NHS
Shropshire, Telford and Wrekin
Clinical Commissioning Group

AGENDA

Meeting Title	Primary Care Commissioning Committee – Part 1	**Date**	4 May 2022
Chair	Mrs Donna Macarthur	**Time**	11.00
Minute Taker	Mrs Chris Billingham	**Venue/ Location**	Via Microsoft Teams

Reference	Agenda Item	Presenter	Time	Paper
PCCC-22-05.26	Welcome and Introductions	Chair	11.00	Verbal
PCCC-22-05.27	Apologies	Chair	11.00	Verbal
PCCC-22-05.28	Declarations of Interests	Chair	11.05	Verbal
PCCC-22-05.29	Minutes of Previous Meeting and Matters Arising:- • PCCC 6 April 2022 • Action Tracker	Chair	11.10	Enc. No. 1 Enc. No. 1A
PCCC-22-05.30	Finance Update	Angharad Jones	11.20	Enc. No. 2
PCCC-22-05.31	Primary Care Report • Workforce • Estates • IT • Contracts	Tom Brettell / Janet Gittins	11.30	Enc. No. 3
PCCC-22-05.32	Primary Care Practice Visits Update	Janet Gittins / Jane Sullivan	11.50	Verbal
PCCC-22-05.33	Risk Register	Claire Parker	12.00	Enc. No. 4
PCCC-22-05.34	Draft Caretaking Policy	Bernie Williams	12.10	Enc. No. 5
PCCC-22-05.35	Results of GP Patient Survey 2020/21	Emma Pyrah	12.20	Verbal
PCCC-22-05.36	Any Other Business	Chair	12.30	Verbal
PCCC-22-05.37	Date of Next Meeting: To Be Confirmed			
	To resolve that representatives of the press and other members of the public be excluded from the remainder of the meeting, having regard to the confidential nature of the business to be transacted,			

	publicity of which would be prejudicial to the public interest. Section 1(2) Public Bodies (Admission to Meetings) Act 1960.			

MINUTES

SHROPSHIRE, TELFORD AND WREKIN PRIMARY CARE COMMISSIONING COMMITTEE
EXTRA ORDINARY PART 1 MEETING
HELD VIA MICROSOFT TEAMS
AT 11 A.M. ON WEDNESDAY 4 MAY 2022

Present

Mr Meredith Vivian	CCG Lay Member – Patient & Public Involvement (Deputy Chair)
Ms Claire Parker	Director of Partnerships

In Attendance

Dr John Pepper	Chair, STW CCG
Mr Gareth Robinson	Director of Delivery & Transformation
Dr Adam Pringle	GP/Healthcare Professional; Governing Body Member
Dr Deborah Shepherd	Medical Director
Dr Julie Garside	Director of Performance
Ms Emma Pyrah	Associate Director of Primary Care
Ms Angharad Jones	Finance Business Partner
Mrs Jane Sullivan	Senior Quality Lead
Mrs Bernie Williams	Primary Care Lead for Contracting & Delegated Commissioning
Mrs Vanessa Barrett	Chair, Healthwatch Shropshire
Mrs Janet Gittins	Partnership Manager
Chris Billingham	Corporate PA; Note Taker

Apologies

Mrs Donna Macarthur	CCG Lay Member – Primary Care (Chair)
Mrs Zena Young	Executive Director of Nursing & Quality
Mrs Claire Skidmore	Executive Director of Finance
Dr Julie Garside	Director of Performance
Mr Tom Brettell	Partnership Manager
Mr Phil Morgan	Primary Care Workforce Lead

PCCC 22-05.26 Welcome and Introductions

Mr Vivian welcomed everyone to the meeting and advised that he was deputising for the Chair - Mrs Macarthur - who was unable attend.

Mr Vivian intimated that the meeting was not quorate due to apologies received from voting members. Items on the Agenda could be discussed, but if decisions were required Mr Vivian and Ms Parker would seek confirmation from Mrs Macarthur and Mrs Skidmore, the two absent voting members, that they were comfortable with any recommendations made.

PCCC 22-05.27 Apologies

Apologies received were as recorded above.

PCCC 22-05.28 Members' Declaration of Interests
The Chair requested any further declarations of interests relating to items on the Agenda which were in addition to those already declared.

There were no further declarations of interests.

PCCC 22-05.29 Minutes of Previous Meeting Held On 6 April 2022 and Matters Arising
Page 1: Dr Shepherd referred to her job title which was stated as Interim Medical Director. She is no longer Interim. Her title is Medical Director.

Page 2: Dr Shepherd referred to the second paragraph of the Finance Update and suggested that "restrictions as to why all of the funding was not spent" should read "reasons why all of the funding was not spent".

The Committee approved the minutes of the meeting which took place on 6 April 2022 as a true and accurate record, provided the above amendments are made.

The Action Tracker was reviewed and updated as appropriate.

Mr Vivian confirmed that, following the April PCCC, Mrs Macarthur had advised him of a discussion regarding the GP Strategy which had taken place in his absence as he was only present for part of the meeting. Mr Vivian was in support of the Committee's discussion and the matter can now be closed as a confirmed decision.

ACTION: Ms Parker to email Committee members detailing any outstanding issue regarding the GP Strategy if item is not closed and advise where it will be monitored going forward.

PCCC 22-05.30 Finance Update
Ms Jones' report was taken as read. The Chair invited questions.

Dr Pringle requested further information regarding the Premises Costs Reimbursement figure which showed an under-spend in the report, but an over-spend on the Risk Register.

Ms Jones advised that there are many unknowns in terms of premises. At the end of 2021 a large accrual was submitted as a provision for those unknowns. It became apparent during the year that it was not required and the under-spend figure is the release of the prior year accrual.

Dr Pringle asked whether the overspend discussed in previous meetings was a genuine risk or whether it is a potential risk because of new premises development and queried whether it was appropriate that it appeared on the Risk Register.

Ms Jones advised that it should remain on the Risk Register until the work has been carried out to help identify the underlying position in relation to premises. Ms Parker agreed and believed that a deep dive and a real understanding of the underspend or overspend will assist prioritisation of the Primary Care Estates Strategy.

Dr Shepherd referred to the efficiency schemes in Table 3 within the report. She believed that certain schemes should be reviewed, particularly the Optum contract which had not delivered as expected. The Wound Incontinence and Self Care schemes should also be reviewed.

Ms Jones advised that implementation of the Optum contract had been delayed which was why the planned figure was higher than the actual figure. Not all schemes are rolled forward but in 2022/23 a larger amount for Optum is included.

Dr Pringle referred to the considerable amount of prescription waste and potential benefits if Practices move to the Repeat Dispensing model which should both reduce their workload and mean that the only drugs issued every month are the drugs that people actually need every month as opposed to drugs they request every month.

The Committee noted the contents of the Finance paper.

PCCC 22-05.31 Primary Care Report

On behalf of Mrs Macarthur, Mr Vivian reminded authors of reports that acronyms should only appear after the full meaning of the acronym has been explained. The report was taken as read and Mr Vivian invited questions.

Asthma

Mr Vivian queried reference within the report to "Telford & Wrekin CCG" successfully obtaining funding from NHS England. Mrs Gittins confirmed that this should read "Shropshire Telford & Wrekin CCG".

Workforce

On behalf of Mrs Macarthur, Mr Vivian queried Locum uptake of the Lantum scheme and whether action was being taken to promote it.

Ms Parker replied that during the last few weeks and the increase in Covid cases, up to 10 Practices were in business continuity which had resulted in a degree of uptake. However, the scheme needed to be more widely promoted. As a result of the work carried out by Shrewsbury Health & Wellbeing Hub, the CCG is aware that some Practices experience difficulty recruiting and retaining Partners and GPs. The Strategy needs to be extended and used as a tool to encourage new GPs to remain in the area.

A regular update will be included in the Primary Care report.

IT

On behalf of Mrs Macarthur, Mr Vivian asked whether the CCG had a sense of Practice compliance with cyber security requirements. No information was supplied by attendees.

ACTION: Mrs Gittins to investigate Practice compliance with cyber security requirements.

Blood Pressure Monitoring @ Home Project

Dr Pepper referred to Blood Pressure Monitoring @ Home and requested information as to what the scheme was aiming to deliver.

ACTION: Mr Brettell to provide Dr Pepper with information on the Blood Pressure Monitoring @ Home Project in a format that can be widely circulated.

Dr Shepherd provided a brief update on the scheme:-

- The project is a national programme aiming to increase the diagnosis of hypertension as it is known that there is a large body of people with hypertension who are unrecognised.
- The CCG was provided with a number of home blood pressure monitoring machines for distribution to participating Practices. They will be lent out to patients for home blood pressure monitoring to facilitate diagnosis and monitoring, particularly in terms of saving appointments and allowing patients to monitor themselves.
- It is a national scheme which all our Practices have been invited to sign up to.
- It is being included within the PCN DES as part of the targeting to improve diagnosis and management of cardiovascular disease.

PCCC 22-05.32 Primary Care Practice Visits Update

At the April meeting a full report was provided around quality visits. Since then, Mrs Gittins had met with Jane Sullivan and members of the Business Improvement (BI) team to discuss how the visits would take place over the summer and early autumn. Information relating to patient experience, patient safety, QOF, CQC, etc. had been reviewed and six Practices have been identified for a visit. Those Practices will be advised what the quality visits entail.

Mr Vivian referred to the burden that visits can place on Practices and requested confirmation that the visits arranged are co-ordinated with other parties who carry out visits, for example Healthwatch and the Quality team.

Mrs Sullivan confirmed that co-ordination of visits with other organisations will take place going forward.

Mrs Barrett advised that Healthwatch carry out visits on a theme or for a set purpose and would usually consult with the CCG on that theme. However, they would not be able to link in with CCG visits because it is important that they continue to express their independence.

PCCC 22-05.33 Risk Register

Ms Parker advised that the Register had been circulated to risk owners for review in preparation for it being handed over to the ICB.

She asked the Committee to consider any issues around the risk relating to the Covid Expansion Fund and provide a view as to whether it should be carried over as a risk or closed.

Ms Jones stated that specific Covid funding given to Practices has been non-recurrent in nature. She was not aware of funding during 2022/23. However, it could be a risk if Practices are reliant on that funding. Ms Parker confirmed that Practices were unaffected as it was an incorrect calculation by NHS England.

Ms Jones confirmed that the risk could be removed from the Register.

Dr Pepper referred to Risk No. 3 on the document – 'Support Practice Business Continuity Plans' and presumed that the work had been done prior to several Practices recently having to enact their Business Continuity Plans.
He queried the success of the plans, and whether any of the learning could be shared with all Practices in Shropshire Telford & Wrekin for the future.

Ms Parker advised that the risk was identified during the pandemic. Plans had been severely tested over recent weeks and two Practices remain in Business Continuity. Ms Parker will

instruct Alex Mace to contact Practices who had to implement their Business Continuity Plans in order to establish learning.

The Committee confirmed their agreement that the Risk Register captured all risks and their mitigations appropriately, and were happy to pass it on from this Committee to its successor in its present form.

ACTION: Ms Parker to instruct Alex Mace to contact Practices who were implementing their Business Continuity Plans to establish learning which can then be shared with all Practices.

The Chair welcomed Gareth Robinson, Director of Delivery & Transformation, who joined the meeting late because of another commitment.

PCCC 22-05.34 Draft Caretaking Policy

Mrs Williams informed the meeting that the policy had been rewritten since its submission to the February Committee. She thanked colleagues from the Quality team who had contributed several valuable points which had been incorporated into the document. She proposed the following further amendments:-

- In the Expressions of Interest questionnaire, to ask how the Practice will acknowledge and act upon any patient concerns that may be raised
- What process will be employed to maintain good governance and reduce risk.
- How clinical supervision and support for staff will be ensured.

Mrs Williams invited questions.

Ms Parker thanked Mrs Williams for her work on the Policy and hoped that the suggested amendments could be approved by the Committee in preparation for the new organisation. She suggested that once approved it is used for the CCG now and then included in the transition document pack.

Mr Vivian referred to the Panel membership and suggested that patient representation may be appropriate. However, Ms Parker was unsure whether such representation would be appropriate in a caretaking situation.

Discussion followed, key points of which were:-

- Caretaking is intended to be short term emergency provision to ensure services are maintained in the event of a Practice closing unexpectedly.
- The process needs to be agile and speedy because circumstances can occur very quickly and the Panel must be able to convene very quickly. The more people who are included from a wide range of organisations, the more difficult that becomes.

Dr Pepper referred to the questions Mrs Williams intended to add to the Expressions of Interest and in particular the reference to clinical supervision and support of staff.

Mrs Sullivan advised that this point was designed to take account of the length of time that caretaking may have to continue whilst an alternative solution is considered to gain assurance

that the staff would continue to be supported to maintain their Mandatory Training and any other training whilst the arrangement is in place.

Discussion followed regarding selection criteria in relation to caretaker Practices. Ms Parker confirmed that in the first instance all Practices and PCNs in Shropshire Telford & Wrekin would be approached. If that approach was unsuccessful, then all independent providers would be approached. However, she wished to check whether that course of action is legally possible or whether caretaking opportunities must be offered to all Providers in the first instance.

As the meeting was not quorate, Mr Vivian proposed that:-

- Clarification should be obtained regarding the legal position in relation to caretaking selection criteria.

- The policy should be updated based on the Committee's discussions and then circulated for electronic sign-off by the Committee.

ACTION: Mrs Williams to update the Policy with amendments as discussed for final circulation and electronic sign-off by the Committee.

ACTION: Ms Parker to check the legal position regarding caretaking selection criteria and the appropriate route for offering caretaking opportunities to providers.

PCCC 22-05.35 Results of GP Patient Survey 2020/21

Ms Pyrah intimated that this action originated in August last year, probably because the GP Survey results are issued in July. For a variety of reasons, a report was not submitted to Committee, for which she apologised. She proposed that, given the proximity of the next set of results being issued in July, this should be a carry forward item to the new Committee to which a full report comparing the results this year to the previous year's results could be provided. One of the criteria used for Practice visit prioritisation is the GP Survey results.

The Committee agreed this course of action.

ACTION: Ms Pyrah to prepare a full report regarding the results of this year's GP Patient Survey to take forward to the new Primary Care Commissioning Committee.

PCCC 22-05.36 Any Other Business

The Chair queried whether Committee should keep Wednesday 1 June available for an Extra Ordinary meeting. Ms Parker replied that it was very unlikely that another Extra Ordinary meeting would be required.

Ms Pyrah advised that Darren Francis had expressed concern regarding bids for capital. If there is no Committee meeting for several months it will delay the ability of the CCG to inform Practices.

ACTION: Ms Pyrah to liaise with Mr Francis regarding bids for capital and the possible requirement for an Extra Ordinary PCCC on 1 June.

Ms Parker confirmed that if no meeting takes place in June, one will be required in early July. There will be a sign-off meeting via the new ICB Board very early in July to sign-off the delegation authorising continuation of the business of Primary Care Commissioning Committee.

Dr Shepherd commented that since PCCC was moved to an 11.00 a.m. start it clashes with the System Quality Group. She requested that when the ICB comes into being a review of meeting times takes place to establish what can be done to minimise clashes with other meetings.

PCCC 22-05.37 Date and Time of Next Meeting
The date and time of the next meeting is yet to be confirmed.

Shropshire Telford and Wrekin CCG Primary Care Committee Action Tracker
Part 1 Meeting – 4 May 2022

Agenda Item	Action Required	By Whom	By When	Date Completed
PCCC-21-08.39 GP Patient Survey 2020/21	Mrs Stevenson to schedule an update on the results of the GPPS 2020/21 into the Agenda planning for a future PCCC.	Emma Pyrah	April 2022 meeting	**February Update:** Ms Pyrah will pick this up and provide an update to the April meeting. **April Update:** Postponed to the May EO meeting in Ms Pyrah's absence on sick leave. **May Update:** Agenda item.
PCCC 21-12.65 Primary Care Report	Mr Ellis to check whether one Practice is not participating in the winter schemes.	Mr Ellis	February 2022 meeting	**April Update:** Agenda item.
PCCC 21-12.66 Shrewsbury Health & Wellbeing Hub	Mr Ellis to raise with the Project Manager of the HWBH the subject of responsibilities and risks attached to an individual signing a lease on behalf of the system.	Mr Ellis	February 2022 meeting	**April Update:** Member of Primary Care team to pick this up.
PCCC 21-12.69 Primary Care Quarterly Quality Report	Dr Davies and Ms Parker to liaise regarding national performance data for quality and include Dave Ashford in discussions regarding collation of the figures for inclusion in reports to CCG Committees going forward.	Dr Davies / Ms Parker	February 2022 meeting	**April Update:** Dr Davies confirmed that data is flowing through and there is now a Primary Care section in the Quality & Performance report going forward. Ms Parker had met with Craig Lovatt from the BI team looking at Practices, PCNs and some of the reasons for admission etc. and this is fitting into the work being

				scoped out around Locally Commissioned Services.
PCCC 22-02.06 Primary Care Report	***SMI Healthchecks:*** Primary Care team to work with Jane Williams to forecast the year end position. ***Blood Pressure Monitoring @ Home:*** Ms Pyrah to discuss allocation of hypertension monitors with the Primary Care team.	Mr Brettell / Jane Williams Ms Pyrah	April 2022 meeting April 2022 meeting	**April Update:** Dr Davies advised that although the CCG had made a considerable improvement on last year, it is still 20% short of the national figure.
PCCC-22-02.08 Draft Caretaking Policy	Mrs Williams to update the Draft Caretaking Policy, taking into account comments and suggestions made during discussions at the February Committee meeting, and provide an updated policy to a future meeting for approval.	Mrs Williams	April meeting	**April Update:** Mrs Williams had not yet finalised. The draft Caretaking Policy will be submitted to the next meeting. **May Update:** Agenda item.
PCCC-22-02.09 Practice Boundary Extensions	Mrs Williams to talk to all Practices about what the request actually is, stressing that it is not about patient numbers.	Mrs Williams	April meeting	**April Update:** Not yet completed.
PCCC-22-02.11 Any Other Business	***Risk Register:*** Risk Register to be an item for discussion on the April Agenda in order for the document to be reviewed by the Committee in advance of transferring into the ICS. ***Highley Medical Practice:*** Mr Brettell and the Primary Care team to ensure that the action plan in relation to Highley is included in the Primary Care report going forward.	Ms Parker Mr Brettell	April meeting Ongoing	**April Update:** Agenda item. **April Update:** Any discussions regarding Highley will take place in the Public Part 1 meeting whenever possible.
PCCC 22-04.17 Finance Update	Ms Parker to consider Dr Pringle's suggestion regarding spending of ARRS funding and in particular his suggestions regarding use of CCG Pharmacists as PCN Pharmacists using ring-fenced funding.	Ms Parker	May meeting	

PCCC 22-04.20 GP Strategy	Ms Parker to circulate Professor Salisbury's report to PCCC members for information.	Ms Parker	May meeting	**May Update:** Report circulated. ***To Be Closed.***

NHS
Shropshire, Telford and Wrekin
Clinical Commissioning Group

REPORT TO: **NHS Shropshire, Telford and Wrekin CCG Primary Care Commissioning Committee**
Meeting held on 4th May 2022

Item Number:	Agenda Item:
PCCC-22-05.30	2021/22 Month 12 Primary Care Financial Position

Executive Lead (s):	Author(s):
Claire Skidmore Director of Finance claire.skidmore@nhs.net	Angharad Jones Finance Business Partner Angharad.Jones1@nhs.net

Action Required (please select):									
A=Approval		R=Ratification		S=Assurance	X	D=Discussion		I=Information	X

History of the Report (where has the paper been presented):		
Committee	**Date**	**Purpose (A,R,S,D,I)**
N/A		

Executive Summary (key points in the report):

The financial performance reported in this paper is for month 12 of 2021/22.

Full Year Outturn:
For Primary Care this is split into two sections. The first is Co-Commissioning (or Delegated) with a reported full year underspend of £4.1m on a budget of £79.2m. The main driver of this underspend is prior year benefits across various spend categories and an underspend on the current year baseline allocation for the Additional Roles Reimbursement Scheme (ARRS). The second section called Primary Care Services (Or Non Delegated) has a reported full year underspend of £3.2m on a budget of £107m. The main driver of this underspend is a £1.2m prior year benefit in relation to Prescribing which is non recurrent in nature.

Efficiency Schemes:
£322k has been achieved in relation to Rates Rebates. Prescribing efficiencies over achieved by £318k on a full year target of £1.589m, equating to 20% over achievement.

22/23 Planning:
The notified ring fenced delegated budget for 22/23 is £82.9m. Detailed analysis has been undertaken which confirms that 22/23 contractual commitments are all forecast to be contained within the allocation with a breakeven position forecast.

Further in year allocations are expected to the sum of £943k to fund specific additional scheme expenditure over and above the £82.9m planned expenditure.

Recommendations/Actions Required:

The committee is asked to:
Note the information contained in this report

Report Monitoring Form

Implications – does this report and its recommendations have implications and impact with regard to the following:		
1.	Is there a potential/actual conflict of interest? *(If yes, outline who has the potential conflict of interest, what it is and recommendation of how this might be mitigated).*	No
2.	Is there a financial or additional staffing resource implication? *(If yes, please provide details of additional resources required).* *Yes, financial cost pressures to the CCG are described throughout the report. Overall financial risk is highlighted in the Governing Body Assurance Framework. Sufficient staff resources to identify and deliver the required efficiency plan is crucial to the achievement of the required financial position.*	Yes
3.	Is there a risk to financial and clinical sustainability? *(If yes, how will this be mitigated).* *Yes, implications to the financial position and longer term financial sustainability of the CCG are described throughout the report*	Yes
4.	Is there a legal impact to the organisation? *(If yes, how will this be mitigated).*	No
5.	Are there human rights, equality and diversity requirements? *(If yes, please provide details of the effect upon these requirements).*	No
6.	Is there a clinical engagement requirement? *(If yes, please provide details of the clinical engagement).*	No
7.	Is there a patient and public engagement requirement? *(If yes,*	No

Strategic Priorities – does this report address the CCG's strategic priorities, please provide details:		
1.	To reduce **health inequalities** by making sure our services take a preventative approach and take account of different needs, experiences and expectations of our communities. *(If yes, please provide details of how health inequalities have been reduced).*	No
2.	To identify and improve **health outcomes** for our local population. *(If yes, please provide details of the improved health outcomes).*	No
3.	To ensure the health services we commission are **high quality**, safe, sustainable and value for money. *(If yes, please provide details of the effect on quality and safety of services).*	No
4.	To improve **joint working** with our local partners, leading the way as we become an Integrated Care System. *(If yes, please provide details of joint working).*	No
5.	To achieve **financial balance** by working more efficiently. *(If yes, please provide details of how financial balance will be achieved).* *The CCG financial position contributes to the System wide performance discussions to ensure that the System sustainability financial plan is monitored. Key variances and risks to the System position are highlighted.*	Yes

Tables included in this report:

2021/22 Month 12 Financial Position

Introduction

1. The financial performance reported in this paper is for Month 12 – March 2022.

Full Year Outturn

Table 1: M12 Full Year Position Delegated

Primary Care Delegated	2021/22 Full Year Budget £'000	2021/22 Full Year Outturn £'000	2021/22 Full Year Variance £'000
General Practice - GMS	49,388	49,429	(41)
General Practice - PMS	377	377	0
Enhanced Services	8,424	6,236	2,188
QOF	7,634	7,070	564
Premises cost reimbursements	8,766	7,084	1,682
Dispensing	2,882	2,772	110
Other - GP Services	3,439	2,127	1,312
Net Reserves	(1,680)	0	(1,680)
Total	**79,230**	**75,095**	**4,135**

2. When submitting the H1 & H2 plan we had planned to overspend the ring fenced delegated budget by £1.68m. This is highlighted on the Reserves line above, an offsetting budget sits within the Non Delegated section of CCG reporting.

3. The final outturn reported on the delegated budget was an underspend of £4.1m. This is driven mainly by prior year benefit released into the current year position. This includes £500k in relation to QOF payments, and £82k in relation to dispensing charges. This is due to the final data received in 21/22 for these areas being lower than the estimate in the year end accounts. At Month 11 and 12 further prior year releases were made in relation to provisions set up for expected premises and Locum costs which did not materialise in year.

4. Additionally £1.4m was released of unspent monies from the 20/21 Additional Roles Reimbursement Scheme (ARRS). The current year spend for ARRS also resulted in an underspend of c£1m against the £3.5m baseline allocation.

5. There is one efficiency scheme associated with the Delegated budget, this is in relation to Premises rates rebates. £322k underspend is reflected in the outturn position on the Premises cost reimbursement budget line. However this saving is negated by an additional cost pressure in relation to Phlebotomy which is highlighted within the Non Delegated budget area.

Table 2: M12 Full Year Position Non Delegated

Primary Care Non Delegated	2021/22 Full Year Budget £'000	2021/22 Full Year Outturn £'000	2021/22 Full Year Variance £'000
Prescribing	83,311	82,072	1,239
Central Drugs	2,323	2,419	(96)
Oxygen	908	792	116
Prescribing Incentive Schemes	373	316	57
Enhanced Services	7,248	7,546	(298)
Primary Care Pay	2,627	2,661	(34)
Primary Care Other	1,943	682	1,261
Primary Care IT	1,943	2,002	(59)
GP Forward View	5,488	5,343	145
Primary Care Reserves	836	0	836
Total	**107,000**	**103,833**	**3,168**

6. The final position on Non Delegated budgets is an underspend of £3.2m. This is driven by a prior year benefit of £1.2m in relation to Prescribing (20/21 final charges were lower than the figure accrued) which is non recurrent in nature, and the £1.6m reserve set up to net off the overspend on the delegated allocation. Partly offset by identified cost pressures including the Phlebotomy Item of Service costs.

7. For prescribing, in year we have seen an average post efficiency growth of 2.33% (Apr-Jan) versus 20/21. The forecast for prescribing expenditure is based on a similar approach to that used last year, using the % growth between the last three months of the previous financial year.

8. We had a number of efficiency schemes in relation to prescribing which are detailed in table 3; we have seen several of the schemes perform better than planned, in spite of a large proportion of the medicines management team supporting the Covid Vaccine programme. The final overachievement in year is £318k.

Table 3: M12 Efficiency Schemes

QIPP Scheme	Full Year Plan (Net) £000s	Full Year Outturn £000s	Variance £000s
Drug Switches	216	303	88
Respiratory	28	75	47
Scriptswitch (Shropshire Practices only)	234	300	66
Optimise (Telford Practices only)	145	202	57
Diabetes	55	154	99
Care Homes	166	149	(17)
POD	415	601	186
Self Care	8	0	(8)
DOLVC	98	74	(24)
Wound	12	0	(12)
Continence (Urotomy)	31	0	(31)
Optum	182	49	(133)
Total	**1,589**	**1,907**	**318**

9. The final submission of the healthcare system financial plan was submitted to NHSEI on the 28th April, this included the CCG financial plan.
10. The notified ring fenced delegated budget for 22/23 is £82.9m. Detailed analysis has been undertaken to map expenditure at category level in accordance with the 22/23 GP Contract.

Table 4: Final 22/23 Delegated Budget

	Plan 2022/23 £'000
Allocation	**82,952**
General Practice GMS	51,948
QOF	7,974
EnhancedServices	11,018
Other GP Services	1,405
Premises Cost Reimbursements	7,651
Dispensing & Prescribing	2,956
Total	**82,952**
Deficit ()/Surplus	**0**

11. In addition to the recurrent allocation of £82.9m, it is expected that the following in year allocation will be received to offset committed expenditure aligned to these schemes.

Table 5: 22/23 Non Recurrent In Year Allocations

Description	£'000's
Subject Access Requests	172
Weight Managem Service	105
Additional PCN Leadership and Management funding	369
Additional IIF funding	297
Total additional contract-related funding	**943**

12. The final non delegated budget equates to a total budget of £103.7m The current breakdown by category of spend is shown in Table 6.

Table 6: Final 22/23 Non Delegated Budget

Category	Plan 2022/23 £'000
Prescribing	85,084
Central Drugs	2,436
Oxygen	918
Enhanced Services	5,253
GP Forward View	4,799
Primary Care Pay	2,467
Primary Care IT	2,009
Primary Care Other	707
Total	**103,673**

13. The delivery of the plan is reliant on the achievement of efficiency schemes. The total plan for Primary Care related schemes is £2.1m

Table 7: 22/23 Primary Care Efficiencies

Description	Plan 2022/23 £'000
Rent Rebates	(315)
Prescribing	(1,781)
Total	**(2,096)**

Conclusion

1. The final position reported for Primary Care as a whole was an underspend of £7.3m. This is primarily down to the release of one off prior year benefits into the finance position.

2. The 22/23 final plan was submitted on 28th April 2022. The final delegated budget shows a forecast breakeven position on the notified allocation of £82.9m. The Non Delegated Budget is a total of £103.7m

3. The delivery of the financial plan is dependent on the achievement of efficiency schemes, for Primary Care the total is £2.1m.

NHS
Shropshire, Telford and Wrekin
Clinical Commissioning Group

REPORT TO: **Shropshire, Telford and Wrekin CCG Primary Care Commissioning Committee**

Item Number:	Agenda Item:
PCCC-22-05.31	Primary Care Update Report

Executive Lead (s):	Author(s):
Claire Parker, Director of Partnerships	Tom Brettell, Primary Care Partnerships Manager Janet Gittins, Primary Care Partnerships Manager Phil Morgan, Primary Care Workforce Lead Darren Francis, Primary Care Estates Lead Bernadette Williams, Primary Care Contracts Lead Antony Armstrong, Primary Care IT Lead

Action Required (please select):									
A=Approval		R=Ratification		S=Assurance		D=Discussion		I=Information	X

History of the Report)where has the paper been presented):		
Committee	**Date**	**Purpose (A,R,S,D,I)**
Primary Care Operational Group	Wed 20th April	D, I

Executive Summary (key points in the report):

- The Primary Care Team continues to manage a complex and demanding workload
- The Team is managing this demand well and is on track/ target across all work-streams. There are currently no significant deliverability concerns.
- This paper highlights work on Estates, IT, Workforce and Contracts however additional reports will be continue to be provided to PCCC meetings to provide members with assurance of the plans and progress of the work of the Partnership Managers and wider Primary Care Team.

Recommendations/Actions Required:

To note the contents of the report and the work currently being undertaken by the Primary Care Team in relation to these areas.

Report Monitoring Form

Implications – does this report and its recommendations have implications and impact with regard to the following:		
1.	Is there a potential/actual conflict of interest? *(If yes, outline who has the potential conflict of interest, what it is and recommendation of how this might be mitigated).*	No
2.	Is there a financial or additional staffing resource implication? *(If yes, please provide details of additional resources required).*	No
3.	Is there a risk to financial and clinical sustainability? *(If yes, how will this be mitigated).*	No
4.	Is there a legal impact to the organisation? *(If yes, how will this be mitigated).*	No
5.	Are there human rights, equality and diversity requirements? *(If yes, please provide details of the effect upon these requirements).*	No
6.	Is there a clinical engagement requirement? *(If yes, please provide details of the clinical engagement).*	No
7.	Is there a patient and public engagement requirement? *(If yes, please provide details of the patient and public engagement).*	No

Strategic Priorities – does this report address the CCG's strategic priorities, please provide details:		
1.	To reduce **health inequalities** by making sure our services take a preventative approach and take account of different needs, experiences and expectations of our communities. *(If yes, please provide details of how health inequalities have been reduced).*	No
2.	To identify and improve **health outcomes** for our local population. *(If yes, please provide details of the improved health outcomes).*	No
3.	To ensure the health services we commission are **high quality**, safe, sustainable and value for money. *(If yes, please provide details of the effect on quality and safety of services).*	No
4.	To improve **joint working** with our local partners, leading the way as we become an Integrated Care System. *(If yes, please provide details of joint working).*	No
5.	To achieve **financial balance** by working more efficiently. *(If yes, please provide details of how financial balance will be achieved).*	No

Partnership Managers Update – Janet Gittins & Tom Brettell

Locally Commissioned Services (LCS) Review
Detailed assessment of 3 specific service areas continues working with CCG colleagues and LMC reps

- C&CC's
- Demand Management
- Minor injuries and Safe Prescribing

A data dashboard has been developed to assist with this work which has highlighted significant opportunities to focus on specific areas including patient behaviour and to explore overlap between these service areas. The dashboard has also highlighted the need for some further focused work to address low acuity attendance at A&E.

Review/redesign work on specific LCS (phlebotomy, spirometry and ear irrigation) continues and is complementary to this broader work.

Learning Disability Annual Health Checks (LDAHCs)
No update for this meeting.

Practice Visits
Following discussion at the April PCCC meeting we have developed some criteria to ensure that visits are targeted appropriately. Using this criteria, 6 practices have been identified for visits over the next few months. Dates for these visits are currently being arranged and a verbal update on these arrangements will be provided at the meeting.

CVD/ Hypertension delivery plan
A system working group has been established to support PCN's and practices to deliver the requirements of the PCN DES to target cardiovascular disease. This work will seek to integrate the Blood Pressure Monitoring @Home Project. A more detailed update will be provided at the next meeting by which time an action plan will be in place.

Blood Pressure Monitoring @Home Project
See above

Virtual Ward
No update for this meeting

Veteran Friendly Practices
Good progress continues on supporting practices to become Veteran Friendly. A more detailed report on the number of practices and some qualitative feedback will be provided later in the year.

Macmillan Community Care Project (MCC)
No update for this meeting

Additional Primary Care Funding
No update for this meeting

Ukrainian Refugee support
The team are supporting working groups in each local authority area to provide structured assistance to Ukrainian refugees as they come to Shropshire and Telford. A range of information and guidance is trickling down from government which we have provided to practices and we are looking to pull this together into a support pack for primary care. We are working with LA colleagues to identify where refugees will be housed in order to provide advance notice and support to practices whose catchments cover that area. This is a fast- moving piece of work so a further verbal update will be provided at the meeting.

Diabetes

The team are currently working alongside Transformation & Commissioning on a review and redesign of all Diabetes pathways into a more simple, integrated package across Shropshire, Telford & Wrekin. NHSEI have now merged funding streams for Diabetes and Diabetes Prevention to allow for more streamlined planning. The review has only just begun so a more detailed update will be provided in May's Report. Annex A provides detail from NHSEI on the key deliverables.

Asthma
The team are supporting a programme of work to address Personalised Care for Children and Young People for which Telford and Wrekin CCG have successfully obtained funding from NHS England. Specifically, this will see the implementation of Personalised Care tools as part of a system change to deliver a non-clinical approach to supporting Children and Young People with a diagnosis of Asthma and will fund:

- a digital health app for children and young people living with Asthma and their parents / carers to educate and enable them to self-manage their condition to be introduced autumn 22: https://digitalhealthpassport.co/
- creative Health Activities for Children and Young People with a diagnosis of Asthma to improve their physical health in relation to their lung function, for example swimming, yoga, singing
- recruitment of a 12-month, 0.8 WTE Asthma Nurse post in Shropshire Community Health Shropshire Community Health Trust to work with Primary Care to identify Children and Young People with a diagnosis of Asthma who require an Asthma Review and to carry out these reviews on their behalf. The offer of social prescribing activities will be made as part of these reviews, as well as encouraging the use of the digital health app

Remote Monitoring Programme
This programme is gathering pace with a number of new care homes coming on line who are part of larger groups which we anticipate will accelerate roll out in other homes owned by the same group. Work is now developing to look at applying the technology to long term conditions with asthma being the first focus area linking into the asthma work detailed at xxx above. Most significantly we have appointed a clinical lead to the programme, Dr Andrew Allsop a GP Partner at Cleobury Mortimer who will help the programme build momentum and achieve the impact it has the potential to.

Estates Update – Darren Francis

Below is a brief update on the ongoing key estates projects and related activity. Where noted, papers are being taken to Primary Care Commissioning Committee and are attached or due to be submitted nearer the date for the next Primary Care Commissioning Committee.

Shawbirch – ETTF New Build
- Build underway and on target for completion around June/July 2022

Whitchurch – ETTF New Build
- Business case and all legal documents now signed
- On site work started in February – completion of Primary Care Centre by September 2024

Shifnal – ETTF New Build

- Full Business Case approved by Primary Care Commissioning Committee in Dec 2021
- Business Case approved by NHSE Regional Team in February 2022
- NHSE National approval given and all legal documentation signed in March 2022
- Build scheduled to start Mar 2022 – expected completion due Mar 2023 (latest)

Shrewsbury Health and Wellbeing Hub (formerly Cavell Centre)

- Work progressing on Clinical Modelling and schedule of accommodation
- Initial patient engagement activity now completed and feedback report released – awaiting start of 2nd phase of patient engagement/consultation
- Ongoing discussions with Shropshire Council and developers/landowners on site options
- Business Case Writer appointed
- Cost Consultants appointed
- First stage architectural and design works progressing – initial Schedule of Accommodation being finalised – to be discussed with GPs over coming months
- FBC due to Primary Care Commissioning Committee in August 2023 – completion July 2025

TelDoc Estates Rationalisation

- Outline Business Case for next stage of TelDoc estates rationalisation programme - due to PCCC May 2022
- Expected to be some uplift in rent and rates reimbursement which will be an ongoing cost pressure to the CCG – details to be costed in the OBC

Ironbridge Power Station Development

- Original planning application submitted by the site developers was turned down and subsequently resubmitted including improved provision for healthcare and affordable housing on the site. Resubmitted planning application was approved at the meeting on 20 September 2021
- STW CCG has secured some capital funding from the developers for healthcare provision – although the first instalments of this are not likely to materialise until after stage 2 of the housing development has been completed (estimated by 2028 – full project runs to 2035)
- Discussions to continue with the neighbouring practices (including Ironbridge, Much Wenlock [inc Cressage branch] and Broseley, as well as others) as all will potentially be affected by the development

Capital Funding for Estates Projects

- The call for bids for next years' round of capital funding has gone out to practices
- Bids deadline is end April to allow for prioritisation process and approval
- Once approved by CCG/ICS, bids will then go to NHSE for final approval before go-ahead given to practices to start works

Contracting update – Bernadette Williams

PCN DES 2022/23

NHSE/I published the service specification - https://www.england.nhs.uk/wp-content/uploads/2022/03/B1357-Network-Contract-Directed-Enhanced-Service-contract-specification-2022-23-primary-care-network-requireme.pdf

There are 9 service requirements:

- Extended Hours (combined Extended Hours and Extended Access service from 1st October 22)
- Medication Review and Medicines Optimisation
- Enhanced Health in Care homes
- Early Cancer Diagnosis
- Social prescribing service
- CVD prevention and diagnosis

- Tackling Neighbourhood Health Inequalities
- Anticipatory Care
- Personalised Care

Investment and Impact Fund 2022/23
The IIF will recommence in full in April 2022. The service specification has been published; https://www.england.nhs.uk/wp-content/uploads/2022/03/B1357-investment-and-impact-fund-2022-23-updated-guidance-march-2022.pdf , there are 27 indicators with 888 points in total across five objectives. £228.1m is allocated to this nationally.

STW Contract changes
Contract variations have been requested for;

- Portcullis – addition of a new partner on to the contract
- Shifnal/Teldoc – partner retiring from Shifnal and partners from Teldoc added to Shifnal contract

These are being processed by GMAST.

GP contract changes 2022/23
Please refer to Annex B.

GP IT Update – Antony Armstrong
The Digital Lead/Partnership Managers within the CCG meet weekly with the MLCSU IT Project Team, to discuss on-going projects, progress reports and any risks and issues through the Digital Operational Group meeting.

Domains
A single domain across STW will secure the Primary Care estate and mitigate against the very real threat of cyber-attack faced by Primary Care and other health and care sector organisations.
Through a fully Midlands & Lancashire CSU (MLCSU) 'managed' GP domain infrastructure, the IT provider will replace all GP Practice and branch Practices existing standalone configurations. This would include installation of a central core infrastructure at Halesfield and replacement of existing local GP EMIS servers with new servers to provide domain, file/print services and EMIS spoke services. Also, a new perimeter edge firewall device will be installed at each site to provide an enhanced layer of security.

Delays caused by the pandemic and teething issues at the early adopter sites have delayed the project from the originally agreed timescales. Through additional resource the CCG are committed to completing the final phase of the domain project by mid-May.

Further engagement is currently being sought by the CCG to assist the CSU with practices who are yet to engage, highlighting the importance of a fully managed domain, being cyber compliant and providing assurance on the IG DSP Toolkit return. These practices have been contacted by the locality managers and good progress is being made.

25 sites are now live on the new Zeus Domain. A further 10 sites have migration dates booked in and engagement is well underway with the T&W practices.

The host sites for the Extended Access service have a dependency on Docman Share which has been purchased from a Primary Care NHSE allocation. The existing Extended Access Data Sharing Agreement has been brought up to date with the inclusion of Docman Share. it has also been reviewed and approved by the MLCSU IG team. The DSA's have been cascaded out to the Extended Access Hosts in the first instance for sign-off and will then be shared with all practices and collated by the CCG.

Notes Digitisation
Procurement is now complete and contract award recommendation report signed-off.
The CCG are reviewing the order form for completion with the Contracting Team for assurance. Payment schedules/milestones with the provider are also being discussed. Once the order form has been completed the CCG can commence with the practice engagement Q&A sessions.
NHSEI have indicated that future funding streams for the Notes Digitisation Project will be through a 'scan on demand' service whereby all notes are held centrally. A meeting has been scheduled the end of April to discuss the existing pilots within the region as well as more details on the 'scan on demand' future project.

Digital Dictation
The provider has been engaging with practices and our MLCSU IT team on pre-requites regarding the software installs and has recently commenced deployment of the cloud-based dictation solution.

Comms Cabinet Refresh
The CCG recognise that there has been an increase in the network/IT infrastructure going into general practice. With hardware relating to the phone system, practice Wi-Fi, HSCN taking up significant space. The CCG have commissioned a third-party to carry out surveys within our practices to identify the current cabinets size, the potential for a new larger cabinet and cable management. The proposal on completion of the surveys will be shared with the CCG to take forward.

N365 (Office 365) Pilot
Pilot phase of the N365 deployment is commencing mid-April to replace the existing version of Microsoft Office with the new Apps for Enterprise. Once full testing/feedback is completed deployment of N365 can be pushed out to computers already on the Zeus managed domain.

Workforce Update – Philip Morgan

GP/GPN Fellowships
The GP Fellowship part of this scheme is well advanced. We have 20 Fellows on the scheme with a few more due to join in the coming months. We are delivering against all 10 components – the highlight being a commissioned Leadership/Quality Improvement Programme – an online suite of development tools which the Fellows can access both in their own time and via action learning sets.

Our recently appointed Clinical lead for this programme, Dr Priya George, is working with us on all aspects of the programme, but particularly in supporting those Fellows who will be leaving the scheme later this year.

Following feedback from the Fellows we are providing more support for those Fellows working on projects with our local PCNs.

The GPN Fellowship part of this scheme is not yet as fully developed as the GP part. There are significant differences between the two parts of the scheme, which are understood nationally, which have led to challenges to operationalising the GPN scheme. However, we have managed to recruit one GPN to our local scheme and have a good level of interest from practices to recruit newly-qualified Nurses later this year

Supporting Mentoring Scheme
Funding is available to:

- Train GPs to be mentors, and
- Pay them for delivering mentoring sessions to other GPs

From April 2022 we have 10 trained mentors who are providing mentoring to GPs across our system, mainly focusing on the GP Fellows (see above). There is significant scope to expand and publicise this scheme once the new arrangements are embedded.

Local GP Retention

29 practices were allocated funding in late 21/22 for bespoke projects including training and development opportunities for GPs. Monitoring of this funding will take place in the 22/23 financial year.

Two new GP "Champions" have been recruited, using this funding, and have started work:

- an "Ethnically Diverse GP Champion", Dr Muhammad Zeb, who is working with the growing number of BAME and IMG doctors on the VTS to support them in remaining in STW after they qualify, and
- a "Newly-Qualified GP Locum Champion", Dr Losa Shui, who is working with ST3s and newly-qualified GPs who choose to work as locums to provide them with support and networking (this cohort of newly-qualified GPs are not able to join the GP Fellowship scheme)
- Both of these GP Champions are local GPs who themselves went through our local VTS

A survey of the ST3s on the STW VTS (around 30) is being carried out in April, with the aim of discovering the trainees' post-CCT plans – the results will enable us to provide more bespoke support

Online Staff Booking Platform

The Lantum online booking platform went live in December 2021 and is proving very popular with practices (42 practices have signed up). However, despite some early success with GPs, only around 30 sessional/locum GPs have signed up to the Platform to date. Ongoing communication and engagement with practices and GPs will take place over the next few months, including with Shropdoc GP members, in an effort to increase these numbers.

Part of the contract with Lantum includes the purchase of licences for our PCNs to use the platform's functionality to help them roster their ARRS staff and plan vaccination programmes. Ongoing engagement is taking place with PCNs to promote this, including a presentation to the May PCN Development meeting.

Future development of the platform will include adding other practice staff groups to the platform, starting with Nurses/ANPs and HCAs. In addition, conversations are taking place with local trusts across the ICB to explore how the platform could be used more widely.

Practice Resilience

Following the allocation of the 21/22 NHSE/I Practice Resilience funding to practices, reporting on the use and impact of this funding will take place in the 22/23 financial year.

ARRS

Recruitment of staff continues steadily across all eight of our PCNs with around 120 ARRS-funded staff currently in post.

Two facilitators have been recruited to support the individual staff groups (Physician Associates and First Contact Physios) with a plan for more facilitators to be recruited soon including Paramedics and Clinical Pharmacists.

General Practitioner Strategy

A GP (General Practitioner) Strategy has been published and signed off by the CCG's PCCC. The Strategy focuses on the three STW ICS People Plan priorities of Attract, Recruit and Retain. Volunteers from practices are being sought to form a steering group which will prioritise the issues in the Strategy, finalise the action plan and advise on implementation.

Health and Wellbeing Survey

The CCG is working with all four local Primary Care contractor groups, and colleagues from the ICS People Team, to discover the current level of provision, and the level of interest in future provision, of health and wellbeing initiatives. The findings from this survey will inform decisions on how to utilise a bespoke NHSE/I funding allocation for health and wellbeing.

2022/23 ICS Funding & Deliverables Letter

Annex A – Further information on key deliverables

This information will be published on the Future NHS Collaboration Hub. Any updates or amendments will be reflected in the published version and annotated, with a notification sent out via regions.

Funding must be used to support the following 2 priority areas in the first instance:

A1: Restore diabetes identification and routine monitoring and management

- Systems should aim to restore diabetes identification and routine management to pre-pandemic levels, to support more people to meet NICE recommended treatment targets. This means increasing the number of people with diabetes receiving the 8 care processes - HbA1C, blood pressure, cholesterol, serum creatinine, urine albumin, foot surveillance, BMI and smoking.
- Systems should utilise the Diabetes Data Hub for NDA data on 8 care processes. This includes a recovery dashboard (which shows the extent of the decline of care process delivery during COVID19) and risk stratification dashboard (which shows the extent to which those that did not previously meet the treatment targets are being prioritised for care process delivery).
- Systems must include baseline data for all eight care processes at PCN level in their plans and refer to what activity will take place to support recovery.
- Projects started under the Recovery Innovation Fund (RIF) in 2021/22 should continue through 2022/23. Other systems may wish to replicate RIF projects with 2022/23 funding. Projects are largely delivering primary care incentive schemes, workforce schemes (upskilling and additional capacity) and digital initiatives. A series of case studies will be published on the Future NHS Workspace as schemes progress.

A2: Increase primary care referrals to the NHS Diabetes Prevention Programme and Low Calorie Diet pilots

- A self-referral pathway is available using the Diabetes UK Know Your Risk Tool and via Providers who are marketing self-referrals online.
- A new national marketing campaign linked to Better Health will begin in early 2022 to promote referrals across all risk groups
- Framework 3 of the programme is now in place to widen access to the programme by offering a choice of digital and face to face services as well as a new cross-ICS tailored remote service for certain groups less likely to join or retain on the programme.
- GPs and local health systems should prioritise referrals based on an eligible blood reading as the most effective way to ensure those at greatest risk of Type 2 diabetes are offered the service.
- Ways to use funding to support DPP referrals are outlined on the Future NHS workspace

- The Low Calorie Diet programme has been expanded to a further 11 ICS areas.

- Participating systems should work to increase the number of primary care referrals made into the programme (target of 500 patients over the two-year referral window)
- Based on the mobilisation funding issued to the first 10 ICSs in 2019/20, it is estimated that participating systems will require £20-25k per year to support effective implementation of the pilots, and this should be funded from diabetes system allocations in 2022/23 and 2023/24.

A3: Interdependencies between national Diabetes, CVD & Prevention Programmes

- People are more at risk of having cardiovascular disease (CVD) if they have atrial fibrillation, high blood pressure, high cholesterol, or diabetes. Evidence suggests that substantial health benefits would accrue if all individuals with conditions that increase CVD risk could be diagnosed, with detection of undiagnosed diabetes producing greatest benefits[1]. Given the interdependencies, it is important that system plans indicate how resources from the national CVD and diabetes programmes for recovery of routine care will be deployed as part of a coordinated approach.

- Similarly, there are a range of services to support people to lose weight and reduce their risk of diabetes delivered by the national Prevention and Diabetes Programmes. This includes; the NHS Diabetes Prevention Programme (for adults with non-diabetic hyperglycaemia or with normoglycaemia and a history of gestational diabetes); the Digital Weight Management Service (for adults with diabetes or hypertension or both) and the Low-Calorie Diets programme (for adults with a diagnosis of diabetes within the last 6 years and within a specified BMI range). Systems should set out how individuals will be directed to the most appropriate lifestyle service. This could be detailed in either diabetes or prevention plans, providing regional teams are appropriately signposted for plan assurance.

- The national programmes have developed aligned assurance templates for regions to reflect the interdependencies.

Systems should also use 2022/23 funding to deliver the following:

A4: Structured education, diabetes Inpatient Specialise Nurse (DISN) services and Multidisciplinary Footcare Teams (MDFTs)

- Systems should make best use of nationally commissioned digital structured education programmes such as My Type 1 Diabetes, Digibete and Healthy Living
- Evidence based programmes should continue to be commissioned as required to offer a range of options for people.
- Promotional resources are available on the Future NHS Collaboration platform.

---

[1] Thomas C, Brennan A, Goka E, *et al*. What are the cost-savings and health benefits of improving detection and management for six high cardiovascular risk conditions in England? An economic evaluation

BMJ Open 2020;**10:**e037486. doi: 10.1136/bmjopen-2020-037486

- Systems must ensure that all trusts have a diabetes inpatient specialist nurse service and all people with diabetes have access to a multidisciplinary footcare team (if required) by March 2023.
- Local sustainability plans should be in place to ensure that DISN and MDFT services are locally funded from April 2023, and this should form a key part of regional oversight work in 2022/23.

The following should not be funded via the allocation, but details should be included in system plans:

A5: Flash Glucose Monitoring for adults with Type 1 diabetes

- Systems should develop plans for provision of flash glucose monitoring for people with diabetes in line with forthcoming NICE guidance.
- Previous NHSE funding for flash is now built into commissioning baselines.

A6: Continuous Glucose Monitoring (CGM) offer for all pregnant women with Type 1 diabetes

- Funding is released to a lead CCG for each system as nominated by Local Maternity Systems (LMS), who are responsible for delivery in partnership with diabetes teams.
- Funding will be released at Month 4 (July) and in Month 9 or 10 (Dec/Jan).
- LMS will be asked to report on prescribing rates quarterly.
- Funding has been modelled on the actual Q1 to Q3 2021/22 activity reported by Local Maternity Systems or the Type 1 diabetes population and predicted rate of pregnancies and based on an anticipated 65% uptake rate, whichever is the higher.
- Should quarterly reporting identify that rates of uptake exceed this, allocations will be adjusted in-year and costs covered within the second payment.
- Systems should therefore offer CGM to all pregnant women living with Type 1 diabetes. An FAQ document has been shared with systems. The latest version is available upon request.

A7: Children and Young Adults with diabetes

- Funding will be made available in 2022/23 to NHSEI regions to establish dedicated and sustainable clinical leadership, develop regional infrastructure and governance and to review local data. Regions will be asked to return a financial template to set out staffing plans. Funding intended for this purpose should not be used on local projects without the prior approval of the CYA Oversight Group
- Funding will be made available to support guided evaluated pilots in improving transition care – with a principal of having at least one pilot per region. Expressions of interest are expected to be invited from regions on behalf of relevant systems in March / April.
- There will also be funding made available to each region to support a regional plan (approved by the national CYA Oversight Group) to address inequalities in access to treatment technology (please note – the purpose of the funding will be to address causes of variation rather than to fund technology).

A8: Type 1 Disordered Eating (T1DE) pilots

- Following positive evaluation findings, the national team are developing a longer-term strategy for expanding the availability of these services from 2022/23. Bids for further pilot sites will be accepted via a regionally led process.

A9: Monogenic diabetes

- The aim of this national project is to support an improvement in referral rates for genomic testing for monogenic diabetes and address significant variation in referrals and identification across trusts, such that the expected number of cases are identified (8 per 100,000 population).
- In 2022/23 NHSEI will again fund an expert team at Exeter University to deliver free virtual training to a nominated medical (consultant or SpR) and nursing lead in each trust.
- Trusts are asked to ensure that a medical and nursing champion receives the training and utilise the local support offer from nationally funded regional Genetic Diabetes Nurses (GDNs) working in partnership with Genomic Medicine Service Alliances (GMSAs).
- The costs of the genetic testing are centrally funded by the NHSEI Genomics Programme.
- For more information go to https://www.diabetesgenes.org/

A10: Use of data to inform improvement

- Key programme metrics based on national data will be discussed at regional oversight groups, to support oversight and accountability.
- Systems should use additional national / local diabetes data to support improvement. This may be in the form of a system diabetes data dashboard, or diabetes metrics included in an existing / broader system dashboard.
- A visual aide to show where different types of diabetes data can be sourced from is in development and will be added to the Diabetes Futures site.
- Clinical improvement programmes should be embedded throughout regions and systems and should be data driven. Nationally provided programmes and resources to support this include Getting It Right First Time, Rightcare and the Best Practice Library are available on the Treatment and Care Future NHS workspace.

GP contract arrangements in 2022/23

Dr Ursula Montgomery Director of Primary Care
Dr Nikki Kanani Medical Director for Primary Care

3 March 2022

Context

- In January 2019, NHS England and the BMA's General Practitioners Committee (GPC England) agreed to the most ambitious GP contract in recent years to transform General Practice between 2019/20 and 2023/24.
- The resulting five-year framework for GP contract reform, Investment and Evolution, implements the commitments set out in the NHS Long Term Plan. The contract invested £8.412m into primary care in 2019/20, rising to £10,784m in 2023/24

Funding as announced in Investment and Evolution in January 2019 (£m)					
	19/20	20/21	21/22	22/23	23/24
Core	8,1 6	8,303	8,532	8,748	8,985
Network contract	296	552	1,153	1,457	1,799
Total	8,412	8,855	9,686	10,205	10,784

Context (continued)

- As the NHS focuses on tackling the covid-19 backlogs that have inevitably built up over the pandemic, our focus is now on recovering services, particularly on long-term condition management and chronic disease control, ensuring timely access for patients with urgent care needs, and regaining momentum on the wider prevention agenda.
- General practice has shown time and again its ability to respond to new challenges raised by Covid-19 with agility and responsiveness. Therefore the contract proposals for 2022/23 seek to maintain stability and limit change for general practice, whilst bolstering investment for the workforce and leadership, supporting our communities to recover, and ensuring patients continue to receive timely, high quality care.
- The vast majority of the proposals are not new. Some are policies which were agreed in principle with GPC England in 19/20 with technical details to be determined; others presented opportunities to provide general practice with increased funding. We have invested a further £402m into the contract this year.

Additional funding since Investment and Evolution in 2019 (£m) excluding Covid-related funding					
	19/20	20/21	21/22	22/23	23/24
Core	-	20	44	64	44
Network Contract	-	166	19	338	654
Total	-	186	63	402	698
Total (cumulative)	-	186	249	651	1,349

Additional Roles Reimbursement Scheme (ARRS): Context

- Investment and Evolution set out the agreement to expand the multi-disciplinary through the ARRS within the Network Contract DES
- The ARRS originally included 5 roles, funded at 70% of a maximum reimbursable amount
- This has been tripled to 15 roles, with funding for 100% of the maximum reimbursable amount
- The roles can be used in ways which suit the needs of your local populations e.g., employing Care Coordinators with a focus on cancer, or Nursing Associates with a focus Sever Mental Illness and Learning Disabilities
- £746M available in 2021/22 to fund 15,500 FTE in post by April 2022. This target has already been met: analysis of ARRS claims and workforce statistics shows over 16,000 FTE recruited by January 2022
- ARRS funding is rising to just over £1 billion in 2022/23 to recruit 21,000 FTE, with flexibility to recruit from 15 roles

Additional Roles Reimbursement Scheme (ARRS): Updates

- As outlined in the Supporting General Practice in 2021/22, from April PCNs will now be able to recruit an additional mental health provider (MHP) where they are able to agree the role with their Community Mental Health Provider
- Additional flexibility to help support recruitment will also be introduced:
  - Broadening of the role to include non-clinical support for patients
  - Inclusion of band 4 in the eligibility
  - Community Mental Health Providers will also be able to engage the MHP from another provider (i.e., the voluntary sector)
- To support you with recruitment, role outlines and job descriptions, interview questions, model job adverts and case studies are available for each role; as well as support for managing estate constraints at https://future.nhs.uk/P_C_N

Enhanced Access: Context

Currently, "extended" access is provided in three ways:

- PCNs deliver extended hours access under the Network Contract DES (£1.44pp) delivered mostly by member practices; and
- CCGs commission extended access services locally, across 7 days a week (£6pp). Majority of these services are currently delivered by federations and other at scale providers, , with large variation across the country
- Practices also receive £30m in global sum (approx. £0.50 pwp) to support 100% coverage of extended access

- In Investment and Evolution (2019), GPC England and NHS England agreed to bring together current extended access services and funding streams under one, single funding stream under the Network Contract DES, to support delivery of a new model of "Enhanced Access"
- This was meant to happen in April 2021, but it was agreed with GPC England in Supporting General Practice in 2021/22 that this would be delayed until April 2022 due to the pandemic
- Service commencement was further delayed until October 2022 to support core general practice capacity and to avoid any disruption over Winter
- Commissioners were strongly encouraged to make local arrangements for a transition of services and funding to PCNs before the national transfer, where this has been agreed with the PCN locally and providers were ready.
- As set out in the plans for PCNs for 2021/22 and 2022/23 in August 2021, commissioners should ensure that PCNs are preparing for this transition, and that they have undertaken good engagement with existing providers

Enhanced Access: New Opportunities

- The changes will allow PCNs greater ability to utilise Enhanced Access capacity, in a way which best meets their patient need

- The new arrangements aim to remove variability across the country, help improve patient understanding of the service, and address inequalities. They will bring the ARRS workforce more consistently into the offer, and support PCNs to use the EA capacity for delivering routine services. The requirements are based on PCNs:
  - providing bookable appointments outside core hours within the Enhanced Access period of 6.30pm-8pm weekday evenings and 9am-5pm on Saturdays
  - utilising the full multi-disciplinary team
  - offering a range of general practice services, including 'routine' services such as screening, vaccinations and health checks, in line with patient preference and need, with PCNs having control over how the EA capacity is used to manage the demand on practices
- PCNs are able to choose to deliver the service themselves or sub-contract delivery to another provider. This could be by taking on the arrangements already in place with CCGs. Commissioners will help to support any transition of arrangements and planning.
- PCNs have flexibility to use the EA capacity where it is most needed. They will be able to provide a proportion of Enhanced Access outside of EA hours, for example early morning or on a Sunday, where this is in line with patient need locally and it is agreed with the commissioner
- An aim of the changes is to help PCNs to have greater control and flexibility over how EA capacity can support them in caring for their patients. These changes are not about existing workforce needing to work more - extended access services are already being provided. These changes aim to maximise the benefit of this capacity.

Primary Care Networks: Clinical Director and Leadership and Management funding

Core PCN funding	Clinical Director funding	Additional funding for 22/23 and 23/24
• Since 2019/20 • £1.50 per registered patient	• Since 2019/20 • Based on 0.25 FTE per average PCN • £0.736 per registered patient (£44m nationally) • In 2021/22, where one practice in a PCN Grouping is signed up to deliver the COVID-19 vaccination programme, there has been an increase in the CD payment to 1FTE (this has applied from April 21-September 21, and December 21-March 22)	• Confirmed additional £43m funding for leadership and management • For next 2 years to provide stability for PCNs • At discretion of CD

In total, £178m will be available for PCNs and their Clinical Directors to support core running, leadership and management of PCNs in 2022/23.

Primary Care Networks: Service Specifications

- As agreed between NHS England and GPC England, Investment and Evolution laid out the plans for gp-contract-2019.pdf (england.nhs.uk) by 2021.

- Structured Medication Reviews, Early Cancer Diagnosis and Enhanced Health in Care Homes were included in the DES from April 2020.

- In recognition of the impact of the pandemic and PCN capacity, the remaining services have been introduced at a slower place than planned. The publication of the plans for PCNs for 2021/22 and 2022/23 (August 2021) confirmed that remaining services would be gradually introduced in a phased approach.

- Further changes have been made from published plans to recognise PCN capacity:
  - The Early Cancer Diagnosis service has been simplified following feedback from the profession
  - Elements of the Anticipatory Care and Personalised Care services have been further deferred

Primary Care Networks: Service Specifications

Early Cancer Diagnosis	• Service simplified to focus on link to system priorities to address recovery of lower than expected rates of prostate cancer referrals, use of FIT tests and tele dermatology (where pathway has been implemented), and work with local system partners.
Cardiovascular Disease Prevention and Diagnosis service	• Limited expansion to include a focus on atrial fibrillation, familial hypercholesteremia and heart failure
Anticipatory Care	• Extension of the period that PCNs have to develop their anticipatory care plans until December 2022. The Anticipatory Care service itself, which will be ICS led, will start in 2023/24.
Personalised Care	• There will be a limited expansion of the service to support delivery of social prescribing to a locally-defined cohort, and a focus on shared decision making training. • The requirement to implement digitally enabled personalised care and support planning for care homes residents has been delayed until

2024,with 2022/23 now a preparatory year.

Primary Care Networks: Service Specifications

Primary Care Networks: Investment and Impact Fund (IIF)

- Three new IIF indicators with additional funding of £34.6m will be introduced in 2022/23 and support recovery initiatives set out in 22/23 System Planning Guidance:
  - Direct Oral Anticoagulants (DOAC) prescribing: ensuring that a greater number of patients with Atrial Fibrillation receive anticoagulation therapy where clinically appropriate
  - FIT testing for cancer referrals: to ensure that more patients with suspected lower gastrointestinal cancer will have their two week wait referral accompanied by a faecal immunochemical test result.
- Funding for these indicators amounts to £34.6m and is additional to the existing £225m funding envelope for the scheme.
- The new indicators are:
  - CVD-05: Percentage of patients on the QOF Atrial Fibrillation register and with a CHA_2DS_2-VASc score of 2 or more (1 or more for patients that are not female), who were prescribed a direct-acting oral anticoagulant (DOAC), or, where a DOAC was declined or clinically unsuitable, a Vitamin K antagonist
  - CVD-06: Number of patients who were prescribed Edoxaban, as a percentage of patients on the QOF Atrial Fibrillation register with a CHA_2DS_2-VASc score of 2 or more (1 or more for patients that are not female) and who were prescribed a direct-acting oral anticoagulant (DOAC)
  - CAN-01: Percentage of lower gastrointestinal two week wait (fast track) cancer referrals accompanied by a faecal immunochemical test result, with the result recorded either in the seven days leading up to the referral, or in the fourteen days after the referral

Core GP Contract: Vaccinations and Immunisations

There will be some minor changes in 2022/23 to the HPV, MMR and MenACWY Freshers programme:

- HPV - The key changes to the HPV vaccination programme are to reflect JCVI advice:
  - A transition from Gardasil 4 to Gardasil 9 during 2022/23. There will be no changes to the way in which practices order Gardasil and a bipartite letter has been published outlining transition and usage of both vaccines.
  - A move from a three-dose schedule to a two-dose schedule (with doses given at least six months apart), for both those aged 15 and over, and for the national HPV MSM vaccination programme. This will align HPV vaccine doses across age groups, as well as aligning school, sexual health and general practice provision.
  - The change will not apply to those who are HIV positive or those who are immunocompromised. Where a three-dose schedule has been started prior to April 2022 this schedule should be adhered to and three doses given
- Measles, Mumps and Rubella (MMR) – the changes are:
  - cessation of the 10 and 1 -year-old catch-up programme.
  - practice participation in a national MMR campaign as per the current contractual requirement for practices to take part in one catch up campaign per year
- The Men ACWY Freshers programme will come to an end on 31 March 2022. This is due to all those eligible having now been offered vaccination either through general practice or school delivery.

Core GP Contract: Vaccinations and Immunisations (continued)

Childhood immunisation catch-up – all routine childhood programmes

- A wider childhood immunisation campaign will take place during 2022 to support recovery of these programmes. This will primarily be aimed at capturing children that have missed these immunisations due to the COVID-19 pandemic and the reduction in uptake over the last two years.
- Practices will be asked to support uptake of routine childhood immunisations for 0 to 5-year olds and will receive the IOS payment of £10.06 per dose

All other programmes continue unchanged

Core GP Contract: Quality and Outcomes Framework (QOF)

- There will be no new additional indicators added to QOF in 2022/23 when the temporary income protection arrangements come to an end in March 2022.
- In 2020/21 and 21/22 the QI modules were repeated in their original format – Learning disabilities and Supporting Early cancer diagnosis due to the impact of the pandemic.
- 2022/23 will see two new QI modules focusing on:
  - optimising patients' access to general practice
  - prescription drug dependency.
- As has been the case since 2019, implementation support will continue to be provided to practices undertaking QOF quality improvement projects.

Digitalisation and reduced bureaucracy

The pandemic has given us new ways to access general practice and to reflect this there will be a changes to:

- require that all appointments which don't require triage are able to be booked online as well as in person or via the telephone. This is to replace the existing contractual requirement that at least 25% of appointments are available for online booking. Guidance will be issued on what type of appointments are expected to be made available for online booking.
- clarify that of the ability for patients can register for a GP practice digitally
- remove the requirement for practices to always print and send copies of the electronic record of deceased patients to Primary Care Support England (PCSE) and require GP practices to respond to Access to Health Records Act (AHRA) requests for deceased patients. It is expected that the savings from not having to print and send the electronic record will far outweigh the additional burden of managing a small number of AHRA requests.
- There will be a continuation of funding in Global Sum (£20M) for one additional year (2022/23) to reflect workload for practices from Subject Access Requests (SARs).

Weight Management Enhanced Service

- The Weight Management Services Enhanced Service will continue in 2022/23 with GP practices receiving a referral fee of £11.50 for each referral to weight management services.
- 97% of practices signed up to the Weight Management Enhanced Service in 2021/22
- Funding will be available in 2022/23 for 1 million referrals
- The service specification will remain largely as it is for 2021/22, although it will be made clearer that:
  - practices should not automatically refer all patients on their obesity register
  - referrals should be made with the explicit agreement of the individual patient.
- The specification will also include references to further helpful materials, such as the Healthy Weight Coach training programme

Beyond Investment and Evolution

- The current five-year GP contract framework agreed by the British Medical Association's General Practitioners Committee (GPC England) concludes at the end of 2023/24. The default position is that the existing GMS contract will automatically roll forwards unless it is changed.
- NHS England and Improvement and DHSC will engage with a range of NHS organisations including the new Integrated Care Boards who will be responsible for commissioning primary care services, patient and professional representative groups.
- This will be to understand views and perspectives, including the extent to which further changes to national contractual arrangements, as opposed to additional local support and commissioning, are required to:
  - support high quality and accessible general practice services
  - support the general practice workforce, and enable primary care to work at the heart of Integrated Care Systems
- Taking account of Dr Claire Fuller's stocktake, this will include looking at how PCNs will further develop and support both practices and the wider systems in which they operate

Q&A

3 March 2022

Closing Comments

3 March 2022

Primary Care Risk Register (Public) - Shropshire, Telford and Wrekin CCG

1	2	3	4	5	6	7	8	9	10	11	12	13	14
Risk ID	**Objective**	**Opened / added by**	**Risk and description**	**Opportunity**	**Existing key controls**	**Existing sources of assurance**	**Gaps in controls or assurances**	**Risk score (consequences x likelihood)**	**Action plan / cost / action lead /(target date) /sufficient mitigation**	**Target risk score for end of financial year**	**Executive Lead and Risk Owner**	**Amendments: name and date**	**Status**
Active Risks													
STW-02		Shrop 19/01/19 T+W 18/05/19	**Workforce** There is a risk that the system fails to recruit and retain workforce clinical staff, reflecting the challenge nationally. This will impact on local GP workload and the delivery of transformational primary care in Shropshire.	1. Primary Care Transformation monies enables practices to create new creative roles 2. The Training Hub is providing a pivotal training service to primary care medical and other health professionals 3. ARRS funding is enabling additional roles to support PCN's	1. Primary care workforce funding projects are in place. 2. Delivery board and operational groups in place to support delivery in line with practice priorities. 3. Workforce and training hub are reported to system People Board to give system oversight and to ensure that primary care is looped into the workforce issues	1. PCN assurance meetings 2. PCN workforce plans aligned to priorities 3. Recruitment in line with ARRS financial envelope 4. Training hub board and group reporting to People Board fro system	1. PCN Workforce plans do not use full resource envelope.	3x3=9 Moderate	1. Promote PCNs to have staff responsible for workforce. 2. Integration of clinical staff/representation on the operational workforce groups 3. Attendance at regional workforce groups to share learning. 4. Report to people board and ensure understanding of primary care workforce issues	3x3=9 Moderate	Exec: C. Parker Owner: C Parker	26/11/2020 C. Ralph Reviewed 1 04 21 T Jones Amended C Parker June 2021 Updates by Phil Morgan 24.01.22	Open
STW-03		07/10/20 C. Ralph	**COVID-19** There is a risk that the COVID-19 pandemic will increase the demand on practices and may also increase the levels of sickness. This means that practices may not be able to maintain access to their services/or to deliver high quality clinical care. This includes ability to manage the backlog and manage staff shortages either through positive tests or self isolation	1. Pressures promote practices and the system to collaborate more effectively.	1. Changes in contractual requirements to relieve practices/support service delivery 2. Additional investment	1. information through newsletters and locality meetings, contact with partnership managers 2. refresh of weekly calls to be undertaken to get information to practice managers 3. Support for the national guidance on the return to work processes	1.Limited formal SITREP reporting 2. Demand and activity modelling needs to be done to show system pressure 3. electronic locum support service including all professions	4x4=16 High	1. Support practices to review business continuity plans 2. Support practices to link plans together/buddy practices 3. Commence work to develop SITREP 4. CCG to identify thresholds and triggers for system response 5. ensure access to IPC and public health support 6. ensure IMT under new national return to work guidelines are in place	3x3=9 Moderate	Exec: C. Parker Owner: C Parker	26/11/2020 C. Ralph Reviewed 1.04.21 T Jones Amended C Parker June 21	Open
STW 05 (Previously S-03)		PCCC 04/19	**Forecasted Expenditure** There is a risk that forecasted expenditure in relation to estates and other delegated functions will adversely affect the CCGs ability to deliver financial balance within the primary care directorate	1. To ensure the financial stability of practices by ensuring rent reviews and completed on time 2. to ensure that opportunities for pilots such as the 'Cavell' project is used to the benefit of the population in the CCG	1. Premises Cost Directions 2. Scheduled programmes of rent reviews 3. Clear approvals process for new business cases 4. Project boards with risk management and mitigation for each of the projects held at least monthly	1. Accurate record keeping 2. Regular contact/liaison with NHSE (GMAS team) 3. Project board oversight for each of the new builds	1. Changes in the primary care team at NHSE 2. Triple lock process for CCG 3. Links to One Public estate	3x4=12 High	1. Ensure the completion of a review of estates and the completion of estates strategy 2. Ensure business cases in development contain innovation to change models of care to deliver a return on investment. 3. Ensure pro-active record keeping/review of rent reviews. 4. To have clear records and monitoring systems that set out when abatements are ending predicting the impact on budgets.	3x4=12 High	Exec: C. Skidmore Owner: C Parker	1 04 21 Risk reviewed T Jones Amended C Parker June 21	Open
STW 07		PCCC 06/21 C Parker	**Covid Expansion Fund** Allocation of practice Covid expansion fund was incorrectly calculated in the national guidance and left a shortfall of 1.2m for the allocation received which was absorbed into the CCG baseline		1. Funding not utilised as part of the pulse oximetry service was put back into the baseline circa £200k		1. In ability to take any funding from primary care to ensure services are funded appropriately	3x3=9 Moderate		3x3=9 Moderate	Exec: C Parker & C Skidmore	New risk added June 2021	Open

STW 08		Tom Brettell 26/01/22, Update 25/03/22	**Highley Practice CQC Rating** Risk to delivery of continuity of care to due adverse CQC rating for Highley Medical Practice. If CQC registration is revoked this will result in termination of GMS contract therefore options need to be worked through. Patient concern likely to lead to significant number of representations and the potential for patients to seek registration elsewhere.	1. an improved / safe service for patients (if actions addressed). 2. review of contingency planning. 3, PCN pilot opportunity	1 - CCG primary care, Quality and Meds man teams supporting the practice to address the actions required to support improvement. 2 - Formal action plan agreed with practice and CQC- meeting weekly to monitor and provide assistance	1 - Action plan 2 - Regular contact with practice 3 - Weekly visits to practice 4 - Feeding back progress to CQC 5- CQC visit to review actions taken to address 2 warning notices has confirmed improvement 6- Feedback on improvement work to key partners, patients and wider community	If the CQC registration is revoked the CCG will need to consider options such as; caretaking arrangements; procurement; list dispersal. Options appraisal complete and ready for deployment.	C = 4 L = 2 TOTAL: 8 Moderate risk	1) Develop a contingency plan to ensure arrangements are in place should redistribution of practice care be required. In place	C = 4 L = 1 TOTAL: 4 Low risk	Exec: C Parker Lead: C Parker	Following detailed support work as outlined in column 6 the CQC has reviewed actions relating to the 2 warning notices served and has confirmed improvements made and areas for further action in advance of full inspection in June/ July. The inspection rating of Inadequate remains in place until the full inspection. 25/3/ 22	Open
Closed Risks													
S-02		PCCC 03/19	There is not an agreed process for the completion of practice visits. There is a risk therefore that there may be emerging issues affecting quality that the CCG is not aware of/cannot support improvement. This means that there is a potential for variation/poor quality of care or inefficient systems and processes.	1. Potential to share good practice across the system. 2. Potential to save process improvements and reduce hand-offs/inefficiencies in practices	1. Maintain and build relationships with GP practices to monitor quality standards. 2. Update quality dashboard regularly. 3. Primary Care to develop a dashboard and process for more effective monitoring of Primary Care Quality.	1. CQC reports and regular meetings with CQC. Regular liaison with NHSE/I. 2. Quality dashboard updated and presented to PCCC quarterly. 3. Regular reporting to Quality and Audit Committee on risks and achievements	1. Infrequent opportunities to review/work with practices 2. Inconsistent opportunities - levels of engagement with practices	3x3=9 Moderate	1. Maintain focus to identify triggers/early signs of issues 2. Triangulate data from multiple sources 3. Close liaison with other professionals/agencies 4. Review complaints/GPPS 5. Work to standardise practice visit approach across the emerging new CCG	3x3=9 Moderate	Exec: Z. Young Owner: S.Ellis/C. Ralph	26/11/20 Actions updated Request for this to be closed with new risk identified for Practice visits which incorporates work across STW CCG.	Closed
STW-01	T+W 4+5 Shrop	C/F Telford 24/06/19 C. Ralph	**Primary Care Networks (PCN)** These new organisations will have to establish how they will work together as a network and share resources. There is a risk of potential delay and/or conflict as the new roles and the new ways of working are established. This would mean that their is inconsistent development of PCNs across the CCG which may affect service provision and access to our patients.	1. There is a potential opportunity for PCNs to create additional competition in the market for services traditionally provided by acute/community services. 2.Opportunity to increase the resilience of practices by sharing resources and effort overtime	1. National guidance for PCN development and the associated network agreements signed by all practices 2. Clinical leadership identified by members of each PCN PCNs to follow guidance from NHSE in regards to their establishment. 3. Guidance on the delivery of DES' for 2020 released 4. 8 PCNs now exist within STW CCG - only one practice remains as an orphan practice but patients are allocated	Notes of PCN meetings/assurance meetings - PCN Development meetings re-established, PCN delivering vaccination programme through existing Enhanced services, PCN development feeding into refreshed single CCG governance. Regular formal and informal meetings in place to engage, collaborate and deliver shared working arrangements. PCN's engaged at place	None	3x3=9 Moderate	1. Take opportunities to seek out the views of practices on the PCN development processes (ongoing) 2. Establish regular meetings with CDs to enable monitoring of progress by August 2020 3. Support PCNs to complete/re-visit baseline assessments as part of the developmental programme by September 2020	1x3=3 Low	Exec: C. Parker Owner: S.Ellis/C. Ralph	Reviewed 1 4 21 Tjones Covid has impacted upon planned development work however risk remains low as new ways of working together arising form Covid opportunities Agreed CLOSE at PCCC June 2021	Closed
STW 06 Previously S-04		PCCC 12/20	Primary Care Services in Whitchurch are under increased pressures due to difficulty in recruiting staff and managing services across several unsuitable small sites. There is a risk that Churchmere Medical Group hand back their contract if the situation continues. The planned closure of Dodington Surgery at end March 2021 adds to this pressure.	To secure the future of Primary Care services in Whitchurch by building a purpose built health care facility - The Pauls Moss Development proposal..	1. GMS Contract in place. 2. Pauls Moss programme proposals in place, although currently awaiting judicial review decision. 3. CCG agreed a transformational funding package to support Churchmere Medical Group to merge with Dodington Surgery and to manage services across 3 sites.	1. Regular contact with Churchmere senior partners. 2. NHSE support with merger and ETTF monies for expansion space costs. 3. Flexible use of new ARRS roles to increase clinical capacity, 4. Judicial review against Pauls Moss development was not upheld there fore the build will now go ahead		2x1=2 Very low	1. Ensure regular contact with CMG to identify issues early. 2. Ensure close liaison with Pauls Moss Development partners to be alerted to judicial review decision and any further appeals. 3. Explore CCG options should a new contract holder be needed	2x1=2 Moderate	Exec: C. Parker Owner: C Parker	Reviewed 1 4 21 Tjones Amended C Parker June 21 Recommend for closure as further risks incorporated into financial risks	Closed

STW - 04		Jane Sullivan 04/21	**Quality Visits** Due to Covid 19 pandemic scheduled Practice Quality Visits have been paused since March 2020. Although remote monitoring has continued a Practice Quality Visit allows for further exploration of subjects and conversations between CCG and Practice to gain assurance and understanding. There is a risk that practices not receiving quality visits may be rated inadequate or RI by CQC without the support of the quality and primary care team as part of the practice visit programme due to Covid-19 outbreaks	1. Potential to share good practice across the system. 2. Potential to save process improvements and reduce hand-offs/inefficiencies in practices	1. Primary care and Quality Lead continue to meet quarterly with CQC to share intelligence. 2. Continue to monitor Practice performance using existing sources of assurance and speak to Practices individually if concerns identified.	1. CQC intelligence 2. Significant event reporting to CCG by Practices 3. Monitoring of Patient experience - PALs/Healthwatch/MP letters/ complaints shared with CCG by NHSE/GP Patient Survey/FFT/N2N 4. Quarterly Quality report submitted to Quality and Performance committee 5. EDEC	1. Missed opportunities during visits to explore specific areas with Practices in further depth. 2. Missed opportunities to share good practice and learning with CCG which discussions during a visit can generate.	3x2= 6 low	1. Proposal to establish a Task and Finish Group to re-establish Practice Quality Visits from Autumn 2021 with identified agenda and terms of reference to provide a unified approach across the CCG. 2. Data and intelligence will be reviewed prior to visit to ensure that they are individual to each Practice and target areas for assurance.	3 x 2 = 6 Low	Claire Parker Zena Young	Newly added 1 4 21 T Jones Amended C Parker June 21 Recommended for closure. A Task & Finish Group was arranged to agree visits to concerning areas. Visits have taken place with only January's planned visits postponed due to system level 4.	Closed

Audit Committee Meeting - Appendix B

RISK MANAGEMENT MATRIX

	Likelihood				
Consequence	**1 Rare**	**2 Unlikely**	**3 Possible**	**4 Likely**	**5 Almost Certain**
1 Negligible	**1 VERY LOW**	**2 VERY LOW**	**3 VERY LOW**	**4 LOW**	**5 LOW**
2 Minor	**2 VERY LOW**	**4 LOW**	**6 LOW**	**8 MODERATE**	**10 MODERATE**
3 Moderate	**3 VERY LOW**	**6 LOW**	**9 MODERATE**	**12 HIGH**	**15 HIGH**
4 Major	**4 LOW**	**8 MODERATE**	**12 HIGH**	**16 HIGH**	**20 EXTREME**
5 Catastrophic	**5 LOW**	**10 MODERATE**	**15 HIGH**	**20 EXTREME**	**25 EXTREME**

	1 – 3	Very Low risk
	4 – 6	Low risk
	8 – 10	Moderate risk
	12 – 16	High risk
	20 – 25	Extreme risk

	Consequence score (severity levels) and examples of descriptions				
Domains	**1. Negligible**	**2. Minor**	**3. Moderate**	**4.Major**	**5. Extreme**
Impact on the safety of patients, staff or public (physical/psychological harm).	**Minimal injury or illness, requiring no/minimal intervention or treatment. No time off work.**	**Minor injury or illness, requiring minor intervention.** **Requiring time off work for >3 days.** **Increase in length of hospital stay by 1-3 days.**	**Moderate injury requiring professional intervention.** **Requiring time off work.** **Increase in length of hospital stay by 4-15 days.** **RIDDOR/agency reportable incident.** **An event which impacts on a small number of patients.**	**Major injury leading to long-term incapacity/disability.** **Requiring time off work for >14 days.** **Increase in length of hospital stay by >15 days.** **Mismanagement of patient care with long-term effects.**	**Incident leading to death.** **Multiple permanent injuries or irreversible health effects.** **An event which impacts on a large number of patients.**
Quality/complaints/audit	**Peripheral element of treatment or service suboptimal.** **Informal complain/injury.**	**Overall treatment or service suboptimal.** **Formal complaint.** **Local resolution.** **Single failure to meet standards.** **Minor implications for patient safety unresolved.** **Reduced performance rating if unresolved.**	**Treatment or service has significantly reduced effectiveness.** **Formal complaint.** **Local resolution (with potential to go to independent review).** **Repeated failure to meet internal standards.** **Major patient safety implications if findings are not acted on.**	**Non compliance with national standards with significant risk to patient if unresolved.** **Multiple complaints/independent review.** **Low performance rating.** **Critical report.**	**totally unacceptable level or quality of treatment/ services.** **Gross failure of patient safety if findings not acted upon.** **Inquest/ombudsman inquiry.** **Gross failure to meet national standards.**

Human resources/organisational/ development/staffing/ competence	Short term low staffing that temporary reduces services quality (1< day).	Low staffing level that reduces the services quality.	Late delivery of key objectives/service due to lack of staff. Unsafe staffing level or competence (>1 day). Low staff morale. Poor staff attendance for mandatory/key training.	Uncertain delivery of key objective/service due to lack of staff. Unsafe staffing level or competence (>5 days). Loss of key staff. Very low staff morale. No staff attending mandatory/key training.	Non-delivery of key objectives/service due to lack to staff. On-going unsafe staffing levels or competence. Loss of several key staff. No staff attending mandatory training /key training on an on-going basis.
Statutory duty/inspections	No or minimal impact or breach or guidance/statutory duty.	Breach of statutory legislation. Reduced performance rating if unresolved.	single breach in statutory duty. Challenging external recommendation/improvement notice.	Enforcement action. Multiple breaches in statutory duty. Improvement notices. Low performance rating. Critical report.	Multiple breaches in statutory duty. Prosecution. Complete systems change required. Zero performance rating. Severity critical report.
Adverse publicity	Rumours. Potential for public concern.	Local media coverage. Short term reduction in public confidence. Elements of public expectation not being met.	Local media coverage - long-term reduction in public confidence.	National media coverage with >3 days service well below reasonable public expectation.	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions raised in the House). Total loss of public confidence.
Business objectives/projects	Insignificant cost increase/schedule slippage	<5 per cent over project budget. Schedule slippage.	5-10 per cent over project budget. Schedule slippage.	Non-compliance with national 10-25 per cent over project budget. Schedule slippage. Key objectives not met.	Incident leading >25 per cent over project budget. Schedule slippage. Key objectives not met.
Finance including claims	Small loss. Risk of claim remote.	Loss of 0.1 - 0.25 per cent of budget. Claim less than £10,000.	Loss of 0.25-0.5 per cent of budget. Claim (s) between £10,000 and £100,000.	Uncertain delivery of key objective/loss of .5 - 1.0 per cent of budget. Claim(s) between £100,000 and £1 million. Purchasers failing to pay on time.	Non-delivery of key objectives/loss of >1 per cent of budget. Failure to meet specification/slip page. Loss of contract/payment by results. Claim(s) > £1 million.
Service/business interruption/environmental impact	Loss/interruption of >1 hour. Minimal or no impact on the environment.	Loss/interruption of >8 hours. Minor impact on environment.	Loss/interruption of >1 day. Moderate impact on environment.	Loss/interruption of >1 week. Major impact on environment.	Permanent loss of service or facility. Catastrophic impact on environment.

NHS
Shropshire, Telford and Wrekin
Clinical Commissioning Group

REPORT TO: **NHS Shropshire, Telford and Wrekin CCG**

Primary Care Commissioning Committee Part 1 Meeting held on

4 May 2022

Item Number:	**Agenda Item:**
PCCC 22-05.34	Shropshire, Telford and Wrekin CCG GP Practice Unplanned Closure Process.

Executive Lead (s):	**Author(s):**
Claire Parker Director of Partnerships	Bernadette Williams – Primary Care Lead Contracting

Action Required (please select):									
A=Approval	**x**	R=Ratification		S=Assurance		D=Discussion		I=Information	

History of the Report :		
Committee	**Date**	**Purpose (A,R,S,D,I)**
PCCC	2/2/2022	A

Executive Summary :

Shropshire, Telford and Wrekin (STW) Clinical Commissioning Group (CCG) has a statutory obligation (legal duty) to ensure all STW residents are able to access primary medical care services.

When a GP practice closes at short notice, it is important that commissioners respond and act in a timely way. Such closures may be the result of actions by the Care Quality Commission (CQC), for example voluntary closure in response to an adverse inspection or cancellation of the practice's registration, or due to the sudden inability of a provider to continue providing a service for some other reason such as bankruptcy.

The risks of such circumstances are increasing as primary care medical practices become more challenged by the changing landscape of health service provision, financial pressures and more robust monitoring of service delivery standards under CQC. It is essential that the CCG can act quickly to ensure the continuity of services for the registered patient population whilst being able to fully consider the most appropriate longer-term arrangements that would need to be put in place.

As well as adhering to the NHS England Policy and Guidance Manual (PGM) a policy has been produced to support commissioners with the process to ensure the appropriate measures are put in place.

A draft caretaking policy was shared at a previous PCCC where the decision was taken that it needed to be STW specific and be simplified which this version is.

Recommendations/Actions Required:
Primary Care Commissioning Committee is asked to: • Approve the proposed guidance to support the CCG in taking the necessary timely action in response to any unplanned closures in the future.

Report Monitoring Form Implications – does this report and its recommendations have implications and impact with regard to the following:		
1.	Is there a potential/actual conflict of interest?	No
2.	Is there a financial or additional staffing resource implication? Reprovision of a GP practices services may result in increased costs to the CCG	Yes
3.	Is there a risk to financial and clinical sustainability?	No
4.	Is there a legal impact to the organisation? The need to seek legal advice at an early stage is referenced in the guidance	Yes
5.	Are there human rights, equality and diversity requirements?	No
6.	Is there a clinical engagement requirement?	No
7.	Is there a patient and public engagement requirement? The need for patient and public engagement in the event of a closure is referenced in the guidance	Yes

Strategic Priorities – does this report address the CCG's strategic priorities, please provide details:		
1.	To reduce **health inequalities** by making sure our services take a preventative approach and take account of different needs, experiences and expectations of our communities.	No
2.	To identify and improve **health outcomes** for our local population.	No
3.	To ensure the health services we commission are **high quality**, safe, sustainable and value for money.	Yes
4.	To improve **joint working** with our local partners, leading the way as we become an Integrated Care System.	No
5.	To achieve **financial balance** by working more efficiently.	No

Unplanned / Unscheduled and Unavoidable Practice Closedown Guidance

Introduction

Whilst a rare event there may be a time when a GP practice closes at short notice and the CCG is required to respond at short notice. In many cases taking preventive action in conjunction with support can avoid closures but there will be times that this may be unavoidable. Such closure may be as a result of many different things such as actions by the Care Quality Commission (CQC), partnership dissolution, or due to the sudden inability of a contractor to continue providing a service for some other reason such as bankruptcy and require immediate action.

The NHS England Primary Medical Care Policy and Guidance Manual PGM[1] should always be followed for both planned and unplanned closures. The following guidance has been written to support in instances where immediate action is required and there is not enough time to work through the usual steps in the policy book.

Immediate Actions to be taken

- The CCG will ensure the legal team is on standby in case of any queries you may have, it is possible they will have been involved before this point anyway.

- Where possible, the CCG will agree a date for closure with the current provider, even if this is still a tight turnaround, so all are aware what date is being worked to.

- The CCG will work with the current provider to understand which job roles will be entitled to TUPE.

- The CCG will send out expressions of interest (EOI) for caretaking arrangements. Where timescales are short it is defendable to approach local providers only.
    - A template is available in appendix A
    - In the covering letter put as much as information as possible regarding the contract e.g. practice details, premises details, list size, financial envelope, high level Transfer of Undertakings (Protection of Employment) (TUPE) information, contract start and end dates, reminding them that by law this will be an Alternative Provider Medical Services (APMS) contract and include the deadline for a response.

- The CCG will establish a panel (sub-set of the Primary Care Commissioning Committee) to review the responses and agree on the preferred bidder which should include a lay person, finance representative, quality, primary care and others as considered necessary

- Once received, the panel members will individually score the bidders' responses to the EOI questions (this could be an agreed sub-set of the panel)

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

- The scorers will then hold a consensus meeting to review all member's scores and agree the "consensus" score for each question.

- From the outcome of the scoring process above, the panel will agree the preferred bidder.

- Once a decision has been made in terms of the approved caretaking provider, the preferred bidder will be informed both verbally and in writing.

- Once the preferred provider has accepted, the other bidders and the current provider will be informed of the outcome in writing.

- Depending on the circumstances a formal notification of termination of the contract will need to be issued to the current provider.

- Communications will be sent to stakeholders informing them of the temporary caretaking arrangements, this includes patients, Healthwatch, local councillors, local practices. Example patient communication are shown in Appendix B, these may need to be made available in different languages depending on the demographics.

- The primary care team will work closely with the new Caretaking provider to ensure that they are in a position to commence on the start date.

- The primary care team will work with the provider to ensure CQC are notified of the change and a new registered manager is allocated, financial information is provided to NHS England and CCG teams.

- Finance teams will ensure that they are clear when payments will start to be made to the new provider and make arrangements in relation to any payments that may need to be split if the change occurs part way through a financial quarter.

- The primary care team will clarify who owns the building and whether there are any implications for rent/building management.

- The primary care team will also work with the provider to schedule one or more patient engagement events which the CCG will attend to explain the change of circumstance to patients and answer any queries.

- On go-live date a member of the primary care team will be on site to provide support.

- The above may all happen within 1-2 weeks; hence the usual Primary Care Commissioning Committee (PCCC) governance route will not have been used (although the panel will have been a sub-set of this). Therefore, a report will be taken to PCCC for retrospective approval of the steps taken and the award of the APMS caretaking contract.

Next steps

The caretaking contract allows time for the CCG to consider next steps for this contract in terms of procurement or list dispersal, therefore once the above immediate process has ended, a report will be written for PCCC providing an overview of the options available which are;

- Extension of current arrangements
- List dispersal/Allowing the contract to expire
- Procurement of services

The report will provide information in relation to the following considerations to support a decision to be made as to the future of the contract;

- Whether the contract specification addresses current local priorities?
- Surrounding practices capacity
    - Workforce/Workload/Estates
- Area deprivation
- Patient choice
    - CQC/National GP Patient survey/transport links
- Strategic fit (PCNs)
- Impact on the wider system (care homes)
- Equitability
- Forthcoming new housing developments
- Financial implications

The first stage is an “initial recommendation”, a period of stakeholder engagement will then be undertaken and a report brought back to PCCC for final decision.

Recommendation

Primary Care Commissioning Committee is asked to:

Approve the proposed guidance to support the CCG in taking the necessary timely action in response to any unplanned closures in the future.

Appendix A

Application Caretaking Arrangements

Provider (applicant) details:

Please complete the following application in the form of a brief business case, describing how the practice would manage the additional demands on capacity, access and resources.

Section 1 – Financial Entitlement

Please confirm your ability to operate the required services in line within the specified allocation also highlighting any potential issues on affordability:

Section 2 – Staff Management

Please describe your proposed arrangements for Staff Management and Leadership of those staff transferring under "TUPE":

Section 3 – Contingency Arrangements

Please describe your proposed contingency arrangements to cover for planned and unplanned increased in workload and / or staff absences and the cover available for medical emergencies:

Section 4 – Overall Service Proposal

Please describe the key features of your overall service proposal:

a) For maintaining essential, additional and enhanced services and developing services at the practice:

b) Your overall clinical approach to delivering the services:

c) How will you put in place the necessary resources to ensure you are ready to provide the services on "Service Commencement Date"

Section 5 – Convenient Service Delivery

Please describe your methods to ensure convenience for patients accessing the services including the consultation methods you will offer patients and any other aspects of your service proposal that will improve convenience for Patients

Section 6 – Primary Care Networks

Providers will be expected to commit to working with the local Primary Care Network to support the local patient population. Please provide a brief statement to this effect.

Section 7 – Quality and Outcomes Framework (QOF)

Providers will be expected to commit to the aims of QOF and aim to achieve above regional average % achievement of QOF points. Please provide a brief statement to this effect.

Section 8 – Management of Practice Premises

Please provide a brief statement confirming that you understand and will deliver what is required of an NHS premises:

Section 9 – Capacity Management

Please provide assurance, having taken into consideration other current pending or potential commitments, that you have sufficient and appropriate capability and capacity to complete the transition process and deliver the services in accordance with the requirements on "Service Commencement Date"

Section 10 – Subcontractors

Providers must provide full company names and registered address of all subcontractors that they intend to use to carry out parts of the clinical services and details of the part of the services which is being subcontracted:

Appendix B – example communication to patients

Patient poster

NHS
Shropshire, Telford and Wrekin
Clinical Commissioning Group

Important Notice for Patients

Due to unforeseen circumstances XXX Practice Partnership has been dissolved at short notice, which has led to the contract being terminated on XX XX XXX.

Shropshire, Telford and Wrekin CCG will need some time to consider the long term options for this practice and as such have selected a caretaker for this contract to ensure you can still access services in the way you have been to date. This caretaking contract has been awarded to XXX for the next xxx months.

You and your family will continue to receive your medical services from this practice. Reception arrangements are unchanged and the practice telephone number remains the same.

Please rest assured that as the CCG works through the longer term process, we are committed to engaging with patients.

If you have any queries please call the number below.

For more information

Shrewsbury Tel: 01743 277500 | Telford Tel: 01952 580300

Notice for practice/CCG website

Important Notice for Patients

Due to unforeseen circumstances XXX Practice Partnership has been dissolved at short notice, which has led to the contract being terminated on xx xx xx. Shropshire, Telford and Wrekin CCG need some time to consider the long term options for this practice and as such have selected a caretaker for this contract to ensure you can still access services in the way have been to date. This caretaking contract has been awarded to xxx for the next xx months. You and your family will continue to receive your medical services from this practice. Reception arrangements are unchanged and the practice telephone number remains the same. Please rest assured that as the CCG works through the longer term process, we are committed to engaging with patients. If you have any queries, please call xx

MJOG message to patients

"please note that due to unforeseen circumstances, a caretaking provider has been put in place for this practices. Please rest assured that you and your family will continue to receive services from this practices. Reception arrangements and the practice telephone number remain unchanged. For further details visit our practice website [INSERT WEBSITE]