FINAL MINUTES OF CALDERDALE COMMISSIONING PRIMARY MEDICAL SERVICES COMMITTEE 25 NOVEMBER 2021 VIA MS TEAMS

PRESENT:

John Mallalieu (JM)	Chair, Lay Member (Finance and Performance) and Deputy CCG Chair
Alison MacDonald (AM)	Lay Member (Patient and Public Involvement)
Lesley Stokey (LS)	Director of Finance
Neil Smurthwaite (NS)	Chief Operating Officer / Chief Finance Officer
Rob Atkinson (RA)	Governing Body Secondary Care Specialist

IN ATTENDANCE:

Debbie Robinson (DR)	Director of Improvement - Community and Primary Care
Emma Bownas (EB)	Deputy Director of Improvement - (Primary Care)
Natalie Sykes (NSy)	Senior Primary Care Improvement Manager
Penny Woodhead (PW)	Chief Quality & Nursing Officer
Councillor Tim Swift (TS)	Representative of Calderdale Health and Wellbeing Board
Neil Coulter (NC)	Senior Primary Care Manager - NHS England /Improvement
Karen Huntley (KH)	Healthwatch Representative
Martin Pursey (MP)	Head of Contracting and Procurement (Minute 51/21)
Rob Gibson (RG)	Corporate Systems Manager (Minute 53/21)
Zoe Akesson (ZA)	Corporate Governance Officer (minute taker)

The meeting was enabled, via MS Teams, to allow members of the public to view but not participate.

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61/21 APOLOGIES FOR ABSENCE

Apologies were received from Dr Steven Cleasby and Dr James Gray. The late arrival of Penny Woodhead was noted. The Chair welcomed the new Senior Primary Care Improvement Manager Natalie Sykes to the meeting.

62/21 DECLARATIONS OF INTEREST

There were no interests declared by those present however the Chair made known the following declarations involving GPs Dr Steven Cleasby and Dr James Gray, which on this occasion were mitigated due to them not attending the meeting. The Chair described how these would have been managed had they been present:

Item 6 GP Patient Survey Results - the GPs have a **Direct Professional Interest** as it could be perceived they could influence the process for managing their own performance and in turn practices could benefit from the decision. It was agreed the GPs receive the paper, stay for discussion and the Chair would actively manage the discussion.

Item 7 Policy Review for Discretionary Financial Assistance - the GPs have a **Direct Professional and Financial Interest** as general practice contract holders in Calderdale who may at some point benefit financially from the policy. It was agreed the GPs receive the paper, but as beneficiaries would be excluded from the discussion and decision.

The Committee members agreed to the conflicts being noted in this way.

63/21 QUESTIONS FROM THE PUBLIC

There were no questions received from the public.

64/21 MINUTES OF THE LAST MEETING

The Committee **RECEIVED** the minutes of the following meetings, which had been approved between meetings and submitted to the Governing Body in October:

- Minutes of the public section of the meeting held on 26 August 2021
- Minutes of the single item meeting held on 1 October 2021

The Committee **RECEIVED** and **NOTED** the decision notice dated 5 November about the Winter Schemes 2021/22 and Quality Resilience and Recovery Scheme.

65/21 MATTERS ARISING

The action log was reviewed:

35/21 To share the draft Estates Strategy document at the next CPMSC development session: This would remain open until a date had been agreed with PCNs.

50/21 To raise any significant medicine optimisation issues within the year in the Director's report. To remain open, noting there was nothing to report for this meeting.

The remainder of the actions were recorded as actioned and closed.

66/21 DIRECTOR'S REPORT

The Chair invited Debbie Robinson to present the Director's report. Debbie informed members of the content of the report and welcomed Emma Bownas to talk through the additional roles reimbursement scheme section of the paper.

Additional Roles Reimbursement Scheme

Emma introduced a short film, produced by an Occupational Therapist working in the Upper Calder Valley Primary Care Network. It was developed to inform GP colleagues of the impact of the role so far, demonstrating the potential of these roles and how practices can improve the use of the additional roles as a service.

In terms of the headcount against the use and overall numbers within the report, Emma pointed out there is currently no target for any of the roles. PCNs can spend their allocated budget on any of the identified roles within the scheme.

There remains a challenge around recruitment. It is difficult to find workforce to fill these roles, particularly mental health practitioners and there are concerns around the rest of the system in some of these roles. With regards to retention, there is a need to encourage career progression moving forwards, to have a clear path and

post outline, for those in roles to stay linked into professions and not become isolated.

Comments and questions were invited.

- A point was made that there would still be challenges referring from General Practice into the system. In response, Emma explained although there will still be issues when referrals are made the advantage of additional role posts may prevent the need to refer with their different skill mix and a solution may be found in primary care but as part of primary care team challenges will be fed back to the CCG. **NS added that the benefits of using this workforce are recognised and it would be good to monitor this over the next 12 months to see other impacts.**
- JM raised a question around availability and supply and the oversight of what GPs are trying to recruit if there is no target per role. In response Emma explained the Calderdale workforce strategy and planning would highlight the gaps and show the use of different roles. The work has started for Calderdale around forecasting and showcasing of the roles however this needs to be done at a larger scale than Calderdale and conversations are happening with universities and external bodies of where these roles can be sought. **The Chair asked that information on the roles being sort is brought back to Committee.**
  ACTION: To include in the next Director's report to Committee - EB
- RA questioned if those accessing General practice are aware this is the way forward and understand that a GP may not always be the person they see. Emma agreed to refresh to comms on social media ensuring the language is accurate so people understand it is part of the same primary care provider and will receive the right treatment rather than seeing a GP.
  ACTION: To refresh social media message - EB

The Chair invited Debbie Robinson to continue presenting the report. Debbie highlighted the following key points:

Winter Investment - NHSE have published their plan to improve access for supporting patients and general practice. The West Yorkshire submission has been

made in line with guidance, some elements have been approved to progress to implementation however there is still work to do at a regional level to work through operational details to ensure the schemes are deliverable. The timescales were short for the creation of the schemes and submission of a plan. The locally funded schemes for Calderdale have been approved for implementation under the urgent decision-making arrangements.

Penny Woodhead joined the meeting.

NHS Digital GP Appointment Data - shows that more than 113, 000 appointments were provided during September. Calderdale General Practice is running at pre-pandemic levels, with 60% appointments being face to face. It was highlighted that all activity done at scale is still not captured in this data set and the teams is not able to access this data at practice level.

Estate Strategy for Primary Care Networks – the engagement work undertaken with key stakeholders, is nearing completion. A final draft of the Estate's strategy will be available for consideration in January. Working with external provider, a discussion will take place with each PCN, to help them understand the document and for them to be able to sense check data they have provided.
ACTION: To arrange an Estates Strategy meeting in January 2022 – DR/ZA
There were no further comments.

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

67/21 CALDERDALE GENERAL PRACTICE PATIENT SURVEY

The Chair invited Natalie Sykes to introduce the report. Natalie presented the GP patient survey results for 2021. Out of 7445 questionnaires sent out, 2793 returned, equating to a 38% response rate. The Committee was reminded that the questionnaire was redeveloped in 2021 to reflect changes to primary care services due to the pandemic, the effect of which should be considered when looking at results over time. It also represents only a small population sample of Calderdale and it is a helpful source of information that can be used in conjunction with other data to help build provide a picture of practice services. Practices are expected to

share the results with patients in their patient participation group to identify any areas for improvement.

The survey results have been reviewed in 2 ways. Firstly, by how Calderdale is performing against the national results with a year-on-year comparison. Many areas showed Calderdale is in line with the national average however for those areas that performed slightly below national average steps have been taken to address these areas, which are outlined in the report. Secondly, it has been reviewed on an individual practice basis. For those practices scoring higher than the CCG average, a recommendation has been put forward to the Committee for their achievements to be acknowledged by letter. For those where the scores are lower it is recommended that a supportive informal visit as part of the quality assurance and surveillance process takes place, to help practices reflect on their model and access review.

A discussion followed and the following comments were made:

- KH questioned the demographics of the people who completed the survey as their responses would be reflective of the population for their specific condition. The Committee requested to learn more about this area
  ACTION: To investigate the results further in relation to demographics / data by protected characteristics - NSy
- Cllr TS reminded the Committee that the satisfaction survey has an expectation, conditioned by press and social media stories, which is a risk. Natalie explained the number of surveys completed doesn't represent population of Calderdale but gives us next steps and this is only one source of information that can help shape practices.
- JM reflected on those practices that are in the lower percentile of questions not just the main 3 questions, that were drawn out in the discussion and asked that these are also picked up as part of the practice conversations, triangulating, so that if a practice is performing well in one area but may benefit from support in another that this is picked up.

The Committee **RECEIVED and REVIEWED** the 2021 national GP patient Survey results and **SUPPORTED** the next steps identified in the paper.

68/21 POLICY FOR DISCRETIONARY FINANCIAL ASSISTANCE TO GENERAL PRACTICES IMPACTED AS A RESULT OF A DISPERSAL LIST

The Chair invited Martin Pursey to present the paper. Martin explained the policy is used in the event of dispersing a patient list, which creates demand on staff and processes. The policy has been previously approved by the committee. This time there is no change in content, it is a request for the continuity of the annual approval to ensure consistency to the approach.

Following a short conversation around review dates and moving into transfer agreement arrangements with a new organisation the review date should be extended to 3 years in line with other policies.

ACTION: To amend the review date of the policy - MP

DECISION: The Committee **AGREED** the policy and change to a 3-year review date**.**

69/21 CONTRACTING UPDATE

The Chair invited Martin Pursey to present the contracting update. Martin highlighted key points from the report including the Extended Access Contract with Pennine GP Alliance and the delay in moving towards the planned transfer of current CCG-commissioned extended access services to PCNs has now been postponed until October 2022.

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

70/21 FINANCE REPORT

The Chair invited Lesley Stokey to present the report. Lesley reminded the Committee that the financial year had been spilt into 2 and the plan for H2 submitted on 16/11/21 but not yet been approved. There is an expectation that we will break even across the financial year.

Lesley reported that plans have been developed and reserve budgets have been moved into non-GP services leaving a contingency £168K, sufficient to manage other variances for the next 6 months. There is an expectation of additional allocations for the additional roles, which is over and above that which is included in the baseline budget, but Lesley assured Committee this carries a low risk.

The additional roles budget for this year is £2.8m and the CCG is forecasting to spend £2.5m this year. The CCG is currently working with PCNs to bring forward next year's recruitment plans to utilise as much underspend as possible. The team is working proactively with PCNs on recruitment plans. The Chair questioned the remaining contingency and Lesley reassured the Committee that she felt comfortable with this and has a high level of confidence in the well-developed plans of the PCNs.

The Committee **RECEIVED** and **NOTED** the 2021/22 financial position on Primary Medical Services delegated budgets.

71/21 RISK REGISTER POSITION STATEMENT RISK CYCLE 3 2021-22

The Chair invited Rob Gibson to present the report. From the 40 risks on the register, 3 were categorised as CPMS risks, all open and currently scored at 8. Rob drew the Committee's attention to the following:

- R1629 reduced to 8 from 12 during this risk cycle, as personalised care team is now in place with clear supervision and line management.
- R1628 reduced to 8 from 12, following the covid vaccination spend
- R1734 was closed and replaced by 1941 and 1942. It was noted that the request this committee sighted on this and Rob informed committee no development since risks have been created. Rob will keep committee updated.

It was confirmed there had been no significant amendments since the risk report was written.

The Committee **REVIEWED** the Risk Register and the management of Commissioning of Primary Medical Services risks and **APPROVED** for review at Governing Body.

72/21 REVIEW OF WORKPLAN

The Committee **REVIEWED** and **AGREED** the workplan.

73/21 DATE AND TIME OF NEXT MEETING

Thursday 24 February 2022, 3.00 – 5.00pm, venue to be confirmed.

Calderdale Commissioning Primary Medical Services Committee Meeting 25 November 2021 Action Sheet

Agenda item	Minute No.	Action Required	Lead	Current Status	Comments/ Completion Date
HOPC Report	35/21	To share the draft Estates Strategy document at the next CPMSC development session	DR	**Open**	October date to be agreed with PCNs
Quality Assurance and Monitoring Process for General Practice	36/21	To present a first draft of the local dashboard at the next Committee.	DR/EB	Closed	Presented to CPMSC 26/08/21
Risk Register Position Statement Cycle 1	38/21	To redefine R1734 around the risk of harm to patients relating to the backlog of work post Covid and to re-look at the score. To complete critical risk template and re-share definition and score with committee before next meeting in August.	EB	Closed	Revised definition and score shared prior to meeting. Discussed under the risk register item 26/08/21.
Finance Report	41/21	LS to provide a brief overview of previous year's utilisation and role occupancy at the next meeting.	LS/DR	Closed	Covered in the Director and Finance reports 26/08/21.
Director's Report	48/21-a	EB to provide an update on the roles (headcount) filled to target for 20/21 and 21/22 in the next Director's report to Committee.	EB/DR	Closed	Included in Director's report
	48/21-b	DR to make a comparison to 2019 data in the next Director's report to Committee.	DR	Closed	Included in Director's report
	48/21-c	DR to include an update on Serious Mental Illness Health Checks in the next Director's report to Committee.	DR	Closed	Included in Director's report
Medicines Optimisation Programme	50/21	HF/DR to raise any significant medicine optimisation issues within the year in the Director's report.	HF/DR	**Open**	Nothing to report November, to remain on action log.

Finance Report	52/21	LS to work with DR on a timeline for the virtual meeting(s) in private with non-conflicted members to approve any discretionary investment proposals.	LS/DR	Closed	Took place 05/11/21
Director's Report	66/21-a	To include information on the additional roles being sort in the Director's update next meeting	EB	Closed	Included in Director of Primary Care Report
	66/21-b	To refresh social media message ensuring language is accurate so people understand it is part of the same primary care provider and will receive the right treatment rather than seeing a GP.	EB	Closed	EB has confirmed with comms that Calderdale CCG messages do go out as part of the West Yorkshire ICB social media messaging to reflect the other roles that are in General Practice. These are periodically refreshed.
	66/21-c	To arrange an Estates Strategy meeting in January 2022	DR/ZA	**Open**	
GP Patient Survey	67/21	To investigate the results further in relation to demographics/ data by protected characteristics	NSy	Closed	data regarding the breakdown of people that had completed the GP patient survey, shared with the committee 17/12/21.
Policy for Discretionary Financial Assistance to General Practices Impacted as a Result of a Dispersal List	68/21	To amend the review date of the policy	MP	**Open**	

NHS
Calderdale
Clinical Commissioning Group

Record of Urgent Decision

The meeting was held under the urgent decision-making process, which was established by Commissioning Primary Medical Services Committee (CPMSC) to deal with matters in between meetings and then report the decision back to next committee.

Committee on behalf of which decision made: Commissioning Primary Medical Services Committee Urgent Decision-Making Panel

Decision Maker(s):

John Mallalieu	CPMSC Chair, Lay Member (Finance and Performance), CCG Deputy Chair
Neil Smurthwaite	Chief Operating Officer, Chief Finance Officer
Lesley Stokey	Director of Finance

Consultee(s):

Dr Majid Azeb	Clinical Lead for Primary Care
Marcus Beecham	Calderdale LMC Operations Director
Dr Fawad Azam	Clinical Director of Calder and Ryburn PCN

Lead Officer:

Debbie Robinson	Director of Improvement - Community and Primary Care

Others Present:

Emma Bownas	Deputy Director of Improvement - Community and Primary Care
Natalie Sykes	Senior Primary Care Quality Improvement Manager
Zoe Akesson	Corporate Governance Officer

Subject: Temporary reduction in branch opening hours at Rosemount House

Details and Rationale:

The practice has taken a pragmatic approach to manage staff sickness and maintain safe clinical services by requesting the temporary reduction in branch surgery hours. The issue is around admin not clinical staff and the practice is currently deploying admin staff to the main site to

alleviate the problem. The reduction in hours (14 hours per week) will not affect the number of appointments available. The variation could take place from 01/02/22 but is reliant on adequate communications being in place to patients. If approved, the practice agreed to review after 3 months.

The Panel:

- recognised the level of access remains the same but questioned what PCN support and how technology, such as self-service monitors, can be used to reduce reception admin,
- proposed that the practice use the 3 months to work on this especially if an extension is likely,
- recognised that during this period circumstances or national restriction on isolation may change allowing staffing levels to recover,
- requested a better understanding of Bankfield's premises position within the PCN Estates Strategy.

Any Relevant Implications:

Risks have been considered and described in the relevant Rapid Impact Assessments detailed within the report.

Decision:

The Panel **APPROVED** the application from Bankfield Surgery to temporarily reduce the branch surgery opening hours at Rosemount House for a period of three months, with the following caveats:

- To amend the recommendation to read 'For a period of **up to** 3 months'
- The Practice to consider, during the period of temporary reduction, how technology and the PCN can support them in resolving capacity issues and maintaining multi-site access
- The Practice provides a position statement by Sept 2022 on what is Banfield's arrangement within the PCN Estates Strategy with regards to the future of Rosemount House.

Report attached?	Yes
Public or Private?	Public
Time and Date of Decision:	16:30, 20 January 2022
Decision Recorded by:	Zoe Akesson, Corporate Governance Officer

Name of Meeting	Commissioning Primary Medical Services Committee Urgent Decision-Making Panel	**Meeting Date**	20/01/2022
Title of Report	Temporary reduction in branch opening hours at Rosemount House	**Agenda Item No.**	1
Report Author	Natalie Sykes, Senior Primary Care Quality Improvement Manager	**Public / Private Item**	Public
Clinical Lead	Dr Majid Azeb, Clinical Lead for Primary Care	**Responsible Officer**	Debbie Robinson, Director of Improvement - Community and Primary Care

Executive Summary

This paper seeks approval of the application from Bankfield Surgery to temporarily reduce the branch surgery opening hours at Rosemount House for a period of 3 months. The practice is experiencing significant staffing pressures due to COVID 19 related absences and has struggled to maintain administrative staff cover over both sites since October 2021.

If approved the variation would take place from 1st February 2022, this date could be brought forward if the practice is able to provide assurance that adequate patient communications have been put in place.

The paper contains a copy of the application form and a risk assessment undertaken by the practice. A Rapid Impact Assessment (RIA) has been supported and approved by colleagues from the quality, engagement, and equality team.

The application and RIA have been shared with the Clinical Lead for Primary Care, Calderdale LMC and the Clinical Director of Calder and Ryburn PCN, who have all given their support to the application.

If the variation is approved, the practice will undertake a review after two months, and if circumstances have not changed then a further request may be received.

Once the outcome of the panel decision is known this will be reported to Bankfield Surgery and the decision recorded through the next meeting of the CPMSC.

Previous Considerations

Name of meeting	N/A	**Meeting Date**	N/A
Name of meeting	N/A	**Meeting Date**	N/A

Recommendations
It is recommended that the Urgent Decision-Making Panel on behalf of the Commissioning Primary Medical Services Committee approve the application from Bankfield Surgery to temporarily reduce the branch surgery opening hours at Rosemount House for a period of 3 months.

Decision ☒	**Assurance ☐**	**Discussion ☐**	**Other:**

Implications

Quality and Safety implications (including whether a quality impact assessment has been completed)	The Quality and Safety implications have been identified and are included within the Rapid Impact Assessment. (Appendix B)
Engagement and Equality Implications (including whether an equality impact assessment has been completed), and health inequalities considerations	The Engagement and Equality Implications have been identified and are included within the Rapid Impact Assessment. (Appendix B)
Resources / Financial Implications (including Staffing/Workforce considerations)	Supportive of staff wellbeing and safety during the COVID 19 pandemic. No financial implications have been identified.
Sustainability Implications	N/A

Has a Data Protection Impact Assessment (DPIA) been completed?	**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)**	Not currently included on the CCG's risk register
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. Introduction

1.1 This paper seeks approval of the application from Bankfield Surgery to temporarily reduce the branch surgery opening hours at Rosemount House for a period of 3 months. The practice is experiencing significant staffing pressures due to COVID 19 related absences and has struggled to maintain administrative staff cover at both sites since October 2021.

1.2 The request to temporarily reduce the branch opening hours will not result in a reduction or change in the services provided by the practice. When the branch site is closed patients will continue to access care and services from the main site. The reduction in hours will not affected the number of appointments offered by the practice.

2. Detail

2.1 Bankfield Surgery has 10,586 registered patients and provides services from two locations Bankfield Surgery (Main Site) and Rosemount House (Branch Site).

2.2 Rosemount House is used as additional accommodation, a temporary 3-year lease was agreed in September 2020 and will continue to be in place until September 2023. The additional space was temporarily provided to Bankfield Surgery when they experienced a sudden increase in the number of new patient registrations, due the closure of a neighbouring practice. The practice is seeking an extension to its main premises, with the intention of relocating all services back to the main site if approved.

2.3 As part of the national response to COVID-19, the CCG established a weekly primary care sit-rep report. The General Practice sit-rep allows the CCG and LMC to collect important information to identify the pressures and challenges within individual practices and across Calderdale as a whole. By sharing this information more widely, system partners are made aware of pressures in General Practice and, where possible can support care delivery at a system level. The below table shows the four OPEL levels practices can self-declare against:

OPEL Level	Definition	Support required
Level 1 Low pressure (Green)	• Business as usual	None Required

Level 2 Moderate pressure (Amber)	• Busier than usual but coping • Managing within available resources • Performance deterioration, mitigating actions taken at individual practice level	None Required
Level 3 Severe pressure (Red)	• Busier than usual and struggling to cope • Increased significant deterioration in performance and quality, majority of mitigating actions taken at individual practice level	PCN Level Support Required
Level 4 Extreme pressure (Purple)	• Unable to cope, only able to meet urgent demand • Risk of service failure, all available mitigating actions taken and potentially exhausted	Whole System Support required (CCG co-ordination role)

2.4 From January 2021 to mid-July 2021 the practice has reported as being at OPEL Level 1 (Low Pressure), during mid-July to mid-October 2021 the practice reported an increase to OPEL Level 2 (Moderate Pressure). Since the 15th October 2021 the practice has consistently recorded on 6 occasions as being at OPEL Level 3 (Severe Pressure).

2.5 As a result of the severe pressures the CCG has agreed to 5 separate urgent on the day requests to reduce the branch opening hours at Rosemount House. The requests have been in direct response to administrative staff having to isolate, testing positive with COVID, or other staff absences such as sickness, compassionate leave and annual leave. The practice has continued to provide the same level of services by deploying and diverting its available workforce to the main site on each occasion. The reduction in hours has not affected the number of appointments offered.

2.6 The short-term requests have alleviated some of the immediate pressures on the practice. However, they continue to struggle to staff the full opening hours for the branch site especially when practice staff are being called on to deliver and support the COVID vaccination programme.

2.7 The recent increase in COVID infection rates continues to impact the practices' ability to cover two sites. Although the current isolation periods have been reduced from 10 days to 7 days it's still having an impact on the number of staff who are absent from the practice. As

at the 12th January 2022, the practice had 4 administrative members of staff absent due to COVID, which represents a 33% reduction in their administrative workforce.

2.8 The requests received from the practice to reduce the opening hours have required an immediate same day response and decision. As the situation is not likely to improve over the coming months the practice is seeking to take a more proactive approach and has requested a temporary reduction in its branch opening hours in order to best manage and maintain safe clinical services.

2.9 The distance between the main site and the branch site is 0.4 miles (0.7km), which equates to a two-minute car journey or alternatively an 8-minute walk on foot.

2.10 Rosemount House is currently open every day between 08:00 - 18:00pm, the temporary revised opening hours suggested by the practice would be as follows:

Monday	08:30 - 17:00
Tuesday	08:30 - 17:00
Wednesday	08:30 - 14:00
Thursday	08:30 - 14:00
Friday	08:30 - 14:00

2.11 Patients are notified one day in advance regarding the location of their appointment, patients are familiar with attending and travelling to either site. Telephone calls to both sites are via a single telephone number.

2.12 Staff absence in general practice is likely to cause a great impact, which can cause significant risk to the viability of patient care and the delivery of clinical services. In order to manage the current increase in demand and staff absences as a result of the COVID 19 situation, the practice is taking proactive steps in order to best manage and maintain safe clinical services. Reducing the branch opening hours at Rosemount House and diverting all staff, resources to Bankfield Surgery will enable both sites to continue to deliver services safely, with no impact on patient care.

2.13 The completed application form for Bankfield Surgery to temporarily reduce the branch surgery opening hours at Rosemount House can be found in Appendix A. It is accompanied by a completed Rapid Impact Assessment (RIA) in Appendix B. The practice has undertaken and completed its own risk assessment which can be found in Appendix C.

3. Next Steps

3.1 Once the outcome of the panel decision is known this will be reported to Bankfield Surgery and the decision recorded through the next meeting of the CPMSC.

3.2 If the variation is approved the practice will be asked to ensure it communicates the changes to patients and updates its practice website.

4. Implications

4.1 Quality & Safety Implications

4.1.1 These have been considered and are described in the completed Rapid Impact Assessment. (Appendix B)

4.2 Engagement and Equality Implications

4.2.1 These have been considered and are described in the completed Rapid Impact Assessment. (Appendix B)

4.3 Risks

4.3.1 These have been considered and are described in the completed Risk Assessment carried out by the Practice. (Appendix C)

5. Recommendations

It is recommended that the Rapid Decision-Making Panel:

i. Note the content of the report, and
ii. approve the application from Bankfield Surgery to temporarily reduce the branch surgery opening hours at Rosemount House for a period of three months.

6. Appendices

Appendix A - Urgent CPMSC Decision Making Template – Bankfield Surgery

Appendix B - Rapid Impact Assessment

Appendix C - Bankfield Surgery Risk Assessment

Appendix A

Calderdale CCG Primary Care COVID-19 Response

Urgent CPMSC Decision Making Template

1. Name of Practice and B-Code:	Bankfield Surgery (B84016)
2. Name and position of person completing form:	Natalie Sykes - Senior Primary Care Quality Improvement Manager
3. Contact name at Practice/contact email address/phone number:	Claire Baggley - Business Manager **Main Site:** Bankfield Surgery 15 Huddersfield Road Elland HX5 9BA Email: claire.baggley@nhs.net Tel: 01422 374662 Direct Line: 01422 387550 Mobile: 07783 877458 **Branch Site:** Bankfield Surgery at Rosemount House Rosemount Estate Elland HX5 0EE Tel: 01422 374662
4a. Name of PCN and Clinical Director of PCN: **4b. Does the Clinical Director from the PCN support the request?**	Calder and Ryburn PCN Dr Fawad Azam Yes
5. Date form completed:	10th January 2022
6. Brief description of request that is being made by the practice:	Bankfield Surgery are requesting a temporary reduction in the opening hours at their branch surgery Rosemount House for a period of 3 months. The request is to temporarily reduce the branch opening hours, the same services will continue to be provided. When the branch site is closed patients will continue to access care and services from the main site. The reduction in hours will not affected the number of appointments offered by the practice.

/continued ……

	The practice is experiencing significant staffing pressures due to COVID 19 related absences and has struggled to maintain staff cover at both sites since October 2021. Rosemount House is currently open every day between 08:00 - 18:00pm.
7. Date and time, changes are proposed to be implemented by the practice: (or add date and note if this is retrospective):	If approved the proposed change in opening hours at Rosemount House would take effect from 1st February 2022 for a period of three months. The revised opening hours suggested by the practice would be as follows: Monday 08:30 - 17:00 Tuesday 08:30 - 17:00 Wednesday 08:30 - 14:00 Thursday 08:30 - 14:00 Friday 08:30 - 14:00
8. Brief description of scenario prompting request:	Bankfield Surgery has 10,586 registered patients and provides services from two locations Bankfield Surgery (Main Site) and Rosemount House (Branch Site). Since the 15th October the practice has reported as being at OPEL Level 3 (serve pressure) on 6 separate occasions. As a result of the severe pressures the CCG has agreed to 5 separate urgent short-term requests to reduce the branch opening hours at Rosemount House. The requests have been in direct response to administrative staff having to isolate, testing positive with COVID, or other staff absences such as sickness, compassionate leave and annual leave. The practice has continued to provide the same level of services by deploying and diverting its available workforce to the main site on each occasion. The reduction in hours has not affected the number of appointments offered. The short-term temporary requests have alleviated some of the immediate pressures on the practice. However, they continue to struggle to staff the full opening hours for the branch especially when practice staff are being called on to deliver and support the COVID vaccination programme. The recent increase in COVID infection rates continues to impact the practices' ability to cover two sites. Although the current isolation periods have been reduced from 10 days to 7 days it's still having an impact on the number of staff who are absent from the practice. As of 12th January 2022, the practice had 4 members of Administrative staff absent due to COVID.

	The requests received from the practice to reduce the opening hours have required an immediate same day decision. As the situation is not likely to improve over the coming months the practice is seeking to take a more proactive approach and has requested a temporary reduction in its branch opening hours in order to best manage and maintain safe clinical services.
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):	Bankfield Surgery are requesting that the CCG support and approve a three-month temporary reduction in the opening hours at their branch surgery Rosemount House. The revised opening hours suggested by the practice would be as follows: Monday 08:30 - 17:00 Tuesday 08:30 - 17:00 Wednesday 08:30 - 14:00 Thursday 08:30 - 14:00 Friday 08:30 - 14:00
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:** Temporary reduction in branch opening hours at Rosemount House for 3 months. All staff, resources and services will be pooled and delivered by the main site at Bankfield Surgery.
11. How long is the practice anticipating the change of service delivery to be in place for, is it hours, days, weeks, etc. What is the anticipated date of reinstatement?	The request is for a three-month temporary reduction in the opening hours at the branch surgery Rosemount House between 1st February 2022 and 1st May 2022. It is anticipated that the reinstatement back to normal opening hours will take effect from 2nd May 2022. A practice review will be undertaken to review the situation in March.
12. Which practice premises or sites does this request effect: **What is the distance between branch and main site?**	**Branch site:** Rosemount House Rosemount Estate Elland HX5 0EE The distance between Bankfield Surgery (main site) and Rosemount House (branch site) is 0.4 miles (0.7km). The

	distances between sites equates to a two-minute car journey or alternatively an 8-minute walk on foot.
13. Has the practice completed and attached a Risk Assessment (attach a copy with this completed Primary Care Emergency Decision Making Template if possible)	The practice has completed a risk assessment and identified some potential risks that can be mitigated against (Appendix C)
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.	**Risks:** • Potentially insufficient staff to safely provide services across two locations • Risk to patients through potential inability to provide clinical and administrative services across two locations • Staff well-being **Mitigations:** • Consolidation of staff to ensure staffing levels are adequate. All staff, resources and services will be pooled and delivered by the main site at Bankfield Surgery. • The branch site will continue to be open a daily basis and they will ensure that blood and pathology samples can still be collected from the branch site. • All telephone calls to the both the main and branch site are already directed to a single telephone number, there will be no need for patients to call a different number or for the practice to divert any phone lines. • Post, prescription requests and mail will continue to be delivered, received, and actioned at the branch site during the reduced opening hours. • The practice will continue to maximise the use of electronic prescriptions
15. What impact will this request have on practice staff / wider system staff? E.g. If a	The proposed request will reduce pressures on the existing workforce and allow resources to be centralised and redeployed from the main site.

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	Staff have been consulted and are supportive of the proposed changes as it will help improve their emotional wellbeing by bringing both teams together.
16a. Has the practice explored sharing resources (for example workforce) 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**: Practices within the PCN don't have any capacity to share any staff resources at present. All existing workforce is being prioritised and redeployed to deliver the COVID vaccination programme.
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** **Please provide any further details:**
17. Does the practice require mutual aid from the wider system or CCG?	**X Yes** ☐ **No** **If the response is yes, specifically what is needed, please provide below any further details given.** If mutual aid is available from the CCG or wider system, then the practice would consider accessing and utilising any additional resources made available. The practice would be interested in seeking mutual aid for any clinical staff or reception staff who would be able to provide cover for staff absences at short notice. Staff would need to be familiar with using systmone and have prior experience of working in general practice as there would be times when they would be expected to work unsupervised.
18. What will the impact be for patients?	The impact for patients is minimal, the request is for a reduction in branch opening hours and access to the branch site will still be available on a daily basis. The same services will continue to be provided from the branch site and when the branch site is closed patients will continue to access care and services from the main site. The branch site is used as additional accommodation and has a temporary lease in place until September 2023.The practice is seeking an extension to its current main

	premises, with the intention of relocating all services back to the main site if approved.
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)**	The practice will make patients and wider partners aware of the temporary changes via the following methods: • All telephone calls to the both the main and branch site are already directed to a single telephone number, there will be no need for patients to call a different number or for the practice to divert any phone lines. • Signage will be displayed at both premises to inform patients that there are temporally reduced opening hours at Rosemount House site. The signage will detail the revised opening hours. • A message informing patients of the temporary change will be added to the practice website • A text message to all patients registered with the practice will be sent to inform them of the changes and how to continue to access care • The branch site will continue to be open a daily basis and they will ensure that blood and pathology samples can still be collected from the branch site. • The practice will ensure staff are on site to collect prescriptions, post, deliveries such as medical records from PCSE, clinical waste collections and to check the vaccine fridge temperature.
18b. If future appointments have already been booked for patients how these appointments will be managed?	Patients are notified one day in advance regarding the location of their appointment. No future appointments are booked in at the branch site.
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?	The distance between Bankfield Surgery (main site) and Rosemount House (branch site) is 0.4 miles (0.7km). The distances between sites equates to a less than two-minute car journey or alternatively an 8-minute walk on foot. Patients are notified one day in advance regarding the location of their appointment and are used to attending and

	travelling to either site. The change will not impact on the patient's ability to access GP services as staff will be redeployed to the main site.
18d. How will clinical information about your patients be shared to ensure that vulnerable patients' health needs continue to be met?	The full patient medical record and clinical information is available and can be accessed by all practice staff working at both sites.
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)	The practice will review its vulnerable patients and ensure that they communicate with them via their usual method to ensure they are aware of any changes that may impact them.

Appendix B

Rapid Impact Assessment

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	Temporary reduction in branch opening hours at Rosemount House Bankfield Surgery are requesting a temporary reduction in the opening hours at their branch surgery Rosemount House for a period of 3 months. The practice is experiencing significant staffing pressures due to COVID 19 related absences and has struggled to maintain administrative staff cover at both sites since October 2021. Rosemount House is currently open every day between 08:00 - 18:00pm. The revised opening hours suggested by the practice would be as follows: Monday 08:30 - 17:00 Tuesday 08:30 - 17:00 Wednesday 08:30 - 14:00 Thursday 08:30 - 14:00 Friday 08:30 - 14:00 The distance between Bankfield Surgery (main site) and Rosemount House (branch site) is 0.4 miles (0.7km). The distances between sites equates to a two-minute car journey or alternatively an 8-minute walk on foot.
2. Type of change	Adjust existing - temporary
3. CCGs	Calderdale
4. Form completed by	Natalie Sykes - Senior Primary Care Quality Improvement Manager Sarah Mackenzie-Cooper- Equality Manager Jill Dufton - Senior Engagement Manager Catherine Borrill, Quality Improvement Lead Lucy Walker, Quality Manager
5. Form agreed to be decision ready on	10th January 2022
6. Proposed review date	31st March 2022
B. Impact Assessment	
1. How does this project/decision impact on Quality ie. Safety, Effectiveness and Experience?	**Safety** **B1a:** Temporarily reducing the branch opening hours at Rosemount House and diverting all staff and resources to Bankfield Surgery will enable the practice to deliver and maintain safe clinical services. **Experience** **B1b:** Patients may 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.

	B1c: Paper script requests for medication will continue to be received and processed on a daily basis from the branch and sent via the Electronic Prescribing Service to the patients nominated pharmacy. **B1d**: All telephone calls to the both the main and branch site are already directed to a single telephone number, there will be no need for patients to call a different number or for the practice to divert any phone lines. **B1e:** Communities may perceive that the reduction in opening hours at the branch site as a reduction in services or indicative of a longer-term plan 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 may need to travel further than their usual branch, this will be additionally difficult for disabled, older people and carers of both adults and children. The distance between Bankfield Surgery (main site) and Rosemount House (branch site) is 0.4 miles (0.7km). The distances between sites equates to a two-minute car journey or alternatively an 8-minute walk on foot. Utilising public transport will add a financial and risk burden and not everyone has access to private transport. **B2b:** The reduction in branch opening hours may cause anxiety for people living locally who may assume that access to services is being reduced or that the site is closing permanently. **B2c:** Some patient groups may be less able to understand the change due to digital exclusion, language or sensory issues
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 the main site will still be required to fulfil safeguarding responsibilities and know who their practice safeguarding lead is, to be able to seek advice. **B3b:** 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. **B3c:** The full patient medical record and clinical information is available and can be accessed by all practice staff working at both sites.
4. Are there any other impacts to consider? Eg. Workforce, organisational or system wide	**Workforce** **B4a:** The proposed request will reduce pressures on the existing workforce and allow resources to be centralised and redeployed from the main site. **B4b:** The proposed request may impact neighbouring practices if patients choose to register with a practice that has improved access to appointment times. **B4c:** There is a risk of reputational damage to the practice and/or CCG due to patients perceived perceptions of the reduction in opening hours which may drive an increase in complaints to the CCG or NHS England.

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:** Wherever possible patients will be offered alternatives from walking to the practice such as telephone/online/video consultations. **B1c:** No mitigation required as positive impact **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 temporary reduction in opening hours. The communications need to reassure patients that there are no changes to services and that services can be accessed from the main site when the branch is closed. The practice will explore if Communication messages can be added to the answer phone message or when people are on hold as an additional source of communication about the change. **B2a:** Patients are notified one day in advance regarding the location of their appointment and are used to travelling between sites. Travel arrangements could be supported by the practice or where necessary home visits arranged. **B2c b and c:** As B1e above ensure communications is accessible and reaches the target audience, it is recommended that the practice utilises its patient participation group to support this piece of work. The practice will also need to consider other ways to reach out (local paper) for groups less likely to access website. **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:** Staff have been consulted and are supportive of the proposed changes as it will help improve their emotional wellbeing by bringing both teams together. **B4b:** Feedback from neighbouring practices will be collected and practice list sizes will be monitored and reviewed to determine if there has been an impact on neighbouring practices. **B4c:** Complaints to the practice, CCG and NHSE will be monitored during the temporary closure and discussed at the practice review meeting in March.

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. A text message to all patients registered with the practice will be sent to inform them of the changes and how to continue to access care The practice will explore if Communication messages can be added to the answer phone message or when people are on hold as an additional source of communication about the change. Signage will be displayed at both premises to inform patients that there are temporally reduced opening hours at Rosemount House site. The signage will detail the revised opening hours.
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 Urgent Decision - Making Panel
4. Date of decision	20th January 2022
E. For Quality Team use only	
1. Reference	IA 93
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

Risk Assessment Form

1. Area / task:

Rosemount House

The practice is experiencing significant staffing pressures due to COVID 19 related absences and has struggled to maintain administrative staff cover over both sites since October 2021.

2. Assessor(s):

Claire Baggley

Karen Bartle

3. Date:

12/01/2022

4. Significant hazards or issues:

A.) Potentially insufficient staff to safely provide services across two locations

B.) Risk to patients through potential inability to provide clinical and administrative services across two locations

C.) Staff well-being

D.) Risk to other users/visitors of Rosemount House

5. Who could be harmed and how?

- Staff wellbeing could be affected due to low staff levels and increased workload. Staff could potentially be put at risk if lone working occurs.
- Patients could potentially be harmed if staffing levels are inadequate.

6. What current control / risk reduction measures are already in place?

- Consolidation of staff to ensure staffing levels are safe and adequate. All staff, resources and services can be pooled and delivered by the main site at Bankfield Surgery.
- All telephone calls to both the main and branch site are already directed to a single telephone number
- The practice will continue to maximise the use of electronic prescriptions
- The practice offers a range of appointment types including online and telephone appointments as well as face to face appointments

7. Assessment of remaining risks: **RISK = SEVERITY X LIKELIHOOD**

Simply multiply the potential severity of the situation by the likelihood of that happening, using the matrix below: (Example: Major (4) x Possible (3) = amber risk (12))

RISKS: (Each hazard needs a separate risk rating)

A.) 8

B.) 8

C.) 6

D.) 6

Total Risk Score = 28

		LIKELIHOOD				
		1 RARE	2 UNLIKELY	3 POSSIBLE	4 LIKELY	5 ALMOST CERTAIN
SEVERITY	1 NEGLIGIBLE	1 Green	2 Green	3 Green	4 Yellow	5 Yellow
	2 MINOR	2 Green	4 Yellow	6 Yellow	8 Amber	10 Amber
	3 MODERATE	3 Green	6 Yellow	9 Amber	12 Amber	15 Red
	4 MAJOR	4 Yellow	8 Amber	12 Amber	16 Red	20 Red
	5 CATASTROPHIC	5 Yellow	10 Amber	15 Red	20 Red	25 Red

If the risk is Green, (1 – 3):
Very low risk scenario. No further action needed.

If the risk is Yellow, (4 – 7):
Low risk scenario. Yellow risks are generally easily resolved locally at practice level.

If the risk is Amber, (8 – 12):
Medium / moderate risk scenario. Management action needed to reduce risk, as soon as reasonably possible. Amber risk issues should be investigated by the manager responsible for the service.

If the risk is Red, (13 – 25):
High-risk scenario. Immediate action needed. These represent serious risk issues that may require investigation as a critical incident

8. Further Control Measures needed to reduce risk:

Temporarily reducing the branch opening hours at Rosemount House and diverting all staff, resources to Bankfield Surgery will enable both sites to continue to deliver services safely, with no impact on patient care.

Hierarchy of Risk Control Measures

A hierarchy of control measures can be applied to all hazards as follows:

1. **Eliminate hazard**
2. **Substitute hazard**
3. **Reduce exposure**
4. **Adapt methodology**
5. **Restrict access**
6. **Planned maintenance**
7. **Personal Protective Equipment (last resort!)**

9. Remaining risk, i.e. after further control measures have been implemented. Please use matrix again

N/A

Name of Meeting	Commissioning Primary Medical Services Committee	**Meeting Date**	3 March 2022
Title of Report	**Directors Report**	**Agenda Item No.**	5
Report Author	Debbie Robinson Director of Improvement (Community & Primary Care) Emma Bownas – Deputy Director of Improvement - Primary Care	**Public / Private Item**	Public
Clinical Lead	Dr Majid Azeb Clinical Lead for Primary Care	**Responsible Officer**	Debbie Robinson Director of Improvement (Community & Primary Care)

Executive Summary
This report seeks a decision from the committee in respect of the extension of the Special Allocation Scheme procedure and provides an update to the committee on the following: 1. Prescribing Support Dietitian Project 2. Additional Roles Reimbursement Scheme 3. Quality Resilience and Recovery scheme and its implementation up to the end of January 2022

Previous Considerations

Name of meeting	CPMSC	**Meeting Date**	25 November 2021
Name of meeting	CPMSC	**Meeting Date**	7 March 2019

Recommendations			
It recommended that the committee: I. **NOTES** the content of the paper. II. **APPROVES** the continuation of the Special Allocation Scheme procedure for a further three years.			
Decision ☒	**Assurance ☐**	**Discussion ☐**	**Other:**

Implications

Quality and Safety implications (including whether a quality impact assessment has been completed)	Detailed within the report
Engagement and Equality Implications (including whether an equality impact assessment has been completed), and health inequalities considerations	Detailed within the report
Resources / Financial Implications (including Staffing/Workforce considerations)	None identified
Sustainability Implications	An element of the QRR scheme focusses on sustainable and environmentally friendly general practice

Has a Data Protection Impact Assessment (DPIA) been completed?	**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 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. Special Allocation Scheme

1.1 At its meeting on the 7 March 2019 the committee received and considered a report that detailed the proposed procedure for the management and decision of appeals lodged by patients that have been referred to the Special Allocations Scheme (locally known as Safe Haven). The final approved procedure can be found in Appendix A.

1.2 The Safe Haven Scheme was introduced in nationally 2004 via a Directed Enhanced Service to ensure that patients who were violent or threatening could still receive primary medical services whilst ensuring that referring practices were protected from undesirable behaviours.

1.3 From time to time there may be occasions where a Practice refers a patient to the Scheme and the patient disagrees with the decision. The procedures approved by the committee are designed to provide a consistent and structured method for addressing this situation which is also compliant with NHS England requirements.

The procedure is due for review, however since its establishment there has only been 1 appeal, in October 2019. There have been no further appeals since this time and no changes to the NHS England Policy and Guidance Manual that impacts on the procedure we have in place.

Recommendation: It is therefore, recommended that the committee approves the continuation of the procedure for a further three years.

2. Prescribing Support Dietitian Project

2.1 At its meeting in August 2021 the committee was informed about the CCG's dietitian in primary care project and was advised that the aim of the short term project was to review prescribing of oral nutritional supplements(ONS) in general practice, improve appropriateness of prescribing and increase our understanding of how a dietitian can work within GP practices to improve the management of malnutrition. The committee was advised that at the time the project had already started to deliver benefits with patients stopping unnecessary food supplements and/or changing to more effective supplements with updated treatment plans.

2.2 Calderdale CCG was an outlier in West Yorkshire on spend on oral nutritional supplements (ONS) per 1000 patients . The CCG agreed to provide 9-month funding for 6 hours a week for a prescribing support dietitian which began in 2021. The results to date are as follows:

- 88 patients have been reviewed across 3 practices in 3 Primary Care Networks (PCNs). Of those patients:
- 24 had their supplement stopped
- 15 had their supplement quantity reduced or switched to a more effective product
- 49 no change (following dietetic assessment)

Savings to date (January 2022): Full year £19,386

Resources have been produced that include:

- Referral guidance for GP practices
- Referral guidance for care homes
- Draft ONS prescribing algorithm for primary care (not yet published)

Learning and Common Themes:

- Most patients started on a ready to drink formulation – less palatable and significantly more expensive
- Lack of promotion of food first advice
- Lack of review/stop dates in letters from the hospital at discharge
- Very few patients have their weight checked or ONS reviewed
- A high proportion of patients had an onward referral to the community dietetic team for weight check and review

2.3 The draft prescribing algorithm will support non-dietetic health care professionals with some of these issues and themes by providing advice on food first and guidance on the choice of nutritional supplements. The prescribing support dietitian has already fed back to dietetic colleagues in the acute trust on ways to improve communication with primary care colleagues by ensuring the inclusion of details around review dates and follow ups. Further work is planned to support improved communication between secondary and primary care around nutritional supplements as these are frequently started without dietetic assessment during hospital admissions.

2.4 **Patient story:**

Patient A commenced ONS in hospital on a standard prescription. The patient was not seen by a dietitian in hospital or referred to community dietitian. A repeat prescription was put in place over 12 months, there was no follow up and no weight check. the patient was reviewed by the prescribing support dietitian and had gained 14kg and was eating and drinking well as they were no longer acutely unwell. All ONS stopped. The Patient was delighted.

2.5 **Next steps:**

The CCG is considering extending the project to end of June 2022 which will allow work in the remaining PCNs to take place. The learning will be shared with PCN Clinical Directors some of whom are considering the recruitment of primary care dietitians through ARRS funding.

3. Additional Roles Reimbursement Scheme – Update

3.1 All 5 Calderdale Primary Care Networks (PCNs) have submitted forecast plans for 2022/23 with recruitment underway.

3.2 The biggest increase planned within the roles is Physician Associates. Use of this role is exclusively planned within Central PCN.

3.3 Following the recruitment of one occupational therapist (OT) that was shared across 2 Primary Care Networks, the decision has been taken to employ a further OT to make 2 whole time equivalents across the two Primary Care Networks.

3.4 New roles for the coming year include a podiatrist, health and wellbeing coach, advanced practitioner, and trainee nurse associate.

3.5 The challenge this year has been related to the availability of mental health practitioners, due in part to the requirements stipulating these must be provided by the Mental Health Trust. As a consequence of this South West Yorkshire Mental Health Partnership Trust have taken the decision to stagger the recruitment of the roles planned for 2021/22 into 2022/23 with only two planned for Calderdale from June 2022 due to a risk of de-stabilising their workforce

3.6 In view of this the PCNs have taken a decision to consider which other roles could provide similar skills and competencies to meet the mental health practitioner need. The CCG will support the PCNs in exploring this further.

3.7 Recruitment and availability of the workforce remains a challenge for the successful utilisation of the funding attached to the Additional Roles Reimbursement Scheme, along with the challenges of providing appropriate professional support, supervision, and training. This is restricted by the rules of the scheme that claims can only be made to fund actual salary paid to an individual. This issue has been recognised by the West Yorkshire Primary Care Workforce Steering as a challenge across the system and is being escalated by PCNs nationally. The Network Contract DES for 2022/23 is awaited and will provide details of the expectation of the scheme for 2022/23.

4. Update on the Quality Risk and Recovery Scheme

4.1 At its meeting on the 5 November 2021, the urgent decision-making panel approved the Quality Resilience and Recovery Scheme for General practice. This is an eight - month scheme which started in November 2021. 19 of the 21 GP practices in Calderdale are signed up to deliver the scheme. By signing up practices have agreed to make demonstratable progress against ALL the indicators detailed within the scheme. The scheme is intended to support practice resilience and system recovery. The scheme aims to deliver 4 broad outcomes to support practices to:

1) meet their population access needs and understand workforce required to deliver them
2) improve health outcomes for vulnerable patients
3) ensure patients received timely care through onward referrals
4) contribute to a sustainable future

4.2 To support the implementation of any actions, at practice or PCN level, as a result of the review of access models within the Enhanced Patient Access and Inclusion domain, the committee agreed to ring fence a non-recurrent improvement fund of £250k, this has been topped up with the funding that is not being utilised by the 2 practices that have not signed up to the scheme. This retains the investment in the scheme and means there will be non-recurrent pot of £304k.

4.3 **The following is an update on progress up to the end of January 2022.**

Enhanced patient access and inclusion:

Sub-Category	Requirement	Submission Date	Progress to Date
Review and revision of the practice access model	Complete a review and revision to the general practice access model	Part One: 31/03/22 Part Two: 02/07/22	32 members of staff from General Practice attended the two Apex refresher sessions held in December 2021 and January 2022. Apex held a further session for Calderdale GP practice staff on 25 January 2022. The session focused on how practices can use Apex to complete the requirements of the QRR access template. The practice access submissions will be reviewed on the 14 April 2022, the panel consists of representatives from Healthwatch, and colleagues form the Primary Care, Equality and Engagement at the CCG.
Registration for patients who are homeless or migrants	Report to the CCG on a quarterly basis the number of new registrations of homeless patients.	07/01/22 08/04/22 08/07/22	11 GP practices have submitted a return which was due on 07/01/22, non-responders have been sent a reminder. 146 GP receptionists have undertaken the homelessness training

	Report on the numbers of staff who have undertaken training detailed within the scheme		Trauma informed training will be organised by the safeguarding team – currently awaiting a date 12 GP practices have signed up to the Safe Surgeries initiative 12 GP practices have carried out data validation on their homeless register 0 homeless patients have been registered with a GP between November and December 2021
Funding Time for Clinical Care	To increase the number of people who have had a health check and long-term condition review	Baseline taken in November 2021	All practices have shown an increase in the number of LTC reviews undertaken since November 2021 The CCG average was 55% in November 2021, data for January 2022 shows its increased to 58%
Reducing Health Inequalities	To increase the recording of protected characteristics	Baseline taken in November 2021	Data from January 2022 shows there has been a small increase in recording for: main spoken language, marital status, and sexual orientation
Physical health checks for patients with severe mental illness	Increase the percentage of mental health checks performed in	CCG average at June 2021 was 14%	18 out of 21 practices have shown a month on month increase in achievement from June 2021.

	2020/21. To achieve a rolling average of 65% completion from June 2022		The CCG average was 14% in June and in January 2022 this had increased to 25% Support to practices has included: Monthly reporting of performance at practice and PCN level SMI Action Plan Template published on Ardens, linking to the clinical system and replicating the template used for Learning Disability Healthchecks. Development of an easy read patient invitation letter co-designed by people with lived experience Invitation Pack, available on Ardens including advice on reasonable adjustments, how to link to social prescribing Clinician Top Tips.
Physical health checks for patients with a learning disability	Increase the percentage of learning disabilities health checks performed in 2020/21.	CCG Performance at March 31st 2021 was 83%	All practices have increased the numbers of health checks completed for people with a learning disability since November 2021. The CCG average at the 4th of February 2022 was 49% completed. Performance is shared weekly at practice and PCN level and the LMC are supporting conversations with individual practices where uptake is low.

			The Strategic Health Facilitator is also working with practices to offer support to increase engagement and uptake. As part of the QRR scheme practices are required to identify a link person to work closely with the strategic health facilitator

Sustainable and environmentally friendly general practice:

Sub-Category	Requirement	Submission Date	Progress to Date
None	Submission of completed template to demonstrate the practice is making progress to develop, environmentally responsible practises	01/02/22	9 GP Practices have submitted a template to demonstrate that they are making progress to develop, environmentally responsible practises Non-responders have been sent a reminder. Templates received to date indicate practices would like to focus on: building efficiency, recycling, green impact workbook, planting trees, electric car charging points, cycling parking and medication prescribing.

Medicines Safety:

Sub-Category	Requirement	Submission Date	Progress to Date
Opioid Prescribing	Develop a practice plan to safely reduce high dose opioid prescribing	31/01/22	11 GP Practices have submitted their High Dose Opioids Plan Non-responders have been sent a reminder.
Short Acting Beta Agonist Prescribing	Develop a practice policy for Short Acting Beta Agonists (SABA) on repeat, for asthmatic patients	31/01/22	10 GP Practices have submitted Short Acting Beta Agonist Dose Plan 3 GP Practices have submitted their Asthma Protocol Non-responders have been sent a reminder.

Supporting Effective System Resilience:

Sub-Category	Requirement	Submission Date	Progress to Date
Clinical Decision-making Support Tool	Increase the practice use of Arden's clinical decision-making support tool	A baseline was taken during October 2021	Data from January 2022 suggests there has been a substantial reduction in the use of Arden's. This issue is being explored further with data quality and the CCG lead for Arden's.

5. Next steps

We will :

- Continue to monitor progress with the scheme and will review this with the Clinical Lead for Primary Care, PCN Clinical Directors and the Calderdale LMC.
- Establish the panel to review the access submissions in April 2022
- Review further the data in relation to the use of the Arden's system with the CCGs Data Quality Team and the CCG lead for the system .
- Develop the framework for the non-recurrent investment with the Calderdale Local Medical Committee.

6. Recommendations

It recommended that the committee:

I. **NOTES** the content of the paper.

II. **APPROVES** the continuation of the Special Allocation Scheme procedure for a further three years.

7. Appendices

Appendix A – Procedure for the Special Allocation Scheme (SAS) / Safe Haven Appeals Panel

Procedure for the Special Allocation Scheme (SAS) / Safe Haven Appeals Panel

Version/Status:	v2.0 / Updated October 2019
Responsible Committee:	Commissioning Primary Medical Services Committee
Date Approved:	November 2019
Author:	Primary Care Quality & Improvement Project Manager
Responsible Lead:	Head of Primary Care Quality & Improvement
Review Date:	March 2022 or following any change in guidance or legislation which requires review

Version History

Version no.	Date	Author	Document Status	Commentary: (document development / approval)	Circulation
0.1-0.5	14.02.2019	Primary Care Quality & Improvement Project Manager	Initial drafts	To be reviewed by Head of Primary Care	
0.6	15.02.2019	Primary Care Quality & Improvement Project Manager	Draft for approval	Updates following review by Head of Primary Care	
0.7	19.02.2019	Primary Care Quality & Improvement Project Manager	Draft for approval	Updates following review by Head of Primary Care & Awaiting approval by Commissioning Primary Medical Services Committee	CPMS Committee
1.0	07.03.2019	Primary Care Quality & Improvement Project Manager	FINAL	Approved by Commissioning Primary Medical Services Committee subject to requested changes and those arising from the DPIA.	Member Practices, NHS England, LMC, PCSE and CCG Primary Care Team
1.1	14.10.2019	Primary Care Quality & Improvement Project Manager	Revised Draft for approval	Revised following publication of National Guidance in the Policy & Guidance Manual April 2019	
2.0	07.11.2019	Primary Care Quality & Improvement Project Manager	FINAL	Approved by Commissioning Primary Medical Services Committee	Member Practices, NHS England, LMC, PCSE and CCG Primary Care Team

Contents

1 Introduction

1.1 From time to time General Practices may request immediate removal of patients from their registered list that have been physically or verbally violent or made threats of violence, to the level that a person feared for their safety. In these instances a patient may be allocated to the Special Allocations Scheme (SAS) known locally as Safe Haven, to ensure they continue to receive primary medical services in a safe and secure environment which can also educate the patients regarding the appropriate use of NHS resources and behaviour.

1.2 The Special Allocations Scheme or Safe Haven will be referred to as The Scheme within this procedure.

1.3 There may be, however, certain occasions where a patient maintains that they have been incorrectly allocated to The Scheme and as such lodge an appeal against this decision.

2 Purpose

2.1 The purpose of this procedure is to ensure that a standardised and suitable process is followed where patients appeal against inclusion on The Scheme.

2.2 The process is supported by the NHS England Primary Medical Care Policy and Guidance Manual (PGM). Section 6 Special Allocation Scheme (SAS) and specifically 6.4.21 Appeals Process

https://www.england.nhs.uk/publication/primary-medical- care-policy-and-guidance-manual-pgm/

3 Process

3.1 Members of the Primary Care Quality and Improvement Team will act as the SAS/Safe Haven Liaison Team and will be the main contact for NHS Calderdale CCG with regards to any action, communication, information and notifications regarding The Scheme from NHS England or Primary Care Support England (PCSE)

3.2 Following on from a patient being allocated to the Scheme by PCSE, all patients would be advised that they can appeal the decision as follows:

3.2.1 Patients should submit a formal written request for appeal to the Special Allocations Scheme (Safe Haven) Liaison Team, as required by the PGM within 28 days of notification of allocation to the Scheme. Verbal requests for appeals will not be accepted.

3.2.2 Written requests should be sent to:

NHS Calderdale CCG

c/o Primary Care – Safe Haven (SAS) Liaison Team
5th Floor
F Mill, Dean Clough
Halifax HX3 5AX
Email: calccg.calderdale.transformation@nhs.net
FAO: Primary Care - Safe Haven (SAS) Liaison Team

3.2.2.1 A patient who is unable to submit their own written request to appeal and requires additional support would be directed to Healthwatch Calderdale and/or Cloverleaf Calderdale:

3.2.2.2 Healthwatch Calderdale
The Elsie Whiteley Innovation Centre
Hopwood lane
Halifax HX1 5ER
Telephone: 01422 399433
Email: info@healthwatchcalderdale.co.uk

3.2.2.3 Cloverleaf Advocacy, Calderdale
Nursery Lane
Ovenden
Halifax HX3 5SW
Telephone: 01422 849589
Email: info@leadthewaycalderdale.org

3.2.2.4 The CCG would take a pragmatic view around adherence to deadlines on a case by case basis but particularly where a patient requires additional support.

3.2.3 Requests for appeals should be acknowledged within 14 days of receipt of request. Paperwork for completion by the patient (see Appendix A & B) will be sent at this time.

3.2.4 The patient will remain on The Scheme while the case is being heard (as per the PGM section 6.4.25) and will be informed of this in the initial letter (see Appendix A).

3.2.5 The Liaison Team will contact the referring Practice to notify of the request for appeal and provide the opportunity to submit evidence in support of the referral once consent has been received from the patient. (see Appendix C)

3.2.6 All additional information must be received within 20 days of sending to the patient. Where additional information is not received, or it is confirmed by the patient that they wish to submit no further evidence, the CCG will assume that the patient no longer wishes to appeal their inclusion on the Scheme.

3.2.7 On receipt of all the evidence from both parties a panel will be convened to review the submitted documentation. The appeal should be reviewed within 28 days of receipt of the patient's appeal, providing consent and supporting information is received within this timeframe. Where it is not

possible due to a delay in receiving the required information for the panel to consider, both parties will be informed and the panel convened as soon as possible thereafter. Neither the referred patient nor the referring practice will be asked to attend the hearing.

3.2.8 A face to face panel may be replaced by a virtual panel to ensure appeals are reviewed within the stated timeframe and panel members availability. In virtual panels, all correspondence, rationale and decisions will be circulated via secure email and retained by the Liaison Team as evidence.

3.2.9 The panel will consist of, as a minimum:

i. Primary Care Manager
ii. Contracting Manager
iii. Quality Manager
iv. Clinical Advisor - A member of the Local Medical Committee (LMC)
v. The panel and process will be arranged by the Primary Care Project Manager
vi. Appropriate deputies may attend on behalf of Panel Members.

3.3 Conduct of the Panel

3.3.2 Members of the Panel shall at all times comply with the standards of business conduct and managing conflicts of interest as laid down in each of the CCG Constitution and the Managing Conflicts of Interest Policy.

3.3.3 Members of the Panel shall respect the privacy of individuals in any part of the process and ensure that information is kept confidential.

3.3.4 The Clinical Advisor will be sourced from the LMC. The Liaison Team will ensure there are no conflicts of interest with the patients' originating practice. The GP undertaking the role of Clinical Advisor will be expected to sign a confidentiality statement.

3.3.5 Secretarial support will be provided by the Primary Care team to ensure appropriate support to the panel members in relation to the organisation and conduct of meetings. Formal minutes will be taken to ensure there is an appropriate governance trail for decisions made. In the case of a virtual panel, this will be in the form of emails which will be sent securely (using NHS Mail) and stored securely.

3.3.6 The updated PGM (April 2019 version) states the panel should be assured of the patients identity (section 6.4.30) and further requires (section 6.4.30.1.2) that the panel re-confirms with the practice, the identity of the patient and cross checks this with the details of the patient making the appeal.

3.3.7 The Primary Care Safe Haven (SAS) Liaison Team will share with the panel all details of the checks taken to establish the patients identify is accurate.

3.4 Process following Review Panel

3.4.2 The panel's decision will be final; the decision will be communicated in writing to all parties within 14 days of the decision.

3.4.3 Where the decision is for the patient to remain on the Scheme, this will be for the minimum period of 12 months or as deemed appropriate by the scheme Provider.

3.4.4 Where the panel finds in favour of the patient, then the patient will be able to register at any GP practice where their address falls within the said GP practice boundary. This would not typically be the referring GP practice as it can be considered that the breakdown in GP-patient relationship would be significant.

3.4.5 PCSE will be informed of the outcome of the panel and, where necessary, be requested to remove all flags from the patient record where the panel finds in the patient's favour.

3.4.6 If the patient feels that the appeal process has not been followed, the patient can make a complaint in the first instance to the CCG via ccg.feedback@calerdaleccg.nhs.uk or in the second instance to the Health Service Ombudsman by visiting www.ombudsman.org.uk

Appendices

See separate attachments in Word to enable practices to complete

Appendix A & B – Patient Consent Letter & Additional Information Form (patient)

Appendix C – Practice Supporting Evidence

Name of Meeting	Commissioning Primary Medical Services Committee	**Meeting Date**	3 March 2022
Title of Report	**Mixenden Hub Development**	**Agenda Item No.**	6
Report Author	Steve Maleham (Interim Estates Adviser) Debbie Robinson Director of Improvement - (Community and Primary Care)	**Public / Private Item**	Public
Governing Body Lead	Neil Smurthwaite Chief Operating Officer	**Responsible Officer**	Debbie Robinson Director of Improvement - (Community and Primary Care)

Executive Summary

The purpose of this report is to update you on the proposed development at Mixenden. As the committee may remember, we initially agreed to fund the additional costs for a replacement GP surgery in the locality.

Unfortunately, the practice have withdrawn from the development. In recognising the importance to North Halifax and its population, the North Halifax PCN have come forward to potentially use the site as a HUB which is consistent with their local PCN estate strategy.

The report therefore seeks approval for the funding of the reimbursement of rent under the Premises Cost Directions (PCDs) for the PCN to occupy the new Mixenden Hub development.

Previous Considerations

Name of meeting	CPMSC	**Meeting Date**	1st March 2018
Name of meeting		**Meeting Date**	

Recommendations

It is recommended that the committee:

i. Notes the content of the paper

ii. Approves Option 3

The proposal to support rent and other costs reimbursement detailed in table 1 for the development at Mixenden and to create a General Practice Primary Care Network hub for North Halifax.

Decision ☒	Assurance ☐	Discussion ☐	Other:

Implications

Quality and Safety implications (including whether a quality impact assessment has been completed)	A Quality Impact Assessment will be completed as part of the process.
Engagement and Equality Implications (including whether an equality impact assessment has been completed), and health inequalities considerations	An Equality Impact Assessment will be completed as part of the process.
Resources / Financial Implications (including Staffing/Workforce considerations)	Detailed in the report
Sustainability Implications	Detailed in the report

Has a Data Protection Impact Assessment (DPIA) been completed?	**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	Risks are detailed within the paper	Risks are contained within the report
Legal / CCG Constitutional Implications	• Obligation to provide primary medical services to the local population.	Any conflicts of interest will be managed in line with the CCG's policy for managing Conflicts of Interest.	Conflicts to be managed in line with CCG's Conflicts of Interest Policy.

1. Introduction

1.1 The proposals for a New District Centre in Mixenden are an important part of delivery on the Council's priorities to reduce inequalities, by improving health outcomes and routes to learning and employment, whilst ensuring integrated and sustainable development at the heart of local communities.

1.2 The Council and CCG have been working to find a viable long-term solution to create a sustainable District Centre, The Mixenden Hub Development, for some considerable time. Progress has been slow but steady given the need to complete a complex land assembly and agree a relevant funding package.

1.3 The intention was to create a transformational new District Centre for Mixenden and include space for a GP surgery, a pharmacy and a library ensuring an integrated and sustainable development at the heart of the local community. The original intention was that a new, purpose-built doctor's surgery would be occupied by Caritas Group Practice and would replace the facility operated from a building at Mixenden Stones. The new facility would support a wider range of services from the immediate locality.

2. Detail

2.1 At its meeting on 1st March 2018, a subgroup of the CPMSC considered and approved an application from Caritas Group Practice for an uplift in rent re-imbursement to support the relocation of their Mixenden Stones facility into new, purpose designed premises at the new Mixenden Hub development. The increase in rent reimbursement at that time was for the sum of £45k and this was built into CCG financial plans and considered affordable.

2.2 Unfortunately, the Caritas Group Practice have recently pulled out of the scheme. This decision has also prompted the pharmacy pulling out of renting the adjacent space within the development. These are personal decisions for the contractors and not a reflection on the development itself.

2.3 Senior managers from the CCG, the Council and the North Halifax Primary Care Network (PCN) have been discussing potential solutions which would enable the Mixenden Hub development to proceed and support the delivery of the PCNs clinical, workforce and estates strategic intentions.

2.3.1. Like many GP practices across England, practices in the PCN struggle to provide essential services because of inadequate premises. There are considerable challenges, not only to deliver the PCN contract but also to expand services to reach what is expected as a mature network. North Halifax PCN believe that the PCN estate can act as a catalyst for changing the way services are delivered locally. They are continuing to work together to develop further their service delivery model but have an ambition to focus on hub and spoke models that suit the PCN and the North Halifax Locality. This will be influenced by the resources, projected population health and care needs and the PCN's evolving service models, which would also consider the provision of at scale primary medical services. The PCN has already made inroads into the delivery of services at scale and the intention through this development is to provide a base for the delivery of integrated services NOT just co-located.

2.3.2. The planned use by the PCN of the Mixenden Hub would be a multipurpose use of the space. The PCN are involved in a number of initiatives and clinical reviews to support the patients of North Halifax including but not limited to:

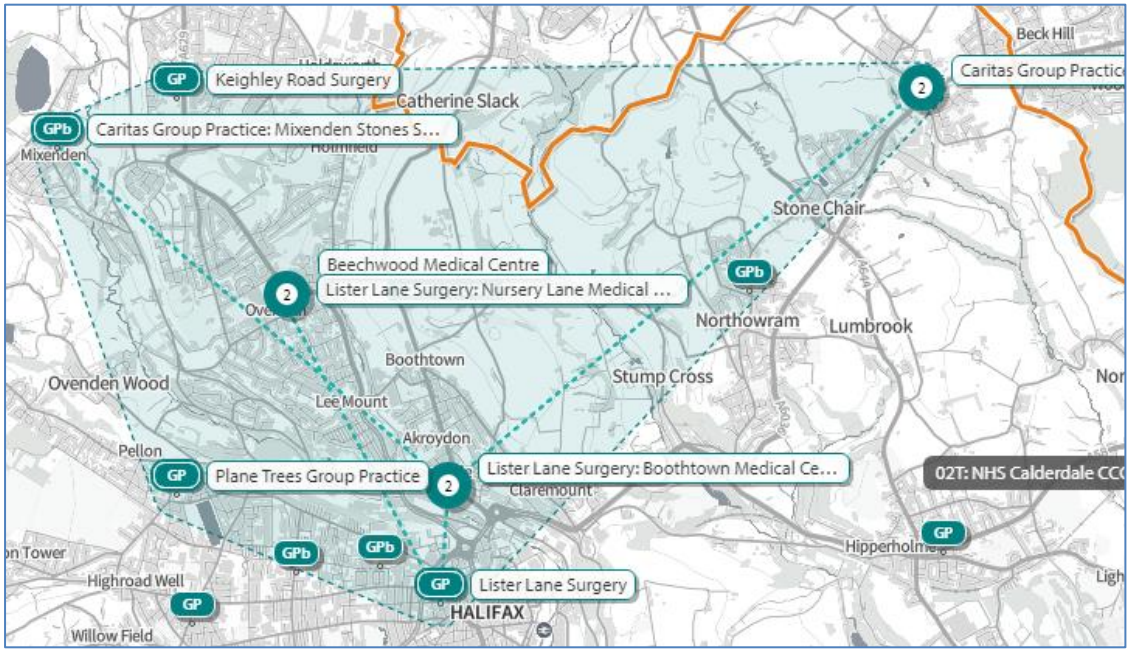
- Medication Reviews by the Community Pharmacy Team which involves letter reconciliation, prescription queries and links to clinics such as hypertension and to expand into Structured Medication Reviews (SMRs)
- The Personalised Care Team make calls to patients with a view to moving to more face to face appointments
- MSK Clinics run along with support from the health and wellbeing coach
- Learning Disability Clinics to support the annual learning disability health checks and health action plans
- Intention to establish Serious Mental Illness Clinics to support the annual SMI health checks and health action plans
- Review of Frailty patients
- Care Home MDTs
- Intention to grow services in line with a Population Health Management (PHM) approach and in line with the PCN DES.

2.4 **North Halifax Primary Care Network**

The Network is made up of five practices delivering services from nine premises, covering the Calderdale wards of Illingworth & Mixenden, Northowram & Shelf, Ovenden and Warley providing services to a population of over 46,000 (source NHSD January 2022 raw list size).

2.5 The network is made up of the following practices:

- **Keighley Road Surgery**
- **Plane Trees Group Practice**
- **Lister Lane Surgery** – operating from three sites Lister Lane Surgery, Nursery Lane Medical Centre and Boothtown Medical Centre
- **Beechwood Medical Centre**
- **Caritas Group Practice** – operating from three sites Woodside Surgery, Shelf Health Centre and Mixenden Stones Surgery



2.6 The current rent reimbursement across the whole PCN is approximately £516,000.

2.7 The practices within the PCN have identified that there are significant pressures in terms of accommodation as they return to seeing more patients face to face and with the expanding clinical workforce which incorporates the ARRS roles across the PCN. The PCN currently employs 17 staff (through the ARR scheme) in addition to their practice core staff and this is set to increase to approximately 30 by March 2024. The majority of the practices could

accommodate the current levels of primary care activity within their premises, however with the services and increased staff numbers associated with the PCN staff, this is inhibiting the practices ambitions and ability to recruit.

2.8 The practices are currently utilising a number of methods to alleviate some of their accommodation pressures in the short term, including:

- Room rotas for clinical rooms
- Hot desking (where practical)
- Flexible and remote working for staff (where practical)
- Utilise non face to face consultation where practical, however it is noted that across the network and Calderdale as a whole, there has been a shift by patients for more face to face consultations, with a split being around 35-40% digital or phone consultations.
- Currently the PCN is utilising space at Mixenden Stones for PCN staff and services, however, this does not provide adequate space and is not conducive to team working.

2.9 The practices have been considering options for short and medium term solutions and prioritise these as part of the development of their PCN estate strategy. A key objective is the provision of suitable accommodation for a hub for PCN staff and services, allowing them to be co-located whilst delivering services in a dispersed model across the practices. The current temporary arrangements at Mixenden Stones Surgery are cramped and not fit for purpose.

In 2016 the CCG invested in an external provider to undertake six-facet surveys for all practice premises in Calderdale. These will be updated in 2022, in line with good practice, but it is worth noting that in terms of space utilisation in 2016, 8 of the North Halifax practice premises were deemed by the external advisers as being fully utilised, with one premise being overcrowded, so we do not expect this picture to have improved.

2.10 The PCN workforce profile anticipated over the period to March 2024 is as follows:

ROLES	20/21	21/22	22/23	23/24	ROOM TYPE
Clinical Pharmacist	**2.5**	3.83	4.00	6.0	CLINICAL/HUB
Social Prescribing Link Worker	**1.95**	1.95	2.00	3.0	CLINICAL/HUB
Physiotherapist	**1.4**	2.18	3	3.0	CLINICAL
Physician Associate	**0**	0	0	0.0	
Paramedic	**0**	1.5	2.00	3.0	CLINICAL/HV
Pharmacy Technician	**0**	0	1	1.0	HUB
Occupational Therapists	**0**	0	1	1.0	CLINICAL/HV
Dietitians	**0**	0	1	1.0	CLINICAL
Chiropodist/Podiatrist	**0**	0	1	1.0	CLINICAL
Health and Wellbeing Coach	**0**	0	1	1.0	CLINICAL/HUB
Care co-ordinator	**2**	2.5	4.50	5.0	HUB
Mental Health Practitioner	**0**	1	2	3.0	CLINICAL
Trainee Nursing Associate	**0**	0	0	0.0	
Nursing Associate	**0**	0	1	2.0	CLINICAL
Total	**7.9**	**13.0**	**21.6**	**30.0**	
PCN MANAGER		1	1	1	OFFICE
PCN COORDINATOR	1	1	1	1	OFFICE
PCN ADMIN			1	2	OFFICE
Sub-Total ADMIN STAFF	**1**	**2**	**3**	**4**	OFFICE
TOTAL ARRS Workforce	**8.9**	**15.0**	**24.6**	**34.0**	

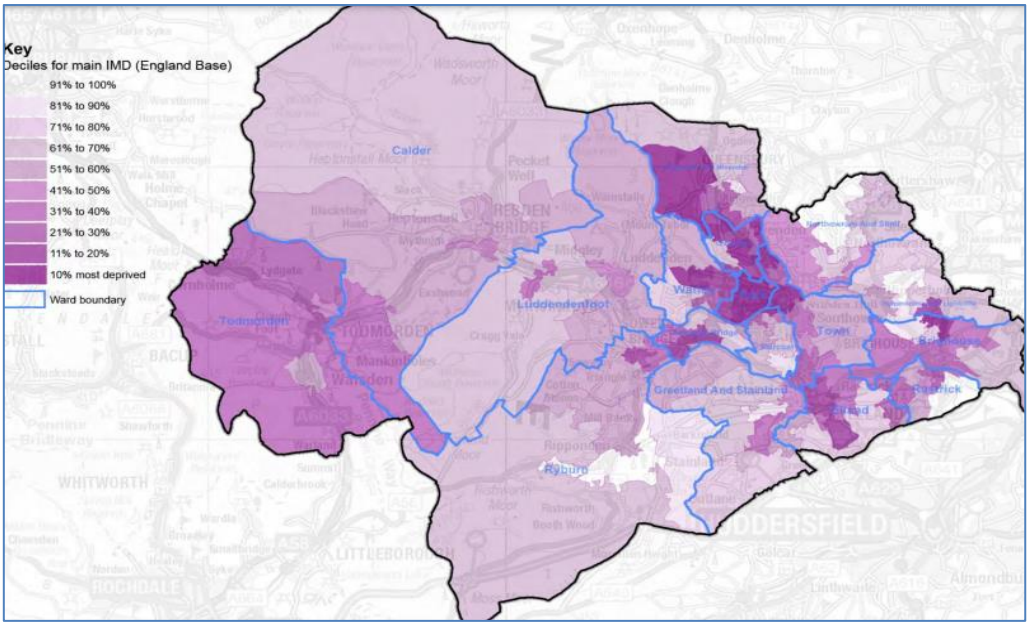
2.11 The PCN are in the process of finalising their estate strategy and a key objective is to develop a hub and primary care at scale model, with PCN services being delivered from a central hub and primary care spokes. The hub would facilitate the ability to re-locate PCN staff from their current cramped space within practice sites, allowing the practices to better utilise, reconfigure or extend their existing premises (where practical) to deliver enhanced primary care services in the future.

2.12 The decision by Caritas Group Practice to withdraw from the scheme creates an opportunity for the PCN to establish its clinical hub within the Councils' Mixenden development.

2.13 **Strategic Need**

The proposed development contributes to the North Halifax transformation programme and will positively contribute to local urban regeneration.

Relative overall deprivation in Calderdale has increased in recent years when compared with other authorities in England. The Index of Multiple Deprivation (IMR) shows the most deprived neighbourhoods in Calderdale are in Park, Ovenden and Illingworth and Mixenden wards. The ward of Illingworth and Mixenden is ranked in the lowest 10% most deprived neighbourhoods in the country. Life expectancy is 9.3 years lower than in the least deprived areas in Calderdale.



2.14 In terms of strategic alignment, the Mixenden proposal is consistent with:

- Calderdale CCGs strategic vision
- PCN Clinical Strategy, Future Operating Model and Workforce Plan
- The Councils transformation ambitions for the area and to support housing developments

2.14.1 **Housing Developments**

Housing work is underway to draw together a collection of Council owned sites that are identified in the draft Local Plan for housing, otherwise referred to as the North Halifax Transformation Programme (NHTP), to procure a delivery partner for three of the sites. These sites are Furness Avenue, Turner Avenue South in Illingworth and Clough Lane in Mixenden. The sites have capacity for over 250 new homes, including an extra care scheme. The objectives for the programme include contributing to an age friendly community for both the surrounding existing homes and new homes. An EOI has already been submitted to WYCAs Brownfield Housing Fund (BHF) and NHTP is on the long list. The identified delivery partner will be expected to work closely with the Council in drafting business cases to secure BHF. The tender has been released and expected to conclude summer 2022.

The development of the new homes represents over £25m in investment. In total, the Local Plan has identified sites for over 1600 new homes in North Halifax, this is spread across 23 sites. Development of this scale requires a coordinated approach across a number of

services to ensure the infrastructure, both hard and soft, is put in place to support this growing community.

2.15 **Assessment of Options**

Three Options have been considered in response to the decision by Caritas Group Practice to withdraw from the scheme:

Option	Key Features	Advantages	Disadvantages
Option 1 Do Nothing	CCG abandons interest in the Mixenden scheme, maintaining current arrangements for the practices and the PCN	Lowest cost option	Significant public sector investment has already been made in the scheme over a number of years. Does not support the place based ambition for the regeneration for North Halifax. Does not support the delivery of the PCNs estate strategy, which will remain an issue and could negatively impact on the delivery of services to patients.
Option 2 Do Something Else	PCN explores an alternative site for its hub ambitions		The PCN would need to start from scratch with an alternative solution to their growing premises requirements.
Option 3 PCN steps in take GP space	PCN steps in to take space within the Mixenden development, replacing the [364 m2] space vacated by CGP's decision to withdraw from the scheme	Offers the quickest solution to PCNs objective of establishing hub. Project is almost 'shovel ready' and capital funding is already secured. Project is fully support by the Local Authority.	PCN may outgrow their space which could constrain future service developments in the longer term

2.16 Additional Considerations

2.16.1 Lease Term

The current assumption is that the Lease will be on an effectively Fully Repairing and Insuring basis (FIR) based on a 15 year term with no break clauses and with 3 yearly rent reviews, which is consistent with other new surgeries within the surrounding area. This is subject to confirmation and there may be scope for the Council and the local NHS to explore, at a senior level, a shorter lease term.

2.16.2 Development Funding

Capital development funding is being provided by the Council via a mix of internal resources and borrowing and is fully approved by the Council's governance arrangements. NHS Commissioners are not providing any capital funding, the request is for revenue to cover the costs associated with recurrent rental etc. However, there are likely to be some moving in costs that the PCN are likely to incur, to make the space suitable for their occupation.

2.16.3 Internal re-design

The PCN leadership team have been working with the Council to review and refine the internal layout of the space available. This is primarily to align the layout to the specific requirements of the PCN staff and services. The adjusted internal layout (subject to final sign off) is shown at Appendix A.

2.16.4 VAT

The Council have confirmed that VAT at the prevailing rate will be charged on any lease payments due under the terms of a lease.

2.16.5 Service Charge

The Council have confirmed that a service charge will be levied to cover the tenants share of the costs associated with utilities, structural maintenance of the building and upkeep of common areas including the car park and landscaping. The cost is based on the demised area allocated to a tenant, as a proportion of the total internal area of the building. The service charge proposed by the council is estimated at circa £35 per sq.m which is considered to be on market for this type of accommodation. The district valuer has indicated verbally, that this

would appear to offer value for money and a formal confirmation will be obtained once the final plans and heads of terms have been signed off.

2.16.6 **Buildings Insurance**

Similar to the Service Charge, the tenant will be responsible for their share of the building insurance costs. The building insurance cost is yet to be confirmed, but for the area proposed to be taken by the PCN the annual cost is likely to be in the region of £2k which is reimbursable under the terms of the Premises Cost Directions (PCD).

2.16.7 **IM&T**

IM&T has been estimated at circa. £25k based on an uplift to the 2018 amount of £20k. IM&T colleagues are currently calculating confirmed costs, taking into account the existing PCN hardware already being used within Mixenden Stones Surgery. These costs cover items such as:

- HSCN line
- PCs/printers, dual monitors per clinical room
- PCs/monitors etc. for admin
- 48 port switches
- Network Cabinet
- Wifi Waps
- Colour Printer
- Scanners

2.16.8 **Stamp Duty Land Tax (SDLT)**

Stamp Duty Land Tax (SDLT) is normally payable by a tenant entering into a commercial lease of 5 years or more and is a reimbursable cost under the terms of the PCDs. If this does arise its likely to be in the region of £6856 which is reimbursable under the terms of the PCDs.

3. Financial Implications for Commissioners

3.1 The costs set out in table 1 below, have been informed by the district valuers market rent report, commissioned by the Council in October 2021. (Appendix B). The financial impact to commissioners on the change from the original Caritas occupation to the proposed North Halifax PCN occupation within the new Mixenden centre is estimated in table 1 below:

Table 1

Recurrent Cost Implications	See Note*	March 2018 Position	February 2022 Position
			Option 3
Area m2	1	358	364
Rent @£182.50 per m2	2	£65,400	
Rent @ £190 per m2	2		£69,160
Car Parking @ £300 per space	3	£ 3,300	£ 3,300
Sub-Total		**£68,700**	**£72,460**
VAT on Lease from Council	4	£13,740	£14,492
Service Charge		unknown	£12,605
Other reimbursable costs (rates, water rates, clinical waste)	5	£39,453	£41,426
Buildings Insurance	6	unknown	£ 2,000
Total Recurrent costs		**£121,893**	**£142,983**
Non-Recurrent Cost Implications			
IT	7	£20,000	£25,000
Stamp Duty Land Tax (SLDT) (allowable under the premises cost Directions)	8	£6,305	£6,856
Project Management Costs (allowable under the premises cost Directions)	9		£23,000
Total Non-recurrent costs		**£26,305**	**£54,856**

Note*	
1	Demised area(s) based on currently available drawings but may be subject to minor change prior to the internal layout design being signed off by the PCN and Council.
2	Rent reimbursement rate based on DV report to Council dated 20th October 2021
3	Car Park reimbursement rate based on DV report to Council dated 20th October 2021
4	VAT will be added to Lease payments at the prevailing rate
5	Estimate to be confirmed closer to scheme completion and occupation
6	Estimate to be confirmed closer to scheme completion and occupation
7	TBC and based on estimates from THIS for IT infrastructure and N3 connection
8	Based on HMRC Tax calculator: www.tax.service.gov.uk/calculate-stamp-duty-land-tax
9	Project Management costs based on 1% of build costs of £2.3m and which are reimbursable under the PCDs

3.2 **Financial Implications for the PCN**

The PCN will need to consider the non-reimbursable cost implications of this proposal, and ensure their financial planning and budgeting accounts for items such as:

- Initial fit out and occupation (e.g., furniture, equipment, logistics)
- Maintenance obligations under the terms of the lease
- Utilities (gas, electric etc)
- Cleaning
- Appropriate legal advice – given the work that has already been done by the solicitor previously acting for Caritas it would be sensible for the PCN to use the same solicitor to avoid unnecessary re-work costs and delays.

4. Risks

4.1 The main risk of not supporting this proposal is that we continue to have inadequate primary care estate to meet the needs of both the workforce and population. The development of services in the community is an NHS and Calderdale Cares priority.

4.2 **CCG:**

4.2.1 Financial risk to CCG due to increased revenue costs. The ringfenced Delegated Primary Care allocation, funds premises reimbursement costs and any increased rent reimbursement/CMR.

4.2.2 Approval was granted in March 2018 for an increase in rent reimbursement of £44k based on a CMR of £68k plus VAT, service charge and other reimbursable costs. The current proposal for the PCN occupation of the space would require a new CMR of £72k plus VAT, service charge and other reimbursable costs. However, the CCG would also be required to maintain the current CMR for Caritas Group Practice, remaining within Mixenden Stones Surgery, which equates to circa. £37k plus VAT and other reimbursable costs per annum.

4.2.3 As a result, the total recurrent investment requirement, including all costs amounts to circa. £143k per annum plus the additional non-recurrent costs estimated at £55k. Approval of the recurrent commitment may restrict the CCGs abilities to meet other priority areas for primary care estate development.

4.2.4 There is a further risk that other PCNs may ask for additional space for ARRS which may not be affordable to replicate in every PCN. However, different PCNs have different estate's needs, availability and priorities.

4.3 **PCN:** Staying at Mixenden Stones Surgery stifles future PCN development and for Caritas Group Practice, who wish to maximise further their service offer – option 3 mitigates this risk.

4.4 **Council:**

4.4.1 Delayed decision threatens viability of the project – this is a key risk, with construction inflation running at 8% currently. A tender exercise has already been completed and shortlisted contractors have submitted priced proposals which are valid for 90 days and expire at the end of February 2022. A delayed decision also prolongs the PCN having to operate from the current unsuitable accommodation.

4.4.2 There is a further risk to the provision of services needed to accommodate the planned 1600 new home developments.

5. Recommendations

5.1 It is recommended that the committee:

iii. Notes the content of the paper

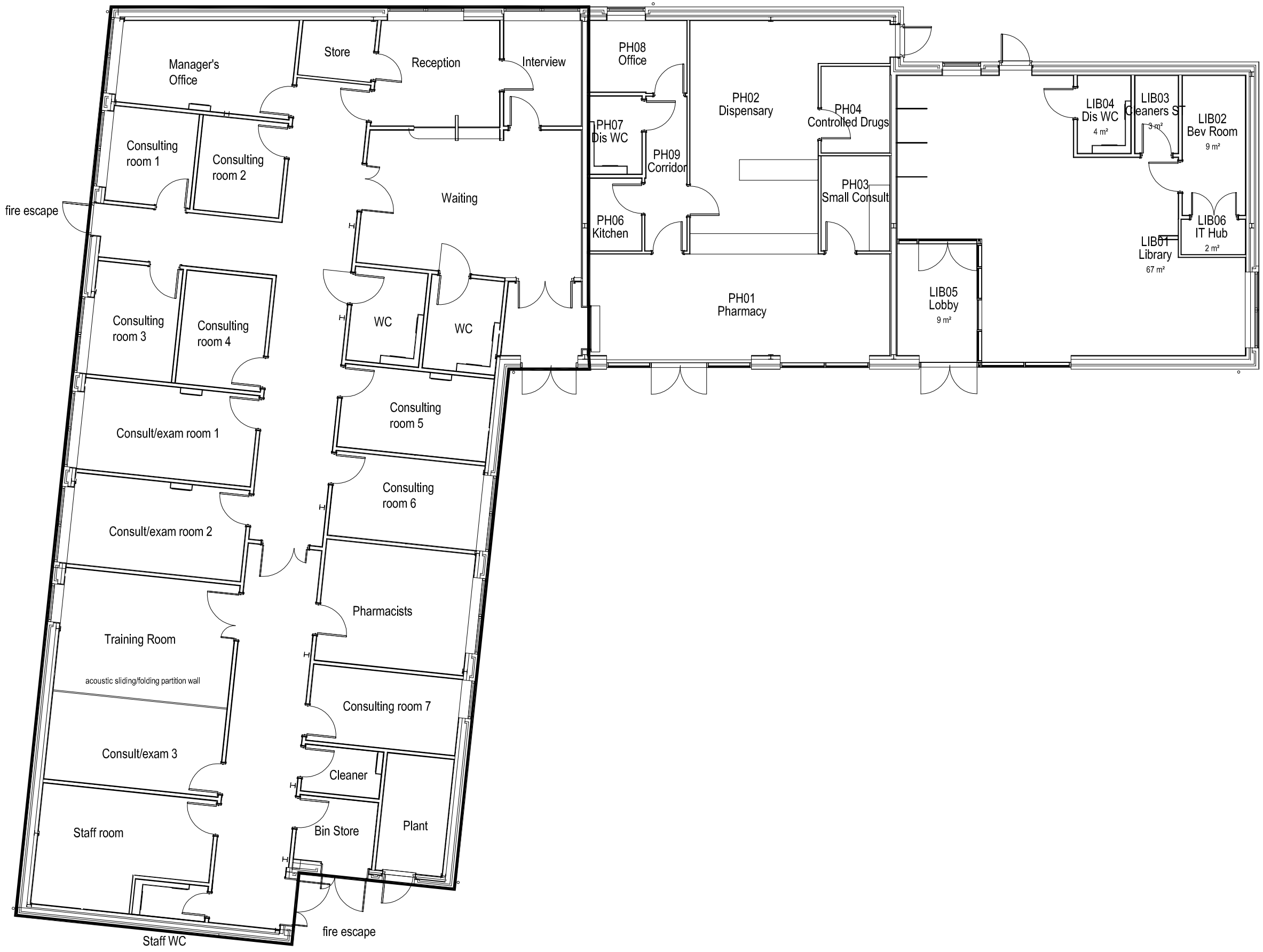
iv. Approves Option 3

The proposal to support rent and other costs reimbursement detailed in table 1 for the development at Mixenden and to create a General Practice Primary Care Network hub for North Halifax.

6. Appendices

Appendix A – Internal Layout Plan for proposed PCN occupation

Appendix B – Market Rent Report (October 2021)



Primary Care Network: Mixenden Health Hub

date: 04/02/2022

scale: 1.125@A3

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Valuation Office Agency

DVS Property Specialists for the Public Sector

Valuation Report for Mixenden Community Hub, Mixenden Road, Halifax, HX2 8QF

Report for:
Lee Wigley BSc (Hons) MRICS
Estates Manager
Calderdale Metropolitan Borough Council

Prepared by:
Ellen Atkin MRICS
Principal Surveyor
RICS Registered Valuer
DVS

Tel: 03000 501703 / 07974 588773

Ellen.atkin@voa.gov.uk

Case Number: 1771517

Client Reference: CA FM 007286

Date: 20 October 2021

DVS Property Specialists for the Public Sector

Contents

1. Introduction

I refer to your instructions dated 9th June 2021 and my Terms of Engagement dated 11th June 2021.

I have inspected and valued the property and I am pleased to report to you as follows.

2. Valuation Parameters

2.1 Identification of Client

This instruction will be undertaken for Calderdale Metropolitan Borough Council the commissioning officer in Lee Wigley.

2.2 Purpose of Valuation

It is understood that you require an update to a valuation undertaken by DVS dated 16 January 2018 for the development of a new community hub on Mixenden Road, Mixenden. The hub will comprise a doctor's surgery and a pharmacy. It is understood that you require the following valuations;

- A rental valuation of the Doctor's Surgery and Pharmacy

2.3 Subject of the Valuation

The property to be valued is the Pharmacy and Doctors Surgery at Mixenden Community Hub, Mixenden Road, Mixenden, Halifax, HX2 8PU.

2.4 Date of Valuation

The date of valuation is 20 October 2021.

Please note that values change over time and that a valuation given on a particular date may not be valid on an earlier or later date.

2.5 Confirmation of Standards

The valuation has been prepared in accordance with the professional standards of the Royal Institution of Chartered Surveyors: RICS Valuation – Global Standards and RICS UK National Supplement, commonly known together as the Red Book.

Compliance with the RICS professional standards and valuation practice statements gives assurance also of compliance with the International Valuations Standards (IVS).

Measurements stated are in accordance with the RICS Professional Statement **'RICS Property Measurement' (2nd Edition), Guidance Note 60 'Valuation of Medical Centres and Surgery Premises'** and, where relevant, the **RICS Code of Measuring Practice (6th Edition)**.

2.6 Agreed Departures from the RICS Professional Standards

There are no departures beyond those restrictions on the extent of investigations and survey, and the assumptions, stated below.

2.7 Basis of Value

The basis of value adopted is Market Rent which is defined at VPS 4, para 5 as:

'*The estimated amount for which an interest in real property should be leased on the valuation date between a willing lessor and a willing lessee on appropriate lease terms in an arm's length transaction, after proper marketing and where the parties had each acted knowledgeably, prudently and without compulsion*.'

It should be noted that the Market Rent basis of value would normally be used to indicate the amount for which a vacant property may be let, or for which a let property may re-let when the existing lease terminates. Market Rent is not a suitable basis for settling the amount of rent payable under a rent review provision in a lease, where the actual definitions and assumptions have to be used in the assessment.

2.8 Special Assumptions

The following agreed special assumptions have been applied:

1. The scheme comprises a single storey community centre, comprising a doctor's surgery, pharmacy and library. The plan supplied shows the Gross Internal Area amounts to 849m² with 32 car parking spaces. The Net Internal Area of each unit has been taken from the email provided from ale Council to the DV on 21 July 2021. The plans shown at Appendix 7.2 show a different NIA than the figures below. Areas adopted are as follows: -
    a. Doctors Surgery – 363.63 m² (+ 11 car parking spaces)
        i. Rooms removed from the floor area include:
            1. GP14 – Lobby 6 m² (shared with the pharmacy)
            2. GP18 – Staff WC 3 m²
            3. GP24 – Cleaner 4 m²
            4. GP27 – Plant Room 8 m²
    b. Pharmacy – 98.52 m² (+ 2 car parking spaces)
    c. Library – 95.55 m² (+ 7 car parking spaces)

2. I have adopted the areas shown above. If any of these measurements are incorrect they may have an impact on the final valuation. If the final measured areas of the GP's demise is larger than these estimates, then the actual rent should not be increased as it will impact on NHS reimbursement costs. However if smaller, then the total rent passing can reduce.
3. The rent on the medical centre accommodation has been valued on a Tenants Internal Repairing (TIR) basis which is consistent with other new surgeries within the Calderdale area.
4. The rent on the pharmacy has been valued on Internal Repairing Only basis (IR) which is consistent with other new pharmacies located in a community health centre building within the Yorkshire region.
5. I have assumed that all works are being built to current NHS requirements as set out in the NHS Health Building Notes (HBN) and Health Technical Memoranda (HTM). Current NHS guidance for planning new Primary and Social Care Premises is set out in the Department of Health's (DH) Design Guidance ("The Design Guidance") - See https://www.gov.uk/government/organisations/department-of-health/series/health-building-notes-core-elements. Within this web site is a link to Health Technical Memoranda.
6. The Government Construction Strategy (s.6.2) https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/60904/CMS-for-publication-v1-2.pdf requires that Procurement should take account of the Government Buying Standard for construction. At a minimum, it requires an appropriate environmental assessment process such as BREEAM or an equivalent (e.g. CEEQUAL, DREAM etc.) appropriate to the size, nature and impact of the project must be carried out on all projects. Where BREEAM is used, all new projects are to achieve an "excellent" rating and all refurbishment projects [in excess of £500k] are to achieve at least "very good" rating, unless site constraints or project objectives mean that this requirement conflicts with the obligation to achieve value for money.
7. All the GP Practice accommodation will be accepted for reimbursement purposes by NHS Calderdale CCG and/or NHS England as being General Medical Services use, required by the contractors in accordance with their agreement in respect of the new GMS contact.

2.9 Nature and Source of Information Relied Upon

In addition to relying upon VOA held records and information, I have assumed that all information provided by, or on behalf of you, in connection with this instruction is as follows;

- The information provided in your instruction e mail dated 9th June 2021 which included the up to date floor and elevation plans for the building.

The sources of any other information used that is not taken from our records will be identified in my report.

2.10 Date of Inspection

The property was inspected on Tuesday 6th July 2021.

2.11 Extent of Investigations, Survey Restrictions and Assumptions

An assumption in this context is a limitation on the extent of the investigations or enquiries undertaken by the valuer. The following agreed assumptions have been applied in respect of your instruction, reflecting restrictions to the extent of our investigations.

- Such inspection of the property and investigations as the Valuer considered professionally adequate and possible in the particular circumstance was undertaken. This comprised undertaking an external inspection only of the property.

- No detailed site survey, building survey or inspection of covered, unexposed or inaccessible parts of the property was undertaken. The Valuer has had regard to the apparent state of repair and condition and assumed that inspection of those parts not inspected would neither reveal defects nor cause material alteration to the valuation, unless aware of indication to the contrary. The building services have not been tested and it is assumed that they are in working order and free from defect. No responsibility can therefore be accepted for identification or notification of property or services' defects that would only be apparent following such a detailed survey, testing or inspection.

- It has been assumed that good title can be shown and that the property is not subject to any unusual or onerous restrictions, encumbrances or outgoings.

- It has been assumed that the property and its value are unaffected by any statutory notice or proposal or by any matters that would be revealed by a local search and replies to the usual enquiries, and that neither the construction of the property nor its condition, use or intended use was, is or will be unlawful or in breach of any covenant.

- Valuations include that plant that is usually considered to be an integral part of the building or structure and essential for its effective use (for example building services installations) but exclude all machinery and business assets that comprise process plant, machinery and equipment unless otherwise stated and required.

- It has been assumed that no deleterious or hazardous materials or techniques were used in the construction of the property or have since been incorporated. However, where an inspection was made and obvious signs of such materials or techniques were observed, this will be drawn to your attention and captured in this report.

- No access audit has been undertaken to ascertain compliance with the Equality Act 2010 and it has been assumed that the premises are compliant unless stated otherwise in this report.

- No environmental assessment of the property (including its site) and neighbouring properties has been provided to or by the VOA, nor is the VOA instructed to arrange consultants to investigate any matters with regard to flooding, contamination or the presence of radon gas or other hazardous substances. No search of contaminated land registers has been made. However, where an inspection was made and obvious signs of contamination or other adverse environmental impact were visible this will have been advised to you, further instructions requested and the observations captured in the report.

  Where such signs were not evident during any inspection made, it has been assumed that the property (including its site) and neighbouring properties are not contaminated and are free of radon gas, hazardous substances and other adverse environmental impacts. Where a risk of flooding is identified during any inspection made, or from knowledge of the locality, this will be reported to you. The absence of any such indication should not be taken as implying a guarantee that flooding can never occur.

- No allowances have been made for any rights obligations or liabilities arising from the Defective Premises Act 1972.

3. Property Information

3.1 Situation

The site is located to the west of Mixenden Road in Mixenden, a village approximately 3 miles to the north west of Halifax in West Yorkshire.

The site is centrally positioned in Mixenden within a low value residential area principally made up of semi detached and terraced properties. There are a large number of local authority and social housing present in the village.

To the east the site faces directly onto Mixenden Road which is a busy route that runs through the village. To the north the site is bounded by Stanningley Road, to the south it adjoins a vacant site and to the west are residential properties fronting Ash Tree Gardens and Stanningley Road. Ash Green Community Primary School is located approximately 150 metres to the south of the site.

3.2 Description

The site is broadly L-shaped and now cleared with the Mixenden Community Library occupying the northern corner. The land was previously occupied by a range of community buildings including a pharmacy, community support office and the local post office, however, these buildings were demolished in 2014. The library building is no longer in use following an arson attack on Saturday 8 August 2020 which left the building in a poor state of repair. The site is located on a hill and falls approximately 3 metres from north to south, along Mixenden Road elevation.

3.3 Tenure

We understand that the site is freehold.

3.4 Lease Provisions

Doctors Surgery

The suggested lease terms for the medical centre are as follows:-

15 year lease with 3 yearly rent reviews on a Tenants Internal Repairing (TIR) basis. This is consistent with other 3PD surgeries within the Calderdale area.

Pharmacy
The suggested lease terms for the pharmacy are as follows:-

15 year lease with 3 yearly rent reviews on an Internal Repairing (IR) basis. This is consistent with other pharmacies within the Calderdale area.

3.5 Easements and Restrictions

I am not aware of any onerous easements or restrictions which could affect the market value of the property.

3.6 Site Area

The site extends to approximately 0.23 hectares / 0.57 acres.

3.7 Floor Area

The plan supplied shows the Gross Internal Area amounts to 849m² with 32 car parking spaces. The Net Internal Area of each unit has been taken from the email provided from Calderdale Council to the DV on 21 July 2021. The plans shown at Appendix 7.2 show a different NIA han the figures below. Areas adopted are as follows:
Doctors Surgery – 363.63 m² (+ 11 car parking spaces)

- Rooms removed from the floor area include:
  - GP14 – Lobby 6 m² (shared with the pharmacy)
  - GP18 – Staff WC 3 m²
  - GP24 – Cleaner 4 m²
  - GP27 – Plant Room 8 m²

Pharmacy – 98.52 m² (+ 2 car parking spaces)
Library – 95.55 m² (+ 7 car parking spaces)

The floor areas given are all calculated on the Net Internal Area (NIA) of each unit as defined in the RICS Property Measurement 1st Edition.

3.8 Accommodation

The site is predominantly cleared with the exception of the Mixenden Community Library occupying the northern corner. The proposed new accommodation is shown in paragraph 3.7 above.

3.9 Defects and Repair

I have not been instructed to carry out a building survey and my comments should not be regarded as such.

3.10 Services

I have been provided with no details about the main services on site. For the purpose of this report I have assumed all main services are connected to the site and no off site infrastructure works are required.

3.11 Access and Highways

The site fronts Mixenden Road is an adopted Highway under the control of the Calderdale Metropolitan Borough Council.

3.12 Energy Performance Certificate

We have not had sight of a current Energy Performance Certificate.

3.13 Planning

I have made informal enquiries of the Planning Authority as to the planning status and potential of the property. These have revealed that planning has been approved for the development of a Community Hub to include doctor's surgery (D1 use) library (D1 use), pharmacy/dispensary (A1 use), 266 sqm of retail space (A1 use), associated landscaping and parking, demolition of the existing library, and development of a community garden. The reference for this is 17/00992/LAA.

3.14 Equality Act 2010

Whilst I have had regard to the provisions of the Equality Act 2010 in making this report, I have not undertaken an access audit nor been provided with such a report. It is recommended that you commission an access audit to be undertaken by an appropriate specialist in order to determine the likely extent and cost of any alterations that might be required to be made to the premises or to your working practices in relation to the premises in order to comply with the Act.

3.15 Mineral Stability

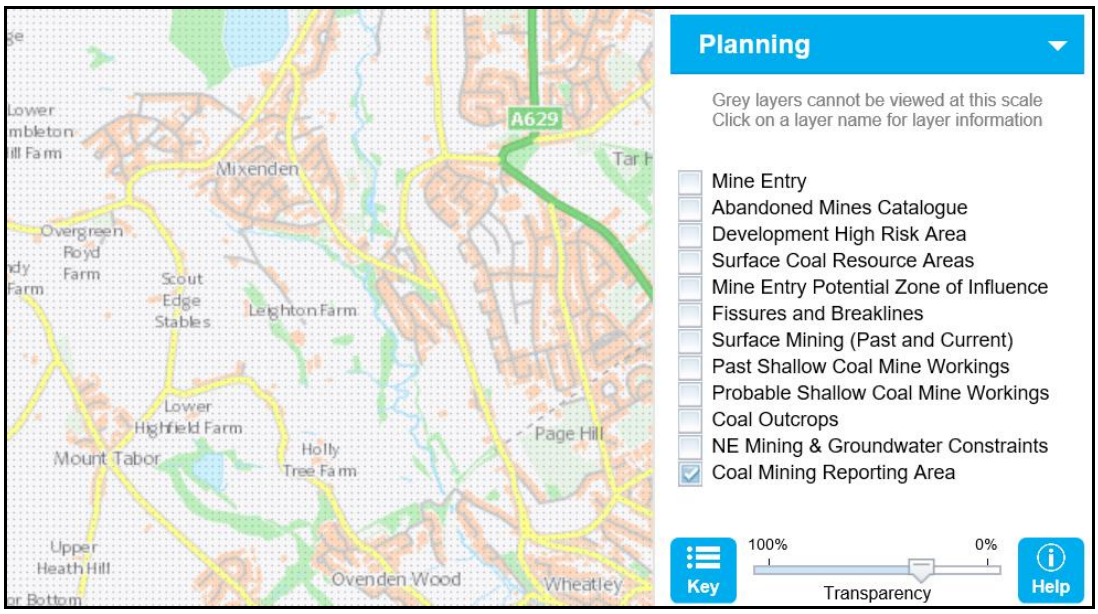
The property is situated in an underground mining area and in view of the possibility of mine workings and the increased risk of damage from underground mining subsidence it is recommended that a report is obtained from the Agency's Mineral Valuer. However, as you have not requested such a report you are deemed to have instructed the Agency to assume in arriving at its valuation:

(1) That the property valued is not at the date of valuation affected by any mining subsidence and will not be so affected in the future, and

(2) that the site is stable and will not occasion any extraordinary costs with regard to Mining Subsidence.

You hereby accept that the Board of HMRC for and on behalf of the Agency and its employees cannot, in these circumstances, provide any warranty, representation or assurance whatsoever to you or any third party as to the mineral stability or otherwise of the subject property valued. You hereby agree to waive any claim which you might otherwise have had against the Board, the Agency or any of their employees for negligence or breach of contract arising from any loss or damage suffered as a result of your specific instructions to take no account of any matters that might reasonably be expected to have been disclosed by an Underground Mining Subsidence Report.

Extract from Coal Authority Website

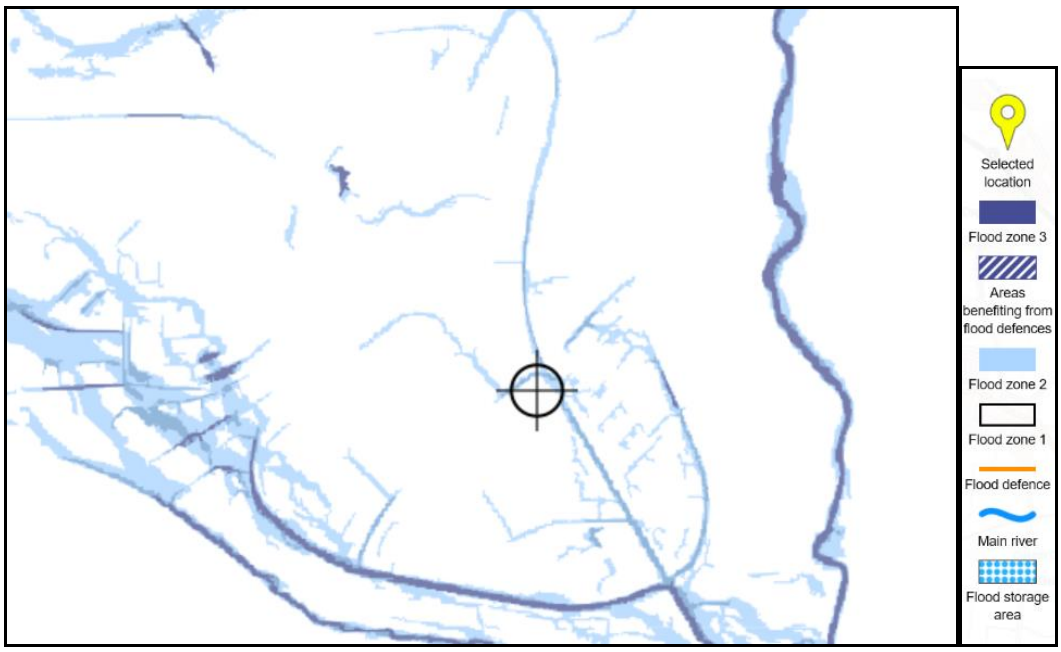


Source: Coal Authority Website

3.16 Environmental Factors Observed or Identified

I have referred to the Environment Agency's Flood Map for planning which indicates the property is not affected by flooding.

Environment Agency Flood Risk Plan



Source: Environment Agency

3.17 Rateable Value

We have undertaken an inspection of the Business Rates List and the following parts have a rateable value:

The Library, Mixenden	Library and premises	£5,200

3.18 Minimum Energy Efficiency Standards (MEES)

In respect of non-exempt domestic and non-domestic property rental properties in England and Wales, I advise as follows.

We have not been provided with an up to date EPC rating for this property and, as such, our valuation is based on the assumption that the subject property will meet the minimum requirements laid down by the Energy Act 2011 and its Regulations and that there will be no adverse impact on value and marketability. It is advisable to obtain an expert's opinion regarding whether an EPC should be commissioned and if the building is likely to meet with the legislative requirements.

4. Valuation

4.1 Valuation Methodology/Approach and Reasoning

The valuation methodology employed to value the subject property has been based on the comparable method of valuation, i.e. comparing the rental values of similar doctor's surgeries, pharmacies and retail units in the general locality of the subject property. Mixenden is a small village location so comparable evidence has been sourced from across Calderdale and suitable adjustments have been made to arrive at the market value of each unit.

4.2 Comparable Evidence

Doctors Surgery Evidence

Property Address – anonymised for reasons of data release compliance	Brief description	NIA	£/m	£/car space	Date of valuation
Purpose built surgery in Bradford BD3 area	Purpose built in 2014 over 2 floors	595 sq m	£186.50 per sqm	£375	4 July 2020
Purpose built surgery in	Brand new purpose built surgery built in	451 sq m	£191 per sqm	£300	27 March 2020

Huddersfield HD2 area	2020 over 2 floors				
Purpose built surgery in Leeds LS14 area	Brand new purpose built surgery built in 2020	620 sq m	£195 per sqm	£262.50	27 Feb 2020
Purpose built surgery in Halifax HX1 area	Purpose built in 1999 extended in 2020 over 2 floors	798 sq m	£180 per sqm on new extension £170 per sqm on 1999 original part	£260	20 Feb 2020
Purpose built surgery in WF16	Purpose built in 2010 over 2 floors	771 sq m	£183 per sqm	£350	15 July 2019

Current Market Rents on modern purpose built surgeries built by Third Party Developers (3PD premises) in and around Bradford, Kirklees Wakefield and Calderdale range from approximately £180/sqm to £195.00/sqm around the valuation date. The comparable properties range in age from the early 2000s to 2020. These rents have been assessed on a tenant's internal repairing basis in line with the 2013 NHS Directions which is the same basis as I've assessed this Health Centre.

There is an argument, given the increase in build costs recently, that rents have increased beyond the £195 per sq m mark. Discussions regarding the rent for a new medical centre in Huddersfield have commenced at £200 per sq m.

In the case of the subject property, I have assumed all building works will comply with NHS Health Building Notes (HBN) and Health Technical Memoranda (HTM). I have also had regard to the proposed location which is a low value residential area in Halifax. Further to this, a value of £190.00/sqm has been adopted for the Health Centre.

There will be a reasonable number of car parking spaces available on site (11 of these are allocated for the surgery), set within a shared car park. There is parking available on the street which is not subject to limitations. Further to this, a rate of £300/space has been adopted which is consistent with rates on parking spaces at other surgeries in and around Bradford, Kirklees and Calderdale.

Having regard to the above, I am of the opinion that a rate of £190/m^2 on the net internal area and £300 per car parking space is appropriate for the proposed subject premises and have therefore valued accordingly. My valuation is set out below.

Doctors Surgery Valuation

Ground floor: 364m^2 @ £190 per m^2	=	£69,160 per annum
11 x Car parking spaces @ £300 each	=	£3,300 per annum
Total	=	£72,460
Say	**=**	**£72,500**

Pharmacy Evidence

NHS dispensing represents between 90% - 95% of turnover for a typical independent pharmacy. Additional income from items sold in the shop are a minor consideration. Therefore, patient numbers from the adjacent surgery drive the prescription numbers but these can also be influenced by the demographics of the catchment area. So elderly or economically inactive population generate higher numbers of prescriptions per patient. Having discussed with specialists in house and externally the current receipt rate per patient is in the region of £2.50 to £3.00 per patient. The reason for the rate remaining at similar levels since 2016 are varied but include the following:

- There has been a cut in NHS funding for pharmacies since 2016.
- Some national players have withdrawn from the pharmacies that they operate in on GP sites.
- An increase in online business reduces the need for physical pharmacies so like many other sectors like banks there is less need for physical outlets.
- There has been a large increase in electronic prescribing which allows patients to pick their prescriptions up anywhere, not just at the pharmacy attached to the GP practice.
- The relaxation of prescribing licences has led to more being granted over the past few years. This has led to an increase in the number of online pharmacies such as Pharmacies for You owned by GPs or larger companies. They are a popular option with patients as they provide an easy way to get prescriptions delivered regularly.

The site at the proposed Mixenden Hub is a prime site as the pharmacy is located next to the surgery. Another factor which increases demand and drives the rent per patient up is immediate competition in the area. As there are no other pharmacies in Mixenden I suggest that rents would be at the top end of the range at £3 per patient. Accordingly, I have adopted this figure in the valuation.

Pharmacy Valuation

3,181 patients x £3	=	£9,543
2 x Car parking spaces @ £300 each	=	£600 per annum
Total	=	£10,143
Say	**=**	**£10,100**

4.3 Opinion of Value

I am of the opinion that the Market Rent of the Doctor's Surgery is **£72,500** (Seventy Two Thousand Five Hundred Pounds) as at 20 October 2021.

I am of the opinion that the Market Rent of the Pharmacy is **£10,100** (Ten Thousand One Hundred Pounds) as at 20 October 2021.

4.4 Currency

All prices or values are stated in pounds sterling.

4.5 VAT

I understand that VAT does not apply to this transaction and my opinion of value reflects this. In the event that my understanding is found to be inaccurate, my valuation should be referred back for reconsideration.

4.6 Costs of Sale or Acquisition and Taxation

I have assumed that each party to any proposed transaction would bear their own proper legal costs and surveyor's fees.

4.7 Market conditions explanatory note: Novel Coronavirus (COVID-19)

The outbreak of COVID-19, declared by the World Health Organisation as a "Global Pandemic" on the 11th March 2020, has and continues to impact many aspects of daily life and the global economy – with some real estate markets having experienced lower levels of transactional activity and liquidity. Travel, movement and operational restrictions have been implemented by many countries. In some cases, "lockdowns" have been applied to varying degrees and to reflect further "waves" of COVID-19; although these may imply a new stage of the crisis, they are not unprecedented in the same way as the initial impact.

The pandemic and the measures taken to tackle COVID-19 continue to affect economies and real estate markets globally. Nevertheless, as at the valuation date some property markets have started to function again, with transaction volumes and other relevant evidence returning to levels where an adequate quantum of market evidence exists upon which to base opinions of value. Accordingly, and for the avoidance of doubt, our valuation is not reported as being subject to 'material valuation uncertainty' as defined by VPS 3 and VPGA 10 of the RICS Valuation – Global Standards.

For the avoidance of doubt, this explanatory note has been included to ensure transparency and to provide further insight as to the market context under which the valuation opinion was prepared. In recognition of the potential for market conditions to move rapidly in response to changes in the control or future spread of COVID-19 we highlight the importance of the valuation date.

5. General Information

5.1 Status of Valuer

It is confirmed that the valuation has been carried out by Ellen Atkin, a RICS Registered Valuer, acting in the capacity of an external valuer, who has the appropriate knowledge and skills and understanding necessary to undertake the valuation competently, and is in a position to provide an objective and unbiased valuation.

5.2 Conflict of Interest

Checks have been undertaken in accordance with the requirements of the RICS standards and have revealed no conflict of interest. As previously disclosed, DVS has had previous material involvement with the property, which has been drawn to your attention. The details are as follows:

Under the NHS Directions 2013 the District Valuer (our health team) is to provide all CMRs (Current Market Rents) and any related advice for all Doctors' surgeries nationwide. I've emailed the NHS in relation to the valuation you have requested and asked them to confirm that they are happy for us to proceed with this instruction.

I confirm that both Neil Coulter, Senior Primary Care Manager, NHS England and NHS Improvement – (NE and Yorkshire) and Calderdale Metropolitan Borough Council are happy for me to proceed with this instruction knowing this conflict will arise in due course.

As both parties are aware, this is an update to a valuation report undertaken by Ellen Atkin dated 16th January 2018.

I confirm that this does not impact on my overriding obligation to act with independence and objectivity.

5.3 Restrictions on Disclosure and Publication

The client will neither make available to any third party or reproduce the whole or any part of the report, nor make reference to it, in any publication without our prior written approval of the form and context in which such disclosure may be made.

You may wish to consider whether this report contains Exempt Information within the terms of paragraph 9 of Schedule 12A to the Local Government Act 1972 (section 1 and Part 1 of Schedule 1 to the Local Government (Access to Information Act 1985) as amended by the Local Government (access to Information) (Variation) Order 2006.

5.4 Limits or Exclusions of Liability

Our valuation is provided for your benefit alone and solely for the purposes of the instruction to which it relates. Our valuation may not, without our specific written consent, be used or relied upon by any third party, even if that third party pays all or part of our fees, directly or indirectly, or is permitted to see a copy of our valuation report. If we do provide written consent to a third party relying on our valuation, any such third party is deemed to have accepted the terms of our engagement.

None of our employees individually has a contract with you or owes you a duty of care or personal responsibility. You agree that you will not bring any claim against any such individuals personally in connection with our services.

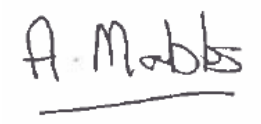
5.5 Validity

This report remains valid for 6 (six) months from its date unless market circumstances change or further or better information comes to light, which would cause me to revise my opinion.

I trust that the above report is satisfactory for your purposes. However, should you require clarification of any point do not hesitate to contact me further.

Ellen Atkin BA (Hons) MRICS
Principal Surveyor DVS
RICS Registered Valuer
DVS

Report reviewed by:

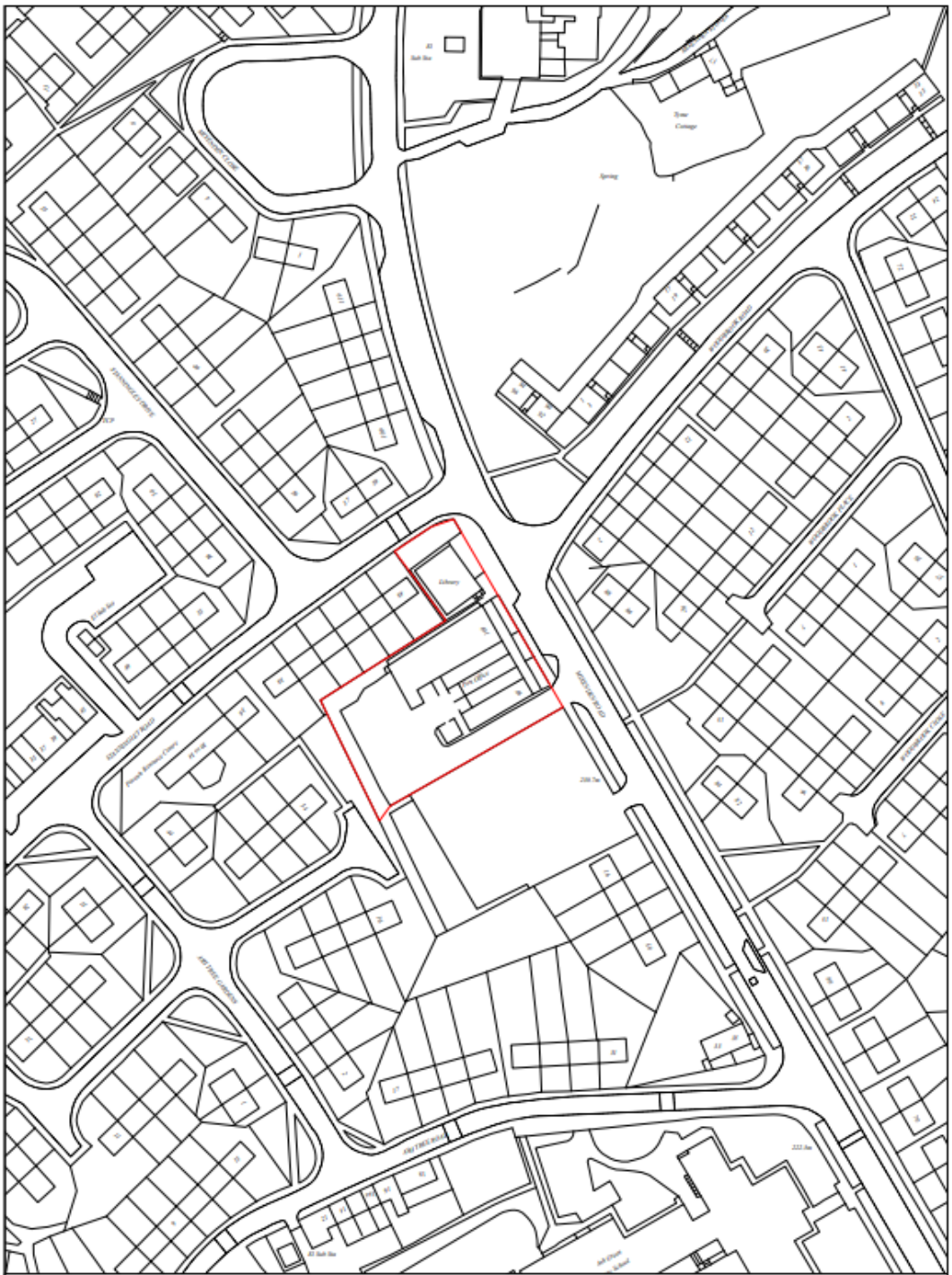


Alison Mobbs MRICS Registered Valuer
Health Team Leader
Senior Surveyor DVS
RICS Registered Valuer
DVS

7. Appendices

7.1 Photographs

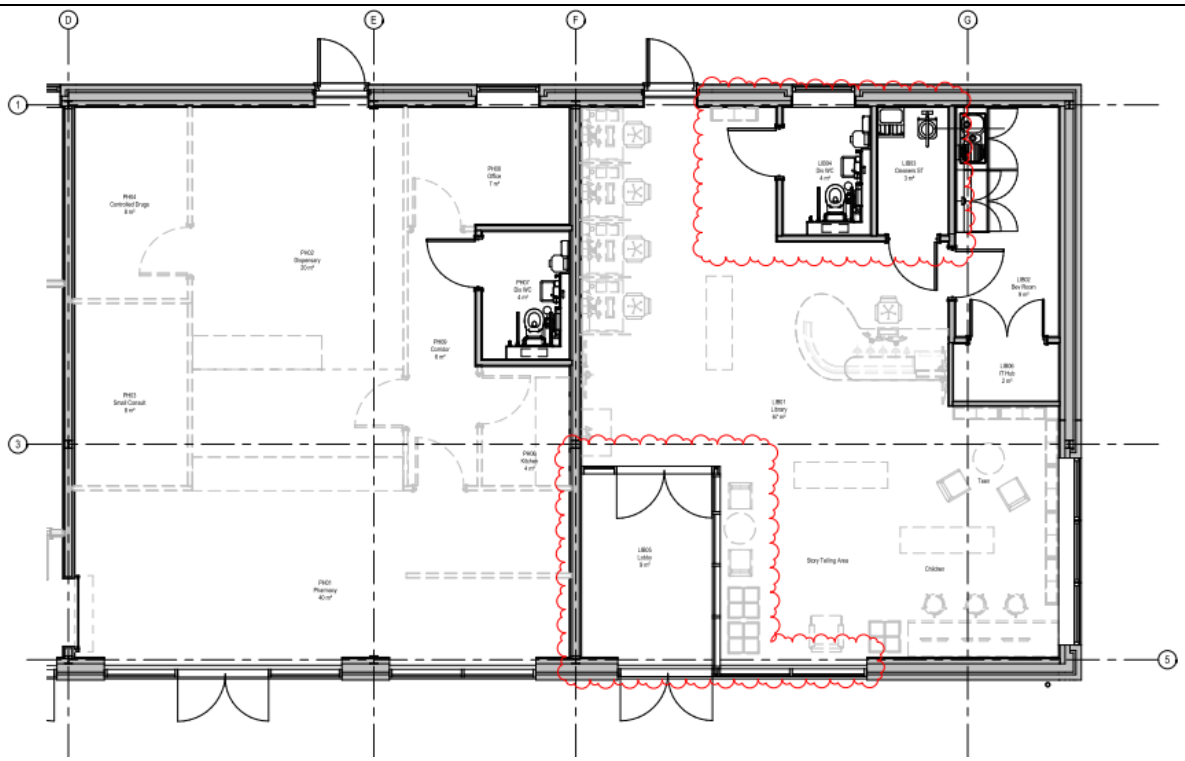
7.2 Plans



Plan title: Mixenden Community Hub, Mixenden Road, Halifax, HX2 8QF

Copyright (c) 2003 Ordnance Survey	Date: 29/6/2021	DM sequence no:	Scale: 1:1250

Floor plan of proposed Doctor's Surgery, Pharmacy and Library at Mixenden Hub



Floor plan of proposed Pharmacy and Library at Mixenden Hub

Item 7

Internal Audit Report
For
NHS Calderdale Clinical Commissioning Group

Primary Medical Care Commissioning and Contracting
Contract Oversight and Management Functions

C02/2022

Contents

Report Author: Danielle Hodson
Report Version: Draft
Report Date: 7 January 2022

Objective

The overall objective of the review was to provide assurance on the management of delegated primary medical care contract oversight and management functions with regards to Primary Medical Care Commissioning and Contracting, and the associated governance arrangements.

Overall Opinion

Internal Audit is required by NHS England (NHSE) to assign their prescribed categories for assurance of primary medical services commissioning, in line with the Primary Medical Care Commissioning and Contracting: Internal Audit Framework for delegated Clinical Commissioning Groups (CCGs) (Appendix 1). This differs from the standard Audit Yorkshire audit opinion levels and can be seen in Section 4 of this report.

Full	The review established that there is a sound system of internal control in place for delegated primary care contract oversight and management functions, with effective arrangements in place for the role of the CCG. There was adequate governance and oversight in regard to primary care contract oversight and management functions by the Commissioning Primary Medical Services Committee (CPMSC), supported by the Primary Care Operational Group (PCOG). On moderate recommendations has been made in relation to the review of practice opening hours.

Assurance on Key Control Objectives

Control Objective	Review Highlights (✓ Positive Assurance, ! Action Required)	Assurance Level	Recommendations (Priority)		
			Major	Moderate	Minor
Primary Care Contract Oversight & Management - There are effective arrangements in place	✓ The CCG maintains an up to date Contract register which is reported on the CCG's website.	**Full**	**0**	**1**	**0**

Control Objective	Review Highlights (✓ Positive Assurance, ! Action Required)	Assurance Level	Recommendations (Priority)		
			Major	Moderate	Minor
relating to the accessibility and quality of GP services, including but not limited to ensuring relevant national and locally applied contract terms in relation to: i. GP Practice opening times and the appropriateness of sub contracted arrangements ii. Managing patient lists and registration issues iii. identification of practices selected for contract review to assure quality, safety and performance, and the quality of the subsequent review and implementation of outcomes iv. Decisions in relation to the management of poorly performing GP practices v. Overall management of practice for mergers and closures.	✓ Currently the CCG has two Personal Medical Service (PMS), one Alternative Provider Medical Service (APMS) and 18 General Medical Service (GMS) contracts with GP Practices. <u>i. GP Practice opening times and the appropriateness of sub contracted arrangements</u> ✓ A standard GMS contract states ”core hours” means the period beginning at 8.00am and ending at 6.30pm on any day from Monday to Friday including bank holidays during a pandemic (2020). ✓ Practices are required to complete an annual Electronic Self-Declaration (eDEC) to log and declare that they are compliant with their contractual terms and conditions. ✓ The eDEC includes confirmation of the individual practice opening hours. ✓ The contracting team receives and reviews the eDEC and follows up any potential issues. ✓ Extended Hours are commissioned via the Network Contract DES specification. ✓ The CCG manage the compliance of the extended hours with request from practices to provide their provisions. This is monitored on an excel spreadsheet. ! Testing was undertaken on five GP practices to compare the hours noted on their website to the core hours. From the review two practice hours did not match the hours stated on the CCGs spreadsheet. One practice confirmed they switched their phone lines off half an hour earlier than 6.30 pm. ✓ The requirements for sub-contracted arrangements are documented in the GMS, PMS and APMS contract terms and conditions.				

Control Objective	Review Highlights (✓ Positive Assurance, ! Action Required)	Assurance Level	Recommendations (Priority)		
			Major	Moderate	Minor
	✓ In September 2021, the CCG presented to LMC and the PCNs detailing the requirements of the sub contracted arrangements to reiterate the requirements. <u>ii. Managing patient lists and registration issues</u> ✓ The role of the CCG in managing patient lists and registration issues is outlined in the Primary Medical Policy and Guidance Manual (PGM). The guidance is prescriptive in terms of the processes to be followed and includes document templates for adaptation. ✓ As outlined in the PGM, Primary Care Support England (PCSE) are responsible for higher level general list maintenance which involves the cross checking of National Health Application and Infrastructure Services (NHAIS) patient system data including NHS numbers. ✓ CCGs are made aware by PCSE when practices do not engage. ✓ The registered lists are compiled every three months and shared with practices to confirm figures but the CCG are not involved in this process. ✓ Out of area registration is undertaken as part of a DES which is the responsibility of NHSE. The CCG does not have a list of registered patients for this DES due to it containing patient identifiable information. <u>iii. identification of practices selected for contract review to assure quality, safety and performance, and the quality of the subsequent review and implementation of outcomes</u> ✓ The CCG have recently introduced a new reporting function, Calderdale General Practice Dashboard, which was presented at the August 2021 CPMSC. This will support the Quality				

Control Objective	Review Highlights (✓ Positive Assurance, ! Action Required)	Assurance Level	Recommendations (Priority)		
			Major	Moderate	Minor
	Assurance and Surveillance Process for General Practice within Calderdale. ✓ This report will include RAG rating the Practices from data held nationally, and enabling triggers for required review. ✓ The Dashboard will be presented to the CPMSC on a quarterly basis from Q4 2021/22 onwards. <u>iv. Decisions in relation to the management of poorly performing GP practices</u> ✓ The recently developed "Primary Care Quality Assurance and Surveillance Process", in line with the dashboard will identify poorly performing GP Practices which will trigger up to a four stage process of review and support. ✓ CQC action plans are monitored for implementation by the CCG as part of their support to the GP Practices. ✓ The CCG maintain a list of all their practices with the most up to date CQC results detailed. This currently shows that all practices received a "good" result. ✓ It was noted that limited CQC visits had been made due to the pandemic, and some CQC recent visits were from 2018. An internal audit review of six CQC visits last dated 2018 were checked to confirm whether an up to date review had been undertaken. It was confirmed that all had been reviewed electronically by the CQC in November 2021 and states “no need to revisit”. As no formal visit had been undertaken the CCG have not update their records. ✓ There is a monthly meeting with the CQC Local Inspector and the Director of Transformation – Primary Care and Transformation and Primary Care Project Officer to share intelligence and informal feedback and raise any practices of concern.				

Control Objective	Review Highlights (✓ Positive Assurance, ! Action Required)	Assurance Level	Recommendations (Priority)		
			Major	Moderate	Minor
	✓ If a provider receives a "requires improvement" result from a CQC visit, NHS Calderdale CCG have a documented "CQC flowchart" process to follow. v. Overall management of practice for mergers and closures. ✓ The process set out in the PGM is followed for practice mergers and closures. ✓ A draft Standard Operating Procedure was developed following a previous practice closure in 2018 which is used as a reference guide ✓ A recent branch closure process was followed for Spring Hall Group Practice (Boots branch) and taken through CPMSC for sign off. This was discussed and approved in the August 2021 meeting. ✓ The recent branch closure was evidenced with detailed discussion, disclosure of documentation and an equality impact statement was undertaken.				
Governance There is effective operation and oversight of the Primary Care Commissioning Committee (or alternative committee with responsibility for the delegated function) in regard to the delegated Contract Oversight and Management Functions (but not in relation to the management of Conflicts of Interest).	✓ The CPMSC reviewed their Terms of Reference on 21 January 2021 and these were updated on 28 January 2021 to reflect the current governance structure. ✓ Specifically the Terms of Reference state one of the responsibilities of the CPMSC is "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)." ✓ These Terms of Reference are in line with the NHSE Delegated commissioning model draft Terms of Reference dated October 2015 published on the NHSE website. ✓ The CPMSC 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	Full	**0**	**0**	**0**

Control Objective	Review Highlights (✓ Positive Assurance, ! Action Required)	Assurance Level	Recommendations (Priority)		
			Major	Moderate	Minor
	c) Practice payments and reimbursement d) Investment in practice development e) Contractual compliance and sanctions ✓ A review of the last four meetings confirmed quoracy during 2021. ✓ A review of the agenda, papers and minutes of the CPMSC and PCOG meetings during 2021 provides evidence of challenge and decision making. ✓ Specific primary care commissioning risks from the corporate risk register are reviewed and discussed formally at the CPMSC on a quarterly basis in line with Committees agreed work plan. This was evidenced in the May 2021 minutes where the Risk Register summary annual report for 2020-21 was presented. ✓ A benchmarking review was undertaken on the Committee papers against other CCG's Primary Care Committees within West Yorkshire. ✓ It was confirmed that CPMSC had similar frequency and duration, and consistent approach to reporting. ✓ The most recent self-assessment of the effectiveness of the CPMSC was undertaken on 21st January 2021. The initial assessment was completed by the Chair and Lead officer and then presented to the Committee for full discussion and agreement before being compiled into the CCG's overall assessment of committees.				
Overall		**Full**	**0**	**1**	**0**

Background Information

NHS England became responsible for the direct commissioning of primary medical care services on 1 April 2013. Since then, following changes set out in the NHS Five Year Forward View, primary care co-commissioning has seen CCGs invited to take on greater responsibility for general practice commissioning, including full responsibility under delegated commissioning arrangements. Where NHS England delegates its functions to CCGs, it still retains overall responsibility and liability for these and is responsible for obtaining assurances that its functions are being discharged effectively.

In agreement with the NHS England Audit and Risk Assurance Committee, from 2018/19 NHS England requires an internal audit of delegated CCGs primary medical care commissioning arrangements. The purpose of this being to provide information to CCGs that they are discharging NHS England's statutory primary medical care functions effectively, and in turn use this information to provide aggregate assurance to NHS England and facilitate NHS England's engagement with CCGs to support improvement.

To support this, in August 2018 NHS England published the Primary Medical Care Commissioning and Contracting: Internal Audit Framework for delegated Clinical Commissioning Groups. The document provides a framework for delegated CCGs to undertake an internal audit of their primary medical care commissioning.

The scope of the work covers:

a) Commissioning and procurement of services
b) Contract Oversight and Management Functions
c) Primary Care Finance
d) Governance (common to each of the areas a-c above)

The audit framework was agreed in 2019/20 to be delivered as a 3 year programme of work to ensure this scope is subject to annual audit in a managed way and within existing internal audit budgets. As Governance is common to each area it was agreed that this is covered in relation to the area of scope under review each year.

Year one 2019/20:	Primary Care Finance. Governance of Primary Care Finance. An audit opinion of Full assurance was given.
Year two 2020/21:	Commissioning and Procurement of Services. Governance of Commissioning and Procurement of Services.

	An audit opinion of Full assurance was given.
Year three 2021/22:	Contract Oversight and Management Functions.
	Governance of Contract Oversight and Management Functions

Key Risks

Key risk associated with this area include:

- The CCG does not discharge NHS England's statutory primary medical care functions effectively.

Objectives & Scope

The objective of the audit was to review the governance arrangements of the new organisation to discharge its functions and effectively make decisions, and provide assurance on application of the governance arrangements, including operation of committees and the scheme of delegation.

In order to meet this objective, the audit focused on the following key control objectives:

Primary Care Contract Oversight and Management Functions

- There are effective arrangements in place relating to the accessibility and quality of GP services, including but not limited to ensuring relevant national and locally applied contract terms in relation to:

i. GP Practice opening times and the appropriateness of sub contracted arrangements
ii. Managing patient lists and registration issues
iii. identification of practices selected for contract review to assure quality, safety and performance, and the quality of the subsequent review and implementation of outcomes
iv. Decisions in relation to the management of poorly performing GP practices
v. Overall management of practice for mergers and closures.

Governance

- There is effective operation and oversight of the Primary Care Commissioning Committee (or alternative committee with responsibility for the delegated function) in regard to the delegated Contract Oversight and Management Functions (but not in relation to the management of Conflicts of Interest).

Methodology

Audit fieldwork will consist of ascertaining, through discussions with key staff, examination of relevant documentation and testing where appropriate, whether:

- Relevant policies, procedures and guidance have been authorised, and communicated to relevant personnel.
- Local processes established by the CCGs are aligned to NHS England policies and guidance e.g. Primary Medical Care Policy and Guidance Manual.
- GP Contracts are in place,
- Documentation is retained, including records of decisions. There is evidence to show decisions were exercised in accordance with NHS England's statutory duties.

Reporting period: 1st April 2021 onwards

Limitations

The assurance given is based on the review work undertaken and is not necessarily a complete statement of all weaknesses that exist or potential improvements. Whilst every care has been taken to ensure that the information provided in this report is as accurate as possible, no complete guarantee or warranty can be given with regard to the advice and information contained. Our work does not provide absolute assurance that material errors, loss or fraud do not exist.

Report Circulation

Draft	Final	Recipient Name	Recipient Title
✓	✓	Debbie Robinson	Head of Primary Care Quality and Improvement
✓	✓	Martin Pursey	Head of Contracting & Procurement
	✓	Lesley Stokey	Director of Finance
	✓	Neil Smurthwaite	Chief Operating Officer / Chief Finance Officer
	✓	Robert Gibson	Corporate Systems Manager

Acknowledgement

The auditor is grateful for the assistance received from management and staff during the course of this review. The following members of the Audit Yorkshire team were involved in the production of this report:

Head of Internal Audit: Helen Kemp-Taylor
Audit Manager: Jonathan Hodgson
Assistant Audit Manager: Danielle Hodson

Date: 7 January 2022

Finding	Risk	Recommendation	Priority	Management Response	Responsible Officer	Target Date
Core and Extended Hours Review A standard GMS contract states ""core hours" means the period beginning at 8.00am and ending at 6.30pm on any day from Monday to Friday" including bank holidays during a pandemic (2020). Testing was undertaken on five GP practices to confirm the hours noted on their website to the core hours. A review of the times of two practices did not match the hours stated on the CCG spreadsheet and one surgery confirmed telephone closure half an hour before the core hours.	The CCG does not discharge NHS England's statutory primary medical care functions effectively. Patient needs are not met.	1. A review of Practice opening times and telephone provision should be undertaken to identify any limitations to patient access during the contractual opening times between 8am and 6:30pm.	Moderate			

Audit Opinion

Categories of Primary Medical Care Commissioning Assurance

NHSE requires delegated CCGs internal audit assign one of four categories to their assurance of primary medical services commissioning:

Assurance level	Evaluation and testing conclusion
Full	• The controls in place adequately address the risks to the successful achievement of objectives; and, • The controls tested are operating effectively.
Substantial	• The controls in place do not adequately address one or more risks to the successful achievement of objectives; and / or, • One or more controls tested are not operating effectively, resulting in unnecessary exposure to risk.
Limited	• The controls in place do not adequately address multiple significant risks to the successful achievement of objectives; and / or, • A number of controls tested are not operating effectively, resulting in exposure to a high level of risk.
No assurance	• The controls in place do not adequately address several significant risks leaving the system open to significant error or abuse; and / or, • The controls tested are wholly ineffective, resulting in an unacceptably high level of risk to the successful achievement of objectives.

The assurance gradings provided here are not comparable with the International Standard on Assurance Engagements (ISAE 3000) issued by the International Audit and Assurance Standards Board and as such the grading of 'Full Assurance' does not imply that there are no risks to the stated control objectives.

Priorities assigned to individual recommendations

Individual recommendations are graded in accordance with the severity of the risk involved to the CCG. Audit Yorkshire has a standard definition for each level of recommendation priority. This is represented in the table below:

Grading	Definition	Guidance on Consistency
Major (High)	Recommendations which seek to address those findings which could present a significant risk to the organisation with respect to organisation objectives, legal obligations, significant financial loss, reputation/publicity, regulatory/statutory requirements or service/business interruption.	These are recommendations which aim to address issues which if not addressed could cause significant damage or loss to the organisation. The expectation is that these recommendations would need to be taken as a matter of urgency. These recommendations should have a high corporate profile – with a clear implementation tracking process in place, overseen by the Board or a Board level committee.
Moderate (Medium)	Recommendations which seek to address those findings which could present a risk to the effectiveness, efficiency or proper functioning of the system but do not present a significant risk in terms of corporate risk.	These are recommendations which if not addressed could cause problems with the safe or effective operation of the system being reviewed. The recommendations should have appropriate profile within the division or business area in which the system being considered sits and some profile at Board /Audit Committee level also. These recommendations should be carefully tracked to ensure that action reduces the risks found
Minor (Low)	Recommendations which relate to issues which should be addressed for completeness or for improvement purposes rather than to mitigate significant risks to the organisation. (This includes routine/housekeeping issues)	All other recommendations fall into this category. This includes recommendations which further improve an already robust system and housekeeping type issues.

Key components in scope of the primary medical services audit framework

The following is in the scope of the primary medical services audit framework:

a. Commissioning and procurement of primary medical services;

i. planning the provision of primary medical care services in the area, including carrying out needs assessments and consulting with the public and other relevant agencies as necessary

ii. the processes adopted in the procurement of primary medical care services, including decisions to extend existing contracts

iii. the involvement of patients / public in those commissioning and procurement decisions

iv. the effective commissioning of Directed Enhanced Services and any Local Incentive Schemes (including the design of such schemes)

v. commissioning response to urgent GP practice closures or disruption to service provision

b. Contract Oversight and Management Functions. Generally these will be those relating to the accessibility and quality of GP services, including but not limited to ensuring relevant national and locally applied contract terms in relation to;

i. GP Practice opening times and the appropriateness of sub contracted arrangements

ii. Managing patient lists and registration issues (for example, list closures, targeted list maintenance, out of area registration, special allocation schemes)

iii. Identification of practices selected for contract review to assure quality, safety and performance, and the quality of the subsequent review and implementation of outcomes

iv. Decisions in relation to the management of poorly performing GP practices and including, without limitation, contractual management decisions and liaison with the CQC where the CQC has reported non-compliance with standards (but excluding any decisions in relation to the performers list)

v. Overall management of practice: (1) mergers (2) closures

c. Primary Care Finance

i. Overall management and the reporting of delegated funds – processes for forecasting, monitoring and reporting

ii. Review of financial controls and processes for approving payments to practices

iii. Review of compliance with coding guidance on a sample basis

iv. Processes to approve and decisions regarding 'discretionary' payments (e.g. Section 96 funding arrangements, Local Incentive Schemes)

v. Implementation of the Premises Costs Directions

d. Governance

i. Operation and oversight of the Primary Care Commissioning Committee (or alternative committee with responsibility for the delegated function) in regard to the points a-c above (but not in relation to the management of Conflicts of Interest).

Appendix 2: Supporting Information

Name of Meeting	Commissioning Primary Medical Services Committee	**Meeting Date**	3 March 2022
Title of Report	**Contracting Update**	**Agenda Item No.**	8
Report Author	Suzanne Howarth, Senior Partner Relationship Manager	**Public / Private Item**	Public
Clinical Lead	Dr Majid Azeb	**Responsible Officer**	Martin Pursey, Director of Partner Relationship Management

Executive Summary
This report provides an update to the Committee in respect of a number of contractual matters where it is felt that the Committee should be apprised of.

Previous Considerations

Name of meeting	N/A	**Meeting Date**	N/A
Name of meeting		**Meeting Date**	

Recommendations
It is recommended that Commissioning Primary Medical Services Committee: 1. Receives and notes the content of the contracting report.

Decision ☐	**Assurance ☒**	**Discussion ☐**	**Other:**

Implications

Quality and Safety implications (including whether a quality impact assessment has been completed)	The report is for information purposes and is not requiring a decision by the Committee
Engagement and Equality Implications (including whether an equality impact assessment has been completed), and health inequalities considerations	The report is for information purposes and is not requiring a decision by the Committee

Resources / Financial Implications (including Staffing/Workforce considerations)	The report is for information purposes and is not requiring a decision by the Committee
Sustainability Implications	The report is for information purposes and is not requiring a decision by the Committee

Has a Data Protection Impact Assessment (DPIA) been completed?	**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 Improving governance	**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 interests will be managed in line with the CCG's policy for managing conflicts of Interest

1. Introduction

1.1 This report provides an update to the Committee in respect of a number of contractual matters where it is felt that the Committee should be apprised of.

2. GP Online Consultation Software – Engage Health & AccuRx

2.1 It has been the intention to re-procure across the WY ICS for GP Online & Video Consultations ready for new provision from April 2022.

2.2 However it was felt due to a number of reasons, that this was not the right time and to reduce the impact on practices and provide continuity and stability, the ICS has recommended that CCGs maintain their existing contracts for a further year. The CCG and LMC have supported this recommendation.

2.3 The Contracting team are preparing the necessary contract documents to extend the online consultation software licences from Engage Health and AccuRx from 1 April 2022 until 31 March 2023.

2.4 There will also be an extension to the AccuRx video consultation by West Yorkshire ICS for the same period.

3. Incorporation Requests

3.1 The CCG have received an Incorporation expression of interest from the Caritas Group Practice. The contracting team have contacted the practice, but they are still in the process of completing the paperwork, at present there is no further update.

4. E-Dec Update

4.1 The annual electronic practice self-declaration (e-DEC) was first introduced to practices in April 2013 and is an annual mandatory data collection.

4.2 The deadline for practices to upload their annual declaration was set for 26th November but due to the busy time in general practice NHS Digital extended the deadline to 17th December 2021.

4.3 At the end of January 2022 all practices in Calderdale had successfully uploaded their declarations. It is a contractual requirement for an annual E-Dec to be made by each practice.

4.4 The Contracting team have asked the Business Intelligence team to review the raw data for 2021 and develop an improved presentation format to use once the data becomes available.

5. Friends & Family Test

5.1 The suspension of the requirement for practices report to commissioners about the Friends and Family Test under the pandemic regulations is anticipated to be suspended until the end of March 2022.

6. Recommendations

6.1 It is recommended that Commissioning Primary Medical Services Committee

1. Receives and notes the content of the contracting report.

Name of Meeting	Commissioning Primary Medical Services Committee	**Meeting Date**	3 March 2022
Title of Report	**Alternative Provider Medical Services – Calder Community Practice**	**Agenda Item No.**	9
Report Author	Natalie Sykes, Senior Primary Care Quality Improvement Manager	**Public / Private Item**	Public
Clinical Lead	Dr Majid Azeb, Clinical Lead for Primary Care	**Responsible Officer**	Debbie Robinson, Director of Improvement - Community and Primary Care

Executive Summary

The Alternative Provider Medical Services (APMS) contract for the GP practice at Calder Community Practice is due to come to an end on 31st March 2022, and the CCG needs to make an urgent decision on what to do next for the patients of the practice.

The paper outlines a number of options and the challenges in the locality of securing viable quality services for a cohort of 2,700 patients in Todmorden.

The paper requests that Commissioning Primary Medical Services Committee supports a direct award of the APMS contract for two years until 31st March 2024. The direct award of the APMS contract will enable the CCG to undertake a thorough evaluation and options appraisal for future delivery of the service.

Previous Considerations

Name of meeting	Senior Management Team Meeting	**Meeting Date**	02/02/2022
Name of meeting	N/A	**Meeting Date**	N/A

Recommendations

It is recommended that Commissioning Primary Medical Services Committee:

1. Note the end date of the current APMS contract for Calder Community Practice as 31st March 2022

2. Note the processes and timescales outlined within the NHS England Primary Care Policy and Guidance Manual for expiring APMS contracts

3. Support and agree a direct award of an APMS contract to the current provider for a two-year period to the 31st of March 2024.

Decision ☒	**Assurance ☐**	**Discussion ☐**	**Other:**

Implications

Quality and Safety implications (including whether a quality impact assessment has been completed)	QIA will be undertaken following a full options appraisal
Engagement and Equality Implications (including whether an equality impact assessment has been completed), and health inequalities considerations	EQIA will be undertaken following a full options appraisal
Resources / Financial Implications (including Staffing/Workforce considerations)	A delegated financial budget exists for this contract.
Sustainability Implications	N/A

Has a Data Protection Impact Assessment (DPIA) been completed?	**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)**	Not currently included on the CCG's risk register Risk to service provision beyond the 31st of March 2022 if no decision is reached on issuing a direct contract award.
Legal / CCG Constitutional Implications	Obligation to provide primary medical services to the local population. NHS Procurement, Patient Choice & Competition Regulations (No.2) 2013; Public Contract Regulations 2015 (as amended)	**Conflicts of Interest (include detail of any identified / potential conflicts)**	Any conflicts of interest will be managed in line with the CCG's policy for managing Conflicts of Interest.

1.0 Introduction

1.1 Alternative Provider Medical Services (APMS) contracts deliver Primary Medical Services on a time limited basis and are procured using the Standard NHS England APMS Contract with its standard essential and additional services specifications and pricing structure.

1.2 Primary medical services for the population registered at Calder Community Practice (Y02572) are provided under a time limited Alternative Provider Medical Services (APMS) which is due to expire on 31 March 2022.

1.3 The current APMS contract to provide Primary Medical Services with Locala, in respect of Calder Community Practice was extended for two years on 1st April 2020.

1.4 There is no further option to extend within the current contract, the CCG can choose to make a direct award of the contract via a tender waiver for a further period. It should be noted that a direct award of contract without undertaking a procurement presents a risk in respect of a challenge made under the current public procurement regulations. The procurement considerations are set out within the paper.

1.5 This paper seeks to provide CPMSC with options for the continued provision of primary medical services for the population registered at Calder Community Practice from 1st April 2022 and to gain agreement on the preferred option of a direct award of the contract to the existing provider for a further 2-year period to the 31st of March 2024.

2.0 Context regarding Primary Medical Services Provision in Upper Calder Valley

2.1 Calder Community practice has 2,716 registered patients and delivers services from Todmorden Health Centre, Todmorden, OL14 5RN.

2.2 The last CQC inspection for Calder Community Practice was published on 29th June 2016 and was rated GOOD. https://www.cqc.org.uk/location/1-1020224614

2.3 The 2021 GP Patient Survey identifies the following results for Calder Community Practice compared with the CCG average:

- **Overall, how would you describe your experience of your GP practice?**
  The results for Calder Community Practice were 82%, the CCG average was 84%

- **Overall experience of making an appointment**
  The results for Calder Community Practice were 80%, the CCG average was 72%

- **Support with managing long-term health conditions**
  The results for Calder Community Practice were 77%, the CCG average was 74%

- **Ease of getting through to your GP practice on the phone**
  The results for Calder Community Practice were 79%, the CCG average was 66%

- **How helpful do you find the receptionists at your GP practice?**
  The results for Calder Community Practice were 94%, the CCG average was 89%

2.4 Calder Community Practice are not currently triggering the Quality Assurance and Surveillance Process (QASP) based on the data reviewed from the January 2022 Calderdale GP dashboard. However, an early review of the February 2022 GP dashboard indicates that the practice is triggering the QASP for the first time. The practice data for February indicates there has been a reduction in uptake for the number of childhood immunisations carried out. January's dashboard data indicated an uptake rate of 92% and February's data shows this has reduced to 86%, the decrease has resulted in the practice triggering the QASP for February. A routine quality assurance visit will be organised and take place during March 2022. The CCG is not aware of any other quality, performance or contractual issues that would prevent the CCG from exercising its discretion to issue a direct award of the contract to the current provider (Locala) for a further 2 years.

2.5 Calder Community Practice is one of 3 practices that make up Upper Calder Valley Primary Care Network. The other 2 are Todmorden Group Practice with a registered list size of 13,483 and Hebden Bridge Group Practice with a registered list size of 18,654.

2.6 In 2019 the CCG reviewed the 2 APMS contracts that were in place in Calderdale, including undertaking a full consultation. The outcome of that review was that the CCG would implement a managed allocation of patients at the following sites; Park, Ovenden, Elland and Sowerby Bridge and seek a separate solution for the patients registered at Todmorden. This was informed by the outcome of the consultation where local people expressed concerns

about being allocated back to a practice where they had previously been registered, lack of choice and concerns about the remaining capacity and resilience of the co-located practice.

2.7 A market testing exercise was conducted and the response from the market had been limited. It was therefore agreed that Locala would be offered a contract extension for 2 years, with a variation to exclude Park site and re-define the practice boundary, whilst work was undertaken to establish a longer-term solution.

2.8 Due to the Covid-19 pandemic requiring the prioritisation and diversion of CCG staffing resources into more critical areas it has not been possible to complete this piece of work on a longer-term solution. The CCG has explored with Upper Valley Primary Care Network potential options however neither of the remaining practices or the PCN are in a position to take on the running and management of the practice at this time.

3.0 Primary Care Policy Guidance Manual

3.1 In line with the NHS England Primary Care Policy and Guidance Manual, this paper sets out the processes that should be followed to identify the options for consideration to ensure that the registered population of the practice are able to access continuous primary medical services.

3.2 There are three key stages to follow in managing the end of a time limited contract. The three key stages are summarised below:

Stage 1 (Minimum 9 to 15 months before contract end (<u>all essential</u>):

Needs assessment;
Impact; and
Engagement proposal.

Stage 2 (12 months before contract end):

Notice period – exit plan;
Commence procurement and either:
Begin negotiations for continuation with contractor; and

Begin exit arrangements of incumbent provider and mobilisation of any new provider.

Stage 3 (At contract end):

Contract end – possible dispersal of patient list:
Variation to contract/extension: and
Commencement of new provider.

3.3 **Stage One** requires the production of a detailed report for the Commissioning Primary Medical Services Committee (CPMSC) to consider. As set out in the Policy and Guidance Manual this report will need to address the following areas:

Needs assessment

a) Is there still a demand for this service in this locality and a requirement for it to continue? For example, to reduce inequalities in access or health outcomes
b) Does the contract specification still address current local priorities?
c) Has the contract delivered on the expected outcomes?
d) Has it provided added value to the local population and service provision?
e) Have you assessed the potential service needs for any forthcoming new developments?
f) What is the capacity of other local providers and the market for other providers to deliver services?
g) Have you given consideration to any specialist services needs in the locality?
h) Are there any needs which are not met by the contract, which could be delivered?
i) Impact
j) Have you considered available outcome and delivery data held nationally and locally, regarding the current service and impact on other providers?
k) Have you compared the cost of the current service against other providers i.e., cost per head of population whilst taking into account any differences in the scope of the services provided?
l) Is the current service still affordable within projected future budgets?
m) Has the contract delivered on the expected financial outcomes?
n) What other objectives might be set within the existing budget?
o) What is the potential impact on service users/patients?
p) What is the potential impact on other service providers, e.g., GPs, pharmacy, local trust, out of hours, community services?

q) What is the potential impact on the current provider, i.e., continued viability within the locality?

r) Have you considered patient choice and equality?

s) Have you considered the potential risks i.e., reputational (adverse publicity Commissioner/provider relationship), market testing, timescales and financial?

t) Have you considered how the expiry of the contract affects compliance with the general duties?

u) Have arrangements been made for involvement of patients and the public

v) Have other local providers and other interested parties i.e., LMC, local members of parliament, review and scrutiny committee, etc. been engaged?

w) Have the local CCGs been engaged?

4.0 Procurement considerations

4.1 The United Kingdom's exit from the European Community and proposed regulatory changes to NHS competition rules, with the introduction of the Provider selection Regime, are likely to have an impact on the detail of the public procurement process commissioners will be required to follow. It is generally felt that for the short term at least any procurement considerations are based on the existing rules, on this basis the consideration of any risk is deemed to be on the cautious side.

4.2 The re-commissioning of an APMS contract with an estimated annual value of £0.85m clearly falls under the purview of the Public Contracts Regulation 2015 (the "PCR") and its successor UK legislation. In addition, given that it is a CCG commissioned service the NHS Procurement, Patient Choice and Competition Regulations (No.2) 2013 (the "NHS Regulations") will also continue to apply. The principles of transparency, equal treatment and non-discrimination will continue to apply.

4.3 The commissioners are in principle and will continue to be under an obligation to undertake some form of process in respect of the commissioning of services which involves: (i) issuing a contract notice to advertise the opportunity; (ii) structuring the process based on compliance with the principles set out above; and (iii) issuing a contract award notice on award of the contract.

4.4 Under the current regulations, there is provision for an alternative procedure to be used without prior advertisement of the opportunity (i.e., a direct award of a contract) to the extent that the commissioners could demonstrate that *"the services can be supplied only by a particular economic operator for any of the following reasons: […] (ii) competition is absent for technical*

reasons". Given the existence of other potential providers of the service, it is unlikely that this option could be used without an associated risk of legal challenge.

4.5 Similarly, the current NHS Regulations provide for the award of a new contract to a single provider without advertisement where the commissioners are satisfied that the services are capable of being provided only by that provider. Again, given the existence of other potential providers, it is unlikely that this option could be taken without risk of successful challenge.

4.6 The risk of a challenge actually being brought is however dependent on a number of factors, including the complexity of the service, the market for these services and whether or not there is an alternative provider who would be interested and capable of providing the services such that they would want to bring a challenge, notwithstanding that there could be an opportunity to bid for the services at a later date.

5.0 Risks and mitigation

5.1 Further extending the service is not without risk primarily around potential challenges from the market on the basis that the directly awarded contract ought to have been advertised, in line with the Public Contract Regulations 2015 (as amended) and the NHS Procurement, Patient Choice and Competition Regulations (No.2) 2013. It should be noted that such a challenge could be brought either as a complaint to NHS England/Improvement as a potential breach of the NHS Regulations, or through the Courts on the basis of a breach of the public procurement regulations.

5.2 The potential sanctions following a successful challenge could include an instruction to undertake a procurement process in advance of when planned for, reputational damage to the commissioners and a possible claim for damages for the lost opportunity to bid for/win the contract depending on the case made by the challenger(s).

5.3 Whilst there is no guarantee that commissioners will receive a complaint and/or formal challenge, the risk of this is considered to be moderately low with the risk of it being successful mitigated by the following:

- The direct award of contract for the extension of service is of a short duration i.e., for a period of up to 2 years.
- There is a requirement to have the service in place for 1st April 2022 making the opportunity less attractive to potential new providers at this time.

- Commissioners will place an appropriate notice advising the market of its intention to directly award a contract to the current provider. The publication of the appropriate notice will not prevent a challenge being brought, but would reduce the time limits for bringing a claim of ineffectiveness (cancellation of the contract that has been awarded) and in effect reducing the time limit for a claim for damages to 30 days following publication of the notice.
- We understand the risks in the options available to us and document our reasons for the recommended approach in an appropriate way.

6.0 Options for ensuring continued primary medical services for the registered population of Calder Community Practice

6.1 As per the Policy Guidance Manual, the CCG has 5 available options to explore with regards to the provision of services for the patients of Calder Community Practice.

Option 1: Do Nothing
This is not permitted. The CCG has a responsibility to the staff, patients and neighbouring practices of Calder Community Practice to follow the guidance, ensuring a solution is obtained regarding the future of the practice.
Option 2: List Dispersal
This means that the patients of Calder Community Practice would be asked to register at another local GP practice Each adult in each registered household will receive a letter advising them of the changes to services and closure of their practice and advise them of the action they need to take to register with a GP practice near their home address.
Feasibility: There is a likelihood that to pursue this action will require a period of engagement and consultation which would exceed the current contract.

This option was consulted on in 2019 and the findings as highlighted above, resulted in the CCG deciding to ensure continued alternative service provision in Todmorden.

Todmorden Group Practice are the only practice whose boundary fully covers the addresses of patients registered at Calder Community Practice. Hebden Bridge Group Practice cover some of the boundary, however, travel and transport concerns were raised as paramount concern from patients that responded to the previous consultation.

Ongoing discussions with the Todmorden Group Practice have highlighted that capacity and resilience remain a challenge and therefore it is unlikely that they would have appropriate capacity in place to meet the additional demand.

No further formal discussions have been undertaken with Hebden Bridge Group Practice regarding a potential boundary change to incorporate Todmorden

Conclusion:

Not a feasible option for 1st April 2022 as the issues highlighted in 2019 have not changed.

Option 3: Managed List Dispersal

For patients to register with an alternative existing practice via CCG supported process

Provided there is a practice with sufficient capacity, the CCG could move lists to one or more local practices who have expressed an interest in taking the patient list(s), wholly or in part. Patients will be allocated to the practices involved and written to informing them of the change in registration.

Feasibility:

The issues highlighted in the feasibility section for Option 2 apply to this option.

Conclusion:

As for option 2 this is not a feasible option to enact for 1st April 2022 as the issues highlighted in 2019 have not changed

Option 4: Procurement

This would mean carrying out a formal tender to find a new healthcare provider to deliver care to the patients of Calder Community Practice via an Alternative Provider Medical Services (APMS) contract.

The CCG could decide to go to the open market and run a full procurement process for a new provider.

Feasibility:

Due to the length of time to hold a full procurement exercise this is not a feasible option that would be concluded for the 1st of April 2022.

In 2019 the CCG undertook a market test to understand the ability to identify a new APMS provider for its dedicated list of 2,700 patients at Calder Community Practice. The Prior Information Notice (PIN) issued was specific in nature and clear around funding arrangements. The CCG received 4 requests to view the information and only 1 submission of interest. Upon review of the submitted interest the CCG took the view that there was not sufficient interest and a clear market response for providing viable quality services for this cohort of 2,700 patients in Todmorden.

A procurement for this list size would not be in line with the CCG strategy to ensure resilient general practices through reducing the number of smaller practices. If this option was to be pursued a full option appraisal should be carried out.

Conclusion:

This option is not achievable within the timescales, and it is expected that it would not be the CCG preferred solution for the future if a full option appraisal was to be completed.

Option 5: Direct Award to Locala for a further 2 years to 31st March 2024
The current contract does not allow for a further period of extension. Following a discussion with the Head of Contracting and Procurement the recommendation to pursue this option would be to extend the service via direct award of a new contract from April 2022 for 2 years and a supporting tender waiver document will need to be completed. It is also recommended that the provider is issued with a 6-month notice period.
Feasibility: The risk of challenge through the offer of a direct award is low when considering the market testing results in 2019. At the current time neither of the other practices within the Upper Calder Valley PCN have expressed an interest in being able to take that practice population in April 2022. However, informal conversations suggest that there may be revised position over a further period of time, through either existing practices or through a wider approach via the potential establishment of a Calderdale Provider collaborative with an early priority focussing on the Town of Todmorden. Regular conversations around the future of the APMS contract for Calder Community Practice have been held with the provider. Locala have confirmed they are able to continue to provide the current contract on the same basis for a further 2 years. The indicative value of the contract which is based on GP Model costings is £67,526.26 per month, which would equate to £1,621,000 to run the service for a further 2 years with the current provider. This is covered through the primary medical Services Delegated budget.
Recommendation: CPMSC is asked to support a direct award of the APMS contract to Locala for a further two years to 31st March 2024. During which time a full evaluation would be completed to inform our future commissioning intentions.

7.0 Next Steps

7.1 If option 5 is approved, then the following needs to be enacted:

i. Produce a tender waiver and issue a new contract to Locala until 31st March 2024.

ii. During the direct award period the CCG will need to identify and prioritise capacity to complete stage 1 (see section 3.5) detailed within the Primary Care Policy and Guidance Manual. Completion of stage 1 will inform and enable Calderdale CPMSC to make an informed commissioning decision for future delivery of the service from 1st April 2024.

8.0 Recommendations

8.1 It is recommended that the Commissioning Primary Medical Services Committee:

i. Note the end date of the current APMS contract for Calder Community Practice as 31st March 2022

ii. Note the processes and timescales outlined within the NHS England Primary Care Policy and Guidance Manual for expiring APMS contracts

iii. Support a direct award of an APMS contract to the current provider for a 2-year period to the 31st of March 2024

Name of Meeting	Commissioning Primary Medical Services Committee	**Meeting Date**	3 March 2022
Title of Report	**Finance Report**	**Agenda Item No.**	10
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

Executive Summary							
Please include a brief summary of the purpose of the report	Key messages for the committee: • The CCG has developed a financial plan for the period April 2021 to September 2021 and a financial plan for the period October 2021 to March 2022 in line with NHS England guidance. • The CCG is expecting to breakeven and that additional allocations will be received in relation to additional roles expenditure. • The CCG is expected to submit draft financial plans in March 2022 for the financial year 2022-23.						
Previous consideration	**Name of meeting**	N/A		**Meeting Date**	N/A		
	Name of meeting	N/A		**Meeting Date**	N/A		
Recommendation (s)	It is recommended that the Committee: 1) **NOTES** the 2021/22 financial position on Primary Medical Services delegated budgets.						
Decision	☐	**Assurance**	☒	**Discussion**	☐	**Other**	Click here to enter text.

Implications	
Quality & Safety implications (including Equality & Diversity considerations e.g., EqIA)	N/A
Public / Patient / Other Engagement	N/A
Resources / Finance implications (including Staffing/Workforce considerations)	N/A

Strategic Objectives (which of the CCG objectives does this relate to – delete as applicable)	▪ Improving value	**Risk** (include link to risks)	N/A
Legal / CCG Constitution Implications	N/A	**Conflicts of Interest** (include detail of any identified/potential conflicts)	N/A

1.0 Key Messages

The purpose of this report is to update the Commissioning Primary Medical Services Committee on the financial position of primary care co-commissioned delegated budgets for the financial year 2021/22 and to update the Committee on the latest position in relation to financial guidance following Covid-19.

NHS England published planning guidance and allocations for the period April to September 2021 and the CCG has developed a draft financial plan which was submitted to the ICS in April.

The delegated primary care co-commissioned financial plan for the period April 2021 to September 2021 was approved by the Committee on 25 May 2021.

The CCG has submitted a draft financial plan for the period October 2021 to March 2022 to the ICS and the consolidated ICS plan is due for submission to NHS England by the 16 November 2021.

2.0 Financial Performance for 2021/22

Calderdale CCG Delegated Primary Medical Services Summary at 31st January 2022

PRIMARY CARE SERVICES:	Annual	In month			Year To Date			Forecast	
Name	Budget	Budget	Actual	Variance	Budget	Actual	Variance	Outturn	Variance
	£000	£000	£000	£000	£000	£000	£000	£000	£000
GMS	19,169	1,597	1,566	(32)	15,974	15,737	(238)	18,882	(287)
PMS	2,475	206	211	5	2,062	2,063	1	2,467	(8)
APMS	762	63	63	(0)	635	635	(0)	762	(0)
QOF	3,081	257	356	99	2,567	2,662	95	3,081	(0)
Enhanced Services	475	80	65	(15)	390	429	39	545	69
Premises - Reimbursed Costs	3,263	272	327	55	2,719	2,819	100	3,322	59
Premises - Other	81	7	7	(0)	67	67	(0)	80	(0)
Prof Fees Prescribing & Dispensing	180	15	25	10	150	163	13	164	(16)
Other GP Services (inc. PCO)	323	27	38	11	269	365	96	390	68
Other Non GP Services	961	80	(39)	(120)	801	845	44	1,079	118
PCN	3,169	134	343	209	2,900	3,335	435	4,110	941
Reserves - Contingency (91811060)	168	14	0	(14)	140	0	(140)	168	0
Total Primary Care Medical	**34,106**	**2,753**	**2,962**	**209**	**28,675**	**29,120**	**445**	**35,050**	**944**

The summary above shows the budget and forecast expenditure for the period April 2021 to March 2022.

The CCG is currently forecasting to overspend against the notified allocation due to the additional roles forecast, however the CCG is expecting additional allocation to be issued to match against the overspend against the baseline allocation. The CCG is therefore expecting to breakeven overall on delegated primary care allocations.

There are a number of variances currently shown in the position with the key areas shown below:

- Other Non-GP Services- Plans have been developed to spend the reserves and the reserves budget has been moved to reflect the investment plan.
- GMS – is currently showing an underspend of £238k. This may change once list size adjustments have been processed.
- Contingency - The contingency budget of £168k is currently available to mitigate future variances.
- PCN -It is expected that additional allocation of £941k will be received to cover any additional roles expenditure over and above the amount included in the CCG baseline. Further information on additional roles is shown in section 3 below. The CCG is not showing an overspend at this point as it is awaiting further guidance from NHS England.

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.
As reported at the last Committee, the expected level of funding available in 2021/22 is approximately £2.8m rising to £5.3m in 2023/24 (figures subject to updates for changes in national guidance and list sizes). 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 CCG is working with PCNs to understand the plans for 2021/22 and the latest forecast based on current and planned recruitment is shown in the table below:

Summary of positions as at January 2022:	Maximum Reimbursable Amount 21/22	Forecast Total costs for 21/22	Forecast Variance 21/22
Calder & Ryburn	527,151	497,064	-30,086
Central Halifax	656,451	654,116	-2,335
North Halifax	586,227	473,536	-112,691
Upper Calder Valley	471,235	483,799	12,564
Lower Valley	555,859	487,369	-68,490
Total	**2,796,923**	**2,595,884**	**-201,039**
% of maximum		93%	

The CCG is forecasting to spend £2.596m on additional roles based on current recruitment plans. This is an increase of £67k compared to the October position reported at the last Committee. Overall, the CCG is expecting to spend 93% of the maximum reimbursable amount which is a very positive position to report.

The CCG is continuing to have detailed conversations with individual PCN to go through the additional roles' forecasts both for this year and planning ahead for 2022/23. Currently the plans for 2022/23 show that the PCNs are planning to maximise the increased budget available in 2022/23 of £3.8m.

4.0 Financial Plan Update for 2022/23

On 24 December 2021, NHS England published the initial guidance outlining the planning and priorities for 2022/23.

The focus for 2022/23 will continue the restoration of services, meeting the new care demands and reducing the care backlogs that are a direct consequence of the pandemic. These are reflected in the 10 priorities outlined below:

a) Invest in our workforce – with more people and new ways of working, and by strengthening the compassionate and inclusive culture needed to deliver outstanding care
b) Respond to COVID-19 ever more effectively – delivering the NHS COVID-19 vaccination programme and meeting the needs of patients with COVID-19.
c) Deliver significantly more elective care to tackle the elective backlog, reduce long waits and improve performance against cancer waiting times standards.
d) Improve the responsiveness of urgent and emergency care build community care capacity. Supported by eliminating 12-hour waits in emergency departments and minimising ambulance handover delays.
e) Improve timely access to primary care – expand capacity, increase the number of appointments available and drive integrated working at neighbourhood and place level.
f) Improve mental health and learning disability services – maintaining continued growth in mental health investment to transform and expand community health services and improve access.
g) Continue to develop population health management, prevent ill-health and address health inequalities
h) Exploit the potential of digital technologies to transform the delivery of care and patient outcomes
i) Make the most effective use of our resources – moving back to and beyond pre-pandemic levels of productivity when the context allows this.
j) Establish integrate care boards and collaborative system working – ICSs to develop a five-year strategic plan

At the time of writing, the NHS is operating within a Level 4 National Incident in response to the emergence of the Omicron variant. The timeline to support the planning process has been adjusted to reflect the pressures these are placing on the health and care system:

17 March Draft submission
28 April Final submission

The CCG is currently working through a high-level draft financial plan for submission in March.

5.0 Investment

At the last Committee, approval was given to develop plans to spend the uncommitted reserves within the financial plan. Plans have now been developed by the CCG and these have been approved in an additional virtual meeting of non-conflicted members of the Committee.

6.0 Risk/Opportunities

- **Risk -** The CCG is not able to make discretionary investments in a timely manner.
- **Risk** – The CCG does not fully spend additional roles allocations and funds may be redistributed.
- **Opportunities –** the CCG has funding in reserves available for investment.

7.0 Recommendations

It is recommended that the Committee:

1) **NOTES** the 2021/22 financial position on Primary Medical Services delegated budgets.

Name of Meeting	Commissioning Primary Medical Services Committee	**Meeting Date**	3 March 2022
Title of Report	**Risk Register Position Statement Risk Cycle 4 and Risk Register Summary Annual Report 2021-22**	**Agenda Item No.**	11
Report Author	Rob Gibson Corporate Systems Manager	**Public / Private Item**	Public
Clinical Lead	Dr Steven Cleasby	**Responsible Officer**	Neil Smurthwaite (Chief Operating Officer)

Executive Summary

This paper presents a summary of the movement of CPMS risks at the end of risk cycle 4 and a summary on risk activity on all CPMS risks on the CCG risk register in the period 2021-22

There are 3 risks related to the commissioning of primary medical services currently on the corporate risk register at the end of risk cycle 4 and 2021-22

All 3 risks have a risk score of 8 and have been on the risk register for every risk cycle in 2021-22

Previous Considerations

Name of meeting	Quality, Finance and Performance Committee	**Meeting Date**	16 December 2021
Name of meeting	Senior Management Team	**Meeting Date**	30 November 2021

Recommendations

It is recommended that the Commissioning Primary Medical Services Committee:

- Reviews the risk register and the management of commissioning of primary medical services risks
- Approves the CCG risk register for commissioning of primary medical services reporting to Governing Body for risk cycle 1 (2022-23)

- Confirms that it is assured that the risk register represents a fair reflection of the risk activity relating to the commissioning of primary medical services being experienced by the CCG during 2021-22. This follows reviews four times a year of their risks at the respective Commissioning Primary Medical Services Committee meetings

Decision ☒	**Assurance ☒**	**Discussion ☐**	**Other:**

Implications

Quality and Safety implications (including whether a quality impact assessment has been completed)	No quality and safety implications
Engagement and Equality Implications (including whether an equality impact assessment has been completed), and health inequalities considerations	No engagement has been undertaken as it is not required An equality impact assessment has not been completed as there are no equality implications
Resources / Financial Implications (including Staffing/Workforce considerations)	There are no resource or finance implications
Sustainability Implications	There are no sustainability implications

Has a Data Protection Impact Assessment (DPIA) been completed?	**Yes ☐**	**No ☐**	**N/A ☒**

Strategic Objectives (which of the CCG objectives does this relate to?)	▪ Achieving the strategic direction for Calderdale ▪ Improving Governance ▪ Improving Quality ▪ Improving Value	**Risk (include risk number and a brief description of the risk)**	As identified in the risk register
Legal / CCG Constitutional Implications	Risk is managed in line with the CCG's Integrated Risk Management Framework	**Conflicts of Interest (include detail of any identified / potential conflicts)**	Any interests will be managed in line with the CCG's Management of Conflict of Interests policy

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 reviewed at SMT as part of the wider risk register review prior to being submitted for review to each of the Committee meetings. This same report also provides assurance to each CPMSC that all risks are being effectively managed

1.2 This report provides assurance on the process for the detailed review of the CCG's risks for risk cycle 4 and sets out the risk activity for CPMS risks on the corporate risk register in 2021-22

1.3 Where there are any new high-level risks (including CPMS risks) scoring 15 or 16 added to the risk register outside the new governance review periods (4 cycles per annum) then this will be reported to SMT at their next available meeting

1.4 Any risks (including CPMS risks) deemed to be critical (i.e., scoring 20 or above) should be reported as soon as practicable via email to all members of the Governing Body and the Senior Management Team, after the risk is added to the register or its score increases to 20, (instead of waiting until the normal risk reporting cycle), with reporting to CCG staff via staff briefings where appropriate

2. Detail: Risk Cycle 4

2.1 Review

2.1.1 The review period for risk cycle 4 commenced on 8 November 2021 and was completed on 24 November with risks being reviewed by their respective owners and senior managers. The risk register was discussed by the Senior Management Team at their meeting on 30 November 2021. There are 3 risks for review by the Commissioning Primary Medical Services Committee

2.1.2 The risks include:

3 open risks with a score of 8 (see 2.1.6)

2.1.3 New risks

There were no new CPMS risks added to the risk register during risk cycle 4

2.1.4 Closed risks

There were no CPMS risks closed during risk cycle 4

2.1.5 High-level risks

There were no open risks classed as serious (scoring 15 or above) on the CPMS risk register

2.1.6 3 open CPMS risks currently have a score of 8:

Risk ID	Risk Summary	Risk Movement
1629	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.	Static for 1 risk cycle
1628	There is a risk that the full amount of Funding for the Additional Roles Reimbursement Scheme available to General Practice in Calderdale for 2021/22 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	Static for 1 risk cycle
1434	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	Static for 1 risk cycle

	attract, develop and retain people to work in general practice roles.	

3. Summary of activity during 2021-22

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

3.2 Summary of activity during 2021-22:

3.2.1 The risk register undertook its quarterly review and was presented at each of the CPMS Committee meetings during 2021-22

3.2.2 There was one critical risk (scoring 16) during 2021-22 (risk 1734). This was during risk cycles 1 and 2. This risk concerned the back log of work post COVOD-19 due to pauses on QOF (Quality Outcomes Framework). Following a review of the risk register during risk cycle 2 at the CPMS committee in the wider context it was concluded that:

- The risk for the CCG was not confined to general practice, rather it is a place risk across Calderdale, felt by pressure on the system and re-set of the system
- The risk combined two pressures and two risks of harm, the first in terms of long-term condition management and frailty, the second in terms of urgent and on the day access

The following approach was agreed:

- That this risk is closed during risk cycle 3
- During risk cycle 3 two new risks were opened and place is considered rather than service
- These two risks (1941 & 1942) were opened and focussed on the management of long-term conditions & frailty and urgent & on the day access
- These risks would be monitored through the Quality, Finance and Performance Committee with potential for CPMSC to be sighted on them.

3.2.3 There were four open risks during risk cycles 1 & 2 and three open risks during risk cycles 3 and 4.

3.2.4 The average risk score for CPMS risks was 8

3.2.5 One risk (1434) was static for six risk cycles

3.2.6 There are three open risks at the end of 2021-22 (see 2.1.6) and have all been on the risk register throughout 2021-22

4. Recommendations

It is recommended that the Commissioning Primary Medical Services Committee:

- Reviews the risk register and the management of commissioning of primary medical services risks
- Approves the CCG risk register for commissioning of primary medical services reporting to Governing Body for risk cycle 1 (2022-23)
- Confirms that it is assured that the risk register represents a fair reflection of the risk activity relating to the commissioning of primary medical services being experienced by the CCG during 2021-22. This follows reviews four times a year of their risks at the respective Commissioning Primary Medical Services Committee meetings

5. Appendices

Appendix 1: CPMS risk register showing all risks at the end of risk cycle 4 and 2021-22

Please note that this is not currently an accessibly compliant document but the CCG is working towards making this document more accessible. The information can be supplied in accessible format on request.

CPMS risks - risk cycle 4 2021-22

Risk ID	Date Created	Risk Type	Risk Rating	Risk Score	Target Risk Score	Target Score Components	Senior Manager	Principal Risk	Key Controls	Key Control Gaps	Assurance Controls	Positive Assurance	Assurance Gaps	Risk Status
1629	20/08/2020	Commissioning Primary Medical Services Committee	8	(I4xL2)	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 Supervisory structure in place for First Contact Practitioners, Clinical Pharmacists (4/5 PCNs), Social Prescribing Link Workers and Care Co-ordinators - mix of employing orgainsations from larger trusts and through PGPA	No overall PCN Additional Roles governance framework in place for adoption locally - being discussed through Primary Care School at West Yorkshire 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 5/5 PCNs Through reporting into the CD/LMC/CCG meeting	For First Contact Practitioners and Mental Health Workers the employment model builds in professional supervision Creation of the personalised care team that includes social prescribing link workers and care co-ordinators, with supervision clearly provided, professional development and clear line management. This has improved retention	Governance Framework	Static - 1 Archive(s)
1628	20/08/2020	Commissioning Primary Medical Services Committee	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 for 2021/22 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.	Absence of Timely submissions of actual position from PCNs	Approach agreed with PCNs via PGPA regarding monthly reporting of forecast position and actuals including clarity regarding who is responsible for which part of the process	Initial plans for 2021/22 have been received from each PCN and progress made to date on recruitment Finance and Primary Care have met with the Clinical Directors individually to discuss and understand plans for spend for 21/22 and opportunities to bring this forward to ensure full allocation used 20/21	Recruitment timeframes	Static - 1 Archive(s)
1434	25/11/2019	Commissioning Primary Medical Services Committee	8	(I4xL2)	4	(I4xL1)	Debbie Robinson	There is a risk that the quality of and access to commissioned primary medical services in Calderdale is compromised due to local and national workforce shortages, resulting in the inability to attract, develop and retain people to work in general practice roles.	1. Calderdale is part of the international GP recruitment programme 2. LWAB funding has been secured to commission the development of a Calderdale workforce strategy, including stocktake of current available workforce and forecasted requirement for the future. 3. Primary care and Community workforce group is established at West Yorkshire and Harrogate Level 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 9. Training Needs Analysis completed for non medical roles within General Practice through West Yorks and available at Calderdale and GP level	1.Gaps exist in relation to current workforce data 2.Calderdale People Plan (in development) 3. Additional Roles Funding however longer term strategy needs addressing at PCN level 4. Absence of clinical and workforce strategies 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 - 6 Archive(s)

Name of Meeting	Commissioning Primary Medical Services Committee (CPMSC)	**Meeting Date**	3 March 2022
Title of Report	**Commissioning Primary Medical Services Committee Annual Report 2020-21**	**Agenda Item No.**	12
Report Author	Zoe Akesson Corporate Governance Officer	**Public / Private Item**	Public
GB Lead	John Mallalieu, CPMSC Chair, Lay Member and Deputy CCG Chair	**Responsible Officer**	Debbie Robinson, Director of Improvement Community and Primary Care

Executive Summary
The Commissioning Primary Medical Services Committee's (CPMSC) Annual Report for 2021/22 aims to provide assurance concerning the effectiveness and performance of the Committee in the delivery of its remit during the year by demonstrating compliance with its Terms of Reference and evidence concerning the delivery of its work plan for 2021/22. The report will be submitted to the Audit Committee for its assurance under its oversight role for the CCG's governance arrangements. Its contents will also be incorporated into the CCG's Annual Report. The activities section will need to be updated to consider any items of key business undertaken by the Committee during the meeting. It is proposed that these changes are agreed with the Committee Chair following the meeting after which the final version of the report will be submitted to the Audit Committee.

Previous Considerations

Name of meeting		**Meeting Date**	
Name of meeting		**Meeting Date**	

Recommendations
It is recommended that the Committee **APPROVES** the draft report for submission to Audit Committee for assurance and incorporation into the CCG Annual Report subject to the Chair's agreement of changes to reflect the outcomes of the self-assessment discussion and any other key items of business undertaken at the meeting.

Decision ☒	**Assurance ☐**	**Discussion ☐**	**Other:**

Implications

Quality and Safety implications (including whether a quality impact assessment has been completed)	The report includes information on how the Commissioning Primary Care Services Committee uses information relating to quality and safety of commissioned primary care services in the governance processes of the CCG
Engagement and Equality Implications (including whether an equality impact assessment has been completed), and health inequalities considerations	The report includes information on how the Commissioning Primary Care Services Committee uses patient and public engagement and equality information to fulfil the statutory duties required of the CCG.
Resources / Financial Implications (including Staffing/Workforce considerations)	None
Sustainability Implications	None

Has a Data Protection Impact Assessment (DPIA) been completed?	**Yes ☐**	**No ☐**	**N/A ☒**

Strategic Objectives (which of the CCG objectives does this relate to?)	Improving governance	**Risk (include risk number and a brief description of the risk)**	None identified
Legal / CCG Constitutional Implications	The committee is required to submit an Annual Report to the Audit Committee for its assurance.	**Conflicts of Interest (include detail of any identified / potential conflicts)**	Any conflicts of interest arising from this paper will be managed in line with the CCG's Management of Conflicts of Interest Policy.

NHS
Calderdale
Clinical Commissioning Group

Commissioning Primary Medical Services Committee

Annual Report

2021- 2022

1.0 Purpose of the Report

1.1 The Commissioning Primary Medical Services Committee's (CPMSC) Annual Report for 2021/22 aims to provide assurance concerning the effectiveness and performance of the Committee. It aims to evidence the effectiveness and impact of the Committee by demonstrating compliance with the Committee's Terms of Reference and delivery of its work plan since 1st April 2021, which are appended to the report.

2.0 Introduction

2.1 The CPMSC is established in accordance with Schedule 1A of the NHS Act 2006 and with NHS Calderdale Clinical Commissioning Group's (CCG) Constitution, Standing Orders and Scheme of Delegation.

2.2 In acceptance of the delegation agreement the Governing Body has determined that the CPMSC will function as a corporate decision-making body for the management of the functions and powers delegated to Calderdale CCG by NHS England, under the terms of the delegation agreement. Consequently, decisions of the Committee related to these delegated functions and delegated powers cannot be overruled by the Governing Body.

2.3 The CPMSC was established in April 2015 and operates in accordance with the delegation agreement entered between NHS England and NHS Calderdale CCG. All the pre-delegation governance aspects of primary care work continue to be enacted through the CCG's existing committee structure.

2.4 The functions of the Committee are undertaken in the context of the aim to increase quality, efficiency, productivity, and value for money and to remove administrative barriers to achieving this within primary medical services.

2.5 The focus therefore, for the Committee has remained the review, planning and procurement of primary medical services in Calderdale. This includes making decisions in respect of:

- Contracts for General Medical Services (GMS), Personal Medical Services (PMS) and Alternative Provider Medical Services (APMS)
- 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)
- Whether to establish new GP practices in an area; approving practice mergers; and 'discretionary' payment (e.g., returner/retainer schemes)

2.6 The ongoing public health emergency has impacted the Committee's traditional business and governance arrangements during the year; however the Committee continued to meet and fully deliver its workplan, using the urgent decision-making panel when necessary for pandemic response priority actions. Information concerning the panel's membership and attendance has been provided alongside that of the Committee in the relevant sections of the report. An overview of the panel's work can be found in Section 7.0 Review of Committee Activities.

3.0 Membership

3.1 The membership of CPMSC, as set out in its Terms of Reference, was as follows:

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

3.2 The members of the Committee were supported by the attendance of Director of Improvement Community and Primary Care, Contracting and Procurement, and the Chief Quality and Nursing Officer. A representative from Calderdale Health and Wellbeing Board, Healthwatch and NHS England are also invited to attend the Committee's meetings and the invitations have been accepted during the year.

3.3 One of the Governing Body Lay Members who sat on the Committee resigned on 31 December 2021. A newly appointed Lay Member of the CCG will take on the role of Deputy Chair of the Committee, following appointment on (add date) .
A GP member of the Committee also resigned on 31 January 2022.

4.0 Frequency of Meetings

4.1 In accordance with its Terms of Reference, CPMSC met when there was business to conduct in line with its workplan. The Committee met formally five times during the year, one of which was a single item meeting.

4.2 In addition in 2021- 22, the Urgent Decision-Making Panel of the Committee met on two occasions.

4.3 Due to the transition to the future statutory organisation being extended to 30 June, further committee meetings will be scheduled in the next quarter dependent on requirements.

5.0 Attendance

5.1 The Committee's attendance record is set out at **Appendix 1.** This includes the record of attendance at meetings of the Urgent Decision-Making Panel.

5.2 Attendance has generally been good however both GB GP members only attended 1 out of the 5 full meetings. This was due to several reasons including conflicts of interest, annual leave and pressure in General Practice leading to clinically active members of the GB supporting the covid vaccination and booster programmes and temporarily stepping down from the Governance actions within the CCG. This did not impact quoracy.

5.3 The Committee was quorate for every formal meeting and all decision-making activity during the year.

6.0 Terms of Reference

6.1 The Terms of Reference for the CPMSC were submitted to and approved by the Governing Body in January 2021(**Appendix 2**). They are next due for review in April 2023 and there have been no major changes this year. However due to the organisational changes that are happening a fresh set of terms of reference will be drawn up once the new arrangements for the ICS have been confirmed, should the Committee remain in existence. The change to the Lead Officer's title from Head of Primary Care Quality and Improvement to 'Director of Improvement Community and Primary Care' will be reflected in the new document.

7.0 Review of Committees Activities

7.1 The CPMSC Annual Workplan for 2021-22 was discussed and received for approval by the Committee at all its meetings during 2021-22 **(Appendix 3).**

7.2 The Committee has had several items of business to manage throughout 2021-22. Conflicts of interest remain challenging but have been managed and recorded appropriately.

7.3 The Committee's key achievements this year include:

- Approving a quality assurance and monitoring process for General Practice which has led to the development of a local Calderdale General Practice Dashboard.

- Making a collective decision to delegate the task of approving the Primary Care Network Development Plan to the CCG's Senior Management Team. The CPMSC members would oversee progress through routine updates at future meetings.

- Ensuring a robust procurement process and evaluation had been followed for selecting the providers for the Calderdale CCG Interim Community Phlebotomy Service and approving the award of contract to the identified bidders through convening an additional single-item meeting.

- Effectively managing the closure of a branch surgery in line with the NHSE policy and guidance manual and issuing a contract variation to remove the branch surgery address from the core GMS contract.

- Receiving updates on key areas of work that support the delivery of General Practice services such as the additional roles scheme, the learning disabilities health checks, general practice access and patient experience, the Estates Strategy document, medicines optimisation, Calderdale General Practice patient survey results.

- Receiving and reviewing regular budget reports for the delegated budget

- Approving the 'Policy for Discretionary Financial Assistance to General Practices Impacted as a Result of a List Dispersal' and agreeing to extend the review date to 3 years to bring in line with other policies.

- Receiving and reviewing the CPMSC risk register for reporting to Governing Body.

- Receiving and reviewing the financial plans for primary medical care services in Calderdale, including the Primary Medical Services Non-Recurrent Spending Plan for 2021/22.

- Considering the Internal Audit report on the audit of delegated CCGs primary medical care commissioning arrangements and the management response. The purpose of this being to provide information to CCGs that it is discharging NHS England's statutory primary medical care functions effectively, and, in turn, use this information to provide aggregate assurance to NHS England and facilitate NHS England's engagement with CCGs to support improvement. The audit was ???????

- Using the Urgent Decision-Making Panel, the Committee was able to approve:
  - the Winter Schemes 2021/22 which included: Additional Capacity for the Acute Visiting Service, In-hours Additional Face to Face Capacity and the Quality Resilience and Recovery Scheme and Associated Improvement Fund to support resilience in General Practice in Calderdale
  - a request from a practice to temporarily reduce its branch opening hours to manage staff sickness and maintain safe clinical services

- To add in decisions /actions from March's meeting

Commented [RD(CC1]: Cant finish until after the march meeting

Commented [JM2]: Only if of a magnitude that merits recognition in the annual report.

7.4 **Covid 19 Response**

7.4.1 All Governance meetings of the CCG have been impacted by the demands of responding to Covid 19 in terms of their governance and the business they have been required to discharge within their remits.

7.4.2 In response to NHS England direction and guidance aimed at enabling organisations, clinicians, managers, and staff to prioritise their front line and operational response and protect public safety the CPMSC:

- continued to meet as a full committee via video conference as required to deliver its workplan,
- ceased holding meetings in public to limit the transmission of the virus,
- continued to publish papers on the CCG website, questions were invited from the public and a decision notice published online shortly after the meetings,
- for matters within the delegated scope of the CPMSC, which required a decision to be made as soon as possible and which could not wait for the next committee or for a further meeting to be arranged, the Committee used the urgent decision-making arrangements.

8.0 Review of the Performance of the Committee

8.1 NHS England and Improvement continues to be committed to reducing the burden and releasing capacity of NHS providers and commissioners to manage the COVID-19 pandemic and allow them to prioritise workload. In terms of board and sub-board meetings this concerns reducing the burden of governance, including the streamlining of papers. In respect of this, the CCG took the decision not to complete committee self-assessments for the period 2021-22.

9.0 Acknowledgments

9.1 I would like to acknowledge the work undertaken by officers in relation to maintaining an effectively operating committee and decision-making process during the challenging time of the global pandemic…to add in any further comments

9.2 The Committee would like to thank all those who have attended the meetings during 2021-22.

10.0 Recommendation

10.1 The Committee is recommended to:
APPROVE the draft report for submission to Audit Committee for assurance and incorporation into the CCG Annual Report subject to the Chair's agreement of changes to reflect the outcomes of the Committee's discussion and any other key items of business undertaken by the Committee at the meeting.

11.0 Appendices

11.1 Appendix 1: Record of Attendance 2021-22
11.2 Appendix 2: Terms of Reference
11.3 Appendix 3: Workplan 2021-22

Appendix 1

Commissioning Primary Medical Services Committee

Record of Attendance for 2021-2022

COMMITTEE MEETINGS

		27/05/21	26/08/21	01/10/21 Single Item Committee	25/11/21	03/03/22
Membership						
John Mallalieu	Chair, Lay Member and Deputy CCG Chair	Y	Y	Y	Y	
Alison MacDonald	Lay Member	Y	Y	Y	Y	**Left organisation**
Denise Cheng-Carter	Lay Member					
Neil Smurthwaite	Chief Operating Officer / Chief Finance Officer	Y	Y	Y	Y	
Lesley Stokey	Director of Finance	Y	Y	Y	Y	
Rob Atkinson	Governing Body Secondary Care Specialist	Y	Y	Y	Y	
Dr Steven Cleasby	Governing Body GP / CCG Chair	Y	**N**	**N**	**N**	
Dr James Gray	Governing Body GP	Y	**N**	**N**	**N**	**Left organisation**
Advisory Members						
Cllr Tim Swift	Representative of Calderdale Health & Wellbeing Board	Y	Y	N	Y	
Karen Huntley	Healthwatch, Kirklees & Calderdale Representative	Y	Y	N	Y	
Neil Coulter	NHS England North (Yorkshire & Humber)	Y	Y	N	Y	
Debbie Robinson	Director of Improvement Community and Primary Care	Y	Y	Y	Y	
Martin Pursey	Head of Contracting	**N**	Y	Y	Y	
Penny Woodhead	Chief Quality and Nursing Officer	Y	**N**	Y	Y	
Attendees						
Zoe Akesson	Corporate Governance Officer	Y	Y	Y	Y	
Suzanne Howarth	Contracts Officer – Primary Care	Y	-	**-**	**-**	
Emma Bownas	Deputy Director of Improvement – Primary Care	Y	Y	Y	Y	
Natalie Sykes	Senior Primary Care Improvement Manager	**-**	-	-	Y	

RAPID DECISION-MAKING PANELS

The quoracy arrangements for meeting of the panel were that the decision would be made by:

The Chair (Lay Member, Finance and Performance) OR the Deputy Chair (Lay Member, Patient and Public Involvement)

and

The Chief Operating Officer from OR the Director of Finance

		05/11/21	**20/01/22**
Membership			
John Mallalieu	Chair, Lay Member (Finance and Performance) and Deputy CCG Chair	Y	
Neil Smurthwaite	Chief Operating Officer / Chief Finance Officer	Y	
Lesley Stokey	Director of Finance	Y	
Advisory Member			
Debbie Robinson	Director of Improvement Community and Primary Care	Y	
Attendee			
Emma Bownas	Deputy Director of Improvement – Primary Care	Y	
Natalie Sykes	Senior Primary Care Improvement Manager	-	
Zoe Akesson	Corporate Governance Officer	Y	

NHS
Calderdale
Clinical Commissioning Group

Commissioning Primary Medical Services Committee

Terms of Reference

Version:	**7.0 FINAL**
Approved by:	Governing Body
Date Approved:	28.01.21
Responsible Senior Officer:	Chief Operating Officer
Review date:	April 2023 or earlier if required by organisational, statutory or regulatory change.

Contents

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) (Deputy Chair of the Committee)
- Chief Operating 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
- 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 Deputy Chair will chair the meeting/that part of the meeting.

4.3 The 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 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 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**

4.7.1 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.

4.7.2 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

4.7.3 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.

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

4.8 **Declarations of interest**

4.8.1 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.

4.8.2 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.

4.8.3 All declarations of interest will be minuted and recorded in line with the CCG's policy on the Management of Conflicts of Interest

4.8.4 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.

4.9 **Administrative Support**

Administrative support for the Commissioning Primary Medical Services Committee will be provided by a member of the Governance Team.

- 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 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 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 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 28.01.21

Change History

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
6.1	Reviewed and amended	CPMSC	21.01.21	Submitted to Governing Body
7.0	**FINAL**	**Governing Body**	**28.01.20**	Website

CPMSC WORK PLAN - 2021-22								
	Lead	**Purpose**	**Frequency**	**May**	**August**	**October - S**	**November**	**March**
Contracting								
Contracting Report including ongoing management and performance of GMS, PMS and APMS contracts	MP	For Assurance	Quarterly	√	√		√	√
Finance								
Finance Report	LS	For Assurance	Quarterly	√	√		√	√
Draft Finance Plan	LS	For Assurance	As required	√				
Delegated Budget	LS	For Decision	**Annually** (date					
PMS Premium Investment Plan 2021-22	LS	For Decision	**Annually** (date					
Assurance Reports								
Director of Improvement - Community and Primary Care Report.	DR	For Assurance	Quarterly	√	√		√	√
Local Dashboard	DR	For Decision/ Assurance	Quarterly		√		√	√
GP Patient Survey Results	NS	For Assurance	As required				√	
Risk Management								
CPMS Risk Review	RG	For Assurance	Quarterly	√	√		√	√
GBAF Review	RG	For Assurance	tbc					
Annual Risk Report	RG	For Assurance	**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				√	
Quality Assurance & monitoring process for primary care		For Decision	As required	√				
Appeals Process (previously Safehaven Guidelines & Procedures - review date March 2022)	DR	For Decision	As required					√
Additional items in year relating to areas of potential high risk or priority								
delegate the approval of the detail of the PCN development plan and its associated investment to the CCG's Senior Management Team	DR	For Decision	As required	√				
Mixenden Hub	DR	For Decision	As required					√
Contracts								
Interim Community Phlebotomy Service	EB	For Decision	As required			√		
Calder Community Practices – APMS contract Extension	DR	For Decision	As required					√
Spirometry testing								√
Contract Variations								
Application to Incorporate - Station Road GMS Contract								√
Conduct of Committee & Development								
Review work plan	DR	For assurance	Quarterly	√	√		√	√
Agree CPMSC Draft Annual Report to include a review of terms of reference and output from self-assessment	DR/JM	For assurance	**Annually**					√
Internal Audit Report	DR	For assurance	As required					√
Follow up development session to review PCN Support and to progress recommendations and further establish/plan requirements in relation to the wider integration agendas. Establish the areas of contractual governance that fall solely within the responsibility of the committee	DR	For assurance	tbc					
ICS Arrangements for the commissioning of Primary Care in Calderdale			tbc - scheduled around updates & decision / notice points					
Future Committee Dates, due to extension of transition until 30/06/22								√

C= cancelled

Additional Meetings / Rapid Decision Making Panel:

01/10/21 - Single Item Committee - Interim Community Phlebotomy Service

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