NHS
Barnsley
Clinical Commissioning Group

Public Primary Care Commissioning Committee
Thursday 26 May 2022 at 09.30am
Via MS Teams

PUBLIC AGENDA

Item	Session	Committee Requested to	Enclosure Lead	Time
1	Housekeeping		Chair	09.30am 5mins
2	Apologies	Note	Chair	
3	Quoracy	Note	Chair	
4	Declarations of Interest relevant to the agenda	Assurance	**PCCC 22/05/04** Chair	
5	Minutes of the meeting held on 24 March 2022	Approve	**PCCC 22/05/05** Chair	09.35am 5mins
6	Matters Arising Report	Note	**PCCC 22/05/06** Chair	09.40am 5mins
Strategy, Planning, Needs Assessment and Co-ordination of Primary Care				
7	Primary Care Network Update	Assurance	**PCCC 22/05/07** Louise Dodson	09.45am 10mins
8	GP IT	Assurance / Information	**Verbal** Louise Dodson	09.55am 5mins
9	Primary Care Estate	Information	**Verbal** Terry Hague	10.00am 5mins
Quality and Finance				
10	Finance Update	Assurance / Information	**PCCC 22/05/10** Ruth Simms	10:05am 5mins
11	CQC Updates	Assurance / Information	**Verbal** Terry Hague	10.10am 5mins
Contract Management				
12	Contractual Issues Report	Approval / Assurance	**PCCC 22/05/12** Terry Hague	10.15am 5mins
13	Practice Delivery Agreement • PDA Sign Up 2022/23	Approval	**PCCC 22/05/13** Louise Dodson	10:20am 20mins
14	The Grove and Dodworth Medical Practice (Apollo Court) Merger – Ratification of virtual agreement	Approval/ Assurance	**PCCC 22/05/14** Terry Hague	10:40am 5mins

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Item	Session	Committee Requested to	Enclosure Lead	Time
Governance, Risk, Assurance				
15	Risk and Governance Report • Assurance Framework • Risk Register	Assurance	**PCCC 22/03/12** Richard Walker	10.45am 5mins
Reflection on conduct of the meeting				
16	• Conduct of meetings • Any areas for additional assurance • Any training needs identified	Note	**Verbal** Chair	10.50am 5mins
Other				
17	Questions from the public relevant to the agenda	Note	**Verbal** Chair	10.55am 5mins
18	Items for escalating to the Governing Body	Note	**Verbal** Chair	
19	**Date and time of the next scheduled meeting:**	Note	**Verbal** Chris Millington	**11.00am 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**

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PRIMARY CARE COMMISSIONING COMMITTEE

26 May 2022

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 Proud	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	
3.2 Maximising Elective Activity		9.1 Digital and Technology	
4.1 Mental Health		10.1 Compliance with statutory duties	✓
5.1 Integrated Care @ System		11.1 Delivery of Enhanced Health in Care Homes	
5.2 Integrated Care @ Place		12.1 Delivering The Covid Vaccination Programme & Meeting The Needs of Patients with Covid-19	
5.3 Implementing Population Health Management And Personalised Care			

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).
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
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) will cease on 30.6.22 • Appointed Cancer Alliance Advisory Board • Public Governor at BHNFT

Name	Current position (s) held in the CCG	Declared Interest
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
Victoria Lindon	Assistant Head of Primary Care Commissioning (NHSE and	• NIL

Name	Current position (s) held in the CCG	Declared Interest
	NHSEI)	
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, 24 March 2022 at 9.30am 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 (up to agenda item 12)
Richard Walker	Head of Governance & Assurance

CLINICAL MEMBERS (NON-VOTING)

Dr Nick Balac	Chairman, Barnsley CCG
Dr Mark Smith	Governing Body Member

IN ATTENDANCE:

Roxanna Naylor	Chief Finance Officer
Jeremy Budd	Director of Strategic Commissioning & Partnerships
Jamie Wike	Chief Operating Officer
Angela Musgrave	Executive Personal Assistant
Nick Germain	Primary Care Manager, NHSEI
Rebecca Clarke	Senior Public Health Principal
Margaret Lindquist	Board Member, Healthwatch Barnsley
Ruth Simms	Finance Manager
Louise Dodson	Primary Care Transformation Manager
Terry Hague	Primary Care Transformation Manager

APOLOGIES:

Chris Edwards	Accountable Officer
Dr Madhavi Guntamukkala	Medical Director
Julie Frampton	Head of Primary Care
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 22/03/01	**HOUSEKEEPING**		
PCCC 22/03/02	**WELCOME AND APOLOGIES**		
	The Chair welcomed members to the meeting and apologies were noted as above.		
PCCC 22/03/03	**QUORACY**		
	The meeting was declared quorate.		

PCCC 22/03/04	**DECLARATIONS OF INTEREST RELEVANT TO THE AGENDA**		
	The Chairman of the CCG declared an interest in item 2 of the Contractual Issues Report (Any Qualified Provider, Vasectomy Contract Termination) as his Practice had given notice as one of the providers of this service. The Chair agreed to allow the Chairman of the CCG to remain present for the Contractual Issues Report. The Chief Operating Officer informed that as he was not a Member of the PCCC he was not on the declarations of interest report. However, as he was 'in attendance' at today's meeting he declared that his wife was an employee of Barnsley Healthcare Federation which was included on the CCG Risk Register.		
PCCC 22/03/05	**MINUTES OF THE LAST MEETING**		
	The minutes of the meeting held on 27 January 2022 were verified as a true and correct record of proceedings.		
PCCC 22/01/06	**MATTERS ARISING REPORT**		
	Members noted the two items in the Matters Arising report were included on the agenda for discussion.		
STRATEGY, PLANNING, NEEDS ASSESSMENT AND CO-ORDINATION OF PRIMARY CARE			
PCCC 22/01/07	**PRIMARY CARE NETWORK UPDATE** <u>Primary Care Investments/Winter Access Funding</u> <u>Winter Access Funding</u> The Primary Care Transformation Manager informed the Committee that following agreement at the Extraordinary PCCC on 16 December 2021 and further discussion at the PCCC on 27 January 2022 a letter was sent to all practices in December 2021 outlining the funding available and how to access it. Each Practice was asked to submit a brief plan, describing how they would spend the allocated funding up to 31 March 2022 and the benefit this would deliver. All 32 practices had returned their plans that provided details on how they intended to utilise the funding. As part of the audit trail, the Primary Care Team had subsequently contacted all practices for confirmation they were utilising the funding as per the plan submitted.		

	Practice Clinical Equipment As agreed at the PCCC meeting on 27 January 2022, practices were contacted to advise that funding had been identified that could be utilised for the purchase of medical equipment. An agreed list of additional medical equipment had been provided and individual practices were asked to prioritise their requirements. It was noted that practices would be reimbursed the cost of equipment and consumables from the list however practices would be responsible for ongoing maintenance and replacements. Practice GP IT (Laptops) All practices had responded to the request to understand the need for additional laptops within practices to support resilience and increased home working. The CCG had placed an order for 239 laptops that would be distributed to practices in a phased approach from April 2022 onwards. Quality and Outcomes Framework and Impact and Investment Funding (QOF and IIF) Following a letter from NHSE/I to all GP Practices on 7 December 2021 regarding temporary GP contract changes to support the Covid-19 vaccination programme, all 32 practices had confirmed the capacity created by the temporary contract changes would allow them to participate in the Covid-19 vaccination programme. All practices would therefore receive the QOF income protected payment. Additionally, because of the IIF temporary changes identified in the letter, all 6 PCN Clinical Directors had confirmed that the PCN Support Payment would be reinvested into primary care services and workforce. The PCN had now received the payment. Members thanked the Primary Care Team for the amount of work that had been carried out within a short period of time and the support provided to practices to ensure the funding had been fully utilised. **The Committee:** • Noted the funding identified had been provided to practices to be utilised as agreed to increase access, support resilience, support homeworking and improve patient care.		

PCCC 22/03/08	**GP IT** The Primary Care Transformation Manager provided members with a verbal update on GP IT. Members noted that it did not appear that any concerns or issues had been identified regarding the CCG GP IT digital maturity assurance questionnaire that was currently being completed and would be submitted to NHSE by the end of March. The CCG was currently awaiting confirmation on GP IT funding for 2022/23. Utilisation of the funding once received would focus on replacing hardware such as laptops and docking stations for additional growth. **The Committee:** • Noted the verbal updated provided on CCG GP IT.		
QUALITY AND FINANCE			
PCCC 22/03/09	**FINANCE UPDATE**		
	The Assistant Finance Manager provided members with an update on the Finance Report. **<u>Forecast Position 2021/22</u>** The forecast position as at month 10 reflected a £1,800k overspend, that was broken down as follows: • technical adjustment outstanding leading to an overspend of £1,274k against the Additional Roles Reimbursement Scheme (ARRS) where funding is being held nationally to drawdown as expenditure is incurred • £966k overspend against the Winter Access Funding, again funding is held nationally and expected to be received in Month 11/12 to eliminate this overspend position. • underspend against the CCG core allocation of £440k which relates in the main to the underutilisation of 2020/21 accruals. A full breakdown is included in Appendix A. It was also reported that the CCG currently had an underspend of £250k against the £1,524k nationally held funding for the ARRS scheme. This underspend was due to delays in recruitment following the continued impact of Covid-19. It was highly likely the funding would be unable to be maximised as year-end approached.		

	The Committee noted the: - • Financial position as at Month 10 • Level of funding being utilised against Additional Roles Reimbursement and the level of likely underspend against the national funding available.		
PCCC 22/03/10	**CQC REPORT** The Primary Care Transformation Manager presented the CQC report that provided members with an update on the current CQC position in relation to our GP Practices and for Barnsley Healthcare Federation i-Heart contracts. **<u>CQC Monitoring and Inspection Programme</u>** The CQC had paused inspection activity from 13 December 2021 to February 2022 with the exception of 'risk to life' concerns, to enable delivery of the booster vaccination programme. Going forward the focus would include lowering the risk threshold from 'risk to life' to 'risk to harm'. The CQC would therefore be inspecting services currently in breach of regulations where concern or intelligence date had been received indicating some risk. The following practices <u>may</u> therefore be picked up within the future inspection programme. • Woodland Drive Medical Centre • Hoyland Medical Centre • High Street Practice • The Kakoty Practice • Dodworth Medical Practice The Primary Care team continued to link in with the CQC and share updates regarding the outcome of the monitoring of Barnsley practices with the Committee. **The Committee noted the :-** • Update regarding the CQC's Monitoring and Inspection Programme.		
CONTRACT MANAGEMENT			
PCCC 22/03/11	**CONTRACTUAL ISSUES REPORT**		
	The Primary Care Transformation Manager presented the Contractual Issues Report that provided members with an update on the current contractual issues in relation to primary care contracts.		

Contract Variations

Ashville Medical Centre

The CCG had received an application to vary the contract to add Dr Wrest as a new partner from 1 April 2022.

Rose Tree Practice

The CCG had received 2 applications to vary the contract of Rose Tree Practice as outlined below:

- Add YMGH limited company as a new partner onto the contract from 1 April 2022
- Remove the current 2 contract holders – Dr Ghani and Y Akhtar Hussain (*as named people, providing the YMGH limited company application was approved)*

High Street Practice

The CCG had received an application to vary the contract to add Dr Khalid as a new partner from 1 April 2022.

Any Qualified provider (AQP) Vasectomy Contract Termination

The CCG had received notice from St Georges Medical Practice to terminate their contract as one of the AQP Vasectomy service providers for Barnsley patients. The contract would therefore cease on 15 June 2022.

Lundwood Medical Centre was also contracted to provide the AQP Vasectomy service for Barnsley patients. The contract with Lundwood Medical Centre would come to an end on 30 September 2022.

The Primary Care Team were liaising with the procurement team to commence the procurement process for the AQP contracts for a Vasectomy Service Non-Scalpel service to minimise any impact o the notice given by St Georges Medical Practice.

Any Qualified Provider Contracts for Community Carpal Tunnel Services including Nerve Conduction

The Primary Care team were looking to commence the procurement process for the AQP contracts for Community Carpal Tunnel Services including Nerve Conduction as contracts were due to cease on 30 September 2022.

BHF SQP Data Set Review

As previously discussed at the PCCC meeting held in August 2021 and subsequently at the CCG's Senior Management Team, it had been agreed to move from a full SQP report to a more streamlined minimum data set

	that would increase confidence, data quality and assurance of the BHF contracted services. A full review had been completed by the Primary Care team against contractual requirements, following which the SQP had been updated. The changes had been discussed and agreed at the Contract Monitoring meeting held in February 2022. BHF colleagues had confirmed that the changes had significantly improved the ease of reporting. The Contract Review Board would continue to monitor the quality of the SQP within the monthly contract meetings. **The Committee:-** 1) Approved the variations to contracts received including: a. The application to vary the contract of Ashville Medical Centre in relation to the addition of Dr Wrest as a new partner from 1 April 2022. b. The applications to vary the contract of Rose Tree Practice to: i. Add YMGH limited company as a new partner onto the Rose Tree Practice PMS contract from 1 April 2022. *ii.* Remove the current 2 contract holders - Dr Ghani and Y Akhtar Hussain c. Noted the variation to the High Street practice to add Dr Khalid as a new partner from 1 April 2022. 2) Noted the termination of the Vasectomy contract received from St Georges Medical Practice and the planned procurement, 3) Noted the planned procurement of the Carpal Tunnel service. 4) Noted the update for assurance of the completion of the BHF Service, Quality and Performance report data set review.		
GOVERNANCE, RISK AND ASSURANCE			
PCCC 22/03/12	**<u>Risk and Governance Report</u>** The Head of Governance & Assurance presented the risk and Governance report that provided the Committee with: • Assurance regarding the delivery of the CCG's annual strategic objectives, and		

	• 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 refreshed at the start of each financial year then reviewed, updated, and reported to every meeting of the Governing Body. 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 allocated to the PCCC for which the Committee was responsible for managing. Of the five risks, there was one red (extreme) rated risk, one amber risk (high), one yellow risk (moderate) and two green (low) risks. Members were asked to review the risks detailed on Appendix 1 to ensure that the risks were being appropriately managed and scored. Following a lengthy discussion regarding Risk 15/04 on the Risk Register, concern was expressed about the CCG's transition to the ICS and whether there would be the appropriate capacity to fulfil the functions currently delegated to the CCG. The Chief Finance Officer commented that the actual capacity within the CCG would 'lift and shift' into the ICS and continue to undertake those duties, providing short term assurance around capacity. There was, however, further clarity required around the governance structures and how decisions would be made following the transition.		

	The Chairman of the CCG requested that an assurance update be provided at the PCCC meeting in May in relation to future governance arrangements for primary care commissioning. <u>PCCC Terms of Reference</u> The Head of Governance & Assurance had reviewed the Terms of Reference and assured the Committee they continued to be fit for purpose. The recommendation was that no changes were required. **The Committee: -** • Reviewed and agreed that the risks were being appropriately managed and scored. • Confirmed that no changes were required to the Committee's TOR.	**RW**	**26.05.22**
PCCC 22/03/13	**Annual Assurance Report 2021/22** The Primary Care Transformation Manager presented the PCCC Annual Assurance Report informing the Committee 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 Committee:-** • Considered and approved the PCCC Annual Assurance Report 2021/22.		
OTHER			
PCCC 22/03/14	**REFLECTION OF CONDUCT OF THE MEETING** The Committee agreed that the meeting had been conducted appropriately.		
PCCC 22/03/15	**QUESTIONS FROM MEMBERS OF THE PUBLIC RELEVANT TO THE AGENDA**		
	There were no questions received from the members of the public.		
PCCC 22/02/16	**ITEMS FOR ESCALATING TO THE GOVERNING BODY** There were no items for escalating to the Governing Body.		
PCCC 22/03/17	**DATE & TIME OF NEXT MEETING** Thursday, 26 May 2022 at 11.00am MS Teams.		

PCCC 22/05/06

NHS Barnsley Clinical Commissioning Group

MATTERS ARISING REPORT TO THE PUBLIC PRIMARY CARE COMMISSIONING COMMITTEE

THURSDAY 26 MAY 2022

1. MATTERS ARISING

The table below provides an update on actions arising from the meeting of the Primary Care Commissioning Committee held on **27 January 2022**.

Minute ref	Issue	Action	Action/Outcome
PCCC 22/03/12	**Risk and Governance Report – Risk 15/04** Assurance update to be provided at the May meeting regarding future governance arrangements for primary care commissioning.	**RW**	**In progress** The ICS' Transition Executive Group has established a task & finish group to consider future arrangements for the commissioning of primary medical services. Barnsley CCG is represented on this group by the Chief Officer and Chief Operating Officer who can provide a verbal update on progress at the PCCC meeting.

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 21/08/11	Barnsley Healthcare Federation (BHF) Contracts Review Update on the BHF Contracts review to be brought to the September meeting.	**TH**	23.03.22 - **Complete** 27.01.22 – SQP data set agreed with BHF and will be presented at the contract meeting in February. Update to be provided to PCCC in March when the successful implementation of the new system will be discussed. Update 30.09.21 **In Progress -** The PC team have worked up a minimum data set that supports the contractual requirements. We have not yet had the opportunity to discuss with BHF.

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PRIMARY CARE COMMISSIONING COMMITTEE

26th MAY 2022

PRIMARY CARE NETWORK (PCN) UPDATE

PART 1A – SUMMARY REPORT

1.	**THIS PAPER IS FOR**						
	Decision		*Approval*		*Assurance*	x	*Information*	
2.	**PURPOSE**						
	This paper provides a summary of the update to the Network Contract Directed Enhanced Service (DES) for 2022/23 and requirements for the PCN. It also outlines requirements for the PCN for the 2022/23 Impact and Investment Fund as well as outlining achievement for 2021/22 Impact and Investment Fund						
3.	**REPORT OF**						

	Name	**Designation**
Executive Lead	Chris Edwards	Chief Officer
Author	Louise Dodson	Primary Care Transformation Manager

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**
Public Primary Care Commissioning Committee	24.03.2022	2021/22 PCN Support Payment – Noted

5.	EXECUTIVE SUMMARY

Primary Care Networks: Network Contract Direct Enhanced Service

NHSE has published the revised Network Contract DES which took effect from 1st April 2022. The priority for the year is to maintain stability and limit change for general practice, whilst increasing investment for the workforce and leadership, supporting communities to recover, and ensuring patients continue to receive timely, high quality care.

The full contract can be found in Appendix A, with a summary found in Appendix B and frequently asked questions in Appendix C

All Barnsley practices have continued to participate in the one Barnsley PCN, with the 6 underlying neighbourhoods remaining unchanged.

The majority of the requirements included in the Network DES are not new, rather they build on existing requirements from previous years for example the utilisation of Additional Roles (ARRS) and deliver of specifications such as Enhanced Health in Care Homes, Early Cancer Diagnosis, CVD Prevention and Diagnosis, Tackling Neighbourhood Health Inequalities and Personalised Care.

However new requirements do include:

- By 31st July 2022 the PCN will provide a plan outlining how they will deliver Extended hours Enhanced Access to a revised specification
- By 1st October 2022 the PCN will begin delivery of an enhanced access and extended hours services with one set of requirements – the PCN will be required to provide 60 minutes per week per 1,000 weighted patients.
- By 30th September 2022 the PCN must proactively offer and improve access to social prescribing, to an identified cohort with unmet needs
- By 1st October the PCN must deliver a proactive social prescribing service for this identified cohort

The PCN and the Primary Care Team are working closely to ensure all requirements are delivered, and plans are developed cohesively.

2022/23 Impact and Investment Fund

The requirements for 2022/23 IIF are split into three domains as follows:

- Preventing and tackling health inequalities
- Providing high quality care
- A sustainable NHS

Within the three domains, the indicators are further split into different areas:

- Preventing and tackling health inequalities
  - Vaccinations and immunisations
  - Tackling health inequalities
  - CVD prevention

	• Providing high quality care
	  o Personalised care
	  o Enhanced health in care homes
	  o Anticipatory care
	  o Cancer
	  o Access
	  o Structured medication reviews and medicines optimisation
	  o Respiratory care
	• A sustainable NHS
	  o Environmental sustainability
	
	Full detail of the IIF indicators can be found in Appendix D, and a summary can be found in Appendix E.
	
	Both the Primary Care Team and the PCN are supporting practices with delivery of the IIF Indicators, including monthly progress updates, utilising PCN Additional Roles (ARRS) to assist delivery and identifying which indicators will require additional support to achieve.
	
	2021/ 2022 Impact & Investment Fund.
	
	As outlined by a letter from NHSE / I to all GP Practices on 7th December 2021 regarding Temporary GP contract changes to support COVID-19 vaccination Programme the majority of IIF indicators were placed on hold. PCN's were required to confirm that as a result of the IIF temporary changes identified in the letter the PCN Support Payment would be reinvested into Primary Care Services and Workforce. All 6 clinical directors agreed to this and the PCN have therefore received the PCN Support Payment.
	
	The remaining IIF indicators were as follows:
	
	• Confirmation that all practices in the PCN have mapped all active appointment slot types to the new set of national appointment categories, and are complying with the August 2020 guidance on recording of appointments - the PCN achieved this requirement
	• 96.16% of patients aged 65 years or over received a seasonal influenza vaccination between 1 September and 31 March
	• 91.22% of at risk patients aged 18 to 64 years received a seasonal influenza vaccination between 1 September and 31 March
	• 90% of patients aged two or three years on 31 August of the year who received a seasonal influenza vaccination between 1 September and 31 March

6.	**THE GOVERNING BODY / COMMITTEE IS ASKED TO:**
	Note – There is an updated Network Contract DES and Impact and Investment fund in place from April 2022 to March 2023. Note – The achievement of the PCN for the 2021/22 Impact and Investment Fund.

7.	APPENDICES / LINKS TO FURTHER INFORMATION
	• Appendix A - Network Contract Directed Enhanced Service: guidance for 2022/23 in England Appendix A • Appendix B – Primary Care Networks: network contract directed enhanced service from April 2022 – cover note Appendix B • Appendix C - Network contract directed enhanced service: frequently asked questions 2022/23 Appendix C • Appendix D – Network Contract Direct Enhanced Service – Impact and Investment Fund 2022/23: Updated Guidance Appendix D • Appendix E – Network Contract Direct Enhanced Service – Impact and Investment Fund 2022/23 Summary Appendix E

Agenda time allocation for report:	*10 minutes.*

PCCC 22/05/07

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	**x**	7.1 Transforming Care for people with LD	
3.1 Cancer		8.1 Maternity	
3.2 Maximising Elective Activity		9.1 Digital and Technology	
4.1 Mental Health		10.1 Compliance with statutory duties	
5.1 Integrated Care @ System		11.1 Delivery of Enhanced Health in Care Homes	
5.2 Integrated Care @ Place		12.1 Delivering The Covid Vaccination Programme & Meeting The Needs of Patients with Covid-19	
5.3 Implementing Population Health Management And Personalised Care			

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)	**See 3.2**	Duties as to reducing inequalities (s14T)	**See 3.5**
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 3.3**	Duty as to patient choice (s14V)	
Duty as to improvement in quality of services (s14R)	**See 3.4**	Duty as to promoting integration (s14Z1)	
Duty in relation to quality of primary medical services (s14S)	**See 3.4**	Public involvement and consultation (s14Z2)	**See 3.6**

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 :

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	x
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***

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?	***N***

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)?	***Y***

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?	***N/A***
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***

Classification: Official

Publication approval reference: B1357

Network Contract Directed Enhanced Service

Guidance for 2022/23 in England

MARCH 2022

Contents

1. Introduction

1.1. The Network Contract Directed Enhanced Service (DES) was introduced during 2019 and will remain in place until at least 31 March 2024. For 2022/23, the Network Contract DES Directions come into force on 1 April 2022 and, following participation in the DES, the requirements on practices and Primary Care Networks (PCNs), as outlined in the Network Contract DES specification, will apply from that date.

1.2. This guidance provides supporting information for commissioners and practices. It does not take precedence over the Network Contract DES Specification.

1.3. The ongoing COVID-19 situation and COVID-19 vaccination programme is placing substantial pressures on general practice, and we are very grateful to all colleagues for the work they are doing to respond swiftly and professionally. NHS England and NHS Improvement has announced a number of changes to the Network Contract DES for 2022/23, as set out in General practice contract arrangements in 2022/23. The Network Contract DES and this guidance reflect those changes.

1.4. This document has been updated since 2019/20 version 1 was agreed by NHS England and the British Medical Association's (BMA) General Practitioners Committee England (GPCE).

1.5. As at the date of publication of this guidance, the Health and Care Bill remains under discussion in Parliament. It is likely that during the period of the 2022/23 Network Contract DES, clinical commissioning Groups (CCGs) will be dissolved and their functions will transfer to Integrated Commissioning Boards (ICBs) as the legal entity at the heart of Integrated Commissioning Systems (ICSs). It is also likely that the delegation of management of primary medical services contracts, including the Network Contract DES, will be taken on by ICBs from CCGs. References in this guidance to "commissioner" are therefore references to CCGs while they exercise those delegated powers and to ICBs when ICBs take on and exercise those powers.

2. Participation in the Network Contract DES

2.1. Participation process

2.1.1 From April 2022 onwards, all Core Network Practices of Previously Approved PCNs will automatically participate in the 2022/23 and subsequent year's Network Contract DES, and any in-year variations unless a Core Network Practice chooses to opt out of participation. An opt-out and opt-in window will apply from the date of publication by NHS England and NHS Improvement of the Network Contract DES Specification or any Network Contact DES Variation. For the 2022/23 Network Contract DES, this opt-out and opt-in window will apply until 30 April 2022 and allows for:

a. Core Network Practices to opt-out of the 2022/23 Network Contract DES following automatic participation; or

b. Non-participating practices wishing to participate to opt-in to the 2022/23 Network Contract DES.

2.1.2 In the event of an in-year variation to the Network Contract DES, all Core Network Practices will automatically participate in the variation unless they choose to opt out, in which case they must do so within a 30 calendar day window from the date of publication by NHS England and NHS Improvement of the variation. Any variations to the Network Contract DES will be made nationally by NHS England and NHS Improvement; local variations to the Network Contract DES Specification, including to the requirements or financial entitlements, must not be made.

2.1.3 A New Practice may join a Previously Approved PCN at any time during the year.

Previously Approved PCNs with no changes to their Core Network Practice membership

2.1.4 Previously Approved PCNs without any changes to their Core Network Practice membership will automatically participate in the 2022/23 Network Contract DES. There is no need for the practices in these PCNs to submit a participation form to their commissioner. A written variation of the primary medical services contract of each Core Network Practice is required to ensure the relevant Network Contract DES Specification forms part of that contract and the commissioner will issue notification through the Calculating Quality Reporting Service (CQRS) for practices to accept. PCNs must ensure their Network Agreement has been updated as necessary.

Previously Approved with changes to their Core Network Practice membership

2.1.5 Where a Previously Approved PCN has one of the following scenarios which leads to a change in the Core Network Practice membership:

a. a Core Network Practice from another PCN joining; and/or
b. a non-participating practice joining; and/or
c. a New Practice joining; and/or
d. a Core Network Practice opting out of participating,

the Core Network Practices must follow the steps as set out in section 4.4 of the Network Contract DES Specification to seek approval of the change to the PCN's Core Network membership. PCNs must complete the Network Contract DES Participation and Notification Form included at Annex A of the Network Contract DES Specification to provide the required information and submit it to the commissioner by the 30 April 2022 or in the case of a Network Contract DES Variation, by the 30th calendar day following publication by NHS England and NHS Improvement of the variation. A single Participation Form can be submitted for a PCN.

2.1.6 Commissioners will consider all the information provided and confirm to the PCN as soon as possible (at the latest, within one month of receipt of the notification) whether or not the practices' participation in the Network Contract DES is confirmed.

2.1.7 PCNs are encouraged to submit the information to the commissioner as soon as possible to support payments, and prior to the next local payment deadline to avoid any disruption in payment. Commissioners should liaise with the PCN to confirm timescales. Where a local payment date has been missed, the commissioner will make the relevant payment in the next month. Where a Previously Approved PCN with changes requires payment adjustment, the commissioner will make these manually in the next month.

2.1.8 Commissioners are not required to wait for 100 per cent geographical coverage in order to approve Core Network Practice participation and PCN continuation or formation.

2.2. PCN unwilling to accept a practice as a Core Network Practice

2.2.1. Where a practice wishes to participate in the Network Contract DES but is unable to find a PCN to join, commissioners will have the ability as a last resort to allocate a practice to a PCN as a Core Network Practice. It is not anticipated that this will happen on a regular basis as it is expected that disagreements over joining a PCN should be managed through mediation, supported by the commissioner and the Local Medical Committee (LMC).

2.2.2. Where agreement cannot be reached through mediation, in order to ensure maximum population coverage through the Network Contract DES, a commissioner may allocate the practice to a PCN, with the full engagement of the LMC, in line with the process as set out in section 4.6 the Network Contract DES Specification.

3. Role of Commissioners and LMCs in reconfirming PCN establishment

3.1. Commissioners and LMCs will need to work together to ensure all practices who wish to join or continue their participation in the Network Contract DES are included within a PCN. Commissioners and LMCs will also need to work with PCNs to ensure that 100 per cent of registered patients are covered by network services, for example by commissioning a local contractual arrangement (see section 4). This may require discussion and mediation between the relevant PCN grouping and practice(s).

3.2. Commissioners will:

a. Liaise with the relevant Integrated Care System (ICS) to ensure each PCN Network Area continues to or does support delivery of services within the wider ICS strategy.
b. Engage with LMCs and bring practices together to resolve issues to ensure 100 per cent population coverage is maintained.
c. Engage with LMCs to aid a practice's participation in the Network Contract DES where the practice is unable to find a PCN.
d. Reconfirm or approve practice participation in the Network Contract DES as part of a PCN, ensuring that the participation requirements have been or continue to be met.

e. Have oversight of PCN footprints to ensure these make long term sense for service delivery and in the context of the GP contract framework.
f. Support PCN development via investment and development support outside of the Network Contract DES.

4. Establishing local agreements with a PCN for delivery of network services for patients of a practice not participating in the Network Contract DES

4.1. Key considerations

4.1.1. Commissioners are required to ensure that that any patients of a practice that is not participating in the Network Contract DES have access to network services.

4.1.2. In those instances where a practice has chosen not to sign up to the Network Contract DES and a commissioner is required to secure network services for the patients of that practice, a commissioner may contract with any other suitable provider for the delivery of network services, such as another PCN or a community services provider. Commissioners must, subject to procurement rules, initially seek to offer the provision of the network service to another Previously Approved PCN via a local agreement. If no Previously Approved PCN is suitable, the commissioner, subject to procurement rules, may offer the network service to any suitable provider and, for the avoidance of doubt, any other suitable provider would not include the practice that has opted out of the Network Contract DES. In commissioning any suitable provider, this must not be on terms better than those set out in the Network Contract DES (including any additional funding) nor divide the service into smaller components. Non-PCN providers commissioned to deliver network services will not be eligible for the Network Participation Payment.

4.1.3. The guidance below applies to those instances where a commissioner is contracting with a PCN through a local agreement to deliver network services to such patients.

4.1.4. Commissioners will need to work with PCNs to agree how any patients from a non-DES practice - a practice not signed up to the Network Contract DES - can be covered by a PCN. The local agreement would usually be with:

a. a single Core Network Practice (as a signatory on behalf of a PCN in a lead provider type of arrangement), or
b. with all the Core Network Practices in the PCN (as a multi-signatory agreement)[1].

4.1.5. These local agreements will be managed locally and the patient population of a non-DES practice, for whom a PCN is providing network services, will not be accounted for within the PCN ODS reference data.

[1] Where the PCN has formed as a legal entity, the local agreement could be made directly with the PCN.

4.1.6. There may be circumstances where more than one GP practice in an area is not participating in the Network Contract DES. Where a single PCN will be providing cover for multiple non-DES practices, this can be via either a single or multiple local agreement(s).

4.1.7. Having agreed which PCN or provider will provide the cover, commissioners will need to ensure the following services/activities[2] are provided to patients of the non-DES practice in accordance with the timescales for these services/activities:

a. a social prescribing service;
b. from 1 April 2022 until 30 September 2022, the extended hours access requirements as listed at section 8.1 of the Network Contract DES specification;
c. from 1 April 2022 until 30 September 2022 the preparatory requirements for Enhanced Access;
d. from 1 October 2022, the Enhanced Access requirements as listed at section 8.1 of the Network Contract DES Specification
e. the Medication Review and Medicines Optimisation requirements as listed at section 8.2 of the Network Contract DES Specification;
f. the Enhanced Health in Care Homes requirements as listed at section 8.3 of the Network Contract DES Specification;
g. the Early Cancer Diagnosis requirements as listed at section 8.4 of the Network Contract DES Specification;
h. the Cardiovascular Disease (CVD) Prevention and Diagnosis requirements as listed at section 8.6 of the Network Contract DES Specification;
i. the Tackling Neighbourhood Health Inequalities requirements as listed at section 8.7 of the Network Contract DES Specification;
j. the Anticipatory Care requirements as listed at section 8.8 of the Network Contract DES Specification; and
k. the Personalised Care requirements as listed at section 8.9 of the Network Contract DES Specification.

4.1.8. These requirements could be included in the local agreement by cross-referring to the relevant sections of the Network Contract DES Specification document. For some of the service requirements, co-operation between the provider of the local agreement and the non-DES practice(s) will be critical to delivery. Further information on the duty of co-operation on all practices is detailed below.

4.1.9. Other provisions that would be expected to be included in a local agreement are:

a. A provision requiring the PCN to provide to the commissioner any details of non-co-operation by a non-DES practice with the PCN who is providing network services via the local agreement to the non-DES practice's patients. This information will be used by the commissioner to

[2] The list outlines the 2022/23 requirements. Commissioners and PCNs will need to review local agreements in future years to ensure they remain aligned to any changes to the Network Contract DES Specification.

consider whether to take any action under the non-DES practice's primary medical services contract;

b. Breach – how breaches by the PCN providing cover are dealt with by the commissioner; and
c. Boilerplate provisions – the usual contractual provisions about commencement, duration, extension, break-clause, termination, variation, dispute resolution, entire agreement, surviving provisions, governing law, etc.

4.1.10. Commissioners should make every effort to find suitable cover to provide network services for patients of a non-DES practice. Where a commissioner has not been able to secure cover to patients of a non-DES practice, this should be notified to the NHS England and NHS Improvement Regional Team.

4.1.11. In areas where the scale of non-participation in the Network Contract DES is significant, NHS England and NHS Improvement will consider the case for establishing a new APMS contract, in addition to existing GMS/PMS/APMS contracts, in order to establish additional primary medical care capacity (covering both essential services and network services) in those areas.

4.2. Payments under a local agreement

4.2.1. For the purposes of the Network Contract DES, payments to a PCN for the provision of PCN services/activities are mostly calculated by reference to the sum of its Core Network Practices' registered lists as at 1 January each year. This sum will not therefore include patients from practices who are not participating in the Network Contract DES. Instead, the patients of practices not participating in the Network Contract DES would need to be accounted for under the local agreement put in place with the PCN that will be providing cover. These local agreements will not be supported by either the General Practice Extraction Service (GPES) or the Calculating Quality Reporting Service (CQRS) and commissioners will be required to manage these out-with of these systems.

4.2.2. In respect of payments under the local arrangement, the simplest approach would be for the commissioner to consider replicating or clearly referring to the relevant payment provisions in section 10 of the Network Contract DES Specification but calculated with reference, where appropriate, to the registered patient size of the non-DES practice. These could include payments that reflect:

a. Core PCN funding;
b. extended hours access;
c. enhanced access
d. care homes premium;
e. clinical director funding; and
f. leadership and management payment

4.2.3. The commissioner and PCN may need to consider on a case by case basis the extent to which the total number of patients that the PCN provides services to (i.e. including the non-DES practice patients) would require additional workforce capacity, in order to support delivery of network services

and therefore what, if any, workforce related payments should be reflected in the local arrangements.

4.2.4. There may also need to be consideration of whether the Clinical Director of the PCN acts on behalf of the non-DES practice. If so, then consideration would need to be given to whether a payment in respect of this (calculated with respect to the patient list size of the non-DES practice) is appropriate.

4.2.5. Commissioners will have local discretion as to whether or not any additional funding can be made available, in part or in full to the PCN providing the cover for the non-DES practice.

4.2.6. The non-DES practice will not be entitled to the Network Participation Payment if not participating in the Network Contract DES.

4.3. Duty of co-operation

4.3.1. To support co-operation between all practices in delivering PCN related services to their patients, regardless of whether or not a practice is participating in the Network Contract DES, the GMS and PMS Regulations require all practices to:

a. co-operate with Core Network Practices of PCNs who are delivering the Network Contract DES services/activities to the collective registered population and as required engage in wider PCN meetings with other PCN providers;
b. inform their patients, as required, of changes to PCN services/activities;
c. support wider co-operation with other non-GP provider members of the PCN;
d. as clinically required, support the delivery of PCN services/activities, be party to appropriate data sharing and data processing arrangements, that are compliant with data protection legislation; and
e. share non-clinical data with members of the PCN to support delivery of PCN business and analysis, following a process that is compliant with data protection legislation.

4.3.2. Alongside the above, a practice's compliance with the GMC Good Medical Practice to act in the best interests of patients and not put them at risk of harm, should provide assurance that non-DES practices will co-operate with the delivery of PCN services/activities. In the event a non-DES practice does not co-operate, the commissioner will need to be made aware of, and address, the matter appropriately in line with normal contract management arrangements.

5. PCN Organisational Requirements

5.1 Membership of a Primary Care Network, network area and crossing commissioner boundaries

5.1.1. Under the Network Agreement, PCN membership is divided into two categories – Core Network Practices and other PCN members. Core Network

Practices are the practices participating in the Network Contract DES[3]. Any other organisations party to the Network Agreement are known as PCN members and may include other providers, such as a GP Federation, community or secondary care trust, community pharmacy, community or voluntary sector provider, and GP practices who are not participating in the Network Contract DES or who are not Core Network Practices of the PCN.

5.1.2. The Core Network Practice membership of a PCN must cover a Network Area that aligns with a footprint that would best support delivery of services to patients in the context of the relevant ICS. The Network Area must also:

a. cover a boundary that makes sense to:
   i. the Core Network Practices of the PCN;
   ii. other community-based providers which configure their teams accordingly; and
   iii. the local community;
b. cover a geographically contiguous area;
c. not cross Clinical Commissioning Group (CCG) or ICS boundaries except where:
   i. a Core Network Practice's boundary or branch surgery crosses the relevant boundaries; or
   ii. the Core Network Practices are situated in different CCGs.

5.1.3. From contractual perspective, a primary medical services provider who holds either:

a. a single eligible primary medical services contract will only be able to hold one Network Contract DES and be a Core Network Practice of a single PCN, this applies regardless of whether or not the single primary medical care provider has multiple sites spanning large areas and/or commissioner boundaries; or
b. multiple eligible primary medical care contracts will be able to have each of those contracts varied to include the Network Contract DES and each practice will be a Core Network Practice of the relevant PCN(s).

5.1.4. A practice not participating in the Network Contract DES could be a PCN member (like any other non-practice provider, i.e. not a Core Network Practice) and therefore be party to a PCN's Network Agreement.

5.1.5. A practice may be a member of more than one PCN, for example where a practice provides services from a branch surgery and sub-contracts the delivery of PCN services and/or activities for that branch surgery to a different PCN, or where a practice is the nominated payee for two PCNs. In these examples, the practice would be a Core Network Practice of one PCN and a PCN member (i.e. non-Core Network Practice) of another PCN. Similarly, within the PCN ODS reference data, GPES and CQRS, practices will only be a Core Network Practice of one PCN.

[3] Practices eligible to participate in the Network Contract DES must hold a primary medical services contract, have a registered list of patients and offer in-hours (essential services) primary medical services.

5.1.6. A practice with one or more branch surgeries in different PCNs acknowledges that its list of patients will be associated with the PCN of which the practice is a Core Network Practice. For PCNs/practices intending to have a different PCN provide PCN services/ activities to a branch surgery, see section 6 for information about sub-contracting arrangements.

5.2 PCN organisational or Core Network Practice membership changes

5.2.1. As outlined in section 2 above, a PCN may seek approval of a change to its Core Network Practice membership as part of the participation process following publication of the 2022/23 Network Contract DES Specification or an in-year variation. This change will be signed off as part of the process for practices confirming participation in the Network Contract DES, as outlined in section 2 of this guidance (and section 4.8 of the Network Contract DES Specification).

5.2.2. Changes to Core Network Practice membership of a PCN can only take place outside of this window in exceptional circumstances as set out in sections 6.6 to 6.9 of the Network Contract DES Specification and with the approval of the commissioner.

5.2.3. Commissioners should maintain accurate records of all PCN Core Network Practice membership approvals and rejections and will be required to demonstrate if requested, the rationale for their decision.

5.2.4. Where a PCN wishes to change its Clinical Director or nominated payee, it must follow the process as set out in sections 6.2 and 6.3 respectively of the Network Contract DES Specification.

5.3 PCN Organisational Data Service (ODS) information and Change Instruction Notice Form

5.3.1. Where changes to PCN membership or nominated payee have been approved by the commissioner, the commissioner must complete and submit the ODS Change Instruction Notice Form[4]. This form must be completed and submitted at the earliest opportunity and by no later than the last working day on or before the 14th day of each month, in order for the change to be actioned by the end of that month in the payment systems. In so doing, commissioners should have due regard to local payment arrangements and the timings implications of this when submitting an ODS Change Instruction Notice. Where the ODS Change Instruction Notice Form is not submitted by the monthly deadline, commissioners may be required to follow a manual exception process (i.e. manual payment reconciliation) to ensure the correct payments are made – see section 10.3 below).

[4] The PCN ODS Change Instruction Notice is available here.

5.3.2. The PCN ODS reference data provides the following information:

Category	Detailed information included
Organisational data for the PCN	ODS code PCN name PCN address Start and end dates of PCN Status (active or inactive)
Core Network Practice(s) to PCN	IsPartnerTo relationship: ODS for Practice and PCN Start and end dates of relationship Relationship Status (active or inactive)
PCN to commissioner mapping	IsCommissionedBy relationship: ODS for PCN and commissioner Start and end dates of relationship Relationship Status (active or inactive)
Nominated payee (NP)	IsNominatedPayeeFor relationship: ODS Code for Nominated Payee and PCN NP Name NP address Start and end dates of relationship Relationship Status (active or inactive) NP Role (whether NP is a practice or not) Note: A Nominated Payee can be payee for more than one PCN. This means some payee records will have multiple 'IsNomiantedPayeeFor' relationships to different PCNs. A PCN can only have one Nominated Payee.

5.3.3. Each PCN will have a single commissioning relationship, regardless of whether the Core Network Practices of a PCN cross commissioner boundaries. In the event a PCN crosses commissioner boundaries, then the relevant commissioners must agree who will be the 'lead' commissioner for the PCN. The agreed 'lead' will be identified as such within both the PCN ODS reference data and subsequently within the relevant GP IT systems for payment processing. The identified lead commissioner will make payments to the relevant Nominated Payee in relation to the Network Contract DES. The lead commissioner and any other relevant commissioner must reconcile any funding allocation discrepancies between themselves and not via national GP payment systems.

5.3.4. Only a PCN's 'lead' commissioner will be able to instruct changes to the ODS reference data and by someone from within the primary care commissioning team.

5.3.5. The NHS Digital ODS Team is not able to distinguish between a delegated or non-delegated CCG. Where a Regional Team submits an ODS Change Instruction Notice, the assumption will be that this is due to the CCG not having delegated authority and/or that this has been agreed locally between the Regional Team and CCG. As such, it is the responsibility of the commissioners (Regional Team and/or CCG) to ensure that they have the authority to submit the ODS Change Instruction Notice, as it will have implications for payment system calculations and processing. Where a

submission is made by a Regional Team, it will also need to be done by someone from within the primary care commissioning team.

5.4 Network Agreement

5.4.1. The Network Agreement sets out the collective rights and obligations of a PCN's Core Network Practices and is required to enable PCN claims of the financial entitlements under the Network Contract DES. It also sets out how the Core Network Practices will collaborate with non-GP providers which make up the wider PCN.

5.4.2. PCNs will continue to be required to use the national mandatory Network Agreement and its Schedules to support the Network Contract DES. The mandatory sections of the Network Agreement cannot be amended, except in those instances where the Network Agreement states that wording in a specific clause may be replaced with wording to reflect agreement which the PCN has reached.

5.4.3. Core Network Practices are required to ensure that PCN arrangements and agreements reached in the Network Agreement are updated to take account of any changes to the Network Contract DES specification. This would include how new services will be delivered, and for any other changes such as when new workforce is recruited.

5.4.4. Where PCNs decide to seek advice related to the Network Agreement, these costs will not be covered under the Network Contract DES nor by commissioners at a local level.

5.5 Recording agreements reached with local providers

5.5.1. In 2020/21, each PCN was required to agree with local community services providers, mental health providers and community pharmacy providers how they would work together. The collaboration agreements reached with these local providers must be documented in Schedule 7 of the PCN's Network Agreement.

5.5.2. As set out in the Network Contract DES Specification, PCNs must update Schedule 7 of their Network Agreement to set out:

a. the specifics of how the appropriate service requirements (those which require joint working with community services providers, community mental health providers and community pharmacy) under the Network Contract DES or other services deemed appropriate will be delivered through integrated working arrangements between PCNs and other providers; and
b. how providers will collaborate, including agreed communication channels, agreed representatives, and how any joint decisions will be taken.

5.5.3. Commissioners should use reasonable endeavours to facilitate the agreement of arrangements, or any subsequent amendment to the arrangements, between the local community services provider(s) and the PCN.

5.6 Clinical Director

5.6.1. The Clinical Director should be a practicing clinician from one of the PCN's Core Network Practices, working regularly within the PCN (regardless of whether the clinician is directly employed, self-employed or engaged via a sub-contracting arrangement) and be able to undertake the responsibilities of the role, representing the PCN's collective interests. It is most likely to be a GP, but this is not a requirement and can be any clinician including one of the PCN additional roles. The post should be held by an individual (or individuals if they are job-sharing the role) from within the PCN and should not be a shared role between PCNs. The Clinical Director should not be employed by a commissioner and provided to the PCN.

5.6.2. PCNs may wish to consider rotating the Clinical Director role within a reasonable term.

5.6.3. A national outline of the key requirements is included in section 5.3 of the Network Contract DES Specification. The Clinical Director has overall responsibility for their key requirements and may, where appropriate, engage others within the PCN to aid in their delivery.

Appointment of Clinical Director

5.6.4. It will be the responsibility of the PCN to agree who their Clinical Director will be. The selection process will be for the PCN to determine but may include:

a. Election - nomination and voting;
b. Mutual agreement between the members;
c. Selection – via application and interview for example; or
d. Rotation within a fixed term (this could equally apply against the above processes).

Managing Conflicts of interest

5.6.5. PCNs and Clinical Directors will be responsible for managing any conflicts of interest, taking account of what is within the best interests of the PCN and their collective patients. They will need to consider how best to manage inappropriate behaviour which negatively impacts on PCN member relationships or delivery of care to patients.

5.7 Data and analytics

5.7.1. Each PCN is required to have in place appropriate data sharing and, where appropriate, data processing arrangements between members of the PCN and any sub-contractors as required. These arrangements must be in place prior to the start of the activity to which they relate. The Data Sharing Agreements and Data Processing Agreement non-mandatory templates are available for PCNs to use.

5.7.2. Where functionality is available, clinical data sharing for service delivery should be read/write access, so that a GP from any practice, and where

required other PCN staff, can refer, order tests, and prescribe electronically and maintain a contemporaneous record for every patient.

5.7.3. PCNs should be routinely monitoring, sharing, and aggregating relevant data across the Core Network Practices. This is to allow for benchmarking of activity and the identification of:

a. opportunities for improvement;
b. variation in access and service delivery; and
c. capacity and demand across the PCN population in order to review and manage appropriately.

5.7.4. The Calculating Quality and Reporting Service (CQRS) includes functionality to enable practice-level data for PCN Core Network Practices to be summed to PCN-level. PCN Core Network Practices and the lead commissioner will be able to review both PCN and practice-level data.

5.7.5. With regards to cross-boundary PCNs identified through the PCN ODS mapping data, reporting within CQRS will not enable PCN related data to be available to multiple commissioners. The commissioners will therefore need to work together and the 'lead CCG' – identified by the PCN ODS reference data - will be required to share all relevant PCN level data with the 'non-lead CCG' to support monitoring and payment information linked to the Network Contract DES. Providing the data is not patient identifiable – which for the purposes of the Network Contract DES it will not be – General Data Protection Regulation (GDPR) does not require a data sharing agreement to be in place between controllers.

5.8 Network Dashboard

5.8.1. The Network Dashboard was introduced during 2020/21 and will evolve each year, in line with feedback from users and the availability of new information to populate it. To access the Dashboard, please either register on the Insights Platform, or login in using your existing Insights Platform account. A user guide is available to help navigate the dashboard.

5.8.2. The dashboard includes key metrics to allow every PCN to see the benefits it is achieving for its local community and patients and is intended to support local quality improvement. It will enable effective benchmarking between practices within PCNs, and between comparable PCNs, and will be accessible, on request, to all commissioners, providers and arms-length bodies working in health and social care.

5.8.3. These indicators will be displayed alongside contextual information for each PCN – for example the size, density and relative level of deprivation of their population.

6. Sub-contracting of network services

6.1 Core Network Practice with sites in different PCNs

6.1.1. When a Core Network Practice of a PCN (PCN 1) is looking to sub-contract services/activities to a different PCN (PCN 2) for a proportion of their registered population (for example where it holds a single contract but delivers services from multiple sites, such as a branch surgery), PCN 1 should give careful consideration to how the patients - to whom PCN 2 will provide PCN services/activities - will be identified. This is particularly important where those patients are under a single registered list under a single primary medical services contract.

6.1.2. Identification of patients for whom PCN 2 will provide PCN services/activities may, for example, be the patients who usually access care at a GP practice site within PCN 1. The GP practice should also take care not to do anything that could mean that a cohort of registered patients were treated differently e.g. a GP practice should not tell specific patients that they can only access PCN services/activities from sites in PCN 2. This is important as the practice needs to ensure that it does not breach any of the practice's obligations to patients set out in its core primary medical services contract.

6.1.3. There are two main options for the sub-contracting of PCN services/activities:

1) Option 1: Sub-contracting via the Network Agreement

a. In this scenario, the practice will be a Core Network Practice of a PCN (PCN 1) and will be signed up to PCN 1's Network Agreement in the usual way. That Network Agreement will note that it has been agreed that another PCN (PCN 2) will provide PCN services/activities to certain patients of the relevant practice. It would be helpful for PCN 1's Network Agreement to set out the reasoning for this. The relevant practice will also sign the Network Agreement of PCN 2 as an "other member" (i.e. not as a Core Network Practice). The details of the sub-contracting arrangement - the financial/service delivery/workforce arrangements - would be set out in an additional schedule of PCN 2's Network Agreement.

b. Careful consideration would need to be given to the role that the relevant practice has in PCN 2. The Network Agreement for PCN 2 would need to be clear on:
   i. setting out what requirements, if any, the relevant practice should be expected to deliver to facilitate the delivery of PCN services/activities to its patients. This might include agreed arrangements for communicating with patients and data sharing, for example;
   ii. defining which matters of PCN 2 the relevant practice may have an interest/vote in; and
   iii. whether there is any PCN 2 related information e.g. financial accounts, that it should not be party to.

2) Option 2: Entering into a separate specific sub-contract

a. In this scenario, the relevant practice could enter into a separate sub-contract with one or more of the Core Network Practices of PCN 2 for the delivery of PCN services/activities. Both PCNs will need to reflect the sub-contracting arrangement in both Network Agreements. In this scenario, it would not be necessary for the relevant practice to sign the Network Agreement of PCN 2.

6.1.4. PCNs will need to carefully consider the pros and cons of each approach, bearing in mind the additional complexity that either of the sub-contracting arrangements may bring and ensure that the agreed position is set out in clear and unambiguous wording. In all cases, the sub-contracting arrangements should include the ability to review/update the sub-contracting arrangements in light of any changes to the Network Contract DES Specification.

6.1.5. In entering into any sub-contracting arrangement, GP practices should at all times ensure they are complying with the sub-contracting requirements within their individual primary medical services contracts. Where a PCN wishes to sub-contract delivery of network services to a GP federation, this is permitted if the arrangement complies with the sub-contracting requirements in each GP practice's primary medical services contract.

6.2 Sub-contracting of clinical and non-clinical services or matters

6.2.1. Following an amendment to GMS and PMS Regulations[5], a sub-contractor to a practice or practices may be allowed to onward sub-contract a clinical matter that relates to the Network Contract DES. If, for example, practices have sub-contracted provision of clinical services to a GP federation, the sub-contract could now allow the GP federation to sub-contract the clinical services to another organisation with the prior written approval of the commissioner. The commissioner's approval will not unreasonably be withheld or delayed.

6.2.2. A sub-contractor to a practice or practice(s) will be allowed to onward sub-contract a non-clinical matter that relates to the Network Contract DES where the prior written approval of the commissioner is given. The commissioner's approval will not unreasonably be withheld or delayed.

7. Additional Roles Reimbursement Scheme

7.1 Workforce planning and ongoing reporting

7.1.1. Expanding the workforce is the top priority for primary care, and commissioners must support their PCNs to undertake recruitment under the Additional Roles Reimbursement Scheme to deliver this priority.

7.1.2. PCNs are required to plan their future workforce requirements in order to support claims under their Additional Roles Reimbursement Sum each year. As set out in the Network Contract DES Specification, each PCN is required to complete and return to the commissioner by 31 August 2022 the workforce planning template[6], providing details of any updated recruitment plans for 2022/23 and by 31 October 2022 any updated indicative intentions through to

[5] The NHS (GMS Contracts and PMS Agreements) (Amendment) (No2) Regulations 2020: https://www.legislation.gov.uk/uksi/2020/911/schedule/1/made?view=plain
[6] This template will be available at https://www.england.nhs.uk/gp/investment/gp-contract/

2023/24. The commissioner will confirm the plan with each PCN's Clinical Director and, once each plan is agreed, will share with NHS England and NHS Improvement Regional Teams by 30 September 2022 for 2022/23 plans, and by 30 November 2022 for indicative future plans.

7.1.3. The PCN may change these plans at any stage provided that such change is shared with the commissioner as this aids management of the redistribution of Additional Roles Reimbursement Scheme funding across all PCNs, as described in section 7.5 of the Network Contract DES Specification.

7.1.4. PCNs working with their commissioners and their ICS are encouraged to have ongoing dialogue in relation to workforce strategies, to ensure these are consistent with broader ICS workforce strategies.

7.1.5. The commissioner must complete and return the six-monthly workforce report to england.primarycareworkforce@nhs.net. There are plans to develop an online template for future returns, and further details will be made available to commissioners in due course.

7.1.6. PCN Core Network Practices must record, on a monthly basis, within the National Workforce Reporting Service (NWRS) information on any staff employed or engaged through the Additional Roles Reimbursement Scheme.

System Support for PCNs

7.1.7. Commissioners and systems are expected to explore different ways of supporting PCNs. These should include, but not be limited to:

a. the immediate offer of support from their own staff to help with co-ordinating and running recruitment exercises;
b. the offer of collective/batch recruitment across PCNs. Where groups of PCNs wish to advertise vacancies collectively, CCGs or ICSs should support this;
c. brokering arrangements to support full-time direct employment of staff by community partners, or to support rotational working across acute, community and (in time) mental health trusts, as well as community pharmacy; and
d. ensuring that NHS workforce plans for the local system are as helpful as possible in meeting PCN intentions.

7.2 Additional Roles Reimbursement Sum

7.2.1. Each PCN will be allocated an Additional Roles Reimbursement sum each year, based upon the PCN's Contractor Weighted Population share of the total Additional Roles Reimbursement Scheme funding. The basis for weighting is the same as for global sum (i.e. Carr-Hill Formula). PCNs will be able to claim up to this maximum sum each year, in line with the rules set out in the Network Contract DES Specification.

7.2.2. Each PCN's Additional Roles Reimbursement Sum will use the Contractor Weighted Population[7] as at 1 January of the financial year preceding and be calculated as follows:

$$\text{PCN's weighted population share} = \frac{\text{PCN's Contractor Weighted Population}}{\text{Total England weighted population}}$$

7.2.3. The Additional Roles Reimbursement Sum for any given year would be calculated as follows:

PCN's Additional Roles Reimbursement Sum = PCN's weighted population share X total national workforce funding

7.3 Ready reckoner

7.3.1. A ready reckoner is available to support PCNs to calculate their indicative Additional Roles Reimbursement Sum based on their PCN Contractor Weighted Population. Table 1[8] sets out the indicative Additional Roles Reimbursement Sum allocations for different PCN sizes from 2022/23 to 2023/24.

7.3.2. For 2022/23 the Additional Roles Reimbursement Sum will be calculated using £16.696 multiplied by the PCN Contractor Weighted Population as at 1 January 2022. The 2022/23 figures in Table 1 are calculated using £16.696 per PCN Contractor Weighted Population. The figures for both years are calculated using the formula in section 7.2 and the January 2022 national population of 61,499,657.

Table 1: Indicative Additional Roles Reimbursement Scheme Sum per PCN Contractor Weighted Population

	2022/23	2023/24
Total National Workforce funding	£1,026,747,000	£1,412,011,000
PCN size (weighted)		
15,000	250,400	344,400
20,000	333,900	459,200
25,000	417,400	574,000

[7] Contractor Weighted Population as defined in Annex A of the Statement of Financial Entitlements (SFE) taken as at 1 January of the financial year preceding. The SFE confirms that this is the number of patients arrived at by the Global Sum Allocation Formula.

[8] For illustrative purposes, both national population and PCN size have been fixed in table 1 to give an indicative view of the funding current PCN population sizes will attract in future as they grow, on average, in line with the growth in the national population. The figures in table 1 do not include any subsequent uplifts that may be agreed to the Agenda for Change pay rates on which the maximum reimbursable sum is based. Figures are therefore subject to change to take this into account in future.

30,000	500,900	688,800
40,000	667,800	918,400
50,000	834,800	1,148,000
80,000	1,335,600	1,836,800
100,000	1,669,500	2,296,000
150,000	2,504,300	3,443,900

7.4 Entitlements not taken up under the Additional Roles Reimbursement Scheme

7.4.1. The Additional Roles Reimbursement Sum funding is only available to fund additional PCN workforce in line with the rules of the scheme.

7.4.2. NHS England expects the funding under the Additional Roles Reimbursement Scheme to be used in full, on the terms set out in the Network Contract DES Specification and in this guidance, in each year of the scheme.

7.4.3. As set out in the Network Contract DES Specification, each PCN is required to complete a workforce plan which commissioners will use to inform their estimation of likely unclaimed Additional Roles Reimbursement Scheme funding. Following this, commissioners will be required to follow the process for redistributing any unclaimed Additional Roles funding in line with the requirements and process as set out in the Network Contract DES Specification.

7.4.4. Any unused funding in a given financial year cannot be carried forward into subsequent years, and a PCN's entitlement to that funding in that year will therefore be lost.

7.5 Principle of additionality and baselines

7.5.1. To receive the associated funding through the Additional Roles Reimbursement Scheme, a PCN must show that the staff delivering health services for whom reimbursement is being claimed are additional and comply with the "principle of additionality" as set out in sections 7.2 of the Network Contract DES Specification. The additionality rule serves both to protect pre-existing local investment in primary care (e.g. by commissioners), as well as to expand capacity. It is not possible for Core Network Practices or commissioners to stop funding staff identified in the baseline exercise on the grounds that these could instead be funded through PCN reimbursement.

7.5.2. Core Network Practices and commissioners will be required to maintain existing funding for baseline staff levels measured as at 31 March 2019 against six of the reimbursable roles – clinical pharmacists, social prescribing link workers, first contact physiotherapists, physician associates, pharmacy technicians, and paramedics. The two baselines established during 2019 are as follows (further detail on how the baselines were established is available in the 2019/20 Additional Roles Reimbursement Scheme Guidance):

a. A PCN baseline declared by the Core Network Practices of the PCN and agreed with the commissioner. It is comprised of the actual whole time equivalent (WTE) staff across these six reimbursable roles and funded by general practice as at 31 March 2019. The PCN baseline will be fixed until 31 March 2024.

b. A Clinical Commissioning Group (CCG) baseline declared by the CCG. It is comprised of the WTE patient facing or first contact time of staff across the six reimbursable roles deployed to support general practice or primary medical care services - either in a specific practice or in the wider community - funded[9] by the CCG as at 31 March 2019 (regardless of whether funded due to direct CCG employment or through a contract). Any admin, travel, triage or other time directly related to patient care is included in the WTE. The commissioner is required to maintain funding for these baseline posts and will be subject to audit. Commissioners will be obliged to continue to fund baseline posts and will be subject to audit. All commissioners have been fully funded for GP contract costs in their primary medical services allocations. CCG baseline posts will have no bearing on PCN additionality claims.

7.5.3. These baselines will be monitored at a national level in line with the *NHS Long Term Plan* commitment that resources for primary medical and community services will increase in real terms by 2023/24 and rise as a share of the overall NHS budget.

7.5.4. The purpose of the baseline is to provide a fixed reference point against which additionality claims should be assessed. Thus, changes to baseline numbers will not be permitted. However, in the rare circumstances that it becomes apparent at a later date that the baseline was incorrect, the PCN Clinical Director and CCG Accountable Officer (or equivalent in the Integrated Commissioning Board) should agree and sign a new declaration confirming that the revised baseline reflects a true position. The changes to the baseline should be reflected, where appropriate, in the next quarterly NWRS and commissioner six-monthly returns.

7.5.5. The PCN and CCG baselines are fixed for five years. PCN reimbursement claims under the Additional Roles Reimbursement Scheme will be assessed against the PCN baseline only.

7.5.6. Practices are required to maintain the declared PCN baseline in order to meet the additionality rules under the Network Contract DES Additional Roles Reimbursement Scheme. Reimbursement claims under the Scheme will be assessed against the PCN baseline only. It should generally be assessed for individual workforce groups, rather than the total number of staff in the PCN baseline in all six reimbursable roles. However, with agreement from the commissioner, a PCN will be able to substitute between clinical pharmacists, first contact physiotherapists, physician associates and paramedics within the practice-funded PCN baseline posts as outlined in section 7.2.4 of the Network Contract DES Specification.

[9] The six reimbursable roles funded include those directly employed by the CCG.

7.5.7. For the purposes of the Additional Roles Reimbursement Scheme claims, WTE is defined as 37.5 hours in line with Agenda for Change (AfC) Terms and Conditions, although this may vary for non-AfC posts. Where AfC does not apply, PCNs should calculate the relevant WTE according to the normal full-time hours for that role in the employing organisation with reimbursement being made on a pro-rata basis accordingly.

7.5.8. A PCN baseline will not be established for health and wellbeing coaches, care coordinators, dietitians, podiatrists, occupational therapists, nursing associates, trainee nursing associates, mental health practitioners (MHPs) or advanced practitioners. While the PCN baseline will not include these roles, the additionality principles will still apply. A PCN claiming reimbursement in respect of these roles does so on the basis that it is for additional staff engaged or employed since 31 March 2019, and that the reimbursement is not being used to subsidise practice-funded roles that existed as at 31 March 2019.

7.5.9. Local agreements for the provision of MHPs (Adult and/or Child and Young Person MHPs) to a PCN must be additional over and above any:

a. MHPs already employed by the secondary care provider of community mental health services to work as a member of, whether full-time or part-time, including on a rotational basis, a general practice or PCN's core multi-disciplinary team as at 31 January 2021; and
b. Improving Access to Psychological Therapies (IAPT) Practitioner already employed by the by the secondary care provider of community mental health services and working co-located within the relevant general practice as at 1 January 2021.

7.5.10. As set out in section 7.6.1 below, any clinical pharmacists who transferred to the PCN by either 31 March 2020 or transferred between 1 April 2021 to 30 September 2021, are exempt from the PCN baseline providing the post was included in the PCN baseline established on 31 March 2019. Similarly, as set out in section 7.6.2 any pharmacists (clinical pharmacists and pharmacy technicians) employed under the *Medicines Optimisation in Care Homes (MOCH) Scheme* who were included in the PCN baseline established on 31 March 2019 and who transferred by 30 September 2021 are exempt from the additionality rules.

7.5.11. Baseline posts occupied by fixed term appointed staff can be considered to be 'filled' only if they are part of a long-term arrangement, which must be in place for a minimum of six months or more. Equally, PCNs will only be eligible to claim reimbursement for additional posts to be occupied by staff on fixed-term contracts, if these are for a minimum period of six months or more, unless the purpose is to provide temporary cover (e.g. sickness or parental leave) for an individual employed through the Additional Roles Reimbursement Scheme. In these circumstances, PCNs will be able to claim up to the maximum reimbursement amount per WTE as set out in the Network Contract DES Specification for actual salary plus employer on-costs (NI and pension), pro-rata for the period of the contract of employment and relevant WTE.

7.5.12. The Additional Roles Reimbursement Scheme cannot distinguish between staff with different job descriptions e.g. a MSK physiotherapist is the same as

a non-MSK physiotherapist for the purposes of the baseline and additionality, so long as both roles have an element of patient-facing or first contact care time in specific practices or in the wider neighbourhood or community.

Changes to PCN baselines and staffing levels

7.5.13. It is expected that PCN staffing levels will change from time to time. PCNs will be required to notify commissioners at the earliest opportunity of any changes to staffing levels, which may affect the PCN's reimbursement entitlement. The mandatory online claim portal includes a section to notify commissioners of any changes.

7.5.14. The PCN should notify the commissioner that a member of staff who is in the PCN baseline or for which the PCN is claiming reimbursement will cease or has ceased to work for the PCN or (for PCN baseline roles) a Core Network Practice. Where possible, the PCN should notify the commissioner in advance of the member of staff's last day of employment (or the last day of the sub-contract where applicable) but no later than the last day of the calendar month in which the member of staff ceased to be employed/engaged.

7.5.15. Where a vacancy arises in a Core Network Practices' PCN baseline WTE, the PCN must apply an equivalent WTE reduction in their workforce funding under the Network Contract DES Additional Roles Reimbursement Scheme. This reduction will be applied from three months (a three-month grace period) after the date at which the vacancy arose and which resulted in the PCN baseline reduction. For example, if one WTE post becomes vacant in a PCN's baseline and is not recruited to within three months, the PCN must deduct one WTE from its reimbursement claim until such time as the PCN baseline vacancy is filled, in order to maintain the principle of reimbursement for additional workforce. Sections 7.2.3 and 10 of the Network Contract DES Specification provide further information.

7.6 Transfer of clinical pharmacists and pharmacy technicians

Transfer of clinical pharmacists from the Clinical Pharmacist in General Practice Scheme

7.6.1. Any clinical pharmacists who were in post as at 31 March 2019 under the *Clinical Pharmacist in General Practice Scheme* were required to transfer to the PCN by 31 March 2020 in order to be eligible for funding through the Additional Roles Reimbursement Scheme and to be exempt from the PCN baseline. A further opportunity was also then made available between 1 April 2021 and 30 September 2021 for any clinical pharmacists still employed under this scheme on 31 March 2021 to transfer and be eligible for funding through the Additional Roles Reimbursement Scheme. Practices are responsible for fully funding any clinical pharmacist posts which have not transferred after the tapering of the *Clinical Pharmacist in General Practice Scheme* funding.

Transfer of pharmacists from the Medicines Optimisation in Care Homes Scheme

7.6.2. For all pharmacists (clinical pharmacists and pharmacy technicians) employed under the *Medicines Optimisation in Care Homes (MOCH) Scheme*, transfer to the PCN must have taken place by no later than 31 March 2021. A further opportunity is available between 1 April 2021 and 30 September 2021 for any MOCH pharmacists still employed under this scheme on 31 March 2021 to transfer and be eligible for funding through the Additional Roles Reimbursement Scheme.

7.6.3. Where MOCH pharmacists do not transfer, commissioners are required to align the priorities of the CCG commissioned MOCH team to that of the Enhanced Health in Care Homes service requirements outlined in section 8.3 the Network Contract DES Specification.

7.7 Additional Roles Reimbursement Scheme claims process

7.7.1. Commissioners should ensure that any staff for which reimbursement is being claimed meet the requirements set out in section 10 of the Network Contract DES Specification.

7.7.2. PCNs must use the mandatory online claim portal for all workforce reimbursement claims under the Additional Roles Reimbursement Scheme, in accordance with sections 10.1, 10.2 and 10.5 of the Network Contract DES Specification. Commissioners may ask PCNs for further evidence to support new workforce reimbursement claims, which may include:

a. A signed contract of employment (can remove personal information where appropriate) clearly setting out the salary.
b. A contract/agreement with a provider for the provision of services.
c. A copy of a Network Agreement – if used as the basis for sub-contracting for services/staff.

7.7.3. In the event the practice(s) within the PCN decide to engage the services of staff reimbursable under the Additional Roles Reimbursement Scheme via a sub-contracting arrangement, the PCN will need to agree with the sub-contractor the relevant costs of the service while bearing in mind the scheme rules. The rules are that reimbursement can only be claimed for 100 per cent, or 50 per cent for mental health practitioners, of **actual salary plus employer on-costs (NI and pension)** up to the maximum amount for the relevant role, as outlined in the Network Contract DES Specification and within the PCNs overall Additional Roles Reimbursement Sum.

7.7.4. For social prescribing link workers engaged via a sub-contract to an organisation outside the PCN, and not directly employed, the reimbursement claim may include a contribution towards the additional costs charged by a sub-contractor for the delivery of social prescribing services. See section 10.1.11 below for details.

7.7.5. Commissioners should ensure that local processes are as straightforward as possible, with clear deadlines for submission of claims, and claims should be processed in a timely manner.

7.7.6. Reimbursement claims will be subject to validation and any suspicion that deliberate attempts have been made to subvert the additionality principles or

to claim costs above and beyond those allowable, will result in a referral for investigation as potential fraud. PCNs may be asked as part of the validation process to re-confirm the position regarding the number of filled baseline posts at the point a reimbursement claim is made. They may also be asked to provide copies of sub-contracting or Service Level Agreements where they are claiming for staff employed or supplied by a third party.

7.7.7. Reimbursement will apply up to the Additional Roles Reimbursement Scheme cap and applies to actual salary plus employer on-costs (NI and pension) only, not to additional hours or recruitment and retention premia agreed in addition.

7.7.8. Commissioners may claim back reimbursement monies where it becomes apparent that a PCN was not eligible to claim reimbursement under the Network Contract DES e.g. because it failed to declare a vacant baseline post.

8. Additional Roles Reimbursement Scheme Workforce

8.1. Additional Roles

8.1.1. A PCN may employ or engage any one or more of the reimbursable roles in accordance with the details set out in section 7 and section 10 of the Network Contract DES Specification. Annex B of the Network Contract DES Specification sets out the minimum role requirements for each of the reimbursable roles from April 2022 and the associated requirements placed on PCNs.

8.1.2. This section provides additional information to support that included in the Network Contract DES and supporting materials available.

8.2. Role descriptions and terms and conditions

8.2.1. Employers of staff recruited under the Additional Roles Reimbursement Scheme will determine what terms and conditions, including salary, they offer new staff and may consider using Agenda for Change bands as a guideline. In doing so, they should take a fair approach with regards to remuneration relative to other staff already working within and across the PCN GP member practices.

8.2.2. Employers will decide the job descriptions of their own staff, ensuring they incorporate the minimum role requirements outlined Annex B of the Network Contract DES Specification and bearing in mind the abilities for the roles to support delivery of network services.

8.2.3. Decisions to amend terms and conditions of employment for existing staff is a matter for the employer following due process.

8.3. Clinical pharmacists

8.3.1. A minimum of 0.5 WTE should apply to the clinical pharmacists employed via the Network Contract DES. This is to ensure the clinical pharmacist is able to

access timely national training and can deliver continuity of care whilst working across multiple providers within the PCN.

8.3.2. Clinical pharmacists being employed through the Network Contract DES funding will either be enrolled in or have qualified from an accredited training pathway that equips the pharmacist to be able to practise and prescribe safely and effectively in a primary care setting currently, the Clinical Pharmacist training pathway[10,11]) and in order to deliver the key responsibilities of the role. NHS England and NHS Improvement will be arranging a funding mechanism to allow all clinical pharmacists to access and complete an approved training pathway that equips the pharmacist to achieve this.

8.3.3. Upon completing the training pathway, the clinical pharmacist receives a 'Statement of Assessment and Progression' which details the learning undertaken and confirms the assessments they have passed. This documentation is available in both hardcopy and electronic format. In addition to this, evidence of training need for any current or future employer can be access through the protected section of the website of the learning provider, which captures the learning of the Clinical Pharmacists participating in their training.

8.3.4. This training requirement can be met with pre-existing qualifications / experience on the basis that it meets the learning objectives of the current approved training pathway funded by NHS England and NHS Improvement. The training will be modular and clinical pharmacists are only required to undertake the training they need to complete the portfolio requirements. This accreditation of prior learning should be undertaken by the supervising senior clinical pharmacist and Clinical Director for the PCN.

Supervision of Clinical Pharmacist

8.3.5. All clinical pharmacists will be part of a professional clinical network and will always be clinically supervised by a senior clinical pharmacist and GP clinical supervisor. The following supervision must be in place for senior clinical pharmacists and clinical pharmacists:

a. Each clinical pharmacist will receive a minimum of one supervision session per month by a senior clinical pharmacist[12];
b. The senior clinical pharmacist will receive a minimum of one supervision session every three months by a GP clinical supervisor; and
c. All clinical pharmacists will have access to an assigned GP clinical supervisor for support and development.

8.3.6. The ratio of senior to junior clinical pharmacists should be up to one to five, and in all cases appropriate peer support and supervision must be in place.

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[10] CPPE Clinical Pharmacists in General Practice Training Pathway https://www.cppe.ac.uk/career/clinical-pharmacists-in-general-practice-education#navTop

[11] CPPE Medicines Optimisation in Care Homes Training Pathway https://www.cppe.ac.uk/career/moch/moch-training-pathway#navTop

[12] This does not need to be a senior clinical pharmacist within the PCN but could be part of a wider local network, including from secondary care or another PCN.

8.3.7. Flexible and innovative approaches to the formation of clinical networks can be adopted and promoted to enhance collaboration/integration across healthcare interfaces.

8.4. MOCH pharmacists

8.4.1. Where any MOCH pharmacists remain, PCNs will be expected to make operational use of the pharmacist's experience in relation to Care Homes as outlined in section 9.3 below and section 8.3 of the Network Contract DES Specification. This will include:

a. supporting care homes with local policies and procedures, training, vaccinations and provide support for any challenges the home may have, including:
b. ordering and storage of medicines to reduce waste
c. supporting care planning and comprehensive geriatric assessments (CGA) structured medication reviews
d. link-in to community services, acute trusts and mental health services
e. supporting weekly care home rounds, working with the MDT
f. working with the wider MDT (including external organisations) to support the delivery of Enhanced Health in Care Homes.

8.5. Further guidance and supporting information

8.5.1. Supporting guidance providing further information to help PCNs employ or engage Social Prescribing Link Workers, Health and Wellbeing Coaches and Care Co-ordinators is available at:

a. Social prescribing link workers - https://www.england.nhs.uk/publication/social-prescribing-link-workers/
b. Health and Wellbeing Coaches - https://www.england.nhs.uk/publication/health-coaching-summary-guide-and-technical-annexes/
c. Personalised Care Institute - https://www.england.nhs.uk/personalisedcare/supporting-health-and-care-staff-to-deliver-personalised-care/personalised-care-institute/

8.5.2. PCNs employing or engaging one of the Allied Health Professionals must consider the qualifications, experience and capabilities when determining which job description is utilised for the role and considering the minimum role requirements set out in Annex B of the Network Contract DES Specification. Further information:
a. on capabilities is available at (while this document refers to the MSK framework, the capabilities have been written for all AHPs): https://www.csp.org.uk/system/files/musculoskeletal_framework2.pdf;
b. https://www.england.nhs.uk/ahp/ahps-in-primary-care-networks/.

8.5.3. Each AHP employed or engaged by a PCN must have access to appropriate clinical supervision and an appropriate named individual for general advice and support daily.

8.5.4. A number of supporting materials are available in the Primary Care Networks Development Support section of the FutureNHS Collaboration Platform.

8.5.5. During 2021/22, all Additional Roles will be made available for inclusion on Smartcards, to support accurate recording of Health Care Professional type in GP records. Further information will be provided in due course as to how these roles can be applied to Smartcards, for both new and existing employees.

9. Service requirements

9.1. Current Extended Hours Access service and future Enhanced Access

9.1.1. Section 8.1 of the Network Contract DES Specification sets out the requirements for:

a. delivery of the current extended hours access and undertaking the preparatory requirements for Enhanced Access from 1 April 2022 to 30 September 2022.
b. and delivery of Enhanced Access from 1 October 2022 onwards.

9.1.2. Where a practice has signed up to the Network Contract DES, it becomes contractually obliged to offer extended hours access, and from 1 October 2022 enhanced access, to its registered patients via the PCN (which can be delivered by the practice or sub-contracted). Therefore, all patients should have access to extended hours services from 1 April 2022, and then enhanced access services from October 2022, through the PCN, but it will be for the PCN to determine how that offer is made available to all its registered patients.

9.1.3. For extended hours access (until October 2022), the additional clinical appointments provided by a PCN are to be held at times that take account of patient's expressed preferences and are outside the hours that the PCN Core Network Practices' are required to provide as part of their primary medical services contracts. This means that if a Core Network Practice was required under a General Medical Services (GMS) contract to provide core services at its premises until 6:30pm, the additional clinical appointments could be provided after 6:30pm. If, however, another Core Network Practice in the PCN provided core services at its premises until 8pm, then:

a. any additional clinical appointments provided after 6:30pm but before 8pm must not be provided at the later closing practice's premises (as these would not be additional hours appointments) but could be provided at the other practice's premises; and
b. a proportion of the additional clinical appointments must be provided after 8pm.

9.1.4. For enhanced access (from October 2022), the Network Standard Hours will cover 6.30pm-8pm during the week. As above, where a Core Network Practice is required under a General Medical Services (GMS) contact to provide core services at its premises after 6.30pm, the patients of that

practice must also have access to enhanced access appointments, and the enhanced access appointments must be in addition to the appointments offered as part of that practice's core hours service offer.

9.1.5. Core Network Practices within a PCN are collectively responsible for the delivery of extended hours access and, from 1 October 2022, enhanced access. In the event the commissioner is not satisfied that a PCN is delivering the requirements in accordance with the Network Contract DES, then the commissioner may take action as set out in section 9 of the Network Contract DES Specification. If a commissioner determines to withhold payment[13], the amount withheld will be an appropriate proportion of the extended hours access payment or enhanced access payment and the Core PCN funding payment.

9.1.6. PCNs have the flexibility to sub-contract extended hours access or enhanced access services to other providers in accordance with any sub-contracting provisions of the GP practices' primary medical services contracts.

9.1.7. The delivery of extended hours access through the Network Contract DES will be in addition to any CCG commissioned extended access services.

9.1.8. In relation to enhanced access, the Specification sets out the minimum universal requirements for PCNs to deliver. It is expected that, where areas already have additional patient services in place locally, commissioners will make arrangements for these to continue (and any changes would be subject to local engagement). Where current levels of capacity or funding as provided under the CCG Extended Access Service at 30 September 2022 exceed the minimum requirements for Enhanced Access set out in the Network Contract DES Specification, commissioners will be expected to ensure that these capacity and funding levels under the CCG Extended Access Service are maintained going forward

Preparatory requirements for implementation of Enhanced Access and requirements for delivery

Preparatory requirements from 1 April 2022 – 30 September 2022

9.1.9. In preparation for Enhanced Access from October 2022, PCNs will be required to develop and agree with the commissioner an Enhanced Access Plan, in accordance with section 8 of the Network Contract DES Specification. PCNs and commissioners should consider what additional relevant information may be required to enable delivery of Enhanced Access. Further guidance will be provided.

9.1.10. PCNs and commissioners should be mindful of the following when developing and agreeing the Enhanced Access Plan:

[13] Payment withheld in this context would be an appropriate proportion of the payments in relation to both extended hours access and Core PCN funding payments.

a. general practice services offered during the Network Standard Hours should include planned care appointments such as vaccinations and immunisations, screening, health checks and PCN services, reflecting the demand and preferences of the PCN's patient population;
b. a PCN's minimum number of appointments per week may:
    i. be delivered concurrently where they exceed the Network Standard Hours; and/or
    ii. with agreement from the commissioner, a proportion may be delivered in continuous periods of at least 30 minutes outside of the Network Standard Hours to better meet the needs of the PCN's patients, for example, to:
        - provide appointments prior to 8am on weekday mornings or 9am on Saturday morning; or
        - provide appointments after 8.30pm on weekday evenings or 5.30pm on Saturday evenings;
c. A PCN's Core Network Practices will have the ability to manage their collective capacity and workforce flexibility across Network Standard Hours and practices' core hours to best meet the needs of their population. By exception, a PCN and commissioner may agree that a proportion of capacity can be used to support management of demand during core hours, where this is regularly high;
d. where a proportion of the minimum appointments are delivered outside of the Network Standard Hours, this does not mean that the Network Standard Hours may be reduced;

e. In reviewing the PCNs' Enhanced Access Plans, the commissioner will need to ensure they form part of a cohesive ICS approach.

9.1.11. The following are key dates for development and approval of the Enhanced Access plan:

a. 31 July 2022 – deadline for submission of draft Enhanced Access Plan to commissioner. The Enhanced Access plan must include the PCN's intentions in relation to the matters set out in section 8.1.15.b.i to 8.1.15.b.vi of the Network Contract DES Specification.
b. 1 August 2022 to 31 August 2022 – period of co-operation in which the PCN and commissioner must work together to agree the Enhanced Access Plan.
c. 31 August 2022 – deadline for commissioner to agree the final iteration of the Enhanced Access Plan.
d. 1 October 2022 – PCNs required to commence delivery of Enhanced Access.

9.1.12. A non-exhaustive list of what would be considered a significant change to the Enhanced Access Plan is included in section 8.1.15.e of the Network Contract DES Specification. In general, where the service changes would require engagement with the PCN's patients, then a PCN should seek input from the commissioner at an early stage to agree whether this would constitute a significant change and require the Enhanced Access Plan to be updated.

Delivery of Enhanced Access from 1 October 2022 onwards

9.1.13. PCNs will need to deliver their agreed Enhanced Access plan from 1 October 2022. The requirements for providing Enhanced Access are set out in the Network Contract DES Specification. A package of implementation guidance is available here and will be further updated before 1 October 2022.

9.1.14. In delivering the Enhanced Access requirements, PCNs should ensure that the mix of services available and workforce used to deliver enhanced access appointments is reflective of patient need, as informed by the patient engagement undertaken in the preparation stage (April – October 2022).

Delivery models for PCN Extended Hours Access and Enhanced Access appointments

9.1.15. It will be up to the PCN to determine the delivery model for extended hours access and enhanced access as part of the Network Agreement, but PCNs will need to ensure this service is offered to the entire PCN population. The exact model of delivery in each PCN may vary and could include:

a. All practices in the PCN continuing to offer extended hours access, and after 1 October 2022 enhanced access, to its own registered list.
b. One practice undertaking the majority of the extended hours access or enhanced access provision for the PCN's population, with other practices participating less frequently (but those practices' registered patients still having access to extended hours access or enhanced access at other sites).
c. One practice offering extended hours access or enhanced access to its own registered list and the other practices sub-contracting delivery for their respective patients.
d. The PCN subcontracting delivery as a whole or elements of the service to another provider for its collective population. A PCN may decide to sub-contract delivery of Enhanced Access and if doing so this must have due regard to the requirements set out in the statutory regulations or directions that underpin each Core Network Practice's primary medical services contracts in relation to sub-contracting, as set out in section 5.6 of the of the Network Contract DES Specification.

9.1.16. Irrespective of the delivery model, the PCN should ensure that all network patients have access to a comparable extended and enhanced access service offer. PCNs should ensure that any sub-contracting arrangements are in accordance with any sub-contracting provisions of the Core Network Practices' primary medical services contracts.

Funding for the Extended Hours Access and Enhanced Access in the Network Contract DES

9.1.17. The part- year funding under the Network Contract DES from 1 April 2022 to 30 September 2022 equates to £0.720 per registered patient On top of this payment of £0.720 per registered patient through the Network Contract DES, practices will receive within their global sum payments around £0.25 per patient to cover the expansion in delivery to 100 per cent of patients. Taken together, the two amounts would total a payment of approximately £0.97 (£0.720 plus £0.25) per registered patient over the course of 1 April 2022 –

30 September 2022 – and continue to receive the £0.50 per annum from October 2022 (i.e. the £0.25 balance of the £0.50 from October 2022 to March 2023 and approximately £0.50 per annum thereafter.

9.1.18. This funding is in addition to funding the practice may already receive from the CCG for delivering their commissioned extended access services between April 2022 to October 2022.

9.1.19. For Enhanced Access from 01 October 2022 to 31 March 2023, payments under the Network Contract DES will be made using PCN Adjusted Populations, which are based on the CCG Primary Medical Care weighted populations. The formula used to calculate these populations includes a 15% adjustment to recognise inequalities and unmet need, and the same Adjusted Populations are used for the calculation for the number of minutes which PCNs are required to provide in Enhanced Access (60 mins per 1000 population, based on the PCN Adjusted Population). The practice-level Adjusted Populations are available here.

9.1.20. PCNs can view their Enhanced Access funding here or in the GP contract ready reckoner.

9.1.21. The recurrent global sum payments as referenced in 9.1.17 will continue.

9.2. Medication Reviews and Medicines Optimisation

9.2.1. Further guidance related to the implementation and delivery of requirements relating to this service have been published[14]. The Network Contract DES Specification sets out that PCNs must have due regard to that separate guidance in delivery of the service requirements.

Recording of SMRs on GP IT systems

9.2.2. The relevant SMR codes must be used to record the occurrence of a SMR and follow up appointments. The relevant SMR codes are available in the supporting Business Rules[15].

Additional metrics and outcomes

9.2.3. PCN rates of prescription of high-carbon inhalers and medicines of low priority will be displayed in the Network Dashboard. Metrics on prescribing quality for anti-microbials and drugs that potentially cause dependency, as well as a wider patient outcome measurement, are being considered and will be informed by future developments, such as the implementation of Public Health England's (PHE) report into prescribed medicines[16]. Once finalised, measures of prescribing quality will be displayed on the new

[14] https://www.england.nhs.uk/publication/structured-medication-reviews-and-medicines-optimisation-2021-22/

[15] Network Contract DES related Business Rules are published by NHS Digital under the relevant years 'Enhanced Services, Vaccinations and Immunisations and Core Contract components' page.

[16] https://www.gov.uk/government/publications/prescribed-medicines-review-report

Network Dashboard. In the meantime, the Network Dashboard will link to existing data on prescribing rates of relevant drugs hosted by the NHS Business Services Authority (NHS BSA) and Open Prescribing. Further detail will be contained in the standalone guidance document.

9.3. Enhanced Health in Care Homes

Relationship of DES to Enhanced Health in Care Homes Framework

9.3.1. The Network Contract DES and requirements for relevant providers of community physical and mental health services within the NHS Standard Contract establish a consistent, national, model for the Enhanced Health in Care Homes (EHCH) service. Commissioners, PCNs and other providers should consider these requirements as a minimum standard. The Enhanced Health in Care Homes requirements remain of vital importance during the COVID-19 pandemic, to support the organisation and delivery of a coordinated service to care home residents, many of whom will be at very high risk of a severe negative impact (directly or indirectly) from COVID-19. Good practice is described in the EHCH Framework which will support implementation of a mature EHCH service.

Definition of Care Home

9.3.2. For the purposes of the EHCH service requirements in the Network Contract DES specification, a 'care home' is defined as a CQC-registered care home service, with or without nursing. Whether each home is included in the scope of the service will be determined by its registration with CQC. The CQC website contains a spreadsheet which can be filtered to show CQC registered care homes. This spreadsheet can be found here and is titled *CQC care directory – with filters* followed by the date of the latest update. Column C can be filtered to show CQC registered care homes. All care homes in this directory are in the scope of the EHCH service.

9.3.3. The EHCH service requirements apply equally to people who self-fund their care and to people whose care is funded by the NHS or their local authority. It is equally applicable to care homes for people with learning disabilities and/or mental health needs and should not be interpreted as only pertaining to care homes for older people. However, secure mental health units are not in scope.

Alignment of Care Homes to PCNs

9.3.4. Commissioners hold overall responsibility for ensuring that each care home is aligned to a single PCN, and this is an ongoing obligation. Commissioners must keep this alignment up to date. In instances after 31 July 2020 where there are changes in circumstance after the initial alignment decision was made - for example when new homes open, or if there is a change to the PCN such that one or more practices no longer participates in the Network Contract DES - the commissioner must have aligned a PCN to that home within three months of becoming aware of the alignment not being in place.

9.3.5. PCNs and commissioners are expected to take into account the following factors when considering which homes align with which PCNs:

a. Where the home is located in relation to PCNs and their constituent practices
b. The existing GP registration of people living in the home
c. What contracts are already held between commissioner and practices to provide support to the home, or directly between the home and practices
d. Existing relationships between care homes and practices.

9.3.6. PCNs that have care homes allocated to them must provide the EHCH service to those care homes.

Delivery plan with local partners

9.3.7. The plan for delivery of the EHCH service should include:

a. An agreement between the PCN, relevant providers of community services and mental health, the care home, the commissioner and other local partners on the operating model for the home round and MDT.
b. Clear roles and responsibilities for delivery of each EHCH requirement, including the ongoing provision of care described in the personalised care and support plan.
c. Agreed risks to the successful delivery of the EHCH service, with clear mitigating actions, owners and timescales for resolution.

Supporting re-registration of patients

9.3.8. In supporting patients to re-register with a practice in the aligned PCN, care homes, PCNs and commissioners must clearly communicate the benefits offered under the EHCH service, and ensure that the patient understands that they will not receive the service if they choose not to re-register. In instances where patients do not have the capacity to understand or make choices on re-registration, this discussion must take place with the person who has power of attorney over their affairs.

Further guidance

9.3.9. Guidance for implementation of the following service requirements - and other aspects of a mature EHCH service - can be found in the EHCH Framework:

a. establishment and operation of a MDT;
b. establishment of information sharing protocols; and
c. delivery of a weekly home round.

9.4. Early Cancer Diagnosis

9.4.1. Primary care has a vital role to play in system-wide improvement efforts to increase the proportion of cancers diagnosed early, supporting the NHS Long Term Plan ambition to diagnose 75% of cancers at stages 1 and 2 by 2028. The ECD service requirements for PCNs seek to improve referral practice and screening uptake through network level activity. Further guidance related to the implementation and delivery of requirements relating to the PCN service, including guidance on the appropriate

management of suspected cancer referrals during the COVID-19 pandemic, is available here.

9.5. Social prescribing service

9.5.1. A PCN must provide a social prescribing service to their collective patients.

9.5.2. This service can be provided by either directly employing Social Prescribing Link Workers or by sub-contracting the provision of the service to another provider. Regardless of which option a PCN chooses to deliver, the PCN should be employing or engaging at least some Social Prescribing Link Worker resource in accordance with section B3 of Annex B of the Network Contract DES Specification.

9.6. Cardiovascular Disease (CVD) Prevention and Diagnosis

9.6.1. CVD is the leading cause of death worldwide and is strongly associated with health inequalities (the most deprived quintile of the population is four times more likely to die from CVD than the least deprived). Hypertension is the most prevalent risk factor, and the focus of this service in 2021/22 which from April 2022, will be expanded to incorporate detection and management of atrial fibrillation (AF) and addressing cholesterol in the context of CVD risk, including detection and management of familial hypercholesterolaemia (FH).

9.6.2. Further guidance related to the implementation and delivery of requirements relating to this PCN service is available here.

9.7. Tackling Neighbourhood Health Inequalities (TNHI)

9.7.1. Since October 2021, PCNs have been required to improve delivery of annual learning disability health checks and action plans for patients over 14, improve recording of patients with a severe mental illness and delivery of comprehensive physical health checks, record the ethnicity of all PCN registered patients (where provided) and appoint a health inequalities lead for the PCN.

9.7.2. PCNs will have met further milestones in December 2021 and February 2022 to identify a population experiencing inequality in health provision and/or outcomes, agree with the commissioner an approach to engagement and tackling the unmet needs of the population, and from 1 March 2022 begin ongoing delivery of its planned intervention. This requirement continues through 2022/23.

9.7.3. Best practice guidance has been published to help inform and support implementation and delivery of these requirements is available here.

9.8. Anticipatory Care

9.8.1There are new requirements around Anticipatory Care for 2022/23. ICSs have lead responsibility for co-ordination of anticipatory care but PCNs will need to agree by 31 December 2022 a delivery plan, to begin in 2023/24. Full details are in the Network Contract DES Specification.

9.9. Personalised Care

9.9.1 There are new requirements around Personalised Care for 2022/23. PCNs must work with commissioners to improve their social prescribing programme and their use of shared decision making, and keep the effectiveness of those measures under review. Full details are in the Network Contract DES Specification

2. Financial entitlements, nominated payee and payment information

10.1. Financial entitlements

10.1.1. Financial entitlements under the Network Contract DES reflect a blended payment as set out in section 10 of the Network Contract DES Specification.

10.1.2. Table 2 provides a summary of the Network Contract DES financial entitlements payable to the PCNs nominated payee. All Network Contract DES payments are inclusive of VAT, where VAT is applicable.

Table 2: Summary of Network Contract DES financial entitlements

Payment details and allocation	Amount	Allocations	Payment timings
Core PCN funding	£1.50 per registered patient[17] per year (equating to £0.125 per patient per month).	CCG core programme allocations	Monthly by the last day of the month in which the payment applies and taking into account local payment arrangements.
Clinical Director contribution	£0.736 per registered patient[17] per year (equating to £0.061 per patient per month).	PMC allocations	Monthly by the last day of the month in which the payment applies and taking into account local payment arrangements.
Staff reimbursements	Actual salary plus employer on-costs (NI and pension) to the maximum per WTE[18] amounts[19] as outlined in	PMC allocations	Monthly in arrears by the last day of the month following the month in which the payment relates and taking into account local payment arrangements.

[17] Based on the patient numbers as at 1 January immediately preceding the financial year. For example, the 1 January 2021 patient figures are used for the 2021/22 financial year.

[18] WTE is usually 37.5 hours in line with Agenda for Change (AfC) Terms and Conditions, although this may vary for non-AfC posts. Where AfC does not apply, PCNs should calculate the relevant WTE according to the normal full-time hours for that role in the employing organisation with reimbursement being made on a pro-rata basis accordingly.

[19] The annual maximum amounts for 2021/22 as outlined in the Network Contract DES are to be pro-rated on the proportion of the year that an individual is in post.

Payment details and allocation	Amount	Allocations	Payment timings
	Network Contract DES Specification. For the London Region PCNs, inner and outer maximum reimbursable rates apply in accordance with the Network Contract DES Specification.		Payment claimable following start of employment.
Extended hours access from 1 April 2022 to 30 September 2022	£0.720 per registered patient[17] (equating to £0.120 per patient per month).	PMC allocations	Monthly by the last day of the month in which the payment applies and taking into account local payment arrangements.
Enhanced Access	The Enhanced Access payment for the period 01 October 2022 to 31 March 2023 is calculated as £3.764 multiplied by the PCN's Adjusted Population (equating to £0.627 per PCN Adjusted Population per month).	PMC allocations	Monthly by the last day of the month in which the payment applies and taking into account local payment arrangements
Care home premium	£120 per bed per year (equating to £10 per bed per month).	PMC allocations	Monthly by the last day of the month in which the payment applies and taking into account local payment arrangements.
Investment and Impact Fund (IIF)	Amount payable dependant on achievement.	PMC allocations	See paragraph 10.1.3 below
Leadership and management payment	£0.699 multiplied by PCN Adjusted Population[20] (equating to £0.058 per adjusted patient per month) where PCN Adjusted Population is based on the CCG primary medical care allocation.	PMC allocations	Monthly by the last day of the month in which the payment applies and taking into account local payment arrangements.

10.1.3. The details on how the IIF operates and associated payments can be found in Section 10.6 and Annexes C and D of the Network Contract DES Specification and the separate IIF guidance[21].

10.1.4. Payments due to the PCN nominated payee for Core PCN Funding, Clinical Director, Care Home Premium and Leadership and Management Payment will be payable in 12 equal monthly instalments and made by the commissioner no later than the last day of the month in which the payments apply and taking into account local payment arrangements. For a Previously Approved PCN with membership changes and a new proposed PCN, these

[20] The PCN Adjusted Population as at 1 January 2022.
[21] https://www.england.nhs.uk/publication/investment-and-impact-fund-2021-22-implementation-guidance/

payments will be made no later than the end of the month in which participation of all Core Network Practices of that PCN has been confirmed, taking into account local payment arrangements. Where an ODS Change Instruction Notice needs to be submitted, this must be by the last working day on or before the 14th day of any month and where it is submitted after this time, the change and payment will not take effect until the end of the following month.

10.1.5. Extended Hours Access payments will be payable in 6 equal monthly instalments from April to September 2022 and made by the commissioner no later than the last day of the month in which the payments apply and taking into account local payment arrangements.

Enhanced Hours Access payments will be payable in 6 equal monthly instalments from October 2022 to March 2023 and made by the commissioner no later than the last day of the month in which the payments apply and taking into account local payment arrangements.

10.1.6. Where the PCN is a Previously Approved PCN and the first payment is paid after April 2022, the first payment (except for Enhanced Access) will be backdated to include payments due from 1 April 2022. Where the PCN is a new proposed PCN after 1 April 2022, the PCN will only be entitled to receive payments for the months for which it delivers the requirements of the Network Contract DES. Refer to section 10.3 for further information on how payment calculations for 2022/23 will be managed.

10.1.7. The Core PCN Funding payment (ie the £1.50 per head payment) and all other Network Contract DES Payments – plus the Network Particiaption payment – will be payable from the commissioner's Primary Care Medical allocations from 2022.23. .

10.1.8. Additional Role Reimbursement Scheme payments will be made monthly in arrears following the start of employment or commencement of service provision. The nominated payee will be required to submit the relevant monthly claims using the online claim portal. Commissioners will make the relevant payments to the nominated payee no later than the last day of the month following the month to which the payment relates and taking into account local payment arrangements.

Network Participation Payment

10.1.9. In addition to the payments made to the PCN's nominated payee under the terms of the Network Contract DES, practices participating in the Network Contract DES will be entitled to the Network Participation Payment (NPP) - as set out in the General Medical Services Statement of Financial Entitlements and Network Contract DES Specification. This payment is £1.761 per weighted patient per year, equating to £0.147 per patient per month. The numbers of weighted patients are based on the Contractor Weighted Population taken as at quarter 4 immediately preceding the financial year (i.e. at 1 January in the preceding financial year). For example, the 2022/23 contractor weighted population figure will be that for quarter 4 in the 2022/23 financial year i.e. at 1 January 2022.

10.1.10. The NPP will be paid monthly in arrears on or before the last day of the month following the month in which the payment relates (i.e. payment for April will be made on or before the end of May). Where a practice is a Core Network Practice of a Previously Approved PCN and the first payment is paid after April 2022, the first payment will be backdated to include payments due from 1 April 2022. Where a practice is a Core Network Practice of a new proposed PCN after 1 April 2022, the practice will only be entitled to receive the NPP for the months for which it is actively participating in the Network Contract DES. Refer to section 10.3 below for further information on how payment calculations for 2022/23 will be managed.

Sub-contracted social prescribing service

10.1.11. For Social Prescribing Services sub-contracted by a PCN to another provider, PCN may claim a contribution towards additional costs charged by the sub-contracted provider. A PCN may claim a contribution of up to £200 per month (£2,400 per year) for each WTE that the sub-contracted provider has apportioned to the PCN related activity. The overall contribution claimed cannot exceed £200 per month, the total amount claimed must not exceed the maximum reimbursable amount for a social prescribing link worker and must be within the PCN's Additional Roles Reimbursement Sum. PCNs may wish to ensure that any sub-contracting agreement explicitly states the relevant costs (or WTE equivalent) as a copy may be requested by commissioners as evidence to support a reimbursement claim.

10.2. Network Contract DES nominated payee

10.2.1. The following paragraphs in the Network Contract DES Specification set out the factual points regarding who can hold the Network Contract DES and be the nominated payee:

a. Paragraph 2.2.10 – "the "**Nominated Payee**" refers to a practice or organisation (which must hold a primary medical services contract) that receives payment of the applicable financial entitlement set out in this Network Contract DES Specification."
b. Paragraph 10.1.1 – "A practice participating in the Network Contract DES acknowledges that payments made under the Network Contract DES are dependent on the Core Network Practices of a PCN working together to deliver the requirements of this Network Contract DES."
c. Paragraph 10.1.6 – "The commissioner must ensure that payments due to a PCN set out in this Network Contract DES are made into the bank account of the Nominated Payee. The PCN must inform the commissioner of the relevant payment details of its Nominated Payee. The PCN will include in the Network Agreement the details of arrangements with the Nominated Payee and may indicate the basis on which the Nominated Payee receives the payments on behalf of the other practices, e.g. as an agent or trustee."

10.2.2. The nominated payee must be party to the PCN's Network Agreement. This is because the Network Agreement forms the legal agreement between the constitute members of the PCN. It will set out how the PCN has agreed to

use the DES funding to support delivery and how the PCN has agreed the funding will be apportioned between the members within the PCN.

10.2.3. Unlike the requirements over who can hold the Network Contract DES, the nominated payee does not have to hold a registered list and be delivering an essential primary medical services contract. The nominated payee must, however, hold a primary medical services contract and be party to the Network Agreement.

10.2.4. An APMS provider (including a provider who holds a hybrid NHS Standard Contract that is delivering primary medical care services under a Schedule 2L arrangement) can therefore be a nominated payee, even if they do not hold the Network Contract DES. As such, it is possible that a GP Federation holding an APMS contract for extended access or improved access (or another reason), could be nominated as the payee if all the Core Network Practices of the PCN agree. It also means that the same GP Federation could be nominated to be the payee for more than one PCN.

10.2.5. There are a few considerations that PCNs and commissioners should be mindful of in nominating a non-GP Practice APMS provider (i.e. a provider who does not hold the APMS contract for delivery of essential primary medical care services). See section 10.3.11 below.

10.3. Network Contract DES Payments

Manual payment arrangements

10.3.1. The Care Home Premium, Additional Roles Reimbursement Scheme and Leadership & Management payments will continue to be processed manually by commissioners and not be calculated automatically via CQRS. These PCN payments are to be made to the nominated payee in accordance with section 10 of the Network Contract DES Specification and using the relevant national subjective and other finance system codes outlined in section 10.3.10 below, as follows:

a. where the nominated payee is a GP practice setup Primary Care Support England (PCSE) Online, the commissioner will be required to process payments via a manual variation to NHAIS; OR
b. where the nominated payee is a non-GP practice APMS provider the commissioner will be required to make local payment arrangements.

10.3.2. For new proposed PCNs approved after 1 April 2022, the PCN will only be entitled to receive the monthly payments for the months it delivers the service requirements of the Network Contract DES. Similarly, the NPP will only be payable to a Core Network Practice of a new proposed PCN for the months they deliver the requirements of the Network Contract DES.

10.3.3. The PCN's nominated payee will be required to sign up and submit the monthly claims via Tradeshift https://www.sbs.nhs.uk/supplier-einvoicing. NHS England are working in partnership with NHS SBS to eliminate paper invoices and deliver e-invoicing via Tradeshift. Tradeshift allows registered users to easily upload their own invoices direct to the web-based portal at www.tradeshift.com offering immediate access to submit and track invoices.

If you have any queries please email SBS-W.e-invoicingqueries@nhs.net or, for more information, visit http://tradeshift.com/supplier/nhs-sbs.

Automated payment arrangements through CQRS

10.3.4. Four payment calculations – the Core PCN Funding, Clinical Director, Extended Hours Access and NPP are **automated** via the CQRS. Apart from the NPP, these PCN payments are to be processed as follows:

a. For GP practice nominated payees – the payment file will be processed directly from CQRS to PCSE Online.
b. For non-GP practice APMS provider nominated payees - commissioners will be required to make manual payments, using the payment calculation information supplied by CQRS – details to be confirmed on how this will be provided. The payments are to be made to the nominated payee, using the relevant national subjective and other finance system codes (see 10.3.10 below) using local payment arrangements.

10.3.5. The NPP will be processed directly from CQRS to PCSE Online as with any other practice related payments. Practices will need to ensure that they validate the payment in CQRS before it proceeds for validation by the commissioner.

10.3.6. CQRS will calculate these four payments using the PCN ODS reference data towards the end of each month. Commissioners should ensure that any changes to the PCN ODS reference data are submitted using the PCN ODS Change Instruction Notice[22] by the last working day on or before the 14th day of each month, so as to ensure the changes take effect prior to the CQRS payment calculation date. In the event a PCN ODS Change Instruction Notice is completed after the 14th day of a month, then changes will not take effect until the subsequent month and the commissioner may be required to follow a manual exception process (i.e. manual payment reconciliation) to ensure the correct payment are made.

10.3.7. Commissioners will need to ensure the NPP and PCN payments within CQRS are all validate through the two approval steps.

Additional payment information

10.3.8. A PCN is required to use the national mandatory online claim portal for all workforce claims. This claim form is to be completed and submitted on a monthly basis in accordance with the instructions from the commissioner. Commissioners are to inform PCNs as soon as possible where claim forms should be returned to. As of 1 April 2021, the portal will be the only way to claim reimbursement under the Additional Roles Reimbursement Scheme.

Any nominated payee

[22] The PCN ODS Change Instruction Notice is available here.

10.3.9. Work is being undertaken to support the introduction of 'any nominated payee'. This is to allow for a non-GP provider to be a PCN's nominated payee and/or for a separate bank account to be link to the PCN ODS code. Further information will be made available in due course.

National subjective and finance system codes for Network Contract DES

10.3.10. Table 3 sets out the relevant subject and finance system codes that commissioners will be required to use to support all payments under the 2022/23 Network Contract DES.

Table 3: National subjective and finance system codes for Network Contract DES payments

Payments	Paycode	APMS/ GMS/ PMS	Paycode Description	Subjective code
Network Participation Payment	PARTIA	A	C&M-APMS *PCN DES Participation*	521610XO
	PARTIG	G	C&M-GMS *PCN DES Participation*	521610XW
	PARTIP	P	C&M-PMS *PCN DES Participation*	521610YD
Core PCN funding	PCNSUA	A	C&M-APMS *PCN DES PCN support*	521610ZE
	PCNSUG	G	C&M-GMS *PCN DES PCN Support*	521610ZI
	PCNSUP	P	C&M-PMS *PCN DES PCN Support*	521610ZL
Clinical Director contribution (population-based payments)	CLINDA	A	C&M-APMS PCN DES Clinical Director	521610YE
	CLINDG	G	C&M-GMS PCN DES Clinical Director	521610YI
	CLINDP	P	C&M-PMS PCN DES Clinical Director	521610YN
Staff reimbursements	CPHARA	A	C&M-APMS *PCN DES Clin Pharmacist*	521610UD
	CPHARG	G	C&M-GMS *PCN DES Clin Pharmacist*	521610UE
	CPHARP	P	C&M-PMS *PCN DES Clin Pharmacist*	521610UO
	SPRESA	A	C&M-APMS *PCN DES Soc Prescribing*	521610VD
	SPRESG	G	C&M-GMS *PCN DES Soc Prescribing*	521610VE
	SPRESP	P	C&M-PMS *PCN DES Soc Prescribing*	521610VI
	PHYSIA	A	C&M-APMS *PCN DES Physiotherapist*	521610VO
	PHYSIG	G	C&M-GMS *PCN DES Physiotherapist*	521610WD
	PHYSIP	P	C&M-PMS *PCN DES Physiotherapist*	521610WE
	PASSOA	A	C&M-APMS *PCN DES*	521610WI

Payments	Paycode	APMS/ GMS/ PMS	Paycode Description	Subjective code
			Physician Assoc	
	PASSOG	G	C&M-GMS *PCN DES Physician Assoc*	521610WO
	PASSOP	P	C&M-PMS *PCN DES Physician Assoc*	521610XA
	DIETIA	A	*C&M-APMS PCN DES Dieticians*	5216108A
	DIETIG	G	*C&M-GMS PCN DES Dieticians*	
	DIETIP	P	*C&M-PMS PCN DES Dieticians*	
	PHARTA	A	*C&M-APMS PCN DES Pharmacy technicians*	5216108B
	PHARTG	G	*C&M-GMS PCN DES Pharmacy technicians*	
	PHARTP	P	*C&M-PMS PCN DES Pharmacy technicians*	
	PODIAA	A	*C&M-APMS PCN DES Podiatrist*	5216108C
	PODIAG	G	*C&M-GMS PCN DES Podiatrist*	
	PODIAP	P	*C&M-PMS PCN DES Podiatrist*	
	OCCTHA	A	*C&M-APMS PCN DES Occupational Therapists*	5216108D
	OCCTHG	G	*C&M-GMS PCN DES Occupational Therapists*	
	OCCTHP	P	*C&M-PMS PCN DES Occupational Therapists*	
	HWELLA	A	*C&M-APMS PCN DES Health and Wellbeing Coach*	5216108E
	HWELLG	G	*C&M-GMS PCN DES Health and Wellbeing Coach*	
	HWELLP	P	*C&M-PMS PCN DES Health and Wellbeing Coach*	
	CARECA	A	*C&M-APMS PCN DES Care Coordinator*	5216108F
	CARECG	G	*C&M-GMS PCN DES Care Coordinator*	
	CARECP	P	*C&M-PMS PCN DES Care Coordinator*	
	HOMRRA	A	*C&M-APMS PCN DES Home/RR paramedic*	521610XD
	HOMRRG	G	*C&M-GMS PCN DES Home/RR paramedic*	521610XE
	HOMRRP	P	*C&M-PMS PCN DES Home/RR paramedic*	521610XI
	NURSAA	A	*C&M-APMS PCN DES Nursing Associate*	5216108L
	NURSAG	G	*C&M-GMS PCN DES Nursing Associate*	
	NURSAP	P	*C&M-PMS PCN DES Nursing Associate*	
	TNURSA	A	*C&M-APMS PCN DES Trainee Nursing Associate*	5216108M
	TNURSG	G	*C&M-GMS PCN DES Trainee Nursing Associate*	
	TNURSP	P	*C&M-PMS PCN DES Trainee Nursing Associate*	

Payments	Paycode	APMS/ GMS/ PMS	Paycode Description	Subjective code
	CPHAPA	A	*C&M-APMS PCN DES Clinical Pharmacist Advanced Practitioner*	5216107S
	CPHAPG	G	*C&M-GMS PCN DES Clinical Pharmacist Advanced Practitioner*	
	CPHAPP	P	*C&M-PMS PCN DES Clinical Pharmacist Advanced Practitioner*	
	PHYAPA	A	*C&M-APMS PCN DES Physiotherapist Advanced Practitioner*	5216107T
	PHYAPG	G	*C&M-GMS PCN DES Physiotherapist Advanced Practitioner*	
	PHYAPP	P	*C&M-PMS PCN DES Physiotherapist Advanced Practitioner*	
	DIEAPA	A	*C&M-APMS PCN DES Dietician Advanced Practitioner*	5216107U
	DIEAPG	G	*C&M-GMS PCN DES Dietician Advanced Practitioner*	
	DIEAPP	P	*C&M-PMS PCN DES Dietician Advanced Practitioner*	
	PODAPA	A	*C&M-APMS PCN DES Podiatrist Advanced Practitioner*	5216107V
	PODAPG	G	*C&M-GMS PCN DES Podiatrist Advanced Practitioner*	
	PODAPP	P	*C&M-PMS PCN DES Podiatrist Advanced Practitioner*	
	OCTAPA	A	*C&M-APMS PCN DES Occupational Therapist Advanced Practitioner*	5216107W
	OCTAPG	G	*C&M-GMS PCN DES Occupational Therapist Advanced Practitioner*	
	OCTAPP	P	*C&M-PMS PCN DES Occupational Therapist Advanced Practitioner*	
	PARAPA	A	*C&M-APMS PCN DES Paramedic Advanced Practitioner*	5216107X
	PARAPG	G	*C&M-GMS PCN DES Paramedic Advanced Practitioner*	
	PARAPP	P	*C&M-PMS PCN DES Paramedic Advanced Practitioner*	
	ADMHPA	A	*C&M-APMS PCN DES Adult Mental Health Practitioner*	5216107Y
	ADMHPG	G	*C&M-GMS PCN DES Adult Mental Health Practitioner*	
	ADMHPP	P	*C&M-PMS PCN DES Adult Mental Health Practitioner*	
	CYPMHA	A	*C&M-APMS PCN DES CYP Mental Health Practitioner*	5216107Z
	CYPMHG	G	*C&M-GMS PCN DES CYP Mental Health Practitioner*	
	CYPMHP	P	*C&M-PMS PCN DES CYP Mental Health Practitioner*	

Payments	Paycode	APMS/ GMS/ PMS	Paycode Description	Subjective code
Care home premium	CHOMPA	A	*C&M-APMS PCN DES Care Home Premium*	5216108G
	CHOMPG	G	*C&M-GMS PCN DES Care Home Premium*	
	CHOMPP	P	*C&M-PMS PCN DES Care Home Premium*	
Extended hours access	EXTHDA	A	*C&M-APMS Extended Hours Access DES (APMS)*	521610UN
	EXTHDG	G	*C&M-GMS Extended Hours Access DES (GMS)*	521610V8
	EXTHDP	P	*C&M-PMS Extended Hours Access DES (PMS)*	521610VW
Enhanced Access		A	*C&M-NCD Enhanced Access*	521610B9
IIF Aspiration Payment	IIFASA	A	*C&M-APMS IIF Aspiration*	5216108H
	IIFASG	G	*C&M-GMS IIF Aspiration*	
	IIFASP	P	*C&M-PMS IIF Aspiration*	
IIF Achievement Payment	IIFACA	A	*C&M-APMS IIF Achievement*	5216108I
	IIFACG	G	*C&M-GMS IIF Achievement*	
	IIFACP	P	*C&M-PMS IIF Achievement*	
Leadership and management payment	LEADPA	A	*APMS PCN DES Leadership Payment*	52161418
	LEADPG	G	*GMS PCN DES Leadership Payment*	52161419
	LEADPP	P	*PMS PCN DES Leadership Payment*	52161420

Payment considerations

10.3.11. The following sets out a number of considerations for commissioners and networks with regards to who is nominated the payee and how payments will be processed:

a. The nominated payee must be party to the Network Agreement (this could mean party to more than one Network Agreement if it is a GP Federation).
b. As outlined above non-GP Practice APMS providers are not currently setup within NHAIS (also known as Exeter) and as such, this system (and its subsequent replacement) cannot be used to process the payments. In 2022/23, commissioners will therefore need to put in place local payment arrangements to make payments to a non-GP Practice APMS provider.
c. APMS contracts are time limited. In the event a non-GP practice APMS provider acting as a nominated payee no longer holds an APMS contract, then the nominated payee will need to be changed to be a provider who holds a primary medical services contract. In this circumstance, the PCN would also need to update their Network Agreement accordingly.
d. There are VAT considerations for the PCN if the APMS provider (e.g. GP Federation) charges any commission for their services in being the nominated payee. These charges would not be reimbursed by commissioners and would remain a liability for the PCN to manage.

Further information on VAT is available in the Network Contract DES and VAT Information Note.

3. Frequently Asked Questions

11.1. A set of Frequently Asked Questions for the Network Contract DES has been published by NHS England and NHS Improvement and will be updated periodically throughout the year.

NHS England and NHS Improvement
www.england.nhs.uk

Classification: Official
Publication approval reference: B1357

To:
- GP practices
- Primary Care Networks
- CCGs:
  - clinical leads
  - accountable officers

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

31 March 2022

Dear Colleagues,

Primary care networks: network contract directed enhanced service from April 2022

Explanatory note

1. NHS England and NHS Improvement (NHSEI) has today published the revised Network Contract Directed Enhanced Service (DES) which takes effect from 1 April 2022. This implements the arrangements set out in the letter of 1 March 2022 for *General Practice contract arrangements in 2022/23*.

2. As the letter sets out, our priority for this year is to maintain stability and limit change for general practice, whilst bolstering investment for the workforce and leadership, supporting our communities to recover, and ensuring patients continue to receive timely, high quality care. The vast majority of the proposals are not new and build on the five-year contractual framework, *Investment and Evolution*, agreed with the BMA's General Practice Committee England (GPC England) in January 2019.

3. The amended DES introduces changes to the following areas, as set out in detail below.

The Additional Roles Reimbursement Scheme

4. The amount available under the 2022/23 Network Contract DES for PCNs to recruit additional staff under the Additional Roles Reimbursement Scheme (ARRS) increases by £280 million to just over £1 billion. PCNs will continue to have flexibility to hire into any of 15 different roles.

5. From April 2022, where agreed between the PCN and the local Community Mental Health Provider, PCNs may be reimbursed for a further Mental Health Practitioner roles (or a further two for PCNs with a population of over 100k) to

support people with complex mental health needs, that can be employed on a 50:50 shared reimbursement model.

Leadership and Management

6. The PCN Clinical Director funding for 2022/23 has been agreed as £0.736 per head or £44 million nationally as part of the five-year deal. The updated 2022/23 DES includes by a further £43 million for a Leadership & Management payment. With the £1.50 per head core PCN funding, there is a total of £178 million available for PCNs and their Clinical Directors to support core running, leadership and management in 2022/23.

Enhanced Access

7. The updated 2022/23 DES reflects the agreement from the 2019 deal and subsequent contract updates to combine the two funding streams currently supporting extended access to fund a single, combined and nationally consistent access offer with updated requirements, to be delivered by PCNs. This brings together the current £1.44 per head Network Contract DES extended hours funding and the current £6 per head CCG-commissioned extended access services. The funding will be paid to PCNs on the basis of the PCN adjusted population, and PCNs may check their funding via the updated 2022/23 GP contract ready reckoner and here.

8. The updated DES sets out the new Enhanced Access arrangements, which aim to remove variability across the country and improve patient understanding of the service. The new offer is based on PCNs providing bookable appointments outside core hours within the Enhanced Access period of 6.30pm-8pm weekday evenings and 9am-5pm on Saturdays, utilising the full multi-disciplinary team, and offering a range of general practice services, including 'routine' services such as screening, vaccinations and health checks, in line with patient preference and need. PCNs will be able to provide a proportion of Enhanced Access outside of these hours, for example early morning or on a Sunday, where this is in line with patient need locally and it is agreed with the commissioner.

9. PCNs will continue to deliver the current extended hours access arrangements from April 2022 until October 2022, at which point the new enhanced access service will begin. PCNs will need to undertake the preparatory requirements from April 2022, as set out in the updated 2022/23 DES specification.

PCN services

10. As set out in August 2021 in our plans for 2022/23, the updated 2022/23 DES includes a limited expansion of the Cardiovascular Disease Prevention and Diagnosis service.

11. The 2022/23 DES includes changes to the Early Cancer Diagnosis service requirements, which have been streamlined and refocussed in response to clinicians' feedback and to focus PCNs on national diagnosis priorities arising from evidence around lower than expected referral rates for prostate cancer.

12. The updated 2022/23 DES also sets out the requirements for the phased introduction of the Anticipatory Care and Personalised Care services. To note, there have been two amendments from the plans published in August 2021.For Anticipatory Care, PCNs now have until December 2022 to develop their anticipatory care plans, with the ICS led Anticipatory Care service starting in 2023/24. For Personalised Care, PCNs now have until 31 March 2024 to implement digitally enabled personalised care and support planning for care home residents.

13. The updated 2022/23 DES includes three new Investment and Impact Fund (IIF) indicators, which are focused on Direct Oral Anticoagulants (DOAC) prescribing and FIT testing for cancer referrals. These changes will help to ensure that a greater number of patients with Atrial Fibrillation receive anticoagulation therapy where clinically appropriate and that more patients with suspected lower gastrointestinal cancer will have their two week wait referral accompanied by a FIT test result.

14. Funding for these indicators amounts to £34.6 million and is in addition to the existing £225 million funding envelope for the scheme.

15. Updated supporting guidance documents are available on our website.

Participation

16. Practices already signed up in 2021/22 will automatically participate in the updated 2022/23 DES. This means that PCNs with no changes to their membership or information do not need to submit any sign-up information to their CCG to continue to participate. PCNs with changes must notify the commissioner by 30 April 2022 to seek approval of those changes.

17. If a practice wishes to sign up to, or opt out of, the DES, it must inform its clinical commissioning group (CCG) by 30 April 2022.The CCG will work with the remaining practices in the PCN to consider the consequences, including whether the PCN remains viable. Similarly, if a practice wishes to opt into the DES, it must inform its CCG by 30 April 2022 in accordance with the process set out in the DES Specification and Guidance.

NHS England and NHS Improvement

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Network contract directed enhanced service

Frequently asked questions 2022/23

Version 1, 31 March 2022

1 Contents

1. Introduction

The Network Contract Directed Enhanced Service (DES) was introduced during 2019 and will remain in place until at least 31 March 2024. For 2022/23, the Network Contract DES Directions come into force on 1 April 2022 and the requirements on practices and Primary Care Networks (PCNs), as outlined in the Network Contract DES specification, will apply from that date.

This document provides a number of frequently asked questions (FAQs), providing additional information to PCNs and commissioners. It will be updated periodically throughout the year and does not take precedence over the Network Contract DES Specification.

2. General FAQs

2.1 Where can I find the relevant Network Contract DES documents?

The Network Contract DES documents can be found at the following links:

a. Network Contract DES Specification: PCN Requirements and Entitlements 2022/23
b. Network Contract DES Guidance for 2022/23 in England
c. Network Contract DES Participation and Notification of Change Form
d. Network Contract DES Additional Roles Reimbursement Scheme Claims Portal
e. Network Contract DES Network Agreement and Schedules
f. Data Sharing and Data Processing Agreements
g. Investment and Impact Fund Guidance 2022/23
h. Framework for Enhanced Health in Care Homes
i. Early Cancer Diagnosis Guidance
j. Structured Medication Reviews and Medicines Optimisation Guidance
k. Cardiovascular Disease (CVD) Prevention and Diagnosis Supplementary Guidance
l. Personalised Care Guidance
m. Anticipatory Care Guidance
n. Workforce planning template 2022/23 will be available here when published.

In addition to the above documents, practices and commissioners should be aware of the cover note published alongside the above documents.

2.2 Once a practice has agreed to participate in the Network Contract DES for 2022/23, can they then later opt out?

After 30 April 2022, a core network practice cannot end its participation in the Network Contract DES except as set out in section 4.9.7 of the Network Contract DES Specification, namely in situations where this is as a result of:

a. expiry or termination of the core network practices primary medical services contract
b. an irreparable breakdown in relationships or an expulsion
c. commissioner consent due to merger or split of a core network practice
d. commissioner determination that the core network practice's participation in the Network Contract DES should cease.

A core network practice may opt out of participating in the Network Contract DES in accordance with sections 4.9.4, 4.9.5 and 4.9.6 respectively of the Network Contract DES Specification.

2.3 Can the core network practice membership of a PCN change during the year?

In most circumstances, the core network practices of a PCN are expected to remain constant throughout the year following their participation in the Network Contract DES having been approved by the commissioner. However, PCN membership may change during the year due to either:

- exceptional circumstances within which the PCN's core network practice membership may need to change after 31 May 2022 participation deadline

or

- a newly formed practice joins a PCN.

The exceptional circumstances are summarised in question 2.2 above and full details are included in sections 6.4, 6.5, 6.6, 6.7, 6.8, 6.9 and 9 respectively of the Network Contract DES Specification. Section 4.5 of the Network Contract DES specification provides further information for a new practice joining a PCN.

2.4 The Network Contract DES Specification states that core network practices will be auto-enrolled into a subsequent year's Network Contract DES or an in-year variation. What does this mean?

A practice participating in the Network Contract DES for 2022/23 will automatically participate in any subsequent year's Network Contract DES and any variation that may take place in-year prior to the 31 March 2023, unless it opts out in accordance with section 4.9 of the Network Contract DES Specification. This means that unless a practice chooses to opt out of the subsequent Network Contract DES or in-year variation during the relevant period, they will be auto-enrolled into the updated Network Contract DES.

2.5 Can PCNs merge at any point during the year?

Full details of the process for two or more PCNs to merge is set out in Section 6.9 of the Network Contract DES Specification.

2.6 Where there is a PCN split that leaves one PCN with a population of below 30k, what options are available to commissioners?

Section 6 of the Network Contract DES Specification sets out the requirements in this situation and, where the remaining practices in the PCN do not then meet the minimum PCN criteria set out in section 5 (and a population of 30k would not meet the minimum criteria unless allowed for rurality reasons), then the PCN cannot be confirmed by the commissioner and the Core Network Practices would need to join another PCN(s) to continue to be signed up to the Network Contract DES.. Commissioners should offer support to local discussions about membership changes. PCNs will need to ensure that they are following any relevant arrangements as set out in their Network Agreement.

2.7 Are PCNs able to form limited companies and what are the implications for commissioners?

Any decisions about the legal entity or form of a PCN and the potential implications for that form is a matter for the PCN and local commissioners and where appropriate they should seek independent advice on how best to proceed.

2.8 Is there a definition of what a 'practicing clinician' is in relation to the clinical director role? Can a locum be a clinical director?

The clinical director should be a practicing clinician from one of the PCN's core network practices, working regularly within the PCN (regardless of whether the clinician is directly employed, self-employed or engaged via a sub-contracting arrangement) and be able to undertake the responsibilities of the role, representing the PCN's collective interests.

Locums would not provide the oversight and continuity that a clinical director needs to be able to deliver the role requirements of a clinical director, as set out in the Network Contract DES Specification for 2021/22. See section 5.3. of the Network Contract DES Specification for further information.

2.9 Where Clinical Directors are approaching the end of the term set out in the Network Agreement, and wish to remain in position, will this need to go to member practices for re-election?

Section 5.6.4 of the Network Contract DES Guidance sets out the process for appointment of the clinical director and as such it is at the discretion of the PCN, subject to the appointment details set out in Schedule 1 of the Network Agreement, whether they would choose to rotate that position or leave it with the incumbent.

2.10 How should specialist services, such as those for homeless populations and those providing special allocation schemes, link to PCNs?

We would want patients who receive such services to be able to access the services that PCN's are required to provide including the new workforce arrangements. We recognise that some pragmatism at local levels may be required to enable this to take place.

3. Additional Roles Reimbursement Scheme (ARRS)

3.1 General

3.1.1 What is considered to be whole time equivalent (WTE)?

WTE is usually 37.5 hours in line with Agenda for Change (A4C) terms and conditions, although this may vary for non-A4C posts. Where A4C does not apply, PCNs should calculate the relevant WTE according to the normal full-time hours for that role in the employing organisation.

PCNs should note that the maximum reimbursable amounts per role under the Network Contract DES are based on WTE being 37.5 hours per week. As such, the reimbursement claimed would need to be pro-rata according to the hours worked and for the proportion of the year that the individual was in post.

3.1.2 Do PCNs have to recruit a specific number of each of the roles each year from their Additional Roles Reimbursement Sum?

PCNs do not have to recruit a fixed or expected number of staff in specific roles. It is up to PCNs to decide the mix of workforce they require from the reimbursable roles under the ARRS to support delivery of the Network Contract DES requirements.

3.1.3 Can PCNs claim reimbursement for additional hours above the usual WTE hours worked?

A PCN may use its Additional Roles Reimbursement sum to reimburse additional hours worked by PCN staff. This can be done at plain time rates only, and the increase in WTE hours must be clearly recorded by the PCN on the online claim portal and on the National Workforce Reporting System.

3.1.4 Can PCN staff employed via the Additional Roles Reimbursement Scheme (ARRS) continue to support the COVID-19 vaccination programme between April 2022 and September 2022 (phase 4)?

Yes, PCN staff employed via the ARRS may continue to support the COVID-19 vaccination programme between April and September 2022 and remain eligible for reimbursement. However, this is only on the basis that they are doing so alongside their ARRS role and continue to deliver the requirements for their role as set out in Annex B of the Network Contract DES. For the avoidance of doubt, this means that any ARRS staff may not be fully or wholly deployed to work within a COVID-19 vaccination clinic and remain eligible for reimbursement.

3.1.5 Has an uplift been applied to the ARRS?

The maximum reimbursement rates for each role under the ARRS of the Network Contract DES remain the same as for the period October 2021- March 2022, and if any uplift to Agenda for Change (AfC) is confirmed, this will be applied to the ARRS rates mid year 2022.

This change does not affect the overall value of a PCN's ARRS sum. The ARRS rates are based on a weighted average of the Agenda for Change pay scale. While the Network Contract DES sets out the rules for reimbursement, a PCN will need to determine what the actual salaries are for their additional roles. The overall value of the ARRS in 2022/23 is in excess of £1billion.

3.1.6 Can commissioners waive the 0.5 WTE minimum for clinical pharmacists?

No, the 0.5 WTE for clinical pharmacists is a requirement and PCNs are unable to use the funding to pay for posts recruited to at less than 0.5 WTE.

3.1.7 A core network practice is recruiting a pharmacist who is enrolled on the training pathway. Can the pharmacist continue on the training pathway if the role they are taking is practice-based, rather than PCN-based?

In order to be on the pathway, it is a requirement that the enrolled pharmacist is working at PCN level (rather than at practice level), therefore in this instance they would no longer be eligible for the pathway.

3.1.8 Can PCNs sub-contract a remote clinical pharmacy service under the ARRS clinical pharmacist role? Are there any considerations to using a remote clinical pharmacy service?

A PCN wishing to use an agency or alternative provider to access clinical pharmacist services under the ARRS, needs to ensure that the role outline set out in Annex B of the Network Contract DES Specification is being delivered and that the clinical pharmacists meet the qualification requirements.

Whether the employment or service arrangement includes remote delivery or not, all aspects of the role outline must be delivered by the role or under the service arrangement to be eligible for reimbursement through the ARRS. This would include (but not be limited to):

- working as part of a PCN multidisciplinary team in a patient facing role to clinically assess and treat patients
- developing relationships and working closely with other pharmacy professionals across PCNs and the wider health and social care system
- maintaining a leadership role in supporting further integration of general practice within the wider healthcare teams

- be responsible for the care management of patients with chronic diseases and offering continuity of service.

A consistent approach to the clinical pharmacist(s) working with the PCN through a service agreement would be expected, with clinical pharmacist(s) working with the PCN's existing MDT to ensure they can consistently support and complement the existing workforce. For example, service provision by a different individual every shift would not fulfil the requirements listed above. The Network Contract DES requires clinical pharmacists employed or engaged through the Additional Roles Reimbursement Scheme to be for a minimum of 0.5 WTE.

Additionally, whether or not an arrangement is through direct employment or service arrangement, it must be intended for a minimum of six months. Therefore, a 'pay as you go' arrangement would not be eligible for reimbursement.

The commissioner and PCN must therefore be assured that all requirements of the Network Contract DES are being met in full for a remote service arrangement to be eligible for reimbursement. Commissioners should make an assessment on an individual basis as to whether the service is delivering the full Network Contract DES requirements, rather than the employment model. Where the requirements of the Network Contract DES are not met, commissioners can withhold the ARRS payments for the relevant role.

3.1.9 Can staff be self employed and still be claimed for via the ARRS?

As set out in Section 5.6 of the Network Contract DES Specification, PCNs are able to either engage or employ roles to deliver PCN services as part of the Additional Roles Reimbursement Scheme (ARRS). Therefore, the PCN would be allowed to engage any appropriate role on a self-employed basis via a provision of service agreement, subject to any applicable off-payroll working rules. To ensure long-term stability for the PCN and its patients, Section 7.4 of the same document specifies that all ARRS roles must be recruited for a minimum of six months, unless the purpose is to provide temporary cover (e.g. sickness or parental leave). This applies whether the roles are directly employed or engaged via a service contract from a third party. In order to be eligible for reimbursement under the Network Contract DES, the PCN must submit the claim for the role though the Additional Roles Reimbursement Scheme claim form, and record it on NWRS. Claims are only eligible for reimbursement through the ARRS if the individual is able to meet

the requirements set out in the appropriate role outline of the Network Contract DES Specification and meet all appropriate training and qualification criteria.

3.1.10 Can PCNs employ staff as apprentices to one of the identified roles and claim for these roles under the Additional Roles Reimbursement Scheme?

Apprenticeships aren't included for any roles under the Additional Roles Reimbursement Scheme and these would need to be funded wholly by the practice/PCN should you wish to employ such a role. Only those roles set out in the Network Contract DES Specification are eligible for reimbursement under the Additional Roles Reimbursement Scheme.

3.1.11 Can PCNs employ staff using zero hours contracts and claim for these via the Additional Roles Reimbursement Scheme?

For any staff employed or engaged via the Additional Roles Reimbursement Scheme, the PCN must ensure that all aspects of the role outline (Annex B- Minimum Role Requirements) are delivered. Moreover, a consistent approach to the role working with the PCN would be expected, with that person working with the PCN's existing MDT to ensure they can consistently support and complement the existing workforce. Additionally, whether or not an arrangement is through direct employment or service arrangement, it must be intended for a minimum of six months. Therefore, a "pay as you go", which on the face of it a "zero hours" arrangement would fall under, would not be eligible for reimbursement.

The commissioner and PCN must therefore be assured that the requirements of the Network Contract DES are being met in full for a role to be eligible for reimbursement.

3.1.12 Is London Weighting (High Cost Area Supplement) available on the ARRS?

The ARRS includes specific maximum reimbursement rates for PCNs in inner London and outer London (fringe is not included), and updates have been made to the online claims portal accordingly. Please refer to section 10.5.3 of the Network Contract DES Specification for details of the inner and outer London maximum reimbursable rates.

3.1.13 Do the mental health practitioners have to be employed by the local secondary care provider of mental health services to be eligible for reimbursement, or can they be a neighbouring provider or another provider like MIND?

The mental health practitioners must be employed by the secondary care provider of community mental health services that covers the PCN geography. This is so that they can provide the necessary links and facilitate access to specialist mental health services where this is clinically appropriate. A local MIND, or similar organisation, would therefore not be an appropriate employing organisation for practitioner roles under ARRS and would render a PCN ineligible to receive reimbursement under ARRS.

3.1.14 Can a PCN employ or engage their own mental health practitioners under ARRS, in addition to those employed and provided by the community mental health provider?

No. To be eligible for reimbursement under ARRS the staff must be employed by the secondary care provider of community mental health services covering the PCN's geography.

3.1.15 Can PCN additional roles be partners in a core network practice, and if so, can the PCN claim reimbursement through ARRS?

The Network Contract DES does not prevent PCN staff from being a partner in a practice. However, the PCN would only be eligible for reimbursement under ARRS for the relevant hours worked in their PCN role (ie undertaking the role responsibilities outlined in the relevant section of Annex B of the Network Contract DES Specification).

Any hours worked on any other duties not related to their PCN role, including those related to their partnership duties, are not eligible for reimbursement and must be covered/paid out with of the DES arrangement. As such, the claim for reimbursement through ARRS will need to be pro-rata to the relevant WTE hours the individual spends working in their PCN role and delivering the requirements outlined in the DES.

3.2 Baseline and additionality

3.2.1 How are staff roles that were vacant at the time the baseline was taken to be accounted for? Were they included in the baseline?

The baseline should only have recorded those posts that had staff in post, with a signed contract of employment, as at 31 March 2019. As such, any posts that were vacant as at 31 March 2019 should not have been included in either the PCN or clinical commissioning group (CCG) baselines.

3.2.2 The Network Contract DES Guidance states that commissioners are expected to continue to fund CCG baseline posts. Does this apply to the CCG-funded posts on the National Clinical Pharmacist in General Practice Scheme and Medicines Optimisation in Care Homes Scheme, where these staff have transferred to PCNs?

No. This is the only exception and commissioners will not be required to continue to fund clinical pharmacist or pharmacy technician posts on the national schemes that have transferred to PCNs.

3.2.3 How will changes to PCN core network practice membership be taken into account in relation to the PCN baseline?

The core network practices in a PCN should agree with the commissioner how the PCN workforce baseline should be amended to reflect a practice joining or leaving the PCN. If a practice is moving to a different PCN, a proportion of the baseline may be transferred to the new PCN's baseline. Any changes should be reflected in National Workforce Reporting Service and CCG six-monthly returns.

3.3 Reimbursement claims

3.3.1 Once the PCN has provided evidence of a contract of employment, and the PCN is being reimbursed, can the reimbursement be setup as a recurrent monthly payment rather than the PCN claiming each month?

PCNs will need to claim on a monthly basis for all staff recruited or engaged via ARRS using the national online claim portal.

3.3.2 Is the reimbursement, once claimed, guaranteed?

Once claimed, PCNs will be entitled to continue to receive reimbursement on an ongoing basis as part of their Additional Roles Reimbursement Sum so long as they

continue to meet the requirements set out as part of the Network Contract DES, which will exist until at least 31 March 2024.

As set out in Investment and Evolution: Update to the GP contract agreement 2020/21 – 2023/24, staff employed or engaged through ARRS will be considered as part of the core general practice cost base beyond 2023/24.

3.3.3 What happens if a member of reimbursed staff goes on parental or sickness leave, can the PCN continue to claim their reimbursement?

There is no automatic right within ARRS for additional funding to cover sickness and parental leave. However, the PCN would continue to be reimbursed during parental and sick leave, in line with the relevant employment contract provisions (ie as salary is reduced as appropriate then the level of reimbursement also would be reduced), as they have employment costs associated with this absence and it is then up to the PCN as to whether they employ temporary cover or not.

This may be an additional expense on top of the employer's responsibility to pay for parental and sickness absence, but the PCN would only be able to claim for the WTE that was 'absent'.

As set out in the section 7.4.1 of the Network Contract DES Specification and section 7.5 of the Network Contract DES Guidance, if a PCN has available funding within their Additional Roles Reimbursement Sum, they may claim reimbursement for a temporary contract (including funding below six months if necessary) if this is to enable provision of cover for sickness or parental leave.

Additionally, as set out in section 7.5.8 of the Network Contract DES Specification, whether a bidding practice has a member of staff on paid leave, eg sickness or parental, is a criterion in the process for redistributing any Additional Roles Reimbursement Funding, if applicable. (ie a PCN may submit a bid for redistributed ARRS funding where this is available to cover parental or sickness leave.)

For clinical pharmacists, it is not possible to offer temporary staff access to the NHS England and NHS Improvement commissioned training pathway or independent prescribing training. As such, PCNs will need to ensure the clinical pharmacist providing the cover has completed the required training.

3.3.4 How are sickness and parental leave, including any claims for temporary cover, to be made via the mandatory electronic online portal?

A PCN will continue to claim the relevant reimbursement amounts via the online portal for the duration of parental and sickness leave. This claim must be in line with the relevant employment contract provisions, reducing accordingly as the salary is reduced and taking into account any statutory maternity pay (SMP) where applicable. Where a PCN is not paying any sickness or parental leave (with the latter where applicable being over and above SMP), then no claim will be submitted for that role for the duration that sickness and parental payments are not made.

Where a PCN has employed or engaged cover for the duration of sickness or parental leave, then the reimbursement must be claimed in accordance with the terms set out in the Network Contract DES Specification. This claim must also be made from within the PCNs Additional Roles Reimbursement Sum, unless it relates to the use of redistributed funding as set out in section 7.5.8 of the Network Contract DES Specification. A PCN will add the role into the electronic online portal as a new line within the relevant months, using a new unique identifier and ensuring it is also recorded in the National Workforce Reporting Service (NWRS).

3.3.5 The funding figures given state maximum values for the staff grading. If a PCN employs someone at the tail-end of the financial year, can they claim the full year reimbursement value (if that cost has actually been incurred), or is the annual figure a total of a maximum monthly reimbursement figure?

The maximum reimbursement amount is to apply on a pro-rata basis on the proportion of the year that an individual is in post ie the annual figure would equate to a monthly maximum reimbursement amount for 1 WTE (37.5 hours under the DES).

3.3.6 The guidance states that the CCG baseline will have no bearing on PCN additionality claims. Is this correct?

Yes, that is correct. CCGs are expected to maintain their baseline funding levels and PCN reimbursement claims are only assessed against the PCN baseline.

3.3.7 What happens to reimbursement if a role within the PCN baseline becomes vacant?

When a vacancy occurs within one of the reimbursable roles in the PCN baseline, this has eligibility implications for claims being made under ARRS, regardless of

who (eg which core network practice) employs the vacant post within the PCN baseline.

In such circumstances, after the three months' grace period of the post becoming vacant, the PCN would not be eligible to claim for one of the same roles (to that of the vacancy) through ARRS, until such time as the vacant post is refilled. This is due to the PCN no longer meeting the additionality rules outlined in the Network Contract DES specification.

By way of an example: if a clinical pharmacist role becomes vacant in the PCN baseline and is not filled within three months, the PCN would not be eligible to claim for one clinical pharmacist under ARRS, until such time as the vacancy is filled. In the interim, the PCN would need to agree how the PCN clinical pharmacist for which funding cannot be claimed will be resourced.

3.3.8 Can the PCN claim reimbursement for a proportion of a 1 WTE for the reimbursable roles to allow the individuals to work across multiple settings eg the PCN and a CCG?

Yes, this is permitted within the rules of the scheme, although PCNs will only be able to claim reimbursement for the proportion of time the individual or service is being provided to the PCN.

With regards to clinical pharmacists, a minimum of 0.5 WTE applies to clinical pharmacists employed or engaged via the Network Contract DES so as to ensure the clinical pharmacist is able to access timely national training and can deliver continuity of care while working across multiple providers within the PCN.

Providing that each individual clinical pharmacist works a minimum of 0.5 WTE then the PCN(s) can claim the relevant WTE reimbursement in accordance with the Network Contract DES. As such, if a single clinical pharmacist is working across multi-PCNs then they must in total work a minimum of 0.5 WTE.

3.3.9 Do all roles reimbursed via ARRS have to fulfil all of the requirements set out in the Network Contract DES Specification for the role?

Any staff reimbursed under ARRS must meet the full requirements set out in the Network Contract DES Specification

3.3.10 How do CCGs transfer claims forms submitted via the portal to finance teams for payment?

At present the portal does not allow approved PCN claim forms to be sent direct to finance teams. In the interim until this process is set up, the Primary Care Workforce team must send the raw approved PCN data to the CCG approver on the first and third week of the month. Please note however, these dates are provisional and could vary depending on workload and priorities within the team.

4. Financial entitlements and payment arrangements

4.1 Where can I find information on the Network Contract DES financial entitlements and payment arrangements?

Section 10 of the Network Contract DES Specification and section 10 of the Network Contract DES Guidance provide details of financial entitlements and payment arrangements in 2022/23.

4.2 What providers can be the nominated payee for a PCN?

A PCN's nominated payee must hold a primary medical services contract and be party to the PCN's Network Agreement. This includes providers who hold an APMS contract as part of a hybrid NHS Standard Contract Schedule 2L arrangement.

The PCN's core network practices must all agree who the nominated payee is, and commissioners must ensure the nominated payee information is included in the PCN ODS data.

4.3 Can a GP Federation who holds an APMS contract for out-of-hours or improved access be a PCN's nominated payee?

Yes, providing the GP Federation holds an APMS contract and all PCN core network practices agree. The same applies if the GP Federation's APMS contract is part of a hybrid NHS Standard Contract Schedule 2L arrangement.

In nominating a GP Federation, PCNs should be mindful that:

- The GP Federation will need to be party to the Network Agreement and the Network Agreement will need to clearly set out the agreement on the financial arrangements.

- In 2022/23 payments will not be able to be made via PCSE Online, if the nominated payee is not setup in this system (this is most likely the case for any GP Federation). GP Federations, who are the nominated payee, will need to invoice for payment using the Tradeshift process (see section 10.3 of the Network Contract DES Guidance).
- In the event a GP Federation no longer holds an APMS contract then the nominated payee would need to be changed to be a provider who holds a primary medical services contract.
- In the event a GP Federation charges a commission to the PCN, there may be VAT considerations and these charges will not be reimbursed by the commissioner.

Commissioners should be mindful that:

- Payments must be made to the single nominated payee and the nominated payee must always hold a primary medical services contract.
- In 2022/23, commissioners will be required to make payments to the non-GP providers using local payment arrangements.
- Commissioners will be required to use the relevant national subjective and other finance system codes and provide any information as required to support national reporting of primary medical services expenditure.
- Commissioners will need to ensure relevant financial reporting information is provided to NHS England and NHS Improvement to monitor spend against the Network Contract DES – specifically where payments are not being made via NHAIS or PCSE Online.

4.4 Some PCNs would prefer for the Network Contract DES payments to be made into a newly established separate PCN bank account rather than the GP practice nominated payee's bank account. Is this allowed?

Commissioners are required to make payments into the bank account of a nominated GP practice as setup within PCSE Online. This is because any GP practices who are nominated as the payee must be paid via PCSE Online and commissioners cannot make alternative local payment arrangements.

4.5 Will Network Contract DES payments be automated?

Section 10.3 of the Network Contract DES Guidance provides details of when and which payments will be automated via the Calculating Quality Reporting Service (CQRS). In summary:

a. Network Contract DES payments will be a mixture of manual and automated payment calculations and processing. The Care Home Premium and ARRS payments will continue to be processed manually by commissioners and not be calculated automatically via CQRS.

   The following four payment calculations – Core PCN Funding, clinical director, Extended Hours Access and NPP – will be automated via CQRS and processed either directly or manually, depending on who the nominated payee is.

   Except for the NPP – which will be processed automatically to participating practices – the three PCN payments are to be processed as follows:

   i. for GP provider nominated payees who are setup in PCSE Online – the payment file will be **processed directly from CQRS** PCSE Online.

   ii. for non-GP APMS provider nominated payees – **commissioners will be required to make manual payments**, using the payment calculation information supplied by CQRS. The payments are to be made to the nominated payee, using the relevant national subjective and other finance system codes using local payment arrangements.

   The NPP will be processed directly from CQRS to PCSE Online as with any other practice related payments.

b. Details of payment calculations for the Investment and Impact (IIF) Fund are available in section 10 and Annex C of the Network Contract DES Specification.

4.6 How will the three PCN payments automated via CQRS link the core network practices in a PCN and when will these calculations be made each month?

CQRS will use the PCN organisational data service (ODS) information on practice to PCN relationships to aid calculating payments of the core PCN funding, extended hours access and clinical director. These calculations will be undertaken towards the end of each month, proceeding the month in which the payment is due.

Commissioners must therefore ensure any changes to the ODS information that will impact payments is correct in accordance with section 5.3 of the Network Contract DES Guidance.

4.7 How will the automated payment calculations be adjusted if there are changes to a PCN's core network practice membership in-year?

Commissioners should ensure that any changes to the PCN ODS reference data are submitted using the PCN ODS Change Instruction Notice.[1] This form must be submitted by the last working day on or before the 28th day of each month proceeding when the calculation is undertaken, so as to ensure the changes take effect prior to the CQRS payment calculation date.

In the event a PCN ODS Change Instruction Notice is completed after the last working day on or before the 28th day of a month, then changes will not take effect until the subsequent month. The commissioner may then be required to follow a manual exception process (ie manual payment reconciliation) to ensure the correct payment is made.

4.8 What are Commissioners required to do to ensure that ODS codes are accurate and up to date?

Commissioners (as set out in section 5.3 of the Network Contract DES Guidance) are required to check the ODS information via one of the options outlined on the following page https://digital.nhs.uk/services/organisation-data-service/primary-care-networks---publication-of-organisational-data-service-ods-codes (see section titled 'Where to find the PCN ODS code and information).

Any further queries on accessing the ODS data should be directed to exeter.helpdesk@nhs.net.

[1] The PCN ODS Change Instruction Notice is available here.

4.9 How do PCNs sign up to receive notifications and alerts through CQRS?

To receive notifications or have this facility set up (where it has previously not been setup), please email support@cqrs.co.uk who will be able to provide assistance.

4.10 How can commissioners update registered list sizes for PCN payments in CQRS during the year if enacting their discretion under paragraph 5.13.3 of the Network Contract DES?

Commissioners can make a request to the CQRS helpdesk at support@cqrs.co.uk to request a change to the list size.

4.11 Will the Network Participation Payment – due to individual practices – be an automatic payment in the same way as the Global Sum payments?

The Network Participation Payment will be automated via CQRS - see question 4.5. In the event a practice no longer participates in the Network Contract DES, then the payments would need to be stopped.

4.12 Some of the Network Contract DES pay codes are split between GMS, PMS and APMS. As these payments will be paid to the PCN's nominated payee and not individual practices, which of the codes should commissioners make payments against?

Some of the earlier pay codes to support the Network Contract DES had subjective codes split between contract type. Where this is the case, commissioners are required to code according to the type of contract held by the nominated payee, in order for NHAIS validations to function correctly.

From 2020/21 onwards, the pay codes to support Network Contract DES payments are established against the same subjective regardless of contract type, except for the Leadership and Management payment. See Table 3 in section 10 of the Network Contract DES Guidance.

4.13 Do PCNs have to use the national Additional Roles Reimbursement Scheme Portal Claim Form?

Yes, PCNs are required to use the mandatory online claim portal to submit reimbursement claims under ARRS.

4.14 What level of verification is required for ARRS claims?

PCNs will be required to make monthly claims for payment once the staff member is in post or the service sub-contract has started. Claims must only be for 'additional' staff as outlined in the Network Contract DES Specification and commissioners will need to ensure the claims meet the additionality principles. PCNs must inform commissioners of any changes to the employment or sub-contract that would result in payments changing or ceasing.

Commissioners are able to request information or evidence to validate claims and these may include, but are not limited to, a:

- signed contract of employment (can remove personal information where appropriate, except for the name of the clinical pharmacist which is required to evidence training requirements are met) clearly setting out the salary
- contract or agreement with a provider for the provision of services
- copy of a Network Agreement – if used as the basis for sub-contracting for services or staff.

5. Network Contract DES service requirements

5.1 Enhanced Health in Care Homes

5.1.1 What is a care home under the Network Contract DES, and which homes are in and out of the scope of the service?

For the EHCH requirements, a 'care home' is defined as a Care Quality Commission (CQC) registered care home service, with or without nursing. Whether each home is included in the scope of the service will be determined by its registration with CQC, which can be found in the CQC's 'care home directory with filters', which is updated monthly here. All CQC-registered care homes with or without nursing are in the scope of the service.

5.1.2 If the list of CQC registered care homes contains services that have not been delivered to before, is there an expectation that these homes are now covered under the Network Contract DES?

For the purposes of the EHCH service requirements in the Network Contract DES specification, a 'care home' is defined as a CQC-registered care home service, with

or without nursing. Whether each home is included in the scope of the service will be determined by its registration with CQC. All care homes in this directory are in the scope of the EHCH service, although a PCN and commissioner may agree that certain 'care home' registered beds are outside of the scope of the EHCH service – for example a registers.

The EHCH service requirements apply equally to people who self-fund their care and to people whose care is funded by the NHS or their local authority. It is equally applicable to care homes for people with learning disabilities and/or mental health needs and should not be interpreted as only pertaining to care homes for older people. However, secure mental health units are not in scope. This scope also applies to the payment of the care homes premium.

5.1.3 What are the requirements regarding registration where care homes are in a different area to the resident's GP Practice and where patients do not wish to register with the practice in a different area?

Under the EHCH service in the DES, each care home should be aligned to a single PCN, with residents supported to re-register with practices in that PCN. Patients may choose not to re-register. In supporting patients to re-register with a practice in the aligned PCN, care homes, PCNs and commissioners must clearly communicate the benefits offered under the EHCH service, and ensure that the patient understands that they will not receive the service if they choose not to re-register.

If a patient chooses not to remain registered with a practice, that practice should not refuse this choice. Further guidance on implementation of the EHCH service is available here

5.1.4 Can a PCN allow a practice from another PCN to provide the Network Contract DES requirements for a care home in their geographical boundary? Or to sub-contract to the local secondary care provider/clinical hub?

Under the EHCH requirements in the Network Contract DES, each care home is aligned to a single PCN, with the residents of that home supported to register with practices in the aligned PCN. Patients will not receive the service if they choose not to re-register.

Commissioners hold responsibility for ensuring that every home in their geographical boundary, as defined by CQC, was aligned to a single PCN by 31 July 2020 and to review this as required where there are PCN changes. Given this

requirement, this scenario is not relevant. PCNs can sub-contract requirements if they wish, but would have to meet any costs associated with that sub-contracting.

5.1.5 What is the care home premium?

The care home premium describes a payment that PCNs are entitled to, to support delivery of the EHCH service to patients in care homes. PCNs will be paid £120 per bed per year on a recurrent basis for beds within care homes that they are aligned to.

Funding for the care home premium is included in CCG primary medical care allocations. The funding level has been based on CQC data on registered care home beds in England and will be payable to PCNs in accordance with section 10.4 of the Network Contract DES Specification once commissioners have agreed:

a. the alignment of care homes to PCNs

b. that PCNs have appropriately and comprehensively coded residents in care homes using the SNOMED codes available for this.

5.2 Structured medication reviews (SMRs)

5.2.1 Who can undertake SMRs?

SMRs can be undertaken by appropriately trained clinicians. PCNs must ensure that only appropriately trained clinicians working within their sphere of competence should undertake SMRs. These professionals will need to have a prescribing qualification and advanced assessment and history taking skills, or be enrolled in a current training pathway to develop these skills and should be able to take a holistic view of a patient's medication.

Although it is expected that SMRs would be conducted primarily by a clinical pharmacist, they may also be conducted by suitably qualified advanced nurse practitioners who also meet the above criteria, as well as GPs.

Specifically, pharmacists must have completed – or at least be enrolled on – the Primary Care Pharmacy Educational Pathway (PCPEP) or a similar 18-month training programme that includes independent prescribing. However, we recognise there are a number of clinical pharmacists who have the necessary skills and experience to undertake SMRs but have not been completed or enrolled on an approved training pathway (eg PCPEP). The Centre for Pharmacy Postgraduate

Education (CPPE) has developed an exemption and equivalence process to recognise the experience and training, and such clinical pharmacists should only undertake SMRs having completed that recognition process.

It is required that any advanced nurse practitioners who undertake SMRs are experienced in working in a generalist setting and able to take a holistic view of all of the patient's medicines. A SMR is not considered complete until qualified consideration has been given to all of the patient's medication, while involving the patient in decisions about their medicines. Clinicians should be encouraged to collaborate with colleagues across the PCN and elsewhere, including acute care and take a multidisciplinary approach to managing complex situations.

In situations where prescribing is particularly complex (eg mental health or end of life) PCN clinicians undertaking SMRs should establish professional relationships and engage proactively with specialist pharmacists, consultants and other health professionals working across the local healthcare system.

5.2.2 Can SMRs be carried out by clinical pharmacists employed by other organisations?

Yes, SMRs can be carried out by clinical pharmacists employed by other organisations (eg NHS trusts) that support PCNs. See question 5.4.1 for further relevant information.

5.2.3 Can suitably qualified pharmacy technicians complete SMRs on behalf of the PCN?

No, pharmacy technicians cannot undertake a SMR. They can, however, support other appropriately trained clinicians, as part of the PCNs multi-professional team, in the SMR process. PCNs must ensure that only appropriately trained clinicians working within their sphere of competence undertake SMRs. See question 5.4.1 for further relevant information.

5.2.4 Should SMRs be conducted with ALL the patients mentioned in the specified groups and in what timescale this should be achieved?

SMRs should be offered to all patients identified and prioritised within the groups listed in the DES service requirements, using appropriate tools. However, the service requirements also state that the actual number of SMRs offered by a PCN will be determined and limited by its clinical pharmacist capacity, as long as that PCN demonstrates all reasonable on-going efforts to maximise that capacity.

5.2.5 Do PCNs now have to offer SMRs to patients on any opioid, gabapentinoid; benzodiazepine, or z-drug?

SMRs should be offered to all patients identified and prioritised within the groups listed in the DES service requirements, using appropriate tools. This explicitly includes patients on any opioid, gabapentinoid; benzodiazepine; or z-drug.

5.2.6 How long should each SMR take, along with preparation time?

We advise that SMRs are complex interventions that will naturally take longer than traditional medication reviews depending on the complexity of the patient and should vary in line with the needs of the individual. PCNs should allow for flexibility in appointment length for SMRs.

5.3 Cardiovascular Disease (CVD)

5.3.1 In the guidance for Familial Hypercholesterolaemia, what is meant by "referrals for further assessment"? Does the referral need to be to secondary care? What constitutes a referral for assessment can vary by area and by the lipid management pathways and services in place within the system.

Over time it is intended that there will be direct access to genetic testing for primary care. PCNs should consider whether referral to a lipid service may be needed, regardless of FH diagnosis, in patients with the a significantly abnormal lipid profile (as indicated in the summary of national guidance for primary and secondary prevention of CVD). In the short term, most referrals for suspected FH are likely to be to lipid specialist services.

5.3.2 Do the people measuring blood pressure need to be clinically trained?

In a clinical or pharmacy setting, blood pressure measurement can be undertaken by anyone who has been suitably trained to do so. This may include non-clinical staff. If hypertension is suspected, further assessment by ambulatory or home blood pressure monitoring (HBPM or ABPM) should be arranged by a member of a practice nursing team, or by a community pharmacist. On review of the data, a diagnosis of hypertension would be confirmed by a GP or another appropriate health care professional.

5.3.3 Why does the DES say that statins should be considered for people with a QRISK score of 10% of higher, but the IIF says 20%?

The IIF incentivises providing support for the top layer of risk. However, it is still intended that people with a QRISK score of 10% and above should be reviewed in line with the summary of national guidance for primary and secondary prevention of CVD.

5.4 Early Cancer Diagnosis

5.4.1 Where can further information be found to support delivery of the early cancer diagnosis specification?

The Network Contract Directed Enhanced Service Early Cancer Diagnosis Support Pack sets out best practice guidance and resources to help inform and support implementation and delivery of the Network Contract DES requirements for Supporting Early Cancer Diagnosis.

5.4.2 Where can additional information be found to support delivery of service requirement 3: Work with its Core Network Practices to adopt and embed the requesting of FIT tests where appropriate for patients being referred for suspected colorectal cancer.

The Network Contract Directed Enhanced Service Early Cancer Diagnosis Support Pack sets out best practice guidance and resources to help inform and support implementation and delivery of the Network Contract DES requirements for Supporting Early Cancer Diagnosis.

These details have been published alongside the Investment and Impact Fund Indicator:

· Percentage of lower gastrointestinal two week wait (fast track) cancer referrals accompanied by a faecal immunochemical test result, with the result recorded either in the seven days leading up to the referral, or in the fourteen days after the referral

This information can be found here.

5.4.3 Where can further information be found to support delivery of service requirement 4: focusing on prostate cancer, and informed by data provided by the local Cancer Alliance, develop and implement a plan to increase the proactive and opportunistic assessment of patients for a potential cancer diagnosis in population cohorts where referral rates have not recovered to their pre-pandemic baseline?

The Network Contract Directed Enhanced Service Early Cancer Diagnosis Support Pack sets out best practice guidance and resources to help inform and support implementation and delivery of the Network Contract DES requirements for Supporting Early Cancer Diagnosis.

Additional resources are also available to support delivery of service requirement 4. These resources are:

Clinical resources · Symptomatic guidance: NG12 · Asymptomatic guidance: Prostate Cancer Risk Management Programme · Gateway C Modules: Symptomatic and Metastatic Prostate Cancer · Best practice timed pathway: Prostate · Prostate Cancer UK's Consensus Statements on PSA testing · Prostate Cancer UK: Online learning

Patient resources · Prostate Cancer UK: Risk Checker · PSA testing and prostate cancer: advice for well men aged 50 and over · Information sheet for patients being referred with suspected prostate cancer

Patient information for your practice (accessible online and to order) · Know your prostate: A quick guide · 'The PSA test and prostate cancer: A quick guide' · 'Understanding the PSA test: A guide for men concerned about prostate cancer · Prostate cancer and other prostate problems: Information for black men · Display box: Prostate cancer: Information for black men

6. Investment and Impact Fund (IIF)

6.1 How can PCNs monitor their performance against the indicators in the IIF?

The PCN Dashboard hosts a dedicated IIF page where indicative PCN performance against the IIF indicators can be viewed and it will be updated on a monthly basis.

The data collection to inform these indicators relies on the relevant coding in GP IT systems.

6.2 How frequently is the information on the PCN dashboard updated?

The PCN Dashboard can now be accessed directly through NHS Applications, or by clicking here. Log in details for previous users of the PCN Dashboard or NHS Applications will remain the same. New users of the PCN Dashboard will need to register for an NHS Applications account here. Data on the dashboard is currently refreshed monthly. For new indicators introduced for 2022/23, these will not be available on the dashboard until summer 2022.

6.3 What can a PCN do if they think their IIF achievement in CQRS is incorrect?

For IIF indicators based on a data extract from GP systems, PCNs will have the opportunity to 'declare' their achievement within CQRS. This means that they will have the opportunity to confirm that the data extracted in relation to them, and the calculations performed in respect of that data, are correct.

If a PCN believes that the underlying data for the PCN (or for one or more core network practices within the PCN) is incorrect in relation to an IIF indicator based on a data extract from GP systems, they should decline to declare their achievement and raise the discrepancy with their commissioner. The commissioner is able, at its sole discretion, to make manual adjustments to data if the PCN can explain to them why it is wrong.

Before doing this, PCNs should run a search on the core network practices' clinical systems to confirm their interpretation. The PCN should also check the business rules for the Network Contract DES service or GPES extract, which system suppliers use to construct GPES extract indicators.

The business rules state the 'code clusters' or 'reference sets' (collections of SNOMED codes) that are used to calculate IIF (and other Network Contract DES) indicators – they do not state the contents of these reference sets ie the actual SNOMED codes. The SNOMED codes contained within each reference set can be found in an accompanying spreadsheet that is published with the business rules.

If a PCN believes that its IIF indicator values for an indicator drawn from data sources other than GP systems is incorrect, they are advised to pursue the matter

via existing channels relating to those data sources. Further information about these channels is provided in IIF Guidance.

6.4 For some PCNs that have a specialised population (for example homeless, asylum seekers, special allocation schemes) it may be difficult to achieve the full target due to exceptions. Would there be an option for exceptional reporting for specialist populations?

The specific acceptable personalised care allowances (PCAs) are shown for each indicator in the IIF guidance. These don't cover specific populations and are for general use. There is no scope to remove patients other than via the exclusions or PCAs shown in the guidance.

6.5 What would happen if a PCN chooses not to declare their IIF achievement and wish to challenge the data on CQRS?

If a PCN disputes its achievement calculation, then it is for the PCN and commissioner to have dialogue to resolve the matter. The commissioner has the power to change the PCN's data (for GPES-derived indicators) if the PCN can provide supporting evidence. Once the PCN and commissioner reach agreement, the PCN will still be paid – though not by the 31 August payment deadline.

6.6 Are commissioners expected to carry out a post payment verification (PPV) process in relation to the IIF payments?

It is for commissioner to determine whether to conduct any investigative activities to ensure that the practice has achieved the points that it claims to have achieved – the Network Contract DES establishes that commissioners are entitled to undertake any such activities as they may deem necessary, but it does not mandate that they must occur. If it is about verifying that any earnings have been reinvested, commissioners should not take an onerous approach on this issue.

6.7 Do PCNs need to provide to their commissioner a spending plan for IIF earnings?

The PCN must provide a simple written commitment to their commissioner that any money earned through the IIF will be reinvested into additional workforce, additional primary medical services, and/or other areas of investment in a core network practice that support patient care (e.g. equipment or premises). The written

commitment does not have to detail the precise areas of spend, this is for PCNs to determine.

6.8 For social prescribing referrals, can you please confirm which codes will be extracted for payments/data purposes?

The following SNOMED code should be used:

- 871731000000106 | Referral to social prescribing service (procedure)

This indicator only counts referrals made to a social prescribing service, as captured by the SNOMED code provided above. This SNOMED code, denoting referral to a social prescribing service, should be used even when the social prescribing service is provided within the practice or PCN – eg if a social prescribing link worker is employed under ARRS. In this case, the referral is internal to the practice/PCN, but it is still a referral to a distinct service.

This indicator does not count offers of social prescribing because it is necessary to know whether the offer has been accepted. It therefore only counts completed referrals to a social prescribing service.

The purpose of this indicator is to count referrals to a service, not unique patient contacts. As such, this indicator does not count recording (by any means) of unique patient contacts by social prescribing link workers or any other type of healthcare professional (eg care co-ordinators or health and wellbeing coaches).

7. Enhanced Access

7.1 What are PCNs required to do from April 2022 to prepare for introducing enhanced access?

From 1st October 2022, PCNs will be required to provide Enhanced Access between the hours of 6.30pm and 8pm Mondays to Fridays and between 9am and 5pm on Saturdays (which are referred to in the Network Contract DES Specification as “Network Standard Hours”).

From 1 April 2022, in preparation for delivery of the service, a PCN - working collaboratively with the commissioner - must produce an Enhanced Access Plan. The draft Enhanced Access Plan must be submitted to the commissioner for agreement on or before 31 July 2022, by the method the commissioner has indicated. The draft Enhanced Access Plan must set out how the PCN is planning to deliver Enhanced Access from October 2022.

Section 8.1.15 of the Network Contract DES Specification sets out the preparatory requirements.

From 01 April 2022 until 01 October 2022, PCNs will be required to deliver the extended hours access requirements, at which point this service will be replaced by the enhanced access service.

7.2 What are the differences between extended hours access and enhanced access and are PCNs required to provide extended hours as set out in the Network Contract DES in addition to the requirements of enhanced access?

The two services are separate and distinct with differing requirements and funding arrangements. From April 2022 until September 2022, PCNs will still need to deliver the extended hours commitments as set out from section 8.1.1 to 8.1.14 of the Network Contract DES Specification. The new enhanced access arrangements as set out from section 8.1.15 of the Network Contract DES Specification will come into force from 1st October but with preparatory work required from April to September.

7.3 Are PCNs able to utilise staff employed via ARRS in enhanced access services?

Yes, staff currently employed or engaged by PCNs and reimbursed through the ARRS may be utilised in the enhanced access period, as long as they are continuing to deliver all the requirements of the relevant role outline set out in the Network Contract DES Specification and are working as part of a multidisciplinary team to deliver that care across in hours and enhanced access.

7.4 Can you advise what will happen to GP Federations who may no longer hold an eligible contract to be a nominated payee for their PCN when the changes to enhanced access come into force?

The arrangements under the Network Contract DES continue to require that the nominated payee must hold a primary medical services contract. We are aware of the situation for GP Federation nominated payees and are working towards being able to continue this through any nominated payee arrangements.

7.5 Does this mean every practice has to be open evening and weekends?

The changes do not mean that every practice has to extend its opening hours. The service is at a PCN level and the approach to the time requirement is the same as it is now for the current Extended Hours access service under the DES and the CCG-commissioned Extended Access services combined, so there is already a workforce delivering this service. Where local EA services commissioned by CCGs are working well, PCNs can choose to sub-contract delivery of the EA requirements with the agreement of the commissioner.

Sundays are not a mandatory part of the new DES EA offer (they are currently part of the extended access service commissioned by CCGs). If there is patient demand for Sunday services, then following consultation there may be some offer on a Sunday in keeping with patient preference.

7.6 Do PCNs have to offer the full range of routine services?

It is up to the PCN to decide the mix of services which will be available during Enhanced Access, and how the workforce – including ARRS workforce – will be used to make full use of the MDT. This will form part of the PCN's Enhanced Access Plan, which should be informed by patient engagement to understand local need and will need to be agreed with the commissioner. The plan will also need to cover which premises will be used to deliver Enhanced Access.

7.7 Is the £6 per head being moved into the PCN DES, i.e. does that mean that PCNs will be paid £6 plus £1.44, making the new offer for enhanced access £7.44 per head?

The funding streams are being brought together to be paid to PCNs under the Network Contract DES, and the 2022/23 Network Contract DES Specification confirms how funding will be allocated. The updated Specification is available here, along with the 2022/23 ready reckoner, for PCNs to use to understand their funding.

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This information can be made available in alternative formats, such as large print, and may be available in alternative languages, upon request. Please contact the Primary Care Group at england.gpcontracts@nhs.net.

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Network Contract Directed Enhanced Service

Investment and Impact Fund 2022/23: Updated Guidance

March 2022

Contents

1. Introduction

1.1 The Investment and Impact Fund (IIF) forms part of the Network Contract Directed Enhanced Service (DES). It supports primary care networks (PCNs) to deliver high quality care to their population, as well as supporting the delivery of priority objectives articulated in the NHS Long Term Plan and in *Investment and Evolution; a five-year GP contract framework to implement the NHS Long Term Plan*.

1.2 In line with the wider Network Contract DES, the IIF for 2022/23 has been designed to support PCNs during their ongoing response to and recovery from the COVID-19 pandemic. This includes focusing on preventative activity for cohorts at particular risk of poor health outcomes from COVID-19, and in tackling health inequalities more directly and proactively.

1.3 The IIF is a financial incentive scheme. It focuses on rewarding high quality care in areas where PCNs can contribute significantly towards the 'triple aim':

- Improving health and saving lives (e.g. through increased diagnosis of hypertension)
- Improving the quality of care for people with multiple morbidities (e.g. through delivering Structured Medication Reviews and increasing the number of asthma patients who are regularly prescribed inhaled corticosteroids)
- Helping to make the NHS more sustainable.

1.4 While the IIF is a PCN-level incentive scheme, there are overlaps between it and the Quality and Outcomes Framework (QOF), which operates at practice level. Some indicators across both schemes incentivise similar activity and practices may find they can make progress towards both simultaneously. This document notes any linkages between IIF indicators and QOF indicators where relevant.

1.5 *Investment and Evolution* set out that the IIF would be worth at least £225 million in 2022/23, rising to at least £300 million in 2023/24. The 2022/23 scheme is worth £260m, following additional funding of £35m to support new indicators in 2022/23.

1.6 Elements of the IIF were suspended in late 2021/22 in response to the emergence of the Omicron variant of COVID-19 and the need to accelerate

the delivery of booster vaccinations. Where indicators were planned to run across both 2021/22 and 2022/23, these will be restarted from 1 April 2022 and PCNs will be paid on the basis of performance for the 2022/23 financial year.

1.7 This document provides guidance on the IIF for 2022/23, including key details of the individual indicators. Information on how performance and achievement will be calculated is also included, and should be read alongside the relevant sections of the 2022/23 Network Contract DES specification (Sections 10.6 and Annexes C and D). For indicators sourced from the GP Extraction Service (GPES), the business rules published by NHS Digital provide full details of how the indicators are constructed from information in GP systems. For Indicators that are not sourced from GPES, more technical details are provided (or links provided for) in this guidance. In addition, CQRS guidance provides details on the submission and reporting of data for all indicators.

2. Structure of the IIF

2.1. This section introduces the key elements of the IIF in 2022/23:

- Domains, areas, and indicators
- Indicator structure, performance, exclusions and exceptions (personalised care adjustments)
- Achievement points
- Achievement payments, prevalence adjustment and list size adjustment
- Monitoring IIF performance.

Domains, areas, and indicators

2.2 The IIF is divided into three domains: (i) prevention and tackling health inequalities, (ii) providing high quality care and (iii) a sustainable NHS. Each domain consists of several areas, which in turn consist of a number of indicators.

2.3 The domains, areas, and indicators for the IIF in 2022/23 are set out in the summary table below, along with respective start dates for each indicator.

Summary of indicators

Domain	Area	Indicators
Prevention and tackling health inequalities	Vaccination and immunisation	**VI-01**: Percentage of patients aged 65 or over who received a seasonal influenza vaccination between 1 September 2022 and 31 March 2023
		VI-02: Percentage of patients aged 18 to 64 years and in a clinical at-risk group who received a seasonal influenza vaccination between 1 September 2022 and 31 March 2023
		VI-03: Percentage of patients aged two or three years on 31 August 2022 who received a seasonal influenza vaccination between 1 September 2022 and 31 March 2023
	Tackling health inequalities	**HI-01:** Percentage of patients on the QOF Learning Disability register aged 14 or over, who received an annual Learning Disability Health Check and have a completed Health Action Plan

Domain	Area	Indicators
		HI-02: Percentage of registered patients with a recording of ethnicity on their GP record
	CVD prevention	**CVD-01:** Percentage of patients aged 18 or over with an elevated blood pressure reading (≥140/90mmHg) and not on the QOF Hypertension Register, for whom there is evidence of clinically appropriate follow-up to confirm or exclude a diagnosis of hypertension
		CVD-02: Percentage of registered patients on the QOF Hypertension Register
		CVD-03: Percentage of patients aged between 25 and 84 years inclusive and with a CVD risk score (QRISK2 or 3) greater than 20 percent, who are currently treated with statins
		CVD-04: Percentage of patients aged 29 and under with a total cholesterol greater than 7.5 OR aged 30 and over with a total cholesterol greater than 9.0 who have been referred for assessment for familial hypercholesterolaemia
		CVD-05: Percentage of patients on the QOF Atrial Fibrillation register and with a CHA_2DS_2-VASc score of 2 or more (1 or more for patients that are not female), who were prescribed a direct-acting oral anticoagulant (DOAC), or, where a DOAC was declined or clinically unsuitable, a Vitamin K antagonist
		CVD-06: Number of patients that are currently prescribed Edoxaban, as a percentage of patients on the QOF Atrial Fibrillation register with a CHA_2DS_2-VASc score of 2 or more (1 or more for patients that are not female) and who are currently prescribed a direct-acting oral anticoagulant (DOAC)

Domain	Area	Indicators
Providing high quality care	Personalised care	**PC-01**: Percentage of registered patients referred to a social prescribing service
	Enhanced health in care homes	**EHCH-01:** Number of patients aged 18 years or over and recorded as living in a care home, as a percentage of care home beds aligned to the PCN and eligible to receive the Network Contract DES Enhanced Health in Care Homes service
		EHCH-02: Percentage of care home residents aged 18 years or over, who had a Personalised Care and Support Plan (PCSP) agreed or reviewed
		EHCH-04: Mean number of patient contacts as part of weekly care home round per care home resident aged 18 years or over
		EHCH-06: Standardised number of emergency admissions on or after 1 October per care home resident aged 18 years or over
	Anticipatory Care	**AC-02:** Standardised number of emergency admissions for specified Ambulatory Care Sensitive Conditions per registered patient
	Cancer	**CAN-01:** Percentage of lower gastrointestinal two week wait (fast track) cancer referrals accompanied by a faecal immunochemical test result, with the result recorded either in the seven days leading up to the referral, or in the fourteen days after the referral
	Access	**ACC-02:** Number of online consultation submissions received by the PCN per registered patient
		ACC-05: By 31 March 2023, make use of GP Patient Survey results for practices in the PCN to (i) identify patient groups experiencing inequalities in their experience of access to general practice, and (ii) develop, publish and implement a plan to improve patient experience and access for these patient groups, taking into

Domain	Area	Indicators
		account demographic information including levels of deprivation
		ACC-07: Number of pre-referral Specialist Advice requests across twelve specialties identified for accelerated delivery per outpatient first attendance
		ACC-08: Percentage of patients whose time from booking to appointment was two weeks or less
		ACC-09: Number of referrals to the Community Pharmacist Consultation Service per registered patient
	Structured medication reviews and medicines optimisation	**SMR-01A:** Percentage of patients at risk of harm due to medication errors who received a Structured Medication Review
		SMR-01B: Percentage of patients living with severe frailty who received a Structured Medication Review
		SMR-01C: Percentage of patients using potentially addictive medicines who received a Structured Medication Review
		SMR-01D: Percentage of permanent care home residents aged 18 years or over who received a Structured Medication Review
		SMR-02A: Percentage of patients aged 18 years or over prescribed both a Non-Steroidal Anti-Inflammatory Drug (NSAID) and an oral anticoagulant in the last three months of the previous financial year, who in the three months to the reporting period end date were either (i) no longer prescribed an NSAID or (ii) prescribed a gastroprotective in addition to both an NSAID and an oral anticoagulant
		SMR-02B: Percentage of patients aged 65 years or over prescribed a Non-Steroidal Anti-Inflammatory Drug (NSAID) and not an oral

Domain	Area	Indicators
		anticoagulant in the last three months of the previous financial year, who in the three months to the reporting period end date were either (i) no longer prescribed an NSAID or (ii) prescribed a gastroprotective in addition to an NSAID
		SMR-02C: Percentage of patients aged 18 years or over prescribed both an oral anticoagulant and an anti-platelet in the last three months of the previous financial year, who in the three months to the reporting period end date were either (i) no longer prescribed an anti-platelet or (ii) prescribed a gastroprotective in addition to both an oral anticoagulant and an anti-platelet
		SMR-02D: Percentage of patients aged 18 years or over prescribed aspirin and another anti-platelet in the last three months of the previous financial year, who in the three months to the reporting period end date were either (i) no longer prescribed aspirin and/or no longer prescribed an anti-platelet or (ii) prescribed a gastroprotective in addition to both aspirin and another anti-platelet
		SMR-03: Percentage of patients prescribed a direct-acting oral anti-coagulant (DOAC), who received a renal function test and have a recording of their weight and Creatinine Clearance Rate, along with a recording that their DOAC dose was either changed or confirmed (not changed)
	Respiratory care	**RESP-01:** Percentage of patients on the QOF Asthma Register who received three or more inhaled corticosteroid (ICS, inclusive of ICS/LABA) prescriptions over the previous 12 months
		RESP-02: Percentage of patients on the QOF Asthma Register who received six or more Short Acting Beta-2 Agonist (SABA) inhaler prescriptions over the previous 12 months

Domain	Area	Indicators
A Sustainable NHS	Environmental sustainability	**ES-01:** Metered Dose Inhaler (MDI) prescriptions as a percentage of all non-salbutamol inhaler prescriptions issued to patients aged 12 years or over
		ES-02: Mean carbon emissions per salbutamol inhaler prescribed (kg CO_2e)

Indicator structure and performance calculation

2.4 IIF indicators are either 'Qualitative' or 'Quantitative'. Quantitative indicators are further divided into four assessment categories: Binary, Standard, Improvement or Composite. In addition, Quantitative indicators can be standardised.

2.5 **Qualitative** indicators consist of a criterion or set of criteria. A PCN can either earn all the points available, or no points, based on whether the criterion or set of criteria are met. Where there are multiple criteria, failure to meet any one of the criteria means that no points are earnt.

2.6 **Quantitative** indicators are constructed from the ratio of a numerator and denominator. For **Binary** and **Standard** Quantitative indicators, this represents the indicator performance (Performance X = Numerator (N)/Denominator (D)). For **Improvement** Quantitative indicators, performance is based on the change in this ratio relative to a base period (Performance X = N/D – N0/D0).[1] For **Composite** Quantitative indicators, both of the above approaches are used to measure performance, with the best performance used as the basis for IIF achievement.

2.7 The desired direction of performance may be upwards or downwards. If it is upwards, a higher indicator value means better performance and a lower one means worse performance; and if it is downwards, a lower indicator value means better performance and a higher one means worse performance.

[1] N0/D0 represents the ratio of a PCN's numerator and denominator from an earlier period e.g. the previous year.

2.8 The denominator of each Quantitative indicator is the target cohort for the intervention in question. In 2022/23 IIF, the target cohort for all Quantitative indicators is a count of eligible patients or interventions (e.g. medications) delivered to a set of eligible patients. For example, for indicator HI-01 the target cohort is people on the QOF Learning Disability Register aged 14 and over.

2.9 In addition to the assessment categories described above, Quantitative indicators can be standardised. This process adjusts each PCN's indicator performance to account for differences in patient demographics that would otherwise, and unjustly, impact on the indicator performance. Annex B provides further details of the methodology used.

Exclusions and Exceptions (Personalised Care Adjustments)

2.10 Exclusions may be applied to some Quantitative indicators, removing patients, and any services or interventions they receive, from the denominator for that indicator. Exclusions are applied prior to assessment of 'success' and are therefore removed even if action or intervention that the IIF indicator seeks to reward has happened. The exact circumstances in which Exclusions apply to IIF indicators are provided in the tables below.

2.11 Personalised care adjustments (PCAs), previously known as 'Exceptions', may be applied to some Quantitative indicators, removing patients, and any services or interventions they receive, from the denominator for that indicator – unless the action or intervention being incentivised by the indicator has occurred, in which case they will be retained. The exact circumstances in which PCAs apply to IIF indicators are provided in the tables below.

2.12 An example of how PCAs would be applied to VI-01 is as follows: A PCN has 1,000 patients aged 65 and over, of whom 600 received a seasonal influenza vaccination. If a practice's clinical system records that 100 of the 1,000 eligible patients were offered a seasonal influenza vaccination but refused and it was also deemed clinically inappropriate to administer the seasonal influenza vaccination to a further 100, then PCN performance in relation to indicator VI-01 would be 75% (= 600/800), not 60% (= 600/1,000).

Achievement points

2.13 The IIF is a points-based scheme. For 2022/23, each PCN can earn a maximum of 1153 IIF points and the value of a point will be £200.00 (adjusted for list size and prevalence – see paragraphs 2.18-2.19). Each indicator is worth an agreed number of points, and how these are achieved depends on whether the indicator is Qualitative, Binary Quantitative, Standard Quantitative, Improvement Quantitative or Composite Quantitative.

2.14 A PCN can earn either all the points or no points for Qualitative indicators, based on whether they meet all the criteria, and for Binary Quantitative indicators, based on whether performance meets the indicator performance threshold.

2.15 The points a PCN can earn for Standard and Improvement Quantitative indicators will depend on how their performance relates to an upper performance threshold and a lower performance threshold.

2.16 The points a PCN can earn for Composite Quantitative indicators will depend on both how their 'standard' performance relates to an upper performance threshold and a lower performance threshold, and how their 'improvement' performance relates to an upper performance threshold and a lower performance threshold.

2.17 The upper performance threshold (or single threshold for Binary Quantitative indicators) for each Standard Quantitative indicator (specifically the 'standard' component to Composite Quantitative indicators) is based on clinical or other expert opinion concerning good practice. Reflecting the aim of reducing unwarranted variation, the lower performance threshold for each indicator has typically been set with reference to the 40th centile of performance in 2019/20 (where baseline data is available).

2.18 Upper and lower thresholds for Improvement Quantitative indicators (and specifically the 'improvement' component to Composite Quantitative indicators) represent changes from each PCN's baseline e.g. 1 and 2 percentage point increases from the percentage performance recorded in the previous year. These may also be based on clinical/expert opinion but may also factor in previous trends over time or natural variation.

2.19 If a PCN's performance for a Standard or Improvement Quantitative indicator is better than or equal to the upper performance threshold, it will earn all the points available for that indicator; if a PCN's performance is worse than or

equal to the lower performance threshold, it will earn zero points; and if performance is between the upper and lower thresholds, it will earn some but not all of the points available for that indicator. Consider a hypothetical Standard Quantitative indicator worth 50 points with an upwards desired direction, a lower performance threshold of 50% and an upper performance threshold of 75%. Then, two IIF points are earnt for every percentage point improvement in performance (50 points/ (75%-50%) = 2 points per percentage point). If a PCN's performance is 70%, it will earn 40 of the 50 available achievement points – because 70% is 4/5ths of the way from 50% (the lower performance threshold) to 75% (the upper performance threshold).

2.20 For Composite Quantitative indicators, the same approach as in 2.19 is used for assigning points for each of the 'standard' and 'improvement' components of performance, with the points earned based on the best of the two. Consider a composite indicator with the same standard thresholds and performance as the hypothetical example in 2.19, with an additional lower Improvement threshold of 0 percentage points (no change from baseline) and an upper Improvement threshold of 10 percentage points (increase from baseline). With the 70% achievement the PCN would be assigned 40 points against the standard thresholds. Then, five points are assigned for each percentage point improvement in performance from baseline (50 points/ (10 percentage points – 0 percentage points). If a PCN's baseline performance (e.g. performance in the 12 months prior to current scheme) is 65%, it will be assigned 25 of the 50 available achievement points – because the 5 percentage point improvement from 65% to 70% is half way from 0 percentage points (the lower improvement performance threshold) to 10 percentage points (the upper improvement performance threshold). The PCN earns 40 points as this is the greater of the two assigned point values (40 and 25).

Achievement payments

2.21 For each indicator, a PCN's achievement payment equals its achievement points multiplied by the value of an IIF point (£200.00 in 2022/23), multiplied by a list size adjustment, and in the case of Quantitative indicators, multiplied by a prevalence adjustment. The value of an IIF point will be subject to annual revision.

2.22 The purpose of the prevalence adjustment and list size adjustment is to more closely relate PCN payments to the effort that a PCN must undertake to earn IIF points. The points-based system means that, for Standard, Improvement and Composite Quantitative indicators, every PCN will earn the same number of *points* for a given 'absolute' improvement in performance. And in addition, for Qualitative and Binary Quantitative indicators, every PCN will earn either no points or the same number of points depending on whether the criterion or criteria, or performance threshold have been met. However, differences in prevalence and in list size mean that PCNs may have to make different levels of effort to achieve a given percentage point (absolute) improvement in performance. Annex A explains how applying a prevalence adjustment and a list size adjustment takes account of these differences.

2.23 In 2022/23, PCNs are entitled to one type of payment under the IIF: a Total Achievement Payment which is the sum of achievement payments for each indicator (as defined above). To be eligible to receive achievement payments, a PCN must comply with the conditions set out in the 2022/23 Network Contract DES specification (section 10.6.17). Crucially, the PCN must provide a simple written commitment to their commissioner that any money earned through the IIF will be reinvested into additional workforce, additional primary medical services, and/or other areas of investment in a Core Network Practice that support patient care (e.g. equipment or premises). The written commitment does not have to detail the precise areas of spend: this is for PCNs to determine.

Monitoring IIF performance

2.24 Each PCN is able to monitor its indicative performance against IIF indicators on the PCN Dashboard, which is now available through the NHS England Applications platform (having moved from NHS ViewPoint in late 2021).

2.25 The dashboard supports PCNs to understand their local population health priorities and the benefits that they are delivering for their patients. It also helps PCNs to identify opportunities to reduce unwarranted variation in performance within their PCN and between PCNs, to improve services. Performance against each 2022/23 IIF indicator is expected to be available monthly by PCN from summer 2022.

3. Prevention and tackling health inequalities domain

3.1 The prevention and tackling health inequalities domain aims to support delivery of the ambitions outlined in Chapter Two of the NHS Long Term Plan. A key focus of the Network Contract DES is prevention – the aim being to help people stay healthy, by detecting disease early, preventing deterioration of health and reducing symptoms to improve quality of life. Indicators in this domain will contribute to the Government's ambition to add five years to healthy life expectancy by 2035.

Vaccination and immunisation area

3.2 Indicators in the vaccination and immunisation area support the ambitions of the NHS Long Term Plan to ensure and expand access to vaccines.

VI-01, VI-02, VI-03: Seasonal influenza vaccination			
Rationale for inclusion	Improving the coverage and uptake of vaccinations is a key public health priority and was a NHS Long Term Plan commitment (p15, p39). Securing high coverage is even more important in the context of COVID-19.		
Indicator type	Standard Quantitative		
Indicator	**VI-01**: Percentage of patients aged 65 or over who received a seasonal influenza vaccination between 1 September 2022 and 31 March 2023	**VI-02:** Percentage of patients aged 18 to 64 years and in a clinical at-risk group who received a seasonal influenza vaccination between 1 September 2022 and 31 March 2023	**VI-03**: Percentage of children aged two or three years on 31 August 2022 who received a seasonal influenza vaccination between 1 September 2022 and 31 March 2023
Running period	1 April 2022 – 31 March 2023		
Denominator	Number of patients aged 65 and over	Number of patients aged 18 to 64 and in a clinical at-risk	Number of children aged two or three

VI-01, VI-02, VI-03: Seasonal influenza vaccination			
		group (as defined in the cohorts outlined in the 2022/23 NHS Seasonal Influenza Programme – see here)[2]	years on 31 August 2022
Numerator	Of the denominator, the number who received a seasonal influenza vaccination between 1 September 2022 and 31 March 2023	Of the denominator, the number who received a seasonal influenza vaccination between 1 September 2022 and 31 March 2023	Of the denominator, the number who received a seasonal influenza vaccination between 1 September 2022 and 31 March 2023
	The flu vaccine can be provided in any patient setting (e.g. general practice, community pharmacy), provided provision is coded in GP IT systems.		
Prevalence numerator	Indicator denominator		
Exclusions	Patients on end of life care		
Personalised care adjustments	1. Patients who declined the offer of a seasonal influenza vaccination 2. Situations in which it is not clinically appropriate to provide a seasonal influenza vaccination. 3. Patient did not reply to two separately coded invites to receive a seasonal influenza vaccination using their preferred method of communication		

[2] Including the following at-risk groups eligible for a free influenza vaccination:
Chronic respiratory disease; Chronic heart disease; Chronic kidney disease; Chronic liver disease; Chronic neurological disease; Learning disabilities (as captured by being on the QOF Learning Disability register); Diabetes; Immunosuppression; Asplenia or dysfunction of the spleen; Morbidly obese; People in long stay residential or homes.
Excluding the following at-risk groups eligible for a free influenza vaccination, on the basis that membership of these groups is not reliably recorded in GP systems:
Pregnant women; Household contact of immunocompromised individual; Household contact of person on NHS shielded patient list; Social care worker; Hospice worker.

VI-01, VI-02, VI-03: Seasonal influenza vaccination			
Desired direction	Upwards		
Thresholds	80% (LT), 86% (UT)	57% (LT), 90% (UT)	45% (LT), 82% (UT)
Points	40	88	14
Data source	General Practice Extraction Service (GPES)		
Subject to declaration?	Yes		
Additional information	NICE Quality Standard 190 on improving seasonal influenza vaccination uptake was published in January 2020. Responsibility for providing seasonal influenza vaccinations in primary care is currently shared between general practice and community pharmacy. Achievement for the IIF seasonal influenza vaccination incentives will be based on the total number of vaccines provided within the network, irrespective of who delivered the vaccine. The IIF seasonal influenza vaccination indicators supplement the existing seasonal influenza vaccination Enhanced Service in general practice, which makes an item of service payment of £10.06 (at the time of publishing this guidance) for each seasonal influenza vaccination provided. Clinical leadership at a PCN level can promote uptake, identifying areas for improvement and disseminating good practice to increase vaccination rates and reduce variation across eligible patient cohorts. • PCN clinical directors should, in partnership with the identified CCG flu lead and national commissioners, engage with: • General practices in the PCN to agree how they will collaborate with each other, and discuss how they will collaborate with community pharmacies in relation to seasonal influenza vaccination uptake • The pharmacy PCN lead, where available, to agree how general practices will collaborate with community pharmacies in relation to seasonal influenza vaccination uptake.		

Tackling health inequalities area

3.3 The social and economic environment in which we are born, grow up, live, work and age, as well as the decisions we make for ourselves, have a significant impact on our health. The COVID-19 pandemic has also highlighted the imbalance in health outcomes and differential experiences of healthcare services between different groups, communities, and regions. IIF indicators in the tackling health inequalities area are designed to help to ensure that everyone gets access to the care they need and focus interventions on groups who experience health inequalities.

HI-01: Percentage of patients on the QOF Learning Disability register aged 14 years or over, who received a learning disability Annual Health Check and have a completed Health Action Plan	
Rationale for inclusion	To tackle the causes of morbidity and preventable deaths in people with a learning disability and/or autism, the NHS Response to COVID Phase 3 letter reiterates the importance of people with a learning disability being identified on their local register and having annual health checks completed.
Indicator type	Standard Quantitative
Running period	1 April 2022 – 31 March 2023
Denominator	Number of patients on the QOF Learning Disability register aged 14 years or over.
Numerator	Of the denominator, the number who received a learning disability Annual Health Check and have a completed Health Action Plan
Prevalence numerator	Indicator denominator
Exclusions	None
Personalised care adjustments	Patient refused the offer of a learning disability health check.

HI-01: Percentage of patients on the QOF Learning Disability register aged 14 years or over, who received a learning disability Annual Health Check and have a completed Health Action Plan	
Desired direction	Upwards
Thresholds	60% (LT), 80% (UT)
Points	36
Data source	General Practice Extraction Service (GPES)
Subject to declaration?	Yes
Additional information	People with a learning disability often have poorer physical and mental health and are four times more likely to die of preventable illnesses than the general population (Disability Rights Commission, 2006). Groups who already experience disproportionately poor health outcomes have also been seen to have additional risks from COVID-19. An annual health check can help to improve the health of people with a learning disability by identifying health concerns at an early stage. The health action plan is an integral part of the requirements around a learning disability health check and so encouraging this requirement will ensure that the Health Check Scheme is seen as a required two-part process, necessary for supporting individuals in any actions or follow up to support their health and well-being. NICE Quality Standard 187 provides the quality standard for learning disability health checks. All checks should be auditable against this standard. This IIF indicator supplements the item of service payment (£140 at the time of publishing this guidance) for annual Learning Disability health checks, which is paid as an Enhanced Service. In providing the annual health check, clinicians are reminded that discussing the Health Action Plan is an essential component of the check and integral to its overall efficacy. Patients should leave their health check with a copy of the action plan discussed, to support them in managing their health and wellbeing. PCNs should also ensure patients with a learning disability are accurately coded. Improving identification of people with a learning disability; guidance for general practice, published in October 2019, states GP practices need to review and update

HI-01: Percentage of patients on the QOF Learning Disability register aged 14 years or over, who received a learning disability Annual Health Check and have a completed Health Action Plan	
	their register and also identify patients who may have a learning disability. The IIF supports case identification by employing a prevalence adjustment and list size adjustment to Achievement Payments. The combined effect of these adjustments is to make a PCN's earning ability in respect of indicator HI-01 proportional to the number of patients on the learning disability register. Further details of these adjustments are provided in Annex A. PCNs and practices are also asked to ensure that patient's ethnicity status and their level of learning disability is recorded in the GP system. In addition to increased levels of health inequality, increasing levels of premature mortality are noted in people with a learning disability aged 18-49 from an ethnic minority. GPs are reminded that in order for a patient to refuse the offer of an annual health check, their capacity should be assessed using the Mental Capacity Act framework. Where the individual does not have capacity a best interest process should be followed. **Further Information** NHS England: Learning Disability Annual Health Checks Mencap charity: Leaflets and resources to encourage people to take up an annual health check Contact (charity): Annual health checks: Factsheet for parents Public Health England: Annual Health Checks and people with learning disabilities guidance includes evidence for an annual heath check and further resources including videos on how to complete an annual health check. RCGP Toolkit NDTI resources

HI-02: Percentage of registered patients with a recording of ethnicity on their GP record	
Rationale for inclusion	COVID-19 has highlighted and exacerbated significant health inequalities in the delivery, experience, and outcomes of care. In response, NHS England and NHS Improvement (NHSEI) committed in Autumn 2020 to a number of short-term actions which aimed to urgently address these inequalities. One such action is to dramatically improve the recording of patient ethnicity data in

HI-02: Percentage of registered patients with a recording of ethnicity on their GP record	
	primary care, to support local and national analytical work, and enable services and outreach work to be targeted at individuals and communities who may benefit most. This indicator supports this aim by recognising PCNs for the accurate and complete recording of patient ethnicity information in clinical systems.
Indicator type	Standard Quantitative
Running period	1 April 2022 – 31 March 2023
Denominator	Total number of registered patients
Numerator	Of the denominator, the number with a recording of ethnicity on their GP record
Prevalence numerator	Indicator denominator
Exclusions	None
Personalised care adjustments	None – note that, for the purposes of this indicator, a patient recorded as having chosen not to state their ethnicity after having been given the opportunity to do so will be counted as a valid recording of ethnicity (and therefore as a 'success', *not* as a Personalised Care Adjustment).
Desired direction	Upwards
Thresholds	81% (LT), 95% (UT)
Points	45
Data source	General Practice Extraction Service (GPES)
Subject to declaration?	Yes

HI-02: Percentage of registered patients with a recording of ethnicity on their GP record	
Additional information	This indicator recognises PCNs for recording ethnicity information for patients for which this information is missing in GP records. Patients should not feel obligated to state their ethnicity if they prefer not to do so. In accordance with this principle, this indicator recognises PCNs for giving patients the opportunity to state their ethnicity, irrespective of whether they choose to do so. This means that, for this indicator, the following are treated as a successful recording of ethnicity: • Ethnicity recorded as not stated (Z code in NHS Data Dictionary ethnic category field) • 1024701000000100 Ethnicity not stated • 763726001 Refusal by patient to provide information about ethnic group (situation) The NHS Data Dictionary states that "National code Z should be used where the person has been given the opportunity to state their ethnic category but chose not to." As such, it should **not** be used in situations where patient ethnicity data is simply missing or unknown.

Cardiovascular disease prevention area

3.4 The NHS Long Term Plan commits to the prevention of 150,000 strokes, heart attacks and dementia cases by 2029 through the earlier detection and treatment of cardiovascular disease (CVD) risk factors. CVD is strongly associated with health inequalities – the most deprived quintile of the population is four times more likely to die from CVD than the least deprived. Of the A, B, C of CVD risk factors (atrial fibrillation, high blood pressure, and cholesterol), hypertension (high blood pressure), has the highest level of undetected prevalence. According to modelling by Public Health England, more than 30% of hypertension cases remain undiagnosed, with the prevalence gap (difference between prevalence and diagnosis) increasing in younger age groups. This is expected to have worsened over the past year due to the impact of COVID-19 on routine blood pressure (BP) monitoring. One of the central aims of the Network Contract DES Cardiovascular Disease Prevention & Diagnosis service requirements is to facilitate actions

to reduce the gap between identified and estimated prevalence in order to minimise population-level CVD risk.

CVD-01: Percentage of patients aged 18 years or over with an elevated blood pressure reading (≥ 140/90mmHg) and not on the QOF Hypertension Register, for whom there is evidence of clinically appropriate follow-up to confirm or exclude a diagnosis of hypertension	
Rationale for inclusion	An estimated 3 million people have a recorded reading of high blood pressure (BP) on GP systems, but have not had appropriate follow up to confirm or rule out a hypertension diagnosis. This issue is expected to have been exacerbated during the pandemic, which has seen a significant reduction in blood pressure readings taking place in primary care. This indicator encourages PCNs to follow up more patients with an elevated BP reading (including through proactive outreach, where possible) to assess them for hypertension, typically through provision of Ambulatory or Home Blood Pressure Monitoring.
Indicator type	Standard Quantitative
Running period	1 April 2022 – 31 March 2023
Denominator	Number of patients aged 18 years or over, not on the QOF Hypertension Register as of 31 March 2022, and who have (i) a last recorded blood pressure reading in the two years prior to 1 April 2022 ≥ 140/90mmHg or (ii) a blood pressure reading ≥ 140/90mmHg on or after 1 April 2022
Numerator	Of the denominator, those patients for whom there is evidence of clinically appropriate follow-up to confirm or exclude a diagnosis of hypertension by 31 March 2023 for cohort (i) and within six months of first elevated blood pressure reading after 1 April 2022 for cohort (ii). Clinically appropriate follow-up includes: 1. Initial BP reading < 140/90 mmHg (only relevant for patients in (i)) OR 2. Initial BP reading ≥ 140/90 mmHg AND a. (Subsequent change of medication AND subsequent blood pressure reading of <140/90 mmHg) OR b. Subsequent occurrence of Ambulatory Blood Pressure Monitoring OR

CVD-01: Percentage of patients aged 18 years or over with an elevated blood pressure reading (≥ 140/90mmHg) and not on the QOF Hypertension Register, for whom there is evidence of clinically appropriate follow-up to confirm or exclude a diagnosis of hypertension	
	c. Subsequent occurrence of Home Blood Pressure Monitoring OR d. (Addition to QOF Hypertension Register AND same day referral for specialist assessment) OR e. (Addition to QOF Hypertension Register AND (subsequent commencement of antihypertensive therapy OR patient declined antihypertensive therapy)).
Prevalence numerator	Number of patients on the QOF Hypertension Register as of 31 March 2022
Exclusions	Patients receiving end of life care
Personalised care adjustments	1. Patients included in part (ii) of the denominator with an initial elevated BP recorded between 1 October 2022 and 31 March 2023 inclusive, who are not followed up by the end of the financial year (patients will carry over to the denominator of CVD-01 in 2023/24). 2. Patient declined ambulatory/home blood pressure testing (Patient chose not to receive intervention). N.B. Patients declining a BP reading alone will **not** trigger a PCA.
Desired direction	Upward
Thresholds	25% (LT), 50% (UT)
Points	71
Data source	General Practice Extraction Service (GPES)
Subject to declaration?	Yes
Additional information	BP readings and clinical follow up can occur in general practice or in a community pharmacy and will still count towards achievement of this indicator, provided this activity is coded in GP clinical systems in accordance with the business rules.

CVD-01: Percentage of patients aged 18 years or over with an elevated blood pressure reading (≥ 140/90mmHg) and not on the QOF Hypertension Register, for whom there is evidence of clinically appropriate follow-up to confirm or exclude a diagnosis of hypertension	
	See guidance for the Network Contract DES CVD Prevention and Diagnosis service requirements for further information and advice on PCN actions to improve hypertension diagnosis. These service requirements are based on the Hypertension diagnosis and management NICE guidelines – particularly Section 1.2. The improved identification of hypertension risk will also be pursued by the Community Pharmacy Hypertension Case Finding service, which will provide increased opportunities for people to have their blood pressure managed in pharmacies. The intention is to update the thresholds for CVD-01 in 2023/24 and beyond, in line with NHSEI's ambition to prevent 150,000 strokes, heart attacks and dementia cases by 2029 through the earlier detection and treatment of CVD risk factors.

CVD-02: Percentage of registered patients on the QOF Hypertension Register	
Rationale for inclusion	This indicator further recognises PCNs for the hypertension diagnoses which can be expected from CVD-01 and the addition of these patients to the QOF Hypertension Register, along with the addition of other patients to the register who did not meet the requirements of CVD-01.
Indicator type	Improvement Quantitative
Running period	1 April 2022 – 31 March 2023
Denominator	Total number of registered patients
Numerator	Of the denominator, the number on the QOF Hypertension Register
Baseline (Improvement)	Percentage of patients on the QOF Hypertension Register on 31 March 2022
Prevalence numerator	Indicator denominator

CVD-02: Percentage of registered patients on the QOF Hypertension Register	
Exclusions	None
Personalised care adjustments	None
Desired direction	Upwards
Thresholds	0.6 percentage point increase (LT), 1.2 percentage point increase (UT)
Points	35
Data source	General Practice Extraction Service (GPES)
Subject to declaration?	Yes
Additional information	Hypertension diagnosis can occur in general practice or as a result of blood pressure monitoring in a community pharmacy, but must be coded in GP clinical systems. This indicator recognises PCNs on the basis of improving their performance relative to a base period – in this case, PCNs will be recognised for increases in the percentage of registered patients on the QOF Hypertension Register, as compared with 31 March 2022. CVD-02 is intended as a complement to CVD-01. While CVD-01 is a process indicator recognising PCNs for undertaking actions that should lead to increased hypertension diagnosis, CVD-02 is an 'outcome' indicator that recognises PCNs for actually achieving those increased diagnoses. Thresholds for this indicator have been chosen to ensure that (i) they align with the number of new hypertension diagnoses expected to arise from achievement of CVD-01, and (ii) they do not incentivise more diagnoses than are known to be needed based on estimates of the size of the prevalence gap.

CVD-03: Percentage of patients aged between 25 and 84 years inclusive and with a CVD risk score (QRISK2 or 3) greater than 20 percent, who are currently treated with statins	
Rationale for inclusion	Statin use has been shown to significantly reduce morbidity and mortality in patients at risk of cardiovascular disease. This indicator rewards practices for identifying and treating with statins the highest risk population for primary prevention of CVD, in line with NICE guideline CG181.
Indicator type	Standard Quantitative
Running period	1 April 2022 – 31 March 2023
Denominator	Number of patients aged 25 to 84 years inclusive and with a CVD score (QRISK2 or 3) greater than 20 percent
Numerator	Of the denominator, the number who are currently treated with statins (who were prescribed statins in the six months to the end of the reporting period)
Prevalence numerator	Indicator denominator
Exclusions	• Patients with established CVD • Patients at end of life
Personalised care adjustments	1. Patient declined 2. Not clinically suitable
Desired direction	Upwards
Thresholds	48% (LT), 58% (UT)
Points	31
Data source	General Practice Extraction Service (GPES)

CVD-03: Percentage of patients aged between 25 and 84 years inclusive and with a CVD risk score (QRISK2 or 3) greater than 20 percent, who are currently treated with statins	
Subject to declaration?	Yes
Additional information	The NHS Long Term Plan sets out ambitions to reduce the number of heart attacks, strokes and dementia cases by 150,000 by 2029/30. Statin use has been shown to significantly reduce morbidity and mortality in patients at risk of cardiovascular disease. High intensity statins are recommended as a cost-effective intervention by NICE. This indicator does not exclude treating people who have a QRISK score of 10% of higher, in line with CG181. However, it emphasises the need as a minimum to ensure that those with the highest need are treated, whilst allowing some flexibility on treatment options for those with a QRISK score of 10-19%. **Links to further resources** NICE Guidance: • Cardiovascular disease: risk assessment and reduction, including lipid modification • Statin intensity - Appendix A: Grouping of statins Accelerated Access Collaborative: • Summary of National Guidance for Lipid Management for Primary and Secondary Prevention of CVD

CVD-04: Percentage of patients aged 29 and under with a total cholesterol greater than 7.5 OR aged 30 and over with a total cholesterol greater than 9.0 who have been referred for assessment for familial hypercholesterolaemia	
Rationale for inclusion	The NHS Long Term Plan commits to increasing the diagnosis of familial hypercholesterolaemia (FH) from 7% to 25% by 2024/25. This indicator recognises PCNs for systematically searching their patient list to identify those with possible FH, and then referring for specialist assessment and/or genetic testing for FH in line with local pathways.
Indicator type	Standard Quantitative

CVD-04: Percentage of patients aged 29 and under with a total cholesterol greater than 7.5 OR aged 30 and over with a total cholesterol greater than 9.0 who have been referred for assessment for familial hypercholesterolaemia	
Running period	1 April 2022 – 31 March 2023
Denominator	Number of patients aged 29 years or under with a total cholesterol greater than 7.5 OR aged 30 years or over with a total cholesterol greater than 9.0.
Numerator	Of the denominator, the number referred for assessment for familial hypercholesterolemia
Prevalence numerator	Indicator denominator.
Exclusions	• Patients already with a genetically confirmed diagnosis of familial hypercholesterolemia • End of life patients • "Secondary hyperlipidaemia/ hypercholesterolemia (disorders)" WITHOUT subsequent "History of Secondary hyperlipidaemia/ hypercholesterolemia" coded
Personalised care adjustments	Referral for assessment for familial hypercholesterolemia declined
Desired direction	Upwards
Thresholds	20% (LT), 48% (UT)
Points	18
Data source	General Practice Extraction Service (GPES)
Subject to declaration?	Yes
Additional information	Familial hypercholesterolaemia (FH) is a genetic disorder which increases the likelihood of coronary artery disease, heart attacks and sudden cardiac death. It affects at least 150,000 people in England. The NHS Long Term Plan commits to increasing the

CVD-04: Percentage of patients aged 29 and under with a total cholesterol greater than 7.5 OR aged 30 and over with a total cholesterol greater than 9.0 who have been referred for assessment for familial hypercholesterolaemia	
	diagnosis of familial hypercholesterolaemia from 7% to 25% by 2024/25. Early detection and genetic diagnosis to enable early intervention will reduce risk and enable better outcomes for FH patients. This indicator recognises PCNs for systematically searching their patient list to identify those with possible FH, excluding any potential secondary causes, assessing further using Simon Broome or Dutch Lipid Network criteria, and then referring on for specialist assessment and/or genetic testing for FH in line with local pathways. The intention is to update the thresholds for CVD-04 in 2023/24, to align with NHSEI ambitions to align with the ambition to diagnose 25% of FH by 2024/25. **Links to further resources** • NICE FH guidance CG71 • Simon Broome Criteria • Dutch Lipid criteria – resource linked via Heart UK • Dutch Lipid criteria – Australian guidelines – Royal Australian College of General Practitioners • Accelerated Access Collaborative: Summary of National Guidance for Lipid Management for Primary and Secondary Prevention of CVD

CVD-05: Percentage of patients on the QOF Atrial Fibrillation register and with a CHA_2DS_2-VASc score of 2 or more (1 or more for patients that are not female), who were prescribed a direct-acting oral anticoagulant (DOAC), or, where a DOAC was declined or clinically unsuitable, a Vitamin K antagonist.	
Rationale for inclusion	This indicator recognises PCNs for increased DOAC prescribing to patients with Atrial Fibrillation (AF), in line with 2021 NICE guidance (NG196) establishing DOACs as first-line treatment for patients with AF.
Indicator type	Standard Quantitative
Running period	1 April 2022 – 31 March 2023

CVD-05: Percentage of patients on the QOF Atrial Fibrillation register and with a CHA_2DS_2-VASc score of 2 or more (1 or more for patients that are not female), who were prescribed a direct-acting oral anticoagulant (DOAC), or, where a DOAC was declined or clinically unsuitable, a Vitamin K antagonist.	
Denominator	Number of patients on the QOF Atrial Fibrillation register and a with CHA_2DS_2-VASc score of 2 or more (1 or more for patients that are not female).
Numerator	Of the denominator, the number who in the 6 months to the reporting period end date were either: • Success criterion 1: Prescribed a direct-acting oral anticoagulant (DOAC), or • Success criterion 2: Where a DOAC was declined or clinically unsuitable, a Vitamin K antagonist. Success criteria are evaluated sequentially. For more information, please consult NHS Digital Business Rules.
Prevalence numerator	Indicator denominator.
Exclusions	• Resolved AF diagnosis • A subsequent CHA_2DS_2-VASc score of less than 2 for females and less than 1 for patients that are not female • Mechanical prosthetic valve replacement (counts as an exclusion for success criterion 1 [DOAC prescribing] – see business rules for more information)
Personalised care adjustments	As this indicator has multiple success criteria that are evaluated sequentially, a PCA for the first success criterion (i.e. DOAC prescribing) will simply shift the patient into the pool for evaluation against the second criterion (i.e. Vitamin K antagonist prescribing), rather than removing them from the denominator altogether. Possible grounds for exception reporting in the traditional sense (i.e. removal from the denominator altogether, unless a success is registered) are: 1. First AF diagnosis in 3 months to reporting period end date 2. Oral anticoagulant clinically unsuitable 3. Oral anticoagulant declined 4. A combination of PCAs applying to success criteria 1 and 2 individually.

CVD-05: Percentage of patients on the QOF Atrial Fibrillation register and with a CHA_2DS_2-VASc score of 2 or more (1 or more for patients that are not female), who were prescribed a direct-acting oral anticoagulant (DOAC), or, where a DOAC was declined or clinically unsuitable, a Vitamin K antagonist.	
	PCAs for success criterion 1 (moves the patient to evaluation under success criterion 2) • DOAC clinically unsuitable (includes recordings of antiphospholipid syndrome). • 'DOAC not indicated' plus last recording of 'Time in Therapeutic Range' >= 65% in the six months to the reporting period end date. • DOAC declined. **PCAs for success criterion 2** • Vitamin K antagonist/ Warfarin clinically unsuitable. • Vitamin K antagonist / Warfarin declined.
Desired direction	Upwards
Thresholds	70% (LT), 95% (UT)
Points	66
Data source	GPES
Subject to declaration?	Yes
Additional information	The NHS Long Term Plan commits to reducing stroke in England in three ways: • Diagnosing more patients with undiagnosed AF (the "detect" gap) • Ensuring patients diagnosed with AF are offered anticoagulation where appropriate (the "protect" gap) • Optimising the anticoagulant pathway to ensure patient outcomes are optimised (the "perfect" gap) This indicator has been developed to support LTP ambitions on the "protect" gap and complement QOF indicator AF007, which

CVD-05: Percentage of patients on the QOF Atrial Fibrillation register and with a CHA_2DS_2-VASc score of 2 or more (1 or more for patients that are not female), who were prescribed a direct-acting oral anticoagulant (DOAC), or, where a DOAC was declined or clinically unsuitable, a Vitamin K antagonist.	
	rewards practices for ensuring that up to 70% of patients on their AF register are anticoagulated. It has two objectives: 1. To increase the overall percentage of AF patients who are prescribed an anticoagulant 2. To increase the use of DOACs as a proportion of anticoagulants prescribed Anticoagulation therapy can prevent around two thirds of strokes caused by AF. However, 16% of patients with AF are not on any form of anticoagulant. Likewise, 14% of patients currently receiving anticoagulation therapy are prescribed Warfarin. NICE guidance was updated in 2021 (NG196) to recommend that clinicians prescribe DOACs, rather than Warfarin as first-line treatment for patients with AF. Warfarin is associated with a more significant risk of serious bleeding (particularly intracranial haemorrhage) than DOACs. DOACs also do not require as much monitoring, freeing up capacity in primary care and improving quality of life for patients. Other benefits of DOACs over Warfarin include: • Fixed dosing with predictable pharmacokinetics and pharmacodynamics • Low drug–drug and food interactions, and no dietary restrictions • Rapid onset and offset and shorter half-life • Predictable effects on clotting, so routine monitoring of clotting factors is not needed • Wide therapeutic window In line with NG196, practices may achieve against this indicator by working to switch patients who are currently prescribed Warfarin or by prescribing patients who are newly diagnosed with AF a DOAC. However, it is important that switching patients who are currently prescribed Warfarin is done in a clinically appropriate way and as the result of a shared decision-making conversation. Recognising the importance of this, the indicator has been designed to accommodate patients who are unsuitable for a switch to DOACs or who declined to do so after a conversation with their clinician. PCNs will not be penalised for continuing to prescribe Warfarin where a patient has declined a DOAC or where a DOAC is clinically unsuitable. In these circumstances, the prescription of Warfarin will count as a “success”. Please consult above and business rules for more information.

CVD-06: Number of patients who are currently prescribed Edoxaban, as a percentage of patients on the QOF Atrial Fibrillation register and with a CHA_2DS_2-VASc score of 2 or more (1 or more for patients that are not female) and who are currently prescribed a direct-acting oral anticoagulant (DOAC).	
Rationale for inclusion	This indicator been introduced to support recent NHSEI Commissioning Guidance which recommends that clinicians should use Edoxaban where this is clinically appropriate. Any savings released will allow more patients with AF and other cardiovascular disease (CVD) to be diagnosed and treated.
Indicator type	Standard Quantitative
Running period	1 April 2022 – 31 March 2023
Denominator	Number of patients on the QOF Atrial Fibrillation register with a CHA_2DS_2-VASc score of 2 or more (1 or more for patients that are not female) and are currently prescribed a direct-acting oral anticoagulant (DOAC)
Numerator	Of the denominator, the number who are currently prescribed Edoxaban (who were prescribed Edoxaban in the 6 months to the reporting period end date)
Prevalence numerator	Indicator denominator
Exclusions	• Resolved AF diagnosis. • A subsequent CHA_2DS_2-VASc score of less than 2 for females and less than 1 for patients that are not female.
Personalised care adjustments	None
Desired direction	Upwards
Thresholds	25% (LT), 35% (UT)
Points	66
Data source	General Practice Extraction Service (GPES)

CVD-06: Number of patients who are currently prescribed Edoxaban, as a percentage of patients on the QOF Atrial Fibrillation register and with a CHA_2DS_2-VASc score of 2 or more (1 or more for patients that are not female) and who are currently prescribed a direct-acting oral anticoagulant (DOAC).	
Subject to declaration?	Yes
Additional information	DOACs are the highest spend medicines category in primary care, costing the NHS in England over £500m per annum. If patient numbers grow and no action, annual expenditure is expected to more than double. In 2021, NHSEI completed a transparent and compliant national procurement to give all DOAC suppliers an opportunity to update their value proposition to the NHS. All suppliers who responded to the procurement have been awarded national framework agreements, effective from 1 January 2022 to 31 March 2024. A single discounted price per product (irrespective of the volume used) is now available across primary and secondary care. NHSEI will manage the contracts to ensure that the rebates are paid in full back to CCGs (less any deduction to recover the NHSEI investment), and also to ensure supply meets demand. Daiichi Sankyo offered the most significant discount for their product, Edoxaban. Overall, the NHS can now treat significantly more patients using Edoxaban than any other DOAC, where clinically appropriate. In line with NG196, practices may achieve against this indicator by prescribing Edoxaban to patients who are newly diagnosed with AF or, depending on local policy, those who are currently prescribed a different brand of DOAC. NICE also supports affordability being taken into account as a differentiation between drugs. It is important that switching patients who are currently prescribed a different brand of DOAC to Edoxaban is done in a clinically appropriate way and as the result of a shared decision-making conversation. To emphasise this, this indicator excludes anyone who is prescribed warfarin because DOACs are contraindicated or because they have declined to switch. The thresholds for this indicator recognise that it can be difficult for primary care clinicians to switch patients from a medication they were originally prescribed in secondary care, even when the new medication is clinically appropriate. NHSEI has engaged with Trusts and CCGs, and will continue to do so, to ensure that DOAC prescribing in secondary care is also aligned to the procurement outcome.

4. Providing high quality care domain

Personalised care area

4.1 Personalised care is one of the five major practical changes to the NHS service model set out in the NHS Long Term Plan. The Long Term Plan commits to (i) rolling out the NHS Personalised Care model across the country, reaching 2.5 million people by 2023/24 and then aiming to double that again within a decade; (ii) widening, diversifying and making more accessible the range of support available to people across the country; (iii) ensuring the delivery of person-centred care; and (iv) expanding the choice and control that people have over the care that they receive.

PC-01: Percentage of registered patients referred to a social prescribing service	
Rationale for inclusion	Social prescribing is one of six key components of the NHS England comprehensive model for personalised care, and is a way for primary care staff and local agencies to refer people to a link worker. The NHS Long Term Plan commits to achieving 900,000 social prescribing referrals by 2023/24. Since 2020/21, PCNs have been required to provide access to a social prescribing service. Funding for employment of social prescribing link workers is been available to PCNs via the Additional Roles Reimbursement Scheme.
Indicator type	Standard Quantitative
Running period	1 April 2022 – 31 March 2023
Denominator	Total number of registered patients
Numerator	Of the denominator, the number referred to a social prescribing service
Prevalence numerator	Indicator denominator
Exclusions	None

PC-01: Percentage of registered patients referred to a social prescribing service	
Personalised care adjustments	Patient declined referral to social prescribing service
Desired direction	Upwards
Thresholds	1.2% (LT), 1.6% (UT)
Points	20
Data source	General Practice Extraction Service (GPES)
Subject to declaration?	Yes
Additional information	Social Prescribing Link Workers give people time to talk and focus on what matters to them as a person, as identified through shared decision-making or personalised care and support planning. They connect people to community groups and agencies for practical and emotional support. In the context of COVID-19, and ongoing self-isolation for some individuals, provision of high-quality social prescribing services can help prevent loneliness, or worsening physical health for at risk individuals. Capacity of the social prescribing service should be considered when making referrals. Where the social prescribing service is provided within the practice/PCN, individual Social Prescribing Link Worker caseloads are recommended to be between 200-250 annually. **Coding** Please note: Where a valid referral has been made (i.e. to a social prescribing service provided in fulfilment of the Network Contract DES requirements relating to social prescribing), the following SNOMED code should be used: • 871731000000106 | Referral to social prescribing service (procedure) This indicator **only** counts referrals made to a social prescribing service**,** as captured by the SNOMED code provided above. This SNOMED code, denoting referral to a social prescribing service,

PC-01: Percentage of registered patients referred to a social prescribing service	
	should be used even when the social prescribing service is provided within the practice or PCN – e.g. if a Social Prescribing Link Worker is employed under the Additional Roles Reimbursement Scheme. In this case, the referral is internal to the practice/PCN, but it is still a referral to a distinct service. This indicator does **not** count **offers** of social prescribing because it is necessary to know whether the offer has been accepted. It therefore only counts completed **referrals** to a social prescribing service. The purpose of this indicator is to count referrals to a service, **not** unique patient contacts. As such, this indicator does not count recording (by any means) of unique patient contacts by Social Prescribing Link Workers or any other type of health care professional (e.g. Care Coordinators or Health and Wellbeing Coaches). **Further Information** Welcome and induction pack for link workers in PCNs. NHS England: Social prescribing Reference guide for PCNs – information on setting up social prescribing services, including support for recruitment, induction and supervision. This guide also outlines quality assurance measures and explains how to gather information to develop a consistent evidence base for social prescribing. NHS England: Summary guide – describes what a good social prescribing scheme looks like, and includes a common outcomes framework to help measure the impact of social prescribing on people, the local system and the voluntary and community sector. Future NHS Social Prescribing Workspace – a space for social prescribing link workers and PCNs to access resources and updates about social prescribing, including national webinars, case studies, forums and contacts for local peer support and development opportunities. Social Prescribing - e-Learning – programme hosted by E-learning for Health and Health Education England aimed at link workers in PCNs. PCN reference guide technical annex

Enhanced health in care homes area

4.2 The Enhanced Health in Care Homes (EHCH) Vanguards programme demonstrated that outcomes for care home residents can be improved by provision of a coordinated care model delivering clinical support in care homes. The NHS Long Term Plan committed in 2019 to rolling out this framework across England between 2020 and 2024.

4.3 The Network Contract DES Enhanced Health in Care Homes Service Requirements embed this framework into the clinical support provided for care homes by PCNs. Indicators in this area support the implementation of the EHCH service requirements by recognising PCNs for strong delivery of key elements of the care model.

EHCH-01: Number of patients aged 18 years or over and recorded as living in a care home, as a percentage of care home beds aligned to the PCN and eligible to receive the Network Contract DES Enhanced Health in Care Homes service	
Rationale for inclusion	The successful delivery of the Enhanced Health in Care Homes service by PCNs requires the accurate and complete recording of care home resident status in GP systems. However, a significant number of care home residents in England are not recorded as being care home residents in GP clinical systems. This indicator recognises PCNs for more completely recording resident occupancy in care homes which are aligned to them.
Indicator type	Standard Quantitative
Running period	1 April 2022 – 31 March 2023
Denominator	Number of care home beds aligned to the PCN and eligible to receive the Network Contract DES Enhanced Health in Care Homes service
Numerator	Number of patients aged 18 years or over and recorded as living in a care home
Prevalence numerator	Indicator denominator

EHCH-01: Number of patients aged 18 years or over and recorded as living in a care home, as a percentage of care home beds aligned to the PCN and eligible to receive the Network Contract DES Enhanced Health in Care Homes service	
Exclusions	None
Personalised care adjustments	None
Desired direction	Upwards
Thresholds	30% (LT), 85% (UT)
Points	18
Data source	Denominator: Manual submission via the Calculating Quality Reporting Service (CQRS) Numerator: General Practice Extraction Service (GPES)
Subject to declaration?	Yes
Additional information	The denominator of this indicator will be populated by manual submission via CQRS of the number of care home beds for which the PCN is paid the care home bed premium, as defined in the Network Contract DES. The numerator of this indicator will count the number of registered patients aged 18 years or over and recorded as living in a care home by looking for the presence of one of the following four SNOMED codes: • 160734000 Living in nursing home • 394923006 Living in residential home • 248171000000108 Lives in care home (finding) • 1240291000000104 Living temporarily in care home (finding) The first three codes can have been added at any point in the past, provided that no alternative code has since been added denoting that the patient is no longer a care home resident. The fourth code must have been added in the previous twelve months.

EHCH-02: Percentage of care home residents aged 18 years or over, who had a Personalised Care and Support Plan (PCSP) agreed or reviewed	
Rationale for inclusion	This indicator rewards PCNs for strong delivery of Personalised Care and Support Plans (PCSPs), a key element of the Network Contract DES Enhanced Health in Care Homes (EHCH) service requirements.
Indicator type	Standard Quantitative
Running period	1 April 2022 – 31 March 2023
Indicator	Percentage of care home residents aged 18 years or over who had a Personalised Care and Support Plan (PCSP) agreed or reviewed.
Denominator	Number of care home residents aged 18 years or over.
Numerator	Of the denominator, the number who had a Personalised Care and Support Plan (PCSP) agreed or reviewed.
Prevalence numerator	Indicator denominator.
Exclusions	Patients not living in care home at end of reporting period.
Personalised care adjustments	1. Patient chose not to receive the intervention 2. Registration with general practitioner practice aligned to care home declined Care home residents are eligible to receive the additional support provided via Network Contract DES Enhanced Health in Care Homes service when they are registered at a practice that is part of the PCN that their care home is aligned to. When a care home resident is registered at a practice that is part of a different PCN, they should be offered the opportunity to re-register at a practice that is part of the PCN that their care home is aligned to. If they decline this offer, they are not eligible to receive this additional support and a Personalised Care Adjustment may be recorded by application of the above SNOMED code to their patient record at the general practice of registration.

EHCH-02: Percentage of care home residents aged 18 years or over, who had a Personalised Care and Support Plan (PCSP) agreed or reviewed	
Desired direction	Upwards
Thresholds	80% (LT), 98% (UT)
Points	18
Data source	General Practice Extraction Service (GPES)
Subject to declaration?	Yes
Additional information	Information and best practice advice guidance for the delivery these interventions can be found in the full guidance for the Network Contract DES EHCH Service Requirements. Further advice can also be found here: • Care Provider Alliance: EHCH - A guide for care homes. • Animation: "The care home weekly round: What does good look like?" Ensuring consistent and comprehensive coverage of Enhanced Health in Care Homes was highlighted as a key ambition for systems in 2022/23 national priorities and operational planning guidance.

EHCH-04: Mean number of patient contacts as part of weekly care home round per care home resident aged 18 years or over	
Rationale for inclusion	Provision of a weekly care home round lies at the heart of the Network Contract DES EHCH service requirements. This indicator will recognise delivery of the weekly care home round, as recorded in practice appointment books.
Indicator type	Standard Quantitative
Running period	1 April 2022 – 31 March 2023
Denominator	Number of care home residents aged 18 years or over

EHCH-04: Mean number of patient contacts as part of weekly care home round per care home resident aged 18 years or over	
Numerator	Number of general practice appointments categorised as 'patient contact as part of weekly care home round'.
Prevalence numerator	Indicator denominator
Exclusions	None
Personalised care adjustments	Registration with general practitioner practice aligned to care home declined • See EHCH-02 for further information about this Personalised Care Adjustment. • As EHCH-04 uses a different data source for the numerator and the denominator, this indicator does not apply the usual principle of Personalised Care Adjustments (PCAs), by which patients are retained in the denominator if they receive the intervention in question. Rather, care home residents to whom this PCA is applied are subtracted from the denominator, irrespective of the extent to which they have received the intervention in question.
Desired direction	Upwards
Thresholds	Mean of 6 patient contacts per care home resident (LT), Mean of 8 patient contacts per care home resident (UT)
Points available	13
Data source	Denominator: General Practice Extraction Service (GPES) Numerator: General Practice Appointments Data (GPAD)
Subject to declaration?	Yes
Additional information	A new set of national appointment categories was announced in March 2021 – one of these categories is “Patient contact as part of weekly care home round”. In 2021/22, IIF indicator ACC-01 recognised PCNs for mapping appointment slot types to these new national categories, as well as for confirming compliance with the August 2020 guidance on *More accurate general practice*

EHCH-04: Mean number of patient contacts as part of weekly care home round per care home resident aged 18 years or over	
	appointment data, published by NHSEI and the British Medical Association. A key principle of the August 2020 guidance is that each patient contact should be recorded as a separate appointment. This indicator builds on these improvements in the quality of general practice appointment data by recognising PCNs for delivery of the weekly care home round, as captured by the number of appointments that are mapped to the "Patient contact as part of weekly care home round" appointment category. This category should only be used to record patient-facing contacts – it should not be used, for example, to record instances where a patient is discussed at a Multi-Disciplinary Team meeting when the patient is not present. The thresholds for this indicator have been calculated based on the expected number of patient-facing contacts that will occur as part of the weekly care home round over a 12 month period. This indicator will count any appointment mapped to the "Patient contact as part of weekly care home round" category, irrespective of appointment mode – the appointment need not necessarily be face-to-face. Any appointment with the status "Attended", "Booked" or "Did Not Attend" will be counted towards the numerator of this indicator. No age restrictions are applied to the indicator, even though the denominator only counts care home residents aged 18 years or over. It is recognised that different patients have different needs – there is no expectation that each individual patient should receive a particular number of contacts as part of the weekly care home round. To reflect this recognition, the numerator for this indicator will be calculated by adding up all the appointments delivered as part of a weekly care home round, across all care home residents. Signing up to the GPAD Data Provision Notice (DPN) has since October 2020 been a core GMS contractual requirement. If a practice is signed up to the Network Contract DES but is not signed up to the GPAD DPN, any patient contacts recorded in its appointment books will not be extracted as part of the GPAD collection, and will not therefore count towards achievement of this indicator. However, any patients registered at that practice and recorded as living in a care home **will** be included in the denominator of this indicator. PCNs are therefore advised to ensure that all member practices are signed up to the GPAD DPN, so that all patient contacts delivered as part of weekly care

EHCH-04: Mean number of patient contacts as part of weekly care home round per care home resident aged 18 years or over	
	home rounds are properly counted for the purposes of this indicator. **Further information** In addition to the PCN Dashboard discussed in paragraphs 2.22 and 2.23 above, a breakdown of appointment volumes by each of the new appointment categories will be made available via an interactive General Practice Appointments Data (GPAD) private dashboard hosted by NHS Digital. This private dashboard will display a range of appointment data to practices and PCNs, with access to be controlled via the user's NHS smartcard. Practice-level appointment data has been available since September 2021, with PCN-level appointment data to be made available in 2022. Click here for a user guide to the NHS Digital GPAD private dashboard, which contains details on how to obtain access; for further information, email ssd.nationalservicedesk@nhs.net.

EHCH-06: Standardised number of emergency admissions on or after 1 October per care home resident aged 18 years or over	
Rationale for inclusion	Admission to hospital on an emergency basis is widely recognised as a negative marker of health outcomes. Evaluation of the Enhanced Health in Care Homes Vanguards found that the enhanced care offer provided by the programme resulted in lower rates of emergency admission to hospital. This indicator will recognise PCNs for improvements in care home resident health outcomes resulting from high quality delivery of the Network Contract DES EHCH service requirements.
Indicator type	Composite Quantitative
Running period	1 October 2022 – 31 March 2023
Denominator	Number of care home residents aged 18 years or over
Numerator	Age and sex standardised number of emergency admissions on or after 1 October for patients in the denominator (see Additional Information section for specification details, and see Annex B for standardisation details)

EHCH-06: Standardised number of emergency admissions on or after 1 October per care home resident aged 18 years or over	
Baseline (Improvement)	1 October 2021 – 31 March 2022
Prevalence numerator	Indicator denominator
Exclusions	See additional information for specification details
Personalised care adjustments	None
Desired direction	Downwards
Thresholds	Improvement: Reduction of 0 (LT), 0.02 (UT) Absolute: 0.15 (LT), 0.1 (UT)
Points	27
Data source	Denominator: General Practice Extraction Service (GPES) (patient level extract identifying patients recorded as living in a care home). Numerator: Hospital Episode Statistics (number of emergency admissions experienced by patients in the denominator).
Subject to declaration?	No – if a PCN believes that their data for this indicator is incorrect, they are advised to contact their commissioner to query the discrepancy.
Additional information	This indicator does not target a specific subset of emergency admissions but broadly all emergency admissions. This takes into consideration the broader drivers of emergency admissions from care homes, incentivising a system approach to delivering the required change through, for example primary and community MDTs. It is considered appropriate to target all-cause admissions for the care home population because the EHCH framework goes beyond general practice, bringing in community services and other primary care partners. Absolute performance against this indicator will be influenced significantly by the population that a PCN serves – for example

EHCH-06: Standardised number of emergency admissions on or after 1 October per care home resident aged 18 years or over	

	PCNs with older care home populations can expect to see higher emergency admission rates. In recognition of this, the indicator is standardised by age and sex (see Annex B for details), meaning that the admission rates calculated across PCNs are adjusted to show performance based on every PCN having the same age-sex demographic. This goes some way to make rates more comparable against the same absolute thresholds. However, partly in recognition that adjusting for age and sex differences will not account for all differences in performance driven by patient characteristics (both observed and unobserved), improvement thresholds are also applied to this indicator (year-on-year changes in emergency admission rates are less influenced by the characteristics of a PCN's registered patients than the emergency admission rate within a given year).
	
	Detailed data specification
	
	The following numerator and denominator details are relevant for both current year performance (1 October 2022 to 31 March 2023) and base year performance (1 Oct 2021 to 1 March 2022 (the latter being relevant to 'improvement' performance assessment).
	
	1. Denominator
	
	• Count: Patients recorded in GP systems as living in a care home (see EHCH-01 for SNOMED codes).
	  • Filters applied:
	  • [AGE] ≥ 18.
	
	2. Numerator
	
	• Data source: Patient level linkage of GPES and HES APC.
	
	• Count: Finished Admission Episodes ([EPISTAT] = 3, [EPIORDER] = 1)
	• Filters applied:
	  • Patients recorded in GP systems as living in a care home (see EHCH-01 for SNOMED codes).
	  • [ADMIMETH] = 21, 23, 24, 28, 2A, 2B, 2C, 2D.
	  • [ADMIDATE] (admission date) between 01/10/22 and 31/03/23
	  • [EPITYPE] = 1; General episodes (excludes birth and delivery episodes)
	  • [SEX] = 1 or 2: The sex of patient is male or female

Anticipatory care area

4.4 Anticipatory Care is a Long-Term Plan commitment to provide proactive and personalised health and support for multimorbid and frail individuals who would benefit most from integrated evidence-based care. Operational Planning Guidance for 2022/23 set out the requirement for ICSs to design, plan for and commission Anticipatory Care for their systems, working with relevant health and care providers and in line with the Anticipatory Care Operating Model. Indicators in this area are designed to support delivery of the AC model by encouraging PCNs, in partnership with other providers, to proactively identify and provide care for individuals through this multidisciplinary model of care.

AC-02: Standardised number of emergency admissions for specified Ambulatory Care Sensitive Conditions per registered patient	
Rationale for inclusion	Ambulatory Care Sensitive Conditions (ACSCs) are conditions that can be managed effectively at home and within the community but are susceptible to exacerbation and potential admission to secondary care. Although such admissions can be unavoidable, there are many instances where conditions could have been managed better, earlier in the community. Through joint work with other system partners, PCNs can improve outcomes for patients with these conditions to achieve a moderation in the rate of ACSC admissions. A subset of ACSCs have been included in the scope of this indicator on the basis that they are amenable to high quality, timely provision of care in general practice.
Indicator type	Composite Quantitative
Running period	1 April 2022 – 31 March 2023
Denominator	Total number of registered patients
Numerator	Age and sex standardised number of emergency admissions for specified Ambulatory Care Sensitive Conditions for patients in the denominator (see Additional Information section for specification details, and see Annex B for standardisation details)
Baseline (Improvement)	1 April 2021 – 31 March 2022

AC-02: Standardised number of emergency admissions for specified Ambulatory Care Sensitive Conditions per registered patient	
Prevalence numerator	Indicator denominator
Exclusions	See Additional Information for details of data specification
Personalised care adjustments	None
Desired direction	Downwards
Thresholds	Reduction: 0 (LT), 0.001 (UT) Absolute: 0.01 (LT), 0.008 (UT)
Points	111
Data source	Numerator: Hospital Episode Statistics (HES) – Admitted Patient Care dataset Denominator: NHAIS/PDS
Subject to declaration?	No – if a PCN believes that their data for this indicator is incorrect, they are advised to contact their commissioner to query the discrepancy.
Additional information	Ambulatory care sensitive conditions (ACSC) are conditions where hospital admissions may be prevented by interventions in primary care (Purdy et al, 2009). NHS Digital describes the most commonly used set of ACS conditions. The conditions included for this indicator (see full details below) are a subset of this set of conditions, considered to be particularly amenable to: • Effective long-term condition management in general practice (Group 1 below). • Rapid primary care response to an acute presentation (Group 2 below) The numerator of this indicator will be standardised by age and sex – see EHCH-06 Additional Information for rationale, and see Annex B for details of standardisation methodology.

AC-02: Standardised number of emergency admissions for specified Ambulatory Care Sensitive Conditions per registered patient	

	Detailed data specification
	
	The following numerator and denominator details are relevant for both current year performance (1 April 2022 to 31 March 2023) and base year performance (1 April 2021 to 1 March 2022 (the latter being relevant to 'improvement' performance assessment).
	
	1. Denominator
	
	• Total number of registered patients.
	
	2. Numerator
	
	• Data source: Hospital Episode Statistics (HES) – Admitted Patient Care dataset).
	
	• Count: Finished Admission Episodes ([EPISTAT] = 3 & [EPIORDER] = 1)
	
	• Filters applied
	  • [ADMIMETH] = 21, 23, 24, 28, 2A, 2B, 2C, 2D.
	  • [ADMIDATE] (admission date) between reporting period start and end dates
	  • [EPITYPE] = 1: It is a General episode:
	  • [STARTAGE] (age at start of episode) between 0 and 120
	  • [MYDOB] (Patient date of birth) not 01/01/1900 or 01/01/1901 representing unknown
	  • [SEX] = 1 or 2: The sex of patient is male or female
	  • [MAINSPEF] is not 501, 560 or 610: The Main specialty is not Obstetrics, Midwifery or General Practice with Maternity Function:
	  • [DIAG_01] does not begin with 'O': The primary diagnosis does not relate to Obstetrics, unless otherwise stated
	  • **Diagnosis and procedural coding for Group 1 and 2 – see bottom of table for full details** (DIAG_01 refers to primary diagnosis, OPERTN_01 refers to primary procedure).
	
	Group 1 – Amenable to effective long-term condition management in general practice
	
	• Asthma: DIAG_01 = J45, J46
	• Congestive heart failure: DIAG_01 = I110, I50, J81.
	  • Exclude where OPERTN_01 = K0-K3, K4, K50, K52, K55-K57, K60, K61, K66-K69, K71, K73, K74
	• Diabetes complications: DIAG_01 = E100-E108, E110-E118, E120-E128, E130-E138, E140-E148.
	• COPD: DIAG1 = J20, J41-J44, J47.

AC-02: Standardised number of emergency admissions for specified Ambulatory Care Sensitive Conditions per registered patient	

	• Only accept DIAG_01 = J20 if a secondary diagnosis code = J41-J44, J47
	• Hypertension: DIAG_01 = I10, I119
	  • Exclude where OPERTN_01 = K0-K4, K50, K52, K55-K57, K60, K61, K66-K69, K71
	• Convulsions and epilepsy: DIAG_01 = G40, G41, R56, O15.
	
	Group 2 – Amenable to rapid primary care response to an acute presentation
	• Influenza & Pneumonia: DIAG_01 = J10, J11, J13, J14, J153, J154, J157, J159, J168, J181, J188.
	  • Exclude if secondary diagnosis = D57.
	• Pyelonephritis: DIAG_01 = N10-N12, N136.
	• Cellulitis: DIAG_01 = L03, L04, L080, L088, L089, L88, L980, I89.1, L01, L02.
	  • Exclude if OPERTN_01 = A-R, S1-S3, S41-S45, S47-S49, T, V, W, X0-X2, X4, X5.
	• ENT infections: DIAG_01 = H66, H67, J02, J03, J06, J312, J04.0.

Cancer area

4.5 Indicators in this area support efforts to reduce the backlog of cancer care caused by the pandemic. They also support the NHS Long Term Plan ambition that the proportion of cancers diagnosed at stages 1 and 2 will rise from around half to three quarters of cancer patients by 2028.

CAN-01 Percentage of lower gastrointestinal two week wait (fast track) cancer referrals accompanied by a faecal immunochemical test result, with the result recorded either in the seven days leading up to the referral, or in the fourteen days after the referral.	
Rationale for inclusion	Evidence suggests that more effective implementation of Faecal Immunochemical Testing (FIT) could support the recovery of cancer waiting times and patient throughput by significantly reducing: 1. Referrals into secondary care, by providing a clear threshold under which patients can be safety-netted in primary care.

CAN-01 Percentage of lower gastrointestinal two week wait (fast track) cancer referrals accompanied by a faecal immunochemical test result, with the result recorded either in the seven days leading up to the referral, or in the fourteen days after the referral.	
	2. Demand for colonoscopy, by reducing the proportion of LGI 2WW referrals sent for colonoscopies which do not ultimately identify any pathology. This indicator will recognises PCNs for increasing the proportion of LGI referrals accompanied by a FIT test result.
Indicator type	Standard Quantitative
Running period	1 April 2022 – 31 March 2023
Denominator	Number of lower gastrointestinal two week wait (fast track) referrals for suspected cancer.
Numerator	Of the denominator, the number of referrals accompanied by a faecal immunochemical test, with the result recorded either in the seven days leading up to the referral, or in the fourteen days after the referral.
Prevalence numerator	Indicator denominator.
Exclusions	None
Personalised care adjustments	Provision of faecal immunochemical test kit declined, without a subsequent recording of a FIT test result
Desired direction	Upwards
Thresholds	40% (LT), 80% (UT)
Points	22
Data source	General Practice Extraction Service (GPES)

CAN-01 Percentage of lower gastrointestinal two week wait (fast track) cancer referrals accompanied by a faecal immunochemical test result, with the result recorded either in the seven days leading up to the referral, or in the fourteen days after the referral.	
Subject to declaration?	Yes
Additional information	There has been an eightfold increase in the colonoscopy backlog (number of patients waiting over six weeks for a colonoscopy) during the pandemic, from which services have yet to fully recover. Lower gastrointestinal (LGI) patients now account for more than a quarter of all patients who do not meet the 62-day standard,[3] with almost all breaching because of colonoscopy waits. It will be impossible to reduce the backlog to pre-pandemic levels unless LGI waiting times are improved. FIT has been introduced into the LGI urgent cancer pathway as a triage tool to support prioritisation of colonoscopy capacity for those at highest risk of colorectal cancer. FIT was first introduced through NICE guidance DG30 as a "rule in" test to the LGI urgent cancer pathway. At the start of the COVID-19 pandemic, FIT was introduced for all patients on the LGI urgent cancer pathway through NHSEI Clinical Guidance on triaging LGI patients. There are a number of steps a PCN may take to ensure that FIT is implemented across all practices: 1. **Encouraging patient uptake of FIT:** Make sure the patient is aware of the importance of completing a FIT test and returning it as quickly as possible. This could include sending instant text message reminders to patients. Cancer Research UK has materials to support patient uptake available on their website. 2. **Working closely with secondary care:** Utilise e-RS pre-referral specialist advice (or 'advice and guidance') where it is unclear if a patient requires an urgent referral based on their FIT result and symptoms. 3. **LGI urgent cancer forms:** Include information on FIT on the LGI 2WW referral form. If primary care is using the FIT result to decide whether a 2WW is appropriate, the numerical result for FIT should be included on the referral form to support secondary care to triage patients appropriately. If the FIT is

[3] 85% of patients diagnosed with cancer after an urgent (two week wait) referral should begin their first definitive treatment within 62 days of the initial referral.

CAN-01 Percentage of lower gastrointestinal two week wait (fast track) cancer referrals accompanied by a faecal immunochemical test result, with the result recorded either in the seven days leading up to the referral, or in the fourteen days after the referral.	
	given to accompany the referral it should be noted that a FIT kit has been given to the patient to complete. The lower threshold for CAN-01 will increase to 65% in 2023/24, to align with expected increased uptake of FIT over the next 12 months.

Access area

4.6 Improving access to general practice services is a core aim of both the NHS Long Term Plan and *Investment and Evolution*, the five-year GP contract framework. COVID-19 has also resulted in rapid and widespread changes in how patients access general practice services. IIF indicators in this area are designed to support improvements in access to general practice by recognising PCNs for helping more patients to access the right care, in the right place, at the right time.

ACC-02: Number of online consultation submissions received by the PCN per registered patient	
Rationale for inclusion	PCNs have been encouraged over the last few years to put in place digital access routes for patients – known as 'online consultation systems'. Having an online access route in place for patients via an online consultation system will become a contractual requirement from 1 October 2021 The purpose of this indicator is to recognise PCN member practices for providing and promoting online access for those patients who choose to use it and who find it beneficial, and to recognise that effective implementation of online systems takes time and effort.
Indicator type	Binary Quantitative
Running period	1 April 2022 to 31 March 2023

ACC-02: Number of online consultation submissions received by the PCN per registered patient	
Denominator	Total number of registered patients
Numerator	Number of online consultation submissions received by the PCN
Prevalence numerator	Indicator denominator
Exclusions	None
Personalised care adjustments	None
Desired direction	Upwards
Threshold	0.26 (single threshold)
Points	18
Data source	Denominator: General Practice Extraction Service (GPES) Numerator: OCVC Extended Collection (from OCVC suppliers)
Subject to declaration?	No – Data for this indicator will be provided on behalf of practices by Online Consultation System suppliers. If a PCN believes that their data for this indicator is incorrect, they are advised to contact their Online Consultation system supplier to query the discrepancy.
Additional information	The numerator will count all online consultation submissions received by all Core Network Practices of the PCN, irrespective of whether they relate to a clinical issue or an administrative issue. Online access is not a replacement for other access routes and will not be suitable for all patients' needs or circumstances. Online access should, therefore, always be available alongside other access options. PCNs should agree their models of access and how their Core Network Practices' online consultation

ACC-02: Number of online consultation submissions received by the PCN per registered patient	
	system is used alongside other access routes, taking into consideration the needs of their local community. The activity level called for by this indicator has been set at a **minimal** level, as its purpose is to demonstrate that practices in the PCN have a functioning online route to access care, for those patients that choose to use it. As such, this IIF indicator is based on a single activity threshold for online consultation submissions received by the PCN – this threshold has been set at a modest level, corresponding to five online consultation submissions received by the PCN per 1000 registered patients per week. This constitutes the minimum activity level needed to be able to demonstrate that member practices have an online access route, that they promote it to their patients and that patients are able to use the system to seek care or advice. To earn points in relation to this indicator, PCNs must ensure that member practices sign up to the Data Provision Notice (DPN) that has been issued in relation to the OCVC Extended Collection that will be used to provide the numerator of this indicator. If a member practice does not sign up to this DPN, any online consultation submissions it receives will not be provided by online consultation platform suppliers as part of this data collection, and will not therefore count towards achievement of this indicator. However, any patients registered at that practice **will** be included in the denominator of this indicator. PCNs are therefore advised to ensure that all member practices are signed up to any DPN that is issued in relation to the OCVC Extended Collection, so that all online consultation submissions received by the practice can be properly counted for the purposes of this indicator. **Further information** • Guidance on implementing an online consultation system: NHS England » Using online consultations in primary care: implementation toolkit. • Guidance on implementing a 'total triage' process using online consultation systems: Report template - NHSI website. • Further guidance and resources are available on the Digital Primary Care - FutureNHS Collaboration Platform (requires login). • Data Provision Notice (DPN) Online and Video Consultation in General Practices

ACC-05: By 31 March 2023, make use of GP Patient Survey results for practices in the PCN to (i) identify patient groups experiencing inequalities in their experience of access to general practice, and (ii) develop, publish and implement a plan to improve patient experience and access for these patient groups, taking into account demographic information including levels of deprivation	
Rationale for inclusion	This indicator will recognise PCNs for taking practical and measurable steps to improve access to general practice for patient groups who experience inequalities and who are at greater risk of experiencing poor access.
Indicator type	Qualitative
Running period	1 April 2022 to 31 March 2023
Denominator	N/A
Numerator	N/A
Prevalence numerator	N/A
Exclusions	N/A
Personalised care adjustments	N/A
Desired direction	N/A
Thresholds	N/A
Points	48
Data source	Manual confirmation of completion via CQRS
Subject to declaration?	No

ACC-05: By 31 March 2023, make use of GP Patient Survey results for practices in the PCN to (i) identify patient groups experiencing inequalities in their experience of access to general practice, and (ii) develop, publish and implement a plan to improve patient experience and access for these patient groups, taking into account demographic information including levels of deprivation	
Additional information	This indicator asks that, by 31 March 2023, PCNs should make use of the 2021/22 General Practice Patient Survey (GPPS) results for member practices to (i) identify patient groups experiencing inequalities in their experience of access to general practice, and (ii) develop and implement a plan to improve access for these patient groups. We particularly suggest that PCNs review the following GPPS questions, as well as considering feedback directly from their patient population: • Q16 – why patients who wanted an appointment did not receive one • Q19 – patients who avoided making an appointment • Q20 – patients' overall experience of making an appointment • Q30 – overall experience PCNs are strongly encouraged to also make use of other data and sources of evidence when identifying groups experiencing inequalities in access, particularly those which provide information on local demographics and levels of deprivation. PCNs should also consider Core20PLUS5[4], which is aimed at supporting the reduction of health inequalities at both national and system level. This plan should take the form of a written document, based on SMART principles,[5] prepared by the PCN with input from all member practices submitted to their CCG, which sets out: • The patient groups being targeted • A plan for improving access for these patient groups • How that improvement will be measured Plans will then be published by the CCG. PCNs should consider developing and sharing their plans with local interested partners, for example, their constituent practices' Patient Participation Groups (PPGs) and local Healthwatch England.

[4] For more information on Core20PLUS5, click here
[5] See Section 5 of QOF Guidance 2022/23 on Quality Improvement for further information about SMART principles.

ACC-05: By 31 March 2023, make use of GP Patient Survey results for practices in the PCN to (i) identify patient groups experiencing inequalities in their experience of access to general practice, and (ii) develop, publish and implement a plan to improve patient experience and access for these patient groups, taking into account demographic information including levels of deprivation	
	Improvement should be aimed at reducing health inequalities and improving patient experience. In developing and implementing their improvement plan, PCNs should also consider any points of overlap or synergies with the 2022/23 QOF Quality Improvement module on improving access to general practice.

ACC-07: Number of pre-referral Specialist Advice requests across twelve specialties identified for accelerated delivery per outpatient first attendance	
Rationale for inclusion	Planning Guidance for 2021/22 and 2022/23 has required that all systems continue to increase utilisation of Specialist Advice in support of elective recovery. It is recognised that these services have a key role to play in supporting the provision of effective and co-ordinated management of care in key specialty areas, preventing unnecessary referrals to secondary care, and freeing up capacity to address the elective care backlog. This indicator has been introduced to reward PCNs for the utilisation of pre-referral Specialist Advice services (sometimes known as Advice and Guidance) in twelve specialties identified for accelerated uptake.
Indicator type	Standard Quantitative
Running period	1 April 2022 – 31 March 2023
Denominator	Total number of outpatient first attendances across twelve specialties identified for accelerated delivery (Cardiology, Dermatology, Gastroenterology, Gynaecology, Neurology, Urology, Paediatrics, Endocrinology, Haematology, Rheumatology, Respiratory, Ear, Nose and Throat).
Numerator	Total number of processed pre-referral Specialist Advice (e.g. Advice and Guidance) requests across the twelve specialties identified for accelerated delivery

ACC-07: Number of pre-referral Specialist Advice requests across twelve specialties identified for accelerated delivery per outpatient first attendance	
Prevalence numerator	Number of registered patients (i.e. no prevalence adjustment)
Exclusions	None
Personalised care adjustments	None
Desired direction	Upwards
Thresholds	0.066 (LT), 0.19 (UT)
Points	44
Data source	Numerator: System Elective Recovery Outpatient Collection (S-EROC) Denominator: Outpatient HES/SUS
Subject to declaration?	Yes – If PCNs believe that their S-EROC data is incomplete, they will have the opportunity within CQRS to decline to declare their achievement, and to provide evidence to their commissioner of any pre-referral Specialist Advice activity undertaken but not included in S-EROC. Commissioners will then be able to update the PCN's indicator data within CQRS.
Additional information	**e-RS configuration** Most SA activity takes place via the NHS e-Referral Service (e-RS). e-RS SA pathways should be designed and commissioned locally in collaboration with both primary and secondary care. Commissioned pathways should then be configured on e-RS in order to enable submission of processed SA requests. PCNs are recommended to raise any technical issues relating to e-RS configuration with the IT/Application Support Team in their ICS. ICSs should have a named Registration Authority Manager who has e-RS access rights and the authority to process smart card role changes. Where Specialist Advice (or Advice and Guidance) is expected from secondary care (as is required by Planning Guidance) but not available, PCNs are recommended to contact the elective care

ACC-07: Number of pre-referral Specialist Advice requests across twelve specialties identified for accelerated delivery per outpatient first attendance	
	commissioning teams in their CCG or ICS to explore whether or how these services may be accessed. Additional information on e-RS for referrers and referring clinician teams is available here. **Data collections and third-party providers** This indicator will measure the number of processed pre-referral SA requests using the System Elective Recovery Outpatient Collection (S-EROC). This national data collection can include SA activity generated through the use of third-party providers where measures have been taken at a local level for data from these providers to be included in submissions to the overall S-EROC collection. Inclusion of data on processed SA requests from third party platforms in S-EROC submissions is an ICS responsibility. It is recognised that there may be some PCNs who use third party SA platforms whose data is not currently included in their system's S-EROC submission. In this instance, it is recommended that PCNs contact the Commissioning or Outpatient Transformation Lead responsible for Referral Optimisation in their ICS. They will be able to engage with Business Intelligence or Information Analysts to understand and influence what is included within ICS submissions in line with S-EROC guidelines. In addition to manual ICS submission of third-party platform SA data into S-EROC, NHSEI has also established a facility for SA data from some third party platforms to flow on an automated basis into S-EROC. NHSEI intends to expand the range of third-party platforms with this automated extraction facility over the coming months. To participate in this automated extraction, the local data controller (typically this will be the CCG) must provide authorisation and consent to the third-party platform to release their data to S-EROC. While participation in this automated extraction facility is typically a CCG responsibility and is not the responsibility of individual PCNs, if a PCN wants to know whether their CCG has signed up to participating in this automated extraction for their third party platform, or wants to ask that they do so, it recommended that they contract their CCG's Performance and/or Analytics Lead within their CCG, who should be able to signpost them on to the data controller for SA platforms. **Raising queries relating to local SA provision** The named roles responsible for SA may vary between CCGs. NHSE/I Regional Leads, Heads of Primary Care and Regional

ACC-07: Number of pre-referral Specialist Advice requests across twelve specialties identified for accelerated delivery per outpatient first attendance	

	Leads for Referral Optimisation should all be able to support the navigation of queries relating to SA to the relevant contacts.
	
	Contact details for Regional Leads for Referral Optimisation can be found through the Referral Optimisation Community of Practice, accessible via FutureNHS.
	
	Guidance and further resources
	
	More information and resources can also be found through the Referral Optimisation Community of Practice portal, accessible via FutureNHS.
	
	Detailed data specification
	
	1. Denominator
	
	• Data source: Secondary User Services (SUS) Outpatient dataset
	• Count: Total number of outpatient first attendances across twelve specialties identified for accelerated delivery (Cardiology, Dermatology, Gastroenterology, Gynaecology, Neurology, Urology, Paediatrics, Endocrinology, Haematology, Rheumatology, Respiratory, Ear, Nose and Throat).
	• Filters applied:
	  • [Administrative_Category] = 1 (NHS funded)
	  • [Attendance_Status] = 5, 6 (attended and was seen)
	  • [First_Attendance] = 1, 3 (first attendance)
	  • [Treatment_Function_Code] = 101, 301, 320, 330, 400, 502, 120, 302, 303, 340, 410, 420
	
	2. Numerator
	
	• Data source: System Elective Recovery Outpatient Collection (SEROC)
	• Count: Total reported processed requests for pre referral specialist advice across twelve specialties identified for accelerated delivery
	• Filters applied
	  • [Type of Referral Optimisation Interaction] = 01 (specialist advice)
	  • [Treatment Function Code for request] = 101, 301, 320, 330, 400, 502, 120, 302, 303, 340, 410, 420
	  • [Request status] ≠ 02 (Still Open / Ongoing)
	  • [Outcome of interaction] ≠ 40 (Rejected)

ACC-08: Percentage of patients whose time from booking to appointment was two weeks or less	
Rationale for inclusion	Improving access to general practice is one of the most significant challenges facing primary care in England, with challenges accessing GP appointments recognised as one of the reasons for public dissatisfaction with the NHS. This indicator recognises PCNs for increases in the percentage of patients whose time from booking to appointment is two weeks or less. It will serve as a 'lead in' to an updated indicator in the 2023/24 IIF which better enables the measurement of the true excess wait time between booking and appointment by introducing 'appointment exception reporting' functionality.
Indicator type	Standard Quantitative
Running period	1 April 2022 – 31 March 2023
Denominator	Number of appointments delivered by the general practice under eight national appointment categories[6]
Numerator	Of the denominator, the number for which the time from booking to appointment was two weeks (14 days) or less
Prevalence numerator	Indicator denominator
Exclusions	None
Personalised care adjustments	None
Desired direction	Upwards
Thresholds	85% (LT), 90% (UT)

[6] General Consultation Acute; General Consultation Routine; Unplanned Clinical Activity; Clinical Triage; Walk-in; Home Visit; Care Home Visit; Care Related Encounter but does not fit into any other category.

ACC-08: Percentage of patients whose time from booking to appointment was two weeks or less	
Points	71
Data source	GP Appointments Data (GPAD)
Subject to declaration?	Yes
Additional information	Improving access to general practice is one of the most significant challenges facing primary care in England, with challenges accessing GP appointments long recognised as one of the reasons for public dissatisfaction with the NHS.[7] At least three government manifesto commitments – to deliver 50 million extra appointments in general practice; deliver 6,000 new GPs; and deliver 26,000 new clinicians in general practice via the Network Contract DES Additional Roles Reimbursement Scheme – aim to tackle this challenge. In spite of being a high policy priority, there is not currently a robust way of measuring progress in tackling some of the key ways that that patients experience poor access to general practice – namely, having to wait a long time for an appointment or to get through to the GP practice on the phone. This indicator makes a start in measuring the excess wait time between booking and appointment in general practice, by rewarding PCNs for increases in the percentage of patients with a time from booking to appointment of two weeks or less. GPAD includes a set of 17 national appointment categories which enable one to distinguish between appointments for which patients will frequently want the first available appointment (so that timely availability is valued by the patient), and appointments such as reviews and check-ups that are typically scheduled in advance. ACC-08 only includes appointments mapped to national categories in the former group, i.e.: • General Consultation Acute • General Consultation Routine • Unplanned Clinical Activity

[7] The 2021 GP Patient Survey results showed that 67% of patients were satisfied with the appointment times available to them, while 58.9% received an appointment at a time they wanted or sooner. While the results represent an increase relative to the 2020 results (when the corresponding results were 63% and 56.5% respectively), the fact remains that a third of survey respondents or more report an inability to obtain a timely appointment.

ACC-08: Percentage of patients whose time from booking to appointment was two weeks or less	
	• Clinical Triage • Walk-in • Home Visit • Care Home Visit • Care Related Encounter but does not fit into any other category. Any appointment mapped to one of the above eight national categories is in scope of ACC-08, irrespective of: • The mode (method) by which the appointment was delivered (e.g. face-to-face, telephone). • Whether the appointment is recorded as 'Attended', 'Booked', or 'Did Not Attend'. **Are general practice waiting times still relevant in a post-pandemic world?** The way that general practice provides care and advice to patients has changed dramatically in response to COVID-19, and some of the positive innovations prompted by the pandemic – for example, a greater focus on triage and online consultations – will become enduring features of general practice. ACC-08 is intended to take account of these changes to general practice. The August 2020 definition of an appointment (namely, appointments are "discrete interactions between a health or care professional and a patient, or a patient's representative") encompasses both triage and online consultations, including asynchronous communications such as a written exchange over an app. Where these interactions are recorded in general practice appointment books, and provided they occur within two weeks of the patient making the request – which would presumably be the case in the vast majority of instances – the interaction would be in scope of ACC-08 and would count as 'success'. **Measuring 'true waiting times' – introducing appointment exception reporting** There are at least two reasons why time from booking to appointment might not capture 'true' waiting time for an appointment in general practice (which might be defined as the difference in time between when a patient wanted an appointment and when they received one). 1. Some patients may explicitly request an appointment on a defined future date, or express a preference concerning the appointment that has the same effect. Alternatively, there may be a clinically defined interval between encounters – e.g. the GP may say "come back and see me in four weeks".

ACC-08: Percentage of patients whose time from booking to appointment was two weeks or less	
	2. Patients may struggle to make contact with their practice at the first time of asking (e.g. the telephone may be engaged), meaning that, even if they request the first available appointment, time from booking to appointment will underestimate the true length of time they waited. To address the first point, which has the potential to negatively affect a PCN's achievement of this indicator, from 2023/24 a new system of appointment exception reporting will be introduced within GP IT systems. This will enable construction of a better measure of waiting times in general practice, by enabling restriction of attention to appointments for which time from booking to appointment is a better proxy for 'true' waiting time. From 2023/24, if one of a number of extenuating circumstances is flagged as applying to an appointment (e.g. patient requests appointment on a defined future date more than two weeks in advance), that appointment will be omitted from ACC-08 if the time from booking to appointment is greater than two weeks. If on the other hand the time from booking to appointment is two weeks or less, the appointment would still be included in calculation of ACC-08 and would count as a success. **Thresholds** In 2022/23, the thresholds for ACC-08 have been set at a relatively modest level – the lower threshold of 85% corresponds to the 20th percentile of current national performance, while the upper threshold of 90% corresponds to the 50th percentile (i.e. median performance). This means that PCNs will need to ensure that performance is at the currently median to earn all available points. The 2022/23 thresholds provide ample headroom for PCNs to continue to book appointments more than two weeks in advance if there are no appointments available in the next two weeks, if the patient requests an appointment in the future, or if there is a clinically indicated interval between appointments. PCNs should continue to make appointments available more than two weeks in advance, and should continue to book patients into these appointments where it is in the patient's best interests to do so. Commissioners are expected to closely monitor the rollout of this indicator to ensure that practices are not closing their appointment books more than two weeks in advance, as part of their assurance that general practice is meeting their contractual requirements. From 2023/24, when appointment exception reporting functionality is introduced in GP IT systems, this indicator will revert to the thresholds originally announced in August 2021 – i.e. a lower

ACC-08: Percentage of patients whose time from booking to appointment was two weeks or less	
	threshold of 90% and an upper threshold of 98%. These more ambitious thresholds reflect the view that, unless one of the five above grounds for exception reporting applies, every patient whose needs would best be met by an appointment in general practice, should receive that appointment within two weeks.

ACC-09: Number of referrals to the Community Pharmacist Consultation Service per registered patient	
Rationale for inclusion	The NHS Community Pharmacist Consultation Service (CPCS) was launched by NHSEI in 2019. Under the CPCS, practices can refer patients with a minor illness for a same day appointment with a community pharmacist. CPCS supports improved access to services, utilises the skills and medicines knowledge of pharmacists, and provides convenient treatment close to patients' homes.
Indicator type	Binary Quantitative
Running period	1 April 2022 – 31 March 2023
Denominator	Total number of registered patients
Numerator	Number of referrals to the Community Pharmacist Consultation Service for patients in the denominator
Prevalence numerator	Indicator denominator
Exclusions	N/A
Personalised care adjustments	N/A
Desired direction	Upwards

ACC-09: Number of referrals to the Community Pharmacist Consultation Service per registered patient	
Thresholds	0.034 (single threshold)
Points	27
Data source	General Practice Extraction Service (GPES)
Subject to declaration?	Yes
Additional information	**Coding** Two new SNOMED codes have been created for practices to use when they have offered to refer a patient to the CPCS: • 1362511000000107 | Referral to Community Pharmacist Consultation Service • 1362521000000101 | Referral to Community Pharmacist Consultation Service refused The numerator of ACC-09 will count the number of times the first code (1362511000000107) is applied to the records of registered patients. **Activity** The activity level called for by this indicator has been set at a **minimal** level, as its purpose is to demonstrate that practices in the PCN have a functioning referral pathway to community pharmacy under the CPCS. As such, this IIF indicator is based on a single activity threshold for CPCS referrals – this threshold has been set at a modest level, corresponding to 0.65 CPCS referrals per 1000 registered patients per week. **Further support and resources** Additional practice support is available nationally (between March and June 2022) to engage directly with practices and PCNs on the implementation of referrals to CPCS. Regional CPCS team contact information and other resources for general practice, PCN and pharmacy staff can be found here. **NHSEI Pharmacy Integration Fund website: CPCS resources** • The Toolkit for pharmacy staff provides a practical guide on providing the NHS CPCS service. • The GP/PCN toolkit provides a practical guide to implementing the minor illness referral pathway from general practice to community pharmacy via CPCS.

ACC-09: Number of referrals to the Community Pharmacist Consultation Service per registered patient	
	• This briefing note explains how the GP referral pathway works and how to implement it in PCNs and practices. • The full CPCS service specification is available here: Advanced Service Specification – NHS Community Pharmacist Consultation Service.

Structured medication reviews and medicines optimisation area

4.7 Indicators in this area focus on structured medication reviews, a National Institute for Health and Care Excellence (NICE) approved clinical intervention that help people who have complex or problematic polypharmacy.

SMR-01A: Percentage of patients at risk of harm due to medication errors who received a Structured Medication Review	
Rationale for inclusion	SMR-01 recognises PCNs for delivering structured medication reviews (SMRs) to patients in priority cohorts. SMRs are a comprehensive clinical review of a patient's medicines and detailed aspects of their health. They are delivered by facilitating shared decision-making conversations with patients aimed at ensuring that their medication is working well for them.
Indicator type	Standard Quantitative
Running period	1 April 2022 – 31 March 2023
Denominator	Total number of patients at risk of harm due to medication errors, as defined by any of the following: • Patients aged 65 or over prescribed an oral NSAID and not prescribed a gastroprotective. • Patients aged 18 or over with a history of peptic ulceration prescribed an oral NSAID • Patients aged 18 or over with a history of peptic ulceration prescribed an anti-platelet • Patients aged 18 or over prescribed both an oral anticoagulant and an oral NSAID within 28 days of each other

SMR-01A: Percentage of patients at risk of harm due to medication errors who received a Structured Medication Review	
	• Patients aged 18 or over prescribed both an oral anticoagulant and an anti-platelet within 28 days of each other. • Patients aged 18 or over prescribed both an aspirin and another type of anti-platelet within 28 days of each other • Patients aged 18 or over with an unresolved heart failure diagnosis prescribed an oral NSAID. • Patients aged 18 or over with an eGFR of less than 45ml per minute prescribed an oral NSAID. • Patients aged 18 or over with an unresolved asthma diagnosis prescribed a non-selective beta-blocker.
Numerator	Of the denominator, the number who received at least one Structured Medication Review
Prevalence numerator	Indicator denominator
Exclusions	N/A
Personalised care adjustments	1. Patient is receiving end of life care (intervention clinically unsuitable) 2. The patient has chosen not to receive the intervention described in the indicator
Desired direction	Upwards
Thresholds	44% (LT); 62% (UT)
Points	26
Data source	General Practice Extraction Service (GPES)
Subject to declaration?	Yes
Additional information	**Links to resources and further guidance** • Network Contract DES: Structured Medication Review Guidance • Royal Pharmaceutical Society: Polypharmacy best practice guide

SMR-01A: Percentage of patients at risk of harm due to medication errors who received a Structured Medication Review	

	• SMR Principles – NHS England Pharmacy Integration Programme – FutureNHS Collaboration Platform
	• Shared Decision Making guidance:
	  • NICE
	  • Keele University SDM Package
	  • CPPE Training

SMR-01B: Percentage of patients living with severe frailty who received a Structured Medication Review	
Rationale for inclusion	SMR-01 recognises PCNs for delivering structured medication reviews (SMRs) to patients in priority cohorts. SMRs are a comprehensive clinical review of a patient's medicines and detailed aspects of their health. They are delivered by facilitating shared decision-making conversations with patients aimed at ensuring that their medication is working well for them.
Indicator type	Standard Quantitative
Running period	1 April 2022 – 31 March 2023
Denominator	Number of patients living with severe frailty.
Numerator	Of the denominator, the number who received at least one Structured Medication Review
Prevalence numerator	Indicator denominator
Exclusions	N/A
Personalised care adjustments	1. Patient is receiving end of life care (intervention clinically unsuitable) 2. The patient has chosen not to receive the intervention described in the indicator
Desired direction	Upwards

SMR-01B: Percentage of patients living with severe frailty who received a Structured Medication Review	
Thresholds	44% (LT); 62% (UT)
Points	9
Data source	General Practice Extraction Service (GPES)
Subject to declaration?	Yes
Additional information	See SMR-01A Additional Information for links to resources and further guidance on structured medication reviews.

SMR-01C: Percentage of patients using potentially addictive medicines who received a Structured Medication Review	
Rationale for inclusion	SMR-01 recognises PCNs for delivering structured medication reviews (SMRs) to patients in priority cohorts. SMRs are a comprehensive clinical review of a patient's medicines and detailed aspects of their health. They are delivered by facilitating shared decision-making conversations with patients aimed at ensuring that their medication is working well for them.
Indicator type	Standard Quantitative
Running period	1 April 2022 – 31 March 2023
Denominator	Total number of patients using potentially addictive medicines, defined as patients falling into either one or both of the following sub-cohorts: • Cohort 1: Patients with 2 or more prescriptions over a 3-month period for any of the following four classes of medicine: a. Gabapentinoids. b. Benzodiazepines. c. Z-drugs. d. Any oral or transdermal opioid other than: i. Weak opioids (Codeine, Dihydrocodeine, Meptazinol). ii. Heroin substitutes (including Methadone, Buprenorphine).

SMR-01C: Percentage of patients using potentially addictive medicines who received a Structured Medication Review	
	• Cohort 2: Patients with a single prescription for an oral or transdermal opioid with > 120 mg oral morphine equivalent
Numerator	Of the denominator, the number who received at least one Structured Medication Review
Prevalence numerator	Indicator denominator

Exclusions	The following exclusions apply to each cohort:
	• Cohort 1: Any opioid prescribed to cancer patients (patients with a cancer diagnosis recorded in the previous 6 months, irrespective of whether this diagnosis is a first/new occurrence, a recurrence, or continuing condition).
	• Cohort 2:
	  • Codeine, Dihydrocodeine, Meptazinol, Heroin alternatives (including Methadone, Buprenorphine).
	  • Cancer patients (patients with a cancer diagnosis recorded in the previous 6 months, irrespective of whether this diagnosis is a first/new occurrence, a recurrence, or continuing condition).

Personalised care adjustments	1. Patient is receiving end of life care (intervention clinically unsuitable) 2. The patient has chosen not to receive the intervention described in the indicator
Desired direction	Upwards
Thresholds	44% (LT); 62% (UT)
Points	9
Data source	General Practice Extraction Service (GPES)
Subject to declaration?	Yes
Additional information	See SMR-01A Additional Information for links to resources and further guidance on structured medication reviews.

SMR-01D: Percentage of permanent care home residents aged 18 years or over who received a Structured Medication Review	
Rationale for inclusion	SMR-01 recognises PCNs for delivering structured medication reviews (SMRs) to patients in priority cohorts. SMRs are a comprehensive clinical review of a patient's medicines and detailed aspects of their health. They are delivered by facilitating shared decision-making conversations with patients aimed at ensuring that their medication is working well for them.
Indicator type	Standard Quantitative
Running period	1 April 2022 – 31 March 2023
Denominator	Number of permanent care home residents aged 18 years or over
Numerator	Of the denominator, the number who received at least one Structured Medication Review
Prevalence numerator	Indicator denominator
Exclusions	N/A
Personalised care adjustments	1. Patient declined offer of a Structured Medication Review 2. Registration with general practitioner practice aligned to care home declined
Desired direction	Upwards
Thresholds	44% (LT); 62% (UT)
Points	9
Data source	General Practice Extraction Service (GPES)
Subject to declaration?	Yes
Additional information	See SMR-01A Additional Information for links to resources and further guidance on structured medication reviews.

SMR-02A: Percentage of patients aged 18 years or over prescribed both a Non-Steroidal Anti-Inflammatory Drug (NSAID) and an oral anticoagulant in the last three months of the previous financial year, who in the three months to the reporting period end date were either (i) no longer prescribed an NSAID or (ii) prescribed a gastroprotective in addition to both an NSAID and an oral anticoagulant.	
Rationale for inclusion	SMR-02 encourages the identification of people at significant risk of gastric bleed with the aim of reducing that risk by either (i) stopping prescribing of the (combination of) medications that is causing the increased risk or (ii) where this is not possible, prescribing a gastroprotective medication to reduce the risk.
Indicator type	Standard Quantitative
Running period	1 April 2022 – 31 March 2023
Denominator	Number of patients aged 18 years or over concurrently prescribed a non-steroidal anti-inflammatory drug (NSAID) and an oral anticoagulant in the last three months of the previous financial year.
Numerator	Of the denominator, the number who, in the three months to the reporting period end date, were either: 1. No longer prescribed an NSAID OR 2. Prescribed a gastro-protective in addition to an NSAID.
Prevalence numerator	Indicator denominator
Exclusions	N/A
Personalised care adjustments	N/A
Desired direction	Upwards
Thresholds	85% (LT), 90% (UT)

SMR-02A: Percentage of patients aged 18 years or over prescribed both a Non-Steroidal Anti-Inflammatory Drug (NSAID) and an oral anticoagulant in the last three months of the previous financial year, who in the three months to the reporting period end date were either (i) no longer prescribed an NSAID or (ii) prescribed a gastroprotective in addition to both an NSAID and an oral anticoagulant.	
Points	4
Data source	General Practice Extraction Service (GPES)
Subject to declaration?	Yes
Additional information	Further information on the background to SMR-02 can be found on the Medicines Safety Improvement Programme Future NHS platform: Anticoagulants – Medicines Safety Improvement Programme – FutureNHS Collaboration Platform.

SMR-02B: Percentage of patients aged 65 years or over prescribed a Non-Steroidal Anti-Inflammatory Drug (NSAID) and not an oral anticoagulant in the last three months of the previous financial year, who in the three months to the reporting period end date were either (i) no longer prescribed an NSAID or (ii) prescribed a gastroprotective in addition to an NSAID.	
Rationale for inclusion	SMR-02 encourages the identification of people at significant risk of gastric bleed with the aim of reducing that risk by either (i) stopping prescribing of the (combination of) medications that is causing the increased risk or (ii) where this is not possible, prescribing a gastroprotective medication to reduce the risk.
Indicator type	Standard Quantitative
Running period	1 April 2022 – 31 March 2023
Denominator	Number of patients aged 65 years or over prescribed a non-steroidal anti-inflammatory drug (NSAID) without a concurrent oral anticoagulant in the last three months of the previous financial year.
Numerator	Of the denominator, the number who, in the three months to the reporting period end date, were either:

SMR-02B: Percentage of patients aged 65 years or over prescribed a Non-Steroidal Anti-Inflammatory Drug (NSAID) and not an oral anticoagulant in the last three months of the previous financial year, who in the three months to the reporting period end date were either (i) no longer prescribed an NSAID or (ii) prescribed a gastroprotective in addition to an NSAID.	
	1. No longer prescribed an NSAID OR 2. Prescribed a gastro-protective in addition to an NSAID.
Prevalence numerator	Indicator denominator
Exclusions	N/A
Personalised care adjustments	N/A
Desired direction	Upwards
Thresholds	85% (LT), 90% (UT)
Points	4
Data source	General Practice Extraction Service (GPES)
Subject to declaration?	Yes
Additional information	Further information on the background to SMR-02 can be found on the Medicines Safety Improvement Programme Future NHS platform: Anticoagulants – Medicines Safety Improvement Programme – FutureNHS Collaboration Platform.

SMR-02C: Percentage of patients aged 18 years or over prescribed both an oral anticoagulant and an anti-platelet in the last three months of the previous financial year, who in the three months to the reporting period end date were either (i) no longer prescribed an anti-platelet or (ii) prescribed a gastroprotective in addition to both an oral anticoagulant and an anti-platelet.	
Rationale for inclusion	SMR-02 encourages the identification of people at significant risk of gastric bleed with the aim of reducing that risk by either (i)

SMR-02C: Percentage of patients aged 18 years or over prescribed both an oral anticoagulant and an anti-platelet in the last three months of the previous financial year, who in the three months to the reporting period end date were either (i) no longer prescribed an anti-platelet or (ii) prescribed a gastroprotective in addition to both an oral anticoagulant and an anti-platelet.	
	stopping prescribing of the (combination of) medications that is causing the increased risk or (ii) where this is not possible, prescribing a gastroprotective medication to reduce the risk.
Indicator type	Standard Quantitative
Running period	1 April 2022 – 31 March 2023
Denominator	Number of patients aged 18 years or over concurrently prescribed an oral anticoagulant and an anti-platelet in the last three months of the previous financial year.
Numerator	Of the denominator, the number who, in the three months to the reporting period end date, were either: 1. No longer prescribed an anti-platelet OR 2. Prescribed a gastro-protective in addition to an anti-platelet.
Prevalence numerator	Indicator denominator.
Exclusions	N/A
Personalised care adjustments	N/A
Desired direction	Upwards
Thresholds	75% (LT), 90% (UT)
Points	4
Data source	General Practice Extraction Service (GPES)

SMR-02C: Percentage of patients aged 18 years or over prescribed both an oral anticoagulant and an anti-platelet in the last three months of the previous financial year, who in the three months to the reporting period end date were either (i) no longer prescribed an anti-platelet or (ii) prescribed a gastroprotective in addition to both an oral anticoagulant and an anti-platelet.	
Subject to declaration?	Yes
Additional information	Further information on the background to SMR-02 can be found on the Medicines Safety Improvement Programme Future NHS platform: Anticoagulants – Medicines Safety Improvement Programme – FutureNHS Collaboration Platform.

SMR-02D: Percentage of patients aged 18 years or over prescribed aspirin and another anti-platelet in the 3 months to 1 April 2022, who in the last three months of the previous financial year, who in the three months to the reporting period end date were either (i) no longer prescribed aspirin and/or no longer prescribed an anti-platelet or (ii) prescribed a gastroprotective in addition to both aspirin and another anti-platelet.	
Rationale for inclusion	SMR-02 encourages the identification of people at significant risk of gastric bleed with the aim of reducing that risk by either (i) stopping prescribing of the (combination of) medications that is causing the increased risk or (ii) where this is not possible, prescribing a gastroprotective medication to reduce the risk.
Indicator type	Standard Quantitative
Running period	1 April 2022 – 31 March 2023
Denominator	Number of patients aged 18 years or over prescribed both aspirin (irrespective of dose/strength) and another anti-platelet in the last three months of the previous financial year.
Numerator	Of the denominator, the number who, in the three months to the reporting period end date, were either: 1. No longer prescribed aspirin and/or no longer prescribed an anti-platelet OR 2. Prescribed a gastro-protective in addition to both aspirin and another anti-platelet.

SMR-02D: Percentage of patients aged 18 years or over prescribed aspirin and another anti-platelet in the 3 months to 1 April 2022, who in the last three months of the previous financial year, who in the three months to the reporting period end date were either (i) no longer prescribed aspirin and/or no longer prescribed an anti-platelet or (ii) prescribed a gastroprotective in addition to both aspirin and another anti-platelet.	
Prevalence numerator	Indicator denominator.
Exclusions	N/A
Personalised care adjustments	N/A
Desired direction	Upwards
Thresholds	75% (LT), 90% (UT)
Points	4
Data source	General Practice Extraction Service (GPES)
Subject to declaration?	Yes
Additional information	Further information on the background to SMR-02 can be found on the Medicines Safety Improvement Programme Future NHS platform: Anticoagulants – Medicines Safety Improvement Programme – FutureNHS Collaboration Platform.

SMR-03: Percentage of patients prescribed a direct oral anti-coagulant, who received a renal function test and a recording of their weight and Creatinine Clearance Rate, along with a recording that their DOAC dose was either changed or confirmed (not changed).	
Rationale for inclusion	SMR-03 supports the dose optimisation of DOACs based on current renal function, with the aim of reducing the risk of unintentionally prescribed overdoses.

SMR-03: Percentage of patients prescribed a direct oral anti-coagulant, who received a renal function test and a recording of their weight and Creatinine Clearance Rate, along with a recording that their DOAC dose was either changed or confirmed (not changed).	
Indicator type	Standard Quantitative
Running period	1 April 2022 – 31 March 2023
Denominator	Number of patients prescribed a direct-acting oral anticoagulant (DOAC)
Numerator	Of the denominator, the number who received a renal function test and have a recording of weight and Creatinine Clearance Rate (CCR), along with a recording that their DOAC dose was either changed or confirmed (not changed)
Prevalence numerator	Indicator denominator
Exclusions	N/A
Personalised care adjustments	Patients whose first DOAC prescription is in the last 3 months of the financial year
Desired direction	Upwards
Thresholds	50% (LT), 75% (UT)
Points	13
Data source	General Practice Extraction Service (GPES)
Subject to declaration?	Yes
Additional information	The most frequent serious adverse event associated with DOACs is a major bleed. The most common modifiable causes of major bleeds associated with DOACs are:

SMR-03: Percentage of patients prescribed a direct oral anti-coagulant, who received a renal function test and a recording of their weight and Creatinine Clearance Rate, along with a recording that their DOAC dose was either changed or confirmed (not changed).	
	• Co-prescription of DOAC and a gastro-toxic drug such as a Non-steroidal anti-inflammatory drug (NSAID), aspirin and/or anti-platelets (affecting an estimated 12,500 patients) • An unintentional prescribed overdose (affecting an estimated 155,200 patients). The Orbit II-AF Registry found that 1 in 25 patients on the incorrect dose of DOAC suffered a major bleed. To prevent people being prescribed an overdose, patient renal function must be regularly monitored (generally once or twice a year) and the dose adjusted based on creatinine levels and weight. Further information on the background to SMR-03 can be found on the Medicines Safety Improvement Programme Future NHS platform: Anticoagulants - Medicines Safety Improvement Programme - FutureNHS Collaboration Platform.

Respiratory area

4.9 Asthma patients in England experience worse outcomes than those in comparable health systems. Indicators in this area encourage PCNs to develop effective medicines regimes for asthma patients by making sure they are prescribed ICS inhalers on a regular basis, in order to support effective self-management and help prevent disease exacerbation and deterioration.

RESP-01: Percentage of patients on the QOF Asthma Register who received three or more inhaled corticosteroid (ICS, inclusive of ICS/LABA) prescriptions over the previous 12 months	
Rationale for inclusion	Inhaled corticosteroids (ICS) are the most effective and first choice preventer drug for adults and older children with asthma. However, prescribing rates remain low in England. Regular use improves symptoms and reduces reliance on short acting beta agonists (SABA), exacerbations and mortality. This indicator recognises PCNs for an increase in the percentage of patients regularly prescribed an inhaled corticosteroid. Combination ICS/LABA inhalers, including maintenance and reliever therapy (MART), are included.

RESP-01: Percentage of patients on the QOF Asthma Register who received three or more inhaled corticosteroid (ICS, inclusive of ICS/LABA) prescriptions over the previous 12 months	
Indicator type	Standard Quantitative
Running period	1 April 2022 – 31 March 2023
Denominator	Number of patients on the QOF Asthma Register
Numerator	Of the denominator, the number who received three or more inhaled corticosteroid (ICS, inclusive of ICS/LABA) prescriptions over the previous 12 months.
Prevalence numerator	Indicator denominator
Exclusions	N/A
Personalised care adjustments	1. Patient added to QOF Asthma Register in last 9 months of the financial year. 2. Not clinically suitable – as measured by: • Presence of 'Inhaled corticosteroid not indicated' SNOMED code. • A recording of mild asthma, without a subsequent recording of moderate or severe asthma. • Fewer than 3 SABA prescriptions in the same 12-month period (fewer than 4 for patients aged under 18).
Desired direction	Upwards
Thresholds	71% (LT), 90% (UT)
Points	31
Data source	General Practice Extraction Service (GPES)
Subject to declaration?	Yes

RESP-01: Percentage of patients on the QOF Asthma Register who received three or more inhaled corticosteroid (ICS, inclusive of ICS/LABA) prescriptions over the previous 12 months	
Additional information	NICE guidelines on the management of asthma recommend inhaled corticosteroids to be used as first-line maintenance therapy. For very mild asthma in patients with infrequent, short-lived wheeze and normal lung function, it may be that an ICS is not required as per NICE guidelines. A personalised care adjustment is available to use in these situations, as detailed above. Most inhaled corticosteroids can be delivered via dry powder inhalers which have a significantly lower carbon footprint than metered dose inhalers. Efforts made towards meeting this indicator should also be complementary in helping to meet asthma indicators in the Quality and Outcomes Framework (QOF), particularly AST005 and AST007. It is important that any decision to switch or start an inhaler is made as the outcome of a shared decision-making conversation. Good inhaler technique is essential for treatment to be effective, irrespective of drug or device. Appropriate training and regular technique checks are required to ensure patients use their inhalers optimally. Poor adherence with inhaled corticosteroids is correlated with poor asthma-related outcomes. Therefore it is important that patients are educated on the importance of regular use, particularly the difference between use of preventers and relievers. ICS is often used with LABA in combination inhalers, which can either be used as preventers or in MART regimes where they act as both reliever as preventer. Current guidance is that MART should be considered in patients who have a history of asthma attacks on medium dose ICS or ICS/LABA. From 2023/24, this indicator will shift to counting inhalers rather than prescriptions, rewarding PCNs based on the percentage of asthma patients prescribed five or more ICS inhalers over 12 months. The thresholds will also be revised to align with NHSEI's ambition that, by 2024/25, 90% of asthma patients should be regularly prescribed an ICS. **Further information for clinicians** • Further resources are available in the "Tools & Resources" section of the Greener NHS programme's FutureNHS workspace: https://future.nhs.uk/sustainabilitynetwork (for any

RESP-01: Percentage of patients on the QOF Asthma Register who received three or more inhaled corticosteroid (ICS, inclusive of ICS/LABA) prescriptions over the previous 12 months	
	access queries, please email sustainabilitynetwork-manager@future.nhs.uk). • NICE: Patient decision aid • British Thoracic Society Position Statement: The environment and lung health • UK Inhaler Group: Inhaler standards and competency document: Guidance on optimal inhaler technique • Greener Practice: How to Reduce the Carbon Footprint of Inhaler Prescribing. • PrescQIPP bulletin 295 and resources: Inhaler carbon footprint. • Asthma and Lung UK: answers to common patient concerns about asthma medications **Further information for patients** • Asthma UK & British Lung Foundation • What does good asthma control look like? • Your personalised asthma action and support plan • Asthma review: Guidance on how to use your inhaler most effectively, tailored to your device **Other references** • **NICE guideline NG80: Asthma: diagnosis, monitoring and chronic asthma management** • Relationship between adherence to inhaled corticosteroids and poor outcomes among adults with asthma

RESP-02: Percentage of patients on the QOF Asthma Register who received six or more Short Acting Beta-2 Agonist (SABA) inhaler prescriptions over the previous 12 months	
Rationale for inclusion	Overuse of short acting beta agonists (SABA) in asthma is higher in the UK than in other European countries and is associated with an increased risk of exacerbations and mortality. This indicator recognises PCNs for a reduction in the percentage of patients receiving six or more SABA prescriptions per year.
Indicator type	Standard Quantitative
Running period	1 April 2022 – 31 March 2023

RESP-02: Percentage of patients on the QOF Asthma Register who received six or more Short Acting Beta-2 Agonist (SABA) inhaler prescriptions over the previous 12 months	
Denominator	Number of patients on the QOF Asthma Register
Numerator	Of the denominator, the number who received 6 or more Short Acting Beta-2 Agonist (SABA) inhaler prescriptions in the previous 12 months.
Prevalence numerator	Indicator denominator.
Exclusions	Patients with dual diagnosis of COPD and asthma.
Personalised care adjustments	N/A
Desired direction	Downwards
Thresholds	25% (LT), 15% (UT)
Points	22
Data source	General Practice Extraction Service (GPES)
Subject to declaration?	Yes
Additional information	Overuse of short acting beta agonists (SABA) in asthma is higher in the UK than in other European countries and is associated with an increased risk of exacerbations and mortality, as seen in the SABINA observational program[2,3]. Therefore, addressing this is key in improving asthma outcomes. SABA may be perceived by the patient to be controlling the disease, but it does not treat the underlying airways inflammation and therefore overreliance puts patients at greater risk of a severe attack. SABA inhalers contribute the largest proportion of greenhouse gas emissions of all inhaler types, so reducing SABA overuse is both desirable for patient outcomes and helps to reduce carbon emissions.

RESP-02: Percentage of patients on the QOF Asthma Register who received six or more Short Acting Beta-2 Agonist (SABA) inhaler prescriptions over the previous 12 months	
	Efforts made towards meeting this indicator should also be complementary in helping to meet asthma indicators in the Quality and Outcomes Framework, particularly AST005 and AST007. It is important that any decision to stop, change or start an inhaler is made as the outcome of a shared decision-making conversation. This indicator is designed to support a gradual process over the whole time period to allow such changes to be made in the appropriate way. A plan for how to reduce SABA use should be personalised for each patient and accompanied by optimising preventer treatment and regular review of changes. Overuse of SABA is correlated with poor asthma-related outcomes. Therefore it is important that patients are educated on the role of SABA in symptom relief but not disease control. The importance of reporting when their SABA use increases and ensuring their asthma management is reviewed, should also be emphasised. Case finding and prioritisation of patients with the highest volume of current SABA use may help to meet this indicator. From 2023/24, this indicator will shift to counting inhalers rather than prescriptions, rewarding PCNs based on the percentage of asthma patients prescribed five or fewer SABA inhalers over 12 months. The thresholds will also be revised to align with NHSEI's ambition that, by 2024/24, no more than 10% of asthma patients should be prescribed 6 or more SABA inhalers per year. **References** • Overuse of short acting B2 agonists in asthma is associated with increased risk of exacerbation and mortality: a nationwide cohort study of the global SABINA programme. • SABINA: An Overview of Short-Acting β_2-Agonist Use in Asthma in European Countries See RESP-01 Additional Information for further resources.

5. A sustainable NHS domain

Inhalers area

5.1 Medicines account for 25% of emissions within the NHS.

5.2 Inhalers alone are responsible for 3% of the NHS carbon footprint. Most of these emissions come from the propellants used in metered dose inhalers (MDIs) to deliver the medicine, rather than the medicine itself. Optimising the choice of inhaler, as part of a shared decision making conversation between the patient and the clinician, can play a significant role in achieving the NHS net zero target.

ES-01: Metered Dose Inhaler (MDI) prescriptions as a percentage of all non-salbutamol inhaler prescriptions issued to patients aged 12 or over	
Rationale for inclusion	People with asthma (3.9 million) are the largest patient group using MDIs in England. Patterns observed in other healthcare systems across the world demonstrate that it is possible to significantly reduce the use of MDIs, and therefore the associated carbon emissions, while maintaining high standards of care. This indicator recognises PCNs for a reduction in the number of MDI prescriptions, as a percentage of all non-salbutamol inhaler prescriptions.
Indicator type	Standard Quantitative
Running period	1 April 2022 – 31 March 2023
Denominator	Number of non-salbutamol inhaler prescriptions issued to patients aged 12 years or over
Numerator	Of the denominator, the number of Metered Dose Inhaler (MDI) prescriptions
Prevalence numerator	Indicator denominator
Exclusions	Prescriptions to patients to whom the “Dry powder inhaler not indicated” SNOMED code has been applied

ES-01: Metered Dose Inhaler (MDI) prescriptions as a percentage of all non-salbutamol inhaler prescriptions issued to patients aged 12 or over	
Personalised care adjustments	None – but note that "Dry powder inhaler not indicated" will function similarly to a "not clinically suitable" PCA.
Desired direction	Downwards
Thresholds	44% (LT), 35% (UT)
Points	27
Data source	General Practice Extraction Service (GPES)
Subject to declaration?	Yes
Additional information	Dry Powder Inhalers (DPI) and Soft Mist Inhalers (SMIs), for example, offer a lower-carbon clinical alternative to MDIs. For most patients, MDIs do not confer any additional clinical advantages over DPIs. Efforts made towards meeting this indicator should also be complementary in helping to meet asthma and COPD indicators in the Quality Outcomes Framework (QOF), particularly AST005, AST007, COPD009 and COPD010. It is important that any decision to change a patient's asthma inhaler is clinically appropriate and done as the outcome of a shared decision-making conversation. This indicator is designed to support a gradual process over the whole time period to allow such changes to be made in the appropriate way. Moving a patient from an MDI to an alternative type of inhaler may not be appropriate for some patients and may disrupt disease control or threaten their safety. Good inhaler technique is essential for inhaler treatment to be effective, irrespective of the type of device. Appropriate training and regular technique checks are required to ensure patients use their inhaler optimally and maximise the benefit of their medication. This is especially important when patients are prescribed a different type of inhaler. Case finding and prioritisation of patients with the highest volume of current SABA use helps to identify which patients would benefit most from a

ES-01: Metered Dose Inhaler (MDI) prescriptions as a percentage of all non-salbutamol inhaler prescriptions issued to patients aged 12 or over	
	change of inhaler, and would also help in meeting the RESP-02 indicator. Feedback suggests that the majority of asthma patients using MDIs would change device for environmental reasons so long as the new inhaler was efficacious, easy to use and fitted their current routine, and that they could change back if needed. Pharmacies will be actively encouraging return of unwanted or used inhalers for more sustainable disposal and can provide a New Medicine Service consultation focused on improved adherence and an inhaler technique check for patients who are prescribed an inhaler for the first time, or who are changing or have changed to a new inhaler device. The intention is to update the thresholds for ES-01 in 2023/24, to align with NHSEI's aim that, in line with best practice in other European countries, by 2023/24 only 25% of non-salbutamol inhalers prescribed will be MDIs. See RESP-01 Additional Information for further resources.

ES-02: Mean carbon emissions per salbutamol inhaler prescribed on or after 1 October (kg CO_2e)	
Rationale for inclusion	Salbutamol Metered Dose Inhalers (MDIs) are the single biggest source of carbon emissions from NHS medicines prescribing. Where a salbutamol inhaler is required, this indicator encourages PCNs to consider prescribing a lower carbon option. This does not necessarily mean changing the type of inhaler that the patient receives (e.g. MDI to Dry Powder Inhaler or DPI), since different salbutamol MDI inhalers can have different carbon emissions. If an MDI is required for the patient, for instance because a DPI is not indicated, prescribing a lower carbon salbutamol MDI will reduce overall carbon emissions from salbutamol inhalers without compromising patient safety or disease control. A table providing the manufacturer-reported or estimated whole lifecycle carbon emissions from each type of salbutamol inhaler is provided below. This table will be used to calculate the numerator of this indicator and can therefore be used by PCNs as a guide to what they can do to reduce the carbon intensity of their salbutamol prescribing.

ES-02: Mean carbon emissions per salbutamol inhaler prescribed on or after 1 October (kg CO_2e)	
Indicator type	Standard Quantitative
Running period	1 April 2022 – 31 March 2023
Denominator	Number of salbutamol inhalers prescribed
Numerator	Total carbon emissions from all inhalers in the denominator (kg CO_2e)
Prevalence numerator	Number of patients prescribed salbutamol inhalers
Exclusions	None
Personalised care adjustments	None
Desired direction	Downward
Thresholds	22.1 kg CO_2e (LT), 18.0 kg CO_2e (UT)
Points	44
Data source	Business Services Authority (BSA) prescribing data, combined with manufacturer-reported or estimated carbon emissions from each type of salbutamol inhaler, compiled by a manufacturer survey and literature review conducted by PrescQIPP.
Subject to declaration?	No – PCNs who believe that ES-02 data collected in respect of them is incorrect are advised to consult the following link, which provides further information about how they may pursue any queries or concerns they have about BSA prescribing data collected in respect of them (see final paragraph of webpage): https://www.nhsbsa.nhs.uk/prescription-data/understanding-our-data/prescription-requests

ES-02: Mean carbon emissions per salbutamol inhaler prescribed on or after 1 October (kg CO_2e)

Additional information

Efforts made towards meeting this indicator should also be complementary in helping to meet asthma and COPD indicators in the Quality Outcomes Framework (QOF), particularly AST005, AST007, COPD009 and COPD010.

Any decision to change a patient's inhaler, including switching brands, should be taken as part of a shared decision-making process.

Case finding and prioritisation of patients with the highest volume of current SABA use may help to meet this indicator.

The numerator of this indicator will be calculated by multiplying the number of each inhaler type prescribed, by the carbon emissions per inhaler for that inhaler type. For example, if a PCN only prescribes two inhaler types, A and B, then

Numerator = Count of inhaler A × Emissions per inhaler A +
Count of inhaler B × Emissions per inhaler B

The following table shows the variation in estimated life cycle carbon emissions for different salbutamol inhaler types, based on a manufacturer survey and literature review conducted by PrescQIPP, and commissioned by NHSEI. Life cycle inhaler emissions include propellant emissions as well as emissions from all other stages in the product life cycle (e.g. transportation, energy and water use, and waste disposal). These estimates are based on manufacturer survey responses where available, and on information in the literature where survey responses were not provided – see below links for further information. These estimated inhaler carbon emissions values will be combined with BSA prescribing data to calculate the ES-02 indicator numerator.

Prescribing term	Carbon emissions per inhaler (kg CO_2e)
Airomir 100 microgram	9.72
Airomir Autohaler 100 microgram	9.72
Easyhaler Salbutamol 100 microgram	0.62
Easyhaler Salbutamol 200 microgram	0.62
Salbutamol CFC free breath actuated inhaler 100 microgram (GENERIC)	11.79

ES-02: Mean carbon emissions per salbutamol inhaler prescribed on or after 1 October (kg CO_2e)

Salbutamol CFC free Inhaler 100 microgram (GENERIC)	25.24
Salamol CFC-Free Inhaler 100 microgram	11.95
Salamol Easi-Breathe 100 microgram	12.08
Salbulin Novolizer 100 microgram	3.75
Ventolin Accuhaler 200 microgram	0.58
Ventolin Evohaler 100 microgram	28.26

We advise PCNs to also consider local prescribing guidance when considering how to make use of this information to reduce the carbon emissions from salbutamol prescribing.

This table contains two entries for generic salbutamol MDI prescribing – one for a breath-actuated MDI (BAI) ("Salbutamol CFC free breath actuated inhaler 100 microgram"), and the other for a conventional pressurised MDI (pMDI) ("Salbutamol CFC free Inhaler 100 microgram").

As it is not currently possible to know which inhaler is dispensed each time a generic salbutamol inhaler is prescribed, carbon emissions associated with generic salbutamol prescribing have been inferred based on IQVIA data which indicates that:

- When a generic salbutamol pMDI is prescribed ("Salbutamol CFC free Inhaler 100 microgram"):
  - Ventolin Evohaler 100 microgram is dispensed 81.5% of the time.
  - Salamol CFC-Free Inhaler 100 microgram is dispensed 18.4% of the time.
  - Airomir 100 microgram is dispensed 0.1% of the time.
- When a generic salbutamol BAI is prescribed ("Salbutamol CFC free breath actuated inhaler 100 microgram"):
  - Airomir Autohaler 100 microgram is dispensed 12.5% of the time.
  - Salamol Easi-Breathe 100 microgram is dispensed 87.5% of the time.

We use this information to impute a carbon intensity to generic salbutamol MDI prescribing, as a weighted average of the

ES-02: Mean carbon emissions per salbutamol inhaler prescribed on or after 1 October (kg CO_2e)	
	carbon intensities of the inhalers that tend to be dispensed when generic salbutamol MDI is prescribed, i.e. Carbon intensity of generic salbutamol pMDI prescribing = . (28.26 × 81.5%) + (11.95 × 18.4%) + (9.72 × 0.1%) = 25.24 kg Carbon intensity of generic salbutamol BAI prescribing = . (12.08 × 87.5%) + (9.72 × 12.5%) = 11.79 kg The calculation of these weighted averages will be reviewed annually. The intention is to update the thresholds for ES-02 in 2023/24, to align with NHSEI's ambition to reduce the mean life-cycle carbon intensity of salbutamol inhalers to 13.4kg by 2023/24. **Further information** Click here for the Greener Practice Guide: How to Reduce the Carbon Footprint of Inhaler Prescribing. Click here for a direct link to the PrescQIPP inhaler carbon emissions data and resources to support lowering the inhaler carbon footprint.

Annex A: Prevalence adjustment and list size adjustment

A.1 This annex explains why a prevalence adjustment (for Quantitative indicators) and list size adjustment are applied when calculating IIF achievement payments, as well as explaining how they are calculated. Further details about calculation of these adjustments are provided in Annex C of the 2022/23 Network Contract DES specification.

Prevalence adjustment

A.2 Prevalence refers to the percentage of a population affected by a given disease or condition. We use this concept to define a generalised 'prevalence' concept for every Quantitative IIF indicator, equal to a prevalence numerator divided by the number of registered patients at the PCN. The prevalence numerator will usually, but not always, be equal to the indicator denominator (the denominator may be a count of eligible patients or a count of interventions e.g. medications delivered to a set of eligible patients). For instance, for indicator VI-01 prevalence is equal to the percentage of a PCN's patients who are aged 65 and over.

A.3 Consider two PCNs that are identical other than one has twice as many patients aged 65 and over. This would mean that PCN has to deliver twice as many seasonal influenza vaccinations to earn the same number of points. Applying a prevalence adjustment compensates that PCN for the extra effort required to earn a given number of points (i.e. achieve a given percentage point improvement in performance).

A.4 An example where the prevalence numerator is not equal to the indicator denominator is ES-02. For ES-02, the indicator denominator is a count of salbutamol inhalers prescribed, whereas the prevalence numerator is a count of the number of patients prescribed salbutamol inhalers. If ES-02 prevalence had been defined using the indicator denominator, this would have made earnings ability proportional to the number of salbutamol inhalers prescribed, which would be contrary to the clinical and environmental policy objectives of reducing unnecessary salbutamol prescribing.

A.5 The prevalence adjustment for an indicator is equal to PCN prevalence divided by national prevalence. For instance, if 20% of the residents of

England registered at practices signed up to the Network Contract DES are aged 65 and over, then a PCN with 30% of registered patients aged 65 and over would have a prevalence adjustment of 1.5 – that is, it would be paid 50% more for each additional achievement point than an otherwise identical PCN with a prevalence equal to the national average prevalence.

A.6 The target cohort for some indicators is the total number of patients registered in the PCN e.g. PC-01. In this case, the denominator equals the PCN list size, and when prevalence is defined as being equal to the indicator denominator, prevalence (denominator divided by PCN list size) is equal to one for all PCNs. As prevalence is equal to one for all PCNs, national average prevalence for this indicator is also equal to one. Therefore, effectively there is no prevalence adjustment for these indicators.

A.7 As well as making payments more proportional to effort, applying a prevalence adjustment also encourages appropriate case finding for indicators whose denominator is under the control of the PCN. Consider indicator HI-01, the denominator for which is the number of patients on the learning disability register aged 14 and over. PCNs and their constituent practices are responsible for adding patients to this register. The prevalence adjustment encourages efforts to identify patients with a Learning Disability and to add them to the register, as case finding increases earnings ability.

List size adjustment

A.8 The list size adjustment is based on a similar principle to the prevalence adjustment. If two PCNs are identical (including having identical prevalence for every IIF indicator) other than one has double the list size, that PCN would have to change its treatment of twice as many patients to earn the same number of points. The list size adjustment compensates larger PCNs for this situation by making the payment per achievement point proportional to list size.

A.9 Formally, the list size adjustment for a PCN is equal to the PCN list size divided by the national average PCN list size (i.e. the total number of patients registered that are a Core Network Practices that are part of a PCN, divided by the total number of PCNs). Thus, if the national average PCN list size is 49,000 and a PCN has 98,000 patients, that PCN's list size adjustment would be 2. In other words, that PCN would be paid twice as

much for each additional achievement point as an otherwise identical PCN with a list size equal to the national average.

Summary

A.10 The net effect of applying a prevalence adjustment (for Quantitative indicators) and a list size adjustment is to make payment proportional to the amount of activity undertaken (e.g. number of patients treated). The effort required to deliver one unit of activity is not fixed, but may vary according to patient demographics, socio-economic status and other characteristics. Likewise, there may be economies of scale, so that treating 200 patients does not require twice as much effort as treating 100 patients. Thus, applying a prevalence adjustment and a list size adjustment does not ensure an exact correspondence between effort and reward, but does bring the two closer together.

Annex B: Indicator standardisation

B.1 Some IIF indicators are standardised. Standardised indicators are indicators with the word ‘standardised’ in the indicator wording. This annex describes the methodology used to standardise IIF indicators.

B.2. Standardised IIF indicators are standardised using Direct Age-Sex Standardisation. Directly age-sex standardised rates express an indicator in terms of the overall rate that would occur in a standard population age-sex structure if it experienced the age-sex specific rates of the observed population.

B.3 The directly standardised rate (DSR) is given by:

$$DSR = \frac{1}{\sum_i w_i} \times \sum_i \frac{w_i O_i}{n_i}$$

where:

- w_i is the number of individuals in the standard population in age and sex group *i*.
- O_i is the observed number of events in the local or subject population in age and sex group *i.*
- n_i is the number of individuals in the local or subject denominator population in age and sex group *i*.

B.4 The standard population used will be the relevant national (aggregated) registered population, usually from the end of the baseline period e.g. 31 March 2022 for indicators running in 2022/23. This is fixed for both baseline and performance periods to ensure that the standardised rates are comparable and allows improvement to be correctly calculated.

B.5 The age-sex groups can vary between indicators – for example, indicators based on smaller numbers may require fewer age-sex groupings to ensure that standardised rates are sufficiently stable. The default approach however is to use five-year age bands up to 95 i.e. 0-4, 5-9, 10-14, 15-19, 20-24, 25-29, 30-34, 35-39, 40-44, 45-49, 50-54, 55-59, 60-64, 65-69, 70-74, 75-79, 80-84, 85-89, 90-94, 95-120.

IIF 2022/23

One page summary for primary care teams: What do I need to do?

Prevention and tackling health inequalities	**Vaccination and immunisation**	• Provide flu vaccinations to:
		  • people aged over 65
		  • people who are clinically at risk
		  • children aged 2 – 3

	Tackling health inequalities	• Complete annual Learning Disability Health Checks and Health Action Plans for patients on the Learning Disability register • Code ethnicity information for all patients in GP clinical systems.
	CVD prevention	• Confirm or exclude hypertension diagnosis for more patients with high blood pressure, through clinically appropriate follow-up • Prescribe statins to patients with higher CVD risk • Refer suitable patients with high cholesterol levels to assessment for familial hypercholesterolaemia • Treat patients with atrial fibrillation with DOACs in line with NICE guidance • For patients treated with DOACs, consider prescribing more of them Edoxaban where clinically appropriate
Providiang high quality care	**Personalised care**	• Refer patients to social prescribing where this could be beneficial
	Enhanced health in care homes	• Ensure care home resident status is coded in GP clinical systems • Provide key elements of the Enhanced Health in Care Homes service to care home residents • Work to improve care and outcomes for care home residents, aiming for a moderate reduction in emergency admissions
	Anticipatory care	• Provide effective long-term condition management and rapid response to acute presentation, aiming for a moderate reduction in emergency admissions for Ambulatory Care Sensitive Conditions (ACSCs)
	Cancer	• Ensure lower gastrointestinal two week wait (fast track) cancer referrals are accompanied by a faecal immunochemical test (FIT) result
	Access	• Provide online consultations as part of a choice of ways to access GP services • Develop and implement a plan to improve access for a patient group experiencing inequalities of access in your area • Use pre-referral Specialist Advice (i.e. Advice and Guidance) services where appropriate • Reduce waiting times for patients booking an appointment with a GP service • Increase use of Community Pharmacist Consultation Service
	Structured medication reviews and medicines optimisation	• Provide Structured Medication Reviews (SMRs) to patients who are eligible for them • Review patients who are prescribed medicines, alone or in combination, which have higher risk of harm such as dependency or gastrointestinal haemorrhage. • Review patients who are prescribed DOACs, recording their creatinine levels, weight and calculating Creatinine Clearance to ensure the dose is correct
	Respiratory care	• Increase use of inhaled corticosteroid (ICS) inhalers for appropriate asthma patients to improve disease management and reduce unnecessary SABA use • Decrease avoidable prescribing of SABA inhalers for asthma patients
A sustainable NHS	**Environmental sustainability**	Alongside the indictors in the respiratory care area, deliver high quality, lower carbon respiratory care for patients: • Decrease use of MDI inhalers by prescribing dry powder inhalers (DPIs) and soft mist inhalers (SMIs) where clinically appropriate and agreed with patient through a shared decision making conversation • When prescribing MDI salbutamol inhalers, prescribe inhalers which have lower carbon emissions (see IIF Guidance for details)

For detailed information, advice and clinical resources relating to all IIF indicators, please consult IIF 2022/23 Guidance on the NHS England and NHS Improvement GP Contract webpages.

NHS
Barnsley
Clinical Commissioning Group

PRIMARY CARE COMMISSIONING COMMITTEE

26 May 2022

FINANCE UPDATE

PART 1A – SUMMARY REPORT

1.	**THIS PAPER IS FOR**
	Decision ☐ *Approval* ☐ *Assurance* ☐ *Information* ☐
2.	**PURPOSE**
	This report provides an update of the forecast financial position as at 31st March 2022 (Month 12).
3.	**REPORT OF**

	Name	Designation
Executive / Clinical Lead	Roxanna Naylor	Chief Finance Officer
Author	Ruth Simms	Finance Manager

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

5.	**EXECUTIVE SUMMARY**
5.1	**2021/22 Year End Position** The year end position at Month 12 reflects a (£391k) underspend which in the main relates to the underutilisation of 2020/21 accruals. A full breakdown is included in Appendix A. The National centrally held funding, as part of the ARRS scheme, for the CCG equates to £1,524k of which the CCG utilised £1,200k, resulting an underspend of £324k.

5.2 2022/23 Budget Update

Conversations on the financial plan have been ongoing since February 2022 with final plans being submitted on 29 April 2022. Latest information suggests this may be subject to further review and update, however it is not anticipated at this stage this will impact on Co-commissioning budgets.

The allocation for 2022/23 for Primary Care Co-commissioning is £44,818k with budget requirements of £47,739k, which is a shortfall of £2,921k 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.

It should be noted that the CCG at the point of closedown will be balanced off with expenditure matching allocations.

The 2022/23 Primary Care Co Commissioning budgets are set out below with the uplifts applied in each area:

Category	2022/23 Budget	% Uplift Applied
Enhanced Services	618,793	0.75% Demographic Growth & 1% Provider Inflation
GENERAL PRACTICE - APMS	1,301,357	0.75% Demographic Growth & increase in core funding per patient of £2.92
GENERAL PRACTICE - GMS	13,314,482	0.75% Demographic Growth & increase in core funding per patient of £2.92
GENERAL PRACTICE - PMS	13,983,387	0.75% Demographic Growth & increase in core funding per patient of £2.92
Other GP Services	582,288	1% Provider Inflation on Locums
Other Premises	32,750	
Premises Cost Reimbursement	5,787,330	Inflation of 6% on Community Health Partnership Rent & 2% Inflation on Other Rents. 1% Inflation on Water and Non Domestic Rates.
Prescribing & Dispensing Doctors	584,440	1% Provider Inflation
QOF	4,321,787	3% increase as per guidance and 0.75% Demographic Growth
Telephone & Transport	311,104	1.1% Inflation on Transport SLA
PCN DES	3,998,618	See assumptions below
Additional Roles Reimbursement	2,903,000	This is the CCG element of our £4,704k full year allocation, as per national guidance, other 38% held centrally by NHS England
Total	**47,739,336**	

5.3

Financial monitoring will commence in Month 2 (May) with full reporting to resume from Month 3 (June) to support the CCG closedown and produce a 3 month set of accounts as per national guidance.

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

The table below highlights the 8 key financial areas in the Primary Care Network DES and expenditure expectations for the full financial year 2022/23.

Category	2022/23 Expenditure expectations April 2022 – March 2023	Assumptions/Calculation
	£'s	
Network Participation	521,311	Weighted list size January 2022 X £1.761 per patient.
Extended Hours (April - September 2022)	190,965	Actual list size (January 2022) X £0.72 per patient
Extended Access (October 2022 - March 2023)	988,970	£3.764 per PCN adjusted population (£0.627 per month)
Care Homes Premium	280,320	£120 per CQC registered bed, 2,336.
Investment and Impact Funding	1,143,000	£3.71 per registered patient (January 2022) equating to £984k and £159k additional as per SDF schedule
Clinical Director	195,208	£0.736 per actual registered patient (January 2022)
Weight Management	84,000	As per SDF Schedule
Leadership and Management Funding	197,000	As per SDF Schedule
Total	**3,600,774**	

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.

6. THE GOVERNING BODY / COMMITTEE IS ASKED TO:

- Note the financial position as at Month 12
- Note the level of funding utilised against Additional Roles Reimbursement for 2021/22
- Note the allocation and Budget requirements for 2022/23 which pending further guidance may be subject to change

7.	**APPENDICES / LINKS TO FURTHER INFORMATION**
	• Appendix A – Finance Monitoring Statement for 2021/22

Agenda time allocation for report:	10 minutes

PCCC 22/05/10
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	
3.2 Maximising Elective Activity		9.1 Digital and Technology	
4.1 Mental Health		10.1 Compliance with statutory duties	
5.1 Integrated Care @ System		11.1 Delivery of Enhanced Health in Care Homes	
5.2 Integrated Care @ Place		12.1 Delivering The Covid Vaccination Programme & Meeting The Needs of Patients with Covid-19	
5.3 Implementing Population Health Management And Personalised Care			

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 (place ✓ beside all that are relevant):

Management of conflicts of interest (s14O)	**See 3.2**	Duties as to reducing inequalities (s14T)	**See 3.5**
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 3.3**	Duty as to patient choice (s14V)	
Duty as to improvement in quality of services (s14R)	**See 3.4**	Duty as to promoting integration (s14Z1)	
Duty in relation to quality of primary medical services (s14S)	**See 3.4**	Public involvement and consultation (s14Z2)	**See 3.6**

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***

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?	***Y***
Where relevant has authority to commit expenditure been sought from Management Team (<£100k) or Governing Body (>£100k)?	***Y***

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***

APPENDIX A

NHS Barnsley Clinical Commissioning Group

NHS BARNSLEY CLINICAL COMMISSIONING GROUP

Finance Monitoring Statement - Primary Care Commissioning (Delegated budgets) - Month 12

FOR THE PERIOD ENDING 31st March 2022

PRIMARY MEDICAL SERVICES	TOTAL ANNUAL BUDGET (£)			2021/22 OUTTURN (£)			
(CO-COMMISSIONING - DELEGATED BUDGETS)	RECURRENT	NON RECURRENT	TOTAL BUDGET (£'000)	2021/22 OUTTURN	VARIANCE OVER / (UNDER)	VARIANCE AS % OF TOTAL BUDGET	Forecast Outturn Variance Explanation
ENHANCED SERVICES	569,227		569,227	617,153	47,926	8.42%	Overspend over a number of areas - **Specialist Allocation Scheme** - (£22k) underspend for 21/22 actuals lower than expected. **Minor Surgery** - overspend relating to 20/21 of £15k and (£82k) underspend for 21/22 actual activity been lower than expected. **Learning Disability** - overspend relating to 20/21 activity higher than expected £20k and £117k overspend for 21/22 actuals higher than expected.
GENERAL PRACTICE - APMS	1,287,770		1,287,770	1,246,330	(41,440)	-3.22%	Primary Care Co Commissioning outturn for GMS, APMS and PMS contracts are based on up to date list sizes (January 2022). List sizes are adjusted quarterly and payments are updated accordingly. Underspend on APMS contracts (£41k), overspend on PMS contracts of £31k and an underspend on GMS contracts of (£31k) Actuals for 21/22 includes the impact of the national increase in the GP Contract.
GENERAL PRACTICE - GMS	12,829,258		12,829,258	12,798,390	(30,868)	-0.24%	
GENERAL PRACTICE - PMS	13,415,160		13,415,160	13,445,871	30,711	0.23%	
OTHER GP SERVICES	1,750,673	(453,355)	1,297,318	1,000,460	(296,858)	-22.88%	Underspend over a number of areas - **Prescribing & Dispensing** - overspend of £8k for 20/21 actuals higher than expected and 21/22 overspend of £9k due to actuals lower than expected. **Interpreting Services** - 21/22 overspend of £21k actuals higher than expected. **Telephone Costs** - 21/22 underspend of (£132k) due to actuals lower than expected. **Locums** - underspend of (£71k) relating to 20/21 underutilisation of accruals. Other 20/21 underutlisation of accruals of (£132k).
OTHER PREMISES	32,750		32,750	10,630	(22,120)	-67.54%	Underspend relates to underutilised accruals from 20/21 and 21 /22 actuals lower than expected
PREMISES COST REIMBURSEMENT	5,778,779	(281,620)	5,497,159	5,372,771	(124,388)	-2.26%	Underspend of (£57k) due to 20/21 underutilisation of accruals, and 21/22 underspend of (£67k) relating to actuals lower than expected for Healthcentre Rents, NDR Rates, Water Rates and Clinical Waste
QOF	3,954,746	(265,609)	3,689,137	3,900,068	210,931	5.72%	Overspend due to 21/22 increase in the value of QOF points
Primary Care Network DES	1,799,880	236,233	2,036,113	1,906,506	(129,607)	-6.37%	Underspend due to underutilised accruals from 20/21 of (£114k), 21/22 underspend of (£13k) on Care Homes Premium, (£18k) underspend on the leadership and management and overspend on the investment and impact fund of £15k based on potential achievement
Additional Roles Reimbursement Scheme	1,912,000	1,194,000	3,106,000	3,102,198	(3,802)	-0.12%	Underspend due to funding in 21/22 not fully utilised
£10m Winter Access Funding		47,000	47,000	15,648	(31,352)	-66.71%	Underspend due to funding in 21/22 not fully utilised
£250m Winter Access Funding		1,170,000	1,170,000	1,170,000	0	0.00%	
TOTAL PRIMARY MEDICAL SERVICES	**43,330,243**	**1,646,649**	**44,976,892**	**44,586,024**	**(390,868)**	-154.97%	

NHS
Barnsley
Clinical Commissioning Group

PRIMARY CARE COMMISSIONING COMMITTEE

26 May 2022

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 / Clinical Lead	Chris Edwards	Chief Officer
Author	Terry Hague	Primary Care Transformation Manager

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>Contract variations</u>**

<u>Penistone Group Practice</u>
Barnsley CCG has received an application to vary Penistone Group Practice (C85004) PMS contract to remove Dr Morris due to retirement from 1 October 2021.

The practice has 17,178 patients and currently has 7 contract holders, Drs Griffin, Gibbons, Rhodes, Vas, Teesdale, and Morris and Mr Morgan.

St George's Medical Centre

Barnsley CCG has received an application to vary St George's Medical Centre (C85619) PMS contract to remove Dr Alvarez from 31 October 2022.

The practice has 7,836 patients and currently has 3 contract holders, Drs Balac, Farhan and Alvarez. The practice advise that they are advertising for new GPs and will continue to provide services to patients with the current partners and using regular locums.

As both of the above PMS Contract Variations require an amendment to the PMS contract, this requires PCCC member's approval. Changes concerning the composition of the contractor 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 variations be approved and the Primary Care Team will ensure the contracts are amended accordingly.

Dr Mellor and Partners

Barnsley CCG has received an application to vary the contract of Dr Mellor and Partners (C85016) contract to add Dr Haldon as a new partner from 1 September 2020 and Dr Dawood from 6 April 2022.

The practice is a GMS practice with 11,734 patients and currently has 4 contract holders, Drs Mellor, Smith, Santiago-Martin and Hollis.

Appropriate due diligence checks have been undertaken both by NHS England colleagues and the CCG

This addition does not require an amendment to the contract due to it being a GMS contract, so this item is noted for information only.

Royston Group Practice

Barnsley CCG has received an application to vary Royston Group Practices GMS contract in relation to a 24 hour retirement for Dr Vakkalanka on 7 January 2022.

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. GP Retainer Scheme Application

In January 2021 the committee approved a National GP Retention Scheme application in respect of Dr Mann to be supported by The Grove Medical Practice (C85019).

Dr Mann's application to work 2 sessions per week would attract funding of £7,999.68 in addition to professional expenses' supplement of £2000 per annum for a maximum of 5 years.

Barnsley CCG have been advised that Dr Mann gave notice to leave the GP Retention scheme from 30 April having completed one full year on the scheme.

3. Rent Reimbursement for GP Practices

The CCG has responsibility to approve rent reimbursements in line with the National Health Services (General Medical Services – Premises Costs Directions) 2013 specifically Part 5 Recurring Premises Costs. The following reviews have been approved and actioned:

i) High Street Practice, 48 High Street, Royston (C85024)
ii) The Kakoty Practice, 170 Sheffield Road, Barnsley (C85009)
iii) Lundwood medical Centre, Pontefract Road, Lundwood and Monk Bretton Health Centre, High Street, Monk Bretton, (C85028)

The CCG continues to fund this increased expenditure through CCG programme budgets.

4. Edec analysis 2020/21

General Practices are required to complete an electronic Annual Practice Declaration (eDEC) which forms an integral part of the NHS England Policy and Guidance Manual book of Primary Medical Services. Submissions are made in December each year.

All practices submitted their responses as required which includes information regarding practice staff numbers and suitability & training and support; premises and equipment; practice services including opening hours, out of hours cover, and practice website; practice and procedures including communicating with patients, medication and consent; information and clinical governance; clinical leads for vulnerable groups; CQC registration; general practice IT and catchment area. In 2021/22 all Barnsley GP practices submitted their eDec on time and did not need to utilise the national extended period offered.

The analysis provided below shows the outcome and provides assurance that most practices are meeting requirements with no quality concerns identified. There are a minimal number of practices who will be contacted as appropriate to corroborate the answers provided and provide guidance where necessary or ensure that an action plan is in place.

Practice Staff Details

All practices have provided assurance that they are fully compliant with requirements including for example, needs analysis being in place for staffing levels, staff employment checks and equal opportunities, annual appraisal and safeguarding policies.

Premises and Equipment

All practices have provided assurance in relation to questions covering matters such as premises being in place to meet appropriate regulatory requirements, for example including infection control, health and safety and accessibility.

2019/20 - The following question has been referred to NHS England and will be reviewed nationally as agreed that there should be a 'not applicable' response option:

Q3B. The premises used for the provision of services under the contract are subject to a plan that has been formally agreed with the NHS England under Regulation 18 (3) if rectification actions are required; or in order to comply with Minimum Standards as of the current Premises Costs Directions.

5 practices answered no to this.

Practice Services

This section covers the provision of services within core hours, including routine and emergency/ out of hours care, access to interpreting services and maintaining up to date information on the GP practice website and currently being open to all patients for both virtual and face to face appointments as clinically appropriate.

A review of opening hours is being completed. Practices have been contacted to check information submitted. There are a number of practices closed to patients between the core hours of 8am and 6:30 pm. This is due to some closing at 6pm some days and some practices have previously been approved to close for one afternoon per month for staff training. In all cases cover is provided though the i-Heart service.

- 5 practices have answered no when asked to confirm that they were able to evidence how it is meeting the reasonable needs of its patient population and the practice has arrangements in place for its patients to access such services throughout the core hours (08:00 – 18:30 Monday to Friday) in case of emergency. The questions gave example responses as below and also requests that the evidence is from patient sources within the preceding 12 months):
  - *Patient Participation Group,*
  - *GP Patient Survey,*
  - *Local Survey,*
  - *Combination of PPG/GPPS/Local Survey,*
  - *Other: FREE TEXT entry.*

  It is possible that the practice does not currently have definitive evidence through the suggested mediums.

All practices confirmed that they have up to date information on their website and are open for both virtual and face to face appointments as clinically appropriate.

Practice Procedures

All practices have provided assurance that they are fully compliant with requirements including for example, their practice leaflet, complaints procedure, patient removals, vaccines storage and administration, patient consent, whistle blowing and chaperones.

A new question was added to this section this year, as below:

The practice can demonstrate (e.g., practice policy, records of refusals) it has not refused any registration on the grounds any patient was unable to provide proof of identify or address or any evidence of immigration status. (GMS Regulations Schedule 3, Part 2, Paragraph 21, PMS Regulations Schedule 2, Part 2, Paragraph 20). 5Z

2 practices have responded no to this.

- 5 practices were unable to evidence engagement with PPG (compared to 4 in 2020/21), however, this may be deemed reasonable given changes in arrangements during the pandemic.

- 3 practices have responded that they are unable to show that the PPG is properly representative of its practice population or that it has made and continues to make efforts to ensure it is representative of its local population.

- 6 practices responded no to having identified someone external to the practice staff can raise concerns with in confidence (e.g., freedom to speak up guardian, local whistleblowing lead). Practices will be supported to resolve this.

- 3 practices responded no when asked if they could confirm they are not advertising the provision of private GP services either by itself or through any other person (via the practice leaflet, practice website or any other written or electronic means). Practices will be contacted to remind of their contractual obligations.

Additionally, the 3 practices who are also dispensing practices have provided assurance that they are compliant with required procedures.

<u>Information and Clinical Governance</u>
All practices have provided assurance that governance arrangements are in place in respect of patient access to patient records and data sharing agreements, clinical leads for vulnerable groups, data protection, electronic transmission of data, validation of NHS number within clinical correspondence.

- 1 practice responded no to the practice having provided training on mental capacity in the last 3 years and assessing staff competence (although it is noted that this is not a contractual requirement.

- 1 practice reported that they did not have a procedure in place to ensure DNAR decisions made in respect of patients with learning disabilities are made in line with good clinical practice. The practice will be contacted, and appropriate support given.

<u>CQC (section 7)</u>
All practices have provided assurance that their CQC registration accurately reflects activities and have responded to advise if the CQC have been notified of changes as per requirements.

General Practice IT (section 8)

Checks have been completed to ensure that IT is being utilised appropriately, for example, NHS mail is the primary email system, electronic discharge letters, diagnostic tests, and summary care records.

A new question was added this year, as below:

The practice has signed a new CCG Practice Agreement since 2019. (Securing Excellence in Primary Care (GP) Digital Services: The Primary Care (GP) Digital Services Operating Model 2019-21) (8T)

2 practices responded that they had not signed an agreement. However, the CCG have a copy of their signed agreement so will contact the practices to advise.

- 5 practices have responded no to being able to process directly booked appointments from NHS 111.
  Guidance note: No applies for circumstances where the capability has not been enabled or is not in use.

- 6 practices have responded as none to the following question:
  The practice & its registered patients have access to a shared online system which allows patients to engage with their GP by:
  Yes / No:
  1. Patients can record their personal health data which is accessible online by the GP
  2. Patients and GPs can online collaboratively set goals and care outcomes and track progress against these
  3. None or N/A

- 7 practices have responded no to the question 'The practice no longer uses a facsimile machine to send/ received patient information'. This will be discussed with the practice for clarification as may have misinterpreted the question and appropriate response.

Catchment Area

There was a delay in access being provided to the catchment area information which is still being resolved.

The committee is asked to note the work completed and assurance provided.

5. National Contract Uplift

We will be applying the national contract uplifts as set out in the April 2022 guidance. GP practices will see changes in core funding as set out in the table below.

	GMS	PMS	APMS
	£/weighted patient	£/weighted patient	£/weighted patient
Inflation - net uplift	£2.92	£2.92	£2.92

	6. <u>Primary Medical Care Policy and Guidance Manual (PGM) Refresh</u> The Primary Medical Care Policy and Guidance Manual (PGM) was first published as 'the Policy Book' in January 2016 to support local commissioners to effectively commission and contract manage primary medical care providers, recognising this was a new area of commissioning for CCGs under delegation. A commitment was made by NHS England to review and refresh the PGM periodically to ensure it remained fit for purpose and reflected the latest legislation and national direction. The PGM was refreshed in November 2017, April 2019, and February 2021. This latest refresh in May 2022 creates version 4 of the PGM and includes information to help Commissioners on the availability of routine services which may have been paused in response to the Covid pandemic, including managing pre-existing conditions and meeting urgent demand. The main changes within this refresh are summarised within Appendix A.
6.	**THE GOVERNING BODY / COMMITTEE IS ASKED TO:**
	1) Consider for approval or noting the variations to contracts received including: a. The application to vary the contract of Penistone Group practice in relation to the retirement of Dr Morris from 1 October 2021. b. The application to vary the contract of St George's Medical Practice to remove Dr Alvarez from 31 October 2022 c. Note the variation to Dr Mellor and Partners contract to add Dr Haldon as a new partner from 1 September 2020 and Dr Dawood from 6 April 2022. d. Note the variation to Royston Group Practices GMS contract in relation to a 24 hour retirement for Dr Vakkalanka on 7 January 2022. 2) Note the notice given by Dr Mann to leave the GP Retention scheme from 30 April having completed one full year on the scheme. 3) Note the rent reimbursement reviews actioned for: a. High Street Practice, 48 High Street, Royston (C85024) b. The Kakoty Practice, 170 Sheffield Road, Barnsley (C85009) c. Lundwood medical Centre, Pontefract Road, Lundwood and Monk Bretton Health Centre, High Street, Monk Bretton, (C85028) 4) Note the analysis of the Edec submissions and assurance provided. 5) Note the national contract uplift to be applied. 6) Note the refresh of the Primary Care Policy and Guidance Manual
7.	**APPENDICES / LINKS TO FURTHER INFORMATION**
	Appendix A - Primary Care Policy and Guidance Manual Refresh

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	
3.2 Maximising Elective Activity		9.1 Digital and Technology	
4.1 Mental Health		10.1 Compliance with statutory duties	
5.1 Integrated Care @ System		11.1 Delivery of Enhanced Health in Care Homes	
5.2 Integrated Care @ Place		12.1 Delivering The Covid Vaccination Programme & Meeting The Needs of Patients with Covid-19	
5.3 Implementing Population Health Management And Personalised Care			

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 3.2**	Duties as to reducing inequalities (s14T)	**See 3.5**
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 3.3**	Duty as to patient choice (s14V)	
Duty as to improvement in quality of services (s14R)	**See 3.4**	Duty as to promoting integration (s14Z1)	
Duty in relation to quality of primary medical services (s14S)	**See 3.4**	Public involvement and consultation (s14Z2)	**See 3.6**

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 A

Primary Medical Care Policy and Guidance Manual (PGM) (V4) – May 2022

1 May 2022 Version 4

Summary of Changes

The PGM was first published as 'the Policy Book' in January 2016 to support local commissioners to effectively commission and contract manage primary medical care providers, recognising this was a new area of commissioning for CCGs under delegation.

A commitment was made to review and refresh the PGM periodically to ensure it remained fit for purpose and reflected the latest legislation and national direction. The PGM was refreshed in November 2017, April 2019 and February 2021.

This refresh includes information to help Commissioners on the availability of routine services which may have been paused in response to the Covid pandemic, including managing pre-existing conditions and meeting urgent demand.

The main changes within this refresh are summarised below:

Executive Summary

- Acknowledges the imminent delegation of some of NHS England and NHS Improvement direct commissioning functions to Integrated Care Boards (ICBs)
- Information on the new *NHS Provider Selection Regime*

Part A: Excellent Commissioning and Partnership Working

- The *Introduction* chapter, minor amendment, reflecting the need to refresh the e learning modules for commissioners to align with the requirements of the new Health and Social Care Bill - **Chapter 1 (1.1.4)**

- No other significant changes

Part B: General Contract Management

- The *Contracts Described* chapter has been updated to highlight the role of the commissioner in maintaining PCN membership, including the latest PCN Requirements and Entitlements – ***Chapter 1 (1.2.6)***

- *The Assurance Framework - Contract Review* chapter has been updated with minor amendments, reiterating CCGs/ICBs obligation in adherence to policy and guidance issued by NHS England and updated data on a range of GP Contracts types – **Chapter 2 (2.3.3) and (2.5.8)**

- A new subchapter, *Registering Civil servant and their dependant, and the dependants of members of the Armed Forces, returning from overseas postings* has been added to the *GP Patient Registration* the *Standard Operating Principles for Primary Medical Care* chapter. This is in line with the change in the regulations in October 2021 – **Chapter 4 (4.15)**

PCCC 22/05/12

- New chapter, *Managing [non-violent] inappropriate and unacceptable patient behaviours, including protecting against discrimination, harassment or victimisation,* has been added to protect GP practice staff and other patients from violent unacceptable behaviours **Chapter 6**

- No other significant changes.

Part D: General

- New chapter *Provision of Occupational Health Services – services funded by the practice* – ***Chapter 4***

- No other significant changes.

PCCC 22/05/13

NHS
Barnsley
Clinical Commissioning Group

PRIMARY CARE COMMISSIONING COMMITTEE

26TH MAY 2022

PRACTICE DELIVERY AGREEMENT - PRIMARY CARE SCHEMES 2022/23

PART 1A – SUMMARY REPORT

1. THIS PAPER IS FOR

Decision		Approval	X	Assurance		Information	

2. PURPOSE

The purpose of this report is to provide Primary Care Commissioning Committee with the proposed Primary Care PDA Schemes and attached finances for 2022/23 for approval.

3. REPORT OF

	Name	Designation
PC Clinical Lead	Dr M Guntamukkala	Medical Director
Executive Lead	Jamie Wike	Chief Operating Officer
Authors	Louise Dodson Terry Hague Louise Darwin Sarah Pollard	Primary Care Transformation Manager Primary Care Transformation Manager Primary Care Transformation Manager Health Improvement Nurse - cardiovascular disease

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
PDA 20222/23 Development Group	03.02.2022	Scheme developments
PDA 2022/23 Development Group	17.02.2022	Scheme developments
PDA 2022/23 Development Group – virtual consultation on draft schemes	08.03.2022 to 22.03.2022	Final scheme consultation
Public Governing Body	12.05.2022	Scheme approval

5. EXECUTIVE SUMMARY

Since 2014/15 Barnsley CCG has developed and implemented a Practice Agreement Scheme between itself and its 32 Member GP Practices called the Barnsley Practice Delivery Agreement (PDA). This is commissioned via an NHS Standard Contract.

The aim of the PDA is to invest in the capacity needed to deliver a consistently high standard of General Practice across Barnsley and has been reviewed and refreshed with consideration to the challenges for Primary Care, particularly during the COVID 19 Pandemic. The focus of the PDA has always been to invest in the infrastructure to deliver and enhance quality of care which reduces health inequalities of patients living in Barnsley. As part of this contract GP practices will receive a consistent income level to assist with staffing capacity and be resilient to meet to changing landscape of the NHS.

The objectives of the 2022/23 PDA are to maintain and develop core services, with a focus on NHS priorities as outlined in the operational planning guidance, promoting services that are clinically safe and appropriate following the Covid pandemic, digital primary care developments and supporting practices with recovery from the Covid pandemic.

The PDA 2022/23 has a total financial value sum of £4.2million with 57% assigned to the Medicines optimisation scheme and the remaining 43% to the other six schemes. The allocation per scheme will be calculated on weighted January 2022 list sizes.

PDA 2022/23 Development Meetings have been well attended with representation from the CCG, BBS IT Services, Practice Managers and the LMC. The purpose of the PDA 2022/23 Development Group was to develop, shape and agree, the 2022-23 PDA schemes, no financial decisions were made at the meeting.

Final drafts of the schemes have now been produced, which have been distributed to the LMC, CCG, and Practice Managers for comment before seeking approval at Governing Body. Final approval, which will include the finances, will be undertaken at Primary Care Commissioning Committee in April 2022.

The 2022/23 Primary Care Schemes of the Practice Delivery Agreement is broken down into 6 core schemes:

Scheme	**PDA Points Allocation**	**£**
Scheme 1: Long Covid - Assessment and Referral Pathway	***30 Points***	**£163,568**
Scheme 2: Cancer • Minimising Harm due to COVID on the Cancer Pathway Delivery • C the Signs – Cancer Early Diagnosis •	***65 Points***	**£354,397**
Scheme 3: Cardiovascular Disease • Atrial Fibrillation - undertaking diagnostics and follow-up for people in high-risk groups, identified with an irregular pulse. • Heart Failure – Optimising medication and engagement in the review of the local heart	***125 Points***	**£681,533**

failure pathway - design and implementation • Secondary Prevention – Optimising treatment for lipid management in people at high risk and support the development of local pathway for new therapies			
Scheme 4: Admin support • Increasing admin capacity to clear backlog • Care navigation training	***50 Points***	**£272,613**	
Scheme 5: Improve Dementia Diagnosis Rate and support the borough in being a Dementia Friendly Town	***20 Points***	**£109,045**	
Scheme 6: Support the National, Regional and Local IT and Digital projects for 2022/23, including for example moving to Cloud Based Telephony, Shared Care Records and Lloyd George Records Digitisation and increasing utilisation of existing tools.	***40 Points***	**£218,090**	
Scheme 7: Deliver the requirements of the Medicines Management Optimisation Scheme • ***Eclipse Live - £67,000*** • ***Specialist Drugs Service/Shared Care - £312,000*** • ***Anticoagulation - £526,460*** • ***Medicines Optimisation - £1,480,157***		£67,000 £312,000 £526,460 £1,480,157 **£2,385,617**	
Total 2021/22 PDA Investment		**£4,184,863**	

A breakdown of each scheme is provided below and also within the appendix.

Long Covid - Assessment and Referral Pathway

The rationale for including the Long Covid pathway in the PDA is to ensure primary care colleagues are fully trained to identify the Long Covid condition and patients are treated for this condition in a timely manner. The intended outcomes of the Long Covid pathway are (1) to increase the number of referrals to the Long Covid Treatment service and (2) to reduce waiting times for initial appointment to the Long Covid Treatment Service.

Practices will be asked to:

- Direct all patients with suspected or confirmed Long Covid to the Your Covid Recovery website,
- Confirm a diagnosis of Long Covid using blood tests and CXR diagnostics and by following the local clinical pathway
- Once a diagnosis is confirmed, to identify the additional health needs required and refer to appropriate services for support

Cancer

The greatest impact to focus on during 22/23 is the emerging priorities especially female bladder and head and neck; patients who are worried about returning to services and ensuring patients whom have been referred are treated quickly.

- To fully implement the C-The Signs tool by Q1 with all GP' in the practice using it. To use the data to identify gaps in referral types and return referrals for the tumour sites back to April 2020 levels for patient groups that are not presenting
- Behavioural Theory interventions - During Q1 take part in practice or PCN Neighbourhood based virtual or face to face workshop of 1 hour
- Work with CCG and Cancer Alliance to amend practices letters, texts and telephone messages using the behavioural insight workbook and tools
- By Q2 to be using at least one tool in the workbook to increase the uptake of patients who are low attendees for at least 1 screening programme and 1 cancer tumour referral pathway. (Could be for a specific group of patients). The workbook will be provided by the CCG.
- Person leading the work on Behavioural Theory interventions in the practice to attend quarterly implementation group and provide progress update
- Work with the CCG dedicated Behavioural Insight Manager to embed the work in the practice and to gain training /development opportunities.

Cardiovascular Disease

The new long-term plan for the NHS includes a new national focus on cardiovascular disease (CVD), including stroke. Both have been recognised as clinical priorities, and a major ambition to prevent 150,000 strokes, heart attacks and dementia cases over the next 10 years. Improving the detection and treatment of the high-risk conditions of AF, hypertension (high BP) and high cholesterol has the potential to unlock considerable health gains. It also enables early identification of other risk factors for CVD, such as smoking and obesity.

Barnsley's Heart Health Alliance intends to review the local heart failure pathway. Effective identification and diagnosis of heart failure and optimisation of first line medication in patients with heart failure will support service redesign and the development of appropriate pathways to access specialist support for people with heart failure and prevent deterioration and hospital admissions.

This will also support the requirements of the PCN CVD Prevention DES 2022-3: earlier identification of heart failure, appropriate HF diagnostic pathway and use of N-terminal pro B-type natriuretic peptide (NTProBNP) testing

To support the implementation of NICE guidance and the new Accelerated Access Collaborative National Guidance for Lipid Management for Primary and Secondary Prevention of CVD, Barnsley are developing local pathways to ensure timely access to appropriate lipid medication. Initial work within primary care is required to ensure all patients with existing cardiovascular disease have been offered first line cholesterol lowering medication which is prescribed at the maximum tolerated intensity and dosage to lower cholesterol to target levels. This work will support the

development of appropriate local pathways for specialist support for additional cholesterol lowering medication as per local/national guidance if target nHDL/LDL not achieved.

Practices will be asked to:

- Atrial Fibrillation - undertaking diagnostics and follow-up for people in high-risk groups, identified with an irregular pulse.
- Heart Failure – Review patients with heart failure to ensure optimal medication
- Engage in the review of the local heart failure pathway - design and implementation
- Secondary Prevention – Review patients with suboptimal cholesterol levels and optimise first-line treatment for lipid management in people at high risk and
- Support the development of local pathway for new lipid lowering therapies as per national guidance

Admin support

The CCG is aware that practices and admin staff have been under extreme pressures over the last two years, through both increased demand and ask.

Therefore, the rationale for including the Admin Support Scheme in the PDA is to enable practices to strengthen admin teams by:

- Ensuring appropriate capacity is in place within GP practices to enable admin teams to clear any backlogs that have built up as a result of the pressures and to ensure system reset for the coming year.
- Releasing admin staff to attend Care Navigation training to ensure that a consistent approach to Care Navigation is used across all GP practices in Barnsley. The Care Navigation training will enable admin staff to better support patients by signposting them to the most appropriate professional or service. This will help patients ensure they receive the right care, first time and as efficiently as possible.

Practices will be asked to:

- Strengthen admin teams by employing additional admin resource or offering additional hours to existing admin staff.
- Utilise the additional admin resource to clear any administration back logs and support system reset.
- Release admin staff to attend Care Navigation Training.

Dementia

Pre-COVID SWYFT delivered practice-based Dementia Screening clinics allowing timely access to specialist services for patients. This scheme intends to re-establish Dementia Screening clinics on a neighbourhood basis, one clinic per

neighbourhood per month.

In addition, Dementia Champions were known and visible in Primary Care pre-COVID. This scheme intends to re-establish those roles and further develop links between Primary Care, Public Health and Voluntary/Community services working with those impacted by Dementia through involvement of the Dementia Action Alliance and/or the Dementia and Me steering group.

The work outlined above is intended to deliver;

- Improved access to specialist services (Memory Assessment)
- Increased Dementia diagnosis rates
- Improved access to support for patients with Dementia and their carers
- Improved patient experience through ongoing service improvement driven by Dementia Champions

Working towards a Dementia Friendly Barnsley is a priority for partners across the system and this work is intended to support that ambition.

Practices will be asked to:

- Refer appropriate patients to the Dementia Screening clinics, delivered by SWYFT
- Maintain a register of People with Dementia and reconcile with the Memory Team on a quarterly basis
- Maintain a register of carers who care for someone with dementia
- Have an in-house trained Dementia Champion who can undertake the Barnsley CCG Dementia Champion Job Profile and inform the CCG of any changes in personnel
- Ensure that the practice is a Member of the Barnsley Dementia Action Alliance and/or the Dementia and Me Steering group
- Disseminate local support services across registers
- Liaise with the Memory Team Advisors
- Evidence that any building changes take into account the dementia environment checklist
- Promotion of the Herbert Protocol

IT and Digital Projects

Support the National, Regional and Local IT and Digital projects for 2022/23, including for example moving to Cloud Based Telephony, Shared Care Records and Lloyd George Records Digitisation.

Since April 2015, all practices have been required to offer patients access to online GP services, this PDA scheme will support practices to maximise utilisation of IT functionality which has been commissioned to offer this access to patients.

Practices will be asked to:

- Engage with national, regional, and local projects to enable successful implementation and completion
- Increasing Utilisation of Commissioned IT Services

  a) increase the number of online consultations

  b) increase the number of video consultations

  c) provide an up-to-date accessible online presence, such as a website that, amongst other key information:

  - links to the online consultation system
  - signposts to validated symptom checker and self-care health information (e.g. nhs.uk) and other online services prominently
  - Allows shared record access, including patients being able to add to their record
  - Allows patients to request and manage prescriptions online
  - Allows online appointment booking
- Increase utilisation and patient engagement from the previous year.
- Utilise The Sound Doctor and aim to increase referrals into the Self-management tool.
- Engage in the implementation of national guidance to support more accurate coding for:

  a) consultation mode and delivery

  b) oximetry and long COVID

  c) all appointments as per National definitions

<u>Medicines Management Optimisation Scheme</u>

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

The scheme consists of the following areas:

- QIPP changes
- Items which should no longer be routinely prescribed in primary care
- Endocrinology: Blood Glucose & Ketone Monitoring
- Respiratory
- Overactive bladder reviews
- Antibiotic Prescribing and Antimicrobial Stewardship (AMS)
- Direct Oral AntiCoagulants (DOACs)
- Carbocisteine Review
- Appliance and Wound Care
- Nutrition

	• Targeted medication reviews • ScriptSwitch • Eclipse Live: RADAR Reviews & High Cost Drug Report • Practice meetings to discuss medicines optimisation issues • Controlled Drugs • Potential Generic Savings • Unlicensed Specials • Dose Optimisation Review • Review of Prescribing Data: Unspecified Drugs and Out of Pocket expenses • Population Health Management Reviews / Eclipse Live PROTECT programme • Amber / Amber G prescribing audit(s) • Additional high priority Medicines Optimisation workstreams
6.	**THE GOVERNING BODY IS ASKED TO:**
	1. Approve the proposed schemes for inclusion within the 2021/22 PDA
7.	**APPENDICES / LINKS TO FURTHER INFORMATION**
	• Appendix 1 – Draft Schemes

Agenda time allocation for report:	20 mins

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?	***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	

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SPECS x 7 TO BE ADDED

PDA 2022-23 – Long Covid

		National Priority	Local Priority
Scheme Number 1 (Contractual Requirement)	Long Covid – assessment and referral pathway	**x**	**x**
RATIONALE FOR INCLUSION (Intended Outcomes)	As per NICE/SIGN/RCGP guidance 'Long COVID' is a commonly used term to describe: • Ongoing symptomatic COVID-19: signs and symptoms of COVID-19 from 4 to 12 weeks. • Post-COVID-19 syndrome: signs and symptoms that develop during or after COVID-19 and continue for more than 12 weeks and are not explained by an alternative diagnosis. The rationale for including the Long Covid pathway in the PDA is to ensure primary care colleagues are fully trained to identify the Long Covid condition and patients are treated for this condition in a timely manner. The intended outcomes of the Long Covid pathway are (1) to increase the number of referrals to the Long Covid Treatment service and (2) to reduce waiting times for initial appointment to the Long Covid Treatment Service.		
HOW TO…	**LCS01 – 30 Points** All patients with suspected or confirmed Long Covid are required to be directed to the Your Covid Recovery website, https://www.yourcovidrecovery.nhs.uk/ Primary Care Colleagues are to confirm a diagnosis of Long Covid using blood tests and CXR diagnostics and by following the clinical pathway below. (Blood tests should include FBC, U&Es , LFTS, TFTs, Bone biochem, Vit D, Auto antibodies, HbA1c, Cholesterol: total/HDL ratio, ferritin, b12, folate, crp, BNP) Long Covid Clincal Pathway Primary Care Once a diagnosis is confirmed, Primary Care colleagues will identify the additional health needs required. Additional tools have been provided below to support clinicians. Physical Health needs:		

	Sheffield Screening Tool FINAL 5.1.21.doc Psychological/ Cognitive: score-sheet-gad-7-anxiety-and-phq-9-depr Recommend patients to complete pages 1 and 2 outside of the appointment, clinician can then use page 3 to discuss the score and next steps with the patient. Overall scoring of Post Covid Function Post Covid Functional Status Scale.pdf Primary Care Colleagues will make the necessary referrals to IAPT using existing referral route, for any ongoing psychological or cognitive needs, patients can also self-refer to IAPT stating Long Covid Rehabilitation in their referral. Primary Care Colleagues will refer to SWYFT SPA for any physical health needs using the referral form below. This form is also available on clinical systems, Long Covid Referral Proforma.docx		
MEASUREMENT	80% of patients with suspected Long Covid diagnosis to be directed to 'Your Covid Recovery website. https://www.yourcovidrecovery.nhs.uk/ Number of referrals to the Long Covid Treatment Service		
FREQUENCY AND DEADLINES	Monthly Extraction		
SNOMED CODES	Long Covid SNOMED codes.pdf		
TEMPLATES	National Guidance: https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/11/C1248-national-		

	guidance-post-covid-syndrome-assessment-clinics-v2.pdf Assessment and Referral templates can be found above. Barnsley Long Covid Pathway overview  Long Covid Pathway Jan 22.pdf		
CCG LEAD OFFICER	Jamie Wike Joshua Lumb		

SCHEDULE 4 – QUALITY REQUIREMENTS

C. Local Quality Requirements

Quality Requirements	Threshold	Method of Measurement	Application Service Specification
2021-22 PDA Schemes			
Scheme 1: Signposted to additional resources	80% of patients with suspected or confirmed Long Covid signposted to 'Your Covid Recovery' website	Monthly extraction using SNOMED code	
Number of Referrals to Long Covid Service	Practices are required to code referrals and liaise with Long Covid service to ensure referrals are appropriate.	Self-declaration	

SCHEDULE 6 – CONTRACT MANAGEMENT, REPORTING AND INFORMATION REQUIREMENTS

A. Reporting Requirements

	Reporting Period	Format of Report	Timing and Method for delivery of Report
National Requirements Reported Centrally			
1. As specified in the DCB Schedule of Approved Collections published on the NHS Digital website at https://digital.nhs.uk/isce/publication/nhs-standard-contract-approved-collections where mandated for and as applicable to the Provider and the Services	As set out in relevant Guidance	As set out in relevant Guidance	As set out in relevant Guidance
National Requirements Reported Locally			
Activity and Finance Report *(note that, if appropriately designed, this report may also serve as the reconciliation account to be sent by the Provider under SC36.22)*	Not Applicable	Not Applicable	Not Applicable
Service Quality Performance Report, detailing performance against Operational Standards, National Quality Requirements, Local Quality Requirements, Never Events and the duty of candour	Not Applicable	Not Applicable	Not Applicable
Complaints monitoring report, setting out numbers of complaints received and including analysis of key themes in content of complaints	Not Applicable	Not Applicable	Not Applicable
Summary report of all incidents requiring reporting	Not Applicable	Not Applicable	Not Applicable
Local Requirements Reported Locally			
Scheme Number **Scheme Title**			

PDA 2022-23 – Cancer

Scheme Number 2 **(Contractual Requirement)**	**Cancer**	National Priority	Local Priority
		x	**x**
RATIONALE FOR INCLUSION (Intended Outcomes)	Minimising Harm due to COVID on the Cancer Pathway Delivery- The greatest impact to focus on during 22/23 is the emerging priorities especially female bladder and head and neck; patients who are worried about returning to services and ensuring patients whom have been referred are treated quickly. Patients who are currently on elective waiting lists and have been waiting for some time (and may continue to do so) as 6% may have a diagnosis of cancer via this route. The management of potential new referrals by General Practitioners and alternatives to referrals / patients who are not presenting to services will also increase early diagnosis and recovery. This can be addressed by targeting people by using specific evidence-based messages that will 'nudge' people to make a change in behaviour via posters and social media channels re: using Behavioural Theory interventions. The programme consists of applying three simple concepts: • Push – use of targeted nudges with community connectors that engage with identified underrepresented/ identified as harmed by Covid populations to push them to their GP instead of sitting on symptoms. • Pull - use of targeted nudges to engage those identified through the primary care workforce to pull people into the primary care system rather than sitting on symptoms. • Stick with – use of nudge messages across the identified cancer specific diagnostic and treatment pathways to ensure patients access services, diagnostics and complete treatment pathways. This is vital to ensure patients are supported and nudged to attend diagnostics and remain engaged throughout ongoing inpatient and outpatient appointments to ensure early diagnosis and treatment		

Current rates from the PHE Profile data (updated December 2021) indicate that the uptake in cervical rates is positive. Although across all the screening programmes there is a variation in uptake across the different GP Practice areas especially for breast screening. This was the same pattern of uptake as pre-covid. As per the outlined in the table below:

Type 20/21 data	UK average %	CCG score	Lowest level of uptake
Screened Breast age 50-70	61.3	51.9	24.3
Cervical aged 25-49	69.1	75.8	68.4
Cervical aged 50-64	75.0	77.2	63.9
Bowel 60-74	66.8	68.9	58.9

Data also is indicating that patients are booking an appointment but a number are not attending. BHNFT are therefore using Behavioural Theory interventions targeted text messages content to reduce this occurrence. This is already increasing the number of women whom are attending compared to having no targeted communication in place.

In other areas using Behavioural Theory interventions in practices It has increased screening rates for women who have not attended before by Increase 139 samples taken (27%) in one practice alone. With 7 additional women referred for further diagnostic activity.

C the Signs

Currently Barnsley is performing below national averages for cancer early diagnosis. The trajectory reflects a 17% gap from the national ambition to have three in four people diagnosed at stage 1 or 2. The COVID impact realised in the reduction in 2 week wait referrals and the pause in screening programmes has made this challenge even greater for the local healthcare system. A clinical decision support tool to support all GP's has been provided to aid recovery for appropriate cancer pathway

	referrals, support risk stratification and safety netting processes, provide advice and guidance and reduce unwarranted referral practice in Primary Care. This tool is called C the Signs. The platform has built in safety-netting mechanisms that enable active surveillance of patients on all cancer pathway, including date, referrer, and pathway. It captures the outcomes of patients sent on a cancer pathway to demonstrate as close to real time, information on referral rates and detection rates. This will enable the development of more consistent referral practice and data to track and improve cancer outcomes enabling delivery of the Quality Outcome Framework (QOF) and the Directed Enhanced Services (DES) specification cancer requirements. In 2021 the C the signs free tool was rolled out to practices. Currently the majority of practices are using it. But data show that not all staff in the practices are using it and for all suspected cancer referrals and safety netting.		
HOW TO…	**CAN01 – C The Signs – 5 Points** To fully implement the C-The Signs tool by Q1 with All GP' in the practice using it. To use the data to identify gaps in referral types and return referrals for the tumour sites back to April 2020 levels for patient groups that are not presenting **CAN02 – Behavioural Theory Interventions – 60 Points** i. Behavioural Theory interventions - During Q1 take part in practice or PCN Neighbourhood based virtual or face to face workshop of 1 hour (at least 50% of staff to attend ensuring a mix of workforce i.e. at least 1 GP, 1 Nurse, 1 Admin role and Care Coordinator to attend); **(10 Points)** ii. Work with CCG and Cancer Alliance to amend practices letters, texts and telephone messages using the behavioural insight workbook and tools **(5 Points)** iii. By Q2 to be using at least one tool in the workbook to increase the uptake of patients who are low attendees for at least 1 screening programme and 1 cancer tumour referral pathway. (Could be for a specific group of		

	patients). The workbook will be provided by the CCG. **(20 Points)** iv. Person leading the work on Behavioural Theory interventions in the practice to attend quarterly implementation group and provide progress update **(5 Points)** v. Work with the CCG dedicated Behavioural Insight Manager to embed the work in the practice and to gain training /development opportunities**. (20 Points)**		
MEASUREMENT & TARGETS	1. As above - Evidence will be collected by the CCG when possible i.e. Attendance at workshops and via the CCG dedicated Behavioural Insight Manager ongoing work supporting practices to embed the work and via training /development opportunities.		
FREQUENCY AND DEADLINES	Final information will be collected 31st March 2023 for payment calculation based on achievement The CCG will draw data from practice systems as needed but cannot access individual staff practice data from C the signs remotely (due to data sharing regulations) Practices will therefore need to provide this information to the CCG re: staff uptake of using the platform at the end of Q1.		
READ CODES			
TEMPLATES			
CCG LEAD OFFICER	Jamie Wike, Chief Operating Officer; Siobhan Lendzionowski, Lead Commissioning and Transformation Manager - Long Term Conditions; Cancer and End of Life/Palliative Care; Diagnostics		

SCHEDULE 6 – CONTRACT MANAGEMENT, REPORTING AND INFORMATION REQUIREMENTS

A. Reporting Requirements

	Reporting Period	Format of Report	Timing and Method for delivery of Report
National Requirements Reported Centrally			
1. As specified in the DCB Schedule of Approved Collections published on the NHS Digital website at https://digital.nhs.uk/isce/publication/nhs-standard-contract-approved-collections where mandated for and as applicable to the Provider and the Services	As set out in relevant Guidance	As set out in relevant Guidance	As set out in relevant Guidance
National Requirements Reported Locally			
Activity and Finance Report *(note that, if appropriately designed, this report may also serve as the reconciliation account to be sent by the Provider under SC36.22)*	Not Applicable	Not Applicable	Not Applicable
Service Quality Performance Report, detailing performance against Operational Standards, National Quality Requirements, Local Quality Requirements, Never Events and the duty of candour	Not Applicable	Not Applicable	Not Applicable
Complaints monitoring report, setting out numbers of complaints received and including analysis of key themes in content of complaints	Not Applicable	Not Applicable	Not Applicable
Summary report of all incidents requiring reporting	Not Applicable	Not Applicable	Not Applicable
Local Requirements Reported Locally			
Scheme Number **Scheme Title**			

PDA Scheme 2022-23 - Cardiovascular Disease (CVD)

Scheme Number 3 (Contractual Requirement)		National Priority	Local Priority
CVD-01 Atrial Fibrillation (weighted by practice new AF diagnosis activity in-year) **CVD-02 Heart Failure** 65% Patients with HF due to LVSD are on maximum dose ACE/ARB and BB OR coded as *on maximum tolerated* ACEI/ARB and BB **CVD-03 Secondary Prevention – cholesterol** 85% Patients with CVD have nHDL recorded in last 2 years AND 65% Patients with CVD whose nHDL (latest) ≥2.5 who have a target nHDL AND lipid disorder monitoring check done recorded 1st April 2022 – 31st March 2023	**CVD-01 Atrial Fibrillation (15 Points)** Practices will be offered a block payment for undertaking diagnostics and follow-up for people in high-risk groups, identified with an irregular pulse. **CVD-02 Heart Failure (50 Points)** Practices should review patients with heart failure (and LVSD) and ensure they are prescribed the maximum tolerated ACEI/ARB and BB. Consideration should be given for additional medication as per local/national guidance if patients remain symptomatic. Practices should engage in the review of local heart failure pathway design. Measure serum natriuretic peptides (NT-proBNP) on people with suspected heart failure and request echo/refer to HF diagnostic clinic as per local guidance. **CVD-03 Secondary prevention of CVD – cholesterol (60 Points)** Practices should ensure all patients with existing CVD are offered a statin and/or ezetimibe to lower nHDL cholesterol by at least 40% from baseline (measure used is nHDL <2.5) and refer to secondary care for additional cholesterol lowering medication as per local/national guidance (TBC) if target not achieved	**x**	**x**
RATIONALE FOR INCLUSION (Intended Outcomes)	The new long-term plan for the NHS includes a new national focus on cardiovascular disease (CVD), including stroke. Both have been recognised as clinical priorities, and a major ambition to prevent 150,000 strokes, heart attacks and dementia cases over the next 10 years. Improving the detection and treatment of the high-risk conditions of AF, hypertension (high BP) and high cholesterol has the potential to unlock considerable health gains. It also enables early identification of other risk factors for CVD, such as smoking and obesity. Barnsley's Heart Health Alliance intends to review		

	the local heart failure pathway. Effective identification and diagnosis of heart failure and optimisation of first line medication in patients with heart failure will support service redesign and the development of appropriate pathways to access specialist support for people with heart failure and prevent deterioration and hospital admissions. This will also support the requirements of the PCN CVD Prevention DES 2022-3: earlier identification of heart failure, appropriate HF diagnostic pathway and use of N-terminal pro B-type natriuretic peptide (NTProBNP) testing To support the implementation of NICE guidance and the new Accelerated Access Collaborative National Guidance for Lipid Management for Primary and Secondary Prevention of CVD, Barnsley are developing local pathways to ensure timely access to appropriate lipid medication. Initial work within primary care is required to ensure all patients with existing cardiovascular disease have been offered first line cholesterol lowering medication which is prescribed at the maximum tolerated intensity and dosage to lower cholesterol to target levels. This work will support the development of appropriate local pathways for specialist support for additional cholesterol lowering medication as per local/national guidance if target nHDL/LDL not achieved. Statin side effects 'overestimated and overdiagnosed', finds large study - Pulse Today		
HOW TO…	**CVD-01 Atrial Fibrillation – 15 Points** Practices should undertake opportunistic pulse checks on all people that are at high risk of developing atrial fibrillation: • Heart failure • Cardiovascular disease • Hypertension • Valve disease • Diabetes • Excessive alcohol intake • >65 years of age • Hyperthyroidism Also check pulse rhythm and rate in people presenting with the following symptoms: • breathlessness • palpitations • syncope or dizziness Appropriate follow-up would include: • 12 Lead ECG		

	• Medical history • Symptoms review: onset, frequency & duration If atrial fibrillation confirmed national/local guidance should be followed: NICE guideline [NG196] Atrial fibrillation: diagnosis and management Published: 27 April 2021 Last updated: 30 June 2021 Clinical system searches will be available for monitoring and to identify target populations: Achievement reporting: • New diagnosis of AF from 1st April 2022 – 31st March 2023 Searches to support delivery • Irregular pulse and no subsequent ECG recorded Monitoring purposes only: • Irregular pulse recorded from 1st April 2022 – 31st March 2023 • Irregular pulse and subsequent ECG recorded (including search to identify 'missing' patients – as above) **CVD-02 Heart Failure – 50 points** 1) Practices should review patients with heart failure (and LVSD) and ensure ACEI/ARB and BB have been titrated to the maximum tolerated dose. Consideration should also be given for additional medication to be started in primary care, if a patient remains symptomatic (e.g. mineralocorticoid/ aldosterone receptor antagonists; Sodium Glucose cotransporter 2 (SGLT2) inhibitors in T2 diabetes) as per national guidance: NICE guideline [NG106] Chronic heart failure in adults: diagnosis and management Published: 12 September 2018 Consideration should also be given for alternative medication - Sacubitril/valsartan (Entresto) – in patients on maximum tolerated ACE/ARB who remain symptomatic. Please seek advice and guidance from specialist team if required. • *Local pathway to follow once finalised*		

	2) Practices should engage with the Heart Health Alliance task and finish group who will be reviewing the local heart failure pathway in 2022-3. In particular, practices should support and contribute to the development of an appropriate local pathway and associated guidance for primary care. 3) Assess for common symptoms (breathlessness, fatigue, swollen ankles and legs) in people with risk factors for developing heart failure, in particular those with cardiovascular disease and/or hypertension. Measure serum natriuretic peptides (NT-proBNP) on people with suspected heart failure and request echo/refer to HF diagnostic clinic as per local guidance. Clinical system searches will be available for register validation, monitoring and to identify target populations: Achievement reporting: • Patients with HF due to LVSD on: ○ maximum dose ACE/ARB OR coded as *on maximum tolerated* ACEI/ARB AND ○ on maximum dose BB OR coded as *on maximum tolerated* BB Searches to support delivery: • Patients with HF due to LVSD • Patients with LVSD but no HF dx (case finding for QOF register) **CVD-03 Secondary prevention of CVD – cholesterol – 60 points** Practices should ensure all patients with existing CVD are offered appropriate intensity and dosage of statin and/or ezetimibe to lower nHDL cholesterol by at least 40% from baseline* and refer to secondary care for additional cholesterol lowering medication as per local/national guidance if target nHDL/LDL not achieved. Summary of national guidance for lipid management for primary and secondary prevention of cardiovascular disease (CVD) Where previous statin intolerance please refer to guidance on re-challenge: National Statin intolerance pathway		

	Local guidance re: specialist lipid lowering therapy to follow Statin side effects 'overestimated and overdiagnosed', finds large study - Pulse Today Consider prioritising as per searches outlined below, i.e. start with patients that have not had a nHDL recorded in L2Y. Then look at those not on a statin/ezetimibe, etc. Patients' baseline nHDL should be reviewed and target nHDL calculated* **and recorded** (40% below baseline). Offer maximum tolerated intensity/dose of statin and/or ezetimibe to reach target nHDL. *Target: >40% from baseline reduction in non-HDLc or LDLc OR if baseline value not available consider target non-HDLc <2.5mmol/L (approximately equivalent to LDLc <1.8mmol/L non-HDL-C value is calculated by **subtracting your HDL-C value from your total cholesterol value**. Target cholesterol is calculated by **multiplying baseline nHDL by 0.6** **Record *lipid disorder monitoring* once all treatment intensities and doses have been optimised.** Clinical system searches will be available for monitoring and to identify target populations: Achievement reporting: • Patients with CVD (see search 1 below) who have nHDL recorded in last 2 years at 31st March 2022 • Patients with CVD whose nHDL (latest) ≥2.5 who have a *target nHDL* AND *lipid disorder monitoring* 1st April 2022 – 31st March 2023 Searches to support delivery: 1. Secondary prevention population (anyone from CVD registers – CHD, stroke/tia, pvd) *NB CKD register not included and those with CVD - excludes those with CKD 4-5)* 2. Of 1) those who have no nHDL recorded in last 2 years 3. Those with nHDL in L2Y above (latest) ≥2.5 4. Of 3. those not on a statin or ezetimibe 5. Of 3. those on suboptimal intensity or dose statin (not on Ezetimibe) 6. Of 3. those on high intensity statin and full dose (not on ezetimibe)		

MEASUREMENT & TARGETS	**CVD-01 Atrial Fibrillation** Payment will be paid proportionally based on number of patients with a new diagnosis of AF from 1st April 2022 – 31st March 2023 For monitoring purposes only: • Irregular pulse recorded from 1st April 2022 – 31st March 2023 • Irregular pulse and subsequent ECG recorded (including search to identify 'missing' patients) **CVD-02 Heart Failure** 65% of Patients with HF due to LVSD on maximum dose ACE/ARB and BB OR coded as *on maximum tolerated* ACEI/ARB and BB Practice has engaged with development and implementation of pathway for patients with heart failure – self declaration **CVD-03 Secondary prevention of CVD – cholesterol** 85% Patients with CVD who have nHDL recorded in last 2 years 65% Patients with CVD whose nHDL (latest) ≥2.5 who have a *target nHDL* AND *lipid disorder monitoring* 1st April 2022 – 31st March 2023		
FREQUENCY AND DEADLINES	Data will be extracted centrally and monitored monthly Final data will be extracted 31st March 2023 for payment calculation based on achievement		
READ CODES	**Atrial fibrillation diagnosis codes** (QOF Cluster): - Atrial fibrillation 49436004 - Atrial fibrillation and flutter 195080001 - Atrial flutter 5370000 - Atypical atrial flutter 15964901000119107 - Chronic atrial fibrillation 426749004 - Controlled atrial fibrillation 300996004 - Lone atrial fibrillation 233910005 - Non-rheumatic atrial fibrillation 233911009 - Paroxysmal atrial fibrillation 282825002 - Paroxysmal atrial flutter 427665004 - Permanent atrial fibrillation 440028005		

	- Persistent atrial fibrillation 440059007 - Rapid atrial fibrillation 314208002 - Typical atrial flutter 720448006 **Irregular Pulse** O/E - pulse irregularly irreg. 163000006 O/E -pulse regularly irregular 163001005 O/E - irregular pulse 275954009 **ECG:** 12 Lead ECG 268400002 Standard ECG 164847006 **Heart Failure/LVSD codes:** Heart Failure (QOF Cluster): - Acute congestive heart failure 10633002 - Acute heart failure 56675007 - Acute left ventricular failure 195114002 - Biventricular congestive heart failure 92506005 - Chronic congestive heart failure 88805009 - Compensated cardiac failure 195112003 - Congestive heart failure due to valvular disease 426611007 - Decompensated cardiac failure 195111005 - Heart failure 84114007 - Heart failure as a complication of care 233924009 - Heart failure with mid range ejection fraction 788950000 - Heart failure with normal ejection fraction 446221000 - Heart failure with reduced ejection fraction 703272007 - Left heart failure 85232009 - New York Heart Association Classification - Class I 420300004 - New York Heart Association Classification - Class II 421704003 - New York Heart Association Classification - Class III 420913000 - New York Heart Association Classification - Class IV 422293003 - Refractory heart failure 314206003		

	- Rheumatic left ventricular failure 43736008 - Right ventricular failure 367363000 Left ventricular Systolic disease (LVSD) (QOF Cluster) - Echocardiogram shows left ventricular systolic dysfunction 407596008 - Left ventricular systolic dysfunction 134401001 **Cholesterol levels:** Serum non-high-density lipoprotein (HDL) cholesterol level 1006191000000106 Target serum non-high-density lipoprotein (HDL) cholesterol level 776871000000108 Lipid disorder monitoring 315598000 **Contraindications:** Maximum tolerated ACEI 2548231015 Maximum tolerated ARB 2549695014 Maximum tolerated BB 2549723016 Statin declined 134396000 Statin contraindicated 459877017 Lipid lowering drugs declined 135826008 Lipid lowering drugs contraindicated 135822005 Patient on maximal tolerated lipid lowering therapy 2159169011		
TEMPLATES	Support and guidance available from: • Health Improvement Nurse, BCCG (see contact details below) Local templates are available: • Barnsley Atrial fibrillation (v2.1) • Barnsley Heart Failure (v3) • Barnsley CHD (v2.1) • Barnsley Stroke/TIA (v2.1) • Barnsley PVD (v2.1)		
CCG LEAD OFFICER	Jamie Wike, Chief Operating Officer Sarah Pollard, Health Improvement Nurse – CVD Tel: 01226 433741		

	Email: Sarahpollard1@nhs.net		

SCHEDULE 4 – QUALITY REQUIREMENTS

C. Local Quality Requirements

Quality Requirements	Threshold	Method of Measurement	Application Service Specification
Scheme 3 2022-23 - Cardiovascular Disease (CVD)			
CVD-01 Atrial Fibrillation Practices will be offered a block payment for undertaking diagnostics and follow-up for people in high-risk groups, identified with an irregular pulse.	Block payment to practice weighted on volume of activity/total activity across all practices	• Number of patients with an Irregular pulse recorded from 1st April 2022 – 31st March 2023 Data will be extracted centrally and monitored monthly (Excludes practice with Vision – alternatives to be considered)	Scheme 3 2022-23 - Cardiovascular Disease (CVD) Service Specification
CVD-02 Heart Failure Practices should review patients with heart failure (and LVSD) and ensure they are prescribed the maximum tolerated ACEI/ARB and BB. Consideration should be given for additional medication as per local/national guidance. Practices should engage in the review of local heart failure pathway design. Measure serum natriuretic peptides (NT-proBNP) on people with suspected heart failure and request echo/refer to HF diagnostic clinic as per local guidance.	65%	• Patients with HF due to LVSD on maximum dose ACE/ARB and BB OR coded as *on maximum tolerated* ACEI/ARB and BB Data will be extracted centrally and monitored monthly (Excludes practice with Vision – alternatives to be considered) • Recorded engagement from the practice during the project including completion of requested information and documentation. • To respond to requested engagement within 14 days as and when required • Declaration that local guidance and pathways have been followed	Scheme 3 2022-23 - Cardiovascular Disease (CVD) Service Specification
CVD-03 Secondary prevention of CVD – cholesterol Practices should ensure all patients with existing CVD are offered a statin and/or ezetimibe to lower nHDL cholesterol by at least 40% from baseline (measure used is nHDL <2.5) and refer to secondary care for additional cholesterol lowering medication as per local/national guidance	85% 65%	• Patients with CVD who have nHDL recorded in last 2 years Data will be extracted centrally and monitored monthly (Excludes practice with Vision – alternatives to be considered) • Patients with CVD whose nHDL (latest) is ≥2.5 who have a *target nHDL* AND	Scheme 3 2022-23 - Cardiovascular Disease (CVD) Service Specification

(TBC) if target not achieved		*lipid disorder monitoring* recorded 1st April 2022 – 31st March 2023 Data will be extracted centrally and monitored monthly (Excludes practice with Vision – alternatives to be considered)	

SCHEDULE 6 – CONTRACT MANAGEMENT, REPORTING AND INFORMATION REQUIREMENTS

A. Reporting Requirements

	Reporting Period	Format of Report	Timing and Method for delivery of Report
National Requirements Reported Centrally			
1. As specified in the DCB Schedule of Approved Collections published on the NHS Digital website at https://digital.nhs.uk/isce/publication/nhs-standard-contract-approved-collections where mandated for and as applicable to the Provider and the Services	As set out in relevant Guidance	As set out in relevant Guidance	As set out in relevant Guidance
National Requirements Reported Locally			
Activity and Finance Report *(note that, if appropriately designed, this report may also serve as the reconciliation account to be sent by the Provider under SC36.22)*	Not Applicable	Not Applicable	Not Applicable
Service Quality Performance Report, detailing performance against Operational Standards, National Quality Requirements, Local Quality Requirements, Never Events and the duty of candour	Not Applicable	Not Applicable	Not Applicable
Complaints monitoring report, setting out numbers of complaints received and including analysis of key themes in content of complaints	Not Applicable	Not Applicable	Not Applicable
Summary report of all incidents requiring reporting	Not Applicable	Not Applicable	Not Applicable
Local Requirements Reported Locally			
Scheme 3 2022-23 - Cardiovascular Disease (CVD)			
CVD-01 Atrial Fibrillation Practices will be offered a block payment for undertaking diagnostics and follow-up for people in high-risk groups, identified with an irregular pulse.	1st April 2022 – 31st March 2023	Data will be extracted centrally (Excludes practice with Vision – alternatives to be considered)	Monitored monthly Final data will be extracted 31st March 2023 for payment calculation based on achievement
CVD-02 Heart Failure Practices should review patients with heart failure (and LVSD) and ensure	1st April 2022 – 31st March 2023	Data will be extracted centrally (Excludes practice with	Monitored monthly Final data will be extracted 31st

	Reporting Period	Format of Report	Timing and Method for delivery of Report
they are prescribed the maximum tolerated ACEI/ARB and BB. Consideration should be given for additional medication as per local/national guidance. Practices should engage in the review of local heart failure pathway design. Measure serum natriuretic peptides (NT-proBNP) on people with suspected heart failure and request echo/refer to HF diagnostic clinic as per local guidance.		Vision – alternatives to be considered) Recorded engagement from the practice during the project including completion of requested information and documentation. Self-Declaration that local guidance and pathways are being followed	March 2023 for payment calculation based on achievement To respond to requested engagement within 14 days as and when required 31st March 2023
CVD-03 Secondary prevention of CVD – cholesterol Practices should ensure all patients with existing CVD are offered a statin and/or ezetimibe to lower nHDL cholesterol by at least 40% from baseline (measure used is nHDL <2.5) and refer to secondary care for additional cholesterol lowering medication as per local/national guidance (TBC) if target not achieved	1st April 2022 – 31st March 2023	Data will be extracted centrally (Excludes practice with Vision – alternatives to be considered)	Monitored monthly Final data will be extracted 31st March 2023 for payment calculation based on achievement

PDA 2022-23 – Admin Support Scheme

		National Priority	Local Priority
Scheme Number 4 (Contractual Requirement)		**x**	**x**
RATIONALE FOR INCLUSION (Intended Outcomes)	The CCG is aware that practices and admin staff have been under extreme pressures over the last two years, through both increased demand and ask. Therefore, the rationale for including the Admin Support Scheme in the PDA is to enable practices to strengthen admin teams by. 1. Ensuring appropriate capacity is in place within GP practice admin teams to enable admin teams to clear any backlogs that have built up as a result of the pressures and to ensure system reset for the coming year. 2. Releasing admin staff to attend Care Navigation training to ensure that a consistent approach to Care Navigation is used across all GP practices in Barnsley. The Care Navigation training will enable admin staff to better support patients by signposting them to the most appropriate professional or service. This will help patients ensure they receive the right care, first time and as efficiently as possible.		
HOW TO…	**AS01 – Increasing admin capacity to clear backlogs (20 Points)** Practices will be required to strengthen admin teams by employing additional admin resource or offering additional hours to existing admin staff. Practices will then be required to utilise the additional admin resource to clear any administration back logs and support system reset. **AS02 – Care Navigation Training (30 Points)** Practices will be required to release admin staff to attend Care Navigation Training. Barnsley CCG will fund the costs associated with		

	the Care Navigation Training separately to the PDA. The PDA requirement is for GP practices to release admin staff to attend the training that will be provided.		
MEASUREMENT	**AS01 –** Self-declaration from practices that all admin backlogs have been cleared. **AS02 –** 75% of admin staff attend Care Navigation Training* *Excluding anyone who has previously attended Care Navigation training within the last 24months.		
FREQUENCY AND DEADLINES	Yearly		
READ CODES	None		
TEMPLATES	None		
CCG LEAD OFFICER	Jamie Wike, Chief Operating Officer Louise Darwin, Primary Care Transformation Manager		

SCHEDULE 4 – QUALITY REQUIREMENTS

C. Local Quality Requirements

Quality Requirements	Threshold	Method of Measurement	Application Service Specification
2022-23 PDA Schemes			
Scheme 2: AS01 Confirmation that Practice admin backlog has been cleared.	Not applicable	Self-declaration	PDA 2022-23 – Scheme 2
Scheme 2: AS02 75% of admin staff attend Care Navigation Training* *Excluding anyone who has previously attended Care Navigation training within the last 24months.	75% of admin staff (data source: NHSE Digital Workforce Submission)	Attendance register	PDA 2022-23 – Scheme 2

SCHEDULE 6 – CONTRACT MANAGEMENT, REPORTING AND INFORMATION REQUIREMENTS

A. Reporting Requirements

	Reporting Period	Format of Report	Timing and Method for delivery of Report
National Requirements Reported Centrally			
1. As specified in the DCB Schedule of Approved Collections published on the NHS Digital website at https://digital.nhs.uk/isce/publication/nhs-standard-contract-approved-collections where mandated for and as applicable to the Provider and the Services	As set out in relevant Guidance	As set out in relevant Guidance	As set out in relevant Guidance
National Requirements Reported Locally			
Activity and Finance Report *(note that, if appropriately designed, this report may also serve as the reconciliation account to be sent by the Provider under SC36.22)*	Not Applicable	Not Applicable	Not Applicable
Service Quality Performance Report, detailing performance against Operational Standards, National Quality Requirements, Local Quality Requirements, Never Events and the duty of candour	Not Applicable	Not Applicable	Not Applicable
Complaints monitoring report, setting out numbers of complaints received and including analysis of key themes in content of complaints	Not Applicable	Not Applicable	Not Applicable
Summary report of all incidents requiring reporting	Not Applicable	Not Applicable	Not Applicable
Local Requirements Reported Locally			
Scheme Number **Scheme Title**			
Scheme 2 – AS02 Total number of admin staff that have attended Care Navigation Training within the last 24 months.	Yearly	Email	Required by 31 May 2022 via email to the Primary Care Generic Inbox barnsleyccg.primarycare@nhs.net

PDA 2022-23 – Dementia Screening and Champions

		National Priority	Local Priority
Scheme Number 5 (Contractual Requirement)	Improve Dementia Diagnosis Rate and support the borough in being a Dementia Friendly Town.	x	x
RATIONALE FOR INCLUSION (Intended Outcomes)	Pre-COVID SWYFT delivered practice-based Dementia Screening clinics allowing timely access to specialist services for patients. This scheme intends to re-establish Dementia Screening clinics on a neighbourhood basis, one clinic per neighbourhood per month. In addition, Dementia Champions were known and visible in Primary Care pre-COVID. This scheme intends to re-establish those roles and further develop links between Primary Care, Public Health and Voluntary/Community services working with those impacted by Dementia through involvement of the Dementia Action Alliance and/or the Dementia and Me steering group. The work outlined above is intended to deliver; - Improved access to specialist services (Memory Assessment) - Increased Dementia diagnosis rates - Improved access to support for patients with Dementia and their carers - Improved patient experience through ongoing service improvement driven by Dementia Champions In addition working towards a Dementia Friendly Barnsley is a priority for partners across the system and this work is intended to support that ambition.		
HOW TO…	**DEM01: Referrals & Register Maintenance - 10 points** i. Refer appropriate patients to the Dementia Screening clinics, delivered by SWYFT ii. Disseminate local support services across registers iii. Liaise with the Memory Team Advisors iv. Maintain a register of People with Dementia		

	and reconcile with the Memory Team on a quarterly basis v. Maintain a register of carers who care for someone with dementia **DEM02 – Dementia Champion – 10 points** i. Have an in house trained Dementia Champion who can undertake the Barnsley CCG Dementia Champion Job Profile and inform the CCG of any changes in personnel ii. Ensure that the practice is a Member of the Barnsley Dementia Action Alliance and/or the Dementia and Me Steering group. iii. Attend 2 Dementia Champion meetings per year. iv. Evidence that any building changes take into account the dementia environment checklist v. Promotion of the Herbert Protocol		
MEASUREMENT	1. Referrals into the Neighbourhood Dementia Screening clinics. 2. Quarterly Reconciliation of Dementia Registers. 3. Membership of the Barnsley Dementia Action Alliance and/or Dementia and Me Steering group – Attending 2 dementia champion meetings per year.		
FREQUENCY AND DEADLINES	As above.		
READ CODES	None.		
TEMPLATES			
CCG LEAD OFFICER	Leanne Sparks Commissioning and Transformation Manager Leanne.sparks@nhs.net		

PDA 2022-23 – Digital Primary Care Scheme

		National Priority	Local Priority
Scheme Number 6 (Contractual Requirement)		**x**	**x**
RATIONALE FOR INCLUSION (Intended Outcomes)	Practices will be asked to support the National, Regional and Local IT and Digital projects for 2022/23, including for example moving to Cloud Based Telephony, Shared Care Records and Lloyd George Records Digitisation. Since April 2015, all practices have been required to offer patients access to online GP services, this PDA scheme will support practices to maximise utilisation of IT functionality which has been commissioned to offer this access to patients.		
HOW TO…	**DPC01 – Implementation of Digital Projects (20 Points)** Practices will be required to engage with National, Regional and Local projects to enable successful implementation and completion Projects are expected to include moving to a Cloud Based Telephony System, the Lloyd George Records Digitisation, Shared Care Records and Clinical Decision Making Toolkits however others will be included as National, Regional and Local projects are developed. **DPC02 – Increasing Utilisation of Commissioned IT Services(30 Points)** a) Practices will increase the number of online consultations that can be used by patients, carers and by practice staff on a patient's behalf, to gather submitted structured information and to support triage, enabling the practice to allocate patients to the right service for their needs b) Practices will increase the number of video consultations that can be used between patients, carers, and clinicians c) Practices will provide an up-to-date accessible online presence, such as a website that, amongst other key information: i. links to the online consultation system		

	ii. signposts to validated symptom checker and self-care health information (e.g. nhs.uk) and other online services prominently iii. Allows shared record access, including patients being able to add to their record iv. Allows patients to request and manage prescriptions online v. Allows online appointment booking Practices will be required to increase utilisation and patient engagement from the previous year. Practices will be enabled with the tools and functionality, as part of CCG infrastructure responsibilities d) Practices should utilise The Sound Doctor and aim to increase referrals into the Self-management tool. To achieve this, practices should engage with The Sound Doctor and the BBS IT team to identify patients to run text campaigns promoting the service, and to embed the links into the Data Entry Templates in clinical systems. These should be linked to QOF and IIF targets as well as local priorities. e) Engage in the implementation of national guidance to support more accurate coding including: i. Consultation method to enable data collection can be carried out, to identify who is accessing face-to-face, telephone, or video consultations, broken down by relevant protected characteristic and health inclusion groups, including ethnicity ii. Practices to utilise published SNOMED codes for oximetry and long COVID to aid data returns (data returns will be undertaken centrally by the CCG where possible). iii. Ensuring all appointments reflect the National definitions to support reporting of core service delivery and appointments data with participation in national data collection		
MEASUREMENT	Increase of utilisation and engagement – baseline for each practice from 2021/22 data of usage, target increase – TBC		
FREQUENCY AND DEADLINES	Data will be monitored quarterly (TBC) Final data will be accessed 31st March 2023		
READ CODES	TBC		

	Video Consultation Online Consultation		
TEMPLATES	None		
CCG LEAD OFFICER			

SCHEDULE 4 – QUALITY REQUIREMENTS

C. Local Quality Requirements

Quality Requirements	Threshold	Method of Measurement	Application Service Specification
2022-23 PDA Schemes			
Scheme 4: **IT & Digital Primary Care**	n/a	n/a	n/a

SCHEDULE 6 – CONTRACT MANAGEMENT, REPORTING AND INFORMATION REQUIREMENTS

A. Reporting Requirements

	Reporting Period	Format of Report	Timing and Method for delivery of Report
National Requirements Reported Centrally			
1. As specified in the DCB Schedule of Approved Collections published on the NHS Digital website at https://digital.nhs.uk/isce/publication/nhs-standard-contract-approved-collections where mandated for and as applicable to the Provider and the Services	As set out in relevant Guidance	As set out in relevant Guidance	As set out in relevant Guidance
National Requirements Reported Locally			
Activity and Finance Report *(note that, if appropriately designed, this report may also serve as the reconciliation account to be sent by the Provider under SC36.22)*	Not Applicable	Not Applicable	Not Applicable
Service Quality Performance Report, detailing performance against Operational Standards, National Quality Requirements, Local Quality Requirements, Never Events and the duty of candour	Not Applicable	Not Applicable	Not Applicable
Complaints monitoring report, setting out numbers of complaints received and including analysis of key themes in content of complaints	Not Applicable	Not Applicable	Not Applicable
Summary report of all incidents requiring reporting	Not Applicable	Not Applicable	Not Applicable
Local Requirements Reported Locally			
Scheme Number 4 **Scheme Title: IT & Digital Primary Care Projects**			
Number of Online Consultations	Quarterly	Clinical Search and/or Provider Data	Quarterly
Number of Video Consultations	Quarterly	Clinical Search and/or Provider Data	Quarterly
Number of Sound Doctor Referrals	Quarterly	Clinical Search and/or Provider Data	Quarterly

Barnsley Clinical Commissioning Group

PRIMARY CARE PRACTICE LEVEL
DRAFT MEDICINES OPTIMISATION SCHEME 2022-23

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 **£X** per weighted patient on the 1 January 2022.

- The work will be completed by 28th February 2023 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 2023 and payments will be made to practices on or before the 30th April 2023:-

- 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 2023 compared with 1 January 2022 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 **£Y.**

- Areas of this scheme which are impacted by (included within) any national prescribing incentive scheme introduced for 2022/2023 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 timeframes and guidance included within the Medicines Management Team QIPP resource pack(s) and/or supporting protocol. 100% of appropriate patients to be offered a change in therapy. • Paracetamol capsules to paracetamol tablets • Co-codamol 8/500 capsules to co-codamol 8/500 tablets • Nifedipine MR tablets to Tensipine® MR tablets • Simple eye ointment to Xailin® Night • Galantamine oral solution to Galzemic® solution • Luventa® XL (galantamine prolonged release) to Galzemic® XL (galantamine prolonged release) • Dicofenac gel to Fenbid® gel • Felodipine MR to Vascalpha® prolonged release • Vagifem® to Vagirux® • Rizatriptan oral lyophilizate to rizatriptan orodispersible • Naproxen E/C to naproxen plain tablets • *Aveeno®/Zeroveen® to Epimax® Oatmeal (TBC)* • *Pentasa® suppositories to Salofalk® suppositories (TBC)* • QIPP changes included in the 2021-22 scheme (see below*) which were not completed across all practices due to prioritization of COVID 19 work in line with NHSE guidance. ***2021-22 scheme areas** • 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 • 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 • 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 and/or APC before December 2022 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 NHS England guidance. The practice will make changes in line with the recommendations in the guidelines and other supporting APC guidelines/ position statements. Supporting resources will be made available. **AND** Prescribing expenditure on OTC items (£ Net Ingredient Cost (NIC) /Age Sex Temporary Resident Originated Prescribing Unit (ASTROPU) is equal to or less than the target set by the CCG (July 2021 to December 2022) OR the practice has demonstrated a 5% reduction (£NIC/ASTRO PU July to December 2022 compared with July to December 2021) **b) Items which should no longer be routinely prescribed in primary care** The practice will review patients prescribed the medications included in the NHS England guidance (including any updates to this national guidance during 2021-22). The practice will make changes in line with the recommendations in the NHS England guidance and corresponding local guidelines, position statements and the Barnsley formulary. A CCG supporting resource pack will be made available. 100% of appropriate patients to be offered a change in therapy. **Sections (a) and (b) to be completed within 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 APC guidance in place at the time the patient is reviewed. **AND** A meeting (which can be held remotely via Microsoft Teams or similar as agreed with the practice) will take place between the practice nurse(s) (+/- other clinicians) and the MMT members supporting the practice to discuss this section of the scheme.

	The following points will be discussed: a) Test strip prescribing within the practice in reference to recent prescribing data b) Barnsley APC guidelines and first line formulary options c) The requirements within this section of the scheme including the audit criteria and standards for achievement. **Following the meeting an action plan will be agreed and submitted by the 10th June 2022** setting out how the practice will achieve this element of the scheme. *Additional information: Audits to monitor progress* *The Medicines Management Team will monitor progress with the above by undertaking a selection of audits in line with CCG SOPs. The audit findings will be shared and discussed with the practice. The audits 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.*
4. Respiratory • **Practice meeting** • **Triple inhalers in COPD** • **ICS/LABA inhalers in COPD and asthma** • **High dose ICS in asthma** • **SABAs** • **Home oxygen / Nebules**	**a) Practice Meeting** A meeting (which can be held remotely via Microsoft Teams or similar as agreed with the practice) will take place between the practice nurse(s) (+/- other clinicians) and the MMT members supporting the practice to discuss this section of the scheme. The following points will be discussed: d) Inhaler prescribing within the practice in reference to recent prescribing data. e) Barnsley APC asthma and COPD guidelines, formulary options and other useful resources. f) Practice level prescribing strategies to optimise prescribing and lower the inhaler carbon footprint. g) The requirements within this section of the scheme including the audit criteria and standards for achievement. **Following the meeting an action plan will be agreed and submitted before the 10th June 2022** setting out how the practice will achieve this element of the scheme. **b) Triple inhalers in COPD** The practice will review patients in line with the COPD algorithm and where combination treatment with an ICS, LABA and LAMA is clinically indicated offer patients a change to a single triple inhaler on the Barnsley formulary at their annual review. **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 (monthly audits to be undertaken by the Medicines Management Team). c) **ICS/LABA inhalers in COPD and asthma** Patients prescribed a non-formulary or less cost effective ICS/LABA inhaler will be reviewed in line with the APC COPD or asthma treatment algorithm to ensure that they are prescribed a device which meets the patient's needs taking into account patient factors, carbon footprint and formulary guidance. The following change in therapy will be offered to appropriate patients in whom the same drug combination and inhaler type (dry powder/MDI) is clinically indicated. The practice will discuss and agree how this will be implemented and how patients will be appropriately educated (including inhaler device changes). • DuoResp Spiromax® or Symbicort® to Fobumix® Easyhaler • Fostair® MDI 100/6 to Luforbec® MDI 100/6 **d) 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. **e) Use of short acting beta 2 agonists (SABAs) in Asthma and COPD patients** i)The practice will continue to review the frequency of use and choice of SABA inhalers in line with local guidance in all asthma and COPD patients during their annual reviews. Patients using more than 6 SABA inhalers per year will be prioritised for review. AND ii)The practice will agree and implement a plan for reviewing and where appropriate switching patients prescribed SABA inhalers with a high carbon footprint to an inhaler with a lower carbon footprint which meets the patient's needs. **f) Home Oxygen Reviews / Nebule Reviews** The practice will engage with the CCG as required to help facilitate the review of selected patients prescribed either home oxygen or nebules. *<u>Additional information: Audits to monitor progress with parts (b) to (e)</u>* *The Medicines Management Team will monitor progress with the above*

	workstreams by undertaking a range of audits in line with CCG SOPs. The audit findings will be shared and discussed with the practice. The practice will be required to meet the 75% audit standard.
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 as agreed with the practice) should take place by the 16th September 2022 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 2022-23. • engaging with the European Antibiotic Awareness Day/ World Antibiotic Awareness Week (November 2022). **b) Prescribing Targets** The percentage of cephalosporin, quinolone and co-amoxiclav from all antibiotics prescribed by the practice (January to December 2022) is below 8% or has reduced by 10% (January to December 2022 compared with January to December 2021). **AND** The number of antibiotic prescriptions (Items/STAR PU) issued by the practice (January to December 2022) is below the target set by the CCG or has reduced by 5% (January to December 2022 compared with January to December 2021). **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. 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 2023.
7. Direct Oral AntiCoagulants (DOACs)	The practice will undertake a review of patients who are prescribed DOACs in line with local and national guidance and the Barnsley formulary. To be completed in line with timeframes set by the Medicines Management Team.
8. Carbocisteine Review	The practice will undertake a review of patients who are prescribed carbocisteine in line with local and national guidance. To be completed in line with timeframes set by the Medicines Management Team.
9. 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 and timeframes: • Catheter valves • Night bags • Barrier creams for moisture associated skin damage (MASD) This is not an exhaustive list and additional priority areas may be incorporated. **b) Stoma Appliance Centralised Ordering Process** The practice will continue to 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)Catheter 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 catheter 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.
10. Nutrition • **ONS in adults** • **Enteral nutrition in paediatrics** • **Malnutrition Pathway with Care Homes**	**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 Barnsley ONS guideline and CCG SOPs. **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)Malnutrition Pathway within Care Homes** The practice will engage with the Medicines Management Team and care homes to support and implement the 'Malnutrition Triangle' (A pathway to effectively prevent & treat malnutrition within care homes using everyday food and drinks).
11. Targeted medication reviews	The practice will complete a medication review on a cohort of patients in line with local/national guidance and timeframes set by the Medicines Management Team. To include, but not limited to, patients prescribed: • Ivabradine 2.5mg • Acamprosate and disulfiram

	• Alimemazine • Melatonin • Mefenamic acid • Choral hydrate • Folic acid solution 5mg/5ml and a cohort of patients prescribed other formulations of folic acid • Iron preparations (a cohort of patients) • Patients prescribed 25 or more medicines Any additional priority areas agreed during the year.
12. ScriptSwitch	a. ScriptSwitch is activated for **ALL** practice prescribers (including locums) for 100% of the time for the period 1st May 2022 to 28th February 2023. b. ScriptSwitch is installed on the laptops of clinicians who are working remotely (liaise with the Medicines Management Team for support with this). c. ScriptSwitch is included on the meeting agenda for discussion in both medicines optimisation practice meetings. The discussion will cover a brief update on any key developments relating to ScriptSwitch functionality and the latest quarterly practice ScriptSwitch report. 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 (April 2022 to February 2023) is equal to or greater than the CCG average for the 21/22 year OR, if below the 21/22 averages, an increase of 20% in the acceptance rate OR the potential cost benefit is achieved compared to the individual practice data for 21/22. *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.*
13. 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 2023.** b. The practice has completed a review of high cost drug data*. Patients will be reviewed to ensure prescribing is appropriate and in line with local guidance. *data from Eclipse solutions website or alternative **To be completed in line with timeframes set by the Medicines Management Team.**
14. 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: 10th June 2022 2nd Meeting: 28th February 2023 **Meetings can be held remotely via Microsoft Teams or similar as agreed with the practice 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 continue to engage with the South

	Yorkshire 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 2023.** **c) Targeted Reviews** The practice will complete a review on a cohort of patients identified by the Scheduled Drug Monitoring Group or CCG Controlled Drug Lead(s). **To be completed by 28th February 2023.**
15. Potential Generic Savings	The practice will complete a review of potential generic savings data provided by the CCG and where appropriate patients will be offered a change to a generic product or other cost effective QIPP brand in line with the local formulary. The review will take place twice during the year in line with timeframes set by the Medicines Management Team.
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 in line with timeframes set by the Medicines Management Team.
17. Dose Optimisation Review	The practice will complete a dose optimisation review of patients prescribed medication identified in the CCG protocol in line with timeframes set by the Medicines Management Team.
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 unspecified data on a monthly basis and this will be reviewed by the practice within 4 weeks. **To be completed every month until 28th February 2023.** Out of pocket expenses data to be reviewed in line with

	timeframes set by the Medicines Management Team.
19. Population Health Management Reviews / Eclipse Live PROTECT programme	Practices will engage with implementation PROTECT programme of work. Agreeing the plan for the routing and review of any “calls to action” in agreed cohorts of practice patients identified to be at risk of hospital admission using population health management tool(s), including the Eclipse Live VISTA Platform PROTECT programme. The numbers of clinical “calls to action” will be agreed with each practice. To be completed in line with timeframes set by the Medicines Management Team.
20. Amber / Amber G prescribing audit(s)	The practice will undertake one or more audits on the prescribing of selected amber or amber G drugs in line with APC guidelines and other local supporting resources. To be completed in line with timeframes set by the Medicines Management Team.
21. 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.

NHS
Barnsley
Clinical Commissioning Group

PRIMARY CARE COMMISSIONING COMMITTEE

26 May 2022

CONTRACTUAL ISSUES REPORT – MERGER APPLICATION

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 / Clinical Lead	Chris Edwards	Chief Officer
Author	Terry Hague	Primary Care Transformation Manager

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

<u>The Grove and Dodworth Medical Practice (Apollo Court) Merger</u>

The CCG have received an application from The Grove Medical Practice and Dodworth Medical Practice to merge the practices.

The CCG have explored the opportunities and risks associated with the merger of the two practices. A detailed report was shared and discussed at the 27 January 2022 meeting of the Primary Care Commissioning Committee.

	The practice rationale to merge the practices is, following becoming the contract holders for Dodworth Medical practice in 2019, the merger would instil patient confidence back into the surgery so was in the best interest of the patients and practice. The merger would also prove beneficial to patients as would give improved access to more clinical appointments and services across all four practice sites and would have no adverse effect to patients. From a practice perspective the merger would be beneficial by removing the burden of double reporting and payment processing. The reduced administrative burden would allow reinvestment in improving our patient care and experience. The financial impact for the CCG is limited to the cost of supporting the IT work required to merge the practice systems which totals £3,294. The quote received from the EMIS connecting healthcare team includes work required for the practice reorganisation and engineering support. The Committee had considered the application to approve, in principle the:- • merger of The Grove Medical Practice and Dodworth Medical Practice • commencement of a public and patient engagement consultation. • timeline and cost for the required IT work to merge the practice systems **Public and Patient Engagement Consultation** The CCG have worked with the practice to support them to undertake a dedicated period of Patient and Public Engagement with their registered patients in order to gain views and feedback in relation to their proposed merger application. The resulting report is shared with the Committee at Appendix A for final ratification before final steps are taken to complete the merger. The proportionate engagement approach taken by the practice was agreed following discussion and input from the CCG Communications and Engagement team based on the scope currently defined within the proposed merger application i.e., that none of the current services provided will be affected from a patient perspective. The report outlines the communication and engagement activity undertaken by the practice, summarises the feedback received and next steps. A Question-and-Answer document for registered patients was developed and feedback invited via a short survey which was made available both online and via hard copy which could be picked up from the practice reception areas. There was also the opportunity to feedback at one of the two virtual drop-in sessions; over the phone or via email too. All registered patients who had provided their consent to be contacted by the practices via text message were informed of the proposed merger and sent a link to the online survey to provide their feedback. In addition to this, posters were displayed in each of the practices promoting the proposed merger and the opportunity for people to have their say to inform the

	decision-making process around this along with the information and links being displayed on each of the respective practice website home pages. Of note: • 71% of respondents (22 registered patients) to the survey highlighted that they were in support of the merger and felt this would be beneficial to patients. • 16% of respondents to the survey (5 registered patients) highlighted that they had slight concerns relating to the proposed merger and provided their contact details to be contacted by the practice to discuss this further. They all cited issues around access for this and made particular reference to difficulties they have faced in relation to getting a face-to-face appointment. • 13% of respondents to the survey (4 registered patients) highlighted that they were against the proposed merger and all cited access reasons for this and made particular reference to difficulties they have faced in relation to getting a face-to-face appointment. The practice will share and discuss the engagement report and develop an action plan in partnership with their Practice Patient Group to build on the areas where patients have provided feedback regarding the current services we provide and build upon the things that work well and also where improvements could be made. Additionally, an Equality Impact Assessment has been completed and is attached at Appendix B for consideration. This has been reviewed by the CCG's Head of Communications, Engagement and Equality and has been found to meet requirements. Although, a suggestion was made regarding the focus on digital communication in relation to the use of text messaging to address seldom heard groups. Because of the anticipated minimal impact on patients the practice were advised to consider how they continue to communicate any changes if the merger is approved. **Timeline** The Barnsley, Bassetlaw, and Sheffield IT Services team have been liaising with EMIS, the practice and the CCG and are advised that there is capacity available the weekend of the 21 May 2022 to undertake the necessary work for the merged practice to be in place from the 23 May 2022. All stakeholders are currently working towards this date to ensure that all due diligence and planning work which would be required for a successful merger outcome are completed. **RECOMMENDATION** The committee was asked by circulation of this paper on 11 May to consider final approval and ratification of the merger given that the impact on patients will be minimal and will in effect benefit from the potential to access the newly formed practice at more sites; with the added benefit to the practice of potential for efficiency due to improved systems, including sharing of IT functionality, and the streamlining of administrative processes.

	A majority response from voting members of the committee was received to approve the merger. The committee is asked to ratify this decision.
6.	**THE GOVERNING BODY / COMMITTEE IS ASKED TO:**
	1) Consider the application for the merger of The Grove Medical Practice and Dodworth Medical Practice for ratification of the interim approval given at the meeting on 27 January 2022 and final approval given through virtual communication on 11 May 2022.
7.	**APPENDICES / LINKS TO FURTHER INFORMATION**
	• APPENDIX A – Engagement summary report relating to the proposal to merge The Grove and Apollo Court GP Practices in Barnsley • APPENDIX B – Equality Impact Assessment – Section 14Z2: Patient and Public Participation Form

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	
3.2 Maximising Elective Activity		9.1 Digital and Technology	
4.1 Mental Health		10.1 Compliance with statutory duties	
5.1 Integrated Care @ System		11.1 Delivery of Enhanced Health in Care Homes	
5.2 Integrated Care @ Place		12.1 Delivering The Covid Vaccination Programme & Meeting The Needs of Patients with Covid-19	
5.3 Implementing Population Health Management And Personalised Care			

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 3.2**	Duties as to reducing inequalities (s14T)	**See 3.5**
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 3.3**	Duty as to patient choice (s14V)	
Duty as to improvement in quality of services (s14R)	**See 3.4**	Duty as to promoting integration (s14Z1)	
Duty in relation to quality of primary medical services (s14S)	**See 3.4**	Public involvement and consultation (s14Z2)	**See 3.6**

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?	***Y***
Has a Single Tender Waiver form been completed if appropriate?	***NA***
Has a Primary Care Procurement Checklist been completed where GPs,	***NA***

	networks or Federations may be a bidder for a procurement opportunity?	
	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 A

Engagement summary report relating to the proposal to merge The Grove and Apollo Court GP Practices in Barnsley

This engagement summary report has been prepared in order to provide a brief overview of the supporting communications and engagement activity undertaken to support the proposal to merge The Grove and Apollo Court GP Practices in Barnsley.

Background Information

Dr Guntamukkala and Dr Vemula have been running Apollo Court since April 2019, alongside The Grove, and already both practices are working very closely together and sharing staff and resources, so the proposed merger is the next obvious step in officially uniting the two.

The practice sites will remain unchanged as will the GPs, Nurses and Practice staff as will the opening hours of all sites. The aim of the merger is to harness the benefits of working as one team across both sites rather than two and enable us to develop the services that we provide for the benefit of our patients.

We have been working with NHS Barnsley Clinical Commissioning Group (CCG) which is the group who plans and buys local GP services for the people of Barnsley, on our application to merge the two practices and a key part of this has been to seek views and feedback from our registered patients on our proposals to merge the two practices.

We developed a tailored programme of supporting communications and engagement activity in support of the above that was undertaken during April and May 2022. Below is a summary of this activity and the enquiries and feedback we received as a result.

Summary of supporting communications and engagement activity undertaken

Our key objectives for the supporting communications and engagement activity around the proposed merger were the following.

- To effectively communicate with and listen to the views and feedback of patients and carers who are currently registered with the two practices in relation to our proposal to merge these.

- To effectively engage with our collective practice population to understand any potential impacts on them as a result of the proposed merger.

- To ensure key colleagues were aware of our engagement with the registered practice population and our proposed next steps

Communicating with and seeking the views of registered patients

We have worked alongside the CCG Primary Care and Communications and Engagement Team to develop our supporting engagement plan to gain feedback primarily from registered patients with the two practices as part of our proposed merger application.

We developed a Question-and-Answer document for registered patients relating to our proposed merger (Appendix 1) and invited feedback via a short survey which was made available both online and via hard copy which could be picked up from our reception areas. There was also the opportunity to feedback to us at one of the two virtual drop-in sessions that we advertised to be held on Tuesday 3 May 2022. Feedback could also be provided over the phone or via email too.

All registered patients who had provided their consent to be contacted by the practices via text message were informed of the proposed merger and sent a link to the online survey to provide their feedback. In addition to this, posters were displayed in each of the practices promoting the proposed merger and the opportunity for people to have their say to inform the decision-making process around this along with the information and links being displayed on each of the respective practice website home pages.

Headline summary of feedback received and from whom

We received a total of 32 completed surveys prior to the closing date of 9th May 2022. 6 people also provided feedback via email. We didn't have anyone register an interest in taking part in the online feedback session that we had planned and publicised to be held on 3 May.

How people responded to our merger proposal

We posed one main question for feedback which was - **After reading through the information provided within the Question-and-Answer document, how do you feel about the proposed practice merger?**

- 71% of respondents to the survey (22 registered patients) highlighted that they were in support of the proposed merger and felt that this would be beneficial for patients.

- 16% of respondents to the survey (5 registered patients) highlighted that they had slight concerns relating to the proposed merger and provided their contact details to be contacted by the practice to discuss this further. They all cited issues around access for this and made particular reference to difficulties they have faced in relation to getting a face-to-face appointment.

- 13% of respondents to the survey (4 registered patients) highlighted that they were against the proposed merger and all cited access reasons for this and made particular reference to difficulties they have faced in relation to getting a face-to-face appointment.

Who provided their feedback?

- All respondents to the survey were registered patients of either The Grove or Apollo Court (45% with Apollo Court and 55% with The Grove).

- The majority of feedback to the survey was provided by registered patients between the ages of 55 and 74 (21 people/ 68% of respondents). Feedback was received from people in nearly all of the age categories provided with the only exceptions being for 18–24-year-olds and people over the age of 80.

- There was an almost even split between male and female respondents (52% male/ 48% female)

- 5 respondents (16%) highlighted that they live and work permanently in a gender other than the one they were born into.

- 97% of respondents described their ethnicity as being White British.

- 97% of respondents described their sexuality as heterosexual with 3% identifying as gay.

- 19 respondents (61%) identified as Christians and 12 respondents (39%) identified as having no religion.

- In relation to disability, 10 people (37% of respondents) highlighted that they do not have any form of disability. 5 people (19% of respondents) highlighted they live with a long-term condition. This was the same for respondents who highlighted that they live with a physical disability. 4 people (12% of respondents) described living with either a speech, cognitive or sensory impairment.

- 3 respondents (10%) identified as being an unpaid Carer for a friend or family member.

Queries received via email and themes

We received a total of 6 email queries throughout the communication and engagement period.

The queries received have been documented, will be followed up by the practice with individuals where required and can be broadly themed as follows.

- More information required about current services = 2
- Issues flagged about accessing current primary care services = 3
- Information requested regarding the GP Practice Patient Group = 1

All of the queries received have been documented and will be followed up by the Practice Team with the individuals directly as they relate to individual queries and concerns.

Next Steps

All the feedback we have received during this short engagement period will be fed back to the Barnsley Primary Care Commissioning Committee to help to inform their decision making in relation to our application to merge the two practices. Subject to final approval, the merger of the two practices will commence at the end of May 2022.

We will communicate the outcome of the decision-making process to all registered patients as well as making a copy of this engagement report available via our practice website and on request. This will also be shared with wider local stakeholders for their information with an update on proposed next steps.

Where contact details have been provided and further information requested relating to individual queries/ issues primarily around access, these will be followed up by the practice team directly with the individuals concerned.

We will also share and discuss the engagement report with our Practice Patient Group and develop an action plan in partnership with them to build on the areas where patients have provided feedback regarding the current services we provide and build upon the things that work well and also where improvements could be made.

Acknowledgements

We would like to take this opportunity to pass on our thanks to all the people who took the time to provide us with their views and valuable feedback as part of this engagement process.

Report produced – 10 May 2022

PCCC 22/05/14

Appendix 1 - Question and answer document for registered patients regarding the proposed practice merger of The Grove and Apollo Court GP Practices

Please see further information below regarding our proposed practice merger. Please read through the information provided prior to providing us with your comments and feedback.

If you have any queries, please do not hesitate to contact us via the details provided.

1. **Why are we proposing to merge the two practices?**
   Dr Guntamukkala and Dr Vemula have been running Apollo Court since April 2019, alongside The Grove, so the proposed merger is the next step in uniting the two.

2. **If the proposal is successful when will the merger take place from?**
   It is anticipated that our merger will take place from 23 May 2022 subject to all regulatory approvals and following engagement with patients and all of the staff who are employed by both of the GP Practices

3. **How will you be communicating to registered patients about the proposals to merge the two practices and how can patients have their say?**
   We will be publicising the proposed merger on our practice websites and Facebook pages, sending texts to patients with the link to our online feedback from, displaying posters in each of the practice sites detailing how people can provide their views and feedback as well as providing paper feedback forms and collection boxes in our reception areas.

4. **Will I still be able to make an appointment to see my usual doctor or nurse?**
   Yes. We very much value the relationships our patients have with our doctors, nurses, and wider practice staff. It is therefore expected that merging practices will further increase our ability to provide you with continuity of care and access to your usual doctor and/or nurse.

5. **Will I still be able to make appointments at my usual doctor's surgery?**
   Yes. We will continue to provide daily in person and telephone appointments to see doctors, nurses and healthcare support workers. You will however have the added option of going to one of our other surgeries if that is more convenient for you.

6. **Will my usual surgery opening times stay the same?**
   Yes – there will be no changes to the usual surgery opening hours.

7. **Will there be changes made to the way I book appointments?**
   No – you will be able to book your appointments in the same way that you do now.

8. **Will I be able to make an appointment to see a doctor and/or nurse at another GP practice site?**
   Once we have successfully merged our IT systems, you will be able to request appointments with any doctor and/or nurse at any of the practice sites, therefore providing you with greater access to a wider range of services and availability.

9. **Will I have to go to another GP Practice site for consultations and/or treatments?**
   No - Our surgeries will be providing the same services as they currently do. However, you will be able to choose to visit another site if you wish to following the merger of the two practices.

10. **Will any service that is currently offered by my usual surgery be removed or stopped?**
    No services will be being removed or stopped. If anything, we anticipate that this merger will bring about a greater choice of services for patients to be able to access.

11. **Will there be any changes to how I access the GP out of hours service?**
    No - In order to access a GP when the practice is closed you will still continue to be signposted to the i-HEART Barnsley service or NHS 111 and they will either direct you to the most appropriate service or arrange for you to access a GP.

12. **Will the current arrangements that I have in place for getting my medicines stay the same?**
    Yes - the arrangements you have in place currently will stay the same.

13. **Will the intended merge affect any treatment or medication I am currently receiving either at my usual surgery or any hospital?**
    No - Any current treatments, medications or investigations will not be affected by our intentions to merge.

14. **Will I need to re-register to become a patient of the merged GP Practice? What will happen to my health records?**
    No- you will not need to re-register; you will remain registered with the same GP as you are now. All of our patients will automatically be merged into a single GP Practice and your health records will reside within a single patient database. The NHS safeguards in relation to patient confidentiality of information will continue to remain in place throughout the transition.

15. **Will the single GP Practice be able to provide new services to patients?**
    We would like to explore the opportunity to provide additional services in the future and this will be subject to further conversations with our practice patient participation group and our registered patients at a later date.

16. **How will the new arrangement benefit GPs and Nurses at the practice?**
    Our clinical staff already rotate across all surgeries but merging the clinical systems will lessen the time spent on administrative duties to free up clinicians to spend more of their time seeing patients.

17. **I have further questions I would like to ask and / or comments I would like to make. How do I do this?**

- **Feedback forms in reception** - Paper feedback forms are available from each of the practice sites along with collection boxes in each of the reception areas.

- **Online** - You can provide your feedback here via our online feedback form which can be accessed via the following link – https://nhsbarnsleyccg-consult.objective.co.uk/public/pmgac/pmgac
- Via **telephone** on Thursday 28th April between 9am – 12pm and Tuesday 3rd May between 12pm – 2pm via contact number 01226 288651.
- Via **email** – please send any comments and feedback you may have relating to our proposed practice merger to the following dedicated email address at barnsleyccg.thegrove.patientfeedback@nhs.net
- Via our **Patient Participation Group** - To assist in getting the patient perspective on our plans we are re-launching our 'Patient Participation Group', to ensure ongoing patient involvement in shaping the future of the practice and the services we offer. If you would like to register your interest in being a member of our PPG, or to simply find out more about our plans then please speak to a member of the team or email us at barnsleyccg.thegrove.patientfeedback@nhs.net
- **Virtual Drop-in Sessions** – We will be running two virtual drop- in sessions on Tuesday 3rd May between 10am and 12 noon and again from 2pm until 4pm. Please contact us via the following email address barnsleyccg.thegrove.patientfeedback@nhs.net if you would like to attend and we can then send you the relevant link.

All feedback received will be collated and considered by both practice and NHS Barnsley CCG before any final decision is made; therefore, we would really appreciate your views on this proposal by Monday 9 May to be able to progress this.

If you have any questions, please do not hesitate to get in touch with us at either practice to speak to a member of the team.

On behalf of The Grove and Apollo Court, thank you for taking the time to give us your feedback, it is much appreciated.

APPENDIX B

Equality Impact Assessment – Section 14Z2: Patient and Public Participation Form

NHS Barnsley Clinical Commissioning Group

Section 14Z2: Patient and Public Participation Form

Introduction

Clinical Commissioning Groups have a duty under Section 14Z2 of the NHS Act 2006 (as amended) to 'make arrangements' to involve the public in commissioning.

- This form is a tool to help commissioners identify whether there is a need for patient and public participation in their commissioning activity, and if required help them plan for a level of participation which is 'fair and proportionate' to the circumstances.
- The form must be completed at the start of the planning process for any commissioning activity and before operational commissioning decisions are taken which may impact on the range of commissioned services and/or the way in which they are provided.
- Completed forms may be used as evidence in the event of a legal challenge. Please retain a copy within your local system.

Step 1 – Title of the plan/proposal/project/commissioning activity and a brief description (including key objectives where appropriate). *Possible examples - procurement of a new service, proposals for service change, national policy development or an operational commissioning decision which affects services, e.g. closure of a GP practice.*

***Location:** Locality, Borough wide, ICS wide*	Barnsley
Title and Brief Description of Proposed Activity:	The Grove Medical Practice and Apollo Court Medical Centre – Merge of practices.
Key Objectives of the Proposed Activity:	• Communicate to patients and public of plans to merge two practices together, offer proposals for changes or development. • Consideration and understanding of the potential economic and social implications of the merger for any affected patients. • Identify any disadvantages of the merger for patients with protected characteristics or health inequalities.

Step 2 – Is there likely to be an impact on patients and the public? ***To assess impact you should consider the overall population and groups/individuals within that population who are likely to be affected.***

If the plans, proposals or decisions are implemented, do you think there will be:

(a) An impact on how services are delivered?
☐ **Yes** ☒ **No**

Please explain your answer and provide further details below:

The proposed merger will increase the ability to offer appropriate patient access or offer appointments to the patient within closer proximity.

(b) An impact on the range of health services available?
☐ **Yes** ☒ **No**

Please explain your answer and provide further details:

No impact to the range of services provided.

- Services will be accessible at all sites.
- Each surgery has sufficient capacity to host all services.

(c) **Any other impact that you can envisage at this point in time?** ***(N.B. If you have answered yes to (a), (b) or (c), it is highly likely that the Section 14Z2 duty applies. The duty always applies to planning of commissioning arrangements (regardless of impact).***

☐ **Yes** ☒ **No**

Please explain your answer and provide further details:

The practice along with the practice PPG do not envisage any other impact currently.

d) Does the Section 14Z2 duty apply to the activity?
☒ **Yes** ☐ **No**

Please explain your answer and provide further details:

With the proposed permanent change in service provision for the registered population at each branch site, it is a necessity that patients are made aware and given an opportunity to comment on the proposals.

Please note that if you have determined that Section 14Z2 does not apply to this particular activity it is good practice to retain a copy of the form should a challenge be made at a later date.

Step 3 – Describe any existing arrangements to involve patients and the public which are relevant to this plan/activity and/or provide relevant sources of patient and public insight? *Examples could include patient and public views by patient and public voice (PPV) partners; surveys; intelligence on patient and public views from partners including other commissioners, Healthwatch and voluntary and community organisations.*

Please briefly complete each question below:

(a) What arrangements/mechanisms are already in place to involve the public which are relevant to this activity? (These may be local, regional, or national):

- Patient Participation Group meetings and monthly email updates, along with invitations for new members to our PPG
- AccuRx florey messages sent to patients regarding the merge of surgeries
- Website notification already in place
- Notification given to Primary Care Networks
- Website notification already in place
- Regular updates on practice Facebook page
- Display of posters with information about the practice plans
- Offered opportunity for patients/public to provide verbal or written feedback
- A message added to patients' prescriptions about the merger

(b) How will the insight available to you help to inform your decision?

- It will identify any significant negative impacts on patients and raise any key concerns within the planning stages that can be addressed.
- To identify any unintended health inequality consequences ahead of the merger.
- By engaging the patients and public it provides the surgeries with a better insight as to whether this is a change that is supported by patients or being driven by the practice.
- The practice will analyse and consider any responses and feedback received from the engagement exercise and will be committed to continuing this following the merger completion.

Step 4 – Are additional arrangements for patient and public involvement required for this activity and in particular how will you ensure that 'seldom-heard' groups, those with 'protected characteristics' under the Equality Act, and those experiencing health inequalities are involved?

(In due course, it will be appropriate to develop a full communications and engagement plan).

a) If yes, provide a brief outline of your approach and objectives for any additional patient and public participation:

There are no additional requirements – the practice has engaged with the practice PPG throughout the process. However, we are currently advertising for additional members of our PPG.

b) Have you considered the following and completed an Equality Impact Assessment:

Seldom-heard groups	☒ **Yes**	☐ **No**
Nine Protected Characteristics	☒ **Yes**	☐ **No**
Health Inequalities	☒ **Yes**	☐ **No**

c) Briefly describe how your proposed participation will be 'fair and proportionate', in relation to your commissioning activity?

The engagement is proportionate particularly given the impact of COVID-19 has on the practice to engage through certain channels i.e. patient attendance at surgeries or face to face PPG meetings through the surgeries respectively.

Members of the public are also given the chance to comment on the proposal through the practice website where alternative feedback options were also referenced. Written and verbal comments were also welcomed via email, over the phone, via virtual feedback session or in person.

Other engagement activities such as AccuRx florey messages sent to patients is intended to reach out to seldom-heard groups, patients with protected characteristics or health inequalities, offering a range of feedback options. These were also advertised in the practice via the paper surveys and via posters on the display boards.

Step 5 - Planning for impact and feedback

(a) Provide a brief outline of how the information collected through patient and public participation will be used to influence the plan/activity.

The feedback received will be used to influence the decision making by the Barnsley Primary Care Commissioning Committee and the outcome will be communicated back out to all patients via a range of different methods.

(b) How will the outcomes of participation be reported back to those involved? *(refer to your communications and engagement plan, if appropriate)*:

The practice will openly notify the public and the patients of the decision made by the Barnsley Primary Care Commissioning Committee.

This will be through individual conversations, accuRx florey messages, posters and a publication on the website and social media platforms.

Individual feedback requiring follow up relating to queries/ concerns will be followed up by the practice team with the people concerned.

(c) How will you assess the ongoing impact of the change on patients and the public after it has been completed?

The practice will commit to continuing engagement during and after the completion of the merger.

Feedback received will be regularly monitored and considered. Complaints will also be monitored.

Given the proximity of each of the branch surgeries, assurances will be provided regarding a maintained level of clinical capacity.

It is not anticipated there will be an impact or change in the service patients will be receiving.

Name of person completing the form: Sarah Hardwick
Job Title: Assistant Practice Manager
E-mail address: sarah.hardwick7@nhs.net
Team: The Grove Medical Practice
Date: 04/05/2022

Once this form is completed please retain a copy for your records and provide an electronic copy to Emma Bradshaw, Engagement Manager at emma.bradshaw1@nhs.net .

Version Control – V4 – Dec 2021

(Appendix 3) NHS Barnsley CCG Equality Impact Assessment (Template)

Title of policy or service:	General Practice	
Name and role of officer/s completing the assessment:	Sarah Hardwick Assistant Practice Manager	
Date of assessment:	04/05/2022	
Type of EIA completed:	**Initial EIA 'Screening'** ■ ***or*** **'Full' EIA process required** ☐ (see appendix 4 for guidance)	*(select one option)*

1. Outline	
Give a brief summary of your policy or service • including partners, national or regional	Primary Care Service, GP Practice in Barnsley. Partners: Dr M Guntamukkala and Dr M Vemula
What outcomes do you want to achieve	Practice Merger
Give details of evidence, data or research used to inform the analysis of impact	See patient engagement report
Give details of all consultation and engagement activities used to inform the analysis of impact	See patient engagement report

Identifying impact:

- **Positive Impact:** will actively promote the standards and values of the CCG.
- **Neutral Impact:** where there are no notable consequences for any group;
- **Negative Impact:** negative or adverse impact; causes or fails to mitigate unacceptable behaviour. If such an impact is identified, the EIA should ensure, that as far as possible, it is eliminated, minimised, or counterbalanced by other measures. This may result in a 'full' EIA process.

2. Gathering of Information – Protected Characteristic Groups

This is the core of the analysis; what information do you have that might *impact on protected groups, with consideration of the General Equality Duty*. Please note that these groups may also experience health inequalities.

Please note: Completion of this section is required for all HR policies and for all external commissioning and transformation project work.

(Please complete each area)	What key impact have you identified?			For impact identified (either positive or negative) give details below:	
	Positive Impact	**Neutral impact**	**Negative impact**	**How does this impact and what action, if any, do you need to take to address these issues?**	**What difference will this make?**
Human rights	☐	☒	☐	No impact to patients. No action required	No difference to service available
Age	☐	☒	☐	No impact to patients. No action required	No difference to service available
Carers	☐	☒	☐	No impact to patients. No action required	No difference to service available
Disability (please consider disability such as physical, hearing, visual impairment, mental health etc.)	☐	☒	☐	No impact to patients. No action required	No difference to service available

Sex	☐	☒	☐	No impact to patients. No action required	No difference to service available
Race	☐	☒	☐	No impact to patients. No action required	No difference to service available
Religion or belief	☐	☒	☐	No impact to patients. No action required	No difference to service available
Sexual orientation	☐	☒	☐	No impact to patients. No action required	No difference to service available
Gender reassignment	☐	☒	☐	No impact to patients. No action required	No difference to service available
Pregnancy and maternity	☐	☒	☐	No impact to patients. No action required	No difference to service available
Marriage and civil partnership (only eliminating discrimination)	☐	☒	☐	No impact to patients. No action required	No difference to service available
Other relevant groups	☐	☒	☐	No impact to patients. No action required	No difference to service available
HR Policies only:	☐	☒	☐	No impact to patients. No action required	No difference to service available

3. Health Inequalities Impact Assessment (Public Health England Health Equity Assessment Tool (HEAT)

- Health inequalities are unjust differences in health and wellbeing between different groups of people (communities) which are systematic and avoidable. Health inequalities in England exist across a range of dimensions or characteristics, including the nine protected characteristics of the Equality Act 2010, socio-economic status, geographic deprivation, or being part of a vulnerable or Inclusion Health group.
-

Health inequalities may be driven by:

- different experiences of the wider determinants of health, such as the environment, income or housing
- differences in health behaviours or other risk factors, such as smoking, diet and physical activity levels
- psychosocial factors, such as social networks and self-esteem
- unequal access to or experience of health services

These conditions influence our opportunities for good health and how we think, feel and act, and this shapes our mental health, physical health, and wellbeing.

People who share protected characteristics, as defined in the Equality Act 2010, may experience poorer health outcomes as a direct result of discrimination or due to different experiences of the factors described above. For further information, please click here to access all the relevant information on the gov.uk website.

Please note: Completion of this section is required for all external commissioning and transformation project work.

Question	Issues to consider	Response
1. What health inequalities (HI) exist in relation to your work?	• Explore existing data sources on the distribution of health across different population groups • Consider protected characteristics and different dimensions of HI e.g., socio-economic status or geographic deprivation	Protected characteristic groups

2. How might your work affect HI (positively or negatively)? How might your work address the needs of different groups that share protected characteristics?	• Consider the causes of these inequalities. What are the wider determinants? • Think about whether outcomes vary across groups, and who benefits most and least • Consider what the unintended consequences of your work might be	N/A		
		Negative	**Positive**	**Main recommendation from your proposal to reduce any key identified negative impact or to increase the identified positive impacts**
	Protected characteristics			
	Carers of patients: unpaid, family members.			
	Looked after children and young people			
	Homeless people. People on the street; staying temporarily with friends /family; in hostels or B&Bs			
	People involved in the criminal justice system: offenders in prison/on probation, ex-offenders.			
	People with addictions and/or substance misuse issues			
	People or families on a low income			
	People with poor literacy or health Literacy: (e.g., poor understanding of health services poor language skills).			
	People living in deprived areas			

	People living in remote, rural and island locations			
	Refugees, asylum seekers or those experiencing modern slavery			
3. What are the next steps?	• What specific actions will you take to address health inequalities and the needs of groups/communities with protected characteristics? • Is there anything that can be done to shift your work 'upstream' to make it more likely to reduce health inequalities?	N/A		
4. How will you monitor and evaluate the effect of your work?	• What quantitative and/or qualitative evaluation will be established to check you have achieved the actions you set? • What output or process measures will you use?	N/A		
5. Review (To be completed 6 to 12 months after first completion)	• Consider lessons learnt – what will you do differently? Identify actions and changes to your programme to drive improvement	N/A		

IMPORTANT NOTE: *If any of the above results in '**negative'** impact, a 'full' EIA which covers a more in- depth analysis on areas/groups impacted must be considered and may need to be carried out.*

Having detailed the actions that you need to take, please transfer these to the action plan below.

4. Action plan				
Issues/impact identified	**Actions required**	**How will you measure impact/progress**	**Timescale**	**Officer responsible**
None	None	N/A	N/A	N/A

5. Monitoring, Review and Publication				
When will the proposal be reviewed and by whom?	**Lead/ Reviewing Officer:**	Kirsty Waknell	**Date of next Review:**	

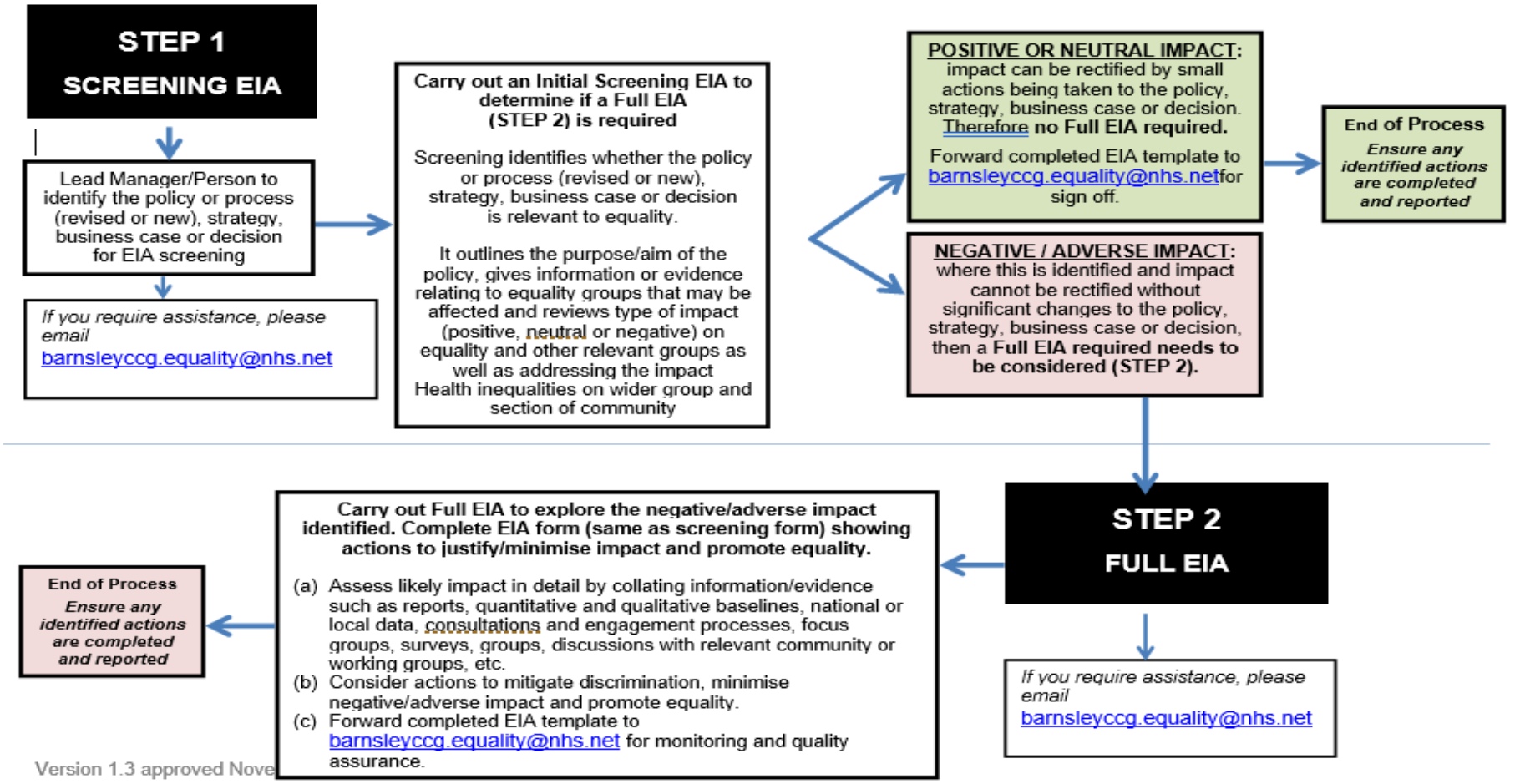
Once completed, this form **must** be emailed to the Equality, Diversity and Inclusion Lead via email at **barnsleyccg.equality@nhs.net** for sign off:

Equality, Diversity and Inclusion Lead signature: **Date:**	Kirsty Waknell

V4 – 03/12/2021

EIA FLOWCHART

Appendix (4) EQUALITY IMPACT ASSESSMENT: Initial EIA 'Screening' and 'Full' EIA Processes



NHS
Barnsley
Clinical Commissioning Group

PRIMARY CARE COMMISSIONING COMMITTEE

26 May 2022

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 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 exception 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.
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	
3.2 Maximising Elective Activity		9.1 Digital and Technology	✓
4.1 Mental Health		10.1 Compliance with statutory duties	
5.1 Integrated Care @ System		11.1 Delivery of Enhanced Health in Care Homes	
5.2 Integrated Care @ Place		12.1 Delivering The Covid Vaccination Programme & Meeting The Needs of Patients with Covid-19	
5.3 Implementing Population Health Management And Personalised Care			

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***

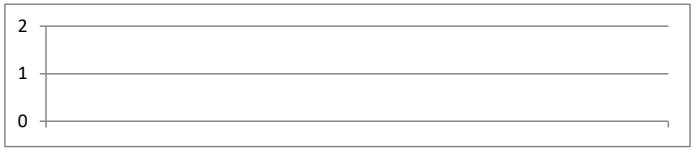
19/05/2022

NHS Barnsley CCG Governing Body Assurance Framework 2022-23

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 Futures Model to: - Comply with mandatory core standards re: interoperability and cyber security - Ensure HSCN supports effective and fast connectivity - Support the identification of equipment that poses a threat to cyber security e.g. pre Windows 10 software - Support the implementation and roll out of the GPIT refresh of IT equipment - Support the wider use of digital technology as described within the Long Term Plan - Working closely with the SY&B digital and IT workstream to deliver the digital road map - Delivery of O365 across Barnsley - Support the transition of video and online consultation software as the Doctorlink contract ends - Support the delivery of the Digital Primary Care First projects - Support the development of the Digital Citizen project in collaboration across "place" - Support the GP practices with digitisation of the Lloyd George records when confirmed by NHSEI - Support the roll out of the corporate Wi-Fi solution - Support the resilience work at Hillder House with the servers and CCG corporate IT needs - Support the upgrade to utilise digital technology for telephony resilience across GP practices and Hillder House 3. Development of a Barnsley "place" Digital Strategy that reflects the "system" digital strategy and aligns with the emerging Eststes strategy	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 NHSE/I Planning Guidance		
	F3 - Develop the underpinning digital and data capability to support population-based approaches		

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	**Apr-22**

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
Gaps in control	**Actions being taken to address gaps in control / assurance**

RISK REGISTER – May 2022

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)	14	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 Additional Role Reimbursement Scheme (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	**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	Head of Primary Care. (Primary Care Commissioning Committee)	Governing Body	**4**	**4**	**16**	04/22	**April 2022** CCG PC team working with PCN to develop plans to meet requirements of the 22/23 PCN Network DES contract and maximise investment through the IIF. **March 2022** Good progress against workforce plan including recruitment to ARRS posts and roles are deployed to	05/22

			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**
		away from their home.				element included within its 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.							**February 2022** No further update **January 2022** Progress has been made recruiting to ARRS roles but some delays mean there remains a small underspend. PC Team continue to work with PCN team to maximise use of ARRS funding.	

			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**	02/22	**February 2022** CCG has continues to manage contract performance through PCCC. **Nov 2021** No further update. **August 2021** TOR have been submitted for the 360 Audit. This year it is Primary Care Finances that are to be audited.	05/22