Chair: Eleri de Gilbert
Enquiries to: nnccg.notts-committees@nhs.net

Nottingham and Nottinghamshire Clinical Commissioning Group

Meeting Agenda (Open Session)

Primary Care Commissioning Committee
Wednesday 19 January 2022 09.00 -09.45
Zoom Meeting

Time	Item	Presenter	Reference
09:00	**Introductory Items**		
	1. Welcome, introductions and apologies	Eleri de Gilbert	PCC/21/192
	2. Confirmation of quoracy	Eleri de Gilbert	PCC/21/193
	3. Declarations of interest for any item on the agenda	Eleri de Gilbert	PCC/21/194
	4. Management of any real or perceived conflicts of interest	Eleri de Gilbert	PCC/21/195
	5. Questions from the public	Eleri de Gilbert	PCC/21/196
	6. Minutes from the meeting held on 15 December 2021	Eleri de Gilbert	PCC/21/197
	7. Action log and matters arising from the meeting held on 15 December 2021	Eleri de Gilbert	PCC/21/198
09:05	**Covid-19 Recovery and Planning**		
	8. Covid-19 Practice Level Update: Operational Pressures Escalation Levels (OPEL) reporting	Joe Lunn	PCC/21/199
	9. Primary Care Support to Care Homes - South Notts	Fiona Callaghan	PCC/21/200
09:20	**Financial Management**		
	10. Finance report – month nine	Michael Cawley	PCC/21/201
09:30	**Risk Management**		
	11. Risk Report	Siân Gascoigne	PCC/21/202
-	**Information Items** *The following items are for information and will not be individually presented.*		
	12. Monthly contract update	Lynette Daws	PCC/21/203
	13. Winter access fund update	Joe Lunn	PCC/21/204
09:40	**Closing Items**		
	14. Any other business	Eleri de Gilbert	PCC/21/205
	15. Key messages to escalate to the Governing Body	Eleri de Gilbert	PCC/21/206
	16. Date of next meeting: 16/02/2022	Eleri de Gilbert	PCC/21/207

Confidential Motion:
The Primary Care Commissioning Committee will resolve that representatives of the press and other members of the public be excluded from the remainder of this meeting, having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest (Section 1[2] Public Bodies [Admission to Meetings] Act 1960.

Register of Declared Interests

• As required by section 14O of the NHS Act 2006 (as amended), the CCG has made arrangements to manage conflicts and potential conflicts of interest to ensure that decisions made by the CCG will be taken and seen to be taken without being unduly influenced by external or private interests.

•This document is extracted, for the purposes of this meeting, from the CCG's full Register of Declared Interests (which is publically available on the CCG's website).
This document was extracted on 13 January 2022 but has been checked against the full register prior to the meeting to ensure accuracy.

• The register is reviewed in advance of the meeting to ensure the consideration of any known interests in relation to the meeting agenda. Where necessary (for example, where there is a direct financial interest), members may be fully excluded from participating in an item and this will include them not receiving the paper(s) in advance of the meeting.

• Members and attendees are reminded that they can raise an interest at the beginning of, or during discussion of, an item if they realise that they do have a (potential) interest that hasn't already been declared.

• Expired interests (as greyed out on the register) will remain on the register for six months following the date of expiry.

Name	Current position (s) held in the CCG	Declared Interest (Name of the organisation and nature of business)	Nature of Interest	Financial Interest	Non-financial Professional Interests	Non-financial Personal Interests	Indirect Interest	Date From:	Date To:	Action taken to mitigate risk
AINSWORTH, David	Locality Director Mid-Notts	Consultancy	Ad hoc nurse consultancy to provider organisations	✓		✓		01/03/2019	Present	Involvement in commissioning work relevant to this interest will be kept under review and specific actions determined as required.
AINSWORTH, David	Locality Director Mid-Notts	Saxon Cross Surgery	Registered Patient			✓		-	Present	This interest will be kept under review and specific actions determined as required - as a general guide, the individual should be able to participate in
AINSWORTH, David	Locality Director Mid-Notts	Merco Agency (nursing agency)	Ad hoc clinical work in a variety of settings	✓				01/07/2020	Present	Involvement in commissioning work relevant to this interest will be kept under review and specific actions determined as required.
AINSWORTH, David	Locality Director Mid-Notts	Sherwood Forest Hospitals Foundation Trust	Member of the Council of Governors		✓			2020	Present	Involvement in commissioning work relevant to this interest will be kept under review and specific actions determined as required.
AINSWORTH, David	Locality Director Mid-Notts	Erewash Borough Council	Lay representative, Remuneration Committee				✓	2020	Present	This interest will be kept under review and specific actions determined as required.
BEEBE, Shaun	Non-Executive Director	University of Nottingham	Senior manager with the University of Nottingham	✓				-	Present	This interest will be kept under review and specific actions determined as required.
BURNETT, Danni	Deputy Chief Nurse	NEMS Community Benefit Services Ltd	Family member employed as Finance Accountant				✓	01/07/2018	Present	This interest will be kept under review and specific actions determined as required.
BURNETT, Danni	Deputy Chief Nurse	Academic Health Science Network	Family member employed in Project Team		✓		✓	01/07/2018	Present	This interest will be kept under review and specific actions determined as required.

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BURNETT, Danni	Deputy Chief Nurse	Castle Healthcare Practice	Registered Patient			✓		01/07/2018	Present	This interest will be kept under review and specific actions determined as required - as a general guide, the individual should be able to participate in discussions relating to this practice but be excluded from decision-making.
CALLAGHAN, Fiona	Locality Director - South Nottinghamshire	Radcliffe on Trent Health Centre	Registered Patient			✓		-	Present	This interest will be kept under review and specific actions determined as required - as a general guide, the individual should be able to participate in discussions relating to this practice but be excluded from decision-making.
CAWLEY, Michael	Operational Director of Finance	Castle Healthcare Practice	Registered Patient			✓		-	Present	This interest will be kept under review and specific actions determined as required - as a general guide, the individual should be able to participate in discussions relating to this practice but be excluded from decision-making.
DADGE, Lucy	Chief Commissioning Officer	Mid Nottinghamshire and Greater Nottingham Lift Co (public sector)	Director	✓				01/10/2017	Present	This interest will be kept under review and specific actions determined as required.
DADGE, Lucy	Chief Commissioning Officer	Pelham Homes Ltd – Housing provider subsidiary of Nottinghamshire Community Housing Association	Director	✓				01/01/2008	30/09/2021	Interest expired no action required.
DADGE, Lucy	Chief Commissioning Officer	First for Wellbeing Community Interest Company (Health and Wellbeing Company)	Director	✓				01/12/2016	01/10/2021	Interest expired no action required.
DADGE, Lucy	Chief Commissioning Officer	Valley Road Surgery	Registered Patient			✓		-	Present	This interest will be kept under review and specific actions determined as required - as a general guide, the individual should be able to participate in discussions relating to this practice but be excluded from decision-making.
DADGE, Lucy	Chief Commissioning Officer	Nottingham Schools Trust	Chair and Trustee			✓		01/11/2017	Present	This interest will be kept under review and specific actions determined as required.
DADGE, Lucy	Chief Commissioning Officer	Care Workers Union	Director (not remunerated)			✓		01/09/2021	Present	This interest will be kept under review and specific actions determined as required.
DADGE, Lucy	Chief Commissioning Officer	Cleaners Union	Director (not remunerated)			✓		01/09/2021	Present	This interest will be kept under review and specific actions determined as required.
DAWS, Lynette	Head of Primary Care	Rivergreen Medical Centre	Family members are registered patients				✓	01/04/2020	Present	This interest will be kept under review and specific actions determined as required - as a general guide, the individual should be able to participate in discussions relating to this practice but be excluded from decision-making.

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DAWS, Lynette	Head of Primary Care	Hill View and Farnsfield Surgery	Registered Patient			✓		-	Present	This interest will be kept under review and specific actions determined as required - as a general guide, the individual should be able to participate in discussions relating to this practice but be excluded from decision-making.
DE GILBERT, Eleri	Non-Executive Director	Middleton Lodge Surgery	Individual and spouse are registered patients at this practice				✓	-	Present	This interest will be kept under review and specific actions determined as required.
DE GILBERT, Eleri	Non-Executive Director	Rise Park Practice	Son, Daughter in law are registered patients				✓	18/10/2019	Present	This interest will be kept under review and specific actions determined as required - as a general guide, the individual should be able to participate in discussions relating to this practice but be excluded from decision-making.
DE GILBERT, Eleri	Non-Executive Director	Nottingham Bench	Justice of the Peace		✓			-	Present	This interest will be kept under review and specific actions determined as required.
DE GILBERT, Eleri	Non-Executive Director	Major Oak Medical Practice, Edwinstowe	Son, daughter in law and grandchildren are registered patients				✓	-	Present	This interest will be kept under review and specific actions determined as required - as a general guide, the individual should be able to participate in discussions relating to this practice but be excluded from decision-making.
GASCOIGNE, Sian	Head of Corporate Assurance	Nottingham University Hospitals NHS Trust	Husband is the Integration Manager	✓		✓		01/08/2019	Present	This interest will be kept under review and specific actions determined as required.
GASCGOIGNE, Sian	Head of Corporate Assurance	Radcliffe Health Centre Patient Participation Group	Father is a member				✓	01/01/2019	Present	This interest will be kept under review and specific actions determined as required.
GASCGOIGNE, Sian	Head of Corporate Assurance	Nottinghamshire Healthwatch	Father is a volunteer				✓	01/01/2019	Present	This interest will be kept under review and specific actions determined as required.
GASCGOIGNE, Sian	Head of Corporate Assurance	Castle Healthcare Practice	Registered Patient			✓		-	Present	This interest will be kept under review and specific actions determined as required - as a general guide, the individual should be able to participate in discussions relating to this practice but
GASKILL, Esther	Head of Quality Intelligence	Mapperley and Victoria Practice	Registered Patient			✓		-	Present	This interest will be kept under review and specific actions determined as required - as a general guide, the individual should be able to participate in discussions relating to this practice but be excluded from decision-making.

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GRIFFITHS, Helen	Associate Director of Primary Care Networks	Musters Medical Practice	Registered Patient			✓		01/04/2013	Present	This interest will be kept under review and specific actions determined as required - as a general guide, the individual should be able to participate in discussions relating to this practice but be excluded from decision-making.
GRIFFITHS, Helen	Associate Director of Primary Care Networks	Castle Healthcare Practice (Rushcliffe Practice)	Spouse is GP Partner	✓			✓	01/10/2015	Present	This interest will be kept under review and specific actions determined as required - as a general guide, the individual should be able to participate in discussions relating to this practice but be excluded from decision-making.
GRIFFITHS, Helen	Associate Director of Primary Care Networks	Embankment Primary Care Centre	Spouse is Director	✓			✓	01/10/2015	Present	To be excluded from all commissioning decisions (including procurement activities and contract management arrangements) in relation to services currently provided by this provider; and Services where it is believed that the provider could be an interested bidder.
GRIFFITHS, Helen	Associate Director of Primary Care Networks	NEMS Healthcare Ltd	Spouse is shareholder	✓			✓	01/04/2013	Present	This interest will be kept under review and specific actions determined as required.
GRIFFITHS, Helen	Associate Director of Primary Care Networks	Partners Health LLP	Spouse is a member	✓			✓	01/10/2015	Present	To be excluded from all commissioning decisions (including procurement activities and contract management arrangements) in relation to services currently provided by Partners Health LLP; and Services where it is believed that Partners Health LLP could be an interested bidder.
GRIFFITHS, Helen	Associate Director of Primary Care Networks	Principia Multi-specialty Community Provider	Spouse is a member	✓			✓	01/10/2015	Present	Participate in discussion or service redesign as clinical expert if organisation is potential provider, withdraw from voting unless otherwise agreed by the meeting chair
GRIFFITHS, Helen	Associate Director of Primary Care Networks	Nottingham Forest Football Club	Spouse is a Doctor for club	✓			✓	01/04/2013	Present	This interest will be kept under review and specific actions determined as required.
LUNN, Joe	Associate Director of Primary Care	Kirkby Community Primary Care Centre	Registered Patient			✓		-	Present	This interest will be kept under review and specific actions determined as required - as a general guide, the individual should be able to participate in discussions relating to this practice but be excluded from decision-making.
LUNN, Joe	Associate Director of Primary Care	The Surgery Lowmoor Road	Family member employed by the Practice and family members registered at the Practice			✓			Present	This interest will be kept under review and specific actions determined as required - as a general guide, the individual should be able to participate in discussions relating to this practice but be excluded from decision-making.

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SIMMONDS, Joanne	Head of Corporate Governance	Elmswood Surgery	Registered Patient			✓		-	Present	This interest will be kept under review and specific actions determined as required - as a general guide, the individual should be able to participate in discussions relating to this practice but be excluded from decision-making.
SUNDERLAND, Sue	Non-Executive Director	Joint Audit Risk Assurance Committee, Police and Crime Commissioner (JARAC) for Derbyshire / Derbyshire Constabulary	Chair		✓			01/04/2018	Present	This interest will be kept under review and specific actions determined as required.
SUNDERLAND, Sue	Non-Executive Director	NHS Bassetlaw CCG	Governing Body Lay Member		✓			16/12/2015	Present	This interest will be kept under review and specific actions determined as required.
SUNDERLAND, Sue	Non-Executive Director	Inclusion Healthcare Social Enterprise CIC (Leicester City)	Non-Executive Director		✓			16/12/2015	Present	This interest will be kept under review and specific actions determined as required.
TILLING, Michelle	Locality Director - City	No relevant interests declared	Not applicable					-	-	Not applicable
TRIMBLE, Dr Ian	Independent GP Advisor	Victoria and Mapperley Practice, Nottingham	Registered Patient			✓		01/10/2020	Present	This interest will be kept under review and specific actions determined as required - as a general guide, the individual should be able to participate in discussions relating to this practice but be excluded from decision-making.
TRIMBLE, Dr Ian	Independent GP Advisor	National Advisory Committee for Resource Allocation	Independent GP Advisor		✓			01/04/2013	Present	Participate in discussion or service redesign as clinical expert if organisation is potential provider, withdraw from voting unless otherwise agreed by the meeting chair
WRIGHT, Michael	LMC Representative, CEO	Practice Support Services Limited - Nottinghamshire	Support service as for profit subsidiary of LMC	✓				01/04/2016	Present	Withdraw from a specified activity or relevant parts of meetings during which relevant subjects are discussed and not to take part in any related vote
WRIGHT, Michael	LMC Representative, CEO	LMC Buying Groups Federation	Manager	✓				01/04/2016	Present	Withdraw from a specified activity or relevant parts of meetings during which relevant subjects are discussed and not to take part in any related vote
WRIGHT, Michael	LMC Representative, CEO	GP-S coaching and mentoring	Support service as for profit subsidiary of LMC	✓				01/04/2016	Present	Withdraw from a specified activity or relevant parts of meetings during which relevant subjects are discussed and not to take part in any related vote
WRIGHT, Michael	LMC Representative, CEO	Nottinghamshire GP Phoenix Programme	Manager		✓			01/04/2016	Present	Withdraw from a specified activity or relevant parts of meetings during which relevant subjects are discussed and not to take part in any related vote

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WRIGHT, Michael	LMC Representative, CEO	Castle Healthcare Practice	Registered Patient				✓	30/09/2016	Present	This interest will be kept under review and specific actions determined as required - as a general guide, the individual should be able to participate in discussions relating to this practice but be excluded from decision-making.
WRIGHT, Michael	LMC Representative, CEO	Notspar and Trent Valley Surgery Special Allocation Schemes (violent patient schemes)	Chair				✓	01/04/2016	Present	Withdraw from a specified activity or relevant parts of meetings during which relevant subjects are discussed and not to take part in any related vote
WRIGHT, Michael	LMC Representative, CEO	Radcliffe-on-Trent Practice	Parents are registered patients				✓	-	Present	This interest will be kept under review and specific actions determined as required - as a general guide, the individual should be able to participate in discussions relating to this practice but be excluded from decision-making.

Nottingham and Nottinghamshire Clinical Commissioning Group

Managing Conflicts of Interest at Meetings

1. A “conflict of interest” is defined as a “set of circumstances by which a reasonable person would consider that an individual’s ability to apply judgement or act, in the context of delivering commissioning, or assuring taxpayer funded health and care services is, or could be, impaired or influenced by another interest they hold”.

2. An individual does not need to exploit their position or obtain an actual benefit, financial or otherwise, for a conflict of interest to occur. In fact, a perception of wrongdoing, impaired judgement, or undue influence can be as detrimental as any of them actually occurring. It is important to manage these perceived conflicts in order to maintain public trust.

3. Conflicts of interest include:

   - Financial interests: where an individual may get direct financial benefits from the consequences of a commissioning decision.
   - Non-financial professional interests: where an individual may obtain a non-financial professional benefit from the consequences of a commissioning decision, such as increasing their reputation or status or promoting their professional career.
   - Non-financial personal interests: where an individual may benefit personally in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit.
   - Indirect interests: where an individual has a close association with an individual who has a financial interest, a non-financial professional interest or a non-financial personal interest in a commissioning decision.

   The above categories are not exhaustive and each situation must be considered on a case by case basis.

4. In advance of any meeting of the Committee, consideration will be given as to whether conflicts of interest are likely to arise in relation to any agenda item and how they should be managed. This may include steps to be taken prior to the meeting, such as ensuring that supporting papers for a particular agenda item are not sent to conflicted individuals.

5. At the beginning of each formal meeting, Committee members and co-opted advisors will be required to declare any interests that relate specifically to a particular issue under consideration. If the existence of an interest becomes apparent during a meeting, then this must be declared at the point at which it arises. Any such declaration will be formally recorded in the minutes for the meeting.

6. The Chair of the Committee (or Deputy Chair in their absence, or where the Chair of the Committee is conflicted) will determine how declared interests should be managed, which is likely to involve one the following actions:
    - Requiring the individual to withdraw from the meeting for that part of the discussion if the conflict could be seen as detrimental to the Committee's decision-making arrangements.
    - Allowing the individual to participate in the discussion, but not the decision-making process.
    - Allowing full participation in discussion and the decision-making process, as the potential conflict is not perceived to be material or detrimental to the Committee's decision-making arrangements.

Nottingham and Nottinghamshire Clinical Commissioning Group

NHS Nottingham and Nottinghamshire Clinical Commissioning Group
Primary Care Commissioning Committee (Public Session)
Unratified minutes of the meeting held on
15/12/2021 09:00-10:00
MS Teams Meeting

Members present:

Eleri de Gilbert	Non-Executive Director (Chair)
Shaun Beebe	Non-Executive Director
Helen Griffiths	Associate Director of Primary Care Networks
Lucy Dadge	Chief Commissioning Officer
Joe Lunn	Associate Director of Primary Care
Sue Sunderland	Non-Executive Director
Danielle Burnett	Deputy Chief Nurse
Michael Cawley	Operational Director of Finance
Dr Ian Trimble	Independent GP Advisor

In attendance:

Lynette Daws	Head of Primary Care
Louise Espley	Corporate Governance Officer (minute taker)
Michael Wright	Nottinghamshire Local Medical Committee
Jo Simmonds	Head of Corporate Governance (part meeting)

Apologies:

Sian Gascoigne	Head of Corporate Assurance
Esther Gaskill	Head of Quality

Cumulative Record of Members' Attendance (2021/22)					
Name	**Possible**	**Actual**	**Name**	**Possible**	**Actual**
Shaun Beebe	09	09	Joe Lunn	09	09
Michael Cawley	09	07	Dr Richard Stratton*	06	04
Lucy Dadge	09	09	Sue Sunderland	09	09
Eleri de Gilbert	09	08	Dr Ian Trimble	09	09
Helen Griffiths	09	07	Danielle Burnett	09	08

** Dr Stratton left 24/09/2021*

	Introductory Items
PCC/21/173	**Welcome and Apologies** Eleri de Gilbert welcomed everyone to the public session of the Primary Care Commissioning Committee meeting, which was being held virtually due to the COVID-19 pandemic. No apologies were received.
PCC/21/174	**Confirmation of Quoracy** The meeting was confirmed as quorate.
PCC/21/175	**Declaration of interest for any item on the shared agenda** There were no identified conflicts of interest.
PCC/21/176	**Management of any real or perceived conflicts of interest** No management action was required.
PCC/21/177	**Questions from the public** Four questions had been received related to the Springfield Medical Centre practice merger from members of the public. Committee Members received the questions ahead of the meeting. Responses will be provided at item PCC 21 182.
PCC/21/178	**Minutes from the meeting held on 17 November 2021** The minutes were agreed as an accurate record of proceedings.
PCC/21/179	**Action log and matters arising from the meeting held on 17 November 2021** Discussions are ongoing regarding a replacement for Dr Stratton. An update will be provided in January 2022. There were no matters arising.
PCC/21/180	**Actions arising from the Governing Body meeting held on 01 December 2021** The Governing Body supported the work of the Committee in developing metrics to understand PCN performance and variation.
	Commissioning, Procurement and Contract Management
PCC/21/181	**Monthly contract update** Lynette Daws presented the item and highlighted the following key points: a) The public contract update provides the latest information on contractual actions in respect of individual providers' contracts across Nottingham and Nottinghamshire. b) There were no specific actions on the contract report to highlight this month. No further points were raised in discussion. The Committee: • **RECEIVED** the public contract update.
PCC/21/182	**Springfield Medical Centre – merger update** Joe Lunn presented the item and highlighted the following key points: a) The paper provides an update on progress following the decision in August 2021

to approve the merger.

b) Dr and Mrs Mohindra hold the GMS contract at Springfield Medical Centre. They have taken the decision to add the partners of the St Albans/Nirmala to their partnership to enable them to retire and exit from the contract, in line with GMS contract regulations. The merger retains the practice under a new partnership.

c) The paper details the communication of the merger to patients and stakeholders. All Springfield Medical Centre patients have received a letter informing them of the merger and briefings shared with stakeholders. Due to the close proximity of the two practices all support services will continue to be provided in the same way as currently.

d) Meetings have taken place with staff at both practices.

e) Patient Participation Groups from both practices have been informed of the merger and posters providing further information are displayed in both practices.

f) The patient experience team has received two enquiries letters were sent to patients, both enquiries related to Dr and Mrs Mohindras' other practice in Hucknall which is not subject to this merger.

g) A follow up letter will be issued to all patients reminding them of the changes from 01 April 2021.

The following points were raised in discussion:

h) The Chair reiterated that Dr and Mrs Mohindra, under their GMS contract are able to go into partnership with the practice St Albans/Nirmala to secure the continuation of primary medical services for their practice population and allowing them to retire. Under the GMS regulations this does not require approval by the CCG or a procurement process. The CCG are therefore unable to pause this process as it is permitted within the regulations of the GMS contract and frequently occurs across general practice when partnerships change. That decision is not under review and was indeed recognised and supported at a previous meeting. The focus of today's discussion is on engagement and the cascade of information to patients and stakeholders.

i) Members were assured that engagement with patients and stakeholders had been appropriate, with lessons having been learnt from previous partnership changes in terms of engaging elected members and scrutiny committees.

j) The role of the CCG in monitoring the quality of services provided by practices was described by way of providing further assurance.

k) The four questions from members of the public were shared in full and responses provided.

l) Question from Peter Kirker – "Should the decision to merge Springfield's patients into an Operose practice be paused for further consideration, given that Operose is owned by a company notorious for seeking to maximise profit at the expense of service delivery - a potential factor in, for instance, the withdrawal of walk-in access to a Birmingham urgent treatment centre since the centre was last CQC'd; and in the CQC finding (after concerns had been raised) that staff at a Balderton practice now felt unappreciated and understaffed?" In response and as previously discussed, it was confirmed that this merger does not require the approval of the CCG as it is a decision for the Practice partners therefore the CCG has no authority to pause the merger. With respect to Balderton Primary Care Centre, the CQC carried out an unannounced inspection in March 2021 due to concerns raised about the practice, particularly in relation to staff and staff numbers. The only area identified that improvements needed to be made related to effective systems and processes to ensure good governance. Both the CCG and CQC continue to offer support to the practice to address these issues, as well as monitoring progress with recruitment and the management of staffing

rotas and to respond to media, MP and stakeholder attention. Following a series of meetings stakeholders have issued a statement in support of the changes the practice is making. The Committee is unable to respond to the issue raised about a Walk in Centre in Birmingham as it has no information or jurisdiction relating to this.

m) Question from Karen Stainer – "I am aware of much patient dissatisfaction with the Operose Practices in the Bulwell area. Has there been a review/ inspection of the practices operated by Operose? If not, could you reassure me that this will be done before Springfield patients are transferred?" In response it was confirmed that St Albans/Nirmala is the only practice run by Operose in the Bulwell area. A CQC inspection of that practice took place in August 2019 and the overall rating was good. The CQC on 09 December 2021 undertook a data review of the practice and found no evidence that any further inspection or re-assessment of the 'good' rating was required. In addition, a review of patient experience contacts over the last two years has not raised any concerns.
n) Question from Pauline Sault – "With regard to the planned transfer of patients from the Springfield practice in Bulwell to the St Albans and Nirmala practice in March 2022, how has the CCG consulted patients at both practices? Have the Patient Participation Groups (PPGs) at both practices been included in the consultation?" In response it was confirmed that the detail of patient and stakeholder engagement was presented in the report. Patient Participation Groups (PPGs) at both practices have been included in the engagement process.
o) Question from Richard Buckwell – "In view of a Judicial Review due to be heard in January/February 2022 about how Operose acquired practices in London in 2021, will the CCG review its decision to support the transfer of patients from Springfield Medical Practice to the Operose run St Albans and Nirmala practice at the end of March 2022? "In responding, the CCG was unable to confirm whether the requested judicial review will take place. If it does take place the CCG will ensure the findings and any implications for Nottingham and Nottinghamshire are considered.
p) The Chief Executive of the LMC shared his views on the absence of succession plans and options for GPs wanting to retire.
q) The CCG confirmed that all practices run by Operose are actively encouraged to engage in their Primary Care Network.

The Committee:

- **NOTED** the update.

PCC/21/183 Winter access fund update

Joe Lunn presented the item and highlighted the following points:

a) The paper provides an update to members following submission of plans to NHSE/I. Plans have received support and delivery has commenced.
b) Work is now focused on the funding flows and claiming process.
c) A further update will be provided to the Committee in January 2022 to review any further requirements associated with the Covid-19 vaccination programme.

The following was raised in discussion:

d) Members requested the detail of the different approaches adopted by the different localities to use of the winter access fund. It was confirmed this information will be shared following the meeting.

e) In respect of the funding it was confirmed that plans are predicated on finding additional staff.

f) Assurance was provided that the differentiated approach to delivery will not adversely impact on the availability of face to face appointments nor drive further inequalities in access. Delivery of appointments will be monitored in order that areas of pressure are identified if and when they arise. The different approaches reflect population health needs and infrastructure/estate issues.

g) A wider discussion followed regarding the CCG's role as strategic commissioner versus provider. It was confirmed that the winter access fund requirements for access are not a contractual requirement and as such powers of enforcement are not in place. The CQC do have powers of intervention although they have suspended visits until the end of December 2021 due to the Covid-19 situation.

h) Winter access will remain as an agenda item each month until the end of March 2022, particularly as the national position regarding Covid-19 evolves.

ACTION:

- Detail of the different approaches to use of the winter access fund across localities to be shared with Members.

The Committee:

- **NOTED** the update and will receive monthly reports on utilisation of the winter access fund.

PCC/21/184 Temporary GP contract changes to support COVID-19 Vaccination Programme

Jo Simmonds joined the meeting.

Joe Lunn presented the item highlighting the following points:

a) On 03 December 2021, NHS England & Improvement (NHSE/I) circulated a letter outlining flexibilities introduced to support GP practices to deliver the Covid-19 vaccination programme.

b) A second letter was received on 08 December 2021 providing more detail on the temporary GP contract changes to support COVID-19 vaccination programme.

c) To provide additional clarity in relation to the flexibilities and requirements of general practices across Nottingham and Nottinghamshire, a letter from Stephen Shortt, James Hopkinson and Amanda Sullivan was circulated 09 December 2021.

The following points were made in discussion:

d) Members noted the letters from NHSE/I and recognised the significance in terms of further pressure on primary care services and staff. At the same time there was concern that patients who require care are able to access it in timely way. In

response it was confirmed that the latest guidance from NHSE/I does not mean general practice can stop Quality and Outcomes Framework (QOF) activity. There is an adjustment to the work rather than a suspension of services.

e) Further correspondence has been received from NHSE/I related to services that need to remain and will be shared with members.

ACTION:

- Further NHSE/I correspondence regarding primary care to be shared with Members.

The Committee:

- **NOTED** the documents circulated and the temporary change to GP contracts to support the COVID-19 vaccination programme.

Strategy, Planning and Service Transformation

PCC/21/185 Review of Primary Care Network NHSE/I Maturity Matrix

Helen Griffiths presented the item and highlighted the following points:

a) The paper provides an update on the progress of Primary Care Network (PCN) development across the ICS in line with the NHSE/I PCN Maturity matrix. The most recent self-assessment was completed in quarter two 2021.
b) The PCN Maturity Matrix is designed to support Network leaders, working in collaboration with system partners and other local leaders within neighbourhoods to work together to understand the development journey both for individual Networks and Places over the five year journey of the PCN contract.
c) PCNs have made significant progress in their development over the last two years despite the impact of the pandemic.
d) The paper includes a summary of system wide recommendations aligned to the five core matrix domains to support PCN development.

The following points were made in discussion:

e) Members were encouraged by the progress and development of PCNs and were pleased that an outcome dashboard continues to be developed.

The Committee:

- **NOTED** the current position of the PCNs against the NHSE/I PCN Maturity matrix
- **CONSIDERED** the support that the ICS can provide to the PCNs to enhance their development and support the delivery of care at Place and across the System.

Covid-19 Recovery and Planning

PCC/21/186 Covid-19 Practice level update: Operational Pressures Escalation Levels (OPEL)

Joe Lunn presented the item and highlighted the following points:

a) General Practice continues to progress through the COVID-19 outbreak with practices across all three Localities (South Nottinghamshire, Mid

Nottinghamshire and Nottingham City) reporting their Operational Pressures Escalation Levels (OPEL) on a daily basis. This enables the CCG to understand where there are pressures in relation to service delivery across General Practice.

b) The paper provides an overview of OPEL reporting for the four weeks to 26 November 2021. Report includes the comparator data for the prior reporting period.

c) 25 of 124 practices reported days where they were at OPEL Level 3 during the four week period (177 days across those practices), 97 practices have reported OPEL Level 2 for the period and 26 practices reported they were consistently OPEL Level 1.

No further points were raised in discussion.

The Committee:

- **NOTED** the OPEL overview report for General Practice for the four weeks to 26 November 2021.

Financial Management

PCC/21/187 **Finance report – month eight**

Michael Cawley presented the item and highlighted the following points:

a) The paper reported the financial position for the month eight 2021/22 and has been prepared in the context of the revised financial regime implemented by NHSE/I in response to the COVID-19 pandemic. Under the H2 regime, the CCG is required to report on the financial year to date position (cumulative from M1 to current month), as opposed to treating the H1 and H2 separately.

b) The year to date position shows a £3.30 million underspend (2.96% of year to date budget). This is primarily due to the reserves forming part of the position (£3.18 million, which is 2.84% of the 2.96% total underspend). The reserves are designed to manage any in-year unforeseen pressures that may arise on those budgets delegated by the CCG to PCCC. For accounting purposes, the total PCCC reserves position remains reported as part of the overall PCCC position.

c) The current forecast position is £1.37m underspend against budget however, within the overall forecast position the PCN spend line shows an overspend. This is a timing related issue between spend being incurred (ARRS spend) and the receipt of top-up allocation funding.

The following points were made in discussion.

d) Further clarification was provided regarding the ARRS claims. NHSE/I guidance requires them to be reported in this way.

The Committee:

- **NOTED** the contents of the Primary Care Commissioning Finance Report.
- **APPROVED** the Primary Care Commissioning Finance Report for the period ending November 2021.

Risk Management

PCC/21/188 **Risk Report**

Jo Simmonds presented the item and highlighted the following points:

a) There are currently eight risks relating to the Committee's responsibilities, an

increase in two risks since the last meeting.

b) Risk RR 160 reflects the significant burden on the primary care workforce due to the high level of sustained pressure in general practice.

c) RR 169 and RR 171 have been added to the register since the last meeting. RR 169 reflects the potential risk that Primary Care Networks (PCNs), PCN Clinical Directors and/or GP Member Practices may become disengaged due to the increasing expectations of PCNs. RR 171 articulates the risk of loss of public confidence in local primary and secondary care health services, as a result of national and local media/reports related to access and waiting times.

No further points were made in discussion.

The Committee:

- **NOTED** the Risk Report and did not highlight any further risks for inclusion in the risk register.

Closing Items

PCC/21/189 **Any other business**

No further business was raised.

PCC/21/190 **Key messages to escalate to the Governing Body**

The Committee:

- **RECEIVED** an update on the winter access fund following NHSE/I approval of the CCGs plans. Implementation of plans will be monitored through to the end of March 2022.
- **RECEIVED** an update on the Springfield Medical Centre merger and addressed the four questions received by members of the public in relation to this item.
- **RECEIVED** an update on temporary GP contract changes to support COVID-19 Vaccination Programme.
- **RECEIVED** the outcome of the review of Primary Care Network NHSE/I Maturity Matrix. The outcome demonstrated good progress in PCN development.

PCC/21/191 **Date of next meeting**:

19/01/2022

MS Teams meeting

Nottingham and Nottinghamshire Clinical Commissioning Group

Primary Care Commissioning Committee
Action Log from the public Committee meeting held on 15 December 2021

MEETING DATE	AGENDA REFERENCE	AGENDA ITEM	ACTION	LEAD	DATE TO BE COMPLETED	COMMENT
ACTIONS OUTSTANDING						
			No actions outstanding			
ACTIONS ONGOING/NOT YET DUE						
15.09.21	PCC 21 118	Reduction in operating hours at Bull Farm	To bring an impact assessment on the reduction of opening hours at Bull Farm Surgery to the February Committee meeting	Joe Lunn	16.02.2022	Not yet due
15.09.21	PCC 21 124	Primary Care IT Strategy	To bring a progress update to the January Committee meeting to confirm that the Strategy has been shared with Bassetlaw CCG; presented to a future PPEC meeting and to provide timescales for the delivery of the Strategy	Steve Murdoch	~~19.01.2022~~ 16.02.2022	Deferred to February 2022.

MEETING DATE	AGENDA REFERENCE	AGENDA ITEM	ACTION	LEAD	DATE TO BE COMPLETED	COMMENT
15.09.21	PCC 21 110	Welcome & Apologies	To confirm Dr Stratton's replacement with the Associate Director of Governance	Lucy Branson/Jo Simmonds	~~17.11.2021~~ ~~15.12.2021~~ 19.01.2022	Discussions are underway with Clinical Leads to identify a GP representative with the capacity to join the Committee. Jo Simmonds will provide an update at that January 2022 meeting.
ACTIONS COMPLETED						
15.12.21	PCC 21 183	Winter Access Fund	Detail of the different approaches to use the winter access fund across localities to be shared with Members.	Joe Lunn	19.01.2022	Complete. On the agenda as an item for information, see PCC/21/204.
15.12.21	PCC 21 184	Temp GP contract changes to support the vaccination programme	Further NHSE/I correspondence regarding primary care to be shared with Members.	Joe Lunn	19.01.2022	Complete. National Letters C1487 and C1488 shared with members as appendices one and two.

Classification: Official
Publication approval reference: C1487

To:
- Chief executives of all NHS trusts and foundation trusts
- CCG accountable officers
- GP practices and PCNs
- Providers of community health services
- NHS111 providers
- PCN-led local vaccination sites
- Vaccinations centres
- Community pharmacy vaccination sites
- ICS and STP leads

cc.
- NHS regional directors
- NHS regional directors of commissioning
- Regional incident directors
- Regional heads of EPRR
- Chairs of ICSs and STPs
- Chairs of NHS trusts, foundation trusts and CCG governing bodies
- Local authority chief executives and directors of public health

NHS England and NHS Improvement
Skipton House
80 London Road
London
SE1 6LH

13 December 2021

Dear Colleagues,

Preparing the NHS for the potential impact of the Omicron variant and other winter pressures

Thank you for everything you and your teams have done since the COVID-19 pandemic began to treat those with the virus, including over half a million people who have needed specialist hospital care, as well as delivering the largest and fastest vaccination programme in our history. This is while maintaining urgent non-COVID-19 services and now working to recover the backlogs that have inevitably built up, providing around 90% of pre-pandemic levels of activity this year, despite continuing to care for thousands of hospital inpatients with COVID-19 over that period.

The discovery of the Omicron variant once again requires an extraordinary response from the NHS. Last night, the Prime Minister announced the new vaccination challenge which will see the NHS deliver more vaccines over the coming weeks than ever before, and will require us to prioritise activities to deliver this.

However, even with the additional protection that vaccine boosters will give, the threat from Omicron remains serious. The UK chief medical officers on 12 December increased their assessment of the COVID-19 threat level to 4, and advice from SAGE is that the number of people requiring specialist hospital and community care could be significant over the coming period.

In light of this, we are again **declaring a Level 4 National Incident**, in recognition of the impact on the NHS of both supporting the vital increase in the vaccination programme and preparing for a potentially significant increase in COVID-19 cases.

This letter therefore sets out important actions we are now asking every part of the NHS to put in place to prepare for and respond to the Omicron threat.

These will:

- Ensure the successful ramp up of the vital COVID-19 vaccine programme.
- Maximise the availability of COVID-19 treatments for patients at highest risk of severe disease and hospitalisation.
- Maximise capacity across acute and community settings, enabling the maximum number of people to be discharged safely and quickly and supporting people in their own homes.
- Support patient safety in urgent care pathways across all services and manage elective care.
- Support staff, and maximise their availability.
- Ensure surge plans and processes are ready to be implemented if needed.

1. Ensure the successful ramp-up of the vital COVID-19 vaccine programme

You will be aware of the Prime Minister's announcement yesterday outlining the latest situation with regards to the Omicron and other variants. The Prime Minister launched an urgent national appeal calling for people to get vaccinated and set out the commitment that all adults in England would be offered a booster jab by the end of the year.

In just over a year since the vaccination programme was launched, more than 100 million jabs have been given. In their December update, the UKHSA estimated that, as of 24 September, 127,500 deaths and 24,144,000 infections had been prevented as a result of the COVID-19 vaccination programme. This is a remarkable achievement, but the urgency of this new national mission requires the NHS to once again step up to support an immediate, all out drive to protect the health of the nation.

A separate letter will set out the immediate next steps for the vaccination programme, describing the ask of systems including:

- Clinically prioritising services in primary care and across the NHS to free up maximum capacity to support the COVID-19 vaccination programme over the next few weeks, alongside delivering urgent or emergency care and other priority services. As the Prime Minister said, this means some other appointments will need to be postponed.

- Delivering at scale whilst also retaining the focus on vaccination of those at greatest risk, including those who are housebound. Continuing to maximise uptake of first and second doses including through identifying dedicated resources to work alongside directors of public health locally.

- Creating capacity, both by maximising throughput, efficiency and opening times of existing sites to operate 12 hours per day as standard, seven days per week as well as running 24 hours where relevant for the local community, and through opening additional pop-up and new sites.

- Increasing training capacity with immediate effect to support lead employers with rapid onboarding and deployment of new vaccinators.

The letter also describes support available including a removal of the current cap on spend against the budget for programme costs, additional vaccine supply and significant expansion of volunteering and recruitment activity.

The NHS has been clear that staff should get the life-saving COVID-19 vaccination – and that is even more important now – to protect themselves their loved ones and their patients, and the overwhelming majority have already done so.

Working with NHS organisations, we will continue to support staff who have not yet received the vaccine to take up the evergreen offer of COVID-19 vaccination. NHS England has released resources on how to help engage and communicate with staff to encourage vaccine uptake within your organisations. We also recommend that CQC regulated services review the new Planning and Preparation guidance which will help organisations prepare for when the regulations (which are subject to parliamentary passage) are introduced.

Flu can be a serious illness for some people and the flu vaccine provides vital extra protection as well as minimising transmission. NHS staff should take every opportunity to encourage patients, including pregnant women, to receive their COVID-19 and flu

vaccines if they are eligible. Healthcare colleagues are asked to make every contact count this winter with pregnant women – and those planning pregnancy – to advise them of the benefits of COVID-19 and flu vaccination.

2. Maximise the availability of COVID-19 treatments for patients at highest risk of severe disease and hospitalisation

Having discovered the efficacy of dexamethasone as a treatment for COVID-19 and begun rolling it out just hours after trial results were announced, saving thousands of lives both here and across the world, the NHS is again at the forefront of new treatments for COVID-19.

The UK was the first country in the world to approve an antiviral (monupiravir) able to be taken at home. It will be available for use by patients at highest risk in the community from 16 December alongside other treatments including monoclonal antibodies. Arrangements for deployment of these treatments was set out in a letter on 9 December alongside the UK policy for use.

Local ICS teams should finalise preparations for COVID-19 Medicine Delivery Unit service implementation, working with regions on final assurance of delivery models.

Separately, the Government also announced the PANORAMIC national study for oral antivirals treatment for at-risk patients. The study will allow medical experts to gather further data on the potential benefits of oral antivirals for the UK's predominately vaccinated population. General practices can refer patients into this study as per the GP and community pharmacy letter.

3. Maximise capacity across acute and community settings, enabling the maximum number of people to be discharged safely and quickly and supporting people in their own homes

The operational imperative is to create the maximum possible capacity within acute care settings to support patient safety in the urgent care pathway, which is currently under significant pressure as the data on ambulance response times and 12 hour waits in A&E shows, to maintain priority access for elective care, particularly P1, P2 and cancer assessment, diagnostics and treatment, and to create capacity to respond to a potential increase in COVID-19 demand.

To that end, you are asked now to work together with local authorities, and partners across your local system including hospices and care homes to release the maximum number of beds (and a minimum of at least half of current delayed discharges) through:

A) An immediate focus to support people to be home for Christmas. Throughout the period between Christmas and New Year, ensure there is support in place to discharge medically fit patients across all seven days of the week.

B) Those patients who do not need an NHS bed, because they do not meet the reasons to reside criteria, must be discharged as soon as practically possible. Working with local authorities, every system will need to put in place sufficient measures in order to reduce by half their own number of patients not meeting the reasons-to-reside criteria. This will necessitate senior system leaders across the NHS and local authorities meeting daily to ensure sufficient progress is made.

C) A significant proportion of discharge delays are within the gift of hospitals to solve. Hospitals should work to eliminate avoidable delays on pathway zero, ie straight home without the need for social care support. Where necessary, this could include using personal health budgets, which has been successfully piloted in Cornwall and Lancashire; or use of hotel beds.

D) Making full use of non-acute beds in the local health and care system. NHS England has today switched back on the full use of spare hospice capacity – both beds and community contacts, through the same national arrangement with Hospice UK that was in place earlier in the year. As well as making use of personal health budgets, hotel beds, and hospices, systems can also make use of independent sector capacity in the community using the following framework. We encourage systems to explore surging community rehabilitation capacity and securing spare capacity from care homes. To support safe discharge of COVID-19 patients, DHSC will be expanding the number of designated beds from CQC accredited providers.

E) Expanding the use of virtual wards and hospital at home models with the full confidence of knowing these models will be supported in forthcoming planning guidance with significant additional funding, to enable a major expansion over the next two years.

Systems already have access to resources within core funding, COVID-19 allocations and through the Hospital Discharge Programme to fund these measures. Where systems can show further funding is necessary in addition to existing budgets then, to facilitate this drive, NHS England will fund additional costs incurred. Commissioners and providers

should notify regional teams of the estimated additional cost and bed benefit as plans are firmed up and claim the actual cost through the existing quarterly claims process.

The NHS will need to increase its effective capacity next year and we are planning on ring-fencing significant national funding for the further development of virtual wards (including hospital at home). Therefore, where steps taken now on virtual wards can have an enduring benefit to overall capacity and have recurrent costs those should be notified at the same time so that we can allow for them on top of core system allocations for 2022/23.

To facilitate this drive, and maintain it thereafter through winter and into next year:

- the Government has announced a further additional £300 million support for domiciliary care workforce, to boost capacity, on top of the existing £162 million workforce scheme.

- A new national discharge taskforce including the NHS, ADASS, national and local government, led by Sarah-Jane Marsh, has been established. Working to both DHSC and NHS England, it will focus on the local authority and NHS actions required to drive progress. This will dock with enhanced regional and local system arrangements that need to be put in place.

4. Support patient safety in urgent care pathways across all services, and manage elective care

Ambulance response: Systems must focus on eliminating ambulance handover delays in order to ensure vehicles and paramedic crews are available to respond to urgent 999 calls as set out in the letter of 26 October, and take action to see patients quickly and avoid 12 hour waits in emergency departments. Working with health, social care, voluntary sector partners and CQC, systems should take a balanced view of risk and safety across all parts of the health system, recognising that the greatest risk may be the patient waiting for an ambulance response.

Prioritising the recruitment of 999 and 111 call handling capacity will be crucial to ensure patients have rapid access into urgent and emergency care services when required. It is therefore important that Regions work closely with Ambulance Trusts and 111 providers to monitor progress on a weekly basis.

Community crisis response: Local systems should take immediate steps to maximise referrals from 999 to the two-hour Urgent Community Response services**.** Good progress has been made in developing and rolling out UCR services across England faster than

planned trajectories, with 27 ICSs now providing UCR services 8-8pm seven days a week.

Further expansion and join-up with other services is needed now, as part of a wider drive to reduce ambulance response times and support people in their own homes. Systems should:

- Where possible, accelerate coverage and capacity of UCR services in line with the 2 hour guidance, to make an impact in January. This includes supporting equipment purchases such as lifting chairs and point of care testing equipment.
- Maximise the number of patients being referred and transferred to UCR from ambulance services.
- Work together with local councils and providers of local pendant alarm/Technology Enabled Care (TEC) providers and reduce the demand on 999 ambulance services through the re-direction of appropriate patients.
- Refresh your local Directory of Services (DoS) so that NHS Service Finder profiles are accurate, up to date and are updated to show that UCR teams will accept referrals from health & social care colleagues including TEC providers.
- Ensure accurate and complete data to via the Community Services Data Set for UCR, so you can track how much the services are being used and helping reduce pressures.

Further information, webinar recordings and tools, such as legal advice, information governance documents and case studies, are available on the Urgent Community Response FutureNHS platform.

Mental health, learning disability and autism: The pandemic has had an impact on the nation's mental health, disrupting daily routines. In response, the NHS has extended mental health support, including introducing 24/7 all-age mental health crisis support lines earlier than planned, and continued to expand services to meet growing need in line with the Long-Term Plan.

Systems are asked to ensure that access to community-based mental health services and learning disability and autism services are retained throughout the COVID-19 surge to ensure that people at risk of escalating mental health problems and those who are most vulnerable can access treatment and care and avoid escalation to crisis point, with face-to-face care retained as far as possible.

Healthcare colleagues are asked to make every contact count this winter with people with SMI and LD – to ensure promotion of health checks and interventions as well as

access to COVID-19 and flu vaccination, in the context of stark health inequalities for these patients.

Managing critical care: Over the course of the pandemic, the NHS showed its determination and flexibility time and time again, not least in rapidly expanding critical care capacity. Indeed, the Health and Social Care Select Committee wrote in their recent report on lessons learned to date that it was 'a remarkable achievement for the NHS to expand ventilator and intensive care capacity'.

We do not know what the demand from Omicron will be on critical care facilities, but it is essential that trusts familiarise themselves with existing plans for managing a surge in patients being admitted with COVID-19, with particular focus on the management of oxygen supplies, including optimising use at ward level. This work should also include a review of how critical care capacity can be expanded and of surge arrangements in critical care networks – acknowledging these will already have been activated in some parts of the country. Further guidance on surge planning will be published based on good practice from the early phases of the pandemic.

Managing elective care: As in the COVID-19 wave last winter, it is crucial that we continue to deliver elective care and ensure that the highest clinical priority patients – including patients on cancer pathways and those with the longest waits – continue to be prioritised. Once again, clinical leadership and judgement about prioritisation and risk will be essential.

There are now 6 million patients waiting for elective care, of whom 16 thousand have been waiting over 104 weeks, as a result of the inevitable disruption caused by the COVID-19 pandemic. It is therefore even more important that diagnostic, first outpatient, elective inpatient and day case capacity should be maintained as far as possible, recognising the requirement to release staff to support the vaccination programme and respond to the potential increase in COVID-19 cases. Systems and NHS trusts should work collaboratively, particularly using the provider collaborative arrangements you have in place to prepare elective contingency plans against different COVID-19 scenarios for discussion and agreement with Regions.

A key feature of plans should be the separation of elective and non-elective capacity where possible, and the use of mutual aid between trusts and across systems and regions where necessary to maintain access to urgent elective care. You should maintain your focus on eliminating waits longer than two years, as set out in H2 planning guidance as far as possible.

Independent sector (IS): Local systems need to significantly step up use of available capacity in the independent sector to help maintain services. IS capacity should be one of the main protected 'green' pathways for treating elective patients during the final quarter of this year. Systems should take action now to agree plans with your local IS providers, building on existing H2 plans, to maximise use of local IS capacity so that as many patients can be treated as possible through the IS route. This should include, where clinically appropriate, additional pathways including cancer.

Any work will be funded consistent with original H2 planning guidance.

Primary care: The vaccination ramp up is the current priority for primary care, supported by the additional funding already announced and changes to GP contract arrangements. Continued access to general practice remains essential for those who need care and the £250 million Winter Access Fund remains available through systems to support general practice capacity more generally, including through the use of locums and support from other health professionals.

Cancer: local systems should stress test their plans to confirm that the elements that helped to sustain cancer services in previous waves are in place, and to ensure that:

- rapid access, including tests and checks for patients with suspected cancer, as well as screening services, are maintained
- provision for P1 and P2 cancer surgery is prioritised
- cancer surgical hubs have been established with cancer surgery consolidated on COVID-19-protected sites, and that centralised triage is in place across local systems to prioritise patients based on clinical need
- arrangements are in place to centralise high volume or high complexity work such as upper GI or head and neck surgery
- local systems have adapted cancer pathways in line with the advice on streamlining cancer diagnostic pathways and keeping them COVID-19-protected
- local systems are maximising the use they make of IS capacity for cancer services, where clinically appropriate
- effective communications with patients and safety netting is in place, and patients are involved in decisions around their care, including when they chose to reschedule
- anyone with concerning symptoms is encouraged to come forward, in line with our 'Help us, Help You' messages.

5. Support staff, and maximise their availability

The experience of the pandemic has shown, once more, that the NHS is nothing without its exceptional staff. NHS staff have been severely tested by the challenges of dealing with the pandemic and its of vital importance that we collectively support them over the months ahead.

Support for staff to stay well and at work: We also ask you to revisit your staff wellbeing offer to ensure it has kept pace with the changing nature of the pandemic, with a continued focus on ongoing health and wellbeing conversations taking place for staff. Health and wellbeing conversations are the best route for exploring the many drivers and root causes of sickness absence and for offering individualised support to staff where it is needed, including with work pressures, worries and relationships.

Employers should be ready to communicate any changes in testing and isolation guidance associated with Omicron as we learn more, as these may well evolve, and to offer staff options wherever possible to continue to contribute when they are unable to come into work, if they are able to do so. In addition, organisations should consider contingency options for significant staff absences to ensure essential services can be maintained.

The pandemic has had a disproportionate impact on our staff from ethnic minority communities. It is therefore vital that as we prepare for this next phase, we take action to address systemic inequality that is experienced by some of our staff including by allowing staff network leads the dedicated time they need to carry out this role effectively. We will continue to collect and publish data on the experiences of our ethnic minority colleagues via the Workforce Race Equality Standard (WRES).

Mental health and wellbeing support: We have strengthened the mental health support offer for health and social care staff to ensure they can get rapid access to assessment and evidence-based mental health services and support as required.

This includes your own occupational health services as well as the 40 local staff mental health and wellbeing hubs across the country which provide proactive outreach and clinical assessment, and access to evidence-based mental health services and support where needed.

Please continue to promote the mental health hubs and the confidential helplines that are available for all staff, and in particular the bereavement helpline (0300 303 4434, 8am-8pm) to support staff who may have been affected by the death of patients and colleagues.

Workforce planning, flexibility and training: System leaders and NHS organisations should review workforce plans for the next three months to ensure that, as per your surge plan testing, you have the appropriate workforce in place to deal with an increase in the number of COVID-19 patients and are able to support the ramp up of the COVID-19 vaccination programme. Organisations should continue to use their staff flexibly to manage the most urgent priorities, working across systems as appropriate.

Where staff require particular support or training to enable their potential redeployment, including for vaccination or to support critical care services, please use the next few weeks to provide this.

Recruitment: Trusts should seek to accelerate recruitment plans where possible, including for healthcare support workers, and where possible bringing forward the arrival of internationally recruited nurses, ensuring they are well supported as they start work in the NHS.

Volunteers: Volunteers play an important part in supporting patients, carers and staff over winter months. In particular, there are a number of high-impact volunteer roles which free up clinical time for clinical tasks, improve communication with families and assist with discharge, and support staff wellbeing. Although volunteers have been active in many NHS trusts, many more experienced volunteers are willing to help yet remain inactive. Trusts are encouraged to take advantage of the available support to restore volunteering and strengthen volunteer management in ways which can contribute significantly to reducing service pressures, including NHS Reserves.

6. Ensure surge plans and processes are ready to be implemented if needed

Incident Co-ordination: In light of the move to a Level 4 national incident, systems and NHS organisations will need to review incident coordination centre arrangements, and should ensure that these are now stood up, including to receive communication and act as the single point of contact.

Surge Plans: As we have done previously, we are asking all systems and NHS organisations to review and test their incident management and surge plans to assess their number of beds (G&A, community and critical care), supplies and staffing, learning the lessons from previous waves of COVID-19, and making preparations to have the capacity in place to meet a potentially similar challenge this winter.

Systems should ensure that preparedness includes making plans to deliver the services needed to vulnerable groups within systems as well as maintaining essential services in primary, community, mental health and learning disability and autism services.

To support regional and national planning, we will ask you to submit your identified maximum capacity, including your plans for critical care capacity, by 17 December.

These plans should detail the incident coordination arrangements, including leadership roles and responsibilities, hours of operation of the incident coordination centre, including out-of-hours contact arrangements. The plans should also detail how organisations will deal with timely information/SitRep reporting.

We will keep under review the timing and scope of the regular sitrep returns and we ask for your cooperation in continuing to make timely returns as requested.

Supplies: As a result of the work undertaken over the past 18 months, nationally held stock levels are more than adequate to respond to any additional increases in demand caused by a new variant. You should maintain normal ordering patterns and behaviours. In advance of the Christmas period, you may wish to review your local current stock levels particularly oxygen supplies, medical equipment and relevant consumables and it is key that you connect into the regional incident arrangements as and when needed.

Oxygen: In addition, through the testing of your surge plans, trusts must ensure that their oxygen delivery systems and infrastructure are able to bear at least the same level of demand when COVID-19 inpatients were at their highest point, and that any improvements or adaptations identified as necessary have been put in place.

Infection prevention and control: Staff and organisations should continue to follow the recommendations in the UK Infection Prevention and Control (IPC) guidance. According to research, IPC measures prevented 760 in-hospital COVID-19 infections each day in wave 1. Organisations must ensure that application of IPC practices is monitored using the IPC Board Assurance Framework and that resources are in place to implement and measure adherence to good IPC practice.

The past two years have arguably been the most challenging in the history of the NHS, but staff across the NHS have stepped up time and time again to do the very best for the nation – expanding and flexing services to meet the changing demands of the pandemic; introducing new treatments, new services and new pathways to respond to the needs of patients with COVID-19 and those without; pulling out all the stops to recover services that have been disrupted, whilst rolling out the largest and fastest vaccination programme in our history. The Omicron variant presents a new and significant threat, and the NHS must once again rise to the national mission to protect as many people as possible through the vaccination programme whilst also now taking steps to prepare for and respond to this threat.

Thank you for everything you have done and continue to do – as we have said before, this is a time when the NHS will benefit from pulling together again in a nationally co-ordinated effort, but please be assured that within the national framework you have our backing to do the right thing in your particular circumstances.

We look forward to speaking to you at the virtual regional events later this week and will keep in regular contact over the coming weeks and months.

Yours sincerely,

Amanda Pritchard
NHS Chief Executive

Professor Stephen Powis
Chief Executive of NHS Improvement

Classification: Official
Publication approval reference: C1488

To:
- ICS and STP leads

cc.
- CCG accountable officers
- PCN-led local vaccination sites
- Community pharmacy-led LVS
- All NHS trust and foundation trust chief executives
- NHS regional directors
- NHS regional directors of commissioning
- All directors of public health
- All local government chief executives
- All GP practices

NHS England and NHS Improvement
Skipton House
80 London Road
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13 December 2021

Dear Colleagues,

National call: Next steps for the NHS COVID-19 vaccine deployment

You will have seen the Prime Minister's address to the nation last night on the latest situation with regards to the Omicron and other variants. Yesterday, the chief medical officers also recommended that the alert level is raised from three to four.

We are writing to you now to ask you once again to support an immediate, all out drive to protect the health of the nation.

Immediate next steps for deployment

The NHS has been asked to offer every eligible adult over the age of 18 a booster vaccination by 31 December. To respond to this national mission, all systems are now asked to work with system partners, including local authorities, other public sector organisations and the voluntary and community sector, to prioritise delivery.

All NHS and local government organisations need to prepare to redeploy their administrative and clinical staff to support delivery of the vaccination programme between now and the new year. CCGs, should do all they can to offer immediate additional administrative support to all PCN and CP sites, to support the organisation and delivery of community outreach vaccination through the use of mobile and pop up clinics.

All General practice teams (not just LVS sites) are now asked to clinically prioritise your services to free up maximum capacity to support the COVID-19 vaccination programme alongside delivering urgent or emergency care and other critical services such as cancer. That could include pausing routine and non-urgent care and redeploying staff to support delivery of COVID-19 vaccinations. Further guidance will follow in an operational note and from RCGP and BMA. **All community pharmacy sites** will be supported to extend their opening hours and ensure they can deliver at their maximum capacity. Further detail will follow in an operational note. **All NHS trusts, including secondary, community and mental health providers**, will need to make alternative arrangements for prescription and sick note requests that are usually sent to primary care. As the Prime Minister said last night, this means that some other appointments will need to be postponed to the new year. If we don't do this now, the wave of Omicron could be so big that cancellations and disruptions would be even greater. We will work with you to ensure consistent messaging to the public to reflect this.

To support the rollout, the Care Quality Commission has confirmed it will postpone on-site inspections in mainstream NHS services for three weeks (ie hospitals, ambulances, GPs, 111), **except** in cases where we have reason to believe serious failings in safety pose a risk to life, or serious harm.

Prioritisation of vaccination

Scientists are very concerned about the spread of Omicron due to the speed with which it spreads and because two doses do not appear to provide much protection, threatening a new wave of infections, hospitalisations and deaths greater even than those seen in previous waves. Thankfully, a booster dramatically improves protection which is why we need to do all in our power to deliver top up jabs and reduce the impact of Omicron.

The JCVI are clear that those at greatest risk must be prioritised, including those residing and working in care homes, health and care staff, those who are housebound, and those severely immunosuppressed.

As the NHS opens bookings to all adults over 18 for a booster by Wednesday 15 December, all systems are asked to ensure that they are both able to deliver at scale and retain their focus on reaching the most vulnerable and ensuring access for all communities. Therefore, all systems are asked to ensure GP-led and community pharmacy-led teams are supported to complete care home and housebound vaccination as soon as possible, preferably by the end of week commencing 13 December as previously advised.

Now is the time to pull out all of the stops to ensure maximum uptake, including first and second doses. Every system, working with their directors of public health and local authority leads, should continue to offer mobile and pop up clinics, community engagement and to support access (eg providing community transport). To do this, all systems are now asked to identify dedicated resource (vaccine, vaccinators and any further resource) work side by side with directors of public health to reach those still yet to have a first or second dose. Funding is available to support this through ICSs, and requests will be processed speedily.

Creating capacity

The immediate priority for all sites is to stand up additional capacity to support this major acceleration. This will need to include maximising throughput and efficiency at existing sites, opening additional pods and extending opening times. Sites should request resources to enable them to operate 12 hours a day as standard, seven days a week. In every community there should be slots available at least 16 hours a day. This should extend to 24 hour operations where relevant for the local community. In earlier phases this was particularly helpful for those working shifts.

Do Not Attend rates are currently running nationally at around 10 per cent so all sites are now asked to review their DNA rates and adjust capacity uploaded to the National Booking Service accordingly. From today, the NBS will automatically cancel appointments where an individual has already received a booster dose and we will continue to encourage the public to remember to cancel if they receive a vaccine at a walk in or at their local GP-led site.

All vaccination sites, including hospital hubs, should be utilising the national protocol as the default legal mechanism to deliver the vaccine programme as it gives the greatest opportunity to utilise the unregistered workforce and create additional vaccinating capacity.

As well as creating capacity for those aged 18 years and over, all systems must ensure that eligible children are able to access vaccination. Guidance for systems on vaccination for 12-15s, including delivery of second doses, will be issued shortly.

Workforce

Lead employers will continue to co-ordinate the workforce, and will now implement a push of workforce out to systems, rather than a traditional demand-led approach. Each lead employer will have up to three military personal deployed to further support co-

ordination and delivery. A full list of lead providers and their contact details are set out here on NHS Futures, and have been provided alongside the cascade of this letter.

All NHS providers need to be prepared to redeploy staff to support the vaccination effort. All NHS providers are now asked to share their workforce availability, and a dedicated point of contact, with their lead employer.

Systems will need to release additional workforce beyond those currently working on the vaccination programme. Wider public sector organisations, including local authorities, fire and rescue and police forces are also asked to identify and release any staff members who are trained vaccinators.

NHS Professionals and St John Ambulance continue to accelerate recruitment and re-engagement. Details of the workforce will be shared with lead employers as it becomes available including offers to support housebound and care home vaccination from St John Ambulance.

All national health bodies are working at pace to share expressions of interest from their employees with lead employers. The civil service has also started a push of people to register with St John Ambulance, NHS Professionals and the Royal Voluntary Service as appropriate.

To ensure we have a safe and competent workforce, additional training capacity will be required. Systems are therefore asked to increase their training capacity with immediate effect to support lead employers with rapid onboarding and deployment.

Vaccine supply, equipment and estates

There are no supply challenges with either the Moderna or Pfizer booster stocks and vaccine supply will be pushed manually from Tuesday to enable you to increase capacity as quickly as possible.

This approach will ensure more than 8.9m doses of Pfizer and Moderna will be available across the network (3.2m already on site; 2.1m in immform; 3.6m planned (minimum additional supply). For VCs and HHs, additional vaccine supply has now been made available on immform.

For PCN and CP-led LVS, regional teams have been asked to provide details for sites that require additional deliveries on Thursday and Friday this week. All sites expecting a delivery on Tuesday can expect their volume doubled, for some sites this will arrive on

Tuesday for others an additional delivery day will be allocated later this week. Further detail will be communicated in an operational note.

For unexpected levels of demand, for example for pop up and mobile clinics, mutual aid policies can be found here. These existing policies allow movement of sufficient vaccines between end users, in quantities sufficient to meet demand and permits movement under NHS England and NHS Improvement direction; NHS regions should therefore feel empowered in the current circumstances to direct supplies to those areas where they are required.

This guidance is there to support good professional decision making to ensure that patients are vaccinated safely and effectively as well as promptly and therefore, it is for pharmacy professionals at a local level to determine what's best to do. If you require additional vaccine supply, please follow the usual processes.

Local authorities are asked to identify opportunities to use existing estate to offer vaccination centres and mobile clinics, drawing on their knowledge and understanding of their local communities. As the school term comes to an end, schools and school halls should be considered.

We recognise that smaller sites are limited by estate, especially in the colder months. Therefore, if you require temporary buildings such as Portakabins, tents, outdoor weather-protective cover to support queues or extended estate, please flag your requirements as soon as possible to your SVOC.

Finance

Recognising this sprint into the New Year will require additional support, additional funding has been requested from HMT, and this framework allows for the current cap on spend against the budget for programme costs to be removed. This means programme resources can be sourced and deployed to support delivery with immediate effect.

The support of local authorities in delivering facilities and resources has been critical to success. To ensure local authorities can continue to support, funding can be made available to support enhancement of the vaccination programme. Where costs are agreed between the local authority and ICS, local authorities should invoice the lead CCG for their ICS system and continue to report costs incurred to the Department for Levelling Up, Housing and Communities to support appropriate accounting and analysis.

Further details including details on contracting, estates and consumables, will shortly be shared with regional directors of finance and directors of finance for local authorities.

Thank you in advance for everything you are doing to continue to deliver the vaccination programme.

Yours sincerely,

Amanda Pritchard
Chief Executive Officer
NHS England and NHS Improvement

Emily Lawson
NHS Senior Responsible Officer, Vaccine Deployment

Eleanor Kelly
LA CEO Advisor

Dr Nikita Kanani
Medical Director for Primary Care
NHS England and NHS Improvement

NHS
Nottingham and Nottinghamshire
Clinical Commissioning Group

Meeting Title:	Primary Care Commissioning Committee (Open Session)	**Date:**	19 January 2022

Paper Title:	COVID – GP Practice OPEL Reporting: Five-weeks to 31 December 2021	**Paper Reference:**	**PCC 21 199**

Sponsor:	Joe Lunn, Associate Director of Primary Care	**Attachments/ Appendices:**	
Presenter:	Joe Lunn, Associate Director of Primary Care		

Purpose:	Approve	☐	Endorse	☐	Review	☐	Receive/Note for: • Assurance • Information	☒

Executive Summary

Arrangements for Discharging Delegated Functions

Delegated function 2 – *Planning the provider landscape*

Delegated function 4 – *Decisions in relation to the commissioning, procurement and management of primary medical services contracts*

General Practice continues to progress through the COVID 19 outbreak with practices, across all three Localities (South Nottinghamshire, Mid Nottinghamshire and Nottingham City), reporting their Operational Pressures Escalation Levels (OPEL) on a daily basis. This enables the CCG to understand where there are pressures in relation to service delivery across General Practice each day.

General Practices and Primary Care Networks (PCNs) continue to review business continuity plans to ensure robust arrangements are in place for individual practices or multiple practices within a PCN. Considering implications when a practice becomes less resilient including the need to work with a neighbouring practice if / when needed to ensure continued service delivery for patients.

This paper provides an overview of OPEL reporting over the five-week period to 31 December 2021.

Relevant CCG priorities/objectives:

Compliance with Statutory Duties	☐	Wider system architecture development (e.g. ICP, PCN development)	☒
Financial Management	☐	Cultural and/or Organisational Development	☐
Performance Management	☐	Procurement and/or Contract Management	☒
Strategic Planning	☐		

Conflicts of Interest:

☒ No conflict identified				
Completion of Impact Assessments:				
Equality / Quality Impact Assessment (EQIA)	Yes ☐	No ☐	N/A ☒	
Data Protection Impact Assessment (DPIA)	Yes ☐	No ☐	N/A ☒	
Risk(s):				
General Practice continues to manage the risk of service delivery on a daily basis and the impact varies across all practices. Reporting continues to enable practices, PCNs and the CCG to understand the risks for General Practice service delivery as a result of the COVID outbreak.				
Confidentiality:				
☒ No				
Recommendation(s):				
The committee is asked to • **NOTE** the OPEL Reporting overview for General Practice for the five-week period to 31 December 2021 • **NOTE** staff absence reporting for the period 29 December 2021 to 7 January 2022				

General Practice OPEL Reporting

1. Introduction

Nottingham and Nottinghamshire practices started reporting their Operational Pressures Escalation Levels (OPEL), on a daily basis in the early stages of the COVID-19 pandemic, from March 2020.

Practices submit their OPEL status by 11:00am each day.

OPEL reporting was introduced for General Practice to help triangulate the overall pressures and to feed into the wider system reporting across the NHS in Nottingham and Nottinghamshire due to the impact of COVID.

The agreed definitions for OPEL reporting are as follows:

OPEL Level 1 - GREEN
Practice is able to meet anticipated demand within its available resources. Additional support is not anticipated.

OPEL Level 2 - AMBER
Practice is showing signs of pressure. Demand is higher than expected levels or capacity is reduced.

OPEL Level 3 - RED
Practice under extreme pressure, unable to deliver all required services. Practice is only able to provide services for urgent medical needs. Practices seek additional support from neighbouring practice(s) in order to minimise disruption to services.

OPEL Level 4 - BLACK
Practice closed.

2. OPEL reporting

This paper provides an overview of OPEL reporting for Nottingham and Nottinghamshire practices.

The figures provided in (red/brackets) are what was reported the previous month *(four-weeks to 26 November 2021, 20 working days)*. This five-week period contains two bank holidays.

2.1. Practice summary

During the five-weeks to 31 December 2021 (23 working days) practices reported the following:

- 45/124 (25/124) practices reported days where they were at OPEL Level 3 – Red (having previously reported Amber or Green):
  - This was for a total of 297 (177) days across all practices
  - Equates to 36% of practices: 4 (4) practices in Mid Notts, 22 (18) practices in the City and 19 (3) practices in South Notts.

- 103/124 (97/124) practices reported days where they were at OPEL Level 2 – Amber:
  - 74 (69) practices reported this level for 10 days or more: 3 (6) practices in Mid Notts, 40 (35) practices in the City and 31 (28) practices in South Notts
  - 29 (28) practices reported this level for less than 10 days: 17 (11) practices in Mid Notts, 6 (11) practices in the City and 6 (6) practices in South Notts

- 17/124 (26/124) practices reported they were consistently OPEL Level 1 – Green:
  - 14% of practices reported OPEL Level 1 – Green for the full 23 days: 17 (21) practices in Mid Notts, 0 (0) practice in the City and 0 (5) practices in South Notts

There are currently 124 practices across Nottingham and Nottinghamshire.

- Mid Notts – 39 practices (31.5%)
- Nottingham City – 46 practices (37%)
- South Notts – 39 practices (31.5%)

3. Absence reporting

As part of planning for the impact on staffing due to the Omicron variant, General Practice were asked on 29 December 2021 to start to report additional information in relation to staff absence (GPs, Other Clinicians and Admin Teams) as part of the daily OPEL reporting, this includes:

- COVID related sickness
- Other sickness
- Other absence

Over the period 29 December 2021 to 7 January 2022 the summary below shows absence levels during this period.

Absences	29.12.21	30.12.21	31.12.21	04.01.22	05.01.22	06.01.22	07.01.22
Mid Notts	88	118	87	129	96	90	73
Nottingham City	110	184	174	118	122	105	86
South Notts	110	178	161	118	110	119	93
TOTAL	**308**	**480**	**422**	**365**	**328**	**314**	**252**

4. Recommendation

The Primary Care Commissioning Committee is asked to

- **NOTE** the OPEL Reporting overview for General Practice for the five-weeks to 31 December 2021
- **NOTE** staff absence reporting for the period 29 December 2021 to 7 January 2022

NHS
Nottingham and Nottinghamshire
Clinical Commissioning Group

Meeting Title:	Primary Care Commissioning Committee (Open Session)	**Date:**	19 January 2022

Paper Title:	South Nottinghamshire Primary Care Support to Care Homes Service	**Paper Reference:**	**PCC 21 200**

Sponsor: **Presenter:**	Joe Lunn, Associate Director of Primary Care Fiona Callaghan, South Nottinghamshire Locality Director	**Attachments/ Appendices:**	

Purpose:	Approve	☒	Endorse	☐	Review	☐	Receive/Note for: • Assurance • Information	☐

Executive Summary

In February 2021 the Primary Care Commissioning Committee (PCCC) approved the request to extend the Primary Care Support to Care Homes contract in South Nottinghamshire for 12 months to 31 March 2022.

- The aim of the contract is to facilitate the delivery of the Enhanced Health in Care Homes (EHCH) specification of the Primary Care Network (PCN) Contract Directed Enhanced Service (DES)
- Over the last year the contract has enabled PCNs and practices to work with care home residents and care homes to develop key areas of patient care
- The funding for this service is £303K per year (recurrent budget)

The proposal is that:

- The Committee approves a new direct award for the Primary Care Support to Care Homes service from 1st April 2022 to 31 March 2024 to align with the Community Transformation timeline and the recent decision of the Prioritisation and Investment Committee to extend the existing community services contracts, where enhanced care homes services are provided for other parts of the Integrated Care System.
- The new direct award for the Primary Care Support to Care Homes service will maintain appropriate provision and support for care homes, residents and parts of the wider health and care system and enables the understanding of the impact of Community Transformation.
- In addition, the South Nottinghamshire Place Based Partnership will work with the Integrated Care Board (ICB) to enable this contract to be held by the Place Based Partnership, recognising that this is unlikely to be a contract the ICB would continue to hold.

Relevant CCG priorities/objectives:

Compliance with Statutory Duties	☐	Wider system architecture development (e.g. ICP, PCN development)	☒
Financial Management	☐	Cultural and/or Organisational Development	☐
Performance Management	☐	Procurement and/or Contract Management	☒
Strategic Planning	☐		

Conflicts of Interest:				
☒ No conflict identified				
☐ Conflict noted, conflicted party can participate in discussion and decision				
☐ Conflict noted, conflicted party can participate in discussion, but not decision				
☐ Conflict noted, conflicted party can remain, but not participate in discussion or decision				
☐ Conflict noted, conflicted party to be excluded from meeting				
Completion of Impact Assessments:				
Equality / Quality Impact Assessment (EQIA)	Yes ☐	No ☒	N/A ☐	Completion of EQIA is underway and will be taken through for approval.
Data Protection Impact Assessment (DPIA)	Yes ☐	No ☐	N/A ☒	Not required for this item.

Risk(s):

The risks associated with not approving the direct award for the provision of the Primary Care Support to Care Homes service in South Notts are:

- Care in care homes is compromised resulting in poorer outcomes for residents and increased clinical risk for affected patients
- The continued implementation of the EHCH framework of the PCN DES is unachievable
- Lack of care home support may result in increased EMAS call outs, hospital admissions and system pressure within primary and secondary care, which are already experiencing severe pressure due to the pandemic
- Engagement and relationship damage across general practice, community services and care home facilities
- Increased concerns and complaints raised, possible patient safety issues and reputational risk to the CCG especially given the current high profile of the care homes sector and the impact of the pandemic
- Inequity of care home provision across the Nottingham and Nottinghamshire system

Confidentiality:

☒No

Recommendation(s):

1. **APPROVE** the direct award for the provision of the South Nottinghamshire Primary Care Support to Care Homes to the South Nottinghamshire PCNs (via GP Federations) for a 2-year period from 1st April 2022 until 31 March 2024.

South Nottinghamshire Primary Care Support to Care Homes Service

1. Background/ Context

In February 2021 the Primary Care Commissioning Committee (PCCC) approved the request to direct award the Primary Care Support to Care Homes Contract to March 2022. The historic GP Care Homes Local Enhanced Service (LES) in South Nottinghamshire ceased at the end of Q2 2020/21, and the remainder of the year's funding was redeployed into a new Primary Care Support to Care Homes contract, effective from the start of Q3 2020/21, delivered by Primary Care Networks (PCN).

The aim of the Primary Care Support to Care Homes contract is to facilitate the delivery of the Enhanced Health in Care Homes (EHCH) specification of the PCN Network Contract Directed Enhanced Service (DES). Over the last year the contract has supported PCNs and practices to work with care home residents and care homes to develop key areas of patient care:

- To support end of life conversations and the completion of Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) forms
- To provide help, documentation and training in hydration and nutrition support and to enhance and promote Care Home Multi-Disciplinary Team (MDT) meetings
- To deliver integrated care to patients living in Care Homes, utilising MDT strategies and approaches where possible, alongside an understanding of local care homes and residents
- To educate and upskill flexibly, dependent on need and areas of focus, together with involvement in the development of training packages that can be utilised across Nottingham and Nottinghamshire and in some cases nationally

Looking forward the PCNs across South Nottinghamshire aim to build upon what has been achieved over the last year whilst utilising the learning that has emerged from the experience of working with care homes and partner organisations, particularly amidst the pandemic.

A recently established South Nottinghamshire Care Homes Steering Group with representation from PCNs, Care Homes and Partners are working together across the Place Based Partnership to review support for education, training and upskilling and further building of relationships and communication. This is alongside the removal of barriers and how to factor in the continuing need to prioritise and flex support for ongoing vaccination programmes and monitoring of care home residents.

Community Services provision to support Care Homes

As outlined in previous PCCC papers, Nottinghamshire Healthcare Trust (NHT) do not provide enhanced support to South Nottinghamshire care home patients which leaves an inequity of provision across the Nottingham & Nottinghamshire system.

To address this inequity, the Primary Care Support to Care Homes contract was designed to run in parallel with the Community Services Transformation Programme, to align with the original aim of an all-inclusive comprehensive service offer from April 2022. The outcome of that work is awaited and indications from the early phases of the Community Services Transformation Programme is that the first stage of development will focus on place-based transformation, followed by a second stage covering specialist services with an expectation that new contractual arrangements will be in place from 1 April 2024.

Continuation of the Primary Care Support to Care Homes service will ensure maintenance of a local support for care homes across South Nottinghamshire. This approach would also remain consistent with the recent approval by the Prioritisation and Investment Committee, for the continuation of the existing community services contract structure and associated contract management processes, through a 2-year direct award from 1st April 2022 until 31 March 2024. This ensures the maintenance of a continued local focus on reporting, delivery of outcomes and service delivery until decisions are finalised during the Community Services Transformation process, whilst providing the time and flexibility to best support that process.

It should be noted that within the contract extensions described above are care home services delivered at a place-based partnership level across the Integrated Care System.

2. Proposal

In no change to previous arrangements, the proposal of this paper is to direct award to the PCNs (via GP Federations) for a 2-year period. This will ensure:

- Maintenance of appropriate provision in line with the reviewed timeframe for the Community Services Transformation Programme
- The understanding of the impact of Community Transformation on care home support, provide assurance and continuity and allow care home residents to receive the right care and support as they need it
- That during the contract period, the South Nottinghamshire Place Based Partnership works with the Integrated Care Board (ICB) to enable this contract to be held by the Place Based Partnership, recognising that this is unlikely to be a contract the ICB would continue to hold.

There is recurrent funding for the contract included in the CCG budget; this has been confirmed by the CCG's Deputy Chief Finance Officer. The value of which is £303K per year.

The CCG's Associate Director of Procurement & Commercial Development has advised that this service should be transacted as a new direct award from 1st April 2022. There is no extension provision within the current contract.

Not agreeing the service provision raises the following risks:

- Care in care homes is compromised resulting in poorer outcomes for residents and increased clinical risk for affected patients
- Without the Primary Care Support to Care Homes, PCNs may not be able to achieve the outcomes within the DES
- Lack of care home support may result in increased EMAS call outs, hospital admissions and system pressure within primary and secondary care, which are already experiencing severe pressure due to the pandemic
- Engagement and relationship damage across general practice, primary care, community services and care homes
- Increased concerns and complaints raised, possible patient safety issues and reputational risk to the CCG especially given the current high profile of the care homes sector and the impact of the pandemic
- Inequity of care home provision across the Nottingham and Nottinghamshire system.

3. Recommendation

The PCCC **approves** the direct award for the provision of the South Nottinghamshire Primary Care Support to Care Homes to the South Nottinghamshire PCNs (via GP Federations) for a 2-year period from 1st April 2022 until 31 March 2024.

Kelly Wallace
PCN Development Manager - South Nottinghamshire Locality
NHS Nottingham and Nottinghamshire CCG
January 2022

NHS
Nottingham and Nottinghamshire
Clinical Commissioning Group

Meeting Title:	Primary Care Commissioning Committee (Open Session)	**Date:**	19 January 2022
Paper Title:	Finance Report Month NINE	**Paper Reference:**	**PCC 21 201**
Sponsor: **Presenter:**	Michael Cawley – Operational Director of Finance	**Attachments/ Appendices:**	

Purpose:	Approve	☐	Endorse	☐	Review	☐	Receive/Note for: • Assurance • Information	☒

Executive Summary

This paper presents the financial position for Primary Care Commissioning Committee (PCCC) spend for month nine 2021/22. This report has been prepared in the context of the revised financial regime implemented by NHSEI in response to the current COVID-19 pandemic for M1-6 (H1) and the commencement of H2 (M7-12). Under the H2 regime, the CCG is required to report on the financial year to date position (cumulative from M1 to current month), as opposed to treating the H1 and H2 separately.

The year to date (M1-9) position shows a £2.57 million underspend (2.05% of year-to-date budget). This is primarily due to PCCC reserves forming part of the position (£2.64 million) offset by small overspends relating to spend associated with Additional Roles (ARRS) and the Winter Access Fund (WAF) that will be reimbursed. By way of re-cap, PCCC reserves are designed to manage any in-year unforeseen pressures that may arise on budgets delegated by the CCG to PCCC. As previously reported, PCCC reserves up to H1 (£2.64 million, 3.2%) were not required and were released back into the overall CCG position. For accounting purposes, the total PCCC reserves position remains reported as part of the overall PCCC position.

Other factors driving the variances are the reversal of prior year accruals in relation to APMS Caretakers (£0.25m) alongside favourable variances in areas such as Dispensing / Prescribing Drs and Other GP Services.

The current forecast position presents a £2.65m overspend (1.59% of total budget). It accounts for a forecast overspend spend associated with ARRS (£5.09m) and WAF (£3.20m) both of which will be funded by NHSEI. The CCG has been advised by NHSEI to present the financial information in this way as part of the national reporting process to secure the relevant funding.

The budgets that are set out in this report for H2 are as per the approved plan.

Relevant CCG priorities/objectives:			
Compliance with Statutory Duties	☐	Wider system architecture development (e.g. ICP, PCN development)	☐
Financial Management	☒	Cultural and/or Organisational Development	☐
Performance Management	☐	Procurement and/or Contract Management	☐
Strategic Planning	☐		

Conflicts of Interest:
☒ No conflict identified

Completion of Impact Assessments:				
Equality / Quality Impact Assessment (EQIA)	Yes ☐	No ☐	N/A ☒	Not required for this item.
Data Protection Impact Assessment (DPIA)	Yes ☐	No ☐	N/A ☒	Not required for this item.

Risk(s):
Risks detailed within the paper.

Confidentiality:
☒No

Recommendation(s):
1. NOTE the contents of the Primary Care Commissioning Finance Report.
2. APPROVE the Primary Care Commissioning Finance Report for the period ending December 2021.

Primary Care Co-Commissioning – Finance Report – DECEMBER 2021

NHS Nottingham & Nottinghamshire CCG

Introduction

This Primary Care Commissioning Committee (PCCC) finance report is written in the context of the revised financial regime implemented by NHSEI in response to the current COVID-19 pandemic.

This paper sets out the month nine reported delegated primary care financial position.

For 2021/22, the temporary financial regime from 2020/21 has continued. For planning purposes, the financial year had been split into two halves (H1 and H2) with each half having a non-recurrent allocation given to the CCG by NHSEI. The overall CCG financial plan for H1 and H2 is a breakeven plan. Within each breakeven plan, an allocation and subsequent budget is included for delegated primary care.

The budgets that are set out in this report for H2 are as per the approved plan.

For financial reporting purposes, under the H2 regime, the CCG is required to report on the financial year to date position (cumulative from M1 to current month), as opposed to treating H1 and H2 separately.

Month Nine PCCC Financial Position

The position is summarised in the table below:

Month 1-9 Position

Variance - under / (over)

Co-Commissioning Category	M1-12 Plan (£m)	M1-9 Budget (£m)	M1-9 Actual (£m)	M1-9 Variance (£m)
Dispensing / Prescribing Drs	2.11	1.54	1.50	0.05
Enhanced Services	4.63	3.61	3.58	0.03
General Practice - APMS	7.73	5.82	5.33	0.50
General Practice - GMS	74.84	56.13	56.60	(0.47)
General Practice - PMS	21.85	16.39	16.32	0.07
Other GP Services	2.17	1.64	1.50	0.14
Other Premises Costs	3.26	2.46	2.68	(0.22)
Premises Cost Reimbursement	15.89	11.95	11.93	0.02
Primary Care Networks	13.71	11.84	11.98	(0.14)
QOF	13.50	10.31	10.31	0.00
Winter Access Fund	1.09	1.09	1.13	(0.04)
Reserves	6.24	2.64	0.00	2.64
Grand Total	**167.00**	**125.42**	**122.86**	**2.57**

Month 9 Position

There is a year-to-date underspend position of £2.57 million comprising:

- Reserves - £2.64m – The PCCC reserve held at month nine comprises of six months reserves released into the CCG position (£2.64m (H1)) that was reported previously, leaving the remainder (£3.6m in H2) of the reserves currently phased into month twelve.

- General Practice – APMS - £0.50m – £0.25m of this position is in relation to the release of prior year end accruals, whilst the remaining £0.25m relates to the commencement of the new APMS contracts and the cessation of caretaking agreements that were previously in place at a rate higher than Global Sum rates

- Dispensing / Prescribing Drs - £0.05m – The spend in this area generally follows a profile like that of Prescribing although the budget is phased evenly across the period.

- Other GP Services - £0.14m – This underspend is mainly relating to the reduction of Locum claims for Maternity compared to what was expected as well as a small underspend on the GP Retainer Scheme.

The above underspends are offset by the following:

- General Practice – GMS - £0.47m – There has been a caretaking contract in place that has cost an additional £0.20m (ceased on 30th September 2021) plus there have been two PMS practices who have transferred to become GMS practices.

- Other Premises Costs - £0.22m – There have been several rent reviews that have taken place and they have contained backdated values to prior years which have subsequently adversely impacted on spend.

Other Matters of Note. Within the Primary Care Networks line there is a budget of £7.562m for ARRS claims. The year-to-date position has exceeded that budget by £0.142m leading to the reported overspend. In addition, allocations have been received in relation to Winter Access Fund (WAF) (£1.085m); the current level of spend is £1.129m therefore showing a reported overspend of £0.04m. Both reported overspends are expected to be temporary as the CCG is expecting additional funding for the additional spend. However, the CCG is required by NHSEI to present and report the information in this way.

Month Nine PCCC Forecast Position

Co-Commissioning Category	M1 - 12 Plan (£m)	FOT Actual (£m)	FOT Variance (£m)
Dispensing/Prescribing Drs	2.11	1.99	0.11
Enhanced Services	4.63	4.77	(0.14)
General Practice – APMS	7.73	7.10	0.63
General Practice – GMS	74.84	75.47	(0.63)
General Practice – PMS	21.85	21.76	0.09
Other GP Services	2.17	2.49	(0.33)
Other Premises costs	3.26	3.57	(0.31)
Premises Cost Reimbursement	15.89	15.90	(0.02)
Primary Care Networks	13.71	18.80	(5.09)
QOF	13.50	13.50	0.00
Winter Access Fund	1.09	4.28	(3.20)
Reserves	6.24	0.00	6.24
Grand Total	**167.00**	**169.66**	**(2.65)**

The current forecast position presents a £2.65m overspend. It accounts for a forecast overspend associated with ARRS (£5.09m) and WAF (£3.20m) both of which will be funded by NHSEI. As already noted, the CCG has been advised by NHSEI to present the financial information in this way as part of the national reporting process to secure the relevant funding.

Primary Care Capital

The CCG has an overall CCG has a capital resource limit of £2.135 million: The capital spend lines being:

- GP premises grants £0.6 million
- GP IT £0.306 million
- Grants to support estates rationalisation £0.126 million
- Mansfield supported living (LD premises grant) £1.103 million.

Due to delays in primary care as a result of Covid pressures and also supply chain issues, it is forecast that the GP premises grants schemes, together with estates rationalisation, will not deliver against the full planned capital resource limit, circa £0.5 million

The Mansfield supported living scheme legal agreement has now been signed and NHS EI are expecting the land payment of £0.483 million to go through in January. The contractor has confirmed on site works for have been incurred by the end of March as planned for the remainder.

The GP IT expenditure had been incurred by the CCG's IT partner NHIS and the CCG is awaiting an invoice.

Primary Care Spend (Non-Delegated Budgets)

[FOR INFORMATION AND COMPLETENESS ONLY]

The financial position for other areas within the remit of Primary Care (but not the PCCC) is set out below. These budgets are considered and overseen by the CCG's Governing Body.

Month 9 Position

Variance - under / (over)

	M1- 9 Financial Position			
Primary Care Area	**M1-12 Plan (£m)**	**M1-9 Budget (£m)**	**M1-9 Actual (£m)**	**M1-9 Variance (£m)**
Primary Care Transformation (Prev GPFV)	9.23	7.03	6.76	0.27
Local Enhanced Services	10.38	7.78	7.48	0.31
Primary Care Development	1.20	0.74	(0.19)	0.93
Primary Care Covid	2.31	2.27	2.22	0.04
GP IT	1.00	0.77	0.47	0.29
Out of Hours	12.27	8.94	8.81	0.13
Meds Management Clinical	3.34	2.51	2.14	0.37
Primary Care Corporate Team	0.52	0.39	0.33	0.06
Total	**40.25**	**30.42**	**28.01**	**2.41**
Prescribing	160.64	120.39	119.59	0.80
Total	**160.64**	**120.39**	**119.59**	**0.80**
Other Primary Care Position	**200.89**	**150.81**	**147.60**	**3.21**

Within the areas of Primary Care detailed above, the main variances on both Primary Care Development and Local Enhanced Services relate to the release of prior year accruals, the underspend position within Prescribing due to the PMD data for October 2021 offset with a reduced level of Oxygen costs that are being incurred, as well as the reversal of prior year accruals released.

Recommendation

The Committee is asked to **NOTE** and **APPROVE** the contents of the Primary Care Commissioning Finance Report for the period ending December 2021.

NHS
Nottingham and Nottinghamshire
Clinical Commissioning Group

Meeting Title:	Primary Care Commissioning Committee (Open Session)	**Date:**	19 January 2022

Paper Title:	Risk Report	**Paper Reference:**	**PCC 21 202**

Sponsor:	N/A	**Attachments/ Appendices:**	Risk Register (Extract) - **Appendix A**
Presenter:	Siân Gascoigne, Head of Corporate Assurance		

Summary Purpose:	Approve	☐	Endorse	☐	Review	☐	Receive/Note for: • Assurance • Information	☒

Executive Summary			
The purpose of this paper is to present the Primary Care Commissioning Committee with risks relating to the Committee's responsibilities. The paper provides assurance that primary care risks are being systematically captured across NHS Nottingham and Nottinghamshire CCG and sufficient mitigating actions are in place and being actively progressed.			
Relevant CCG priorities/objectives:			
Compliance with Statutory Duties	☒	Wider system architecture development (e.g. ICP, PCN development)	☐
Financial Management	☐	Cultural and/or Organisational Development	☐
Performance Management	☐	Procurement and/or Contract Management	☐
Strategic Planning	☒		
Conflicts of Interest:			
☒ No conflict identified			

Completion of Impact Assessments:				
Equality / Quality Impact Assessment (EQIA)	Yes ☐	No ☐	N/A ☒	None required for this paper.
Data Protection Impact Assessment (DPIA)	Yes ☐	No ☐	N/A ☒	None required for this paper.

Risk(s):
Report contains all risks from the CCG's Corporate Risk Register which fall under the remit of the Primary Care Commissioning Committee.
Confidentiality:
☒No
Recommendation(s):
1. COMMENT on the risks shown within the paper (including the high/red risk) and those at **Appendix A**; and
2. HIGHLIGHT any new risks identified during the course of the meeting for inclusion within the Corporate Risk Register.

Nottingham and Nottinghamshire Clinical Commissioning Group

Primary Care Commissioning Committee
Monthly Risk Report

1. Introduction

1.1 The purpose of this paper is to present the Primary Care Commissioning Committee with risks relating to the Committee's responsibilities. It provides assurance that primary care risks are being systematically captured across NHS Nottingham and Nottinghamshire CCG and sufficient mitigating actions are in place and being actively progressed.

2. Risk Profile

2.1 There are currently **eight** risks relating to the Committee's responsibilities (as detailed in **Appendix A**). This is the same number of risks that was presented to the previous meeting.

2.2 Since the last meeting, risks have been reviewed by the Head of Corporate Assurance, in conjunction with Associate Director of Primary Care.

2.3 The table to the right shows the risk profile of the eight risks within the Committee's remit. There are two high / **red** risks as outlined below.

Risk Matrix

Impact	1 - Rare	2 - unlikely	3 - Possible	4 - Likely	5 - Almost Certain
5 - Very High					
4 – High			2	2	
3 – Medium			3	1	
2 – Low					
1- Very low					

Likelihood

Risk Ref	Risk Narrative	Current Risk Score
RR 160 *(Jan 2021)*	Sustained levels of significant pressure on primary care workforce, due to the COVID vaccination programme, management of long-term conditions and the impact of deferrals/delays in secondary care activity, present a potential risk in relation to staff resilience, exhaustion and 'burn out'. ***Update:*** *The quality of primary care services continues to be monitored by the CCG; this includes work which has been undertaken to develop the Primary Care Support and Assurance Framework which is now routinely presented to the PCCC meetings. The LMC also continues to provide support to GP Practices as and when required. The primary care OPEL reporting has been revised; reporting level 1 (green) indicates that resource is able to be provided in support of other GP practices. PCN workforce planning and 'roving' workforce support is also in place.* *It was recognised that there continues to be a high level of sustained*	Overall Score 16: **Red** (I4 x L4)

	pressure within primary care, which is exacerbating the risk around staff exhaustion and 'burn out'. The risk score remains at 16. Further discussions are being held with the Associate Director of Primary Care and the Associate Directors of PCNs in relation to mitigations for this risk.	
RR 171 *(Oct 2021)*	There is a potential risk of loss of public confidence in local primary and secondary care health services, as a result of national and local media/reports, known quality issues, as well as growing public concerns regarding increasing waiting list times and access to General Practice. Lack of confidence may impact the extent to which citizens interface with healthcare services. This, in turn, presents a risk of increased pressure on urgent and emergency care services as services will not be accessed until a point of crisis. ***Update:*** *The CCG's Communication Team is doing a significant media focus on the COVID booster campaign, flu campaign, RSV, mental health support and how the public should access urgent care services. Particular reference is being given to the use of 111 and the urgent treatment centres. There is also continuing effort to boost the public's confidence on the use of community pharmacy services.* *Work is also ongoing to respond to ongoing media and MP enquiries. Further updates and mitigations are being sought from relevant CCG lead officers.*	Overall Score 16: **Red** (I4 x L4)

3. Risk Identification

3.1 There have been no new risks identified since the last meeting.

4. Archiving of Risks

4.1 There are no risks proposed for archiving since the last meeting.

5. Amendments to Risk Score/Narrative

5.1 There have been no amendments to risk score and/or narrative since the last meeting.

6. Recommendations

6.1 The Committee is asked to:

- **COMMENT** on the risks shown within the paper (including the high/red risk) and those at **Appendix A**; and
- **HIGHLIGHT** any new risks identified during the course of the meeting for inclusion within the Corporate Risk Register.

Siân Gascoigne

Head of Corporate Assurance

January 2022

NHS Nottingham and Nottinghamshire CCG Corporate Risk Register (January 2022)

Risk Ref	Oversight Committee	Directorate	Date Risk Identified	Risk Description	Risk Category	Executive Lead	Risk Owner	Initial Risk Rating			Existing Controls	Mitigating Actions	Current Risk Rating			Mitigating Actions Progress Update:	Last Review Date	Trend
								Impact	Likelihood	Score			Impact	Likelihood	Score			
	(Relevant committee in the CCG's governance structure responsible for monitoring risks relating to their delegated duties)		(Date risk originally identified)	(These are operational risks, which are by-products of day-to-day business delivery. They arise from definite events or circumstances and have the potential to impact negatively on the organisation and its objectives.)							(The measures in place to control risks and reduce the likelihood of them occurring).	(Actions required to manage / mitigate the identified risk. Actions should support achievement of target risk score and be SMART (e.g. Specific, Measurable, Assignable, Realistic and Time-bound).				(To provide detailed updates on progress being made against any mitigating actions identified. Actions taken should bring risk to level which can be tolerated by the organisation).		(Movement in risk score since previous month)
RR032	Primary Care Commissioning Committee	Finance and Resources	Jul-19	There is a potential risk that there may be insufficient primary care workforce to meet the needs of the CCG's population. Factors contributing to this include, but are not limited to, the following: • Uncertainty around funding and reliance, in short term, on non-recurrent external funding does not enable sustainable workforce development; • Engagement with Primary Care Networks on workforce planning, of both traditional and additional roles, is not fully informed due to the operational pressures and competing development pressures and expectations; and • The impact of COVID-19 on the workforce may result in reduced resilience that will impact on staff career decisions. The above risk may be exacerbated due to lack of capacity within Primary Care to establish, and embed, recruitment processes, as well as challenges in the supply and adaptability of staff to transition to working within Primary Care.	Commissioning	Stuart Poynor	Andrea Brown / Helen Griffiths	4	4	16	• Role and remit of the Primary Care Commissioning Committee (and supporting governance structures - e.g. primary care quality / contracting teams); • Routine Primary Care workforce updates in PCCC's committee work programme for August 2020 and January 2021; • Establishment of Primary Care Cell, as part of CCG's COVID-19 incident response; • ICS Primary Care Workforce Strategy, ICS Primary Care Board and ICS Primary Care Workforce Group; • Establishment of Primary Care Networks (PCNs) (and/or other collaboration/federation activities) and PCN workforce plans; • System Planning approach to primary care development and transformation ensuring the best use of System Transformation funding via NHSE/I and System Workforce Development/CPD funding via HEE.	Action: To ensure that routine Primary Care workforce updates are provided to PCCC. Action: To continue to deliver requirements of ICS Primary Care Workforce Strategy: to request further update regarding delivery of the Strategy to the CCG's PCCC.	4	3	12	**January 2022:** An update in relation to primary care workforce was presented to the September 2021 meeting; assurance was provided in relation to some elements, however, there continued to be questions in relation to delivery of overall Primary Care Workforce Strategy. The risk narrative and score were reviewed, but it was felt that future assurance was required regarding the primary care nursing workforce to make a final decision on the risk score. It was advised by the Associate Director of Primary Care that work has been undertaken (with support from the CCG's data analysis team) to pull together GP and nursing workforce data for the Primary Care Support and Assurance Frameworks. This should provide further assurance to the Team, and PCCC, of the risks associated with primary care workforce. The risk score will be reassessed once the Primary Care Support and Assurance Frameworks are routinely provided to PCCC. It was agreed the risk score should remain at 12. Further work is being undertaken to determine the impact of the mandated COVID vaccination for GP Practice staff. It was agreed that a separate risk should be articulated around this element.	11/01/2022	↔
RR126	Primary Care Commissioning Committee	Commissioning	May-20	There is a potential risk to the sustainability of safe and effective primary care services as a result of a number of factors. These include, but are not limited to: • challenges with GP Practice estate not meeting infection, prevention and control (IPC) requirements; • pressures on primary care services/capacity due to potential future vaccination programmes, as well as increased levels of primary care activity as a result of activity in secondary care being deferred/delayed; • 'early warning' concerns identified through the Primary Care Support and Assurance Frameworks (which includes workforce, financial, estates and quality indicators).	Commissioning	Lucy Dadge	Joe Lunn	4	4	16	• Primary Care Quality Groups; Primary Care Support and Assurance Groups (in development); • Primary Care 'Cell' within the CCG's emergency response infrastructure; • Roll-out of IT infrastructure/technology to support virtual working (e.g. telephone appointments, etc.); • Routine OPEL reporting and escalation processes; • Establishment of CMCs and ability to step up/step down if needed; • PCN 'buddying' processes in place; • 'Roving' workforce support across Practices; • Clinical vulnerable COVID risk assessment for all primary care workforce.	Action: To develop and embed the Primary Care Support and Assurance Frameworks and associated reporting.	4	3	12	**January 2022:** 'Place based' Primary Care Quality Groups continue to meet. Work has been undertaken to broaden the remit of these meetings to become Primary Care Support and Assurance Groups, which are centred around the Primary Care Support and Assurance Framework. Assurance reporting around quality concerns is being reviewed within this Group. Work has been undertaken to develop the Primary Care Support and Assurance Frameworks across the three Places. These continue to be presented quarterly to meetings of the Committee. OPEL reporting remains in place and is reported, routinely, to the PCCC (monthly) and the IMT (twice a week). Primary Care is also now considered as part of routine system OPEL meetings. PCCC reporting has been strengthened to enable trend analysis to be undertaken. Quality/insight processes are in place, working alongside GP Practices to review data and 'soft intelligence' regarding the quality of primary care services being delivered. It was also highlighted that quality staff now 'sit' within the CCG's Primary Care Team.	11/01/2022	↔
RR137	Primary Care Commissioning Committee	Commissioning	May-20	There is an increased risk of COVID-19 infection to clinically vulnerable (including BAME) primary care workforce which may impact the provision of primary care services across the CCG's population. This may particularly impact areas of Mid-Nottinghamshire and Nottingham City.	Workforce	Lucy Dadge	Joe Lunn	3	4	12	• Primary Care Quality Groups; Primary Care Support and Assurance Groups (in development) • Primary Care 'Cell' within the CCG's emergency response infrastructure; • Roll-out of IT infrastructure/technology to support virtual working (e.g. telephone appointments, etc.); • Routine OPEL reporting and escalation processes; • Establishment of CMCs and ability to step up/step down if needed; • PCN 'buddying' processes in place; • 'Roving' workforce support across Practices; • Clinical vulnerable COVID risk assessment for all primary care workforce.	Action: To develop and embed the Primary Care Support and Assurance Framework and associated assurance reporting.	3	3	9	**January 2022:** The main mitigation to this risk continues to be the digitalisation of the Primary Care service provision. The CCG has sought assurance from all GP Practices that risk assessments have been completed and any subsequent actions identified. Further actions have also been identified following a review of Primary Care Estate to determine whether it is compliant with new IPC requirements. 100% of GP Practices have responded, providing assurance that appropriate mitigations are in place for their staff. COVID vaccinations have been delivered to all front line health and social care staff; and all clinically vulnerable staff and members of the population. Booster vaccination programmes are now in place. Risk score remains at 9 in line with the current concerns regarding the Omicron variant.	11/01/2022	↔
RR138	Primary Care Commissioning Committee	Commissioning	Jun-20	The impact of COVID-19 test, track and trace on workforce may impact primary care service provision. The likelihood of this risk materialising is greater for smaller/single-handed practices.	Workforce	Lucy Dadge	Joe Lunn	3	4	12	• Primary Care 'Cell' within the CCG's emergency response infrastructure; • Roll-out of IT infrastructure/technology to support virtual working (e.g. telephone appointments, etc.); • Routine OPEL reporting and escalation processes; • Establishment of CMCs and ability to step up/step down if needed; • PCN 'buddying' processes in place; • 'Roving' workforce support across Practices; • Clinical vulnerable COVID risk assessment for all primary care workforce.	Action: To develop and embed the Primary Care Support and Assurance Framework and associated assurance reporting.	3	3	9	**January 2022:** The 'track and trace' element of the risk is no longer relevant, however, work is still ongoing with the CCG's IPC Team to develop, and work through, a toolkit for GPs that will allow them to continue to work if a family member/close contact tests positive with COVID-19. GPs will have to continue to self-isolate if they test positive and are required to follow guidelines relating to the Omicron variant. Risk is to remain at a score of 9.	11/01/2022	↔
RR160	Primary Care Commissioning Committee	Commissioning	Jan-21	Sustained levels of significant pressure on primary care workforce, due to the COVID vaccination programme, management of long term conditions and the impact of deferrals/delays in secondary care activity, present a potential risk in relation to staff resilience, exhaustion and 'burn out'.	Commissioning	Stuart Poynor / Lucy Dadge	Joe Lunn / Andrea Brown / Helen Griffiths	4	4	16	• ICS HR Directors HR Group (weekly meetings); • Locality Teams' relationships with GP Practices; • Local workforce resilience programmes; informal team meetings; • Flexible working/shift patters (eRostering); • OPEL reporting (sharing of resources); PCN workforce and well-being support; • LMC pastoral support.	Action: To seek assurance regarding the support and well-being initiatives been taken forward at PCN and locality level. Action: To receive assurance at PCCC in relation to the quality of primary care services.	4	4	16	**January 2022:** The quality of primary care services continues to be monitored by the CCG; this includes work which has been undertaken to develop the Primary Care Support and Assurance Framework which is now routinely presented to the PCCC meetings. The LMC also continues to provide support to GP Practices as and when required. The primary care OPEL reporting has been revised; reporting level 1 (green) indicates that resource is able to be provided in support of other GP practices. PCN workforce planning and 'roving' workforce support is also in place. An update was also provided at the September 2021 PCCC meeting on the development of PCN Workforce Plans. In response to discussions at Committee meetings, it was recognised that there continues to be a high level of sustained pressure within primary care, which is exacerbating the risk around staff exhaustion and 'burn out'. The risk score remains at 16. Further discussions are being held with the Associate Director of Primary Care and the Associate Directors of PCNs in relation to mitigations for this risk.	11/01/2022	↔
RR163	Primary Care Commissioning Committee	Commissioning	May-21	Due to national, and regional, funding regimes for PCNs, there is a potential risk of service failure if funds for costs associated with mandated service delivery are retrospectively received. This, in turn, presents a potential risk to the quality of primary care services received by the CCG's population.	Service Delivery	Lucy Dadge	Helen Griffiths / Mick Gawley	3	4	12	• Timely and efficient management of approval and sign off of PCN payments, where required, processed through the relevant CCG Committees and ICS Primary Care Programme Board; • Timely payment to the PCNs by CCG; • Close working with NHSE in line with requirements/ processes and eligibility, particularly on payments paid directly by NHSE to PCNs; • Open and transparent dialogue with PCNs on availability of funds/budgets and working with the PCNs to support them in accessing relevant monies available to them; • Use of the Primary Care Support and Assurance Framework to understand and provide any early insights into the financial resilience and management of PCN funds.	Action: To develop and embed the Primary Care Support and Assurance Framework and associated assurance reporting.	3	4	12	**January 2022:** This risk is being managed through close working with NHSE and ensuring their requirements/eligibility for PCN payments are promptly met. Processes are also in place to ensure the approval and 'sign off' of PCN payments through the appropriate governance structure within the CCG. Work has been completed on the development of the Primary Care Support and Assurance Framework which provides early insight into the financial resilience and management of PCN funds. These continue to be presented on a quarterly basis to the Committee.	11/01/2022	↔
RR169	Primary Care Commissioning Committee	Commissioning	Sep-21	There is a potential risk that Primary Care Networks (PCNs), PCN Clinical Directors and/or GP Member Practices may become disengaged due to the increasing expectations of PCNs, as outlined in contract changes from October 2021. This may result in resignation from the PCN DES Contract and, in turn, variation in services available to the members of the CCG's population. Further pressures may exacerbate this risk which include, but are not limited to, the required development of PCNs, the broader transformation of primary care, the delivery of the Phase 3 COVID and Flu vaccination programme, managing a surge in primary care demand and management of Long Term Conditions.	Commissioning	Lucy Dadge	Helen Griffiths	3	4	12	• Role and remit of the PCN Team and Locality Teams; ongoing relationships with GP Member Practices; • Role and remit of the LMC; • Support provided by GP Federations.	*In development with relevant CCG officers.*	3	3	9	**January 2022:** A meeting is scheduled with the Associate Director of PCNs to determine latest update and mitigations in relation to this risk.	11/01/2022	↔

Risk Ref	Oversight Committee	Directorate	Date Risk Identified	Risk Description	Risk Category	Executive Lead	Risk Owner	Initial Risk Rating			Existing Controls	Mitigating Actions	Current Risk Rating			Mitigating Actions Progress Update:	Last Review Date	Trend
	(Relevant committee in the CCG's governance structure responsible for monitoring risks relating to their delegated duties)		(Date risk originally identified)	(These are operational risks, which are by-products of day-to-day business delivery. They arise from definite events or circumstances and have the potential to impact negatively on the organisation and its objectives.)				Impact	Likelihood	Score	(The measures in place to control risks and reduce the likelihood of them occurring).	(Actions required to manage / mitigate the identified risk. Actions should support achievement of target risk score and be SMART (e.g. Specific, Measurable, Assignable, Realistic and Time-bound).	Impact	Likelihood	Score	(To provide detailed updates on progress being made against any mitigating actions identified. Actions taken should bring risk to level which can be tolerated by the organisation).		(Movement in risk score since previous month)
RR171	Quality and Performance Committee / Primary Care Commissioning Committee	Comms and Engagement	Oct-21	There is a potential risk of loss of public confidence in local primary and secondary care health services, as a result of national and local media/reports, known quality issues, as well as growing public concerns regarding increasing waiting list times and access to General Practice. Lack of confidence may impact the extent to which citizens interface with healthcare services. This, in turn, presents a risk of increased pressure on urgent and emergency care services as services will not be accessed until a point of crisis.	Reputational	Amanda Sullivan	Alex Bail / Lucy Dadge	4	5	20	• ICS Comms and Engagement Team; with routine (and ad-hoc) engagement with key stakeholders (e.g. Local Councillors, MPs, etc.); • CCG attendance at Health Overview and Scrutiny Committees; • Routine communication mechanism (e.g. GP TeamNet, Website, Social Media).	Action(s): 10 high impact actions (Urgent Care) - *To be discussed with Caroline Nolan;* Action: Implementation of the Winter Access Fund.	4	4	16	**January 2022:** This risk was approved at the November and December meetings of the O&P and PCCC Committees respectively. The CCG's Communication Team is doing a significant media focus on the COVID booster campaign, flu campaign, RSV, mental health support and how the public should access urgent care services. There is also continuing effort to boost the public's confidence on the use of community pharmacy services. Work is also ongoing to respond to ongoing media and MP enquiries. Further updates and mitigations are being sought from relevant CCG lead officers.	11/01/2022	↔

Nottingham and Nottinghamshire Clinical Commissioning Group

Meeting Title:	Primary Care Commissioning Committee (Open Session)	**Date:**	19 January 2022

Paper Title:	Nottingham and Nottinghamshire Public Contract Update	**Paper Reference:**	**PCC 21 203**

Sponsor:	Joe Lunn, Associate Director of Primary Care	**Attachments/ Appendices:**	
Presenter:	Lynette Daws, Head of Primary Care		

Purpose:	Approve	☐	Endorse	☐	Review	☐	Receive/Note for: • Assurance • Information	☒

Executive Summary

Arrangements for Discharging Delegated Functions
Delegated function 2 – *Plan the primary medical services provider landscape, including considering and making decisions in relation to agreeing variations to the boundaries of GP practices.*
Delegated function 4 – *Decisions in relation to the commissioning, procurement and management of primary medical services contracts*
Delegated function 7 – *Approving GP practice mergers and closures*
Delegated function 10 – *Decisions in relation to the management of poorly performing GP practices, including decisions and liaison with the CQC where the CQC has reported non-compliance with standards*

This public contract update provides latest information on contractual action in respect of individual providers' contracts, across Nottingham and Nottinghamshire, which have been discussed by the Primary Care Commissioning Committee (PCCC) in the previous 12 months.

Some items, due to their commercially sensitive and confidential nature, may have been previously discussed by the Primary Care Commissioning Committee in the confidential session of the meeting. These items will be included in the public contracts update as soon as they are able to be shared in public.

There are various contractual requests or changes which practices can apply to undertake including boundary changes, practice mergers, branch closures and formal list closures. This overview will be given to ensure the Committee is sighted on the progress of agreed contractual changes.

All contractual changes follow due process in line with the NHS England Primary Care Policy and Guidance Manual (PGM). The PGM provides Commissioners of GP services with the context and information to commission and manage GP contracts ensuring that all providers and patients are treated equitably.

Relevant CCG priorities/objectives:			
Compliance with Statutory Duties	☒	Wider system architecture development (e.g. ICP, PCN development)	☐
Financial Management	☒	Cultural and/or Organisational Development	☐
Performance Management	☒	Procurement and/or Contract Management	☒

Strategic Planning		☒		
Conflicts of Interest:				
☒ No conflict identified				
Completion of Impact Assessments:				
Equality / Quality Impact Assessment (EQIA)	Yes ☐	No ☐	N/A ☒	Not required for this item.
Data Protection Impact Assessment (DPIA)	Yes ☐	No ☐	N/A ☒	Not required for this item.
Risk(s):				
No risks are identified within the paper.				
Confidentiality:				
☒No				
Recommendation(s):				
1. The Committee to **RECEIVE** the Public Contract Update.				

NHS Nottingham and Nottinghamshire Clinical Commissioning Group
Primary Care Commissioning Committee Public Meeting – January 2022

Contracts Update – Public Meeting

This public contracts update provides latest information on contractual action in respect of individual providers' contracts which have been discussed by the Primary Care Commissioning Committee in the previous 12 months. Some items due to their commercially sensitive and confidential nature may have been previously discussed by the Primary Care Commissioning Committee in the confidential session of the meeting; however, this decision can now be shared in the public domain.

Updates since the last meeting are highlighted in bold. This item is for information only.

Ref.	Date reported to Committee	Description of Contractual Issue	Update	Status
1.	**January 2022**	**Balderton Primary Care Centre - Media Coverage**	**Balderton Primary Care Centre received media coverage (local and national) relating to patient concerns about access and getting through on the telephone. The provider responded with a statement highlighting the improvements being made. This includes a new telephone system to make it easier for patients to get through, which enables staff to monitor call volumes and waiting times in real time. The practice is also actively recruiting to increase team numbers.** **The Primary Care Team meets regularly with the practice in line with the APMS contract requirements and provides ongoing support.**	**In progress**
2.	December 2021	Springfield Medical Centre – merge into The Practice St Albans and Nirmala	Dr and Mrs Mohindra, partners on the Springfield Medical Centre contract, have taken the decision to retire in 2022. Having considered their options, they approached The Practice St Albans and Nirmala as their closest neighbouring practice to agree a sustainable and long-term succession plan. Following discussions, Springfield Medical Centre will merge into The Practice St Albans and Nirmala. The Primary Care Commissioning Committee supported this approach at the Confidential August 2021 meeting. A letter was sent to all registered patients at Springfield Medical Centre on 15 October 2021, advising them of the change. The Primary Care Commissioning Team has liaised with multiple support services, stakeholders and other system partners to ensure they are aware of the change and	In progress

			can offer support to their clients. Tailored communication resources have also been shared with stakeholders to help reach vulnerable patient groups. **A second patient letter will be sent to all registered patients at Springfield Medical Centre in January 2022.**	
3.	August 2021	Sherrington Park Medical Practice – List Closure	Sherrington Park Medical Practice submitted a formal list closure application; a paper was presented to the Primary Care Commissioning Committee in September 2021. PCCC supported the recommendation to defer the list closure application approval as additional supporting information was required from the practice. The outcome has been communicated to the practice and a follow up discussion has taken place.	Completed
4.	August 2021	Rise Park Surgery – boundary change	Rise Park Surgery submitted an application to extend their practice boundary. A paper was presented to the Primary Care Commissioning Committee in August 2021 and the proposal was approved. The outcome has been communicated to the practice.	Completed
5.	July 2021	Oakwood Surgery (Bull Farm Branch) – Branch Opening Hours	Oakwood Surgery expressed an interest in reducing the current operating hours at Bull Farm branch site – the proposal for change is to reduce the hours by two hours per day. The practice has reviewed attendance data at the surgery since taking on the branch site and activity levels at the beginning and end of each day has been extremely low. The patient consultation started on 5th July 2021 and the engagement event took place on 19 July 2021. A paper was presented to the Primary Care Commissioning Committee in September 2021 and the proposal was approved. A review of the impact of the change in hours is to be presented to PCCC within 6 months. The outcome has been communicated to the practice.	Completed
6.	March 2021	Queens Bower Surgery – contract termination	The GP took the decision to end the contract and a caretaking arrangement was put in place. Rise Park Surgery provided a temporary caretaking arrangement until 30 September 2021, from the Queens Bower Surgery premises. Following patient engagement an options appraisal was presented to Primary Care Commissioning Committee in July 2021, the decision was to allocate patients to practices near to their home address. A mapping process to allocate patients to their nearest practice took place. A letter to inform patients of the allocation process was	Completed

			sent (August 2021), with a follow up letter (September 2021) providing patients with their allocated new practice details. The practice closed on the 30 September 2021.	
7.	March 2021	Platform One Practice – Contract Update	The Platform One Practice contract ended on 30 June 2021. Following an external procurement process, Nottingham City GP Alliance (NCGPA) was awarded the contract to provide primary care services from Upper Parliament Street, Nottingham. The new practice is called Parliament Street Medical Centre. The new contract with NCGPA commenced 1 July 2021. The new boundary for the practice means that 7,800 patients that reside in the boundary (currently registered with Platform One Practice) transferred to the new practice. The remaining 3,000 patients that reside outside the boundary (previously registered with Platform One Practice) were allocated to a practice closest to their home address. Communications were sent to all patients, the CCG recognised that a letter is not the only or always the best method. A Stakeholder Group was established as an expert panel to support patient engagement during the mobilisation period. Meetings took place on 3 March 2021, 7 April 2021, 5 May 2021 and 7 July 2021 with a number of agreed actions for the Group to progress (the development of Key Worker Briefings, Posters and Wallet Cards, all distributed to key stakeholders). Highlight reports from the Group were provided to the Committee. Regular mobilisation meetings took place with NCGPA. Exit planning meetings took place with the incumbent provider. All patients on the allocation list were sent a letter (June 2021) containing further details regarding the transfer to their new practice; patients were automatically registered by their new practice. Parliament Street Medical Centre opened 1 July 2021, the website went live on the same day and patients have been booking appointments. The Primary Care Commissioning Team remain in regular contact with the new provider.	Completed

Nottingham and Nottinghamshire Clinical Commissioning Group

Meeting Title:	Primary Care Commissioning Committee (Open Session)	**Date:**	19 January 2022
Paper Title:	Winter Access Fund – Update	**Paper Reference:**	**PCC 21 204**
Joe Lunn, Associate Director of Primary Care	Joe Lunn, Associate Director of Primary Care Joe Lunn, Associate Director of Primary Care	**Attachments/ Appendices:**	

Purpose:	Approve	☐	Endorse	☐	Review	☐	Receive/Note for: • Assurance • Information	☒

Executive Summary

At the Open Session of the Primary Care Commissioning Committee in November and December 2021, an update was provided outlining the guidance issued and plans submitted by the CCG to meet NHS England & Improvements (NHSE/I) document "Our plan for improving access for patients and supporting general practice" with additional funding of £250m nationally to support delivery. This is now referred to as the "Winter Access Fund" (WAF).

NHSE/I have started a monthly reporting process in relation to delivery against the WAF.

The first submission detailing how our three Place Based Partnerships are implementing plans was submitted on 5 January 2022.

Relevant CCG priorities/objectives:

Compliance with Statutory Duties	☒	Wider system architecture development (e.g. ICP, PCN development)	☐
Financial Management	☒	Cultural and/or Organisational Development	☐
Performance Management	☒	Procurement and/or Contract Management	☒
Strategic Planning	☐		

Conflicts of Interest:

☒ No conflict identified

Completion of Impact Assessments:

Equality / Quality Impact Assessment (EQIA)	Yes ☐	No ☐	N/A ☒	Not required for this item.
Data Protection Impact Assessment (DPIA)	Yes ☐	No ☐	N/A ☒	Not required for this item.

Risk(s):
General Practice staffing risk due to increased support to the COVID Vaccination Programme. General p Practice staff absence due to COVID isolation requirements impacting on delivery of additional face to face appointments.
Confidentiality:
☒No
Recommendation(s):
1. **NOTE** the update in relation to the monthly reporting process for “Improving Access for Patients and Supporting General Practice” (Winter Access Fund) and the submission made to NHSE/I on 5 January 2022.

Our plan for improving access for patients and supporting general practice (Winter Access Fund)

1. Introduction

At the Open Session of the Primary Care Commissioning Committee in November and December 2021, an update was provided outlining the guidance issued and plans submitted by the CCG to meet NHS England & Improvements (NHSE/I) document "Our plan for improving access for patients and supporting general practice" with additional funding of £250m nationally to support delivery. This is now referred to as the "Winter Access Fund" (WAF).

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The first submission detailing how our three Place Based Partnerships are implementing plans was submitted on 5 January 2022.

2. Reporting Timelines and Requirements

The national Winter Access Fund assurance framework reporting process has recently been published by NHSE/I.

Reporting will be undertaken on a monthly basis and requires completion of a national reporting template to demonstrate progress:

- Qualitative commentary on progress against the WAF plans.
- Details of additional appointments provided that have been captured outside of GPAD (General Practice Appointment Data).
- Commentary if required in relation to nationally prepopulated financial details
- GPAD extracted by the national team, responses to queries raised as required
- Risks and mitigations in relation to delivery
- Areas of support/next steps

A copy of the reporting timetable is outlined below:

Reporting Period	Deadline for Systems to submit Report
Until 30 November	5th January – 5pm
Until 31 December	1st February – 5pm
Until 31 January	1st March – 5pm
Until 28 February	29th March – 5pm
Until 31 March	29th April – 12 noon

The Primary Care Commissioning Committee will be provided with a monthly report providing an update in relation to NHSE/I submissions going forward.

3. Submission for Nottingham and Nottinghamshire CCG – 5 January 2022

NHSE/I provided the template for completion, the completed template for the submission made on 5 January 2022 is shown below:

WAF Plan: Commentary on Budget, Spend and Delivery by ICS

MIDLANDS	WAF Plan Budget	YTD Allocation	YTD Actual	YTD Variance
Nottingham and Nottinghamshire	4,518k	904k	460k	-443k
Commentary and actions	**Summary** • *There were four PCNs in November that have initiated WAF projects increasing access to over half of the Nottingham City Locality population.* • *Activity has taken place for some PCNs/Practices in South Notts* • *No WAF activity in Mid Notts due to capacity being directed to vaccinations* **What is going well:** • Additional sessions from HCAs through to GPs providing capacity to improve access from what it otherwise would have been. • Patients willing to attend outside normal hours with very few DNAs. • Practices / PCNs have delivered high numbers of COVID and flu vaccinations since September. • Nottingham City East PCN was able to start a spoke clinic, utilising the hub available via the City GP Alliance. The clinic is offering additional same day activity with 10 sessions per week being available, 16 appointments per session. This has provided additional urgent same day activity in this area. Impact of the additional activity during November is still be assessed alongside the ramping up of the booster vaccination programme in PCNs. • BACHS PCN were able to offer additional 33 GP and nurse sessions from 3 locations • Bestwood & Sherwood PCN were able to offer an additional 130 GP appointments and over 40 additional nurse appointments • Unity PCN have held additional GP and nurse sessions with exact numbers to be quantified **Concerns / issues / risks going forward:** • Overall practice capacity is being impacted by high staff absence rates and staff turnover – linked to COVID and other issues – and diversion of capacity towards supporting vaccination. The high number of staff having to isolate due to COVID is impacting on the ability of practices to deliver face to face appointments as they would like. **Progress with implementation of Community Pharmacy Consultation Service:** • Practices are engaging well with the CPCS; progress with moving forward to implementation is happening (e.g. 8 or the 12 practices in Nottingham West are offering the service) but is being impacted by staff absence and prioritisation of vaccination and urgent care in both practices and community pharmacies. **Patient feedback / communication issues around primary care access:** Practices reporting that they are receiving fewer complaints and negative feedback from patients. **Current time between appointment booking and appointment held and any challenges / issues around this:** • Unity in Arrow: 3-4 days for routine • Nottingham West: the majority of practices offer book on the day, with a combination of total triage and booked GP nurse and ARRS appointments **Issues / improvements around telephony:** • Highcroft: secured a new telephony system which is having a positive impact on patient experience of getting an appointment. • Nottingham West: practices are aware of the functionalities of MS teams to call out to patients freeing up incoming calls. Practices are reviewing systems for requesting prescriptions over the phone in order to free up reception time. NOTE: Quantitive information is currently being collected and will be included in next submission.			

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4. Recommendation

Primary Care Commissioning Committee are asked to **NOTE** the update in relation to the monthly reporting process for “Improving Access for Patients and Supporting General Practice” (Winter Access Fund) and the submission made to NHSE/I on 5 January 2022.