NHS
Barnsley
Clinical Commissioning Group

Public Primary Care Commissioning Committee
Thursday, 27 May 2021 at 09.30am to 11.10am
Via MS Teams

PUBLIC AGENDA

Item	Session	Committee Requested to	Enclosure Lead	Time
1	Housekeeping		Chair	9.30am 5mins
2	Apologies	Note	Chair	
3	Quoracy	Note	Chair	
4	Declarations of Interest relevant to the agenda	Assurance	**PCCC 21/05/04**	
5	Minutes of the meeting held on 25 March 2021	Approve	**PCCC 21/05/05** Chair	9.35am 5mins
6	Matters Arising Report	Note	**PCCC 21/05/06** Chair	9.40am
Strategy, Planning, Needs Assessment and Co-ordination of Primary Care				
7	ICS Primary Care Collaborative	Information	**PCCC 21/05/07 Nick Balac**	9.40am 10mins
8	Primary Care Strategy • PC Strategy Group ToR • PC Delivery Group ToR • PC Project Brief • PC Delivery Model	Approval	**PCCC 21/05/08** Julie Frampton	9.50am 15mins
Quality and Finance				
9	Finance Update	Information	**PCCC 21/05/09** Ruth Simms	10.05am 5mins
10	CQC Update Report	Assurance	**PCCC 21/05/10** Julie Frampton	10.10am 10mins
11	Contractual Issues Report	Approval/ Assurance	**PCCC 21/05/11** Julie Frampton	10.20am 15mins
12	Medicines Optimisation PDA Scheme	Assurance	**PCCC 21/05/12** Chris Lawson	10.35am 10mins
13	Covid Expansion Funding	Approval	**PCCC 21/05/13** Julie Frampton	10.45am 5mins
Governance, Risk, Assurance				
14	Risk and Governance Report • Assurance Framework • Risk Register	Approval/ Assurance	**PCCC 21/05/14** Richard Walker	10.55am 10mins

Reflection on conduct of the meeting				
15	• Conduct of meetings • Any areas for additional assurance • Any training needs identified	Note	**Verbal** Chair	11.05am
Other				
16	Questions from the public relevant to the agenda	Note	**Verbal** Chair	11.05am
17	Items for escalating to the Governing Body	Note	**Verbal** Chair	11.05am 5mins
18	**Date and time of the next scheduled meeting:** Thursday, 29 July 2021 at 09.30am to 10.30am via MS Teams	Note	**Verbal** Chris Millington	**11.10am** **Close**

Exclusion of the Public:

The CCG Primary Care Commissioning Committee should consider the following resolution:

***"That representatives of the press and other members of the public be excluded from the remainder of this meeting due 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**

NHS
Barnsley
Clinical Commissioning Group

PRIMARY CARE COMMISSIONING COMMITTEE

27 May 2021

Declaration of Interests, Gifts, Hospitality and Sponsorship Report

PART 1A – SUMMARY REPORT

1.	**THIS PAPER IS FOR**						
	Decision		*Approval*		*Assurance*	X	*Information*	
2.	**PURPOSE**						
	To foresee any potential conflicts of interests relevant to the agenda.						
3.	**REPORT OF**						

	Name	**Designation**
Executive / Clinical Lead	Richard Walker	Head of Governance & Assurance
Author	Paige Dawson	Governance, Risk & Assurance Facilitator

4. SUMMARY OF PREVIOUS GOVERNANCE

The matters raised in this paper have been subject to prior consideration in the following forums:

Group / Committee	**Date**	**Outcome**
N/A		

5. EXECUTIVE SUMMARY

Conflicts of interest are 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.

The table below details what interests must be declared:

Type	Description
Financial interests	Where individuals may directly benefit financially from the consequences of a commissioning decision e.g., being a partner in a practice that is commissioned to provide primary care services;
Non-financial professional interests	Where individuals may benefit professionally from the consequences of a commissioning decision e.g., having an unpaid advisory role in a provider organisation that has been commissioned to provide services by the CCG;
Non-financial personal interests	Where individuals may benefit personally (but not professionally or financially) from a commissioning decision e.g., if they suffer from a particular condition that requires individually funded treatment;
Indirect interests	Where there is a close association with an individual who has a financial interest, non-financial professional interest or a non-financial personal interest in a commissioning decision e.g., spouse, close relative (parent, grandparent, child, etc.) close friend or business partner.

Appendix 1 to this report details all Committee Members' current declared interests to update and to enable the Chair and Members to foresee any potential conflicts of interests relevant to the agenda. In some circumstances it could be reasonably considered that a conflict exists even when there is no actual conflict.

Members should also declare if they have received any Gifts, Hospitality or Sponsorship.

6. THE GOVERNING BODY / COMMITTEE IS ASKED TO:

- Note the contents of this report and declare if Members have any declarations of interest relevant to the agenda or have received any Gifts, Hospitality or Sponsorship.

7. APPENDICES / LINKS TO FURTHER INFORMATION

- Appendix A – Primary Care Commissioning Committee Members' Declaration of Interest Report

Agenda time allocation for report:	5 minutes

PART 1B – SUPPORTING INFORMATION & ASSURANCE

1. Links to Corporate Priorities, GBAF and Risk Register

This report provides assurance against the following corporate priorities on the Governing Body Assurance Framework

1.1 Urgent & Emergency Care		6.1 Efficiency Plans	
2.1 Primary Care		7.1 Transforming Care for people with LD	
3.1 Cancer		8.1 Maternity	
4.1 Mental Health		9.1 Digital and Technology	
5.1 Integrated Care @ System		10.1 Compliance with statutory duties	✓
5.2 Integrated Care @ Place			

The report also provides assurance against the following red or amber risks on the Corporate Risk Register:	*N/A*

2. Links to statutory duties

This report has been prepared with regard to the following CCG statutory duties set out in Chapter A2 of the NHS Act

Management of conflicts of interest (s14O)	✓	Duties as to reducing inequalities (s14T)	
Duty to promote the NHS Constitution (s14P)		Duty to promote the involvement of each patient (s14U)	
Duty to exercise its functions effectively, efficiently and economically (s14Q)		Duty as to patient choice (s14V)	
Duty as to improvement in quality of services (s14R)		Duty as to promoting integration (s14Z1)	
Duty in relation to quality of primary medical services (s14S)		Public involvement and consultation (s14Z2)	

3. Governance Considerations Checklist *(these will be especially relevant where a proposal or policy is brought for decision or approval)*

3.1 Clinical Leadership

Have GB GPs and / or other appropriate clinicians provided input and leadership?	***NA***

3.2 Management of Conflicts of Interest (s14O)

Have any potential conflicts of interest been identified and managed appropriately, having taken advice from the Head of Governance & Assurance and / or the Conflicts of Interest Guardian if appropriate?	***Y***

3.3 Discharging functions effectively, efficiently, & economically (s14Q)

Have any financial implications been considered & discussed with the Finance Team?	***NA***
Where relevant has authority to commit expenditure been sought from Management Team (<£100k) or Governing Body (>£100k)?	***NA***

3.4 Improving quality (s14R, s14S)

Has a Quality Impact Assessment (QIA) been completed if relevant?	***NA***
Have any issues or risks identified been appropriately addressed having taken advice from the Chief Nurse (or Deputy) if appropriate?	***NA***

3.5	**Reducing inequalities (s14T)**	
	Has an Equality Impact Assessment (EIA) been completed if relevant?	***NA***
	Have any issues or risks identified been appropriately addressed having taken advice from Equality Diversity & Inclusion Lead if appropriate?	***NA***
3.6	**Public Involvement & Consultation (s14Z2)**	
	Has a s14Z2: Patient and Public Participation Form been completed if relevant?	***NA***
	Have any issues or risks identified been appropriately addressed having taken advice from the Head of Comms & Engagement if appropriate?	***NA***
3.7	**Data Protection and Data Security**	
	Has a Data Protection Impact Assessment (DPIA) been completed if relevant?	***NA***
	Have any issues or risks identified been appropriately addressed having taken advice from the SIRO, IG Lead and / or DPO if appropriate?	***NA***
3.8	**Procurement considerations**	
	Have any issues or risks identified been appropriately addressed having taken advice from the procurement Shared Service if appropriate?	***NA***
	Has a Single Tender Waiver form been completed if appropriate?	***NA***
	Has a Primary Care Procurement Checklist been completed where GPs, networks or Federations may be a bidder for a procurement opportunity?	***NA***
3.9	**Human Resources**	
	Have any significant HR implications been identified and managed appropriately, having taken advice from the HR Lead if appropriate?	***NA***
3.10	**Environmental Sustainability**	
	Have any significant (positive or negative) impacts on the environment or the CCG's carbon footprint been identified?	***NA***

NHS Barnsley Clinical Commissioning Group

NHS Barnsley Clinical Commissioning Group Register of Interests

This register of interests includes all interests declared by members and employees of Barnsley Clinical Commissioning Group. In accordance with the Clinical Commissioning Group's Constitution the Clinical Commissioning Group's Accountable Officer will be informed of any conflict of interest that needs to be included in the register within not more than 28 days of any relevant event (e.g. appointment, change of circumstances) and the register will be updated as a minimum on an annual basis.

Register: Primary Care Commissioning Committee

Name	Current position (s) held in the CCG	Declared Interest
Nick Balac	Chairman	• Partner at St Georges Medical Practice (PMS) • Practice holds AQP Barnsley Clinical Commissioning Group Vasectomy contract • Member Royal College General Practitioners • Member of the British Medical Association • Member Medical Protection Society • The practice is a member of Barnsley Healthcare Federation which may provide services for Barnsley CCG • Two Partners at St Georges Medical Practice (PMS) are Partners on the Practice Contract at Kingswell Surgery (PMS). • Clinical Lead Primary Care SYB ICS (commissioning)
Nigel Bell	Lay Member for Governance	• Lay Member representing South Yorkshire & Bassetlaw organisations on the Integrated Assurance Committee of South Yorkshire & Bassetlaw Integrated Care System

Name	Current position (s) held in the CCG	Declared Interest
Chris Millington	Lay Member	• Partner Governor Barnsley Hospital NHS Foundation Trust (ceased July 18) • Partner Governor role with Barnsley Hospital NHS Foundation Trust (from 6 February 19)
Mike Simms	Secondary Care Clinician	• Provider of Corporate and Private healthcare and delivering some NHS Contracts.
Chris Edwards	Governing Body Member	• Family member employed by Chesterfield Royal. • Family member employed by Attain. • Works as Accountable Officer for Rotherham CCG. • Works one day a week at the ICS as Capital and Estates and Maternity lead.
Mark Smith	GP Governing Body Member	• Senior Partner at Victoria Medical Centre also undertaking training and minor surgery roles. • Director of Janark Medical Ltd • The practice is a member of Barnsley Healthcare Federation which may provide services for Barnsley CCG
Madhavi Guntamukkala	Medical Director	• Senior GP in a Barnsley Practice (Apollo Court Medical Practice & The grove Medical Practice) Practices provide services under contract to the CCG • Spouse – Dr M Vemula is also partner GP at both practices • The practice is a member of Barnsley Healthcare Federation which may provide services for Barnsley CCG

Name	Current position (s) held in the CCG	Declared Interest
Richard Walker	Head of Governance & Assurance	• Daughter working for Health Education England.
Julie Frampton	Head of Primary Care	• NIL

Name	Current position (s) held in the CCG	Declared Interest
Victoria Lindon	Assistant Head of Primary Care Commissioning (NHSE and NHSEI)	• NIL
Nick Germain	NHS England & Improvement, Primary Care Manager	• NIL

NHS Barnsley Clinical Commissioning Group

Minutes of the PUBLIC Primary Care Commissioning Committee meeting held on Thursday, 25 March 2021 at 9.30pm via MS Teams

PRESENT: (VOTING MEMBERS)

Chris Millington (*Chair*)	Lay Member for Patient & Public Engagement and Primary Care Commissioning
Nigel Bell	Lay Member for Governance
Mike Simms	Secondary Care Clinician
Richard Walker	Head of Governance & Assurance
Chris Edwards	Chief Officer

CLINICAL MEMBERS (NON-VOTING)

Dr Madhavi Guntamukkala	Governing Body Member
Dr Mark Smith	Governing Body Member
Dr Nick Balac	Chair Barnsley CCG

IN ATTENDANCE:

Julie Frampton	Head of Primary Care
Angela Musgrave	Executive Personal Assistant
Nick Germain	Primary Care Manager, NHSEI
Carrie Abbott	Public Health, BMBC
Roxanna Naylor	Chief Finance Officer
Ruth Simms	Assistant Finance Manager

APOLOGIES:

Julia Burrows	Director of Public Health, BMBC

MEMBERS OF THE PUBLIC:

There were no members of the public present at the meeting.

Agenda Item	Note	Action	Deadline
PCCC 20/03/01	**HOUSEKEEPING**		
PCCC 20/03/02	**WELCOME AND APOLOGIES**		
	The Chair welcomed members to the meeting and apologies were noted as above.		
PCCC 20/03/03	**QUORACY**		
	The meeting was declared quorate.		
PCCC 20/03/04	**DECLARATIONS OF INTEREST RELEVANT TO THE AGENDA**		
	There were no declarations of interest relevant to the agenda.		

PCCC 20/03/05	**MINUTES OF THE LAST MEETING**		
	The minutes of the meeting held on 28 January 2021 were verified as a true and correct record of proceedings with the following amendments:- <u>Contractual Issues Report</u> • The Committee **approved the** sale and lease back application for Huddersfield Road Surgery. <u>PCCC Terms of Reference</u> • Remove reference to the Primary Care Operational Group as this meeting is the Primary Care Forum and is already included in the ToR. <u>Workforce Risk Review – Risk Reference CCG 14/10 on the CCGs Risk Register</u> • This risk had been discussed at a preceding Governing Body meeting. Following feedback from this meeting a review of the risk would be carried out and any amendments to the wording would be brought back to the next PCCC meeting.		
PCCC 20/04/06	**MATTERS ARISING REPORT**		
	<u>PCCC 20/01/10 - Workforce Risk Review</u> Members noted the update provided. <u>PCCC 20/07/07 – GP patient Survey 2020</u> Update included within the Contractual Issues Report at agenda item 10.		
STRATEGY, PLANNING, NEEDS ASSESSMENT AND CO-ORDINATION OF PRIMARY CARE			
PCCC 20/01/07	There was nothing to report relating to the strategy, planning, needs assessment and co-ordination of Primary Care.		
QUALITY AND FINANCE			
PCCC 20/01/08	**FINANCE UPDATE**		
	The Assistant Finance Manager presented an update of the financial position and details of funding allocations for delegated Primary Care Co-Commissioning budgets as at 31 January 2021 (month 10). <u>Forecast Position 2020/21</u> The forecast position as at 31 January 2021 (month 10), was £873k underspend with the largest variance of £439k		

	relating to an underspend against the Additional Roles Reimbursement funding. This figure was expected to increase further with the likelihood that none of the funding held nationally for additional roles would be accessed. Appendix A provided information on additional variances relating to GP services, premises cost reimbursement and the Quality Outcomes Framework (QoF) payments to practices. Following a discussion regarding QoF payments to practices the Chair of the CCG recommended that any underspends were managed throughout the year to ensure maximising investment and capacity in Primary Care. **The Committee:** • **Noted the information provided in the Finance Update report.**		
PCCC 20/03/09	**CQC REPORT** The Head of Primary Care presented the CQC report that provided members with an update on the current CQC position in relation to Barnsley GP Practices and Barnsley Healthcare Federation i-Heart contracts. Following the Care Quality Commission (CQC) implementation of a Transitional Regulatory Approach that focussed on existing Key Lines of Enquiry, current inspection activity was being limited to where there may be a serious risk of harm or where it supported the system's response to the pandemic. Three Barnsley CCG GP practices had been contacted in line with the CQC's Transitional Regulatory Approach. Following positive discussions with all three practices it was confirmed that no further monitoring activity was required at this stage. The remaining Barnsley CCG GP practices were currently low priority due to their score within the CQC monitoring dashboard and therefore no further CQC activity was planned. **The Committee noted:** • **The CQC's implementation of the Transitional Regulatory Approach and the assessments completed.**		

CONTRACT MANAGEMENT			
PCCC 20/03/10	**CONTRACTUAL ISSUES REPORT**		
	The Head of Primary Care presented the Contractual Issues Report that provided members with an update on the current contractual issues in relation to primary care contracts. <u>In Year Contract Variation</u> The CCG had received an application to remove Drs Baruah and Mahmood from the Hoyland Medical Practice contract due to their resignation on 31 July 2020 and 17 October 2019 respectively. The practice had informed the CCG that they would be recruiting salaried GPs to replace the lost sessions. It was reported that the practice had omitted to inform NHSE or the CCG of the resignations and the Primary Care team had since worked with the practice to remind them of the correct procedure to follow and to ensure due diligence had been carried out. <u>Extended Access and Out of Hours Contract Extensions – Barnsley Healthcare Federation (BHF)</u> The current contracts that had been in place since 2017 with BHF to provide Extended Access and Out of Hours services to Barnsley patients were due to end on 31 March 2021. NHS England had planned changes for extended access services that would introduce a new standardised service specification as part of the Network Contract DES. In January 2021 the CCG had been informed of a delay to this work and it was unlikely introduction would take place before April 2022. It was reported that ceasing the contracts with BHF would greatly impact patient access and ultimately put a considerable burden back onto GP practices. It was therefore recommended to extend the current Extended Access and Out of Hours contracts for a further 12 months from 1 April 2021 to 31 March 2022. Due to the timeline involved, voting members of the Committee had virtually confirmed their approval to extend the contracts for a further 12 months. The Committee was asked to ratify the approval of the extension to contracts. .		

	<u>GP Practice Premises Sale and Return</u> The CCG had received an application for Sale and Leaseback of:- a) Garland House Surgery, 1 Church Street, Darfield, Barnsley b) Woodgrove Surgery, 2 Doncaster Road, Wath-on-Dearne, Rotherham The Primary Care Team had worked with NHSE, PCC to review the information contained in the lease agreement to confirm the documentation was in line with regulations and to ensure the CCG had complied with the guidance and rules. It was recommended that the Committee approve the application given the assurance provided and the inclusion of the break clause in the lease if this were to be necessary to comply with future estates strategies. <u>GP Survey Feedback Analysis</u> The results of the GP Patient Survey published in August 2020 had been analysed. Attached at appendix A was a report that provided the Committee with information on the outcome and aims. Attention was brought to some of the questions and responses and in particular the number of patients who were not aware of what services GP practices offered online, had not used any online services or hadn't tried to use the practice website. In order to address this issue the CCG would be working with telephony providers to streamline this facility to ensure improved telephone access for patients. Overall Barnsley CCG benchmarked well both nationally and with peers with average feedback results being within 5% when compared with the national result. <u>E-Declaration Update</u> In December each year GP Practices were required to complete and electronically submit an Annual Practice Declaration (eDEC). Due to Covid-19 and the additional pressures faced by GP practices this year there had been a number of extensions to the deadline for submitting responses. All practices within Barnsley had now submitted their responses as required which ensured their contractual obligations had not been breached and the CCG was now compliant.		

	<u>Primary Medical Care Policy and Guidance Manual Update</u> NHS England periodically reviewed and refreshed the Primary Medical Care Policy and Guidance Manual to ensure it remained fit for purpose and reflected the latest legislation and national direction. In February 2021 a refresh was published that carried forward the planned changes from April 2021. The Committee received a summary of all the points changed within the guidance manual and noted that the CCG would ensure the changes were reflected within the reporting mechanism to ensure compliance. **The Committee: -** **1. Noted the resignation of Drs Baruah and Mahmood from Hoyland Medical Centre from 31 July 2020 and 17 October 2019 respectively.** **2. Ratified the 12 month extensions to the Barnsley Healthcare Federation Extended Access and Out of Hours contracts from 1/4/21 to 31/3/2022.** **3. Approved the Sale and Lease back application from Dr Mellor & Partners for the leases for Garland House Surgery and Woodgrove Surgery.** **4. Noted the GP survey analysis.** **5. Noted the update regarding practice completion of their eDec submission.** **6. Noted the summary provided of the update of the Primary Medical Care Policy and Guidance Manual.**		
PCCC 20/03/11	**CLINICAL SYSTEMS BRIDGING AGREEMENT**		
	The Head of Primary Care presented the Clinical Systems Bridging Agreement Report that informed members of the requirement to approve the Call-Off Order Forms for the Bridging Agreements for the CCG and our GP Practices following expiry of the Continuity Call Off Agreements (CCOA) in March 2021. The CCOA agreements were put in place during 2020 as a transition from GPSoC to GPIT Futures with the expectation that the entire GP IT estate would be re-competed under the new national GP IT Futures framework.		

	Unfortunately, due to the impact of Covid-19 and the re-focus of priorities at NHS Digital, the CCG and GP practices, there had been insufficient time to enable a full re-procurement 'Off Catalogue' as envisaged within the GP IT Futures Framework and Business Case. The CCOAs were due to expire at the end of March 2021 and therefore the CCG needed to put in place alternative agreements to bridge the period of time between the expiry of the CCOAs and when the CCG would be able to re-compete their requirements to ensure suitable contractual arrangements were in place. The Bridging Agreement process had therefore been completed enabling retention of all solutions within the existing Barnsley CCG GP IT estate. The Bridging Agreements would take effect from 1 April 2021 and would run for a maximum of 18 months. Members were informed that the CCG would work with NHS Digital to ensure the entire GP IT estate was re-competed under the new national GP IT Futures framework before the end of this period. **The Committee:** • **Approved the Call Off Order Forms for GP IT solutions.**		
PCCC 21/03/12	**360 ASSURANCE REPORT**		
	The Head of Primary Care presented the 360 Assurance Report that provided the Committee with an update on the 360 Assurance Audit regarding Primary Care Governance and Governance Contracting. Members were informed that as part of NHSE's requirement for independent assessments an annual assurance audit was carried out to ensure primary care delegated functions to the CCG were being properly discharged. The four domains set out in NHSE's Internal Audit Framework were: • Commissioning and Procurement of Services • Contract Oversight and Management Functions • Primary Care Finance • Governance (common to each of the above areas) The Committee's attention was brought to two areas of low risk, including actions to mitigate the risks, included in the final 360 Assurance Report that would be		

	implemented by the Head of Primary Care and the Primary Care Team. The Committee noted that this year's 360 Assurance Report was the highest level obtainable and reflected the CCGs position as an outstanding CCG. **The Committee:** • Noted the content of the 360 Assurance report.		
GOVERNANCE, RISK AND ASSURANCE			
PCCC 21/03/13	The Head of Governance & Assurance presented the risk and Governance report that provided the Committee with the:- • Assurance regarding the delivery of the CCG's annual strategic objectives • Assurance that the current risks to the organisation were being effectively managed and monitored appropriately <u>Assurance Framework</u> The Assurance Framework continued to be reviewed and updated. Appendix 1 of the report provided the Committee with an extract from the GBAF of the two risks for which the Committee were the assurance provider. Both risks had been scored as 'Amber' High Risk and related to: • Risk Ref 2.1 - the delivery of Primary Care priorities if identified threat(s) were not successfully managed and mitigated and; • Risk Ref 9.1 – the key deliverables of Digital Technology if identified threats(s) were not appropriately managed and mitigated. <u>Risk Register</u> There were currently five risks on the Corporate Risk Register for which the Committee were responsible for managing. Of the five risks, there was one red risk (extreme), one amber risk (high), one yellow risk (moderate) and two green (low) risks. It was reported that a review of the risk in relation to Primary Care Workforce would be carried out and any amendment to the wording would be brought back to the next Committee. All risks continued to be reviewed and updated regularly.		

	<u>Annual Assurance Report</u> The Committee was reminded that all of the CCG's Committees were required to produce an Annual Assurance Report that provided the Accountable Officer and the Governing Body with assurance that the Committees had carried out their delegated responsibilities and managed the key risks within their remit. It was noted that as part of the Delegation Agreement the PCCC Annual Assurance Report would be provided to NHSE. The Chair of the CCG commented that as the PCCC meetings had clashed with another meeting he had been unable to attend all the meetings; however to ensure attendance going forward the timing of the PCCC had been amended to facilitate better attendance. It was confirmed that a foot note would be included in the Assurance Report to reflect this comment. **The Committee:** • Considered and approved the Draft PCCC Annual Assurance Report 2020-21.	**RW/AM**	**Complete**
OTHER			
PCCC 21/03/14	**REFLECTION OF CONDUCT OF THE MEETING** The Committee agreed that the meeting had been conducted appropriately.		
PCCC 21/03/15	**QUESTIONS FROM MEMBERS OF THE PUBLIC RELEVANT TO THE AGENDA**		
	There were no questions received from the members of the public.		
PCCC 21/03/16	**ITEMS FOR ESCALATING TO THE GOVERNING BODY** It was agreed to escalate the following items to the Governing Body for information:- • To note the highest level of achievement as reported in the 360 Assurance Audit Report • That the Committee had received and reviewed the GP Survey Feedback Analysis		
PCCC 20/01/14	**DATE & TIME OF NEXT MEETING** Thursday, 27 May 2021 at 9.30am via MS Teams.		

PCCC 21/05/06

NHS Barnsley Clinical Commissioning Group

MATTERS ARISING REPORT TO THE PUBLIC PRIMARY CARE COMMISSIONING COMMITTEE

THURSDAY, 27 MAY 2021

1. MATTERS ARISING

The table below provides an update on actions arising from the meeting of the Primary Care Commissioning Committee held on **25 March 2021**

Minute ref	Issue	Action	Action/Outcome
PCCC 21/03/13	Annual Assurance Report Due to a meetings clash it was agreed that a footnote be added to the Assurance Report to reflect that the timing of the PCCC had been amended to facilitate better attendance from the Chair of the CCG.	**RW/AM**	**Complete**

2. ITEMS FROM PREVIOUS MEETINGS CARRIED FORWARD TO FUTURE MEETINGS

Table 2 provides an update/status indicator on actions arising from earlier Board meetings held in public.

Minute ref	Issue	Action	Action/Outcome
PCCC 20/07/07	GP Patient Survey 2020 A thorough analysis of all the results would be carried out and a full report including an action plan would be presented at a future meeting of the Committee.	**JF**	26.11.20 Update Analysis reported at November meeting. A full analysis to be presented at a future meeting once the Primary Care Team had an opportunity to engage with practices in more detail post Covid.

South Yorkshire and Bassetlaw
Integrated Care System

Proposal to establish a *South Yorkshire and Bassetlaw ICS Primary Care Collaborative*

XX Name
XX Date

Why now?

- In line with the '*Integration and Innovation: working together to improve health and social* care' white paper,
- SYB ICS partners are developing a framework to support the creation of the SYB ICS statutory body
- The plan will focus on transition in 2021/22 and establishment from 1st April 2022
- ICS partners are clear that a focus should be placed on strengthening a number of key building blocks within the system including establishing…..

Provider collaboratives across SYB

The aim of this proposal:

- This proposal is a thought piece on how a Primary Care Collaborative might be established within the SYB ICS footprint
- The ambition is to engage widely and take views to further develop the proposal
- It is acknowledged that national Provider Collaborative establishment guidance is anticipated at some point in 21/22 and the establishment of the SYB ICS PC Collaborative will need to consider and take account of this

The proposed role of a SYB ICS PC Collaborative

- As the ICS becomes established, it is important that PC is represented effectively within the new arrangements.
- The aim is to build on the positive progress made by the SYB ICS Primary Care Steering Board so far and ensure that PC has a representative voice within the ICS
- It is proposed that the collaborative supports the ICS on delivering its "***quadruple aim***" of 'better health and wellbeing for the whole population, better quality care for all patients and sustainable services for the taxpayer alongside the reduction of health inequalities
- Work collectively with other ICS Provider Collaboratives as they become established

1. Do you agree with these 4 statements?

Proposed areas of responsibility for a SYB ICS PC Collaborative

1. Creating a representative voice for PC to ensure PC is at the centre of ICS decision making
2. Shaping the role and influence of primary care in its widest sense in SYB Health and care partnership
3. Ensuring that the PC voice is represented on the future ICS NHS Board
4. Ensuring PC plays its part in achieving the ICS ambitions of the quadruple aim
5. To oversee the delivery of the PC strategy in SYB
6. Engaging with and influencing the work of other provider collaboratives across the SYB footprint
7. Supporting PC to collaborate and transform across the SYB footprint where it makes sense to do so, eg health inequalities/PHM, workforce development, education, BI
8. Some level of delegation from the ICS is anticipated (TBC during 21/22)

2. Do these areas of responsibility look right?

3. Thoughts on representing PC v representative of PC?

4. Are we missing anything?

How we might establish the SYB ICS PC collaborative (1):

- It is proposed that a GP clinical lead is appointed to oversee the development of the SYB ICS PC collaborative, give a representative view of PC, fulfil the role of NHS ICS Board member and provide support and PC expertise into the ICS statutory organisation
- The voice of PC needs to be heard at all levels, ie individual organisation, PCN, Place and ICS system
- The voice of PC needs to be heard across all professions, ie GP, Dental, Pharmacy and Optometry
- The SYB ICS PC collaborative will be representative; therefore, a structured governance model is required to ensure good communication and engagement up and down the levels

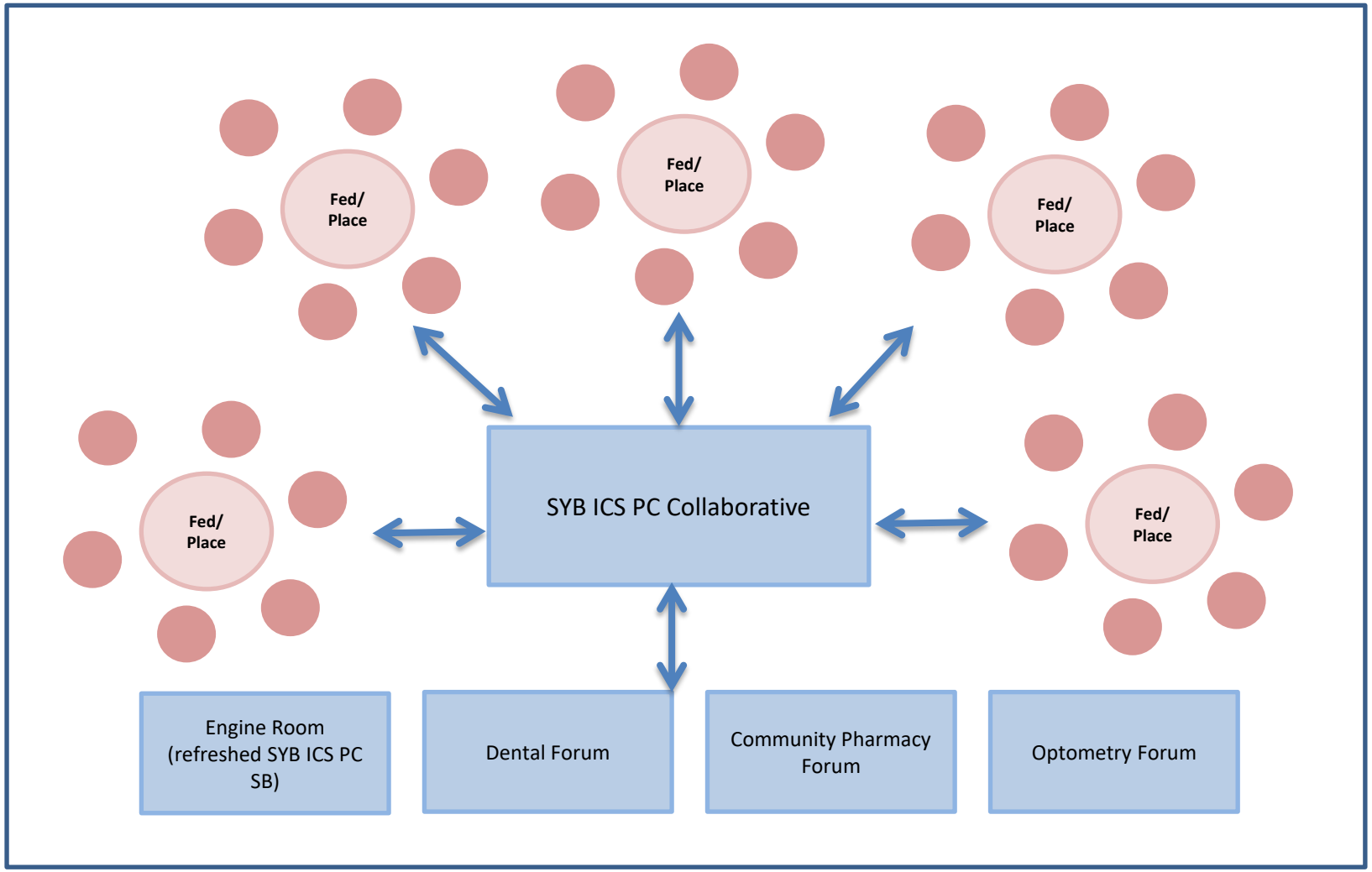
How we might establish the SYB ICS PC collaborative (2):

- The managerial PC ICS lead works alongside the GP clinical lead as experience suggests that a positive clinical/managerial partnership creates a good foundation for innovation and communication
- ICS resources will need to be identified to support the development of the SYB ICS PC collaborative
- A compact is agreed and signed across all parties to confirm support for the approach and also the role and function of the group and its members.
- It is clear that Primary Care is developed and delivered at many levels within the 5 SYB places. The expectation is that this model continues and the ICS PC Provider Collaborative will complement the work that already exists in the 5 ICS places

5. Do these proposals look right/Are we missing anything?

6. Views on GP lead and appointment process

Proposed Governance diagram



Proposed Governance principles

- The proposed governance model should use current arrangements already in place and should not create bureaucratic meeting arrangements
- Lines of conversation and communication must be genuinely bottom up and top down
- It is the responsibility of all parties to work collectively to make the governance arrangements effective and the SYB IC PC Collaborative a success

7. Does the governance model look right?
8. Do the principles look right?
9. Are we missing anything?

The current SYB Primary Care Steering Board

- The current SYB ICS PC Steering Board is well represented, ambitious and should be congratulated in its support to the wider PC system over recent years. It has also supported the development of the recently published SYB Primary Care Strategy.
- The Steering Board is starting to focus its attention on delivering the ambitions of the PC Strategy and the proposal is to maintain the group, drive forward with this agenda, provide assurance to the PC Collaborative and also provide further support as required.

10.Does this feel the right direction for the current PC Steering Board?

The proposed membership of the SYB ICS Collaborative

- GP Clinical Lead (Chair)
- ICS PC Lead
- GP Representative from each place
- SYB Dental representative
- SYB Optometry representative
- SYB Community Pharmacy representative

The collaborative will recognise the need to avoid silos and how to create an understanding of physical health/mental health and public health. The group will need to consider how this is taken forward.

11. How does this look/feel?
12. Approach to identifying GP's from each place?

Next steps

- Engagement and feedback process April/May
- Once the engagement exercise is complete, feedback will be considered and a proposal to establish a SYB ICS Primary Care Collaborative will be submitted to the ICS Health Executive Group in June 2021??
- The ambition is to establish a SYB ICS PC Collaborative and move to this model by **during quarter 3, 2021**.

13. How feasible is this/are we up for it?

QUESTIONS?

FEEDBACK COMMENTS

7th April – Lesley Smith

Can we add the left shift and added value of at scale points in to the consultation?

8th April - DCCG PCCCC

What will the PC contractual model be across SYB. Place or system and will PCCC's be required?

8th April – LMC informal meeting

Make sure we think about estates and capital and the role the PC Collaborative could play in this.

It is important that it is a leadership role aswell as someone who can put forward a representative view. Sometimes, the individual will have to make the call because not everyone will agree

Requires someone who can work collaboratively

The PC Collaborative is key to PC being seen as an equal partner across SYB

Let's be imaginative about how we progress

12th April – Alison Knowles

My only further thought on reading the paper is whether more needs to be made of the link in optometry and dental to secondary care? They have very different contractor models to GP and pharmacy

15th April – Community Pharmacists

Tom Bissett

Thanks Jackie

It has already sparked some conversations and as you note generally positive

Thomas Bisset
Ward Green Pharmacy
Tel: 01226 320790

FEEDBACK COMMENTS

15th April – Community Pharmacists

Claire Thomas

Hi Jackie,

Many thanks for the presentation – lots to think about!

I've been thinking about the Community Pharmacy Forum – in the past we had a SYB Local Pharmacy Network (LPN) which had an appointed Chair who I understand had to go through a formal process to become appointed – the LPN did some great work whilst Peter Magirr was in post but since he stepped down and he wasn't replaced and therefore the funding for his role disappeared, the LPN inevitably disappeared.

If the LPCs agree that in order to make the community pharmacy forum a success and have a strong community pharmacy voice feeding up directly from pharmacists/pharmacies on the ground and from the PC collaborative back down, that it would be beneficial to have someone formally appointed/recruited (like you said with the appropriate skills and experience possibly against a person spec?) – is that something we could ask of the ICS to support?

This is such an important opportunity for community pharmacy to have a voice and help to become more integrated, working more collaboratively with other health and care providers that I feel it is important that it is appropriately resourced and that anyone appointed to lead/Chair the forum is afforded the time and head space to do this role well.

Kind Regards
Claire

Claire Thomas MPharm MSc

FEEDBACK COMMENTS

AO's 19th April

The name (PC is being seen as GP's)

Should it be an appointed GP or other profession?

Will it be an entity or is advisory space?

It is ambiguous but needs to be. It can be representative but doesn't represent

FEEDBACK COMMENTS

Alastair Bradley – 19/4/21 via email

Dear Jackie

Thank you for sharing the slides on 8 April. I do have a few observations particularly from the provider and LMC viewpoint.

Slide 5, point 5 mentions delivery of ICS strategy. I would want the PC Collaborative to develop strategy and tell the ICS Board what needs funding. I would make an extra point on Slide 5 about developing PC strategy mainly at Place to reflect local needs rather than all being done at SY&B level.

Slide 6. I think this should really say the PC collaborative needs to listen to individual contractors/PCNs Place providers and be the voice for them into the ICS. We also need to understand initiatives at ICS level that will impact PC and be able to have on equal voice in their development. Especially if there are to be unified budgets on IT or premises.

We also need to ask how the statutory duty to consult with LMCs will be discharged at ICS level by the PC Collaborative. Eg should there be a separate LMC rep on this Collaborative to represent SYLMC? One for each LMC might be too many. LMCs need to be involved in decisions of a financial nature that impact GPs or pathway redesign - as we are at present with CCGs. Also LMCs are the representative body for general practice and general practitioners and any body requiring GP representation needs to include the LMCs whether as a decision-maker or as an external voice.

Kind regards

Alastair

Alastair Bradley
Chair
Sheffield Local Medical Committee
Media House, 63 Wostenholm Road
Sheffield, S7 1LE
Tel: (0114) 258 8755
Fax: (0114) 258 9060

FEEDBACK COMMENTS

5th May 21

Andrew Cash and Lesley Smith

1. Really support the proposal
2. Really support PC at scale – would like to see this going further
3. Need to mindful of language such as a single voice for PC. This is because the ICS will also need mechanisms in place for PC contracting and also performers list
4. Happy to progress with PC Collaborative but need to put a place holder on being the ICS Board rep until national guidance published.

Nick B response

Need to manage point 3

The single voice refers to a united and cohesive primary care which is consequently empowered to engage in the development and delivery of the ICS strategy as an equal and confident partner.

The consensual voice begins within Practice, PCN locality, Place and SYB ie follows the Layering principle. All need to feel included and to have some ownership of future direction and developments and to understand how their contribution makes a difference.

No one has ever indicated in any of the discussions I have attended that this refers to primary care contracting or the performers list. These have to continue to be independently, objectively and consistently managed across SYB. However, general practice and primary care should have confidence in the arrangements.

Thanks, Nick

OPTOMS 6th May

Really supportive

No current Optom Forum. Will consider how to estabish/get the optom view to feed into the PC Collab

Resources would be required (Karen to work with colleagues to determine)

Will starting thinking about who will be on the PC Collab

Important that everyone has an equal voice around the table and not dominated by one profession

FEEDBACK COMMENTS

Dear Karen and Jackie,

I hope you are both well

Further to Jackie's presentation and our follow up conversation regarding a potential opportunity for a proposal to be developed to ask for some funding to help facilitate the formation of a community pharmacy forum, representatives from the SYB LPCs met this morning and have agreed:

The proposed structure for the development of a Primary Care Provider Collaborative seems good and we welcome the opportunity for the wider primary care providers such as Community Pharmacy to have representation on this collaborative underpinned by the formation and work of a community pharmacy forum.

Membership of the forum will be formed by 2 representatives from each place making a total membership of 10. (Further discussion with the committees will be held regarding who the members will be and regarding the appointment of a chair/leadership team - decisions may be influenced based on the outcome of the funding proposal). Additional attendees will be invited to the forum depending on issues/topics/projects that arise so that we have a wealth of experience/knowledge and greater collaboration with all stakeholders that have an impact on pharmacy services or patient pathways that community pharmacy are part of. Examples of potential attendees include; the IPMO Chief Pharmacist, education/training representatives, patient representatives, PCN Clinical pharmacists, technicians etc

We would like to propose a request for funding for one half day session (4hrs) per week per place = 5 sessions (2.5 days) at an hourly rate of £35/hr (£700 per week across SYB) - with flexibility as to how the funding can be utilised to best support leadership and establishment of the forum - this is a new opportunity/process for us all so we will need to be adaptable as the formal ICS structures develop.

We understand a paper will go to the ICS Health Executive Group in June to recommend the proposals set out in Jackie's presentation as a way forward - please let us know if you need any further information from us at this stage.

Kind Regards
Claire

Claire Thomas MPharm MSc
Chief Officer
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NHS
Barnsley
Clinical Commissioning Group

PRIMARY CARE COMMISSIONING COMMITTEE

27 May 2021

PRIMARY CARE STRATEGY

PART 1A – SUMMARY REPORT

1.	**THIS PAPER IS FOR**

Decision		Approval	X	Assurance	X	Information	

2. PURPOSE

The purpose of the report is to update PCCC on the work to date regarding the development of the Primary Care Strategy and transformational plans for work to deliver an integrated Primary Care Delivery Model.

3. REPORT OF

	Name	Designation
Executive Lead	Chris Edwards	Chief Officer
Author	Julie Frampton	Head of Primary Care

4. SUMMARY OF PREVIOUS GOVERNANCE

The matters raised in this paper have been subject to prior consideration in the following forums:

Group / Committee	Date	Outcome
N/A		

5. EXECUTIVE SUMMARY

As primary care works towards resuming normal working post the Covid pandemic the CCG has reviewed it's working groups for primary care and have established the Primary Care Strategy Group, as a subgroup of PCCC, and the Primary Care Delivery Group to support operational delivery as work progresses.

The Barnsley Primary and Community transformation aims, in line with the NHS Long Term Plan (2019), Integrated Care System (ICS) Primary Care Strategy, and Network Contract Direct Enhanced Service (DES), to reflect the reinstatement of primary care services, transformation of services at "place" which will focus on seamless, accessible and integrated care, delivered by primary and community care teams whilst ensuring primary medical care is the foundation of a high performing "place" health care system.

	The Strategy Group has formed the Terms of Reference for the group and for the Operational Delivery Group. The Strategy group has also reviewed and established the high level Project Brief which sets out the work plan and is reflected in the start of the Primary Care Strategy – Barnsley Primary Care Delivery Model. These documents are the base for moving forward and as work progresses these documents will be reviewed, updated, and reported back to the PCCC.
6.	**THE PRIMARY CARE COMMISSIONING COMMITTEE IS ASKED TO:**
	• **Approve the Terms of Reference for the Primary Care Strategy Group** • **Approve the Terms of Reference for the Primary Care Delivery Group** • **Approve the Project Brief** • **Note the contents of the Primary Care Delivery Model**
7.	**APPENDICES / LINKS TO FURTHER INFORMATION**
	Appendix 1 – Primary Care Strategy Group TOR Appendix 2 – Primary Care Delivery Group TOR Appendix 3 – Project Brief Appendix 4 – Primary Care Delivery Model

Agenda time allocation for report:	15 mins

PCCC 21/05/08
PART 1B – SUPPORTING INFORMATION & ASSURANCE

1. Links to Corporate Priorities, GBAF and Risk Register

This report provides assurance against the following corporate priorities on the Governing Body Assurance Framework (*place ✓ beside all that apply*):

1.1 Urgent & Emergency Care		6.1 Efficiency Plans	
2.1 Primary Care	✓	7.1 Transforming Care for people with LD	
3.1 Cancer		8.1 Maternity	
4.1 Mental Health		9.1 Digital and Technology	
5.1 Integrated Care @ System		10.1 Compliance with statutory duties	
5.2 Integrated Care @ Place			

The report also provides assurance against the following red or amber risks on the Corporate Risk Register:	*Provide ref(s) or state N/A*

2. Links to statutory duties

This report has been prepared with regard to the following CCG statutory duties set out in Chapter A2 of the NHS Act (place ✓ beside all that are relevant):

Management of conflicts of interest (s14O)	**See 3.1**	Duties as to reducing inequalities (s14T)	**See 3.4**
Duty to promote the NHS Constitution (s14P)		Duty to promote the involvement of each patient (s14U)	
Duty to exercise its functions effectively, efficiently and economically (s14Q)	**See 3.2**	Duty as to patient choice (s14V)	
Duty as to improvement in quality of services (s14R)	**See 3.3**	Duty as to promoting integration (s14Z1)	✓
Duty in relation to quality of primary medical services (s14S)	**See 3.3**	Public involvement and consultation (s14Z2)	**See 3.5**

2A. Links to delegated primary care commissioning functions

This report is relevant to the following responsibilities for primary care commissioning delegated to the CCG (place ✓ beside all that are relevant):

Decisions in relation to the commissioning, procurement and management of GMS, PMS and APMS contracts (inc breach notices etc)		Decisions in relation to the management of poorly performing GP Practices	
Planning the primary medical services provider landscape in Barnsley (inc closures, mergers, dispersals)		Decisions in relation to the Premises Costs Directions Functions	
Planning the Commissioning of Primary Medical Services in Barnsley	✓	Co-ordinating a common approach to the commissioning of primary care services	✓
Manage the delegated allocation for commissioning of primary medical care services in Barnsley			

3. Governance Considerations Checklist *(these will be especially relevant where a proposal or policy is brought for decision or approval)*

3.1 Clinical Leadership

Have GB GPs and / or other appropriate clinicians provided input and leadership?	***NA***
If relevant provide brief details here OR cross refer to detailed report if used	

3.2 Management of Conflicts of Interest (s14O)

Have any potential conflicts of interest been identified and managed appropriately, having taken advice from the Head of Governance & Assurance and / or the Conflicts of Interest Guardian if appropriate?	***Y***
If relevant provide brief details here OR cross refer to detailed report if used	

3.3 Discharging functions effectively, efficiently, & economically (s14Q)

Have any financial implications been considered & discussed with the Finance Team?	***Y***
Where relevant has authority to commit expenditure been sought from Management Team (<£100k) or Governing Body (>£100k)?	***NA***
If relevant provide brief details here OR cross refer to detailed report if used	

3.4 Improving quality (s14R, s14S)

Has a Quality Impact Assessment (QIA) been completed if relevant?	***NA***
Have any issues or risks identified been appropriately addressed having taken advice from the Chief Nurse (or Deputy) if appropriate?	***NA***
If relevant provide brief details here OR cross refer to detailed report if used	

3.5 Reducing inequalities (s14T)

Has an Equality Impact Assessment (EIA) been completed if relevant?	***NA***
Have any issues or risks identified been appropriately addressed having taken advice from Equality Diversity & Inclusion Lead if appropriate?	***NA***
If relevant provide brief details here OR cross refer to detailed report if used	

3.6 Public Involvement & Consultation (s14Z2)

Has a s14Z2: Patient and Public Participation Form been completed if relevant?	***NA***
Have any issues or risks identified been appropriately addressed having taken advice from the Head of Comms & Engagement if appropriate?	***NA***
If relevant provide brief details here OR cross refer to detailed report if used	

3.7 Data Protection and Data Security

Has a Data Protection Impact Assessment (DPIA) been completed if relevant?	***NA***
Have any issues or risks identified been appropriately addressed having taken advice from the SIRO, IG Lead and / or DPO if appropriate?	***NA***
If relevant provide brief details here OR cross refer to detailed report if used	

3.8 Procurement considerations

Have any issues or risks identified been appropriately addressed having taken advice from the procurement Shared Service if appropriate?	***NA***
Has a Single Tender Waiver form been completed if appropriate?	***NA***
Has a Primary Care Procurement Checklist been completed where GPs, networks or Federations may be a bidder for a procurement opportunity?	***NA***
If relevant provide brief details here OR cross refer to detailed report if used	

3.9 Human Resources

Have any significant HR implications been identified and managed appropriately, having taken advice from the HR Lead if appropriate?	***NA***
If relevant provide brief details here OR cross refer to detailed report if used	

3.10	**Environmental Sustainability**

Have any significant (positive or negative) impacts on the environment or the CCG's carbon footprint been identified?	***NA***
If relevant provide brief details here OR cross refer to detailed report if used	

APPENDIX 1

PCCC 21/05/08.1

NHS Barnsley Clinical Commissioning Group

BARNSLEY PRIMARY CARE STRATEGY GROUP

1. OBJECTIVES

The Primary Care Strategy Group will support the development of a Primary Care delivery model by taking the opportunity to improve the quality of services for patients whilst also improving efficiency, lowering costs, and providing more care outside of hospital. Its priorities would include refocusing on prevention, putting people in charge of their own health and healthcare, and matching services more closely to individuals' risks and specific characteristics. The Primary Care Strategy Group will support the development and delivery of primary care services that are strongly aligned to national, regional, and local health and care priorities.

The Primary Care Strategy Group will:

- Maintain quality, safety and economic stability whilst transforming delivery
- Ensure clinicians are central to leadership and delivery
- Deliver coordination between place and system to agree and assure the delivery of transformation and service change
- Strengthen relationships
- Support community team integration and implementation
- Ensure the investment in Primary Care is delivered to maximum effect
- Support the delivery of Out of Hospital care
- Focus on Mental Health
- Focus on health inequalities
- Focus on prevention and self help
- Improve quality and patient experiences wherever care is being delivered

The Primary Care Strategy Group role is then to:

- Report progress to the Primary Care Commissioning Committee (PCCC)
- Co-ordinate the health & care priorities and system changes whilst ensuring delivery against agreed timescales
- Ensure that recommendations are made to the PCCC for decision to proceed
- Ensure that service changes have been developed in line with Commissioning Intentions and with strong clinical and professional leadership and ownership to ensure robust delivery of care
- Deliver the community wide financial plan
- Keep abreast of and link into wider system change and impact at local level – e.g. Integrated Care System Primary Care Plans and SYB Integration

- Support the provision of a sustainable Health and Care economy
- Provide direction to the Primary Care Forum for the operationalisation of service change and delivery

2. KEY RESPONSIBILITIES

The Primary Care Strategy Group will be responsible for:

- Providing leadership to ensure a co-ordinated and consensus approach
- Ensuring the necessary and required wider public engagement where significant changes to the Primary Care delivery model may occur
- Ensuring all service changes have been developed in line with strong clinical and professional leadership and ownership to ensure robust delivery of care which meets the Commissioning Intentions, outcomes, and measures
- Holding to account all colleagues in the delivery of the agreed plan to the timescales set out within it
- Ensuring that the health & care system performance is not compromised as service change and new delivery arrangements are implemented
- Ensuring that effective communication links are established with the wider Health and Care Partners
- Ensuring the Primary Care delivery model delivers sustainable services
- Developing a clear Work Programme under the following priorities:
  - Development and delivery of primary care transformation to incorporate the Long Term Plan and Primary Care Network developments
  - Quality improvement and reduction in health inequalities
  - Supporting the contractual requirements
  - Primary care workforce and training
  - Estates and digital IT
- Defining the following:
  - the scope (what is to be done)
  - timescales (when it will be done)
  - resource requirements (who will do it)
  - costs
  - risks and issues
  - quality expectations
  - planned outcomes

  - anticipated benefits

- Liaising with CCG Communication and Engagement Team to ensure that Patient and Public Engagement activities are coordinated across Barnsley.

3. MEMBERSHIP

CCG Chair
CCG Medical Director
CCG Head of Primary Care
CCG PC Finance Lead
Lead PCN Clinical Director
BHF Representative
SWYPFT Representative
Adhoc people as agenda requires

4. FREQUENCY OF MEETINGS

The meetings will be monthly unless instructed by the Chair (meetings could be more frequent if work requires a more responsive approach)

5. ADMINISTRATIVE ARRANGEMENTS

- There will be administrative support via the CCG Secretariate
- Wherever possible the agenda and papers will be circulated electronically 7 days in advance

APPENDIX 2

PCCC 21/05/08.2

NHS Barnsley Clinical Commissioning Group

BARNSLEY PRIMARY CARE DELIVERY GROUP

1. OBJECTIVES

The Primary Care Delivery Group will support the Primary Care Strategy Group by ensuring the delivery of the emerging Primary Care Delivery Model. Its priorities would include developing project plans that enable the delivery of the new model of service provision and supporting the Task and Finish Groups established to deliver the transformation. The Task and Finish Groups will work across primary care focussing on improving services for people, reducing inequalities, and providing integrated and accessible services.

The Primary Care Delivery Group will:

- Support community team integration and implementation
- Support the delivery of Out of Hospital care
- Improve quality and patient experiences wherever care is being delivered
- Co-ordinate the Task and Finish groups to ensure the delivery of the work streams are on track and are congruent
- Ensure the Task and Finish groups have appropriate service/provider representatives

2. KEY RESPONSIBILITIES

The Primary Care Delivery Group will be responsible for:

- The operational delivery of the plans developed by the Primary Care Strategy Group
- Developing clear project plans that define the following:
    - the scope (what is to be done)
    - timescales (when it will be done)
    - resource requirements (who will do it)
    - costs
    - risks and issues
    - quality expectations
    - planned outcomes
    - anticipated benefits
- Reporting progress to the Primary Care Strategy Group
- Ensuring all appropriate people are represented on the Task and Finish groups

3. MEMBERSHIP

- CCG Head of Primary Care
- CEO BHF
- CCG Medical Director
- Task and Finish Group Project Managers
- Representative SWYPFT
- Representative Community Pharmacy
- Adhoc people as agenda requires

4. FREQUENCY OF MEETINGS

The meetings will be monthly unless instructed by the Chair of the Primary Care Strategy Group.

APPENDIX 3 - Project Brief and Plan: The purpose of this document is to outline the Barnsley Primary and Community transition aims in line with the NHS Long Term Plan (2019) and Network Contract Direct Enhanced Service (DES) to reflect the reinstatement of primary care services, transformation of services at "Place" which will focus on seamless, accessible and integrated care, delivered by primary and community care teams and ensuring primary medical care is the foundation of a high performing health care system.

Primary Care Transition Project Brief

Objectives

Objectives for delivery are:

- Restoration of Business as Usual across Primary Care
- Development of a transition plan that incorporates a realistic implementation timeframe to maintain safety measures to prevent an increase in C-19 transmission
- Uses pertinent clinical information to establish priority groups of services for restoration
- Makes best use of the workforce to support people as they reconnect with health and care services
- Embed changes to service delivery from technology and wider service collaboration from "place" and "system" provision

Scope

- Primary and Community Care
- Mental Health Services
- Long Term Condition management
- Cancer Services
- Community Pharmacy
- Community Optometry
- Community Dental
- Voluntary Sector
- Care Homes

Interdependencies

- NHS Long Term Plan
- SYB ICS PC Strategy
- Integrated place based plans
- PCN development and maturity
- NHS People Plan
- Capital and Revenue Plans
- GPIT Futures
- Local Authority Plans
- Public Engagement Plans

Deliverables & Milestones

- **Helping people to live a healthy and independent life** - Balancing health management, health promotion and facilitating secondary prevention for those with chronic conditions.
- **Detecting health problems quickly** - Detection and rapid response to health issues leading ultimately to better health outcomes. Improving access routes to primary care and develop community diagnostics. Utilise lessons from the pandemic response.
- **Delivering timely, effective local integrated care and support** integrated teams work together avoiding unnecessary admissions, proactively managing patients with complex needs, support and maximise timely discharges.
- **Health checks** reinstated across all sectors starting with LD and Mental Health
- **Plans for re-instating all screening, vaccinations, and Immunisations**
- **Reduce variability and health inequalities** – Practice performance and quality of care patients receive benchmarked with peers. Develop personalisation plans based on needs.
- **National Service Specifications** - Ensuring that the specific goals of the Long Term Plan make a significant impact against the "triple aim" of:
  - Improving health and saving lives
  - Improving the quality of care for people with multiple morbidities
  - Helping to make the NHS more sustainable

Benefits & Measurement

Benefit

- **More coordinated services –** where people do not have to repeat their story
- **Access to a wider range of professionals** in the community, enable access to people and services in a single appointment, Right Care principles
- **Appointments that work around people's lives**, with shorter waiting times and different ways to get treatment and advice including digital, telephone-based, and face-to-face
- **More influence,** giving more power over how their health and care are planned and managed
- **Personalisation** and a focus on prevention and living healthily, recognising what matters to people and their individual strengths, needs and preferences
- **Wider range of services in a community setting**, so people don't have to default to the acute sector
- Developing a **more population-focused approach** to "system" and "place" decision-making, resource allocation, drawing on primary care expertise as central partners

Measurement

- **Greater resilience**: by making the best use of shared staff, buildings, and other resources to help balance demand and capacity over time
- **Better work/ life balance**: with more tasks routed directly to appropriate professionals, such as clinical pharmacists, social prescribers, physician associates, physiotherapists and other ARRs roles
- **More satisfying work** with each professional able to focus on what they do best

Critical Success Factors

- Maintain quality, safety and economic stability whilst transforming delivery
- Ensure clinicians are central to leadership and delivery
- Deliver coordination between" place" and "system" to agree and assure delivery of transformation and service change
- Improved access to cancer care
- Improved access to diagnostics
- Improved access to Mental Health and Crisis services
- Decrease in health inequalities
- Focussed actions on prevention and self help
- Ensure the investment in Primary Care is delivered to maximum effect
- Support the delivery of Integrated Out of Hospital care

• **Workforce** - Ensure the workforce of the future have the skills to respond to a wider profile of services and PCN workforce plans are further developed and matured.	• **Improved care and treatment for patients**, by expanding access to specialist and support services such as social care • **Greater influence** on the wider health system, leading to more informed decisions about where resources are spent • **Cooperation across organisational boundaries** and teams to allow better coordination of services • **More resilient primary care**, acting as the foundation of integrated systems	
Plan	**Key Stakeholders**	**Risks and Issues**
Defining the following: • **Detailed project plans developed for all work streams including:** ▪ **the scope (what)** ▪ **timescales (when)** ▪ **resource requirements (who)** ▪ **costs** ▪ **quality expectations\ outcomes** ▪ **anticipated benefits** ▪ **Risk assessment and mitigation** ▪ **Clear roles and responsibilities** ▪ **Communications plan**	• **CCG & ICS** • **PCN/Providers/Local Authority/Voluntary sector/Acute Care** • **Staff across Primary, Community and Social care** • **Health Watch\PPGs\Expert Patient Groups**	• **Lack of engagement** • **People reluctant to access care due to safety fears** • **Stakeholders do not support delivery plans** • **Over ambitious plans that are not deliverable** • **C-19 variants resistant to vaccine** • **DES and GMS contracts do not support delivery** • **Non-recruitment to workforce plans** • **ICS\Integration process slows delivery progress**

APPENDIX 4

PCCC 21/05/08.4

NHS
Barnsley
Clinical Commissioning Group

Primary Care Delivery Model Development

Author: Julie Frampton
Head of Primary Care
V1.1 April 2021

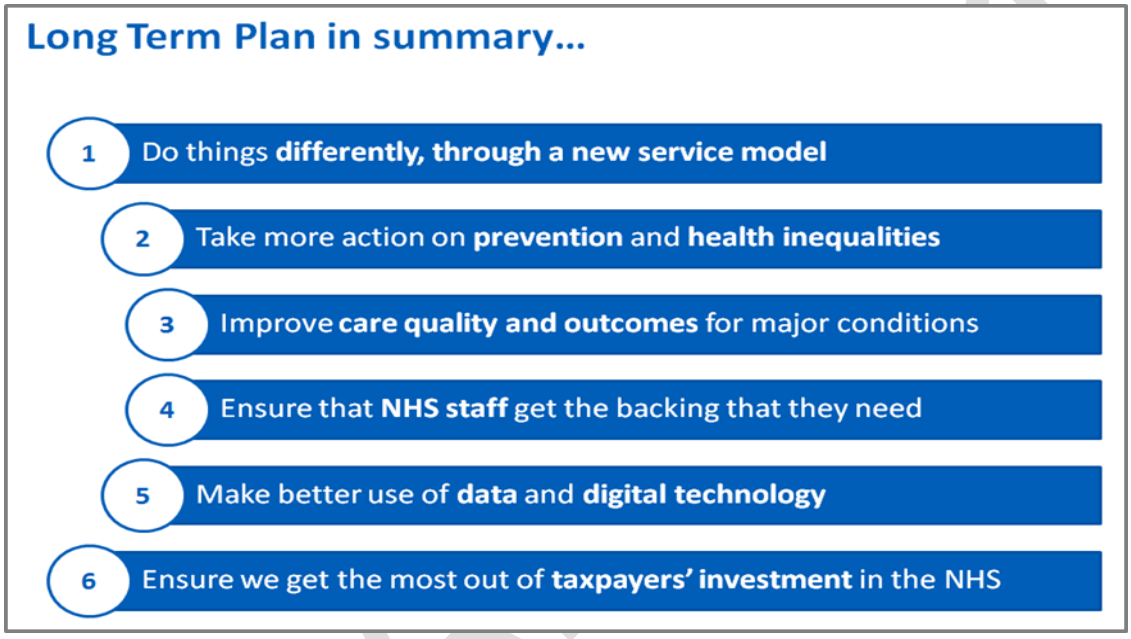
APPENDIX 4

NHS Barnsley Clinical Commissioning Group

Primary Care Delivery Model

Purpose

The purpose of this document is to outline the development of the Primary Care Delivery Model in line with the NHS Long Term Plan (2019) and Network Contract Direct Enhanced Service (DES) and to reflect the system sign up to the South Yorkshire and Bassetlaw (SYB) Integrated Care Systems (ICS) Primary Care Strategy. Barnsley Primary Care Delivery Model will focus on seamless, accessible, and integrated care, delivered by integrated primary care teams and ensuring primary medical care is the foundation of a high performing health care system.



The CCG will lead and support the development of the delivery model which takes a systematic approach to the planning and delivery of all care services provided in primary care settings and requires movement away from traditional fair shares to a more targeted approach for certain populations. The basis for this is described as 'layering' i.e. which activities and developments are most efficiently and effectively done at different levels of scale as noted in the diagram below. How primary care achieves these outcomes will be decided at the appropriate layer, recognising the concept of 'layering' and the principle of subsidiarity where decision making, and

empowerment are devolved to the most appropriate lowest level across our ICS.

Barnsley CCG aims to improve the health and wellbeing of the people of Barnsley. It shares this ambition with partners from across health and care as well as voluntary and community based organisations.

We recognise that fundamental to achieving this ambition we need strong and resilient primary and community care services. This requires a more integrated system to support a workforce that is multi-skilled and able to adapt to changes in the way that health and care services are provided as our services transform into a new model of care.

We recognise that in responding to new ways of working we need to develop these skills and competencies in collaboration with our partners and our patients. As such there will be a focus on what brings us together and how we will jointly tackle the challenge, whilst also highlighting locally sensitive solutions. This is not going to be an easy task, there are many challenges facing General Practice, including the covid pandemic, workforce, and rising demand. In Barnsley we will work together to develop a resilient and sustainable delivery model in which general practice can thrive.

Benefits

In Barnsley we already have a track record of working as one, investing consistently and equitably in primary care, in “at scale” networked provision via Barnsley Healthcare Federation for all our practice populations and in ensuring that no practice or its registered population are left behind.

Patients will benefit from extended access and responsiveness of the local care system by:

- **More coordinated services -** where they do not have to repeat their story multiple times
- **Access to a wider range of professionals** in the community, so they can get access to the people and services they need in a single appointment
- **Appointments that work around their lives**, with shorter waiting times and different ways to get treatment and advice including digital, telephone-based and face-to-face
- **More influence** when they want it, giving more power over how their health and care are planned and managed
- **Personalisation** and a focus on prevention and living healthily, recognising what matters to them and their individual strengths, needs and preferences

Practices will benefit by:

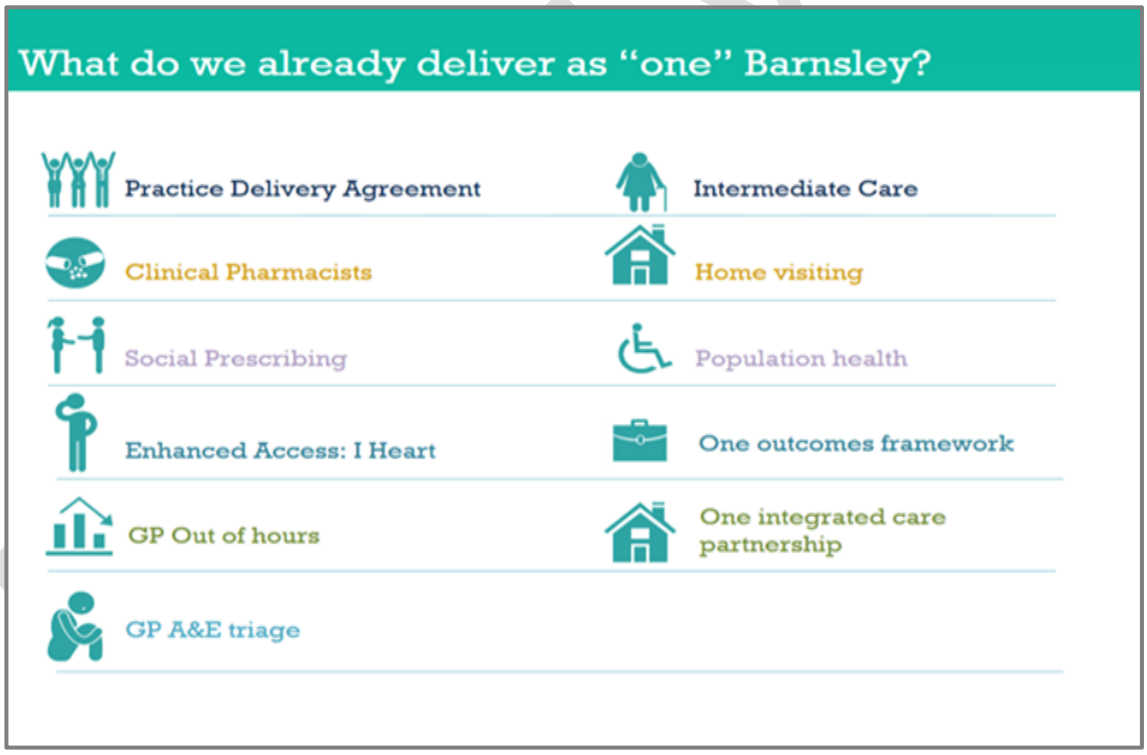
- **Greater resilience**: by making the best use of shared staff, buildings, and other resources, they can help to balance demand and capacity over time
- **Better work/ life balance**: with more tasks routed directly to appropriate professionals, such as clinical pharmacists, social prescribers, physicians’ associates, physiotherapists, care coordinators and other roles within the

Additional Roles scheme. Including wider system partners to support the delivery of care will also support

- **More satisfying work** with each professional able to focus on what they do best
- **Improved care and treatment for patients**, by expanding access to specialist and support services such as social care
- **Greater influence** on the wider health system, leading to more informed decisions about where resources are spent

Wider health and care system will benefit by:

- **Cooperation across organisational boundaries** and teams to allow better coordination of services
- **Wider range of services in a community setting**, so patients don't have to default to the acute sector
- Developing a **more population-focused approach** to system wide decision-making and resource allocation, drawing on primary care expertise as central partners
- **More resilient primary care**, acting as the foundation of integrated systems



Primary Care at "place" will have a wide reaching membership which should include providers from the local system such as:

- community pharmacy
- Optometrists
- dental providers
- social care providers

- voluntary sector organisations
- community services providers
- local government

Service Risks - Operational Stage:

- Failure to secure sustainable income streams to support ongoing services
  - Mitigation – The Network DES ensures a number of income streams that can be utilised to sustain finances across the PCN. There are several primary care contracts that could be utilised in ways to support the development of the delivery model
- Failure to source adequate, affordable staffing and facilities (within constraints of commissioned contract values)
  - Mitigation - The development will encompass existing practice and community infrastructure and there are opportunities for new staff in specific role/professions. The Neighbourhood Networks provide a structure to support delivery of more "hub and spoke" delivery that link with other provider structures enabling local provision within "place". There is an opportunity to look at the workforce model that we completed by WPS to support this model.
  - Mitigation – Exploring new roles and being creative regarding staffing skill mix could produce a workforce more stable and sustainable for delivering primary care

Interdependencies

The Primary Care Delivery Model will be strongly aligned to national, ICS and local health and social care priorities (place). It focusses heavily on addressing the health care needs of local people affecting our community and addresses the needs of the most vulnerable, reducing the health inequalities experienced by our population.

The development of the neighbourhood model will address the issues experienced by our communities, target those health inequalities specific to each neighbourhood and address the key public health themes such as lifestyle, social isolation, emotional health, alcohol intake, obesity, and smoking. It also links to mental health and the health and wellbeing strategy.

Barnsley GPs have a history of working together to innovate. Neighbourhood working Groups have already been established and now it is necessary to review these groups with a view to wider support mechanisms and to engage healthcare providers to implement the PCNs by promoting joint working with providers and the public.

Expected deliverables

Helping people to live a healthy and independent life

The need to balance health management with one of health promotion and protection is well documented with the following aspirations across the life course. They offer the basis of the outcome statements for this element of the plan in which primary and community services play a key role in facilitating secondary prevention for those with chronic conditions.

Outcome Statement

- Babies are born healthy
- Pre-school children are safe, healthy and develop their potential
- Children & young people are safe, healthy, and equipped for adulthood
- Working age adults live healthy lives for longer
- Older people age well into their retirement
- Frail people are happily independent.
- Those with chronic conditions are supported to make lifestyle choices which may prevent further exacerbation of the problem.

To achieve these, we will:

- Make every contact count, using any exchange with patients to share information that may aid their own well-being
- Engage with the "seldom heard" people – those who do not engage with traditional primary care and health promotion programmes
- Deliver seamless services
- Enhance preventative health activities, reduce clustering of unhealthy lifestyle behaviours
- Improve timely risk management to improve detection and early diagnosis of diseases such as cancers
- Seek to realise the capacity in individuals and communities through empowering people to be in control of their own Health & Well-being
- Chronic long term management programmes which relate to health promotion and the roles of community teams
- Increase uptake of screening programmes

Detecting health problems quickly

The ability to detect and therefore respond to health issues quickly is at the heart of modern healthcare. Early detection will lead to earlier care and advice and ultimately to better health outcomes.

Outcome Statements

- Individuals will have good and prompt access to healthcare provided through a variety of means
- Community teams will have access to a wide range of diagnostic tools to support early diagnosis and treatment
- Community teams will have prompt access to specialist advice

- Staff in hospitals who could be providing their service in a primary/community setting will be enabled do so
- Those who have a condition for which a risk stratification approach can be enabled will be enabled

To achieve these, we will:

- Continue to increase access and availability of core primary care services/teams
- Work with providers to develop the working models
- Work across frailty community resource teams
- Ensure the falls strategy supports general health promotion and falls prevention is followed by assessment and management of people at risk of falls or who have fallen.
- Provide a greater range of diagnostic tests and follow up checks and clinics closer to home, so people only travel to hospital for specialised services. Work with secondary care clinicians/teams to develop an appropriate model
- Review existing staffing resource across all sectors to build a holistic, integrated approach to a patient's needs rather than as a single/specialist service/pathway.
- Optimise and quality assures contractual arrangements to secure high quality and cost effective care from all sectors across Health and Social Care to include other services such as Dental, Optometry and Community Pharmacy and the third sector.

Delivering timely, effective local integrated care and support

The delivery of fast, effective, and local integrated care and support is the cornerstone of the Primary Care Delivery Model and will be delivered through a wide range of professionals and services working within integrated teams to meet communities and individual's needs. This will mean that all staff working at a community level will see themselves as part of an extended community team. The integrated care structure will be strengthened as the basis for planning, co-ordination, and delivery of local services by multi-agency teams against individual needs and clinically agreed pathways.

It is well recognised that when older people have protracted lengths of stay in hospitals this leads to poorer outcomes and increased dependency. It is therefore essential that integrated teams work together with the aim of avoiding unnecessary admissions to hospital. When a hospital admission is required, it is essential that the patient's length of stay is minimised and integrated teams proactively case manage patients with complex needs to support and maximise timely discharges.

Outcome Statements

- Patients will receive care from a team within their community and will not feel the boundaries that often exist between teams and sectors as those providing care will be seen as a single team regardless of professional background
- Integrated teams in the Neighbourhoods will be the point of influence for the delivery and resourcing of community based services
- Care will be co-ordinated at a Neighbourhood level, with local integrated teams holding responsibility for patient care and case management
- All patients with a chronic condition will have an individual care plan
- Services will be planned and delivered to support people to remain safely at home, or close to home, care will be delivered locally against agreed pathways and delivered by integrated teams across primary, community, social and third sector care with support packages tailored to the individual as necessary to their needs.
- Where more specialist care is required, specialist roles will support the Neighbourhood teams (e.g. CVD, Cancer/palliative care, Chronic Obstructive Pulmonary Disease {COPD}, Diabetes etc.) to access this in a timely way and ensure that the individual is supported through the specialist element of their need, returning where possible to community based care or indeed no need for further care

To achieve these, we will:

- Support Neighbourhood networks and teams, so they rapidly become the essential mechanisms for planning and delivering a truly integrated set of services
- Remove the boundaries between teams moving towards single integrated teams managed at a Neighbourhood level
- Develop a range of services to better manage patients within the community (e.g. CVD, diabetes, COPD, palliative care) though recognising that many of these already exist, seek to co-ordinate, and organise care better together
- Recognise that the older population have increasingly complex needs and co-morbidities. It is therefore essential that we treat the older person holistically rather than on an individual specialist based service/pathway.
- Systematically and proactively plan and co-ordinate packages of care using agreed care pathways and protocols, enabling all relevant professionals to talk to each other, utilising modern technology and case conferencing.
- Develop a more pro-active approach to the management of complex patients in the community
- Systematically and proactively identify the needs of people living within their local communities, including those at risk or requiring high levels of care and support to inform service planning and co-ordination.
- Optimise the use of modern technology to monitor, protect and communicate with each individual assessed as vulnerable, in their home.
- Develop and implement models of care and services which increases the range of services available 7 days per week, 24 hours a day

Involving people in decisions about local services and their care

Change is most effective when those that it affects are involved in bringing it about. A new approach to the involvement of individuals and communities should be enabled, one which engages people in formulating ideas about service development and change before any plans are made as well as seeks feedback on service experience. As such citizens become much more partners in the design of and quality of services rather than solely as recipients.

Outcome statements

Influence

- Communities feel ownership of their local services and know they can influence them
- Communities are offered opportunity to engage in the future shape of services for a community
- Communities and individuals know where to go and who to speak to if they have ideas about service development
- Communities receive consistent and equitable service provision and care

Feedback

- People receiving services know how they can give feedback on them
- People can see a direct link between their feedback and service improvement
- Every contact will count, local teams providing services will engage actively with people and seek their views on the services provided

Information

- Information (whether condition specific or related to service availability/improvement) is easily accessible to all
- Community infrastructure in the widest sense is used as a means through which information can be accessed

To achieve these, we will:

Work with and empower the local communities utilising a variety of methods to obtain the views of people on integrated team working within the Neighbourhood delivery model. This will focus initially on the areas with the highest levels of deprivation and resulting health inequalities to improve the health of the local population and to provide excellence in primary care.

Planning, organising, and delivering local integrated care

The model of care proposed here is one which draws on all expertise within a community, individuals and communities themselves, all primary care contractors, social care teams, community and wider community teams (i.e. health visitors,

district nurses, dentists, optometrists, community pharmacists) and the third sector providers and private providers as they relate to the model.

Effective planning systems are often the simplest, those that have the least bureaucracy, yet where everyone is clear on where decisions are made and how to influence this. The vision we have presented through the varying themes in this strategic plan, mean that a system of planning and organisation has to be enabled that engages a wide range of people, responds to National requirements but most importantly is able to reflect and respond to local needs.

Outcome Statements

- Expertise from communities and teams working within communities is harnessed and utilised to make local care as effective as it can be
- Local clinical leaders will set the vision for local care
- Quality and safe care is at the forefront of localised service delivery
- The primary and community workforce will have a wide range of skills developed across a team based concept of skill development
- Modern technology will be used where appropriate to support access to, and the delivery of local care

To achieve this, we will:

- Further develop local integrated teams with clear accountability relationships to the organisations that employ them
- Further develop partnerships for planning and building local services
- Further develop integrated teams for service delivery via existing resources/teams coming together and being recognised as one local team
- Enable pathways of care through clear clinical leadership
- Provide strong leadership and create capacity and capability for Neighbourhoods to plan and co-ordinate local integrated care.

Reduce the variability

The CCG has a duty to continually improve the quality of medical care services. This has been achieved through active engagement with our member practices and the development of a quality dashboard. This has enabled the CCG to work with practices to understand their performance and the quality of care their patients receive benchmarked with their peers. Whilst this has led to improvements there remains significant variation across practices. Covid-19 has further exposed some of the health and wider inequalities across our system, in order to address these, we will need to review the scale and pace of progress in reducing health inequalities.

Outcome Statements

- Develop a local quality improvement plan (benchmarking data) – promoted by strong accountable clinical leadership

- Practices have access to data and information tools to develop practice based improvement plans where necessary
- Development of a Neighbourhood/PCN quality dashboard that links to the ICS as “layers”
- Create a culture of sharing excellence

To achieve this, we will:

- Further develop local integrated teams with clear accountability relationships to the organisations that employ them
- Further develop partnerships for planning and building local services
- Further develop integrated teams for service delivery via existing resources/teams coming together and being recognised as one local team
- Enable pathways of care through clear clinical leadership
- Provide strong leadership and create capacity and capability for Neighbourhoods to plan and co-ordinate local integrated care.
- Build a “support team” to assist integrated teams with improving their quality performance

Delivering the Primary Care Development Model (needs developing)

The development of the Primary Care Delivery model is only the beginning of the journey. Much more important is the ability to realise its intent and translate the strategy to action.

It is clear that the plan offers a vehicle for the implementation of many organisational objectives and the delivery of the ICS, place, and neighbourhood plans. The CCG would support all partners to develop an approach to each of the key topic areas.

Technology (need to expand)

We will continue to support practices to increase the number of patients using online services to reduce the burden on them in relation to appointment booking, issuing prescriptions for repeat medication and dealing with access to medical records enquiries.

The increased amount of data and information available provides an important basis to focus on quality improvement. Bringing together the different skills and perspectives of people across the organisations in the PCNs to learn from each other, consider variation across providers and improve services for patients.

Estates (need to review)

The premises from which primary care services are delivered form a vital part of the infrastructure for Neighbourhoods. Increasingly premises will be required to support members of the multidisciplinary teams, visiting clinicians, pharmacists, physiotherapists, and specialist doctors. They will need to accommodate digital

solutions that support patients and streamlined administration and may be co-located with other support and community services.

The formation of the PCN provides an opportunity to reconsider the capacity, condition, and appropriateness of existing premises (last assessed in 2015 by Capita), split between clinical and non-clinical accommodation and the current ownership arrangements. A number of practices across Barnsley have utilised some of the existing capital funding routes including existing (BAU) capital for improvement grants, the Estates and Technology Transformation Fund to update their property.

The design of estate will be dependent on the local stock of premises and the extent to which existing premises can be used differently, have realistic investment opportunities to improve or extend, re-purpose buildings or invest in new developments linked to the Integrated Care System estates plan. Any emergent models will need to be supported by all partners to ensure patients are able to access services conveniently when they need to and may not always require physical co-location of all services under one roof. The model should facilitate improved, efficient use of existing estate rather than focus on initiatives requiring substantial capital investment and include key stakeholders for example Barnsley Metropolitan Borough Council, Barnsley NHS FT, and other providers.

Commissioners will support the revenue funding impact of existing and future premises and work to seek options to update, repurpose or extend existing premises where appropriate within the parameters of the NHS GMS (Premises Cost) Directions to maximise use of and ensure the provision of good quality health care accommodation.

Conclusion (need to review)

In Barnsley we will work collaboratively to make the NHS Long Term Plan a reality. We wish to create an environment in which everyone can continue to thrive, and our services become even more effective and efficient. Our strategy update aims to deliver community-based, person-centred care that:

- Promotes health and wellbeing
- Offers a true focus on prevention
- Supports people to be active in managing their own health and care
- Helps to keep people out of hospital as much as possible.

This will be a transformational journey for building patient-centred, out-of-hospital care, which will be realised over a number of years through a focus on improving outcomes for patients and thinking beyond traditional boundaries and business models.

Barnsley Clinical Commissioning Group
Putting Barnsley People First

PRIMARY CARE COMMISSIONING COMMITTEE

27 May 2021

FINANCE UPDATE

PART 1A – SUMMARY REPORT

1.	**THIS PAPER IS FOR**						
	Decision		*Approval*		*Assurance*		*Information*	X
2.	**REPORT OF**		
		Name	*Designation*
	Executive Lead	Roxanna Naylor	Chief Finance Officer
	Author	Ruth Simms	Finance Manager
3.	**EXECUTIVE SUMMARY**		

2021/22 Budget Update - H1

The financial framework for 2021/22 is split April – September 2021 H1 and October 2021 – March 2022 H2. H1 is a rollover of the H2 arrangements in 2020/21 and H2 is subject to further guidance.

The allocations for H1 (April to September 2021) for Primary Care Co-commissioning is £20,672k with budget requirements being at £21,713k, which is a shortfall of £1,041k which will be funded from CCG programme costs. The pressure is a result of national GP contract negotiations, planning requirements, the Primary Care Network Contract DES and historical increases from decisions on premises. The expenditure budget for H1 only includes the CCG element of the Additional Roles Reimbursement at 56.4%, and assumes that 44.4% will be funded from nationally held resource.

The 2021/22 Primary Care Co Commissioning budgets for H1 are set out below with the uplifts applied in each area:

Category	2021/22 Budget £'s H1 – April to September 2021	% Uplift Applied
Enhanced Services	288,885	0.75% Demographic Growth & 1% Provider Inflation
GENERAL PRACTICE - APMS	643,885	0.75% Demographic Growth & increase in core funding per patient of £2.87

GENERAL PRACTICE - GMS	6,414,629	0.75% Demographic Growth & increase in core funding per patient of £3.32
GENERAL PRACTICE - PMS	6,707,580	0.75% Demographic Growth & increase in core funding per patient of £3.32
Other GP Services	272,738	1% Provider Inflation on Locums
Other Premises	16,375	
Premises Cost Reimbursement	2,877,724	Inflation of 3% on Community Health Partnership Rent & 2% Inflation on Other Rents. 1% Inflation on Water and Non Domestic Rates.
Prescribing & Dispensing Doctors	273,041	1% Provider Inflation
QOF	1,977,373	3% increase as per guidance and 0.75% Demographic Growth
Telephone & Transport	225,147	1% Inflation on Transport SLA
PCN DES	2,029,143	See assumptions below
Total Budget	**21,726,519**	

Primary Care Network (PCN) Direct Enhanced Services (DES) Assumptions

The table below highlights the 6 key financial areas in the new Primary Care Network DES and expenditure expectations for the full financial year 2021/22. This may be subject to change following H2 planning guidance and any further requirements set out nationally.

Category	**2021/22 Expenditure expectations April 2021 – March 2022 £'s**	**Assumptions/Calculation**
Network Participation	520,822	Weighted list size January 2021 X £1.761 per patient.
Extended Hours	380,890	Actual list size (January 2021) X £1.44 per patient
Additional Roles Reimbursement Scheme (ARRS)	2,028,039	This budget is based on national guidance (April 2021). Baseline ARRS funding £2,028k (56.4%) is included within the CCGs budget position and a further maximum of £1,620k (44.4%) is held by NHS England for the CCG to drawdown.
Care Homes Premium	280,320	£120 per CQC registered bed, 2,336.
Investment and Impact Funding	653,768	£2.47 per registered patient (January 2021)
Clinical Director	194,447	£0.736 per actual registered patient (January 2021)
Total	**4,057,212**	

	Additional core PCN funding equating to £1.50 per registered patient (January 2021) totalling £396,225 (full year budget) has been allocated to the PCN DES, which will be funded in addition to the above from CCG Programme Allocations in line with planning guidance requirements. Full forecast positions will be reported to the committee in August 2021. Updates on the financial position are reported on a monthly basis through the Integrated Performance Report which is a standing agenda item at the Finance and Performance Committee and Governing Body.
4.	**THE COMMITTEE IS ASKED TO NOTE:**
	• Note the update on the financial framework for 2021/22 and budgets set for the period April 2021-September 2021
5.	**APPENDICES**
	N/A

Agenda time allocation for report:	10 minutes.

PART 1B – SUPPORTING INFORMATION

1.	Links to the Governing Body Assurance Framework	Risk ref(s)
	This report provides assurance against the following risks on the Governing Body Assurance Framework:	*N/A*
2.	**Links to CCG's Corporate Objectives**	**Y/N**
	To have the highest quality of governance and processes to support its business	✓
	To commission high quality health care that meets the needs of individuals and groups	✓
	Wherever it makes safe clinical sense to bring care closer to home	✓
	To support a safe and sustainable local hospital, supporting them to transform the way they provide services so that they are as efficient and effective as possible for the people of Barnsley	✓
	To develop services through real partnerships with mutual accountability and strong governance that improve health and health care and effectively use the Barnsley £.	✓
3.	**Governance Arrangements Checklist**	
3.1	**Financial Implications**	
	Has a financial evaluation form been completed, signed off by the Finance Lead / CFO, and appended to this report?	*N/A*
	Are any financial implications detailed in the report?	*N/A*
3.2	**Consultation and Engagement**	
	Has Comms & Engagement Checklist been completed?	*N/A*
	Is actual or proposed engagement activity set out in the report?	*N/A*
3.3	**Equality and Diversity**	
	Has an Equality Impact Assessment been completed and appended to this report?	*N/A*
3.4	**Information Governance**	
	Have potential IG issues been identified in discussion with the IG Lead and included in the report?	*N/A*
	Has a Privacy Impact Assessment been completed where appropriate (see IG Lead for details)	*N/A*
3.5	**Environmental Sustainability**	
	Are any significant (positive or negative) impacts on the environment discussed in the report?	*N/A*
3.6	**Human Resources**	
	Are any significant HR implications identified through discussion with the HR Business Partner discussed in the report?	*N/A*

NHS
Barnsley
Clinical Commissioning Group

PRIMARY CARE COMMISSIONING COMMITTEE

27 May 2021

CQC REPORT

PART 1A – SUMMARY REPORT

1. THIS PAPER IS FOR

Decision		Approval		Assurance	X	Information	

2. PURPOSE

The purpose of the report is to provide members with an update on the current CQC position in relation our GP Practices and for Barnsley Healthcare Federation i-Heart contracts.

3. REPORT OF

	Name	Designation
Executive Lead	Chris Edwards	Chief Officer
Authors	Terry Hague Julie Frampton	Primary Care Transformation Manager Head of Primary Care

4. SUMMARY OF PREVIOUS GOVERNANCE

The matters raised in this paper have been subject to prior consideration in the following forums:

Group / Committee	Date	Outcome
Quality and Patient Safety Committee	18/01/2021	Noted

5. EXECUTIVE SUMMARY

CQC Inspections

The CQC have informed the CCG that they are planning their GP practice inspection programme for 2021-22. Their approach to inspection activity is as outlined below:

The CQC's approach to inspection activity from April

Throughout the pandemic, our regulatory role has not changed. Our core purpose to ensure that the public receive safe, effective, compassionate, and high-quality care has remained at the centre of our activities – and this will continue.

Our inspection activity from April is a continuation of our inspection programme and our approach to inspecting GP locations has not significantly changed.

We will be minimising the time we spend on site as part of our inspection activity and we will work with providers to gather evidence in different ways. For example:

- *Conducting online interviews with staff*
- *Asking providers to share links to our Give Feedback on Care campaign to encourage patient feedback*
- *GP specialist advisors digitally accessing clinical records systems meaning they don't always need to be on site. More information about this is set out in Mythbuster 12. We would encourage practices to look at the search areas ahead of inspection.*

As well as continuing to respond to risk we will be starting the reinspection of locations with breaches of regulation and those rated requires improvement overall without breaches of regulation. We will also be starting to inspect services registered for over 12 months which have never been inspected.

Our approach

Practices rated inadequate overall or in special measures and newly registered services

- *These will be comprehensive inspections of all five key questions.*
- *Clinical systems searches and associated clinical records reviews will be used for all (these will be conducted off-site where possible)*

Practices rated requires improvement overall

- *We will be using a more focused and proportionate approach to re-rate GP practices with rated requires improvement. We will use an extended version of our existing focused inspection methodology to recognise improvement or deterioration.*
- *These inspections will cover the safe, effective and well-led key questions (as a minimum), plus any other areas required (including key questions with breaches of regulation or rated requires improvement or inadequate).*
- *We will use this approach to update overall ratings – ratings for key questions which are not inspected will be carried forward from previous inspection activity in line with our approach for good and outstanding practices.*
- *Clinical systems searches and associated clinical records reviews will be undertaken for all (these will be conducted off-site where possible).*

Practices rated good with a breach of regulation

- *Where possible, practices rated good with a breach of one key question will be followed up without undertaking a location site visit.*
- *Where we do not undertake a site visit, we cannot update the overall rating – any changes to ratings are limited to key question or population group level*.

	The CQC have shared with and encouraged practices to review their Mythbuster 12 which describes the remote access to medical records approach. Upcoming inspections are detailed below: • The Rose Tree Practice was inspected on the 18 May 2021 due to their current rating of Requires Improvement from their last inspection which took place on the 2 October 2019, following a rating of Inadequate in February 2019. The CCG have been liaising with the practice to gain assurance of a completed action plan to meet the areas identified within the CQC evidence table report as not meeting requirements. • Lakeside Surgery is due to be inspected in June 2021 as the practice does not have a current rating since the change in contract holder/ registered manager. • The Kakoty Practice and High Street Practice will be re-inspected later in the year. Although both practices are rated as Good overall, they each have one indicator rated as Requires Improvement: o High Street Practice were rated as Requires Improvement for being an effective practice at their inspection on 8 October 2019 o The Kakoty Practice were rated as Requires Improvement for being an effective practice at their inspection on 10 December 2019 The CCG have been liaising with the practices to gain assurance of a completed action plan to meet the areas identified within the CQC evidence table report as not meeting requirements. • A remote inspection of Hoyland Medical Practice took place on 6 May in response to information received by the CQC. The outcome of the inspections will be shared at a later committee meeting when formal feedback from the CQC is available.
6.	**THE PRIMARY CARE COMMISSIONING COMMITTEE IS ASKED TO:**
	• Note the CQC's inspection planning and approach for 2021-22 • Note the inspection of Rose Tree Practice • Note the upcoming inspections for Lakeside Surgery, The Kakoty Practice and High Street Practice • Note the remote inspection undertaken at Hoyland Medical Practice.
7.	**APPENDICES / LINKS TO FURTHER INFORMATION**
	N/A

Agenda time allocation for report:	10 mins

PCCC 21/05/10
PART 1B – SUPPORTING INFORMATION & ASSURANCE

1. Links to Corporate Priorities, GBAF and Risk Register

This report provides assurance against the following corporate priorities on the Governing Body Assurance Framework (*place ✓ beside all that apply*):

1.1 Urgent & Emergency Care		6.1 Efficiency Plans	
2.1 Primary Care	✓	7.1 Transforming Care for people with LD	
3.1 Cancer		8.1 Maternity	
4.1 Mental Health		9.1 Digital and Technology	
5.1 Integrated Care @ System		10.1 Compliance with statutory duties	
5.2 Integrated Care @ Place			

The report also provides assurance against the following red or amber risks on the Corporate Risk Register:	*Provide ref(s) or state N/A*

2. Links to statutory duties

This report has been prepared with regard to the following CCG statutory duties set out in Chapter A2 of the NHS Act (place ✓ beside all that are relevant):

Management of conflicts of interest (s14O)	**See 3.1**	Duties as to reducing inequalities (s14T)	**See 3.4**
Duty to promote the NHS Constitution (s14P)		Duty to promote the involvement of each patient (s14U)	
Duty to exercise its functions effectively, efficiently and economically (s14Q)	**See 3.2**	Duty as to patient choice (s14V)	
Duty as to improvement in quality of services (s14R)	**See 3.3**	Duty as to promoting integration (s14Z1)	
Duty in relation to quality of primary medical services (s14S)	**See 3.3**	Public involvement and consultation (s14Z2)	**See 3.5**

2A. Links to delegated primary care commissioning functions

This report is relevant to the following responsibilities for primary care commissioning delegated to the CCG (place ✓ beside all that are relevant):

Decisions in relation to the commissioning, procurement and management of GMS, PMS and APMS contracts (inc breach notices etc)	✓	Decisions in relation to the management of poorly performing GP Practices	
Planning the primary medical services provider landscape in Barnsley (inc closures, mergers, dispersals)		Decisions in relation to the Premises Costs Directions Functions	
Planning the Commissioning of Primary Medical Services in Barnsley		Co-ordinating a common approach to the commissioning of primary care services	
Manage the delegated allocation for commissioning of primary medical care services in Barnsley			

3. Governance Considerations Checklist *(these will be especially relevant where a proposal or policy is brought for decision or approval)*

3.1 Clinical Leadership

Have GB GPs and / or other appropriate clinicians provided input and	***NA***

	leadership?	
	If relevant provide brief details here OR cross refer to detailed report if used	

3.2	**Management of Conflicts of Interest (s14O)**	
	Have any potential conflicts of interest been identified and managed appropriately, having taken advice from the Head of Governance & Assurance and / or the Conflicts of Interest Guardian if appropriate?	***Y***
	If relevant provide brief details here OR cross refer to detailed report if used	

3.3	**Discharging functions effectively, efficiently, & economically (s14Q)**	
	Have any financial implications been considered & discussed with the Finance Team?	***Y***
	Where relevant has authority to commit expenditure been sought from Management Team (<£100k) or Governing Body (>£100k)?	***NA***
	If relevant provide brief details here OR cross refer to detailed report if used	

3.4	**Improving quality (s14R, s14S)**	
	Has a Quality Impact Assessment (QIA) been completed if relevant?	***NA***
	Have any issues or risks identified been appropriately addressed having taken advice from the Chief Nurse (or Deputy) if appropriate?	***NA***
	If relevant provide brief details here OR cross refer to detailed report if used	

3.5	**Reducing inequalities (s14T)**	
	Has an Equality Impact Assessment (EIA) been completed if relevant?	***NA***
	Have any issues or risks identified been appropriately addressed having taken advice from Equality Diversity & Inclusion Lead if appropriate?	***NA***
	If relevant provide brief details here OR cross refer to detailed report if used	

3.6	**Public Involvement & Consultation (s14Z2)**	
	Has a s14Z2: Patient and Public Participation Form been completed if relevant?	***NA***
	Have any issues or risks identified been appropriately addressed having taken advice from the Head of Comms & Engagement if appropriate?	***NA***
	If relevant provide brief details here OR cross refer to detailed report if used	

3.7	**Data Protection and Data Security**	
	Has a Data Protection Impact Assessment (DPIA) been completed if relevant?	***NA***
	Have any issues or risks identified been appropriately addressed having taken advice from the SIRO, IG Lead and / or DPO if appropriate?	***NA***
	If relevant provide brief details here OR cross refer to detailed report if used	

3.8	**Procurement considerations**	
	Have any issues or risks identified been appropriately addressed having taken advice from the procurement Shared Service if appropriate?	***NA***
	Has a Single Tender Waiver form been completed if appropriate?	***NA***
	Has a Primary Care Procurement Checklist been completed where GPs, networks or Federations may be a bidder for a procurement opportunity?	***NA***
	If relevant provide brief details here OR cross refer to detailed report if used	

3.9	**Human Resources**	
	Have any significant HR implications been identified and managed appropriately, having taken advice from the HR Lead if appropriate?	***NA***

	If relevant provide brief details here OR cross refer to detailed report if used
3.10	**Environmental Sustainability**

Have any significant (positive or negative) impacts on the environment or the CCG's carbon footprint been identified?	***NA***
If relevant provide brief details here OR cross refer to detailed report if used	

NHS
Barnsley
Clinical Commissioning Group

PRIMARY CARE COMMISSIONING COMMITTEE

27 May 2021

CONTRACTUAL ISSUES REPORT

PART 1A – SUMMARY REPORT

1. THIS PAPER IS FOR

Decision		Approval	X	Assurance	X	Information	

2. PURPOSE

The purpose of the report is to provide members with an update on the current contractual issues in relation to our primary care contracts.

3. REPORT OF

	Name	Designation
Executive Lead	Chris Edwards	Chief Officer
Authors	Terry Hague Julie Frampton	Primary Care Transformation Manager Head of Primary Care

4. SUMMARY OF PREVIOUS GOVERNANCE

The matters raised in this paper have been subject to prior consideration in the following forums:

Group / Committee	Date	Outcome
N/A		

5. EXECUTIVE SUMMARY

1. <u>In Year Contract Variation</u>

<u>Dodworth Medical Centre (Apollo Court)</u>

Barnsley CCG has received an application to vary Dodworth Medical Centre (Apollo Court) PMS contract to remove Barnsley Healthcare Federation from 1 June 2021.

The practice has 5,004 patients and currently has 3 contract holders.

The CCG have also been contacted regarding plans to merge this practice with The Grove Medical Practice which is a GMS practice with a list size of 5305. This will be brought to a future committee meeting for consideration following receipt of a formal application.

The above requires a Contract Variation amendment to the PMS contract, this requires PCCC member's approval. Changes concerning the composition of the contractor/s of a PMS agreement require commissioner consent in writing for a variation to the contract as defined by section 7.5 within the Contract Variations section of the Primary Medical Care Policy and Guidance Manual (PGM) (v3)

The PGM also requires that individuals meet the eligibility criteria for holding a PMS agreement. NHSE have conducted all necessary due diligence checks.

It is recommended that the contract variation be approved, and the Primary Care Team will ensure the contracts are amended accordingly.

Penistone Group Practice

Barnsley CCG has received an application to vary Penistone Group Practices PMS contract in relation to a 24 hour retirement for Dr Morris on 1 April 2021.

A 24-hour retirement is a process by which members of the NHS pension scheme seek to qualify their retirement benefits whilst continuing to work (albeit with a break). 24-hour retirement benefits usually involves resigning from all involvement in an NHS contract, not returning to the NHS in any capacity for at least 24 hours and not working for more than 16 hours per week in the first month of retirement.

This 24 hour retirement does not require an amendment to the contract, so this item is included to note for information only.

2. GMS PMS Equalisation

In Summer 2013 NHS England commenced a review of the funding of PMS practices due to the significant variation in approach to these contracts both in terms of the financial resources invested and the additional objectives included in contracts.

You will recall that in 2020/21 the CCG continued with the work towards the GMS/PMS equalisation and this Committee approved the approach recommended to continue with the reconciliation.

For 2021/22 the CCG has reviewed the variance between GMS/PMS contracts and will not be applying any additional uplifts to PMS practices as we have achieved equalisation between the two contracts.

To note from June 2021, we will be applying the national contract uplifts as set out in the April 2021 guidance (see following table)

	GMS	PMS	APMS
	£/weighted patient	**£/weighted patient**	**£/weighted patient**
Seniority reinvestment	A [£0.45]	A [£0.45]	-
Inflation and other changes - net uplift	B [£2.87]	B [£2.87]	B [£2.87]
Total uplift (D)	A+B [£3.32]	A+B [£3.32]	B [£2.87]

	3. <u>Home Visiting Contract Extension – Barnsley Healthcare Federation - Extraordinary Meeting 29th April 2021</u> An extraordinary meeting of the PCCC was held to review and ask for approval of a Single Tender Waiver for Barnsley Healthcare Federation (BHF) to continue to provide Home Visiting services to Barnsley patients. It was recommended that the Home Visiting contract be extended until 31st March 2022, delivered by BHF, as ceasing the contract would greatly impact General Practice and would put a considerable burden back into GP practices at a time when resources are stretched to meet the current priority mandates from NHS England, or there could be a risk of increasing unnecessary A & E attendance. The Single Tender waiver for the contract was approved by the committee.
	4. <u>Online Consultation - Doctorlink</u> Online consultations for patients is described in NHSEI's Digital Transformation Strategy. Practices were required to offer online consultations by April 2020 and video consultations by April 2021. Doctorlink were the successful provider from the joint procurement by Barnsley Doncaster, Sheffield, and Bassetlaw CCGs. The Doctorlink system was selected due to its ability to provide a digital triage and advice tool which could be integrated into practice systems with patients being directed to the most appropriate service and, if required, able to book an appointment with an appropriate clinician. Doctorlink were awarded a 2 year contract commencing on 1 September 2019. Currently only one GP practice within Barnsley is utilising the Doctorlink system fully as intended. All 32 practices have implemented Doctorlink in line with the NHSE contractual requirements, 5 of our practices are 'connected', but only 4 utilise the function. To note: "Connected" appointments mean patients can and have booked appointments online, but the system will revert to "Unconnected" if there are not enough appointments set up for patients to choose. "Unconnected" means the appointment request has gone through the practice as an email request for the practice to action. The Doctorlink contract will not be extended at the contract end date of 31 August 2021 as it does not provide value for money nor support general practice in the way it was envisaged. Barnsley CCG is working with CCG's across South Yorkshire and Bassetlaw (SYB) and the Integrated Care System (ICS) Digital team following the guidance regarding the procurement of an online consultation system. This needs to provide an effective online consultation system that will be acceptable to general practice, provide value for money and more user friendly for both GPs and patients.

	5. <u>Barnsley Healthcare Federation Contracts Review</u> Discussions have taken place with Barnsley Healthcare Federation (BHF) regarding data entry and quality, timeliness of reporting and accuracy due to the high number of outstanding issues associated with the report. This had been an ongoing issue for a number of months pre Covid and, to support BHF during the pandemic, we stepped down formal contract meetings for most of 2020-21 and undertook a "light touch" approach which caused a further delay in the resolution of these issues. In an effort to start 2021-22 with all outstanding issues resolved it was agreed with the Chief Executive Officer at BHF that they would settle and reconcile the reporting for 2020-21 and start the 2021-22 financial year afresh. However, this was request was not met impacting on the 2020-21 report's accuracy. Unfortunately, the first Service Quality Performance (SQP) report for 2021-22 was received late resulting in very little time for the PC team to review the report ahead of the Contract meeting. The first initial review showed that there was a number of data entry issues which has resulted in lack of confidence in the reporting process undertaken by BHF. At May's BHF Contract meeting all of our concerns were fully discussed, and the CCG agreed a number of actions with BHF to support confidence and trust in the performance data received via the SQP for all the contracts that BHF currently hold. The intention is to avoid Contractual Breech notices on all BHF contracts.
6.	**THE PRIMARY CARE COMMISSIONING COMMITTEE IS ASKED TO:**
	1. Consider the contract variations: a. Approve the removal of Barnsley Healthcare Federation from the Dodworth Medical Practice (Apollo Court) contract b. Note the 24 hour retirement request for Dr Morris at Penistone Group Practice. 2. Note the contractual uplifts and equalisation of GMS/PMS contractual payments 3. Note the approval of the Single Tender Waiver for the Home Visiting Service contract to 31 March 2022. 4. Note the cessation of the Doctorlink contract from 31 August 2021. 5. Note the contract review discussions with Barnsley Healthcare Federation for assurance.
7.	**APPENDICES / LINKS TO FURTHER INFORMATION**
	None

Agenda time allocation for report:	15 mins

PCCC 21/05/11

PART 1B – SUPPORTING INFORMATION & ASSURANCE

1. Links to Corporate Priorities, GBAF and Risk Register

This report provides assurance against the following corporate priorities on the Governing Body Assurance Framework (*place ✓ beside all that apply*):

1.1 Urgent & Emergency Care		6.1 Efficiency Plans	
2.1 Primary Care	✓	7.1 Transforming Care for people with LD	
3.1 Cancer		8.1 Maternity	
4.1 Mental Health		9.1 Digital and Technology	
5.1 Integrated Care @ System		10.1 Compliance with statutory duties	
5.2 Integrated Care @ Place			

The report also provides assurance against the following red or amber risks on the Corporate Risk Register:	*Provide ref(s) or state N/A*

2. Links to statutory duties

This report has been prepared with regard to the following CCG statutory duties set out in Chapter A2 of the NHS Act (place ✓ beside all that are relevant):

Management of conflicts of interest (s14O)	**See 3.1**	Duties as to reducing inequalities (s14T)	**See 3.4**
Duty to promote the NHS Constitution (s14P)		Duty to promote the involvement of each patient (s14U)	
Duty to exercise its functions effectively, efficiently and economically (s14Q)	**See 3.2**	Duty as to patient choice (s14V)	
Duty as to improvement in quality of services (s14R)	**See 3.3**	Duty as to promoting integration (s14Z1)	
Duty in relation to quality of primary medical services (s14S)	**See 3.3**	Public involvement and consultation (s14Z2)	**See 3.5**

2A. Links to delegated primary care commissioning functions

This report is relevant to the following responsibilities for primary care commissioning delegated to the CCG (place ✓ beside all that are relevant):

Decisions in relation to the commissioning, procurement and management of GMS, PMS and APMS contracts (inc breach notices etc)	✓	Decisions in relation to the management of poorly performing GP Practices	
Planning the primary medical services provider landscape in Barnsley (inc closures, mergers, dispersals)		Decisions in relation to the Premises Costs Directions Functions	✓
Planning the Commissioning of Primary Medical Services in Barnsley		Co-ordinating a common approach to the commissioning of primary care services	
Manage the delegated allocation for commissioning of primary medical care services in Barnsley	✓		

3. Governance Considerations Checklist *(these will be especially relevant where a proposal or policy is brought for decision or approval)*

3.1 Clinical Leadership

Have GB GPs and / or other appropriate clinicians provided input and leadership?	***NA***

	If relevant provide brief details here OR cross refer to detailed report if used	
3.2	**Management of Conflicts of Interest (s14O)**	
	Have any potential conflicts of interest been identified and managed appropriately, having taken advice from the Head of Governance & Assurance and / or the Conflicts of Interest Guardian if appropriate?	***Y***
	If relevant provide brief details here OR cross refer to detailed report if used	
3.3	**Discharging functions effectively, efficiently, & economically (s14Q)**	
	Have any financial implications been considered & discussed with the Finance Team?	***Y***
	Where relevant has authority to commit expenditure been sought from Management Team (<£100k) or Governing Body (>£100k)?	***NA***
	If relevant provide brief details here OR cross refer to detailed report if used	
3.4	**Improving quality (s14R, s14S)**	
	Has a Quality Impact Assessment (QIA) been completed if relevant?	***NA***
	Have any issues or risks identified been appropriately addressed having taken advice from the Chief Nurse (or Deputy) if appropriate?	***NA***
	If relevant provide brief details here OR cross refer to detailed report if used	
3.5	**Reducing inequalities (s14T)**	
	Has an Equality Impact Assessment (EIA) been completed if relevant?	***NA***
	Have any issues or risks identified been appropriately addressed having taken advice from Equality Diversity & Inclusion Lead if appropriate?	***NA***
	If relevant provide brief details here OR cross refer to detailed report if used	
3.6	**Public Involvement & Consultation (s14Z2)**	
	Has a s14Z2: Patient and Public Participation Form been completed if relevant?	***NA***
	Have any issues or risks identified been appropriately addressed having taken advice from the Head of Comms & Engagement if appropriate?	***NA***
	If relevant provide brief details here OR cross refer to detailed report if used	
3.7	**Data Protection and Data Security**	
	Has a Data Protection Impact Assessment (DPIA) been completed if relevant?	***NA***
	Have any issues or risks identified been appropriately addressed having taken advice from the SIRO, IG Lead and / or DPO if appropriate?	***NA***
	If relevant provide brief details here OR cross refer to detailed report if used	
3.8	**Procurement considerations**	
	Have any issues or risks identified been appropriately addressed having taken advice from the procurement Shared Service if appropriate?	***NA***
	Has a Single Tender Waiver form been completed if appropriate?	***NA***
	Has a Primary Care Procurement Checklist been completed where GPs, networks or Federations may be a bidder for a procurement opportunity?	***NA***
	If relevant provide brief details here OR cross refer to detailed report if used	
3.9	**Human Resources**	
	Have any significant HR implications been identified and managed appropriately, having taken advice from the HR Lead if appropriate?	***NA***

	If relevant provide brief details here OR cross refer to detailed report if used	
3.10	**Environmental Sustainability**	
	Have any significant (positive or negative) impacts on the environment or the CCG's carbon footprint been identified?	***NA***
	If relevant provide brief details here OR cross refer to detailed report if used	

NHS
Barnsley
Clinical Commissioning Group

PRIMARY CARE COMMISSIONING COMMITTEE
27 May 2021

2020/21 Practice Delivery Agreement

Medicines Optimisation Section(s)

PART 1A – SUMMARY REPORT

1.	**THIS PAPER IS FOR**
	Decision ☐ *Approval* ☑ *Assurance* ☐ *Information* ☐
2.	**PURPOSE**
	The purpose of this report is to seek approval for the scheme and the budget to fund the 21/22 Medicines Optimisation section of the Practice Delivery Agreement.
3.	**REPORT OF**

	Name	Designation
Executive / Clinical Lead	Dr Madhavi Guntamukkala	GP Governing Body Lead
Author	Chris Lawson	Head of Medicines Optimisation

4.	**SUMMARY OF PREVIOUS GOVERNANCE**
	The matters raised in this paper have been subject to discussion with primary care clinicians throughout the last year. The Barnsley Area Prescribing Committee has endorsed all of the supporting guidance and first line evidence based formulary choices included within this scheme. The Barnsley GB approved the content of the 21/22 PDA MO programme at its May 2021 meeting.
5.	**EXECUTIVE SUMMARY**
	<u>Introduction</u> The PDA is commissioned via an NHS Standard Contract.

The 2021/22 Barnsley Practice Delivery Agreement (PDA) is being reviewed and refreshed to align to the aims and investment in the COVID Recovery, the NHS Long Term Plan and the changing landscape of the NHS in addition to delivering on the integration agenda.

The Medicines Optimisation section of this plan has completed its review and is fully "worked up" and a delay in its agreement may compromise delivery against the Medicines Optimisation 21/22 QIPP Plan, which is detailed down to delivery at GP practice level with preparatory work commencing in June 2021.

The aim(s) of the scheme is to promote medicines optimisation Quality , Innovation, Productivity and Prevention (QIPP) work :-

- improving the quality , evidence based usage of medicines which improves outcomes for patients: reduces morbidity and mortality and non-elective admissions.

- to support the COVID pandemic response and recovery.

- supporting primary care clinicians to manage specialist medicines in primary care and reducing interface medicines related issues: COVID 19 has significantly increased the numbers of patients being managed/ a movement (left shift) of activity from secondary to primary care

- maximising any financial prescribing efficiency opportunities which improve or maintain patient care.

Between 2012 and 2017 Barnsley CCG has annually developed and implemented a Medicines Management/ Optimisation QIPP/Quality Scheme. In 2017/18 this was incorporated into a Medicines Optimisation section of the Practice Delivery Agreement (PDA) between the CCG and its Member GP Practices. Also incorporated within this medicines optimisation section were three primary care medicine services ; Anticoagulation, Eclipse Live RADAR Reviews and Shared Care (Specialist) Medicines.

Where there is an advantage to any work being delivered at Locality Network or Integrated Care Network (Barnsley) level , then GP practices will be encouraged to undertake work across these networks towards a placed based care approach as referenced within the NHS Long Term Plan.

The concept of the Practice Delivery Agreement (PDA), whilst supporting practices to invest in the infrastructure to deliver services to their practice population, also supports the CCG to deliver its general duties as outlined within the Health and Social Care Act Part 1 Section 26.

Principles and Methodology

The principle of the PDA is that practices sign up to deliver all schemes written into the contract. All schemes have been developed based on current national and local priority work programmes and are focussed on the health needs of the Barnsley population.

The Medicines Optimisation (MO) section has been developed with input from individual primary care clinicians at practice level. There was an opportunity for Practice engagement during the early stages of development section to ensure that areas are achievable and supported in Primary Care. Included are a number of areas from the 2020/21 scheme which were delayed due to the COVID pandemic. The scheme also provides an opportunity for Primary Care to propose their own Medicines Optimisation scheme ideas based on population health need and responding to current priorities.

The scheme engages with and integrates with all other service provision through the Barnsley Area Prescribing Committee as a medicines provider interface.

The CCG Medicines Management Team work on a wider collaborative footprint to ensure that GP Practices are provided with an set of targets for delivery and reporting timeframes and reporting templates are clear and well understood by GP practices and allow practices to demonstrate that targets have been safely achieved over monthly submission periods. This process is facilitated through the production of standard codes, work protocols templates and searches.

Progress

The CCG has developed the draft 2021/22 Medicines Optimisation Practice Delivery Agreement section based on priorities and the challenges facing the health of the population and the health service in general.

The Medicine Optimisation section of the PDA has 4 core schemes:

1. Medicines Optimisation Scheme
2. Shared Care (Specialist) Drugs Management
3. Anticoagulation Management
4. Eclipse Live (RADAR) reviews

A summary of each of these sections are included below and the 2020/21 Medicines Optimisation Scheme has additionally been appended to this paper.

Medicines Optimisation Scheme

The draft 2021/22 Medicines Optimisation Scheme has been appended to this paper. The work against this plan is directly linked with the CCG Medicines Optimisation QIPP plan , which is planned to deliver £3.5 million QIPP in 21/22.

There is an integrated team approach to undertaking work which is complex and varies across practices. Each practice "owns" it's Practice Medicines QIPP Delivery Plan and reports against it each month.

Shared Care (Specialist) Drugs Management

This service enables patients receiving specialist medicines to be safely managed in primary care by GP practices and it reduces pressure on specialist services (hospital, community and integrated) ; inpatient and outpatient activity and costs. It enables patients to transfer faster over to primary care management and reduces hospital length of stay. It reduces number of patients travelling to specialist centres for treatment and improves convenience for them being managed locally by their GP practice.

	Anticoagulation Management This is specialist primary care service. Clinics run several times each week across every GP practice and about one third of practices also initiate patient on Warfarin. Clinics are run by practice nurses with specialist training and clinics are overseen by an autonomous (GP or ANP) prescribing clinician. **Eclipse Live RADAR Reviews** Red and Amber RADAR alerts are reviewed by GP's (autonomous clinicians specialised in diagnosis and referral) The Eclipse Live software identifies patients at high risk of hospital admission due to medicines related risk. **Approval** The MO section of the PDA is planned to deliver £3.5 million of QIPP efficiencies within the 21/22 financial year. The payments to GP practices for the delivery of ALL services and work included within the MO section of the PDA is £2.4 million. The budget for the Medicines Optimisation section will be discussed and approved by the Primary Care Commissioning Committee to manage any conflicts of interests.
6.	**THE PRIMARY CARE COMMISSIONING COMMITTEE IS ASKED TO:**
	Approve the 21/22 Medicines Optimisation section of the Practice Delivery Agreement and budget.
7.	**APPENDICES / LINKS TO FURTHER INFORMATION**
	• Appendix A – 2021/22 Draft Primary Care Practice Level Medicines Optimisation Scheme

Agenda time allocation for report:	10 minutes

PART 1B – SUPPORTING INFORMATION & ASSURANCE

1. Links to Corporate Priorities, GBAF and Risk Register

This report provides assurance against the following corporate priorities on the Governing Body Assurance Framework (*place ✓ beside all that apply*):

1.1 Urgent & Emergency Care		6.1 Efficiency Plans	✓
2.1 Primary Care	✓	7.1 Transforming Care for people with LD	
3.1 Cancer		8.1 Maternity	
4.1 Mental Health		9.1 Digital and Technology	
5.1 Integrated Care @ System		10.1 Compliance with statutory duties	✓
5.2 Integrated Care @ Place			

The report also provides assurance against the following red or amber risks on the Corporate Risk Register:	

2. Links to statutory duties

This report has been prepared with regard to the following CCG statutory duties set out in Chapter A2 of the NHS Act (place ✓ beside all that are relevant):

Management of conflicts of interest (s14O)	✓	Duties as to reducing inequalities (s14T)	✓
Duty to promote the NHS Constitution (s14P)	✓	Duty to promote the involvement of each patient (s14U)	✓
Duty to exercise its functions effectively, efficiently and economically (s14Q)	✓	Duty as to patient choice (s14V)	✓
Duty as to improvement in quality of services (s14R)	✓	Duty as to promoting integration (s14Z1)	✓
Duty in relation to quality of primary medical services (s14S)	✓	Public involvement and consultation (s14Z2)	✓

2A. PCCC ONLY - PLEASE DELETE IF NOT APPLICABLE
Links to delegated primary care commissioning functions

This report is relevant to the following responsibilities for primary care commissioning delegated to the CCG (place ✓ beside all that are relevant):

Decisions in relation to the commissioning, procurement and management of GMS, PMS and APMS contracts (inc breach notices etc)		Decisions in relation to the management of poorly performing GP Practices	
Planning the primary medical services provider landscape in Barnsley (inc closures, mergers, dispersals)		Decisions in relation to the Premises Costs Directions Functions	
Planning the Commissioning of Primary Medical Services in Barnsley		Co-ordinating a common approach to the commissioning of primary care services	
Manage the delegated allocation for commissioning of primary medical care services in Barnsley	✓		

3. Governance Considerations Checklist *(these will be especially relevant where a proposal or policy is brought for decision or approval)*

3.1 Clinical Leadership

Have GB GPs and / or other appropriate clinicians provided input and leadership?	***Y***
If relevant provide brief details here OR cross refer to detailed report if used	

3.2 Management of Conflicts of Interest (s14O)

Have any potential conflicts of interest been identified and managed appropriately, having taken advice from the Head of Governance & Assurance and / or the Conflicts of Interest Guardian if appropriate?	***Y***
If relevant provide brief details here OR cross refer to detailed report if used	

3.3 Discharging functions effectively, efficiently, & economically (s14Q)

Have any financial implications been considered & discussed with the Finance Team?	***Y***
Where relevant has authority to commit expenditure been sought from Management Team (<£100k) or Governing Body (>£100k)?	***NA***
If relevant provide brief details here OR cross refer to detailed report if used	

3.4 Improving quality (s14R, s14S)

Has a Quality Impact Assessment (QIA) been completed if relevant?	***NA***
Have any issues or risks identified been appropriately addressed having taken advice from the Chief Nurse (or Deputy) if appropriate?	***NA***
If relevant provide brief details here OR cross refer to detailed report if used	

3.5 Reducing inequalities (s14T)

Has an Equality Impact Assessment (EIA) been completed if relevant?	***NA***
Have any issues or risks identified been appropriately addressed having taken advice from Equality Diversity & Inclusion Lead if appropriate?	***NA***
If relevant provide brief details here OR cross refer to detailed report if used	

3.6 Public Involvement & Consultation (s14Z2)

Has a s14Z2: Patient and Public Participation Form been completed if relevant?	***NA***
Have any issues or risks identified been appropriately addressed having taken advice from the Head of Comms & Engagement if appropriate?	***NA***
If relevant provide brief details here OR cross refer to detailed report if used	

3.7 Data Protection and Data Security

Has a Data Protection Impact Assessment (DPIA) been completed if relevant?	***NA***
Have any issues or risks identified been appropriately addressed having taken advice from the SIRO, IG Lead and / or DPO if appropriate?	***NA***
If relevant provide brief details here OR cross refer to detailed report if used	

3.8 Procurement considerations

Have any issues or risks identified been appropriately addressed having taken advice from the procurement Shared Service if appropriate?	***NA***
Has a Single Tender Waiver form been completed if appropriate?	***NA***
Has a Primary Care Procurement Checklist been completed where GPs, networks or Federations may be a bidder for a procurement opportunity?	***NA***
If relevant provide brief details here OR cross refer to detailed report if used	

3.9	**Human Resources**	
	Have any significant HR implications been identified and managed appropriately, having taken advice from the HR Lead if appropriate?	***NA***
	If relevant provide brief details here OR cross refer to detailed report if used	
3.10	**Environmental Sustainability**	
	Have any significant (positive or negative) impacts on the environment or the CCG's carbon footprint been identified?	***NA***
	If relevant provide brief details here OR cross refer to detailed report if used	

PCCC 21/05/12

Barnsley Clinical Commissioning Group

PRIMARY CARE PRACTICE LEVEL MEDICINES OPTIMISATION SCHEME 2021-22 (Scheme live from 1st July 2021)

Background

The purpose of this scheme is to encourage the high quality, safe and cost-effective use of medicines across the patient pathway.

Principles

- A Medicines Optimisation does not simply reward low cost prescribing, but should include criteria relating to the quality of prescribing.

- To maximise financial opportunities (best use of the Barnsley £) and ensure financial stability within the Clinical Commissioning Group (CCG), its vital that the CCG and its constituent practices maintain oversight and control of prescribing costs. Any reduction of prescribing costs at the expense of compromising patient health is not acceptable.

- An incentive scheme should encourage practices to consider both cost and also quality, and hence the cost-effectiveness of their prescribing, and reward practices appropriately.

- There is recognition that where practices are already achieving the targets specified in the scheme practices should be rewarded in the same way as those practices meeting the targets for the first time, however that all practices should work to meet a minimum target and therefore will be required to undertake some work against each of the schemes criteria.

Details of the Scheme

- Completing ALL of the work within the scheme would reward practices **£5** per weighted patient on the 1 January 2021.

- The work will be completed by 28th February 2022 unless otherwise stated in the scheme. Payments to practices will be 100% awarded to practices who meet ALL of the target and completion deadlines. A reporting template will be provided to practices with dates for return (attached Appendix A).

- Any practice failing to meet any of the scheme criteria targets will forfeit their right to any payment under the scheme. It's expected that practices will actively undertake work to achieve against all work areas.

- Practices who have missed a deadline for not completing work due to exceptional circumstances may submit an appeal for consideration by CCG's Quality and Cost Effective Prescribing Group (QCEPG)

- Calculated rewards will be endorsed by the QCEPG in March 2022 and payments will be made to practices on or before the 30th April 2022:-

    - The QCEPG will review 2021/22 EPACT and Eclipse Live prescribing data against the same Medicines Optimisation Scheme criteria to validate /verify changes. They may request that searches are run again by practices to validate reporting.

    - Where there has found to be an error in practice reporting or reversal of any scheme implemented changes then the CCG retains the right to request proportional reimbursement for practice payments which have been made under this scheme.

    - Where there has been a significant reduction in the quality of prescribing e.g. excessive waste identified as occurring which has been reported to the practice. Then the CCG retains the right to request proportional reimbursement for practice payments which have been made under this scheme.

    - Any offer of practice support made, particularly if not taken up, would be taken into consideration by the QCEPG when making a decision to forfeit, suspend or reduce a practice payment.

- Any practice list size changes greater than +/- 1% 1 January 2022 compared with 1 January 2021 will be taken into consideration when calculating end of year outturn.

- To ensure financial stability of the CCG, there will be a maximum total payment under the Medicines Optimisation Scheme of **£2.4million.**

- Areas of this scheme which are impacted by (included within) any national prescribing incentive scheme introduced for 2021/2022 will be subject to review and may be amended by the CCG Quality & Cost Effective Prescribing Group.

Finance Issues

- National guidelines govern the types of expenditure that are permitted using these payments. Payments should be used for the benefit of the patients of the practice, having regard to the need to ensure value for money

- It should be noted that these payments cannot be used for the purchase of health care (hospital or community services), or for drugs.

Support

- Practices will be provided with a summary of their prescribing position against the criteria within this scheme and their practice target for each of the criteria.

- The CCG Medicines Management Team is happy to support practices to review prescribing in the areas within the scheme and this should be discussed and agreed with the medicines management team member(s) supporting your practice. **The overall responsibility for completion of work within the scheme and reporting lies entirely with the practice**.

Medicines Optimisation Scheme Criteria

Indicator	Measure
1. QIPP changes	The reviews will be carried out in line with the 2021/22 CCG QIPP resource pack/SOP: 100% of appropriate patients to be offered a change in therapy. **By 16th July 2021:** • Fluticasone 50microgram/Salmeterol 25microgram MDI (Seretide® 50) to Combisal® 50 MDI • Fluoxetine 10mg capsules/tablets to fluoxetine oral solution or half a 20mg dispersible tablet. • Buprenorphine 7 day patch to Sevodyne® • Co-careldopa tablets to Sinemet® tablets • Cyanocobalamin tablets to CyanocoMinn® or CyanocoB12® tablets • Estriol 0.01% cream to Ovestin® cream • Formula B® phosphate enema to Cleen® ready to use enema • Venlafaxine XL 225mg tablets and capsules to Vencarm® XL 225mg capsules **By 13th August 2021:** • Metformin MR to Yaltormin® • Alogliptin or linagliptin and metformin dual treatment prescribed as two separate drugs to be prescribed generically as the respective combination product • SGLT2 inhibitors (canagliflozin, dapagliflozin or empagliflozin) and metformin dual treatment prescribed as two separate drugs to be prescribed generically as the respective combination product **By 17th September 2021:** • QVAR® MDI to Kelhale® • Gaviscon® Advance to Acidex® Advance (where a prescription remains appropriate in line with local and national guidance) Please note that this is not an exhaustive list and any additional areas agreed by the QCEPG/APC before December 2021 may also be incorporated.

2. Items which should no longer be routinely prescribed in primary care	**a) Over the counter (OTC) items which should no longer routinely be prescribed in primary care** The practice will review patients prescribed the medicines included within local self care guidance and/or NHS England guidance and make changes in line with the recommendations in the guidance. Supporting resources will be made available. **AND** Prescribing expenditure on OTC items (NIC/ASTRO PU) is equal to or less than the target set by the CCG (July 2021 to December 2021) OR the practice has demonstrated a 5% reduction (NIC/ASTRO PU July to December 2021 compared with July to December 2020) **b) Items which should no longer be routinely prescribed in primary care** The practice will continue to review patients prescribed the medications included and make changes in line with the recommendations in the NHS England guidance and corresponding local guidance (including APC position statements). A CCG supporting resource pack will be made available. **100% of appropriate patients to be offered a change in therapy.** **To be completed by timeframes set by the Medicines Management Team.**
3. Endocrinology: Blood Glucose & Ketone Monitoring	**Blood Glucose & Ketone Monitoring** The practice will continue to review choice and frequency of use and continue to offer a formulary choice of blood glucose and blood ketone test strips to appropriate diabetic patients in line with local guidance. Additional Information a. A meeting (which can be held remotely via Microsoft Teams or similar) will take place between the practice nurse(s) and the MMT members supporting the practice to discuss this workstream. An action plan will be agreed and submitted before the 13th August 2021 setting out how the practice will achieve this element of the scheme. b. The Medicines Management Team will monitor progress with the reviews. An audit will be completed by the Medicines Management Team for a random sample of

	10* diabetes patients who have been prescribed a glucose test strip and 10* patients prescribed a ketone test strip and who have had an annual review between September 2021 and November 2021. The findings from this audit will be discussed with the practice nurses by the 10th December 2021 and the key discussion points documented on the practice action plan. The audit will need to demonstrate that the usage and choice of test strips/meter is in line with local guidance for at least 75% of patients. If the 75% standard is not met in the December audit, a second audit will be completed by the 28th February 2022 for a further 10* to 20 patients [in line with the CCG SOP(s)] who have had an annual review between December 2021 and 28th February 2022 and the practice will need to demonstrate that the 75% standard has been met. **For practices with less than 10 eligible patients, all eligible patients should be included in the audit.**
4. Respiratory • **Triple inhalers** • **High dose ICS in asthma** • **SABAs** • **Home oxygen** • **Nebules**	**a)Triple Inhalers in COPD** The practice will review patients in line with the COPD algorithm and offer suitable patients a change to a triple therapy inhaler at their annual review. Additional information i) A meeting (which can be held remotely via Microsoft Teams or similar) will take place between the practice nurse(s) and the MMT members supporting the practice to discuss this workstream. **An action plan will be agreed and submitted before the 13th August 2021** setting out how the practice will achieve this element of the scheme. ii) On the 1st July 2021, the MMT member will run a search to identify patients with COPD prescribed the following three inhaled drugs as two or three separate inhalers: LABA, LAMA and ICS. Each month (from September 2021) the MMT will re-run the search to identify patients who have had a COPD review and complete an audit of these patients. **Practices will need to demonstrate that a change to a triple therapy inhaler has been considered and discussed for at least 75% of patients who meet the criteria**. iii) The MMT will provide feedback to the practices on progress with this area of the scheme throughout the year including whether or not the 75% target is or is not being met to help support the clinicians completing the COPD annual reviews.

To be completed by 28th February 2022

b) High dose inhaled corticosteroids (ICS) in Asthma

The practice will continue to offer step down of inhaled corticosteroids in patients with asthma who have good control.

Additional information

i) A meeting (which can be held remotely via Microsoft Teams or similar) will take place between the practice nurse(s) and the MMT members supporting the practice to discuss this workstream and agree an action plan.

The action plan will be submitted before the 13th August 2021 setting out how the practice will achieve this element of the scheme.

ii) The Medicines Management Team will monitor progress with the reviews. An audit will be completed by the Medicines Management Team for a random sample of 10* asthma patients who are prescribed a high dose ICS (i.e. 800 micrograms beclomethasone per day or equivalent) and who have had an annual review between September 2021 and November 2021.

The findings from this audit will be discussed with the practice nurses by the 10th December 2021 and the key points from the discussion documented on the practice action plan. **The audit will need to demonstrate that step down has been considered and discussed for at least 75% of patients with good control.**

If the 75% standard is not met, a second audit will be completed by the 28th February 2022 for a further 10* patients who have had an annual review between December 2021 and 28th February 2022 and the practice will need to demonstrate that the 75% standard has been met.

**For practices which have less than 10 asthma patients who are prescribed a high dose ICS, and who have had an annual review between the respective dates, all patients should be included in the audit.*

c)Use of short acting beta 2 agonists (SABAs) in Asthma and COPD patients

The practice will continue to review the use of salbutamol and terbutaline in all asthma and COPD patients during their annual reviews.

	Additional information i) A meeting (which can be held remotely via Microsoft Teams or similar) will take place between the practice nurse(s) and the MMT members supporting the practice to discuss this workstream. An action plan will be agreed and **submitted before the 13th August 2021** setting out how the practice will achieve this element of the scheme. ii) An audit will be completed by the Medicines Management Team for a random sample of 10* patients (including at least 5 patients with asthma) who have ordered more than 12 SABA inhalers in the period 1st September 2020 to 31st August 2021 and who have had an annual review between September 2021 and November 2021. The findings will be discussed with the practice nurses by the 10th December 2021 and the key points from the discussion documented on the practice actions plan. **The practice will need to demonstrate that SABA usage has been reviewed, discussed and changes made to therapy where clinically indicated and that the first line option(s) have been considered where appropriate in at least 75% of patients.** If the 75% standard is not met in this audit, a second audit will be completed by the 28th February 2022 for a further 10 patients who have had an annual review between December 2021 and 28th February 2022 and the practice will need to demonstrate that the 75% standard has been met. **For practices who have less than 10 patients who have ordered more than 12 SABA inhalers in the period 1st July 2020 to 30th June 2021 and who have had an annual review between the respective dates all patients should be included in the audit.* **d) Home Oxygen Reviews** The practice will engage with the CCG to help facilitate the review of selected patients prescribed home oxygen between July 2021 and February 2022. **e) Nebule Reviews** The practice will engage with the CCG to help facilitate the review of patients prescribed nebules between July 2021 and February 2022.
5. Overactive bladder reviews	The practice will review a cohort of patients who have been prescribed medication treatment for overactive bladder to ensure: • Patients are being prescribed medication in line with local and national guidance and that a

	treatment break has been offered and considered where clinically appropriate. • Patients are prescribed the most cost effective clinically appropriate treatment in line with local guidance. Reviews should be completed in line with the CCG SOP and timeframes.
6. Antibiotic Prescribing and Antimicrobial Stewardship (AMS)	**a) AMS Practice Meeting** The practice will discuss and reflect on antibiotic prescribing and antimicrobial stewardship during a meeting with allocated CCG Medicines Management Team member(s). The meeting (which can be held remotely via Microsoft Teams or similar) should take place by the 15th October 2021 and incorporate the following discussion points: • antibiotic prescribing patterns within the practice in reference to recent prescribing data • prescribing guidelines and other useful resources • key points within the CCG antimicrobial stewardship resource pack 2021-22 • engaging with the European Antibiotic Awareness Day/ World Antibiotic Awareness Week (November 2021) during the Covid pandemic **b) Prescribing Targets** The percentage of cephalosporin, quinolone and co-amoxiclav from all antibiotics prescribed by the practice (January to December 2021) is below 8% or has reduced by 10% (January to December 2021 compared with January to December 2020). **AND** The number of antibiotic prescriptions (Items/STAR PU) issued by the practice (January to December 2021) is below the target set by the CCG or has reduced by 5% (January to December 2021 compared with January to December 2020). **c) Audit work** The practice will audit the use of prophylactic antibiotics for urinary tract infections and complete other selected audits as per the requirements and timeframes in the CCG antimicrobial stewardship resource pack 2021-22. The audit results will demonstrate that 80% of prescribing is in line with local guidance OR The practice will agree and implement an action plan if

	the 80% target has not been met. Action plan to be agreed and submitted by 28th February 2022.
7. Anticoagulation: INR self testing pilot	The practice will engage with the Medicines Management Team to evaluate the role of INR self testing in patients receiving warfarin.
8. Appliance and Wound Care Reviews and Ordering Processes	**a) Appliance and Wound Care Reviews** i) The practice will engage with the Medicines Management Team Specialist Nurses and other members of the team to complete a review of patients prescribed appliances and wound care products and offer patients a change to cost effective formulary alternatives where appropriate. ii)The practice will review patients prescribed the following products in line with CCG SOPs: • Adhesive remover sprays by 16th July 2021 • Leg bags by 17th September 2021 • Barrier creams for moisture associated skin damage (MASD) by 12th November 2021 This is not an exhaustive list and additional priority areas may be incorporated. **b) Stoma Appliance Centralised Ordering Process** The practice will engage with the Medicines Management Team Specialist Nurse and other members of the team in reviewing the process for the ordering of stoma products by patients. The practice will work with the team to explore and implement new approaches to ordering (e.g. nurse led order line) to ensure that patients receive appropriate quantities of cost effective formulary products in a timely manner. **c) ONPOS Direct Ordering of Dressings** The practice will engage with the Medicines Management Team Specialist Nurse and other members of the team to support ongoing implementation and further roll out of the ONPOS project.
9. Nutrition • **ONS in adults** • **Enteral nutrition in paediatrics** • **Centralised ordering pilot**	**a) Oral Nutritional Supplements (ONS) in Adults** i) The practice will continue to engage with the Medicines Management Dietitian and other members of the team to ensure ONS prescribing and associated processes (including the management of ONS post hospital discharge) are in line with APC guidance. ii) The practice will review patients prescribed compact

	oral nutritional supplements, milk based oral nutritional supplements and juice based oral nutritional supplements in line with the respective algorithms included in the Barnsley ONS guideline and CCG SOPs. iii) The practice will engage with the Medicines Management Dietitian to review the prescribing of fat emulsions in line with the Barnsley APC guideline. **b) Enteral Nutrition in Paediatrics** The practice will continue to engage with the Medicines Management Dietitian and other members of the team to ensure prescribing is in line with local APC guidance. **c) Centralised Ordering /Prescribing of Nutritional Supplements Pilot** The practice will engage in discussions/planning and support where required the centralised prescribing/ordering of nutritional supplements.
10. Targeted medication reviews	The practice will complete a medication review on a cohort of patients in line with local/national guidance and CCG timeframes. To include, but not limited to, patients prescribed: • Levothyroxine 12.5 micrograms • Oxybutynin liquid • Acamprosate and disulfiram • Vitamin B co preparations and thiamine • Melatonin • Nifedipine 5mg and 10mg capsules • Gamolenic acid • Haloperidol 500 microgram tablets • Meptazinol • Patients prescribed 25 or more medicines Any additional priority areas agreed during the year.
11. ScriptSwitch	a. ScriptSwitch is activated for **ALL** practice prescribers (including locums) for 100% of the time for the period 1st July 2021 to 28th February 2022. b. ScriptSwitch is installed on the laptops of clinicians who are working remotely (liaise with the Medicines Management Team for support with this). c. A quarterly ScriptSwitch report is reviewed and discussed in every medicines optimisation practice meeting between July 2021 and February 2022. The

	key points and actions will be summarised within the practice action plan following each meeting. d. Prompts for areas included within this scheme are not rejected without exceptional reason and prescribers will use the feedback prompt to advise of the reason. e. An acceptance rate or percentage of the potential cost benefit (July 2021 to February 2022) is equal to or greater than the CCG average for the 20/21 year OR, if below the 20/21 averages, an increase of 20% in the acceptance rate OR the potential cost benefit is achieved compared to the individual practice data for 20/21. *If there are technical difficulties due to ScriptSwitch suppliers and not the practice then this will be taken into account. Practice level ScriptSwitch activity will be monitored and points will not be awarded to practices who are deemed to be deliberately changing their prescribing behaviour in order to achieve part e.*
12. Eclipse Live: RADAR Reviews & High Cost Drug Report	a. The practice will be signed up to Eclipse Live software; run RADAR reports a minimum of once a week and prioritise for review the patients identified to be at the highest clinical risk • 100% of Barnsley red admission avoidance and monitoring high priority alerts to be reviewed at least once every 1 to 2 weeks • A minimum of 75% of purple alerts every 1 to 2 weeks, in practices where PINCER reporting reviews are not undertaken. • A minimum of 50% of Barnsley admission avoidance and monitoring amber alerts and 25% of blue alerts to be reviewed every 1 to 2 weeks. **To be completed every 1-2 weeks up to 28th February 2022.** b. The practice has completed a review of high cost drug data available via the Eclipse Solutions website for their practice over a recent 6 month period. Patients will be reviewed to ensure prescribing is appropriate and in line with local guidance. **To be completed by 17th September 2021.**
13. Practice meetings to discuss medicines optimisation issues	At least two meetings* have been held and attended by 50% or more of relevant practice clinicians and allocated CCG Medicines Management team members

	The meeting agenda and updated practice medicines optimisation action plan (template available) will be submitted by the following dates: 1st Meeting: 13th August 2021 2nd Meeting: 28th February 2022 **Meetings can be held remotely via Microsoft Teams or similar and should include the following discussion points:* - *topical prescribing issues linking with local/national prescribing guidelines* - *reflection of practice prescribing patterns with reference to recent practice level prescribing data (prescribing data including CCG prescribing charts/data and Open Prescribing data will be reviewed by the MMT and selected data will be shared and discussed in at least one meeting)* - *progress with medicines optimisation workstreams.* *Where meetings have not taken place due to CCG staff being unavailable this will be taken into account.*
14. Controlled Drugs • **Opioid prescribing in chronic pain** • **Practice SOP** • **Targeted reviews**	**a) Opioid Prescribing in Chronic Pain** i) The practice will continue to undertake a pain management review at least once every 6 months for patients who are prescribed 120mg/day of oral morphine or equivalent, in line with the CCG resource pack. ii) The practice will engage with the South Yorkshire and Bassetlaw Campaign to Reduce Opioid Prescribing (CROP) project. **b) Practice Controlled Drug SOP** The practice will ensure that they have an up-to-date SOP in place for the prescribing and management of controlled drugs within the practice. Template SOP will be made available. **To be completed by 28th February 2022.** **c) Targeted Reviews** The practice will complete a review on a cohort of patients identified by the Scheduled Drug Monitoring Group. **To be completed by 28th February 2022.**
15. Potential Generic Savings	The practice will complete a review of potential generic savings data provided by the CCG and patients will be offered a change to a generic product where appropriate. The review will take place twice during the year: the first time before 15th October 2021 and the second time before the 28th February 2022.

16. Unlicensed Specials	The practice will complete a review of unlicensed specials data provided by the CCG for their practice and patients will be offered a change to a licensed preparation where appropriate. The review will take place twice during the year: the first time before 15th October 2021 and the second time before the 28th February 2022.
17. Dose Optimisation Review	The practice will complete a dose optimisation review of patients prescribed medication identified in the CCG protocol. **To be completed by 13th August 2021.**
18. Review of Prescribing Data: Unspecified Drugs and Out of Pocket expenses	The practice will review patients prescribed medication, which is processed by the NHSBSA with an unspecified drug code or incurs an out of pocket expense, in line with local formulary and guidance. The MMT will provide data on a monthly basis and will be reviewed by the practice within 4 weeks. **To be completed every month until 28h February 2022.**
19. Population Health Management Reviews	Practices will take forward up to three population health management pieces of work on agreed cohorts of patients identified to be at risk of hospital admission using population health management tool(s), including the Eclipse Live VISTA Platform.
20. Additional high priority medicines optimisation workstreams	There may arise additional in year medicines optimisation opportunities which will benefit the healthcare economy more than work within the plan. Should this arise practices will be provided with an explicit plan of work.

Version 1. April 2021

(DRAFT 0.7)

NHS
Barnsley
Clinical Commissioning Group

PRIMARY CARE COMMISSIONING COMMITTEE

27 MAY 2021

GENERAL PRACTICE COVID CAPACITY EXPANSION FUND

PART 1A – SUMMARY REPORT

1. THIS PAPER IS FOR

Decision		Approval	X	Assurance		Information	

2. PURPOSE

The purpose of the report is to make recommendations to the Primary Care Commissioning Committee and seek approval for the General Practice Covid Capacity Expansion Funding to practices on the basis set out within the paper.

3. REPORT OF

	Name	Designation
Executive Lead	Chris Edwards	Chief Officer
Author	Julie Frampton	Head of Primary Care

4. SUMMARY OF PREVIOUS GOVERNANCE

The matters raised in this paper have been subject to prior consideration in the following forums:

Group / Committee	Date	Outcome
SMT	9 April 2021	Approval from PCCC

5. EXECUTIVE SUMMARY

On the 19 March 2021 NHSE/I wrote to all CCGs and GPs setting out details of a second General Practice Covid Capacity Expansion Fund. Nationally this fund consists of £120 million of revenue funding to be allocated through ICS to CCGs for general practice, for the purpose of supporting the expanding general practice capacity up from April 2021 until the end of September 2021 based on the previous requirements of the first offer in November 2020.

The fund is ring-fenced exclusively for use in general practice with CCGs asked to determine how best it is spent within general practice, with a focus on simplicity and speed of deployment, within a number of parameters. The letter explicitly asks that CCGs do not introduce overly burdensome administrative processes for PCNs and practices to secure support.

	The letter encourages use of the fund to stimulate the creation of additional salaried GP roles that are attractive to practices and locums alike and for the employment of staff returning to help with COVID, or to increase the time commitment of existing salaried staff. The conditions attached to the allocation and use of this funding are as set out in the initial General Practice Covid Capacity Expansion Fund letter, and systems are expected to use the funding to make further progress on the seven priorities identified in that letter. These are: 1. Increasing GP numbers and capacity 2. Supporting the establishment of the simple COVID oximetry@home model. 3. First steps in identifying and supporting patients with Long COVID. 4. Continuing to support clinically extremely vulnerable patients and maintain the shielding list. 5. Continuing to make inroads into the backlog of appointments including for chronic disease management and routine vaccinations and immunisations. 6. On inequalities, making significant progress on learning disability health checks. This will require additional focus given current achievement is one fifth lower than the equivalent position last year; and actions to improve ethnicity data recording in GP records 7. Potentially offering backfill for staff absences where this is agreed by the CCG, required to meet demand, and the individual is not able to work remotely. Following receipt of the first letter the CCG has been working with local partners to develop pathways for Covid oximetry and Covid assessment and rehabilitation services and we will ask general practice to continue to support people requiring these services. The proposal would be that payment is made to practices on a monthly allocation basis once this is received into the CCG. The funding is non-recurrent and should not be used to fund commitments running beyond this period. To note: this funding is not allocated to support COVID-19 vaccination directly, however systems are expected to prioritise spending on any PCNs committed to deliver the Covid Vaccination Enhanced Service (including for cohorts 10-12) whose capacity requirements are greater.
6.	**THE PRIMARY CARE COMMISSIONING COMMITTEE IS ASKED TO:**
	• Approve the proposals and recommendations made within the paper
7.	**APPENDICES / LINKS TO FURTHER INFORMATION**
	• Appendix A – Letter to CCGs and General Practice – Supporting General Practice: Additional £120M Funding for April – September 2021

Agenda time allocation for report:	10 mins

PCCC 21/05/13
PART 1B – SUPPORTING INFORMATION & ASSURANCE

1. Links to Corporate Priorities, GBAF and Risk Register

This report provides assurance against the following corporate priorities on the Governing Body Assurance Framework (*place ✓ beside all that apply*):

1.1 Urgent & Emergency Care		6.1 Efficiency Plans	
2.1 Primary Care	✓	7.1 Transforming Care for people with LD	
3.1 Cancer		8.1 Maternity	
4.1 Mental Health		9.1 Digital and Technology	
5.1 Integrated Care @ System		10.1 Compliance with statutory duties	
5.2 Integrated Care @ Place			

The report also provides assurance against the following red or amber risks on the Corporate Risk Register:	*Provide ref(s) or state N/A*

2. Links to statutory duties

This report has been prepared with regard to the following CCG statutory duties set out in Chapter A2 of the NHS Act (place ✓ beside all that are relevant):

Management of conflicts of interest (s14O)	**See 3.1**	Duties as to reducing inequalities (s14T)	**See 3.4**
Duty to promote the NHS Constitution (s14P)		Duty to promote the involvement of each patient (s14U)	
Duty to exercise its functions effectively, efficiently and economically (s14Q)	**See 3.2**	Duty as to patient choice (s14V)	
Duty as to improvement in quality of services (s14R)	**See 3.3**	Duty as to promoting integration (s14Z1)	
Duty in relation to quality of primary medical services (s14S)	**See 3.3**	Public involvement and consultation (s14Z2)	**See 3.5**

2A. Links to delegated primary care commissioning functions

This report is relevant to the following responsibilities for primary care commissioning delegated to the CCG (place ✓ beside all that are relevant):

Decisions in relation to the commissioning, procurement and management of GMS, PMS and APMS contracts (inc breach notices etc)		Decisions in relation to the management of poorly performing GP Practices	
Planning the primary medical services provider landscape in Barnsley (inc closures, mergers, dispersals)		Decisions in relation to the Premises Costs Directions Functions	
Planning the Commissioning of Primary Medical Services in Barnsley		Co-ordinating a common approach to the commissioning of primary care services	✓
Manage the delegated allocation for commissioning of primary medical care services in Barnsley			

3. Governance Considerations Checklist *(these will be especially relevant where a proposal or policy is brought for decision or approval)*

3.1 Clinical Leadership

Have GB GPs and / or other appropriate clinicians provided input and	***NA***

	leadership?	
	If relevant provide brief details here OR cross refer to detailed report if used	

3.2 Management of Conflicts of Interest (s14O)

Have any potential conflicts of interest been identified and managed appropriately, having taken advice from the Head of Governance & Assurance and / or the Conflicts of Interest Guardian if appropriate?	***Y***
If relevant provide brief details here OR cross refer to detailed report if used	

3.3 Discharging functions effectively, efficiently, & economically (s14Q)

Have any financial implications been considered & discussed with the Finance Team?	***Y***
Where relevant has authority to commit expenditure been sought from Management Team (<£100k) or Governing Body (>£100k)?	***NA***
If relevant provide brief details here OR cross refer to detailed report if used	

3.4 Improving quality (s14R, s14S)

Has a Quality Impact Assessment (QIA) been completed if relevant?	***NA***
Have any issues or risks identified been appropriately addressed having taken advice from the Chief Nurse (or Deputy) if appropriate?	***NA***
If relevant provide brief details here OR cross refer to detailed report if used	

3.5 Reducing inequalities (s14T)

Has an Equality Impact Assessment (EIA) been completed if relevant?	***NA***
Have any issues or risks identified been appropriately addressed having taken advice from Equality Diversity & Inclusion Lead if appropriate?	***NA***
If relevant provide brief details here OR cross refer to detailed report if used	

3.6 Public Involvement & Consultation (s14Z2)

Has a s14Z2: Patient and Public Participation Form been completed if relevant?	***NA***
Have any issues or risks identified been appropriately addressed having taken advice from the Head of Comms & Engagement if appropriate?	***NA***
If relevant provide brief details here OR cross refer to detailed report if used	

3.7 Data Protection and Data Security

Has a Data Protection Impact Assessment (DPIA) been completed if relevant?	***NA***
Have any issues or risks identified been appropriately addressed having taken advice from the SIRO, IG Lead and / or DPO if appropriate?	***NA***
If relevant provide brief details here OR cross refer to detailed report if used	

3.8 Procurement considerations

Have any issues or risks identified been appropriately addressed having taken advice from the procurement Shared Service if appropriate?	***NA***
Has a Single Tender Waiver form been completed if appropriate?	***NA***
Has a Primary Care Procurement Checklist been completed where GPs, networks or Federations may be a bidder for a procurement opportunity?	***NA***
If relevant provide brief details here OR cross refer to detailed report if used	

3.9 Human Resources

Have any significant HR implications been identified and managed appropriately, having taken advice from the HR Lead if appropriate?	***NA***

	If relevant provide brief details here OR cross refer to detailed report if used	
3.10	**Environmental Sustainability**	
	Have any significant (positive or negative) impacts on the environment or the CCG's carbon footprint been identified?	***NA***
	If relevant provide brief details here OR cross refer to detailed report if used	

NHS
Barnsley
Clinical Commissioning Group

PRIMARY CARE COMMISSIONING COMMITTEE

27 May 2021

RISK AND GOVERNANCE REPORT

PART 1A – SUMMARY REPORT

1. THIS PAPER IS FOR

Decision		*Approval*		*Assurance*	✓	*Information*	

2. PURPOSE

- To assure the Primary Care Commissioning Committee members re the delivery of the CCG's annual strategic objectives.
- To assure the Primary Care Commissioning Committee of current risks to the organisation are being effectively managed and monitored appropriately.

3. REPORT OF

	Name	Designation
Executive / Clinical Lead	Richard Walker	Head of Governance & Assurance
Author	Paige Dawson	Governance, Risk & Assurance Facilitator

4. SUMMARY OF PREVIOUS GOVERNANCE

The matters raised in this paper have been subject to prior consideration in the following forums:

Group / Committee	Date	Outcome
N/A		

5. EXECUTIVE SUMMARY

Introduction

In common with all committees of the CCG, the Primary Care Commissioning Committee receives and reviews at every meeting extracts of the Governing Body Assurance Framework (GBAF) and Corporate Risk Register providing details of the risks allocated to the Committee for monitoring and updating.

Assurance Framework

The Governing Body Assurance Framework (GBAF) facilitates the Governing Body in assuring the delivery of the CCG's annual strategic objectives. The GBAF is refreshed at the start of each financial year then reported to every meeting of the Governing Body as part of the Risk & Governance Exception Report.

Appendix 1 of this report provides the Committee with an extract from the GBAF of the two risks for which the Primary Care Commissioning Committee is the assurance provider. Two risks are scored as 'Amber' High Risk:

- Risk ref 2.1 Primary Care - There is a risk to the delivery of Primary Care priorities if the following threat(s) are not successfully managed and mitigated by the CCG:
    - Engagement with primary care providers and workforce
    - Workforce and capacity shortage, recruitment and retention
    - Under development of opportunities of primary care at scale, including new models of care
    - Primary Care Networks do not embed and support delivery of Primary Care at place
    - Not having quality monitoring arrangements embedded in practice
    - Inadequate investment in primary care
    - Independent contractor status of General Practice
- Risk ref 9.1 Digital Technology - There is a risk that the key deliverables will not be achieved if the following threats to delivery are not appropriately managed and mitigated:
    - Lack of IT technical expertise locally for input into projects and programmes of work / lack of technical support to ensure deliverables are robust
    - Primary Care colleagues fatigued with the amount of IT work scheduled
    - Short timelines to deliver projects
    - Supplier and equipment delays
    - constructive and timely engagement by system partners to deliver a SCR by 20/21
    - system wide strategic digital strategy and planning currently under-resourced with no dedicated Barnsley resource available to progress this work
    - Incomplete information available from NHS Futures regarding future work.

Risk Register

The Risk Register is an important governance document that facilitates the effective management of the CCG's strategic and operational risks. The Risk Register is a repository of current risks to the organisation, including risk ratings and the controls in place to mitigate the risk. The full risk register is submitted to the Committee on a six monthly basis, (March and September), the red and amber rated risks are considered at each meeting of the Committee. In line with reporting timescales, Members' attention is drawn to Appendix 1 of this report which provides the Committee with an extract risk register report associated with the Primary Care Commissioning Committee.

	There are currently five risks on the Corporate Risk Register allocated to the PCCC for which the Committee is responsible for managing. Of the five risks, there is one red (extreme) rated risk, one amber risk (high), one yellow risk (moderate) and two green (low) risks. Members are asked to review the risks detailed on Appendix 1 to ensure that the risks are being appropriately managed and scored. As discussed at the meeting of the Committee in March 2021 the wording of the risk reference 14/10 relating to primary care workforce has been reviewed and updated by the Head of Primary Care since the last meeting so that it more accurately reflects the current risks to the CCG in this regard however there is currently no recommendation to reduce the score related to this risk. Members are asked to review the risk detailed on Appendix 1 to ensure that the risk is being appropriately managed and scored.
6.	**THE COMMITTEE IS ASKED TO:**
	• Review and agree that the risks are being appropriately managed and scored
7.	**APPENDICES / LINKS TO FURTHER INFORMATION**
	• Appendix 1 - GBAF • Appendix 2 – Risk Register

Agenda time allocation for report:	5 minutes

PART 1B – SUPPORTING INFORMATION & ASSURANCE

1. Links to Corporate Priorities, GBAF and Risk Register

This report provides assurance against the following corporate priorities on the Governing Body Assurance Framework

1.1 Urgent & Emergency Care	✓	6.1 Efficiency Plans	✓
2.1 Primary Care	✓	7.1 Transforming Care for people with LD	✓
3.1 Cancer	✓	8.1 Maternity	✓
4.1 Mental Health	✓	9.1 Digital and Technology	✓
5.1 Integrated Care @ System	✓	10.1 Compliance with statutory duties	✓
5.2 Integrated Care @ Place	✓		

The report also provides assurance against the following red or amber risks on the Corporate Risk Register:	*ALL*

2. Links to statutory duties

This report has been prepared with regard to the following CCG statutory duties set out in Chapter A2 of the NHS Act

Management of conflicts of interest (s14O)		Duties as to reducing inequalities (s14T)	
Duty to promote the NHS Constitution (s14P)	✓	Duty to promote the involvement of each patient (s14U)	
Duty to exercise its functions effectively, efficiently and economically (s14Q)		Duty as to patient choice (s14V)	
Duty as to improvement in quality of services (s14R)		Duty as to promoting integration (s14Z1)	
Duty in relation to quality of primary medical services (s14S)		Public involvement and consultation (s14Z2)	

3. Governance Considerations Checklist *(these will be especially relevant where a proposal or policy is brought for decision or approval)*

3.1 Clinical Leadership

Have GB GPs and / or other appropriate clinicians provided input and leadership?	***NA***

3.2 Management of Conflicts of Interest (s14O)

Have any potential conflicts of interest been identified and managed appropriately, having taken advice from the Head of Governance & Assurance and / or the Conflicts of Interest Guardian if appropriate?	***NA***

3.3 Discharging functions effectively, efficiently, & economically (s14Q)

Have any financial implications been considered & discussed with the Finance Team?	***NA***
Where relevant has authority to commit expenditure been sought from Management Team (<£100k) or Governing Body (>£100k)?	***NA***

3.4 Improving quality (s14R, s14S)

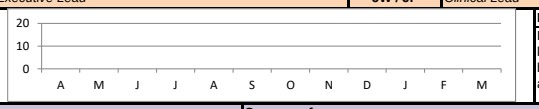
Has a Quality Impact Assessment (QIA) been completed if relevant?	***NA***
Have any issues or risks identified been appropriately addressed having taken advice from the Chief Nurse (or Deputy) if appropriate?	***NA***

3.5	**Reducing inequalities (s14T)**	
	Has an Equality Impact Assessment (EIA) been completed if relevant?	***NA***
	Have any issues or risks identified been appropriately addressed having taken advice from Equality Diversity & Inclusion Lead if appropriate?	***NA***
3.6	**Public Involvement & Consultation (s14Z2)**	
	Has a s14Z2: Patient and Public Participation Form been completed if relevant?	***NA***
	Have any issues or risks identified been appropriately addressed having taken advice from the Head of Comms & Engagement if appropriate?	***NA***
3.7	**Data Protection and Data Security**	
	Has a Data Protection Impact Assessment (DPIA) been completed if relevant?	***NA***
	Have any issues or risks identified been appropriately addressed having taken advice from the SIRO, IG Lead and / or DPO if appropriate?	***NA***
3.8	**Procurement considerations**	
	Have any issues or risks identified been appropriately addressed having taken advice from the procurement Shared Service if appropriate?	***NA***
	Has a Single Tender Waiver form been completed if appropriate?	***NA***
	Has a Primary Care Procurement Checklist been completed where GPs, networks or Federations may be a bidder for a procurement opportunity?	***NA***
3.9	**Human Resources**	
	Have any significant HR implications been identified and managed appropriately, having taken advice from the HR Lead if appropriate?	***NA***
3.10	**Environmental Sustainability**	
	Have any significant (positive or negative) impacts on the environment or the CCG's carbon footprint been identified?	***NA***

21/05/2021 **NHS Barnsley CCG Governing Body Assurance Framework 2020-21**

PRIORITY AREA 2: PRIMARY CARE	Delivery supports these CCG objectives:		PRINCIPAL THREATS TO DELIVERY
Delivery of the Long Term Plan Delivery of the Primary Care Network Contract DES to support the continued development of the Primary Care Network and sustainable primary care medical services. Support the reset of core GMS/PMS/APMS contract delivery across primary care Support the embedding of new ways of working earned from the pandemic Deliver investment into Primary Care and improve health inequalities via the Practice Delivery Agreement (PDA). Support practice quality improvement and CQC rating by use of the Quality Dashboard and regular meeting to support action plan delivery for those practices having domains that "require improvement" Ensure recruitment/retention/development of the clinical and non-clinical workforce Work with the PCN to maximise recruitment under the Additional Roles Reimbursement Scheme and take action to support them to meet recruitment plans Support the recruitment and retention of extra doctors working in general practice. Improve access particularly during the working week with more bookable appointments at evenings and weekends. Improve access by offering online booking, online consultation, total triage and other digital options and to focus on supporting improvements in practices with long waits for routine appointments Provide CCG support to implement the current Service Specification and to support preparation for the remaining Service Specification to be delivered from Oct 2021 Meet 2021/22 trajectories set out in the Network Contract DES and support planning to achieve the KPIs. Improve infrastructure, digital capability, digital literacy and inclusion. Deliver delegated Primary Care functions to be confirmed via mandated internal audit reviews	Highest quality governance High quality health care ✓ Care closer to home ✓ Safe & sustainable local services ✓ Strong partnerships, effective use of £ ✓ **Links to SYB STP MOU** 8.3. General Practice and primary care		There is a risk to the delivery of Primary Care priorities if the following threat(s) are not successfully managed and mitigated by the CCG: - Engagement with primary care providers and workforce - Workforce and capacity shortage, recruitment and retention - Under development of opportunities of primary care at scale, including new models of care - Primary Care Network and Neighbourhoods do not mature and develop to a level that supports the integrated delivery of Primary Care at place - BHF do not develop as a strong partner to support Primary Care at Scale - Not having quality monitoring arrangements embedded in practices - Inadequate investment in primary care - Independent contractor status of General Practice - Preparations for moving to ICS as a statutory body impacts on capacity to deliver transformation

Committee Providing Assurance			**PCCC**	*Executive Lead*	**JW / JF**	*Clinical Lead*	**MG**
Risk rating	Likelihood	Consequence	**Total**			**Date reviewed**	**May-21**
Initial	3	4	12			Rationale: Likelihood has been scored at 3 (possible) but will be kept under review. Consequence has been scored at 4 (major) because there is a risk of significant variations in quality of and access to care for patients if the priorities are not delivered.	
Current	3	4	12				
Appetite	3	4	12				
Approach	**TOLERATE**						



Key controls to mitigate threat:	Sources of assurance	Rec'd?
All practices are required to complete the National Workforce Data Return. ARRs roles identified in the PCN workforce plan and recruitment plans in place. Monitoring in place.	National database regularly updated to show workforce National PCN Dashboard developed and evolving CCG to monitor recruitment by PCN	Ongoing
Additional investment above core contracts through PDA delivers £4.2 to Barnsley practices to improve sustainability and attract workforce to the Barnsley area	Ongoing monitoring of PDA (contractual / QIPP aspects via FPC, outcomes via PCCC).	Ongoing
Optimum use of BEST sessions A contract is in place with BHF for the BEST programme which enables the CCG to support the programme	BEST programme and Programme co-ordination being led by BHF Contract management meetings in place to assess and reporting via PCCC	Ongoing
Established a Primary care Strategy Group and delivery Group to support delivery of the primary Care Transformation programme. Development of Neighbourhood working within each of the 6 Neighbourhoods supported by the PCN and CCG. Bi-monthly PCN meetings established for all practices in the PCN. The 3 service specification from the Network Contract DES are now being undertaken by practices across each Neighbourhood. Work with the PCN to prepare for the next Service Specifications Work with the PCN regardin tackling health inequalites which have been further impacted by Covid. PCN Manager meetings set up with the CCG PC Team to support the Long Term Plan and DES delivery.	Primary Care Strategy Group working as a sub-group of PCCC Primary Care Delivery Group working to deliver the transformation programme6 Neighbourhood Networks have been agreed with the support of a single Primary Care Network facilitated by the GP Federation. This supports the transition and development of the PCN via the Neighbourhoods to deliver the primary care elements of the NHS Long Term Plan and Network Contract DES. Meetings are set for the year to ensure that the PCNs are able to meet regularly.	Ongoing
BHF - Existence of strong federation supports Primary Care at Scale	BHF contract monitoring, oversight by PCCC	Ongoing
Practices increasingly engaging with Community, voluntary and social care providers Personalisation/Social Prescribing - My Best Life is a successful programme supporting the people of Barnsley to work towards self care and the PCN are now delivering a young peoples Social Prescribing service. Work towards joining the services together as directed in the Network Contract DES. Collaboration to deliver primary care transformation and service delivery	Personalisation and Social Prescribing are key elements in the Long Term Plan. Care Coordiantios, Health and Wellbeing Coaches are in place to support people with self care. Primary Care Strategy Group working as a sub-group of PCCC Primary Care Delivery Group working to deliver the transformation programme	Ongoing
Engagement and consultation with Primary Care (Membership Council, Practice Managers etc.)	NHS England 360 Stakeholder Survey results shared with stakeholders and published on the CCG website. Ensuring BCCG stakeholders have a high level of satisfaction with the CCG's leadership & engagement.	Ongoing
SYB ICS has a workforce hub established, regular PC workforce meetings established which enables PC in Barnsley to collaborate with other CCGs, HEE, providers and Universities.	BCCG is represented on all workforce groups. Reporting is via PCCC for Primary care.	Ongoing

Gaps in assurance	Positive assurances received
APRIL 2021 - under recruitment in 2020-21 to ARRs roles has impacted on the additional support for the practices within the PCN - RISK HAS BEEN UPDATED TO REFLECT.	*APRIL 2021 - Workforce plans have been discussed with BHF who facilitate recruitment on behalf of the PCN to maximise the opportunity to recruit roles this coming year.*
Gaps in control	**Actions being taken to address gaps in control / assurance**
PCN CD/Management meetings do not have regular input from CCG PC Commissioner therefore not able to support the development and maturing of the PCN nor have an effective comms route for sharing ICS/Regional and emergent information to support the Network Contract DES delivery.	The PC Team and PCN CDs work with member practices to address any gaps/ variance and to develop a workforce plan going forward supported by the Additional Role Recruitment via the Network Contract DES. The rolling recruitment and inclusion of new roles each year supports the PCN service delivery. Working closely with BHF to ensure the PCN maximise the recruitment opportunity for Barnsley. Practices encouraged to look at skill mix with innovative recruitment. The Primary Care Network and underpinning 6 Neighbourhood Networks are established and working on all elements of the Network Contract DES and Long Term Plan. The PC Team work closely with the PCN Managers to ensure delivery is on track. NHS England 360 Assurance audit in progress to provide NHS England with assurance of robust Primary Care processes. New topics are identified each year and the Head of Primary Care works with 360 to complete each plan.

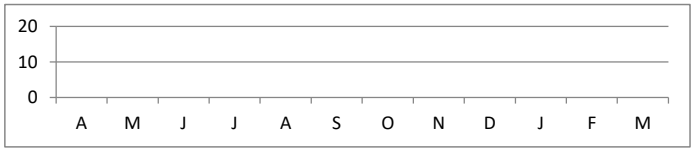
21/05/2021

NHS Barnsley CCG Governing Body Assurance Framework 2020-21

PRIORITY AREA 9: DIGITAL AND TECHNOLOGY	*Delivery supports these CCG objectives:*		PRINCIPAL THREATS TO DELIVERY
1. Development of a system wide shared care record 2. Ensure the delivery of the GP IT Operating Model to: - Comply with mandatory core standards re: interoperability and cyber security - Support the transition to HSCN from N3 *(transition now complete)* - Support the roll out of Windows10 to secure system security from cyber attack - Support the implementation and roll out of the NHS App, eConsultaion. APEX, GPIT refresh of IT equipment, Govroam *(noting that NHS App rolled out, APEX decommissioned, GPIT refresh in place, Govroam under review)* - Support the wider use of digital technology as described within the Long Term Plan - Comply with the transition from GPSoC to GP IT Futures *(transition now complete)* - Working closely with the SY&B digital and IT workstream to deliver the digital road map - Delivery of O365 across Barnsley - Support the catch up of Windows10 upgrades in primary care - Ensure full delivery of online consultation systems to general practices where these are not already in place - Lead the transition to the new GPIT Futures Digital Care Services Framework arrangements.	Highest quality governance		There is a risk that the key deliverables will not be achieved if the following threats to delivery are not appropriately managed and mitigated: - Lack of IT technical expertise locally for input into projects and programmes of work / lack of technical support to ensure deliverables are robust - Primary Care colleagues fatigued with the amount of IT work scheduled - Short timelines to deliver projects - Supplier and equipment delays - constructive and timely engagement by system partners to deliver a SCR by 20/21 - system wide strategic digital strategy and planning currently under-resourced with no dedicated Barnsley resource available to progress this work - Incomplete information available from NHS Futures regarding future work.
	High quality health care	✓	
	Care closer to home	✓	
	Safe & sustainable local services	✓	
	Strong partnerships, effective use of £	✓	
	Links to SYB STP MOU		

Committees providing assurance	**PCCC & SMT**	*Executive Lead*	**JB**	*Clinical Lead*	**JH**

Risk rating	Likelihood	Consequence	**Total**
Initial	3	4	12
Current	3	4	12
Appetite	3	4	12
Approach	**Tolerate**		



Date reviewed	**May-21**
Rationale: Likelihood has been scored at 3 as transition to new provider has been successfully completed but will be kept under review. Consequence has been scored at 4 given the major impact on the CCG and the system if digital and It technology is not safeguarded and fully exploited.	

Key controls to mitigate threat:	**Sources of assurance**	**Rec'd?**
Barnsley IT Strategy Group	Monthly meetings to review SCR progress and refresh Digitial Roadmap. Minutes to GB	Ongoing
BBS IT Delivery Group and BBS Digital Strategy Group established	Monthly meetings to review progress of the delivery of key projects and programmes. Updates to SMT, GB and PCCC	Ongoing
GP IT and Corporate IT service commissioned from BBS IT Services, the successor to eMBED. The new shared service is now establishing working protocols. Shared staffing allows for technical and network experience to be available to the CCG. Additional staffing to be secured if Digital First EOIs are successful as bids include resource.	CCG representatives attend the BBS IT Delivery Group and BBS Digital Strategy Group. KPIs and other performance monitoring data is provided and reviewed. Isses would be escalated to SMT in first instance.	Ongoing
SYB has led a procurement leading to the identification of Doctorlink as the preferred local provider of online consultation services. Contact in place until Oct 2021 with another 2 year option.	Every Barnsley practice has Doctorlink installed for use within their practice.	Complete
Redcentric become the commissioned service to maintain HSCN	Transition to new HSCN network now complete across the Barnsley CCG & primary care estate	Complete

Gaps in assurance	**Positive assurances received**
Governance process to be established for the IT groups eg link with the IT Strategy group and the CCG Operational Group	
Gaps in control	**Actions being taken to address gaps in control / assurance**

RISK REGISTER – May 2021

Domains
1. Adverse publicity/ reputation
2. Business Objectives/ Projects
3. Finance including claims
4. Human Resources/ Organisational Development/ Staffing/ Competence
5. Impact on the safety of patients, staff or public (phys/psych)
6. Quality/ Complaints/ Audit
7. Service/Business Interruption/ Environmental Impact
8. Statutory Duties/ Inspections

Likelihood		Consequence		Scoring Description			Current Risk No's	Review
Almost Certain	5	Catastrophic	5	Red	Extreme Risk	(15-25)	9	Monthly
Likely	4	Major	4	Amber	High Risk	(8- 12)	20	3 mthly
Possible	3	Moderate	3	Yellow	Moderate Risk	(4 -6)	6	6 mthly
Unlikely	2	Minor	2	Green	Low Risk	(1-3)	3	Yearly
Rare	1	Negligible	1					
				Total = Likelihood x Consequence				

The initial risk rating is what the risk would score if no mitigation was in place. The residual/current risk score is the likelihood/consequence (impact) of the risk sits when mitigation plans are in place

			Initial Risk Score						Residual Risk Score					
Ref	**Domain**	**Risk Description**	**Likelihood**	**Consequence**	**Score**	**Mitigation/Treatment**	**Lead Owner of the risk**	**Source of Risk**	**Likelihood**	**Consequence**	**Score**	**Date Risk Assessed**	**Progress/ Update**	**Date for re-assessment**
CCG 14/10	2, 5, 6	If the Barnsley area is not able to attract & retain a suitable & sufficient Primary Care clinical workforce e.g. due to delays in recruiting into the ARRS roles there is a risk that: (a)Primary Medical Services for patients are inconsistent (b)The people of Barnsley will receive a poorer quality of healthcare services (c)Patients services could be further away from their home.	**3**	**3**	**9**	The Long Term Plan includes a section on workforce planning and Network Contract DES includes provision for a number of Primary Care specific roles that will support the delivery of services. The Network Contract DES has several deliverables that will support existing service delivery, utilise roles under the Additional Roles Scheme, support reduction in healthcare inequalities, and that will work towards achieving sustainable service delivery in Barnsley. The Primary Care Strategy Group has a workforce element included within its	Head of Primary Care. (Primary Care Commissioning Committee)	Governing Body	**4**	**4**	**16**	05/21	**May 2021** Work is underway to support the ARRs recruitment to the PCN. There are new staff expected in post from May to July. **April 2021** As discussed at PCCC in March 2021 the wording of the risk has been reviewed and updated so that it more accurately reflects the current risks to the CCG in this regard however	06/21

			Initial Risk Score						Residual Risk Score					
Ref	**Domain**	**Risk Description**	**Likelihood**	**Consequence**	**Score**	**Mitigation/Treatment**	**Lead Owner of the risk**	**Source of Risk**	**Likelihood**	**Consequence**	**Score**	**Date Risk Assessed**	**Progress/ Update**	**Date for re-assessment**
						transformation plans and will support the Barnsley "Place" Workforce Plan. The Primary Care Strategy Group will incorporate the SYB ICS Primary Care Strategy to support consistent service delivery across the ICS reflecting the needs of Barnsley as a "place". NHS England has published an Interim People Plan to support the workforce challenge. Links have been developed with the Medical School to enhance attractiveness of Barnsley to students							there is currently no recommendation to reduce the score related to this risk. **March 2021** No further update.	

			Initial Risk Score						Residual Risk Score					
Ref	**Domain**	**Risk Description**	**Likelihood**	**Consequence**	**Score**	**Mitigation/Treatment**	**Lead Owner of the risk**	**Source of Risk**	**Likelihood**	**Consequence**	**Score**	**Date Risk Assessed**	**Progress/ Update**	**Date for re-assessment**
CCG 15/03		If the CCG does not effectively discharge its delegated responsibility for contract performance management there is a risk that the CCG's reputation and relationship with its membership could be damaged.	**3**	**4**	**12**	The CCG has access to existing primary care commissioning resource within the Area Team under the RASCI agreement. The CCG has an open channel of communication with the Membership Council regarding commissioning and contracting arrangements (e.g. equalisation).	Head of Primary Care (Primary Care Commissioning Committee)	Risk Assessment	2	4	**8**	05/21	**May 2021** No further update. **Feb 2021** 360 Assurance audit has been completed for 2020-21 and indications are of good assurance of quality and contract management **Oct/Nov 2020** The PC action from the 360 audit has been completed. The CCG continues to manage its delegated responsibilities.	08/21