is receiving bi-weekly updates from CCGs on their flu plans, the target for both patients and staff, the expansion of the

programme later in the season to those in the 50-64 year old age group subject to vaccine supply and after existing eligible groups have been prioritised.

The Committee was asked to note the position with regards to the Additional Roles Reimbursement Scheme (ARRS) for Calderdale PCNs. It was noted that this had already been reported to NHSE due to timescales around returns. DR notified the Committee that there was likely to be some further funding made available from the WY ICS to support PCN development and the CCG was waiting for further details. In relation to NHS111, DR advised the meeting that the contractual requirement for appointment per 500 registered patients per day available for direct booking by NHS 111 had been extended.

Finally, work is due to start in October by internal audit on the Primary Care Commissioning Review. The specific area of review for this year is Commissioning and Procurement of Primary Medical Services.

Comments and questions were invited.

- In response to a question around the availability of flu vaccines for the 50-64 year old age group, NS assured the Committee that confirmation had been received from NHSE that there was stock available and this would be rolled out in a phased release. The deployment would be through the national procurement route for both Pharmacy and General Practice. He went on to say that if problems did occur there was a good route to feed into the regional and national flu meetings.

- In relation to the risk highlighted in the paper that all practices may not be able to maximise use of the APEX tool, DR responded to say the CCG along with the LMC and PCNs were ensuring that all practices were made aware of the tool and the great benefits that could be gained from using it.

- There was an observation made that the first contact practitioners were proving popular however some community practitioners such as paramedics had not yet being added to the additional roles scheme to ensure the system was not destabilised. SC agreed it was good to see clinical support in the system and asked about the utilisation of appointment slots and measuring the efficiency of these services. In response, EB said that there were plans to look at the impact and demand but also gain a better understanding of what these new roles could bring and how they would contribute to proactive care.

- NS added that since writing the report there had been movement on digital and good progress had been made with Calderdale agreeing as a system to have the availability of an additional functionality, making it easier to communicate by providing a balance between face-to-face, digital and on line.

DECISION

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

29/20 CONTRACT REPORT

MP drew the Committee's attention to the following points in the report;

There was an update on the contracting position and solutions around future aligning of the GP online and video consultations into a new framework. Learning taken from

this would be used to look at aligning any future procurement from a joint functionality perspective. The report described elements set out in the Network DES 2020-21 and the concept of auto-enrolment for GPs. There was an update on the incorporation applications received by the Committee with the novations for Boulevard and Springhall Group Practice now being complete. There was a section on the national medical performers list, which the CCG along with NHSE colleagues have to ensure is maintained and vetted on a regular basis.

MP concluded by providing an update on a complaint received last year about a decision the Committee made on PMS premium funding. Paused due to the pandemic, this was now being picked up again and would be dealt with through the formal dispute resolution process. LS added that the CCG had followed the process as requested by NHSE but asked NC for any advice he could provide from an NHSE perspective in relation to equitable funding. NC agreed to look into this.

ACTION: MP to share details of the PMS funding complaint with NC who would look into this and provide advice/feedback from an NSHE perspective. **MP/NC**

Questions and comments were invited.

- SC raised GP online and video consultations and the importance of using in practice. DR informed the Committee that maximising the function of the 2 systems was discussed at the GP Leadership meeting where it was agreed that each PCN would agree on one system so that all practices maximise the same one and learn together. NS added that WY ICS Digital has been successful in a bid to look at web site access and review best practice. This should dovetail with the work being done locally and result in a positive direction of travel from all partners; ensuring patients receive the same offer of GP access anywhere in Calderdale.

DECISION

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

30/20 FINANCE REPORT

In presenting the report, LS reminded the Committee that the CCG was working under a very strict financial regime. The budgets had been issued for the first 6 months of the year, which were less than what the 6 month equivalent of the CCG's plan was for this year and in light of this the CCG was reporting a net overspend of £349k until the end of September.

The allocation for delegated primary care for the first 4 months was £232k leaving a net pressure of £117k for August and September. Overspends were as a consequence of not being able to move budgets around. The biggest variance was due to changes in contracts and overspends against PCNs.

October to March budgets were issued at the end of September. The CCG had a confirmed allocation of £15.7m with some allocations for specific DESs of £195K, which would give a total of £15.9m. The CCG's total net confirmed allocation for the first 6 months was £31.7m, which was not far off its initial plan for the year of £31.8m. This was positive news, with a confirmed allocation to deliver the plan for this year. The CCG are asked to submit their plan to NHSE by 22nd October 2020, once approved it will be shared with the Committee.

With regards to the PMS premium, following the Committee's decision equitable

funding would be in place from 01/10/20. This year there was a confirmed reserve budget of £580k and the full year adjustment will be available from 2021/22 with a budget of £666k.

Changes made to the PMS contract last year resulted in an increase in the reserve budgets equating to £710k. A recommendation was put to the Committee for their agreement to deploy these reserves and make appropriate investment in primary care in relation to Winter and COVID pressures. Conscious of the timing, decisions may need to be made swiftly so in order to facilitate that LS recommended one or more separate additional meetings of non-conflicted members' takes place to approve investments of the £710k reserve and report to the next formal committee of the decisions. All other normal process would be followed such as the QIA and EQIA process around rapid decision making.

Helen Hunter left the meeting.

Questions and comments were invited.

- The GPs acknowledged they were conflicted but emphasised the importance of clinical input around deciding the most effective way of utilising this resource. DR assured the Committee conversations were taking place. Each scheme being considered is explored informally with both the LMC and Clinical Directors and there is a named clinical lead either an Associate or GP Governing Body clinical lead for each of the schemes.

JG and SC left the meeting whilst the decision took place.

DECISION

The Committee **APPROVED** setting up an additional virtual meeting in private with non-conflicted members to approve any discretionary investment proposals.

The Committee **NOTED** the 2020/21 financial position on Primary Medical Services delegated budgets and the indicative allocations for 2020/21October to March.

JG and SC re-joined the meeting.

31/20 ESTATES REPORT

DR presented a report that proposed some Golden Rules that all submissions for premises development proposals in Calderdale must meet before being considered for investment support. In addition, the paper outlined new guidance to PCNs to commence work on estates in conjunction with workforce planning. Since the group met, further guidance had been issued for commissioners and officers were working through the implications.

The paper reminded the Committee that at its meeting on the 23rd July 2020 it agreed to the establishment of a small sub-group to develop this work. The paper presented the work of the group and sought the Committees views on the Golden Rules to see if they were workable. These would be communicated out to practices so they understood the process they are working towards.

The Chair asked the Committee for their views and comments.

- JM emphasised the need to define the submission process for practices ensuring they have clarity on how to evidence. DR confirmed there were a number of

documents the CCG could direct them to such as the Commissioner Guide and the Expectation to PCN Guidance and by starting conversations early could advise where to find the best advice.

- A question was raised about the new guidance incorporating the changes in the way care is delivered in light of COVID and if the needs of the population had been refreshed. DR responded by explaining that practices should have considered their existing arrangements as part of the process. Practices would be challenged to ensure they have considered how they supported patients previously. DR reminded the Committee that this was only the first gateway and if successful at this point it would then go to NHSE for their scrutiny and overall decision.

JG and SC left the meeting whilst the decision took place.

DECISION:

The Committee **APPROVED** the Golden Rules**.**

The Committee **NOTED 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 involving workforce and estates planning.

JG and SC re-joined the meeting.

32/20 RISK REGISTER POSITION STATEMENT

RG presented the information relating to the third risk cycle 2020-21.
There were 7 risks in total, 4 new risks scoring 12 and 1 marked for closure. All 6 open risks were between 8 and 12 therefore no significant risks to report.

Comments and observations were invited.

- In response to a question relating to R1629 about additional roles, it was explained to the committee that this was not about the professionalism of the people but recruiting them into an environment that they might not be familiar with and likewise the environment not familiar with them and the consequences of that. By putting it on the risk register it made the Committee alive to this.

- In relation to R1628 maximising funding available, LS assured the Committee that a lot of work was happening with PCNs to maximise plans and develop templates.

- JM suggested splitting R1630 vaccination of population, as there would be different inputs to managing this. Although accountable for it as a whole, some parts of the risk could be managed and splitting would show the level of risk differently.

DECISION

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

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

33/20 NOTICE OF URGENT DECISIONS

DR informed the Committee of 3 urgent decisions that had been made. The committee members were reminded that on the 3rd of September 2020 they considered and approved the process for making urgent decisions that were required in relation to matters of such urgency, and relating to the management of COVID-19, that they will not wait until the next scheduled meeting of the Committee and therefore warrant the use of urgent decision process.

Since then 2 practices have submitted applications under this process, both for a 3 month delay in providing face to face services from one of their respective branch surgery premises.

An application from Hebden Bridge Group Practice advised that "*It is not physically possible at present to safely socially distance and protect both patients and staff in the Luddendenfoot Branch Surgery. As a result this location will not be providing face to face appointments. Additional access has been made available to these patients.*" This application was approved.

A further application from another practice had been agreed in principle subject to further conditions and clarification. The Local Medical Committee was consulted for a view on both applications. The decision notices on these applications would be published on the CCGs website.

Comments and questions were invited.

- A question was raised about keeping patients informed of what was happening. DR explained that practices are asked to communicate clearly with patients and to provide the CCG with evidence of their patient engagement and responses around this.

DECISION

The Committee **NOTED** the updated.

34/20 WORKPLAN

The work plan was reviewed and there were no comments.

DECISION

The Committee **AGREED** the work plan.

SC and JG Left the meeting

35/20 PMS PREMIUM INVESTMENT 2020/21

The Chair noted that the conflicted individuals were not present for this item.

DR outlined the paper that sought approval of the investment of the PMS premium funding for 2020/21. It recommended that PMS premium monies are distributed to practices via PCNs based on weighted list size at the 1st April 2020 and that this is topped up to £3php from reserves.

DR assured the Committee that clinical input into this proposal, had been via the Local Medical Committee and also the Clinical Lead for Primary Care, both parties confirmed their support for the approach being proposed.

The PCNs and practices would be asked to consider the 4 objectives below when using this funding;

- 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

In previous years, funding had been targeted at additional clinical prescribing capacity only and its clear from patient feedback and practices alike that there is a need to take a more flexible approach this year to enable those at the front line to determine how best to invest the funding to maximise the general practice response over winter.

Comments and thoughts were invited.

- The Committee agreed to this investment approach.

- LS was comfortable with the financial recommendation of £3 per head which would take the investment pot to the full year effective of what the PMS premium would be for next year and the difference would come from the reserves.

- There was a short discussion around skills and being able to tailor to their PCNs. The Committee was informed that conversations were happening about methods and approach. There is multi-disciplinary support in place from the CCG to help PCNs deliver such as the APEX Insights and Population Health Management work, which will give a better understanding of their population.

- The skills and funding should improve access, however if it fails to do so the CCG would need to re-think how it would do it for next year. The CCG understands the risk and that it may take longer to develop.

Cllr. Tim Swift left the meeting

DECISION

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

The Committee **APPROVED** the proposal for investment of the PMS premium funding for 2020/21 as detailed in the report.

36/20 DATE AND TIME OF NEXT MEETING IN PUBLIC

The Committee **NOTED** that the next meeting would take place on Thursday 21st January 2021, 3.00 – 5.00pm, via MS Teams

Commissioning Primary Medical Services Committee Meeting wef 15 October 2020 – Action Sheet

Agenda item	Minute No.	Action Required	Lead	Current Status	Comments/ Completion Date
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**	**Closed**	Since the last meeting Healthwatch had prepared and shared a report on Calderdale's response to the pandemic, to which the CCG was preparing a formal response.
Contracting Report	**29/20**	MP to share details of the PMS funding complaint with NC who would look into this and provide advice/feedback from an NSHE perspective.	**MP/NC**	**Open**	

NHS
Calderdale
Clinical Commissioning Group

Name of Meeting	Commissioning Primary Medical Services Committee	Meeting Date	21/01/2021
Title of Report	Notification of Urgent Decisions	Agenda Item No.	4b
Report Author	Debbie Robinson -Head of Primary Care Quality & Improvement	Public / Private Item	Public
GB / Clinical Lead	John Mallalieu - CCG Deputy Chair	Responsible Officer	Debbie Robinson, Head of Primary Care Quality & Improvement

Executive Summary							
Please include a brief summary of the purpose of the report	The current COVID-19 situation means that urgent decisions may be required by the CCG in relation to matters which are within the delegated scope of the Commissioning Primary Medical Services Committee. These are matters of such urgency, and relate to the management of COVID-19, that they will not wait until the next scheduled meeting of the Committee and warrant the use of urgent decision processes, utilising good governance approaches. An urgent decision process has been put in place, which is detailed within the report, and this requires the notification of all decisions taken under such a process to be brought to the next routine meeting of the Committee.						
Previous consideration	**Name of meeting**	-		**Meeting Date**			
	Name of meeting	-		**Meeting Date**	Click here to enter a		
Recommendation (s)	That the Committee **NOTE** the urgent decisions taken under the urgent decision procedure.						
Decision		**Assurance**	☒	**Discussion**	☐	**Other**	Click here to

Implications					
Quality & Safety implications	Will be set out in each decision notice.				
Engagement & Equality implications (including whether an equality impact assessment has been completed)	Will be set out in each decision notice.				
Resources / Finance implications (including Staffing/Workforce considerations)	Will be set out in each decision notice.				
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?	All	**Risk** (include risk number and a brief description of the risk)	none		
Legal / CCG Constitutional Implications	None identified	**Conflicts of Interest** (include detail of any identified/potential conflicts)	None Identified Any conflicts of interest will be managed in line with the CCGs Conflict of Interest Policy.		

1. Introduction

1.1 The current COVID-19 situation means that urgent decisions may be required by the CCG in relation to matters which are within the delegated scope of the Commissioning Primary Medical Services Committee (see appendix 1). These are matters of such urgency, and relate to the management of COVID-19, that they will not wait until the next scheduled meeting of the Committee and warrant the use of urgent decision processes set out within terms of reference (TOR), constitution and utilising good governance approaches .For example these may include the temporary closure of premises and or the suspension of specific services

2. Detail

2.1 The following process was agreed for making urgent decisions by the Commissioning

Primary Medical Services Committee:

Decisions are made by:

- The Chair (John Mallalieu) or Vice Chair (Alison MacDonald) and
- An executive member of the committee – The Chief Operating Officer (Neil Smurthwaite) or the Director of Finance Officer (Lesley Stokey).

This is done in prior consultation with:

- LMC representatives (Dr Richard Loh and Mr Marcus Beacham)
- The Primary Care Clinical Lead (Dr Majid Azeb) (Subject to Conflicts of Interest)

The meetings will be held virtually on Microsoft teams, as required

Briefing papers will be sent out at least 24 hours in advance of the meeting

The decisions are recorded on an urgent decision template, which will be sent out to all members of the Committee within 1 working day of the decision. If it is possible to enact a decision at a routine Committee meeting the urgent decision making process will not be used and the submission will be considered by the full committee.

2.2 Since the last meeting of the CPMSC, the urgent decisions process has been used on two occasions:

I. 26th November 2020 – Winter Schemes 2020/21 - proposal of three additional winter schemes for investment, non-recurrently, from the primary medical services delegated budget, (decision notice appended);

- Additional Capacity for the Acute Visiting Service
- Calderdale CCG COVID Clinical Assessment Centre (CCAC)
- In-Hours Streaming in A&E

II. 11th December 2020 - Support for Primary Care in Wave 2 of the COVID-19 Pandemic (decision notice appended).

3. Next Steps

The urgent decisions process will remain in place during this stage of the COVID-19 pandemic. Notification of decisions taken will continue to be reported to the Committee, and will also be published on the CCG's website.

4. Recommendations

4.1 It is recommended that the Committee:

That the Committee **NOTE** the urgent decisions taken under the urgent decision procedure

5. Appendices

Appendix 1 - Winter Schemes 2020/21 - proposal of three additional winter schemes for investment, non-recurrently, from the primary medical services delegated budget; (Decision notice)

Appendix 2 - Support for Primary Care in the Second wave of the COVID-19 Pandemic (Decision notice)

Appendix 1

Calderdale Clinical Commissioning Group

Record of Urgent Decision

Committee/Body on behalf of which decision made: Commissioning Primary Medical Services Committee

Decision Maker(s):

Name	Role
John Mallalieu	Committee Chair, Lay Member (Finance and Performance)
Neil Smurthwaite	Chief Operating Officer
Lesley Stokey	Director of Finance

Consultee(s):

Name	Role
Dr Majid Azeb	Clinical Lead for Primary Care
Dr Farrukh Javid	Clinical Lead for Urgent Care
Marcus Beecham	LMC Service Manager
Dr A Ross Dr G Chandrasekaran Dr N Taylor Dr N Akhtar Dr Fawad	PCN Clinical Directors

Clinical/GB Lead:	Dr Majid Azeb	Clinical Lead for Primary Care
Lead Officer:	Debbie Robinson	Head of Primary Care, Quality and Improvement

Others Present;

Emma Bownas	Senior Primary Care Quality and Improvement Manager
Zoe Akesson	Corporate & Governance Officer

Subject:

Winter Schemes 2020/21 - proposal of three additional winter schemes for investment, non-recurrently, from the primary medical services delegated budget;

1. Additional Capacity for the Acute Visiting Service
2. Calderdale CCG COVID Clinical Assessment Centre (CCAC)
3. In-Hours Streaming in A&E

Decision:	1. **APPROVED** the Additional Capacity for the Acute Visiting Service scheme. 2. **APPROVED** the Calderdale CCG COVID Clinical Assessment Centre acknowledging it would be price variant based on demand and weekly control. 3. **APPROVED** the In-Hours Streaming in A&E scheme with the recommendation to review demand on weekly basis.
Details and Rationale:	**1. Additional Capacity for the Acute Visiting Service (AVS)** Details and rationale were set out in the report. The Committee agreed that it would allow GPs to work on a smaller geographical scale, provide a higher utilisation and allow for a safer operating model. **2. Calderdale CCG COVID Clinical Assessment Centre (CCAC)** Details and rationale were set out in the report. The Committee acknowledged the following points; • patients that were unable to travel could use the Acute Visiting Service • appointments would be booked directly via SystmOne • overflow and duty of care remained with the patient's own practice • the CCG would require regular reporting on capacity issues and notification of agreements around flexing **3. In-Hours Streaming in A&E CRH** Details and rationale were set out in the report. The Committee recognised the risk around a 1.5wte and the cost implications if it was not possible to recruit to. A weekly check on demand would be required going forwards.
Any Relevant Implications (Quality/Safety, Engagement/Equality, Resources/Finance, Data	An Equality and Engagement checklist was completed. An Equality Impact Assessment has been developed and Rapid Impact Assessments have being completed for each of the services and have been signed off by the CCGs Quality Team.

Protection, Risk, Legal/Constitutional, Conflicts of Interest etc):	There is an agreed arrangement with the COVID Clinical Assessment Centre and the In-Hours A&E Streaming Service that the staff in these services may flex, which would have an impact on the budget.	
Report attached?	No	
Public/Private?	Private	
If private, give reason(s):	Commercial Sensitive	
Time and Date of Decision:	26th November 2020 at 3pm	
Decision Recorded by:	**Name**	**Role**
	Zoe Akesson	Corporate & Governance Officer

Appendix 2

NHS Calderdale
Clinical Commissioning Group

Record of Urgent Decision

Committee/Body on behalf of which decision made:	Commissioning Primary Medical Services Committee

Decision Maker(s):

Name	Role
John Mallalieu	Committee Chair, Lay Member (Finance and Performance)
Neil Smurthwaite	Chief Operating Officer
Lesley Stokey	Director of Finance

Consultee(s):

Name	Role

Clinical Lead:	Dr Majid Azeb	Clinical Lead for Primary Care
Lead Officer:	Debbie Robinson	Head of Primary Care, Quality and Improvement

Subject: Support for Primary Care in the second wave of the COVID-19 Pandemic

Decision:

- **SUPPORTED** the principles set out in the paper which allow for prioritisation of service delivery based on clinical judgement.
- **APPROVED** the priority areas set out in the paper.
- **APPROVED** the principle of income protection arrangements for locally commissioned services and the minor surgery DES for Q3 and Q4 as set out within the paper.
- **APPROVED** the approach to the investment of the "additional funding from NHSE"

Details and Rationale:

Details are set out in the attached report.

Written comments from John Mallalieu (Lay Member: Finance) were taken into account.

It was acknowledged that the approach being taken around GPs using their professional clinical judgements in prioritising services was agreed with the LMC. The CCG would continue to follow up on any

	patient or stakeholder concerns with the individual practices and where necessary seek input from the clinical lead for Primary Care and the LMC. It was recognised that consistent messaging is part of the approach to communications and the practices have all been issued with a clear and consistent communications tool kit. There is some further work to do in relation to practice websites and the CCG has agreed to lead a piece of work supporting this. It has been confirmed that the GP Leadership meetings will be reduced to monthly from December. In relation to the General Practice Covid Capacity Expansion Fund, it was confirmed that there is an agreed mandate in line with principles detailed in section 2.4 of the report.
Any Relevant Implications (Quality/Safety, Engagement/Equality, Resources/Finance, Data Protection, Risk, Legal/Constitutional, Conflicts of Interest etc):	As set out in attached report
Report attached?	Yes
Public/Private?	Public
If private, give reason(s):	

Time and Date of Decision: 11 / 12 / 2020

Decision Recorded by:

Name	Role
Zoe Akesson	Corporate Governance Officer

Name of Meeting	Commissioning Primary Medical Services Committee		Meeting Date	21/01/2021
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, Chief Operating 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. The Flu Vaccination Programme for 2020/21 2. Progress on the development of PCNs 3. The recently commissioned winter schemes 4. Estates			
Previous consideration	Name of meeting	CPMSC	Meeting Date	15/10/2020
	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 the Flu Vaccination Programme 2020/21

1.1 At its meeting on the 15th October 2020 the Committee was advised that 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. The national aspiration is to deliver 75% uptake of the 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

A further target this year is to offer 100% of frontline health and social care workers a vaccine and then the Programme was extended from the 1st December 2020 to enable 50 to 64 year olds to have a free flu vaccination at their GP practice or community pharmacy.

1.2 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 2 weekly update on flu uptake using information from practices clinical systems. This allows tracking of progress in delivery for each patient cohort.

1.3 The latest data shows that we have exceeded the 75% target for the age 65 or over cohort for all PCNs. However, there are some areas that require more focus e.g. 2-3 year olds. The practices receive the latest flu uptake figures weekly. Conversations have taken place with practices where figures have been lower than anticipated for this point in the flu vaccination season. Regular discussions take place at the Practice Manager Action Group (PMAG) meetings where practices are able to raise any issues/concerns they have with the programme.

1.4 There have previously been issues with accessing vaccine supplies however; practices continue to be able to access national stocks. Recently no issues have been identified. A Calderdale overall position is detailed in Appendix A.

2.0 Primary Care Network (PCN) Development

2.1 PCN Workforce Additional Roles Reimbursement Scheme

2.1.1 The latest financial position is reported within the Finance Paper presented to Committee. In line with guidance Calderdale CCG has submitted two plans to NHSE. The first shows details of planned spend for 2020/21 and the second submission on 31st October 2020 shows high level PCN plans up to 2024. Assurance has been provided and received by NHSE in relation to the plans following submission.

2.1.2 The Scheme guidance contained strict conditions for use of the available £1.3m funding with not all of the funding being available within the CCG's allocation. To access the remaining funding, retained by NHSE, robust plans were required to be submitted and Calderdale PCNs had no plans for £116k of the total budget. However, due to the ongoing challenges as a result of COVID-19 and the demand on general practice to administer the COVID-19 vaccine, West Yorkshire and Harrogate CCGs developed a set of principles that were agreed in order to support general practice at this time. Contained within the principles was a stated expectation to continue to promote the Additional Roles Reimbursement scheme to its PCNs including employing flexibility to support the Covid-19 response where appropriate.

2.1.3 Following discussion with the Calderdale Local Medical Committee (LMC) the following parameters have been agreed in order for the CCG to draw down the money within the current national guidance:

- The funding is being drawn down to support delivery of the COVID Vaccination programme
- The funding is only to be used for roles that are within the ARRS scheme (pharmacists are a role that could assist with vaccination). It was agreed Pharmacists who are supporting the vaccination programme on a short term basis do not have to enrol or be engaged on the Clinical Pharmacy Training Programme.
- Relax rules relating to a requirement for minimum 6 month employment. This will allow the funding to be used to employ sessional staff or existing staff on additional hours. Claimable rates of pay would need to be within the banding of the ARRS scheme and at plain time rates. If PCNs wish to pay enhanced rates that portion would not be able to be claimed. The claims process as for all other ARRS roles remains the same.
- Current underspend is variable across the PCNs therefore it was agreed that the funding is distributed to the PCNs on actual underspend unless the Clinical Directors agree to split the funding equally across Calderdale.

2.1.4 The additional roles that have been recruited into and those planned for, show a split across the 10 available roles. As shown in Appendix B:

2.1.5 These plans have been influenced by the requirement to deliver the PCN DES:

- The work to develop the delivery model for the Enhanced Health in Care Homes has successfully developed the role of care co-ordinator within the PCNs and the early feedback from system partners is of the value of this role in improving the timeliness of care for individuals and also the relationships between General Practice and Care Homes.

- Population Health Management work has also provided opportunity for the social prescribing link worker roles to be refreshed and focussed with a view to measuring impact on outcomes for individuals and also strengthen links with the Staying Well service and the Voluntary Sector.

- There is a growing evidence base for the value of health coaches in improving health outcomes for individuals that are shown to reduce the number of visits to GP surgeries and this is shown through the plans for future years. Finally one PCN has employed an Occupational Therapist with another currently recruiting. Professional leadership for this role has been provided by SWYPFT and there is potential for the Occupational Therapist to further enhance the value of the Social Prescribing Link Workers through clinically supporting the case load and development.

2.1.6 **Risks** - There are two risks identified on the CCGs risk register, as detailed in the risk report. One relates to the recruitment, retention and professional leadership for the roles that are new to General Practice. Work is being scoped at a West Yorkshire and Harrogate Partnership level to look at a framework or to develop support mechanisms to support this but is at an early stage. In Calderdale there is opportunity for an approach to be developed and agreed through the workforce group and Calderdale, Community Collaborative Partnership Board.

A new and emerging risk is the availability of paramedics and the potential requirement for this role to undertake additional training to be “PCN ready”. At present it is unclear as to whether

this will affect the plans that the PCNs have in place for recruitment. A risk will be added to the risk register once the impact of this requirement is fully understood for Calderdale.

2.2 **Primary Care Network Development Funding - 2020/21 Update**

2.2.1 At its meeting on 15th October 2020 the Committee was advised that each ICS/STP will receive further PCN development funding in 2020/21 and that 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.

2.2.2 We have now been advised that WY has £1,885,500 allocated for PCN Development in 2020/21. The programme board has listened to the feedback from system partners and has agreed the following structure with regard to the allocation of funds:

Area	Description	Proposed Allocation
PCN Project delivery Funding	Funding to be allocated directly to our 52 PCNs to undertake the co-produced framework	£1,300,000 (£25,000 per PCN)
PCN Clinical Director Leadership Funding	programmes and pathway development	£133,120* (8 sessions of backfill funding per PCN over 12 months, £2,560 per PCN)
ICS Clinical Engagement - Clinical Reference Group – PCCS	Budget to support Clinical Reference group in at scale work, i.e. any planned work/projects (CD forum, IT platforms and commissioned support).	£250,000
Clinical Lead – PCCS Programme Board	Interim secured support from a clinical lead into the Programme Board – 8 sessions per month from January to March 21. 12-month Clinical Lead post from April 21	£7,680 £35,000*
Community Pharmacy – support in to PCNs	Supporting capacity and time for Community Pharmacy PCN representatives to be part of PCN networks/meetings	£65,000 (costs worked up looking at the CP backfill rate of £100 per session)
VCS capacity support	Support to VCS organisations to develop their working relationships with PCNs for example social asset mapping.	£75,000 (£15,000 per place)

* Exact sessional rates to be confirmed which may impact on the amounts listed in the table.

We are currently awaiting further detail on how the will above be progressed including detail of the governance and reporting arrangements. A further update will be provided as the work progresses.

2.3 **Covid Vaccination programme at PCN level**

2.3.1 The first stage of the vaccine rollout is progressing well across Calderdale following deliveries to the first Primary Care Networks (PCNs). Central PCN went live on 14 December 2020. This was followed by North, Upper Valley and Calder and Ryburn on 21st December 2020. The Lower Valley PCN is due to go live week commencing 4 January, 2021. PCNs have offered vaccinations to patients aged 80 and over, so all areas should be covered by early January 2021. PCNs will also be starting to vaccinate care home residents and staff in larger care homes over the next few weeks. It is important that none of the vaccine doses are wasted so if slots become available at very short notice they may need to be offered to available patients

and staff working through the JCVI (Joint Committee on Vaccination and Immunisation) guidance. PCNs maintain a short-notice, reserve list of patients and staff who can be contacted to fill slots. Vaccination uptake data will be provided at the meeting.

2.3.2 The CCG will have a community site in the centre of Halifax. The go live date is affected by both the availability of the vaccine and the go live of the national booking system. At present the timelines are; national booking system go live on 8th January 2021, other community hubs go live 11th January and pharmacy contracts go live on 18th January. Once open, over time the community facility can offer an at scale offer for up to 500 patients per day. NHSE are currently undertaking a designation process for all community pharmacies who have expressed a wish to be part of this contract. As with PCNs, the assurance process will look at the site, processes and staffing.

2.3.3 Now that patients aged over 80 are being offered vaccinations by PCNs, hospital hubs will be focusing on vaccinations for care home staff and health and social care staff. Deliveries have just been confirmed for additional hospital hubs in West Yorkshire, including Calderdale Royal Hospital and Huddersfield Royal Infirmary so we will be able to offer vaccinations to frontline staff, alongside care home staff from our area. CHFT took delivery of their first batch of vaccines week commencing on 29th December. A small task and finish group is to be established, led by the Public Health team to interpret the prioritisation of JVCI guidance in relation to a broad range of health and care staff, including those who work in the third and independent sector.

3.0 Update on the recently Commissioned Winter Schemes

3.1 The Committee is reminded that at its meeting on the 15th of October 2020 it agreed that due to the timing of the next meeting and the need to deploy reserves and make appropriate investment to mitigate Winter and COVID pressures, the schemes detailed below were to be considered under the urgent decision making processes.

3.2 In-hours A&E Streaming Services

3.2.1 The In-hours A&E Streaming service, provided by Pennine GP Alliance (PGPA), commenced on the 1st December 2020 and is available until 9th April 2021. This service has been developed in partnership with the CCG Clinical Lead for Primary Care, the CHFT Clinical Lead and Matron for A&E.

3.2.2 The service accepts all appropriate referrals of patients over one year of age following triage in the emergency department who are identified as attending with a primary care presentation. Current operating hours are from 12pm-6pm with maximum of 24 appointments available per day. The service is expected to respond to demand flexibly through increasing and decreasing staffing and operating hours as appropriate and through discussion with the commissioner and A&E. The number and timings of appointments were based on modelling provided by A&E.

3.2.3 In order to maximise the available capacity and collect learning, weekly meetings are held with the PGPA Services Director, A&E Matron and Senior Primary Care Quality and Improvement Manager. In addition monthly data monitoring and patient experience measures are in place.

3.2.4 At present capacity remains available and uptake has fluctuated. The weekly meetings are proving beneficial in solving teething problems and also developing relationships. Workforce availability has not proved a challenge to date.

3.3 **Covid Clinical Assessment Clinic**

3.3.1 The Covid Clinical Assessment Clinic, provided by PGPA, began on the 7th December 2020 and will be available until the 9th April 2021. The clinic provides appointments at a single site for patients who require a face to face assessment in General Practice and are COVID-19 Positive or symptomatic. The service operates from 12 noon to 6 pm each week day excluding bank holidays and weekends and in addition to receiving referrals from General Practice, will also accept referrals directly from the NHS111 Covid Assessment Service. Fully staffed the clinic has the capacity for 54 appointments per day.

3.3.2 At present capacity remains available and uptake is steady. Reporting from the first few weeks shows utilisation from across Calderdale Practices. Initially there were concerns raised about workforce availability however, to date, this has not proved a challenge.

3.4 **Learning Disability Health Checks**

3.4.1 NHS England's ambition is for 75% of people on GP Learning Disability Registers to have an Annual Health Check (AHC) by March 2021. This is being monitored through the Transforming Care Partnership at a national and regional level. The prioritisation of Health Checks for people with a learning disability was also one of the 7 key deliverables expected within the letter of the 9th November 2020, Supporting General Practice – Additional £150 million of funding from NHS England. To support achievement in Calderdale, SWYPFT have been funded to provide 1 Whole Time Equivalent Learning Disability Nurse to undertake health checks for people with a learning disability. They are working alongside General Practice to reach people who have not engaged in the past and also to standardise delivery.

3.4.2 This support will assist practices in reaching the target but will still require practices to carry out health checks. At 4th January 2021 Calderdale had achieved 25% of completed health checks, see Appendix C. Weekly monitoring at practice level is shared with all practices along with a weekly meeting with the SWYPFT team to share their position and agree any helpful messages. 2 GP practices have declined the additional funded support and have provided assurance that they will achieve the target at practice level.

4.0 Estates – Update

4.1 Since the last discussion on Estates in October 2020, 2 key pieces of work have been agreed and are being taken forward, these are as follows:

4.1.1 **NHSE Funding for producing a PCN Estate strategy** - Working with the regional Strategic Estates Adviser the CCG has secured funding from NHSE to procure professional services to develop and produce an Estates Strategy for the CCG and its PCNs. The expected output is a strategic document that will provide a good picture of the current estates landscape for Calderdale that includes Health and Social Care partners. This will enable the CCG to better support the planning of the Primary Care Network's estate requirements e.g. improving physical environments, allocation of funding and ensuring service provision aligns with estate needs etc.

This work is due to commence on the 11th of January 2021, further updates will be provided as the work progresses.

The Primary Care Data Gathering Programme is expected to deliver the following key outcomes:-

- A baseline of consistent data collected for every NHS reimbursed GP practice across England, with a nationally prescribed process to maintain it.
- Further enhancement of SHAPE (Strategic Health Asset Planning and Evaluation), this is a web enabled application which links national public health, primary care and demographic data with information on healthcare estates performance and facilities location, thereby maintaining it as the preferred strategic planning analytical platform for the NHS.
- Outputs from the data collection will be visually displayed on SHAPE to further support local strategy development, investment requests, and future emergency planning; this will be accessed by Sustainability and Transformation Partnerships (STPs) / Integrated Care Systems (ICSs) and Clinical Commissioning Groups (CCGs) (as primary care commissioners) and made available to Primary Care Networks (PCNs), and
- An assessment of the appropriateness of aligning the primary care data collection with the ERIC returns(Estates Return Information Collection) (mandatory for all NHS Trusts) to provide a full system overview

Community Health Partnerships (CHP) has been appointed to lead the programme across England on behalf of NHSE /me. There 4 waves in the programme and the West Yorkshire ICS is in wave 4 which commenced at the end of December 2020.

Members of the CCGs Primary Care Team will be the main link with CHP and will liaise with other colleagues as required. It is expected that by the end of March 2021:-

- All desktop work outside of GP engagement (including existing survey extraction) for all four waves to be completed.
- All information collated to date will be uploaded on SHAPE.
- SHAPE training to be conducted in February and April 2021, in line with finalisation of desktop work for each wave.
- Full delivery of the SHAPE Primary Care Atlas, including KPIs analysis tool and reporting functions, with in-house editing enabled for local systems.

4.1.2 A further more detailed paper on Primary Care Estates will be brought to the full Committee meeting in May 2021.

5.0 Recommendations

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

Appendix A - Flu Vaccination Programme 2020/21 - Calderdale CCG

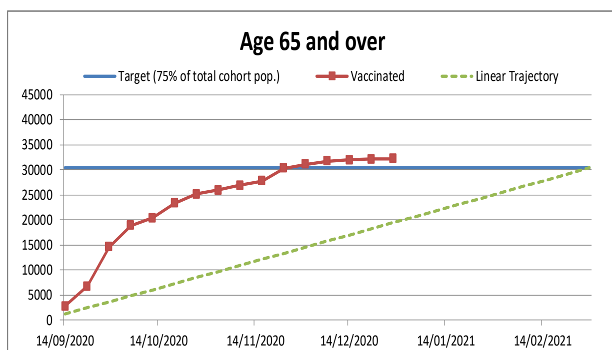
Appendix B - Calderdale PCN Additional Roles (summary)

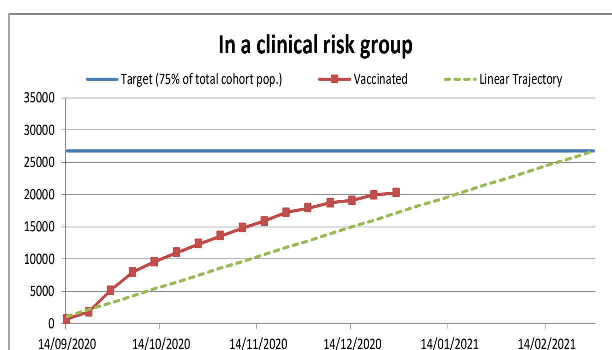
Appendix C - Leaning Disability Health Check Uptake 4th January 2021

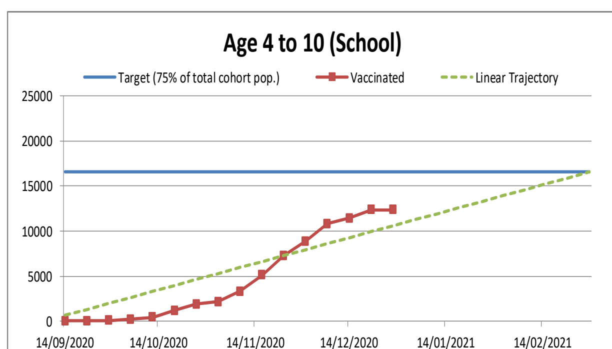
Flu Vaccination Programme 2020/21 - Calderdale CCG

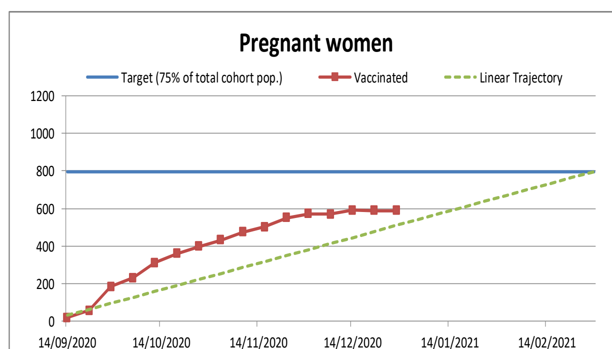
Cohort	Pop. Size of cohort	Vaccinated W/C 21.12.20	Invited W/C 21.12.20	Vaccinated W/C 28.12.20	Invited W/C 28.12.20	Total Invited	Total Vaccinated	%Achieved	Vaccination Target
In clinical at risk group	35710	19939	21197	20223	21755	21755	20223	56.6%	75%>
Age 2 to 3 years	5024	2572	2172	2607	2171	2171	2607	51.9%	75%>
Age 4 to 10 (School)	22027	12352	438	12364	438	438	12364	56.1%	75%>
Age 65 and over	40530	32176	24472	32267	24463	24463	32267	**79.6%**	**75%>**
Pregnant women	1061	589	597	588	580	580	588	55.4%	75%>
Learning disability	1439	827	-	833	-	-	833	57.9%	75%>

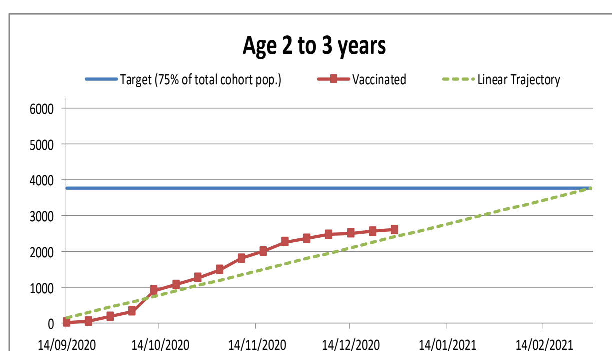
Cohort	Pop. Size of cohort	Vaccinated W/C 21.12.20	Invited W/C 21.12.20	Vaccinated W/C 28.12.20	Invited W/C 28.12.20	Total Invited	Total Vaccinated	%Achieved	Vaccination Target
All patients at risk - declined or contraindication this year	14047								tbc
Carer (These patients are already counted in the at risk age groups)	4639	3242	2397	3262	2403	2403	3262	**70.3%**	tbc
COVID shielding not at risk for flu	293	101	170	102	170	170	102	**34.8%**	tbc
Age 50 to 64 NOT at risk	29272	7378	14807	7957	14812	14812	7957	**27.2%**	tbc

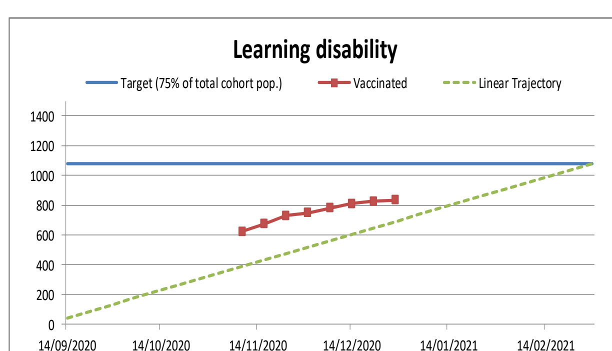












Appendix B

Calderdale PCN Additional Roles (summary)

Summary by Role	2021/22 Total WTE	2022/23 Total WTE	2023/24 Total WTE
Clinical pharmacist	12.52	15.27	16.27
Social prescribing link worker	10.79	11.79	14.74
Physiotherapist	10.5	10.5	14.5
Physician associate	2	2	4
Paramedic	9.5	10	12
Pharmacy technician	3	5	5
Occupational therapists	2	2	3
Dietitians	0	1	2
Chiropodist/podiatrists	0	0.5	1
Health and Wellbeing coach	1	4	7
Care co-ordinator	6	8	11
Mental Health Practitioner	5	9	13
Trainee Nursing Associate	0	0	0
Nursing Associate	0	0	0

Appendix C

Calderdale CCG GP Practices: Learning Disability Healthcheck Completion position as at 04.01.21						
Registered practice	**Registered practice ID**	**LD Register**	**LD Healthchecks Completed**	**% LD HC Completed**	**LD Healthcheck outstanding**	**% of Healthchecks outstanding**
Bankfield Surgery	B84016	102	16	16%	86	84%
Beechwood Medical Centre	B84613	103	18	17%	85	83%
Brig Royd Surgery	B84007	26	0	0%	26	100%
Calder Community Practice	Y02572	13	1	8%	12	92%
Caritas Group Practice	B84618	68	12	18%	56	82%
CHURCH LANE SURGERY	B84011	58	0	0%	58	100%
Keighley Road Surgery	B84010	83	16	19%	67	81%
King Cross Practice	B84021	51	5	10%	46	90%
Lister Lane Surgery	B84612	56	1	2%	55	98%
Longroyde Surgery	B84623	23	10	43%	13	57%
PLANE TREES GROUP PRACTICE	B84013	68	35	51%	33	49%
Rastrick Health Centre	B84014	29	13	45%	16	55%
Rosegarth Surgery	B84005	60	18	30%	42	70%
RYDINGS HALL SURGERY	B84003	58	4	7%	54	93%
Spring Hall Medical Centre	B84012	151	74	49%	77	51%
Stainland Road Medical Centre	B84009	58	23	40%	35	60%
Station Road Surgery	B84001	95	51	54%	44	46%
The Boulevard Medical Practice	B84019	87	0	0%	87	100%
The Northolme Practice	B84008	49	35	71%	14	29%
Todmorden Group Practice	B84006	96	34	35%	62	65%
Valley Medical Centre, Hebden Bridge	B84004	107	9	8%	98	92%
		1441	**375**	**25%**	**1066**	**75%**

Name of Meeting	Commissioning Primary Medical Services Committee	**Meeting Date**	21/01/2021
Title of Report	**Finance Report**	**Agenda Item No.**	7
Report Author	Lesley Stokey - Director of Finance	**Public / Private Item**	Public
GB / Clinical Lead	Neil Smurthwaite, Chief Operating Officer	**Responsible Officer**	Neil Smurthwaite, Chief Operating Officer

<table>
<tr><th colspan="9">Executive Summary</th></tr>
<tr><td>Please include a brief summary of the purpose of the report</td><td colspan="8">Key messages for the committee to note at Month 8 are:

▪ The Primary Medical Services delegated budget allocations of £32m and is forecasting to deliver a balanced position.
▪ The CCG has reserves available for investment.
▪ PCNs have developed workforce plans in relation to additional roles and is forecasting to spend £1.47m in 2020/21</td></tr>
<tr><td rowspan="2">Previous consideration</td><td colspan="2">Name of meeting</td><td colspan="3">N/A</td><td colspan="2">Meeting Date</td><td>N/A</td></tr>
<tr><td colspan="2">Name of meeting</td><td colspan="3">N/A</td><td colspan="2">Meeting Date</td><td>N/A</td></tr>
<tr><td>Recommendation (s)</td><td colspan="8">It is recommended that the Committee:

1. NOTES the 2020/21 financial position on Primary Medical Services delegated budgets.
2. NOTES the forecast additional PCN roles expenditure position
3. APPROVES setting up an additional virtual meeting in private with non-conflicted members to approve any discretionary investment proposals.</td></tr>
<tr><td>Decision</td><td>☒</td><td>Assurance</td><td>☒</td><td>Discussion</td><td>☐</td><td>Other</td><td colspan="2">Click here to enter text.</td></tr>
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<tr><th colspan="4">Implications</th></tr>
<tr><td colspan="2">Quality & Safety implications (including Equality & Diversity considerations e.g. EqIA)</td><td colspan="2">N/A</td></tr>
<tr><td colspan="2">Public / Patient / Other Engagement</td><td colspan="2">N/A</td></tr>
<tr><td colspan="2">Resources / Finance implications (including Staffing/Workforce considerations)</td><td colspan="2">N/A</td></tr>
<tr><td>Strategic Objectives (which of the CCG objectives does this relate to – delete as applicable)</td><td>▪ Improving value</td><td>Risk (include link to risks)</td><td>N/A</td></tr>
<tr><td>Legal / CCG Constitution Implications</td><td>N/A</td><td>Conflicts of Interest (include detail of any identified/potential conflicts)</td><td>N/A</td></tr>
</table>

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.

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

Financial guidance and allocations were 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.

The CCG has a reserves balance in 2020/21 in the main due to the end of an APMS contract at the end of 2019/20.

The PCN have developed workforce plans to spend a forecast £1.47m in 2020/21 on additional roles.

2.0 Financial Performance as at November 2020

High Level Forecast position M1-M12	Delegated Primary £'000
Initial Allocation - Covid Regime	-31,526
Latest Forecast for M12	32,032
Net overspend	506
Covid costs to date M1-M12	0
Other pressures (forecast M1-M12)	506
Total variance	506
Allocation adjustment M8	-507
Net position	-1
Expected further allocations:-	
- Retrospective Hosptal Discharge Programme	
- Primary Care Aditional Roles	
Net adjusted forecast	**-1**

For the year the CCG has a notified confirmed allocation of £31,526k for delegated primary medical services. In addition the CCG received additional retrospective allocations of £507k. The CCG is forecasting to spend £32,032k which is a breakeven position against the allocations received.

Calderdale CCG Delegated Primary Medical Services Summary at 30th November 2020

PRIMARY CARE SERVICES:	Annual	In month			Year To Date (£)			Forecast M08	
Name	Budget	Budget	Actual	Variance	Budget	Actual	Variance	Outturn	Variance
	£000	£000	£000	£000	£000	£000	£000	£000	£000
GMS	18,372	1,531	1,576	45	12,248	12,205	(43)	18,337	(36)
PMS	1,667	139	140	1	1,112	1,131	20	1,677	10
APMS	762	63	63	(0)	508	508	0	762	0
QOF	2,714	226	226	(0)	1,810	1,810	(0)	2,714	(0)
Enhanced Services	314	26	16	(11)	209	199	(11)	295	(19)
Premises - Reimbursed Costs	3,202	267	289	22	2,135	2,154	19	3,240	38
Premises - Other	262	22	24	3	175	177	3	262	1
Prof Fees Prescribing & Dispensing	82	7	93	86	55	142	87	141	59
Collaborative Payments	0	0	0	0	0	0	0	0	0
Other GP Services (inc. PCO)	163	14	177	163	108	276	168	327	164
Other Non GP Services	759	63	(17)	(80)	506	506	0	759	0
Pensions	0	0	0	0	0	0	0	0	0
PCN	2,093	174	330	156	1,395	1,567	172	2,601	508
Reserves (91811030)	1,484	233	139	(93)	1,098	563	(535)	159	(1,324)
Reserves - Contingency (91811060)	159	13	0	(13)	106	0	(106)	758	599
Total Primary Care Medical	**32,033**	**2,778**	**3,056**	**278**	**21,464**	**21,239**	**(225)**	**32,032**	**(1)**

The more detailed analysis of the forecast in the table above shows a breakdown of the expenditure by category.
In previous months budgets had been set based on 2019/20 outturn as per NHS England guidance under the temporary finance regime. However the CCG has now been able to realign budgets in line with the 2020/21 financial plan and also for any know subsequent changes.

The most significant variances are as follows:

- Other GP Services - is showing an overspend due to increase in maternity, adoption and sick leave
- PCN is showing an overspend due to the additional roles forecast expenditure being in excess of baseline budget. The CCG will be able to reclaim additional allocation for the PCN additional roles.
- Reserves have been released to fund overspends on other budget lines however there is a net reserves balance available for investment.

3.0 Additional Roles Update

As part of the GP Forward View, funding has been made available to PCNs to expand workforce capacity including investment in new roles such as physician associates.
The expected level of funding available in 2020/21 is £1.6m rising to £5.3m in 2023/24, a summary is shown below:

Calderdale CCG PCN Additional Roles	2020/21 Budget	2021/22 Budget	2022/23 Budget	2023/24 Budget
Calder & Ryburn	298,864	524,415	721,949	992,593
Central Halifax	378,845	664,758	915,156	1,258,228
Lower Valley	318,128	558,218	768,486	1,056,574
North Halifax	334,034	586,128	806,908	1,109,401
Upper Calder Valley	270,343	474,370	653,054	897,870
Total	1,600,214	2,807,890	3,865,553	5,314,666

The latest forecast across the five Calderdale PCNs is to spend £1.47m of the maximum possible £1.6m available for reimbursement. The table below shows the forecast by workforce role for the 2020/21. Plans for 2021/22 have been developed to build on the existing workforce profile in 2020/21 and to include new paramedic and mental health practitioner roles.

	2020/21 Forecast	
Summary by Role 2020/21	**Total**	
	WTE	**£**
Clinical pharmacist	12.52	£520,574
Social prescribing link worker	10.79	£330,232
Physiotherapist	9.40	£437,473
Physician associate	2.00	£26,862
Pharmacy technician	3.00	£36,750
Occupational therapists	1.60	£25,967
Dieticians	0.00	£0
Chiropadist/podiatrists	0.00	£0
Health and Wellbeing coach	1.00	£8,847
Care co-ordinator	6.00	£86,776
Trainee Nursing Associate	0.00	£0
Nursing Associate	0.00	£0
Total	**46.31**	**£1,473,482**
Budget		**£1,600,214**
Variance		**-£126,732**

4.0 New Investments 2020/21

In October the Committee approved that the part year reserves balance of £710k be released for investment to improve capacity and to respond to winter related pressures. In order to facilitate timely decision making it was agreed that investment proposals could be signed off by virtual meetings of non-conflicted members and that the outcome be reported at the next formal committee meeting.

As full year allocations have been received we now have increasing certainty around our reserves position. The summary below shows that we have a potential total reserves investment fund available of £1.4m, against which £0.7m has been approved by Committee to spend.

Reserves summary	£'000
Reserves	1,484
Contingency	159
less other budget variances	(216)
Net reserves	1,427
Investment reserve approved October	-710
Additional investment reserve	717

This leaves a forecast balance of £0.7m available to make additional investments. It is again recommended that in order to facilitate timely decision making regarding investments to support additional covid and winter pressures, that a virtual committee meeting of non-conflicted members be held and the outcome reported at the next formal committee meeting.

5.0 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.

6.0 Recommendations

It is recommended that the Committee:

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

NHS
Calderdale
Clinical Commissioning Group

Name of Meeting	Commissioning Primary Medical Services Committee	Meeting Date	13/01/2021
Title of Report	**Annual Review of the Committee Terms of Reference**	Agenda Item No.	9
Report Author	Andrew O'Connor, Senior Corporate Governance Officer	Public / Private Item	Public
GB / Clinical Lead	John Mallalieu Committee Chair	Responsible Officer	Debbie Robinson (Head of Primary Care Quality and Improvement)

Executive Summary	
Please include a brief summary of the purpose of the report	The Commissioning Primary Medical Services Committee (CPMSC) is asked to undertake it annual review of its Terms of Reference. In advance of this, several changes have been agreed with the Chair and Lead Officer which are proposed for consideration and agreement. The main changes relate to: 1. Changes to the membership of the committee, including required attendees, and the committee's quoracy arrangements. These amendments respond to recent changes to the CCG's organisational leadership and structure. 2. The establishment of Urgent Decision Making powers for the committee. Other more minor changes are also proposed as detailed in the report. All proposed changes are reflected as tracked changes in the draft Terms of reference provided at Appendix 1 to this paper.

Previous consideration	Name of meeting		Meeting Date	
	Name of meeting		Meeting Date	

Recommendation (s)	
	It is recommended that the CPMSC: 1) **REVIEWS** the terms of reference as amended and subject to any further amendment **RECOMMEND** them to the Governing Body for approval. 2) **PROPOSE** the revised membership of the committee to the Remuneration and Nomination Committee.

Decision	☒	Assurance	☐	Discussion	☒	Other	Click here to enter text.

Implications			
Quality & Safety implications		Not applicable	
Public / Patient / Other Engagement		Not applicable	
Resources / Finance implications		Not applicable	
Strategic Objectives	▪ Improving governance	**Risk**	None
Legal / CCG Constitutional Implications	None	**Conflicts of Interest**	No conflicts of interest have been identified. Any conflicts will be managed in line with the CCG's Management of Conflicts of Interest Policy.

1. Introduction

1.1 The Commissioning Primary Medical Services Committee (CPMSC) is asked to undertake its annual review of its Terms of Reference to ensure it remains fit for purpose.

1.2 In advance of the Committee's review, several changes have been agreed with the Chair and Lead Officer which are proposed for consideration and agreement. These changes are set our and explained in the body of the report and captured as tracked changes in the draft Terms of Reference provided at Appendix 1 to this paper.

2. Proposed Changes

2.1 Committee Membership and Quoracy

2.1.1 Due to recent changes in the organisational structure following the appointment of the new Accountable Officer, which is a shared post with Calderdale Metropolitan District Council, changes are required to both the membership and quoracy arrangements within the Committee Terms of Reference.

2.1.2 The Committee's **current** membership and quoracy arrangements are set out in the table below.

<table>
<tr><th>Current Committee Membership</th><th>Current Quoracy</th></tr>
<tr><td>Lay Member (Finance and Performance) (Chair)</td><td rowspan="6">Meetings shall be considered quorate when the following are present:
• A Lay Member
• Either the Chief Finance Officer or the Chief Officer
• Either the Secondary Care Specialist or the Registered Nurse</td></tr>
<tr><td>Lay Member (Public Patient Involvement) (Deputy Chair)</td></tr>
<tr><td>Chief Officer</td></tr>
<tr><td>Chief Finance Officer/Deputy Chief Officer</td></tr>
<tr><td>The Secondary Care Specialist or
the Registered Nurse</td></tr>
<tr><td>Two GP Members of the Governing Body</td></tr>
<tr><td colspan="2">Required attendees
▪ A representative of Calderdale Health and Wellbeing Board as nominated by that organisation
▪ A representative of Healthwatch as nominated by that organisation
▪ Representative of NHS England
▪ Head of Primary Care Quality and Improvement
▪ Head of Contracting and Procurement
▪ Head of Finance
▪ Chief Quality & Nursing Officer
▪ Administrative support</td></tr>
</table>

2.1.3 Given that the Accountable Officer is a shared post it is not recommended that the Accountable Officer role is included as a member of the Committee.

2.1.4 There is no requirement for the Accountable Officer to be a member of the Committee. There is a requirement of the Committee to be constituted with a Lay Member and Executive majority and for the Chair and Vice Chair to be Lay Members. This would continue to be the case under these changes.

2.1.5 The **proposed** membership of CPMSC is as follows:

<table>
<tr><th>Proposed Committee Membership</th><th>Current Quoracy</th></tr>
<tr><td>Lay Member (Finance and Performance) (Chair)</td><td rowspan="6">Meetings shall be considered quorate when the following are present:
• A Lay Member
• Chief Operating Officer or Director of Finance
• Either the Secondary Care Specialist or the Registered Nurse</td></tr>
<tr><td>Lay Member (Public Patient Involvement) (Deputy Chair)</td></tr>
<tr><td>Chief Operating Officer</td></tr>
<tr><td>Director of Finance</td></tr>
<tr><td>The Secondary Care Specialist or
the Registered Nurse</td></tr>
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▪ A representative of Calderdale Health and Wellbeing Board as nominated by that organisation
▪ A representative of Healthwatch as nominated by that organisation
▪ Representative of NHS England
▪ Head of Primary Care Quality and Improvement
▪ Head of Contracting and Procurement
▪ ~~Head of Finance~~
▪ Chief Quality & Nursing Officer
▪ Administrative support</td></tr>
</table>

2.2 Urgent Decision Making

2.2.1 During the response to Covid 19 the Committee agreed urgent decision arrangements in recognition that there would be decisions required during the period that were of such urgency that they could not wait until the next meeting of the Committee and which could not wait for a further meeting to be organised.

2.2.2 In such circumstances, the Committee agreed that the decision making authority delegated to the Committee may be exercised by the Committee Chair **OR** Deputy Chair **AND** the Chief Operating Officer **OR** Director Finance having had prior consultation with the CCG Clinical Lead for Primary Care and/or a Calderdale Local Medical Committee representative. Moreover, that any decision made would be notified to the committee within 24 hours and reported to the next committee meeting in public.

2.2.3 In order to ensure that, should such exceptional circumstances arise again in the future, whether in the context of a pandemic or other form of crisis or emergency, the Committee has the appropriate Governance in arrangements in place that will allow it to discharge its duties as demanded by the circumstances at hand, it is proposed that the following paragraph is inserted at 4.7. The paragraph continues to reflect the urgent decision-making arrangements as previously agreed by the Committee for the period of the Covid 19 response.

PROPOSED

4.7 Urgent Decision Making

From time to time, exceptional circumstances may arise, such as in the context of emergency or crisis, which require urgent decisions to be made by the Committee that cannot wait until the next scheduled committee meeting or for a further meeting to be arranged and justify the use of emergency powers.

In such cases, the decision making authority delegated to the committee may be exercised by:

- the Committee Chair **OR** Deputy Chair
  and
- the Chief Operating Officer **OR** Director Finance

Prior to making the decision, the above will have consulted with the CCG Clinical Lead for Primary Care and/or a Calderdale Local Medical Committee representative.

2.3 Further Changes

The below table sets out in summary further changes of lesser materiality that are proposed.

Location	Change	Rationale
Throughout	“Vice Chair” replaced by Deputy Chair”.	To align with the Terms of Reference of other committees
4.9 – Admin Support (Para 1)	Admin support to the Committee now provided by the Governance Team.	To reflect organisational changes
4.9 – Admin Support (bullet 3)	Minutes to be circulated electronically to members of committee and attendees for approval within 21 days of the meeting.	To reflect current practice, specifying the deadline. Will enable minutes to flow through to the next meetings of the Governing Body for its information.
4.9 – Admin Support (bullet 4)	Admin support to submit approved minutes to Governing Body.	To reflect current practice.
4.9 – Admin Support (bullet 10)	Remove requirement to provide NHSE with executive summary following meeting.	To reflect agreement with NHSE that executive summary is not required due to having representation at Committee meetings and receiving final minutes.
6.3 Reporting	Remove requirement to provide NHSE with executive summary.	To reflect agreement with NHSE that executive summary is not required due to having representation at Committee meetings and receiving final minutes.
6.4 Reporting	When presenting minutes to Governing Body, Chair to report	To reflect current practice and capture expectation in Terms of

	on any key committee decision or issues.	Reference

3. Recommendations

3.1 It is recommended that the Committee:

1) **REVIEWS** the terms of reference as amended and subject to any further amendment **RECOMMEND** them to the Governing Body.

2) **PROPOSE** the revised membership of the committee to the Remuneration and Nomination Committee.

4. Appendices

Appendix 1: CPMSC Terms of Reference V 6.1

NHS
Calderdale
Clinical Commissioning Group

Commissioning Primary Medical Services Committee

Terms of Reference

Version:	~~**6.0**~~ **6.1 FINAL DRAFT**
Approved by:	Governing Body
Date Approved:	~~22.10.20~~ TBC
Responsible Senior Officer:	Chief Operating Officer
Review date:	April ~~2022~~ 2023 or earlier if required by organisational, statutory or regulatory change.

Contents

1. Constitution and Purpose

2. Authority

3. Membership

4. Arrangements for the conduct of business

5. Duties/responsibilities of the Committee

6. Reporting arrangements

7. Conduct of the Committee

NHS Calderdale Clinical Commissioning Group

Commissioning Primary Medical Services Committee

1.0 Constitution and Purpose

1.1 In accordance with its statutory powers under section 13Z of the National Health Service Act 2006 (as amended), NHS England has delegated the exercise of the functions specified in Schedule 2 to these Terms of Reference to NHS Calderdale CCG.

1.2 The Commissioning Primary Medical Services Committee ("Committee") is established in accordance with Schedule 1A of the "NHS Act" and with NHS Calderdale Clinical Commissioning Group's (CCG) Constitution, Standing Orders and Scheme of Reservation and Delegation.

1.3 The Governing Body has determined that the CPMS Committee will function as a corporate decision-making body for the management of the delegated functions and the exercise of the delegated powers.

Statutory Framework

1.4 NHS England has delegated to the CCG authority to exercise the primary care commissioning functions set out in Schedule 2 in accordance with section 13Z of the NHS Act.

1.5 Arrangements made under section 13Z may be on such terms and conditions (including terms as to payment) as may be agreed between NHS England and the CCG.

1.6 Arrangements made under section 13Z do not affect the liability of NHS England for the exercise of any of its functions. However, the CCG acknowledges that in exercising its functions (including those delegated to it), it must comply with the statutory duties set out in Chapter A2 of the NHS Act and including:

a) Management of conflicts of interest (section 14O);

b) Duty to promote the NHS Constitution (section 14P);

c) Duty to exercise its functions effectively, efficiently and economically (section 14Q);

d) Duty as to improvement in quality of services (section 14R);

e) Duty in relation to quality of primary medical services (section 14S);

f) Duties as to reducing inequalities (section 14T);

g) Duty to promote the involvement of each patient (section 14U);

h) Duty as to patient choice (section 14V);

i) Duty as to promoting integration (section 14Z1);

j) Public involvement and consultation (section 14Z2).

1.7 The CCG will also need to specifically, in respect of the delegated functions from NHS England, exercise those set out below:

a) Duty to have regard to impact on services in certain areas (section 13O);
b) Duty as respects variation in provision of health services (section 13P).

1.8 The Committee will be subject to any directions made by NHS England or by the Secretary of State.

2.0 Authority

2.1 The Committee has been established in accordance with the above statutory provisions and under delegated authority from the Governing Body to enable the members to make collective decisions on the review, planning and procurement of primary medical care services in Calderdale, under delegated authority from NHS England.

2.2 The Primary Medical Care Commissioning Committee has authority from the Governing Body to make decisions within the bounds of its remit. Specifically:

a) Financial Plans in respect of primary medical services
b) Procurement of primary medical services
c) Practice payments and reimbursement
d) Investment in practice development
e) Contractual compliance and sanctions

2.3 The decisions of the Committee shall be binding on NHS England and NHS Calderdale CCG.

2.4 The Commissioning Primary Medical Services Committee is authorised by the Governing Body to investigate any activity within its terms of reference. It is authorised to seek any information it requires within its remit, from any employee of Calderdale CCG or member of the Governing Body and they are directed to co-operate with any reasonable request made by the Committee.

2.5 The Committee is authorised to delegate tasks to such individuals, sub-groups, working groups or individual members as are necessary to fulfil its responsibilities within its terms of reference. The committee may not delegate executive powers delegated to it within these terms of reference (unless expressly authorised by the Governing Body) and remains accountable for the work of any such group.

2.6 In order to ensure that any conflicts of interest are appropriately managed within CPMSC sub-groups, the minutes of those meetings will be submitted to the committee detailing any conflicts and how they have been managed.

2.7 The Committee is authorised by the Governing Body to commission reports or surveys it deems necessary to help fulfil its obligations. In doing so, the committee must operate within the requirements of the CCG's Standing Financial Instructions and Standing Orders.

2.8 In exceptional cases, the Committee is authorised to obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary. In doing so the committee must follow any procedures put in place by the Governing Body for obtaining legal or professional advice. The Governing Body is to be informed of any issues relating to such action.

2.9 Any such arrangements shall reflect appropriate arrangements for the management of conflicts of interest.

3.0 Membership

3.1 The Committee shall be established as a committee of the Governing Body and consist of:

Members

- Lay Member to the Governing Body (Chair of the Committee)
- Lay Member (Patient and Public Involvement) (~~Vice~~ Deputy Chair of the Committee)
- ~~Chief Officer~~ Chief Operating Officer
- ~~Chief Finance Officer/Deputy Chief Officer~~ Director of Finance
- The Secondary Care Specialist or the Registered Nurse
- Two GP Members of the Governing Body

Attendees

- A representative of Calderdale Health and Wellbeing Board as nominated by that organisation
- A representative of Healthwatch as nominated by that organisation
- Representative of NHS England
- Head of Primary Care Quality and Improvement
- Head of Contracting and Procurement
- ~~Head of Finance~~
- Chief Quality & Nursing Officer
- Administrative support

3.2 Other officers may be invited to attend any or part of any meeting as and when appropriate.

4.0 Arrangements for the Conduct of Business

4.1 Meetings of the Committee shall:

a) Be held in public, subject to the application of 23(b);

b) the Committee may resolve to exclude the public from a meeting that is open to the public (whether during the whole or part of the proceedings) whenever publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution and arising from the nature of that business or of the proceedings or for any other reason permitted by the Public Bodies (Admission to Meetings) Act 1960 as amended or succeeded from time to time.

4.2 **Chairing the Committee**

The Chair of the Committee shall always be a lay member of the committee. In the event of the chair of the Committee being unable to attend for all or part of the meeting, the ~~Vice~~ DeputyChair will chair the meeting/that part of the meeting.

4.3 The V~~ice~~ Deputy Chair of the Committee shall always be a lay member of the Committee.

4.4 **Quoracy**

4.4.1 Meetings shall be considered quorate when the following are present:

- A Lay Member
- ~~Either the Chief Finance Officer or the Chief Officer~~
- Either the Chief Operating Officer or the Director of Finance
- Either the Secondary Care Specialist or the Registered Nurse

4.4.2 Members of the committee may participate in meetings by telephone or by the use of video conferencing facilities where they are available and with prior approval by the Chair of the meeting or if the Chair of the meeting is not present, by the ~~Vice~~ Deputy Chair of the meeting. Participation in a meeting by any of these means shall be deemed to constitute presence in person at the meeting.

4.5 **Voting**

Should a vote need to be taken, only the members of the committee shall be allowed to vote. In the event of a tied vote, the Chair shall have a second and casting vote.

4.6 **Frequency of meetings**

4.6.1 The Committee shall meet as business dictates and at least once per year.

4.6.2 When the Chair of the Committee deems it necessary in light of the urgent circumstances to call a meeting at short notice, the notice period shall be such as s/he shall specify.

4.7 Urgent Decision Making

From time to time, exceptional circumstances may arise, such as in the context of emergency or crisis, which require urgent decisions to be made by the Committee that cannot wait until the next scheduled committee meeting or for a further meeting to be arranged and justify the use of emergency powers.

In such cases, the decision making authority delegated to the committee may be exercised by:

- the Committee Chair **OR** Deputy Chair
  and
- the Chief Operating Officer **OR** Director Finance

Prior to making the decision, the above will have consulted with the CCG Clinical Lead for Primary Care and/or a Calderdale Local Medical Committee representative.

Any decision made will be notified to the Committee within 24 hours and reported to the next Committee meeting in public.

~~4.7~~4.8 **Declarations of interest**

4.8~~7~~.1 Members of the Committee shall abide by the requirements of the CCG's Constitution, Standing Orders, Standing Financial Instructions and Management of Conflicts of Interest Policy.

4.8~~7~~.2 Any conflicts of interest (real or potential) shall be managed in line with the CCG's Policy and Statutory Guidance on the Management of Conflicts of Interest.

4.8~~7~~.3 All declarations of interest will be minuted and recorded in line with the CCG's policy on the Management of Conflicts of Interest

4.~~7~~.4 The interests of all the members of the committee including those required attendees shall be recorded on the CCG's register(s) of interests and publicised on the CCG's website.

~~4.8~~4.9 **Administrative Support**

Administrative support for the Commissioning Primary Medical Services Committee will be provided by a member of the ~~Primary Care Quality and Improvement~~ GovernanceTeam.

- Agreement of the agenda with the Chair and Head of Primary Care Quality and Improvement
- Circulation of agendas and supporting papers to Committee members at least ten calendar days prior to the meeting.

- Drafting of minutes for approval by the Chair within seven working days of the meeting and circulation to members of the committee and attendees for approval electronically within 21 working days of the meeting.
- Submission of the approved minutes to the Governing Body for information.
- Keeping an accurate record of attendance
- Keeping an accurate record of the management of conflicts of interest
- Matters arising and issues to be carried forward
- Maintain an on-going list of actions, specifying members responsible, due dates and keeping track of these actions
- Maintaining the annual work-plan for the Committee
- ~~Following each meeting, forward an executive summary report to the, NHS England and NHS Improvement – (NE and Yorkshire) together with the minutes of the meeting once approved and the minutes of any sub-groups to which responsibilities are delegated under paragraph 6.4 below.~~
- Following each committee meeting or meetings of any sub-groups to which responsibilities are delegated under paragraph 2.5, forward the approved minutes to NHS England and NHS Improvement – (NE and Yorkshire).

5.0 Duties/responsibilities of the Committee

5.1 The Committee has been established in accordance with the above statutory provisions to enable the members to make collective decisions on the review, planning and procurement of primary medical care services in Calderdale, under delegated authority from NHS England.

5.2 In performing its role the Committee will exercise its management of the functions in accordance with the agreement entered into between NHS England and NHS Calderdale CCG, which will sit alongside the delegation and terms of reference.

5.3 The functions of the Committee are undertaken in the context of a desire to promote increased co-commissioning to increase quality, efficiency, productivity and value for money and to remove administrative barriers.

5.4 The role of the Committee shall be to carry out the functions relating to the commissioning of primary medical services under section 83 of the NHS Act.

5.5 This includes the following:

- GMS, PMS and APMS contracts (including the design of PMS and APMS contracts, monitoring of contracts, taking contractual action such as issuing breach/remedial notices, and removing a contract);

- Newly designed enhanced services ("Local Enhanced Services" and "Directed Enhanced Services");

- Design of local incentive schemes as an alternative to the Quality Outcomes Framework (QOF);

- Decision making on whether to establish new GP practices in an area;

- Approving practice mergers; and

- Making decisions on 'discretionary' payment (e.g., returner/retainer schemes).

5.6 The CCG will also carry out the following activities:

a) Plan, including needs assessment, primary medical care services in Calderdale;

b) Undertake reviews of primary medical care services in Calderdale;

c) Co-ordinate a common approach to the commissioning of primary care services generally;

d) Have oversight and review the financial plans for primary medical care services in Calderdale;

e) Taking procurement decisions in respect of primary medical services. These shall be in line with statutory requirements and guidance, the CCG's Constitution and Standing Orders and the Delegation Agreement between NHS England and the CCG.

5.7 The Committee has the authority to approve policies in respect of all areas of its responsibilities.

5.8 **Governing Body Assurance Framework and Risk Management**

5.8.1 The Committee shall oversee the continued development of the Governing Body Assurance Framework in respect of the principal risks relating to those functions, responsibilities and powers delegated to the CPMS Committee.

5.8.2 The CPMS Committee has responsibility for operational risks relating to those functions, responsibilities and powers delegated to the CPMS Committee. The Committee shall:

- Review and monitor the corporate risk register in respect of the risks identified above, requesting action by accountable individuals to manage risks, as required.

- Recommend to the Governing Body, the content of the corporate risk register which relates to those risks that fall within the responsibility of the CPMSC, and are rated at 15 or above, as a true reflection of the current risk position.

- Provide the Audit Committee with assurance that risks associated with Commissioning Primary Medical Services Committee are being managed in line with the Integrated Risk Management Framework.

6.0 Reporting

6.1 The Committee shall receive the minutes of any sub group or working group established under paragraph 2.5.

6.2 The Governing Body shall receive the minutes of the Committee's formal meetings.

6.3 ~~Following each meeting, the Committee shall produce an executive summary report which will be submitted to the NHS England and NHS Improvement – (NE and Yorkshire), together with its minutes once approved. The summary report and minutes will be for information. These will be submitted together with the minutes of any sub-groups to which responsibilities are delegated under paragraph 2.5.~~

Following each committee meeting or meetings of any sub-groups to which responsibilities are delegated under paragraph 2.5, forward the approved minutes to NHS England and NHS Improvement – (NE and Yorkshire for its information).

6.4 Following each meeting, the Chair of the Committee shall draw to the attention of the Governing Body alongside the minutes any key decisions or issues.

7.0 Conduct of the Committee

7.1 All members shall have due regard to and operate within the Constitution of the CCG, standing orders, standing financial instructions and other financial procedures.

7.2 Members of the committee shall abide by the 'Principles of Public Life' (The Nolan Principles) and the NHS Code of Conduct.

7.3 Members of the Committee have a collective responsibility for the operation of the Committee. They will participate in discussion, review evidence and provide objective expert input to the best of their knowledge and ability, and endeavour to reach a collective view.

7.4 The committee shall agree an Annual Work Plan with the Governing Body and in line with the Governing Body's Assurance Framework.

7.5 The Committee shall undertake an annual self-assessment of its own performance against the annual plan, membership and terms of reference. This self-assessment shall form the basis of the annual report from the Commissioning Primary Services Committee to the Audit Committee

7.6 The review of the terms of reference should also take account of any Directions issued by the Department of Health or NHS England and any revised model terms of reference issued by NHS England.

7.7 Any resulting changes to the terms of reference shall be submitted for approval by the Governing Body.

ENDS ~~22.10.202~~0

Change History

Comment [D1]: leave until all changes are agreed with the chair prior to going to committee

V. no.	Changes applied	By	Date	Circulation
0.1	Amendment of NHS England model terms of reference to apply to Calderdale CCG	Corporate and Governance Manager	20.01.15	Chief Officer, Chair of Audit Committee, Chair, Chief Finance Officer Head of Primary Care Quality NHSE
0.2	Proposed amendment to add NHS England to 'in attendance' to allow NHSE to attend if necessary to 'advise on any technical matters'. To clarity para 8.3 '..after each meeting'.	Alison Knowles, NHSE	21.01.15	Chief Officer, Head of Primary Care Quality.
0.2	No additional changes		29.01.15	Lay Advisor
0.3	Proposed amendments, Lay Advisor to the Governing Body	Incorporated for review	04.02.15	Governing Body and SMT
1.0	**FINAL**	Governing Body	05.02.15	Governing Body, NHS England, website
1.1	Proposed amendments	John Mallalieu	25.03.16	
1.2	Proposed amendments	Judith Salter	12.04.16	
1.3	Proposed amendments	Judith Salter/John Mallalieu	13.0416	CPMS Committee (21st April 2016)
2.0	**FINAL**	Governing Body	09.06.16	Governing Body, website
2.1	Proposed amendment – to amend deadline for sending papers out, incorporate authority to approve policies, update responsibilities to incorporate GBAF and risk register, update requirements regarding sub-groups in line with the revised statutory guidance on management of conflicts of interest.	Judith Salter	20.01.17	CPMSC Committee
2.2	**Amend** 4.8 to read 10 'calendar days' **Remove** 6.3 – requirement to produce an 'executive summary' as the committee is meeting sufficiently regularly to have timely minutes.	CPMSC	02.2.2017	Submitted to Governing Body 6 April 2017

3.0	**FINAL**	Governing Body	06.04.17	Governing Body, website
3.1	Submitted to the CPMSC (development) for review	JS	01.02.18	CPMSC
3.2	Additional amendments from CPMSC and Audit Yorkshire	JS	07.03.18	CPMSC
4.0	**FINAL**	Governing Body	12.04.17	Governing Body, website
4.1	Proposed amendment following CPMSC review on 24.01.19	CPMSC	11.04.19	Submitted to Governing Body
5.0	**FINAL**	**Governing Body**	**11.04.19**	**Website**
5.1	**Reviewed and amended**	**CMPSC**	**13.02.20**	Submitted to Governing Body
6.0	**FINAL**	**Governing Body**	**22.10.20**	Submitted to NHSE Website

NHS
Calderdale
Clinical Commissioning Group

Name of Meeting	Commissioning Primary Medical Services Committee (CPMSC)	Meeting Date	15/10/2021
Title of Report	**Risk Register Position Statement Risk Cycle 4 2020-21 (9-25 November 2020) for CPMS**	Agenda Item No.	10
Report Author	Rob Gibson, Corporate Systems Manager	Public / Private Item	Public
GB / Clinical Lead	Dr Steven Cleasby, CCG Chair	Responsible Officer	Neil Smurthwaite, Chief Operating Officer

Executive Summary							
Please include a brief summary of the purpose of the report	The CCG Risk Register currently contains a total of 37 risks. There are 2 risks marked for closure this risk cycle meaning that 35 risks are open. 6 of total CCG risks (16%) fall for consideration by the Commissioning Primary Medical Services Committee. Of these one is marked for closure meaning there are 5 open risks at the end of risk cycle 4. Among the 6 CPMS risks: • 3 open risks scoring 12 • 1 risk decreasing • 1 risk marked for closure						
Previous consideration	**Name of meeting**	SMT			**Meeting Date**	02/12/20	
	Name of meeting				**Meeting Date**		
Recommendation (s)	It is recommended that the Committee: 1. Reviews the CPMS Risk Register and the management of CPMS risks. Approves the CPMS Risk Register for reporting to Governing Body, subject to any amendments requested.						
Decision	☒	**Assurance**	☒	**Discussion**	☐	**Other**	Click here to enter text.

Implications						
Quality & Safety implications	There are no quality & safety implications.					
Engagement & Equality implications (including whether an equality impact assessment has been completed)	No engagement has been undertaken.					
Resources / Finance implications (including Staffing/Workforce considerations)	There are no resources / finance implications.					
Has a Data Protection Impact Assessment (DPIA) been completed? (Please select)	**Yes**		**No**		**N/A**	x
Strategic Objectives (which of the CCG objectives does this relate to?	Improving value	**Risk** (include risk number and a brief description of the risk)	Risk is managed in line with the CCG's Integrated Risk Management Framework. Risks are			

			captured on the Corporate Risk Register or the Governing Body's Assurance Framework (GBAF) as appropriate.
Legal / CCG Constitutional Implications	There are no legal / CCG Constitutional implications	**Conflicts of Interest** (include detail of any identified/potential conflicts)	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 4 of 2020-21 the CCG Risk Register had a total of 37 risks. There were 6 CPMS risks, of which 5 are open:

2.3 Open risks scoring:

Risk ID	Risk summary	Risk score	Risk movement
1631	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	Static for 1 risk cycle
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	Static for 1 risk cycle
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 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	12	Static for 1 risk cycle
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	8	Decreasing from 12 to 8 *(Reduced the risk slightly as a consequence of the potential flexibility on the use of funding)*

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 2 risk cycles

2.4 There was 1 risk closed during risk cycle 3:

Risk ID	Risk summary	Risk score	Reason for closure
1560	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.	4	Reached tolerance

3. Recommendations

It is recommended that the CPMS Committee:

- **CONFIRMS** that it is **ASSURED** that the Risk Register represents a fair reflection of the risks relating to the commissioning of primary medical services for risk cycle 4 2020-21.

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 28 January 2021.

5. Appendices

- CPMS risk register showing all risks during risk cycle 4 2020-21

All CPMS risks for risk cycle 4 2020-2021

Risk ID	Date Created	Risk Type	Risk Category	Risk Rating	Risk Score	Target Risk Rating	Target Score	Senior Manager	Principal Risk	Key Controls	Key Control Gaps	Assurance Controls	Positive Assurance	Assurance Gaps	Risk Status
1631	21/08/2020	Commissioning Primary Medical Services Committee	CPMS - F&P	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 Scope the potential for a contract extension with the existing provider	Contract meeting with existing provider.	none identified	Appears to be no ability to influence NHSE to make the postion known	Static - 1 Archive(s)
1630	21/08/2020	Commissioning Primary Medical Services Committee	F&P - Performance	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 20 novThis has been published and Calderdale pharmacies offering flu vaccination shared with practices	20 nov The Calderdale flu group is meeting regularly since July to monitor flu campaign progress and issues The flu uptake by cohort is monitored on a biweekly basis and this is received at SMT	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 20 nov Calderdale ccg making good progress toward achieving 75% ambition for over 65s and expect to achieve this. Delivery progress by PCN and CCG is shared regularlrly with the practices since november	Details of the NHSE extended vaccination programme to wider cohorts from November are as yet unknown limiting meaningful planning by providers. 20 nov details released today around extended cohort, for further discussion at next flu meetings both CCG and ICS	Static - 1 Archive(s)
1629	20/08/2020	Commissioning Primary Medical Services Committee	CPMS - Q	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 Awaiting details of a PCN support offer from NECS	Static - 1 Archive(s)
1628	20/08/2020	Commissioning Primary Medical Services Committee	CPMS - F&P	8	(I4xL2)	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) Some flexibility in utilisation of funding available to support the Covid Vaccination programme.	Further clarity required in to the level of flexibility that can be applied locally.	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 Submission to NHSE	Further detailed submissions for each PCN plan awaited to increase CCG assurance that forecasted spend will become actual	Decreasing
1434	25/11/2019	Commissioning Primary Medical Services Committee	CPMS - Q	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 4. 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 - 2 Archive(s)
1560	22/05/2020	Commissioning Primary Medical Services Committee	CPMS - F&P	4	(I4xL1)	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	Closed - Reached tolerance

Risks Report Summary

CCG: NHS Calderdale CCG

Archive Deadline: 18/12/2020

New Risks: 5

Total Risks: 37

Old Risks: 32

Marked for Closure: 2

CPMSC WORK PLAN 2020-21								
	Lead	**Purpose**	**Frequency**	**April**	**July**	**Oct**	**Jan**	**Mar**
Contracting								
Contracting Report	MP	For assurance	Quarterly	C	√	√	√	
Ongoing management and performance of GMS, PMS and APMS contracts								
CPMSC Extended Access extension	MP	For decision	As required				√	
Finance								
Finance Report	NS	For assurance	Quarterly	C	√	√	√	
Draft Finance Plan	LS	For assurance	As required		√			
Request to pause discretionary spend /investments	LS	For decision	As required		√			
PMS Premium Investment Plan 2020/21	DR	For decision	As required			√		
Request to set up additional virtual meeting in private with non-conflicted members to approve any discretionary investment proposals	LS	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	Quarterly	C	√	√	√	
PCN Development/Maturity Matrix Action Plan/timeline	DR	For assurance						
Risk Management								
CPMS Risk Review	RG	For decision	Quarterly	C	√	√	√	√
GBAF Review	RG	For decision	Bi-annually					
Annual Risk Report	RG	For decision	Annually (date tbc)					
Policies & Procedures								
Review Policy for discretionary financial assistance as a result of a list dispersal **(September 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	tbc					
Approval of Branch Surgery for Bankfield Surgery	DR	For Decision	As required		√			
Establish a time limited Estates Sub Group	DR	For decision	As required		√			
Estates Sub Group - Approval of Gold Rules	DR	For decision	As required			√		
Contract Variations								
Spring Hall Group Practice - Application for novation of GMS contract	MP	For decision		√				
Primary Care Covid-19 Response and Re-set – Variation Application Hebden Bridge Group Practice – Extension Request to Existing Arrangement	EB	For decision					√	
Primary Care Covid-19 Response and Re-set – Variation Application Spring Hall Group Practice – Extension Request to Existing Arrangement	EB	For decision					√	
Conduct of Committee & Development								
Review work plan	DR	For assurance	Quarterly	C	√	√	√	√
Agree CPMSC Draft Annual Report to include a review of terms of reference and output from self-assessment	DR/JM	For assurance	Annually					√
Review of terms of reference and output from self-assessment	DR/JM	For assurance	Annually				√	
Internal Audit Report	DR	For assurance	As required					√

	Lead	Purpose	Frequency	April	July	Oct	Jan	Mar
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 assurance	tbc					
Movement of future meeting dates	JM/DR	For decision	As required		√			

C= cancelled

Additional Meetings / Rapid Decision Making Panel:

21/04/2020 - single item Spring Hall Group Practice - Application for novation of GMS contract (electronically)

17/09/20 - Primary Care Covid-19 Response and Re-set – Variation Application Hebden Bridge Group Practice

08/10/20 - Primary Care Covid-19 Response and Re- set – Variation Application Spring Hall Group Practice

08/10/20 - Primary Care Covid-19 Response and Re-set – Variation Application Hebden Bridge Group Practice – **Further Information**

26/11/20 - Winter Schemes 2020/21 - proposal of three additional winter schemes for investment, non-recurrently, from the primary medical services delegated budget;

1. Additional Capacity for the Acute Visiting Service
2. Calderdale CCG COVID Clinical Assessment Centre (CCAC)
3. In-Hours Streaming in A&E

09/12/20 - Support for Primary Care in the second wave of the COVID-19 Pandemic (electronically)

NHS
Calderdale
Clinical Commissioning Group

Name of Meeting	Commissioning Primary Medical Services Committee	Meeting Date	21/01/2021
Title of Report	**Primary Care Covid-19 Response and Re-set – Variation Application Hebden Bridge Group Practice – Extension Request to Existing Arrangement**	Agenda Item No.	11
Report Author	Emma Bownas Senior Primary Care Quality and Improvement Manager	Public / Private Item	Public
Clinical Lead	Dr Majid Azeb - Primary Care Clinical Lead	Responsible Officer	Debbie Robinson – Head of Primary Care

Executive Summary	
Please include a brief summary of the purpose of the report	This paper contains a request received by Hebden Bridge Group Practice to extend the agreement to suspend face to face appointments at Luddendenfoot Branch Surgery. The Committee is requested to consider the application and provide the practice with their decision. An Urgent Decision Making Panel approved the application to suspend face to face appointments at Luddendenfoot Branch Surgery on the 8th October 2020 until the 4th January 2021. The conditions of the approval were that the practice considered how they could safely offer some form of face to face service provision at the Luddendenfoot Surgery throughout the week, if the current COVID-19 environmental situation remained. They acknowledged this maybe a reduced offer from the pre-covid opening hours but the panel expressed a desire for some form of face to face provision to be offered from January 4th 2020. If following consideration the practice considered there was no opportunity to safely offer any level of face to face service within the COVID-19 guidance then a further application was requested to be submitted by the 17th December 2020. The outcome of the Decision Making Panel will be communicated to Hebden Bridge Group Practice and a note of the decision will be recorded at the next Commissioning Primary Care Services Committee. The report contains the request for an application detailing the reasons for an extension to the current arrangement.

Previous consideration	Name of meeting	Urgent Decision Making Panel	Meeting Date	08/10/2020
	Name of meeting		Meeting Date	Click here to enter a date.

Recommendation (s)	It is recommended that the Committee: Approves the three month extension to the original application from Hebden Bridge Practice to suspend face to face appointments at Luddendenfoot Branch Surgery in line with their application and due to the physical limitations of the building to deliver safe services to patients in line with COVID-19 security guidelines.

Decision	☒	Assurance	☐	Discussion	☐	Other	Click here to enter text.

Implications							
Quality & Safety implications		Rapid Impact Assessment was completed for the first application and has been reviewed as still current					
Engagement & Equality implications (including whether an equality impact assessment has been completed)		Communications to patients have been considered however change is being requested on the grounds of safety.					
Resources / Finance implications (including Staffing/Workforce considerations)		No financial or resources impact identified for the CCG					
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?	None Identified	**Risk** (include risk number and a brief description of the risk)		None Identified			
Legal / CCG Constitutional Implications	None Identified	**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. Introduction

1.1 This paper contains a request received on 11th December 2020 by Hebden Bridge Group Practice to extend the current agreement to suspend face to face appointments at Luddendenfoot Branch Surgery

2. Detail

2.1 A Commissioning Primary Medical Services Committee Urgent Decision Making Panel approved the application to suspend face to face appointments at Luddendenfoot Branch Surgery on the 6th October 2020 until the 4th January 2021 following receipt of a written application that included a floor plan, environmental risk assessment in line with COVID-19 Security Guidelines and an Equality and Quality Impact Assessment.

2.2 The conditions of the approval were that Hebden Bridge Group Practice considered how they could safely offer some form of face to face service provision at the Luddendenfoot Surgery throughout the week, if the current COVID-19 environmental situation remained. It was acknowledged this maybe a reduced offer from the pre-covid opening hours but the panel expressed a desire for some form of face to face provision to be offered from January 4th 2020.

2.3 If, following consideration, Hebden Bridge Group Practice considered there was no opportunity to safely offer any level of face to face service within the COVID-19 guidance then a further application was requested to be submitted by the 17th December 2020. A further application was received by the CCG on the 11th December 2020 and there has been a delay in the administrative process at the CCG. The practice has been informed and an extension provided to the current arrangements until 1st February 2021 to allow for the application to be considered.

2.4 The Practice has submitted an extension request which is as follows:

"The Practice has reviewed its position regarding the provision of face to face appointments on the Luddendenfoot site and believes that the circumstances described in the submissions accepted by the panel during their assessment are still pertinent and that the risks to our patients, staff and others remain.

We have further reviewed the physical constraints that the building presents to us including the possibility of any changes to the building. We have done this in the light of the unchanged situation regarding the pandemic, the ongoing need to ensure social distancing and the safety of both our patients, our staff, the dispensing pharmacy's clients and their staff. Our first duty is to ensure the safety of patients and staff and in order to maintain service delivery and ensure reliance in the staff team it is considered that opening this building up for face to face appointments would increase the risk of all who are using the building. Hebden Bridge Group Practice has had a low level of positive cases identified within the staff team and believe this is in part due to the way in which the working environment and working practices have been established in line with COVID security.

We have considered the services that we are able to offer to all our registered patients and separately, any of our patients who would ordinarily use the Luddendenfoot clinic. This is in the context of delivering Covid Vaccinations at pace as part of the Upper Calder Valley response and ensuring other routine services are delivered such as the learning disability health checks, including for those living in care homes.

We have received no complaints from our patients at the lack of a face to face service at Luddendenfoot.

We have concluded after all this consideration that there remains no safe way to open the surgery at Luddendenfoot.

Therefore we apply for a further 3 month extension in the hope that by then, with the advent of the vaccination programme, that we will be able to safely reopen the services.

We can confirm that as soon as the guidance changes around covid security we will look to re-open the site for face to face appointments as we recognise that the Luddendenfoot Branch Surgery provides services to the more deprived communities in our practice area."

2.5 The request for extension has been shared with the Calderdale LMC and CCG Primary Care Clinical Lead who are supportive of the application

2.6 For context the application, environmental risk assessment, floor plan and rapid impact assessment are included in appendix A

3. Next Steps

3.1 Once the outcome of the panel decision is known this will be reported to Hebden Bridge Group Practice and the decision recorded through the next meeting of the CPMSC.

4. Implications

4.1 Quality & Safety Implications

These have been considered and are described in the completed Rapid Impact Assessment.

5. Recommendations

It is recommended that the Committee

Approves the three month extension to the original application from Hebden Bridge Practice to suspend face to face appointments at Luddendenfoot Branch Surgery in line with their application and due to the physical limitations of the building to deliver safe services to patients in line with COVID-19 security guidelines.

6. Appendices

a) Original Application
b) Further Supporting Information
c) Rapid Impact Assessment
d) Environmental Risk Assessment
e) Floor Plan

Appendix A: Original Application

Primary Care COVID-19 Response
Emergency CPMSC Decision Making Template

1. Name of Practice and B-Code:	**Hebden Bridge Group Practice B84004**
2. Name and position of person completing form:	**Tony Martin Practice Business Manager**
3. Contact name at Practice/contact email address/phone number:	**Tony Martin, Practice Business Manager tony.martin4@nhs.net 0142 841204**
4a. Name of PCN and Clinical Director of PCN: **4b. Does the Clinical Director from the PCN support the request?**	**Upper Calder Valley PCN Dr Nigel Taylor** **Yes**
5. Date form completed:	**02/09/2020**
6. Brief description of request that is being made by the practice:	**We are currently not using the Luddendenfoot site, although the building is open as the pharmacy operates from there.** **The building is very small with one GP and one nurse consulting room. All services that are usually offered there are offered at our other two sites and available to the same patients. There is no reduction in service.** **Following completion of an environmental risk assessment on the building, it would be difficult to ensure the safety of patients and staff and comply with COVID-19 safety guidance and protocols**
7. Date and time, changes are proposed to be implemented by the practice: (or add date and note if this is retrospective):	**Review in three months or sooner if the guidance changes**
8. Brief description of scenario prompting request:	***The need to assure CCG of our commitment to returning to "normal service" as described in Standard Operating Procedure from NHSE and the letter which required contract holders to resume face to face appointments at all premises*** ***i Standard operating procedure for General Practice in the context of Coronavirus (COVID-19)*** ***ii Update to GP Contracts – 9th July 2020***

9. Brief description of what the practice needs a decision on from the CCG. e.g. temporary closure or relocation, cessation of specific service (this does not include closure for deep cleaning):	**That we continue to provide face to face services usually delivered from that site from our other two sites**
10. Is the practice asking for a:	☐ **Partial closure of services** ☐ **Full closure of services** ☐ **Cessation of services** ☐ **Relocation of services** ☐ **Co-location of services** X **Other , please specify below:** **That we continue to provide face to face services usually delivered from that site from our other two sites until it's safe to do otherwise**
11. How long is the practice anticipating the change of service delivery to be place in for, is it hours, days, weeks, etc. What is the anticipated date of reinstatement?	**Review in three months or sooner if the guidance changes**
12. Which practice premises or sites does this request effect: **What is the distance between branch and main site?**	☐ **Main practice site** X **Branch site (please name)** ☐ **Main practice and branch site** **Luddendenfoot Surgery, Kershaw Estate** **2.2 miles**
13. Has the practice completed and attached a Risk Assessment (attach a copy with this completed Primary Care Emergency Decision Making Template if possible)	**Risk assessed at the time of initial lockdown. Created red site and latterly green site with PCN partners**
14. As part of the risk assessment process what areas has the practice highlighted as key risks and what mitigations has the practice noted that will be put in place in relation to these risk areas noted? If Branch closure, consider arrangements to collect mail, prescriptions and buildings insurance.	**Mail is already delivered to main site. Anything left by patients is transported to main site each day.** **Daily van run for samples in the rare case there are any on site** **Prescription requests taken via telephone and online** **Building still open as used by pharmacy**

15. What impact will this request have on practice staff / wider system staff? E.g. If a practice site is closed what is the impact of the closure on staffing, co-located services e.g. pharmacy? How will admin and clinical staff be redeployed	**None.** **Re opening at this time would put staff and patients at risk**
16a. Has the practice explored sharing resources (for example workforce) with neighbouring practices or within the PCN? **16b. If yes response to 16a, have any contracting, subcontracting / mutual aid agreements been put in place with neighbouring practices or within the PCN?**	X **Yes** ☐ **No** **If the response is yes, please provide any further details given including name of practice**: **We have a well established arrangement with our PCN partner Practices. This request has no bearing on that** X **Yes** ☐ **No** **Please provide any further details:** Until this week all red patients were seen at Todmorden Group Practice and clinical capacity shared. From yesterday due to TGP capacity issues based on their clinicians risk assesements all red patients are seen at VMC by HBGP clinicians. Visiting is shared
17. Does the practice require mutual aid from the wider system or CCG?	☐ **Yes** X **No** **If the response is yes, specifically what is needed, please provide below any further details given.**
18. What will the impact be for patients? **Prompt questions?** **18a.What are the practices plans to communicate the proposed changes to service delivery to patients and wider partners, including updates on the situation? (consider websites, prescriptions, text messages, notices)** **18b. If future appointments have already been booked for patients how these appointments will be**	**None. There is no disruption in service** **This was done in March at the time of the change in response to lockdown** **n/a**

managed?	
18c. Will the decision to close/interrupt services impact on patients' ability to access GP services? For example will they need to access services further away, or be provided by someone else?	**This has been in place since March. There's no disruption in service. Where a face to face appointment is deemed necessary after triage, patients attend either of our two main sites. To date there has not been a single complaint about this.**
18d. How will clinical information about your patients be shared to ensure that vulnerable patients' health needs continue to be met?	**Our clinical system (SystmOne) is in place on all three sites. This request has no impact on this.**
18e. How does the practice intend to make sure their vulnerable* patients get the right level of service and understand what's happening? (*Vulnerable – older, disabled, non/limited-English speaking, those with communication needs)	**We have been communicating with individual vulnerable patients re this during telephone consultations and triage since March**

Appendix B: Further Supporting Information

08.10.2020

Commissioning Primary Services Committee Panel

Further information- Luddendenfoot Surgery

All of our patients are registered with the Practice rather than a specific site. Prior to Covid-19 patients could choose to be seen at any of our three sites and to see any clinician.
Again, prior to Covid-19 we offered a single GP session from the Luddendenfoot site each Monday, Tuesday, Thursday and Friday morning.
Since Covid-19 and in accordance with NHSE guidelines, all patients have an initial consultation with a GP or Advanced Nurse Practitioner via telephone, video or EConsult.
If following that consultation the clinician believes that the patient should be seen face to face for clinical reasons, an appointment is offered at our Grange Dene or Valley Medical Centre sites.
In our role as a member Practice of the Upper Calder Valley Primary Care Network we engage with the Acute Visiting Service. In addition, we have a GP allocated to home visits each day.
Where the patient is unable to travel to those sites, they will be visited at home.
The Luddendenfoot site is a small single storey building which is shared with a Community Pharmacy.
The pharmacy opens from 8am through to 5.30pm daily.
The pharmacy is independent of the Practice and also operates as a shop.
There is a single common shared entrance directly into the waiting room which is approximately 3m x 4m. Please see attached floor plan- the area outlined in black is the waiting room.
The pharmacy state that they have a daily patient and customer footfall of between 70 – 85 people into that waiting area and that there are occasions when there is more than one person in the waiting room at any one time.
In addition, they have up to six staff behind the counter. The staff wear PPE as the pharmacy states "we cannot guarantee the minimum distancing required".
I understand that patients and customers are asked to enter to the left of the room and exit in an anticlockwise direction observing social distancing to a minimum of 1m if wearing a mask and 2m if not.
Following NHSE guidance at the start of the pandemic and with completion of an environmental risk assessment on the building, the Practice suspended face to face contact with patients on this site as we could not otherwise guarantee the safety of patients and staff in accordance with COVID-19 guidelines.
We took account of the continued operation of the pharmacy. Many patients during the pandemic are self managing with the support of community pharmacies such as this. It is an essential service that cannot be provided any other way.
We also took account of the single shared entrance, the small waiting area where 2m social distancing is impossible and the continuous and unpredictable footfall of pharmacy customers.
Most importantly, the decision to temporarily stop face to face appointments on this site has resulted in no reduction in service.
We assure patients when a clinical decision is made that they need to be seen in person, where they are unable to travel to our other sites they will be visited at home.
Since we temporarily stopped face to face appointments on this site, we have had no complaints from patients or their representatives regarding this at all.
In fact, at our recent "flu vaccination day" many patients complimented us on the efforts we have made to ensure that they are still able to access good healthcare in a safe manner during such unprecedented times.
The recent letter from Calderdale Local Medical Committee underlines the dilemma Practices are faced with in their desire to deliver services according to contract and the need to put the safety of staff and patients first.
The letter reminds us that throughout the pandemic NHSE encouraged Practices to operate a triage model where no face to face consultations took place without a preliminary remote consultation. This

position was confirmed in the “Phase 3 Recovery” letter, also adding that face to face consultations should take place when appropriate.
The Practice can assure the panel that we have always and continue to abide by this guidance and that this applies to all of our patients.
However, the Practice is unable to control access to the building by the 70- 85 people per day which use the pharmacy, through a single shared entrance into a waiting room where social distancing is almost impossible.

Appendix C: Rapid Impact Assessment Tool

Rapid Service Change Impact Assessment Tool

This tool has been developed in response to the COVID-19 Pandemic and the need for the NHS to respond by rapidly changing commissioning and delivery of services. Please complete all sections. Instructions are in ***italics.*** Email for all correspondence: calccg.QIAQualityTeam@nhs.net

A. Rapid Service Change Details	
1. Description of change	Hebden Bridge Group Practice are requesting that its Luddendenfoot site remains closed, with the exception of the Pharmacy. The rationale is: • The building is very small with one GP and one nurse consulting room. And it would not be possible to safely deliver patient services there. • All services that are usually offered there are offered at the other two sites and available to the same patients. • There is no reduction in service. • The change has been successfully implemented since March 2020. Patients requiring face to face appointments will need to travel to Valley Medical Centre (Hebden Bridge) or Grange Dean Medical Centre (Mythomroyd), which are 3.9 miles and 2.5 miles away respectively. The practice has reduced the need for face to face appointments by using telephone triage and online consultations. Patients have been informed of the closure via the practice website and the practice have been communicating with individual vulnerable patients re this during telephone consultations and triage since March. All telephone calls are routed to the main sites and paper script requests will be collected on a daily basis from the branch.
2. Type of change	~~Stop /~~ Partial stop ~~/ Start new / Adjust existing~~
3. CCGs	Calderdale
4. Form completed by	Clare Wyke, Quality Improvement Lead, CCG Emma Bownas, Primary Care, CCG Sarah Mackenzie-Cooper, Equality and Diversity Manager, CCG Clare Robinson, Head of Safeguarding, CCG
5. Form agreed to be decision ready on	*11/09/2020*
6. Proposed review date	3 months or before if National Guidance changes
B. Impact Assessment	
1. How does this	**Safety**

project/decision impact on Quality ie. Safety, Effectiveness and Experience?	**B1a:** Consolidation of staff onto main sites will enable safe delivery of face-to-face appointments for those patients that meet the criteria. **Experience** **B1b:** Minimising face-to-face appointments (by introducing telephone triage and online consultations) might cause anxiety for some patients, especially if the clinician considers their need can be met remotely. **B1c:** Patients will need to travel further for face-to-face appointments. This will impact those people who do not have access to a car, especially those with mobility difficulties. **B1d:** Paper script requests for medication will be collected on a daily basis from the branch and sent via Electronic Prescribing Service to pharmacy of patient choice. **B1e:** Communities may perceive that the continued closure of the site is indicative of longer term plans to close the site more permanently.
2. How does this project/decision ensure that protected or vulnerable groups are able to access services and understand any changes? *(see notes in Section E4)*	**B2a** – Patients who need face to face appointments will need to travel further than their usual branch, this will be additionally difficult for disabled, older people and carers of both adults and children. Utilising public transport will add a financial and risk burden. One bus route includes a 15 minute walk. Not everyone has access to private transport and lockdown measures are being updated locally. **B2b** – The continued closure of the branch may cause anxiety for people living locally who may assume it is closed permanently. **B2c –** The digitally excluded may struggle with accessing virtual consultations, because of financial, technical or trust issues. **B2d** – Some patient groups are less comfortable/confident engaging with clinicians virtually and may avoid the GP or feel they are getting less of a service. This is likely to affect older and disabled patients.
3. How does this project/decision impact on the duty to safeguard children, young people and adults at risk (including Human Rights eg. restrictions of liberty)?	**B3a** Practice Staff moving to two sites still required to fulfil safeguarding responsibilities and know who their practice safeguarding lead is, to be able to seek advice. **B3b** There is a risk that the GP 0-19 Practitioner (Health Visitor) links meeting may be reduced, but important Safeguarding children information should still be shared by other means eg virtual processes.

	B3c Practice Safeguarding policies and staff training should be in place as required by commissioners and regulators and aligned with local approaches for both practices so should be no impact.
4. Are there any other impacts to consider? Eg. Workforce, organisational or system wide	**Workforce** **B4a:** Staff have been re-located for 3 months to a different site from their regular place of work. The extension of this change might negatively impact in terms of morale, travel and team cohesion.
C. Risks and Mitigations	
1. What actions can be taken to reduce any negative impacts? (If none please state so)	**B1a:** no mitigation required as positive impact. **B1b:** Patients have been advised of the changes to service via their preferred communication mechanism ie. post, telephone, text etc. Requests for face-to-face appointments will be assessed on a case-by-case basis so that the clinical needs of the patients are met in an appropriate way. **B1c:** Wherever possible patients will be offered alternatives from walking to the practice such as telephone/online/video consultations. **B1d:** no mitigation required as positive impact **B1e:** Clear communications are required via the practice website with information about when this will be reviewed, and explanation as to the reasons for the closure. The CCG are supporting practices with communications across Calderdale. **B2a** – Travel arrangements could be supported by the practice or where necessary home visits arranged. Triage conversations should include reassurance about the access to virtual appointments and active listening where patients feel they need to be seen. **B2b** – As B1e above ensure communications is accessible and reaches the target audience – consider other ways to reach out (local paper) for groups less likely to access website. **B2c & d –** Support patients to access virtual consultations through confidence building, technical support and triage conversations checking access and comfort. Where necessary arrange face to face appointments based on broader need rather than clinical. **B3a: B3a:** Each Practice have their own Safeguarding Lead and the CCG team are aware of these so no mitigation should be needed. Practices can also contact the CCG safeguarding team for advice and support and can access the CCG Intranet site which contains safeguarding files with critical safeguarding information – no other

	mitigation required **B3b –** Each Practice has a named 0-19 Practitioner (HV) who links with GP Safeguarding lead so key information to safeguard children can continue to be shared. Regular contact between Designated nurse CCG and Head of Safeguarding Locala is in place to monitor. **B3c** – no mitigation required **B4a:** Practice staff have been consulted and are supportive of the changes. Furthermore staff contracts stipulate the expectation to work across the 3 practices.
2. How could the impacts and/or mitigating actions be monitored?	The Primary Care Team will continue to monitor delivery of the mitigations via the CPMSC Ops Group on a monthly basis and will escalate any issues raised accordingly.
3. Are there any communications or engagement considerations or requirements?	The CCG Communications Team are working with Practices across Calderdale to support consistent messaging regarding changes to Primary Care delivery. The Practice will also be required to ensure that messages on their own website are clear.
D. Decision/Accountable Persons	
1. Agreement to proceed?	Yes / No *Delete as appropriate and add detail or rationale*
2. Any further actions required?	*Eg. risk to be added to COVID-19 Programme Risk Register*
3. Names and roles of accountable decision makers	CPMSC Rapid Decision Making Panel
4. Date of decision	
E. For Quality Team use only	
1. Reference	COVID19/RIA/45
2. Hyperlink	
3. Notes (Review date)	
4. Equality considerations	In order to answer B2 the groups that need consideration are; Protected characteristics; age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex, sexual orientation (Use the hyperlinks for further information) Other groups would include, but not be limited to, people who are; carers, homeless, living in poverty, asylum seekers/refugees, in stigmatised occupations (e.g. sex workers), use substances, geographically isolated (e.g. rural) and surviving abuse

Appendix D: Environmental Risk Assessment- Luddendenfoot Surgery

	Environment	Risks	Actions to mitigate	By when	By whom
Reduce face to face patient contact to contain COVID19 while delivering clinical services to registered population	**Small building, one GP and one nurse clinical room, waiting room, store rooms. Independent pharmacy on site with four staff** **One shared entrance, shared waiting room approx. 3m x 3m, narrow corridor approx. 1m x 12m to fire exit** **Patient traffic to pharmacy**	**Risk of transmission Covid19 to patients and staff.** **Indoors** **Patients cannot social distance 2m**	**Stop face to face appointments on site. Eliminate Practice traffic** **Creation of Red site for PCN at TGP** **Telephone / video / online consultations** **Face to face appointments at GD / VMC following triage and using PPE** **Electronic prescribing in place. Paper scripts and hand delivered post transported to GD daily** **Mail redirected to VMC** **All samples to GD / VMC** **Home visits as normal following telephone assessment and using PPE**	**March 2020 Reviewed as guidance changes**	**TM / Partners**

Appendix E: Luddendenfoot Floor Plan

Approximate Direction North

01100	NIA	30.43 m²
01110	NIA	28.39 m²
NHSPS Vacant	NIA	8.29 m²
NHSPS Shared Area	NIA	45.34 m²
NHSPS Common Parts	GIA	29.98 m²

00/001 Waiting Room
00/002 Reception
00/003 Consulting Room
00/004 Examination Room
00/005 Office
00/006
00/007
00/008 Corridor
00/009
00/010
00/011
00/012
00/013 Chemist
00/014 Treatment Room
00/015 Consulting Room
00/016

1 .5 0 1 2 3 4 5 10
metres

Ground Floor*
GEA 162.74 m²
GIA 149.15 m²
NIA 137.21 m²
*Whole floor areas, not the sum of parts listed above

CAD EXERCISE ONLY

This drawing has been made compliant by Gleeds using drawings supplied by NHS Property Services.

Gleeds accept no responsibility for floor plan inaccuracies. This floor plan has not been verified by on-site measurements.

KERSHAW DRIVE
Luddenden Dene C of E (VC) Junior Infant & Nursery School
Luddenden Dene Nursery School and Youth Centre
El Sub Sta
TCB
Clinic
DAISY HILL CLOSE

Location Plan

Scale 1:2500

Building Outline

Care should be taken when drawings are printed to avoid image distortion. This plan has been compiled from client supplied drawings.

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Notes:

Date	Comments	Rev.

NHS Property Services

Site Address

Luddendenfoot Clinic
Kershaw Drive
Halifax
HX2 6PB

Site	Orig.	Role	Level	Type	Rev.
LFHC01B01	GL	CAD	GF	FP	R03

Floor/Level	GROUND FLOOR
Scale	1:100 @ A3
Date	SEP 2016

NHS Calderdale Clinical Commissioning Group

Name of Meeting	Commissioning Primary Medical Services Committee	Meeting Date	21/01/2021
Title of Report	**Primary Care Covid-19 Response and Re-set – Variation Application Spring Hall Group Practice – Extension Request to Existing Arrangement**	Agenda Item No.	13
Report Author	Emma Bownas Senior Primary Care Quality and Improvement Manager	Public / Private Item	Public
GB / Clinical Lead	Neil Smurthwaite Chief Operating Officer	Responsible Officer	Debbie Robinson – Head of Primary Care)

Executive Summary							
Please include a brief summary of the purpose of the report	This paper contains an application for an extension to the agreement to suspend face to face appointments at Spring Hall Group Practices Branch surgery in Boots Halifax. The Committee is requested to consider the application in view of the decision to use the Boots site for delivery of COVID-19 Vaccinations. An Urgent Decision Making Panel approved the application to suspend face to face appointments at Boots Branch Surgery on the 30th September 2020 until the 4th January 2021. This was approved on the basis that Spring Hall Group Practice had been approached by Boots, the landlord, to request that the branch surgery did not open to face to face appointments due to the potential risk of transmission with increase in footfall at the store and the reduced ability to make the environment COVID secure. The application was approved until the 4th January 2021 where it was expected that the practice would re-open to provide a face to face service from this branch site. Recently an application was received by the CCG from Boots Uk Ltd to provide the fixed Covid vaccination site for Calderdale. This required utilising the Spring Hall Group Practice Branch Surgery. The CCG considered the application and sought a view from Spring Hall Group Practice who agreed to allow their site to be used by Boots UK Ltd to provide Covid vaccinations. In view of the need for Calderdale to have a fixed Covid vaccination site and the benefit to the population on delivering the Covid vaccinations the committee are recommended to approve the request.						
Previous consideration	Name of meeting		Meeting Date				
	Name of meeting		Meeting Date	Click here to enter a date.			
Recommendation (s)	It is recommended that the Committee Approve the request for Spring Hall Group Practice to continue to suspend face to face appointments for a further three month period up to March 31st 2021						
Decision	☒	Assurance	☐	Discussion	☐	Other	Click here to enter text.

<table>
<tr><th colspan="8">Implications</th></tr>
<tr><td colspan="2">Quality & Safety implications</td><td colspan="6">Rapid Impact Assessment was completed for the first application and has been reviewed as still current</td></tr>
<tr><td colspan="2">Engagement & Equality implications
(including whether an equality impact assessment has been completed)</td><td colspan="6">Communications to patients have been considered however change is being requested on the grounds of safety.</td></tr>
<tr><td colspan="2">Resources / Finance implications (including Staffing/Workforce considerations)</td><td colspan="6">No financial or resources impact identified for the CCG</td></tr>
<tr><td colspan="2">Has a Data Protection Impact Assessment (DPIA) been completed? (Please select)</td><td>Yes</td><td></td><td>No</td><td></td><td>N/A</td><td>x</td></tr>
<tr><td>Strategic Objectives
(which of the CCG objectives does this relate to?</td><td>None Identified</td><td colspan="3">Risk (include risk number and a brief description of the risk)</td><td colspan="3">None Identified</td></tr>
<tr><td>Legal / CCG Constitutional Implications</td><td>None Identified</td><td colspan="3">Conflicts of Interest
(include detail of any identified/potential conflicts)</td><td colspan="3">Any conflicts of interest will be managed in line with the CCG's policy for managing Conflicts of Interest.</td></tr>
</table>

1. Introduction

1.1 This paper contains a request to extend the current agreement to suspend face to face appointments at Boots Branch Surgery.

2. Detail

2.1 An Urgent Decision Making Panel approved the application to suspend face to face appointments at Spring Hall Group Practices Branch surgery in Boots Halifax on the 30th September 2020 until the 4th January 2021. This was approved as Spring Hall Group Practice had been approached by Boots UK Ltd, the landlord, to request that the branch surgery did not open to face to face appointments due to the potential risk of transmission with increase in footfall at the store and the reduced ability to make the environment COVID secure.

2.2 The decision documents included a Rapid Impact Assessment alongside a written application. Supporting information was received to provide the Urgent Decision Making Panel with further assurance as detailed:

- there is an agreed communications plan in place, including an update on the website
- explaining alternative places to go;
- an increase in home visits if required to cover the population;
- written evidence from Boots not to use their site;
- written confirmation that this site would not attract rent if the building was not being used for a branch surgery.

2.3 The condition of approval was that the Boots Site commenced face to face appointments from 4th January 2021.

2.4 Recently, an application was received by the CCG from Boots UK Ltd to provide the fixed Covid vaccination site for Calderdale. This required utilising the Spring Hall Group Practice Branch Surgery. The CCG considered the application and sought a view from Spring Hall Group Practice who agreed to allow their site to be used by Boots to provide Covid vaccinations. Notification from NHSE that Boots UK Ltd had been accepted as a fixed site for Calderdale was received and therefore it is not possible for Spring Hall Group Practice to provide face to face services from that site at the current time.

2.5 During the suspension of face to face services there have been no complaints received in relation to the Boots site. The surgery has three other sites at Spring Hall Lane, Queens Road and Southowram that are providing face to face services and have sufficient access to home visiting capacity as required.

2.6 For context the original application and Rapid Impact Assessment has been included within the papers.

3. Next Steps

3.1 Once the outcome of the panel decision is known this will be communicated to Spring Hall Group Practice.

4. Implications

4.1 Quality & Safety Implications

4.1.1 These have been considered and are described in the completed Rapid Impact Assessment.

5. Recommendations

It is recommended that Committee

Approves a 3 month extension (to 31st March 2021) to the original application from Spring Hall Group Practice to allow for the delivery of a fixed Covid Vaccination Site at Boots Pharmacy. This site will be utilised to deliver vaccines and it is recommended that this is a priority need to benefit the people of Calderdale.

6. Appendices

a) Original Application
b) Rapid Impact Assessment

Appendix A: Original Application

APPENDIX A

Primary Care COVID-19 Response

Emergency CPMSC Decision Making Template

1. Name of Practice and B-Code:	Spring Hall Group Practice B84012
2. Name and position of person completing form:	Liz Coulson Practice Manager
3. Contact name at Practice/contact email address/phone number:	Liz Coulson Liz.coulson@nhs.net 01422 386394
4a. Name of PCN and Clinical Director of PCN: 4b. Does the Clinical Director from the PCN support the request?	Central PCN Dr Nadeem Akhtar Yes
5. Date form completed:	23/9/2020
6. Brief description of request that is being made by the practice:	The request is for our branch site at Boots Halifax to remain unavailable for the public to enter.
7. Date and time, changes are proposed to be implemented by the practice: (or add date and note if this is retrospective):	Commenced at the beginning of COVID pandemic lock down.
8. Brief description of scenario prompting request:	The Boots branch is situated at the back of the Boots store which means that anyone attending the site has to walk through the entire length of the store. Which means that potentially ill patients will be working through The site has an open waiting area with reception desk with no protective screens or barriers. There are 2 treatment rooms leading off the waiting area. It is not possible for a one way system to be imposed or adequate social distancing measures to be implemented. The rooms used do not have any outside ventilation as they are housed within the building without access to outside walls All our other sites are within 2 miles of the Boots branch and have patient access available.

9. Brief description of what the practice needs a decision on from the CCG. e.g. temporary closure or relocation, cessation of specific service (this does not include closure for deep cleaning):	**We require a decision from the CCG that the branch site in Boots can remain unavailable to the public for face to face encounters.**
10. Is the practice asking for a:	**☐ Partial closure of services** **☐ Full closure of services** **☐ Cessation of services** **☐ Relocation of services** **☐ Co-location of services** **X Other , please specify below:** **The request is to keep the Boots site closed to the public**
11. How long is the practice anticipating the change of service delivery to be place in for, is it hours, days, weeks, etc. What is the anticipated date of reinstatement?	**Depending on the status of COVID Pandemic and when it is safe to do so. This will be reviewed in no less than three months**
12. Which practice premises or sites does this request effect: **What is the distance between branch and main site?**	**☐ Main practice site** **X Branch site (please name)** **Boots Halifax** **2 miles**
13. Has the practice completed and attached a Risk Assessment (attach a copy with this completed Primary Care Emergency Decision Making Template if possible)	**Yes. Please find attached**
14. As part of the risk assessment process what areas has the practice highlighted as key risks and what mitigations has the practice noted that will be put in place in relation to these risk areas noted? If Branch closure, consider arrangements to collect mail, prescriptions and buildings insurance.	**Boots** **The store has asked that we do not open again at this time and we agree for the following reasons:-** • **The waiting area is completely open plan with no protective barriers** • **There is no space to ensure adequate social distancing** • **The rooms used do not have any outside ventilation as they are housed within the building without access to outside walls** • **It will increase the footfall of potentially ill patients entering the store** • **Moving staff from other sites will mean the breaking of bubbles into an inadequately protected site**

	• **Boots has had all telephone lines diverted to the Spring Hall Lane site.** • **No mail is delivered to this site** • **No prescription requests come to this site** • **This site will not be closed permanently but at this moment in time it is not felt to be safe for staff and patients to use but this will be reviewed with the store and ourselves in no less than 3 months.**
15. What impact will this request have on practice staff / wider system staff? E.g. If a practice site is closed what is the impact of the closure on staffing, co-located services e.g. pharmacy? How will admin and clinical staff be redeployed	**There will not be an impact on staff as we will be continuing with arrangements that are already in place.**
16a. Has the practice explored sharing resources (for example workforce) with neighbouring practices or within the PCN? **16b. If yes response to 16a, have any contracting, subcontracting / mutual aid agreements been put in place with neighbouring practices or within the PCN?**	☐ **Yes** ☐ **No N/A** **If the response is yes, please provide any further details given including name of practice**: ☐ **Yes** ☐ **No N/A** **Please provide any further details:**
17. Does the practice require mutual aid from the wider system or CCG?	☐ **Yes** **X No** **If the response is yes, specifically what is needed, please provide below any further details given.**
18. What will the impact be for patients? **Prompt questions?** **18a.What are the practices plans to communicate the proposed changes to service delivery to patients and wider partners, including updates on the situation? (consider websites, prescriptions, text**	**The impact has already been experienced by the patients as we are asking to retain our current arrangements with the Boots site.** **We have streamlined access by encouraging patients to use digital methods to contact the surgery rather than in person or via the telephones.** **Patients are initially contacted by telephone or email/econsult and then a decision made whether a face to face appointment is necessary.** **If face to face appointments are deemed necessary the other sites are providing access for patients under**

messages, notices) **18b. If future appointments have already been booked for patients how these appointments will be managed?** **18c. Will the decision to close/interrupt services impact on patients' ability to access GP services? For example will they need to access services further away, or be provided by someone else?** **18d. How will clinical information about your patients be shared to ensure that vulnerable patients' health needs continue to be met?** **18e. How does the practice intend to make sure their vulnerable* patients get the right level of service and understand what's happening? (*Vulnerable – older, disabled, non/limited-English speaking, those with communication needs)**	**strict Infection Control procedures.** **Any changes to the operation at sites is always publicised via the website and also by posting notices at the sites involved.** **Vulnerable patients were contacted by our nurses and the social prescriber when lockdown was initiated to ensure they understood how to contact the surgery and to how to access their medication.** **The language line is used extensively during consultations to enable effective consultations.** **All communication needs are assessed prior to conducting consultations to ensure they are effective.**

Appendix B: Rapid Impact Assessment

Rapid Service Change Impact Assessment Tool

This tool has been developed in response to the COVID-19 Pandemic and the need for the NHS to respond by rapidly changing commissioning and delivery of services. Please complete all sections. Instructions are in ***italics.*** Email for all correspondence: calccg.QIAQualityTeam@nhs.net

A. Rapid Service Change Details	
1. Description of change	Spring Hall Group Practice are requesting that its branch site at Boots Halifax remains closed to the public as a temporary arrangement. The site has been closed since March 2020. The rationale is: • The waiting area is completely open plan with no protective barriers • It will increase the footfall of potentially ill patients entering the store • It is not possible for a one way system or adequate social distancing to be implemented • Moving staff from the main site will mean the breaking of bubbles into an inadequately protected site • The treatment rooms do not have any outside ventilation • This site will not be closed permanently but at this moment in time it is not safe for staff to use • All other sites are within a 2 mile radius of the Boots branch Patients have been informed of the closure via the practice website and the practice has been communicating with individual vulnerable patients re this during telephone consultations and triage since March. All telephone calls are routed to Spring Hall Lane and mail is taken there. The main sites and paper script requests will be collected on a daily basis from the branch.
2. Type of change	~~Stop /~~ Partial stop ~~/ Start new / Adjust existing~~
3. CCGs	Calderdale
4. Form completed by	Clare Wyke, Quality Improvement Lead, CCG Emma Bownas, Primary Care, CCG Sarah Mackenzie-Cooper, Equality and Diversity Manager, CCG Catherine Borrill, Quality Improvement Lead, CCG
5. Form agreed to be decision ready on	30/09/2020
6. Proposed review date	3 months or before if National Guidance changes

B. Impact Assessment	
1. How does this project/decision impact on Quality ie. Safety, Effectiveness and Experience?	**<u>Safety</u>** **B1a:** Consolidation of face-to-face appointments onto 3 out of 4 sites will enable safe delivery of appointments for those patients that meet the criteria. **<u>Experience</u>** **B1b:** Minimising face-to-face appointments (by introducing telephone triage and online consultations) might cause anxiety for some patients, especially if the clinician considers their need can be met remotely. **B1c:** Patients will need to travel further for face-to-face appointments. This will impact those people who do not have access to a car, especially those with mobility difficulties. **B1d:** Paper script requests for medication will be collected on a daily basis from the branch and sent via Electronic Prescribing Service to pharmacy of patient choice. **B1e:** Communities may perceive that the continued closure of the sites is indicative of longer term plans to close the site more permanently.
2. How does this project/decision ensure that protected or vulnerable groups are able to access services and understand any changes? *(see notes in Section E4)*	**B2a** – Patients who need face to face appointments will need to travel further than their usual site, this will be additionally difficult for disabled, older people and carers of both adults and children. Utilising public transport will add a financial and risk burden. Not everyone has access to private transport and lockdown measures are being updated locally. **B2b** – The continued closure of the sites may cause anxiety for people living locally who may assume it is closed permanently. **B2c –** The digitally excluded may struggle with accessing virtual consultations, because of financial, technical or trust issues. Information on the website currently directs people to online services which require an email address and access to the internet. **B2d** – Some patient groups are less comfortable/confident engaging with clinicians virtually and may avoid the GP or feel they are getting less of a service. This is likely to affect older and disabled patients. **B2e** – The group practice serves deprived communities, with a significant number of patients from Asian backgrounds with other more recent migrants and refugees/asylum seekers. The changes to services may be less well understood and access to the website may

	be more limited to these groups as well as the impact of travel being more significant. The Covid impact on these communities has been particularly significant in terms of infection rates and secondary impact on finance, outcomes and experience.
3. How does this project/decision impact on the duty to safeguard children, young people and adults at risk (including Human Rights eg. restrictions of liberty)?	**B3a** Practice staff moving to three sites are still required to fulfil safeguarding responsibilities and know who their practice safeguarding lead is, to be able to seek advice. **B3b** There is a risk that the GP 0-19 Practitioner (Health Visitor) links meeting may be reduced, but important Safeguarding children information should still be shared by other means eg virtual processes. **B3c** Practice Safeguarding policies and staff training should be in place as required by commissioners and regulators and aligned with local approaches for both practices so should be no impact.
4. Are there any other impacts to consider? Eg. Workforce, organisational or system wide	**<u>Workforce</u>** **B4a:** Following an environmental risk assessment and advice from Infection Prevention and Control locally, it was recommended that practice create bubbles of staff to prevent spread in the event of a positive Covid test. This has been done at Spring Hall **B4b:** The extension of this change might negatively impact staff in terms of morale, travel and team cohesion.
C. Risks and Mitigations	
1. What actions can be taken to reduce any negative impacts? (If none please state so)	**B1a:** no mitigation required as positive impact. **B1b:** Patients have been advised of the changes to service via their preferred communication mechanism ie. post, telephone, text etc. Requests for face-to-face appointments will be assessed on a case-by-case basis so that the clinical needs of the patients are met in an appropriate way. **B1c:** Wherever possible patients will be offered alternatives from walking to the practice such as telephone/online/video consultations. **B1d:** no mitigation required as positive impact **B1e:** Clear communications are required via the practice website with information about when this will be reviewed, and explanation as to the reasons for the closure. The CCG are supporting practices with communications across Calderdale. **B2a** – Travel arrangements could be supported by the practice or where necessary home visits arranged. Triage conversations should include reassurance about the access to virtual appointments and

	active listening where patients feel they need to be seen. **B2b** – As B1e above ensure communications is accessible and reaches the target audience – consider other ways to reach out (local paper) for groups less likely to access website. **B2c & d –** Support patients to access virtual consultations through confidence building, technical support and triage conversations checking access and comfort. Where necessary arrange face to face appointments based on broader need rather than clinical. **B2e** – Messages need to be made available in local community languages (using interpreter requests and local intelligence), these can also be shared with community and religious leaders to disseminate. The local authority (Queens Road Neighbourhood Centre) has been doing regular community outreach on Covid, they could be asked to raise awareness of accessing health services in the area. **B3a:** Each Practice has a Safeguarding Lead and the CCG team are aware of these so no mitigation should be needed. Practices can also contact the CCG safeguarding team for advice and support and can access the CCG Intranet site which contains safeguarding files with critical safeguarding information – no other mitigation required **B3b –** Each Practice has a named 0-19 Practitioner (HV) who links with GP Safeguarding lead so key information to safeguard children can continue to be shared. Regular contact between Designated nurse CCG and Head of Safeguarding Locala is in place to monitor. **B3c** – no mitigation required **B4a:** no mitigation required **B4b:** Practice staff have been consulted and are supportive of the changes.
2. How could the impacts and/or mitigating actions be monitored?	The Primary Care Team will continue to monitor delivery of the mitigations via the CPMSC Ops Group on a monthly basis and will escalate any issues raised accordingly.
3. Are there any communications or engagement considerations or requirements?	The CCG Communications Team are working with Practices across Calderdale to support consistent messaging regarding changes to Primary Care delivery. The Practice will also be required to ensure that messages on their own website are clear and include alternative access mechanisms than online.

D. Decision/Accountable Persons	
1. Agreement to proceed?	Yes / No *Delete as appropriate and add detail or rationale*
2. Any further actions required?	*Eg. risk to be added to COVID-19 Programme Risk Register*
3. Names and roles of accountable decision makers	CPMSC Rapid Decision Making Panel
4. Date of decision	
E. For Quality Team use only	
1. Reference	COVID19/RIA/46
2. Hyperlink	
3. Notes (Review date)	
4. Equality considerations	In order to answer B2 the groups that need consideration are; Protected characteristics; age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex, sexual orientation (Use the hyperlinks for further information) Other groups would include, but not be limited to, people who are; carers, homeless, living in poverty, asylum seekers/refugees, in stigmatised occupations (e.g. sex workers), use substances, geographically isolated (e.g. rural) and surviving abuse

NHS Calderdale Clinical Commissioning Group

Name of Meeting	Commisioning Primary Medical Services Committee	Meeting Date	21/01/2021
Title of Report	Calderdale Extended Access Contract – Request for Extension of Service	Agenda Item No.	14
Report Author	Martin Pursey, Head of Contracting and Procurement	Public / Private Item	Public
GB / Clinical Lead	-	Responsible Officer	Martin Pursey

Executive Summary				
Please include a brief summary of the purpose of the report	This paper provides background to the position in relation to the Extended Access contract commissioned by the CCG; and in light of that position requests consideration of the options available to the CCG. The paper requests approval to seek to extend the provision of the service through direct award of short term contract to the current service providers or alternative providers should this not be possible.			
Previous consideration	Name of meeting	none	Meeting Date	none
	Name of meeting		Meeting Date	
Recommendation (s)	It is recommended that the Committee: 1. Note that the Extended Access contract expires at 31st March 2021. 2. Note and consider the position in respect of the anticipated delay in transfer of responsibility for delivery of extended access to PCNs. 3. Approve the recommendation to extend, by way of Single Tender Waiver, to proceed with Option 2 to allow the continuation of service by the current and/or new providers for a period of 6 months up to 12 months from 1st April 2021.			

Decision	☒	Assurance	☐	Discussion	☐	Other	

Implications						
Quality & Safety implications	N/A					
Engagement & Equality implications (including whether an equality impact assessment has been completed)	Any implications informed within the body of the paper.					
Resources / Finance implications (including Staffing/Workforce considerations)	Any implications informed within the body of the paper.					
Has a Data Protection Impact Assessment (DPIA) been completed? (Please select)	Yes		No		N/A	

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)	Risks identified within the body of the paper
Legal / CCG Constitutional Implications	Compliance with SFIs/SOs in respect of procurement legislation	**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 Purpose of Report

1.1 This paper provides background to the position in relation to the Extended Access contract commissioned by the CCG; and in light of that position requests consideration of the options available to the CCG. The paper requests approval to seek to extend the provision of the service through direct award of short term contract to the current service provider or alternative provider should this not be possible.

2.0 Background

2.1 The CCG's Extended Access contract was extended to expire at the end of March 2021. The annual value of the contract (based on listed population and £6 per head) is £1,344,456 . The actual value of contract for the period from 1st April 2021 will clearly be determined by the length of contract required to align with when national guidance is enacted.

2.2 National GP contract documentation set out the expectation that from 1st April 2021 that existing Extended Access (EA) and Extended Hours (formerly a Directed Enhanced Service (DES) but now part of the PCN DES) contractual boundaries would be removed and the requirements around delivering extended access would transfer to PCNs.

2.3 It is understood that funding available nationally for access is being maintained but at this time it is unsure how this will translate into payments for PCNs and/or service providers if it is subcontracted. Whilst this remains unclear it could represent a potential financial risk for the CCG.

2.4 The publication of the national access review was expected to be this year but this has not yet been released. In addition we were anticipating release of a service specification setting out detailed requirements for PCNs from 1 April 2021 but this has not been published either. We understand that the specification forms part of the national GP contract negotiations which are onging.

2.5 It is therefore required that the CCG makes provision for the continuity of this service for what is likely to be at least 6 months but potentially 12 months to ensure both this continuity but also taking into account the sustainability and resilience of providers during this period of extended service.

Local Context

2.6 North Halifax PCN is stating a preference for developing their own model and we are advised that this PCN wants to move away from the Pennine GP Allaince model from April 2021.

2.7 The remaining four PCNs in have indicated that they would be content to work within the existing arrangements and PGPA has indicated that they are prepared to extend the service.

2.8 There is an added complexity which may impact locally about the type of contract used to commission this service. If it's via Alternative Provider Medical Service (APMS) contract, then the contract holder can carry out functions on behalf of PCNs. If the contract model switches to the national PCN DES and the PCNs subcontract this service from the provider (i.e. GP Federation), the provider will no longer be providing the service or hold an APMS contract which will affect their ability to do work on behalf of PCNs.

Other considerations

2.9 With the contract due to expire at the end of March 2021 as commissioners we need to be mindful of the providers' resilience and sustainability in being able to continue to provide a service i.e. staff who are contracted to deliver services will need a decision or indication of our intent sooner rather than later.

2.10 Due to the continuing response to COVID etc, in consideration to the 'noise' in the system we should anticipate that there may be a national delay in the required commencement of the DES specification to at least 1st October 2021.

2.11 Any contract for the extension of service has to be caveated with the fact that national specification and timeline could supersede what we are proposing locally and therefore the extension arrangements and contract would be subject to change.

2.12 It is anticipated that once the DES specification is published there is likely to be a requirement to impact assess and undertake some engagement if the model of delivery and location of delivery is changing, clearly this will take time.

2.13 It is likely that next year will be described as a transitional year and that some of the ambition of the GP contract might be scaled back, particularly in the area of interconnectivity with wider urgent care system.

3.0 Options

3.1 The current Extended Access contract was extended initially to align timelines to coincide with the anticipated transfer of the responsibility of Extended Access to Primary Care Networks. This alignment takes the expiry of these contracts to 31st March 2021.

3.2 The CCG has subsequently been advised that the transfer of this responsibility intended for 1st April 2021 is likely to be delayed for at least six months with the possibility that the delay may extend up to twelve months.

3.3 The CCG is therefore presented with a number of options, these being:

	Description of Option	**Benefits**	**Risks**
Option 1	**Do Nothing** Effectively this will allow the contracts to end on 31st March 2021 without it being replaced	• Reduction in expenditure • No requirement to run procurement process	• Contrary to NHS policy • Reduced patient access to primary medical services • Increased pressure on the local system e.g. GP Practices, A&E, GP Out of Hours
Option 2	**Extend** provision of service with either current and/or new providers – Direct Award of contract for **6 Months** up to **12 months** from 1st April 2021 Estimated contract value: £682k - £1.36m	• Service already in place able to work with established providers • Allows current provider to plan for continuing service • Build on existing contract terms • No requirement to find resource to run procurement process • Application of	• Procurement challenge (considered to be low risk) • Increased cost may impact on affordability • Lack of confirmation of funding stream to support service • Failure to agree terms for extension that meet requirements or value for money

		exemption afforded under Procurement Policy Note (PPN 01/20) in respect of urgent requirement	• May require flexibility in terms of duration due to changes in national guidance
			• Existing providers may not wish to continue with providing the service:
			  ○ Contract length
			  ○ Contract model
			• This option may result in more than one provider within a CCG geography.
			• Provider ability to secure resource for less than 12 month contract

Option 3	**Procure** short term contract with effect from **1st April 2021**	• Fully compliant with procurement rules • Clear review and articulation of service requirements • Ability to demonstrate current market interest	• Uncertainty over confirmation of length of requirement • Lack of confirmation of funding stream to support service • Clarity over the type of model to be commissioned • Increased cost sought from the market • Perceived lack of support from CCG to current providers in building capacity and capability • Lack of capacity to support a formal procurement process

4.0 Preferred Option

4.1 In consideration of the options presented above support is requested to pursue Option 2 as the most pragmatic to allow for the continuation of the Extended Access service. This option is to **extend** provision of service with either current and/or new providers through a Direct Award of contract for a period of 6 months up to **12 months** from 1st April 2021.

5.0 Next steps

5.1 Should approval to proceed be granted the CCGs will:

- Complete Single Tender Waiver documentation to reflect decision to directly award contracts.
- Commence discussions with the existing provider to secure the extension to service from 1st April 2021 for at least 6 months (subject to further guidance being forthcoming).
- Complete and sign contract documentation with providers.

6. Recommendations

It is recommended that the Committee:

1. Note the Extended Access contract expires at 31st March 2021.
2. Note and consider the position in respect of the anticipated delay in transfer of responsibility for delivery of extended access to PCNs.
3. Approve the recommendation to extend, by way of Single Tender Waiver, to proceed with Option 2 to allow the continuation of service by the current and/or new providers for a period of 6 months up to 12 months from 1st April 2021.