NHS
Northumberland
Clinical Commissioning Group

Northumberland Primary Care Commissioning Committee

Wednesday 13 April 2022 at 10:00 hrs
via MS Teams

AGENDA

Time	Item	Topic	Enc	PDF page	Presenter
1000	1	1.1 Welcome 1.2 Apologies 1.3 Declarations of conflicts of interest 1.4 Quoracy*			Chair
1005	2	2.1 Previous Minutes – February 2022 2.2 Public Action Log – February 2022	✓ ✓	2 8	Chair
1010	3	**Operational** 3.1 Finance Update 3.2 Quality Assurance Report Q2/Q3 3.3 Revisiting the Progress on Recovery of Practices post COVID-19	 ✓ ✓	 9 18	 J Connolly C Coyne/R Hudson P Phelps
1030	4	**Strategic** 4.1 Estates and Premises – A progress update ***(presentation)***			J Mitchell
1040	5	Any Other Business			Chair
1045	6	**Date and time of next meeting:** Wednesday 8 June 2022 at 10:00hrs via MS Teams			Chair

* 3 members, including at least the Chair or the Lay Governor and at least the CCG Chief Operating Officer or the Chief Finance Officer.

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Minutes of the Public Meeting of NHS Northumberland Primary Care Commissioning Committee, held on Wednesday 9 February 2022

Members Present (on-line)

Janet Guy (JG)	Chair and Lay Member, NHS Northumberland CCG
Karen Bower (KB)	Lay Member – Corporate Finance and Patient and Public Involvement, NHS Northumberland CCG
Siobhan Brown (SB)	Chief Operating Officer, NHS Northumberland CCG
Jon Connolly (JC)	Chief Finance Officer, NHS Northumberland CCG
Rachel Mitcheson (RM)	Service Director for Integration and Transformation, NHS Northumberland CCG
Annie Topping (AT)	Executive Director of Nursing, Quality and Patient Safety, NHS Northumberland CCG
Paul Turner (PT)	Executive Director of Commissioning, Contracting and Corporate Governance, NHS Northumberland CCG

In attendance (on-line)

David Thompson (DT)	Healthwatch Northumberland
Adam Foster (AF)	NHS England/Improvement
Jane Lothian (JL)	Local Medical Committee (LMC)
Diane Gonsalez (DG)	NHS Northumberland CCG
Pamela Phelps (PP)	NHS Northumberland CCG
Robin Hudson (RH)	NHS Northumberland CCG
David Kyle (DK)	NHS Northumberland CCG
David Lea (DL)	NHS Northumberland CCG
Jamie Mitchell (JM)	NHS Northumberland CCG
Emma Robertson (ER)	NHS Northumberland CCG
Barbara Allsopp (BA)	NHS Northumberland CCG (Minutes)

NPCCC/22/01 Agenda Item 1.1 Welcome

JG welcomed attendees to the Northumberland Primary Care Commissioning Committee (PCCC) and informed the committee that the meeting would be audio recorded for use in the production of the minutes and the recording destroyed following their ratification. JG also confirmed the meeting would be video recorded and the video placed on to the public website for information. There were no questions received prior to the meeting from members of the public.

NPCCC/22/02 Agenda Item 1.2 Apologies

Apologies were received from Richard Glennie (RG) and Chris Black (CB)

NPCCC/22/03 Agenda Item 1.3 Declarations of conflicts of interest

No declarations of interest were received.

NPCCC/22/04 Agenda Item 1.4 Quoracy

The meeting was quorate.

NPCCC/22/05 Agenda Item 2.1 Previous Minutes – December 2021

The minutes of the previous meeting held in December 2021 were reviewed and accepted as a true record.

NPCCC/22/06 Agenda Item 2.2 Public Action Log

The action log was reviewed, and outstanding actions discussed. The action log was subsequently updated with additional comments.

NPCCC/22/07 Agenda Item 3.1 Finance Update

JC presented the financial position for Primary Care that is reported through the Clinical Commissioning Group accounts for the 2021-22 financial year as at 31 December 2021. This also included an update on the temporary financial arrangements put in place by the government in response to the COVID-19 outbreak.

A year to date pressure of £0.1m and full year forecast of £0.4m was reported in relation to costs of the PCN additional roles and reimbursement scheme (ARRS) posts against the core baseline allocation the CCG holds in its delegated budgets. The CCG expects to receive this extra funding on a retrospective basis before the year end. Once the additional roles allocation top up is received for the costs incurred, the end of year forecast position is expected to be an underspend of approximately £600k.

JC confirmed primary care funding is not being taken away from primary care, the amount of funding being put into primary care is being reduced to cover the underlying gap. In summary there is £3.5m short of what the CCG would wish to spend to what the CCG require for the actual budget. JG thanked JC for confirming the position of funding and reiterated that GPs were aware that the CCG has been subsidising the gap from CCG general funding in primary care with no loss to primary care, adding that the CCG has supported general practice very well.

JL acknowledged the ongoing ARRS funding, highlighting that in the current General Medical Services (GMS) contract it will become a larger portion of the overall funding. She asked how this would be monitored to not create unintentional inequities across the county. JC acknowledged this point and recognised this was an ongoing challenge.

JL also asked for an update on the Integrated Care System (ICS) and Integrated Care Board (ICB) development and asked how primary care funding management will be amalgamated with ICB funding across place and the ICS. JC confirmed the development timetable was now focussed on 1 July but noted that the timetable could slip further back. Plans are still some way off for knowing exactly how things will operate into the future. JC confirmed it was right to raise the risk and concern over the work needed on the timetable, but no further clarity was yet available at present. JG reiterated the importance of raising any concerns through the development process.

KB referred to the General Practice Information Technology (GPIT) and asked for clarification on how the spend that NECS make on behalf of the CCG is monitored. JC confirmed this is monitored through the Chief Finance Officer (CFO) group across the area; a lead works with NECS on this at high level and the overall position monitored.

SB joined the meeting.

NPCCC/22/08 Agenda Item 3.2 Contract Baseline Report

AF presented the contract baseline report to provide PCCC with information regarding the number and types of primary medical care contracts; the directed enhanced services (DES) and a summary of on-going contractual issues/changes. PCCC were asked to review the information and provide comment.

Some highlights included the recent merger of Widdrington and Felton practices and their subsequent name change to 'Northumberland Health'. Also, the patient engagement for Longhoughton practice has begun on the lead up to the proposed closure.

PCCC were informed that the minor surgery DES quarter 3 is partially income protected at a national level and quarter 4 will be fully income protected for those practices who have signed up to the COVID-19 vaccination programme. It was noted that the section on learning disabilities DES contained some errors in relation to the total money earned column and AF confirmed an updated copy of the paper would be provided to members for their information.

DT referred to the data relating to health checks for learning disabilities (LD) and physical health, noting the significant variation in the practices that carry out those checks, and asked whether steps should be taken to raise the proportion of people having the health checks on the register. RH explained how this remains a focus on monthly quality reports, as well as forming good links with the CCG GP lead who has been working on engaging with practices to make sure processes are streamline. Each check takes 30-40 minutes to complete and cannot be delegated to other professionals in the primary health care teams, as well as different practices having different percentages of LD patients on their registers. There is an acknowledgement that practices recognise the importance, as well as the need, for doctors to protect time to complete the checks, however the pressure is already on GPs with regard to patient access and face-to-face contact by patients. AT confirmed this work was very much on the agenda at a strategic and operational level with the transforming care group that meet and work closely with LD nurses, who have good working relationship at practice level, as well as a vaccine inequity board, to closely monitor flu and COVID-19 vaccination uptake by patients with LD.

In relation to the GP retention scheme, KB asked what happened after 5 years of a GP being on the scheme and asked whether NHSE track the GP if they aren't retained in Northumberland to ensure value for money. AF confirmed that a GP completes a leaver form if they come out of the GP retention scheme, which includes the question of why they are leaving. This form is completed at any point the GP leaves the scheme. When a GP leaves the scheme they can go on to do whatever work they wish, either within the same practice, the CCG or in a different area.

JL pointed out that there were several retention schemes that have been in place from the earlier retainer schemes through to the current retention scheme. Some excellent GPs have been retained through the scheme and the importance of looking at the long term equity, the long term consequences and the effect on the overall workforce was highlighted.

The chair confirmed PCCC accepted the informative report.

NPCCC/22/08/01 ACTION: AF to provide members with an updated copy of the Contract Baseline Report containing the corrected information in the learning disabilities DES section.

NPCCC/22/09 Agenda Item 3.3 GP Out of Hours Assurance Report

The chair confirmed that an updated copy of the report was circulated prior to the meeting as some of the tables within the document needed relabelling.

DK presented the quality assurance update pertaining to the GP Out of Hours (OOHs) service in Northumberland, provided by Vocare, which covered Q1 and Q2 of 2021/22. Key points of data from the report were highlighted including over 40% of all referrals from the 111 service having had a disposition timescale of 2 hours or below which causes significant challenge for the GP OOHs service. The 111 disposition timescales are driven by the national pathways triage system, based on the balance of risk. No serious incidents were raised in this report and 5 complaints against 6045 contacts were received. Overall DK said, based on the information provided and review of the service, Vocare has provided a safe and efficient service. PCCC was asked to note the content of the report and make comment.

KB asked whether a review is carried out on incidents relating to delays of 2 hours and below. It was noted that a full investigation on each patient was not carried out when they were not seen in a time frame, only where it has led to further care or an ambulance response. DK confirmed Vocare receive an alert to review, and take matters very seriously, if they go over timescales.

The chair noted that some failures were identified in the report, but overall targets were being met, or breached by a very small percentage. PCCC considered the contents and was reassured matters are being acted on when, and where, necessary.

NPCCC/22/10 Agenda Item 3.4 Access Improvement

During the pandemic GPs were mandated to reduce face-to-face appointments to protect patients from COVID-19 infection and other ways of working were introduced. However, under the circumstances, the changes did not take account of patient or practice preferences. Very significant publicity has come about since, regarding access to general practice services. Northumberland CCG secured funding to deliver a bespoke project that would address patient engagement, a local action plan to support access improvements and understand the choices patients are willing to make in order to assess appropriate provision and access for patients. CL and ER presented an update on the improving access project to date and the work undertaken with a market research company called Explain.

A local action plan will be produced at the end of March based on the findings of patient surveys, which will be shared with practices, and the collated data will help the primary care commissioning team for future service delivery and identifying any issues.

To date, through the engagement period (19 January to 25 February) face-to-face on- street surveys, an online survey, focus groups and in-depth interviews have been set up and undertaken, plus outreach surveys and focus groups delivered via the voluntary sector. Some interim online results were provided for information including levels of satisfaction with the ability to get an appointment dropping from 6.5 pre-covid to 5.4 at present. However, 61% of those asked said a phone call is their preferred method of contact.

PP explained how this work will provide access to information that hasn't been received before. It will help map the results across the population to develop a picture of the demographics which will ultimately help in responding to access requirements including bank holidays to provide an effective service. RH confirmed he was pleased with the progress so far whilst recognising the importance of the information to facilitate a two-way conversation. This would enable the public to know how the practices are operating when they see a quiet waiting room, how they are there to provide a service, and how they are responding to the pandemic. RM and AT echoed the positive comments.

AT asked if the research was reaching all sectors of the community in Northumberland to bring all the voices and experiences together to inform this piece of work. ET explained 'Being Woman' and other voluntary sector organisations are undertaking funded work to focus on supporting surveys in the harder to reach, black, Asian and minority ethnic (BAME) sector of the community. DT highlighted that some community members do not have access to IT and are therefore disadvantaged, and ET reassured him that a large number of paper surveys had been issued to those people who didn't have internet access as well as street surveys with the public.

KB expressed her positivity towards the voluntary, community and social enterprise sector of the community being paid to support the survey work.

A discussion was held on the difficulties a number of patients have experienced when trying to contract practices via the telephone. RH quoted some of the statistics found through a recent audit on calls received by his practice over a 4 week period, with a patient list size of 10200. On

average 2.5k calls were received on a Monday with 1800-1900 on the other days of the week; the management of which with the current level of staff being a massive task.

JG thanked those involved for the valuable and important piece of work that was being undertaken and expressed the wish for PCCC to receive some further feedback once the results have been concluded.

NPCCC/22/11 Agenda Item 4.1 Primary Care Networks, their development and what the future looks like

PP presented an update on the development of Primary Care Networks (PCNs) and gave an overview of where PCNs are going, how they are developing and how the PCNs fit with the forthcoming development of the Integrated Care System (ICS).

In the original PCN prospectus the main aim was to stabilise general practice and help solve the capacity gap, become a proven platform for further local NHS investment and dissolve the divide between primary and community care, as well as systematically delivering new services to implement the Long Term Plan. After being established in 2019 COVID-19 hit. The development has since been subsequently driven reactively with different models developing within the PCNs since then, with the impact of COVID-19 bringing a reliance on networks within the community which is increasing.

Funding and the multiple elements of income were explained, as well as the management structure of each PCN, with each having a clinical director and management lead. Variances exist with some having dedicated management support and some have dual roles. PCNs learn, share and work together often, with regular meetings, as well as meeting with the CCG on a weekly basis.

Looking forwards the interface with the CCG is changing with movement to an Integrated Care System. Localities are likely to transfer to PCN footprints and a redesign is required to maintain engagement with General Practice for commissioning and service transformation priorities. A framework is in place now with support from the CCG and LMC to help the transition of thinking and representation of general practice. Subsequent areas of positive growth beyond COVID were explained including population health management, integration and relationships with the wider health and community services, workforce growth and stability of general practice, as well as engagement with service users.

JG appreciated that the report gave a clear picture how the PCNs were progressing and was particularly interested in what the PCNs can achieve beyond COVID and how they will develop when the ICS is formulated. JG asked for a copy of the slides to be circulated to members after the meeting.

JL explained Northumberland has a good infrastructure and expressed her confidence that this will remain the case when ICS changes come into fruition. A discussion was held on how the contracts for PCNs, as they are not formal bodies, and this, their development and how they are resourced will have to be taken into consideration with regard to the management of finances within the new structure.

AT asked about the federation model and whether this was suitable for consideration for practices in Northumberland. PP explained there are federations in Northumberland; West with a provider alliance which is separate entity and Valens with its single practice model. In rurality the variation on demographic and geographical factors does not translate easily into a single provider federation in Northumberland so well. Autonomy of practices being formal businesses with a shift to PCNs is a step towards collaborating together and providing services and a single county federation may not add any benefit to what is already in place at the moment with PCNs.

With regard to patient participation groups (PPGs) DT asked whether it was envisaged each PCN would have a PPG. PP explained this approach had already started to develop. With population health management key for the future, there will be the need to grow and evolve, but it will be pivotal moving forward for development with engagement in our local networks.

JG informed attendees that internal audit is undertaking an audit of the development of PCNs to add to the knowledge of how PCNs were developing, across different areas, as well as sharing best practice. This will add to the growing development and how models are evolving to support future needs and transition of cross practice working.

NPCCC/22/11/01 ACTION: BA to provide members with a copy of the PCN development slides for their information.

NPCCC/22/12 Agenda Item 5 Any Other Business

No items were raised.

NPCCC/22/13 Agenda Item 6 Date and Time of Next Meeting

The next public meeting will be held on Wednesday 13 April at 10:00 am.

NHS Northumberland Clinical Commissioning Group

Public Primary Care Commissioning Committee - REGISTER OF ACTIONS

Log owner: PCCC Chair

DATE: February 2022		**Private Primary Care Commissioning Committee**				
Number	**Date Identified**	**Target Completion Date**	**Description and Comments**	**Owner**	**Status**	**Comment**
NPCCC/21/24/03	14/05/2021	01/09/2021	**Estates** - J Mitchell to investigate the development of Standard Operating Procedures (SOPs) to give to practices when they request changes to premises or work to be undertaken to enable practices to manage the correct processes and stages	J Mitchell	In-progress	Progressing. The SOPs have now been drafted, these are undergoing final review (this has been a little delayed due to Winter pressures and Covid work) however they will be ready for circulation to Practices by the end of March. Update March 2022: **The Estates SOPs are almost complete now and available to be issued to practices as required. As soon as the last remaining SOPs are completed the CCG will send out a communication to practices to let them know these are available to download.**
NPCCC/21/51/02	13/10/2021	01/12/2021	**Recovery of practices** - PP to revisit the progress on the recovery of practices and provide an update at the next PCCC	P Phelps	In-progress	GP recovery was presented at the Oct PCCC and data analysis progressing. Will be presented at other committees, CMB etc. **Update to be provided at next PCCC (April 2022) - combined with LQG data / work being prepared.**
NPCCC/22/08/01	09/02/2022	01/03/2022	**Learning Disabilities DES** – AF to provide members with an updated copy of the Contract Baseline Report containing the corrected information in the learning disabilities DES section.	A Foster	Complete	BA circulated.
NPCCC/22/11/01	09/02/2022	18/02/2022	**PCN Development** - BA to provide members with a copy of the PCN development slides for their information.	B Allsopp	Complete	

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Meeting title	Northumberland Primary Care Commissioning Committee	
Date	13 April 2022	
Agenda item	3.1	
Report title	Finance Update – Month 11	
Report author	Chief Finance Officer	
Sponsor	Chief Finance Officer	
Private or Public agenda	Public	
NHS classification	Official	
Purpose (tick one only)	Information only	✓
	Development/Discussion	✓
	Decision/Action	
Links to Corporate Objectives	Ensure that the CCG makes best use of all available resources	✓
	Ensure the delivery of safe, high quality services that deliver the best outcomes	
	Create joined up pathways within and across organisations to deliver seamless care	
	Deliver clinically led health services that are focused on individual and wider population needs and based on evidence.	
Northumberland CCG/external meetings this paper has been discussed at:	N/A	
QIPP	N/A	
Risks	Strategic Risk 946 – Financial Balance Operational Risk 1983 - Primary Care delegated allocation	

Resource implications	N/A
Consultation/engagement	N/A
Quality and Equality impact assessment	Completed
Research	N/A
Legal implications	CCG statutory financial duties
Impact on carers	N/A
Sustainability implications	N/A

Northumberland Clinical Commissioning Group

QUALITY and EQUALITY IMPACT ASSESSMENT						
1. Project Name	Finance Update – Month 11					
2. Project Lead	**Director Lead**	**Project Lead**				**Clinical Lead**
	Chief Finance Officer	Chief Finance Officer				Clinical Director
3. Project Overview & Objective	Primary Care finance update.					
4. Quality Impact Assessment	**Impact Details**	**Pos/ Neg**	**C**	**L**	**Scores**	**Mitigation / Control**
Patient Safety	N/A					
Clinical Effectiveness	N/A					
Patient Experience	N/A					
Others including reputation, information governance and etc.	N/A					
5.Equality Impact Assessment	**Impact Details**	**Pos/ Neg**	**C**	**L**	**Scores**	**Mitigation / Control**
What is the impact on people who have one of the protected characteristics as defined in the Equality Act 2010?	N/A					
What is the impact on health inequalities in terms of access to services and outcomes achieved for the population of Northumberland? (which is in line with the legal duties defined in the National Health Service Act 2006 as amended by the Health and Social Care Act 2012), for example health inequalities due to differences in socioeconomic circumstances?	N/A					
6. Research *Reference to relevant local and national research as appropriate.*	N/A					
7. **Metrics** *Sensitive to the impacts or risks on quality and equality and can be used for ongoing monitoring.*	**Impact Descriptors**	**Baseline Metrics**				**Target**
	N/A					

8. Completed By	Signature	Printed Name	Date
Chief Finance Officer	**Jon Connolly**	Jon Connolly	31.03.22
Additional Relevant Information:			
8. Clinical Lead Approval by	**Signature**	**Printed Name**	**Date**
Additional Relevant Information:			
9. Reviewed By	**Signature**	**Printed Name**	**Date**
Comments			

Northumberland
Clinical Commissioning Group

Northumberland Primary Care Commissioning Committee
13 April 2022
Agenda Item: 3:1
Primary Care Finance Update – Month 11
Sponsor: Chief Finance Officer

Members of the Northumberland CCG Primary Care Commissioning Committee are asked to:

1. Note the financial position for the first 11 months of 2021-22.

2. Note the financial risks identified.

Purpose

This report presents the financial position for Primary Care that is reported through the Clinical Commissioning Group accounts for the 2021-22 financial year as at 28 February 2022. Appendix 1 shows this position broken down across the relevant areas of primary care expenditure in more detail.

The report is also to update the committee on the temporary financial arrangements put in place by the government in response to the Covid-19 outbreak.

Financial Arrangements for 2021-22

For the 2021-22 financial year the Government extended the temporary financial arrangements that were put in place for NHS Organisations in response to the Covid-19 pandemic.

Integrated Care Partnerships (ICPs) were again given system envelopes to manage within as part of the wider Integrated care systems (ICSs) for the period to 30 September 2021 on the back of these plans.

The envelopes comprise of CCG adjusted allocations, System top up funding and a Covid-19 fixed allocation, these are all based upon the 2020-21 H2 envelopes adjusted by NHSEI for known pressures and policy priorities for 2021-22.

The arrangements for H1 include a continuation of the block arrangements for NHS organisations adjusted for Inflation and distribution of additional specific funding (such as mental health investment (MHIS) or service development funding (SDF)). These arrangements have continued into H2 period, with the addition of an allocation transfer from CCG programme to delegated primary care to cover known pressures in 2021/22.

Delegated Primary Care Reported Position as at 28 February 2022

Appendix 1 sets out the financial position as at Month 11. This currently shows a year-to-date pressure of £0.3m and full year forecast of £1.4m. The pressure reported is mainly due to the costs of PCN additional roles and reimbursement scheme (ARRS) posts and winter access funding (WAF), where the CCG is yet to receive the funding.

The CCG reports its forecast position for additional roles and the winter access fund through the monthly non ISFE finance return. A proportion of the ARRS and WAF budgets are held centrally by NHSEI, and the CCG reports its forecast cost for additional roles and winter access through the ledger and non ISFE in order to highlight and request any additional funding required.

The CCG expects to receive this extra funding on a retrospective basis before the year end. On receipt of the funding the forecast position is expected to be an overall underspend versus plan of £0.3m after receiving ARRS additional funding retrospectively of £1m, and winter access funding of £0.6m.

To note within the position:

- There is a 3.55% uplift to practice contract funding from 20/21 and 0.25% demographic growth.
- Additions / Changes to the Primary Care Network DES have been included:
    - Expansion of additional roles
    - Increase of Care Home Premium payment to £120 per CQC registered bed
    - Investment and Impact Fund included at £0.83 per patient
    - Addition of Long Covid funding of £163k
- Increase in QOF points from 567 to 635 for the new Vaccination and Immunisation and Mental Health Indicators.
- Additional Winter Access Funding (WAF) of £557k received, to improve patient access.
- The overspend position shown for the year to February 2022 and end of year forecast position are due to the timing of additional roles and WAF costs and top up funding (as mentioned above).

Risks are assessed as follows:

- The pressure arising from nationally agreed contract changes have been recurrently funded from Core CCG budgets (currently system top ups under the temporary financial arrangements), therefore creating a recurrent funding problem for the CCG's overall position and the amount of resources available for investment in other areas outside of delegated primary care.
- This risk has again been addressed non-recurrently from system top up funding in the H2 plan.
- Looking forward into the next financial year and the move from CCGs into Integrated Care Boards (ICBs), this pressure has been raised across the ICB footprint and information has been collated for the whole region in looking at how to fund these funding gaps recurrently in the future.

CCG commissioned Primary Care

The CCG also has several other services commissioned with primary care outside of the delegated primary care allocation and they can be seen at the bottom of appendix 1. These areas are also being

reported in line with the temporary financial arrangements in place nationally due to COVID-19 as mentioned earlier.

Out of Hours:

The CCG continues to have an out of hours contract with Vocare limited for the provision of GP out of hour's access in 2021-22.

Primary Care Commissioned Services (PCCS):

The CCG has a service specification of additional Local Enhanced Services available for GP practices to sign up to. Some of the services below, are again income protected for Q3 21-22 and all PCCS services are expected to be fully spent and committed this year.

Quarters 1 & 2 of 2021-2022

- Practices continue to deliver the 2020-2021 PCCS specification
- Income remains protected with automated payments at the 2020-2021 rates to ensure that cashflow is unaffected during COVIDThe exception to this is Digital Dermatology, which commenced on 1 August 2021 to align with ICP level programme.

Quarter 3 & 4 of 2021-2022

- Practice commences delivery of the newly commissioned 2021-22 services including:
- Care Closer to Home
- Digital Dermatology
- Deep Vein Thrombosis community pathway
- Engagement
- Flu Immunisation
- Immune Modifying Drug monitoring in primary care
- Practice Activity Scheme (TBC)
- Practices Medicines Management
- Primary Care Interface with Urgent and Emergency Care pathway
- Primary Care Phlebotomy – evidenced transfer of activity
- Prostate Specific Antigen monitoring in primary care
- Serious Mental illness Physical Health Checks
- Understanding Our Communities
- Equipment Funding Contribution

GP Forward View (GPFV) / Primary Care Transformation (PCT):

The CCG has now received GPFV non-recurrent allocations in H1 and H2, details are shown in appendix 1 finance paper. These allocations are all expected to be fully committed in year.

Access is funded from CCG baseline allocations and is also expected to be fully committed with GP practices this year.

GPIT:

The North of England Commissioning Support Unit (NECS) manages this spend on behalf of the CCG and use it to maintain the GPIT infrastructure in accordance with the core requirements set nationally.

NECS have coordinated all of the primary care IT requirements during the COVID-19 period. This category also contains the costs of other software packages the CCG funds for primary care use including GPTeamNet and Sunquest.

Recommendation

The Committee are asked to:

- Note the financial position for the first 11 months of 2021-22.
- Note the financial risks identified.

Appendix 1: Primary Care Overview M11

Appendix 1

Northumberland CCG Primary Care Overview - Month 11 2021-22

FMR Heading	Detail	Annual Budget (£000's)	YTD Budget (£000's)	YTD Actual (£000's)	YTD Variance (£000's)	Forecast outturn (£000's)	Forecast Variance (£000's)	Description of budget area
General Practice	GMS	10,773	9,875	9,950	75	10,860	87	Payment for core essential services based upon weighted practice list size.
	PMS Contract	24,096	22,080	22,133	53	24,150	54	
	Total	34,870	31,956	32,084	128	35,010	140	
QOF	QOF	5,931	5,437	5,343	(93)	5,829	(102)	Quality and Outcomes Framework (QOF) is a annual reward and incentive scheme for practices based upon achievement against set indicators.
	Total	5,931	5,437	5,343	(93)	5,829	(102)	
Enhanced Services	DES - Learning Disabilities	164	151	199	48	217	53	Additional services provided by practices to assist with local and national population need or priorities. Practices have to sign up to deliver these services.
	DES - Weight management	-	-	15	15	15	15	
	DES - Minor Surgery	528	484	330	(154)	363	(166)	
	DES - Long Covid	163	149	149	(0)	163	-	
	DES - Medical Exemption	2	2	2	0	2	-	
	Winter Access Fund	557	511	109	(402)	1,139	582	
	Northumberland Premium	654	599	598	(1)	654	0	
	Total	2,068	1,896	1,402	(494)	2,553	485	
Premises Cost Reimbursement	Rates	650	596	577	-19	618	(31)	Reimbursements made to practices in respect of their premises costs.
	Rent	3,950	3,621	3,537	(84)	3,841	(109)	
	Water Rates	74	68	58	-9	51	(22)	
	Total	4,674	4,284	4,172	(112)	4,511 -	163	
Other GP Services	CQC Fees	212	195	195	0	207	(5)	Reimbursement to practices for CQC fees
	GP Retainer	98	90	83	(7)	90	(8)	Support scheme for GPs considering leaving the profession.
	Dispensing/Prescribing	1,679	1,539	1,408	(131)	1,549	(130)	Costs of GP prescribing reimbursed on a cost per script basis
	Locum Sickness/Parental	400	366	366	0	460	60	Costs of locum cover for both maternity and sickness.
	Seniority	-	-	-	0	-	-	
	Suspended GP	21	19	6	(13)	8	(13)	Costs of suspended GPs.
	Total	2,410	2,209	2,058	(152)	2,314 -	96	
Primary Care Networks (PCNs)	DES - Extended Hours	477	358	352	(5)	472	(5)	Costs in relation to Primary Care Networks (PCNs). Payments are made in line with national guidance.
	PCN Clinical Director	243	183	179	(4)	240	(4)	
	PCN Participation	657	492	497	4	661	4	
	PCN Additional Roles	2,328	2,087	2,992	905	3,294	966	
	Care Home Premium	415	311	311	0	415	-	
	PCN Leadership Payment	238	218	218	0	238	-	
	PC Networks	-	-	(282)	(282)	-	-	
	Investment & Impact Fund	900	819	1,251	432	1,058	158	
	Total	5,257	4,468	5,519	1,050	6,378	1,120	
GP Support Fund	GP Support Fund	57	57	57	-	57	-	
	Total	57	57	57	-	57	-	
Reserves	Reserves	-	-	-	-	-	-	
	Total	0	0	0	0	0	0	
Grand Total		**55,267**	**50,307**	**50,635**	**327**	**56,651**	**1,384**	
Other CCG funded services								
Out of Hours		2,202	2,019	2,019	0	2,202	0	Main out of hours contract with Vocare LTD, Revised Agreed contract lower than annual budget set.
Primary Care Commissioned Services		2,854	2,616	2,652	36	2,893	39	Local Enhanced service specification schemes plus other schemes including Sharps and Pharmacy first payments and optical contract with Primary eyecare LTD. Spirometry Funding added £150k
GPIT		998	920	925	5	1,003	5	GPIT contract with North of England Commissioning Support Unit. Also includes GPIT resilience non recurrent allocation, Contribution to the HSCN CoIN network, expenditure on Windows 10 upgrade for practices and cost of local primary care software packages including MIG work, SUNQUEST, GP Teamnet.
Primary Care Networks (PCNs)		509	466	466	0	509	0	Additional £1.50 per head funding for establishing PCN's.
Sub Total Other CCG Primary Care Services		**6,563**	**6,021**	**6,062**	**41**	**6,607**	**44**	
GP Forward View Allocations								
GPFV Access funding (REC)		1,958	1,877	1,877	-	1,958	-	Extended access funding as applied to CCG baselines.
Online Consultation Software Systems		94	90	93	2	94	-	NR allocation received in year
Improved GP Access		35	33	33	-	35	-	NR allocation received in year
Practice Resilience		45	43	45	2	45	-	NR allocation received in year
Training Hubs		70	67	67	-	70	-	NR allocation received in year
Fellowships-Core Offer		6	5	3	(2)	6	-	NR allocation received in year
PCN Development		157	151	151	-	157	-	NR allocation received in year
Infrastructure & Resilience		72	69	69	-	72	-	NR allocation received in year
GP Retention		71	65	65	-	71	-	NR allocation received in year
Sub Total GP Forward View		**2,508**	**2,400**	**2,403**	**2**	**2,508**	**0**	
Total CCG Primary Care		**64,338**	**58,728**	**59,099**	**371**	**65,767**	**1,429**	

Northumberland Clinical Commissioning Group

Meeting title	Northumberland Primary Care Commissioning Committee	
Date	13 April 2022	
Agenda item	3.2	
Report title	Quarterly Quality Assurance Report Q2 & Q3 2021/22	
Report author	Head of Performance and Assurance	
Sponsor	Chief Operating Officer and Medical Director	
Private or Public agenda	Public	
NHS classification	Official	
Purpose (tick one only)	Information only	
	Development/Discussion	✓
	Decision/Action	
Links to Corporate Objectives	Ensure that the CCG makes best use of all available resources	
	Ensure the delivery of safe, high quality services that deliver the best outcomes	✓
	Create joined up pathways within and across organisations to deliver seamless care	
	Deliver clinically led health services that are focused on individual and wider population needs and based on evidence.	
Northumberland CCG/external meetings this paper has been discussed at:	N/A	
QIPP	N/A	
Risks	Strategic Risk 407 – National and local agreed outcomes	
Resource implications	N/A	
Consultation/engagement	Patient, public, stakeholder, clinical.	

Quality and Equality impact assessment	Completed.
Data Protection Impact Assessment	N/A
Research	N/A
Legal implications	N/A
Impact on carers	N/A
Sustainability implications	N/A

QUALITY and EQUALITY IMPACT ASSESSMENT						
1. Project Name	Quarterly Quality Assurance Report Q2 & Q3 2021/22					
2. Project Lead	**Director Lead**	**Project Lead**			**Clinical Lead**	
	Chief Operating Officer	Head of Performance and Assurance			Medical Director	
3. Project Overview & Objective	This report provides a quarterly assurance update on the quality of primary medical services.					
4. Quality Impact Assessment	**Impact Details**	**Pos/ Neg**	**C**	**L**	**Scores**	**Mitigation / Control**
Patient Safety	N/A					
Clinical Effectiveness	N/A					
Patient Experience	N/A					
Others including reputation, information governance and etc.	N/A					
5.Equality Impact Assessment	**Impact Details**	**Pos/ Neg**	**C**	**L**	**Scores**	**Mitigation / Control**
What is the impact on people who have one of the protected characteristics as defined in the Equality Act 2010?	N/A					
What is the impact on health inequalities in terms of access to services and outcomes achieved for the population of Northumberland? (which is in line with the legal duties defined in the National Health Service Act 2006 as amended by the Health and Social Care Act 2012), for example health inequalities due to differences in socioeconomic circumstances?	N/A					
6. Research *Reference to relevant local and national research as appropriate.*	N/A					
7**. Metrics** *Sensitive to the impacts or risks on quality and equality and can be used for ongoing monitoring.*	**Impact Descriptors**	**Baseline Metrics**			**Target**	
	N/A					
	N/A					
	N/A					
8. Completed By		**Signature**			**Printed Name**	**Date**
Senior Clinical Quality Officer		**Sara Anderson**			Sara Anderson	21/03/22

Additional Relevant Information:			
8. Clinical Lead Approval by	**Signature**	**Printed Name**	**Date**
Additional Relevant Information:			
9. Reviewed By	**Signature**	**Printed Name**	**Date**
Comments			

Northumberland Clinical Commissioning Group

Northumberland Primary Care Commissioning Committee
13 April 2022
Agenda Item: 3.2
Quarterly Quality Assurance Report Q2 & Q3 2021/22
Sponsor: Chief Operating Officer

Members of the Northumberland Primary Care Commissioning Committee are asked to:

1. **Consider the 2021/22 Q2 & Q3 quality assurance update and provide comment.**

Purpose

This report provides the 2021/22 Q2 and Q3 quality assurance update which consists of review outcomes by the Primary Care Quality and Sustainability Panel and findings of Care Quality Commission (CQC) inspections.

Background

In April 2013, NHS England (NHSE) published the Primary Medical Services Assurance Framework. The framework sets out a 3-stage assurance process:

- Stage 1: Intelligence gathering and Local Assurance Meeting at NHSE
- Stage 2: Local Quality Group (LQG) at NHS Northumberland Clinical Commissioning Group (CCG) level to review data shared by NHSE
- Stage 3: Escalation from CCG to NHSE for formal contract management if deemed necessary.

As a delegated commissioner of primary medical services, the CCG convened its first LQG meeting in July 2016. Subsequent meetings are held after receipt of NHSE, QOF and other locally generated quarterly data.

The CCG has built on the above process and developed an enhanced Quality Assurance Framework. This revised framework was shared with PCCC in December 2019.

GP Quality Dashboard

At the time of carrying out the assessment in Quarter one, there was increased access to more recent data from NHS England compared to previous quarters. As a part of generating some resilience for the management of COVID-19 some of the earlier data from the national data sets was not available. This is likely to remain an issue for an increased time to come. Where possible the CCG local data has been used to overcome this issue.

Many practices across both the CCG and the country were asked by NHS England / Improvement to prioritise their workload and workforce. This prioritisation was to ensure a robust COVID-19 vaccine delivery programme and to ensure all patients registered are risk stratified, their needs identified and those at greatest risk have access to the care and support they need. The vaccination programme continues to be delivered successfully with the performance reported within Northumberland to be one of the strongest both within the region and across the country.

The CCG also continues to monitor overall performance, identifying where the greatest emphasis will be required when services begin to return to more routine work. A COVID recovery monitoring process is in place for General Practice, as with other parts of the health and care system in Northumberland.

Quarter 2 and Quarter 3 2021/22 Updates

It should be acknowledged that general practice remains under significant pressure due to the COVID pandemic and recovery. It has been important that the local quality group monitors performance and at the same time ensure that all practices receive the support that they need from the CCG during these unprecedented times.

The Local Quality Group undertook a review of the indicators and in this report will focus on areas to focus upon the following areas:

- Performance indicators for the Medicine management indicators, Cervical screening, SMI Mental Health and Learning Disability checks.
- Clinical indicators within the NHSE / CCG indicator set
- Safeguarding
- Sustainability visits and outcomes

Performance indicators

Cervical Screening – Quarter 2

The most recent cervical screening related to the Quarter 2 position. Overall Northumberland was placed 3rd highest performing CCG in the country with an overall average of 78.2% in relation to screening 25 to 49 years old. The practice performance ranged from 70.3% to 87.1%.

Within the 50 to 64 years old cervical screening group Northumberland was placed 6th compared to other organisations within the country with an overall average of 78.5%. The range of practice performance was between 69% - 88.5%. The Local Quality Group noted that most GP practices not achieving in Quarter 1 reported an improved performance in Quarter 2.

Action - The CCG has provided additional funding to support practices as they recover their cervical screening services.

Q2 2021/22 performance (compared to Q1 2021/22)			
Cervical screening age range (Target 80%)	**CCG**	**England**	**Practice Range**
25 -49 years	78.2% (77.2)	68.6% (68.9%)	70.3% - 87.1% (69.8% - 86.7%)
50 – 64 years	78.5% (77.8%)	75% (75%)	69% - 88.5% (66.9% - 88.6%)

Cervical Screening – Quarter 3

The release of the 2021/22 Q3 Cervical data is awaited so no update was available at the time of producing this report.

Medicines Management – Quarter 2 and Quarter 3

The quarterly performance for the practice medicine management (PMM) indicators overall, remains strong across the CCG. There has been no issues or risks identified via the Medicines Management group and overall, at present risks are low.

Serious Mental Illness annual health checks – Quarter 2

The overall SMI health checks performance for Northumberland improved when compared with the previous quarter's performance. In Quarter 2 the performance was reported at 32.62% compared with 31.45% in the previous quarter against the national target of 60%.

Serious Mental Illness annual health checks – Quarter 3

The overall SMI health checks performance for Northumberland improved when compared to the previous quarter's performance. In Quarter 3 the performance was reported at 33.81% compared with 32.62% in the previous quarter against the national target of 60%.

Action - This health check process has been adapted for both EMIS and SystmOne practices as a standardised approach. SMI health checks are included in the 2021/22 PCCS incentive scheme. The combination of both these initiatives is expected to achieve the 60% target by the end of the financial year. GP practices are now actively planning appointments for patients who have not had a recent health check and CCG leads continue to work with practices.

Learning disability annual health checks – Quarter 2

The CCGs overall average performance has increased in Quarter 2 to 27.1% compared to 11.9% in Quarter 1.

Learning disability annual heath checks – Quarter 3

The CCGs overall average performance has increased in Quarter 3 to 40.8% compared to 27.1% in Quarter 2.

The CCG has not achieved its target for learning disability checks despite significant effort from all practices in difficult circumstances. Patients with a learning disability suffer health inequality and need to be reviewed annually. The actions being taken to address this drop in numbers, which have been multifactorial, includes:

- Blood bottle stocks and provision was at crisis point and the back log of long-term condition management required rationing of blood bottles in this county for about 6 months of 2021. This was raised regionally and nationally as it was not a similar picture throughout England.
- Administration and clinical workforce were hit by unprecedented covid numbers even within the pandemic of 2020, this continues to be the case now, perhaps worse than ever in Feb/March 2022.
- Staff absence rate has an impact as these patients need reasonable adjustments to attend, such as longer appointments, the right family member/carer with them who knows them best to tell the story or relay the information. The cascade effect of one member of staff being off makes a difference to the attendance rate and ability to fit in another appointment.
- General clinical workforce shortage in primary care is challenging.

Actions

- Support given to GP practices with clinical issues from lead clinicians
- Regular updates in clinical areas
- Support to practices with the community learning disability team for those patients who find our services hard to reach,
- For those finding vaccinations difficult, vaccinations are able to be done at home/placement
- Learning from LeDeR death reviews continue to find areas to improve upon in our pathways

Review of clinical indicators

The CCG has reviewed again each practice's performance against a wide range of clinical indicators which include the long-term health checks for Coronary Heart disease, Respiratory and Diabetes. Urgent care intervention is also included.

Whilst it is realised that with the prioritisation of COVID19 activities has taken priority over carrying out some of these activities, where practices have been identified as an outlier, the CCG has reviewed whether the practice's underperformance is deteriorating, constant or improving over recent quarters. Where the performance is either deteriorating or is constant, the CCG will support the practices recovery over future months through more in-depth monitoring and closer working.

There are 21 clinical indicators used which all have targets set against them:

- 5 x diabetes indicators
- 6 x public health indicators

- 2 x mental health indicators
- 3 x respiratory indicators
- 3 x coronary heart disease indicators
- 2 x medicines management indicators

Some practices are showing as an outlier as they have not submitted any data. In Quarter 2, four practices have been flagged as they have not submitted data, this in turn causes the reporting to be inaccurate and leaves gaps.

Serious incidents

There were no serious incidents reported during this period relating to GP practices within Northumberland.

Safeguarding

There are no safeguarding issues in relation to practices raised during the period of review.

The named nurse Primary care (NNPC) continues to support GP practices with Safeguarding in primary care. To date the NNPC has attended 34 practices 'supporting families' meetings either face to face or via teams. Attendance at these meetings allow the NNPC to share learning from Case Reviews and CQC inspections, to discuss any training needs or training opportunities for Primary Care staff in addition to supporting and advising on safeguarding concerns.

The NNPC has delivered a number of lunch and learn sessions via MS Teams with a particular focus on domestic abuse. Recent local Domestic Homicide reviews (DHRs) had identified learning for Primary Care. The recommendations from the DHR included:

- reiterating the importance of coding health records for vulnerability and domestic abuse
- a reminder to primary care staff of the facility to discuss complex patients in practice MDT meetings
- GPs to be more proactive with repeat DNA's/ WNB of complex patients and exercise professional curiosity.

Sustainability visits

Sustainability visits have continued to be delivered remotely for the remainder of 20 21/22.

With the easing of covid restrictions over the last quarter, it is the intention that visits planned for 2022/23 may be offered face-to-face if this is the preferred method of practices.

The most common themes that continue to be discussed during the meetings include:

- The wellbeing of staff during the COVID-19 pandemic and the on-going recovery of general practice.
- The management of the workload – balancing staffing and capacity, with delivering healthcare services, alongside practice recovery plans

- Digital requirements and the infrastructure required to support practices.
- Development of the Primary Care Networks (PCNs)
- Management of estates – both generating capacity to resource the management of COVID-19 patients and the growing workforce in PCNs, along with the vaccination programmes and the reconfiguration of practice surgeries including the closure of branch surgeries.

Care Quality Commission (CQC) Update

It is expected that the CQC will be back to 'business as usual' in April 2022 and therefore back to carrying out site visits. Additional changes are expected once the Integrated Care Board (ICB) is established. The way the CQC are going to work in related to visits will change and will be managed on a risk-based model (risk bands 1-3).

Action: The CCG has requested that the CQC give advance notice of visits to ensure requests for information are dealt with in a timely way. This will also enable the CCG to triangulate what is required.

Action: Meetings between the CCG and CQC will be reinstated to on a monthly basis**.**

Five practices were previously identified and written to in September 2021. Of these practices four have shown an improving trend in performance across a number of clinical indicators, and they will be receiving letters to affirm this. One has also shown improvement however it still has outlying performance indicators which need addressing and a letter will be sent to ask for an update on their recovery.

A further practice which has been identified as an outlier on the indicator dashboard. The main areas of focus are upon diabetes care and A&E attendances and they will be contacted by letter to ask for assurance that these issues are being addressed.

Many have raised concerns about the additional burden this has placed upon them. A number of themes has emerged from the practice responses including their QOF achievement. This work was paused nationally during the height of the pandemic, and it is taking time to recover performance due to staff absences and the ongoing vaccine programme. Consequently, QOF achievement cannot be a reliable measure of quality for the remainder of this year.

The level 2 indicators for medicines management (MM03 & MM04) are already addressed through the medicines optimisation team and there are no areas of clinical concern.

None of the practices identified demonstrate any significant clinical concerns.

Summary

Of the five practices that received a letter from CCG there has been an improving trend in performance across a number of clinical indicators over the last 2 quarters. A further practice

has been identified as an outlier on the performance dashboard and will be contacted by the CCG to seek assurance.

Recommendation

The Primary Care Commissioning Committee is asked to consider the quality assurance update and provide comment.