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

NHS
Nottingham and Nottinghamshire
Clinical Commissioning Group

Meeting Agenda (Open Session)

Primary Care Commissioning Committee
Wednesday 15 December 2021 09.00 -10.00
Zoom Meeting

Time	Item	Presenter	Reference
09:00	**Introductory Items**		
	1. Welcome, introductions and apologies	Eleri de Gilbert	PCC/21/173
	2. Confirmation of quoracy	Eleri de Gilbert	PCC/21/174
	3. Declarations of interest for any item on the agenda	Eleri de Gilbert	PCC/21/175
	4. Management of any real or perceived conflicts of interest	Eleri de Gilbert	PCC/21/176
	5. Questions from the public	Eleri de Gilbert	PCC/21/177
	6. Minutes from the meeting held on 17 November 2021	Eleri de Gilbert	PCC/21/178
	7. Action log and matters arising from the meeting held on 17 November 2021	Eleri de Gilbert	PCC/21/179
	8. Actions arising from the Governing Body meeting held on 01 December 2021	Eleri de Gilbert	PCC/21/180
09:05	**Commissioning, Procurement and Contract Management**		
	9. Monthly contract update	Lynette Daws	PCC/21/181
	10. Springfield Medical Centre – merger update	Joe Lunn	PCC/21/182
	11. Winter access fund update	Joe Lunn	PCC/21/183
	12. Temporary GP contract changes to support COVID-19 Vaccination Programme	Joe Lunn	PCC/21/184
09:25	**Strategy, Planning and Service Transformation**		
	13. Review of Primary Care Network NHSE/I Maturity Matrix	Helen Griffiths	PCC/21/185
09:40	**Covid-19 Recovery and Planning**		
	14. Covid-19 Practice Level Update: Operational Pressures Escalation Levels (OPEL) reporting	Joe Lunn	PCC/21/186
09:45	**Financial Management**		
	15. Finance report – month eight	Michael Cawley	PCC/21/187
09:50	**Risk Management**		
	16. Risk Report	Siân Gascoigne	PCC/21/188
10:00	**Closing Items**		
	17. Any other business	Eleri de Gilbert	PCC/21/189

18. Key messages to escalate to the Governing Body	Eleri de Gilbert	PCC/21/190
19. Date of next meeting: 19/01/2022	Eleri de Gilbert	PCC/21/191

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 9 December 2021 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 Hopsitals 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 Borogh 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.

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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
17/11/2021 09:00-10:40
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
Sian Gascoigne	Head of Corporate Assurance
Esther Gaskill	Head of Quality

Apologies:

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

** Dr Stratton left 24/09/2021*

	Introductory Items
PCC/21/153	**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/21/154	**Confirmation of Quoracy** The meeting was confirmed as quorate.
PCC/21/155	**Declaration of interest for any item on the shared agenda** There were no identified conflicts of interest.
PCC/21/156	**Management of any real or perceived conflicts of interest** No management action was required.
PCC/21/157	**Questions from the public** No questions had been received.
PCC/21/158	**Minutes from the meeting held on 20 October 2021** The minutes were agreed as an accurate record of proceedings, subject to the following amendment: - Page 3, item PCC 21 141 amend DDG to CCG.
PCC/21/159	**Action log and matters arising from the meeting held on 20 October 2021** Two actions have future dates for completion. one action is on-going and one complete. There were no matters arising.
	Commissioning, Procurement and Contract Management
PCC/21/160	**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/21/161	**PCN DES – Unclaimed fund 2021/22 – outcome report** Helen Griffiths presented the item and highlighted the following key points: a) The paper provides details of contractual requirements for the Primary Care Networks (PCNs) Unclaimed Fund process for the Additional Roles Reimbursement (RES) for 2021/2022, as documented in the 'Network Contract Directed Enhanced Service Contract specification 2021/22 – PCN Requirements and Entitlements'. b) PCNs completed workforce plans detailing their recruitment plans for 2021/22 in

August 2021. Plans were shared with the Committee in October 2021.

c) During October 2021 PCNs were invited to submit workforce bids against the unclaimed funds. A review panel was established to assess the bids against the criteria detailed within the PCN specification.

d) The value of the Additional Roles Reimbursement Scheme (ARRS) System Unclaimed Fund Pot was £526,283. Bids amounting to £1,073,991 were received.

e) 15 PCNs submitted bids. All that met the criteria received a portion of the fund. Detail of the approved bids was provided in appendix 2. The key challenge/risk faced by PCNs relates to the ability to recruit to the new posts funded.

The following points were raised in discussion.

f) Members commented on the Nottingham City allocation, noting that it appears low comparative to their contribution. It was felt that this may be due to the City practices not having the capacity to develop bids. It is hoped this gap will be addressed by the additional funding for leadership and management to be discussed at item 13 PCC 21 165.

The Committee:

- **NOTED** the proposed process as per the PCN DES specification to utilise the projected underspend of the ARRS allocation.
- **NOTED** the allocations of the ARRS unclaimed funding.
- **NOTED** the risks associated with the implementation and delivery of the unclaimed funding.

Quality Improvement

PCC/21/162 **Primary Care Quality report**

Esther Gaskill presented the item and highlighted the following points:

a) The paper provides detail in relation to; quality dashboard ratings for quarter two, an update on the activity of the Primary Care Quality Groups and Primary Care Quality Team, a summary of current CQC ratings and an overview of practices receiving enhanced support from the Quality Team.

b) In respect of the quality dashboard, three practices received a ‘green’, three star rating meaning they comply with all measures. Overall, 95 practices are rated green, 25 amber with no practices having a red rating.

c) This quarter there was a focus on two childhood immunisation indicators; vaccinations for under two’s and pre-school vaccinations. The quality team will follow up with practices where further support is required to increase the uptake of vaccinations.

d) Primary Care Quality groups at place level have merged to create one overarching Quality Group. The Quality Group reviews each quality dashboard, patient experience information and patient safety incident reports. The patient experience report highlighted that the most contacts were from patients seeking additional clarification following receipt of a letter informing them about their transfer to a different practice following closure. As a result the content of such letters will be reviewed.

e) During quarter two, 47 patient safety incidents were received by the CCG relating to primary care. None of the incidents reported met the national serious incident framework threshold.

f) The report detailed the CQC ratings for all practices; 19 practices are rated outstanding, 98 good, one requires improvement and none are rated inadequate. Six practices are yet to be rated by the CQC.

g) The CQC have introduced a new monitoring approach to help prioritise activity. This involves a monthly review of practice information resulting in a risk assessment for each practice. If the review indicates a high/very high risk an inspection will follow.

h) Covid-19 continues to have an impact in practices and a number of practices are supporting the phase three Covid-19 vaccination programme in addition to the flu vaccination programme.

The following points were made in discussion:

i) Members were encouraged to see the positive results detailed in the report. JRB Healthcare were commended following their recent 'good' rating from the CQC. JRB Healthcare took on the contract and this rating represents a significant improvement for this practice.

The Committee:

- **NOTED** the Primary Care Quality report for November 2021.

Michael Wright joined the meeting during this item.

Strategy, Planning and Service Transformation

PCC/21/163 National Primary Care Patient Survey report – 2020/21

Esther Gaskill presented the item and highlighted the following points:

a) The GP Patient Survey (GPPS) is an England-wide survey providing practice level data about patients' experiences.

b) 44,211 questionnaires were sent out, and 15,710 were returned completed. This represents a response rate of 36%, an improvement on the previous year.

c) CCG overall GP experience of satisfaction results range from 76% to 87%. 35 practices score 90% or above. The lowest practice is rated 55% in terms of experience.

d) In Mid Nottinghamshire, Sherwood Medical Partnership had the poorest results flagging as outliers ten times. This practice also flagged up eight times in 2020.

e) In Nottingham City, Greendale Primary Care Centre and Queens Bower Surgery both flagged nine times. Lime Tree Surgery eight times, John Ryle Medical Practice and Bilborough Medical Centre seven times. Bilborough has been top of the worst performing practices for the last three years.

f) In South Nottinghamshire, Highcroft Surgery flagged nine times with Oakenhall Medical flagging six times.

g) Use of online bookings is below the national average in all localities although Nottingham City has seen an improvement during the last year. Mid Nottinghamshire performance has declined against this measure. Repeat prescription usage sees South Nottinghamshire in line with the national average but Mid Nottinghamshire and Nottingham City is 5-6% below the national average.

h) With regard to the ease of getting through to a practice by phone, Nottingham City and South Nottinghamshire scored well whilst Mid Nottinghamshire requires slight improvement.

i) Overall experience of the GP Practice sees the CCG surpass the national average. South Nottinghamshire exceeds the national average by 5% with Mid

Nottinghamshire and Nottingham City 1% below the national average.

j) New to the survey is a question associated with COVID-19; 'have you, at any time in the last 12 months, avoided making a general practice appointment for any reason. The results show South Nottinghamshire 5% below the national average and Mid Nottinghamshire and Nottingham City in line with the national average.

k) The number of patients who have responded as shielding due to being vulnerable to COVID-19 highlights MMid Nottinghamshire 3% above the national average and Nottingham City 3% below.

l) A reduction in performance with respect to the management of long term conditions as a consequence of the COVID-19 pandemic is evident from the survey results.

The following points were made in discussion:

a) Members noted the results and were encouraged to see some high performing practices, although it was acknowledged that the response rate of 36% is low.

b) Results that were of concern were discussed, particularly in relation to access to practices via the telephone. It was noted that some practices have recently implemented new phone systems and it was hoped this would have a positive impact. The importance of patients being able to make contact with a practice via telephone was emphasised and would be addressed further at item PCC 21 164.

c) Practices reporting poor results, for example Highcroft are currently receiving a higher level of support from the CCG.

d) Michael Wright informed members of a patient choice project that the LMC and Healthwatch will be undertaking and agreed to bring the outcome to the Committee at a future meeting.

The Committee:

- **NOTED** the National Primary Care Patient Survey summary for 2020/21.

PCC/21/164 Improving access for Patients and Supporting General Practice

Joe Lunn presented the item and highlighted the following points:

a) On 14 October 2021, NHS England & Improvement (NHSE/I) published the guidance "Our plan for improving access for patients and supporting general practice" with additional funding of £250m nationally to support delivery.

b) Each CCG/ICS area was asked to develop plans to deliver the requirements detailed in the guidance in order to secure funding to support the system over winter.

c) Nottingham and Nottinghamshire CCG worked with colleagues in Primary Care to develop plans. The plans submitted include a mixture of centralised hub and PCN solutions to improve access and include a greater number of face to face appointments, increased availability of urgent appointments and increased staffing levels during peak times of activity. Conversations are underway with LMC colleagues to discuss flexible pools to address workforce requirements.

d) In addition, work is underway to review some of the underpinning operational and Infection Prevention and Control (IPC) requirements.

e) The national cloud based telephony (national) solution was highlighted as a route to improving access for patients although the proposals from NHSE/I only offer a software solution and do not address hardware requirements. It was also

noted that many practices are committed to existing contracts with regard to their telephone systems, therefore change would take some time to be implemented.

f) The plans submitted are for a budget of £4.6 million for the CCG. Funds must be utilised between November 2021 and March 2022.

g) As part of the process NHSE/I asked for confirmation of how the plans would support elective, urgent care and long-term condition management.

h) Formal feedback from the national team is awaited but the CCG has been advised to progress the plans with immediate effect.

The following points were made in discussion:

a) Members noted the plans and the national project in respect of telephony systems. Discussion followed specifically related to telephony and the importance of back office functions and management strategies at PCN level. Members agreed that this would be important to incorporate into the developing ICS Primary Care Strategy.

b) Confidence in being able to deliver the plans was discussed along with how accessible the various options will be for patients. In confirming ease of access for patients members were informed that patients would access the additional support via their usual practice.

c) The time limited nature of the funding was noted and a level of concern raised that public/patient expectations will be raised that will not be able to be fulfilled beyond March 2022.

d) Members noted the significant amount of work that had been done to produce the plans in a short timeframe. Following discussion members were assured that the hub and PCN models described will ensure the whole area will benefit from the investment and meet the requirements as described by NHS England /Improvement (NHSE/I).

The Committee:

- **NOTED** the update in relation to plans for Improving Access for patients and supporting general practice.

PCC/21/165 PCN Leadership and Management Funds 2021/22

Helen Griffiths presented the item and highlighted the following points:

a) The paper provides details of additional funding that has been provided by NHS England to the Primary Care Networks (PCNs) to support leadership and management capacity within the PCN for the remainder of this financial year.

b) NHSE/I has not specified how this funding should be used other than stating '*It is up to Clinical Directors to recommend how the funding is best deployed across the PCN to create additional leadership and management capacity'.*

c) The Nottingham and Nottinghamshire allocation of £778k is to be reimbursed to PCNs as a monthly payment. All PCNs have been asked to inform the CCG of their plans and intentions for the use of the funds.

d) Five PCNs have submitted plans to date.

No further points were made in discussion.

The Committee:

- **NOTED** the additional allocation and distribution of funding available to PCNs to support leadership and management capacity for the duration of 2021/22.

Covid-19 Recovery and Planning

PCC/21/166 **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) daily. This enables the CCG to understand where there are pressures in relation to service delivery across General Practice each day.

b) The paper provides an overview of OPEL reporting for the four weeks to 29 October 2021. 32 of 124 practices reported days at OPEL level three having previously reported amber or green. 97 practices reported days at OPEL level 2 and 25 practices reported consistently at OPEL level one.

No further points were raised in discussion.

The Committee:

- **NOTED** the OPEL reporting overview for General Practice for the four weeks to 29 October 2021.

Financial Management

PCC/21/167 **Finance report – month seven**

Michael Cawley presented the item and highlighted the following points:

a) The paper reported the financial position for the month seven 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.

b) The year to date (M1-7) position shows a £3.34 million underspend (3.44% of year to date budget). This is primarily due to the underspend of primary care reserves forming part of the position (£3.18 million, 3.27% of the 3.44% total underspend). [As previously reported, £2.64m of the underspend representing the PCCC reserves held at month six, were released into the CCG's final H1 position.]

c) Other factors driving the variances are the reversal of prior year accruals in relation to Alternative Provider Medical Service's (APMS) Caretakers (£0.25m) alongside favourable variances in areas such as Dispensing / Prescribing Drs and Premises Cost Reimbursement. This month there are additional charges in relation to two rent reviews for practices; backdated to 2017 totalling £0.28m and final caretaking charges of £0.05m.

d) The CCG in conjunction with the ICS, is currently working on the H2 Financial Plan that is due to be submitted to NHSEI on 18 November 2021. For H2 a comparable level of PCCC reserves is planned to be set aside. By adopting this approach, the risk of the PCCC's balanced position target being compromised is minimised.

No further points were made in discussion.

The Committee:

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

Risk Management

PCC/21/168 **Risk Report**

Sian Gascoigne presented the item and highlighted the following points:

a) There are currently six risks relating to the Committee's responsibilities, the same number of risks that was presented to the last meeting.

b) There is one high risk, RR 160 related to pressure on Primary Care workforce with a score of 16. The register also includes a related risk, RR 032 scored at 12 addressing workforce capacity.

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/21/169 **Health Scrutiny Committee Papers – Nottingham and Nottinghamshire**

The papers were provided for information in order that members are aware of information shared with the Scrutiny Committees. Members were informed that the City Scrutiny Committee had recorded their thanks to Nottingham City practices for their on-going work during an extended time of significant pressure.

PCC/21/170 **Any other business**

No further business was raised.

PCC/21/171 **Key messages to escalate to the Governing Body**

The Committee:

- **RECEIVED** the Quality report for quarter two. 95 practices are rated green, 25 are amber with no practices having a red rating. In terms of CQC ratings, 19 practices are rated outstanding, 98 good, one requires improvement and none are rated inadequate. Six practices are yet to be rated by the CQC.
- **RECEIVED** the patient survey report. Across the CCG the response rate to the survey was 36%. Overall experience of the GP Practice sees the CCG surpass the national average. South Nottinghamshire exceeds the national average by 5% with MidMid Nottinghamshire and Nottingham City 1% below the national average.
- **RECEIVED** the report on utilisation of funds to improve primary care access from November 2021 to March 2022 following the NHSE/I publication 'Our plan for improving access for patients and supporting general practice'. The plans submitted are for a budget of £4.6 million for the CCG and offer a PCN and centralised hub model to improve availability and access.

PCC/21/172 **Date of next meeting**:
15/12/2021
MS Teams meeting

NHS
Nottingham and Nottinghamshire
Clinical Commissioning Group

Primary Care Commissioning Committee
Action Log from the public Committee meeting held on 17 November 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	Not yet due

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	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 December meeting.
ACTIONS COMPLETED						

NHS
Nottingham and Nottinghamshire
Clinical Commissioning Group

Meeting Title:	Primary Care Commissioning Committee (Open Session)	**Date:**	15 December 2021

Paper Title:	Nottingham and Nottinghamshire Public Contract Update	**Paper Reference:**	**PCC 21 181**

Sponsor:	Joe Lunn, Associate Director of Primary Care	**Attachments/ Appendices:**	Public Contract Update
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.

The following lines will be removed following the December 2021 meeting as these contractual issues are now completed and were first reported to PCCC 12 months ago. These will be moved to archive:

Line 6	Whyburn Medical Practice – Contract Update (APMS)
Line 7	Peacock Healthcare – Contract Update (APMS)
Line 8	Bilborough Medical Centre – Contract Update (APMS)
Line 9	Grange Farm Medical Centre – Contract Update (APMS)

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 paper.
Data Protection Impact Assessment (DPIA)	Yes ☐	No ☐	N/A ☒	Not required for this paper.

Risk(s):
No risks are identified within the paper

Confidentiality:
☒No

Recommendation(s):
1. The Committee is asked to **RECEIVE** the Public Contract Update.

NHS Nottingham and Nottinghamshire Clinical Commissioning Group
Primary Care Commissioning Committee – December 2021 Public Meeting

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.	August 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 15th October 2021, advising them of the change. Follow up communications will be sent to patients. 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 can offer support to their clients. Tailored communication resources have also been shared with stakeholders to help reach vulnerable patient groups.	In progress
2.	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

Ref.	Date reported to Committee	Description of Contractual Issue	Update	Status
3.	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
4.	July 2021	Oakwood Surgery (Bull Farm Branch) – Branch Opening Hours	Oakwood Surgery has 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
5.	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 is providing a temporary caretaking arrangement until 30 September 2021, from the Queens Bower Surgery premises. Patient engagement has taken place and a report has been prepared. Options appraisal presented to Primary Care Commissioning Committee in July 2021 and decision supported to allocate patients to practices near to their home address. The mapping process to allocate patients has been completed. A letter to inform patients of the allocation process has been sent. A further letter was sent in September providing patients with their allocated new practice details. The practice closed on the 30 September 2021.	Completed
6.	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	Completed

Ref.	Date reported to Committee	Description of Contractual Issue	Update	Status
			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, which have been distributed to key stakeholders). Highlight reports from the Group were provided to the Committee. Regular mobilisation meetings have taken place with NCGPA. Exit planning meetings took place with the incumbent provider. All patients on the allocation list were sent a letter containing further details regarding the transfer to their new practice; patients were 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 PCCT remain in regular contact with the new provider.	
7.	December 2020	Whyburn Medical Practice – Contract Update	Primary care services for Whyburn Medical Practice patients were being provided through a temporary caretaking arrangement. An external procurement process took place to secure a permanent provider; the successful provider is Primary Integrated Community Services (PICS) – the temporary caretaker provider. This is a contract change. There will be no change to patient care; patients will continue to receive primary care services from the current location. The new APMS contract for	Completed

Ref.	Date reported to Committee	Description of Contractual Issue	Update	Status
			Whyburn Medical Practice commenced 1 July 2021; contract and quality review meetings have been scheduled.	
8.	December 2020	Peacock Healthcare – Contract Update	Primary care services for Peacock Healthcare patients were being provided through a temporary caretaking arrangement. An external procurement process took place to secure a permanent provider; the successful provider is Primary Integrated Community Services (PICS) – the temporary caretaker provider. This is a contract change. There will be no change to patient care; patients will continue to receive primary care services from the current location. The new APMS contract for Peacock Healthcare commenced 1 July 2021; contract and quality review meetings have been scheduled.	Completed
9.	December 2020	Bilborough Medical Centre – Contract Update	Primary care services for Bilborough Medical Centre patients were being provided through a temporary caretaking arrangement. An external procurement process took place to secure a permanent provider; the successful provider is Nottingham City GP Alliance (NCGPA) – the temporary caretaker provider. This is a contract change. There will be no change to patient care; patients will continue to receive primary care services from the current location. The new APMS contract for Bilborough Medical Centre commenced 1 July 2021; contract and quality review meetings have been scheduled.	Completed
10.	December 2020	Grange Farm Medical Centre – Contract Update	The Grange Farm Medical Centre contract will come to its natural end 30 September 2021. An external procurement process took place to secure a provider; the successful provider is Nottingham City GP Alliance (NCGPA). The contract with NCGPA will start 1 October 2021. This is a contract change. There will be no change to patient care; patients will continue to receive primary care services from the current location. The new APMS contract for Grange Farm Medical Centre commenced 1 October 2021; contract and quality review meetings have scheduled.	Completed

Nottingham and Nottinghamshire Clinical Commissioning Group

Meeting Title:	Primary Care Commissioning Committee (Open Session)	**Date:**	15 December 2021

Paper Title:	Springfield Medical Centre Merge into St Albans & Nirmala Medical Centre with Closure of Premises - Update	**Paper Reference:**	**PCC 21 182**

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* At its meeting in August 2021, the Confidential Primary Care Commissioning Committee (PCCC) supported the proposal for Springfield Medical Centre to merge into The Practice St Albans and Nirmala from 1 April 2022. This will result in the closure of the Springfield Medical Centre premises on 31 March 2022, following six months' notice to the landlord. PCCC asked that an update be provided at the December 2021 meeting that included feedback from the patient engagement that had taken place by the practice. The purpose of this paper is to provide the Committee with an update on the progress to date.

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 ☒	*An EQIA has been approved and is being updated with progress*

Data Protection Impact Assessment (DPIA)	Yes ☐	No ☐	N/A ☒	Not required for this paper.

Risk(s):

Should the relationship between Springfield Medical Centre and The Practice St Albans & Nirmala break down and one of the practices decides to withdraw, it is expected that the Springfield Medical Centre GMS contract will be handed back to the CCG. This could result in the CCG managing a dispersal of the patient list due to the small list size. Both practices have entered into a Business Transfer Agreement which is a legal document that outlines the terms of the transfer arrangements for both parties.

There is a potential risk of delay should the building work at The Practice St Albans not be completed, as scheduled. The building work is to accommodate the increased list size. Assurance has been provided by The Practice St Albans that the minor works required will be completed on time and they have received confirmation from their Landlord.

Confidentiality:

☒No

Recommendation(s):

1) The Primary Care Commissioning Committee is asked to **NOTE:**

a) the update for Springfield Medical Centre to merge into The Practice St Albans and Nirmala from 1 March 2022;

b) the closure of the Springfield Medical Centre premises.

Springfield Medical Centre Merge into St Albans & Nirmala Medical Centre with Closure of Premises – Update

1. Introduction

Dr and Mrs Mohindra, partners on the Springfield Medical Centre GMS contract, have taken the decision to retire in 2022. Having considered their options, they approached The Practice St Albans and Nirmala, a GMS contract, as their closest neighbouring practice to agree a sustainable and long-term succession plan. Following discussions, the Springfield Medical Centre will merge into the Practice St Albans and Nirmala.

This proposal was supported by the Primary Care Commissioning Committee (PCCC) at the confidential meeting in August 2021, effective 31 March 2022. The Springfield Medical Premises will close on 31 March 2022, 6 months' notice has been given to the landlord.

PCCC asked that an update be provided at the December 2021 meeting that included feedback from patient engagement undertaken by the practice.

2. Patient update

A letter was sent to all registered patients at Springfield Medical Centre on 15th October 2021, advising of the change. The Primary Care Commissioning Team has worked closely with the CCG Communications & Engagement Team and Patient Experience Team to ensure communications with patients in relation to the change were clear, concise, supportive and available in formats that reflect the demographic profile of the patient list. This included a list of frequently asked questions, contact numbers and email addresses for the relevant teams to support patients. A stakeholder briefing has been issued to MPs, local councillors, Health Scrutiny Committee and HealthWatch, along with other system partners.

As both practices are located in Bulwell most services will remain the same including the Health Visiting Team (based at Bulwell Riverside Health Centre), Interpreter & Translation Service, Local Mental Health Team and services supporting those with severe multiple disadvantages. The Primary Care Commissioning Team has liaised with support services such as The Nottingham Refugee Forum, Juno Women's Aid, Framework, Notts Deaf Society, My Sight Nottingham and the Learning Disabilities Primary Care Liaison Nurse as part of stakeholder engagement to ensure that the support workers/services are aware of the changes and able to offer support to their clients. Tailored communication resources have also been shared with stakeholders to help reach vulnerable patient groups.

Dr and Mrs Mohindra have held two meetings with the staff at Springfield Medical Centre to advise them of the changes and discuss options for transferring their employment to The Practice St Albans and Nirmala. The senior team at The Practice St Albans and Nirmala, have met with their staff to inform them of the changes. They have also met with the staff at Springfield Medical Centre to introduce themselves and answer any queries the staff may have about their employment transferring to The Practice St Albans and Nirmala. Both Mrs Mohindra and The Practice St Albans and Nirmala have fed back that both meetings with staff have been positive. The Patient Participation Groups at both Springfield Medical Centre and The Practice St Albans and Nirmala have been informed of the changes as part of the engagement process. Both practices have the poster and FAQs on display in the waiting room, Springfield Medical Centre also has copies of the patient letter in the waiting room and the statement on their website.

The Patient Experience Team has received two enquiries from patients regarding the closure of Springfield Medical Centre; both of which were asking if the closure of Springfield Medical Centre will impact on The OM Practice in Hucknall which Dr and Mrs Mohindra also hold the contract for. Assurance was given to the patients that this change only relates to Springfield Medical Centre. There

has been one media enquiry regarding these changes which came from a reporter for the Hucknall and Bulwell Dispatch. The CCG Communications and Engagement team responded to the enquiry.

The timeline below provides a summary of the activities undertaken to date and the outstanding activities to be completed prior to 31 March 2022.

Summary of main activities	Dates	Progress to date
Media responses prepared by the Communications and Engagement Team	**17 Sept 2021**	Completed
All public facing materials signed off for use by Primary Care Commissioning Team (PCCT) and Communications and Engagement Team	**17 Sept 2021**	Completed
Chair of Health Scrutiny Committee informed	**Sept 2021**	Completed
Based on information contained within the EQIA regarding patient profile, relevant support groups engaged to inform and share tailored communication resources and channels to reach vulnerable patient groups	**Sept/Oct 2021**	Completed
Notice serviced on Springfield Medical Centre Landlord (six months formal notice)	**1 Oct 2021**	Completed
Staff at Springfield Medical Centre and The Practice St Albans and Nirmala informed	**Mon 11/Tues 12 Oct 2021**	Completed
Individual patient letters issued	**W/C 11 Oct 2021**	Completed – patient letters were sent by PCSE on Friday 15th October
Practice Patient Participation Groups informed	**W/C 11 Oct 2021**	Completed
Stakeholder communications issued: stakeholder briefing to MPs, local councillors, Health Scrutiny Committee, HealthWatch and across other system partners	**14 – 15 Oct 2021**	Completed
Patient communications issued to support groups	**14 – 15 Oct 2021**	Completed
FAQ shared with Patient Experience Team and uploaded to CCG website	**14 – 15 Oct 2021**	Completed
NHIS appoint Project Manager to oversee the IT closure of Springfield Medical Centre and transfer of patients and clinical system to The Practice St Albans and Nirmala	**Nov 2021**	Completed
PCCT undertake a site visit to Springfield Medical Centre	**8 Dec 2021**	
Follow up letter issued to patients of changes due to take place	**11 January 2022**	
Final contractual actions completed including final site visit by PCCT	**March 2022**	
Springfield Medical Centre premise closure and merge into The Practice St Albans and Nirmala	**1 April 2022**	

The Primary Care Commissioning Team have met with NHIS regarding close-down procedures for Springfield Medical Centre; a Project Manager from NHIS has been appointed to oversee the process and support the practice with the close down/transfer of the clinical system and local IT. Springfield Medical Centre will be supported by The Practice St Albans and Nirmala with the completion of clinical tasks and various other housekeeping tasks that must be carried out prior to close-down.

3. Next Steps

A follow up patient letter will be issued in January 2022 to remind patients of the changes. All patients currently registered at Springfield Medical Centre will automatically be transferred to The Practice St Albans and Nirmala. This transfer may need to take place a few days before the merger date as the clinical system provider (SystmOne – TPP) are unable to transfer the clinical system unit on the 1 April 2022. The Primary Care Commissioning Team has liaised with The Practice St Albans and Nirmala and the CCG Information Governance team to ensure that there are appropriate data sharing agreements in place to enable the transfer to take place before 1 April 2022.

The Primary Care Commissioning Team continues to meet with both practices on a regular basis to review the project plan and ensure we are on track to meet the project milestones.

4. Recommendation

The Primary Care Commissioning Committee is asked to NOTE:

- the update for Springfield Medical Centre to merge into The Practice St Albans and Nirmala from 1 March 2022
- the closure of the Springfield Medical Centre premises

Nottingham and Nottinghamshire Clinical Commissioning Group

Meeting Title:	Primary Care Commissioning Committee (Open Session)	**Date:**	15 December 2021

Paper Title:	Winter Access Fund – "Our Plan for Improving Access for Patients and Supporting General Practice"	**Paper Reference:**	**PCC 21 183**

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 2021, a brief update was provided outlining the guidance released by NHS England & Improvement (NHSE/I) on 14 October 2021, "Our plan for improving access for patients and supporting general practice" with additional funding of £250m nationally to support delivery. This funding is now referred to as the "Winter Access Fund".

Nottingham and Nottinghamshire CCG worked with colleagues in Primary Care to develop plans and responded to NHSE/I with plans outlining our approach to meet the requirements which demonstrated how primary care would increases appointments available for patients and the associated increase in full time equivalent staff to deliver this.

The CCG have now received confirmation from NHSE/I that plans have been approved with final queries being resolved. Plans are now being implemented across the three Place Based Partnerships.

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 paper.
Data Protection Impact Assessment (DPIA)	Yes ☐	No ☐	N/A ☒	Not required for this paper.

Risk(s):

No risks are identified within this paper

Confidentiality:

☒No

Recommendation(s):

1. **NOTE** the update in relation to approved plans for "Improving Access for Patients and Supporting General Practice" to support the system over winter (Winter Access Fund).

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

1. Introduction

As updated at the Open Session of the Primary Care Commissioning Committee (PCCC) in November 2021, NHS England & Improvement (NHSE/I) released the guidance "Improving access for patients and supporting general practice" on 14 October 2021 with additional funding of £250m nationally to support delivery.

https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2021/10/BW999-our-plan-for-improving-access-and-supporting-general-practice-oct-21.pdf

2. CCG Plans Approved

Nottingham and Nottinghamshire CCG worked with colleagues in Primary Care to develop plans and responded to NHSE/I with plans outlining our approach to meet the requirements to demonstrate how primary care would increases appointments available for patients and the associated increase in full time equivalent staff to deliver this. CCG Teams worked closely with PCN Clinical Directors and Clinical Leads in the three Place Based Partnerships (PBP) across Nottingham and Nottinghamshire to develop plans for their individual populations – Mid Nottinghamshire, Nottingham City and South Nottinghamshire.

The CCG have now received confirmation from NHSE/I that plans have been approved with final queries being resolved.

Plans are now being implemented across the three Place Based Partnerships to utilise the funding available to Nottingham and Nottinghamshire totalling £4.699m. This will support additional capacity to deliver increased appointments in general practice over the winter period.

3. Key Deliverables

NHSE/I Regional colleagues have share the key deliverables expected to be used to monitor the Winter Access Fund (subject to confirmation from the national team). as follows:

- Number of additional appointments provided
- Increase in Face to Face appointments (GP/All)
- CPCS sign up
- Expenditure against nominal allocation
- Time between appointment booking to appointment held

4. Funding Flows and Claiming Processes

NHSE/I have liaised with CCG finance colleagues in relation to funding flows and claiming processes. To support this PCNs have been asked to confirm the phasing of funding over the period November 2021 to March 2022, this will ensure the CCG receives allocations to meet delivery against the schemes.

As well as providing phasing across period of delivery NHSE/I colleagues have also asked for this to be identified against the four spend categories below:

- WAF Patient access experience
- WAF primary care hubs
- WAF resilience urgent care
- WAF other actions

A summary of funding phasing against the four categories will need to be included by finance colleagues as part of the month 8 financial reporting processes (non-ISFE).

An early view of the claiming process has been shared with the CCG (currently being finalised by NHSE/I), this is likely to see the the introduction of a Winter Access Fund Portal. The portal will use a similar process to ARRS whereby claims are submitted on a monthly basis by PCNs with supporting evidence. This allows the CCG to review and approve claims where in lines with plans.

5. Next Steps

Practice Based Partnerships have started delivery against plans, increasing appointments available to patients and will continue to roll-out plans over winter.

Once the claiming processes are confirmed, CCG colleagues will share the guidance with PCNs to ensure a clear and timely process is in place to capture expenditure against plans.

PCCC will be updated at future meetings in relation to expenditure and delivery against plans.

6. Recommendation

PCCC are asked to **NOTE** the update in relation to approved plans for “Improving Access for Patients and Supporting General Practice” to support the system over winter (Winter Access Fund).

NHS
Nottingham and Nottinghamshire
Clinical Commissioning Group

Meeting Title:	Primary Care Commissioning Committee (Open Session)	**Date:**	15 December 2021

Paper Title:	Temporary GP contract changes to support COVID-19 Vaccination Programme	**Paper Reference:**	**PCC 21 184**

Joe Lunn, Associate Director of Primary Care	Joe Lunn, Associate Director of Primary Care Joe Lunn, Associate Director of Primary Care	**Attachments/ Appendices:**	**Appendix A** – Letter Dated 3 December 2021 **Appendix B** – Letter Dated 8 December 2021 **Appendix C** – Letter Dated 9 December 2021

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

Executive Summary

On 3 December 2021, NHS England & Improvement (NHSE/I) circulated a letter outlining flexibilities introduced to support GP practices to deliver the vaccination programme the guidance (Appendix A).

This letter was followed by a second letter on 8 December 2021, providing more detail on the temporary GP contract changes to support COVID-19 vaccination programme (Appendix B).

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 (Appendix C) was circulated 9 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):				
No risks are identified within this paper				
Confidentiality:				
☒No				
Recommendation(s):				
1. Primary Care Commissioning Committee are asked to **NOTE** the documents circulated and the temporary changes to GP contracts to support the COVID-19 vaccination programme.				

Appendix A

Official
Publication approval reference: C1468

Skipton House
80 London Road
London
SE1 6LH

To: ICS and STP Leaders

Copy to:
- CCG Accountable Officers
- GP practices
- PCN-led local vaccination services
- Community pharmacy-led local vaccination services
- Vaccination centres
- Chief Executives of all NHS trusts and foundation trusts
- NHS Regional Directors
- NHS Regional Directors of Commissioning
- Directors of Public Health
- All Local Government Chief Executives

3 December 2021

Dear Colleague

JCVI advice in response to the emergence of the B. 1. 1.529 (Omicron) variant: next steps for deployment

On Monday the government accepted updated advice from the Joint Committee on Vaccination and Immunisation (JCVI) following the emergence of the Omicron variant.

The JCVI advise an acceleration of COVID-19 vaccination to increase protection ahead of any wave of infection and to help reduce the impact of the Omicron variant of COVID-19. The JCVI recommend that:

> *"Booster vaccination eligibility should be expanded to include all adults aged 18 years to 39 years.*
>
> *"Booster vaccination should now be offered in order of descending age groups, with priority given to the vaccination of older adults and those in a COVID-19 at-risk group. Booster vaccination should not be given within three months of completion of the primary course.*
>
> *"Severely immunosuppressed individuals who have completed their primary course (three doses) should be offered a booster dose with a minimum of three months between the third primary and booster dose. Those who have not yet received their third dose may be given the third dose now to avoid further delay. A further booster dose can be given in three months, in line with the clinical advice on optimal timing.*
>
> *"Both the Moderna (50 microgram) and Pfizer-BioNTech (30 microgram) vaccines should be used with equal preference in the COVID-19 booster programme."*

The JCVI also advise that children and young people aged 12 to 15 years should be offered a second dose of the Pfizer-BioNTech COVID-19 vaccine at a minimum of 12 weeks from the first dose. No immediate action is required, and we will write separately on implementation of this advice.

A full copy of the JCVI's advice can be found here.

NEXT STEPS FOR DEPLOYMENT

The JCVI are clear that those at greatest risk must be prioritised, including those who are housebound, and those severely immunosuppressed. Therefore, the NHS will offer vaccination in descending age groups, with priority given to the vaccination of older adults and those in a COVID-19 at-risk group first.

IMPLEMENTING THE NEW DOSING INTERVAL

The National Booking Service (NBS) is now being updated to reflect the three-month (91 days) interval from second dose to booster. Our intention is to go live as soon as possible and no later than 13 December. As these changes are being made, existing booking arrangements will remain in place: individuals in cohorts 1-10 can book their booster from five months (152 days) post second dose, for slots from six months (182 days) after their second dose.

UKHSA is now updating the Patient Group Directive (PGD), the National Protocol and Green Book Guidance to reflect the three-month interval. We expect these to be updated no later than 13 December. We will ensure the NBS opening and PGD publication are aligned.

INCREASING CAPACITY

We recognise the pressure all local services are under, however as the Secretary of State for Health and Social Care has said, the 'new national mission' is to increase vaccine capacity. There are no supply challenges with either the Moderna or Pfizer booster stocks, therefore all vaccination sites are now asked to load their NBS calendars to the end of January, where possible.

For PCN-led Local Vaccination Services: Given the invaluable contribution and scale of effort required in primary care, several measures will now be put in place to support all PCN-led local vaccination services. These include creating capacity and financial support. These will allow wherever possible practices and PCNs to continue to pursue the clinical ambitions underlying QOF and IIF while releasing capacity to support the increased vaccine effort:

a) **Creating capacity:** Creating capacity within primary care will be enabled by the following: If participating in the vaccination programme, income protection for the Minor Surgery DES will apply from 1 December 2021 until 31 March 2022. Local commissioners should make the monthly payments to practices for the Minor Surgery DES that they made for the corresponding period from 1 December 2018 to 31 March 2019. No contract enforcement will be taken where no activity is done under the Minor Surgery Additional Service from 1 December 2021 to 31 March 2022. Capacity released must be redeployed to vaccination.

b) From 1 December 2021 to 31 March 2022, where contractors consider it clinically appropriate, routine health checks for those over 75 and for new patients may be deferred.

c) The evidence-based care provided via QOF continues to be important in minimising health inequalities, securing the best outcomes for those with long term conditions and preventing wider system impacts. In order to support the ongoing response to COVID-19 and the increase in vaccination capacity, combined with the need to target proactively and support our most vulnerable patients during this period, we will introduce the following changes for 2021/22:

    - Some QOF indicators will continue to be paid on the basis of practice performance. These include vaccination, cervical screening, register indicators and those related to optimal prescribing.

    - Others will be subject to income protection based upon historical practice performance, in a similar way to arrangements in 2020/21.

    - To be eligible for income protection, practices will need to agree with their commissioner a plan that will set out how QOF care will be delivered wherever possible but with priority according to clinical risk, and accounting for inequalities.

    - QOF will recommence in April 2022.

d) For the IIF, the indicators introduced in April 2021 covering flu immunisation and the completed work on appointment recording and categorisation will be paid as normal. The remaining indicators will be suspended and the funding repurposed. The majority of the funding allocated to these suspended indicators will instead be allocated to PCNs via a PCN Support Payment, on a weighted patient basis, subject to confirmation from the PCN that it will be reinvested into services or workforce. The remaining funding will instead be allocated to a new IIF incentive to support PCNs whose practices are fully participating in the vaccination programme. Further details will follow. IIF will recommence in April 2022.

e) The Dispensing Services Quality Scheme will be amended to reduce the requirement for medication reviews from a minimum of 10% of dispensing patients to a minimum of 7.5% for 2021/22. Practices are asked to prioritise patients who they consider to be higher-risk or would benefit most from a review.

Financial support: Enhanced financial support for PCN-led local vaccination services, to help sites attract and retain staff, including during unsociable parts of the week, is now available. This comprises:

- an increase to the Item of Service (IoS) fee to £15 per jab administered on weekdays and Saturdays from 1 December 2021 to 31 January 2022 (exclusive of days designated as a Bank Holiday) and an increase to the IoS fee to £20 per jab administered on Sundays or Bank Holidays over the same period
- an increase in the supplement for third dose and booster vaccination of house-bound patients to £30 from £20 until 31 December, backdated for those already carried out

- a temporary supplement of £10 for the administration of COVID-19 vaccinations to severely immunosuppressed people from 1 December 2021 to 31 January 2022. From 1 December, LVS sites are advised to select the 'other residential settings' field within the Point of Care systems to ensure an additional supplementary payment of £10 can be applied to the Item of Service fee for any doses administered to patients identified as severely immunosuppressed. Point of Care system suppliers have been requested to amend the text within their system to reflect this change and this will be introduced imminently but should not prevent any site from recording this information and claiming the additional payment. Please note this payment will not apply to any vaccinations administered prior to 1 December 2021
- an enhanced payment to support Clinical Director and management leadership of PCN sites to 1 WTE for the period 1 December 2021 to the end of March 2022.

Regulatory activity: The CQC have confirmed that routine inspections of practices will continue to be paused, and only risk-based assessment will be undertaken, where deemed critical to safety and quality.

We recognise this additional support may now enable additional PCNs to participate in the vaccination programme, therefore the sign-up window for the Phase Three GP COVID-19 Vaccination Enhanced Service (ES) has now been reopened. Practices who wish to sign up should liaise with their local commissioner as soon as possible to discuss next steps.

PCNs that have opted in to deliver boosters to Cohort 10 will be able to deliver boosters to Cohorts 11 and 12 once these cohorts are opened. In addition, PCNs should prepare for further delivery of vaccination cohorts if announced.

There is some opportunity for PCN-led local vaccination services to be onboarded to the NBS where there is a strategic need. Please liaise with your local commissioner so that regions can prioritise available licences. Any sites onboarded onto the NBS should use the system for the majority of their bookings.

For Community Pharmacy-Led Local Vaccination Services: Recognising the critical role community pharmacy LVS plays in local communities, we will provide the enhanced financial support to CP-led LVS to help sites attract and retain staff, including during unsociable parts of the week. This comprises:

- an increase to the IoS fee to £15 per jab administered on weekdays and Saturdays from 1 December 2021 to 31 January 2022 and an increase to the IoS to £20 per jab administered on Sundays or Bank Holidays over the same period
- an increase in the supplement for third dose and booster vaccination of house-bound patients to £30 from £20 until 31 December, backdated for those already carried out
- a temporary supplement of £10 for the administration of COVID-19 vaccinations to severely immunosuppressed people from 1 December 2021 to 31 January 2022. From 1 December, LVS sites are advised to select the 'other residential settings' field within the Point of Care systems to ensure an additional supplementary payment of £10 can be applied to the Item of Service fee for any doses administered to patients identified as severely immunosuppressed. Point of Care system suppliers have been requested to amend the text within their

system to reflect this change and this will be introduced imminently but should not prevent any site from recording this information and claiming the additional payment. Please note this payment will not apply to any vaccinations administered prior to 1 December 2021.

In addition, we are discussing with the Pharmaceutical Service Negotiating Committee any further measures that may be required to support community pharmacy in delivering vaccinations.

For Hospital hubs: Hospital hubs continue to play a critical role in the vaccination of health and care staff. Given the scale of the challenge, we are now asking hospital hubs to work with their system partners to review their capacity and extend their booster offer.

As a priority, hospital hubs should continue to offer vaccinations to their staff and extend their offer to patients who are immunosuppressed, as well as opportunistic vaccination of inpatients and outpatients, as a minimum. If they did so in the first phase of the vaccination programme, hospital hubs should again implement local booking solutions to vaccinate other health and social care workers and unpaid carers in their area. Where this is required locally, hospital hubs should also provide an offer to the general public by becoming a hospital hub plus and utilising the NBS or local booking systems.

WORKFORCE

Systems have highlighted workforce as a rate limiting factor for increasing capacity, particularly in rural areas. Therefore, the following steps to improve access to additional workforce are now being put in place:

- A request to the Ministry of Defence to secure military personnel to provide rapid deployment vaccination teams across England.
- All national NHS organisations have now been asked to deploy their registered healthcare professionals into vaccination services.
- Clinical students are being invited to work bank shifts when not engaged in educational activities or on placement. Students will be contacted directly and asked to rapidly register.
- NHS Professionals have committed to recruiting staff including registrants, unregistered vaccinators, healthcare support workers and administrators.
- Contingency staff pools offered through NHS Professionals (vaccine operational support teams) will be expanded, increasing coverage across the country.
- St John Ambulance are re-engaging existing volunteers and recruiting additional vaccinator volunteers, patient advocates and post vaccination observers.
- A new campaign to recruit more stewards and volunteers has been launched by the Royal Voluntary Service. All vaccination services can book these volunteers directly through the GoodSam app.

Your system lead employer can provide assistance and access to all of the resources listed above. Their contact details are set out here on FutureNHS, and have been provided alongside the cascade of this letter.

Finally, in their December update, the UKHSA estimate that, as of 24 September, 127,500 deaths and 24,144,000 infections have been prevented as a result of the COVID-19 vaccination programme. As we approach the anniversary of offering the first vaccination in the world outside of a clinical trial, we want to thank you for your continued commitment to saving lives and protecting communities.

Yours sincerely

Amanda Pritchard	**Dr Emily Lawson**	**Dr Nikki Kanani**	**Ed Waller**
NHS Chief Executive	NHS SRO Vaccine Deployment	Deputy SRO, COVID-19 Vaccination Deployment Programme, Medical Director for Primary Care	Director of Primary Care

Classification: Official
Publication approval reference: C1475

Appendix B

To:
- GP practices
- Primary care networks
- NHS England and NHS Improvement regions:
  - directors
  - directors of commissioning
- Clinical commissioning groups:
  - clinical leads
  - accountable officers

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

8 December 2021

Dear Colleagues

Temporary GP contract changes to support COVID-19 vaccination programme

1. In our letter of 3 December, NHS England and NHS Improvement set out plans for an acceleration of COVID-19 vaccination following the emergence of the Omicron variant. This letter sets out further details of the actions we are taking to support GPs, primary care networks (PCNs) and their teams to progress this expansion of the vaccination programme alongside prioritisation of timely patient access to general practice services this winter.

2. We recognise that balancing your resources this winter between the urgent needs of your patients, the management of long term conditions, and the vital task of vaccination and public health is a daily challenge. The measures in this letter seek to support your professional clinical judgement in balancing these considerations.

The Quality and Outcomes Framework (QOF)

3. The evidence-based care provided via QOF continues to be important in minimising health inequalities and securing the best outcomes for those with long term conditions. However, to support the ongoing response to COVID-19 and the increase in vaccination capacity, combined with the need to target proactively and support our most vulnerable patients during this period, we are making the following changes to QOF in 2021/22 – applying to all practices – which will be reflected in an amended statement of financial entitlement (SFE):

   a. Practices should focus on the four vaccination and immunisation indicators, the two cervical screening indicators, the register indicators and the eight prescribing

indicators (see Appendix 1). These will continue to operate on the basis of practice performance in 2021/22.

b. Forty-six QOF points for new indicators where there is no historic performance to use as the basis for income protection (the eight points associated with the new for 2021/22 cancer indicators, 20 points from the new for 2021/22 mental health indicators and 18 points from the non-diabetic hyperglycaemia indicator that was introduced for 2020/21) will be reallocated. These will increase the total points available for the eight prescribing indicators, reflecting the continued importance of effective prescribing in the management of long term conditions. We appreciate the work you will have undertaken in these domains to date and that you will continue to clinically prioritise care.

c. The remaining indicators will be income protected using a methodology very similar to the one applied in 2020/21: most income-protected indicators for 2021/22 will be paid based on achievement in 2018/19, while the income-protected indicators relating to diabetes and hypertension will be based on 2019/20 achievement, given some indicators in those domains were new for the 2019/20 year (see Appendix 2). Points will be subject to a list size and prevalence adjustment calculated in the usual way at year end. Practices are expected to continue to apply their clinical judgement and deliver as much patient care in these areas as they can, with a focus on the highest risk patients, but their income will not be dependent on recorded QOF achievement this year for the income-protected indicators.

d. The quality improvement (QI) domain will be paid to practices in full.

e. To be eligible for income protection, practices will need to agree with their commissioner a plan that will set out how QOF care will be delivered wherever possible, but with priority according to clinical risk and accounting for inequalities. We will be working with the Royal College of GPs (RCGP) and the British Medical Association (BMA) to provide some guidance to systems and practices.

4. All activity undertaken should continue to be coded. The Calculating Quality Report Service (CQRS) will continue to operate in 2021/22 and achievement data will be collected and reported for all indicators. Aspiration payments will continue as at present. Payment for QOF may be made later than usual for 2021/22, given that the proposed changes to the scheme are being made towards the end of the year.

5. QOF will recommence in full from April 2022.

Investment and Impact Fund (IIF)

6. The following changes will apply to IIF for 2021/22, implemented via a forthcoming Variation to the Network Contract Directed Enhanced Service (DES):

    a. The three flu immunisation indicators, and the appointment categorisation indicator (as the work is complete), will continue to operate on the basis of PCN performance in 2021/22 (see Appendix 3).

    b. The remaining indicators will be suspended and the funding allocated (worth £112.1m) repurposed (see Appendix 4).

    c. £62.4m of the funding allocated to these suspended indicators will instead be allocated to PCNs via a PCN support payment, to be paid on a weighted patient basis, subject to a simple confirmation from the PCN that it will be reinvested into services or workforce.

    d. £49.7m will be allocated to a new binary IIF indicator, paid on the basis of all practices within a PCN being signed up to phase 3 of the COVID-19 Vaccination Enhanced Service as at 31 December 2021, remaining signed up until 31 March 2022, and actively delivering the programme. Given the opt-in deadline of **10 December 2021**, practices not signed up to the phase 3 Enhanced Service would need to opt in by 10 December 2021, be assured to go live in early January, and continue to participate in the enhanced service until 31 March 2022 to be eligible for this indicator. Payment for this indicator will be made on a registered list size basis after the end of the financial year. Where, in exceptional circumstances, the commissioner agrees with one or more practices that they should not participate in the COVID-19 Vaccination Enhanced Service (as a result of wider access, performance or patient safety issues) then the PCN may still receive payment with those practices excluded from consideration. The payment will not apply if any practice in the PCN otherwise declines to participate in the programme.

7. As with QOF, CQRS will continue to operate in 2021/22 and achievement data will be collected and reported for all indicators. Recording of activity should continue. Payment for IIF may be made later than usual for 2021/22, given that the proposed changes to the scheme are being made towards the end of the year.

8. IIF will recommence in full from April 2022.

Wider measures

9. If participating in the vaccine programme, income protection for the Minor Surgery DES will apply from 1 December 2021 until 31 March 2022. Local commissioners

should make the monthly payments to practices for the Minor Surgery DES that they made for the corresponding period from 1 December 2018 to 31 March 2019. No contract enforcement will be taken where no activity is done under the Minor Surgery Additional Service from 1 December 2021 to 31 March 2022. Capacity released must be redeployed to vaccination.

10. From 1 December 2021 to 31 March 2022, where contractors consider it clinically appropriate and they are participating in the vaccine programme, routine health checks on request for those over 75 who have not had a consultation in the last 12 months, and for new patients may be deferred.

11. The Dispensary Services Quality Scheme will be amended to reduce the requirement for medication reviews from a minimum of 10% of dispensing patients to a minimum of 7.5% for 2021/22. Practices are asked to prioritise patients who they consider to be higher-risk or would benefit most from a review.

Additional telephony support

12. As a component of the NHS England and NHS Improvement Winter Access programme, NHSX have agreed a time-limited offer with Microsoft for general practice to utilise MS Teams telephony functionality. This solution will enable staff to use MS teams to make outbound only calls independently of the existing telephone solutions. This will free up the existing lines for incoming calls. Practices will keep their current telephony supplier and associated number in place to support the receiving of calls. This national offer is an additional component to the Microsoft Teams application currently provided and will increase telephone capacity at no additional cost to the practice. The additional outbound only call functionality will expire on 30 April 2023.

13. If you have already responded to the baselining questionnaire indicating interest, this functionality will be enabled for all Teams users in your practice. Further communications will follow from the NHSmail Team confirming the date of availability and providing links to the support site which contains details of how to access including training and support.

14. Contact the team on scwcsu.nhsei.winterpressures.advancedtelephony@nhs.net if you no longer wish to progress with this offer, or if you did not complete the original questionnaire, but wish to take up this offer.

Next steps

15. The sign-up window for the phase 3 GP COVID-19 Vaccination Enhanced Service has therefore been reopened. Practices who wish to sign up should liaise with their local commissioner as soon as possible to discuss next steps.

Yours sincerely,

Ed Waller
Director of Primary Care
NHS England and NHS Improvement

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

Appendix 1: QOF performance-based indicators 2021/22

Table 1: Performance-based public health indicators with unchanged points values 2021/22

Indicator ID	Indicator wording	Points	Payment thresholds	Points at the lower threshold
VI001	The percentage of babies who reached 8 months old in the preceding 12 months, who have received at least 3 doses of a diphtheria, tetanus and pertussis containing vaccine before the age of 8 months	18	90-95%	3
VI002	The percentage of children who reached 18 months old in the preceding 12 months, who have received at least 1 dose of MMR between the ages of 12 and 18 months	18	90-95%	7
VI003	The percentage of children who reached 5 years old in the preceding 12 months, who have received a reinforcing dose of DTaP/IPV and at least 2 doses of MMR between the ages of 1 and 5 years	18	87-95%	7
VI004	The percentage of patients who reached 80 years old in the preceding 12 months, who have received a shingles vaccine between the ages of 70 and 79 years	10	50-60%	-
CS005	The proportion of women eligible for screening aged 25-49 years at end of period reported whose notes record that an adequate cervical screening test has been performed in the previous 3 years and 6 months	7	45-80%	-
CS006	The proportion of women eligible for screening and aged 50-64 years at end of period reported whose notes record that an adequate cervical screening test has been performed in the previous 5 years and 6 months	4	45-80%	-
			Total	**75**

Table 2: Performance-based prescribing indicators with changed points values 2021/22

Indicator ID	Indicator wording	Original points	Updated points	Payment thresholds
AF007	In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy	12	25	40-70%
CHD005	The percentage of patients with coronary heart disease with a record in the preceding 12 months that aspirin, an alternative anti-platelet therapy, or an anti-coagulant is being taken	7	15	56-96%
HF003	In those patients with a current diagnosis of heart failure due to left ventricular systolic dysfunction, the percentage of patients who are currently treated with an ACE-I or ARB	6	12	60-92%
HF006	The percentage of patients with a current diagnosis of heart failure due to left ventricular systolic dysfunction, who are currently treated with a beta-blocker licensed for heart failure	6	12	60-92%
STIA007	The percentage of patients with a stroke shown to be non-haemorrhagic, or a history of TIA, who have a record in the preceding 12 months that an anti-platelet agent, or an anti-coagulant is being taken	4	8	57-97%
DM006	The percentage of patients with diabetes, on the register, with a diagnosis of nephropathy (clinical proteinuria) or micro-albuminuria who are currently treated with an ACE-I (or ARBs)	3	8	57-97%
DM022	The percentage of patients with diabetes aged 40 years and over, with no history of cardiovascular disease and without moderate or severe frailty, who are currently treated with a statin (excluding patients with type 2 diabetes and a CVD risk score of <10% recorded in the preceding 3 years)	4	7	50-90%
DM023	The percentage of patients with diabetes and a history of cardiovascular disease (excluding haemorrhagic stroke) who are currently treated with a statin	2	4	50-90%
			Total	**90**

Table 3: Disease register indicators

Indicator ID	Indicator	Points
AF001	The contractor establishes and maintains a register of patients with atrial fibrillation	5
CHD001	The contractor establishes and maintains a register of patients with coronary heart disease	4
HF001	The contractor establishes and maintains a register of patients with heart failure	4
HYP001	The contractor establishes and maintains a register of patients with established hypertension	6
PAD001	The contractor establishes and maintains a register of patients with peripheral arterial disease	2
STIA001	The contractor establishes and maintains a register of patients with stroke or TIA	2
DM017	The contractor establishes and maintains a register of all patients aged 17 or over with diabetes mellitus, which specifies the type of diabetes where a diagnosis has been confirmed	6
AST005	The contractor establishes and maintains a register of patients with asthma aged 6 years or over, excluding patients with asthma who have been prescribed no asthma related drugs in the preceding 12 months	4
COPD009	The contractor establishes and maintains a register of: 1. Patients with a clinical diagnosis of COPD before 1 April 2021 and 2. Patients with a clinical diagnosis of COPD on or after 1 April 2021 whose diagnosis has been confirmed by a quality assured post bronchodilator spirometry FEV1/FVC ratio below 0.7 between 3 months before or 6 months after diagnosis (or if newly registered in the preceding 12 months a record of an FEV1/FVC ratio below 0.7 recorded within 6 months of registration); and 3. Patients with a clinical diagnosis of COPD on or after 1 April 2021 who are unable to undertake spirometry	8
DEM001	The contractor establishes and maintains a register of patients diagnosed with dementia	5
MH001	The contractor establishes and maintains a register of patients with schizophrenia, bipolar affective disorder and other psychoses and other patients on lithium therapy	4
CAN001	The contractor establishes and maintains a register of all cancer patients defined as a ‘register of patients with a diagnosis of cancer excluding non-melanotic skin cancers diagnosed on or after 1 April 2003’	5
CKD005	The contractor establishes and maintains a register of patients aged 18 or over with CKD with classification of categories G3a to G5 (previously stage 3 to 5)	6

Indicator ID	Indicator	Points
EP001	The contractor establishes and maintains a register of patients aged 18 or over receiving drug treatment for epilepsy	1
LD004	The contractor establishes and maintains a register of patients with learning disabilities	4
OST004	The contractor establishes and maintains a register of patients: 1. Aged 50 or over and who have not attained the age of 75 with a record of a fragility fracture on or after 1 April 2012 and a diagnosis of osteoporosis confirmed on DXA scan, and 2. Aged 75 or over with a record of a fragility fracture on or after 1 April 2014 and a diagnosis of osteoporosis	3
RA001	The contractor establishes and maintains a register of patients aged 16 or over with rheumatoid arthritis	1
PC001	The contractor establishes and maintains a register of all patients in need of palliative care/support irrespective of age	3
OB002	The contractor establishes and maintains a register of patients aged 18 years or over with a BMI ≥30 in the preceding 12 months	8
	Total	**81**

The points allocated to these indicators in Table 4 are reallocated to the prescribing indicators in Table 2.

Table 4: Indicators without historic performance

Indicator ID	Indicator wording	Points	Payment thresholds
MH007	The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of alcohol consumption in the preceding 12 months	4	50-90%
MH011	The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of a lipid profile in the preceding 12 months (in those patients currently prescribed antipsychotics, and/or who have pre-existing cardiovascular conditions, and/or smoke, and/or are overweight [BMI of ≥23 kg/m2 or ≥25 kg/m2 if ethnicity is recorded as White]) or preceding 24 months for all other patients	8	50-90%
MH012	The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood glucose or HbA1c in the preceding 12 months	8	50-90%
CAN004	The percentage of patients with cancer, diagnosed within the preceding 24 months, who have a patient Cancer Care Review using a structured template recorded as occurring within 12 months of the date of diagnosis	6	50-90%
CAN005	The percentage of patients with cancer, diagnosed within the preceding 12 months, who have had the opportunity for a discussion and been informed of the support available from primary care, within 3 months of diagnosis	2	70-90%
NDH001	The percentage of patients with non-diabetic hyperglycaemia who have had an HbA1c or fasting blood glucose performed in the preceding 12 months	18	50-90%
	Total points to be reallocated		**46**

Appendix 2: QOF income-protected indicators 2021/22

Table 5: Indicators to be paid based on performance in 2018/19 (with indicator dates amended as appropriate)

Indicator ID	Indicator description	Points
AF006	The percentage of patients with atrial fibrillation in whom stroke risk has been assessed using the CHA2DS2-VASc score risk stratification scoring system in the preceding 12 months (excluding those patients with a previous CHADS2 or CHA2DS2-VASc score of 2 or more)	12
CHD008	The percentage of patients aged 79 years or under with coronary heart disease in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less	12
CHD009	The percentage of patients aged 80 years or over with coronary heart disease in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less	5
HF005	The percentage of patients with a diagnosis of heart failure on or after 1 April 2021 which: 1. Has been confirmed by an echocardiogram or by specialist assessment between 3 months before or 6 months after entering on to the register; or 2. If newly registered in the preceding 12 months, with no record of the diagnosis originally being confirmed by echocardiogram or specialist assessment, a record of an echocardiogram or a specialist assessment within 6 months of the date of registration.	6
HF007	The percentage of patients with a diagnosis of heart failure on the register, who have had a review in the preceding 12 months, including an assessment of functional capacity and a review of medication to ensure medicines optimisation at maximal tolerated doses	7
STIA010	The percentage of patients aged 79 years or under with a history of stroke or TIA in whom the least blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less	3
STIA011	The percentage of patients aged 80 years and over with a history of stroke or TIA in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less	2
AST006	The percentage of patients with a diagnosis of asthma on or from 1 April 2021 with either: 1. a record of spirometry and one other objective test (FeNO or reversibility or variability) between 3 months before or 6 months after diagnosis; or 2. If newly registered in the preceding 12 months with a diagnosis of asthma recorded on or after April 2021 but no record of objective tests being performed at the date of registration, with a record of spirometry and one other objective test (FeNO or reversibility or variability) recorded within 6 months of registration	15

Indicator ID	Indicator description	Points
AST007	The percentage of patients with asthma on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using a validated asthma control questionnaire, a recording of the number of exacerbations, an assessment of inhaler technique and a written personalised action plan	20
AST008	The percentage of patients with asthma on the register aged 19 or under, in whom there is a record of either personal smoking status or exposure to second-hand smoke in the preceding 12 months	6
COPD010	The percentage of patients with COPD on the register, who have had a review in the preceding 12 months, including a record of the number of exacerbations and an assessment of breathlessness using the Medical Research Council dyspnoea scale	9
COPD008	The percentage of patients with COPD and Medical Research Council (MRC) dyspnoea scale ≥3 at any time in the preceding 12 months, with a subsequent record of an offer of referral to a pulmonary rehabilitation programme (excluding those who have previously attended a pulmonary rehabilitation programme)	2
DEM004	The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months	39
DEP003	The percentage of patients aged 18 or over with a new diagnosis of depression in the preceding 1 April to 31 March, who have been reviewed not earlier than 10 days after and not later than 56 days after the date of diagnosis	10
MH002	The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive care plan documented in the record, in the preceding 12 months, agreed between individuals, their family and/or carers as appropriate	6
MH003	The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood pressure in the preceding 12 months	4
MH006	The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of BMI in the preceding 12 months	4
RA002	The percentage of patients with rheumatoid arthritis, on the register, who have had a face-to-face review in the preceding 12 months	5
BP002	The percentage of patients aged 45 or over who have a record of blood pressure in the preceding 5 years	15
SMOK002	The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 12 months	25

Indicator ID	Indicator description	Points
SMOK004	The percentage of patients aged 15 or over who are recorded as current smokers who have a record of an offer of support and treatment within the preceding 24 months	12
SMOK005	The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses who are recorded as current smokers who have a record of an offer of support and treatment within the preceding 12 months	25
	Total	**244**

Table 6: Indicators to be paid based on 2019/20 performance (with indicator dates amended as appropriate)

Indicator ID	Indicator description	Points
DM0012	The percentage of patients with diabetes, on the register, with a record of a foot examination and risk classification: 1) low risk (normal sensation, palpable pulses), 2) increased risk (neuropathy or absent pulses), 3) high risk (neuropathy or absent pulses plus deformity or skin changes in previous ulcer) or 4) ulcerated foot within the preceding 12 months	4
DM014	The percentage of patients newly diagnosed with diabetes, on the register, in the preceding 1 April to 31 March who have a record of being referred to a structured education programme within 9 months after entry on to the diabetes register	11
DM019	The percentage of patients with diabetes, on the register, without moderate or severe frailty in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less	10
DM020	The percentage of patients with diabetes, on the registers, without moderate or severe frailty in whom the last IFCCHbA1c is 58 mmol/mol or less in the preceding 12 months	17
DM021	The percentage of patients with diabetes, on the register, with moderate or severe frailty in whom the last IFCC-HbA1c is 75 mmol/mol or less in the preceding 12 months	10
HYP003	The percentage of patients aged 79 years or under with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less	14
HYP007	The percentage of patients aged 80 years and over with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less	5
	Total	**71**

Table 7: Indicators awarded in full for 2021/22

Indicator ID	Indicator description	Points
QIECD005	The contractor can demonstrate continuous quality improvement activity focused upon early cancer diagnosis as specified in the QOF guidance.	27
QIECD006	The contractor has participated in network activity to regularly share and discuss learning from quality improvement activity focused on early cancer diagnosis as specified in the QOF guidance. This would usually include participating in a minimum of two peer review meetings	10
QILD007	The contractor can demonstrate continuous quality improvement activity focused on care of patients with a learning disability as specified in the QOF guidance	27
QILD008	The contractor has participated in network activity to regularly share and discuss learning from quality improvement activity focused on the care of patients with a learning disability as specified in the QOF guidance. This would usually include participating in a minimum of two network peer review meetings	10
	Total	**74**

Appendix 3: Existing IIF indicators paid on a performance basis 2021/22

Indicator	Thresholds	Valuation
VI-01: Percentage of patients aged 65 years or over who received a seasonal influenza vaccination between 1 September and 31 March	80% (LT), 86% (UT)	£9.0m / 40 pts
VI-02: Percentage of at-risk patients aged 18 to 64 years who received a seasonal influenza vaccination between 1 September and 31 March	57% (LT), 90% (UT)	£19.8m / 88 pts
VI-03: Percentage of patients aged two or three years on 31 August of the relevant financial year who received a seasonal influenza vaccination between 1 September and 31 March	45% (LT), 82% (UT)	£3.2m / 14 pts
ACC-01: Confirmation that all practices in the PCN have mapped all active appointment slot types to the new set of national appointment categories, and are complying with the August 2020 guidance on recording of appointments	n/a - Binary indicator	£6.1m / 27 pts

Appendix 4: Suspended IIF indicators 2021/22

Indicator	Thresholds	Valuation
HI-01: Percentage of patients on the Learning Disability register aged 14 years or over, who received an annual Learning Disability Health Check and have a completed Health Action Plan	49% (LT), 80% (UT)	£8.1m / 36 pts
HI-02: Percentage of registered patients with a recording of ethnicity	81% (LT), 95% (UT)	£10.1m / 45 pts
CVD-01: Percentage of patients aged 18 years or over, not on the QOF hypertension register as of 30 September 2021, and who have (i) a last recorded blood pressure reading in the two years prior to 1 October 2021 >= 140/90mmHg or (ii) a blood pressure reading >= 140/90mmHg on or after 1 October 2021, for whom there is evidence of clinically appropriate follow-up to confirm or exclude a diagnosis of hypertension by 31 March 2022	20% (LT), 25% (UT)	£12.0m / 53 pts
CVD-02: Percentage of registered patients on the QOF hypertension register	Increase 0.2pp (LT), Increase 0.3pp (UT)	£6.1m / 27 pts
PC-01: Percentage of registered patients referred to social prescribing	0.8% (LT), 1.2% (UT)	£4.5m / 20 pts
EHCH-01: Number of Patients recorded as living in a care home, as a percentage of care home beds eligible to receive the Network Contract DES Enhanced Health in Care Homes service	30% (LT), 85% (UT)	£4.1m / 18 pts
EHCH-02: Percentage of care home residents aged 18 years or over, who had a Personalised Care and Support Plan (PCSP) agreed or reviewed	80% (LT), 98% (UT)	£4.1m / 18 pts
EHCH-03: Percentage of permanent care home residents aged 18 years or over who received a Structured Medication Review	80% (LT), 98% (UT)	£4.1m / 18 pts
EHCH-04: Mean number of patient contacts as part of weekly care home round on or after 1 October per care home resident	3 (LT), 4 (UT)	£2.9m / 13 pts
ACC-02: Number of online consultations on or after 1 October per 1000 registered patients	130 over 6 months (5 per 1000 per week) (single threshold)	£6.1m / 27 pts
ACC-03: By 31 March 2022, analyse and discuss the implications of data on Type 1 A&E attendance rates for minor conditions with the local ICS, making a plan to reduce unnecessary attendances and admissions.	n/a Binary indicator	£12.6m / 56 pts

Indicator	Thresholds	Valuation
ACC-04: Work collaboratively with local community pharmacy colleagues to develop and commence delivery of a plan to increase referrals to the Community Pharmacist Consultation Service, with referral levels increasing by no later than 31 March 2022.	n/a Binary indicator	£12.6m / 56 pts
ACC-05: By 31 March 2022, make use of GP Patient Survey results for practices in the PCN to identify patient groups experiencing inequalities in their experience of access to general practice, and develop and implement a plan to improve access for these patient groups.	n/a Binary indicator	£12.6m / 56 pts
ES-01: Metered Dose Inhaler (MDI) prescriptions as a percentage of all non-salbutamol inhaler prescriptions issued on or after 1 October	53% (LT), 44% (UT)	£6.1m / 27 pts
ES-02: Mean carbon emissions per salbutamol inhaler prescribed on or after 1 October (kg CO2e)	22.5kg (LT), 19.4kg (UT)	£6.1m / 27 pts

Appendix C

Nottingham and Nottinghamshire
Clinical Commissioning Group

Flexibilities introduced to support GP practices to deliver the vaccination programme

Dear Colleague

We are taking this opportunity to write to you following the publication of the letter from Amanda Pritchard, Dr Emily Lawson, Dr Nikki Kanani and Ed Waller (dated 3rd December) regarding the ***JCVI advice in response to the emergence of the B. 1. 1.529 (Omicron) variant: next steps for deployment*** of the vaccination programme.

Thank you to those PCNs who opted in to deliver phase 3 of the vaccination programme, for your continued excellent work to support the roll out of the COVID-19 vaccination programme. The contribution of General Practice to the Nottingham and Nottinghamshire Programme has meant that over 254,347 Nottingham and Nottinghamshire residents since September 2021 have received their booster vaccination. That is an incredible achievement and we wish to thank all members of our practice teams for their support to the programme.

Friday's national letter outlines the urgency

- to offer boosters to all >18 before the end of January, to protect our population from the impact of covid-19 infection as well as protecting vital NHS services this winter
- to offer boosters to our most vulnerable who have reached 3 months from second dose before Christmas

The phase 3 programme to vaccinate the 50+ population, which began in September, scaled back the number of vaccination centres, to deliver the programme across a greater number of sites like GP practices and Community Pharmacies. The request now is for a rapid rollout and we would request that General Practice reconsider how it can assist to protect out population and the wider system from the omicron variant.

To support your considerations, nationally there have been the following **financial changes to PCN delivery**:

- GP/CP providers increase in vaccination payments from 1st December (formal announcement expected):
- £15 for vaccinations (Monday to Saturday) – to 31st Jan 2022
- £20 (Sunday/BH) – to 31st Jan 2022
- £30 (housebound) – to 31st Dec 2021, backdated to the start of phase 3
- £10 supplement to vaccines administered to severely immunosuppressed people 1st Dec 2021-31st January 2021
- Increase in payment for PCN clinical directors (from 0.75 to 1.0 WTE to 31st March 2022)

National flexibilities to enable GP Practices to deliver vaccinations are outlined in 2 letters:

- Publication Approval Reference C1468 – issued 3 December 2021

- **C1468-jvci-advice-in-response-to-the-emergence-of-the-b.1.1.529-omicron-variant-next-steps-for-deployment.pdf (england.nhs.uk)**
- Publication Approval Reference C1475 – issued 8 December 2021
- **C1475-letter-temporary-gp-contract-changes-to-support-covid-19-vaccination-programme.pdf (england.nhs.uk)**

FOR ACTION: PCN/Practice participation in the vaccination programme

- Practices participating in Phase 3 of the COVID Vaccination Programme will now benefit from protected income due to several changes in the national contractual requirements for 2021/22.
- Practices are required to submit their Practice plans which outline the additional planned vaccination activity in support of the PCN delivery, because of income protection, for support by the CCG
- Practices that are not delivering the Phase 3 COVID Vaccination Programme will **NOT** benefit from the protected income outlined in these letters
- The CCG encourages all practices that have previously "opted out" of the Phase 3 Enhanced Service to reconsider participation in Phase 4
- Those practices who did not "opt in" to deliver 40+ vaccinations (without this, practices cannot deliver as part of Phase 4) should reconsider participation in Phase 4
- **Please inform your locality team by 12.00noon on Friday 10 December 2021.**

City: ✉ nnccg.citylocalityteam@nhs.net
Mid Notts: ✉ nnccg.midnotts.psos@nhs.net
South Notts: ✉ nnccg.southnottslocality@nhs.net

Flexibilities explained:

Creating capacity: Creating capacity within primary care will be enabled by the following: If participating in the vaccination programme, income protection for the Minor Surgery DES will apply from 1 December 2021 until 31 March 2022. Local commissioners should make the monthly payments to practices for the Minor Surgery DES that they made for the corresponding period from 1 December 2018 to 31 March 2019. No contract enforcement will be taken where no activity is done under the Minor Surgery Additional Service from 1 December 2021 to 31 March 2022. Capacity released must be redeployed to vaccination.

- **Practices participating in Phase 3 of the COVID Vaccination Programme will now benefit from protected income for the Minor Surgery DES for the period 1 December 2021 to 31 March 2022.**
- **Individual patients will need to be assessed by practices to determine clinical need for Minor Surgery during this period.**
- **Income protection will apply to all practices engaged in the delivery of the vaccination programme.**
- **The CCG encourages practices currently not engaged in the delivery of COVID vaccine programme to "opt in" now to help maximise delivery; this is now supported by the changes to the national contractual requirements for 2021/22.**

From 1 December 2021 to 31 March 2022, where contractors consider it clinically appropriate, routine health checks for those over 75 and for new patients may be deferred

- **Practices are required to consider where it is clinically appropriate to defer routine health checks**

The evidence-based care provided via QOF continues to be important in minimising health inequalities, securing the best outcomes for those with long term conditions and preventing wider system impacts. To support the ongoing response to COVID-19 and the increase in vaccination capacity, combined with the need to target proactively and support our most vulnerable patients during this period, we will introduce the following changes for 2021/22:

- **Practices participating in Phase 3 of the COVID Vaccination Programme will now benefit from protected income for some QOF indicators for the financial year 2021/22.**
- **Again, the CCG encourages practices currently not engaged in the delivery of COVID vaccine programme to "opt in" now to help maximise delivery; this is now supported by the changes to the national contractual requirements for 2021/22.**

Some QOF indicators will continue to be paid based on practice performance. These include vaccination, cervical screening, register indicators and those related to optimal prescribing.

- **Activity for these QOF domains will continue – no QOF income protection applies**

Others will be subject to income protection based upon historical practice performance, in a similar way to arrangements in 2020/21.

To be eligible for income protection, practices will need to agree with their commissioner a plan that will set out how QOF care will be delivered wherever possible but with priority according to clinical risk, and accounting for inequalities. Further details around this form a local commissioner point of view will follow in the next few of days.

- **Practices will need target proactively and support our most vulnerable patients during this period. Identifying and caring for patients will be a judgement to be made at practice level, tools in eHealthscope and Ardens will help practices to identify those patients and allow practices to risk stratify and prioritise.**

QOF will recommence in April 2022.

- **QOF for 2022/23 will recommence in line with national contractual requirements.**

For the IIF, the indicators introduced in April 2021 covering flu immunisation and the completed work on appointment recording and categorisation will be paid as normal. The remaining indicators will be suspended and the funding repurposed. The majority of the funding allocated to these suspended indicators will instead be allocated to PCNs via a PCN Support Payment, on a weighted patient basis, subject to confirmation from the PCN that it will be reinvested into services or workforce. The remaining funding will instead be allocated to a new IIF incentive to support PCNs whose practices are fully participating in the vaccination programme. Further details will follow. IIF will recommence in April 2022.

- **All practices will need to continue to deliver against specific IIF indictors as there will be no income protection against them e.g. flu immunisations, appointment recording and categorisation**
- **Remaining IIF indicators will be suspended and repurposed in two ways:**
  (1) PCN Support Payment (£62.4m nationally) – paid on a weighted patient basis, and
  (2) Remaining funding (£49.7m nationally) – allocated to new IIF incentive to support PCNs whose practices are fully participating in the vaccination.
- **IIF for 2022/23 will recommence in line with national contractual requirements.**
- **Where not all practices within a PCN are contributing to the vaccination programme the CCG will enact a proportional payment to the practices actively delivering vaccinations. e.g. 6/7 practices engaged in the delivery of the vaccination programme; therefore, payment under new IIF incentive will only be allocated to the 6 practices participating**

The Dispensing Services Quality Scheme will be amended to reduce the requirement for medication reviews from a minimum of 10% of dispensing patients to a minimum of 7.5% for 2021/22. Practices are asked to prioritise patients who they consider to be higher-risk or would benefit most from a review.

- **DSQS will continue to be managed by NHSE/I Regional colleagues as this remains a function under Pharmacy Regulations.**

In addition to the nationally agreed flexibilities, you have our full support for continued involvement in the programme through the following mechanisms:

- Repurpose extended access or extended hours capacity to support vaccination
- Where possible we will redeploy CCG staff to support PCN clinic-based model. This resource will be prioritised for PCNs where uptake is more challenging
- Repurposing of PLT in January 2022 to support practice-based vaccinations
- Put your PCN appointments onto the National Booking Service (to maximise appointments, manage eligibility and reduce DNAs)
- Working with local partners to address variation in vaccination uptake and provide a targeted coordinated response.

Next steps

PCN capacity to support the vaccination programme for those engaged should improve and PCNs indicate in their plans what additional (an increase from current plans) vaccination delivery the increased flexibilities will enable with a statement confirming individual practice participation.

Please submit your revised plan detailing the number of expected additional vaccinations per week through to the 31 January 2022. This will then this will help to inform the weekly vaccine allocation requests. Please submit to your locality team by 10.00am on Thursday 16 December 2021:

- **City: ✉ nnccg.citylocalityteam@nhs.net**
- **Mid Notts: ✉ nnccg.midnotts.psos@nhs.net**
- **South Notts: ✉ nnccg.southnottslocality@nhs.net**

We will work with you over the coming days through our locality teams, and with Beth Carney (PCN Vaccination lead) and Dr Hilary Lovelock (Clinical Lead), to understand your practice based clinic model and how you can increase your offer of support to the vaccination programme.

We strongly recommend, considering the increased flexibilities and new COVID variant, that you commit to providing vaccination services for your population.

Please do not hesitate to contact Beth (**Beth.carney@nhs.net**) or your locality team to discuss your options in more detail.

Thank you once again for your on-going commitment to the delivery of the Covid vaccination to our local population.

Stephen Shortt
CCG Clinical Chair
stephen.shortt1@nhs.net

James Hopkinson
CCG Clinical Chair
james.hopkinson@nhs.net

Amanda Sullivan
Accountable Officer
Amanda.sullivan7@nhs.net

9th December 2021

Nottingham and Nottinghamshire Clinical Commissioning Group

Meeting Title:	Primary Care Commissioning Committee (Open Session)	**Date:**	15 December 2021
Paper Title:	Review of Primary Care Network NHSE/I Maturity Matrix	**Paper Reference:**	**PCC 21 185**

Sponsor: **Presenter:**	Lucy Dadge – Chief Commissioning Officer Helen Griffiths - Associate Director for Primary Care Network Development	**Attachments/ Appendices:**	Appendix 1 NHSE PCN Maturity Matrix Appendix 2 Summary of the individual PCN position against the NHSE PCN Maturity Matrix Appendix 3 Summary of the PCNs positions across the NHSE PCN Maturity Matrix Domains.

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

Executive Summary

This paper provides an update on the progress of the Primary Care Network (PCN) development across the ICS in line with the NHS England (NHSE) PCN Maturity Matrix. The self-assessment was completed during Quarter 2 and submitted to NHSE on 8th October 2021.

The Primary Care Co-Commissioning Committee is asked to note the ongoing development and progress of the PCNs, as well as consider the proposed actions for supporting their ongoing development over the five-year (2019 – 2024) national programme.

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 ☒	No change, update only
Data Protection Impact Assessment (DPIA)	Yes ☐	No ☐	N/A ☒	No change, update only
Risk(s):				
No risks identified				
Confidentiality:				
☒No				
☐Yes (please indicate why it is confidential by ticking the relevant box below)				
☐The document contains Personal information				
☐The CCG is in commercial negotiations or about to enter into a procurement exercise				
☐The document includes commercial in confidence information about a third party				
☐The document contains information which has been provided to the CCG in confidence by a third party				
☐The discussion relates to policy development not yet formalised by the organisation				
☐The document has been produced by another public body				
☐The document is in draft form				
Recommendation(s):				
1. **NOTE** the current position of the PCNs against the NHSE PCN Maturity Matrix 2. **CONSIDER** 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.				

Nottingham and Nottinghamshire Clinical Commissioning Group

Review of Primary Care Network NHS England Maturity Matrix

1. Introduction

This paper provides an update on the progress of the Primary Care Network (PCN) development across the ICS in line with the NHS England (NHSE) PCN Maturity Matrix. The self-assessment was completed during Quarter 2 and submitted to NHSE on 8th October 2021.

The Primary Care Co-Commissioning Committee is asked to note the ongoing development and progress of the PCNs, as well as consider the proposed actions for supporting their ongoing development over the five-year (2019 – 2024) national programme.

2. Context

The national PCN Maturity Matrix was developed in August 2019 by NHSE and outlines the key components that underpin the successful development and ambitions of a PCN. It sets out a 'progression' model that develops from the initial start-up to establish a PCN, through to evolving the scope and scale of the role of Networks in delivering an integrated model of care for the population health of their neighbourhoods.

The PCN Maturity Matrix is not a binary checklist or a performance management tool, it 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, as well as how groups of PCNs can collaborate at Place Level in the planning and delivery of care.

Using the Maturity Matrix as a basis for discussion, allows Networks to:

- Come together around a shared sense of purpose, identify where PCNs are in their journey of development, and consider how they can continue to build on existing improvements, such as those that may have been enabled by the GP Forward View, and other local integration initiatives.
- Make plans for further development which continues to evolve integrated care and approaches to population health management.
- Identify ongoing development needs using the NHSE PCN Development Support Prospectus as a guide for implementing local support plans.

The Maturity Matrix, as attached in Appendix 1, highlights the four columns showing a development journey over time organised into 'Foundation', Step 1, Step 2 and Step 3 across five indicators, against the following domains:

1. Leadership, planning and partnerships
2. Use of data and population health management
3. Integrating care
4. Managing resources
5. Working in partnership with people and communities.

The Maturity Matrix should be used pragmatically and flexibly with the Networks, viewing PCN development as a five-year journey and building on progress that is already in place in improving and transforming care and services for patients and the local population.

3. Completion of the PCN Maturity Matrix

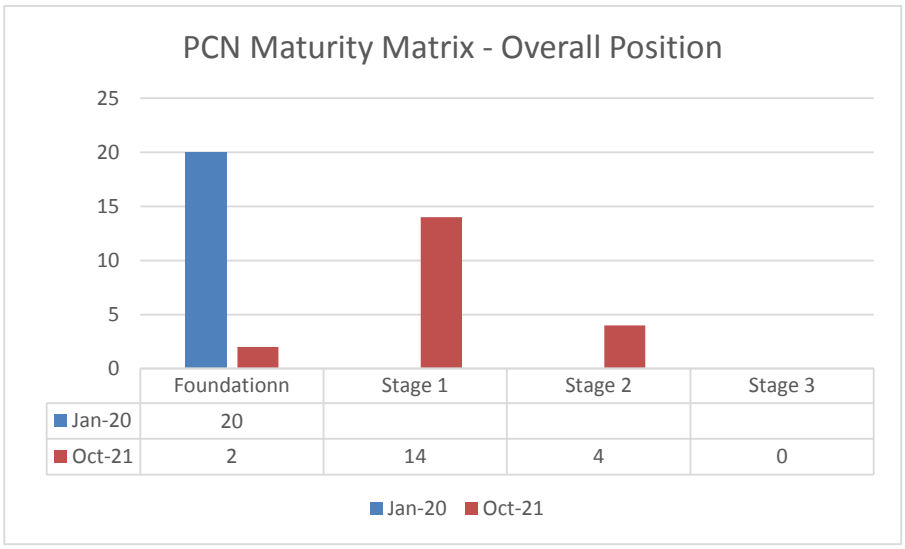
The PCNs first completed a baseline assessment of the Maturity Matrix in October 2019 to understand their starting position. At the request of NHSE the Maturity Matrix was reviewed seven months into the PCN DES contract going live, in January 2020, however, this was work was paused, as advised by NHSE, due to the Covid-19 Pandemic. For the initial two reviews, all PCNs were declaring their position across all domains at Foundation Level, being still in the early stages of their PCN development.

NHSE requested a further review to be undertaken during August and September of this year. A detailed survey was required for completion which outlined 72 questions. Individual responses were considered by each PCN and aggregated up at System level, being submitted to NHSE via an interactive online form.

The ICS has an assurance meeting with NHSE scheduled for January 2022 to review the submission.

4. Summary of PCN Maturity Matrix

The graph below shows that the PCNs have made a significant progress in their development 0ver the last two years, despite the impact that the pandemic has had on primary care.



Within the 5 domains of the Maturity Matrix, NHSE focus on the following areas that feature within the NHSE PCN Prospectus. The support domains include: Leadership; Organisational Development; Change Management; Clinical Director Leadership; Population Health Management; Collaborative Working; Managing Resources; Asset Based Community Development & Social Prescribing.

Nottingham and Nottinghamshire Clinical Commissioning Group

Appendix 2 provides a summary of the individual PCN position against the NHSE PCN Maturity Matrix
Appendix 3 provides a summary of the PCNs positions across the NHSE PCN Maturity Matrix Domains.

5. ICS recommendations for supporting development

The PCNs receive funding to support their development through the Primary Care Transformation Monies, specifically ring fenced as PCN Development Funds. This enables the PCNs to focus on their individual PCN model, and action plan to delivery against the Maturity Matrix. It is important to note that where the System can support the PCNs to deliver the developments at scale, a collaborative approach is offered to the PCNs.

Below is a proposed summary of identified recommendations for the System to support future PCN development. The information has been aligned to the five core Matrix Domains with the intention to work with the wider system partners, strategic planning colleagues, Locality Teams, Communication and Engagement Team, and the System Analytical Intelligence Unit to provide this support and an enabling approach to PCN development.

5.1 Leadership, planning and partnerships

- ***Indicator 1 – The PCN can articulate a clear vision for the network and actions for getting there. GPs, local primary care leaders, local people and community organisations, the voluntary sector and other stakeholders are engaged to help shape this***
    - ❖ To assist PCNs in articulating a clear vision, ensure the strategic direction of the System, and the vision of system partners is clear and understood to PCNs.
    - ❖ Ongoing organisational development to develop PCNs across a wider membership in each neighbourhood. Offer of various engagement sessions to PCNs, to support understanding of how wider engagement can support integration and improved outcomes for patients.
- ***Indicator 2 – Clinical directors are able to access leadership development support***
    - ❖ Continue to provide a local leadership development programme, as well as share educational offers to support the leadership and development of PCNs through locally defined sessions and wider NHSE education sessions.
- ***Indicator 4 – Joint planning is underway to improve integration with broader 'out of hospital' services as networks mature. There are developing arrangements for PCNs to collaborate for services delivered optimally above the 50k footprint***
    - ❖ To ensure that primary care and PCNs are represented in key workstreams of the System Transformation Programme, including Prevention; Community Services; Unplanned Care; Planned Care; Children and Young People; Mental Health.
- ***Indicator 5 – There are local arrangements in place for the PCN (for example through the PCN Clinical Directors) to be involved in Place/System strategic***

decision-making that both supports collaboration across networks and with wider providers including NHS Trusts/FTs and Local Authorities

- ❖ Ensure local governance structures and engagement arrangements support PCN representation at Place and System level and continue to evolve as the ICB is established.

- ***Indicator 6 – The PCN has established an approach to strategic and operational decision-making that is inclusive of providers operating within the network footprint and delivering network-level services. There are local governance arrangements in place within networks to support integrated partnership working***
  - ❖ The current work to review of the Primary Care Strategy and the ongoing implementation to deliver the revised strategy will ensure ongoing engagement and support with system partners.
- ***Indicator 7 – The PCN Clinical Director is working with the ICS leadership to share learning and support other PCNs to develop***
  - ❖ ICS Clinical Director Network Monthly meetings and Place Based Partnership meetings are supported and scheduled to build relations and support shared learning across the Networks. A strategic system update is provided at each monthly meeting.

5.2 Use of data and population health management

- ***Indicator 9 – The PCN is using existing readily available data to understand and address population needs and are identifying the improvements required for better population health***
  - ❖ To continue to work with the recently established System Analytical Intelligence Unit to provide PCNs with data, information, and intelligence to inform decision making for care delivery. To continue to support the development of local existing functions, including eHealthscope, the local PCN Dashboard, and TeamNet.
- ***Indicator 10 – Analysis on variation in outcomes and resource use between practices and PCNs is readily available and acted upon***
  - ❖ Share data that highlights any areas of variation to enhance delivery of care and sharing of best practice.
- ***Indicator 12 – Data and soft intelligence from multiple sources (including and wider than primary care) is being used to identify interventions***
  - ❖ To continue to work with the System Analytical Intelligence Unit in supporting the development of a System Information Dashboard to support future interventions and delivery of primary care.
- ***Indicator 15 – Systematic population health analysis allows the PCN to understand in depth their population's needs, including the wider determinants of health, and design interventions to meet them, acting as early as possible to keep people well and address health inequalities. The PCN's population health model is fully functioning for all patient cohorts***
  - ❖ Provide a facilitated session for each PCN to focus on Population Health Management and their population needs, to identify any gaps in care and workforce requirements.

- ***Indicator 16 – On-going systematic analysis and use of data in care design, case management and direct care interactions to support proactive and personalised care***
    - ❖ Seek support from colleagues to continue to develop proactive and personalised care initiatives that are consistent across the System, and where PCNs can promote and support a personalised proactive care approach. Input being sought from the Communication and Engagement Team to provide consistent messaging and promotion of engagement in the evolving care offer.

5.3 Integrating care

- ***Indicator 17 – The PCN is starting to build local plans for improving the integration of care for their populations, informed by the Long-Term Plan, GP contract framework and locally agreed system/place priorities.***
    - ❖ Encourage and support PCNs to continue to develop and mature their relationships with Partners which is reflected in their local PCN plans.
- ***Indicator 19 – Integrated teams, which may include social care, are working within the network and supporting delivery of integrated care to the local population. Plans are in place to develop MDT ways of working, including integrated rapid response community teams and the delivery of personalised care***
    - ❖ Continue to support multi-agency working, including social care, to maximise multi-disciplinary working outputs, including working to a Standard Operating Procedures for the delivery of multi-disciplinary team (MDT) meetings, and working with the Ageing Well Programme
- ***Indicator 20 – Components of comprehensive models of care are defined for all population groups, with clear gap analysis and workforce plans***
    - ❖ Enhance personalisation of care through the PCN Additional Roles and Reimbursement Scheme emerging roles who will support a proactive approach to wellbeing.
    - ❖ Support workforce planning across PCNs in line with population health management data.
    - ❖ Review the delivery of models of care and share areas of best practice.
- ***Indicator 23 – Fully integrated teams are in place within the PCN, comprising of the appropriate clinical and non-clinical skill mix. MDT working is high functioning and supported by technology. The MDT holds a single view of the patient. Care plans and co-ordination in place for all high-risk patients***
    - ❖ Review inter-operability across all Partners to support MDT delivery.
    - ❖ Review of all PCN estates and consideration of future requirements in line with the future Primary Care Strategy.

5.4 Managing resources

- ***Indicator 25 - Primary care, in particular general practice, has the headroom to make change***
    - ❖ Continue to support PCNs to innovate and make change by providing dedicate time within the ICS Clinical Director Network meetings.

- ❖ Support PCNs to consider leadership capacity and infrastructure to support development.

- ***Indicator 27 – Steps taken to ensure operational efficiency of primary care delivery, such as delivering the Time to Care programme, and support general practices experiencing challenges in delivery of core services***
  - ❖ Workshops for PCNs to support their operational efficiency of their PCNs
- ***Indicator 29 – Data is used in clinical and non-clinical interactions to make best use of resources***
  - ❖ All PCNs to continue to receive annual financial PCN statements to confirm funding available (aligned to the PCN DES contract) and to support best use of resources.

5.5 Working in partnership with people and communities

- ***Indicator 31 – Approach agreed to engage with local communities***
  - ❖ Dedicated support to PCNs to develop an engagement plan understanding what initiatives will be taking place across the system and how information and be passed up and down to ensure maximum output and involvement.
- ***Indicator 33 – The PCN is engaging directly with their population and are beginning to develop trusted relationships with wider community assets***
  - ❖ Support the development of community relationships and their development and share best practice.
  - ❖ Community assets continue to be reviewed to support delivery of care with the support of the Social Prescribing Link Workers.
  - ❖ Support the roll out of the Green Social Prescribing Programme
- ***Indicator 38 – Community networks are understood and connected to the PCN***
  - Support from the Engagement Team, working with Localities and Patient Participation Groups to share PCN developments with local communities and develop the community voice.

6. Place approach to support PCN development

The three Locality Teams are currently reviewing their PCN positions against the Maturity Matrix to identify a place-based approach to supporting their PCNs development and to identify what can be done at scale at across ‘Place’ to support the PCNs maturity, provide a consistent approach, as well as continue to support the collaboration of a Network of Networks.

7. Conclusion

The exercise of reviewing the PCN Maturity Matrix over the summer has been a valuable stock take of the progress and development of the PCNs over this last year. It is positive to note that advancements continue to be made in all areas, across all domains, despite the challenges brought about by primary care meeting the needs and demands of the pandemic. The proposed action plan and approach as outlined to be delivered at System level, coupled with local action plans at Place level will provide a comprehensive enabling framework for the PCNs to continue to mature and thrive.

NHS
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The Primary Care Commissioning Committee is asked to:

- **NOTE** the current position of the PCNs against the NHSE PCN Maturity Matrix
- **CONSIDER** 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.

Appendix 1

Primary Care Network Maturity Matrix

August 2019

NHS England and NHS Improvement

Primary Care Network Maturity Matrix

What is the PCN Maturity Matrix?

The Primary Care Network (PCN) Maturity Matrix outlines components that underpin the successful development of networks. It sets out a progression model that evolves from the initial steps and actions that enable networks to begin to establish through to growing the scope and scale of the role of networks in delivering greater integrated care and population health for their neighbourhoods.

The matrix was built through learning from the initial wave of Integrated Care Systems who commenced early work on the design and development of PCNs during 2017/18. It has since been refreshed in light of the NHS Long Term Plan and the GP Contract Framework. A number of systems have developed their own version of the maturity matrices to meet local need.

Purpose of the Maturity Matrix

The PCN maturity matrix is not a binary checklist or a performance management tool. It is designed to support network leaders, working in collaboration with systems, places and other local leaders within neighbourhoods, to work together to understand the development journey both for individual networks, and how groups of networks can collaborate together across a place in the planning and delivery of care. Using the matrix as a basis for these discussions will allow networks to:

- Come together around a shared sense of purpose, identify where PCNs are in their journey of development and consider how they can build on existing improvements such as those that may have been enabled by the GP Forward View and other local integration initiatives.
- Make plans for further development that help networks to continue to expand integrated care and approaches to population health, and that can best meet the health and care needs of the population served by the network.
- Identify support needs using the PCN Development Support Prospectus as a guide for framing support plans

A development journey for PCNs

Across England, PCNs will be at varied stages of development. A number of networks will be building on already established integrated ways of working and emerging population-health based new care models, with GP practices, other primary care providers, community services, secondary care, mental health, local authorities, the voluntary sector, local people and communities already collaborating on existing transformation schemes and initiatives. It is important the momentum of these existing ways of working is retained where that is already adding value for patients, staff and the wider population

Investment and evolution: A five-year framework for GP contract reform to implement The NHS Long Term Plan sets out a trajectory for how networks can build over time, for example with the planned introduction of the contract service specifications. The matrix is designed to complement that framework and to set out the wider supportive development journey in how networks can grow their capabilities to support local priorities. It will help STPs and ICSs to work with providers within networks to enable those journeys in a way that also reflects the priorities systems identify in their 5 year delivery strategies. As for the prospectus support domains, the PCN maturity matrix covers areas that may, from April 2020, be part of PCN service specifications.

General practices are central to the successful development of PCNs but the matrix is intended to support a holistic multi-agency view of the development of networks. 'Neighbourhoods' are the cornerstone of integrated care, served by groups of GP practices working with NHS community services, social care, mental health, other providers, voluntary organisations, local people and communities to deliver more coordinated and proactive services. It is important that development discussions framed around the matrix are able to bring together the insights and expertise of a range of local stakeholders who will be working together to provide improvements in integrated care.

How to use the matrix

Components of the matrix

The matrix is set out as a table of components for the development of PCNs and is organised as follows:

- There are four columns showing a development journey over time – organised into 'Foundation', Step 1, Step 2 and Step 3
- The columns are subdivided in to components that PCNs may find it helpful to consider as part of their development journey and components that ICSs and STPs will also want to consider as part of the wider supporting infrastructure that enables network development
- There are five rows which organise the components into the following
    - Leadership, planning and partnerships
    - Use of data and population health management
    - Integrating care
    - Managing resources
    - Working in partnership with people and communities

A basis for development discussions

Experience from the initial community of Integrated Care Systems shows that the matrix was most effectively used when it provided the basis for local development discussions. Practices within a network came together with their CCGs and other local organisations – for example local authorities and community services – for a shared discussion on current progress and future plans for integrated care and networks. The output of these discussions was typically a shared set of priorities and actions for how the network would evolve. There is no 'one size fits all' approach on how best to organise and hold these discussions. System primary care leaders, CCG primary care directors and PCN clinical directors should come together to agree an approach that works best locally – which could, for example, inform the development of system and place level priorities and actions to support networks. The PCN Development Support Prospectus and the funding available to systems for PCN development can be utilised to support these local development discussions.

The matrix should be used pragmatically and flexibly, with networks viewing PCN development as a multi-year journey, and one that can build on progress that has already been made in improving and transformation care and services for patients and populations. **Initial discussions may want to reference the maturity matrix and focus on the following questions: Where are you now? Where do you want to be in a year? How will you get there and what do you need? Within this discussion networks will need to think about the time needed, the capacity required, the support needed to build sustainable skills and confidence to deliver.** This will enable PCNs to identify where the network wants to focus its development activity during the remainder of 19/20 and subsequent years. Network development should be a continuous improvement process, which enables plans to grow and mature, and therefore systems and their networks should consider holding further periodic reviews using the matrix – for example on an annual or bi-annual basis.

Conversations between providers operating across the network's footprint are crucial for building, trust and confidence and helping develop partnerships. Where any ICSs or STPs are confident that they have already undertaken a level of local development discussions against previous or locally developed versions of the matrix, it is expected those systems will apply a proportionate approach in how any further discussions are taken forward. In these cases, systems should assure themselves through appropriate local governance channels (including in dialogue with PCN Clinical Directors) that there is sufficient existing intelligence on network development to inform support activities during 19/20, including for the deployment of any transformation funding, and there is an understanding of local PCN level priorities that can in turn inform the development of system primary care strategies.

There is also an important role for systems in support the development of PCNs. The maturity matrix draws out how systems can do this across each theme of the matrix, ensuring that PCNs have the infrastructure, resources and relationships to thrive operationally and financially and make an important strategic contribution.

To complement the maturity matrix, there is a simple diagnostic spreadsheet tool that can support systems to understand local PCN maturity, target support and inform any local development plans. The tool enables PCNs to put the matrix 'into action'.

PCN Maturity Matrix

	Foundation	Step 1	Step 2	Step 3
Leadership, planning and partnerships **Prospectus Domains:** Leadership, OD, Change management, CD leadership	For PCNs: • The PCN can articulate a clear vision for the network and actions for getting there. GPs, local primary care leaders, local people and community organisations, the voluntary sector and other stakeholders are engaged to help shape this. • Clinical directors are able to access leadership development support. For Systems • Systems are actively supporting GP practices and wider providers to start establishing networks and integrated neighbourhood ways of working and have identified resources (people and funding) to support PCNs on their development journey. • Systems have identified local approaches and teams to support PCN Clinical Directors with the establishment and development of networks and for clinical directors in their new roles.	For PCNs: • The organisations within the PCN have agreed shared development actions and priorities. • Joint planning is underway to improve integration with broader 'out of hospital' services as networks mature. There are developing arrangements for PCNs to collaborate for services delivered optimally above the 50k footprint. • There are local arrangements in place for the PCN (for example through the PCN Clinical Directors) to be involved in place/system strategic decision-making that both supports collaboration across networks and with wider providers including NHS Trusts/FTs and local authorities. For Systems: • Primary care is enabled to have a seat at the table for system and place strategic planning. • As set out in the LTP, there is a system level strategy for PCN development and transformation funding, with support made available for PCN development. System leaders supports PCN clinical directors to share learning and support development across networks.	For PCNs: • The PCN has established an approach to strategic and operational decision-making that is inclusive of providers operating within the network footprint and delivering network-level services. There are local governance arrangements in place within networks to support integrated partnership working. • The PCN Clinical Director is working with the ICS/STP leadership to share learning and support other PCNs to develop. For Systems: • Primary care is enabled to play an active role in strategic and operational decision-making, for example on Urgent and Emergency Care. Mechanisms in place to ensure effective representation of all PCNs at the system level. • PCN Clinical Directors work with the ICS/STP leadership to share learning and work collaboratively to support other PCNs.	For PCNs: • PCN leaders are fully participating in the decision making at the system and relevant place levels of the ICS/STP. They feel confident and have access to the data they require to make informed decisions. For Systems: • Primary care leaders are decision making members of the ICS and place level leadership, working in tandem with partner health and care organisations to allocate resources and deliver care.
Use of data and population health management **Prospectus Domain**: Population Health Management	For PCNs: • The PCN is using existing readily available data to understand and address population needs, and are identifying the improvements required for better population health. For Systems: • Infrastructure is being developed for PHM in PCNs including facilitating access to data that can be used easily, developing information governance arrangements & providing analytical support.	For PCNs: • Analysis on variation in outcomes and resource use between practices and PCNs is readily available and acted upon. • Basic population segmentation is in place, with understanding of key groups, their needs and their resource use. This should enable networks to introduce targeted interventions, which may be initially focussed on priority population cohorts • Data and soft intelligence from multiple sources (including and wider than primary care) is being used to identify interventions. For Systems: • Basic data sharing, common population definitions, and information governance arrangements have been established that supports PCNs with implementation of PHM approaches. • There is some linking of data flows between primary care, community services and secondary care.	For PCNs: • All primary care clinicians can access information to guide decision making, including identifying at risk patients for proactive interventions, IT-enabled access to shared protocols, and real-time information on patient interactions with the system. • Functioning interoperability within networks, including read/write access to records,. For Systems: • There is a data and digital infrastructure in place to enable a level of interoperability within and across PCNs and other system partners, including wider availability of shared care records • Analytical support, real time patient data and PHM tools are made available for PCNs to help understand high and rising risk patients and population cohorts, and to support care design activities.	For PCNs: • Systematic population health analysis allows the PCN to understand in depth their population's needs, including the wider determinants of health, and design interventions to meet them, acting as early as possible to keep people well and address health inequalities. The PCN's population health model is fully functioning for all patient cohorts. • Ongoing systematic analysis and use of data in care design, case management and direct care interactions support proactive and personalised care For Systems: • Full interoperability is in place across the organisations within PCNs, including shared care records across providers. • System partners work with PCNs to design proactive care models and anticipatory interventions based on evidence to target priority patient groups and to reduce health inequalities.

PCN Maturity Matrix

	Foundation	Step 1	Step 2	Step 3
Integrating care **Prospectus Domain:** Collaborative Working (MDTs)	For PCNs: • The PCN is starting to build local plans for improving the integration of care for their populations, informed by the Long Term Plan, GP contract framework and locally agreed system/place priorities. • The PCN is aware of the organisations they need to engage to develop multi-agency approaches to integrated care and are beginning to make initial approaches. For Systems: • Systems support the PCNs to build relationships across physical and mental health service providers and social care partners to facilitate the delivery of Integrated care.	For PCNs: • Integrated teams, which may include social care, are working within the network and supporting delivery of integrated care to the local population. Plans are in place to develop MDT ways of working, including integrated rapid response community teams and the delivery of personalised care. • Components of comprehensive models of care are defined for all population groups, with clear gap analysis and workforce plans. For Systems: • Systems support the building of relationships across providers of physical and mental health services, and social care partners. • System workforce plans supports the development of integrated neighbourhood teams.	For PCNs: • Early elements of new models of care defined at Step 1 now in place for most population segments, with integrated teams including social care, mental health, the voluntary sector and ready access to secondary care expertise. Routine peer review takes place. • The PCN and other providers have in place supportive HR arrangements (e.g. formalised integrated team governance and operational management) that enable multi-agency MDTs to work together effectively. For Systems: • There is continued development of partnerships across primary care, community services, social care, mental health, the voluntary sector and secondary care that are enabling on-going MDT development. Workforce sharing protocols in place.	For PCNs: • Fully integrated teams are in place within the PCN, comprising of the appropriate clinical and non-clinical skill mix. MDT working is high functioning and supported by technology. The MDT holds a single view of the patient. Care plans and co-ordination in place for all high risk patients. • There are fully interoperable IT, workforce and estates across the PCN, with sharing between networks as needed. For Systems: • Systems have developed and implemented integrated care models that meet with objectives of the LTP.
Managing resources	For PCNs: • Primary care, in particular general practice, has the headroom to make change • There are people available with the right skills to make change happen. For Systems: • System plan in place to support managing collective financial resources that includes PCNs. • PCN development support funding is being used to address PCN development needs.	For PCNs: • Steps taken to ensure operational efficiency of primary care delivery, such as delivering the Time to Care programme, and support general practices experiencing challenges in delivery of core services. For Systems: • Systems have put in place arrangements that support PCNs with improvements in the efficiency of primary care delivery and enable PCNs to make optimum use of their resources.	For PCNs: • The PCN has sight of resource use and impact on system performance and can pilot new incentive schemes where agreed locally. For Systems: • Systems support networks to have sight of resource use and impact on system performance and that can enable piloting of new incentive schemes.	For PCNs: • The PCN takes collective responsibility for managing the resource flowing to the network. Data is used in clinical and non-clinical interactions to make best use of resources. For Systems: • Systems support PCNs to take collective responsibility for managing the resource flowing to the network and use data in clinical and non-clinical interactions to make best use of resources.
Working in partnership with people and communities **Prospectus Domain:** Asset based community development & social prescribing	For PCNs: • Approach agreed to engaging with local communities. • Local people and communities are informed and there are routes for them contribute to the development of the PCN. For Systems: • Systems are providing PCNs with expertise to support local involvement of people and communities.	For PCNs: • The PCN is engaging directly with their population and are beginning to develop trusted relationships with wider community assets. • The PCN has undertaken an assessment of the available community assets that can support improvements in population health and greater integration of care. • The PCN has established relationships with local voluntary organisations and their local Healthwatch. For Systems: • Systems have put in place arrangements to support PCNs to develop local asset maps in partnership with their local community to enable models of social prescribing for personalised care.	For PCNs: • The PCN is routinely connecting with and working in partnership with wider community assets in meeting their population's needs. • Insight from local people and communities, voluntary sector is used to inform decision-making. • Community networks are understood and connected to the PCN. For Systems: • Systems are facilitating effective partnerships with local community assets within PCN footprints. • The system is developing a strategy to support communities to develop and build particularly in those areas that face the greatest inequalities.	For PCNs: • The PCN has fully incorporated integrated working with local Voluntary, Community and Social Enterprise (VCSE) organisations as part of the wider network. • Community representatives, and community voice, are embedded into the PCN's working practices, and are an integral part of PCN planning and decision-making. • The PCN has built on existing community assets to connect with the whole community and codesign local services and support. For Systems: • The community assets and partnerships developed by PCNs are being connected in to strategic planning at place and system level.

Appendix 2

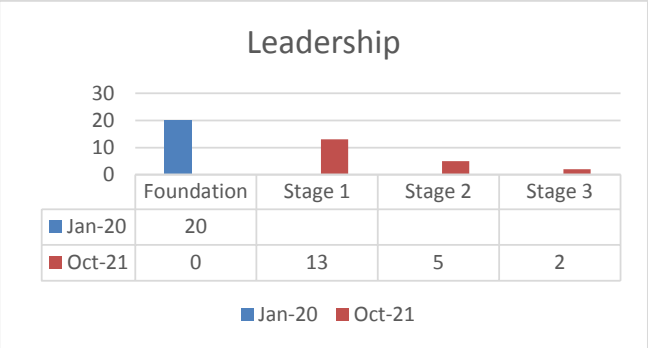
Maturity Matrix - Overall position of PCNs

Note: The overall position is based on where the majority of indicators have been completed.

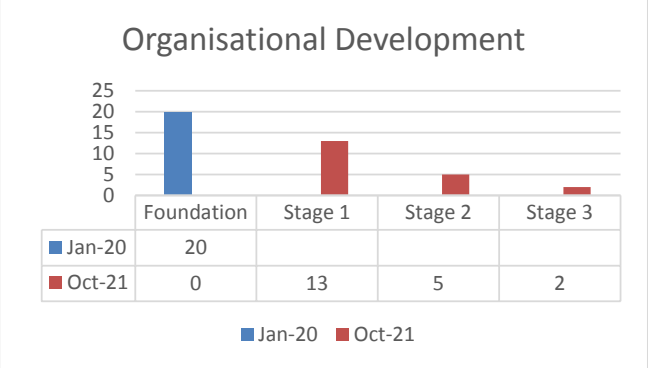
PCN	Overall PCN Maturity		
	Foundation	Step 1	Step 2
Ashfield North		Step 1	
Ashfield South		Step 1	
Mansfield North		Step 1	
Newark		Step 1	
Rosewood		Step 1	
Sherwood		Step 1	
Bulwell & Top Valley			Step 2
BACHS			Step 2
Radford & Mary Potter		Step 1	
Bestwood & Sherwood		Step 1	
Nottingham City East		Step 1	
Nottingham City South			Step 2
Clifton & Meadows			Step 2
Unity		Step 1	
Arnold & Calverton		Step 1	
Arrow Health	Foundation		
Byron		Step 1	
Nottingham West		Step 1	
Rushcliffe		Step 1	
Synergy Health	Foundation		

Appendix 3
PCN Maturity Matrix – Review of Indicators Jan 2020 and Oct 2021

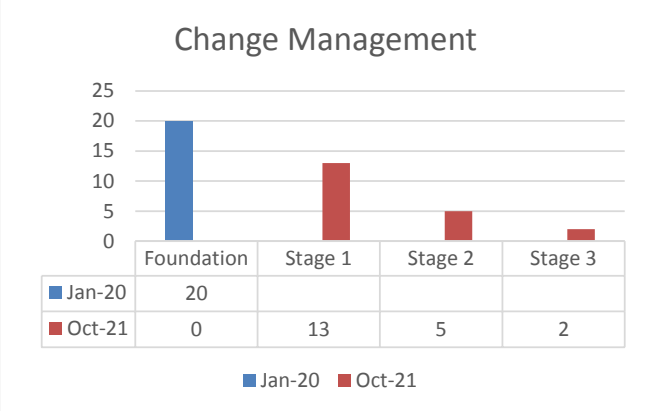
Leadership



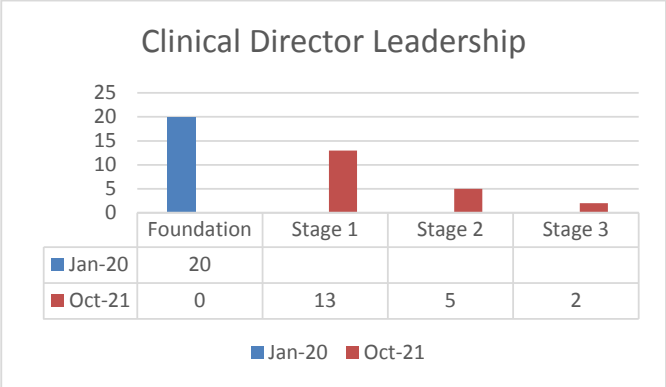
Organisational Development



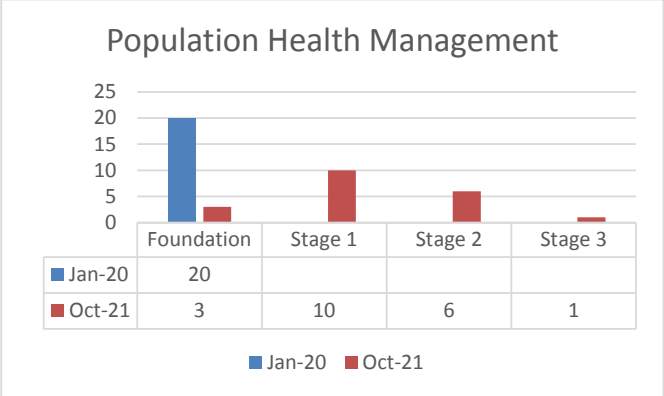
Change Management



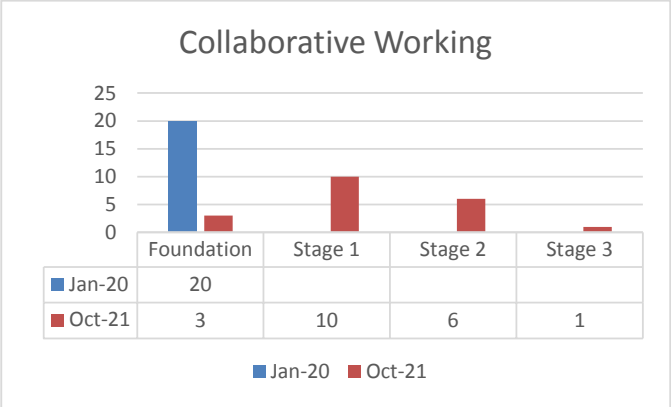
Clinical Director Leadership



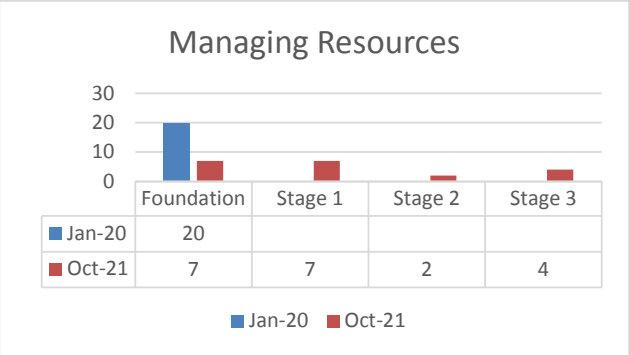
Population Health Management



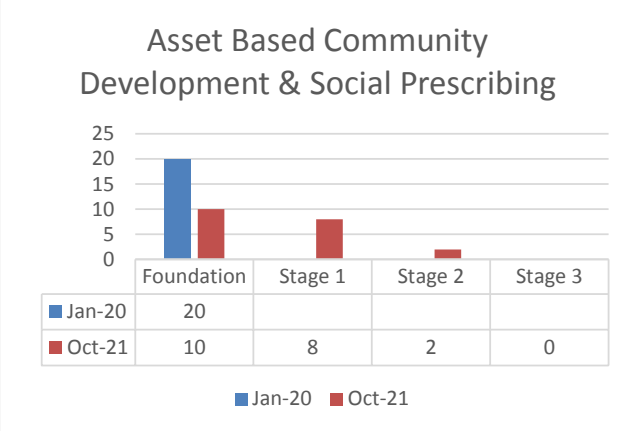
Collaborative Working



Managing Resources



Asset Based Community Development & Social Prescribing



NHS
Nottingham and Nottinghamshire
Clinical Commissioning Group

Meeting Title:	Primary Care Commissioning Committee (Open Session)	**Date:**	15 December 2021

Paper Title:	COVID – GP Practice OPEL Reporting: 4 weeks to 26 November 2021	**Paper Reference:**	**PCC 21 186**

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 four-week period to 26 November 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 ☒	Not required for this paper.
Data Protection Impact Assessment (DPIA)	Yes ☐	No ☐	N/A ☒	Not required for this paper.
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):				
1. The committee is asked to **NOTE** the OPEL Reporting overview for General Practice for the four weeks to 26 November 2021.				

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 29 October 2021, 20 working days)*.

2.1. Practice summary

During the four-weeks to 26 November 2021 (20 working days) practices reported the following:

- 25/124 (32/124) practices reported days where they were at OPEL Level 3 – Red (having previously reported Amber or Green):
  - This was for a total of 177 (213) days across all practices
  - Equates to 20% of practices: 4 (5) practices in Mid Notts, 18 (20) practices in the City and 3 (7) practices in South Notts.

- 97/124 (97/124) practices reported days where they were at OPEL Level 2 – Amber:
  - 69 (63) practices reported this level for 10 days or more: 6 (7) practices in Mid Notts, 35 (35) practices in the City and 28 (21) practices in South Notts
  - 28 (34) practices reported this level for less than 10 days: 11 (15) practices in Mid Notts, 11 (11) practices in the City and 6 (8) practices in South Notts

- 26/124 (25/124) practices reported they were consistently OPEL Level 1 – Green:
  - 20% of practices reported OPEL Level 1 – Green for the full 20 days: 21 (17) practices in Mid Notts, 0 (0) practice in the City and 5 (8) 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. Recommendation

The Primary Care Commissioning Committee is asked to **NOTE** the OPEL Reporting overview for General Practice for the four-weeks to 26 November 2021.

Nottingham and Nottinghamshire Clinical Commissioning Group

Meeting Title:	Primary Care Commissioning Committee (Open Session)	**Date:**	15 December 2021
Paper Title:	Finance Report Month EIGHT	**Paper Reference:**	**PCC 21 187**
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 eight 2021/22. This report has been prepared in the context of the revised financial regime implemented by NHS Engand /Improvement (NHSE/I) 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 (M1-8) 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). By way of re-cap, those reserves are designed to manage any in-year unforeseen pressures that may arise on those 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.

The 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 is showing £1.37m underspend (0.82% of total budget), however, offsetting the expected Reserves underspend is an overspend position of £5.38m in relation to ARRS that will be funded by NHSE/I but has had to be reported in this manner to highlight the value to the National Team of NHSE/I.

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 November 2021.				

Primary Care Co-Commissioning – Finance Report – OCTOBER 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 eight reported delegated primary care financial position.

For 2021/22, the temporary financial regime from 2020/21 has continued. The financial year has been split into two halves for planning purposes, with the first half (H1) continuing with a non-recurrent allocation being given to the CCG. The overall CCG financial plan for H1 is a breakeven plan. Within this 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.

Month Eight PCCC Financial Position

The position is summarised in the table below:

Month 1-8 Position

Variance - under / (over)

Co-Commissioning Category	M1-12 Plan (£m)	M1-8 Budget (£m)	M1-8 Actual (£m)	M1-8 Variance (£m)
Dispensing / Prescribing Drs	2.11	1.36	1.21	0.15
Enhanced Services	4.63	3.27	3.25	0.02
General Practice - APMS	7.73	5.19	4.76	0.43
General Practice - GMS	74.67	49.73	50.20	(0.47)
General Practice - PMS	21.85	14.57	14.47	0.10
Other GP Services	2.17	1.46	1.34	0.12
Other Premises Costs	3.26	2.20	2.43	(0.24)
Premises Cost Reimbursement	15.89	10.64	10.62	0.01
Primary Care Networks	13.71	10.38	10.38	(0.00)
QOF	13.50	9.25	9.25	0.00
Reserves	6.40	3.18	0.00	3.18
Grand Total	**165.92**	**111.21**	**107.92**	**3.30**

Month 8 Position

There is a year to date underspend position of £3.30 million comprising:

- Reserves - £3.18m – The PCCC reserve held at month eight comprises of six months reserves released into the CCG position (£2.64m) that was reported on last month, leaving £0.54m accrued to date for any PCCC unforeseen pressures occurring in H2.

- General Practice - APMS - £0.43m – £0.25m of this position is in relation to the release of prior year end accruals, whilst the remaining £0.18m 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 - £0.15m – 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 - £0.12m – 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.

Offset to a smaller extent by an overspend position on:

- General Practice – GMS - £0.47m – There has been a caretaking contract in place that has cost an additional £0.16m although this came to an end on 30th September 2021 and there have been two PMS practices transfer to GMS.

- Other Premises Costs - £0.24m – There have been a number of Rent Reviews that have taken place and they have contained backdated values to prior years.

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 is currently within that budget. If in the future total claims were to exceed £7.562m, the CCG would be able to claim additional funding from NHSEI for the excess.

Month Eight PCCC Forecast Position

Co-Commissioning Category	M1 - 12 Plan (£m)	FOT Actual (£m)	FOT Variance (£m)
Dispensing/Prescribing Drs	2.11	1.81	0.30
Enhanced Services	4.63	4.88	(0.24)
General Practice – APMS	7.73	7.14	0.59
General Practice – GMS	74.67	75.30	(0.63)
General Practice – PMS	21.85	21.71	0.14
Other GP Services	2.17	2.00	0.16
Other Premises costs	3.26	3.19	0.07
Premises Cost Reimbursement	15.89	15.93	(0.05)
Primary Care Networks	13.71	19.08	(5.38)
QOF	13.50	13.50	0.00
Reserves	6.40	0.00	6.40
Grand Total	**165.92**	**164.55**	**1.37**

The current forecast position is showing £1.37m underspend. The forecast adverse variance on the Primary Care Networks line will be offset with income from NHSEI and represents forecast ARRS claims above £7.562m. It is required to be disclosed in this manner to be in line with NHSEI regional and national reporting requirements.

Primary Care Capital

The CCG has an overall CCG capital resource limit (CRL) of £2.135 million and includes spend in primary care areas. 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. The capital grant agreement remains unsigned at this point, but the regional housing lead at NHSEI is expecting this to be signed during quarter three and that the £1.103 million will be spent by the end of this financial year.

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 8 Position

Variance - under / (over)

	M1- 8 Financial Position			
Primary Care Area	**M1-12 Plan (£m)**	**M1-8 Budget (£m)**	**M1-8 Actual (£m)**	**M1-8 Variance (£m)**
Primary Care Transformation (Prev GPFV)	8.65	6.10	5.85	0.25
Local Enhanced Services	10.38	6.92	6.61	0.31
Primary Care Development	1.06	0.46	(0.31)	0.77
Primary Care Covid	2.31	2.26	2.22	0.04
GP IT	1.00	0.69	0.50	0.19
Out of Hours	12.27	7.83	7.74	0.09
Meds Management Clinical	3.34	2.23	1.90	0.33
Primary Care Corporate Team	0.53	0.35	0.29	0.06
Total	**39.53**	**26.82**	**24.79**	**2.04**
Prescribing	160.64	106.98	107.02	(0.05)
Total	**160.64**	**106.98**	**107.02**	**(0.05)**
Other Primary Care Position	**200.17**	**133.80**	**131.81**	**1.99**

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 breakeven position within Prescribing due to the PMD data for September 2021 offset with a reduced level of Oxygen costs that are being incurred, as well as the reversal of prior year accruals released and the underspends within the Primary Care Team and Medicines Management staffing budgets. (This is after accounting for the recent national pay award that was announced).

Recommendation

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

NHS
Nottingham and Nottinghamshire
Clinical Commissioning Group

Meeting Title:	Primary Care Commissioning Committee (Open Session)	**Date:**	15 December 2021

Paper Title:	Risk Report	**Paper Reference:**	**PCC 21 188**

Sponsor:	N/A	**Attachments/ Appendices:**	Risk Register (Extract) - **Appendix A**
Presenter:	Jo Simmonds, Head of Corporate Governance		

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. NOTE the addition of new risk **RR 169** (*PCN disengagement*) and risk **RR 171** (*loss of public confidence*) to the Corporate Risk Register following approval at the confidential session of the previous Primary Care Committee meeting;
2. COMMENT on the risks shown within the paper (including the high/red risk) and those at **Appendix A**; and
3. HIGHLIGHT any new risks identified during the course of the meeting for inclusion within the Corporate Risk Register.

NHS
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 an increase in two risks since the last 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; one is outlined below and the second is referenced in Section 3 of the paper.

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 *(January 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. The LMC 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 pressure within primary care, which is exacerbating the potential for staff exhaustion and 'burn out'. As such, the risk score remains at 16.*	Overall Score 16: **Red** (I4 x L4)

3. Risk Identification

3.1 There have been two new risks identified since the last meeting; one of which relates to previous discussions at the Committee regarding the potential for Primary Care Networks (PCNs), PCN Clinical Directors and/or GP Member Practices to become disengaged. The second risk has been articulated following discussions at the Governing Body, and subsequently with the Accountable Officer, around potential concerns regarding the loss of public confidence in local health services.

Both risks were approved at the confidential session of the November 2021 Primary Care Commissioning Committee and, as such, are now being reported within the 'open' session. Risk **RR 171** was also approved at the November 2021 meeting of the Quality and Performance Committee.

Risk Ref	Risk Narrative	Current Risk Score
RR 169 *(Oct 2021)*	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.	Overall Score 9: **Amber** (I3 x L3)
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.	Overall Score 16: **Red** (I4 x L4)

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:

- **NOTE** the addition of new risk **RR 169** (*PCN disengagement)* and risk **RR 171** (*loss of public confidence)* to the Corporate Risk Register following approval at the confidential session of the previous Primary Care Committee meeting;
- **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

December 2021

NHS Nottingham and Nottinghamshire CCG Corporate Risk Register (December 2021)

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 orginally 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)
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	**December 2021:** 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.	07/12/2021	↔
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	**December 2021:** '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. Meetings with the widened membership commenced in August 2021. Assurance reporting around quality concerns will be reviewed within this Group. Work has been undertaken to develop the Primary Care Support and Assurance Frameworks across the three Places; an update was presented to the October 2021 meeting. These continue to be presented quarterly to meetings of the Committee. OPEL reporting remains in place and is reported, routinely, to the PCCC (monthly). 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. Work continues with Locality Teams to take appropriate action in relation to any Practices which continually report as 'amber' and 'red'. 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.	07/12/2021	↔
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	**December 2021:** 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.	07/12/2021	↔
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 Lum	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	**December 2021:** 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.	07/12/2021	↔
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 Lum / 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	**December 2021:** 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 was presented at the October and November 2021 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.	07/12/2021	↔
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 Cawley	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	**December 2021:** 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. An initial paper, and discussion, relating to progress with the Primary Care Support and Assurance Framework was presented to the confidential session of the October 2021 meeting of the Committee. These continue to be presented on a quarterly basis to the Committee.	07/12/2021	↔
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.	*To be populated once risk agreed.*	3	3	9	*New risk to be presented to the open session of the December 2021 PCC Committee.*	07/12/2021	New
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	Alice Ball / 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	*New risk to be presented to the open session of the December 2021 PCC Committee.*	07/12/2021	New