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NHS
West Suffolk
Clinical Commissioning Group

WEST SUFFOLK CCG
PRIMARY CARE COMMISSIONING COMMITTEE

Wednesday, 23 December 2020 – 2.00pm

In response to the challenges facing the NHS and to reduce the risk of coronavirus transmission, members of the public will not be able to attend this meeting but are invited to submit questions relating to agenda items via email to jo.mael@suffolk.nhs.uk. The minutes of the meeting and answers to any questions submitted by the public will be published on the CCG website after the meeting.

AGENDA

1400	**1.**	**Apologies for Absence**	*Chair*
1402	**2.**	**Declarations of Interest and hospitality and gifts**	*All*
1403	**3.**	**Minutes of Previous Meeting** *To approve minutes of West Suffolk CCG Primary Care Commissioning Committee meetings held on 26 August and 27 October 2020.*	*Chair*
1404	**4.**	**Matters arising and review of outstanding actions.** ***To review** outstanding issues from the previous meeting of the West Suffolk CCG Primary Care Commissioning Committee.*	*Chair*
1410	**5.**	**General Update** ***To receive a verbal report** from the Director of Integration, West Suffolk CCG*	*Kate Vaughton*
1415	**6.**	**Primary Care Contracts Performance Report** ***To receive and note** a report from the Senior Primary Care Manager*	*Emma Gaskell (WSCCG PCCC 20-30)*
1425	**7.**	**Primary Care Delegated Commissioning – Finance Report** ***To receive and note** a report from the Director of Finance*	*Jane Payling (WSCCG PCCC 20-31)*
1430	**8.**	**Enhanced Services Update** ***To receive and note** a report from the Senior Primary Care Manager*	*Rachel Seago (WSCCG PCCC 20-32)*
1440	**9.**	**Virtual Meetings - Report of decisions** 1. 20 October 2020 - QOF funding 2020/21	*Lois Wreathall (WSCCG PCCC 20-33)*

1445	**10.**	**Contractual Update** ***To receive and note*** *the report.*	*Stuart Quinton* *(WSCCG PCCC 20-34)*
1455	**11.**	**Primary Care Estates Overview** ***To receive and note*** *a report from the Director of Corporate Services and System Infrastructure*	*Amanda Lyes* *(WSCCG PCCC 20-35)*
1505	**12.**	**Covid-19 Vaccination in Primary Care Networks** ***To receive and note*** *a verbal update from the Deputy Director of Primary Care*	*Lois Wreathall*
1515	**13.**	**Annual Plan of Work**	
1517	**14.**	**Date and Time of next meeting** *2.00pm – 4.00pm, Wednesday, 24 February 2021*	
1520	**15.**	**Questions from the public – 10 minutes** **(See above)**	

Exclusion of the Press and Public

The Primary Care Commissioning Committee is recommended to exclude representatives of the press, and other members of the public, from the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest; Section 1(2), Public Bodies (Admission to Meetings) Act 1960.

Declarations of Interest - West Suffolk CCG Primary Care Commissioning Committee Members

Title	First Name	Last Name	Declared Interest
Lay Member for Governance and Vice Chair CCG	Geoff	Dobson	Former Director of Resource Management with Suffolk County Council
			Family member attending Healthier You, NHS Diabetes Prevention Programme''
CCG Chair	Christopher	Browning	PMS Provider, Practice Partner Long Melford
			Out of Hours doctor for Care UK and Suffolk GP Federation
			Wife is Consultant at West Suffolk Hospital
			Clinical Director for WGGL PNN"
Lay Member	Steve	Chicken	Owner and MD of Galliform Ltd, consultancy and training company. No NHS activity
			Lay Member for Ipswich and East Suffolk CCG
			Wife is President and Director of East of England Co-op
Chief Officer	Ed	Garratt	Accountable Officer for Ipswich and East Suffolk CCG
			Accountable Officer for North East Essex CCG
			Executive Lead - Suffolk and North East Essex Integrated Care System
Director of Performance Improvement	Paul	Gibara	Director of Performance Improvement for SNEE CCGs
Director of Corporate Services and System Infrastructure	Amanda	Lyes	Director of Corporate Services and System Infrastructure for Ipswich and East Suffolk and North East Essex CCGs
Director of Nursing	Lisa	Nobes	Chief Nursing Officer for Ipswich and East Suffolk CCG and North East Essex CCG
Director of Finance	Jane	Payling	Director of Finance for Ipswich and East Suffolk CCG and North East Essex CCG
			Trustee of Cambridge Theatre Trust
Lay Member for Patient and Public Involvement	Linda	Tuck	Nil
Chief Operating Officer	Kate	Vaughton	Director of Integration for West Suffolk NHS Foundation Trust, non-voting member of Board
Director of Strategy and Transformation	Richard	Watson	Director of Strategy and Transformation for Ipswich and East Suffolk, North East Essex CCGs and West Suffolk CCGs
			Husband is employee of Hadleigh Group Practice

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Minutes of a meeting of the West Suffolk CCG Primary Care Commissioning Committee held in public on Wednesday, 26 August 2020 via Microsoft Teams with members of the public invited to email in questions prior to the meeting.

PRESENT:

Lynda Tuck	Lay Member, Patient and Public Involvement (Chair)
Jennifer Kearton	Deputy Director of Finance
Geoff Dobson	Lay Member for Governance
Lois Wreathall	Deputy Director of Primary Care
Dr Christopher Browning	West Suffolk CCG Chair
Wendy Cooper	NHS England
Kathleen Hedges	NHS England
Laura Traill	NHS England
Andy Yacoub	Healthwatch

IN ATTENDANCE:

Jo Mael	Corporate Governance Manager
Rachel Seago	Senior Primary Care Manager
Daniel Turner	Senior Estates Development Manager

20/29 APOLOGIES FOR ABSENCE

Apologies for absence were noted from;

Steve Chicken	Lay Member
Ed Garratt	Chief Executive
Paul Gibara	Director of Performance Improvement
Simon Jones	Local Medical Committee
Jane Payling	Director of Finance
Stuart Quinton	Suffolk Primary Care Contracts Manager, NHS England
Cllr James Reeder	Health and Wellbeing Board
Kate Vaughton	Director of Integration

20/30 DECLARATIONS OF INTEREST AND HOSPITALITY AND GIFTS

No declarations were received.

20/31 MINUTES OF THE PREVIOUS MEETING

The minutes of a West Suffolk CCG Primary Care Commissioning Committee meeting held on 24 June 2020 **were approved** as a correct record.

20/32 MATTERS ARISING AND REVIEW OF OUTSTANDING ACTIONS

There were no matters arising and the action log was reviewed and updated.

20/33 GENERAL UPDATE

The Deputy Director of Primary Care reported:

- Key focus was currently on primary care network reimbursed roles and Covid-19 recovery.
- Further clarification was awaited in respect of the 2020/21 flu campaign with regard to PPE and how practices might be recompensed for associated costs.
- Winter planning was underway and was more Alliance based.

The Committee noted the update.

20/34 COVID-19 UPDATE FROM GP SERVICES

The formal response to Covid-19 (C19) began in March 2020, after the NHS's preparation and response to C19 was triggered with the declaration of a Level 4 National Incident in January 2020. In late May 2020 the recovery process began.

During the C19 response, GP service provision had changed significantly, adopting new ways of working including widespread use of video and telephone appointments. Risks had been mitigated through agreed escalation processes with funding to deal with mitigating service requirements having been resourced, where appropriate, through national funding streams.

Next steps were outlined in Section 2 of the report.

The Committee noted the report.

20/35 PRIMARY CARE CONTRACTS AND PERFORMANCE

The Committee was in receipt of a report which provided an update on contractual and performance related matters in respect of GP Practices, together with actions taken.

The report provided information and outlined ongoing actions in respect of the following areas;

- Prescribing and medicines management
- Serious mental illness physical health checks
- Learning Disabilities (LD) health checks
- Dementia

Key points highlighted during discussion included;

Learning Disability and Serious Mental Illness health checks were measured on a quarterly basis. In response to questioning, the Committee was reassured that the a member of the CCG Chief Operating Team regularly attended meetings in relation to the Learning Disabilities Mortality Review (LeDeR).

Dementia diagnosis performance remained challenging although it was noted that a number of patients referred to the memory assessment service subsequently received mild cognitive impairment diagnoses and other patients declined referral into the service. Having queried whether contact had been made with the Suffolk and North East Essex Dementia Forum, the Committee was informed that the CCG had good links with the Forum and received monthly briefings. It should be recognised that the dementia diagnosis target had been set nationally

and whilst, West Suffolk patients were being identified and supported, a national target might not be appropriate at local level.

The Committee noted the content of the report.

20/36 PRIMARY CARE DELEGATED COMMISSIONING – FINANCE REPORT

The Committee was provided with an overview of the month four Primary Care Delegated Commissioning Budget and other associated primary care budgets.

At the end of month four, the GP Delegated Budget spend was £518k over spent with Other Primary Care indicating spend of £1,339k.

As the budget for Other Primary Care, for months 1-4 had been posted at a higher level, to one cost centre, based on the Covid-19 budget model, and had not been assigned to each area of spend, there was no budget currently shown against those lines of expenditure.

The Local Enhanced Services (LES) spend was payment made to practices for months 1-4 based on average payments in 2019-20.

As the CCG allocations had only been published to the end of month four, only risks in relation to that period had been included in the forecast. Those included pending rent increases, forecast list size adjustments and locum allowance, based on prior year.

In response to questioning, the Committee was informed that it was anticipated that by month 12 the budget would be approximately £1.5m overspent which was expected to be offset by underspend elsewhere within primary care and the use of contingency.

Having noted that practice list size and locum allocation had been identified as risks, it was explained that contract values were adjusted according to list size on a quarterly basis and increased locum costs as a result of increased sickness had been factored into the forecast.

It was hoped that the receipt of more information in respect of the future financial architecture would held to provide clarity and shape risks going forward.

The Committee noted the financial performance at month four.

20/37 PRIMARY CARE ENHANCED SERVICES (ESs)

The Committee received a report which provided an update on the status of the Enhanced Services available to Primary Care.

The GMS contract did not cover a number of clinical areas within its core which subsequently required CCGs to commission extra services as those elements were included in the PMS contract.

GMS parity had been agreed by the Executive Committee as part of the PMS review and the Committee had previously agreed an uplift to those parity Enhanced Services (ES) of 3:05% for the period 1 August 2020 to 31 March 2021.

The Committee had also agreed during Covid-19 that practices would be paid an estimated payment based on previous activity for months 1 – 4 of the financial year.

There were six GMS parity Enhanced Services (ES) and four further ES that were reviewed annually. Rheumatolgy, DVT and Polypharmacy had currently ‘rolled over’ from 2019/20 as they were under review by the Medicines Management Team. The Leg Ulcer ES for the Bury & Blackbourne practices had also been rolled forward in 2020/21.

The PCCC had previously approved to combine two budgets for the Care Home ES; to run the existing CCG Care Home LES 1 April – 30 September 2020. At that point the PCN DES specification started (1st October 2020) at a cost of £120 per bed until 31 March 2021 (£60 per bed half year effect). The CCG LES would be reissued from 1 October 2020 to 31 March 2021 to maintain the total cost of £196.66 (full year price) that 'top up ' money would be paid directly into the PCN and activity recorded by each practice via PORT

The CCG had introduced PORT, which was an online portal already used by Ipswich and East CCG, from 1 August 2020 – it allowed practices to enter activity against each ES on a monthly basis.

For auditing purposes all practices were required to formally sign-up to each ES if they decided to take up the offer.

All ES paperwork had been shared with practices using the Clarity TeamNet software previously purchased by the CCG using GPFV Resilience Funding; Clarity TeamNet had the functionality for sharing information from the CCG to practices.

The Committee noted the update.

20/38 PRIMARY CARE NETWORK (PCN) FUNDING

The Committee was in receipt of a report which provided an update on PCN development, funding and reimbursed roles.

This year the West Suffolk CCG PCNs had remained in the same footprint as last year, which was helpful in terms of continuity and gaining maturity and cohesion.

In addition to the payments made to the PCNs nominated payee under the terms of the Network Contract Direct Enhanced Service (DES), practices participating in the Network Contract DES would 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. That payment was £1.761 per weighted patient per year, equating to £0.147 per patient per month.

The Network Contract DES was due to go live on 1 October 2020. Under the Network Contract DES, funding was made available to PCNs through a new Additional Roles Reimbursement Scheme (referred to as 'the scheme') to recruit up to an additional 20,000 full time equivalent (FTE) posts across five specific roles, over the next five years. The intention of the scheme was to grow additional capacity through new roles, and by doing so, help to solve the workforce shortage in general practice. It was not to fill existing vacancies or subsidise the costs of employing people that were already working in primary care, whether funded by a practice, a Clinical Commissioning Group (CCG) or a local NHS provider.

Reimbursement through the new Additional Roles Reimbursement Scheme would only be for demonstrably additional people (or, in future years, replacement of those additional people as a result of staff turnover). This additionality rule was also essential for demonstrating value for money for the taxpayer and reimbursement claims would be subject to validation.

The report went on to detail the additional roles for which reimbursement could be obtained and recruitment to those roles to date. Further information was provided in relation to extended access, enhanced health in care homes and early cancer diagnosis.

Having queried progress in respect of social prescribing, the Committee was informed that whilst it was a good service, further work was required to tailor the service across urban and rural areas and to ensure that a greater number of people were reached.

It was suggested that the CCG explore the facilitation of Healthcoachs' to provide in-depth support where it might be required.

Although the CCG had identified a need for additional phlebotomists and mental health workers at a local level, those roles were not applicable for reimbursement within the national contract.

The Committee noted the report.

20/39 NATIONAL GP PATIENT SURVEY 2020

The Committee was in receipt of a report which summarised and highlighted key points from the National GP Patient Survey (GPPS) 2020.

- The GP Patient Survey (GPPS) was an England-wide survey, providing practice-level data about patients' experiences of their GP practices.
- Ipsos MORI administered the survey on behalf of NHS England.
- In WSCCG, 6,336 questionnaires were sent out, and 2,875 were returned completed which represented a response rate of 45%.
- The GP Patient Survey provided data at practice level using a consistent methodology, which meant it was comparable across organisations.
- In 2018 the questionnaire was redeveloped in response to significant changes to primary care services as set out in the GP Forward View, and to provide a better understanding of how local care services were supporting patients to live well, particularly those with long-term care needs.
- The GP Patient Survey measured patients' experiences across a range of topics, including: your local GP services; making an appointment; your last appointment; overall experience; your health; when your GP practice was closed.

The results as reported were positive overall and demonstrated the hard work that had taken place at practice level. However, with growing health and social pressures and the huge challenge presented by Covid-19, the need to support practices to improve and operate as a system had never been more important. Where practices had scored below average, the CCG was working with the staff to understand why that result was recorded, what could be done to improve the situation and how the CCG might influence or assist.

The Healthwatch representative advised that following work carried out in Milton Keynes, Healthwatch had recently reviewed CCG websites in respect of communications **and agreed** to share the outcome of the review outside of the meeting.

The Committee noted the report.

20/40 CLOSURE OF THE WHITE HOUSE SURGERY, MILDENHALL AND RELOCATION TO THE NEW MILDENHALL HUB

The Committee was advised of an application received from the White House Surgery GP Practice, Mildenhall to close its White House Surgery premises and relocate to the new Mildenhall Hub upon completion of the building.

The report went on to provide supporting background information on the process to be followed when such an application was received, detail patient and public engagement, and factors for consideration, prior to seeking a decision on the application.

Healthwatch was assisting the practice with communications to patients.

It was noted that White House patients were now being seen at the Reynard Surgery prior to the practice being able to utilise the Mildenhall Hub.

Having been informed that use of the Mildenhall Hub remained subject to approval of a business case that was currently with NHS England, the Committee felt unable to approval that element of the recommendation at present and subsequently;

1) **Approved** the application from White House Surgery to close its White House Surgery premises **noting** that patients were currently able to be seen at the Reynard Surgery.

2) **Noted** that a further report would be presented at such point as there was more clarity in respect of the business case associated to use of the Mildenhall Hub.

20/41 ANNUAL PLAN OF WORK

The annual plan of work was received and it was noted that it would be updated prior to presentation to the next meeting.

20/42 DATE OF NEXT MEETING

The next meeting was scheduled to take place on Tuesday, 27 October 2020 and was anticipated to be a meeting 'in common' across the three CCGs.

20/43 QUESTIONS FROM THE PUBLIC

The following questions were received via email prior to the meeting from an Ixworth Patient Association representative. The Committee noted that Ixworth practice was within Ipswich and East Suffolk CCG's area. Response to the questions is noted below;

1) What happened to the 100 Day Challenge? Our Parish Councils organised AF-monitor sessions which generated a lot of interest about stroke prevention - except it would seem among our GPs… Preventing the increase in Urinary Tract Infections was another one of the challenges - what happened next? I recall there was a third challenge? It's hard to motivate the members of the Association when initiatives just disappear.

   Response - NHSE 100-day challenge was a national programme with participation by many CCGs/Trusts. The concept of the 100-day challenge was to make rapid changes to services in three identified disciplines. The disciplines identified in West Suffolk were; Ear Nose and Throat, Cardiology and Urology. Within cardiology Atrial Fibrillation (AF) was a focus with two distinct areas, protection and perfection. Protection was looking at ensuring those with suspected AF were treated quickly and effectively. Perfection looked at reviewing the medication of those that had already been diagnosed to ensure they were using the most effective medication. All GP practices had been given at least one AliveCor Kardia device. Protect and perfect would be maintained and various publications

had been produced to provide more information about AF and what to do if you were tested and found to have suspected AF.

ENT: The work we did regarding open access appointments, advice and guidance and direct access to Audiology and MRI IAMs had become embedded within business as usual. The learning from the open access appointment work should feed into the Outpatient Department Transformation project.

Urology: change of pathway embedded and comprehensive patient leaflet produced.

The Committee requested that it receive a report on each element of the 100-day Challenge to a future meeting.

2) Efforts to improve waiting times for elective surgery were presented at the beginning of last year and the thoughts of patients requested. Obviously dealing with Covid-19 has created problems but some news would help reassure patients. They are asked their views then silence.

Response – Covid-19 had resulted in re-prioritisation with key focus now being on the recovery of waiting lists. A patient and professional portal was being developed at West Suffolk NHS Foundation Trust which would give patients information on waiting lists by speciality.

3) What is the progress with PCNs? -Alas, Ixworth seem not interested and there seems little the public or the patients can do without changing practice on mass… not unnaturally a sense of disillusionment arises.

Response being sought from Ipswich and East Suffolk CCG.

4) Preventing the increase in broken bones through osteoporosis was signalled by Public Health Suffolk as an issue but no GP Champion seems to have emerged. Also respiratory concerns were raised. The feeling is the public get there interest raised then no action they can see.

Response being sought from Ipswich and East Suffolk CCG.

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Meeting of the West Suffolk CCG Primary Care Commissioning Committee held 'in common' with the Primary Care Commissioning Committee of Ipswich and East Suffolk CCG and GP Commissioning Committee of North East Essex CCG, on Tuesday 27 October 2020, via Microsoft Teams
Members of the public were invited to email questions prior to the meeting.

PRESENT:

Lynda Tuck	Lay Member, Patient and Public Involvement (Chair)
Geoff Dobson	Lay Member for Governance
Paul Gibara	Director of Performance Improvement
Jane Payling	Director of Finance
Lois Wreathall	Deputy Director of Primary Care
Dr Christopher Browning	West Suffolk CCG Chair
Simon Jones	Suffolk, Local Medical Committee
Charlotte Mackenzie	NHS England
Stuart Quinton	Primary Care Contracts Manager, NHS England

IN ATTENDANCE:

Sarra Bargent	Head of Clinical Quality – Primary Care, North East Essex CCG
Ameeta Bhagwat	Head of Financial Planning and Management Accounts
David Brown	Deputy Chief Operating Officer, Ipswich and East Suffolk CCG
Dr John Flather	GPCC Member, North East Essex CCG
Pam Green	Chief Operating Officer, North East Essex CCG (Part)
Dr Max Hickman	Elected Member, North East Essex CCG
Dr Firas Hussein	Elected Member, North East Essex CCG
Dr Lorna Kerr	Secondary Care Doctor
Graham Leaf	Lay Member for Governance
Lisa Llewellyn	Director of Workforce
Jo Mael	Corporate Governance Manager
Charlotte Mackenzie	Head of Finance, North East Essex CCG
Claire Pemberton	Head of Primary Care, Ipswich and East Suffolk CCG
Jon Price	Chair, GPCC, North East Essex CCG
Dr V Raja	Essex Local Medical Committee
Carol Sampson	Head of Medicines Management, North East Essex CCG
Vicky Sawtell	Deputy Director of Performance and Contracts
Anthony West	Head of Transformation (Planned Care), North East Essex CCG

20/44 APOLOGIES FOR ABSENCE

Apologies for absence were noted from;

Steve Chicken	Lay Member
Ed Garratt	Chief Executive
Cllr James Reeder	Health and Wellbeing Board

Kate Vaughton	Director of Integration
Andy Yacoub	Chair, Healthwatch

The meeting was confirmed as quorate.

20/45 DECLARATIONS OF INTEREST AND HOSPITALITY AND GIFTS

No declarations of interest, hospitality or gifts were received.

20/46 THE RESTORATION OF PRIMARY CARE SERVICES POST COVID-19

The Committee was in receipt of a report which provided information about the issues facing General Practice as services were re-started following the first wave of Covid-19. The report also set out the key points of the current NHS England guidance on the subject.

At the time of the Covid-19 pandemic starting to have a significant impact on the safe delivery of services delivered by general practice, NHS England had issued several pieces of guidance. In summary that guidance had asked practices to ensure that all patients were triaged by telephone and to only see patients face to face if clinically necessary. It also asked practices to stop a significant amount of non-urgent activity such as routine checks, to minimise infection risks. The net effect was that a significant amount of routine care was either stopped altogether or delivered remotely.

As the peak of the first wave passed, local practices and the CCGs started to have conversations about how services should be restored in a way that was safe for patients and staff and provided effective care. Appendix B to the report provided a description of the key issues in respect of service restoration and how primary care was responding in each case. Appendix C identified the position of the three CCGs against a range of metrics which had been set out by NHS England, with key areas to be addressed set out in paragraph 3.3 of the report. Learning from Wave 1 that might be applied to Wave 2 was outlined in Section 4 of the report.

Whilst it was queried whether practices would be able to facilitate virtual ward rounds for care homes during the second wave of Covid-19, the importance of highlighting such suggestions for consideration was recognised.

The Committee noted the content of the report.

20/47 PRIMARY CARE STRATEGY REFRESH

The Committee was provided with an opportunity to review the draft STP primary medical service strategy; to provide assurance as to how primary care would meet the objectives of the NHS Long Term Plan and continue to deliver the commitments of the General Practice Forward View (GPFV) whilst remaining consistent with local Alliance and primary medical care strategies.

General practice played a pivotal role in delivering localised, high quality, safe and effective services to its population. There had been an increased focus on the role of primary care, how it was structured and how services were delivered. More recently as described in the document, Investment and evolution; a five-year framework for GP contract reform, to support the implementation of the NHS Long Term Plan.

The patients of Suffolk and North East Essex are generally served by high quality practices with care delivered by experienced and qualified professionals. There was some variation in access and performance.

In 2019 NHS England wrote to the STP/ICSs requesting that joint primary care strategies were refreshed or developed in the context of the NHS Long Term plan and the new GP Contract which saw the formation of Primary Care Networks.

A strategy was produced and signed off by the ICS Sustainability and Transformation Partnership Board using existing primary care strategies that were locally co-produced between 2015-2017 by GPs, practice managers, patients and partner organisations. Those documents remained relevant and aligned with current priorities.

In 2017, the STP collectively submitted a GPFV submission which was rated 'good' by NHS England. Content from that, the three Alliance strategies and the ICS Operational plan also remained central to the development of the new joint strategy.

With the introduction of Primary Care Networks, the strategy went further in supporting a 'bottom up approach' that strengthened the role at neighbourhood level.

The strategy as presented, focused on existing, agreed local plans and fulfilled the requirements requested by NHS England for submission, and set out **current** programmes of action. It was recognised that action plans needed go further to respond both to new national requirements and local need, and to articulate:

- further local demand management measures including alignment of Alliance prevention and self-care strategies;
- local support for Primary Care Networks, specifically including their Clinical Directors;
- workload management measures beyond national measures;
- further workforce plans (specifically but not limited to recruitment and retention issues);
- estates and digital integration;
- a local funding strategy for primary care.

The strategy was now being reviewed for 2020, to include the challenges that we are currently facing and to update the strategy in general. The CCGs would continue to refine the document (Appendix 1), working with wider partners to ensure it was a strategy that reflected the wider ambitions of the system.

The need to make distinction between primary and community services was emphasized. It was noted that community services within Suffolk were linked with secondary care providers. It was felt that more clarity was required with regard to primary care team links with community and integrated neighbourhood teams**. Primary Care leads within the CCGs agreed** to review the document to ensure clarity prior to the final draft.

It was explained that the primary care strategy was based on population health needs with different delivery across the ICS. The need to consider services based on the needs of the population and ensure the integration of teams to deliver those services was emphasized.

The Committee noted the Strategy and commitment to the next steps.

(Pam Green joined the meeting)

20/48 SUFFOLK AND NORTH EAST ESSEX FLU UPDATE

The Flu vaccination was one of the most effective interventions that could reduce pressure on the health and social care system during winter. 2020/21 had the potential to be one of the most challenging in the administration of the flu vaccine because of the impact of Covid-19 on health and social care services, so it was important that there were plans in place to increase the effort to deliver the Flu vaccine (NHSE, 2020) as those most at risk from flu were also vulnerable to Covid-19.

Groups to be offered the vaccine were identified paragraph 1.3 of the report with key elements of the Suffolk and North East Essex Flu and Covid-19 Plan detailed in Section 2 of the report and governance in Section 3.

Progress to date and next steps included;

Six workstreams had been identified with clear delivery objectives, a job advert was currently live to fulfil a lead for Covid-19 workstreams One and Two (Delivery Model and Logistics).

The CCGs had been working closely with GP practices to ensure maximum preparedness in primary care leading to the achievement of maximum vaccine uptake in eligible groups. GP Practices, community pharmacies and providers had ordered vaccine for the 2020/21 as per national guidance in the 1st annual flu letter (to deliver 2019/20 ambitions). National vaccine manufacturers had closed to additional orders from primary care. Additional vaccine would now only be available via DHSC.

To ensure the primary care patient record was reflective of status, a data and technology workstream had been established. That workstream was able to monitor uptake and delivery of the Flu vaccine and had mapped data flows from acute, school and pharmacy records.

The Flu communications went live on 21 September (in line with national communications) and would continue through October and November 2020.

As of 6 October 2020:

- Suffolk and North East Essex are in the top six CCGs for achievement to date compared to East of England (out of 21 CCGs).

- Vaccinations for high risk groups were progressing well with 75% of care home residents and 73% of pregnant women already completed. The over 65 group was 35% completed, which was our biggest cohort, Suffolk and North East Essex were on track for completion within the deadline of 15 December 2020.

- School immunisations were on track and there had been no impact on vaccinations due to school closures or bubble closures, the school immunisations team business continuity plan was robust and tied into the primary care business continuity plan in the case of full local lockdowns.

- Community pharmacy had delivered double the amount of flu vaccinations in comparison to the same time last year.

The Committee was informed that, since circulation of the report, practices could now order additional vaccines although flu stock remained for ‘at risk’ cohorts at present.

It was explained that Suffolk figures within the report were based on actual figures and that North East Essex figures were based on informed data.

In response to questioning, the Committee was advised that pharmacies, along with schools, sent practices notifications of those patients that had received vaccinations in order that all information might be collated by the CCG.

Having queried the reported maternity vaccination numbers, it was explained that maternity departments had been issued with vaccine and were directly providing vaccinations to pregnant women.

The Committee noted the content of the report.

20/49 PRIMARY CARE PERFORMANCE REPORT FOR SUFFOLK AND NORTH EAST ESSEX

The Committee was in receipt of a report which provided an update on performance related matters in respect of GP Practices and actions taken; seeking further recommendations and areas for consideration for the Primary Care teams.

The report provided information and outlined ongoing actions in respect of the following areas;

- Prescribing and medicines management
- Severe mental illness and physical health checks
- Learning Disabilities (LD) health checks
- Dementia diagnosis rates
- Care Quality Commission practice ratings

The following points were highlighted during discussion;

- Prescribing – each CCG's overspend was similar to that of last year. Practices were aware of the need to review processes such as polypharmacy.
- Performance targets – Severe Mental Illness health checks, Learning Disability health checks and Dementia diagnosis performance had all been adversely affected by the pandemic. Norfolk and Suffolk NHS Foundation Trust had been working with Suffolk practices to assist with data cleanse of patient lists. The Local Enhanced Service had been re-issued to allow for work to be carried out virtually. A review of learning disability health check data in quarter one had identified performance was low which might be a result of the pandemic and the reluctance of individuals to attend appointments. Learning Disability nurses were providing reassurance and considering other ways of working.
- Care Quality Inspections had mainly paused during March- September 2020 and were now beginning to recommence. The CCGs continued to support practices where appropriate.

North East Essex CCG figures within the report associated to STAR PU antibiotics were queried and the **Head of Medicines Management agreed** to clarify the position outside of the meeting.

The Committee noted the report and that North East Essex CCG had previously agreed a 'deep dive' into medicines management.

20/50 CONTRACTUAL UPDATE

The report served to update the Committee on the contractual changes relating to GP practices within the Suffolk and North East Essex STP over the last quarter (July-September 2020). Key issues were as follows;

Branch closures - the White House Surgery (D83078) had removed its branch site 'White House Surgery' from the contract following approval at the last West Suffolk Primary Care Commissioning Committee (26/08/2020). A report which sought approval to operate out of the Mildenhall Hub would be presented at the relevant PCCC if the estates business case was approved. (West Suffolk CCG)

Practice name changes:

- Christmas Maltings and Clements Practice (D83012) had formally changed its name to Unity Healthcare. (West Suffolk CCG)
- The White House Surgery (D83078) had formally changed its name to The Reynard Surgery. (West Suffolk CCG)

List closures:

- Mayflower Medical Centre (F81019), Harewood Surgery (F81606) and Fronks Road Family Surgery (F81221) continued to communicate to the public that they were not accepting new patients. That was also displayed on the NHS Choices page for each practice. (North East Essex CCG)
- The Barham and Claydon Surgery (D83615) had formally applied to close its list to new patients for 12 months. That would be presented for decision in November following the current stakeholder engagement exercise. (Ipswich and East Suffolk CCG)

Super Partnerships:

- Suffolk Primary Care Super Partnership variation agreement was near completion. The partnership had been sent a formal contract letter to recognise the partnership formation in 2017, but the variation agreement would be effective from 01/01/2020. (Ipswich and East Suffolk CCG & West Suffolk CCG)
- The Colte Partnership Super Partnership variation agreement was near completion. The partnership had been sent a formal comfort letter to recognise the partnership formation in 2017, but the variation agreement would be effective from 01/10/2020. (North East Essex CCG)

The Committee noted the content of the report.

20/51 INTEGRATED CARE SYSTEM (ICS) WIDE FINANCE REPORT – SEPTEMBER 2020 (MONTH 6)

The Committee was provided with an overview of the month six Primary Care Delegated Commissioning budget and other associated Primary Care budgets for the three CCGs which made up the Suffolk and North East Essex Integrated Care System (ICS).

Due to the Covid-19 situation, allocations for NHS finance were initially released for the first six months of the year, and included the Delegated Primary Care (DPC) budget. For months 1-6 a combined DPC allocation £74,503k was received, against which a cumulative overspend had been made of £1,887k broken down by CCG as set out in paragraph 2.1.

Although the CCGs had recently received confirmation of their full year allocations, to date there had only been a release of budget to month six and there was only a requirement to report a financial position for months 1-6. The budgets and forecast would be amended to reflect the full year position from October (m7) reporting. Allocations for months 7-12 remained largely unchanged from those in months 1-6.

The current overspend for the two Suffolk CCGs was driven predominantly by the PMS Premiums, List Size increases up to Q2 and Locum cover allowance. The issue had been raised consistently at recent primary care committees with the current overspend reflecting the balance of the allocation received compared with the payments made to practices, for which the higher than average level of PMS in Suffolk results, inter alia, in a cost pressure.

North East Essex was managing to meet its financial requirements within budget, the position would be reviewed in line with months 7-12 allocation.

As the CCGs had reported the financial position for months 1-6 only, risks in relation to that period had been included in the forecast. Across three CCGs those included pending rent reviews, practice support, forecast list size adjustments and locum allowance. That would continue to apply going forward.

The budget for Primary Care Delegated Commissioning was received as a specific allocation whilst budget for Other Primary Care was received as part of the CCG programme allocation.

based on the Covid-19 budget model. Other Primary Care Services included Local Enhanced Services and GPFV.

To date the position across the ICS was an overspend of £635k against a budget of £7,016k.

In response to questioning the Director of Finance reported that a key issue for the second part of the year would be the impact of the Covid-19 second wave on budgets issued in line with the expected recovery of services.

All CCGs were to be subject to audit in respect of Covid-19 expenditure and Ipswich and East Suffolk CCG had been notified it would be audited in the first round of audits.

The Committee noted the content of the report.

20/52 PRIMARY CARE NETWORK (PCN) – SUMMARY UPDATE

The Committee was updated on the latest developments and requirements for Primary Care Networks (PCNs) and provided with assurance of progress against the primary care contract.

There were five main elements to the PCN network contract for 2020/21; Additional Roles Reimbursement Scheme, Impact and Investment Fund and the introduction of three service specifications. The report went on to detail progress in respect of each of those areas.

Key points highlighted during discussion included;

- West Suffolk Primary Care Networks (PCNs) continued to grow with development tracked across a number of issues.
- All North East Essex CCG practices were now in a PCN and less change was anticipated in year two.
- North East Essex CCG received regular reports against the maturity matrix, and it was anticipated that Suffolk CCGs would receive similar reports going forward.
- The maturity matrix tracked PCN development and system progress. Some elements, such as the sharing of records, were outside the responsibility of the PCN.
- NHS England had added another two roles to the list of additional roles for reimbursement. There was concern by NHSE that recruitment had not yet been as envisaged and it was likely that the reason was that practices were being cautious and seeking evidence of benefit and support prior to recruiting.
- Investment and impact fund – PCNs would need to achieve certain elements in order to access future funding. The requirements of the fund were similar to those of the Quality Outcomes Framework and there would be a need for practices to share information within their respective PCNs.
- Care homes – equipment had been provided to care homes to facilitate virtual ward rounds. North East Essex CCG had 175 care homes within its area and all had been allocated to a PCN.
- Dedicated workforce leads within the ICS had resulted in a huge improvement for practices.

It was quered whether as a result of increased GP contact with care home residents there had been any increase in referrals to dentistry, dietitians, therapists to be proactive in preventing illness or speeding up recovery. It was explained the community services were evolving around PCNs, INTs and care homes.

Care home forums had been established and provided a link with primary care and available support.

Having noted that GP trainees were only due to spend a year in hospital, it was highlighted that training had been disruptive during 2020 due to the change of roles and limited learning opportunities as a result of the pandemic. It was suggested that the trainees might require

additional support. The Committee was informed that the Deanery was taking the matter forward and putting systems in place to make transitional change.

The benefit of being able to work at scale in respect of recruitment was emphasized.

The Committee noted the content of the report.

20/53 PATIENT PARTICIPATION GROUP (PPG) UPDATE

NHS England had mandated that all practices must have a PPG as set out in paragraph *5.2* (Patient Participation) of the GMS contract detailed within the report.

Engagement by the CCG with its PPGs was detailed in Appendix 1 to the report and the Ipswich and East Suffolk PPG network was seen as an exemplar nationally. Presentations, learning and support was made available to Regional and National Teams.

The PPGs had supported the introduction of Care Navigators into practice through communication of their role to the local population and PPG members provided support to the vulnerable during Covid-19 via befriending schemes, help with shopping and medicines collection.

SNEE PPGS were active and not isolated forums. PPG networks were being established where learning could be shared, and messages and communication cascaded. There had been transformation in the way practices engaged with PPGs via technology which had been welcomed.

Future challenges included how PPGs might become embedded in PCNs going forward. The benefit of PPGs being moved to a locality footprint was highlighted. Some PPG chairs are already active members of their locality meetings.

The Committee noted the report **and welcomed** future combined progress updates.

20/54 WORKFORCE UPDATE

The Committee was in receipt of a report which summarised key project areas underway within workforce which included; recruitment; pipeline of workforce; workforce planning; quality assurance and supply; retention; apprenticeships; and wellbeing support.

Key points highlighted included;

- Workforce remained challenging across the ICS and primary care. The mutual aid agreement which enabled the movement of staff across the system during the pandemic had been extended into winter, although it was recognised that it might prove more challenging in light of the recovery of services alongside the second wave.

- The health and wellbeing of staff was paramount and support had been provided in a number of ways which included occupational therapy, and mental health support.

- The need to work together and collaboratively, making the best use of resources, to develop services had been recognised.

- At the Colchester Health and Care Academy the primary care team had described how it had developed roles within practices.

- The range of available placements and integration work was encouraging.

- It was recognised that the recruitment of additional roles was not just about workforce but also the willingness of practices to accept those roles and often it was different roles that were required.

- The ability for primary care to have the capacity and capability to train staff within work was critical to future sustainability. The need to continue to attract funding to facilitate such work was highlighted.

The Committee noted the report.

20/55 DATE OF NEXT MEETING

The next meeting was scheduled to take place on Wednesday, 23 December 2020.

20/56 QUESTIONS FROM THE PUBLIC

No questions had been received.

integrated working

WEST SUFFOLK CCG – PRIMARY CARE COMMISSIONING COMMITTEE
ACTION LOG: 26 August 2020 (updated)

MINUTE	DETAILS	ACTION	BY WHOM	TIMESCALE/UPDATE
Meeting of 24 July 2019				
19/47	Enhanced Service Review	Whilst overall the enhanced services were felt to be effective, it was suggested that, in order for the Committee to gain assurance, that the development of more robust evaluation and monitoring information be explored.	Lois Wreathall	26/08/20 – work ongoing
Meeting of 26 August 2020				
20/43	Questions from the Public	<u>100-day Challenge</u> The Committee requested that it receive a report on each element of the 100-day Challenge to a future meeting.	Lois Wreathall	

integrated working

NHS
West Suffolk
Clinical Commissioning Group

PRIMARY CARE COMMISSIONING COMMITTEE

Agenda Item No.	**06**
Reference No.	**WSCCG PCCC 20-30**
Date.	**23 December 2020**

Title	**Primary Care Contracts Performance Report**
Lead Director	Kate Vaughton - Director of Integration, West Suffolk
Author(s)	Emma Gaskell - Senior Primary Care Manager, WSCCG
Purpose	To provide the committee with an overview of primary care services in West Suffolk including performance information relating to specific data and the wider context

Applicable CCG Clinical Priorities:

1.	Develop clinical leadership	
2.	Demonstrate excellence in patient experience & patient engagement	**x**
3.	Improve the health & care of older people	**x**
4.	Improve access to mental health services	**x**
5.	Improve health & wellbeing through partnership working	**x**
6.	Deliver financial sustainability through quality improvement	**x**

Action required by Primary Care Commissioning Committee:

To consider and discuss contractual obligations and other information contained within the Primary Care Dashboard and agree any appropriate actions required.

Purpose

To update the Committee on contractual and performance related matters in respect of GP practices and actions taken, to seek further recommendations, and highlight areas for consideration for NHSE and the Primary Care Team.

1. Prescribing and Medicines Management

Prescribing budget
The budget has now been set. An underspend of £96,336 is predicted at M08 based on M01-M06 actual spend and M07-M08 predicted spend.

Antibiotics prescribing (12 months to September 2020)

- WSCCG within the NHSE QP target for broad-spectrum antibiotic prescribing.
- WSCCG within upper limit (and 0.005 away from lower limit) of the NHSE QP target for all antibiotic prescribing.

2. Severe Mental Illness (SMI) Physical Health Checks

Performance - rolling 12 months @ Q2 2020

	% of SMI Patients that have received a health check (Target 60%)
Ipswich and East Suffolk CCG	43.6%
North East Essex CCG	19.0%
West Suffolk CCG	21.5%

All CCGs have experienced a downturn in performance in Q2 due to the impact of Covid-19 and all are working with practices to restore service.

In Suffolk the CCGs are working with Norfolk & Suffolk Foundation Trust (NSFT) to continue the data cleansing of lists per practice. Evidence has shown that this has safely reduced the number of patients who are eligible for an annual SMI physical health check by up to 20%. This should contribute to improved results. Regular contact with the SMI leads at each practice continue encouraging referrals to NSFT for those hard to engage patients and also for patients where the practice has only been able to complete a part check. For patients who are not keen to attend a GP practice in person, the practice can undertake part of the check remotely/virtually and NSFT can attempt to complete the check face to face.

3. Learning Disabilities (LD) Health Checks

Practices are continuing to undertake annual health checks (AHCs) despite the recent lockdown. At the end of quarter two, WSCCG practices have completed 20 % of checks YTD (three times higher than the end of Q2 last year). The temporary change in the AHC target from 75% to 67% still stands. Concerns have been raised around the way NHSE currently calculate this and this is being investigated. We await an update.

Work to complete AHCs in primary care continues:

- NHSE has included the completion of AHCs in a list of clinical priorities for CCGs in the General Practice Covid Capacity Expansion Fund guidance. Non-recurrent funding has been attached to these priorities as a whole and CCGs are required to decide how this is spent. WSCCG acknowledge that financial restrictions are not necessarily the overriding limiting factor that is making the completion of LD AHCs by practices such a challenge. However, it has been agreed to incentivise practices by rewarding them financially (per AHC) when they achieve 67% of completed

checks. Based on the proportion of funds allocated from this sum to LD, a West Suffolk practice will receive an extra £59.75 per LD AHC completed if that practice achieves the 67% target (this payment may fluctuate very slightly as LD register sizes can be amended throughout the year).

- GP practices have received information about shielding for extremely vulnerable patients. This now includes patients with Down's Syndrome and practices have been asked to ensure all of these patients are offered a flu vaccination and ensure their AHC is completed. Practices have been given easy read templates to support this.

- LD nurses continue to communicate regularly with all GP practices to ensure they are equipped and supported to implement both face to face and virtual health checks where appropriate.

- The LD nurses continue to align GP practice LD registers with the Social Care list as well as with information that NSFT holds. There is to be a particular focus on the 14-18 year old cohort going forward.

- WSCCG and IESCCG Primary Care Teams continue to meet regularly with the Suffolk LD liaison nurses in order to share information about individual practice performance.

- WSCCG and IESCCG have been updating contact lists for LD practice leads in order that we can establish regular communication with this group and encourage shared learning.

- The CCGs are supporting practices to ensure all relevant areas within QOF and related to the IIF are being covered.

- Dr Rosalind Tandy has been particularly proactive and productive in the completion of LD AHCs. She has kindly agreed to share her knowledge and experience with practice managers and primary care LD leads to support other practices to take a similar approach.

4. Dementia Diagnosis:

Work continues in delivering the ICS action plan in each area and various initiatives are being considered for input to help Ipswich and East Suffolk to turn the curve. The ask remains that primary care continue to be aware of memory services being open for business and referrals made as appropriate so we can diagnose and importantly help support those in the community.

Dementia Diagnoses as a % of estimated prevalence

NAME	Oct %	Sept %	Change
NHS NORTH EAST ESSEX CCG	63.2	62.6	0.6
ENGLAND	62.9	63	-0.1
SUFFOLK AND NORTH EAST ESSEX STP	61.9	61.6	0.3
NHS IPSWICH AND EAST SUFFOLK CCG	61.4	61.6	-0.2
NHS WEST SUFFOLK CCG	61.1	60.3	0.8

5. Flu Vaccination

There has been a significant focus on flu immunisation this season. Based on figures published via the "Immform" platform, as at the end of week 49 there has been an 18 % increase in the number of flu vaccinations in the 65+ age group compared with the same period last year. Uptake in all cohorts is now better than this time last year. All exceed current local and national uptakes.

Comparison of Immform flu vaccination rates (as of end of week 49)

WSCCG average	65 and over	Under 65 at risk	Children aged 2	Children aged 3	Pregnant women
2019/20	68.7	41.9	41.1	39.7	45.4
2020/21	81.3	49.4	60.3	64.6	51.1

6. Primary Care Network (PCN) Development

6.1

- All patients in West Suffolk are covered by a Primary Care Network.
- Primary Care Networks have recently agreed their workforce plans.
- All West Suffolk care homes have now been aligned to a Primary Care Network as required within the Network Contract DES.
- Primary Care Networks are in the process of mobilising towards Early Cancer Diagnosis Specification.
- Planning and preparation for the Investment and Impact Fund (IIF) from 01.01.20 is underway (see 6.2).
- NHS England have now confirmed their expectation that primary care estate will be developed and managed at a PCN level.

6.2 The Investment and Impact Fund (IIF) has been introduced as part of the updated 2020/21 Network Contract Directed Enhanced Service (DES). It will run from 1 October 2020 until 31 March 2021 and will support primary care networks (PCNs) to deliver high quality care to their population. The IIF is an incentive scheme, supporting PCNs to contribute towards improving health, improving quality and making the NHS more sustainable. The focus is on tackling health inequalities and preventative activity for cohorts at risk of poor health outcomes.

The IIF is be worth £24.25 million in 2020/21, rising to £150 million in 2021/22, £225 million in 2022/23 and £300 million in 2023/24. Its content for 2021/22 and beyond will be agreed as part of contract negotiations with the BMA. Documentation has been published to provide guidance on the structure of the IIF for 2020/21 and includes details of the individual indicators and information on how performance and achievement will be calculated.

The IIF is divided into two domains:
(i) prevention and tackling health inequalities
(ii) providing high quality care.
Both contain contain indicators. Six indicators are included in 2020/21.

The IIF is points-based. In 2020/21, each PCN can earn a maximum of 194 IIF points and the value of a point will be £111.00 (adjusted for list size and prevalence). The value will be reviewed annually. Each indicator is worth an agreed number of points, and the points each PCN earns for each indicator will depend on their performance.

7. Recommendation

7.1 The Committee is invited to note the above information and consider any further appropriate action.

Classification: Official

Publishing approval reference: PAR0127

Network Contract Directed Enhanced Service

Investment and Impact Fund 2020/21: guidance

17 September 2020

Contents

1. Introduction

1.1 The Investment and Impact Fund (IIF) has been introduced as part of the amended 2020/21 Network Contract Directed Enhanced Service (DES). In 2020/21, the IIF will run for six months, from 1 October 2020 until 31 March 2021. It will support primary care networks (PCNs) to deliver high quality care to their population, and the delivery of the 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*. The IIF in 2020/21 will resource PCNs to play a leading role in the ongoing response to COVID-19, focusing on preventative activity for cohorts at risk of poor health outcomes, and in doing so tackling health inequalities more directly and proactively.

1.2 The IIF is an incentive scheme. It focuses on resourcing high quality care in areas where PCNs can contribute significantly towards the 'triple aim':

- improving health and saving lives (eg through improvements in medicines safety)
- improving the quality of care for people with multiple morbidities (eg through increasing referrals to social prescribing services)
- helping to make the NHS more sustainable.

1.3 The IIF will be worth £24.25 million in 2020/21, rising to at least £150 million in 2021/22, £225 million in 2022/23 and £300 million in 2023/24. Content for 2021/22 and beyond will be agreed as part of contract negotiations with the BMA.

Purpose of this document

1.4 This document provides guidance on the structure of the IIF for 2020/21, including details of the individual indicators on which performance is being focused. Information on how performance and achievement will be calculated is also included, and should be read alongside the relevant sections of the 2020/21 Network Contract DES specification (Section 9.8 and Annexes C and D).

2. Structure of the IIF

2.1. This section introduces the key elements of the IIF in 2020/21:

- domains, areas and indicators
- indicator structure, performance and personalised care adjustments
- achievement points
- achievement payments, prevalence adjustment and list size adjustment
- total achievement payments and preparation payments
- monitoring IIF performance.

Domains, areas and indicators

2.2 In 2020/21, the IIF is divided into two domains: (i) prevention and tackling health inequalities and (ii) providing high quality care. Both contain areas and these in turn contain indicators. Six indicators are included in 2020/21.

2.3 The domains, areas and indicators for 2020/21 are set out in the summary table below:

Domain	Area	Indicators
Prevention and tackling health inequalities	Prevention	PR01: Percentage of patients aged 65 and over who received a seasonal flu vaccination
	Tackling health inequalities	HI01: Percentage of patients on the learning disability register aged 14 and over who received an annual learning disability health check
Providing high quality care	Personalised care	PC01: Percentage of patients referred to social prescribing
	Medicines safety	MS01: Percentage of patients aged 65 and over currently prescribed a non-steroidal anti-inflammatory drug (NSAID) without a gastro-protective medicine MS02: Percentage of patients aged 18 and over currently prescribed an oral anticoagulant (warfarin or a direct oral anticoagulant) and an antiplatelet without a gastro-protective medicine MS03: Percentage of patients aged 18 and over currently prescribed aspirin and another antiplatelet without a gastro-protective medicine

Indicator structure, performance and personalised care adjustments

2.4 A PCN's performance in relation to each indicator is equal to a numerator divided by a denominator. The desired direction of performance may be upwards or downwards. If it is upwards, a higher indicator value means better performance and a one means worse performance; and if it is downwards, a lower indicator value means better performance and a higher one means worse performance.

2.5 The denominator of each indicator is equal to the size of the target cohort for the intervention in question. In 2020/21, the target cohort for all indicators is a group of patients eligible for an intervention. For example, for indicator HI01 the target cohort is people on the learning disability register aged 14 and over.

2.6 Personalised care adjustments (PCA) may be made in relation to two indicators only: PR01 and HI01. Applying a PCA to a patient removes them from the denominator of that indicator. A PCA may be applied for two reasons in relation to indicator PR01: when the patient declined the offer of a seasonal flu vaccine; and when it was not clinically appropriate to administer a seasonal flu vaccine. One reason is permitted for applying a PCA in relation to indicator HI01: when a patient refused the offer of a learning disability health check.

2.7 An example of how PCAs would be applied to PR01 is as follows: A PCN has 1,000 patients aged 65 and over, of whom 600 received a seasonal flu vaccine. If GP IT systems record that 100 of the 1,000 patients were offered a seasonal flu vaccine but refused and it was deemed clinically inappropriate to administer the seasonal flu vaccine to a further 100, then PCN performance in relation to indicator PR01 would be 75% (= 600/800), not 60% (= 600/1,000).

2.8 For all indicators, performance will capture the percentage of a target cohort receiving an intervention.

Achievement points

2.9 The IIF operates in a similar way to QOF, albeit with calculation of achievement at the network level rather than practice level.

2.10 The IIF is a points-based scheme. In 2020/21, each PCN can earn a maximum of 194 IIF points and the value of a point will be £111.00 (adjusted for list size and prevalence – see paragraph 2.14). Each indicator is worth an agreed number of points, and the points each PCN earns for each indicator will depend on how their

performance relates to an upper performance threshold and a lower performance threshold.

2.11 The upper performance threshold for each indicator is based on clinical or other expert opinion on good practice. Reflecting the aim of reducing unwarranted variations, the lower performance threshold for each indicator has typically been set with reference to the 40th centile of performance in 2018/19 (thresholds for social prescribing referrals have been based on expectations of the resource available to PCNs).

2.12 If a PCN's performance for an 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, 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 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. If a PCN's performance is 70%, it will earn 80% of the points available for that indicator – that is, 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).

Achievable payments

2.13 For each indicator, a PCN's achievement payment equals its achievement points multiplied by the value of an IIF point (£111.00), multiplied by a prevalence adjustment, multiplied by a list size adjustment. The value of an IIF point will be subject to annual revision.

2.14 The purpose of the prevalence adjustment and list size adjustment is to more closely relate PCN payments to the effort that a PCN must make to earn IIF points. The points-based system means that, for each indicator, every PCN will earn the same number of points for a given percentage point improvement in performance. 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 improvement in performance. Annex A explains how applying a prevalence adjustment and a list size adjustment takes account of these differences.

Total achievement payments

2.15 In 2020/21, PCNs are entitled to one type of payment under the IIF, namely a total achievement payment, which is the sum of achievement payments for each indicator (as defined above). To be eligible to receive a total achievement payment, a PCN must comply with the conditions set out in the 2020/21 Network Contract DES specification (section 9.9A.13). Crucially, the PCN must commit in writing to the commissioner that it will reinvest the total achievement payment into additional workforce and/or primary medical services.

Monitoring IIF performance

2.16 Each PCN will be able to monitor its indicative performance against IIF indicators on a new network dashboard. This dashboard will be available through an online platform. Every PCN will be able to see the benefits it is achieving for its patients, with performance against each IIF indicator available quarterly by PCN and constituent practice from autumn 2020. The network dashboard will help PCNs to identify opportunities to reduce unwarranted variation in performance within their PCN and between PCNs, and to improve services for patients.

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.

Prevention area

3.2 The aim of the prevention area is to help people stay healthy, by detecting disease early, preventing deterioration of health and reducing symptoms to improve quality of life. Indicators in the prevention area will contribute to government's ambition to add five years to healthy life-expectancy by 2035. Relevant indicators will also support the prevention-focused ambitions of the NHS Long Term Plan, such as ensuring access to vaccines. Preventative activity is particularly vital to protect those most vulnerable from COVID-19.

PR01: Percentage of patients aged 65 and over who received a seasonal flu 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). To support the ongoing response to COVID-19, government has set out ambitions for a significantly expanded seasonal flu vaccination for at-risk groups, including the over 65s. This indicator directly supports delivery of this ambition. NHS operational planning guidance and contracting guidance for 2020/21 reaffirms a system-wide commitment to the implementation of the national public health annual influenza immunisation programme. NICE Quality Standard 190 on improving flu vaccine uptake was published in January 2020.
Numerator	Number of patients aged 65 and over who received a seasonal flu vaccination In addition to counting flu vaccines provided during the IIF's six-month period of operation between 1 October 2020 and 31 March 2021, flu vaccines provided between 1 September 2020 and 30 September 2020 will also count towards the numerator. The flu vaccine can be provided in any patient setting (eg general practice, community pharmacy), provided provision is coded in GP IT systems.
Denominator	Total number of patients aged 65 and over.
Personalised care adjustments allowed	Patients who have declined a flu vaccine. Situations in which it is not clinically appropriate to provide a flu vaccine.
Desired direction	Upwards
Upper threshold	77%
Lower threshold	70%
Points available	72
Data source	General Practice Extraction Service (GPES)
Additional information	Responsibility for providing flu vaccines in primary care is currently shared between general practice and community pharmacy, and there is a parallel indicator for delivery to the over 65s in the Pharmacy Quality Scheme (PQS). To

PR01: Percentage of patients aged 65 and over who received a seasonal flu vaccination	
	encourage collaboration and discourage competition across a network, achievement for both the IIF and PQS flu incentives will be based on the total number of vaccines provided within the network, irrespective of who delivers the vaccine. The lower and upper thresholds for both indicators are set at the same rate. The IIF flu vaccine incentive supplements the existing influenza vaccine Directed Enhanced Service contract in general practice, which makes an item of service payment of £10.06 for each flu vaccine provided. This IIF indicator will also be complemented by the parallel incentive in PQS, which will reward community pharmacy for flu vaccine uptake by patients aged 65 and over. By incentivising both PCNs and community pharmacies in this way, we expect to achieve: • a collaborative approach across each PCN's footprint, leading to increased uptake of flu vaccinations in the eligible population • quality improvement, by more timely transfer of notifications of vaccine provision from community pharmacy to general practice, and prompt update of the patient record in general practice, reducing the risk of patients receiving multiple flu vaccinations. 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 flu vaccine uptake • the pharmacy PCN lead, where available, to agree how general practices will collaborate with community pharmacies in relation to seasonal flu vaccine uptake. NHS England: 2020/21 annual flu letter

Tackling health inequalities area

3.3 The NHS was founded to provide universal access to healthcare, yet 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. IIF indicators in the tackling health inequalities area will help to ensure that everyone gets access to the care they need by focusing on specific patient groups who experience health inequalities.

HI01: Percentage of patients on the learning disability register aged 14 and over who received an annual learning disability health check	
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. 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. NICE Quality Standard 187 provides the quality standard for learning disability health checks.
Numerator	Number of patients on the learning disability register aged 14 years and over who received an annual learning disability health check. In addition to counting annual learning disability health checks provided during the IIF's six month period of operation between 1 October 2020 and 31 March 2021, annual learning disability health checks provided between 1 April 2020 and 30 September 2020 will also count towards the numerator.
Denominator	Total number of patients on the learning disability register aged 14 years and over.
Personalised care	When a patient refused the offer of a learning disability health check.

HI01: Percentage of patients on the learning disability register aged 14 and over who received an annual learning disability health check	
adjustments allowed	
Desired direction	Upwards
Upper threshold	80%
Lower threshold	49%
Points available	47
Data source	General Practice Extraction Service (GPES)
Additional information	This IIF indicator supplements the £140 item of service payment for annual Learning Disability health checks, which is paid as an Enhanced Service. This IIF incentive complements the 2020/21 QOF Quality Improvement Module Supporting people with Learning Disabilities which is focused on the quality of care that General Practices deliver for patients with a learning disability. 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 GPs need to review and update 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 HI01 proportional to the number of patients on the learning disability register. Further details of these adjustments are provided in Annex A. 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

4. Providing high quality care domain

4.1 The Providing high quality care domain aims to ensure that the NHS continues to provide a world-leading quality of care for those with the greatest need, through the Personalised care area and the Medicines safety area.

Personalised care area

4.2 Personalised care is one of the five major practical changes to the NHS service model 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.

PC01: Percentage of patients referred to social prescribing	
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. Social prescribing link workers give people time to talk, and focus on what matters to the 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. The NHS Long-Term Plan commits to achieving 900,000 social prescribing referrals by 2023/24. To help deliver this ambition, the Update to the GP contract agreement 2020/21-2023/24 states that each PCN must provide access to a social prescribing service from 2020/21. Funding for employment of social prescribing link workers has been available to PCNs via the Additional Roles Reimbursement Scheme since April 2019.
Numerator	Number of patients referred to social prescribing. In addition to counting social prescribing referrals made during the IIF's six month period of operation between 1 October 2020 and 31 March 2021, social prescribing

PC01: Percentage of patients referred to social prescribing	
	referrals made between 1 April 2020 and 30 September 2020 will also count towards the numerator.
Denominator	PCN list size
Personalised care adjustments allowed	None
Desired direction	Upwards
Upper threshold	0.8%
Lower threshold	0.4%
Points available	25
Data source	General Practice Extraction Service (GPES)
Additional 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.

Medicines safety area

4.3 The NHS England and NHS Improvement Medicines Safety Improvement Programme was launched in response to the WHO challenge **Medication without harm**, which aims to reduce severe, avoidable medication-associated harm globally by 50% by 2022. It is estimated that 237 million medication errors occur in the NHS in England every year, of which about 44 million occur at the prescribing stage in primary care setting. During the COVID-19 pandemic more people on long-term medication have moved to electronic repeat dispensing. In this context it is vital that initial prescriptions are made in line with established best practice for reducing harm to patients.

4.4 The medicines safety area of the IIF aims to (i) support local reviews of prescribing, alongside other risk factors for potential harm; (ii) minimise the use of medicines that are unnecessary and where harm may outweigh benefits; (iii) identify where the risk of harm can be reduced or mitigated, including through prescribing of alternative medicines or medicines that mitigate risk; and (iv) reduce the number of hospital admissions that may be associated with medicines.

MS01, MS02, MS03: Gastro-protective prescribing			
	MS01	**MS02**	**MS03**
Indicators	Percentage of patients aged 65 and over currently prescribed a non-steroidal anti-inflammatory drug (NSAID) without a gastro-protective medicine.	Percentage of patients aged 18 and over currently prescribed an oral anticoagulant (warfarin or a direct oral anticoagulant (DOAC)) and an antiplatelet without a gastro-protective medicine.	Percentage of patients aged 18 and over currently prescribed aspirin and another antiplatelet without a gastro-protective medicine.
Rationale for inclusion	Patients prescribed the specific medicines described in MS01, MS02 and MS03 without a gastro-protective medicine are at a heightened risk of hospitalisation due to gastro-intestinal bleed. These indicators, which are also reported on the NHS Business Services Authority medicines safety dashboard, aim to encourage general practice to prescribe gastro-protective medicines alongside these medicines to reduce related hospital admissions.		

MS01, MS02, MS03: Gastro-protective prescribing			
	MS01	**MS02**	**MS03**
	Indicator MS01 complements the 2019/29 QOF quality improvement module on prescribing safety, which included a focus on safe prescribing of NSAIDs.		
Numerator	Number of patients aged 65 and over currently prescribed a NSAID without a gastro protective medicine.	Number of patients aged 18 and over currently prescribed an oral anticoagulant and an antiplatelet without a gastro-protective medicine.	Number of patients aged 18 years and over currently prescribed aspirin and another antiplatelet without a gastro-protective medicine.
Denominator	Number of patients aged 65 and over currently prescribed a NSAID.	Number of patients aged 18 and over currently prescribed an oral anticoagulant and an antiplatelet.	Number of patients aged 18 and over currently prescribed aspirin and another antiplatelet.
Personalised care adjustments allowed	None		
Desired direction	Downwards		
Upper threshold	30%	25%	25%
Lower threshold	43%	40%	42%
Points available	32	6	12
Data source	NHS Business Services Authority primary care prescribing data		
Additional information	The following contextual indicators are available to support monitoring. They will not be used to calculate IIF achievement. Indicators available through the medicines safety dashboard: • In relation to MS01: Patients admitted to hospital with gastro-intestinal bleed as a percentage of patients aged 65 and over who were prescribed a NSAID without a gastro-protective medicine. • In relation to MS02: Patients admitted to hospital with gastro-intestinal bleed as a percentage of patients aged 18 and over		

MS01, MS02, MS03: Gastro-protective prescribing			
	MS01	**MS02**	**MS03**
	who were prescribed an oral anticoagulant and an antiplatelet without a gastro-protective medicine • In relation to MS03: Patients admitted to hospital with gastro-intestinal bleed as a percentage of patients aged 18 and over who were prescribed aspirin and another antiplatelet without a gastro-protective medicine. Indicators available through the network dashboard: • In relation to MS01: Percentage of patients prescribed an NSAID and a gastro-protective medicine who were prescribed a gastro-protective medicine above the licensed prophylactic dose. Use of gastro-protective medicines has been associated with *Clostridium difficile* infection (CDI). The risk of CDI is thought to relate to the dose at which the gastro-protective medicine is prescribed. Therefore, prescribing of gastro-protective medicines above the licensed prophylactic dose is a marker of increased risk of CDI.[1]		

[1] While gastro-protective (proton pump inhibitor and H_2 receptor antagonist) product licences state a dose or indication for prophylaxis while on NSAIDs, they do not do so for patients on anticoagulants or antiplatelets, nor are recommended doses given in national guidance. For this reason, the network dashboard will only report patients prescribed above the licensed prophylactic dose in relation to MS01, and not in relation to MS02 or MS03. CCGs often have local prescribing guidance on recommended lower doses for prophylaxis for anticoagulants/antiplatelets.

Annex A: Prevalence adjustment and list size adjustment

A.1 This annex explains why a prevalence adjustment 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 D of the 2020/21 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 IIF indicator – it equals the denominator (that is, the size of the target cohort) divided by the PCN list size. For instance, for indicator PR01, 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 flu 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 (ie achieve a given percentage point improvement in performance).

A.4 Formally, the prevalence adjustment for an indicator is equal to the PCN prevalence divided by the national average 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.5 For one indicator, PC01, the target cohort is all the PCN's patients. Therefore, the denominator equals the PCN list size, and 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 this indicator.

A.6 As well as making payments more proportional to effort, applying a prevalence adjustment also encourages case finding for indicators whose denominator is

under the control of the PCN. Consider indicator HI01, 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. In the absence of a prevalence adjustment, this indicator could introduce a perverse incentive for PCNs to improve their performance by not adding people to the learning disability register if they are perceived as unlikely to consent to receiving an annual health check. Applying a prevalence adjustment both eliminates any such perverse incentive and incentivises PCNs to expand their registers, as earning potential is proportional to the size of the denominator.

List size adjustment

A.7 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.8 Formally, the list size adjustment for a PCN is equal to the PCN list size divided by the national average PCN list size (ie 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 47,000 and a PCN has 94,000 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.9 The net effect of applying a prevalence adjustment and a list size adjustment is to make payment proportional to the amount of activity undertaken (eg 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.

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PRIMARY CARE COMMISSIONING COMMITTEE

Agenda Item No.	**07**
Reference No.	**WSCCG PCCC 20-31**
Date.	**23 December 2020**

Title	**Primary Care Delegated Commissioning- Finance Report**
Lead Director	Jane Payling, Director of Finance
Author(s)	Wendy Cooper, Finance Manager (Primary Care-Ipswich & East Suffolk and West Suffolk CCGs)
Purpose	To provide the committee with an overview of the M8 Primary Care Delegated Commissioning Budget

Applicable CCG Priorities		
1.	Develop clinical leadership	
2.	Demonstrate excellence in patient experience & patient engagement	
3.	Improve the health & care of older people	
4.	Improve access to mental health services	
5.	Improve health & wellbeing through partnership working	
6.	Deliver financial sustainability through quality improvement	**x**

Action required by the Primary Care Commissioning Committee:

To note the report.

1. Purpose

To provide the committee with an overview of the M8 Primary Care Delegated Commissioning Budget and other associated primary care budgets.

2. Key Points

At the end of M8, the GP Delegated Budget was £501k overspent – please see the table below for a summary of key variances:

Application of Funds	YTD			FULL YEAR			Variance Analysis
	Budget	Actual	Variance	Budget	Forecast	Variance	
	£'000	£'000	£'000	£'000	£'000	£'000	
GMS/PMS Core Contract	15,821	17,653	1,832	23,731	26,384	2,653	Variance due to PMS Premium and Qtr3 list size increase
QOF/Seniority/Other	2,533	2,536	2	3,800	3,803	4	
Enhanced Services	339	339	(0)	509	509	(0)	
Premises costs	1,706	1,721	15	2,562	2,581	19	
Professional fees - Dispensing/Prescribing	1,583	1,573	(10)	2,374	2,360	(14)	
Locum allowance/GP Retainers	97	186	89	145	278	133	Includes anticipated locum sickness/maternity claims
Primary Care Networks	1,632	1,629	(3)	2,459	2,445	(15)	
Other - Recharges	1,855	155	(1,700)	2,512	233	(2,280)	Contingency to be offset against in year increase e.g. list size increase
Primary Care Delegated Commissioning	**25,566**	**25,791**	**225**	**38,093**	**38,594**	**501**	

The CCG has received the full year allocation for the Primary Care Delegated budget. This included a retrospective top-up allocation for months 1-6.

The retrospective top-up allocation has the effect of reducing the month 6 position to break even reducing the YTD and forecast overspend in this financial year.

Other Primary Care shows an underspend of £1,409k at M8, as summarised in the table below:

Application of Funds	YTD			FULL YEAR			Variance Analysis
	Budget	Actual	Variance	Budget	Forecast	Variance	
	£'000	£'000	£'000	£'000	£'000	£'000	
Local Enhanced Services	1,053	1,036	(17)	1,571	1,082	(488)	
GPFV	1,741	1,741	0	2,966	2,966	0	
Primary Care Contingency	316	0	(316)	921	0	(921)	
Other Primary Care	**3,109**	**2,777**	**(332)**	**5,458**	**4,048**	**(1,409)**	

The CCG has also received the full year allocation GP Forward View (GPFV) and a retrospective top-up allocation for any overspend in months 1-6.This has enabled the CCG to create a non-recurrent Primary Care Contingency budget which will be used to offset areas of over-spend in Primary Care.

3. Risks / Opportunities

Risks not reflected in the above full year forecasts are further increases in rent reimbursement and additional practice management support.

4. Recommendation

The Committee is asked to note the financial performance at Month 8.

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PRIMARY CARE COMMISSIONING COMMITTEE

Agenda Item No.	**08**
Reference No.	**WSCCG PCCC**
Date.	**23 December 2020**

Title	**Enhanced Service Update**
Lead Director	Kate Vaughton, Director of Integration
Author(s)	Rachel Seago, Senior Primary Care Manager
Purpose	The purpose of this report is to update the committee on the Locally delivered Enhanced Services

Applicable CCG Priorities		
1.	Develop clinical leadership	
2.	Demonstrate excellence in patient experience & patient engagement	
3.	Improve the health & care of older people	
4.	Improve access to mental health services	
5.	Improve health & wellbeing through partnership working	
6.	Deliver financial sustainability through quality improvement	**x**

Action required by the Primary Care Commissioning Committee:

The Committee are invited to note the contents of this paper.

1. Background

1.1 Following the revision to the locally enhanced services on 1st August 2020, this paper is an update to the committee.

1.2 A table of the current Enhanced Services available to west Suffolk practices until 31 March 2021 is below, together with a brief description, all specifications will be reviewed in February 2021:

Enhanced Service	Brief description
Access*	For the provision of Access by offering all core and additional services at all times during core hours (Monday to Friday 8:00- 18:30)
Care Homes	To sit alongside the NHSE Directed Enhanced Service to provide top-up funding. To adopt a proactive approach for the treatment of Care Home residents:
Shared Care	For the provision and monitoring of Shared Care Drugs. Shared Care Drugs are classified as 'amber' on the CCG's Traffic Light System, meaning initiated and stabilised by a specialist in secondary care, then transferred to GP prescribing under the terms of a Shared Care Agreement (SCA). The SCA clarifies the responsibilities of the specialist and the responsibilities of the GP.
DVT	To provide a high quality service offering assessment, advice and treatment in an appropriate setting. Referrals to secondary care of the patients with low probability of the condition will be reduced. The service will operate within acceptable waiting times between referral and treatment and will provide value for money.
SMI	This specification aims to commission an enhanced provision to better address physical health risks and needs within primary care. By offering all patients deemed to have a serious mental illness an annual physical healthcheck.
Depo*	For the provision of Depo-Neuroleptics by offering injection of depo-neuroleptics to patients whom require it to stay active in their community; in partnership with the Mental Health Trust.
Leg ulcers	Only available to Bury and Blackbourne practices. To development a single specification of leg ulcer clinic to provide an improved system of care for patients living with VLU in Suffolk. Develop a shared responsibility across Suffolk for the collective reduction in VLU annual costs.
Zoladex*	For the provision of Zoladex by offering injection of Zoladex to patients whom require it.
Polypharmacy	Polypharmacy Medication Reviews with a focus on appropriate deprescribing of Dependence Forming Medicines (DFMs) are strongly promoted
Phlebotomy*	For the provision of phlebotomy.
Wound Care*	For the provision of Wound care.

Minor Injury*	For the provision of Minor Injury services by offering effective, evidence based treatment for minor injuries in Primary Care, which can be monitored and audited.

*The GMS contract has a number of clinical areas not covered in its core which require CCGs to commission extra services as these elements are included in the PMS contract.

1.3 All practices have formally signed-up, activity recording and invoicing has commenced. This was following the estimated payment period from 1 April 2020 to 31 July 2020 – the estimated payments were made based on previous activity and to reduce administrative burden on Practices.

2. Current Status

2.1 In West Suffolk we agreed the implementation of PORT which is a portal accessible to all practices for the function of reporting ES activity; however after review of its functionality and in collaboration with Practice Mangers, it has been agreed to reintroduce a monitoring spreadsheet. A further factor to this decision is that the IT Manager who built and is responsible for all upgrades/trouble shooting etc. has left NEL.

2.2 We have set-up the monitoring spreadsheet to record all activity which is managed day to day by Olivia Rigo (Project Officer in the Primary Care Team) and overseen by Rachel Seago (Snr Primary Care Manager). This has removed duplication in the system and is an easier way to see gaps in data and ensure we have a full picture of all activity. We can therefore be assured that all data is collected and recorded.

2.3 We also ran a 'How to' session with Practices around invoicing and recording of Enhanced Services to ensure accuracy.

2.4 Attached to this paper is a flowchart which depicts the process for creation of a new Enhanced Service for Primary Care; this is to ensure consistency and to ensure everyone is consulted i.e. Executive Board and LMC.

3. Recommendation

3.1 The Committee is asked to note this report.

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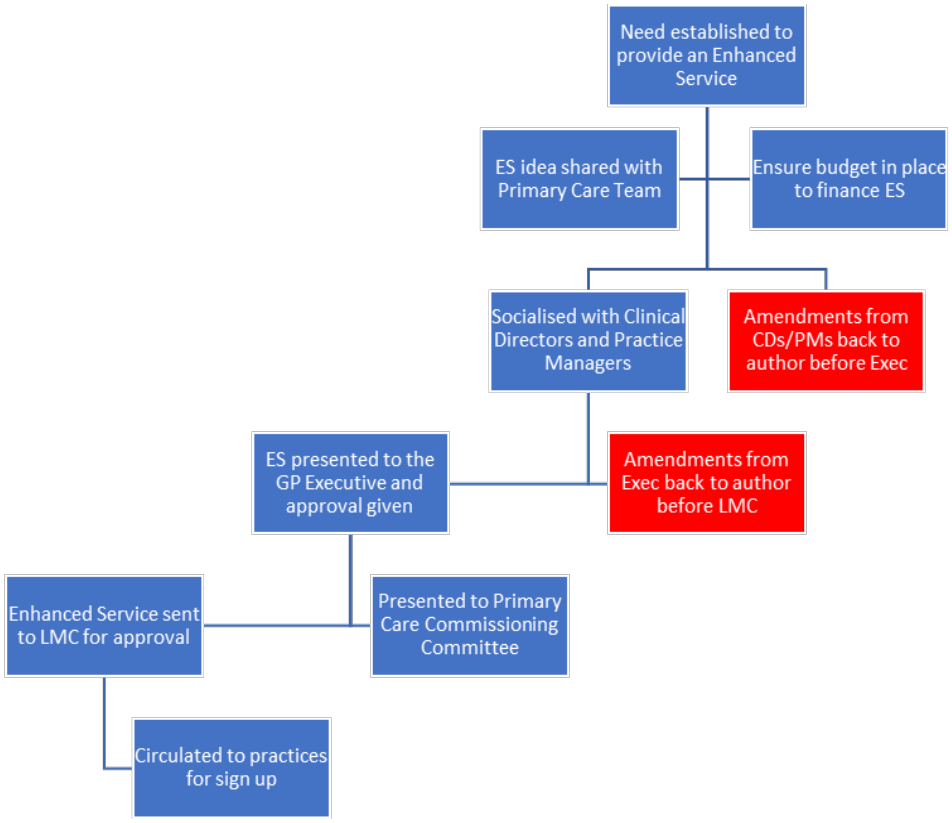
Process for creation of new Enhanced Service for Primary Care

Considerations before creating a new Enhanced Service (ES):

- Have other providers, contractual and/or commissioning arrangements been considered?
- Is this ES for individual practices or PCNs?
- Is there a budget in place for the payment mechanism within the ES?



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PRIMARY CARE COMMISSIONING COMMITTEE

Agenda Item No.	**09**
Reference No.	**WSCCG PCCC 20-33**
Date.	**23 December 2020**

Title	**Virtual Meetings – Report of Decision**
Lead Director	Lois Wreathall, Deputy Director of Primary Care
Author(s)	Jo Mael, Corporate Governance Manager
Purpose	To report formally in public the following decision made at a virtual meeting since the previous meeting held in public. 1. 20 October 2020 – Quality Outcome Framework Funding 2020/21

Applicable CCG Priorities		
1.	Develop clinical leadership	
2.	Demonstrate excellence in patient experience & patient engagement	
3.	Improve the health & care of older people	
4.	Improve access to mental health services	
5.	Improve health & wellbeing through partnership working	
6.	Deliver financial sustainability through quality improvement	**x**

Action required by the Primary Care Commissioning Committee:

To note and endorse the decision made at a virtual meeting as appended to the report.

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WEST SUFFOLK CCG
PRIMARY CARE COMMISSIONING COMMITTEE

20 October 2020 (Virtual Meeting)

Decision Record

QOF funding 2020/21
To receive and approve *a report from the Deputy Director of Primary Care*

Lois Wreathall
Report No: WSCCG/CGC 20-20P

Primary Care Commissioning Committee Members:

Lynda Tuck (Chair), Lay Member for Patient and Public Involvement
Geoff Dobson, Governing Body Lay Member for Governance
Ed Garratt, Chief Executive
Paul Gibara, Director of Performance Improvement
Jane Payling, Director of Finance
Kate Vaughton, Director of Integration

Declarations of Interest

No declarations of interest were received.

Decision

The Committee approved the principle on the points contained within the report together with the associated monetary award.

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PRIMARY CARE COMMISSIONING COMMITTEE

Agenda Item No.	**10**
Reference No.	**WSCCG PCCC 20-34**
Date.	**23 December 2020**

Title	**Contractual Update**
Lead Officer	Lois Wreathall, Deputy Director or Primary Care, West Suffolk CCG
Author(s)	Stuart Quinton – Senior Contract Manager (Suffolk & North East Essex STP), NHS England and NHS Improvement (East of England) Laura Triall – Contract Manager (Suffolk & North East Essex STP), NHS England and NHS Improvement (East of England) Kathleen Hedges – Contracting Support Manager (Suffolk & North East Essex STP), NHS England and NHS Improvement (East of England)
Purpose	To update and inform the Primary Care Commissioning Committee about the contractual changes over the last quarter (October – December 2020).

Applicable CCG Priorities		
1.	To promote self care	
2.	To ensure high quality local services where possible	√
3.	To improve the health of those most in need	
4.	To improve health & educational attainment for children & young people	
5.	To improve access to mental health services	
6.	To improve outcomes for patients with diabetes to above national averages	
7.	To improve care for frail elderly individuals	
8.	To allow patients to die with dignity & compassion & to choose their place of Death where appropriate	
9.	To ensure that the CCG operates within agreed budgets	

Action required by the Primary Care Commissioning Committee:

The Primary Care Commissioning Committee is asked to note the contents of this paper.

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1. Introduction

1.1 This paper serves to update the Committee on the contractual updates relating to GP practices within the Suffolk and North East Essex STP over the last quarter (October – December 2020). Depending on the activity within the quarter, the update may include details of branch closures; list closures; mergers; practice name changes; and updates on super partnerships.

Committee members are asked to take note of the updates below and are invited to ask questions.

2. Contractual Updates

2.1 List Closures:

- The Barham & Claydon Surgery (D83615) have formally closed their list to new patients for 12 months following the approval at a private Ipswich and East Suffolk CCG Primary Care Commissioning Committee (10/11/2020). (Ipswich & East Suffolk CCG)
- Harewood Surgery (F81606) have re-opened their list of patients from 01/11/2020. (North East Essex CCG)
- St James Surgery (F81052) currently have a closed list of patients. We are in the process of establishing if this is a temporary list closure or if they will be submitting a formal closure application.

2.2 Mergers:

- Norwich Road Surgery (D83058), Chesterfield Drive Surgery (D83039) and Deben Road Surgery (D83050) will be making an application to merge their practice. The patient engagement process is underway, and the application will be brought to Ipswich & East Suffolk's CCG PCCC meeting. (Ipswich & East Suffolk CCG)

2.3 Super Partnerships:

- The Suffolk Primary Care Super-Partnership contract variation agreement has been sent to the partnership for signing. (Ipswich & East Suffolk CCG and West Suffolk CCG)
- The Colte Super-Partnership contract variation agreement has been sent to the partnership for signing. (North East Essex CCG)

3. Recommendation

3.1 The Primary Care Commissioning Committee is asked to note the contents of this paper.

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PRIMARY CARE COMMISSIONING COMMITTEE

Agenda Item No.	**11**
Reference No.	**WSCCG PCCC 20-35**
Date.	**23 December 2020**

Title	**Primary Care Estates Overview**
Lead Director	Amanda Lyes, Director of Corporate Services and System Infrastructure
Author(s)	Julia Hiley, Acting Senior Estates Development Manager
Purpose	To provide Primary Care Commissioning Committee with an update on primary care estates developments

Applicable CCG Priorities	
1. Develop clinical leadership	**x**
2. Demonstrate excellence in patient experience & patient engagement	**x**
3. Improve the health & care of older people	**x**
4. Improve access to mental health services	**x**
5. Improve health & wellbeing through partnership working	**x**
6. Deliver financial sustainability through quality improvement	**x**

Action required by the Primary Care Commissioning Committee:

To consider and discuss the information contained within the paper and agree any appropriate actions required

1. Wider programme updates

1.1. Primary Care Estates Strategy

Work on the development of the primary care estates strategy continues to progress although this has been significantly hampered by the impacts of Covid with key staff having been redeployed and resources depleted. A higher-level system wide estates strategy has been developed at an ICS level which is required in order to allow access to future capital bidding, the content of the primary care estates strategy is being written to underpin the principles of this. Due to the delays from Covid it is anticipated that the draft strategy will be completed in quarter 4 of 2020/21.

1.2. Primary care data gathering pilot wave

Following on from the update provided to PCCC in July 2020. The national team have provided an update to the Primary Care Data Gathering Pilot workstream as summarised below:

- COVID-19 and the subsequent NHSE comms / premises access restrictions have resulted in several revisions of programme delivery approach and timescales.
- Further discussion and reflection have occurred about the likelihood of comms publication in January 2021, and it has been agreed that a full programme refocus was required to ensure optimal delivery amidst the ongoing uncertainty. With all of this in mind, the Programme Board has approved delivery in line with the following:
  - Full completion of all programme elements without engaging with GP's (i.e. desktop data gathering) will continue and be completed by March 2021 including survey extraction; information upload to SHAPE; SHAPE training and final SHAPE Atlas including KPIs analysis tool and reporting functions
  - GP engagement and surveys for all four waves to be pushed into 2021/2022 (national comms publication dependent)
  - Programme completion in December 2021, although aspiration for this to be pulled back to October 2021 by refining tender process

Positively, this revised programme brings forward the full SHAPE development and training plan, meaning systems will be able to use their data to inform local planning sooner than expected.

1.3. ETTF Capital funding

The committee are reminded that the primary source of transformational estate capital for Primary Care will be closing at the end of March 2021. The government have not yet announced how the budget will be replaced, but it is expected a new form of Primary Care estates funding will be made available which will be centred around business cases for schemes from a PCN perspective only. Individual Practice requests for transformational estate funding are unlikely to be supported. Should a Practice require a general improvement to their premises, however, (Improvement Grant) funding for refurbishments will remain and CCG's will be informed of their Improvement Grant budgets for 2021/2022 in the New Year.

2. New report (S106 contributions)

The following Section 106 agreements have triggered for Ipswich & East Suffolk Practices. All triggered S106 Agreements have been sent to the relevant PCN Clinical Director to encourage their practices to work alongside the Estates team who are working proactively to support practices in coming up with schemes that meet the Section 106 agreement criteria.

Location	No. of housing units	Contribution Received	Deadline for spend	Aligned to Practice	Comments
Former Grampian Harris Sit, St Edmunds Drive Elmswell	190	£25,692 Received	5/4/29	Woolpit HC	Payable on occupation of 50th Dwelling
Location	**No. of housing units**	**Contribution Received**	**Deadline for spend**	**Aligned to Practice**	**Comments**
Land north of Folly Road, Great Waldingfield	93	£40,656 Received	12/12/21	Surgeries in Sudbury	Received
Former Armorex site, Preston Road, Lavenham, Sudbury	44	£17,107.56 received	30/6/25	Lavenham Long Melford	Received
Harp Close Meadow (North), Waldingfield Rd, Sudbury	100	£43,578 Received	15/5/28	Surgeries in Sudbury	Received
Guildford Europe, Radiator Rd, Great Cornard, Sudbury	110	£18043.45 received	15/7/21	Hardwick House	Received
Kentford Lodge Bury Road, Kentford CB8	98	£23,657 received	24/3/21	Reynard	Received
Parcel F Marham Parkway Fornham All Saints	900	£66,355 received	2022-2025	Surgeries in Bury	Received
Lark Grange Mount Road, Bury	100	£123,879 received	2022-2025	Mount Farm	Received
Land Close view, Aspal Lane, Beck Row	117	£20,386 received	1/1/28	Mildenhall surgeries	Received
Land Part of Phase 4a Bellflower Crescent, Red Lodge	374	£144,240.28 received	No payback date	Reynard Surgery	Received
Land South of Worlington Road, Barton Mills	78	£15,710.73 received	4/10/23	Mildenhall Surgeries	Received
Development site Meddler Stud, Bury	63	£32,400	No payback	Reynard	Received

Road, Kenford		received	date		
Land East of Barrow Hill, Barrow	-	£25,137 received	18/2/25	Guildhall and Barrow	Received
Land NW of Haverhill, Anne Sucklings Lane, Little Wratting	200	£400,395 received	12/3/25	Haverhill surgeries	Received
Kininvie, Fordham Road, Newmarket CB8	63 bed care home	£10,118 received	14/7/25	Rookery/Orchard House	Received
Orchids Grove Land, South of Chapelwent Rd, Haverhill	87	£33,220 received	19/8/25	Clements FP	Received
Total S106 triggered	**£1,040,573**				

3. Primary Care Developments – Progress by Practice

The table below provides a brief summary of all Primary Care Estates developments which are subject to a Project Initiation Document (PID), Outline Business Case (OBC) or Full Business Case (FBC). It also demonstrates recently completed schemes or those now moving into delivery.

Practice	Current project status	Project Description	Update	Progress since last report	Target delivery date
Guildhall & Barrow	In delivery	Extension	Delivery begins February 2021 completion June 2021	→	June 2021
Hardwick House (Sudbury PCC)	OBC	New build Primary Care Centre	OBC with PCCC December 2020 for approval. FBC expected August 2021	→	Build starts September 2021
Reynard Phase 1	PID	Internal reconfiguration	PID with NHSE for approval December 2020. No OBC or FBC required	→	Works start January 2021
Stanton Surgery	In delivery	Extension and reconfiguration (replacing portacabin)	Business case approved in November; delivery begins December 2021	→	Works start December 2020
Woolpit West Wing	EOI	Refurbishment	Practice aware they need to complete a PID before end of March to secure	↑	21/22

			ETTF funding		
Rendlesham (Wickham Market)	In delivery	Internal reconfiguration	Business case approved in August, now in delivery	➔	Works expected to complete by March 2021

The following schemes are potential pipeline projects which have not as yet progressed to PID stage, many of which are linked to Section 106 funding:-

Practice	**Current project status**	**Project Description**	**Update**	**Progress since last report**	**Target delivery date**
Brandon	EOI	Installation of automatic door	EOI approved, but awaiting PID	No progression	n/a

4. Next Steps

4.1. Develop and implement the emerging updated and amended CCG's primary care estates strategy in parallel to the wider alliance and ICS strategies and reflect the guidance received from NHSE around a requirement for PCNs to develop a PCN estates strategy.

5. Recommendation

- The Committee is invited to consider the information within this paper and agree any appropriate actions going forward.

WSCCG PRIMARY CARE COMMISSIONING COMMITTEE ANNUAL PLAN OF WORK:

January	**February 2021**	March
	• General Update • Primary Care Contracts and Performance Incl CQC report • Finance Report • Enhanced Service Review • NHSE Complaints	
April 2021	May	**June 2021**
• General Update • Primary Care Contracts and Performance Finance Report		• General Update • Primary Care Contracts and Performance Report • Finance Report • Estate update • IT update • TOR • LES 2020 sign off incl review and evaluation of previous year • NHSE Complaints
July	**August 2021**	September
	• General Update • Primary Care Contracts and Performance Report • Finance Report • Estate update • IT update • NHSE Complaints	
October 2021 (in common)	November 2019	**23 December 2020**
		• General Update • Primary Care Contracts and Performance Report • Finance Report