FINAL MINUTES OF CALDERDALE
COMMISSIONING PRIMARY MEDICAL SERVICES COMMITTEE
4TH MARCH 2021
VIA MS TEAMS

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

PRESENT:

John Mallalieu (JM)	Chair, Lay Member (Finance)
Neil Smurthwaite (NS)	Chief Operating Officer
Lesley Stokey (LS)	Director of Finance
Dr James Gray (JG)	GP Governing Body Member, Calderdale CCG
Dr Steven Cleasby (SC)	GP Governing Body Member, Calderdale CCG Chair
Alison MacDonald (AM)	Lay Member (Patient & Public Involvement)
Rob Atkinson (RA)	Governing Body Secondary Care Specialist

IN ATTENDANCE:

Penny Woodhead (PW)	Chief Quality and Nursing Officer
Martin Pursey (MP)	Head of Contracting and Procurement
Debbie Robinson (DR)	Head of Primary Care, Quality and Improvement
Emma Bownas (EB)	Senior Primary Care Quality and Improvement Manager
Neil Coulter (NC)	Senior Primary Care Manager - NHS England /Improvement
Karen Huntley (KH)	Healthwatch Representative
Cllr Tim Swift (TS)	Representative of Calderdale Health & Wellbeing Board
Danielle Hodson (DH)	Assistant Internal Audit Manager Audit Yorkshire (Item 6)
Rob Gibson (RG)	Corporate Systems Manager (Item 7)
Zoe Akesson (ZA)	Governance Support Officer (minute taker)
	Members of the public were not in attendance

TABLE OF CONTENTS

17/21 APOLOGIES FOR ABSENCE

There were no apologies of absence received.

18/21 DECLARATIONS OF INTEREST

SC and JG declared their financial and professional interest in item 5 Head of Primary Care Report. As there were no decisions to be made the Committee agreed for them both to remain in the discussion, which would be managed by the Chair accordingly.

SC and JG declared their direct financial interest in the private section of the meeting in item 15 Primary Medial Services Non-Recurrent Spending Plan 2020/21. Both colleagues had not received the papers for this item and would be asked to leave at the end of the public section on the meeting.

19/21 QUESTIONS FROM THE PUBLIC

There were no questions received from the public.

20/21 MINUTES OF THE LAST MEETING

The Committee reviewed the minutes of the last meeting on 21ST January 2021 and **APPROVED** these as an accurate record of the meeting.

21/21 MATTERS ARISING

The action log was reviewed. All the actions were recorded as complete.

22/21 HEAD OF PRIMARY CARE REPORT

In presenting the report, DR provided an update on the Learning Disability Health Checks up take, the Primary Care Network (PCN) workforce Additional Roles Reimbursement Scheme and the Covid vaccination programme in Calderdale.

On 1st March 2021, the percentage uptake across Calderdale of Learning Disability Health Checks was 58%, which supersedes the figure quoted in the paper. It was noted that an update has today been sent to Clinical Directors (CDs) and PCN Managers on the latest position. For those practices with the lowest delivery, the CCG has received either verbal or written assurance that they have a plan in place to achieve the target of 75% by the end of March 2021. However, the risk for not meeting the target has been reflected on the CCG's risk register.

Comments and questions were invited on the first part of the report and the following point was noted.

A question was raised if there was a further objective after reaching the 75% target. EB explained there are 3 targets:

- 67% for the CCG to reach by 31/03/21
- An ambition of 75% set in the GP Forward View to reach by 31/03/21
- 80% for PCNs to receive the maximum funding from the Investment and Innovation Fund

The CCG maintain the ambition of 75% of health checks being completed by the end of March 2021. There has been no confirmation about national expectations for 2021/22 however it was agreed that the aim locally should be that all people with a learning disability receive a health check and work will continue towards 100% achievement. It was also recognised that next steps are for people with a learning disability to have a health action plan to support better health outcomes. TS highlighted this work combines with that of the Health and Wellbeing Board and at its next informal meeting would be taking a broader view around health care services for people with learning disabilities. JM added that it should be encouraged that

there is a phased approach for the 2021-22 health checks to deliver 100% across the year and it becomes a regular automated part of medical practice.

ACTION: DR to pick-up conversation around LD health checks with primary care colleagues and re-establish the target for completion for 2021-22.

The second part of the report was an update on the Primary Care Network Additional Roles Scheme. DR highlighted that from April every PCN will become entitled to a fully embedded whole time equivalent Mental Health Practitioner. Calderdale PCNs had plans to progress this role prior to the national announcement and have been advised to continue their local discussions rather than await the final confirmation of the national contract negotiations.

The final section of the paper was in relation to the Covid vaccination programme in Calderdale, the detail in the paper was correct as at the 15th February when the report was published. In addition, NS updated the Committee that 94% of the top 4 cohorts have been vaccinated, which includes care homes and the clinically extremely vulnerable. Health and Social Care workers currently stand at 70%, which is above the national average and NS assured the Committee that the offer of vaccine is always available if staff change their mind. Work continues in the system to ensure underrepresented areas are covered including pop-up clinics at mosques and specialist clinics for people with Learning Disabilities. The programme's next target set by NHSE is 15th April 2021 for all those in cohort 1-9 to have had their first vaccine. Vaccine supply would be increasing over the next few weeks with the start of the second doses. NS assured the Committee there is a good infrastructure in place with the ability to flex with more community pharmacies going forward ensuring choice and coverage for Calderdale.

Comments and questions were invited and the following points were noted.

In relation to patient feedback, PW explained that the CCG's engagement team has been working with a range of partners on an insight report of people accessing the vaccine. The first draft is available for sharing and highlights the good feedback and areas for improvement.

With regards to a question if Patient Reference Groups were happening, DR explained contractually these should have been happening from July and would send a reminder to primary care colleagues.

PW reminded the Committee that the vaccine programme is working hard on innovative ways to approach people with LD but there will still be plenty of work to ensure people in this cohort get vaccinated. DR was asked to provide an update at the next Committee, in conjunction with the engagement work on people accessing vaccines.

ACTIONS:

- **MP to send a reminder to primary care colleagues about PRGs**
- **DR to provide assurance around extra activity for people with Learning Disabilities at next Committee**
- **PW to share with the Committee the Insight report on people accessing vaccines.**

The Committee **NOTED** and were **ASSURED** with the contents of the report.

23/21 INTERNAL AUDIT REPORT - PRIMARY MEDICAL CARE COMMISSIONING AND CONTRACTING: COMMISSIONING AND PROCUREMENT OF SERVICES

DH presented the internal audit report and draft action prior to final submission. The following key points were made:

- Arrangements are in place for planning the provision of Primary Care (PC) services evidence suggests appropriate needs assessment were undertaken in QIAs, EQIAs and public engagement.
- Process for existing PC contracts is adequate although noted that the policy requires updating and 3 contracts were not published on the public contracts register which has now been rectified.

- The Patient and Public Involvement was evident at the CCG. The Annual statement of Involvement report and dedicated web page on specific strategic objectives were on the CCG's website.
- Collaborative working is evident.
- The Involving People' Strategy was not on the website at the time of the review due to formatting issues, but this has now been resolved.
- No local incentive schemes at Calderdale although reviewed the direct enhanced schemes and these were confirmed as being followed.
- Urgent GP practice closures were pertinent and have been done in line with the urgent decision-making process.
- All governance systems and processes are in place including an up to date Terms of Reference however it was found that this was not dated and would be rectified.
- All the findings from the report have been talked through and agreed with DR and MP.

DH asked for comments or further information to put into the report before being finalised.

MP made a comment on language. He felt the procurement policy did not require updating but would merit an update as the procurement policy applies to all procurement activity which has then been split into primary care activity. DH would reword to read that it is more of a reflection than requirement.

ACTION: DH to reword the finding around the procurement policy. MP to document his response accordingly.

The Committee recognised the 3 contracts missed off the register was a minor administrative error and was assured this had been dealt with.

The Terms of Reference (TOR) had been reviewed for the CPMSC Operational Group to sign-off at its next meeting. The Chair suggested for governance purposes

and to support the Operational Group that the TOR is brought to the next Committee for oversight.

The Chair concluded it was a very positive report, with helpful feedback evidencing good systems in place.

DECISION: The Committee AGREED the Internal Audit report and draft action plan prior to issuing of the final report subject to the rewording around the procurement policy.

Karen Huntley joined meeting

24/21 NATIONAL FLU IMMUNISATION PROGRAMME 2020-21 – CALDERDALE REVIEW

In presenting an overview of the Calderdale Flu Immunisation Programme for 2020-21, RG pointed out that there was a number of new cohorts this year due to the pandemic which included secondary school aged children and there was a greater emphasis on tackling health inequalities. Uptake figures for Calderdale were greatly improved on previous years and we compared very favourably against other CCGs across West Yorkshire. Collaboration took place across the Integrated Care System sharing risks and a local Calderdale Flu Group was established. The good work would continue with the first meeting of the "next season" flu group taking place in June 2021 to prepare for the programme for 2021/22 and areas for improvement.

The Committee recognised the progress with flu vaccinations considering the pandemic and the good system approach. The Chair strongly recommended a summarised version of the report to Governing Body.

The Committee **NOTED** and were **ASSURED** about the delivery of the Calderdale Flu Immunisation Programme for 2020-21.

25/21 CONTRACTING REPORT

MP shared key points of the report with the Committee. MP referred to the changes to the policy and guidance manual on how to approach primary care contracts. The GP Online Consultation Software contract would be extended for 9 months as this would be beneficial to general practice to ensure consistency and access until the national procurement contract comes into effect. MP explained it had been difficult to gain signatures from GP colleagues for the local contract variations to bring them up to date with national variations that have been issued previously. There are currently 11 outstanding, which were being followed-up on a regular basis. With regards to the national variations, the contracting team is currently working through these with NHSE colleagues to complete and MP would give an update going forwards. The report concluded with information on current primary care contracts and current issues that are ongoing. MP concluded by thanking his team for their continued hard work during the last 3 months whilst operating without a senior member of the team.

The Committee **NOTED** and were **ASSURED** with the contents of the report

26/21 FINANCE REPORT

The delegated budget allocation for primary medical services is £32.8m and the CCG was forecasting to deliver a balanced position, once expected additional allocations had been received. LS reported a forecast overspend of £497K and explained that the spend for additional roles was shown in the baseline to highlight the need for the resource. This process had been agreed with NHSE and reflected the requirement for them to repay the claim.

For additional roles an allocation was received on £1.6m however the refreshed forecast is £1.2m (figure not included in paper) the reason being that PCNs' expected plans have not translated into additional resource, and also delays in getting claims through for which we were budgeting higher spend. PCNs have been asked to submit claims on time to allow for more accurate forecasting in future. More developed plans are being prepared for next year including new posts around

ambulance and Mental Health Practitioner posts and LS would share a refreshed plan at the next meeting.

There was a conversation at the last Committee on reserve utilisation to support winter capacity and Covid on a non-recurrent basis, which would be discussed later in the private section of the meeting.

With regards to 2021-22 there has been an indication that it would be the same process as this year with a prescribed budget received in quarterly increments throughout the year, but this has still to be confirmed. Currently, with no official planning guidance there are no details for delegated budgets or operating framework other than the extended access and the additional roles would carry on as usual. The Integrated Care System is working on high level planning in preparation to understand CCGs' positions when allocations come through.

The Committee **NOTED** and were **ASSURED** on the 2020/21 financial position on Primary Medical Services delegated budgets.

27/21 COMMISSIONING PRIMARY MEDICAL SERVICES COMMITTEE DRAFT ANNUAL REPORT AND COMMITTEE ANNUAL SELF ASSESSMENT

DR informed the meeting that items 10 and 11 would be taken together.

DR shared the Committee's draft annual report for the financial year 2020/21. The report aimed to provide assurance to the Audit committee around the effectiveness and performance of the Committee and would need to be amended to reflect any findings from the self-assessment discussion and any items of key business that have taken place at this meeting. The Committee was asked to comment on the content of the draft report and if it was satisfied that the Committee had delivered its duties and responsibilities as set out in the terms of reference. The following items were raised:

- A suggestion was made for the annual report item and committee self-assessment to presented as one item in the future.

- To strengthen the report by referring to the Committee having oversight of performance such as the learning disability annual health checks.
- To strengthen the sentence around the Internal Audit Report and how well it has been received.
- To check advisory members against TOR

The Committee received the Chair and Lead Officer's assessments and agreed it was reflective. Following a short discussion, it was agreed an area for development would be to strengthen on an ongoing basis the Committee's management of conflicts.

DECISION: The Committee APPROVED 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.

28/21 REVIEW OF WORKPLAN

The work plan was reviewed, and the Chair asked for any additions/amendments.

RA raised the reintroduction of the primary care dashboard. DR explained that as the national dashboard is not yet available, she has discussed with the with the Clinical Lead an interim approach, which will be brought for sign-off in May then for regular reporting. NS added that the WY&H System Oversight and Assurance Group could provide a source of key indicators to help define the content of the report.

29/21 DATE AND TIME OF NEXT MEETING IN PUBLIC:

Thursday 27th May 2021, 3.00 – 5.00pm, via MS Teams

Calderdale Commissioning Primary Medical Services Committee Meeting 4th March 2021 Action Sheet

Agenda item	Minute No.	Action Required	Lead	Current Status	Comments/ Completion Date
HOPC Report	21/21	To discuss LD health checks being business as usual with primary care colleagues and re-establish the target for completion for 2021-22.	DR	Open	
HOPC Report	21/21	To send a reminder to primary care colleagues about Patient Reference Groups restarting from July 2020.	MP	**Closed**	
HOPC Report	21/21	To provide assurance around extra activity for people with learning disabilities at next Committee.	DR	Open	
HOPC Report	21/21	To share the Insight report on people accessing vaccines.	PW	**Closed**	Emailed 17/03/21
Internal Audit Report	22/21	To reword the finding around the procurement policy. To update the annual report and submit to Audit Committee.	DH/MP DH	**Closed** **Closed**	Reworded 16/04/21 Submitted 13/05/21
CPMSC Annual Report	27/21	To update and submit to Audit Committee.	ZA	**Closed**	Submitted 13/05/21

Name of Meeting	Commissioning Primary Medical Services Committee	**Meeting Date**	27 May 2021
Title of Report	**Head of Primary Care Report**	**Agenda Item No.**	5
Report Author	Debbie Robinson, Head of Primary Care, Quality, and Improvement Emma Bownas, Senior Primary Care Quality and Improvement Manager Tina Stanley, Primary Care Improvement Manager	**Public / Private Item**	Public
Clinical Lead	Neil Smurthwaite, Chief Operating Officer	**Responsible Officer**	Debbie Robinson, Head of Primary Care, Quality and Improvement

Executive Summary
This report provides an update to the Committee on the: 1. Updated Standard Operating Procedure for General Practice 2. Learning Disability Health Checks 3. Digital Update 4. Primary Care Network Development 5. Estates Update 6. Interim Phlebotomy Capacity

Previous Considerations

Name of meeting	Commissioning Primary Medical Services Committee	**Meeting Date**	21 January 2021
Name of meeting	Commissioning Primary Medical Services Committee	**Meeting Date**	4 March 2021

Recommendations
The Committee is asked to: i. Note the content of the paper ii. Consider the proposal of receiving the Draft Estates Strategy at a Committee Development Session iii. Agree to delegate the approval of the PCN development plan to the CCGs Senior Management Team

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

Implications

Quality and Safety implications (including whether a quality impact assessment has been completed)	Detailed within the paper
Engagement and Equality Implications (including whether an equality impact assessment has been completed), and health inequalities considerations	Detailed within the paper
Resources / Financial Implications (including Staffing/Workforce considerations)	Detailed within the paper
Sustainability Implications	NA

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

1. Updated Standard Operating Procedure (SOP) To Support Restoration Of General Practice

1.1 Ahead of government rules on social distancing changes from the 17th of May, NHS England Medical Director for Primary Care and Director of Primary Care has written to General Practices to advise them of the changes to the Standard Operating Procedure for General Practice. The letter can be found at Appendix 1. In summary, the main expectations are:

- GP practices must all ensure they are offering face to face appointments.
- Practices should respect preferences for face to face care unless there are good clinical reasons to the contrary.
- All practice receptions should be open to patients, adhering to social distancing and IPC guidance.
- Patients should be treated consistently regardless of mode of access. Ideally, a patient attending the practice reception should be triaged on the same basis as they would be via phone or via an online consultation system.

1.2 Officers of the CCG have worked with local GP leadership on communications to patients and have encourage all GPs and their teams to make use of the Communication toolkit which has been developed on access to Primary Care, this includes practical help and support.

2. Learning Disability Health Checks

2.1 In the financial year 2020/21 work was ongoing within General Practice to achieve the ambition of 75% of people on GP Learning Disability Registers in Calderdale to have had an Annual Health Check (AHC) by the end of March 2021. The CCG is awaiting the final published confirmation of achievement for 2020/21 and this will be reported into the next committee meeting.

2.2 In the meantime, the national ambition for CCGs remains 75% of people with a learning disability having had a health check and completed their health action plan however in Calderdale we have committed to matching the achievement of 2020/21, expected to be around 81%.

2.3 However, recognising the importance of ensuring these health checks and health action plans are good quality and improve outcomes for people with a learning disability the work in 2021/22 will build on progress made in increasing the numbers undertaken and focus on quality. The health action plan is important and should be co-produced by the person with a learning disability or family or support worker. The health action plan provides information about how the person can make healthy choices, what help they can get to assist with this and what someone might need to look out for as a sign things are not right in order to seek assessment early.

2.4 To this end, there are a number of priorities for next year:

a) A trajectory for achievement has been agreed with the Clinical Lead for Primary Care split across the 4 quarters of the year. This is weighted towards more checks being undertaken in quarter 4 but with a clear encouragement for practices to move to planning completion of Health Checks throughout the year and to offer face to face checks where appropriate.
b) Practices to validate the register and ensure that people on the register have a learning disability.
c) Practices to case find and ensure that people who should be on the register are.
d) Working in collaboration CHFT to align data.
e) Establish a small task and finish group to work through specific actions and what support is required for the ambition to be achieved and sustained – this will include wider system partners.

3. Digital

3.1 Digitisation of Lloyd George Records (DLGR)

The digitisation of Lloyd George medical records programme was under review nationally to ensure that the most effective delivery model is implemented to meet the GP contractual commitment to digitise all records by March 2022. An integrated approach to streamlining general practice patient records management across all parts of the system, including digitising legacy paper records, has also been under review.

The CCG has been awaiting the publications of the framework of approved suppliers to enable the implementation of this work. In anticipation, in Calderdale, we have undertaken an expression of interest (EoI) exercise with our practices to understand the appetite and

need in Calderdale, which links with the existing work around developing the PCN estates strategy. To date 15 practices have submitted expressions of interest covering approximately 161k records, spread over circa. 26.5 rooms totaling circa. 350 sq.m of space, which could be utilised differently.

However, we have now been advised that the programme has been paused pending a decision by the programme on the project design.

3.2 **Electronic Prescription Service (EPS) Phase 4 - National**

The National role out of the Electronic Prescription Service phase 4 was completed during 2020-21 to ensure that any patient without a nominated pharmacy could still receive a digital prescription.

All 21 practices in Calderdale, the Safe Haven Service and Pennine GP Alliance's Extended Access Service are all live with EPS phase 4.

3.3 **General Practice Appointment Data (GPAD) Mapping**

NHS Digital has been collecting data from general practice appointment systems and publishing it, collated by CCG area, since 2018. This data provides a picture of general practice appointments. There are, however, limitations to the insights that can currently be gained from this data due to the wide variation in recording between practices, driven by the use of multiple IT systems and different recording approaches in practices.

NHS Digital acknowledge that this reporting '*information does not give a complete view of GP activity so should not be used to infer a view of workload*.'

To support and improve this data, there is a national piece of work currently being undertaken to ensure general practice appointment slots all map back to common, nationally agreed slot types called GPAD Mapping. Mapping locally defined slot types to a standard set of GP Appointment Categories will provide a consistent view of GP Appointment data in aggregate. This is crucial to enable GP practices, Primary Care Networks (PCNs), Clinical Commissioing Groups (CCGs) and national teams to:

- be confident that data collected from appointment systems reflects true activity;
- plan capacity and workforce to improve health and care delivery for patients;

- understand the impact of service changes, for example the use of triage, video contacts and online encounters, which were rolled-out during the COVID-19 response; and
- inform national policy development by giving a true picture of how capacity is used.

Guidance on GPAD mapping has recently been updated and published and the timeframe for practices to complete this mapping work has been extended to 30th June 2021.

Both the CCG and the LMC are fully supportive of this mapping exercise and are actively encouraging practices to complete their mapping as soon as possible. The position as at 18th April 2021 is 33% of slots have been mapped. Webinars showing practices how to complete the mapping are currently running, if the CCG has received a more up to date position a verbal update will be provided during the meeting.

3.4 **GP Online and Video Consultations – National**

As a reminder, the provision of GP Online and Video Consultation remains a contractual requirement and was highlighted as part of the core digital offer which practices must provide to patients.

All practices in Calderdale have implemented solutions for both Online and Video Consultation, however, utilisation remains mixed across practices.

Engagement support at practice level was suspended during Covid-19 but is now being ramped up. Each CCG across Calderdale, Kirklees and Wakefield has identified its 5/6 practices with the lowest utilisation rates, who will be offered support from the Digital WY ICS team. All practices in Calderdale have enabled the OC system but it would appear that the approach to promotion with patients differs from practice to practice. The practices with the highest utilisation have sent out text messages to their patients to promote the service whereas some practices have just enabled the link on their website. Each practice has the opportunity to work individually with the Business Change Manager to understand the barriers/concerns and support the practices to increase the digital offer to their patients.

The digital programme team are gathering information on all the systems in use across WY&H to understand other offers in the market, considering both functionality and usability against costs, which will help to inform future procurement requirements. It is the intention

to procure across the ICS during 2021-22 with the intention of a new supplier(s) to be in place from April 2022.

4. Primary Care Network Development

4.1 The CCG supported the PCN Clinical Directors to commission an independent consultant to undertake a review of the 5 Calderdale PCNs. This was to ensure that the review remained free of stakeholder influence and would enable an objective analysis and subsequent recommendations. A clear proposal detailing the focus for the review and intended outcomes was agreed by all 5 Clinical Directors (CDs) to ensure full ownership of the themes and intended outcomes. The proposal focused on three key areas for review, these were:

Governance Arrangements:

- Contract requirements within the DES
- PCN Management Structures
- Decision making processes and accountabilities
- Relationship between PCN and Practices
- Financial management and reporting
- Governance at Calderdale wide level

The Role of the Clinical Director:

- Actual role against agreed profile
- Challenges and Achievements identified by the Clinical Directors

Operational Delivery and Development

Review DES contract requirements the establishment of the workforce including monitoring processes:

- Service development processes and subsequent delivery
- Operational and back office support linking to the 'Nominated Payee' functions

4.2 The final report was intended to offer an opportunity to not only review implementation to date, but also to establish a framework across all PCNs that is consistent, effective and maximises the resources available to ensure the delivery of outcomes for Calderdale as a

district, our practices and ultimately our patients. A key recommendation of the report was that:

"The review sponsors to arrange a facilitated session for the Clinical Directors, PCN Practice Manager Leads, key senior managers from the CCG and LMC Executive representation to consider the recommendations made and support the development of an Action Plan for moving forward".

4.3 The workshop has now taken place and was attended by the CCG's Chief Operating Officer, the Head of Primary Care and the Clinical Lead for Primary Care. As part of the workshop agreements in principle, were made by the Clinical Directors in respect of the operational support and the potential structure of that support across the PCN's, along with proposed changes to the governance structures surrounding the PCN's and their associated management boards.

4.4 The PCN Clinical Directors are currently drafting the joint action plan for consideration by the CCG. The Committee has previously approved investment for PCN Development support to pump prime key elements of the agreed action plan and is **asked to delegate the approval of the plan and its associated investment to the CCGs Senior Management Team**, the outcome will then be reported to the next meeting along with regular update on progress throughout the coming months.

5. Estates Update

5.1 Overview

There are a number of key pieces of work being carried out focussing on General Practice Estates both nationally and locally. Below is a high-level summary of each project.

5.2 Calderdale Estates Strategy incorporating the PCN Estates Strategies – Local

As advised in January 2021 the CCG and the NHSE/I Strategic Estates advisor have engaged AA Projects to produce a strategic document that will provide a good picture of the current Estates landscape for general practice that also includes information from health and social care partners. This is intended to enable the CCG to better support the planning of Primary Care Networks estate requirements e.g. improving physical environment, the allocation of funding and ensuring service provision aligns with the estate needs. This work commenced in January 2021 and it is anticipated that the final draft of the strategy will be

available at the end of May 2021. **The committee is asked to consider receiving this strategic document as part of a committee development session in the first instance.**

5.3 **Calderdale Premises Funding Governance Process**

As part of the CCG's Delegated Commissioning responsibilities, it is required to ensure delivery of delegated functions in respect of Premises and Estates, premises cost directions functions, premises, and strategic estates planning. To support this, officers have developed a new Governance Process to enable the CCG to receive, validate and consider funding applications from practices for premises development.

There is currently a focus on the GP estate and its suitability to support the delivery of modern primary care services across Calderdale. The estate from which primary care services are delivered will need to be aligned with the emerging clinical service models for PCNs and be able to accommodate an expanded workforce and new models of care.

In developing the estate strategies, we recognise that we will receive requests from member practices for NHS funding support to enhance the built environment within primary care. In recognition, the intention is to implement a clear, transparent governance process in order to receive, validate and consider applications from Practices for funding support (both capital and/or revenue).

The improved governance arrangements have been established on the basis of the following core principles:

- **A Structured governance process** with clear decision points supported by a suite of guidance, tools and templates.
- **A new CCG Infrastructure Group** to act as a screening panel for premises funding applications and provide general premises advice to the Committee.
- **Stratification of applications** into 4 distinct types based on indicative capital value of the scheme, requiring specific information requirements to support a funding application.
- **Effective reporting** to capture key information and track the status and progress of applications received; and
- **A partnership approach** - The CCG and NHS England working collaboratively to facilitate a fair and transparent process of considering all applications irrespective of the

capital and revenue characteristics. The Calderdale Local Medical Committee will be asked to input at key stages of the process.

The details of this and the associated documentation has been shared with practices.

5.4 **Primary Care Data Gathering**

As previously advised the CCG is involved in the National Primary Care Data Gathering Programme, The programme is intended to bring the information held on general practice premises in England up to a consistent baseline standard nationally, providing both ICS' CCGs and PCNs with the tools to support local planning and decision making. This data is considered key to evidencing and identifying areas of need, opportunities for investment, and demonstrating cases for change.

The CCG has been working with Community Health Partnerships and Community Ventures locally, to gather all data required centrally. We are now at the stage of requiring practice knowledge to complete remaining gaps and to validate information collated during the initial programme stages.

Upon programme completion, the data produced will be available to ICS's, CCGs, PCNs and individual practices via the Strategic Health Asset Planning and Evaluation tool (SHAPE), The web enabled application links national public health, primary care and demographic data with information on healthcare estates performance and facilities location.

The anticipated timeline for this work to be completed is August 2021, which includes a 7-week period between 24th May 2021 and 12th July 2021 for the engagement and gap analysis with individual practices.

6. Interim Phlebotomy Capacity

6.1 Agreement has been made by the CCG Senior Management Team to procure an interim community phlebotomy service until 31st March 2022.

The need for an increase in capacity is due to:

- A reduction in available capacity because of an increase in appointment lengths in line with service compliance with Covid-19 Secure Guidelines
- To support the system with re-set and stabilisation including the re-commencement of Quality Outcome Framework activity and a general increase in attendances both of which are anticipated to result in an increase in demand.

6.2 The decision to test the market and go to procurement has been made due to the fact that there are two current providers of phlebotomy services in Calderdale both of which have identified challenges with providing the existing capacity due to competing service demands calling on the existing workforce.

6.3 There is a risk that Market Testing will not yield a provider to deliver the service in which case further conversations will need to be re-opened with existing providers.

6.4 The outcome of the procurement and any decision to award will be presented to the Commissioning Primary Care Services Committee for approval. Due to the timing of committee meetings it may be necessary to ask the chair to convene and an additional meeting.

6.5 A wider review of phlebotomy provision is underway as part of the GP Led Community Services review that will include service(s) to meet the needs of outpatient, community, and General Practice phlebotomy patient needs. Any future provision will be informed by the Diagnostic Recovery and Renewal Work being led through West Yorkshire and Harrogate Health and Care Partnership. This review and service design for the future will be undertaken using The Working Together to Get Results Methodology and through a collaborative provider partnership of CHFT and General Practice Next Steps

7. Recommendations

The Committee is asked to:

i. Note the content of the paper
ii. Consider the proposal of receiving the Draft Estates Strategy at a Committee Development Session
iii. Agree to delegate the approval of the PCN development plan to the CCGs Senior Management Team

8. Appendices

Appendix 1 B0497 GP Access Letter May 2021

Publications approval reference: B0497

An electronic copy of this letter, and all other relevant guidance from NHS England and NHS Improvement can be found here:
https://www.england.nhs.uk/coronavirus/primary-care

13 May 2021

Dear colleagues

UPDATED STANDARD OPERATING PROCEDURE (SOP) TO SUPPORT RESTORATION OF GENERAL PRACTICE SERVICES

Guidance on the phased easing of Covid-19 restrictions continues to be issued by government, in line with the Coronavirus roadmap out of lockdown, with services following and adapting accordingly.

As such, ahead of government rules on social distancing changing from 17 May, we would like to draw your attention to the Standard Operating Procedure which will be published shortly, and which will update and replace previous guidance.

- **Half of all general practice appointments during the pandemic have been delivered in person, GP practices must all ensure they are offering face to face appointments**. As the chair of the Royal College of GPs has said 'once we get out of the pandemic and things return to a more normal way of living and working, we don't want to see general practice become a totally, or even mostly, remote service', so while the expanded use of video, online and telephone consultations can be maintained where patients find benefit from them, this should be done alongside a clear offer of appointments in person.

- Patients and clinicians have a choice of consultation mode. Patients' input into this choice should be sought and **practices should respect preferences for face to face care unless there are good clinical reasons to the contrary**, for example the presence of COVID symptoms. If proceeding remotely, the clinician should be confident that it will not have a negative impact on their ability to carry out the consultation effectively. The RCGP has published guidance on 'Remote versus face-to-face: which to use and when?'. We are asking CCGs to prioritise support to practices who are reporting very low levels of face to face appointments

- **All practice receptions should be open to patients,** adhering to social distancing and IPC guidance. This is important for ensuring that patients who do not have easy access to phones or other devices are not disadvantaged in their ability to access care. Receptions will not yet feel like they did pre-pandemic – for example where space is very constrained patients may be asked to queue outside. Individuals with COVID-19 symptoms or who meet criteria for self-isolation should continue to follow public health guidance. Posters providing information about the symptoms of coronavirus and to direct patients that have symptoms or a positive test result in the last 10 days not to enter the building are available on the Public Health England Campaign Resources Centre website.

- **Patients should be treated consistently regardless of mode of access**. Ideally, a patient attending the practice reception should be triaged on the same basis as they would be via phone or via an online consultation system.

- Practices should continue to engage with their practice population regarding access models and should actively adapt their processes as appropriate in response to feedback.

Annex A contains more information on workload recording, communication with patients and the support available to practices.

Thank you for your continued hard work and and for your ongoing commitment to continuing to deliver the highest quality general practice services.

Dr Nikki Kanani

Medical Director for Primary Care

Ed Waller

Director of Primary Care

Annex A

Communication with patients

Engagement undertaken by Healthwatch and other patient groups has shown that there are a number of patients struggling to navigate the current access routes into practices, and this difficulty can disproportionately affect some communities over others, for example those with poorer access to smartphones or those who have low confidence in using them, and those who may be traditionally underserved.

A communications toolkit for practices and networks can help ensure there is clear information available to all patients about how to access GP services; this information should be made available in accessible formats to all patients, including to those who do not have digital access and those for whom English is a second language. The GP access card supports patients who do not have a fixed address to register with a GP and further information and materials can be found here.

There are resources available on the Public Health England Campaign Resources Centre to support you with communications. Materials are available in different languages and easy read versions.

At a minimum, this information should be provided and maintained on all practice websites, with clear advice about:

- how to contact the GP and ask for help.
- how face-to-face or walk-in services can be accessed.

We recommend that practices review existing telephone and online access routes, with a view to avoiding lengthy or complex messages and other information which may be confusing for patients, and ensuring maximum transparency, being clear where possible about the length of time patients may be holding for on the phone. Example scripts and copy are available in the communications toolkit.

We will continue to communicate to patients through our #HelpUsHelpYou campaign.

Support available to practices:

There is a range of programmes available to practices to support workforce expansion, adoption of digital tools, communication with patients and embedding of new workflows. The majority of the funding associated with this is being deployed by CCGs and incorporates both short-term COVID-19 capacity funding and longer-term programme funding.

Supporting and expanding the workforce:

- Additional Roles, through the reimbursement scheme, has almost doubled this year, representing an average of 12-13 FTE in post for each PCN for the

whole year. Paramedics, mental health practitioners and advanced practitioners have been added to the scheme, and caps removed on first contact physiotherapists and pharmacy technicians. Significant funding is available in 2021/22 to support the development of PCNs and the ARRS workforce including for PCN development; for systems to commission learning and training from training hubs; and for estates and technology transformation for more modernised buildings and better use of technology.

- Funding for GP and nurse New to Practice fellowships, the Supporting Locums scheme and support for establishing GP flexible pools continues, as does local GP retention funding and access to the national GP retention scheme for those GP that require additional support to remain in practice
- Additional capacity is available through use of emergency registered GP returners, locums and vaccine volunteers
- As we move into the second phase of the vaccine programme, PCNs who are delivering to cohorts 10-12 should continue to access additional workforce in line with guidance on the 'Role of PCN LVS sites in Phase 2 of the COVID-19 vaccination programme' published in March 2021. CCGs will be able to provide support where necessary.
- If you or your team need support, the Looking after you too and Looking after your team coaching support offer is available for all primary care staff.

Optimising your practice access model:

- The Access Improvement Programme is already supporting over 700 practices with advice and support to adapt the best operational processes as well as coaching and support for teams. This programme is prioritised on practices whose patients are experiencing the longest routine waits - if you feel you may benefit then get in touch with your local commissioner. There is nationally funded support, via commissioners, that is available for all practices to support them in using online consultation tools in a way that meets their needs, including support with demand modelling, implementation, communications and digital inclusion. This is in addition to the support that suppliers provide on use of their specific product(s). Where helpful commissioners should also use this funding to work with PCNs on collaborative models of care delivery to better match available capacity with demand, e.g. using virtual hubs across a PCN footprint or wider. These offer opportunities to share workload, bring in additional capacity, optimise use of team members such as ARRS roles and help manage excess demand.

Name of Meeting	Commissioning Primary Medical Services Committee	**Meeting Date**	27 May 2021
Title of Report	**Quality Assurance and Monitoring Process for General Practice**	**Agenda Item No.**	6
Report Author	Emma Bownas, Senior Primary Care Quality and Improvement Manager	**Public / Private Item**	Public
Clinical Lead	Dr Majid Azeb, Clinical Lead for Primary Care	**Responsible Officer**	Debbie Robinson, Head of Primary Care, Quality and Improvement

Executive Summary

This report requests approval from the Committee to agree the quality assurance and monitoring process for General Practice within Calderdale.

The paper seeks to describe an approach to monitoring and any action required in line with guidance contained within the Policy and Guidance Manual (v3) published in January 2021 in section 2.4.

The approach incorporates the formal stages described within NHS England Quality Concerns Trigger Tool and takes learning from other areas with permission

If the Committee approves the quality assurance and monitoring process the next step will be to develop the dashboard which will be presented at the next meeting of the Committee in August 2021 for approval.

Previous Considerations

Name of meeting	Commissioning Primary Medical Services Committee	**Meeting Date**	8 May 2021
Name of meeting		**Meeting Date**	

Recommendations
The Committee is recommended to : • note the content of the paper • approve the quality assurance and monitoring process • agree to the development of a local dashboard which will be presented to the August meeting of the Committee for approval.

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

Implications

Quality and Safety implications (including whether a quality impact assessment has been completed)	The Quality Assurance and Monitoring Process will provide a clear, transparent and effective method for assessing, monitoring and managing the quality of General Practices in Calderdale
Engagement and Equality Implications (including whether an equality impact assessment has been completed), and health inequalities considerations	An Equality and Engagement checklist has been completed, and an Equality Impact Assessment has been developed
Resources / Financial Implications (including Staffing/Workforce considerations)	No financial implications noted There is a resource implication in relation to staff time from the CCG across a number of teams.
Sustainability Implications	NA

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)**	1734 There is a risk of harm to patients given the backlog of work post COVID-19 due to pauses on QOF, screening and elective referrals.

			Part of the mitigation was to agree indicators to monitor quality in the absence of the national dashboard
Legal / CCG Constitutional Implications	To support the CCG to be able to discharge its responsibility for Primary Care Commissioning under delegated responsibility from NHS England.	**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. Background

1.1 The CCG has a responsibility under delegated responsibility from NHS England for improving and developing the quality and performance of general practice. This should include a process for responding to and managing quality, performance, and contractual concerns effectively in a safe and timely manner in accordance with the NHS England Quality Concerns Process. This paper sets out a proposed Quality Assurance and Monitoring Process for General Practice in Calderdale.

1.2 NHS Calderdale CCG previously utilised the Primary Care Web Tool to monitor individual GP Practices quality and performance. The Primary Care Web Tool was used alongside other intelligence such as patient complaint information, GP Patient Experience Survey Results and use of secondary care data such as A&E attendances and secondary care referrals at practice level. The Primary Care Web Tool information was considered in the CCG's former Quality Committee and any potential areas of concern relating to a Calderdale wide issue or individual practice were identified and appropriate action agreed. This ranged from an informal visit to understand and identify contributing factors to concerns requiring a formal approach through the Quality Surveillance Process. Although custom and practice this approach to monitoring has not been formalised through the Commissioning of Primary Care Committee within one documented process. This paper sets out the process for approval by the Committee.

1.3 The Quality Assurance and Monitoring Process describes the proposed approach which will enable effective assessment, measurement, triangulation and benchmarking of quality indicators and performance metrics from a range of sources through a dashboard across all general practice providers. It then provides guidance as to what supportive approach and actions will result from the initial trigger and what stage the provider is at in the process. Formally recording the process and agreeing the monitoring metrics will ensure a clear and transparent process which is delivered through collaboration between the CCG and provider.

1.4 The aim is to take a supportive approach to improvement where the data and intelligence identifies issues, to enhance the quality of services provided and prevent harm to patients. It is vital that all parties are transparent, through the duty of candour and the contractual

relationship with commissioners. This will assist in ensuring strong and sustainable primary medical services for the future.

1.5 Covid-19 has had an impact on the delivery of primary medical services by General Practice as described in risk 1734 on the Calderdale CCG risk register. “There is a risk of harm to patients given the backlog of work post COVID-19 due to pauses on QOF, screening and elective referrals, in addition to patients not presenting with symptoms and challenges faced with “reset” resulting in increased morbidity and mortality and widening of health inequalities. This risk may be increased by PCN involvement in Covid-19 vaccine deployment which puts further pressure on clinical capacity”. The details of the risk recognise there is a gap in assurance relating to an agreed formal quality monitoring and assurance process including a dashboard to identify quality concerns and risks early. This paper seeks to start and address this gap.

1.6 The quality assurance and monitoring paper has been shared with the LMC for comment and consideration. Any changes made to the process following feedback from the LMC along with any broader comments regarding the approach will be shared verbally with the Committee at the meeting on the 27th May 2021. Verbal agreement has already been provided regarding their willingness to engage in the development of the General Practice Dashboard referred to later in the paper.

2. Detail

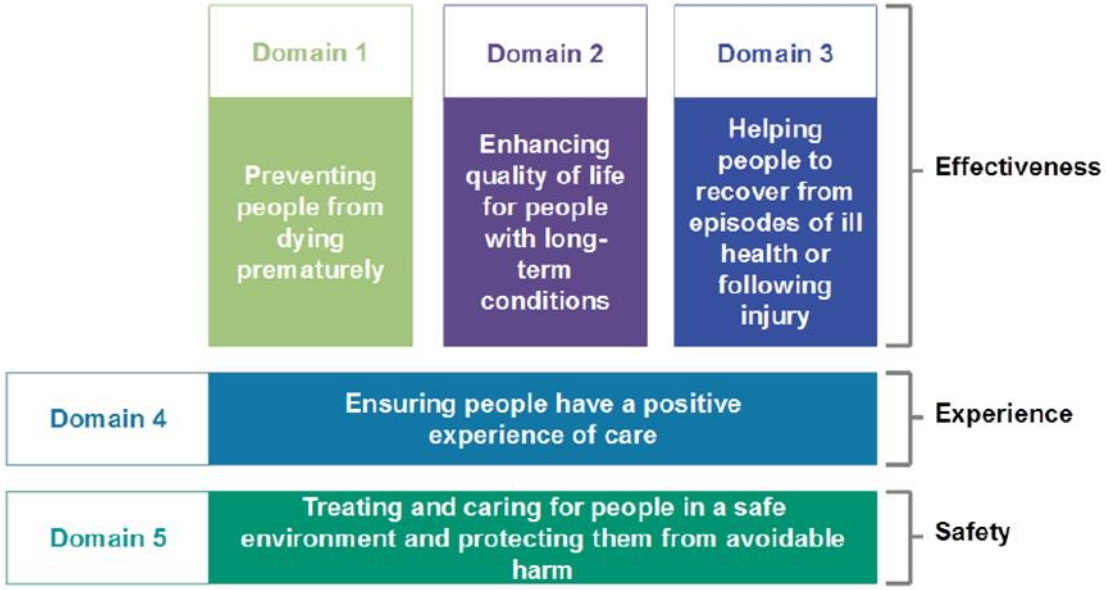
2.1 This process will clearly define:

- How the dashboard will support data analysis and monitoring. This should define the different quality and performance indicators used. This will also include their source, acceptable range, target and where required, the CCG average.
- How a GP practice triggers the informal or formal stages of the process, and what actions will result from this trigger involving the Provider, CCG and NHS England.
- The different stages in the process and how this interfaces with the NHS Quality Concerns Trigger tool. Each stage will articulate what the CCG’s responses/options and actions are for each stage. The stages will also articulate how the CCG will offer early and effective intervention and support when quality and or performance appears

to be deteriorating to safeguard and support practices to deliver high standards of safe quality care.

2.2 The Dashboard

- The General Practice Dashboard will provide an overview of practice performance against identified quality measures. The aim would be to review monthly as part of the Primary Care Operational Group and ensure it is considered by members of the quality, contracting and primary care team along with any other intelligence from external sources including CQC and patient and public feedback. The dashboard will be divided into the 5 domains of the NHS Outcomes Framework and all quality, performance and contractual requirements will be aligned to the domains. Quality will continue to be defined by the Darzi, (2008) definition: Patient Safety, Clinical Effectiveness, and Experience of patients. Therefore, all three domains of quality will be represented within the five domains.



2.2 The Proposed Indicators

Once the Quality Assurance and Monitoring Process has been approved by the Committee it is recommended that a small group comprising quality, contracting, business intelligence, data quality and primary care & medicines optimisation colleagues is formed to agree specific indicators and the monitoring parameters. This will also include clinical input through the CCG Clinical Lead for Primary Care and the LMC.

The proposed indicators will be based on:

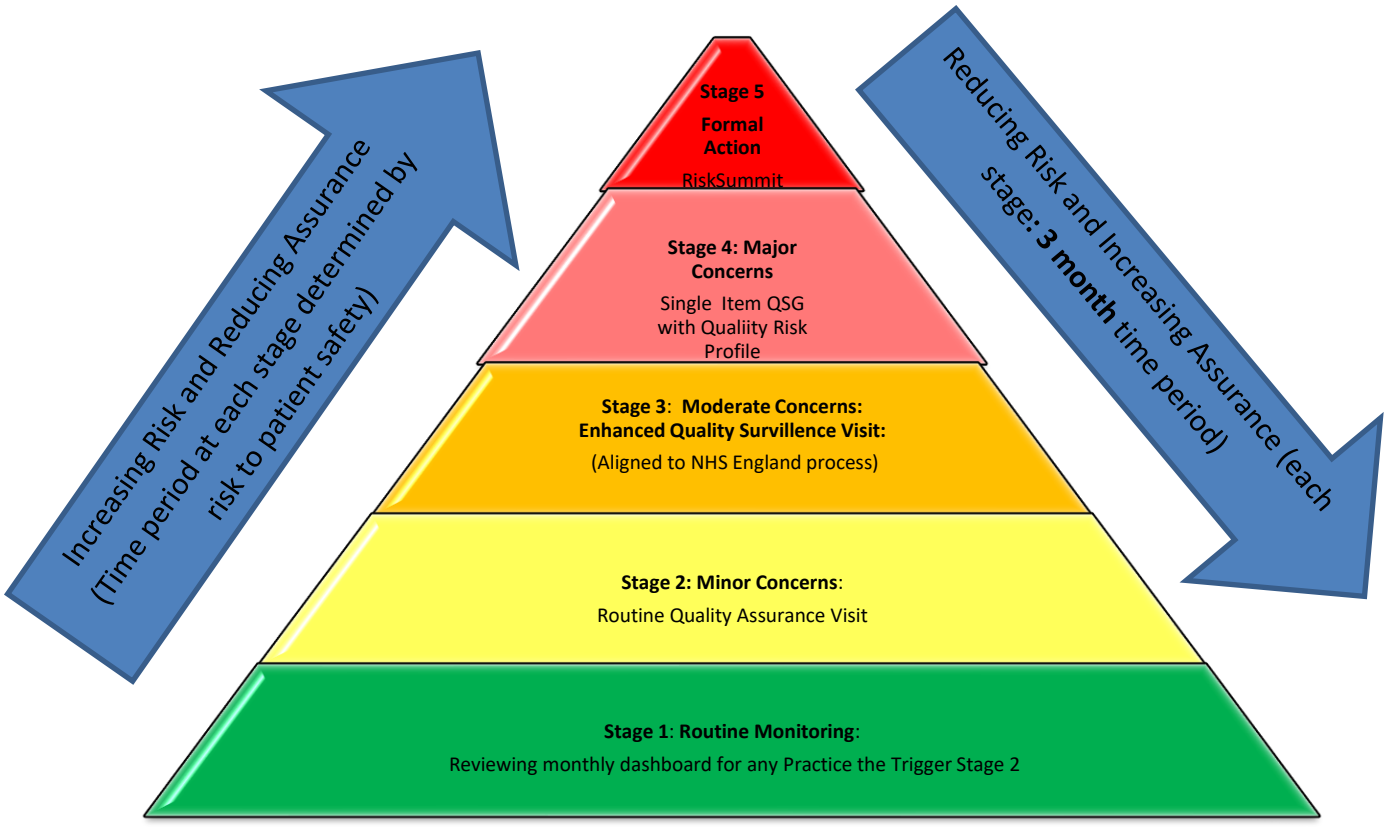
- nationally measured and defined targets required of General Practice
- indicators that measure delivery of outcomes agreed through West Yorkshire and Harrogate Health and Care Partnership that pertain to General Practice
- locally defined measures
- contain a rationale for inclusion linked to health outcomes for people

Where appropriate a Red, Amber Green rating will be applied. Where the indicators do not have a defined measure of success discussion will be undertaken to understand whether a statistical process can be applied to identify outliers, identify practice specific trends, spikes in activity and evidence of improvement/deterioration that will inform action.

The dashboard, indicators and trigger criteria will be presented at the August 2021 meeting of the committee.

2.3 General Practice Quality Assurance and Performance Escalation Stages

The process will have 4 Stages, illustrated below and then described in further detail



Stage 1: Routine Monitoring (Quality Assurance)

2.4.1 This process is intended to be an ‘early warning’ to identify practices that may require advanced diagnostics to address concerns regarding unwarranted variation or identify ‘vulnerable’ practices that may require signposting to additional support/resources. This ‘early warning’ is first and foremost a supportive measure to encourage insight into practice quality issues and or concerns and signpost, guide and support the practice where required.

2.4.2 It is proposed that the Calderdale CCG General Practice Dashboard is developed and then populated through support from Business Intelligence and Data Quality using a range of resources monthly. Where appropriate, these will be RAG rated. It is important to note that any outlying RAG rating does not necessarily mean that there is a concern, but it does indicate that the quality and or performance in the area identified needs further examination.

2.4.3 Following development of the dashboard it will be necessary to agree the approach to understanding what will contribute to an initial trigger. It is suggested that the indicators are reviewed on an annual basis.

2.4.4 The Calderdale General Practice dashboard will be presented into the Primary Care Operational Group monthly, highlighting any practices that are triggering on the dashboard, a discussion would be held to share any further intelligence relating to the practice and any mitigating circumstances with a rational agreed as to whether the recommendation is that the practice moves to Stage 2.

2.4.5 The Trigger criteria will be agreed once the dashboard is finalised, however it is suggested that it is based on consideration of the following:

- A number of Red and Amber indicators (to be determined)
- A CQC report that assesses the ‘SAFE’ and or ‘WELL-LED’ KLOEs as Requires Improvement.
- A serious incident identified in the practice.
- Any new intelligence/ significant complaint or whistleblowing issue of significant importance.
- A CQC report which provides an overall assessment of Requires Improvement
- A CQC report which provides an overall assessment of Inadequate

Any of these triggers may result in escalation to stage 3 or 4 dependent on the patient safety risk.

2.5 **Stage 2: Minor Concerns – Routine Quality Assurance Visit**

2.5.1 A Practice Visit will be arranged with 2-3 members of the CCG from the appropriate members of the Primary Care, Quality and Contracting teams; this may include the clinical lead for primary care. The initial visit and any potential subsequent visits will be led by an appropriate member of the Primary Care or Quality Team dependent on the area (s) of concern such as, but not exclusively, unwarranted clinical variation, workforce, safeguarding, performance or contractual concerns.

2.5.2 The practice visit is intended to be an informal way for the CCG to have an open discussion with practices about the dashboard data which may identify them as outliers for good, deteriorating or underperforming practice or care. There will be key lines of enquiry and scope agreed for this visit to ensure everyone is fully sighted on the purpose and outcomes expected.

2.5.3 The overall purpose of the visit:

- Supportive process to provide a deep dive analysis and understanding of the data/ intelligence with the practice into the concerns the dashboard/incident/CQC report may have highlighted.
- To identify whether the practice was sighted on these concerns and what actions have been already taken to address this.
- Improve patient outcomes by offering appropriate support, guidance and managing quality issues.
- Discuss Quality Improvement support needs
- Enable the sharing and development of good practice and action plans as required

2.5.4. Following the visit, a letter will be provided to the practice to summarise the key discussion points, actions and next steps. This would include any contractual information or concerns noted from quality, performance, contracting and CQC findings.

These next steps will be agreed through the membership of Primary Care Operational Group (that includes NHSE representation and will include:

- No further action – any concerns have been addressed within the meeting and full assurance received
- Improvements were already in progress by the practice: Primary Care Operational Group can recommend that they remain in monitoring for three months to ensure sustained improvement occurs, or the Practice could be deescalated from enhanced monitoring if robust and clear sustained improvements and assurance were noted at the visit and agreed at Primary Care Operational Group.
- Where improvement opportunities are identified then the practice will be requested to submit an action plan including timescales. A clear timescale and subsequent monitoring of the action plan including frequency and form will be agreed. Where concerns are not addressed in a timely manner the Primary Care Operational Group can determine to escalate the process to stage 3.
- If patient safety concerns are significant with minimal or no assurance, Primary Care Operational Group can recommend escalation to Stage 3 or Stage 4 dependent on the risk identified and status of assurance. This would start the formal process as described in the Commissioners Quality Concerns Trigger Tool by NHS England.

2.5.5 At any time during Stage 2, if there is an increasing risk to patient safety and an urgent response is required, the CCG can escalate immediately to stage 3 or 4, dependent on the risk.

2.5.6 Governance arrangements for Stage 2: The reporting of Practices at will occur through Primary Care Operational Group with overall reporting to CPMSC. The CCG may choose to formally inform NHS England and or CQC of any concerns and may request further support or guidance from the NHS England Contracting team.

2.6 **Stage 3 Moderate Concerns: Enhanced Quality Surveillance Visit:**
(This follows the NHS Trigger Tool process 'Enhanced Quality Assurance Process').

2.6.1 This is the formal reactive element of the quality assurance and monitoring process and manages persistent and/or increasing quality/performance concerns. The provider is escalated to this level where increasing risk is identified. The process for stage 3 is that

described in the enhanced quality assurance process as detailed in the NHS England Quality Concerns trigger tool.

2.6.2 At any time during Stage 3, if there is an increasing risk to patient safety and an urgent response is required, the CCG can escalate immediately to stage 4, dependent on the risk.

2.6.3 It is expected that as soon as Stage 3 is triggered that the following three meetings/ visit must be planned as a matter of urgency:

1. An Investigation / Quality Review Meeting (QRM) should be arranged within 5 working days. This meeting should include all relevant CCG teams (Primary Care, Quality, Performance, and Contracting) with consideration as to whether to invite NHS England, CQC and other relevant parties. The designated Chair will be dependent on the concern/concerns raised.

   The purpose of the meeting is to prepare for a formal visit to the practice, discuss and ensure a shared understanding of any emerging risks and agree commissioner actions as required.

   Outcomes from the meeting will include:

   - Details of all Quality, Performance and Contracting concerns should be clearly noted
   - Review of the existing action plan and consideration as to further formal contractual actions or support strategies that may be implemented.
   - Agree key lines of enquiry and scope for the Targeted Quality/Monitoring Assurance Visit.
   - Consideration to initiate the NHS England Quality Risk Profile to support any decision making.
   - Consideration as to whether to instigate formal discussions with NHS England and CQC surrounding performance, quality and safety and contractual concerns.
   - Consideration as to whether contracting action should be taken in relation to any remedial and breach notifications.
   - Consideration as to escalation to stage 4 depending on risk and concern to patient safety.

- Arrangement of follow up QRMs as required, reviewing progress against any action plan and the outcome of Targeted Quality/Monitoring Assurance Visit/s.

2. A Targeted Quality/Monitoring Assurance Visit must be arranged within 10 working days of this Stage 3 being triggered with the relevant team agreed. The purpose of the visit is to:

- Provide further quality assurance based on key lines of enquiry agreed at the Investigation/ Quality Review Meeting.
- To provide further guidance or support sign posting for quality improvement.
- Ensure that the practice is fully sighted on all the concerns and has a robust action plan with clear SMART objectives with timescales that is agreed by the CCG.
- Provide a clear report to a follow up QRM and the Practice of the outcome of the visit.

3. A Formal Enhanced Quality Review Meeting.

2.6.4 The evidence and intelligence supporting the outcomes in the Action Plan should be reviewed alongside current Quality, Performance and Contracting data and intelligence at a Formal Enhanced Quality Review Meeting.

2.6.5 There are 3 options available as an outcome of this meeting:

a) If assurance has been evidenced with changes embedded and sustained: The outcome could be that this practice is recommended to Primary Care Operational Group to be de-escalated to Stage 2 Informal Enhanced Surveillance for monitoring for a further 3 months. At that point a decision can be made to escalate further or remain on Formal Enhanced Surveillance depending on the long-term progress and performance.

b) If assurance is evidenced due to significant changes to the contract holder status or substantial changes in the practices which eradicates or significantly reduces the concern, a recommendation to Primary Care Operational Group could be that it is deescalated to Stage 1. However, this would require clear and robust documentation and risk assessment on the decision made.

c) The final option reflects where there is little assurance or evidence to indicate that the improvement in performance and or patient safety concerns have been addressed in a robust and sustained manner. The Formal Enhanced Quality Review Meeting can recommend to Primary Care Operational Group that this practice is escalated to stage 4 dependent on the risk. If this practice is being escalated to Stage 4 the following should occur:

- Primary Care Operational Group will approve the recommendation of the Practice moving to stage 4.
- A Quality Risk Profile should be developed to support and inform decision making. The purpose of the risk profile is to systematically assess the risks to quality of provision at a point in time. The profile should be used where persistent/increasing quality concerns have been identified. This will give focus to where further exploration is required. There is an acknowledgment that relevant stakeholders will be actively involved in the development of the profile. The profile can be re-run at any time to demonstrate an increasing or decreasing level of assurance.
- A meeting between Commissioners and Regulators to determine next steps should be convened within 5 working days of this decision to escalate.

2.6.6 The practice will be formally informed of the outcome, expectations of the practice and next steps to ensure they are fully informed of the decision and rationale for this.

2.6.7 The reporting of practices at Formal Enhanced Surveillance will occur through Primary Care Operational Group with overall reporting to CPMSC and the private section of Quality, Finance and Performance Committee. The CCG may choose to formally inform NHS England and/or CQC via letter of any concerns and may request further support or guidance from the NHS England Contracting team.

2.7 **Stage 4 – Major Concerns – Single Item Quality Surveillance Group**

2.7.1 Formal communication to the practice should occur surrounding the increased surveillance to stage 4 Single Item QSG. The Quality Risk Profile should be shared with the provider. A Single Item QSG meeting should be convened within 5-7 working days and should involve all relevant CCG team members and Heads of Service as well as all relevant Regulators and parties. This will be chaired by the Chief Quality and Nursing Officer or their deputy.

2.7.2 This Single Item QSG should:

- Review all the evidence, data and intelligence from all QSG members alongside the Quality Risk Profile.
- Provide a summary of the practice timeline of events, actions, mitigation, and assurance so far, evidence of sustained and embedded change.
- The summary should also include a timeline of all interventions by the CCG and support mechanisms from external resources.
- The Single Item QSG should provide an overall summary of the current concern and risk to quality and patient safety, risk to the practice sustainability, and should summarise the concern and risks to the practice, patients and staff, mitigation in place and system risk to surrounding GP Practices.
- The Single Item QSG members are required to determine the level of assurance they have currently surrounding quality, patient safety, staff safety, performance at the Practice.

2.7.3 Actions from the Single Item QSG:

- The members of the Single Item QSG should determine and agree on next steps surrounding an additional review period given to the practice to provide evidence of improvement or whether escalation straight to a Risk Summit is required (Stage 5).
- If a review and improvement period is decided then clear aims, objectives and timescales through an action plan and any contractual notices should be formally presented to the practice by letter and by a visit from the CCG team. Also, it should determine the frequency of any more Quality Assurance Visits. A further Formal Enhanced Quality Review meeting date should be set to review progress at the end of the review period to determine whether the risk is improving or deteriorating.
- If a review period is granted to give the practice time to improve, a series of monitoring mechanisms needs to be agreed and implemented including regular written and verbal contact, visits and monitoring by the Primary Care Team as well as planned or unplanned Quality Assurance Visits.
- A formal Enhanced Quality Review meeting at the end of the review period will determine whether the practice can be deescalated to stage 3 for a period of 3 months of monitoring or whether a further monitoring period for sustainability of improvement is decided at Stage 4.

2.7.4 Should the identified risk remain or increase at any point of Stage 4 a Risk Summit will be convened.

2.8 **Stage 5: Formal Action: Risk Summit**

2.8.1 The organisation, such as the CCG, CQC or NHSE England, raising the concern should immediately arrange an intelligence-sharing teleconference with relevant parts of the system to determine whether a risk summit should be held. Usually this should be within 24 hours of the concern being identified which matches one or more of the trigger mechanisms. If a decision is made to recommend a Risk Summit, there must be certainty that there is a serious quality failure that cannot be resolved through established and routine operational systems. This Summit should be convened in a matter of days.

2.8.2 A Risk Summit is a significant event that requires statutory organisations across the health and care system to come together to give specific, focussed consideration to the concerns raised. This should facilitate rapid, collective judgements to be taken about the specific risk to quality.

2.8.3 The National Quality Board (NQB) (2017) stated that a Risk Summit should be considered when:

- Serious quality failings are identified by any organisation or part of the system, and
- The organisation or part of the system believes that there is a need to act rapidly to protect patients and or staff.

2.8.4 Serious quality concerns may be identified through a range of routes (NQB 2017):

- Individual organisations' routine quality and operational performance monitoring systems;
- Quality Surveillance Groups;
- Completion of the Quality Risk Profile Tool
- CQC Chief Inspectors
- Information sharing meetings; or
- A single material event.

2.8.5 A Risk Summit enables the organisations which make up the health and care system to:

- Give specific, focused consideration to the concern raised, sharing information and intelligence, including with the service provider where the quality risk has been identified;
- Facilitate rapid, collective judgements to be taken about quality within the provider organisation in question; and
- Agree any actions needed as a result of the risk identified. As above, it should be emphasised that action is likely to be needed across the system, not only by a particular provider where the risk has manifested (NQB, 2017)

2.8.6 The Risk Summit should follow National Quality Board Guidance (NQB, 3rd Edition July 2017). This guidance provides a clear and consistent framework for all NHS bodies across England to assist in the management of serious quality risks and failures. It describes the purpose and potential triggers for calling a Risk Summit; the roles and responsibilities of the different participants; the governance arrangements for Risk Summits and practical advice in preparing for and conducting a Risk Summit.

2.8.7 The guidance provides templates for the agenda, letters, checklists and a document for formal recording of the details discussed and follows up actions at the Risk Summit.

2.8.8 The Risk Summit membership (discussed below) should discuss the concerns and risks and review this considering the provider and the wider GP system. This Summit can be chaired by NHS England and NHS Improvement, or potentially the CCG as co-commissioners. This will be determined as part of the teleconference.

Membership varies but can include any of the following (*minimum attendance):

- * NHSE DCO Team (Director, Medical and Nurse Directors)
- * NHS Improvement (delivery and improvement director and a clinical lead)
- * Care Quality Commission
- Public Health England
- * Relevant CCG (accountable officer or nominated Director level representation)
- * Local Authority (joint commissioned services)
- * Relevant Provider (GP Partners and contract holders)
- * General Medical Council
- * Nursing and Midwifery Council

- * Health Education England
- Local HealthWatch (as appropriate)
- * Secretariat (to be provided by a senior manager within the 'chair' organisation'
- *Communications support from the chair organisation, if necessary.
- Other commissioners with an interest
- Other local government agencies
- Local supervising authority midwifery officer
- Police
- Safeguarding boards
- Expert witnesses; and
- Other professional regulators

3. Governance arrangements Stage 4 and 5:

The reporting of Practices at Formal Action stages will occur through Primary Care Operational Group with overall reporting to CPMSC and the Private section of Quality, Finance and Performance Committee and Governing Body.

3.1 Review

It is recommended that this process is reviewed annually to ensure that it is in line with national and local policies as well as system priorities.

4. Implications

a. Quality & Safety Implications: This Process will provide a clear and transparent effective process for assessing, monitoring and managing quality and performance.

b. Engagement & Equality Implication: Engagement will be sought through LMC Executive once the principle and outline process has been agreed.

c. Legal / CCG Constitutional Implications: To support the CCG to be able to discharge its responsibility under delegated responsibility for Primary Care Commissioning from NHS England.

5. Next Steps

To establish a small working group including clinical representation through the Clinical Lead for Primary Care and the LMC a General Practice Dashboard which will be presented at the next meeting of the committee in August 2021

6. Recommendations

The Committee is recommended to :

I. note the content of the paper
II. approve the quality assurance and monitoring process
III. agree to the development of a local dashboard which will be presented to the August meeting of the Committee for approval.

7. Appendices

Appendix A - **Calderdale CCG Primary Care Quality Assurance/Surveillance Flowchart**

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.

Calderdale CCG Primary Care Quality Assurance and Monitoring Flowchart

Item 6 Appendix 1

Routine Surveillance
Dashboard populated and RAG applied to each indicator for each practice

Return to Routine Surveillance

Do any practices trigger Stage 1? ie. One or more of the following:

- Total of 10 or more RED or AMBER indicators (mixed or otherwise)
- ≥6 REDs
- CQC reports Requires Improvement for Safe and/or Well Led domains, or for overall
- CQC reports Inadequate for overall
- Serious incident identified
- New intelligence e.g. complaint/whistleblowing re: risk to patient care or safety
- Concerns raised from quarterly practice visit

No

Yes

PCOG assess each practice re: eligibility for Stage 2 Minor Concerns considering:

- Existing service improvement/action plans
- Practice has sight of issues and provides assurance of improvements
- Atypical practice populations affecting indicators

Is PCOG assured that actions/improvements have been made and are sustainable?

Yes

No

Practice enters Stage 2 – Minor Concerns – monitored by PCOG

- CCG practice visit (consider evidence, action plans, CQC reports, contracts etc.)
- Determine whether to alert CQC and whether specific action plan required
- Assess whether escalation to Stage 3 required
- Review monthly for 3 months (normally) from entering Stage 2

Is PCOG assured that concerns addressed or resolved?

Yes

No

Practice enters Stage 3 – Moderate Concerns – monitored by PCOG

- Formal Investigation/Quality Review meeting within 5 days from entering Stage 3
- Identify all concerns with actions, timeframes and review period
- Maintain effective written communication between practice and CCG throughout
- Arrange targeted Quality Monitoring Assurance visits within 10 days of entering Stage 3
- Monthly monitoring by PCOG (and reported to CPMSC and Quality, Finance and Performance Committee)
- Enhanced Quality Review meeting at end of review period (usually 3 months)

Are CPMSC and QFPC assured that improvements made and sustained?

Yes

No

Practice enters Stage 4 – Major Concerns – monitored by CPMSC, QFPC and GB

- Formal communication with practice
- Arrange single item QSG (commissioners + regulators) within 5-7 days of entering Stage 4
- Complete Quality Risk Profile and share with practice
- Consider Risk Summit
- Action plan monitored monthly by PCOG and reported to CPMSC, QFPC and GB

Are CPMSC, QPFC and GB assured that improvements made and sustained?

Yes

No

Risk Summit following National Quality Board Guidance

Consider rapid escalation to Stages 3 or 4 at any point in the process if significant patient safety concerns

Consider rapid escalation to Stages 3 or 4 at any point in the process if significant patient safety concerns

NHS
Calderdale
Clinical Commissioning Group

Name of Meeting	Commissioning Primary Medical Services Committee	**Meeting Date**	27 May 2021
Title of Report	**Contracting Update**	**Agenda Item No.**	7
Report Author	Suzanne Howarth, Senior Contracts Manager	**Public / Private Item**	Public
GB / Clinical Lead	Dr Majid Azeb, Clinical Lead for Primary Care	**Responsible Officer**	Martin Pursey Head of Contracting & Procurement

Executive Summary								
Please include a brief summary of the purpose of the report	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 consideration	**Name of meeting**		**Meeting Date**					
	Name of meeting		**Meeting Date**	Click here to enter a date.				
Recommendation (s)	It is recommended that Primary Care Commissioning Committee: 1. Receives and notes the content of the contracting report.							
Decision	☐	**Assurance**	☒	**Discussion**	☒	**Other**	Click here to enter text.	

Implications							
Quality & Safety implications	The report is for information purposes and is not requiring a decision by the Committee						
Engagement & Equality implications (including whether an equality impact assessment has been completed)	The report is for information purposes and is not requiring a decision by the Committee						
Resources / Finance implications (including Staffing/Workforce considerations)	The report is for information purposes and is not requiring a decision by the Committee						
Has a Data Protection Impact Assessment (DPIA) been completed? (Please select)	**Yes**		**No**		**N/A**	X	
Strategic Objectives (which of the CCG objectives does this relate to?	Reduce avoidable variation in healthcare and patient experience	**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. General Update – GP Changes

2.1 The CCG had not been notified of any changes during May 2021.

3. PCN Incorporation Update

3.1 It is possible for individual GPs or Partnerships holding a GMS, PMS or APMS contract to seek commissioner approval to operate and deliver services through a company limited by shares (called a 'qualifying body' in PMS) – this process is known as 'incorporation'.

3.2 It is anticipated that GP practices operating on a PCN footprint, may seek to incorporate, it is thought this would strengthen their collaboration with their PCN partners to deliver the Primary Medical Services, the network contract and any other locally commissioned services.

3.3 To support effective decision making, NHS England and Improvement in collaboration with regional and CCG colleagues have co-developed a toolkit to standardise the approach for assessing requirements and considerations. The toolkit includes a standardised assessment framework to support commissioner decision making processes, a supporting guidance document is available to help commissioners apply the framework and consider essential checks and risk mitigations, an application template for providers aligned to the framework and an example due diligence procedure that CCGs can adapt to suit local arrangements.

4 GP Online Consultation Software

4.1 As reported previously, the GP Online Consultation Software contract is provided by Engage Consult Solution. The contract is due to expire at the end of June 2021.

4.2 In view of the advice from NHS Digital not to enter into a new procurement during 2020/21, it has been agreed by the committee to make a Direct Award of a 9 month contract to Engage Consult Solution which will now expire on 31st March 2022.

4.3 The value of the contract will be amended to reflect the actual number of practices using the video consultation element of the package. Several practices are utilising the AccuRx video consultation as an alternative.

5. Covid Temporary Closures

5.1 The Committee are asked to note the outcome of a management review of the approval to a temporary suspension of the delivery of face to face appointments at two branch surgeries in Calderdale.

5.2 In January 2021 the Committee approved the suspension of delivery of face to face appointments at two branch surgeries for a maximum period of 12 months. The CCG retained the right to revoke this notice should guidance change and it became safe to open for both the population and staff team.

5.3 The requests were made by Spring Hall Group Practice in relation to provision of services at its branch surgery at Boots, Halifax and Hebden Bridge Group Practice in relation to the services provided at Luddenden Foot. The Committee delegated provision for this decision to be reviewed three monthly with the practice and the Primary Care Team, Calderdale CCG to ensure that guidance remains unchanged.

5.4 The first managerial review for both practice requests took place on 1st April 2021 where confirmation was received into the Primary Care Team that the situation for both practices remained unchanged.

6 National Contract Variations

6.1 The 2020/21 National Contract Variation templates have been published by NHS England, the contracting team are populating the variations and will be distributing to practices. The previously reported outstanding 11 Variations from 2019/20 have been received.

7. Direct awards

7.1 The 2021-22 GP Community Services contracts are currently in draft form, following receipt of the sign up information from practices. These contracts will be populated and distributed to practices for signatures over the coming days.

7.2 Following approval for an extension to the GP Extended Access Contract, the decision was made to directly award Pennine GP Alliance with a further 12 month contract. The 2021/22 contract for Extended Access has been drafted and sent to the providers for comment before finalising and signing by both parties.

8. Practice Incorporation Requests

8.1 The CCG have received Incorporation expressions of interest from Station Road Surgery and the Caritas Group Practice. In line with the required process the contracting team sent acknowledgement letters, updated Incorporation application templates and guidance but has yet to receive the completed documentation. The contracting team have contacted the practices but they are still in the process of completing the paperwork.

9. Recommendations

It is recommended that Primary Care Commissioning Committee:

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

Name of Meeting	Commissioning of Primary Medical Services Committee	**Meeting Date**	27 May 2021
Title of Report	**Risk Register Position Statement Risk Cycle 1 2021-22 (15 February - 3 March 2021)**	**Agenda Item No.**	8
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
At the end of risk cycle 1 2021-22 the CCG Risk Register contained a total of 38 risks. There were 5 risks marked for closure this risk cycle meaning that 33 risks were open; there were 35 open risks at the end of the last risk cycle. Of the total CCG risks: - 32 (84%) were categorised as quality, finance & performance risks - 6 (16%) were categorised as commissioning of primary medical services (CPMS) risks

Previous Considerations

Name of meeting	SMT	**Meeting Date**	09/03/21
Name of meeting		**Meeting Date**	

Recommendations
It is recommended that the Committee: 1. Reviews the Risk Register and the management of Commissioning of Primary Medical Services risks 2. Approves the CCG Risk Register for commissioning of primary medical services risks reporting to Governing Body for risk cycle 2, subject to any amendments requested

Decision ☐	Assurance ☒	Discussion ☐	Other:

Implications

Quality and Safety implications (including whether a quality impact assessment has been completed)	There are 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
Resources / Financial Implications (including Staffing/Workforce considerations)	There are no resources / 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?)	Improving quality	**Risk (include risk number and a brief description of the risk)**	Risk is managed in line with the CCG's Integrated Risk Management Framework. Risks are captured on the Corporate Risk Register or the Governing Body's Assurance Framework (GBAF) as appropriate.
Legal / CCG Constitutional Implications	There are no legal / CCG Constitutional implications	**Conflicts of Interest (include detail of any identified / potential conflicts)**	There are no conflicts of interest.

1. Introduction

1.1 This report sets out the current risks captured on the CCG's Corporate Risk Register for the Committee's review and approval *(*Appendix 1*)* and

1.2 Provides assurance those risks with a risk rating that has been static for a number of cycles are being reviewed formally at each cycle.

2. Detail

2.1 The review period for risk cycle 1 of 2021-22 commenced on 15 February 2021 and was completed on 3 March with risks being reviewed by their respective risk owners and senior managers. The risk register was discussed by the Senior Management Team at their meeting on 9 March. There are 6 risks for review by the Commissioning of Primary Medical Services Committee.

2.2 The risks include:

- 1 new risk scoring 16 (2.3)
- 2 risks marked for closure (2.4)
- 1 Serious risk (2.3)
- 2 open risks with a score of 12 (see 2.6)

2.3 <u>New Risks</u>

There is 1 new CPMS risk added to the Risk Register during the current risk cycle:

Risk No	**Risk summary**	**Risk score**
1734	There is a risk of harm to patients given the backlog of work post COVID-19 due to pauses on QOF, screening and elective referrals, in addition to patients not presenting with symptoms and challenges faced with "reset" resulting in increased morbidity and mortality and widening of health inequalities. This risk may be increased by PCN involvement in Covid-19 vaccine deployment which puts further pressure on clinical capacity.	16

2.4 Risks for Closure

There are 2 risks marked for closure:

Risk no	Description of risk	Reason for closure
1631	Patients will not have access to extended primary medical services when the current contract expires on the 31st March 2021, this is due to the delay in publishing NHSE commissioning intentions for 2021/22 resulting in a reduced offer to patients and a negative impact on the reputation of the CCG	Reached tolerance
1630	The Calderdale population will not be adequately vaccinated against influenza during the 2020 flu campaign due to the impact of the COVID-19 pandemic. Resulting in increased risk of illness, hospitalisation, mortality and additional pressures on primary and secondary medical services over the winter period.	Reached tolerance

2.5 High Level Risks

There is 1 open CPMS risk classed as a Serious Risk (with a score of 16) (see 2.3).

2.6 2 open CPMS risks currently have a score of 12:

Risk No	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 2 risk cycles
1628	There is a risk that the full amount of Funding for the Additional Roles Reimbursement Scheme available to General Practice in Calderdale is not able to be claimed resulting in Calderdale losing investment into General	Increased from 8 to 12 due to the receipt of

	Practice and directly impacting on patient outcomes and pressure on the healthcare system across Calderdale	the actual position from the PCNs showing a larger underspend than forecast

3. CPMS risk register update since the end of risk cycle 1

The corporate risk register was approved by Governing Body at its meeting on 29 April 2021 with no amendments.

Risk 1734 (see 2.3) (concerning the backlog of work post COVID-19 due to pauses on QOF) is discussed in the Quality Assurance Process Paper due to be presented at CPMSC. Within the assurance gaps of this risk mention is made of the development of a dashboard to monitor quality. This Quality Assurance Process paper will describe the steps to be taken in order to develop the dashboard so we can progress with it with the aim to have it up and running in August.

4. Next Steps

4.1 The CCG's corporate risk register will be updated accordingly as part of the current risk review (risk cycle 2 2021-22) and the risk register will be reported to the next Governing Body meeting on 29 July 2021 in line with the CCG's governance process.

5. Recommendations

4.1 It is recommended that the Committee:

- Reviews the CCG Risk Register and the management of commissioning of primary medical services risks
- Approves the CCG Risk Register for commissioning of primary medical services risks reporting to Governing Body for risk cycle 2, subject to any amendments requested.

6. Appendices

Appendix 1 - Risk register of CPMS risks for risk cycle 1 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.

Risk cycle 1 2021-22 for all CPMS risks

Risk ID	Date Created	Risk Type	Risk Rating	Risk Score	Target Risk Rating	Target Score	Senior Manager	Principal Risk	Key Controls	Key Control Gaps	Assurance Controls	Positive Assurance	Assurance Gaps	Risk Status
1734	03/03/2021	Commissioning Primary Medical Services Committee	16	(I4xL4)	8	(I4xL2)	Debbie Robinson	There is a risk of harm to patients given the backlog of work post COVID-19 due to pauses on QOF, screening and elective referrals, in addition to patients not presenting with symptoms and challenges faced with "reset" resulting in increased morbidity and mortality and widening of health inequalities. This risk may be increased by PCN involvement in Covid-19 vaccine deployment which puts further pressure on clinical capacity.	• Amendments to national GP contract to re-prioritise work including a re-focus of the Quality and Outcomes National Framework • Commitment to reduce unnecessary bureaucracy to focus on clinical care • Additional CCG investments made to PCNs to support local winter resilience and increase in demand • Investment of the Calderdale share of the £150million Covid-19 resource to support further increase in capacity and focus on 7 identified goals	Final national contract for 2021/22 to include details of how to manage the backlog Backlog unquantified at Practice, PCN or Calderdale level	•Continue to use soft-intelligence e.g. complaints or stakeholder feedback to monitor and address issues. • Continued engagement of CDs, PMs and LMC to respond to feedback and address any concerns • Recent guidance to focus on clinical prioritisation to support clinical capacity at practice level and focus on the 7 priority goals detailed in the General Practice Covid Capacity Expansion Fund • Continued use of datix and serious incident process to identify where this has resulted in harm and ensure cases are reviewed and identified learning implemented	CPMSC Head of Primary Care Report - Quarterly	• Reconfirm the Quality Indicators that will be monitored in the absence of the new national dashboard including impact on different communities. • Systematic monitoring of the 7 key goals listed in the General Practice Covid Capacity Expansion Fund letter • Once quantified, system needs to be in place to monitor progress against the backlog.	New - Open
1629	20/08/2020	Commissioning Primary Medical Services Committee	12	(I4xL3)	4	(I4xL1)	Debbie Robinson	There is a risk that the additional roles being introduced within General Practice will not be utilised to their maximum benefit, will compromise the safe delivery of care and intervention for patients and be asked to practise outside of their scope of competency, due to limited professional and clinical experience in general practice of these roles resulting in the potential for harm to patients, poor retention and recruitment rates and a lost opportunity for general practice to maximise the roles and support the GP workforce effectively.	Employment models for some of the new roles that include professional leadership and clinical governance for the individuals from an established provider of those roles GP mentorship in place for the new professionally qualified roles Registered Professionals must work within their code of conduct	No coherent operating model in place across PCNs for the additional roles No overall PCN Additional Roles governance framework in place for adoption locally - being discussed through Primary Care School at ICS level	Working within the governance systems already in place and compliant with the CQC in General Practice Where employed by a host organisation strong professional and clinical leadership and training exists PCN nursing leadership role in place in 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	No coherent leadership or operating model for the wider primary care team in place within PCNs	Static - 2 Archive(s)
1628	20/08/2020	Commissioning Primary Medical Services Committee	12	(I4xL3)	4	(I4xL1)	Debbie Robinson	There is a risk that the full amount of Funding for the Additional Roles Reimbursement Scheme available to General Practice in Calderdale is not able to be claimed resulting in Calderdale losing investment into General Practice and directly impacting on patient outcomes and pressure on the healthcare system across Calderdale	Reporting deadlines in place as outlined in the PCN Contract Directly Enhanced Scheme Reporting of position agreed into the monthly LMC/CD/CCG meeting in order to understand the current position, any slippage to plan and agree other plans to ensure spend. (CCG Finance and Primary Care Colleagues are sighted on this) Some flexibility in utilisation of funding available to support the Covid Vaccination programme.	Absence of Timely submissions of actual position from PCNs	Detailed spreadsheet by month of expected spend to review against actual Current position shared and approach agreed with CCG/LMC and PCNs around management	Initial plans have been received from each PCN and progress made to date on recruitment Submission to NHSE	Actual spend has been received by CCG at end of Feb 2021 which showed larger underspend than PCN forecast	Increasing
1631	21/08/2020	Commissioning Primary Medical Services Committee	8	(I4xL2)	8	(I4xL2)	Debbie Robinson	There is a risk that patient will not have access to extended primary medical services when the current contract expires on the 31st March 2021, this is due to the delay in publishing NHSE commissioning intentions for 2021/22 resulting in a reduced offer to patients and a negative impact on the reputation of the CCG	Approval at CPMSC 21.01.21 to directly award the extended access contract to the current provider for a 6 month period to extend to 12 months from 01.04.21. Waiver completed Intention communicated from head of contracting to provider and accepted	Awaiting formality of signed contract	Waiver Written acceptance from the provider Signed contract in place	Waiver completed Written Acceptance received	Signed contract	Closed - Reached tolerance
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 - 3 Archive(s)
1630	21/08/2020	Commissioning Primary Medical Services Committee	4	(I2xL2)	4	(I2xL2)	Debbie Robinson	There is a risk that the Calderdale population will not be adequately vaccinated against influenza during the 2020 flu campaign due to the impact of the COVID-19 pandemic . Resulting in increased risk of illness, hospitalisation, mortality and additional pressures on primary and secondary medical services over the winter period.	Key providers have delivery plans in place to vaccinate the patients in line with NHSE ambitions and guidance as advised in first and second flu letters. Calderdale CCG has coordinated system meetings with all providers and commissioners to develop a locality plan and identify risks and mitigations to delivery The WYH ICS have set up a Flu board to seek assurance from all places around flu plans, the CCG is attending these meetings to represent Calderdale	the community pharmacy service specification has not yet been published impacting on development of this sectors plans and collaborative working between providers 20 novThis has been published and Calderdale pharmacies offering flu vaccination shared with practices	20 nov The Calderdale flu group is meeting regularly since July to monitor flu campaign progress and issues The flu uptake by cohort is monitored on a biweekly basis and this is received at SMT	16/21 Calderdale practices have returned a flu questionnaire to the CCG which identifies their progress with flu plans, the majority are expressing reasonable confidence in their plans to deliver to existing flu cohorts 20 nov Calderdale ccg making good progress toward achieving 75% ambition for over 65s and expect to achieve this. Delivery progress by PCN and CCG is shared regularlrly with the practices since November	Details of the NHSE extended vaccination programme to wider cohorts from November are as yet unknown limiting meaningful planning by providers. 20 nov details released today around extended cohort, for further discussion at next flu meetings both CCG and ICS	Closed - Reached tolerance

Name of Meeting	Commissioning Primary Medical Services Committee (CPMSC)	**Meeting Date**	27 May 2021
Title of Report	**Risk register summary annual report – 2020-21**	**Agenda Item No.**	9
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 an update on risk activity on all CPMSC risks on CCG risk register in the period 2020-21
- There are 6 risks related to the commissioning of primary medical services currently on the corporate risk register at the end of 2020-21.
- None of these risks have a risk score of 15 or above

Previous Considerations

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

Recommendations

It is recommended that the Committee:

- **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 2020-21. This follows reviews four times a year of their risks at the Commissioning Primary Medical Services Committee.

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

Implications

Quality and Safety implications (including whether a quality impact assessment has been completed)	There are 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
Resources / Financial Implications (including Staffing/Workforce considerations)	There are no resources / finance implications
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?)	Improving value	**Risk (include risk number and a brief description of the risk)**	Risk is managed in line with the CCG's Integrated Risk Management Framework. Risks are captured on the Corporate Risk Register or the Governing Body's Assurance Framework (GBAF) as appropriate.
Legal / CCG Constitutional Implications	There are no legal / CCG Constitutional implications	**Conflicts of Interest (include detail of any identified / potential conflicts)**	There are no conflicts of interest

1. Introduction

1.1 The CCG's approach to the management of risks is set out in the Integrated Risk Management Framework. All CPMS risks on the CCG's corporate risk register are the responsibility of the CPMSC and all risks are reviewed at SMT as part of 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 an update on activity of CPMS risks on the corporate risk register at the end of financial year 2020-21

1.3 To set out all CPMS risks and their activity during the financial year 2020-21

2. Detail

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

2.2 Summary of activity during 2020-21:

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

2.2.2 The risk register was presented at the other three Committees held during 2020-21 with the risk register for risk cycle 4 being presented at its meeting on 21 January 2021

2.2.3 The highest number of open risks was during risk cycle 3 when there were 6

2.2.4 The average risk score for CPMS risks was 12

2.2.5 No risk was static for more than 2 risk cycles

2.2.6 There were no critical CPMS risks on the CCG risk register during 2020-21 and no risk achieved a risk rating of higher than 12

2.3 At the end of the financial year 2020-21 the CCG risk register had a total of 6 CPMS risks, of which 5 are open:

2.4 Open risks scoring:

Risk ID	Risk summary	Risk score	Risk movement
1631	Patients will not have access to extended primary medical services when the current contract expires on the 31st March 2021, this is due to the delay in publishing NHSE commissioning intentions for 2021/22 resulting in a reduced offer to patients and a negative impact on the reputation of the CCG	12	Static for 1 risk cycle
1630	The Calderdale population will not be adequately vaccinated against influenza during the 2020 flu campaign due to the impact of the COVID-19 pandemic. Resulting in increased risk of illness, hospitalisation, mortality and additional pressures on primary and secondary medical services over the winter period.	12	Static for 1 risk cycle
1629	The additional roles being introduced within General Practice will not be utilised to their maximum benefit, will compromise the safe delivery of care and intervention for patients and be asked to practise outside of their scope of competency, due to limited professional and clinical experience in general practice of these roles resulting in the potential for harm to patients, poor retention and recruitment rates and a lost opportunity for general practice to maximise the roles and support the GP workforce effectively.	12	Static for 1 risk cycle
1628	The full amount of Funding for the Additional Roles Reimbursement Scheme available to General Practice in Calderdale is not able to be claimed resulting in Calderdale losing investment into General Practice and directly impacting on patient outcomes and pressure on the healthcare system across Calderdale	8	Decreasing
1434	The quality of and access to commissioned primary medical services in Calderdale is compromised due to local and national workforce shortages, resulting in the inability to attract, develop and retain people to work in general practice roles.	8	Static for 2 risk cycles

2.5 There was 1 risk closed on the risk register at the end of financial year 2020-21:

Risk ID	Risk summary	Risk score	Reason for closure

1560	There is a risk that GP practices who have received patients as a result of the closure of APMS practices will have additional work to align the care of the patients with their standards and approaches due to the information received through the clinical records. This may result in: 1) the receiving practices requiring increased clinical capacity to review the patients and ensure that they are receiving appropriate care and treatment 2) additional work in order to ensure QOF achievement is met, both of which may impact the income of practices and therefore result in further requests for reimbursement	4	Closed - Reached tolerance

3. Recommendations

It is recommended that the CPMS Committee:

- **CONFIRMS** that it is **ASSURED** that the corporate risk register represents a fair reflection of the risk activity relating to CPMSC being experienced by the CCG at the end of 2020-21

4. Appendices

- Appendix 1: CPMS risk register showing all risks on the CCG risk register at the end of financial year 2020-21

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

All CPMS risks at end of financial year 2020-21

Risk ID	Date Created	Risk Type	Risk Category	Risk Rating	Risk Score	Target Risk Rating	Target Score	Senior Manager	Principal Risk	Key Controls	Key Control Gaps	Assurance Controls	Positive Assurance	Assurance Gaps	Risk Status
1631	21/08/2020	Commissioning Primary Medical Services Committee	CPMS - F&P	12	(I4xL3)	8	(I4xL2)	Debbie Robinson	There is a risk that patient will not have access to extended primary medical services when the current contract expires on the 31st March 2021, this is due to the delay in publishing NHSE commissioning intentions for 2021/22 resulting in a reduced offer to patients and a negative impact on the reputation of the CCG	Existing contract in place. Exploration of potential to extend the contract for a fixed period Raise by primary Care Leads with NHSE at each meeting for several months	Financial implications need to be quantified and reported Position statement to be included in Contracting to CPMSC Scope the potential for a contract extension with the existing provider	Contract meeting with existing provider.	none identified	Appears to be no ability to influence NHSE to make the postion known	Static - 1 Archive(s)
1630	21/08/2020	Commissioning Primary Medical Services Committee	F&P - Performance	12	(I4xL3)	4	(I2xL2)	Debbie Robinson	There is a risk that the Calderdale population will not be adequately vaccinated against influenza during the 2020 flu campaign due to the impact of the COVID-19 pandemic . Resulting in increased risk of illness, hospitalisation, mortality and additional pressures on primary and secondary medical services over the winter period.	Key providers have delivery plans in place to vaccinate the patients in line with NHSE ambitions and guidance as advised in first and second flu letters. Calderdale CCG has coordinated system meetings with all providers and commissioners to develop a locality plan and identify risks and mitigations to delivery The WYH ICS have set up a Flu board to seek assurance from all places around flu plans, the CCG is attending these meetings to represent Calderdale	the community pharmacy service specification has not yet been published impacting on development of this sectors plans and collaborative working between providers 20 novThis has been published and Calderdale pharmacies offering flu vaccination shared with practices	20 nov The Calderdale flu group is meeting regularly since July to monitor flu campaign progress and issues The flu uptake by cohort is monitored on a biweekly basis and this is received at SMT	16/21 Calderdale practices have returned a flu questionnaire to the CCG which identifies their progress with flu plans, the majority are expressing reasonable confidence in their plans to deliver to existing flu cohorts 20 nov Calderdale ccg making good progress toward achieving 75% ambition for over 65s and expect to achieve this. Delivery progress by PCN and CCG is shared regularlrly with the practices since november	Details of the NHSE extended vaccination programme to wider cohorts from November are as yet unknown limiting meaningful planning by providers. 20 nov details released today around extended cohort, for further discussion at next flu meetings both CCG and ICS	Static - 1 Archive(s)
1629	20/08/2020	Commissioning Primary Medical Services Committee	CPMS - Q	12	(I4xL3)	4	(I4xL1)	Debbie Robinson	There is a risk that the additional roles being introduced within General Practice will not be utilised to their maximum benefit, will compromise the safe delivery of care and intervention for patients and be asked to practise outside of their scope of competency, due to limited professional and clinical experience in general practice of these roles resulting in the potential for harm to patients, poor retention and recruitment rates and a lost opportunity for general practice to maximise the roles and support the GP workforce effectively.	Employment models for some of the new roles that include professional leadership and clinical governance for the individuals from an established provider of those roles GP mentorship in place for the new professionally qualified roles Registered Professionals must work within their code of conduct	The clinical pharmacist role has not got established professional leadership and governance across PCNs This is similar for care co-ordinators and Social Prescribing link Workers No overall PCN Additional Roles governance framework in place for adoption locally - being discussed through Primary Care School at ICS level	Working within the governance systems already in place and compliant with the CQC in General Practice Where employed by a host organisation strong professional and clinical leadership and training exists PCN nursing leadership role in place in 4/5 PCNs	None	Retention has been a challenge for Social Prescribing link workers and clinical pharmacists Awaiting details of a PCN support offer from NECS	Static - 1 Archive(s)
1628	20/08/2020	Commissioning Primary Medical Services Committee	CPMS - F&P	8	(I4xL2)	4	(I4xL1)	Debbie Robinson	There is a risk that the full amount of Funding for the Additional Roles Reimbursement Scheme available to General Practice in Calderdale is not able to be claimed resulting in Calderdale losing investment into General Practice and directly impacting on patient outcomes and pressure on the healthcare system across Calderdale	Reporting deadlines in place as outlined in the PCN Contract Directly Enhanced Scheme Reporting of position agreed into the monthly LMC/CD/CCG meeting in order to understand the current position, any slippage to plan and agree other plans to ensure spend. (CCG Finance and Primary Care Colleagues are sighted on this) Some flexibility in utilisation of funding available to support the Covid Vaccination programme.	Further clarity required in to the level of flexibility that can be applied locally.	Detailed spreadsheet by month of expected spend to review against actual Current position shared and approach agreed with CCG/LMC and PCNs around management	Initial plans have been received from each PCN and progress made to date on recruitment Submission to NHSE	Further detailed submissions for each PCN plan awaited to increase CCG assurance that forecasted spend will become actual	Decreasing
1434	25/11/2019	Commissioning Primary Medical Services Committee	CPMS - Q	8	(I4xL2)	4	(I4xL1)	Debbie Robinson	There is a risk that the quality of and access to commissioned primary medical services in Calderdale is compromised due to local and national workforce shortages, resulting in the inability to attract, develop and retain people to work in general practice roles.	1. Calderdale is part of the international GP recruitment programme 2. LWAB funding has been secured to commission the development of a Calderdale workforce strategy, including stocktake of current available workforce and forecasted requirement for the future. 3. Primary care workforce group is established 4. Primary Care network contract supporting development of workforce plans 5. Additional roles funding available through PCNs at 100% reimbursement from April 2020 6. Role out of Apex Insight tool to practices to understand capacity and demand 7. New national contractual requirements on workforce from April 2020 8. Investment to support local delivery of GP career plus, ACP Career Plus made for 2020/21 and support from national PCN DES relating to GP and GPN Fellowship	1.Gaps exist in relation to current workforce data 2.Calderdale Workforce Plan (in development) 3.Infancy of PCNs with no coherent workforce strategy or plan at present - plans developed in relation to the 4. Additional Roles Funding however longer term strategy needs addressing at PCN level	1. Central reporting requirements including progress against additional roles 2.Quarterly Dashboard reports to Quality Committee & Commissioning Primary Medical Services Committee 3. CQC programme for assurance	1.CQC Inspection reports. 2.CPMSC minutes	CQC routine inspections have been suspended during covid-19 Pandemic	Static - 2 Archive(s)
1560	22/05/2020	Commissioning Primary Medical Services Committee	CPMS - F&P	4	(I4xL1)	4	(I4xL1)	Debbie Robinson	There is a risk that GP practices who have received patients as a result of the closure of APMS practices will have additional work to align the care of the patients with their standards and approaches due to the information received through the clinical records. This may result in: 1) the receiving practices requiring increased clinical capacity to review the patients and ensure that they are receiving appropriate care and treatment 2) additional work in order to ensure QOF achievement is met, both of which may impact the income of practices and therefore result in further requests for reimbursement	Additional reimbursement has been agreed with LMC in excess of the agreed amount within the CCG Policy QOF payment was not affected for the financial year ending 2020/21 Receiving practices have a full 12 months to ensure appropriate reviews are undertaken in relation to QOF Due to changes in contractual requirements as a result of COVID-19 there is income protection in place for practices relating to elements of QOF	None	Agreement through LMC of additional financial payment to practices above that agreed within policy CPMSC performance report detailing QOF achievement Datix reporting in relation to quality of care	Evidence of additional payment issued to receiving practices through Primary Care Budget	The amount of additional work required for patients transferring is not quantified as practices are still working through the patient reviews	Closed - Reached tolerance

CPMSC WORK PLAN - 2021-22							
	Lead	**Purpose**	**Frequency**	**May**	**August**	**November**	**February**
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 tbc)				
PMS Premium Investment Plan 2021-22	LS	For Decision	**Annually** (date tbc)				
Assurance Reports							
Head of Primary Care Report	DR	For Assurance	Quarterly	√	√	√	√
Key Indicators	DR	For Decision/ Assurance	Quarterly	√			
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			√	
Additional items in year relating to areas of potential high risk or priority							
Contract Variations							
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				

C= cancelled

Additional Meetings / Rapid Decision Making Panel:

Name of Meeting	Commissioning Primary Medical Services Committee	**Meeting Date**	27 May 2021
Title of Report	Finance Report	**Agenda Item No.**	11
Report Author	Lesley Stokey - Director of Finance	**Public / Private Item**	Public
Clinical Lead	Neil Smurthwaite, Chief Operating Officer	**Responsible Officer**	Neil Smurthwaite, Chief Operating Officer

Executive Summary
Key messages for the committee: ▪ The Primary Medical Services delegated budget has achieved a breakeven position in 2020/21 in line with its financial plan. ▪ The CCG has developed a draft financial plan for the period April 2021 to September 2021 in line with NHS England guidance.

Previous Considerations

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

Recommendations
It is recommended that the Committee: 1. **NOTES** the 2020/21 financial position on Primary Medical Services delegated budgets. 2. **APPROVES** the draft financial plan for April – September 2021

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

Implications

Quality and Safety implications (including whether a quality impact assessment has been completed)	NA
Engagement and Equality Implications (including whether an equality impact assessment has been completed), and health inequalities considerations	NA

Resources / Financial Implications (including Staffing/Workforce considerations)	NA
Sustainability Implications	NA

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 Value	**Risk (include risk number and a brief description of the risk)**	NA
Legal / CCG Constitutional Implications	NA	**Conflicts of Interest (include detail of any identified / potential conflicts)**	NA

1. Key Messages

1.1 The purpose of this report is to update the Commissioning Primary Medical Services Committee on the financial position of primary care co-commissioned delegated budgets for the financial year 2020/21 and to update the Committee on the latest position in relation to financial guidance following Covid-19 and the draft plan for 2021/22.

1.2 The CCG has now submitted its financial accounts for 2020/21 and I am pleased to report that the delegated primary care co-commissioned delegated budgets were in balance for the financial year and delivered the planned breakeven position.

1.3 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.

1.4 The delegated primary care co-commissioned financial plan for the period April 2021 to September 2021 is included in this report for approval by the Committee.

2. Financial Performance for 2020/21

High Level Forecast position M1-M12	Delegated Primary Medical Services Budgets £'000
Initial Allocation - Covid Regime	-31,526
Latest Forecast for M12	32,589
Net overspend	1,063
Covid costs to date M1-M12	0
Other pressures (forecast M1-M12)	1,063
Total variance	1,063
Allocation adjustment M12	-1,063
Net position	0
Expected further allocations:-	
- Retrospective Hosptal Discharge Programme	0
- Primary Care Aditional Roles	0
Net adjusted forecast	**0**

2.1 For the year the CCG has a notified confirmed allocation of £31,526k for delegated primary medical services. In addition, the CCG received additional allocations of £1,063k. The CCG is forecasting to spend £32,589k which is a balanced position against the allocations received. The CCG has received the balance of additional roles allocations that were outstanding at the previous Committee report.

3. Additional Roles Update

3.1 As part of the GP Forward View, funding has been made available to PCNs to expand workforce capacity including investment in new roles such as physician associates.
The expected level of funding available in 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

3.2 The CCG is working with PCNs to understand the plans for 2021/22 and will be able to provide an update to the next Committee meeting.

4. Financial Plan for 2021/22.

4.1 NHS England published planning guidance and allocations for the period April to September 2021 on the 25th March 2021. The ICS issued a local timetable for financial plans to be submitted by the 16th of April and ICS consolidated submission to NHS England on the 6th May.

4.2 A draft financial plan was taken to Governing Body on the 29th April.

4.3 For delegated co-commissioning, the draft financial plan has been updated to take account of:

- changes the GP contract for PMS and GMS and updated pound per head values.
- changes to lists sizes based on Jan-21 which will be updated as soon as April 2021 is available.
- creation of a 0.5% contingency as per planning guidance.
- where additional allocations are expected for example additional roles this has been excluded from the draft budget.

4.4 The draft budget has been developed for the full year and then scaled down to get the draft plan for the period April to September 2021.

4.5 The CCG is anticipating an allocation for the period of £16,787k and expenditure budgets of £16,354k and a contingency budget of £84k, leaving a reserve budget of £349k.

4.6 A more detailed breakdown of the draft financial plan is shown in the table below:

Delegated Co-Commissioning Draft Financial Plan	21/22 Annual Budget	April - September Budget
General Practice - GMS	£19,169,262	£9,584,631
General Practice - PMS	£2,474,778	£1,237,389
General Practice - APMS	£761,698	£380,849
Enhanced Services	£315,483	£157,742
PCN's	£1,240,726	£620,363
ARRS	£1,555,932	£777,966
Dispensing/Prescribing Drs	£180,294	£90,147
Other GP Services	£322,559	£161,279
Premises Cost Reimbursement	£3,287,076	£1,643,538
Other Premises Costs	£233,810	£116,905
QOF	£3,080,624	£1,540,312
Other Services	£86,201	£43,101
Internal Reserve	£697,687	£348,843
Contingency	£167,870	£83,935
Total Expenditure Budgets	**£33,574,000**	**£16,787,000**
Expected Allocation	**£33,574,000**	**£16,787,000**
Surplus / Deficit	**£0**	**£0**

5. Risk/Opportunities

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

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

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

6. Recommendations

It is recommended that the Committee:

1) NOTES the 2020/21 financial position on Primary Medical Services delegated budgets.
2) APPROVES the draft financial plan for the period April 2021 to September 2021.