Thursday 25 August 2022
09:00am to 12:00noon
Via Teams invite

NHS
Cheshire and Merseyside

Meeting of the System Primary Care Committee

Agenda

Chair: Erica Morriss

AGENDA NO & TIME	ITEM	LEAD	ACTION / PURPOSE	PACK PAGE NUMBER
09:00am	**Preliminary Business**			
PCC/8/22/01	Welcome, Introductions and Apologies Anthony Leo, Place Director - Halton Delyth Curtis, Place Director – Cheshire West Tony Foy, Non Executive Director Matt Harvey, Liverpool Local Pharmaceutical Committee (LPC) representative	Chair	Verbal	-
PCC/8/22/02	Declarations of Interest *(members are asked to declare if there are any declarations in relation to the agenda items or if there are any changes to those published in the ICB Register of Interests)*	Chair	Verbal	-
09:10am	**Establishing the System Primary Care Committee**			
PCC/8/22/03 10 minutes	Terms of Reference	CW	Paper Approval	3
09:20am	**ICB System Level Assurance and Overview**			
PCC/8/22/04 15 minutes	Primary Care Operating Model – Progress Paper and presentation	CW	Paper Assurance	17
PCC/8/22/05 15 minutes	Policy and Contracting Update	CL	Paper Assurance	30
PCC/8/22/06 15 minutes	GP Patient Survey 2022 – Overview	RPJ	Paper Assurance	41
PCC/8/22/07 15 minutes	Primary Care Finance Report (excel document attached separately)	MB	Paper Assurance	63
PCC/8/22/08 10 minutes	Dispute Resolution Process	CL	Paper Decision	70
10:30	**Pharmacy Specific – Update**			
PCC/8/22/09 10 minutes	Pharmaceutical Services Regulations Committee – Update and Minutes from last meeting	TK	Paper Information	83
10:40	**Comfort break**			
10:50	**Place Specific – Escalation Issues and Updates**			
PCC/8/22/10 20 minutes	Knowsley – Primary Care PMS/Finance Update	AF	Paper Assurance	89

AGENDA NO & TIME	ITEM	LEAD	ACTION / PURPOSE	PACK PAGE NUMBER
PCC/8/22/11 20 minutes	West Cheshire – Hope Farm List Closure Recommendation	LM	Paper Ratification of Decision	283
	West Cheshire – Blacon New Build	LM	Paper Ratification of Decision	
	Willason Weekend Hours	LM	Paper Ratification of Decision	
PCC/8/22/12 10 minutes	Warrington – Enhanced Access Consultation	KH	Paper Assurance	317
11:40	**Non Aligned Primary Care – Dental/Opthalmic**			
PCC/8/22/13 10 minutes	Dental and General Opthalmic Services – Update on Assurance Process and Next Steps	CL/TK	Tabled Assurance	
PCC/8/22/14 10 minutes	Pre Delegation Assessment Framework Template – Dental and General Opthalmic Services (GOS)	CL	Document Information	323
	AOB / CLOSE OF MEETING			

Date and time of next meeting:

20th October 2022, Venue TBA

Lead Initials	Name and position
CW	Clare Watson, Assistant Chief Executive
CL	Christopher Leese, Associate Director of Primary Care (Cheshire East/Cheshire West)
MB	Mark Bakewell, Deputy Director of Finance
RPJ	Professor Rowan Pritchard-Jones, Medical Director
TK	Tom Knight, Head of Primary Care, NHS England and NHS Improvement NW
AF	Alistair Macfarlane, Head of Primary Care Transformation (Knowsley)
LM	Laura Marsh, Associate Director of Transformation & Partnerships, Cheshire West
KH	Katie Horan, Senior Engagement and Equality Manager (Warrington/Halton)

Meeting Quoracy arrangements:
Quorum for meetings of the System Primary Care Committee will be :

At least five Committee members are present in total, including:

- At least one Non Executive Director or System Partner*
- At least one Clinical Member*
- At least two ICB Directors (or their nominated deputies)

*If regular members are not able to attend they should make arrangements for a representative to attend and act on their behalf

NHS
Cheshire and Merseyside

NHS C&M ICB
System Primary Care Meeting

Committee Terms of Reference

25 August 2022

Report author & contact details	Rebecca Knight, Head of Assurance & Risk (Halton / Warrington) Rebeccaknight1@nhs.net
Report approved by (sponsoring Director)	The Committee Terms of Reference were approved by the C&M ICB Board at the meeting held on 01 July 2022. The report has been approved by Clare Watson, Assistant Chief Executive.
Responsible Officer to take actions forward	Clare Watson, Assistant Chief Executive

Cheshire and Merseyside ICB
System Primary Care meeting

Committee Terms of Reference

Executive Summary	NHS Cheshire & Merseyside Integrated Care Board met on 01 July 2022. The draft Terms of Reference for the System Primary Care Committee were reviewed and approved at the above meeting. The Terms of Reference are attached for information.				
Purpose (x)	**For information / note**	**For decision / approval**	**For assurance**	**For ratification**	**For endorsement**
	X				
Recommendation	**The Committee is asked to:** • Note the approved Terms of Reference • Identify any key points where amendments may be needed				
Key issues	N/A				
Key risks	N/A				
Impact (x) (further detail to be provided in body of paper)	**Financial**	**IM &T**	**Workforce**	**Estate**	
	Legal	**Health Inequalities**	**EDI**	**Sustainability**	
	X				
Route to this meeting	As described earlier, the Terms of Reference have been approved by the NHS C&M ICB at its meeting held on 01 July 2022.				
Management of Conflicts of Interest	N/A				
Patient and Public Engagement	N/A				
Next Steps	In the event of any proposed amendments, these will be captured in a report to the next NHS C&M ICB meeting				
Appendices	System Primary Care Committee Terms of Reference				

Glossary of Terms	**Explanation or clarification of abbreviations used in this paper**

NHS
Cheshire and Merseyside

C&M ICB

System Primary Care Committee

Terms of Reference

Document revision history

Date	Version	Revision	Comment	Author / Editor
XX	1.0	Initial ToRs		Ben Vinter

Review due
Xxx xxx 2022/3

1. Introduction

NHS C&M has been established to

- improve outcomes in population health and healthcare
- tackle inequalities in outcomes, experience and access
- enhance productivity and value for money
- help the NHS support broader social and economic development

The System Primary Care Committee has been established to oversee the ICB's exercise of its statutory powers relating to the provision of primary medical services under the NHS Act 2006, as amended by the Health and Care Act 2022,

2. Purpose

NHS C&M has established a series of Primary Care Committees (nine of which sit within place-based arrangements, the tenth being a System-wide Primary Care Committee with oversight of the full Cheshire & Merseyside area) to function as the corporate decision-making forum for the management of the delegated functions and the exercise of the delegated powers.

These Terms of Reference relate to the NHS C&M System-wide Primary Care Committee. Please see separate Place-Based Primary Care Committee ToR for the role of those committees within each place.

3. Statutory Framework

The Health and Care Act 2022 amends the NHS Act 2006 by inserting the following provisions:

13YB Directions in respect of functions relating to provision of services

(1) NHS England may by direction provide for any of its relevant functions to be exercised by one or more integrated care boards.

(2) In this section "relevant function" means—

(a) any function of NHS England under section 3B(1) (commissioning functions);

(b) any function of NHS England, not within paragraph (a), that relates to the provision of—

(i) primary medical services,

(ii) primary dental services,

(iii) primary ophthalmic services, or

(iv) services that may be provided as pharmaceutical services, or as local pharmaceutical services, under Part 7;

(c) any function of NHS England by virtue of section 7A or 7B (exercise of Secretary of State's public health functions);

(d) any other functions of NHS England so far as exercisable in connection with any functions within paragraphs (a) to (c).

82B Duty of integrated care boards to arrange primary medical services

(1) Each integrated care board must exercise its powers so as to secure the provision of primary medical services to such extent as it considers necessary to meet the reasonable requirements of the persons for whom it has responsibility.

(2) For the purposes of this section an integrated care board has responsibility for— (a) the group of people for whom it has core responsibility (see section 14Z31), and (b) such other people as may be prescribed (whether generally or in relation to a prescribed service).

In exercising its functions, NHS C&M must comply with the statutory duties set out in NHS Act, as amended by the Health and Care Act 2022, including:

a) Having regard to and acting in a way that promotes the NHS Constitution (section 2 of the Health Act 1989 and section 14Z32 of the 2009 Act);
b) Exercising its functions effectively, efficiently and economically (section 14Z33 of the 2006 Act);
c) section 14Z34 (improvement in quality of services),
d) section 14Z35 (reducing inequalities),
e) section 14Z38 (obtaining appropriate advice),
f) section 14Z40 (duty in respect of research),
g) section 14Z43 (duty to have regard to effect of decisions)
h) section 14Z44 (public involvement and consultation),
i) sections 223GB to 223N (financial duties), and
j) section 116B(1) of the Local Government and Public Involvement in Health Act 2007 (duty to have regard to assessments and strategies).

In addition NHS C&M will follow the Procurement, Patient Choice and Competition (no2) Regulations 2013 and any subsequent procurement legislation that applies to the ICB.

4. Delegated Powers and Authority – Role of the Committee

The Committee is established as a Committee of NHS C&M Integrated Care Board (ICB) in accordance with the NHS Act, as amended by the Health and Care Act 2022, and is subject to any directions made by NHS England or by the Secretary of State.

The Committee has been established in accordance with the above statutory provisions to enable collective decision-making on the review, planning and procurement of primary care services in relation to GP primary medical services and community pharmacy as part of the NHS C&M's statutory commissioning responsibilities across Cheshire & Merseyside under delegated authority from NHS England.

In performing its role, the Committee will exercise its management of the functions in accordance with the agreement entered into between NHS C&M and NHS England. The agreement will sit alongside the delegation and terms of reference in accordance with the NHS C&M constitution.

In carrying out its role, the Committee will work alongside the nine place-based Primary Care Committees, providing oversight and assurance of effective primary care services across Cheshire & Merseyside. The Committee will also work closely with the Pharmaceutical Services Regulations Committee (PSRC).

The functions of the Committee are undertaken in line with NHS C&M's desire to promote increased co-commissioning to increase quality, efficiency, productivity and value for money and to remove administrative barriers.

4.1 Commissioning of Primary Medical Services

The role of the System Primary Care Committee shall be to oversee, coordinate and promote alignment of the functions amongst Places relating to the commissioning of primary medical services under section 82B of the NHS Act in relation to GP primary medical services and community pharmacy. This includes the following:

- Develop a system-wide Primary Care Strategy including implementing the GP Forward View, or successor, through robust contractual arrangements with general practices and appropriate developmental support.
- To review and consider the aggregate position of agreed service specifications and contractual proposals for all NHS C&M commissioned services from primary care providers
- Develop outline framework/ expectations in regard to GMS, PMS and APMS contracts (including the oversight and monitoring of contracts, approving material contractual action such as removing a contract)
- Newly designed enhanced services
- Performance monitoring, oversight and assurance, on agreed schemes and services, and compliance to NHSE/I; escalating issues on to NHSE/I in line with first level Delegation
- Making recommendations related to alignment of decisions on 'discretionary' payment in Place (e.g., returner/retainer schemes).
- To co-ordinate a common approach to the commissioning and delivery of primary care services
- To manage the budget for commissioning of primary care services, including delegated rents and rates in line with Premises Directions.

4.2 Commissioning of Community Pharmacy

- Develop outline framework/ expectations in regard to Community Pharmacy – National requirements Core and Enhanced. Including associated budgets, quality assurance and all existing NHSEI functions.
- Local discretionary/ non-core schemes

4.3 Additional responsibilities

- The NHS C&M Primary Care Committee will also carry out the following activities:
- Support Primary Care development across Cheshire & Merseyside including oversight of:
- primary care networks (PCNs) ongoing development as the foundations of out-of-hospital care and building blocks of place-based partnerships
- Workforce, resilience and sustainability
- Maximisation of GP Contract opportunities such as ARRS (Additional roles) and QOF outcomes
- To plan, including needs assessment, for primary care services across Cheshire & Merseyside and to support planning at scale for primary care
- Oversight of the development of an integrated Estates programme across Cheshire & Merseyside

- To consolidate risk reviews of primary care services, aggregating findings and supporting solutions/ mitigations at places
- To ensure contract proposals achieve health improvement and value for money
- To oversee quality and safety of services delivered in primary care – receiving regular reports from the ICB Quality and Performance Committee and Finance, Investment and Our Resources Committee providing updates and assurance on primary care related quality, finance and performance issues
- Ensure that conflicts of interest have been mitigated in line with the NHS C&M Conflicts of Interest Policy, and all actions/ decisions involving consultation with Committee members or GPs will record any declarations of interest.
- Development of an integrated Estates programme at local level using flexibilities available through PCN arrangements, mixed estates with other partners, premises improvement grants and capital investment monies
- Ratifying time limited Place based recommendations related to this committee's remit or determining to 'call-in' such a recommendation and provide an alternative course of action

4.4 Risk Management

The Committee will ensure the appropriate management of risks in relation to primary care; receiving regular reporting of primary care related Corporate Risks, and relevant Board Assurance Framework (BAF) – these will include reference to relevant Place Delivery Assurance risks – both strategic and corporate as per NHS C&M Risk Management Strategy.

5. Membership & Attendance

5.1 Members

The membership shall consist of the following voting members:

- At least 1 ICB NED (Chair)
- At least 1 ICB Partner Member (1 to be the Deputy Chair)
- Assistant Chief Executive (or Deputy)
- Associate Director of Primary Care
- Representative from each of the recognised primary care professional groups in accordance with the remit of the Committee (i.e. general practice and community pharmacy)
- Director of Nursing
- Director of Finance
- Medical Director (or Associate Medical Director for Primary Care)
- Independent GP
- At least 2 Place Directors or designate

In attendance by invitation:

- Healthwatch nominated representative
- Public Health representative
- Local Medical Committee (LMC) representative
- Pharmaceutical Services Regulations Committee (PSRC) representative

All Committee members may appoint a deputy to represent them at meetings of the Committee. Committee members should inform the Chair of their intention to nominate a deputy to attend/act on their behalf and any such deputy should be suitably briefed and suitably qualified (in the case of clinical members).

The Committee may also request attendance by appropriate individuals to present agenda items and/or advise the Committee on particular issues.

5.2 Attendees

Only members of the Committee have the right to attend Committee meetings, but the Chair may invite relevant staff to the meeting as necessary in accordance with the business of the Committee.

Meetings of the Committee may also be attended by the following individuals who are not members of the Committee for all or part of a meeting as and when appropriate. Such attendees will not be eligible to vote.

The Chair may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussion of particular matters.

6. Meetings

6.1 Leadership

The Committee is Chaired by an ICB NED.

6.2 Quorum

A meeting of the Committee is quorate if the following are present:

- At least five Committee members in total, including;
  - At least one NED or system Partner*
  - At least one Clinical Member*
  - At least two ICB Directors (or their nominated deputies).

**If regular members are not able to attend they should make arrangements for a representative to attend and act on their behalf.*

6.3 Decision-making and voting

Decisions should be taken in accordance with the financial delegation of the Executive Directors and directors present and/or any authority delegated to the committee by the ICB. These terms of reference will be reviewed against the ICB Scheme of Reservation and Delegation once that document is formally approved by the ICB.

The Committee will usually make decisions by consensus. Where this is not possible, the Chair may call a vote.

Only voting members, as identified in the “Membership” section of these terms of reference, may cast a vote.

A person attending a meeting as a representative of a Committee member shall have the same right to vote as the Committee member they are representing.

In accordance with ICB policy, no member (or representative) with a conflict of interest in an item of business will be allowed to vote on that item.

Where there is a split vote, with no clear majority, the Chair will have the casting vote.

6.4 Frequency

The Committee will normally meet in private.

The Committee will normally meet six times each year and arrangements and notice for calling meetings are set out in the Standing Orders. Additional meetings may take place as required.

The Board, ICB Chair, Committee Chair, or Chief Executive may ask the Committee to convene further meetings to discuss particular issues on which they want advice.

In accordance with the Standing Orders, the Committee may meet virtually when necessary and members attending using electronic means will be counted towards the quorum.

6.5 Administrative Support

The Committee shall be supported with a secretariat function. Which will include ensuring that:

- The agenda and papers are prepared and distributed in accordance with the Standing Orders having been agreed by the Chair with the support of the relevant executive lead
- Records of members' appointments and renewal dates are retained and the Board is prompted to renew membership and identify new members where necessary
- Good quality minutes are taken in accordance with the standing orders and agreed with the chair and that a record of matters arising, action points and issues to be carried forward are kept
- The Chair is supported to prepare and deliver reports to the Board
- The Committee is updated on pertinent issues/ areas of interest/ policy developments; and
- Action points are taken forward between meetings.

6.6 Accountability and Reporting Arrangements

The Committee is accountable to the Board and shall report to the Board on how it discharges its responsibilities.

The minutes of the meetings shall be formally recorded by the secretary and submitted to the Board.

The Committee will submit copies of its minutes and a key issues report to the ICB following each of its meetings. The Committee will also provide a key issues report to each of the place-based

primary care committees and will receive an equivalent report from each of the place-based primary care committees.

The Committee will receive regular key-issues reports from the Pharmaceutical Services Regulations Committee (PSRC).

The Committee will provide the Board with an Annual Report. The report will summarise its conclusions from the work it has done during the year.

The outputs of the group may be reported to NHSE/I supporting assurance, awareness and interaction.

7. Behaviours & Conduct

Members will be expected to conduct business in line with the ICB values and objectives and the principles set out by the ICB.

Members of, and those attending, the Committee shall behave in accordance with the ICB's constitution, Standing Orders, and Standards of Business Conduct Policy.

All members shall comply with the ICB's Managing Conflicts of Interest Policy at all times. In accordance with the ICB's policy on managing conflicts of interest, Committee members should:

- Inform the chair of any interests they hold which relate to the business of the Committee.
- Inform the chair of any previously agreed treatment of the potential conflict / conflict of interest.
- Abide by the chair's ruling on the treatment of conflicts / potential conflicts of interest in relation to ongoing involvement in the work of the Committee.
- Inform the chair of any conflicts / potential conflicts of interest in any item of business to be discussed at a meeting. This should be done in advance of the meeting wherever possible.
- Declare conflicts / potential conflicts of interest in any item of business to be discussed at a meeting under the standing "declaration of interest" item.
- Abide by the chair's decision on appropriate treatment of a conflicts / potential conflict of interest in any business to be discussed at a meeting.

As well as complying with requirements around declaring and managing potential conflicts of interest, Committee members should:

- Comply with the ICB's policies on standards of business conduct which include upholding the Nolan Principles of Public Life
- Attend meetings, having read all papers beforehand
- Arrange an appropriate deputy to attend on their behalf, if necessary
- Act as 'champions', disseminating information and good practice as appropriate
- Comply with the ICB's administrative arrangements to support the Committee around identifying agenda items for discussion, the submission of reports etc.

Equality diversity and inclusion
Members must demonstrably consider the equality, diversity and inclusion implications of decisions they make.

8. Review

The Committee will review its effectiveness at least annually

These terms of reference will be reviewed at least annually and earlier if required. Any proposed amendments to the terms of reference will be submitted to the Board for approval.

SCHEDULE 1 – DELEGATED FUNCTIONS

A. Decisions in relation to the commissioning, procurement and management of Primary Medical Services Contracts, including but not limited to the following activities:

   i. decisions in relation to Enhanced Services
   ii. decisions in relation to Local Incentive Schemes (including the design of such schemes)
   iii. decisions in relation to the establishment of new GP practices (including branch surgeries) and closure of GP practices
   iv. decisions about 'discretionary' payments
   v. decisions about commissioning urgent care (including home visits as required) for out of area registered patients

B. The approval of practice mergers
C. Planning primary medical care services in the Area, including carrying out needs assessments
D. Undertaking reviews of primary medical care services in the Area
E. Decisions in relation to the management of poorly performing GP practices and including, without limitation, decisions and liaison with the CQC where the CQC has reported non-compliance with standards (but excluding any decisions in relation to the performers list)
F. Management of the Delegated Funds in the Area
G. Premises Costs Directions functions
H. Co-ordinating a common approach to the commissioning of primary care services with other commissioners in the Area where appropriate; and
I. Such other ancillary activities as are necessary in order to exercise the Delegated Functions.

SCHEDULE 2 – RESERVED FUNCTIONS OF NHSE

A. Management of the national performers list
B. Management of the revalidation and appraisal process
C. Administration of payments in circumstances where a performer is suspended and related performers list management activities
D. Capital Expenditure functions
E. Public Health Section 7A functions under the NHS Act
F. Functions in relation to complaints management
G. Decisions in relation to the Prime Minister's Challenge Fund; and
H. Such other ancillary activities that are necessary in order to exercise the Reserved Functions

NHS
Cheshire and Merseyside

Committee Report

NHS Cheshire and Merseyside
System Primary Care Committee

Date: 25th August 2022

NHS Cheshire and Merseyside
Primary Care Committee (System Level)

NHS Cheshire and Merseyside

Date of meeting:	25th August 2022
Agenda Item No:	PCC/8/22/04
Report title:	**Primary Care Update TOM (Target Operating Model) Progress and Next Steps**
Report Author & Contact Details:	Christopher Leese Associate Director of Primary Care c.leese@nhs.net
Report approved by:	Clare Watson, Assistant Chief Executive

Purpose and any action required	**Decision/ Approve** →		**Discussion/ Gain feedback** →	x	**Assurance** →	x	**Information/ To Note** →	**X**

Route to this meeting / Committee/Advisory Group previously presented to (if applicable)

Executive Summary and key points for discussion

This paper is to provide the Primary Care Committee with an overview of the agreed operating model for Primary Care including (1) agreed Governance and discharge of functions (2) Next Steps for further development and refinement.

Appendix 1 details

- the agreed Operating Model for Day 1 of Primary Care
- the draft Terms of Reference for the Place level Primary Care Committees to under pin the governance arrangements which have yet to be formally signed off and agreed.

Recommendation/ Action needed:	**The Committee is asked to:** Note the updates in respect of the Primary Care TOM (Target Operating Model) which is ***for information and assurance***

Which purpose(s) of an Integrated Care System does this report align with?

Please insert **'x'** as appropriate:

1. Improve population health and healthcare	**x**
2. Tackle health inequality, improving outcome and access to services	**x**
3. Enhancing quality, productivity and value for money	**x**
4. Helping the NHS to support broader social and economic development	

C&M ICB Priority report aligns with:

Please insert **'x'** as appropriate:

1. Delivering today	**x**
2. Recovery	**x**
3. Getting Upstream	**x**

C&M ICB Priority report aligns with:	
4. Building systems for integration and collaboration	x

Place Priority(s) report aligns with: *(Place to add)*	
Please insert **'x'** as appropriate:	

Governance and Risk

Does this report provide assurance against any of the risks identified in the ICB Board Assurance Framework or any other corporate or Place risk? **No**					
What level of assurance does it provide?					
Limited		**Reasonable**	**X**	**Significant**	
Any other risks? **YES** If **YES** please identify within the main body of the report.					
Is this report required under NHS guidance or for a statutory purpose? (*please specify*) **NO**					
Any **Conflicts of Interest** associated with this paper? If **YES** please state what they are and any mitigations undertaken. **NONE**					
Any current services or roles that may be affected by issues as outlined within this paper? **NO**					

Primary Care Update – TOM (Target Operating Model)

1.0 Summary of Current Position

1.1 The Primary Care Target Operating Model (TOM) for Day 1 of the ICB was drawn up in conjunction with each of the former CCG/Place Primary Care Leads in a process that commenced in January 2022.

1.2 The agreed detail is contained within the presentation in Appendix 1 but in summary ;

- Primary Care Contracts (National) both Pharmacy and General Practice are a core ICB (corporate function) not devolved to place formally, but discharged at place with local leadership and decisions made at place.
- For General Practice these decisions will be made at Place Primary Care Committees which are ICB Committees held at place level. They will work in tandem with the system level committee
- Appendix 1 Terms Of Reference for Place Primary Care Committees gives more details on this although these have still not been ratified or agreed so this is an early draft version.
- Current staffing and roles at place remain as is
- Each place has a named contracts lead / lead(s) who will work with the core ICB team to discharge the overall function
- Place teams lead completely the transformational and development side of primary care which can be agreed and managed through other governance routes.
- Schemes of delegation to support the above are still be agreed and worked through
- It is recognised that over time this model may change to ensure sharing of resources, staff and skills across place as current vacancy disparities exist and different areas have more challenges and therefore may need additional resources.

1.3 For key elements **Table 1** summarises below the arrangements between ICB Corporate and Place (ICB)

Table 1

ICB	Place
Core Delegated National Primary Medical Services PMS GMS Contracts and DES (***via local place based teams (PBT).*** *For local contracts ICB view on some aspects/ring fenced spend?*	**Primary Care Local Contracts** **Place elements of DES's** such as PCN Development ARRS enabling Enhanced Access facilitation/planning, C19 ES mobilisation etc **Leading local issue** e/g practice closures
National Policy Book for Primary Medical Services *via PBT*	**Primary Care Development/Relationship Management**
	Primary Care Strategy, Transformation and integration
Community Pharmacy National Contract *via PBT*	**Community Pharmacy Development and Local Schemes**
APMS Contract Management (National Elements) *via PBT*	**APMS Contract Management (Local Elements)**

1.4 For Community Pharmacy, existing Governance arrangements continued as is from NHSE/I included those staff that undertook those functions remaining as aligned staff from NHS England. Details of this are contained in the Community Pharmacy update on this Committee agenda.

1.5 The Target Operating model was signed off by the Executive Team and all Primary Care Leads in each place in June.

1.6 An update on Community Pharmacy for Cheshire and Merseyside is given separately on the agenda

2.0 Progress to Date

2.1 Each place is working through the Place governance expectations to ensure all Place Primary Care Committees are up and running in September subject to onward agreement of the Terms of Reference by the ICB Board.

2.2 Safe continued services were maintained from 1st July in respect of General Medical Services including no disruption to payments to practices nor ongoing contract management

2.3 Continued operation of existing Community Pharmacy Contract Staff aligned from NHSE/I including continued safe governance and oversight.

2.4 Named place Primary Care Contract Leads working with the core ICB Primary Care Lead

2.5 Adaption of existing NHSEI Primary Care leads forum to fortnightly joint leads meeting for dissemination of information

2.6 Place leading major areas of contracting working with the core ICB team and place based contracting leads.

2.7 Commencing areas of review of contracting and assurance outlined in the policy and contracting update.

3.0 Next Steps

3.1 Further work to understand the alignment between Primary Care Contracts and the wider contracting portfolios in working together

3.2 Scoping functions that can be done once across the contracting teams.

3.3 Agreeing which issues, if any need to be escalated to the system primary care committee including the following;

- Termination of contracts, severe breaches and sanctions
- Procurement of APMS decisions
- Values to a certain amount in line with any delegation agreements
- Serious issues of patient harm/threat to operations across a Place
- Where the Delegation Agreement with NHSE/I advises that NHSE/I should be made aware, e.g Stage 2 Disputes (a paper in respect of this is on the Committee agenda).

3.4 The above issues need to be worked into a framework with Place Directors/Associate Directors Of Finance so that this can be managed to prevent any onward breaches of the Delegation agreement with NHS England.

4.0 Recommendations

The Committee is asked to Note the updates in respect of Primary Care TOM and progress to date, which is *for information and discussion.*

5.0 Officer contact details for more information

Chris Leese
Associate Director of Primary Care – c.leese@nhs.net
c.leese@nhs.net

Appendix 1

Day 1 Model Proposal (TOM) (also included as a separate document within the pack)

day 1 model proposal _v6.pptx

Place Primary Care Committees – Terms Of Reference
(note this is a draft copy and subject to amendment and change following the ICB Board meeting – available on request)

CM PLACE PCC ToR v3.docx

Primary Care – Day 1 Operating Model Summary Proposal v6

Presentation to Primary Care Leads 13.5.2022

Chris Leese, Associate Director of Primary Care - Cheshire CCG

Reminder - Headline Summary – DRAFT – PC ICB/Place functions red areas note final decision

via other work areas – green arrow signifies a interplay between place and ICB so could vary in degrees of involvement and responsibility

ICB	Place
Core Delegated National Primary Medical Services PMS GMS Contracts and DES (*via local place based teams (PBT).* *For local contracts ICB view on some aspects/ring fenced spend?*	**Primary Care Local Contracts** **Place elements of DES's** such as PCN Development, ARRS enabling, Extended Access facilitation/planning, C19 ES mobilisation etc, maj **lead/involvement in core contract decisions** e/g practice closures
National Policy Book for Primary Medical Services *via PBT*	**Primary Care Development/Relationship Management**
	Primary Care Strategy, Transformation and integration
Community Pharmacy National Contract *via PBT*	**Community Pharmacy Development and Local Schemes**
APMS Contract Management (National Elements) *via PBT*	**APMS Contract Management (Local Elements)**
Estates (ICB elements – e.g rent and rates reviews, estates compliance with core contract) *via PBT,* *noting ICB group outcomes awaited*	**Estates – local rationalisation, planning and spend of IGs, Capital Grants etc (with ICB overview)**
Finance (core payments/decisions that relate to above* *via PBT*) *note awaiting outcome of ICB group*	**Finance (payments*/decisions on local schemes/non core)**
For noting : Some Med Opt issues are being explored at ICB / System level	**Medicines Optimisation and associated local schemes**
Primary Care IT – ICS level contracts/procurement/monitoring/support (PBT) – *note awaiting outcome of ICB group on this*	**IT - Local Support for implementation/new ways of working/IT linked to transformation**
Primary Care Quality–National contract (via PBT) *note ICB work ongoing re complaints/MPs letters etc and quality*	**Quality Improvement (Post CQC, post compliance visits etc) Local Scheme Quality Assurance issues**

PLACE LED RELATIONSHIPS

Overview

CCG Primary Care Leads have been meeting monthly to help co design the work in this presentation, with CW

Place will be the primary driver and team formation for Primary Care functions **but for some functions in green on the previous slide (e.g transformation, locally commissioned services) these will be subsumed into place structures and functions (work in progress)**

On Day 1 staff who deal with Primary Care Functions will be undertaking the same role (albeit some line management arrangements may be different in line with other functions, tbc shortly, particularly those who reported to Board Level Execs). This may change for some staff over time

Existing primary care teams will remain in current place/CCG formation on 1st July (until place senior staff in place)

The ICB core team will need some dedicated resource - determined by centralised contracting functions, and as required by the permanent senior post holders in ACEO team. To pre empt this, **each place primary care lead was asked to identify a team member who will be the 'dotted line support' to the ICB central primary care team.** For most this is the existing primary care lead and existing primary care leads forums will continue until the new AD confirms onward meetings.

This person will 'hook' place into the ICB 'central team' for Primary Care Contracting yet still be a member of the place based arrangements where their role crosses into, for example, development and transformation. One size doesn't fit all!

Over time there may be changes to some staff's direct report to reflect the core ICB functions
Matrix working may be required, depending on organisational needs, and the skills and experience of staff, who;

- may be asked to support work in (and across) different Places
- may be asked to work centrally
- may be asked to pick up and/or support delivery of programmes and projects

General Principles

- For the contracting element, we expect year 1 to be a roll on of local arrangements / will not be an ICB position on everything policy wise in 2 months or so **pending any regional/national operating models**
- That includes honouring existing decisions/decisions made that span the new arrangements
- May include any alignment of different policies on areas for example on appeals, Special Allocations but on day 1 they will remain as they currently are
- This Includes local enhanced services rolling on (which are a place led function but recognise crossover into core general practice as important income) which was requested by place.
- Majority of further alignment/movement of functions to final place will during the remainder of this year
- Community Pharmacy Contracts 'Team' will continue to provide function and use existing governance which may become more aligned over team (is an ICB function as per previous slide)
- Quality, IT, Finance, BI and other cross over areas still under discussion but there will need to be some final mapping
- The core ICB team and primary care place leads will work together on shared initiatives towards any alignment that may be required in some of the above areas

Governance this work was led by Ben Vintner

- 9 place based ‘primary care committee’ that are ICB committees at place where delegated GMS/Policy Book decisions will be made and connect ICB/Place on primary care contracting/finance (as most PCCs do now)

- There will be a system overview ICB ‘primary care committee ’ which will meet less frequently to provide overall assurance

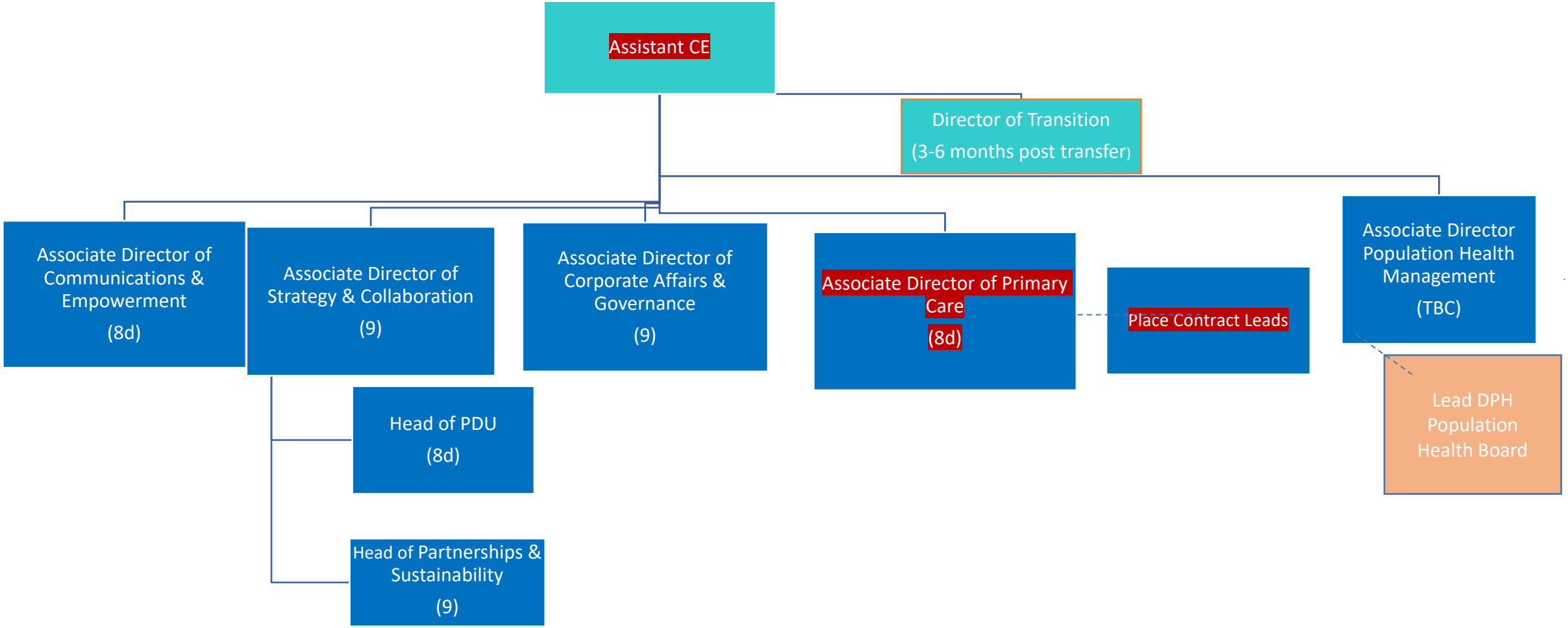
- Current proposal is the place level committees will be managed jointly by the core ICB/Place contract lead and the Place Directors

- The Place ‘lead contract person’ will work with the core ICB team to manage this in line with national requirements where applicable, and the Place Director or nominated person. Place Governance leads and primary care leads should be working this through in terms of dates/membership etc

- Decisions on other non core issues such as discretionary spend may be made elsewhere as they are not subject to double delegation ‘rules’. Governance for this and areas such as transformation will be determined by place (in progress)

- **Community Pharmacy Contracts ‘Team’ will continue to use existing governance which may become more aligned over time**

Assistant CE Senior Leadership Structure noting place contract lead arrangement inserted



Questions/Discussion

NHS
Cheshire and Merseyside

Committee Report

NHS Cheshire and Merseyside Primary Care Committee (System Level)

Date: 25th August 2022

NHS Cheshire and Merseyside
Primary Care Committee (System Level)

NHS Cheshire and Merseyside

Date of meeting:	25th August 2022
Agenda Item No:	PCC/8/22/05
Report title:	**Primary Care Update – Policy and Contracting**
Report Author & Contact Details:	Christopher Leese Associate Director of Primary Care c.leese@nhs.net
Report approved by:	Clare Watson

Purpose and any action required	**Decision/ Approve** →		**Discussion/ Gain feedback** →	x	**Assurance** →	x	**Information/ To Note** →	**X**

Route to this meeting / Committee/Advisory Group previously presented to (if applicable)

Executive Summary and key points for discussion

The Primary Care Policy and Contracting Update is to provide the Committee with information and assurance in the following areas ;

- Core GP Practice Contracting Summary
- National Contract Position – General Practice
- Covid-19 and Seasonal Flu Vaccination Programmes Enhanced Services
- Asylum Seekers and Refugees
- Additional Roles
- Clinical Waste re procurement
- Key NHS Cheshire and Merseyside Contracting and Policy Priorities for 2022/23

Appendix 1 contains key information and assurance documentation to underpin the transfer of primary care (general medical and pharmacy) to the ICB and relating to the Clinical Waste re procurement.

Recommendation/ Action needed:	**The Committee is asked to:** Note the updates in respect of Primary Care Policy and Contracting Update which is ***for information and assurance.***

Which purpose(s) of an Integrated Care System does this report align with?

Please insert **'x'** as appropriate:

1. Improve population health and healthcare	**x**
2. Tackle health inequality, improving outcome and access to services	**x**
3. Enhancing quality, productivity and value for money	**x**
4. Helping the NHS to support broader social and economic development	

C&M ICB Priority report aligns with:	
Please insert **'x'** as appropriate:	
1. Delivering today	**x**
2. Recovery	**x**
3. Getting Upstream	**x**
4. Building systems for integration and collaboration	**x**

Place Priority(s) report aligns with: *(Place to add)*	
Please insert **'x'** as appropriate:	
Covers all Places in terms of contracting	

Governance and Risk

Does this report provide assurance against any of the risks identified in the ICB Board Assurance Framework or any other corporate or Place risk?
No

What level of assurance does it provide?

Limited		**Reasonable**	**X**	**Significant**	

Any other risks? **NO**
If **YES** please identify within the main body of the report.

Is this report required under NHS guidance or for a statutory purpose? (*please specify*) **NO**

Any **Conflicts of Interest** associated with this paper? If **YES** please state what they are and any mitigations undertaken. **NONE**

Any current services or roles that may be affected by issues as outlined within this paper? **NO**

Primary Care Update – Policy and Contracting

1.0 National Contracting Summary (General Medical and Pharmacy)

1.1 Cheshire and Merseyside ICB is responsible for the management of the national contracts for General Practice via a Delegation agreement with NHSE/I (NHS England and NHS Improvement). This delegation agreement commenced 1st July following a national assurance process.

1.2 We hold the following number of National GMS/PMS/APMS for Cheshire and Merseyside by which the General Medical Contracting function is discharged across the ICS (more details can be found in Appendix 1);

GMS/PMS Contracts = 336
APMS Contracts = 47

1.3 The number of GP Practices across Cheshire and Merseyside is 355 looking after a population of 2.7 million people with the GP Practices grouped into 55 Primary Care Networks to deliver certain functions under the relevant Contracts.

1.4 The Governance of the individual GP Contracts is managed through the Primary Medical Care Policy and Guidance Manual https://www.england.nhs.uk/publication/primary-medical-care-policy-and-guidance-manual-pgm/. The ICB must manage the contracts in line with the Policy Book.Further detailed contract documentation can be found here NHS England » GP Contract

1.5 In addition, since 1st July, the National Community Pharmacy Contracts held previously by NHS England were assigned to the ICB as a core function under similar arrangements to Medical Contracts, following a national assurance process.

1.6 NHS Cheshire and Merseyside holds 630 pharmacy contracts covering nationally commissioned essential, advanced and enhanced pharmaceutical services. These are commissioned under the national community pharmacy framework governed via the National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013). Appendix 1 contains more information in this respect of the individual contracts held.

1.7 More information about the national Community Pharmacy Contract can be found via this link https://www.england.nhs.uk/primary-care/pharmacy/community-pharmacy-contractual-framework/. An update on Community Pharmacy for Cheshire and Merseyside is given separately on the agenda

1.8 The Governance and operational arrangements for contracts is given in the accompanying Operating Model paper also on the Committee agenda

1.9 It should be noted that under the terms of the Delegation Agreement with NHSE/I (point 1.1) national contracts cannot be onwardly delegated for management outside of the ICB's internal structures or to an non NHS body to manage except where indicated and in circumstances outlined in the FAQ Document in Appendix 1. All contracts held are between

Cheshire and Merseyside ICB under delegated agreement with NHSE/I, and the primary care contractor.

2.0 National Contract Position – General Practice 2022/23

2.1 From 1st April 2022 all GP practices were required to return to their pre-Covid position with regards to national and local contracting. GP practices were asked to focus on 'recovery and restoration' of general practice services, returning to pre-pandemic levels and scope of delivery as quickly as possible over 2022-23.

2.2 Further information as to the expectations on General Practice moving forward can be found here Letter template (england.nhs.uk)

2.3 On 11th July 2022 the following changes to the GMS and PMS Contract Regulations and APMS Directions came into force:

- The requirement for GP practices to always print and send copies of the electronic record of deceased patients to Primary Care Support England (PCSE) has been removed.
- The requirement for GP practices to respond to valid Covid-19 exemption confirmation requests has now been tied to either legislative requirements for individuals to be vaccinated or prove they are exempt for clinical reasons, or guidance in place to that effect.

The recently published GP contract variations reflect these changes. The variation notices incorporate changes made to the contract Regulations and Directions in April 2022 and July 2022. Places are currently in the process of sending out these updates to GP practices to formally notify them of changes to their contracts.

2.4 Updated standard GMS, PMS and APMS contracts will be published in due course and will reflect the introduction of Integrated Care Boards (ICBs). During the period before publication, ICBs wishing to refresh existing contracts should await publication of the new standard contract documentation. ICBs needing to enter into new contracts should adapt the existing standard contract accordingly and seek advice if necessary.

2.5 The national Qualities and Outcomes Framework (QOF) which supports Quality Improvement in General Practice has also returned to usual reporting following specific arrangements agreed during the Covid pandemic. The above letter (2.2) details that restoration also

2.6 The Primary Care Network DES (Directed Enhanced Service) which governs the services expected of Primary Care Networks (PCNs) which are groups of practices working together to provide services under that DES only, was revised and agreed for 2022/23 – more information is given in the wider specification here https://www.england.nhs.uk/wp-content/uploads/2022/03/B1357-Network-Contract-Directed-Enhanced-Service-contract-specification-2022-23-primary-care-network-requireme.pdf

2.7 A key deliverable for all PCNs and therefore key contract priority for the ICS this year, is the **Delivery of Enhanced Access from 1st October**. These are additional 'general practice' appointments/services provided primarily out of core hours (8-6.30) for patients to access. These can be delivered at defined locations within the PCN geography. The exact mix of

appointments and services is to be determined locally based on local demand and patient engagement. More information is given in the linked specification above.

2.8 Each Place team is currently working through the following deadlines through their place based contract team/Place Directors. The first deadline was 31st July 2022 for all PCNs to submit plans to provided Enhanced Access under the Primary Care Network DES specification. The ICS achieved 100 per cent in that area and the table below gives that detail ;

Place	Number of PCNs	No of Plans Received	No of Plans not received
Liverpool	**9**	**9**	**0**
Cheshire West	**9**	**9**	**0**
Cheshire East	**9**	**9**	**0**
Knowsley	**3**	**3**	**0**
Wirral	**5**	**5**	**0**
Halton	**2**	**2**	**0**
Warrington	**5**	**5**	**0**
St Helens	**4**	**4**	**0**
Sefton	**2**	**2**	**0**

2.9 By 31st August 2022 all signed off plans submitted have to be agreed and communicated back to PCNs. It has been agreed that each Place Director would sign off the plans for their place, in tandem with the contract sign off for each Place. Following sign off there will be a set up phase with full service commencing on 1st October 2022.

2.10 The ICB will be assured as Cheshire and Merseyside so it is imperative that each place reports 100 per cent sign up and onward coverage. NHSE/I are co assuring with the ICB as we move forward with each place and a verbal update at the committee with regards to progress on point 2.9 will be given. A full paper with a plan summary will come to the next Committee with each Place Primary Care Committee when operational, receiving a summary for assurance.

3.0 Covid-19 and Seasonal Flu Vaccination Programmes - Enhanced Services

3.1 Following the publication of interim advice from the Joint Committee on Vaccination and Immunisation (JCVI) for the autumn, NHS England published the 'Next steps for COVID-19 vaccination' letter on the 22 June 2022.

3.2 The 'COVID-19 vaccination enhanced service specification for autumn/winter 2022 for general practice' was published on the 30 June 2022, updating and outlining the scheme requirements.

3.3 GP practices and PCNs were asked to submit their expression of interest in taking part in the phase 5 autumn/winter programme by the 14 July 2022. 46 Primary Care Networks have expressed interest in providing either all or part of the specification and this work is being coordinated through the Regional Vaccination Team – please note the number is subject to change as the regional team work through those expressions of interest.

3.4 It should be noted that the national expectation is that usual primary care services would continue alongside the delivery of this Enhanced Service and former CCGs were asked to consider this when forwarding expressions of interest from PCNs. Clearly as we approach Winter there will be a high level of oversight required to ensure capacity , demand and staff welfare are managed, not least because of the additional draw on front line Primary Care staff already managing a high workload.

3.5 Community Pharmacies were able to express an interest under the specification given below https://www.england.nhs.uk/coronavirus/publication/covid-19-vaccination-enhanced-service-specification-for-autumn-winter-2022-for-community-pharmacy/. So far 59 Community Pharmacies have expressed an interest and this work is being coordinated through the Regional Vaccination Team – please note this number is subject to change as the regional team work through the expressions of interest.

3.6 In addition, NHS England have published the 'COVID-19 autumn booster and flu vaccine programme expansion' letter on the 15 July 2022 which sets out the next steps for the flu (and COVID-19) vaccination programmes for autumn and winter. This follows a national announcement that confirmed additional cohorts will now be offered the flu vaccine and the confirmation of acceptance of JCVI advice for the COVID-19 booster dose.

4.0 Asylum Seekers and Refugees (Discretionary Contract request)

4.1 Place colleagues are currently working through a series of local arrangements in response to an ask in relation to Ukrainian citizens seeking refuge in the UK https://www.england.nhs.uk/wp-content/uploads/2022/06/B1604-meeting-the-initial-health-needs-of-people-arriving-in-the-uk-from-ukraine-140622.pdf

4.2 This is being led through each place who have continued either local arrangements, enhanced existing offers or commissioned new local arrangements. Over time wider work will be required on aligning our approaches towards the primary care needs of refugees and Aslyum Seekers, alongside the health needs of onward referral areas such as Mental Health. Over time the ICB will be looking to align some of these approaches, based on Place and patient feedback, in discussion with our LMC colleagues.

4.3 It is worth noting that registration for these groups of patients is to be managed in line with existing arrangements in line with the national registration SOP given here https://www.england.nhs.uk/south/wp-content/uploads/sites/6/2019/04/patient-registration-standard-operating-principles-nov-2015.pdf– but the letter above allows for enhanced arrangements for health checks and other needs to be met through additional funding.

5.0 GP Patient Survey July 2022

5.1 The GP Patient Survey results were published during July and a fuller summary of this is given as a separate agenda item.

6.0 Additional Roles Summary

6.1 Additional roles (ARRS) underpin the PCN (Primary Care Network) Directed Enhanced Services

6.2 Information on additional roles can be found here ;

https://www.england.nhs.uk/publication/network-contract-directed-enhanced-service-contract-specification-2022-23-pcn-requirements-and-entitlements/

https://www.england.nhs.uk/publication/network-contract-directed-enhanced-service-guidance-for-2022-23-in-england/

6.3 The ICB has a clear early ambition to maximise ARRS across the 9 places and ensure alignment with ICB level and place workforce strategies.

6.4 The current status of spend and roles for the ICB is shown in the tables below.

Table 6a ARRS Allocation and Anticipated spend

Cheshire & Merseyside ICB -Additional Roles Reimbursment Scheme July 2022-March 2023	Total £000
ARRS Total Allocation	39,031
ICB Baseline	24,088
Central Drawdown	14,943
Anticipated claims (FOT)	31,855
Remainder available from Central Drawdown	7,176

Table 6b Analysis at Place Level

Cheshire & Merseyside ICB QYG	CHESHIRE EAST	CHESHIRE WEST	HALTON	KNOWSLEY	LIVERPOOL	SEFTON	ST HELENS	WARRINGTON	WIRRAL	Total
ARRS Total Allocation	6563	6320	1789	2,909	7,564	3,811	2,784	2680	4611	39,031
ICB Baseline	4050	3900	1104	1,796	4,668	2,352	1,718	1654	2846	24,088
Central Drawdown	2513	2420	685	1,114	2,896	1,459	1,066	1026	1765	14,943
Anticipated claims (FOT)	4045	3912	2063	2,838	7,124	3,811	2,658	2556	3665	32,672
Remainder available from Central Drawdown	2518	2408	-274	71	440	0	126	124	946	6,360

Table 6c-Full Time Equivalent (FTE) per Role/ Place

Cheshire & Merseyside ICB QYG	CHESHIRE EAST	CHESHIRE WEST	HALTON	KNOWSLEY	LIVERPOOL	SEFTON	ST HELENS	WARRINGTON	WIRRAL	Total
Pharmacy Technicians	13.9	10.7	4.0	4.0	23.0	3.4	4.0	8.0	3.3	**74.3**
Clinical Pharmacists	33.2	33.4	12.0	15.2	48.7	14.7	17.4	26.0	27.1	**227.7**
Advanced Practitioner (Clinical Pharmacist)	1.6	0.0	1.0	0.0	4.2	1.2	2.0	0.0	0.0	**10.0**
Dietitians (excluding Advanced Practitioner)	0.0	2.0	3.0	0.0	3.0	0.0	0.0	0.0	0.0	**8.0**
Advanced Practitioner (Dietitian)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
First Contact Physiotherapists	12.7	12.3	1.0	6.6	13.5	3.0	13.0	13.0	11.4	**86.5**
Advanced Practitioner (Physiotherapist)	0.0	0.0	0.0	0.0	4.6	0.0	0.0	0.0	0.9	**5.6**
Occupational Therapists	2.0	4.7	4.0	1.0	2.0	0.0	1.0	1.0	0.0	**15.7**
Advanced Practitioner (Occupational Therapist)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
Paramedics (excluding Advanced Practitioner)	3.9	9.0	5.0	6.0	1.0	0.0	0.0	9.0	9.3	**43.2**
Advanced Practitioner (Paramedic)	0.0	0.0	1.0	0.0	0.0	0.0	1.0	0.0	0.0	**2.0**
Podiatrists (excluding Advanced Practitioner)	0.0	0.0	0.0	0.0	0.0	0.0	1.6	0.0	2.0	**3.6**
Advanced Practitioner (Podiatrist)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
Physician Associates	5.8	1.8	3.0	14.0	7.7	1.1	13.4	0.0	11.7	**58.5**
Care Co-Ordinators	27.4	16.8	18.0	10.6	83.9	8.7	10.0	12.0	15.4	**202.8**
Health and Wellbeing Coaches	0.0	2.0	6.0	6.0	17.6	0.0	6.0	2.0	12.9	**52.5**
Social Prescribing Link Workers	20.4	36.4	0.0	19.0	31.4	23.0	11.0	5.0	20.8	**167.0**
Nursing Associates	0.6	0.0	11.0	2.0	15.0	0.0	8.8	2.0	2.2	**41.6**
Trainee Nursing Associates	3.0	1.0	2.0	1.0	5.0	0.0	0.0	0.0	2.0	**14.0**
Adult Mental Health Practitioner	1.0	0.0	6.0	5.0	3.0	0.0	11.0	7.0	0.0	**33.0**
Children and Young Persons Mental Health Practitioner	1.0	0.0	0.0	3.0	0.0	0.0	0.0	0.0	0.0	**4.0**
Total FTE	**126.5**	**130.1**	**77.0**	**93.4**	**263.7**	**54.9**	**100.2**	**85.0**	**119.1**	**1,050.0**

7.0 CQC (Care Quality Commission) Status of GP Practices

7.1 It will be the ambition of the ICB to ensure access to good quality services across the patch regardless of place and location and further information and actions will be expected of the ICB and place to address this. The contracting and quality teams will be working together to develop plans for improvement across the ICS to ensure consistent level of high quality primary care. A further update and actions agreed will be presented at the next Committee meeting.

8.0 Clinical Waste Re-Procurement

8.1 Previous approval from each former CCG for a re-procurement by NHS England nationally on their behalf for Clinical Waste services has transferred to the ICB. This covers the following areas ;

- General Practice and dispensing doctors
- Community Pharmacy and dispensing doctors
- Home patient CW service (where current schemes are in place)

Further information is contained in Appendix 1 in this respect.

9.0 Summary of key priorities for Contracting and Policy 2022/23

In Summary the key priorities for the ICB for nationally delegated contracts this year are;

9.1 Policy;

- Development of a high-level Primary Care Strategy at ICB level, with Place developing and agreeing local strategies that include primary care on an integration/transformation partnership approach to future delivery.

- Embedding local governance as per the Day 1 Operating model to ensure appropriate contracting arrangements via Place Primary Care Committees and agreed Terms Of Reference
- Adherence to the National Delegation agreement with NHSE/I and a consistent approach to contract management
- Embedding the National Pharmacy Contracting arrangements within the ICB
- Beginning the alignment of where differences of approach have been taken in CCGs/Place toward aspects of the local contract to ensure consistency of policys.
- Commencing the assurance process in relation to Dental and Ophthalmic Primary Care Contracts for onward sign off by December, in readiness for 1st April alignment to the ICB. In effect from 1st April 2023 all 4 Primary Care Contractor Groups will be the responsibility of the ICB, subject to this assurance process for Dental and Ophthalmic services. A slide on the next steps for Dental and Optom will be presented at the Committee meeting for discussion and assurance.

9.2 Contracting Priorities

- Delivery of the Covid 19 Enhanced Service as part of the response to the ongoing challenge of Covid 19, in line with other providers
- 100 per cent coverage of all PCN populations by 31st August to meet the ask in relation to Enhanced Access
- Supporting the restoration of full services and QOF to all places during 2022/23 underpinned by local Place approaches to key enablers such as Workforce
- Maximisation of more flexible funding streams such as Additional Roles (ARRS)
- Development and Agreement of a high level performance dashboard/criteria for all contractors across Cheshire and Merseyside
- Place level oversight monitoring developed and in place to underpin C and M Assurance
- Access to high level quality care across Cheshire and Merseyside in terms of service access and CCQ ratings.
- Review of Delegated and discretionary spend
- Working with colleagues in the general contracting portfolio to look at functions that can be done once across the ICS and policys and processes that can be done in a different way to ensure greater economies of scale.

10.0 Recommendations

10.1 The Committee is asked to Note the updates in respect of Primary Care Policy and Contracting which is *for information and assurance.*

11.0 Officer contact details for more information

Chris Leese
Associate Director of Primary Care – c.leese@nhs.net
c.leese@nhs.net

Appendix 1 (not included in the committee pack but can be circulated on request)

Copy of Delegation Agreement with NHSE/I for Delegated Functions

CM Delegation Agreement Final - sig

Contract notice transferring Primary Care Contracts to the ICB

Cheshire and Merseyside - DA Cont

Safe Delegation Checklist

Copy of MASTER Safe Delegation Checl

FAQ – Delegated Responsibility

B1749_Primary Care Delegation Agreemen

Clinical Waste Reprocurement information

Clinical Waste Procurement Strategy

CW PC briefing slides.pdf

NHS
Cheshire and Merseyside

Committee Report

NHS Cheshire and Merseyside
System Primary Care Committee

Date: 25th August 2022

NHS Cheshire and Merseyside
Primary Care Committee (System Level)

NHS Cheshire and Merseyside

Date of meeting:	25th August 2022
Agenda Item No:	PCC/8/22/06
Report title:	**General Practice Patient Survey 2022 - Summary**
Report Author & Contact Details:	Taken from a previous summary prepared by • Rowan Pritchard Jones • Jonathan Griffiths • Business Intelligence Team Christopher Leese Associate Director of Primary Care c.leese@nhs.net
Report approved by:	Clare Watson, Assistant Chief Executive

Purpose and any action required	**Decision/ Approve** →	**x**	**Discussion/ Gain feedback** →	x	**Assurance** →	x	**Information/ To Note** →	

Route to this meeting / Committee/Advisory Group previously presented to (if applicable)

Executive Summary and key points for discussion
The Committee are asked to discuss the findings of the General Practice Patient Survey 2022 and note the next steps in this respect. Appendix 1 contains National Headlines for the survey in the form of a summary and the overall national slide deck for Cheshire and Merseyside Appendix 2 contains a further local analysis by the Business Intelligence Team.

Recommendation/ Action needed:	

Which purpose(s) of an Integrated Care System does this report align with?	
Please insert **'x'** as appropriate:	
1. Improve population health and healthcare	
2. Tackle health inequality, improving outcome and access to services	
3. Enhancing quality, productivity and value for money	**X**
4. Helping the NHS to support broader social and economic development	

C&M ICB Priority report aligns with:
Please insert **'x'** as appropriate:

C&M ICB Priority report aligns with:	
1. Delivering today	x
2. Recovery	
3. Getting Upstream	
4. Building systems for integration and collaboration	

Place Priority(s) report aligns with: *(Place to add)*	
Please insert **'x'** as appropriate:	

Governance and Risk						
Does this report provide assurance against any of the risks identified in the ICB Board Assurance Framework or any other corporate or Place risk? **YES**						
What level of assurance does it provide?						
Limited		**Reasonable**	**X**	**Significant**		
Any other risks? **NO** If **YES** please identify within the main body of the report.						
Is this report required under NHS guidance or for a statutory purpose? (*please specify*) **NO**						
Any **Conflicts of Interest** associated with this paper? If **YES** please state what they are and any mitigations undertaken. **NONE**						
Any current services or roles that may be affected by issues as outlined within this paper? **NO**						

General Practice Patient Survey 2022

1.0 Summary

1.1 The GP Patient Survey is an annual survey taking place in England to gather data about patient's experiences of their GP practice. In Cheshire and Merseyside 134,514 questionnaires were dispatched, with 38,417 returned (29% response rate). Although 38,417 responses is high, the sample sizes at a practice level are relatively small. This is the first survey in 'ICB' format.

1.2 A range of topics are covered by the questionnaire which provides data at practice, PCN, ICS and national levels. The data can be used to:

- Comparing ICS data with the national result
- Analysing trends within our ICS over time
- Comparing PCNs results within our ICS to identify who to learn from and who to approach for further support.
- Supporting Practices or PCNs with particular issues, usually in line with other information, data or qualitative feedback– particularly Practices where there may be big differences from past survey results, in line with usual contract management.

2.0 Results

2.1 The slide pack included in Appendix 1 provides further detail on the results. **Table 1** below provides a snapshot of those questions where comparison can be made to previous years and to the national result. We have highlighted the 2022 results and colour-coded them – the red results are where we are performing above the national average, and the blue results where we are performing below the national average. It is pleasing to note that Cheshire and Merseyside are scoring above average for the majority of indicators.

2.2 There are four areas where the ICB are performing below the national average overall. These are:

- Ease of getting through on the phone
- Experience of making an appointment
- Support for Long Term Conditions
- Time taken to receive care when the practice is closed (ie Out of Hours) (this has been flagged with relevant commissioning teams)

2.3 You will note that all results indicate a drop compared to previous years, in some cases considerably so. This could reflect changes due to the pandemic, increased demand and recent information regarding 'face to face' appointments that was released nationally.

2.4 The ICB need to be very aware of the pressures being faced in General Practice against the backdrop of this ongoing publicity and bear this in mind when talking to General Practice about these survey result. The Royal College of General Practitioners has made a statement about the results which you can read via this link "GP patient survey reflects 'overstretched' service working under intense and unsustainable pressure (rcgp.org.uk)".

2.5 As you might expect, there is variation between PCNs. The slide deck shows the detail of this. For this paper we have identified how many times each PCN finds itself either in the 'top five' or 'bottom five' PCNs for each indicator. **Tables 2 and 3 below** detail this.

2.6 The ICB need to be aware that sharing best practice from one area may not be directly applicable to another because of variation in demographics, geography, deprivation etc. We also need to be mindful of some of the factors outlined in point 2.3

Table 1

Question	2020	2021	2022	National average 2022
Overall experience of GP (% saying 'good')	84%	84%	**74%**	72%
Ease of getting through on the phone (% saying 'easy')	64%	67%	**51%**	53%
Helpfulness of Receptionists (% saying 'helpful')	90%	89%	**83%**	82%
Ease of use of practice website (% saying 'easy')	78%	76%	**68%**	67%
Experience of making an appointment (% saying 'good')	66%	70%	**55%**	56%
Satisfaction with appointment times (% saying 'satisfied')	65%	67%	**55%**	55%
Was HCP good at listening to you (% saying 'yes')	90%	91%	**86%**	85%
Did HCP treat you with care and concerns? (% saying 'yes')	89%	90%	**85%**	83%
Did HCP recognise/understand mental health issue (% saying 'yes')	88%	89%	**83%**	81%
Were you involved in decision making? (% saying 'yes')	94%	94%	**91%**	90%
Did you have confidence and trust in HCP (% saying 'yes')	96%	96%	**94%**	93%
Were your needs met (% saying 'yes')	95%	94%	**92%**	91%
Have you had support from local services over last 12 months t help your long term condition(s) (% saying 'yes')	79%	74%	**64%**	65%
Time taken to receive care when practice closed (% saying time taken was 'about right')	64%	71%	**52%**	53%

Table 2

PCNs found in the 'bottom five' PCNs for each indicator more than once

PCN	Place	Number of times in the 'bottom five'
Newton and Haydock	St Helens	9
West Knowsley	Knowsley	8
Liverpool First	Liverpool	7
North Liverpool	Liverpool	7

Aintree	Liverpool	4
East Warrington	Warrington	3
iGPC	Liverpool	2
Widnes	Halton	2
Kirkby	Knowsley	2

Table 3

PCNs found in the 'top five' PCNs for each indicator more than once

PCN	Place	Number of times in the 'top five'
CHAW	Cheshire East	6
SMASH	Cheshire East	5
Winsford	Cheshire West	4
Macclesfield	Cheshire East	4
Neston and Willaston	Cheshire West	4
Middlewood	Cheshire East	3
Central Liverpool	Liverpool	3
Childwall and Wavertree	Liverpool	3
Knutsford	Cheshire East	2
Healthier South Wirral	Wirral	2
Princeway	Cheshire West	2
Healthier West Wirral	Wirral	2

3.0 Main Survey Conclusions

3.1 The results of the 2022 GP Patient Survey demonstrate an overall drop in satisfaction with General Practice at a national level that is reflected in Cheshire and Merseyside. While important not to ignore this fact it is good to note that practices in Cheshire and Merseyside have performed better than the national average for most indicators.

3.2 Clearly, covid was a factor in some practices returning to normal and both the LMC and practices have stressed this. In Cheshire and Merseyside we aspire to having outstanding, high quality General Practice for the people we serve. The ICB can use these results to help inform and improve in those areas.

3.3 Focus in particular should be given to the following key areas ;

- Access by telephone
- Appointment with preferred professional/convenient times and dates
- More work to communicate benefit of other staff in the Additional roles
- Encouragement of uptake of on line services
- The overall 'journey' of making an appointment via whatever method is chosen by members of the public

3.4 Focused support for some places such as Liverpool place which has overall lower results in most areas than places such as Cheshire

3.5 Understanding the further analysis contained in Appendix 2 which shows that there is a correlation between GP headcount and survey results in some PCNs, and calls to 111 from some PCNs and some survey results. These have been shared with place team.

4.0 Next Steps

4.1 Communications team have been made aware of the results findings and are prepared with reactive statements promoting the quality of General Practice across Cheshire and Merseyside noting our above average performance.

4.2 Information has been sent to Place leads for them to lead further onward work at place in terms of quality, contracting , development and triangulation with other indicators

4.3 We have requested more detailed data BI analysis to support Place to do further tailored work. Appendix 2 contains a presentation of a further cut of data provided to support this

4.4 The Cheshire and Merseyside Primary Care Team to use these results to inform the ongoing development of our Primary Care Strategy, and for Place to use as same for Place level strategies.

4.5 Informing development opportunities across the patch to do things once again, for example further care navigation training and maximisation of additional roles.

4.6 Place led specific asks for onward assurance could include

- Further recruitment initiatives,
- High level PCN-level action plans to address these results
- Encourage further utilisation (subject to funding) of APEX style demand tools to understand this further where not already used.
- Further engagement with local Primary Care Leadership Forum(s) and LMC's for discussion and comment.

4.7 Places potentially using the results to inform actions and spend in any local contracts to reflect these priorities. This would include further work to understand deprivation and health inequalities in some places.

4.8 Understand and map number of GPs and other professionals per population per PCN, particularly for those with lower results. Further full staffing mix factors analysed to understand the impact of additional GPs/ GP WTE on many of the results, aligning with Place level workforce strategies.

4.9 Ensuring that Place Enhanced Access plans and Workforce plans address factors highlighted in this survey.

5.0 Recommendations

The Committee are asked to **discuss** the findings of the GP Patient Survey 2022 and **note** the further actions planned, most of which will be led by Place colleagues.

6.0 Officer contact details for more information

Chris Leese
Associate Director of Primary Care – c.leese@nhs.net
c.leese@nhs.net

Appendix 1

National Headlines Infographic (available on request)

GPPS_2022_National
_infographic_PUBLIC.

Overall detailed summary for Cheshire and Merseyside ICS (available on request)

CHESHIRE AND
MERSEYSIDE INTEGR

Appendix 2

Further analysis by the Business Intelligence Team (included in the committee pack)

ICS_PatientSurvey_N
HS111_GPWHE 0208

Cheshire and Merseyside
Health and Care Partnership

NHS
Midlands and Lancashire
Commissioning Support Unit

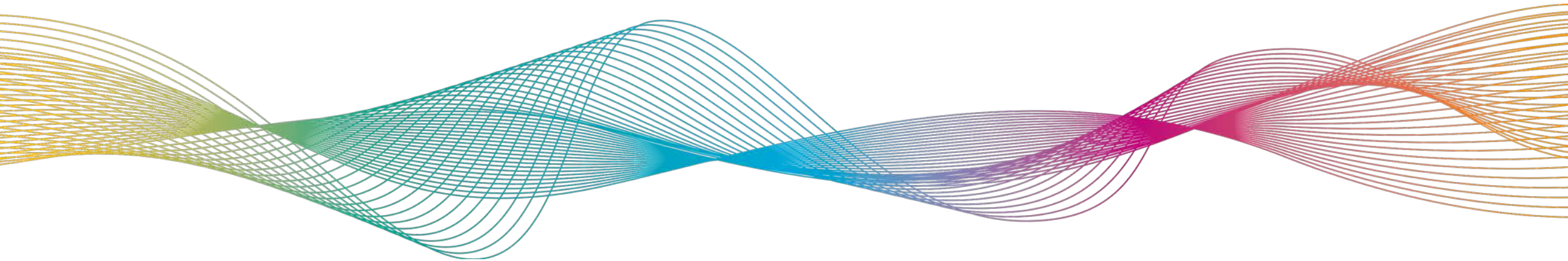
Cheshire and Merseyside Integrated Care System

GP Patient Survey 2022 – Highlights
GP WTE Workforce data – June 2022
NHS 111 call volume data – July 2022

Cheshire and Merseyside
Health and Care Partnership

NHS
Midlands and Lancashire
Commissioning Support Unit

2022 GP Patient Survey highlights



Background information about the survey

- The GP Patient Survey (GPPS) is an England-wide survey conducted annually, providing data about patients' experiences of their GP practices and is a snapshot of patient experience at a given time

- In Cheshire and Merseyside Integrated Care System, **134,514** questionnaires were sent out, and **38,417** were returned completed This represents a response rate of **29%**.

- Key observations are provided for a selection of questions from the survey in this presentation where only 'positive response' percentages are shown in the slides

Overall experience

Question 32: Overall, how would you describe your experience of your GP practice?

Nationally the positive response rate to this question is 72%, with Cheshire & Merseyside ICS slightly improving on this figure at 74%. PCN responses range between 57% at Liverpool First PCN (Liverpool Place) and 85% at both Childwall & Wavertree PCN (Liverpool Place) and Rural Alliance PCN (Cheshire West Place)

Making an appointment

Question 16: Were you satisfied with the appointment (or appointments) you were offered?

Nationally, the positive response rate to this question is 72%, with Cheshire & Merseyside ICS slightly improving on this figure at 73%. PCN responses range between 59% at West Knowsley PCN (Knowsley Place) and 85% at Neston & Willaston PCN (Cheshire West Place)

Question 21: Overall, how would you describe your experience of making an appointment?

Nationally the positive response rate to this question is 56%, with Cheshire & Merseyside ICS broadly matching this figure at 55%. PCN responses range between 37% at Newton & Haydock PCN (St Helens Place) and 73% at Rural Alliance PCN (Cheshire West Place)

Cheshire and Merseyside Health and Care Partnership

NHS Midlands and Lancashire Commissioning Support Unit

Local GP Services

Question 1: Generally, how easy is it to get through to someone at your GP practice on the phone?

Nationally the positive response rate to this question is 53%, with Cheshire & Merseyside ICS broadly matching this figure at 51%. PCN responses differ greatly between 19% at Aintree PCN (Liverpool Place) and 83% at Knutsford (Cheshire East Place). No other PCN falls below 30% so further investigation would need to be carried out at practice level in Aintree PCN to identify the issue

Question 2: How helpful do you find the receptionists at your GP practice?

Nationally the positive response rate to this question is 82%, with Cheshire & Merseyside ICS slightly improving on this figure at 83%. PCN response rates range between 72% at Newton & Haydock PCN (St Helens Place) and 92% at Rural Alliance PCN (Cheshire West Place)

Local GP Services cont.

Question 4: How easy is it to use your GP practice's website to look for information or access services?

Nationally the positive response rate to this question is 67%, with the Cheshire & Merseyside ICS slightly improving on this figure at 68%. PCN response rates range between 48% at West Knowsley PCN (Knowsley Place) and 81% at St Helens Central PCN (St Helens Place)

Question 30: During your last general practice appointment, did you have confidence and trust in the healthcare professional you saw or spoke to?

Nationally the positive response rate to this question is 93%, with the Cheshire & Merseyside ICS slightly improving on this figure at 94%. PCN response rates were all consistently higher than 88%

When your GP Practice is closed

Question 47: Overall, how would you describe your last experience of NHS services when you wanted to see a GP but your GP practice was closed?

Both Nationally and for Cheshire & Merseyside ICS the positive response rate to this question is 50%. PCN response rates range between 28% at West Knowsley PCN (Knowsley Place) and 62% at Princeway PCN (Cheshire West Place)

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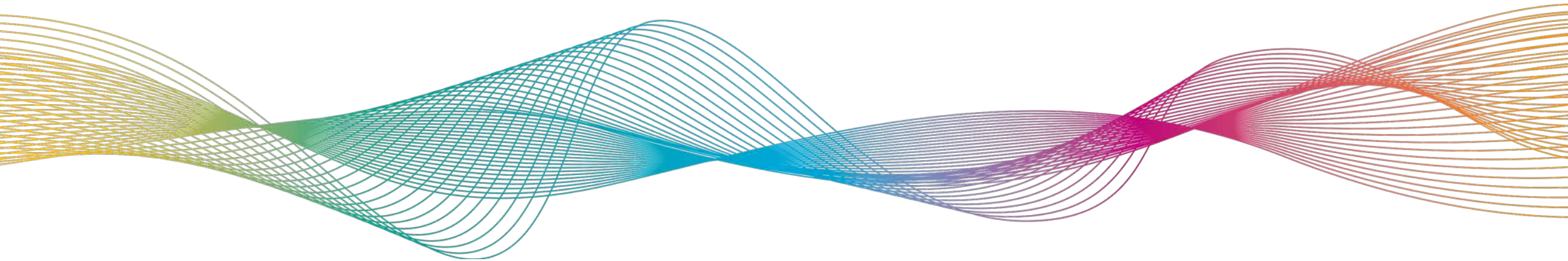
GP WTE Workforce data - June 2022



Cheshire and Merseyside
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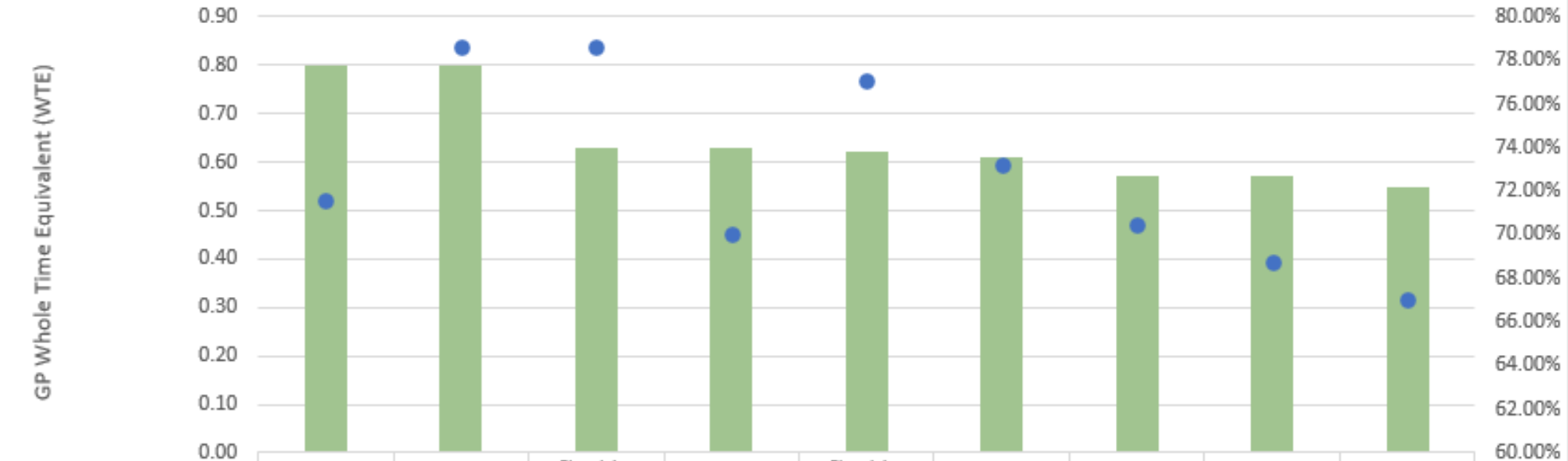
NHS Cheshire & Merseyside

GP Whole Time Equivalent (WTE) & Good overall experience of GP Practice by Place



	Liverpool	Wirral	Cheshire West	Halton	Cheshire East	Warrington	Sefton	St Helens	Knowsley
GP_WTE	0.80	0.80	0.63	0.63	0.62	0.61	0.57	0.57	0.55
Good overall experience	71.55%	78.60%	78.66%	70.00%	77.11%	73.20%	70.50%	68.75%	67.00%

data source: NHS Digital, workforce data (June 2022) & GP Patient Suvery

Overall Knowsley Place has the lowest GP WTE workforce rate (as indicated by the green bar), along with the lowest positive response rate to the Patient Survey question: **Overall, how would you describe your experience of your GP practice?** (indicated by the blue dot)

GP WTE Place/PCN (rate per 1000 pop)

Liverpool Place	0.80
CHILDWALL and WAVERTREE PCN	1.11
ANFIELD and EVERTON PCN	1.06
IGPC PCN	1.04
CENTRAL LIVERPOOL PCN	0.87
AINTREE PCN	0.77
THE PICTON PCN	0.76
SWAGGA PCN	0.72
NORTH LIVERPOOL PCN	0.57
LIVERPOOL FIRST PCN	0.32

Wirral Place	0.80
HEALTHIER SOUTH WIRRAL PCN	1.16
WALLASEY PCN	0.85
HEALTHIER WEST WIRRAL PCN	0.79
BIRKENHEAD PCN	0.72
MORETON AND MEOLS PCN	0.48

Overall Liverpool Place and Wirral Place have the highest rate of GPs WTE (per 1000 pop). However, not all PCN's within each Place are equitable. The Patient Survey shows that two of the PCNs in Liverpool Place have the highest and lowest patient satisfaction scores for the question - ***'Overall, how would you describe your experience of your GP practice*?** Childwall and Wavertree PCN scored highest (85%) and they have the second highest GP WTE rate across the ICS footprint (GP WTE 1.11), with Liverpool First PCN scoring the lowest (GP WTE 57%) for the same question which seems to corelate to the fact that Liverpool First PCN has the lowest GP WTE workforce results across the ICS footprint (GP WTE 0.32)

GP WTE Place/PCN (rate per 1000 pop)

Knowsley Place	**0.55**
KNOWSLEY CENTRAL AND SOUTH	0.68
KIRKBY PCN	0.66
WEST KNOWSLEY PCN	0.32

Sefton Place	**0.57**
SOUTH SEFTON PCN	0.58
SOUTHPORT and FORMBY PCN	0.56

Overall Knowsley Place and Sefton Place have the lowest rate of GPs WTE (per 1000 pop). West Knowsley PCN (GP WTE Rate 0.32) also has the lowest patient satisfaction score on a number of questions on the GP Patient Survey. In addition Knowsley CCG has the highest NHS 111 call volume across Cheshire & Merseyside.

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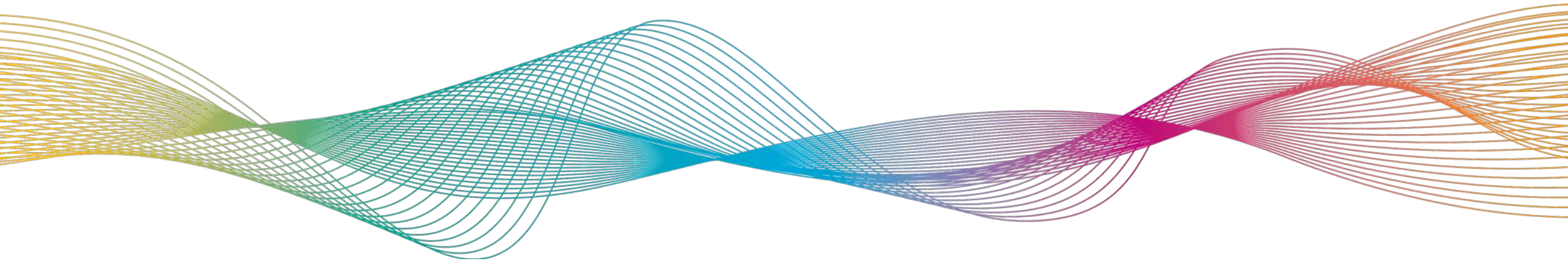
NHS 111 data - July 2022



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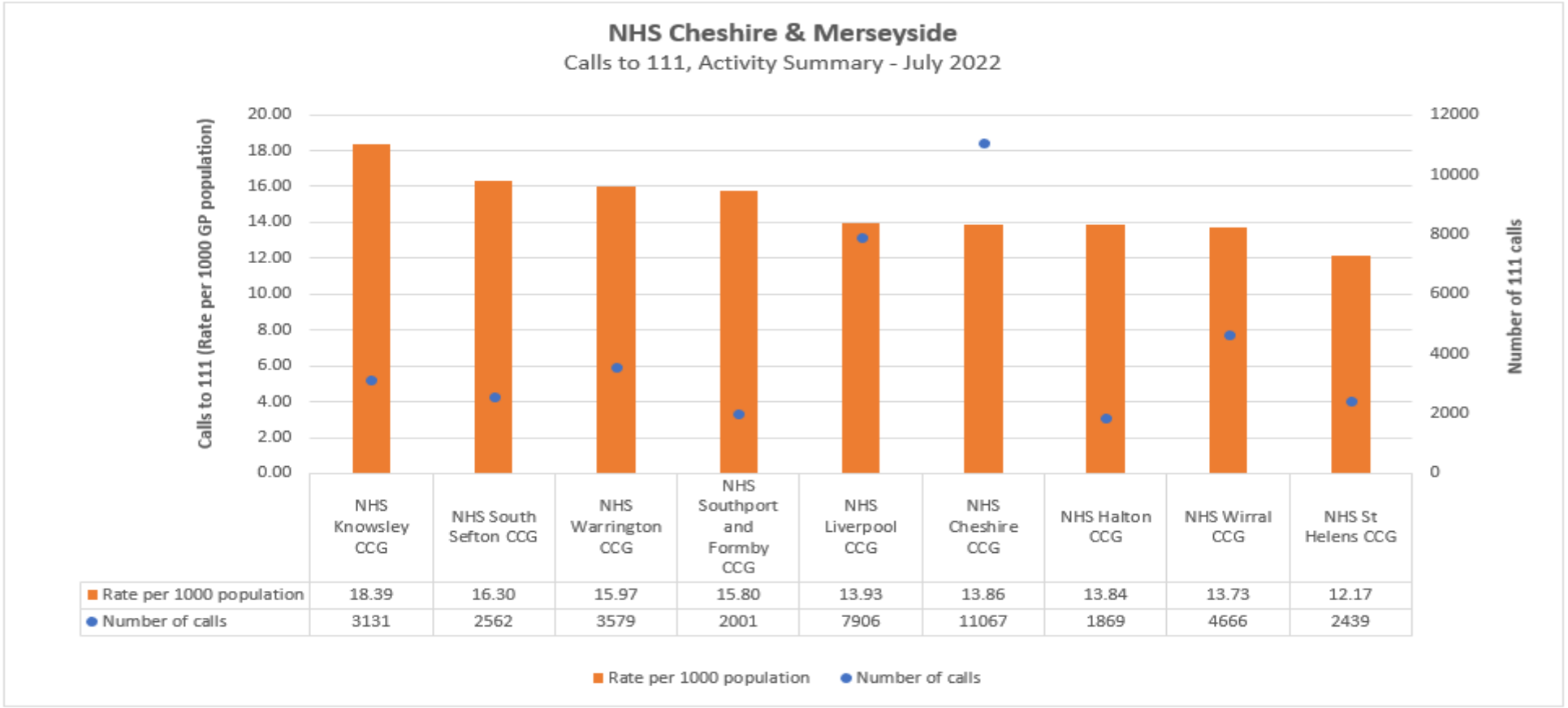

Data source: North West Ambulance Service (NWAS)

Report date: 2nd August 2022

NHS Knowsley CCG has the highest NHS 111 call rate per 1000 population and also the lowest GP WTE workforce rate across Cheshire & Merseyside ICS. NHS Cheshire CCG has the highest number of calls due to them having the largest patient population. However, when the data is compared as a rate per 1000 population across the other CCGs in Cheshire & Merseyside it is equitable.

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Committee Report

NHS Cheshire and Merseyside
System Primary Care Committee

Date: 25th August 2022

NHS Cheshire and Merseyside
System Primary Care Committee

NHS Cheshire and Merseyside

Date of meeting:	25th August 2022
Agenda Item No:	PCC/8/22/07
Report title:	**Primary Care Update – Finance**
Report Author & Contact Details:	Lorraine Weekes-Bailey Senior Primary Care Accountant
Report approved by:	Mark Bakewell- Deputy Director of Finance

Purpose and any action required	**Decision/ Approve** →		**Discussion/ Gain feedback** →		**Assurance** →	x	**Information/ To Note** →	x

Route to this meeting / Committee/Advisory Group previously presented to (if applicable)

N/a

Executive Summary and key points for discussion

- The purpose of this report is to provide the Primary Care Commissioning Committee of the Cheshire and Merseyside Integrated Care Board (ICB), with a detailed overview of the financial position in related to primary care expenditure.
- Due to the work required regarding bring together the 9 CCG ledgers during Quarter 2 to inform the combined ICB position, information is presented at CCG level for the period ending 30th June 2022 and represents the latest available. Work continues to develop the ICB reporting arrangements to ensure consistency of approach and understanding of the combined position.
- The report covers three areas of spend, the national allocation for Primary Care Co-Commissioning, Local Place Primary Care funding commitments and Prescribing and will highlight any key variances within the financial position compared to the submitted ICB plan
- The paper also provides a breakdown of the Additional Roles Reimbursement Scheme (ARRS) allocation and the central drawdown available.

Recommendation/ Action needed:	**The Committee is asked to:** • note the combined CCG financial summary position as at the end of Quarter One within the 22/23 financial year, noting the relative availability of in-year information • note the work required during the second quarter to standardise forecast methodologies in order ensure consistency of approach and resulting combined reporting approach for the ICB.

Which purpose(s) of an Integrated Care System does this report align with?

Please insert **'x'** as appropriate:

Which purpose(s) of an Integrated Care System does this report align with?	
1. Improve population health and healthcare	x
2. Tackle health inequality, improving outcome and access to services	x
3. Enhancing quality, productivity and value for money	x
4. Helping the NHS to support broader social and economic development	x

C&M ICB Priority report aligns with:	
Please insert **'x'** as appropriate:	
1. Delivering today	x
2. Recovery	x
3. Getting Upstream	x
4. Building systems for integration and collaboration	x

Place Priority(s) report aligns with:	
Please insert **'x'** as appropriate:	

Governance and Risk						
Does this report provide assurance against any of the risks identified in the ICB Board Assurance Framework or any other corporate or Place risk? **No**						
What level of assurance does it provide?						
Limited		**Reasonable**	x	**Significant**		
Any other risks? **Yes** If **Yes** please identify within the main body of the report.						
Is this report required under NHS guidance or for a statutory purpose? (*please specify*) **Yes**						
Any **Conflicts of Interest** associated with this paper? If **Yes** please state what they are and any mitigations undertaken. **None**						
Any current services or roles that may be affected by issues as outlined within this paper? **No**						

Primary Care Finance Update

1.0 Introduction

1.1 The purpose of this report is to provide the Primary Care Commissioning Committee of the Cheshire and Merseyside Integrated Care Board (ICB), with a detailed overview of the financial position in related to primary care expenditure.

1.2 Due to the work required regarding bring together the 9 CCG ledgers during Quarter 2 to inform the combined ICB position, information is presented at CCG level for the period ending 30th June 2022 and represents the latest available. Work continues to develop the ICB reporting arrangements in order to ensure consistency of approach and understanding of the combined position.

1.3 The report covers three areas of spend, the national allocation for Primary Care Co-Commissioning, Local Place Primary Care funding commitments and Prescribing and will highlight any key variances within the financial position compared to the submitted ICB plan.

2.0 Q1 Financial Position

2.1 The below table, illustrates an overall summary of the allocations received by the former NHS Clinical Commissioning Groups and the associated forecasts covering the period April-June 2022. However it should be noted that there is still a time lag in-year information available (e.g 6 week time lag for prescribing information) at this stage of the year and confidence in forecast outturn position will improve during the second quarter as in year run rates are established.

Primary Care Position Summary June 2022	Forecast Outturn		
	Budget (£000's)	Forecast (£000's)	Variance (£000's)
Cheshire & Merseyside ICB Primary Care			
Local Primary Care	26,320	24,611	1,709
Delegated Primary Care	112,329	112,088	241
Prescribing	121,364	118,593	2,771
PRIMARY CARE TOTAL	**260,013**	**255,292**	**4,721**

2.2 The overall Primary Care and Prescribing budgets show an underspend of £4.721m, consisting of underspends against planned values for local primary care commissioned services and prescribing budgets. However, noting that the position is relatively early in the year and again there is a known time-lag in some data sources in order to inform the forecast position.

2.3 Further analysis is provided below on each of the relevant budgets and forecasts and their associated variances.

3.0 Local "Place" Primary Care

3.1 The below table illustrates the budget and anticipated forecast for Local "Place" Primary Care for the period of April-June 2022, combining the 9 CCG positions into a single ICB level position for the first time.

Primary Care Position Summary June 2022	Forecast Outturn		
	Budget (£000's)	Forecast (£000's)	Variance (£000's)
Local Place Primary Care			
Primary Care Scheme	3,691	3,336	355
Primary Care Local Enhanced Services/Other	8,336	7,455	881
Primary Care Access Fund	3,763	3,681	82
Primary Care IT	4,094	3,928	166
Out of Hours	6,436	6,211	225
LOCAL PRIMARY CARE TOTAL	**26,320**	**24,611**	**1,709**

3.2 The local "Place" Primary Care budget is showing an underspend of £1.709m, but further work is required in order to ensure consistency of approach as a result of bring together the 9 separate organisations positions.

3.3 The main driver the underspend in respect of the Primary Care Local Enhanced services category is that, prior to April 2022, the '£1.50 Core PCN funding was funded via Local Primary Care monies as opposed to the Delegated Co-Commissioning budget. However, after the plans were submitted in June, NHS England made the decision to fund the £1.50 Core Primary Care Network (PCN) Funding as part of the Primary Care Co-Commissioning budget.

3.4 The equivalent spend is therefore now reflected within the Delegated Co-Commissioning budget. The planned budget remains within the local budget, but without any associated forecasted spend. Therefore, leading to an underspend of approximately £0.881m

4.0 Primary Care Delegated Commissioning

4.1 The below table illustrates the budget and anticipated forecast for Primary Care Co-Commissioning for the period of April-June 2022, , combining the 9 CCG positions into a single ICB level position for the first time.

Primary Care Position Summary June 2022	Forecast Outturn		
	Budget (£000's)	Forecast (£000's)	Variance (£000's)
Delegated Primary Care			
General Practice - GMS	46,729	46,447	282
General Practice - PMS	24,578	24,648	(70)
Other List Based Services	2,152	2,152	(0)
Premises Reimbursements	7,964	8,474	(510)
NHS Property Services	3,123	3,078	45
Other Premises	795	773	22
Enhanced Services	3,153	3,731	(578)
PCN DES	5,104	5,519	(415)
Additional Roles	8,029	8,029	0
QOF	6,263	6,137	125
Other - GP Services	4,439	3,100	1,339
DELEGATED PRIMARY CARE TOTAL	**112,329**	**112,088**	**241**

4.2 The 9 CCG's were allocated £112.329m with regards to 'Delegated' Primary Care budgets covering the Q1 period of 1st April- 30th June 2022.

4.3 The devolved Primary Care budgets have been set based on known recurrent Primary Care commitments for the 22/23 financial year and included relevant contract uplifts such as

- GMS/PMS Global sum payments were increased from £96.78 to £99.70 per weighted patient
- An increase in the value of a Quality and Outcomes Framework (QOF) points from £201.16 to £207.56 (3.2% increase) noting that the allocation received allows for this increase, together with a forecast for demographic growth and QOF achievement.

4.4 The Delegated Primary Care Co-Commissioning budget is a discrete allocation and should be noted that historically, for some of the former Clinical Commissioning Groups (CCG's) the allocations received, were not sufficient to cover the contractual requirements needed to fund the required expenditure.

4.5 This therefore results in a number of overspends which will need to be further understood at an overall ICB level including the resulting position in the PCN DES category of £0.415m and the Enhanced services category of £0.578m

4.6 Below is a summary of the revised PCN DES patient weightings per category that have now been finalised, noting that these costs have changed slightly since the original plans were submitted by CCG's.

- **Core PCN Payment-** £1.50 per head/ based on registered list size.
- **Clinical Director payment** of £0.736 per/head based on registered list size.
- **Extended Access/Enhanced Access payment** of £0.720 per/head based on registered list size April to September 2022, then £3.764 per/head based on adjusted population value from October 2022 to March 2023.
- **Impact and Investment Fund payment** up to £4.221per /head based on registered list size (to be achieved, not automatically paid).
- **Leadership and Management Support payment** of £0.699 per/head based on adjusted population value.

4.7 Premises Reimbursement costs also overspent by £0.510m, this is due to the rent re-valuations that have taken place during the end of the financial year 2021/2022 and the first quarter of the year this financial year April - June 2022. Again this will require review in the longer term and link to estates strategy and decision making around practice 'estates' requests

5.0 Prescribing

5.1 The Prescribing budget as per submitted plan across the former CCG's was £121.364m for the period of April 2022- June 2022.

5.2 As above, prescribing data is generally provided 6-8 weeks in arrears, and therefore it is difficult to accurately predict at this stage the in-year run rate, but based on available month 1 information, the anticipated forecast is £118.593m, resulting in an overall underspend of £2.771m as can be seen in the table below

Primary Care Position Summary June 2022	Forecast Outturn		
	Budget (£000's)	Forecast (£000's)	Variance (£000's)

Prescribing				
Itemised Prescription Payment & Central Drugs	118,446	115,460		2,986
Oxygen	1,207	1,220		(13)
Local Schemes	159	186		(27)
Prescribing Other	1,552	1,727		(175)
PRESCRIBING TOTAL	**121,364**	**118,593**		**2,771**

5.3 It should be noted that the estimated forecast at the end of March 2022 for many former CCG's was higher than the actual costs that were received. It has been difficult to use previous methodologies to predict prescribing costs and trends due to covid as prescribing has been less predictable and further work is required to ensure consistency of methodologies in this area

6.0 Additional Roles Reimbursement Scheme (ARRS) 2022/23

6.1 The Additional Roles Reimbursement Scheme (ARRS) underpin the PCN (Primary Care Network) Direct Enhanced Service with the amount available for PCNs to recruit additional staff increasing again in the 22/23 financial year by £280m nationally, to just over £1 billion. PCNs will continue to have flexibility to hire into any of the 15 different roles.

6.2 The total funding available for Cheshire and Merseyside PCN's is £39.031m, with £24.088m included in the Primary Care Co-Commissioning baseline. Once the PCN's costs exceed this a further request of up to £14.943m can be made by the ICB to draw down from the central team at NHS England as per the below table

Cheshire & Merseyside ICB -Additional Roles Reimbursment Scheme July 2022-March 2023	Total £000
ARRS Total Allocation	39,031
ICB Baseline	24,088
Central Drawdown	14,943

6.3 Finance teams are working closely with PCN's to update forecast assumptions and to ensure that they are in the best position to utilise as much of the allocation as possible.

7.0 Recommendations

7.1 The Primary Care committee are asked to note the combined CCG financial summary position as at the end of Quarter One within the 22/23 financial year, noting the relative availability of in-year information

7.2 The committee is also asked to note the work required during the second quarter to standardise forecast methodologies in order ensure consistency of approach and resulting combined reporting approach for the ICB.

8.0 Officer contact details for more information

Lorraine Weekes-Bailey
Senior Primary Care Accountant– lorraine.weekes@nhs.net

NHS
Cheshire and Merseyside

Committee Report

NHS Cheshire and Merseyside
System Primary Care Committee

Date: 25th August 2022

NHS Cheshire and Merseyside
Primary Care Committee (System Level)

NHS Cheshire and Merseyside

Date of meeting:	25th August 2022
Agenda Item No:	PCC/8/22/08
Report title:	**ICB Dispute Resolution NHS Contracts – Primary Care GMS PMS (and APMS contracts under appropriate clauses)**
Report Author & Contact Details:	Christopher Leese Associate Director of Primary Care
Report approved by:	Clare Watson, Assistant Chief Executive

Purpose and any action required	**Decision/ Approve**	**x**	**Discussion/ Gain feedback**	x	**Assurance**	x	**Information/ To Note**	

Route to this meeting / Committee/Advisory Group previously presented to (if applicable)

Executive Summary and key points for discussion

This paper is to outline and agree the approach in respect of the Dispute Resolution Process for GMS (General Medical Services) and PMS (Personal Medical Services) NHS Contracts (And APMS- Alternative Provider Medical Services - where the appropriate clause is invoked) in line with the Primary Medical Care Policy and Guidance Manual (The NHS Policy Book/PGM)

Appendix 1

- Link to Primary Medical Care Policy and Guidance Manual Part C 4 'Managing Disputes' section refers
- Extract from Policy Book as above (Part C 4 Managing Disputes)

This paper applies to General Practice (Primary Medical Care) contracts only

Recommendation/ Action needed:	**The Committee is asked to:** **Agree** the approach in respect of Managing Disputes within Cheshire and Merseyside ICS in line with Part C Section of 4 of the Primary Medical Care Policy and Guidance Manual ('The Policy Book')

Which purpose(s) of an Integrated Care System does this report align with?

Please insert **'x'** as appropriate:

1. Improve population health and healthcare	
2. Tackle health inequality, improving outcome and access to services	
3. Enhancing quality, productivity and value for money	**X**
4. Helping the NHS to support broader social and economic development	

C&M ICB Priority report aligns with:	
Please insert **'x'** as appropriate:	
1. Delivering today	**x**
2. Recovery	
3. Getting Upstream	
4. Building systems for integration and collaboration	

Place Priority(s) report aligns with: *(Place to add)*	
Please insert **'x'** as appropriate:	

Governance and Risk					
Does this report provide assurance against any of the risks identified in the ICB Board Assurance Framework or any other corporate or Place risk? **YES**					
What level of assurance does it provide?					
Limited		**Reasonable**	**X**	**Significant**	
Any other risks? **NO** If **YES** please identify within the main body of the report.					
Is this report required under NHS guidance or for a statutory purpose? (*please specify*) **Yes – managing disputes with primary medical care contractors (General Practice)**					
Any **Conflicts of Interest** associated with this paper? If **YES** please state what they are and any mitigations undertaken. **NONE**					
Any current services or roles that may be affected by issues as outlined within this paper? **NO**					

Primary Care – Disputes in relation to NHS Contracts under GMS PMS (and some APMS clauses)

1.0 Summary of Current Position

1.1 The Primary Medical Care Policy and Guidance Manual (PGM) (also known at The Policy Book) outlines the process to determine the action required when a contractor has requested to follow the NHS dispute resolution process or where the Commissioner elects to follow the NHS dispute resolution procedure. The policy focuses on primary medical care contracts in their various forms.

1.2 GMS (General Medical Services) and PMS (Personal Medical Services) contracts require the parties to make every reasonable effort to communicate and co-operate with each other to resolve the dispute before referring the dispute for determination in accordance with the NHS dispute resolution procedure before commencing further legal proceedings.

1.3 The dispute resolution process for APMS (Alternative Provider of Medical Services) contracts is specific to the agreement as set out in the APMS contract. The APMS contract must be reviewed in the event of a dispute and that process followed. The APMS Directions do not require the NHS dispute resolution to be included in the APMS contract and more commercial terms are usually set out but it may be that the process applicable to GMS and PMS is followed in which case this policy can be applied.

1.4 Currently many 'Places' have their own policy in line with the national policy book but these were applicable to their respective CCG's as statutory bodies. The ICB should therefore set out its approach to disputes for agreement for the contracts named, so that contractors and place-based staff are able to understand and access this in line with the Policy and Guidance Manual.

1.5 It is important to address this now due to pending disputes at place but also to safeguard against any future challenges which may in turn breach the ICB's Delegation agreement with NHSE/I

2.0 Suggested new process in line with policy book

2.1 As stated, GMS and PMS contracts require the parties to make every reasonable effort to communicate and co-operate with each other to resolve the dispute before onward referral. This includes the informal stage of the policy book steps below

2.2 The first step as determined by the NHS Policy Book is an informal process where ;

- The parties must make every reasonable effort to communicate their issues in relation to decision-making and rationale and must co-operate with each other to resolve any disputes that emerge informally before considering referring the matter for determination through formal dispute resolution procedures.

- The formal process should not be initiated until the informal process has been exhausted and it should be noted that both parties may wish to involve the relevant professional representative (e.g. LMC).

2.2 In terms of the ICB this informal stage of the process should be undertaken by the local team (or corporate ICB staff) involved in the original decision and steps suggested in the Policy Book should be followed including mediation, to try and resolve this informally. The relevant Place Director/Place Exec Lead for contracts should oversee this process and be kept aware and involved to try and reach agreement. Any potential financial issues should have already been flagged at this stage hence the involvement of Place based Associate Directors of Finance.

2.3 The Corporate ICB Primary Care team should be made aware of issues at the informal stage so that it can prepare for any future escalation and should be assured that the place team is addressing this informally in line with the Policy Book, including involvement of the LMC at place.

2.4 Where the informal stage is unsuccessful then the contractor may proceed to Managing Disputes Stage 1 – Local Dispute Resolution outlined in the Policy Book.

2.5 At this stage the ICB will assign either another Place team to review this or the ICB Primary Care corporate team who will follow the process outlined in the NHS Policy Book with regards to timescales, meetings and notifications (C4 Section 4 Clause 4.4). An appropriate task and finish group will be set up to oversee this.

2.6 That onward team identified will follow all necessary steps and report to the ICB corporate the outcome of their results for review before communicating to the provider. The sign off for this stage will be via the Primary Care ICB Exec Lead for Primary Care or their nominated report.

2.7 If the provider still wishes to pursue the dispute beyond Stage 1 Formal then the ICB Corporate Team must involve and notify NHSE/I as per section 4.5 Stage 2 (NHS Dispute Resolution Procedure) of the Delegated commissioning arrangements agreement- - the provider at this stage writes direct to Primary Care Appeals (PCA) at NHSR (NHS Resolution) who now take the lead for this stage, to a final decision.

2.8 At this stage the place team working with the ICB Corporate team must ensure all relevant documentation requested is forwarded under the direction of NHS Resolution in line with the asks under the Policy Book

2.9 Please note that it is imperative that adequate resources are directed to stage 2.2 within Place, supported by the corporate team, to resolve these issues informally. Additional

mediation support can be sourced for this including finance and governance if required, but the overall approach must be informal and partnership led in nature.

3.0 Recommendations

3.1 The Committee is asked to **agree** the high level process given above in respect of ICB Dispute Resolution NHS Contracts – Primary Care GMS PMS (and APMS contracts under appropriate clauses) noting some further work will be required to embed this, working with LMC colleagues and others**.**

4.0 Officer contact details for more information

Chris Leese
Associate Director of Primary Care – c.leese@nhs.net
c.leese@nhs.net

Appendix 1

- Link to Primary Medical Care Policy and Guidance Manual Part C4 ‘Managing Disputes’ refers

https://www.england.nhs.uk/publication/primary-medical-care-policy-and-guidance-manual-pgm/

- Extract from Policy Book as above (included in the paper pack)

dispute resolution.docx

1 Managing Disputes

1.1 Introduction

1.1.1 This policy describes the process to determine the action required when a contractor has requested to follow the NHS dispute resolution process or where the Commissioner elects to follow the NHS dispute resolution procedure.

1.1.2 The policy focuses on primary medical care contracts in their various forms.

1.2 Background

1.2.1 The Commissioner must identify whether the contract is an NHS contract or a non-NHS contract. In GMS contracts, the Commissioner can do this by reviewing clause 14 of the standard GMS contract. A similar clause will also be set out within PMS and APMS contracts.

1.2.2 An NHS contract (as set out at section 9 of the NHS Act) is an arrangement under which one health service body arranges for the provision of goods or services to another health service body. It must not be regarded as giving rise to contractual rights or liabilities.

1.2.3 A non-NHS contract is where the contract is legally binding.

1.2.4 Contractors have the right to be regarded as a health service body under regulation 10 of the GMS Regulations or regulation 9 of the PMS Regulations or where the APMS contractor is a health service body by virtue of section 9 of the NHS Act.

1.2.5 Where a contractor is regarded as being a health service body, its contract will be an NHS contract. Where a contractor is not regarded as a health service body, its contract will not be an NHS contract. Health service body status affects the eligibility and application process for NHS dispute resolution.

1.2.6 GMS and PMS contracts require the parties to make every reasonable effort to communicate and co-operate with each other to resolve the dispute before referring the dispute for determination in accordance with the NHS dispute resolution procedure or, where applicable, before commencing Court proceedings.

1.2.7 There are two different routes that can be taken for resolving contractual disputes, depending on the contractor's health service body status:

1.2.7.1 where the contractor is a health service body and the contract is an NHS contract the steps laid out in this policy will be used to resolve all matters of dispute. The parties should not make a claim at Court in relation to the contracts; or

1.2.7.2 where the contractor is not a health service body and the contract is a non-NHS contract, the dispute can either be resolved using the process described within this policy or using the Court system.

1.2.8 The dispute resolution process for APMS contracts is specific to the parties' agreement as set out in the APMS contract. The APMS contract must be reviewed in the event of a dispute and that process followed. The APMS Directions do not require the NHS dispute resolution to be included in the APMS contract and more commercial terms are usually set out.

1.2.9 The use of the Court system can be an expensive and public route. In normal circumstances, non-health service bodies will elect to follow the NHS dispute resolution.

1.2.10 Where the parties have followed this policy and the NHS dispute resolution to the end determination, the result is binding. A second referral to the Court system for a further ruling on the same issue cannot be made other than to enforce the decision as having the status of a County Court Judgement or to seek Judicial Review of the process.

1.3 Managing Disputes – Informal Process

1.3.1 The parties must make every reasonable effort to communicate their issues in relation to decision-making and rationale and must co-operate with each other to resolve any disputes that emerge informally before considering referring the matter for determination through formal dispute resolution procedures.

1.3.2 The formal process should not be initiated until the informal process has been exhausted and it should be noted that both parties may wish to involve the relevant professional representative (e.g. LMC).

1.3.3 The use of an informal resolution process helps develop and sustain a partnership approach between contractor and Commissioner.

1.3.4 The informal process may include (but is limited to):

1.3.4.1 regular telephone communications;

1.3.4.2 face-to-face meetings at a mutually convenient location; and/or

1.3.4.3 written communications.

1.3.5 It is essential that the Commissioner maintains accurate and complete written records of all discussions and correspondence on the contract file in relation to the dispute at all levels of dispute resolution. The Commissioner should ensure that it responds to contractor concerns and communications in a timely and reasonable manner.

1.4 Managing Disputes – Stage 1 (Local Dispute Resolution)

1.4.1 The timescales set out in this stage 1 are indicative only. The Commissioner should ensure any timescales used are appropriate to the circumstances. Regardless of timescales, the parties must ensure that every reasonable effort to communicate and co-operate with each other is made prior to invoking stage 2 of the NHS dispute resolution procedure.

1.4.2 Where a dispute arises, the Commissioner should refer to the relevant policy that covers the issue that caused the dispute to determine whether due process has been followed.

1.4.3 The contractor should notify the Commissioner of its intention to dispute one or more decisions made in relation to its contract. This notification should usually be received no later than 28 days after the Commissioner advises the contractor of its decision except in exceptional circumstances.

1.4.4 The Commissioner will immediately cease all actions in relation to the disputed notice or decision, until:

1.4.4.1 there has been a determination of the dispute and that determination permits the Commissioner to impose the planned action; or

1.4.4.2 the contractor ceases to pursue the NHS dispute resolution procedure or Court proceedings,

1.4.4.3 whichever is the sooner.

1.4.5 Where the Commissioner is satisfied that it is necessary to terminate the contract or impose a Contract Sanction before the NHS dispute resolution procedure is concluded in order to:

1.4.5.1 protect the safety of the contractor's patients; or

1.4.5.2 protect NHS England from material financial loss;

1.4.5.3 then the Commissioner shall be entitled to terminate the contract or impose the contract sanction at the end of the period of notice it served. This should only be followed with close reference to the GMS Regulations and PMS Regulations, pending the outcome of that procedure.

1.4.6 The paragraphs below set out a process that may be adopted for stage 1 (Local Dispute Resolution).

1.4.7 The Commissioner may acknowledge the notification of dispute within seven days of receipt and request the submission of supporting evidence from the contractor within a further 28 days from the date they receive the letter. An example acknowledgement letter is provided in Annex 1.

1.4.8 Upon receipt of the evidence the Commissioner should review the evidence within 28 days and invite the contractor to attend a meeting, which should be as soon as possible, but at the very latest within a further 28 days. The contractor(s) has the opportunity to invite representative bodies to support it at the meeting, for example, the LMC. An example invite letter is provided in Annex 2.

1.4.9 Once the meeting has been held, the Commissioner should notify the contractor in writing of the outcome of the meeting, whether the dispute will now need to be moved to stage 2 of the NHS dispute resolution procedure (refer to the example stage 1 outcome letter in Annex 3) or that the dispute has been successfully resolved (refer to the example stage 1 outcome letter in Annex 4).

1.4.10 Where the matter is resolved, the issue can be deemed closed and the Commissioner should document the outcome accordingly on the contract file.

1.4.11 Where the matter remains unresolved, the process may be escalated to the next stage of the dispute resolution procedure.

1.4.12 At this point the Commissioner should commence preparation of the contract file to ensure that if and when NHSR or Court requests submission of evidence in respect of the dispute the documentation is in order.

1.5 Managing Disputes – Stage 2 (NHS Dispute Resolution Procedure)

1.5.1 The informal process and stage 1 (Local Dispute Resolution) should be exhausted before proceeding to this stage of the process. The Commissioner or a contractor wishing to follow this route must submit a written request for dispute resolution to Primary Care Appeals (PCA) at NHSR, which carries out the NHS dispute resolution functions of the Secretary of State in the GMS Regulations and the PMS Regulations, which should include:

1.5.1.1 the names and addresses of the parties to the dispute;

1.5.1.2 a copy of the contract; and

1.5.1.3 a brief statement describing the nature and circumstances of the dispute.

1.5.2 The written request for dispute resolution must be sent within three years from the date on which the matter gives rise to the dispute occurred or should have reasonably come to the attention of the party wishing to refer the dispute. Please see NHSR PCA (formerly FHSAU) determination reference 17156 for further details on the date that the dispute should have reasonably come to the attention of the relevant party.

1.5.3 The Commissioner will be required to prepare documentation evidence and potentially an oral presentation in response to evidence presented in support of the dispute. Each party will be asked to prepare representations on the dispute, which will be circulated to the other party and an opportunity to provide observations on the other party's representations will be given. Again, the observations of each party will be circulated to the other party.

1.5.4 The Commissioner should not underestimate the preparation that will be required in the event that evidence is required by NHSR PCA, as all records

pertaining to the contractor in question may be required, including (but not limited to) all contract documentation and contract variations, all written correspondence (both to and from the Commissioner and the contractor) and any electronic correspondence that may have passed between the parties, in relation to the dispute. This process will benefit from a clearly recorded contract file.

1.5.5 The Commissioner must ensure that records of communications and contract files are maintained to a high standard and all documentary evidence is collated correctly prior to submission to NHSR PCA

1.5.6 Once NHSR PCA has reached a conclusion (the determination) the Commissioner will receive a copy and will be required to act upon it. A copy of the Guidance Note for parties involved in Dispute Resolution at the NHSR PCA is attached in Annex 5 and should be followed by the parties to the dispute.

Delegated commissioning arrangements

The Delegation Agreement includes a section on Claims and Litigation which is likely to include a dispute with a GMS, PMS or APMS contractor that has been referred to Stage 2 of the NHS dispute resolution procedure. In such cases, the CCG/ICB is required to act in accordance with the Delegation Agreement which includes but is not limited to:

- notifying NHS England of any documents concerning the dispute and providing copies of these documents;
- co-operating fully with NHS England in relation to such dispute and the conduct of such dispute;
- providing, at its own cost, to NHS England all documentation and other correspondence that NHS England requires for the purposes of considering and/or resisting such dispute; and/or
- at the request of NHS England, taking such action or step or providing such assistance as may in NHS England's discretion be necessary or desirable having regard to the nature of the dispute and the existence of any time limit in relation to avoiding, disputing, defending, resisting, appealing, seeking a review or compromising such dispute or to comply with the requirements of NHSR PCA (formerly the FHSAU) in relation to such dispute.

NHS
Cheshire and Merseyside

Committee Report

Cheshire and Merseyside ICB
System Primary Care Committee
Date: 25th August 2022

Cheshire and Merseyside ICB
System Primary Care Committee

NHS Cheshire and Merseyside

Date of meeting:	25th August 2022
Agenda Item No:	PCC/8/22/09
Report title:	Minutes of NHS England Pharmaceutical Services Regulations Committee (PSRC)
Report Author & Contact Details:	Pam Soo
Report approved by:	

Purpose and any action required	**Decision/ Approve** →		**Discussion/ Gain feedback** →		**Assurance** →		**Information/ To Note** →	X

Route to this meeting / Committee/Advisory Group previously presented to (if applicable)
NHS England Pharmaceutical Services Regulations Committee (PSRC)

Executive Summary and key points for discussion

Community Pharmacy Services and the Dispensing elements of Dispensing Doctors contracts are managed through the regulatory mechanisms of *The National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 (as amended)*- now referred to in this paper as "The Regulations".

As part of the ICS governance structure the monthly minutes of the PSRC will be submitted to the Cheshire and Merseyside ICB Place Primary Care Meeting for noting.

Summary of the decisions made by the PSRC during the meeting held on 18th July 2022:

2 x Applications for Distance Selling Pharmacies – Approved

- CAS-3205166-J0G6R3
  Applicant: 24/7 Medicine Limited c/o Rushport Advisory LLP, 10-12 Barnes High Street Barnes SW13 9LW

  Premises: 15 Stuart Rd, Waterloo, Liverpool L22 4QR

- CAS-140603-C8H0B6
  Applicant: Sharief Healthcare Ltd C/O Rushport Advisory LLP 10-12 Barnes High Street Barnes SW13 9LW

  Premises: Pharmacy Unit 2 Roundwood Drive St Helens WA9 5JD

1 x Application for a Change of Ownership – Approved

- CAS-155241-Z1L8J9
  Applicant: AIM Rx Ltd

  Premises: 77 High Street Newton-le-Willows Merseyside WA12 9SL

2 x Application for Change of Core Hours – Refused

- Ponda's Chemist Ltd FP677 Ponda's Chemist 7 Cheviot Square Winsford CW7 1QS
- O'Brien's Pharmacy Ltd FPP13 Riverside Pharmacy Riverside Centre for Health Park Street Liverpool L8 6QP

1 x Application for Change of Core Hours – Not heard due to inaccuracy of information provided by the applicant.

- Wise Pharmacies Ltd FVR81 Wise Pharmacy 11 London Road Sandbach Cheshire CW11 3BD

Recommendation/ Action needed:	**The Committee is asked to:** Note the minutes of this meeting

Which purpose(s) of an Integrated Care System does this report align with?	
Please insert **'x'** as appropriate:	
1. Improve population health and healthcare	x
2. Tackle health inequality, improving outcome and access to services	x
3. Enhancing quality, productivity and value for money	x
4. Helping the NHS to support broader social and economic development	

C&M ICB Priority report aligns with:	
Please insert **'x'** as appropriate:	
1. Delivering today	x
2. Recovery	x
3. Getting Upstream	
4. Building systems for integration and collaboration	

Place Priority(s) report aligns with:	
Please insert **'x'** as appropriate:	

Governance and Risk						
Does this report provide assurance against any of the risks identified in the ICB Board Assurance Framework or any other corporate or Place risk? (*please list*)						
What level of assurance does it provide?						
Limited		**Reasonable**		**Significant**	x	
Any other risks? No. If **YES** please identify within the main body of the report.						

	Is this report required under NHS guidance or for a statutory purpose? (*please specify*) – yes as required under The National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 (as amended)
	Any **Conflicts of Interest** associated with this paper? If **YES** please state what they are and any mitigations undertaken. No
	Any current services or roles that may be affected by issues as outlined within this paper? No

	Process Undertaken & Impact Considerations	**Yes**	**No**	**N/A**	**Comments** (i.e. date, method, impact e.g. feedback used). ***Greater detail to be covered in main body of report***
Document Development	Financial – any resource impact?		No		Pharmacies are renumerated based on activity and new premises do not attract financial payments of any kind in their own right.
	Patient / Public Involvement / Engagement	Yes			Patient engagement is a statutory element of the Pharmaceutical Needs assessments which decisions are based on.
	Clinical Involvement / Engagement		No		Only appropriate for FtP applications or some considerations of contractual breach
	Equality Impact Analysis (EIA) - any adverse impacts identified? EIA undertaken?	Yes			Considered as part of each regulatory decision process
	Regulatory or Legal - any impact assessed or advice needed?	Yes			All decisions taken with reference to The National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 (as amended) – any advice required provided by Primary Care Contracting (PCC)
	Health Inequalities – any impact assessed?	Yes			Analysis of Health Inequalities is a statutory element of the Pharmaceutical Needs assessments which decisions are based on.
	Sustainable Development – any impact assessed?		No		

Next Steps:	. Decisions to be noted by the committee

Responsible Officer to take forward actions:	None

Appendices:	Ratified Minutes July 2022 PSRC .doc (not included in the pack but available on request)

Minutes of NHS England Pharmaceutical Services Regulations Committee (PSRC)

1. Executive Summary

Community Pharmacy Services and the Dispensing elements of Dispensing Doctors contracts are managed through the regulatory mechanisms of *The National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 (as amended)*- now referred to in this paper as "The Regulations".

As part of the ICS governance structure the monthly minutes of the PSRC will be submitted to the Cheshire and Merseyside ICB Place Primary Care Meeting for noting.

2. Introduction / Background

Community Pharmacy Services and the Dispensing elements of Dispensing Doctors contracts are managed through the regulatory mechanisms of *The National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 (as amended)*- now referred to in this paper as "The Regulations".

In order to manage and implement these regulations NHS England has established local committees to be known as Pharmaceutical Services Regulations Committees ("PSRC"). Each PSRC is authorised by NHS England to undertake any activity within these terms of reference. These committees are Regulatory and work under the governance of these Regulations.

NHS England has delegated decision making to each PSRC in relation to matters under the Regulations including:

- Market Entry / Exit applications for Community Pharmacy and Dispensing Doctors,
- contractual matters for consideration e.g. amendment to opening hours, consideration of Breach or Remedial notices for breaches in contractual Terms of Service,
- Fitness to Practice applications pertaining to Superintendent Pharmacists or Directors of companies providing pharmaceutical Services
- Upkeep of the published Pharmaceutical List. (list of all pharmacies and dispensing doctors in each Health and Wellbeing Board Area)

The voting membership of each PSRC shall be as follows:
• Director of Commissioning (or their suitable, nominated deputy) who will chair the meeting in the absence of the Head of Primary Care;
• Head of Primary Care (or their suitable, nominated deputy) who will chair the meeting; and
• Up to two lay members (or equivalent).
Voting members are supported by co-opted committee members including:
• Pharmacy Contract Manager (or equivalent); and
• Pharmacy professional adviser (or equivalent) (if applicable).

Due to the knowledge and understanding of the Regulations that is required, PSRC lay members are considered to be 'expert volunteers' for the purposes of NHS England's volunteering policy and should receive the appropriate fee.

All members of the PSRC must have a good knowledge and understanding of the Regulations in order to reduce the likelihood of a successful appeal against decisions made. It is essential that members build up expertise in the Regulations and therefore consistency of attendance is expected.

Full Terms of References (TOR) for the PSRC can be found on page 14 of the Pharmacy Manual: https://www.england.nhs.uk/wp-content/uploads/2019/08/pharmacy-manual-v2.pdf

Where appropriate, decisions are taken with regard to the Pharmaceutical Needs Assessments. These are published by each Health and Wellbeing Board every 3 years with regard to the Joint Strategic Needs Assessments and determine the requirements for Pharmaceutical Services in each health and wellbeing Boards area.

3. Report

Summary of the decisions made by the PSRC during the meeting held on 18th July 2022:

2 x Applications for Distance Selling Pharmacies – Approved

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- Wise Pharmacies Ltd FVR81 Wise Pharmacy 11 London Road Sandbach Cheshire CW11 3BD

4. Recommendations

Committee to note decisions taken 18th July 2022

5. Officer contact details for more information

Pam Soo- Senior Primary Care Manager NHS England – North West Region

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NHS
Cheshire and Merseyside

Committee Report

Cheshire and Merseyside ICB
Place Primary Care Meeting Knowsley
Date: 25 August 2022

Cheshire and Merseyside ICB
Place Primary Care Meeting Knowsley

Date of meeting:	25th August 2022
Agenda Item No:	PCC/8/22/10
Report title:	Knowsley Place Primary Care Funding Review update
Report Author & Contact Details:	Alistair Macfarlane alistair.macfarlane2@knowsleyccg.nhs..uk Tel 07717 420 999
Report approved by:	

Purpose and any action required	**Decision/ Approve** →		**Discussion/ Gain feedback** →		**Assurance** →		**Information/ To Note** →	✓

Route to this meeting / Committee/Advisory Group previously presented to (if applicable)

Ongoing process, updates previously provided to NHS Knowsley CCG PCC prior to disestablishment

Executive Summary and key points for discussion

- Knowsley place has underlying overspend against delegated Primary Care Budget
- Main sources of overspend have been identified as historic service investments which have either not been updated to reflect national changes and therefore are duplicative in nature or local investments which do not appear to be resulting in improved outcomes for Knowsley patients compared to other local peers or benchmarked primary care performance measures.
- CCG/ICB teams have been working with Knowsley GP practices and LMC partners to achieve resolution in respect of these issues
- The ICB has now formally advised GP practices of its intended approach and timeline for proposed funding changes to ensure a return to a more sustainable financial position
- Work is ongoing, in collaboration with General Practice representatives, to develop a new specification for a local Primary Care Quality Improvement Scheme which will utilise available funding 'envelope' for Primary Care in Knowsley
- As part of this work The ICB will ensure that its responsibilities in respect of its duties under the Public Sector Equality Duty are met
- Final specification for local Primary Care Quality Improvement Scheme and Impact Assessment on the changes required to Primary Care funding in Knowsley will be submitted to PCC for consideration and approval once completed.

Cheshire and Merseyside ICB
Place Primary Care Meeting Knowsley

Recommendation/ Action needed:	**The Committee is asked to:** Note the content of this briefing and the steps taken to ensure a return to a more sustainable financial position in respect of Primary Care delegated budget for Knowsley place. Note the proposed timeline for resolution of these issues, the work ongoing to develop a new specification for a local Primary Care Quality Improvement Scheme in Knowsley and the plans in place to ensure that the ICB meets its responsibilities in respect of its duties under the Public Sector Equality Duty.

Which purpose(s) of an Integrated Care System does this report align with?	
Please insert **'x'** as appropriate:	
1. Improve population health and healthcare	x
2. Tackle health inequality, improving outcome and access to services	x
3. Enhancing quality, productivity and value for money	x
4. Helping the NHS to support broader social and economic development	

C&M ICB Priority report aligns with:	
Please insert **'x'** as appropriate:	
1. Delivering today	x
2. Recovery	
3. Getting Upstream	x
4. Building systems for integration and collaboration	x

Place Priority(s) report aligns with: ***(Place to add)***	
Please insert **'x'** as appropriate:	
Improving access to Primary Care	x
Reducing avoidable hospital attendances and admissions	x
Single 'front door' for health, social care, wellbeing and self-care information advice and guidance	x
Targeted approach to population health	

Governance and Risk						
Does this report provide assurance against any of the risks identified in the ICB Board Assurance Framework or any other corporate or Place risk? (*please list*)						
What level of assurance does it provide?						
Limited		**Reasonable**		**Significant**		
Any other risks? **No** If **YES** please identify within the main body of the report.						
Is this report required under NHS guidance or for a statutory purpose? (*please specify*) **No**						
Any **Conflicts of Interest** associated with this paper? If **YES** please state what they are and any mitigations undertaken. **No**						
Any current services or roles that may be affected by issues as outlined within this paper? **No**						

Cheshire and Merseyside ICB
Place Primary Care Meeting Knowsley

Document Development	Process Undertaken & Impact Considerations	Yes	No	N/A	**Comments** (i.e. date, method, impact e.g. feedback used). ***Greater detail to be covered in main body of report***
	Financial – any resource impact?	x			
	Patient / Public Involvement / Engagement	x			
	Clinical Involvement / Engagement	x			
	Equality Impact Analysis (EIA) - any adverse impacts identified? EIA undertaken?			x	Final Impact Analysis in development
	Regulatory or Legal - any impact assessed or advice needed?			x	Final Impact Analysis in development
	Health Inequalities – any impact assessed?			x	Final Impact Analysis in development
	Sustainable Development – any impact assessed?			x	Final Impact Analysis in development

Next Steps:	. As set out in paper

Responsible Officer to take forward actions:	Alistair Macfarlane, Head of Primary Care Transformation

Appendices:	**Appendix One – Primary Care Contracting (PCC) reports on Knowsley Primary Care Funding** Knowsley CCG Report of Findings I Knowsley CCG Report of Findings I **Appendix Two – JR consulting Integrated Impact Assessment for Knowsley GP practices** JR Consulting Integrated Impact As

Knowsley Place Primary Care Funding Review update

1. Executive Summary

This paper provides an update to the NHS Cheshire and Merseyside Primary Care Committee with regards to ongoing actions being undertaken within Knowsley place to address primary care funding challenges and progress towards a sustainable position for General Practice in Knowsley.

An underlying budget deficit in relation to the Knowsley Primary Care delegated primary care allocation has been identified with annual expenditure exceeding the delegated amount by approx. £1.6m per annum.

This situation has largely arisen due to a combination of additional historic service investments made to GP practices in Knowsley. Combined funding for these schemes on top of annual core contract payments for GMS / PMS contracts meant that total expenditure exceeded the delegated budget provided to the CCG from NHS England (based on allocation formula in place).

An external review of the issues described was undertaken in 2020 confirmed the initial findings of an internal CCG review, identifying areas of duplication in respect of funding and highlighting relative absence of measurable improvements in performance metrics by General Practice services in Knowsley when compared to local and national peers despite these levels of investment.

NHS Knowsley CCG and, from July 2022 onwards NHS Cheshire and Merseyside ICB, have sought to engage with General Practice and LMC colleagues over the past 18 months to identify resolutions to the funding position, address inequities in practice funding levels within Knowsley and ensure that future investments in General Practice removed duplication and included clear goals and objectives to deliver measurable improvements in care for patients.

In July 2022 the ICB formally responded to a range of issues and requests raised by GP practices, setting out its plans to bring the process to a conclusion and achieve a sustainable funding position compared to levels of delegated primary care budgets in Knowsley.

The ICB will continue to use of available delegated primary care and, where appropriate, other programme funding to make such investments to support necessary improvements

in care and accelerate the transformation of Primary Care planning and provision in line with the ambitions of the NHS Long Term Plan.

A final Impact Assessment in respect of these plans, and the Final specification for the local Primary Care Quality Improvement Scheme currently in development, is planned to be submitted to the Primary Care Committee for review and approval at its September meeting.

2. Introduction / Background

2.1 This paper provides an update to the NHS Cheshire and Merseyside Primary Care Committee with regards to ongoing actions being undertaken within Knowsley place to address primary care funding challenges and progress towards a sustainable position for General Practice in Knowsley compared to levels of delegated primary care budgets.

2.2 The report provides committee members with background information in relation to these issues, describes the actions taken to date reach a resolution and the ICB plans to bring this process to a conclusion.

2.3 The Primary Care Committee is asked to:

- Note the background to this issue and the underlying causes of overspend versus Primary Care delegated budgets in Knowsley.
- Note the steps taken to work with Knowsley GP practices to achieve resolution in respect of these issues and the feedback received from General Practices
- Note the ICBs responsibilities in respect of its duties under the Public Sector Equality Duty
- Note the development of the 'new' specification for a local Primary Care Quality Improvement Scheme, and the ongoing work being undertaken in collaboration with General Practice representatives to finalise this specification.
- Pending review of the final Impact Assessment, note the ICBs intended approach and timeline for proposed funding changes to ensure a return to a more sustainable financial position

3. Background

3.1 NHS Knowsley CCG identified an underlying budget deficit in relation to its delegated primary care allocation during 2020/21, with annual expenditure exceeding the delegated amount by approx. £1.6m per annum.

3.2 The CCG undertook a detailed review of the reasons for the level of overspend during the 2020/21 and commissioned an external organisation (Primary Care Contracting - PCC) to review the issues as described.

3.3 Following a two-stage process PCC confirmed the findings of the internal review, identifying areas of duplication in respect of funding and highlighting relative performance delivery of General Practice services in Knowsley to local and

national peers despite these levels of investment. PCC reports are included as appendix 1 to this report.

3.4 This situation was largely due to a combination of additional historic service investments consisting of 3 schemes in particular:

3.4.2 'PMS Premium' this scheme, the details of which had originally been agreed prior to the establishment of the CCG, included payment for services which are the commissioning responsibility of local authorities, for elements which now form part of General Practice core contract requirements or current Quality and Outcomes Framework (QOF) or Primary Care Network DES.

3.4.3 'Fairness in Primary Care' payments to practices for historic employment of salaried GPs to improve relative rates of access to GP appointments per 000 registered patients

3.4.4 'Primary Care Quality Premium (PCQP)' a locally developed quality improvement scheme which included a range of measures including PCN Network level improvement plans, 'stretch' targets for clinical management of long-term conditions and prescribing related incentives.

3.5 Combined funding for these schemes, on top of annual core contract payments for GMS / PMS contracts, meant that total expenditure exceeded the delegated budget provided to the CCG from NHS England (based on allocation formula in place).

3.6 It also became evident that the local schemes had not been updated as required for relative national changes (in particular the national directive issued in 2014 to review PMS contracts addressing the wide variation in core funding per patient, so that all practices receive the same weighted price per patient by 2020-2021).

3.7 There were a range of other issues identified during the process including

- Issues regarding equitable funding levels between GMS / PMS practices (particularly driven by continued payment of PMS premium)
- Issues in relation to 'distance from target' in respect of the CCG delegated budget allocation
- Levels of local investment did not appear to be resulting in improved outcomes for Knowsley patients compared to other local peers or benchmarked primary care performance measures e.g. Access / patient experience / CQC ratings
- The continuation of 'stability' payments historically agreed with one individual GP practice at the time of a merger which should have ceased as was provided for a time limited period to support transition

4. Engagement with practices and Local Medical Committee

4.1 Following receipt of these reports from PCC the CCG held initial conversations with GP practices and LMC during June and July 2021 seeking to identify resolutions to the funding position, address inequities in practice funding levels within Knowsley and ensure that future investments in General Practice removed duplication and included clear goals and objectives to deliver measurable improvements in care for patients.

4.2 These initial discussions included the presentation by the CCG of its high-level intention to consolidate funding associated with the three schemes outlined above into a single funding 'envelope' for non-core GP practice funding/investment with this envelope being reduced over a transitional period to address the over-spend.

4.3 The intended outcome of this process would provide for a non-core GP practice funding envelope of approx. £4.6M per annum (compared to the unsustainable level of expenditure across the three schemes which is currently approx. £5.7m), together with removal of the 'stability' payments being made to the individual practice this would address a significant proportion of the funding gap required to adjust the level of funding in accordance with the delegated allocation.

4.4 This revised 'envelope' would still place Knowsley practices at the highest levels of primary care funding compared to peers (based on available benchmarking information)

Name of CCG	Average payments per registered patient	Average payments per weighted patient
KNOWSLEY CCG - REVISED FUNDING	£174.35	£152.33
KNOWSLEY CCG - CURRENT FUNDING	£182.74	£159.65
INDICATIVE SAVING	£8.39	£7.32

Blackpool CCG	£174.71	£155.97
South Tyneside CCG	£146.97	£133.91
Sunderland CCG	£155.43	£138.33
Durham Dales, Easington, and Sedgefield CCG	£176.36	£147.47
South Sefton CCG	£154.67	£142.92
Halton CCG	£154.88	£142.16

Wirral CCG	**£162.49**	**£145.62**
St Helens CCG	**£152.21**	**£133.61**
Liverpool CCG	**£169.33**	**£151.83**
Average across the 30 NW CCGs	**£157.00**	**£147.89**

4.5 It should be noted that even after this adjustment, a small recurrent pressure will remain (circa £0.1-£0.2m), however the revised envelope of £4.6m available for investment would result in Knowsley practices receiving high levels of funding compared to established benchmark peers with established similarities in population health and levels of deprivation etc.

4.6 The CCG fully recognised the challenges for some practices that these changes would create and the need for a sufficient period of adjustment (particularly for PMS practices) and as such indicated from the outset that a transitional period would be utilised to implement the full impact of any changes.

4.7 Unfortunately little progress was made during initial meetings with GP practices and LMC representatives, in September 2021 Knowsley GP practices commissioned an external consultant (JR Consulting Limited) to help support them in understanding the impact on funding changes. The report produced by JR Consulting was received in December 2021and is included as appendix 2 to this report.

4.8 Following further correspondence between the CCG and Mid Mersey LMC, acting as the practice's representative, a formal response on behalf of the 18 PMS practices in Knowsley was received on 17th June 2022. This response indicated that practices would only be prepared to consider a funding adjustment over a 4-year period with additional requests for support from 'Place and ICS regarding redesign, redundancies and estates'.

4.9 Following its formal establishment and the disestablishment of NHS Knowsley CCG on 1st July NHS Cheshire and Merseyside wrote formally to all Knowsley GP practices in July to set out its response to the practices position and the plans in place to bring the process to a conclusion.

- Given the fact PMS practices have continued to receive PMS premium funding for over 8 years beyond the review date and final 2020/21 deadline for implementation of the NHS England directive has now passed, NHS Cheshire & Merseyside (ICB) have no reasonable alternative but to implement the required adjustment, removing the PMS premium payment with a 12 month pace of change to commence from October 2022 in order to bring consistency and alignment of approach with other PMS practices in Cheshire and Merseyside.

- Continuation of Fairness funding payments would represent potential duplication for payments from other schemes and other overlapping funding from other primary care initiatives (e.g. Access schemes), payments under this scheme would therefore also cease from October 2022 with a with a 12-month transition to full cessation being applied.
- Payments made under the 'Primary Care Quality Premium' scheme would also cease to be replaced by a local Quality Improvement Scheme utilising the available delegated funding envelope of approx. £4.6M. This new scheme will support development and delivery of general practice-based services to be provided to the local population in accordance with patient need. The scheme will be available to all Knowsley practices on an equitable basis and will be designed in collaboration with them to achieve clearly measurable improvements in primary care quality which will be complementary too, but not duplicative of, other NHS funded initiatives or schemes relating to General Practice/Primary Care and will be in addition to any 'core contract' / 'enhanced service' / 'primary care network' / 'additional roles' funding that practices / networks would expect to receive in line with national guidance.
- Whilst further information would need to be provided by individual practices to provide a definitive response, NHS Cheshire and Merseyside is not aware of any legal basis for which it would be responsible for redundancy costs incurred by a GP practice should these ultimately materialise. The ICB did, however, commit to working with practices as a system to mitigate as far as possible any workforce implications of the planned changes.

4.10 The ICB Place team commenced detailed work with GP practice representatives in August 2022 to develop and specify a local Quality Improvement Scheme, weekly workshops are taking place to develop and design clearly defined principles, outcomes, performance measures and detailed schedules for this specification with supported provided by other ICB place teams and input from the Associate Medical Director Primary Care this process is planned for completion by 30th September 2022.

4.11 The detailed specification remains in development, but key priority areas have already been identified.

- Monitoring of patient feedback, complaints and national GP survey results consistently show that access to advice and appointments is a critical element to patient experience and good patient care.
- Whilst the PCN Directed Enhanced Contract (DES) contract offered by NHSE/I for 2022/23 includes plans to address these issues to some extent by requiring PCNs to deliver a single, consistent, combined 'extended access' offer to whole PCN populations and changes to core GMS/PMS contracts have introduced the requirements for practices to offer and promote electronic consultation options there remains significant variation

in access arrangements between individual GP practices both within PCNs and across Knowsley as a whole.

- The impact of necessary changes to access arrangements designed to protect patient and staff safety in response to the COVID pandemic has introduced further complexity for patients as the inability, or perception that they are unable to get appointments when they need one is thought to contribute to patients seeking treatment at alternative, often inappropriate, settings.
- The aim of the scheme will be support practices in fundamentally redesigning and implementing a new model for Primary Care access in Knowsley, to ensure that all patients seeking treatment or assessment are able to make contact with contact their practice in a manner of their choosing, receive a prompt response to this contact and, through the implementation of consistently applied assessment and signposting, are able to receive advice, support or consultation with an appropriately qualified health care professional, via a method that both meets their needs and is in line with their preferences, if required.
- A range of indicators, monitored at Place, PCN and individual practice level, will be utilised to establish baseline, target, and minimum expected levels of improvement for all aspects of patient access, including initial response times, face to face, telephone and digital services that are provided by practices to complement the extended access metrics captured within PCN Direct Enhanced Serves
- Measures are anticipated to include, but are not limited to:
    - Average response times to inbound telephone calls across core hours
    - Average response times to electronic consultation or triage questionnaire submissions
    - Triage outcome dispositions to practice consultations by type (e.g., face to face/telephone/remote consultation)
    - Triage outcome dispositions to other services by type (e.g., Walk in Centre/UTC/Out of Hours provider/Emergency Department)
    - The number of minutes of appointment (of any type) available per week with the following clinician types: GPs, clinical pharmacists, advanced nurse practitioners, qualified physicians' associates, paramedics, physiotherapists, Mental Health practitioners
    - Patient and Practice staff experience and satisfaction surveys

- Developing and implementing such a model will require considerable change to the way in which GP practices plan and manage their workforce, improvements in communication and engagement with patients, public and partners and, by necessity this new access model will require close collaboration between GP practices working alongside other Primary Care providers to develop and implement plans for a consistent, combined primary care offer to the local population.

- The Access component of the scheme will be focused on delivery, and funding, being based on collective achievement of outcomes by practices on a PCN or place basis.
- In addition to the plans for a transformation in Primary Care access the scheme will also feature a range of robust measures to support improvements in safe and effective prescribing by GP practices.

5. Impact Assessment

5.1 Clearly there is a requirement to ensure that the potential impacts of the changes described above, on the local population, registered patients, practices, and staff, are fully understood, with evaluation of impact assessments and consideration of wider requirements to consult considered.

5.2 The CCG/ICB have been working with its Equality & Inclusion team to help develop the appropriate response and documents in relation to paying due regard to the Public Sector Equality Duty.

5.3 The team's primary function is to assist in identifying risks and any equality implications that may need further review at the different stages in the process.

5.4 To meet equality legislation, the ICB must consider the issues of:

- Eliminating discrimination, harassment, and victimisation
- Advancing equality of opportunity
- Fostering good relations between different groups and people

5.5 For Equality Analysis purposes, the test concerns people and groups who have the following protected characteristics, under the Equalities Act 2010.

- Race
- Age (young and Old)
- Sex (gender)
- Disability
- Religion and belief
- Sexual orientation
- Gender reassignment
- Pregnancy & maternity
- Marriage and civil partnerships

5.6 An initial pre-consultation equality analysis included review of the findings of the report produced by JR Consulting limited, provided a general overview of the situation and potential equality concerns and set out the further areas of detail required which will support production of a final Equality Assessment once all the details of the proposed funding changes are known (in particular the details of the revised local Quality Improvement Scheme specification).

5.7 The full scheme specification, including this final Impact Assessment, will be presented to a future Primary Care Committee for formal consideration and approval.

6. Recommendations

6.1 Whilst recognising the challenges for Knowsley General Practices, it remains the case that from a financial management perspective GP practice funding in Knowsley is in an unsustainable position with regards to expenditure against delegated primary care allocation.

6.2 GP practices in Knowsley have benefitted from significant investment over and above core contractual requirements to drive and deliver improvements in care delivered to patients and improve quality through adoption of best practice.

6.3 The ICB will continue to use of available delegated primary care and, where appropriate, other programme funding to make such investments to support necessary improvements in care and accelerate the transformation of Primary Care planning and provision in line with the ambitions of the NHS Long Term Plan. The plans set out within this paper for changes to General Practice Funding arrangements continue to offer scope to make use of these funds in a targeted manner which supports individual practice improvements and the accelerated development of collaborative planning and delivery

6.4 A final Impact Assessment in respect of these plans, and the Final specification for the local Primary Care Quality Improvement Scheme currently in development, is planned to be submitted to the Primary Care Committee for review and approval at its September meeting in order to ensure that the ICB can take the necessary actions required to achieve a sustainable funding position compared to levels of delegated primary care budgets in Knowsley.

7. Officer contact details for more information

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Knowsley CCG

Primary Care Funding Review (July 2020)

Phase 1

Report of the internal evaluation (December 2020)

Contents

Introduction

PCC were approached by the Chief Finance & Contracting Officer for Knowsley CCG in Mid-October 2020 requesting support in connection with their significant 'Distance from Target' (DFT). A potential underlying deficit of circa £1m for 2020/21 arises when comparing committed primary care expenditure against the CCGs primary care allocation which has implications for year-on-year growth levels through to 2023/24. There also appeared to be a lack of additionality and performance in connection with the level of primary care investment over and above core funding.

There are a number of local incentive and quality funding schemes in operation at Knowsley CCG (KCCG) on top of national core payments which need to be scrutinised to establish what additional value and impact they are delivering. The question arises, can KCCG clearly see outcomes linked to this additional investment and is there potential duplication across these schemes.

Client request

PCC were asked to specifically:

- Provide an independent review of the internal evaluation of KCCG primary care funding issues, impact and performance.
- Provide relative benchmarking / appropriate supporting information in support of the previous point.
- Support the design of a revised performance framework to ensure the best possible use of the primary care resources in recognition of current primary care strategies and national policy.
- Potentially support KCCG in further discussion with primary care providers on current position and potential alternative future models.

PCC were provided with the internally prepared Primary Care Funding Review presentation dated July 2020, a copy of which can be found at appendix 1.

Approach

PCC provided a proposal that divided the support in three phases and this was agreed in late October 2020. It was requested that the support be focused upon phases two and three.

The phases are as follows:

Phase 1	Evaluation of Knowsley CCG internal position statement
Phase 2	Investigation of emerging outliers at phase 1 and all locally commissioned services to establish any duplication, review of additionality, any links that can be made with PCN development and initial communication messages

Phase 3	Develop a proposed commissioning plan to be taken forward from 1st April 2021 using the findings from phase 1 and 2

NHS Funding allocations: Clinical Commissioning Groups

KCCG has 25 practices serving a population of circa 167,000 patients and was identified nationally as having the highest allocation per patient in 2019/20 of £1,742 https://commonslibrary.parliament.uk/research-briefings/cbp-8399/ For the same period the lowest allocation was Oxfordshire CCG at £1,091 per patient and across England the overall funding equated to £1,318 per registered patient.

The above report states that the formula used to distribute funding means that CCGs with elderly populations, in urban areas, or in more deprived areas tend to have higher target allocation than they would under a simple population-based formula. These weighting criteria apply to the Knowsley area.

The above report also states that all of the 10 highest allocations are across the North East and North West of England and so benchmarking with other CCGs local to Knowsley or across these regions would be appropriate for the purposes of this report.

The KCCG Primary Care Funding Review presentation dated July 2020 is attached at Appendix 1 and slide No. 4 sets out the five-year allocation summary from 2019/20 to 2023/24. Due to the consistent DFT KCCG will only receive minimal levels of growth funding over this period which they have described as insufficient to cover inflation and national must do's.

For the financial year 2020/21 KCCG have a 'revised delegated allocation' of £32.34m as set out on slide 4 of the presentation and slide 5 reflects a set of expenditure assumptions totalling £33.28m hence the circa £1m shortfall in funding.

Analysis of client presentation slides:

2020/21 Delegated Budget Expenditure assumptions (slide 5)

Many of the categories set out on this slide are typical areas of expenditure for any organisation responsible for delivering primary medical services. It is not the intention of this report to scrutinise each and every item but to focus upon those areas that either appear atypical and/or inequitable. It is normal for local incentive schemes to be reviewed annually to ensure they are addressing local need and supporting commissioning intentions and this will form part of phase 2 of this support package.

The following categories are suggested for review at Phase 2:

Category	**£000s**
GMS Fairness in Primary Care	450
PMS premium	2,492
PMS Fairness in Primary Care	899
Primary Care Quality Premium (*)	1,144

£1.59 Practice Patient Access (*)	305
Stability Payment	130
Total	**£5,420**

(*) additional funding is applied to support these schemes from Programme Allocations as set out in slide 7 amounting to £448,000 and will also be included in the review at phase 2. A total of £5.868m.

Category	**£000s**
Premises – reimbursable and subsidy (**)	**£5,005**

(**) The premises costs will also be reviewed to assess the impact of committed expenditure upon the KCCG primary care allocation and in turn the DFT especially in connection with the LIFT building(s) on their patch and the service charge subsidies that have been approved.

Across the 30 North West CCGs the total expenditure on premises is £98.5m (NHSD) with KCCG being ranked as the 4th highest on spend per registered patient. Across KCCG the average cost per registered patient for premises is £20.44, however six practices are funded at over £30 and one practice at over £88.

2020/21 Delegated Budgets – Glossary (slide 6)

This slide of the presentation provides supporting information behind the expenditure areas set on slide 5.

Other Primary Care Budgets, funded from Programme Allocation (slide 7)

KCCG is applying £1.934m of programme funding to a number of primary care schemes as follows:

1) Local Enhanced Services such as anticoagulation, phlebotomy
2) Primary Care Quality Premium (PCQP) scheme
3) A patient access KPI scheme
4) A contract with PC24 for the provision of in-hours face to face appointments across a number of sites and a home visiting service to provide additional GP capacity.

The PCQP scheme uses £258k over and above the funding of £1.449m from the delegated budget and further comments are provided in this report at slide 12.

Isolating the Access KPI from the original list of 25 PMS KPIs to enable it to be offered to both PMS and GMS practices has led to an increase in the necessary funding of £190k and this is provided by using programme allocations. Using allocation funds and programme fund means this scheme costs £305k per annum.

The contract with PC24 is due to expire on 31st March 2021 and so an opportunity will arise to reconsider the commissioning of these services. PCC understands that this service has developed over time, originating from the award of Prime Ministers

Challenge Fund monies and encompasses the requirement to provide Extended Access services.

The original strategy for Extended Access services, as set out in Investment and Evolution: A five-year framework for GP contract reform to implement The NHS Long Term Plan was for this service to be delivered by Primary Care Networks from April 2021. PCC have contacted the central GP contracting team to ascertain if this this is still the case, and we await their response.

With the impact of Covid-19 and the potential vaccination programme we understand that the local PCNs do not feel they will be ready to deliver Extended Access from April 2021 and so KCCG will need to extend the current PC24 contract until possibly the Autumn of next year.

PMS versus GMS 2014/15 to 2020/21 (slide 8)

We understand from KCCG that all practices were originally offered the option of a PMS agreement but not all practices elected to make a change. The graph demonstrates that those who did not take up this offer have experienced a lower price per weighted patient over the previous seven years.

GMS contracts are agreed nationally with PMS agreements agreed locally. PMS agreements allow for tailoring of the agreement to reflect local need and innovation in service delivery and are paid a premium in recognition of their enhanced service offer.

NHS England introduced the PMS Equitable Funding Review in 2014 to promote equal opportunity to all GP practices and support the fairer distribution of funding at a local level. The process was due to conclude by 31 March 2016. The principles and timeframes for the *implementation* of the redistribution of the PMS premium can be found in a letter from NHS England dated 16 May 2016 as follows: https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2016/05/implement-pms-fund-changes.pdf

PCC carried a review of the publicly available KCCG Governing Body minutes from February 2015 to October 2018. The paper from October 2018, page 149, point 7.2 states “in line with national policy, the CCG has commenced work to withdraw the Personal Medical Services (PMS) contract premium established pre CCG establishment to invest in General Practice improvements across both PMS and General Medical Services (GMS) contracts. As in 2017/18 the CCG has used the PCQP as a mechanism to achieve this requirement”. From this paper it would appear that the PMS review has been undertaken and the aim of fairer funding has been achieved, however from slide 10 it appears that the PMS practices receive a “PMS premium (gross)” payment over and above the payments made to the GMS practices.

Phase 2 of this support work will review the PMS KPIs which have not been reviewed since 2013 to establish if are still currently relevant and not duplicated in other areas of primary medical care delivery.

PMS+ - Premium paid above GMS at 2020/21 prices (slide 9)

The KCCG PMS premium has been budgeted at £2.5m and linked to the delivery of 24 KPIs. One of the original KPIs is now incorporated into the Primary Care Quality Premium and offered to both PMS and GMS practices.

It will need to be determined if the KPIs:

- Secure outcomes that go beyond that expected of core general practice
- Are still the responsibility of KCCG (or the Local Authority i.e., public health related)
- Form part of the requirements to support CQC registration
- Form part of the current Quality and Outcomes Framework (QOF)

It has been reported that all PMS practices achieve the highest banding for KPI achievement and therefore the maximum funding available. This would suggest a lack of challenge behind the scheme and a possible disconnect with the Primary Care Dashboard indicators as set out on slide 13.

2020/21 £ per patient local benchmarking (slide 10)

As stated earlier in this report https://commonslibrary.parliament.uk/research-briefings/cbp-8399/ it is appropriate to compare KCCG with the other nine CCGs in the North East and North West of England as listed therein as all are in the top 10 CCGs receiving the highest allocations per patient for England.

The local benchmarking figures shown on this slide demonstrates that the KCCG PMS practice premium has no equivalent style payment with practices in Liverpool CCG, Halton CCG or St. Helens CCG. Due to this premium payment the KCCG PMS practices receive the highest price per patient which can be further increased from £124.84 to £131.87 when the PMS Fairness in Primary Care funding is included. This also means that KCCG PMS practices received £36.91 per patient higher than St. Helens CCG and £33.39 per patient higher than Halton CCG.

All practices across these four CCGs are non-dispensing and all are classified as operating in conditions classified as urban per NHS Digital https://digital.nhs.uk/data-and-information/publications/statistical/nhs-payments-to-general-practice. From the table below where data has been gathered from NHS Digital it can be seen that Halton CCG has virtually all PMS practices, but operates at £98.48 per patient.

CCG name	PMS practices	GMS	APMS
Knowsley CCG	16	9	0
St. Helens CCG	7	26	1
Halton CCG	13	1	0
Liverpool CCG	2	77	6

For KCCG GMS practices the inclusion of the Fairness in Primary Care funding, which they all receive, takes their average price per patient from £105.05 to £112.08 which is over and above the price per patient for practices in Halton CCG and St. Helens CCG.

During the drafting of this report PCC were notified that the Liverpool CCG Local Quality Improvement Scheme is costed at £26.37 per patient and not at £23.67 as detailed in the presentation and so their price per patient for benchmarking purposes should be increased from £117.13 to £119.83.

The Liverpool CCG Local Quality Improvement Scheme costed at £26.37 per patient is currently in place until March 2021. The scheme recognises the difference in needs of the population across that city and confirms that targets are tailored accordingly. This takes their price per patient to £119.83 which is higher than Halton CCG, St. Helens CCG and KCCG (GMS practices) but the scheme is targeted and equitable.

A further comparative exercise has been undertaken using data recently published by NHS Digital https://digital.nhs.uk/data-and-information/publications/statistical/nhs-payments-to-general-practice for payments to general practice.

Selecting only those ten CCGs with the highest NHS Funding Allocation for 2019/20, the price per patient is as follows and KCCG comes out as the highest.

Name of CCG	Average payment per registered patient	Average payment per weighted patient
Knowsley CCG	£182.74	£159.65
Blackpool CCG	£174.71	£155.97
South Tyneside CCG	£146.97	£133.91
Sunderland CCG	£155.43	£138.33
Durham Dales, Easington and Sedgefield CCG	£176.36	£147.47
South Sefton CCG	£154.67	£142.92
Halton CCG	£154.88	£142.16
Wirral CCG	£162.49	£145.62
St. Helens CCG	£152.21	£133.61
Liverpool CCG	£169.33	£151.83
Average across the 30 NW CCGs	£157.00	£147.89

2020/21 Fairness in Primary Care Funding (slide 11)

Fairness in Primary Care Funding is paid to 22 out of the 25 KCCG practices and represents legacy payments linked to the Lord Darzi NHS review of 2008 to increase GP capacity in primary care.

The table below reflects the range in price per weighted patient from £2.33 to £17.73 and shows the three practices receiving the highest funding levels per weighted patient and the one practice receiving the lowest funding level per weighted patient. The average price per weighted patient if distributed equally would be £7.03.

Practice name	Funding per annum	Weighted list size January 2020	Price per weighed patient
Roby Medical Centre	£40,604	2,290	£17.73
Health centre Halewood	£77,946	5,567	£14.00
Dr Massarani & Partners	£143,381	10,955	£13.09
Dr K F Thong	£15,482	6,649	£2.33

It appears these payments are not dependent upon providing evidence of general practice staffing additionality and as such can be viewed as an addition to baseline for those practices in receipt of this funding. This scheme appears not to be equitable.

2019/20 Primary Care Quality Premium / Improvement Plan / Practice Patient Access (slide 12)

The Primary Care Quality Premium (PCQP) amounting to £1.934m is part funded from the delegated allocation amounting to £1.4m and part funded from programme allocations amounting to £0.5m. It is divided into two streams with 21 practices in the first group and 4 practices in the second group.

The funding is set at £11.59 for each of the two groups, with £10 being allocated to Quality and £1.59 to Access.

For the first group of 21 practices their £10 of Quality funding is divided into a direct payment of £1.50 to their respective PCNs, £1.00 direct to practices for PCN improvement (which is on top of the DES payment of £1.761 per weighted patient) and £7.50 for identified quality improvements.

For the second group of 4 practices their £10 of Quality funding is divided into a direct payment of £1.50 to their respective PCNs and £8.50 to various Quality components with bespoke targets to incentivise improvements following their "*requires improvement"* rating by the CQC.

The support payment for PCN funding is ongoing and mandated so no savings can be made in this area. The other elements of this scheme could be assessed in terms of their outcomes and also reviewed to ensure they are over and above core contract requirements and/or PCN payments already in place. PCC understands that the outcomes are determined year on year and the service specification to which this slide relates is for 2019/20. A revision will be needed for 2021/22 as no specification is in place for the current year 2020/21.

The indicators for the patient access element of this scheme appear to fall under either core contract requirements and/or PCN requirements. Following a review of the results if it can be shown that there is full compliance it would suggest that lessons have been learned and so do not need to be repeated year on year.

Allowing the access KPI to be offered to all practices has led to an increase in expenditure of £88k demonstrating that any revised KPI offer across all practices will

require a precise monitoring regime so as to stay within the delegated allocation and not make use of programme funding unless a clear rationale is in place.

Primary Care Performance Dashboard March 2020 (slide 13)

The primary care dashboard provides a snapshot of how practices are performing across a given number of indicators. From the results it is clear that performance levels are variable and can be summarised as follows:

- The highest achieving practices had a score of 18/24 indicators (PMS)
- The lowest achieving practice had a score of 7/24 indicators (PMS)
- The *Patient experience* indicator shows that 10/25 practices met all indicators
- The *Access* indicator shows that 2/25 practices met all indicators
- The *Prevention and Screening* indicator shows that 0/25 practices met all indicators
- The *Effective use of medicine* indicator shows that 3/25 practices met all indicators
- The *LTC management* indicator shows that 2/25 practices met all indicators
- The *Effective use of resources* indicator shows that 7/25 practices met all indicators
- The *Improving Quality* indicator shows that 19/25 practices met all indicators

When the review of the existing KPIs is undertaken it would need to be mapped to the dashboard indicators.

These results also demonstrate variation across the eight KCCG training practices.

GP workforce averages Cheshire and Merseyside (slide 14)

Comparing KCCG with Liverpool CCG, Halton CCG and St. Helens CCG as previously done in this report and then across Cheshire and Merseyside as a whole PCC can comment as follows:

We agree with the assumption that the GPs provided under the Fairness in Primary Care scheme should be included in the analysis and the GPs provided through the PC24 contract should be excluded.

The table below shows that KCCG has the highest number of patients per FTE GP:

Name of CCG	No. of patients per FTE GP	No. of patients per GP Trainer
Knowsley CCG	1,841	16,750
Liverpool CCG	1,373	8,077
Halton CCG	1,605	10,248
St. Helens CCG	1,537	9,013
Cheshire and Merseyside average	1,500	9,329

The above results are at odds with the fact that KCCG invests £1,349m in the Fairness in Primary Care Scheme which is designed to increase GP capacity. It will be interesting to see if this funding is being used to fund other clinical staff and Phase 2 will look more closely at this area.

KCCG also has the lowest number of GP trainers per patient across the region.

CQC ratings – as at December 2019 (slide 15)

From the Care Quality Commission website www.cqc.org.uk it has been noted that four practices have been awarded a rating of 'requires improvement' overall and of these two have PMS agreements.

The safety domain shows that five practices (20%) require improvement and areas highlighted by CQC include:

- Safe recruitment practices
- Premises security and H&S checks
- Security of personal information and prescriptions
- Proper processes for recalling and dealing with complaints
- Incident reporting
- Safe management of medicines
- Appropriate action for test and laboratory results
- Learning from when things went wrong

KCCG has provided additional funding to these practices to address these issues.

Summary/considerations (slide 16)

PCC consider that the points outlined in this summary slide and based upon the information and explanations provided are a fair assessment of the challenges facing KCCG.

Conclusion and next steps

PCC can confirm that having carried out an independent review of the internal evaluation of KCCGs primary care funding issues, impact and performance and carried out some benchmarking exercises can confirm we are in agreement with the local findings as detailed on the presentation undertaken in July 2020.

A number of themes have emerged, most notably the inequity in funding across the KCCG general practices. There is substantial investment in local schemes which does not appear to be reflected by way of results in the quality measures being applied. There are four local practices with a CQC rating of 'requires improvement' and five local practices not meeting the safety standard at their last inspection. The primary care dashboard scores are very variable and reflect some very low achievement levels.

The funding for Fairness in Primary Care, the PMS premium and the PCQP net of payments to PCNs could be used to introduce an updated set of KPIs and Quality

Measures aligned to the latest health demographics, GPFV and KCCG operational plan.

Reinvesting the whole sum in primary care will be a commissioning decision, but funding in respect of any duplication found in the current set of KPIs could be used to address the KCCG funding shortfall and so reduce the DFT.

With the current funding streams reflecting inequity across practices, varying performance levels and additional roles being funded via PCNs there appears to be an opportunity to reinvest this funding with a refreshed set of indicators and also setting aside some funding to address any vulnerability issues arising and/or to support practices to achieve positive CQC ratings.

In any plan to redistribute funding and/or action any clawback there will be winners and losers and so a potential risk arises that some practices may become vulnerable. KCCG has five practices with less than 3,000 registered patients and so their viability will need to be taken into account.

From the work carried out to date PCC suggests that the Phase 2 support activity be focused in the following areas:

- Investigation of the outliers and the impact upon the KCCG delegated budget – does performance reflect the additional investment when compared with other CCGs.
- Review the Fairness in Primary Care scheme paid to 22 out of the 25 practices and determine whether this investment in local primary care has achieved its intended outcome of providing more GP resource and if not, how to proceed during 2021/22.
- Review the original 24 PMS premium KPIs (no review since April 2013) and establish if these are still relevant and not duplicated. Some may have become subsumed into the core contract, be the responsibility of the local authority, be part of CQC registration requirements or form part of the Quality and Outcomes Framework (QOF). The results can then be used to inform any revised performance framework from April 2021 ensuring alignment with CCG operation plans, GPFV and local demographics.
- Review the PCQP scheme following a review of the current KPIs and use the results to inform any revised performance framework from April 2021.
- Review of the PC24 contract elements and the contract termination date. Also review the in-hours walk-in service element to see if this is utilised equally by all practices or if any practice(s) use it over and above others. Look at available options for each element of the current contract.
- Agreement of those areas where VfM is not easily identifiable – what are the outcomes, can they be measure and what is their impact.
- Agreement of the PCN position and development needs and if any ongoing services can be commissioned at a PCN level as well as ensuring that any further PCN funding available during 2020/21 is secured.
- Development of local messages for sharing with practices, the LMC and other key stakeholders.

- Phase 2 summary of findings report and suggested next steps on how best to utilise the primary care resource available to KCCG.

This financial position seems to have evolved over a long period of time and through fundamental organisation changes across the NHS in 2013 and with PMS contracts not being handed back to KCCG until 2015 following award of their Delegated status. With ongoing change and the prospect of a Cheshire and Merseyside CCG merger being muted the opportunity to address historical funding inequity seems timely.

Appendix 1 – Primary Care Finding Review presentation

Primary Care
funding 06_08_20 sl

Knowsley CCG

Primary Care Funding Review (July 2020)

Phase 2

Review of outlier expenditure areas identified at Phase 1 (January 2021)

Contents

Introduction

This report forms part of the Phase 2 support package being provided by PCC. Phase 1 of the work which comprised a review of the internal evaluation of the Primary Care Funding Review (July 2020) was submitted to and approved by the Chief Finance & Contracting Officer for Knowsley CCG (KCCG) on 14 December 2020. It was reconfirmed at that time that the focus of the Phase 2 work was to be around the principles of *duplication* and *added value*.

The Phase 1 review listed a number of areas that would be scrutinised in detail at Phase 2 as they appeared to be either atypical and/or inequitable and these are as follows:

Category	**£000s**
GMS Fairness in Primary Care	450
PMS premium	2,492
PMS Fairness in Primary Care	899
Primary Care Quality Premium	1,144
£1.59 Practice Patient Access	305
Stability Payment	130
Total	**£5,420**

The above list reflects the number of local incentive and quality funding schemes in operation at KCCG on top of national core payments.

A review of premises costs was also to be undertaken to assess the impact upon the KCCG budgeted expenditure for 2020/21 of the local LIFT buildings service charge subsidies.

Category	**£000s**
Premises – reimbursable and subsidy (**)	**£5,005**

Fairness in Primary Care (GMS and PMS)

As a combined area of budgeted expenditure these schemes total £1.349m for 2020/21. The original intention behind this national funding was to increase GP capacity in under- doctored areas. Knowsley qualified for funding under this scheme which pre-dates the Lord Darzi review of 2008.

PCC understands that some of this funding was used by local practices to directly employ GPs with the remainder of the funding used by Knowsley PCT to directly

employ GPs and deploy them across the patch as needed. As part of Knowsley PCT ceasing operations in 2013 the employed GPs were transferred to local practices under TUPE regulations. Subsequently an agreement was reached that the funding was to support a move to increase the volume of GP appointment to 70 hours per week from the prevailing level of 60 hours per week per 1,000 population. Primary Care Committee papers confirm that this volume of appointments continues to be achieved and in some instances is being exceeded.

There continues to be a difficulty in recruiting GPs to Knowsley practices and this is reflected in the July 2020 presentation slide 3(b). The slide sets out the GP FTE averages for Cheshire and Merseyside with KCCG having the lowest number of GPs per head of population even though the Fairness in Primary Care GPs are included.

The original intention to increase the volume of GP appointments to 70 hours per week per 1,000 population is also being incentivised through the Access element of the PCQP for the last four years.

The following questions arise:

- Is this funding ring-fenced by NHSE in the allocation and limiting what KCCG can do with the funding?
- Can this funding be matched to additional GPs at a practice level?
- Is this funding enabling some practices to remain viable?
- Should the payments under the Access indicator (PCQP) for the achievement of 70 hours of GP appointments per week per 1,000 of population only be paid to those practices (3 in number) not in receipt of Fairness in Primary Care funding?

PMS premium

As an area of budgeted expenditure for 2020/21 this scheme totals £2.492m.

The purpose of any local incentive scheme such as this PMS+ premium offer should be to reflect local need, and add value and innovation in service delivery. The premium is then in recognition of the expected improvement in health outcomes as a result of this additional investment.

The prevailing PMS+ premium scheme variation agreement can be found at appendix 1 and outlines the original 25 KPI indicators. Subsequently the *Access* indicator was removed from the scheme in order for it to be offered to both PMS and GMS practices and as a first step in the removal of the PMS+ premium. The Access indicator is now offered as part of the Primary Care Quality Premium Scheme.

The KPI indicators currently offered to the sixteen PMS practices at a rate of £19.79 per patient have not been reviewed since 2013 and consequently do not reflect the wide-ranging changes that have taken place nationally since that time. Given the way in which this contract is structured it means that practices can pick and choose which indicators they wish to focus upon as only 70% achievement is necessary in order to receive 100% of the funding. As a consequence of this, some KPIs may have very little uptake and therefore lead to no appreciable improvement across the patch for that specific area, for example breastfeeding.

PCC understands from the Primary Care Commissioning Committee (PCCC) papers (January 2017) that based upon submitted evidence a KPI funding level was set for each PMS practice with three possible funding levels ranging from Band A-C (C being the highest). Following delegation KCCG re-introduced a monitoring process to gauge whether PMS practices had been operating at their funding level.

It would appear that all PMS practices are paid at the Band C achievement level without having to provide evidence of actual achievement.

Approach

A review of the KPIs sought to establish if they are currently relevant, not duplicated in other areas of primary care delivery or are no longer providing added value as originally intended.

It was indicated that the main sources of duplication would potentially be found in the following areas:

- Form part of the services where commissioning responsibility lies with the Local Authority i.e., public health related services
- Form part of the requirements to support ongoing CQC registration
- Form part of the current Quality and Outcomes Framework (QOF)
- Form part of General Practice core contract requirements
- Form part of the enhanced service offer, now being funded via Primary Care Networks (PCNs)
- Are covered by updates introduced by changes in national policy

The review needed to establish if any elements of the scheme secured outcomes that go beyond that expected of local GMS practices, have led to increases in performance which support the ongoing investment in the scheme and continues to support KCCG in its statutory duty to secure continuous improvement in the quality of primary medical services.

Results of the PMS KPI review

A review has taken place of 17 of the 24 KPIs which can be found at appendix 2. The first page of appendix 2 provides a summary of the areas of duplication that have been identified thus far and the subsequent pages provide the relevant explanations and links to evidential documentation.

Conclusion and next steps

The impetus behind this review was to establish if the KPI scheme was delivering added value and the expected improvements in health outcomes for the local population as a result of the additional investment.

In conclusion it appears that of those KPIs that have been reviewed there is duplication by virtue of them being superseded by a plethora of national changes and updates that have come about across the primary care landscape since their last review in 2013. The main changes are in the updates to the Quality and Outcomes Framework (QOF) and the requirements to support a practices' ongoing CQC registration.

A decision will need to be taken by the Commissioner as to the future of this KPI scheme. PCC understands that KCCG is keen to continue to invest in primary care but the investment must represent value for money, add value and be linked to performance. The Commissioner may decide upon a combination of decommissioning the current offer, introducing a new offer and using some of the funding to address the budgeted distance from target (DFT).

If it is decided to retire the current KPI scheme and replace it with a new KPI scheme each new indicator would need to standalone and have a payment linked to its achievement, where failure to achieve a target leads to no payment.

Primary Care Quality Premium / £1.59 Practice Patient Access

As an area of budgeted expenditure for 2020/21 this scheme totals £1.934m using a combination of primary care allocation and programme allocation funding.

The aim of the PCQP scheme is to support practices to deliver quality improvements within general practice at a time of limited resource growth and this may be focused upon elements of the scheme or bespoke improvement plans.

The scheme is linked to achievement and an assessment panel reviews evidence submitted by each practice. An appeals process is in place should any practice wish to challenge the outcome of the review process.

An allowance is made in the specification, where exceptional circumstances arise, such as a flu pandemic, for this to be taken into account when determining payment.

A PCQP has been in place in 2014 and is an enhanced service to enable practices to achieve continuous quality improvements in patient care and experience. It is also designed to achieve key elements of the KCCG operational plan and the delivery of local, national and QIPP targets.

This scheme allows KCCG the opportunity to focus on key areas as follows:

- Where performance is not where it could/should be when reviewing the Improvement and Assessment Framework (IAF) indicators;
- To incentivise national policy delivery such as in the NHS Long Term Plan;
- To support the effective use of scarce practice and wider NHS resources;
- To create and promote a learning and improvement culture across General Practice;
- As a member of the Health & Care Partnership (HCP) for Cheshire and Merseyside the PCQP gives KCCG the opportunity to promote the key prevention priorities within General Practice.

The premium reflects KCCG's commissioning plan as approved by the Clinical Membership Group (CMG) and to participate in the scheme practices must meet the following criteria:

- Attend at least 75% of all CMG meetings in the financial year
- Be represented at ALL meetings of their Locality Assurance Group (this is a forum to ensure progress is monitored and if necessary, remedial plans are developed, submitted and monitored. Also, a forum of peer support and shared

learning). KCCG facilitates these meetings and assurance of submitted evidence is provided by Mersey Internal Audit Agency.

Where a practice is rated as *inadequate* or *requires improvement* by the CQC and/or is subject to a KCCG improvement plan, they will not be automatically eligible for this premium and a bespoke agreement may be offered by KCCG.

The PCQP is now divided into five sections and in each section all elements must be delivered to achieve the payment.

A summary of indicators from the three most recent specifications are as follows:

Indicators	**2017/18**	**2018/19**	**2019/20 & 2020/21**	**2021/22**
Access (head of weighted population)	£1.59	£1.59	£1.59	KCCG to agree
Developing the Knowsley GP Federation (head of registered population)	£1.00	£0.75	removed	n/a
Primary Care Network Funding (head of registered population)	n/a	n/a	£1.50	Funding level set nationally
Primary Care Network Improvements (head of registered population) *(*) Unplanned admission avoidance*	n/a	n/a	£1.00 (*)	KCCG to agree
Improving Quality (head of registered population)	£6.00	£4.25	£3.50	Quality Team to update
Prescribing (head registered population)	£3.00	£2.50	£4.00	Medicines Management Team to update

Access

The budgeted expenditure for this element of the PCQP scheme is set at £305k for 2020/21 and a summary of the criteria is set out at appendix 4 for the years 2017/18, 2018/19 and 2019/20.

When the Access KPI was removed from the PMS+ premium scheme in order for it to be offered to all practices and as a first step in the removal of the PMS+ premium it attracted an increase in expenditure. This amounts to £88k in the 2020/21 budgeted expenditure forecast.

Payments are linked to achievement following verification of results and submitted evidence.

From 2019/20 *additional roles* have been funded via the Network Contract DES and as a result practices, as part of this indicator were asked to update their access policy to incorporate these new roles. New access methods including on-line consultations

were also promoted as well as recognising the use of triage techniques to ensure patients access the most appropriate professional to meet their needs.

For the year 2021/22 KCCG will need to make an assessment of the outcomes being achieved by this indicator to ensure there is ongoing and maintained performance improvements.

Reflecting upon the elements of this indicator KCCG may wish to continue supporting practices to maintain and build upon the progress that has been secured around:

- Providing 70 GP appointments per week per 1,000 patients – even though this is supported by the additional Fairness in Primary Care funding scheme for the majority of practices.
- Providing 25 Nurse appointments per week per 1,000 patients – the combined level of 95 GP and Nurse appointments is being met (PCCC minutes, March 2020) and/or superseded by some practices, so continue to support to maintain this level of achievement. Also, for appointments to be recorded in appointment books in line with guidance issued in August 2020.
- Providing same day access when clinically appropriate - seek to improve telephone and/or on-line triage models.
- Promoting on-line services – the national target of 30% for patients registering for at least one on-line service is the benchmark, (PCCC minutes, March 2020 states 20 practices are not achieving this level) so further support/investment could be provided until national targets are met.
- Maintaining the skill base of *non*-face to face consultations achieved during the covid-19 pandemic.
- Clinical supervision for all clinical staff groups providing direct patient care – supporting the induction and the practicalities of cross site working of those in *additional roles.*
- New appointment datasets – uptake of new reporting models when introduced, (awaiting IT updates nationally).

An opportunity to make financial savings would arise if elements of this indicator were retired from the list provided at appendix 4 and where KCCG are confident they form part of core contract requirements and/or are now securely embedded in service delivery.

A decision could be taken to continue to support *patient access* at current investment levels by being more tailored to *adding value* and supporting local and national performance targets.

Developing the Knowsley GP federation

This element of the PCQP was previously provided to support practices to developed a pan-Knowsley GP Federation. Practices were to make a contribution of £0.25 per registered patient in 2017/18 in order to provide start-up funding and £0.75 in 2018/19. This was to be an integral component of the GPFV programme whose aim was to deliver primary care at scale.

This funding is no longer provided.

Primary Care Network Funding

The minimum funding support of £1.50 per registered patient is set nationally and is provided in order to support management and organisational development of the PCNs.

There is no opportunity to make a financial saving in regard to this part of the PCQP scheme.

Primary Care Network Improvements (Unplanned admission avoidance: Integrated Community Frailty Team (ICFT)

The ICFT was established in March 2019 following a review of non-elective admissions which identified a significant cohort of Knowsley patients aged 65 and over were admitted to hospital and subsequently discharged within 24 hours. Evidence from the ICFT indicated that a proportion of these admissions could have been avoided with appropriate community-based support.

Participating practices were required to contribute to achieving a KCCG determined expected monthly PCN level of appropriate referrals to the ICFT from December 2019 to March 2020.

This element of the scheme has continued during 2020/21.

The 2020/21 QOF guidance states that practice must maintain accurate disease registers and for disease prevalence to remain comparable with 2019/20 levels. One of the disease registers to be maintained is for patients with a record of frailty fracture and a diagnosis of osteoporosis and separated into two age groups. Part of the patient care planning process would include reducing the risk of unplanned admission and A&E attendance.

To date PCC can find no record of the outcome of this element of the PCQP for 2018/19 in the PCCC minutes.

Improving Quality

For the year 2017/18 this element of the PCQP scheme as paid at £6.00 per registered patient and included the following indicators. A fuller description of each indicator can be found at appendix 5:

- Utilisation of the referral quality (RQ) system
- Clinical records
- Safeguarding
- Learning Disabilities
- Preventing ill health

The PCCC papers for May 2018 report that practices have made progress and delivered a number of achievements to date and these have been reviewed at the PCQP Locality Assurance Meetings. The scheme closed on 30 June 2018 with the expectation was that practices would be informed of their achievement by 30 September 2018. The PCC papers for March 2019 confirmed that all practices achieved all aspects of the scheme concluding an investment of £2.034m.

For the year 2018/19 this element of the PCQP scheme as paid at £4.25 per registered patient and included the following indicators;

- Prevention at scale (Health & Care Partnership priority area)
- Improving the quality of clinical records (developing a learning culture)
- Clinical review of patients with Heart Failure who are NOT managed by the Community CVD Service
- Improvement in the achievement of NICE targets for Diabetes Care

The scheme was not signed off until November 2018 with 23/25 practices being eligible to participate. The PCCC papers for May 2019 report that participating practices were to have submitted required evidence by 31 March 2019 and that outcomes would be advised by 30 June 2019. To date PCC can find no record of the outcome of the PCQP for 2018/19 in the PCCC minutes.

For the year 2019/20 this element of the PCQP scheme as paid at £3.50 per registered patient and included the following indicators;

- Hypertension
- Locality Diabetes plan
- Risk and incidence management
- Compliance with CCG Commissioning policy
- Practice support for non-clinical invoice validation initiatives

To date PCC can find no record of the outcome of the PCQP for 2019/20 in the PCCC minutes.

Prescribing

This element of the scheme sets out to deliver improvements in medicines management at a time of limited resource growth.

It has been noted that in relation to this element of the PCQP scheme, PMS+ practices must choose therapeutic areas that are different from those stipulated in their PMS+ contract such that improvements made in prescribing here cannot be used to fulfil the terms of their PMS+ contract.

All prescribing components are compulsory to be able to qualify for full payment and a fuller summary of the components for this part of the scheme can be found at appendix 6.

For the year 2017/18 this part of the PCQP scheme was paid at £3.00 per registered patient and included the following components:

- Prescribing Lead Role
- Medicines Safety
- Good Practice Prescribing
- Management of the Practice Prescribing Resource

The PCCC papers for March 2020 confirmed that all practices achieved all aspects of the scheme.

For the year 2018/19 this part of the PCQP scheme was paid at £2.50 per registered patient and included the following components:

- Prescribing Lead Role
- Medicines Safety
- Antimicrobial Stewardship
- Medication review
- Management of the Practice Prescribing Resource

To date PCC can find no record of the outcome of the PCQP for 2018/19 in the PCCC minutes.

For the year 2019/20 this element of the PCQP scheme as paid at 4.00 per registered patient and included the following components:

- Prescribing Lead Role
- Polypharmacy reviews
- Antibiotic Medication review
- Quality and Safety
- Maintain a 0% cost growth
- De-prescribing of medication in line with the Pan Mersey prescribing recommendations

To date PCC can find no record of the outcome of the PCQP for 2019/20 in the PCCC minutes.

For 2020/21 the scheme continues and PCC understands payments are based on an income guarantee as part of the response to Covid-19.

Stability Payment

The budgeted expenditure for 2020/21 is set at £130k and is paid to one practice.

The practice in question holds a GMS contract and has merged with two other practices which were previously commissioned under PMS agreements. The mergers came about following a GP retirement and were supported by KCCG as the two PMS sites were within the locality of the GMS site and so made sense geographically.

PCC understands that this payment will continue to be applied non-recurrently until the PMS+ review is concluded.

Reviewing the dashboard results contained in the July 2020 Primary Care Funding Review, slide 3(a) reflects that this provider is only achieving nine of the 24 indicators. For the seven categories on the dash-board they attract a score of zero in four areas.

There appears to be no legal basis to pay a GMS practice any additional payment over and above the global sum payment. Indeed, the historic correction factor payments, negotiated as part of the national negotiation of the GMS contract in 2004 to provide an income guarantee, have since been phased out. This resulted in some practices receiving less income than they would have previously received and was phased in over a period of seven years beginning in 2014/15. The PMS review process was designed to mirror that process, albeit over a four year period, resulting in an equal sum being paid per patient for the delivery of core primary medical services.

Premises – reimbursable and subsidy

For the financial year 200/21 KCCG has a budgeted expenditure for premises of £5,004,637 which can be broken down as follows;

Area of budgeted expenditure	**£**
Reimbursable rent (CHP / NHSPS)	2,953,106
Subsidies	1,633,949
Notional rent	139,540
Actual rent	253,042
Rent reserve	25,000
Total	**5,004,637**

Across the KCCG patch there are 25 practices with 19 receiving a premises subsidy. One subsidy, amounting to £198k relates to vacant space at the Cross Lane site which is funded from programmes. KCCG supports 33 premises solutions.

KCCG has made a commitment to high quality premises via LIFT buildings for their primary care providers with the result that 15.5% of the delegated allocation for 2020/21 is dedicated to premises costs.

The subsidies have wide ranging values and PCC understands that each has been negotiated separately. A review of each lease would be necessary to establish if a more equitable system of subsidy could be introduced and to establish if any savings could be achieved in regard to premises costs. It appears that the space identified in the lease documentation in respect of many practices is less than the space that the practice actually occupies. There could potentially be a risk to the practice if the

landlord subsequently let some of this undocumented space to another tenant. It is this factor that is behind the level of subsidy payments being paid.

PC24 contract

It was agreed that this Phase 2 report would not scrutinise this contract, however, following responses to the covid-19 vaccine rollout an update is now provided.

During the drafting on the Phase 1 report in December 2020 it was unclear, due to the ongoing pandemic whether the original Network Contract DES intention for PCNs to deliver extended access from April 2021 would still go ahead. In this letter from NHSE dated 7 January 2021 it states that there will be a delay to the planned introduction of the new standardised specification for extended access as part of the Network Contract DES and the associated national arrangements for the transfer of CCG extended access funding. It is not anticipated that these changes will come into effect before April 2022 https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/C1026_Freeing-up-GP-practices-letter_070121.pdf

PCC understands that KCCG will extend the current contract with PC24 for 2021/22 by way of a contract variation and the funding will be limited to £6 per weighted patient. This represents a reduction in funding on 2020/21 levels.

Conclusion and Themes

A review of the outliers identified at Phase 1 has been carried out and the results can be summarised as follows:

Category	Potential savings
GMS Fairness in Primary Care PMS Fairness in Primary Care	Can it be established if this funding is linked to actual GPs. The 70 hours per week of GP appointments per 1,000 patients is being achieved as agreed.
PMS premium	A review of a sample of the KPIs suggests that an updated set of indicators needs to be designed as well as a new payment structure with the commissioner deciding upon the level of investment and/or saving.
Primary Care Quality Premium	PCC has been unable to find a recording of the results as this scheme for the last 3 years. The specification states that payment is linked to achievement.
£1.59 Practice Patient Access	Potential to remove some indicators where it is considered they are now embedded and only incentive three practices – who do not receive Fairness in Primary Care payments - to meet the 70 hours of GP appointment per week per 1,000 patients.

PC24	A saving can be made in 2021/22 by limited the funding to £6 per weighted patient for the *extended access* component of this contract.
Stability Payment	The payments of £130k per annum are linked to the PMS review. If the KPI payments are replaced by a new set of indicators and offered to PMS and GMS practices this payment will no longer qualify. The apparent lack of legal authority to make this payment needs to be addressed.

Throughout the review process two themes have emerged:

- Layering – over the years as new initiatives were introduced, they have been applied in layers with little or no removal of anything already in place. Having a variety of schemes in place demands a lot of management time to oversee and validate.
- Variation – across practices there is variation in funding profiles for Fairness in Primary Care, PMS+ premium and premises subsidies. There is also variation in performance levels across practices. Taking the primary care dashboard from March 2020 at appendix 7 it can be seen that the highest scoring practice achieves 18/24 indicators and the lowest scoring practice achieves 7/24 indicators. Removing the six Improving Quality indicators from the dashboard as they relate to the last CQC inspection and thus reducing the scoring to 18 indicators it can been seen at appendix 8 that 19/25 practices achieve 50% or less of the indicators and 6/25 achieve 50% or more of the indicators. One practice has a score of 3/18 indicators. Given the level of investment and duplication as outlined in this report the challenge for KCCG is to address this conflict. There are areas of unwarranted variation in performance levels suggesting practices require ongoing support and for performance to be gauged over a broader number of indicators.

Appendix 1 PMS+ agreement variation dated 1 October 2011

VARIATION AGREEMENT

DATED 1ST OCTOBER 2011

BETWEEN

KNOWSLEY PRIMARY CARE TRUST

AND

(INSERT NAME OF CONTRACTOR)

This is a Variation Agreement in respect of the Personal Medical Services Agreement dated [insert date of the PMS contract] (the PMSA) between Knowsley Primary Care Trust (the PCT) and [insert name of the contractor]

(the Contractor).

1. This Variation is effective from **(insert date)** and unless terminated earlier in accordance with the provisions of the PMSA shall subsist until the Expiry Date as specified in the PMSA.

2. Save as provided in this Variation the services will be delivered in accordance with the terms of the PMSA.

3. In Clause 2.1.1 of the PMSA the words " objectives and targets" are replaced with " Band C for each of the Key Performance Indicators" and at the end of that Clause there is inserted " Payment under the Agreement will depend upon the Overall Performance Percentage achieved as calculated in accordance with Schedule 2.

4. Schedule 2 of the PMSA is replaced with Schedule 2 herein and shall take effect

5. Schedule 10 of the PMSA is replaced with Schedule 10 herein and shall take effect

Schedule 2 - Key Performance Indicators

1. The key areas of focus and importance are identified by their inclusion as Key Performance Indicators (KPIs) of this Schedule 2. The KPIs are organised into various areas as per the headings below and consist of 25 individual KPIs which are each given a percentage weighting as set out next to the heading.

2. The calculation of the KPIs will be based on actual performance against each weighting as follows;

Achievement of band A – 25% of KPI weighting

Achievement of band B – 50% of KPI weighting

Achievement of band C – 100% of KPI weighting

3. For the avoidance of doubt the Contractor achieves Band A when all the elements in Band A are achieved, Band B when all the elements of Band A and Band B are achieved and Band C when all the elements of Band A, B and C are achieved for each KPI. Save that for Medicines Management the Band will depend upon the overall combined percentage achieved in respect of the components set out in Appendix 1

4. Failure to achieve the minimum performance level of any KPI will result in 0% of the KPI weighting. For example, in Response to Major Incidents, if the Contractor fails to achieve Band C the percentage weighting will be zero.

5. The KPIs will be measured where applicable on the actual list size (and not the weighted list size).

6. The Performance Measures are not exhaustive and the Contractor will be required to provide such information as requested from time to time by the PCT in order to allow the PCT to identify whether the elements in the KPI have been satisfied.

7. After the end of each financial year the performance ratings achieved by the Contractor for each KPI shall be combined, to calculate the Overall Performance Percentage for the preceding financial year (see example at Appendix 2). For the avoidance of doubt, where the Contractor has more than one practice surgery subject to this Agreement, the KPIs shall be calculated in respect of each individual Practice.

8. The Overall Performance Percentage will then be applied to formulate a separate Band as follows

Overall Performance Percentage 0% to 49.9% - Payment Band A

Overall Performance Percentage 50% to 74.9% - Payment Band B

Overall Performance Percentage 75% to 100% - Payment Band C

9. The Payment Band will then be applied in accordance with Schedule 10 (Payment Mechanism), so as to give an Actual Practice PMS Payment.

10. The data source for monitoring will be the Contractors IT system.

11. For each element of the specification with a percentage target and where the Contractor is achieving the higher target a 1% below target tolerance will be allowed

ACCESS		Weighting 7.5%
	Standard	**Performance Measure**
A	The practice is contactable via one telephone number between 08.00 hrs and 18.30 hrs, Monday to Friday.	Ad hoc telephone checks Core Hours Monitoring
	The contractor will offer a minimum of 70 GP/Nurse Clinician appointments per 1000 patients per week	The contractor is able to demonstrate the relevant number of appointments via randomised sample of dates on practice appointment system
	The contractor will offer a minimum of 25 Practice Nurse appointments per 1000 population per week	The contractor is able to demonstrate the relevant number of appointments via randomised sample of dates on practice appointment system Audit of appointment system
B	Each practice premises shall be open and have reception staff available for face-to-face bookings and contact between 08.00 hrs and 18.30 hrs, Monday to Friday.	Ad hoc visits to check doors open at the times stated and reception staff available.
	The contractor provides a range of appointments from 08.00 hrs to 18.30 hrs, Monday to Friday. Contractors with a half day closure will have reactive collaborative arrangements for appointments in place.	The contractor is able to demonstrate the relevant number of appointments via randomised sample of dates on the practice appointment system up to 18.30hrs
	The practice list is open to new patients	The contractor is able to demonstrate having an open list
C	The contractor provides a range of surgeries covering morning, afternoon and evening periods. Surgeries will remain open until 18.30 hrs, Monday to Friday, with evening surgery terminating to allow sufficient time to deal with late visits, telephone calls, prescription requests and administrative duties.	Duty rota made available to the PCT Ad hoc visits to check clinician available throughout the day
	Where the contractor is not providing extended hours under a DES, the contractor provides the minimum requirements under the extended hours access scheme/guidance as published by the Department of Health from time to time	Audit of appointment system

	The contractor offers patient's choice with regards to the gender of their GP when making advanced booked appointments. This could be achieved on a collaborative basis with neighbouring practices.	The contractor is able to demonstrate the availability of a choice of gender of GP and offer as per patient record/system.
PREVENTION		**Weighting 5%**
Standard		**Performance Measures**
A	The contractor shall record all reported diseases as agreed with the PCT on a designated disease register The contractor monitors recorded levels of disease and these should be within accepted tolerances as defined by the PCT and recorded on disease registers. The contractor has written policies and/or procedures for recording incidence The contractor is able to provide commentary on differences between observed and expected disease prevalence The contractor will work with the PCT Public Health team (hereinafter referred to as Public Health) to develop an action plan with time scales as agreed with the PCT and implement such action plan for disease registers that vary by more than 1 standard deviation as defined by public health intelligence	Registers made available to PCT Evidence of monitoring tolerance levels Copy of policy made available to the PCT Written details of reasons for difference Copy of action plan made available to the PCT
B	The contractor will work with Public Health to identify key priorities as identified in the Joint Service Needs Assessment (JSNA) that are applicable to the practice. The contractor is able to demonstrate collaborative working with Public Health. The contractor will initiate a minimum of one visit per year from Public Health. The contractor has developed an action plan with timescales as agreed with the PCT and implemented such action plan to address each of the key priorities identified above.	List of identified priority areas made available to the PCT Minutes/record of meetings with public health Copy of action plan made available to the PCT
C	The contractor is part of a network with other practices and/or stakeholders that actively discuss and initiate preventive initiatives	Record of attendance at network meetings and notes of meetings made available to the PCT Notes/attendance registers for meetings

	The contractor is able to demonstrate, that they have implemented relevant preventative initiatives	Action plans and processes initiated made available to PCT
HEALTH IMPROVEMENT		**Weighting 5%**
Standard		**Performance Measures**
A	The contractor is providing health promotion brief interventions/advice and is referring patients electronically to lifestyle support/services. The contractor is able to demonstrate that 100% of frontline staff (staff who have direct contact with patients) have had brief intervention training. The contractor has implemented and is fully compliant with the (single point of access) referral pathway into the lifestyle services 'hub'.	Evidence of number of referrals made available to the PCT Dates and records of attendance at brief intervention training made available to the PCT Lifestyle hub referral template installed on practice system and use made available to PCT
B	The contractor works with Public Health to identify lifestyle issues and key priorities associated with their population on an annual basis and set in place evidence based interventions to improve health e.g. smoking, alcohol, and weight management. The contractor has developed an action plan with timescales as agreed with the PCT and has implemented such action plan to address each of the key priorities identified.	Lifestyle issues identified and Minutes/records of meetings with public health made available to PCT Copy of action plan with timescales made available to PCT
C	The contractor can demonstrate change in lifestyle profiles and is achieving outcomes over a reasonable period of time as agreed with the PCT based on the areas in the action plan in Level B selected for improvement.	Evidence of patients quitting smoking, improving weight, reducing alcohol intake etc made available to PCTNumbers of patients losing weight, quitting smoking etc recorded
Cervical Screening		**Weighting 3%**
Standard		**Performance Measure**
A	The contractor knows and can identify the cervical screening eligible cohort. All nurse smear takers are adequately trained to recognised national standards.	Numbers in cohort made available to PCT Certificates/records of training/attendance made available to PCT

	The contractor is able to demonstrate the numbers of eligible women who were exempted for a cervical smear and the reasons why All smear takers are up to date with refresher training, where appropriate	Details of numbers exempted made available to PCT Record of attendance at refresher training made available
B	Does not apply to this area	
C	The contractor shall improve year on year in working towards achieving the cervical screening national minimum target (CSNMT) (currently 80% uptake) as amended from time to time. ***For practices at <CSNMTuptake:*** The contractor has increased uptake by 5% (or to CSNMT) from their baseline figures for the previous financial year using practice data with exclusions as agreed between the contractor and the PCT OR Where the contractor fails to achieve a 5% increase or to CSNMT the contractor will work with Public Health in developing an action plan with timescales as agreed with the PCT to deliver the CSNMT and has implemented such action plan ensuring compliance to NHS Cervical Screening Programme (NHSCSP) Guidance ***For practices at >CSNMT uptake:*** The contractor is able to provide evidence that they have maintained CSNMT or over from the baseline figures as above using practice data with agreed exclusions	Figures made available via audit of practice system Audit of practice system detailing level of uptake Action plan made available to PCT Audit of practice system showing uptake levels maintained
Breast Screening		**Weighting 3%**
Standard		**Performance Measure**
A	The contractor has a system in place that highlights women who have not attended for breast screening	Search of practice system with numbers made available to PCT

	The contractor is able to identify and provide evidence of the number of women eligible for breast screening	Search of practice system with numbers made available to PCT
B	Does not apply to this area	
C	The contractor promotes breast screening to women that are known not to have attended The contractor shall improve breast screening uptake and work towards the breast screening national minimum target (BSNMT) (currently 70% uptake) as amended from time to time. ***For practices at <BSNMT uptake:*** The contractor has increased uptake by 5% from the previous round throughout the financial year **OR** Where the contractor fails to achieve a 5% increase from the previous round, the contractor will work with Public Health in developing an action plan with timescales as agreed with the PCT and has implemented such action plan to increase uptake in preparation for the next round ***For practices at <u>></u>BSNMT uptake:*** The contractor is able to provide evidence that they have maintained BSNMT or over on each occasion in the financial year from the previous round	Leaflets in surgery, posters in surgery, evidence of targeting these patients Audit of practice system with numbers made available to PCT Action plan made available to PCT Audit of practice system showing uptake levels maintained
Bowel Screening		**Weighting 3 %**
Standard		**Performance Measure**
A	Does not apply to this area	
B	The contractor has a system in place that highlights patients who have not attended for bowel screening	Evidence of system detailing how patients identified available to PCT

	The contractor is able to identify and provide evidence of the numbers eligible for bowel screening The contractor is able to demonstrate the numbers of eligible individuals who did not return the bowel screening kit	Audit of practice system Audit of practice system
C	The contractor shall improve year on year in working towards an uptake of 60% ***For practices at <60% uptake:*** The contractor has increased uptake by 5% (or to 60%) from the baseline figures (as approved by the PCT) for the previous financial year ***For practices at ≥60% uptake:*** The contractor is able to provide evidence that they have maintained 60% or over from the baseline figures as above	Audit of practice system detailing uptake Audit of practice system showing increase in uptake Audit of practice system showing maintained or increased levels over 60%
Child Health and Childhood Immunisations		**Weighting 7%**
Standard		**Performance Measure**
A	The contractor provides sufficient childhood immunisation clinics for all infants within the practice population The contractor provides the 6 to 8 week development check. The contractor will alert the health visitor if additional medical or social needs of the family are identified during the post natal period. The contractor achieves a minimum of 70% uptake of all childhood immunisations (not including the contribution of the PCT immunisation team).	Clinic times recorded and made available to PCT Evidence of checks/system Alerts recorded and numbers made available to PCT

	The contractor has identified a lead for childhood immunisations who will quality assure provision within the practice and ensure that child immunisation data is submitted by the 22nd of each month to the Child Health system (PARIS).	Audit of uptake
	The contractor is able to provide evidence regarding the numbers of families that have attended appointments for immunisation and action taken to engage those families who have not	Name of lead provided to the PCT Audit of systems Audit of numbers attending during year
	The contractor is able to demonstrate that they are working in partnership with the health visiting service in implementing the Healthy Child Programme (HCP) 0-5yrs targeted pathway	Policy detailing how partnership working takes place and links with the Healthy Child Programme
B	The contractor works in partnership with the health visiting service and the PCT immunisation team in proactively engaging families who do not attend for two or more appointments	Evidence of joint working and engagement
	The contractor will achieve 90% uptake of childhood immunisations, For hard to reach families all vaccinations count towards target regardless of who administers the vaccination (GP, Practice Nurse, Commissioned Immunisation Team)	Audit of uptake of immunisations
C	The contractor provides a coordinated, holistic approach to child health provision including the 6-8 week development health review, maternal mental wellbeing assessment and childhood immunisation clinics	Policy detailing co-ordinated approach
Influenza Vaccination		**Weighting 2%**
Standard		**Performance Measure**
A	Does not apply to this area	
B	Does not apply to this area	
C	The contractor works towards year on year improvement for influenza vaccination with a focus on low uptake / at risk groups under 65	Audit of practice system showing numbers of uptake in low uptake/at risk groups under 65

	years of age in particular children under 16 years and pregnant women ***For practices at <60% (or PCT target as amended from time to time) uptake in under 65's:*** The contractor has increased uptake by 5% or to the PCT aspiration annual target (currently at 60% uptake)) from the baseline figures (as approved by the PCT) for the previous financial year with a focus on groups on low uptake (e.g. children under 16 and pregnant women) **OR** Where the contractor fails to achieve a 5% increase or the target as above the contractor will work with public health in developing an action plan with timescales as agreed with the PCT to and has implemented such action plan to increase uptake ***For practices at ≥60% (or PCT target as amended from time to time) uptake in under 65's:*** The contractor is able to provide evidence that they have maintained target or over from the baseline figures as above in low uptake groups	Audit of practice system showing numbers of uptake Action plan made available to PCT Audit of practice system showing maintained uptake of 60%
Pneumococcal Vaccination		**Weighting 2%**
Standard		**Performance Measure**
A	Does not apply to this area	
B	Does not apply to this area	
C	The contractor works towards year on year improvement for pneumococcal vaccination ***For practices at ≤60%(or PCT target as amended from time to time) uptake:***	Audit of practice system showing numbers of uptake in at risk groups

	The contractor has increased uptake in at risk groups by 5% (or to target currently 60%) from the baseline figures (as approved by the PCT) for the previous financial year ***For practices at ≥60% (or PCT target as amended from time to time) uptake:***	Audit shows increase of 5% or to 60% uptake
	The contractor is able to provide evidence that they have maintained target or over from the baseline figures as above	Audit of practice system showing maintained uptake of 60%
Safeguarding		**Weighting 5%**
Standard		**Performance Measure**
A	The contractor shall have in place and adopt a robust Safeguarding (Children) Policy Statement in accordance with all relevant legislation and guidance and conduct a self-audit against key criteria as set out in the RCGP Safeguarding Children and Young People Toolkit 2011 (as amended from time to time) which would provide a minimum Safeguarding Standard for GP Practices. The Policy shall include an identified Safeguarding GP lead for the practice The Safeguarding Policy and procedures are easily accessible and regularly reviewed (not less than annually) and updated as and when necessary (eg. to comply with changes in legislation/ guidance) and the Safeguarding Policy and procedures are kept together with key Safeguarding related guidance.	Policy to be maintained along with other practice policies and made available to the PCT
	The Safeguarding GP lead ensure the Policy is reviewed and updated as planned All staff are aware of the policy and procedures and how to access them	Name of Safeguarding GP lead incorporated into policy.
	Compliance with safer recruitment processes as outlined by the RCGP in the Safeguarding Toolkit to include CRB checks and at least two references	Evidence of reviews/updates

	Practice Manager to hold copies of CRB clearance and two references for new staff members.	Audit of recruitment processes
	Regular communication with the Health Visitor for non school age children or for school age children, with the School Nurse, to discuss the list of children with safeguarding concerns with clear communication channels for situations where the contractor has concerns about a child as they arise.	Communication notebook or similar process instituted in the practice
	The contractor will ensure recognised Safeguarding training for all staff and GP trainees attached to practice (GP's to complete level 2 and be working towards level 3, practice nurses level 2 and non clinical staff level1 as per the Intercollegiate Document 2010)	Evidence of training either completed or booked for staff
	Certificates of attendance at training programmes in house or external to be retained by Practice Manager or Safeguarding Lead	.
	The contractor has a clear Supervision Policy and arrangements, in line with the Intercollegiate Document 2010 and Working Together 2010 (both as amended from time to time) for the supervision of all staff (including trainees and non clinical staff) that covers safeguarding issues.	Staff must be able to demonstrate clarity about what to do if they have a safeguarding concern and who to approach for advice.
	Review of Significant safeguarding events at least twice yearly (Significant safeguarding events and SUDI to be included in the Significant Event Analysis meetings or practice meetings as necessary on a regular basis)	Minutes of meetings, reviews and outcomes of discussions available to the PCT
	Children who are looked after, or are subject to a child protection plan or about whom there are safeguarding concerns have appropriate read codes on the 'problem' page to highlight their status and any issues of concern.(Read codes should cover: Children subject to a child protection plan; looked after children; children in need; domestic abuse; alcohol and	Review of Self Audit

	substance misuse; teenage pregnancy, parental mental health problems)	
B	The contractor compiles and maintains up to date electronic safeguarding lists of “looked after children” and “children subject to a child protection plan”	Contractor signed declaration that lists are maintained and up to date
	The contractor links family members (at least those living at the same address) of vulnerable children in the computer.	Audit of practice system
	The contractor will develop and maintain an electronic ‘flagging’ system to link and identify children and families where there are safeguarding concerns. For example: Information about vulnerable children (as above) to be flagged in the child’s notes using appropriate read codes and also where appropriate in the notes of siblings and significant family members	Audit of practice system
	Regular (monthly) meetings with health visitor (subject to adequately commissioned service by the relevant, responsible commissioning organisation) and where relevant the school nurse to discuss the safeguarding list with clear communication channels for situations as they arise.	Minutes of meeting and outcomes of the discussions recorded and available to PCT.
	Clear auditable procedures on responding to case conference reports and recording the outcome of these reports in the child’s medical record. Completed reports to be scanned on to the child’s records (Guidance on completion available in the safeguarding toolkit)	Evidence of reports and location
	Incorporation of safeguarding issues into practice protocols (for adults and children) in respect of depression, alcohol misuse, domestic abuse, drug misuse, pre-existing disability, new patient medicals, 6-8 week checks and ante and post natal checks, These should incorporate potential risk where siblings have been subject to previous child protection	Protocols made available to PCT

	concerns and where the parents have been identified as vulnerable. (NICE guidelines) Audit of general practice systems and procedures using self assessments tools (outlined by the RCGP) of different aspects of safeguarding including case conference report audits	Audits available for review
C	The contractor has a policy in place and is complying with that policy to record who brought a child to the surgery in each consultation and noting the family situation where relevant (for example teenage pregnancy noting age of partner, exploring family dynamics if interaction of the child with carer triggers concern). If this is not recorded for all children then all vulnerable children should have this recorded. The contractor has a Safeguarding learning and development plan for the following year for the practice and safeguarding development needs and continuing training identified and provided for all practice staff GPwSI annual review of practice procedures, audits, policies, communication channels and development plan.	Copy of policy and audit of practice systems Training arrangements /records either in-house or external reviews and development plan made available to the PCT Evidence of GPwSI reviews and comments regarding procedures and plans etc
Children and Young People		**Weighting 1%**
Standard		**Performance Measure**
A	The contractor has commenced the process of working towards the *You're Welcome* quality criteria for young people friendly health services The contractor has identified a *You're Welcome* lead (within the practice) The practice lead has engaged with the PCT' You're Welcome Lead Officer (as designated by the PCT You're Welcome Steering Group) and received the 'Get Wise to You're Welcome' training	You're Welcome Lead name made available to PCT Training register/certificates of attendance made available to PCT

B	The contractor is working towards achieving the *You're Welcome* quality criteria for young people friendly health services The contractor has completed a *You're Welcome* online self assessment against the 10 themes within the quality criteria The contractor is working with the PCT You're Welcome Lead Officer in developing an action plan on areas that require improvement arising out of the online assessment	 Copy of online self assessment made available to PCT Action Plan made available to PCT
C	The contractor is an accredited site through achieving the *You're Welcome* Kitemark and the Kitemark is displayed in the practice The contractor will submit all evidence required for verification to the PCT You're Welcome Lead Officer and participate in the verification process	Certificate of accreditation made available to the PCT Details of verification process made available to PCT
Maternity Services		**Weighting 3%**
Standard		**Performance Measure**
A	The contractor provides maternity services in partnership with existing locally commissioned Maternity Services and deliver the services at times and venues that are convenient to local women Self assessment against NICE Guidance: Antenatal Care Pregnancy and complex social factors The contractor will alert the Community Midwifery Team if additional medical or social needs are identified throughout pregnancy	Evidence of working in partnership Self Assessment report provided to the PCT Process/System for informing Community Midwifery Team made available to PCT
B	Does not apply to this area	
C	The contractor ensures that all pregnant women are referred in line with the PCT' early access to maternity service pathway and will promote direct access to a midwife.	Audit of number of women to maternity services pathway

Breast Feeding Promotion		Weighting 3%
Standard		**Performance Measure**
A	Does not apply to this area	
B	Does not apply to this area	
C	The contractor is an accredited Breastfeeding Welcome venue	Certificate of accreditation made available to PCT
	The contractor adheres to UNICEF UK baby friendly standards	Practice policy detailing UNICEF UK baby friendly standards available and evidence of compliance
	The contractor will not distribute or stock any literature/promotional materials which advertise formula milk in line with the international code of marketing of breast milk substitutes	Certificate of accreditation to demonstrate this
	100% of the practice clinical staff have accessed the appropriate training in respect of the above	Certificates/register of attendance made available
	The contractor is able to demonstrate adherence to the international code of marketing of breast milk substitutes	
Sexual Health Services		**Weighting 5%**
Standard		**Performance Measure**
A	The contractor provides a basic contraceptive service to all relevant patients that includes taking a detailed sexual history, offer up-to-date comprehensive and non-discriminatory sexual health advice and information and signpost and/or refer to the most appropriate local service(s) for treatment.	Anonymised audit of practice system to show information recorded
	The contractor and staff shall be familiar with the British Association for Sexual Health and HIV Standards.	Evidence to show provision
	The contractor ensures that condoms are made available to their patients	Evidence of data and Audit of system
	The Contractor shall record a patient's sexual history by using READ codes agreed with the PCT The contractor is able to demonstrate	Signs/leaflets available in practice

	that sexual health information is made available to their practice population The contractor is able to demonstrate the number of patients that have a sexual history recorded and the number of patients referred into sexual health services The contractor has a sufficient stock of condoms and is able to provide when required	 Audit of practice system Evidence of orders via public health
B	Does not apply to this area	
C	The contractor is able to demonstrate the number of staff trained in Long Acting Reversible Contraceptives (LARC) methods **OR** If the contractor does not itself provide LARC methods they will be able to demonstrate that provision for LARC is accessible to their population The practice screens 10% of their eligible population for Chlamydia (and gonorrhoea if appropriate) The contractor is responsible for ensuring 100% of individuals that are found to be positive for Chlamydia or gonorrhoea, by the contractor, are offered treatment and initiates partner notification The contractor knows their HIV population and provides support, follow up and associated referral(s) and treatment The contractor maintains a register identifying patients with HIV	Certificates of training made available to the PCT Evidence demonstrating referral process made available to PCT Audit of practice system to show % of eligible patients being screened Audit of practice system Audit of systems Maintained register made available to the PCT
Cancer Referrals		**Weighting 5%**

Standard		Performance Measure
A	The contractor has a system in place for chasing results of clinical investigations and acting upon those that are abnormal in a timely manner	Audit of system
	The contractor has a robust system in place that refers patients with suspected cancer (as set out in the criteria for two week referrals) within 24 hours.	Audit of referral process and systems
	The contractor has a system in place to check for confirmation of receipt of referrals.	Audit of system Receipts documented
	The contractor has a system to inform patients of the urgent referral and that its importance is fully understood.	Audit of system
B	Does not apply to this area	
C	The contractor has a system in place to check whether or not a suspected cancer patient attended their cancer referral appointment and if not, the contractor will find out why and discuss with the patient.	Protocol made available to PCT/Audit of system
	The contractor will carry out an audit on an annual basis to retrospectively identify cancer diagnosis, documenting lessons learned from delayed diagnosis and implement changes to practice/procedures to improve early diagnosis	Evidence of Audit and results and details of changes made to practice/procedures
Medicines Management		**Weighting 9%**
Standard		**Performance Measure**
A	Detail at Appendix 1 The practice achieves 25% - 49.9% of the Medicines Management Component	
B	Detail at Appendix 1 The practice achieves 50%- 74.9% of the Medicines Management Component	
C	Detail at Appendix 1 The practice achieves 75% -100% of the Medicines Management Component	
Palliative Care/Terminal Care		**Weighting 5%**

Standard		Performance Measure
A	The contractor maintains a supportive care register and informs the Out of Hours provider(s) of all terminal cases	Evidence of the register made available to PCT
B	The contractor has regular formal recorded internal meetings to discuss the supportive care register and all cases	Notes of meetings made available to PCT
C	The contractor adheres to the Gold Standard Framework, as applied locally	Evidence of adherence
Minor Surgery		**Weighting 5%**
Standard		**Performance Measure**
A	Does not apply to this area	
B	Does not apply to this area	
C	The contractor provides minor surgery being curettage, cautery, cryocautery of warts and verrucae, and other skin lesions where clinically appropriate	The practice is able to demonstrate the provision of minor surgery Evidence of relevant training and annual audit of histology results
Identification of Hard to Reach/Easy to Miss Groups		**Weighting 4%**
Standard		**Performance Measure**
A	Does not apply to this area	
B	Does not apply to this area	
C	The contractor works with Public Health in identifying their hard to reach/easy to miss groups The contractor is able to demonstrate the numbers of patients within their practice by race, disability, gender, transgender, age and sexual orientation. The contractor is able to demonstrate the number of patients in their hard to reach/easy to miss groups including; deprivation, homelessness, domestic violence, mental	Meeting dates/notes of meetings Audit of practice system using defined coding Audit of practice system using defined coding

	health, substance misuse, BME and those with disabilities. The contractor works with and implements Public Health Initiatives for their hard to reach/easy to miss groups	 Action plans and documents detailing initiatives and implementation
Learning Disabilities		**Weighting 2%**
Standard		**Performance Measure**
A	As per the requirements of the PCT DES	The practice is able to demonstrate achievement of the quality standards detailed in the DES
B	Does not apply to this area	
C	The contractor completes annually section 2 of the Learning Disabilities Performance and Self Assessment Framework "Reducing Health Inequalities"	Completed Section 2
Osteoporosis		**Weighting 3%**
Standard		**Performance Measure**
A	As per the requirements of the PCT DES	The practice is able to demonstrate achievement of the quality standards detailed in the DES
B	Does not apply to this area	
C	The contractor proactively searches for, tests and manages patients at high risk of osteoporosis as per the bone pathway The contractor is able to demonstrate an increase in referrals to the falls team	Evidence of searches and management of identified patients and compliance with the bone pathway Audit of practice system to provide number of referrals
Equality		**Weighting 4%**
Standard		**Performance Measure**
A	The contractor records patient ethnicity and first language both in the patient's notes and on the practice database	Audit of practice system

	The contractor can demonstrate year on year increase in recording of patient ethnicity and first language for patients attending practice ***For practices at ≤90% recorded data:*** The practice is able to provide evidence that they have increased recording by 20% (or to 90%) ***For practices at ≥90% recorded data:*** The practice is able to provide evidence that they have increased performance	Audit of practice system showing increase in number of patients with ethnicity and first language recorded
B	Does not apply to this area	
C	The contractor record patient ethnicity and all dimensions as per the Knowsley Single Equality Scheme The contractor works towards year on year improvement in collecting all data related to equality and diversity monitoring with an aim of being fully compliant with Knowsley's Single Equality Scheme (2009 – 2012 and beyond). The contractor can demonstrate recording all dimensions of the Single Equality Scheme The contractor can demonstrate recording of patients opting out of providing information required for Single Equality Scheme dimensions	Audit of practice system Audit of practice system showing year on year increase in recording of all dimensions of single equality scheme Evidence available detailing patients opting out of providing information
Response to Major Incidents		**Weighting 2%**
Standard		**Performance Measure**
A	Does not apply to this area	
B	Does not apply to this area	

C	The contractor has a robust, written major incident/emergency plan which links in with the PCT protocol/plan for emergency planning	Copy of major incident/emergency plan made available to PCT
Governance		**Weighting 4%**
Standard		**Performance Measure**
A	The contractor conforms to both clinical and information governance standards	Evidence of compliance
	The contractor implements all NICE guidelines applicable to the services to ensure clinical effectiveness	Protocol for implementing appropriate NICE guidance available to the PCT and evidence of implementation
	The contractor will have completed and can demonstrate completion of the IG Toolkit version 8 and evidence of working towards completion of version 9	IG Toolkit completion report
	The contractor can provide evidence of written Clinical Governance Policies	Written policies available to PCT
B	Does not apply to this area	
C	The contractor undertakes untoward incident reviews within one month one month of the untoward incident and implements changes identified in the review	Copy of reviews and actions undertaken available to PCT
	The contractor will have records/notes of meetings to discuss untoward incident reviews	Records/notes available to PCT
	The contractor will have written plans and details of implementation of changes identified via review/audit	Action plans and changes to be implemented made available to PCT
Infection Prevention and Control		**Weighting 2.5%**
Standard		**Performance Measure**
A	The contractor will ensure compliance with the National Hygiene Code and will work closely with the Infection Prevention Control (IPC) team to ensure that service and practice	Evidence as to how compliance is achieved Dates of meetings and record of discussions with the IPC team

	Healthcare Associated Infection (HCAI) risks are assessed, recorded and minimised. The contractor appropriately prescribes antibiotics in line with local formulary, ensuring that relevant risk factors are taken into consideration. The contractor will undertake an annual audit of the IPC standards in line with the National Hygiene Code The contractor has developed and implemented an action plan to ensure compliance with the IPC standards and the National Hygiene Code	Medicines management prescribing data and audits Results of audit made available to the PCT Action plan made available to the PCT
B	Does not apply to this area	
C	The contractor has a system in place for identifying patients who have sustained a community attributable HCAI The contractor has an effective system that alerts staff of those patients with a HCAI The contractor is able to demonstrate appropriate involvement in Root Cause Analysis processes	Review of system detailing how patients identified Alert system detailed in Infection Control Policy. Audit and report for RCA made available to thePCT

Appendix 1 **Medicines Management Component PMS** **July 2011**

	Percentage of the Meds Man component	**Requirement**	**Comments**
1.	12%	The practice will ensure with assurances to the PCT that all relevant NHS medicines safety alert recommendations relevant to primary care are implemented.	http://www.nrls.npsa.nhs.uk/resources/ This includes NPSA alerts relevant to medicines used in primary care and any ad hoc CMO alerts or Central Alert System Drug alerts.
2.	10%	The practice will have a Clinical Prescribing Lead who will be a point of contact for PCT Medicines Management and be responsible for leading the practice programme of work on the Medicines Management component of PMS. They are responsible for regularly updating clinical and non clinical members of the practice on local medicines management policy and guidelines and agreeing practice implementation. They should attend one out of two PMS Prescribing Lead meetings throughout the year in a 12 month period. The meetings will be organised by PCT Medicines Management. The practice prescribing lead will also be responsible for authorising practice PGDs (can be based on template local PGDs) and SOPs related to medicines management. A log of Prescribing Lead activity should be maintained for assurances to the PCT .	The PMS Prescribing Lead Group Meetings provided by the PCT are separate to the Prescribing Incentive Scheme Group Meetings.

3.	10%	The practice will ensure and with verifiable assurances to the PCT that all Local medicines management indicators as defined in (MM indicators, balanced score card) are undertaken to a level that complies with green status.	These are the medicines management quality indicators used in QoF 6.
4.	3%	The practice will ensure that standard operating procedures(SOPs) are in place and compliance to the procedures are audited (with evidence available to the PCT covering management of controlled drugs, and other relevant areas covered by the PCT Medicines Policy.	PCT Medicines Policy to be provided on intranet
5.	2%	The practice will undertake review of benzodiazepine prescribing within a structured clinical programme if level of prescribing is red or amber on the prescribing indicator balanced score card), in order to step down benzodiazepine prescribing as appropriate to the next level (e.g. red to amber or amber to green).	ePACT Prescribing balanced score card indicator to be provided by PCT
6.	5%	The practice will actively audit antibiotic prescribing and adherence to local formulary, and implement as appropriate strategies such as deferred prescribing to ensure that antibiotic prescribing is within green status (prescribing indicator balanced scorecard).	ePACT Prescribing score card indicator to be provided by PCT
7.	14%	The practice will undertake specific activity with evidence of work and improvement to ensure that all national QIPP Indicators with local targets as appropriate are achieved within 3 years of the target being introduced.	QIPP Indicators and local targets to be provided by PCT.

8.	14%	Based on recommendations from Mid Mersey and /or North Mersey MMC agreed by Knowsley MMC, the practice will actively review patients as appropriate to implement local guidance **NB. This does not include shared care guidance**. A log of activity related to this work should be held by the practice for assurance to the PCT.	Recommendations will be available on MMC websites http://www.midmerseymmb.nhs.uk/policystatements.html It is proposed that a Shared Care LES will be introduced in addition.
9.	2%	The practice will agree a protocol for communication with regards to prescription /medication queries with local pharmacies. This protocol should be in writing and evidence of implementation should be available for assurance to the PCT .	A template version will be available from the PCT
10.	2%	The practice will meet on a regular basis with the local community pharmacists to discuss relevant medicines matters. A log of meetings and actions should be available for assurance to the PCT .	Local pharmacies are defined as neighbourhood pharmacies that dispense for the practice catchment.
11.	26%	The practice will operate within the practice prescribing budget in line with good practice cost effective prescribing.	Monitoring ePACT practice prescribing profile in line with good practice trends? MM Team assessment.

Version 7

Schedule 10 Payment Mechanism

1. The Overall Performance Percentage and Payment Band shall be calculated in accordance with Schedule 2.

2. Subject to Paragraph 4 below, the Contractor will be paid for each financial year an amount equivalent to the respective Payment Band achieved for the preceding financial year multiplied by the weighted list size, payable in 12 monthly instalments. The payments are as follows

   Payment Band A - £70 per patient (weighted)

   Payment Band B - £80 per patient (weighted)

   Payment Band C - £90 per patient (weighted)

3. In the first financial year following the Variation the payment shall be calculated using a Payment Band as selected by the PCT. If the Contractor fails to achieve that Payment Band or above at the end of Year 1 the PCT shall be entitled to recover from the Contractor an amount equivalent to the difference between that paid to the Contractor for Year 1 and the actual achievement payment at the end of Year 1 and the PCT shall be entitled to deduct that amount from any future payments to the Contractor.

4. The weighted list size of the Contractor will be checked every quarter and payments adjusted up or down following this.

5. Where the Contractor has opted out or opts out of any Additional Services or Out of Hours the Payment Band will be top sliced using the percentages and in accordance with the GMS Financial Statement of Entitlements.

Signed on behalf of Knowsley PCT

Name …….

Position ……..

Signed by the Contractor

…….

…….

Appendix 2 Results of the PMS KPI review

KPI indicator	%	Areas of duplication					
		Contract	QOF	Local Authority	CQC registration	PCN	Other
Prevention	5%					✓	PCQP 2017- 2020
Health Improvement	5%	✓				✓	
Cervical screening	3%		✓		✓		
Breast screening	3%		✓				
Bowel screening	3%		✓				
Child health and childhood imms							
Influenza vaccine	2%		✓			✓	
Pneumococcal vaccine							
Safeguarding	5%				✓		PCQP 2017/18
Children and young people							
Maternity services							
Breast feeding promotion							
Sexual health services							
Cancer referrals	5%					✓	
Medicines management	9%	✓	✓		✓	✓	PCQP 2017-2020
Palliative care	5%		✓				
Minor surgery	5%	✓			✓		
Hard to reach groups							
Learning disability	2%		✓			✓	PCQP spec 2017/18
Osteoporosis	3%	✓	✓				PCQP spec 2019/20
Equality	4%	✓					PMS regs 2015
Response to Major incidents	2%				✓		
Governance	4%	✓			✓		
Infection control	2.5%	✓			✓		PCQP 2018/19 & 2019/20, PCCC minutes, National policy

ACCESS		Weighting 7.5%	Proposed areas of duplication
Standard		Performance Measure	Contract / QOF / Local Authority / CQC registration / PCNs / Enhanced services / National policy
A	The practice is contactable via one telephone number between 08.00 hrs and 18.30 hrs, Monday to Friday. The contractor will offer a minimum of 70 GP/Nurse Clinician appointments per 1000 patients per week The contractor will offer a minimum of 25 Practice Nurse appointments per 1000 population per week	Ad hoc telephone checks Core Hours Monitoring The contractor is able to demonstrate the relevant number of appointments via randomised sample of dates on practice appointment system The contractor is able to demonstrate the relevant number of appointments via randomised sample of dates on practice appointment system Audit of appointment system	**Removed** - The Access KPI and attached funding was removed from this enhanced scheme with an updated offer being made to both PMS and GMS practices. The indicator has been updated and together with the attached funding now forms part of the Primary Care Quality Premium (PCQP) scheme.
B	Each practice premises shall be open and have reception staff available for face-to-face bookings and contact between 08.00 hrs and 18.30 hrs, Monday to Friday. The contractor provides a range of appointments from 08.00 hrs to 18.30 hrs, Monday to Friday. Contractors with a half day closure will have reactive collaborative arrangements for appointments in place. The practice list is open to new patients	Ad hoc visits to check doors open at the times stated and reception staff available. The contractor is able to demonstrate the relevant number of appointments via randomised sample of dates on the practice appointment system up to 18.30hrs The contractor is able to demonstrate	

		having an open list	
C	The contractor provides a range of surgeries covering morning, afternoon and evening periods. Surgeries will remain open until 18.30 hrs, Monday to Friday, with evening surgery terminating to allow sufficient time to deal with late visits, telephone calls, prescription requests and administrative duties. Where the contractor is not providing extended hours under a DES, the contractor provides the minimum requirements under the extended hours access scheme/guidance as published by the Department of Health from time to time The contractor offers patient's choice with regards to the gender of their GP when making advanced booked appointments. This could be achieved on a collaborative basis with neighbouring practices.	Duty rota made available to the PCT Ad hoc visits to check clinician available throughout the day Audit of appointment system The contractor is able to demonstrate the availability of a choice of gender of GP and offer as per patient record/system.	
PREVENTION		**Weighting 5%**	**Proposed areas of duplication**
Standard		**Performance Measures**	**Contract / QOF / Local Authority / CQC registration / PCNs / Enhanced services / National policy**
A	The contractor shall record all reported diseases as agreed with the PCT on a designated disease register The contractor monitors recorded levels of disease and these should be within accepted	Registers made available to PCT Evidence of monitoring tolerance levels	Historically there was an over recording of COPD patients which was rectified and reduced by updated spirometry testing. **QOF** – the contractor maintains a set of disease registers and the requirements of the

	tolerances as defined by the PCT and recorded on disease registers. The contractor has written policies and/or procedures for recording incidence The contractor is able to provide commentary on differences between observed and expected disease prevalence The contractor will work with the PCT Public Health team (hereinafter referred to as Public Health) to develop an action plan with time scales as agreed with the PCT and implement such action plan for disease registers that vary by more than 1 standard deviation as defined by public health intelligence	Copy of policy made available to the PCT Written details of reasons for difference Copy of action plan made available to the PCT	scheme encourage accurate reporting and the monitoring of prevalence levels year on year as payment is linked to average National prevalence levels and national average list sizes. Focused action upon disease prevention has taken place using the PCQP scheme for two areas as follows: **PCQP specification for 2017/18** This element of the KPI was incorporated under *Improving Quality* i.e. to improve the identification and management of Hypertension and atrial fibrillation, and to reduce variation across practices. Practices will receive payment for auditing and addressing quality issues in respect of expected versus observed prevalence for both of these areas and to provide assurance of compliance with NICE quality standards. Practices audit and action plans to be produced and submitted by 30.04.2018. **PCQP specification for 2018/19** The practice plan to be updated and delivered in 2018/19 for Hypertension and atrial fibrillation areas of prevention. Practice to carry out an annual clinical review of patients with Heart Failure not managed by the CVD service.

			Practice to increase the percentage of patients receiving all 8 Diabetes care processes and develop a locality action plan. **PCQP specification for 2019/20** Hypertension - Practices to support the implementation and use of the Blood Pressure Quality Improvement toolkit. Practices to implement locality plans developed in 2018/19 for diabetes care.
B	The contractor will work with Public Health to identify key priorities as identified in the Joint Service Needs Assessment (JSNA) that are applicable to the practice. The contractor is able to demonstrate collaborative working with Public Health. The contractor will initiate a minimum of one visit per year from Public Health. The contractor has developed an action plan with timescales as agreed with the PCT and implemented such action plan to address each of the key priorities identified above.	List of identified priority areas made available to the PCT Minutes/record of meetings with public health Copy of action plan made available to the PCT	**Local Authority -** Public Health services were transferred to the local authority in 2013. PCC understands that no services are commissioned by the local authority direct with GP practices at Knowsley.
C	The contractor is part of a network with other practices and/or stakeholders that actively discuss and initiate preventive initiatives	Record of attendance at network meetings and notes of meetings made available to the PCT Notes/attendance registers for meetings	**PCN** – this constitutes the network which has the practice and other stakeholders as members. They are collectively responsible for the population health management of the registered patients within the PCN boundary.

	The contractor is able to demonstrate, that they have implemented relevant preventative initiatives	Action plans and processes initiated made available to PCT	Potential non-achievement due to lack of maturity at PCN level but funding is available via the PCN for this activity.
HEALTH IMPROVEMENT		**Weighting 5%**	**Proposed areas of duplication**
Standard		**Performance Measures**	**Contract / QOF / Local Authority / CQC registration / PCNs / Enhanced services / National policy**
A	The contractor is providing health promotion brief interventions/advice and is referring patients electronically to lifestyle support/services. The contractor is able to demonstrate that 100% of frontline staff (staff who have direct contact with patients) have had brief intervention training. The contractor has implemented and is fully compliant with the (single point of access) referral pathway into the lifestyle services 'hub'.	Evidence of number of referrals made available to the PCT Dates and records of attendance at brief intervention training made available to the PCT Lifestyle hub referral template installed on practice system and use made available to PCT	**PCN** – The Additional Roles Reimbursement Scheme and the role of the Social Prescribing Link Worker, Health and Wellbeing Coaches and Care Coordinators all of which is 100% funded via the Network Contract DES address the intention behind this KPI. The training and role of the Care Navigator in frontline staff will have superseded the work in this KPI. **Weight management** – From 2020/21 is introduced a new *non-contractual* requirement for GPs to offer to refer people with obesity into weight management services where this is clinically appropriate and where these services are commissioned locally. Page 38 paragraph 6.13 in this link: https://www.england.nhs.uk/wp-content/uploads/2020/03/update-to-the-gp-contract-agreement-v2-updated.pdf
B	The contractor works with Public Health to identify lifestyle issues and key priorities associated with their population on an annual basis and set in place evidence based interventions to improve health e.g. smoking, alcohol, and weight management. The contractor has developed an action plan with timescales as agreed with the PCT and	Lifestyle issues identified and Minutes/records of meetings with public health made available to PCT Copy of action plan with timescales made available to PCT	

	has implemented such action plan to address each of the key priorities identified.		NHSE will seek to commission additional weight management services over and above local authority public health responsibilities.
C	The contractor can demonstrate change in lifestyle profiles and is achieving outcomes over a reasonable period of time as agreed with the PCT based on the areas in the action plan in Level B selected for improvement.	Evidence of patients quitting smoking, improving weight, reducing alcohol intake etc made available to PCT Numbers of patients losing weight, quitting smoking etc recorded	
Cervical Screening		**Weighting 3%**	**Proposed areas of duplication**
Standard		**Performance Measure**	**Contract / QOF / Local Authority / CQC registration / PCNs / Enhanced services / National policy**
A	The contractor knows and can identify the cervical screening eligible cohort. All nurse smear takers are adequately trained to recognised national standards. The contractor is able to demonstrate the numbers of eligible women who were exempted for a cervical smear and the reasons why	Numbers in cohort made available to PCT Certificates/records of training/attendance made available to PCT Details of numbers exempted made available to PCT	**QOF** – register needed to action QOF requirements. **CQC** – Under the EFFECTIVE domain, question E3 asks "How does the service make sure that staff have the skills, knowledge and experience to deliver effective care, support and treatment?" The potential sources of evidence to the following prompts would cover this KPI: E3.2 **QOF** – exception reporting was replaced in 2019/20 with a personalised care adjustment to better reflect individual clinical situations and patients' wishes.

	All smear takers are up to date with refresher training, where appropriate	Record of attendance at refresher training made available	**CQC** – as above for this category A banding.
B	Does not apply to this area		N/A
C	The contractor shall improve year on year in working towards achieving the cervical screening national minimum target (CSNMT) (currently 80% uptake) as amended from time to time. ***For practices at <CSNMTuptake:*** ▪ The contractor has increased uptake by 5% (or to CSNMT) from their baseline figures for the previous financial year using practice data with exclusions as agreed between the contractor and the PCT OR ▪ Where the contractor fails to achieve a 5% increase or to CSNMT the contractor will work with Public Health in developing an action plan with timescales as agreed with the PCT to deliver the CSNMT and has implemented such action plan ensuring compliance to NHS Cervical Screening Programme (NHSCSP) Guidance ***For practices at >CSNMT uptake:***	Figures made available via audit of practice system Audit of practice system detailing level of uptake Action plan made available to PCT	**QOF** – Update from 2020/21 to the Quality Improvement (QI) module 'Early Cancer Diagnosis' with the objectives of: • Improving participation in national screening programmes for the practice's registered population • Referral practices for patients suspected of having cancer Practices to undertake quality improvement activity for *both* screening and early diagnosis. A five-step plan for the practices to undertake is set out on page 5 of this document: https://www.england.nhs.uk/wp-content/uploads/2020/02/20-21-qof-qi-cancer.pdf The work is intended to align with existing efforts of local public health commissioning teams and cancer alliances. The work is to be undertaken at both a practice and network level and include peer reviews.

	▪ The contractor is able to provide evidence that they have maintained CSNMT or over from the baseline figures as above using practice data with agreed exclusions	Audit of practice system showing uptake levels maintained	It has recently been confirmed that this QI module will be repeated for 2021/22 https://www.england.nhs.uk/wp-content/uploads/2021/01/C1054-supporting-general-practice-in-21-22.pdf **QOF –** For 2020/21 and in the response to highlight the critical importance of restoring this service the points allocated were doubled with the payment formula being amended whereby practices will accrue a greater number of points once they achieve the lower payment threshold. This will have the effect of paying practices a higher amount as they reach the lower threshold. Incentive to achieve the national minimum target of 80% is already rewarded via the QOF. **Comment** - results for Q4 in 2018/19 show that only 2 practices achieved the national target of 80% uptake and so this KPI is not adding value (PCCC minutes, September 2020). This result covers both PMS and GMS practices**.** **Comment** – From 01.04.2021 cervical screening becomes an essential service i.e funded by core contract payments. https://www.england.nhs.uk/wp-

			content/uploads/2021/01/C1054-supporting-general-practice-in-21-22.pdf
Breast Screening		**Weighting 3%**	**Proposed areas of duplication**
Standard		**Performance Measure**	**Contract / QOF / Local Authority / CQC registration / PCNs / Enhanced services / National policy**
A	The contractor has a system in place that highlights women who have not attended for breast screening The contractor is able to identify and provide evidence of the number of women eligible for breast screening	Search of practice system with numbers made available to PCT Search of practice system with numbers made available to PCT	**QOF** – Update from 2020/21 to the Quality Improvement (QI) module 'Early Cancer Diagnosis' with the objectives of: • Improving participation in national screening programmes for the practice's registered population • Referral practices for patients suspected of having cancer Practices to undertake quality improvement activity for *both* screening and early diagnosis. A five-step plan for the practices to undertake is set out on page 5 of this document: https://www.england.nhs.uk/wp-content/uploads/2020/02/20-21-qof-qi-cancer.pdf The work is intended to align with existing efforts of local public health commissioning teams and cancer alliances. The work is to be undertaken at both a practice and network level and include peer review.
B	Does not apply to this area		
C	The contractor promotes breast screening to women that are known not to have attended The contractor shall improve breast screening uptake and work towards the breast screening national minimum target (BSNMT) (currently 70% uptake) as amended from time to time. ***For practices at <BSNMT uptake:*** ▪ The contractor has increased uptake by 5% from the previous round throughout the financial year **OR**	Leaflets in surgery, posters in surgery, evidence of targeting these patients Audit of practice system with numbers made available to PCT	

	▪ Where the contractor fails to achieve a 5% increase from the previous round, the contractor will work with Public Health in developing an action plan with timescales as agreed with the PCT and has implemented such action plan to increase uptake in preparation for the next round ***For practices at <u>></u>BSNMT uptake:*** The contractor is able to provide evidence that they have maintained BSNMT or over on each occasion in the financial year from the previous round	Action plan made available to PCT Audit of practice system showing uptake levels maintained	It has recently been confirmed that this QI module will be repeated for 2021/22 https://www.england.nhs.uk/wp-content/uploads/2021/01/C1054-supporting-general-practice-in-21-22.pdf Whilst this service is delivered by other providers it is recognised that actions taken in general practice can increase uptake of national cancer screening programmes. **Comment** - results for Q2 in 2018/19 show that only 1 practice achieved the national target of 80% uptake and so this KPI is not adding value (PCCC minutes, September 2020). This result covers both PMS and GMS practices.
Bowel Screening		**Weighting 3 %**	**Proposed areas of duplication**
Standard		**Performance Measure**	**Contract / QOF / Local Authority / CQC registration / PCNs / Enhanced services / National policy**
A	Does not apply to this area		**QOF** – Update from 2020/21 to the Quality Improvement (QI) module 'Early Cancer Diagnosis' with the objectives of: • Improving participation in national screening programmes for the practice's registered population • Referral practices for patients suspected of having cancer
B	The contractor has a system in place that highlights patients who have not attended for bowel screening The contractor is able to identify and provide evidence of the numbers eligible for bowel screening	Evidence of system detailing how patients identified available to PCT Audit of practice system	

	The contractor is able to demonstrate the numbers of eligible individuals who did not return the bowel screening kit	Audit of practice system	Practices to undertake quality improvement activity for *both* screening and early diagnosis. A five-step plan for the practices to undertake is set out on page 5 of this document: https://www.england.nhs.uk/wp-content/uploads/2020/02/20-21-gof-qi-cancer.pdf The work is intended to align with existing efforts of local public health commissioning teams and cancer alliances. The work is to be undertaken at both a practice and network level and include peer review. Whilst this service is delivered by other providers it is recognised that actions taken in general practice can increase uptake of national cancer screening programmes. It has recently been confirmed that this QI module will be repeated for 2021/22 https://www.england.nhs.uk/wp-content/uploads/2021/01/C1054-supporting-general-practice-in-21-22.pdf Early introduction of new diagnostic tests such as Faecal Immunochemical Testing (FIT) to test for bowel cancer may improve uptake of this screening test.
C	The contractor shall improve year on year in working towards an uptake of 60% ***For practices at <60% uptake:*** The contractor has increased uptake by 5% (or to 60%) from the baseline figures (as approved by the PCT) for the previous financial year ***For practices at ≥60% uptake:*** The contractor is able to provide evidence that they have maintained 60% or over from the baseline figures as above	Audit of practice system detailing uptake Audit of practice system showing increase in uptake Audit of practice system showing maintained or increased levels over 60%	

			Comment - results for Q2 in 2018/19 show that only 3 practices achieved the national target of 60% uptake and so this KPI is not adding value (PCCC minutes, September 2020). This result covers both PMS and GMS practices.
Child Health and Childhood Immunisations		**Weighting 7%**	**Proposed areas of duplication**
Standard		**Performance Measure**	**Contract / QOF / Local Authority / CQC registration / PCNs / Enhanced services / National policy**
A	The contractor provides sufficient childhood immunisation clinics for all infants within the practice population The contractor provides the 6 to 8 week development check. The contractor will alert the health visitor if additional medical or social needs of the family are identified during the postnatal period. The contractor achieves a minimum of 70% uptake of all childhood immunisations (not including the contribution of the PCT immunisation team). The contractor has identified a lead for childhood immunisations who will quality assure provision within the practice and ensure that child immunisation data is submitted by the	Clinic times recorded and made available to PCT Evidence of checks/system Alerts recorded and numbers made available to PCT Audit of uptake Name of lead provided to the PCT Audit of systems	

	22nd of each month to the Child Health system (PARIS). The contractor is able to provide evidence regarding the numbers of families that have attended appointments for immunisation and action taken to engage those families who have not The contractor is able to demonstrate that they are working in partnership with the health visiting service in implementing the Healthy Child Programme (HCP) 0-5yrs targeted pathway	Audit of numbers attending during year Policy detailing how partnership working takes place and links with the Healthy Child Programme	
B	The contractor works in partnership with the health visiting service and the PCT immunisation team in proactively engaging families who do not attend for two or more appointments The contractor will achieve 90% uptake of childhood immunisations, For hard to reach families all vaccinations count towards target regardless of who administers the vaccination (GP, Practice Nurse, Commissioned Immunisation Team)	Evidence of joint working and engagement Audit of uptake of immunisations	
C	The contractor provides a coordinated, holistic approach to child health provision including the 6-8 week development health review, maternal	Policy detailing co-ordinated approach	

	mental wellbeing assessment and childhood immunisation clinics.		
Influenza Vaccination		**Weighting 2%**	**Proposed areas of duplication**
Standard		**Performance Measure**	**Contract / QOF / Local Authority / CQC registration / PCNs / Enhanced services / National policy**
A	Does not apply to this area		N/A
B	Does not apply to this area		N/A
C	The contractor works towards year on year improvement for influenza vaccination with a focus on low uptake / at risk groups under 65 years of age in particular children under 16 years and pregnant women ***For practices at <60% (or PCT target as amended from time to time) uptake in under 65's:*** ▪ The contractor has increased uptake by 5% or to the PCT aspiration annual target (currently at 60% uptake) from the baseline figures (as approved by the PCT) for the previous financial year with a focus on groups on low uptake (e.g. children under 16 and pregnant women) **OR** ▪ Where the contractor fails to achieve a 5% increase or the target as above the contractor will work with public health in developing an action plan with timescales	Audit of practice system showing numbers of uptake in low uptake/at risk groups under 65 Audit of practice system showing numbers of uptake Action plan made available to PCT	Influenza vaccination is commissioned nationally by NHSE and delivered mainly through primary care and this KPI seeks to increase uptake annually in the low uptake / at risk groups. KCCG in partnership with KMBC public health and PHE are able to analyse datasets in relation to prevention and screening including influenza vaccination uptake in *at risk* groups, pregnant women and children aged 2 and 3 years. **PCN** – as the vehicle for collaboration between GP practices and community pharmacy PCNs are ideally placed to take the lead on improving flu vaccine coverage. The IIF for 2020/21, PCNs will receive additional funding for achievement at a network level between 70% and 77% for flu vaccinations provided to patients aged 65 years and over. https://www.england.nhs.uk/wp-

	as agreed with the PCT to and has implemented such action plan to increase uptake ***For practices at ≥60% (or PCT target as amended from time to time) uptake in under 65's:*** ▪ The contractor is able to provide evidence that they have maintained target or over from the baseline figures as above in low uptake groups	Audit of practice system showing maintained uptake of 60%	content/uploads/2020/09/C0713-202021-General-Medical-Services-GMS-contract-Quality-and-Outcomes-Framework-QOF-Guidance.pdf **QOF** – for 2020/21 the points allocated to influenza vaccination are doubled as detailed in Table 1 on page 7 of this report for some high risk disease areas: https://www.england.nhs.uk/wp-content/uploads/2020/09/C0713-202021-General-Medical-Services-GMS-contract-Quality-and-Outcomes-Framework-QOF-Guidance.pdf **Comment** - during 2019/20 only 5 practices achieved the 55% uptake target for the under 65years *at risk* cohort (PCCC minutes, June 2020) suggesting this KPI is not adding value. **Comment** – PCCC minutes (September 2020) reports that flu vaccine uptake consistently presents as a trigger indicator, meaning that the greatest number of practices are failing to meet the target. (this covers both PMS and GMS practices).
Pneumococcal Vaccination		**Weighting 2%**	**Proposed areas of duplication**
Standard		**Performance Measure**	**Contract / QOF / Local Authority / CQC registration / PCNs / Enhanced services / National policy**
A	Does not apply to this area		

B	Does not apply to this area		
C	The contractor works towards year on year improvement for pneumococcal vaccination ***For practices at ≤60% (or PCT target as amended from time to time) uptake:*** ▪ The contractor has increased uptake in at risk groups by 5% (or to target currently 60%) from the baseline figures (as approved by the PCT) for the previous financial year ***For practices at ≥60% (or PCT target as amended from time to time) uptake:*** ▪ The contractor is able to provide evidence that they have maintained target or over from the baseline figures as above	Audit of practice system showing numbers of uptake in at risk groups Audit shows increase of 5% or to 60% uptake Audit of practice system showing maintained uptake of 60%	
Safeguarding		**Weighting 5%**	**Proposed areas of duplication**
Standard		**Performance Measure**	**Contract / QOF / Local Authority / CQC registration / PCNs / Enhanced services / National policy**
A	The contractor shall have in place and adopt a robust Safeguarding (Children) Policy Statement in accordance with all relevant legislation and guidance and conduct a self-audit against key criteria as set out in the RCGP Safeguarding Children and Young People Toolkit 2011 (as amended from time to	Policy to be maintained along with other practice policies and made available to the PCT	**CQC registration** – All GP practices are required to be registered with this independent regulator of health and social care. Under their inspection regime CQC follow a set of Key Lines of Enquiry (KLOE).

	time) which would provide a minimum Safeguarding Standard for GP Practices. The Policy shall include an identified Safeguarding GP lead for the practice The Safeguarding Policy and procedures are easily accessible and regularly reviewed (not less than annually) and updated as and when necessary (e.g. to comply with changes in legislation/ guidance) and the Safeguarding Policy and procedures are kept together with key Safeguarding related guidance. The Safeguarding GP lead ensure the Policy is reviewed and updated as planned All staff are aware of the policy and procedures and how to access them Compliance with safer recruitment processes as outlined by the RCGP in the Safeguarding Toolkit to include CRB checks and at least two references Practice Manager to hold copies of CRB clearance and two references for new staff members Regular communication with the Health Visitor for non-school age children or for school age children, with the School Nurse, to discuss the	Name of Safeguarding GP lead incorporated into policy. Evidence of reviews/updates Audit of recruitment processes Communication notebook or similar process instituted in the practice	<u>Under the SAFE domain, question S1 asks</u> "How do systems, processes and practices keep people safe and safeguarded from abuse?" The potential sources of evidence to the following prompts would cover this KPI: S1.1 S1.2 S1.3 S1.4 S1.5 S1.6 S1.7 <u>Under the SAFE domain, question S6 asks</u> "Are lessons learned and improvements made when things go wrong?" The potential sources of evidence to the following prompts would cover this KPI: S6.2 S6.3 S6.4

	list of children with safeguarding concerns with clear communication channels for situations where the contractor has concerns about a child as they arise.		
	The contractor will ensure recognised Safeguarding training for all staff and GP trainees attached to practice (GP's to complete level 2 and be working towards level 3, practice nurses level 2 and non clinical staff level 1 as per the Intercollegiate Document 2010) Certificates of attendance at training programmes in house or external to be retained by Practice Manager or Safeguarding Lead	Evidence of training either completed or booked for staff	
	The contractor has a clear Supervision Policy and arrangements, in line with the Intercollegiate Document 2010 and Working Together 2010 (both as amended from time to time) for the supervision of all staff (including trainees and non clinical staff) that covers safeguarding issues.	Staff must be able to demonstrate clarity about what to do if they have a safeguarding concern and who to approach for advice.	
	Review of Significant safeguarding events at least twice yearly (Significant safeguarding events and SUDI to be included in the Significant Event Analysis meetings or practice meetings as necessary on a regular basis)	Minutes of meetings, reviews and outcomes of discussions available to the PCT	
	Children who are looked after, or are subject to a child protection plan or about whom there are	Review of Self Audit	

	safeguarding concerns have appropriate read codes on the 'problem' page to highlight their status and any issues of concern (Read codes should cover: Children subject to a child protection plan; looked after children; children in need; domestic abuse; alcohol and substance misuse; teenage pregnancy, parental mental health problems)		
B	The contractor compiles and maintains up to date electronic safeguarding lists of "looked after children" and "children subject to a child protection plan" The contractor links family members (at least those living at the same address) of vulnerable children in the computer. The contractor will develop and maintain an electronic 'flagging' system to link and identify children and families where there are safeguarding concerns. For example: Information about vulnerable children (as above) to be flagged in the child's notes using appropriate read codes and also where appropriate in the notes of siblings and significant family members Regular (monthly) meetings with health visitor (subject to adequately commissioned service by the relevant, responsible commissioning organisation) and where relevant the school nurse to discuss the safeguarding list with clear	Contractor signed declaration that lists are maintained and up to date Audit of practice system Audit of practice system Minutes of meeting and outcomes of the discussions recorded and available to PCT.	

	communication channels for situations as they arise. Clear auditable procedures on responding to case conference reports and recording the outcome of these reports in the child's medical record. Completed reports to be scanned on to the child's records (Guidance on completion available in the safeguarding toolkit) Incorporation of safeguarding issues into practice protocols (for adults and children) in respect of depression, alcohol misuse, domestic abuse, drug misuse, pre-existing disability, new patient medicals, 6-8 week checks and ante and post natal checks, These should incorporate potential risk where siblings have been subject to previous child protection concerns and where the parents have been identified as vulnerable. (NICE guidelines) Audit of general practice systems and procedures using self assessments tools (outlined by the RCGP) of different aspects of safeguarding including case conference report audits	Evidence of reports and location Protocols made available to PCT Audits available for review	**PCQP specification for 2017/18** – This element of the KPI was incorporated as part of *Improving Quality* i.e. demonstrate compliance with requests for attendance at and/or completion of reports for case conferences. **PCQP specification for 2017/18** This element of the KPI was incorporated as part of the *Improving Quality* i.e. undertake a self-assessment audit programme and produce an action plan, tools and case conference report audits.
C	The contractor has a policy in place and is complying with that policy to record who brought a child to the surgery in each consultation and noting the family situation where relevant (for example teenage	Copy of policy and audit of practice systems	

	pregnancy noting age of partner, exploring family dynamics if interaction of the child with carer triggers concern). If this is not recorded for all children then all vulnerable children should have this recorded. The contractor has a Safeguarding learning and development plan for the following year for the practice and safeguarding development needs and continuing training identified and provided for all practice staff GPwSI annual review of practice procedures, audits, policies, communication channels and development plan.	Training arrangements /records either in-house or external reviews and development plan made available to the PCT Evidence of GPwSI reviews and comments regarding procedures and plans etc	**CQC registration** Under the EFFECTIVE domain, question E3 asks "How does the service make sure that staff have the skills, knowledge and experience to deliver effective care, support and treatment?" The potential sources of evidence to the following prompts would cover this KPI: E3.1 E3.2 E3.3 E3.4 **Comment** – does this KPI represent further activity over and above that expected from GMS contract holders?
Children and Young People		**Weighting 1%**	**Proposed areas of duplication**
Standard		**Performance Measure**	**Contract / QOF / Local Authority / CQC registration / PCNs / Enhanced services / National policy**
A	The contractor has commenced the process of working towards the *You're Welcome* quality		**Comment** – does this KPI represent further activity over and above that expected from GMS contract holders?

	criteria for young people friendly health services ▪ The contractor has identified a *You're Welcome* lead (within the practice) ▪ The practice lead has engaged with the PCT' You're Welcome Lead Officer (as designated by the PCT You're Welcome Steering Group) and received the 'Get Wise to You're Welcome' training	You're Welcome Lead name made available to PCT Training register/certificates of attendance made available to PCT	
B	The contractor is working towards achieving the *You're Welcome* quality criteria for young people friendly health services ▪ The contractor has completed a *You're Welcome* online self-assessment against the 10 themes within the quality criteria ▪ The contractor is working with the PCT You're Welcome Lead Officer in developing an action plan on areas that require improvement arising out of the online assessment	Copy of online self-assessment made available to PCT Action Plan made available to PCT	
C	The contractor is an accredited site through achieving the *You're Welcome* Kitemark and the Kitemark is displayed in the practice The contractor will submit all evidence required for verification to the PCT You're Welcome Lead Officer and participate in the verification process	Certificate of accreditation made available to the PCT Details of verification process made available to PCT	

Maternity Services		Weighting 3%	Proposed areas of duplication
Standard		Performance Measure	Contract / QOF / Local Authority / CQC registration / PCNs / Enhanced services / National policy
A	The contractor provides maternity services in partnership with existing locally commissioned Maternity Services and deliver the services at times and venues that are convenient to local women Self-assessment against NICE Guidance: Antenatal Care Pregnancy and complex social factors The contractor will alert the Community Midwifery Team if additional medical or social needs are identified throughout pregnancy	Evidence of working in partnership Self-Assessment report provided to the PCT Process/System for informing Community Midwifery Team made available to PCT	
B	Does not apply to this area		
C	The contractor ensures that all pregnant women are referred in line with the PCT' early access to maternity service pathway and will promote direct access to a midwife.	Audit of number of women to maternity services pathway	
Breast Feeding Promotion		**Weighting 3%**	**Proposed areas of duplication**
Standard		**Performance Measure**	**Contract / QOF / Local Authority / CQC registration / PCNs / Enhanced services / National policy**
A	Does not apply to this area		
B	Does not apply to this area		

C	The contractor is an accredited Breastfeeding Welcome venue The contractor adheres to UNICEF UK baby friendly standards The contractor will not distribute or stock any literature/promotional materials which advertise formula milk in line with the international code of marketing of breast milk substitutes 100% of the practice clinical staff have accessed the appropriate training in respect of the above The contractor is able to demonstrate adherence to the international code of marketing of breast milk substitutes	Certificate of accreditation made available to PCT Practice policy detailing UNICEF UK baby friendly standards available and evidence of compliance Certificate of accreditation to demonstrate this Certificates/register of attendance made available	**Comment** – does this KPI represent further activity over and above that expected from GMS contract holders?
Sexual Health Services		**Weighting 5%**	**Proposed areas of duplication**
Standard		**Performance Measure**	**Contract / QOF / Local Authority / CQC registration / PCNs / Enhanced services / National policy**
A	The contractor provides a basic contraceptive service to all relevant patients that includes taking a detailed sexual history, offer up-to-date comprehensive and non-discriminatory sexual health advice and information and signpost and/or refer to the most appropriate local service(s) for treatment.	Anonymised audit of practice system to show information recorded	**Comment** – does this KPI represent further activity over and above that expected from GMS contract holders?

	The contractor and staff shall be familiar with the British Association for Sexual Health and HIV Standards. The contractor ensures that condoms are made available to their patients The Contractor shall record a patient's sexual history by using READ codes agreed with the PCT The contractor is able to demonstrate that sexual health information is made available to their practice population The contractor is able to demonstrate the number of patients that have a sexual history recorded and the number of patients referred into sexual health services The contractor has a sufficient stock of condoms and is able to provide when required	Evidence to show provision Evidence of data and Audit of system Signs/leaflets available in practice Audit of practice system Evidence of orders via public health	
B	Does not apply to this area		
C	▪ The contractor is able to demonstrate the number of staff trained in Long Acting Reversible Contraceptives (LARC) methods **OR** ▪ If the contractor does not itself provide LARC methods they will be able to demonstrate that provision for LARC is accessible to their population	Certificates of training made available to the PCT Evidence demonstrating referral process made available to PCT	

	The practice screens 10% of their eligible population for Chlamydia (and gonorrhoea if appropriate) The contractor is responsible for ensuring 100% of individuals that are found to be positive for Chlamydia or gonorrhoea, by the contractor, are offered treatment and initiates partner notification The contractor knows their HIV population and provides support, follow up and associated referral(s) and treatment The contractor maintains a register identifying patients with HIV	Audit of practice system to show % of eligible patients being screened Audit of practice system Audit of systems Maintained register made available to the PCT	
Cancer Referrals		**Weighting 5%**	**Proposed areas of duplication**
Standard		**Performance Measure**	**Contract / QOF / Local Authority / CQC registration / PCNs / Enhanced services / National policy**
A	The contractor has a system in place for chasing results of clinical investigations and acting upon those that are abnormal in a timely manner The contractor has a robust system in place that refers patients with suspected cancer (as set out in the criteria for two week referrals) within 24 hours.	Audit of system Audit of referral process and systems	**PCN** – From 1st October 2020 (revised from 1st April 2020 due to Covid-19) under the Network Contract DES the PCN is to provide an Early Cancer Diagnosis service as set out in para 7.4 https://www.england.nhs.uk/wp-content/uploads/2020/03/Network-Contract-DES-Specification-PCN-Requirements-and-Entitlements-2020-21-October-FINAL.pdf

	The contractor has a system in place to check for confirmation of receipt of referrals. The contractor has a system to inform patients of the urgent referral and that its importance is fully understood.	Audit of system Receipts documented Audit of system	This new Early Cancer Diagnosis service requirement for PCNs seeks to improve referral practice and screening uptake through network level activity and to support the ambition set out in the LTP to increase the proportion of patients diagnosed with cancer at stage 1 and 2.
B	Does not apply to this area		
C	The contractor has a system in place to check whether or not a suspected cancer patient attended their cancer referral appointment and if not, the contractor will find out why and discuss with the patient. The contractor will carry out an audit on an annual basis to retrospectively identify cancer diagnosis, documenting lessons learned from delayed diagnosis and implement changes to practice/procedures to improve early diagnosis	Protocol made available to PCT/Audit of system Evidence of Audit and results and details of changes made to practice/procedures	
Medicines Management		**Weighting 9%**	**Proposed areas of duplication**
Standard		**Performance Measure**	**Contract / QOF / Local Authority / CQC registration / PCNs / Enhanced services / National policy**
A	Detail at Appendix 1 The practice achieves 25% - 49.9% of the Medicines Management Component		This KPI has eleven indicators: 1) Medicines safety alerts are implemented – this element was included in the PCQP for 2017/18, 2018/19 and 2019/20.
B	Detail at Appendix 1 The practice achieves 50%- 74.9% of the Medicines Management Component		

C	Detail at Appendix 1 The practice achieves 75% -100% of the Medicines Management Component		2) Clinical Prescribing lead per practice – this element was included in the PCQP for 2017/18, 2018/19 and 2019/20. 3) Meet local meds management indicators (need a copy of the balanced scorecard in order to clarify). 4) Having a SOP in place covering the management and use of controlled drugs – this element is included in the PMS agreement for 2016/17 at clause 11. 5) Benzodiazepine review with a view to step down prescribing as appropriate – this element was included in the PCQP for 2019/20. Practices were asked to ensure prescribing is in line with the Pan Mersey prescribing recommendations. The PMS agreement includes following NICE recommendations (which include this medication). 6) Antibiotic prescribing, adherence to local formulary and deferred prescribing – these were elements included in the PCQP for 2018/19. 7) Meet national QIPP indicators with local targets achieved within 3 years of introduction – the PCQP for 2019/20 has an over-riding aim of supporting KCCG QIPP schemes (para 2.5) as well as the practices' QIPP financial savings target where this has been agreed with the practice.

			8) Implement local guidance (does not include shared care guidance) – Is this different for GMS practices? 9) Agreed protocol for communication in regard to prescription/medication queries with local pharmacies - Is this different for GMS practices? 10) Practice to meet regularly with the local community pharmacists to discuss relevant medicines matters – working in partnership with community pharmacists is work now carried out at a PCN level. 11) Practice to operate within their prescribing budget – the PCQP for 2019/20 (section 5.6) asks practices to work within their prescribing budget and/or meet their QIPP financial targets. **CQC registration** – All GP practices are required to be registered with this independent regulator of health and social care. Under their inspection regime CQC follow a set of Key Lines of Enquiry (KLOE). <u>Under the SAFE</u> domain S4 asks 'How does the provider ensure the proper and safe use of medicines, where the service is responsible?" **QOF** – Quality Improvement (QI) indicator 2019/20 Prescribing safety. This indicator was introduced for 2019/20 to seek to fulfil the recommendation in the Report

			of the Review of QOF and is to encourage contractors to help meet the WHO challenge to reduce the level of medication-related harm by 50% and help meet the five-year action plan to reduce antimicrobial resistance. **Comments** – the PCQP 2019/20 specification states that KCC has the highest prescribers of antibiotics across the country (para 5.4.1) and the highest national percentage of patients prescribed 10 or more unique medications. **Comment** - the primary dashboard (PCCC minutes, September 2020 p182) records low level achievement of medication reviews. Structured medication reviews to be supported by funding at a PCN level.
Palliative Care/Terminal Care		**Weighting 5%**	**Proposed areas of duplication**
Standard		**Performance Measure**	**Contract / QOF / Local Authority / CQC registration / PCNs / Enhanced services / National policy**
A	The contractor maintains a supportive care register and informs the Out of Hours provider(s) of all terminal cases	Evidence of the register made available to PCT	**QOF** – Palliative Care. Establishment and maintenance of a register of patients in need of palliative care/support irrespective of age. This assists the practice to provide more appropriate and patient focused care. **Comment** – GMS practices would also inform the OOH provider of terminal cases.

B	The contractor has regular formal recorded internal meetings to discuss the supportive care register and all cases	Notes of meetings made available to PCT	**QOF** – End of Life Quality Improvement (QI) indicator 2019/20. This indicator was introduced in 2019/20 to seek to fulfil the recommendation in the Report of the Review of QOF and is to support contractors to recognise areas of care, develop an improvement plan and share learning across their network.
C	The contractor adheres to the Gold Standard Framework, as applied locally	Evidence of adherence	**Comment** – GMS practices would also adhere to the Gold Standard Framework (GSF) so no added value being provided.
Minor Surgery		**Weighting 5%**	**Proposed areas of duplication**
Standard		**Performance Measure**	**Contract / QOF / Local Authority / CQC registration / PCNs / Enhanced services / National policy**
A	Does not apply to this area		N/A
B	Does not apply to this area		N/A
C	The contractor provides minor surgery being curettage, cautery, cryocautery of warts and verrucae, and other skin lesions where clinically appropriate	The practice is able to demonstrate the provision of minor surgery Evidence of relevant training and annual audit of histology results	**Contract** – the PMS agreement template 2016/17 – 2020/21 cites at Schedule 1, Part 2 minor surgery as an *additional service*. The wording in this KPI mirrors the contract wording at paragraph 1.22. <u>Caveat</u> – PCC are not party to the PMS agreements entered into by KCCG with local practices so have had to assume that they will include this clause and that no contractors have opted-out of this service. Any PMS provider that has opted out of providing minor surgery as an additional service should not be paid for this KPI.

			CQC – Under the EFFECTIVE domain, question E3 asks "How does the service make sure that staff have the skills, knowledge and experience to deliver effective care, support and treatment?" The potential sources of evidence to the following prompts would cover this KPI: E3.2
Identification of Hard to Reach/Easy to Miss Groups		**Weighting 4%**	**Proposed areas of duplication**
Standard		**Performance Measure**	**Contract / QOF / Local Authority / CQC registration / PCNs / Enhanced services / National policy**
A	Does not apply to this area		
B	Does not apply to this area		
C	The contractor works with Public Health in identifying their hard to reach/easy to miss groups The contractor is able to demonstrate the numbers of patients within their practice by race, disability, gender, transgender, age and sexual orientation. The contractor is able to demonstrate the number of patients in their hard to reach/easy to miss groups including; deprivation, homelessness, domestic violence, mental	Meeting dates/notes of meetings Audit of practice system using defined coding Audit of practice system using defined coding	**Comment** – does this KPI represent further activity over and above that expected from GMS contract holders?

	health, substance misuse, BME and those with disabilities. The contractor works with and implements Public Health Initiatives for their hard to reach/easy to miss groups	Action plans and documents detailing initiatives and implementation	
Learning Disabilities		**Weighting 2%**	**Proposed areas of duplication**
Standard		**Performance Measure**	**Contract / QOF / Local Authority / CQC registration / PCNs / Enhanced services / National policy**
A	As per the requirements of the PCT DES	The practice is able to demonstrate achievement of the quality standards detailed in the DES	**Enhanced Services** – Learning Disabilities Health Check Scheme is commissioned nationally, with improved quality standards now incorporated into QOF under the QI domain for 2020/21. **QOF** – Establish and maintain a register of patients with learning disabilities (includes people of any age). **QOF** – **Quality Improvement (QI) indicator for 2020/21** Improving care for people with Learning Disabilities. This indicator includes a number of quality improvements such as, improving accuracy of the GP register, increased uptake of annual health checks, optimisation of medications in line with STOMP etc. https://www.england.nhs.uk/wp-content/uploads/2020/02/20-21-qof-qi-

			supporting-people-with-learning-disabilites.pdf This QI indicator for 2020/21 has been revised to reflect the impact of covid-19 and the reprioritising of aspects of care. The revised guidance has amended the requirements of this QI domain to focus upon care delivery and restoration of services using QI tools e.g. practices should set improvement targets and monitor their performance to ensure that progress is being made in restoring full operation of annual health checks for people with Learning Disabilities as well as the delivery of flu vaccinations to this cohort of patients. 37 points are available for this indicator. https://www.england.nhs.uk/wp-content/uploads/2020/09/C0713-202021-General-Medical-Services-GMS-contract-Quality-and-Outcomes-Framework-QOF-Guidance.pdf It has recently been confirmed that this QI module will be repeated for 2021/22 https://www.england.nhs.uk/wp-content/uploads/2021/01/C1054-supporting-general-practice-in-21-22.pdf **PCN** – practices can refer patients to Social Prescribing Link Workers for identified specific

			support. Also funding via the IIF is available to support the uptake of LD health checks. **Other** – support and guidance is available to practices from the NWB LD Health Facilitation Team. An advanced health practitioner is in post from NWB working across all practices to support this area of work. (PCCC minutes March 2020).
B	Does not apply to this area		N/A
C	The contractor completes annually section 2 of the Learning Disabilities Performance and Self Assessment Framework "Reducing Health Inequalities"	Completed Section 2	Section 2 of the Learning Disabilities Performance and Self-Assessment Framework seeks feedback on *Staying Healthy, keeping safe and Living well* and the results to inform commissioning decisions. **PCQP specification for 2017/18** - This element of the KPI was incorporated under *Improving Quality* i.e. undertake a self-assessment audit. **Comment** – PCCC minutes (September 2020) reports that only 4/25 practices have achieved the rolling 12month target of 75% or above for LD health checks. PCCC minutes (March 2020) reports 6/25. These results cover both PMS and GMS practices.
Osteoporosis		**Weighting 3%**	**Proposed areas of duplication**

Standard		Performance Measure	Contract / QOF / Local Authority / CQC registration / PCNs / Enhanced services / National policy
A	As per the requirements of the PCT DES	The practice is able to demonstrate achievement of the quality standards detailed in the DES	**Contract** – In 2017/18 additional requirements were included in GP contracts to support routine frailty identification and care, reflecting the key role of general practice. This required GP practices to use an appropriate evidenced based tool, such as the Electronic Frailty Index (eFI), to identify patients aged 65 and over who may be living with moderate or severe frailty, deliver a clinical review and any other clinically relevant interventions. https://www.england.nhs.uk/wp-content/uploads/2018/01/17-pms-variation-notice.pdf Caveat – PCC are not party to the local PMS agreements entered into by KCCG with local practices so have assumed that they will include this variation.
B	Does not apply to this area		N/A
C	The contractor proactively searches for, tests and manages patients at high risk of osteoporosis as per the bone pathway The contractor is able to demonstrate an increase in referrals to the falls team	Evidence of searches and management of identified patients and compliance with the bone pathway Audit of practice system to provide number of referrals	**QOF** – The identification, diagnosis and treatment of osteoporosis forms part of QOF. The 2020/21 payment is conditional on practices continuing to accurately maintain the register and for disease prevalence to be comparable with 2019/20 levels. Three points are available.

			PCQP 2019/20 specification - Increases in referral to the Integrated Frailty Community Team (ICFT) was included in the PCQP 2019/20 at £1.00 per registered patient and to be operated at a PCN level. PCC have assumed this is still in place for 2020/21 as the PCQP specification was not updated post 2019/20.
Equality Standard		**Weighting 4%** **Performance Measure**	**Proposed areas of duplication** **Contract / QOF / Local Authority / CQC registration / PCNs / Enhanced services / National policy**
A	The contractor records patient ethnicity and first language both in the patient's notes and on the practice database The contractor can demonstrate year on year increase in recording of patient ethnicity and first language for patients attending practice ***For practices at <u>≤</u>90% recorded data:*** ▪ The practice is able to provide evidence that they have increased recording by 20% (or to 90%) ***For practices at <u>≥</u>90% recorded data:*** ▪ The practice is able to provide evidence that they have increased performance	Audit of practice system Audit of practice system showing increase in number of patients with ethnicity and first language recorded	**Contract** – The recently updated Standard PMS Agreement template states that "Promoting equality and addressing health inequalities are at the heart of NHS England's values". Contract holders have an equality duty towards those patients with protected characteristics. https://www.england.nhs.uk/wp-content/uploads/2020/12/20-21-PMS-Agreement-October-2020.pdf <u>Caveat</u> – PCC are not party to the local PMS agreements entered into by KCCG with local practices so assumed that they will include this aspect. **PMS Regulations 2015** - The plan to introduce a new regulatory requirement from January 2021 for practices to record ethnicity

			data where this is provided by the patient is now in place (regulation 60A): https://www.legislation.gov.uk/uksi/2020/1415/made Prior to this, all NHS organisations were asked to proactively review and ensure the completeness of patient ethnicity data by no later than the 31 December 2020.
B	Does not apply to this area		N/A
C	The contractor record patient ethnicity and all dimensions as per the Knowsley Single Equality Scheme The contractor works towards year on year improvement in collecting all data related to equality and diversity monitoring with an aim of being fully compliant with Knowsley's Single Equality Scheme (2009 – 2012 and beyond). The contractor can demonstrate recording all dimensions of the Single Equality Scheme The contractor can demonstrate recording of patients opting out of providing information required for Single Equality Scheme dimensions	Audit of practice system Audit of practice system showing year on year increase in recording of all dimensions of single equality scheme Evidence available detailing patients opting out of providing information	PCC have not had access to the Knowsley Single Equality Scheme document however, it is safe to say that any such scheme would recognise the legal responsibility as set out in the Equality Act 2010 in relation to the nine protected characteristics. The contractor would need to be able to identify those patients who have a protected characteristic in order to address health inequalities. **PMS Regulations 2015** – Under the regulations where a contractor makes a relevant request in regard to ethnicity and the patient (or an appropriate person) responds the contractor must record this information in their medical record. Where the patient indicates they would "prefer not to disclose" their ethnicity, this must also be recorded in their medical record.

Response to Major Incidents		**Weighting 2%**	**Proposed areas of duplication**
Standard		**Performance Measure**	**Contract / QOF / Local Authority / CQC registration / PCNs / Enhanced services / National policy**
A	Does not apply to this area		N/A
B	Does not apply to this area		N/A

C	The contractor has a robust, written major incident/emergency plan which links in with the PCT protocol/plan for emergency planning.	Copy of major incident/emergency plan made available to PCT.	**CQC registration** – All GP practices are required to be registered with this independent regulator of health and social care. Under their inspection regime CQC follow a set of Key Lines of Enquiry (KLOE). CQC state on their website that during an inspection they will look at what arrangements are in place to respond to emergencies and major incidents. https://www.cqc.org.uk/guidance-providers/gps/nigels-surgery-69-business-continuity-arrangements-emergencies-major

Governance		Weighting 4%	Proposed areas of duplication
Standard		**Performance Measure**	**Contract / QOF / Local Authority / CQC registration / PCNs / Enhanced services / National policy**
A	The contractor conforms to both clinical and information governance standards The contractor implements all NICE guidelines applicable to the services to ensure clinical effectiveness The contractor will have completed and can demonstrate completion of the IG Toolkit version 8 and evidence of working towards completion of version 9 The contractor can provide evidence of written Clinical Governance Policies	Evidence of compliance Protocol for implementing appropriate NICE guidance available to the PCT and evidence of implementation IG Toolkit completion report Written policies available to PCT	**Contract** – The recently updated Standard PMS Agreement template states that the contractor must have in place a "system of clinical governance" by way of a framework through which they endeavour to continuously improve the quality of its services and safeguard high standards of care by creating and environment in which clinical excellence can flourish. https://www.england.nhs.uk/wp-content/uploads/2020/12/20-21-PMS-Agreement-October-2020.pdf Clause 11 (Clinical Governance) the contractor must have a named individual who is responsible for the effective operation of the system of clinical governance. Clause 9.2.2 (Quality Standards) the contractor shall comply with standards and recommendations issued by NICE. Clause 34.4.4 (Personal Data) the contractor shall comply with the NHS Information Governance toolkit (to the extent that it applies to the contractor).

			Caveat – PCC are not party to the PMS agreements entered into by KCCG with local practices so have assumed that they will include these variations.
B	Does not apply to this area		
C	The contractor undertakes untoward incident reviews within one month of the untoward incident and implements changes identified in the review The contractor will have records/notes of meetings to discuss untoward incident reviews The contractor will have written plans and details of implementation of changes identified via review/audit	Copy of reviews and actions undertaken available to PCT Records/notes available to PCT Action plans and changes to be implemented made available to PCT	**Contract** - The recently updated Standard PMS Agreement template states at: https://www.england.nhs.uk/wp-content/uploads/2020/12/20-21-PMS-Agreement-October-2020.pdf Clause 9.2.4 (Quality Standards) the contractor shall carry out the services in accordance with Good Practice and shall comply with the standards and recommendations from any audit and serious untoward incident and Serious Incident Reporting. Caveat – PCC are not party to the PMS agreements entered into by KCCG with local practices so have assumed that they will include this variation. **CQC registration** – All GP practices are required to be registered with this independent regulator of health and social care. Under their inspection regime CQC follow a set of Key Lines of Enquiry (KLOE).

			Under the SAFE domain at S6 the following question is asked “are lessons learned and improvement made when things go wrong”. Responses to the prompts for this question would cover this area of the KPI.
Infection Prevention and Control Standard		**Weighting 2.5%** Performance Measure	**Proposed areas of duplication** Contract / QOF / Local Authority / CQC registration / PCNs / Enhanced services / National policy
A	The contractor will ensure compliance with the National Hygiene Code and will work closely with the Infection Prevention Control (IPC) team to ensure that service and practice Healthcare Associated Infection (HCAI) risks are assessed, recorded and minimised. The contractor appropriately prescribes antibiotics in line with local formulary, ensuring that relevant risk factors are taken into consideration. The contractor will undertake an annual audit of the IPC standards in line with the National Hygiene Code The contractor has developed and implemented an action plan to ensure compliance with the IPC standards and the National Hygiene Code	Evidence as to how compliance is achieved Dates of meetings and record of discussions with the IPC team Medicines management prescribing data and audits Results of audit made available to the PCT Action plan made available to the PCT	**Contract** – The recently updated Standard PMS Agreement template states at: https://www.england.nhs.uk/wp-content/uploads/2020/12/20-21-PMS-Agreement-October-2020.pdf Clause 14 (Infection Control) the contractor must ensure it has appropriate arrangements in place for infection control and decontamination. Caveat – PCC are not party to the PMS agreements entered into by KCCG with local practices so have assumed that they will include this variation. **PCQP specification 2018/19** – all practices required to address high levels of antibiotic prescribing as KCCG is an outlier when compared with national, local and comparator CCG averages.
B	Does not apply to this area		

C	The contractor has a system in place for identifying patients who have sustained a community attributable HCAI The contractor has an effective system that alerts staff of those patients with a HCAI The contractor is able to demonstrate appropriate involvement in Root Cause Analysis processes	Review of system detailing how patients identified Alert system detailed in Infection Control Policy. Audit and report for RCA made available to the PCT	**PCQP specification 2019/20** – all practices required to adopt the KCCG produced formulary for use on EMIS web to further reduce patient safety risks and improve adherence to the Pan Mersey formulary. **National policy** – This policy has a strong focus on infection prevention and control and a five-year national action plan. GP practices will be aware of the necessity to monitor and demonstrate appropriate use of antimicrobials. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/784894/UK_AMR_5_year_national_action_plan.pdf **PCCC Minutes** (January 2018) - state that a rolling programme of infection control visits is undertaken by North West Boroughs Healthcare NHS Foundation Trust (NWB). Results are high which is supported by the high standard of primary care estate in many cases. **CQC registration** – All GP practices are required to be registered with this independent regulator of health and social care. Under their inspection regime CQC follow a set of Key Lines of Enquiry (KLOE). Under the SAFE domain S1.8 asks 'How are standards of cleanliness and hygiene

			maintained? Are there reliable systems in place to prevent and protect people from a healthcare-associated infection? The potential sources of evidence in connection with this prompt would meet this KPI.

Appendix 3 CQC Key Lines of Enquiry and Prompts: Sources of evidence

https://www.cqc.org.uk/sites/default/files/20180628%20Healthcare%20services%20KLOEs%20prompts%20and%20characteristics%20FINAL.pdf

Appendix 4 Improving Access £1.59 per weighted patient

Improving Access £1.59 / head-weighted list
For the year 2017/18

Practices will be expected as a minimum to:

1) Open 8.00am – 6.30pm, Monday to Friday (excluding Bank Holidays) and provide bookable appointments within those hours
2) Offer access to both male and female clinical members of staff. (NB: This does not have to cover all sessions and can be agreed locally)
3) Provide a minimum of 70 appointments per 1000 registered patients with a GP/ Nurse Clinician/Nurse Practitioner. This can include face to face, telephone, Patient on-line or Skype/video consultations which must be recorded in the consultation record on EMIS. Important: To comply with information governance requirements, email consultations must be undertaken via Patient Access/*Patient on-line*.
4) In addition, provide a minimum of 25 appointments per 1000 registered patients with a Practice Nurse.
5) Provide same day access where required (based on clinical need) for all registered patients, both adults and children
6) Publicise access arrangements using a variety of means (patient leaflet, practice website, PPG, posters and leaflets, telephone holding messages, TV/LCD display in waiting areas)
7) Ensure that all staff are aware of, and actively promote to patients, the practice access arrangements
8) Work to achieve the 20% uptake for patient on-line services and
9) Practices must be able to evidence the active promotion of extended access services so that their patients are aware that they can book an appointment with a GP in a local setting between 6.30pm and 8pm Monday to Friday and 8am-8pm on Bank Holidays and also on Saturday and Sunday between 10am and 8pm.

Evidence and Assurance to be provided:

a) The practice access plan to be clearly and prominently displayed within the practice premises, on phone messages and published on the practice website.
b) Extended access arrangements to be clearly displayed in the practice, on phone messages and published on the website.
c) Appointment schedules and the uptake of appointments to be made available to the CCG on request to demonstrate compliance with 1) to 5) above from 1st November 2017 to 31st March 2018.
d) Evidence of the work undertaken by the practice to promote patient on-line services
e) The CCG team will carry out random audits/checks of the above throughout the term of the PCQP.

Improving Access £1.59 / head-weighted list
For the year 2018/19 (summary of amendments to 2017/18 specification)

2017/18 (1)
be open and accessible to patients to walk in Monday to Friday between 8am and 6.30pm excluding bank holidays

2017/18 (3)
for a minimum of 46 weeks and excluding Bank Holidays, provide 70 GP / Nurse Clinician* appointments per 1000 patients per week

Appointments are 10 minutes, where a longer appointment is arranged for a person with chronic conditions e.g.30 minutes, this will be counted as three appointments. Home visits will be classed as 3x10 minute appointments

**a nurse clinician, is correctly designated as an Advanced Nurse Practitioner (ANP), educated to Masters Level in clinical practice and has been assessed as competent in clinical practice, and makes autonomous decisions in the assessment, diagnosis and treatment of patients*

2017/18 (4)
for a minimum of 46 weeks and excluding Bank Holidays, provide 25 Practice Nurse** appointments per 1000 patients per week.

Appointments are 10 minutes. Double appointments will be measured as 2x10 minute appointments

** *Where there are capacity challenges in the provision of practice nursing i.e. for smaller practices the practice can provide a composite 95/1000 per week of GP / Nurse Clinician / Practice Nurse appointments.*

2017/18 (8)
achieve 25% (of registered patients) uptake of patient on-line services, uptake is defined as a patient registering for online access and accessing their account at least once.

Evidence and Assurance to be provided (updates)

New for 2018/19:

a) The CCG will undertake random checks of adherence to access standards and will produce reports via EMIS IQ which will be shared with practices.

b) The practice will self-declare its evidence of meeting the core hours opening standards within a CCG provided template.

c) Should the practice not achieve the 25% PoL target, it will provide evidence of work it has undertaken to promote patient on-line services. Practices are to use the agreed Read codes to detail this activity.

Improving Access £1.59 / head-weighted list
For the year 2019/20 (summary of amendments to 2017/18 and 20118/19 specification)

The introduction of additional roles via the DES that provide direct patient care e.g. Clinical Pharmacists, Physician Assistants and Paramedics, and access channels, including on-line consultations and telephone triage.

Through initiatives that monitor access and ensure appropriate clinical supervision, the 2019/20 PCQP will ensure that patients are able to access the high-quality care they need from an appropriate professional.

Review patient access policy - to ensure it meets contractual obligations, continues to delivery, as a minimum previously mandated PCQP appointment availability, is informed by patient insight and supports registered patients to receive accessible, high quality care from appropriately skilled practitioners able to meet their needs.

New access methods – e.g. via triage to ensure patients access the most appropriate professional to meet their needs and use of a wider range of clinical professionals together with on-line consultations which will form part of the overall access/appointment score.

In order to ensure consistency in the measurement of practice access the CCG will adopt metrics as set out below:

Access method	'Base' time	Notes
GP/Nurse clinician*: face to face appointment	10 minutes	Pre-planned 'double'/'treble' appointment slots will be taken into account (e.g. double appointment = 20 minutes)
GP/Nurse clinician: telephone appointment	10 minutes	
GP/Nurse clinician: econsult/Online consultation	10minutes	
GP/Nurse clinician: home visit	30 minutes	
GP/Nurse clinician: video consultation	5 minutes	
Practice Nurse: face to face appointment	10 minutes	
Practice Nurse: telephone appointment	5 minutes	
Other clinician: face to face appointment	15 minutes	
Other clinician: telephone appointment	5 minutes	

Locality peer review - participating practice's access policy and plans, appointment schedules and other data will be subject to locality review by 31st March 2020.

Clinical supervision – practice will have policies in place to cover all clinical staff groups providing patient care, supported by nominated and suitable trained clinical supervisors.

Evidence and assurance to be provided (updates):

New for 2019/20

a) Practice to ensure submission of Friends and Family data is completed monthly from Dec 2019 onwards.
b) Practice to provide evidence of how the Healthwatch Knowsley 'Feedback Centre' is promoted to registered patients.
c) Practice to provide copy of access policy in line with specification.
d) Practice to provide evidence of appointment availability via Edenbridge Apex software.
e) All of above to be subject to locality peer review during Q1 of 2020/21

Appendix 5 PCQP - Improving Quality

For the year 2017/18 this element of the PCQP included the following indicators;

- Utilisation of the referral quality (RQ) system - to improve the quality and management of referrals to achieve 80% by 31 January 2018 and 85% by 30 June 2018. No other referral methods to be used from 1st October 2018 in-line with national policy.
- Clinical records – an audit of 10% of the practice population to assure quality of record keeping using a template supplied by KCCG.
- Safeguarding - to provide assurance that practices are adhering to Safeguarding statutory responsibilities.
- Learning Disabilities - to provide assurance that practices are adhering to their Learning Disability responsibilities through a self-assessment audit. Improving uptake of annual health checks to 85% and development of health action plans.
- Preventing ill health - to improve the identification and management of high blood pressure (using NICE quality standards) and atrial fibrillation (using GRASP-AF tool), and to reduce variation across practices. Practices will receive payment for auditing and addressing quality issues in respect of expected versus observed prevalence. Audit and action plans to be delivered in 2018/19.

For the year 2018/19 this element of the PCQP included the following indicators;

- Prevention at scale (Health & Care Partnership priority area) – implementation of action plans developed in 2017/18 and evidence of reduction in unwarranted variation.
- Improving the quality of clinical records (developing a learning culture) - maintain the improvements achieved through the 2017/18 in the variation, completeness and quality of clinical records.
- Clinical review of patients with Heart Failure who are NOT managed by the Community CVD Service – to address the variation in the completion and quality of reviews of patients with heart failure in line with NICE Quality Standards.
- Improvement in the achievement of NICE targets for Diabetes Care – to address practice variation in the 8 care processes, with a 'stretch' target to be agreed with each practice. The overall intention of achieving a CCG average of 50% by March 2019. Evaluated plans to be actioned during 2019/20 and 2020/2021.

For the year 2019/20 this element of the PCQP included the following indicators;

- Hypertension – to support the implementation and use of the Blood Pressure Quality Improvement toolkit developed by the Cheshire and Merseyside Public Health Collaborative (CHAMPS). The toolkit to establish baseline prevalence/management of patients in line with NICE during Qs 3/4 2019/20 with improvement plans being implemented during 2020/21.

- Locality Diabetes plan – implementation of plans developed in 2018/19.
- Risk and incidence management - to participate in the implementation and operational delivery of Datix, to support early warning of quality issues and shared learning from review and reflection of reported incidents.
- Compliance with CCG Commissioning policy - practices to ensure that all referrals for further investigation or care are made in line with, and cognisant of the policy.
- Practice support for non-clinical invoice validation initiatives - During 2019/20 and 2020/21 the CCG plans to undertake a validation exercise to provide assurance that Secondary Care activity is accurately and appropriately coded and charged for and practices will support this initiative.

Appendix 6 Prescribing

For the year 2017/18 this element of the PCQP scheme as paid at £3.00 per registered patient and included the following indicators;

- Prescribing Leads Roles and Implementation of a Prescribing Review Practice Plan – leadership, medicines safety work, implementing NICE recommendations, switches, patient reviews, promoting de-prescribing, consultation on Pan Mersey APC documents, management of antibiotic prescribing and feedback on OptimiseRx software.
- Medicines safety – Audit of practice implementation of selected MHRA Drug Safety Alerts
- Medicines safety – High Risk prescribed medication searches
- Medicines safety – Prescribing review of Pregabalin and Gabapentin
- Good practice prescribing – Antimicrobial stewardship
- Good practice prescribing – Use of Antimicrobials in Urinary Tract Infections
- Good practice prescribing – Audit of Medication Reviews
- Management of the practice prescribing resource – remain within practice prescribing budget and commit to support the meds management team in delivery of QIPP targets.

For the year 2018/19 this element of the PCQP scheme as paid at £2.50 per registered patient and included the following indicators;

- Prescribing Leads Roles and Implementation of a Prescribing Review Practice Plan – leadership, medicines safety work, implementing NICE recommendations, switches, patient reviews, promoting de-prescribing, consultation on Pan Mersey APC documents, management of antibiotic prescribing and feedback on OptimiseRx software.
- Medicines safety – monitoring of high-risk drug monitoring for patients with overdue blood monitoring, management of high risk drug prescribing, implementation of MHRA alerts.
- Good practice prescribing – Antimicrobial stewardship
- Good practice prescribing – reduce inappropriate antibiotic prescribing, peer review individual prescribing, address STAR-PU variations, delayed/deferred antibiotic prescribing, raise patient awareness of AMR, update antimicrobial stewardship plan.
- Good practice prescribing – Update practice policy and procedure for medication reviews, introduce a system and process to reduce the number of overdue medication reviews.
- Management of the practice prescribing resource – remain within practice prescribing budget and commit to support the medicines management team in delivery of QIPP targets.

For the year 2019/20 this element of the PCQP scheme as paid at 4.00 per registered patient and included the following indicators;

- Prescribing Leads Roles and Implementation of a Prescribing Review Practice Plan – leadership, medicines safety work, feedback to the monthly Pan Mersey consultations, implementing medicines safety work, adherence to NICE recommendations, appropriate switches and patient reviews that increase prescribing cost-effectiveness.
- Medicines safety – Polypharmacy reviews as KCCG has the highest national percentage of patients prescribed 10 or more unique medications, review of at least 30% of patients or 15 patients in small practices for those patients on 10 or more medications and read code the review,
- Medicines safety - AMR to address variation in antibiotic prescribing across practices, improve STAR-PU position, raise patient awareness of AMR, AMR action plan
- Quality and safety – Cold chain monitoring (cold chain policy in place and attendance and training event), Medication review improvement plan (no more that 20% medication reviews overdue at the year-end)
- Maintain a 0% cost growth – Management of prescribing budgets. Optimising the safe and effective use of medicines for maximum patient benefit, provide best value to the NHS and reduce medicines waste. Delivery of practice QIPP financial target where this has been agreed.
- De-prescribing of medication in line with Pan Mersey prescribing recommendations - All patients reviewed and actively de-prescribe a give list of medications which have proven to be relatively ineffective or are no longer appropriate to be prescribed on the NHS.

Appendix 7 Primary Care Performance Dashboard March 2020

3) a) Primary Care Performance Dashboard March 2020

NHS Knowsley Clinical Commissioning Group

Locality	Practice	Pt. Experience (out of 2 indicators)	Access (out of 2 indicators)	Prevention & Screening (out of 5 indicators)	Effective Use of Medicine (out of 3 indicators)	LTC Management (out of 4 indicators)	Effective use of Resources (out of 2 indicators)	Improving Quality (out of 6 indicators)	Overall Achievement (out of 24 indicators)
East Knowsley	Aston Healthcare Limited	0	0	0	2	2	1	2	7
	Cedar Cross Medical Centre ★	2	1	0	2	2	1	6	14
	Longview Medical Centre	2	1	1	3	3	2	6	18
	Nutgrove Villa Surgery ★	2	1	0	2	2	0	2	9
	Park House Medical Centre ★	2	1	1	1	2	2	6	15
	Prescot Medical Centre	2	2	1	3	3	2	3	16
	Tarbock Medical Centre	1	0	3	3	2	1	6	16
Halewood	Hollies Medical Centre	2	2	0	2	1	1	6	14
	Rosebeath Surgery	2	1	1	1	1	1	6	13
	The Health Centre Surgery ★	2	1	0	2	4	2	5	16
Kirby	Dr Mazarani & Partners	1	1	0	1	1	2	6	12
	Dr R King's Practice	1	1	0	2	2	1	6	13
	Millbrook Medical Centre	1	1	0	0	2	0	6	10
	The Macmillan Surgery	1	1	2	1	3	1	5	14
	Tremham Medical Centre	1	1	0	1	3	0	6	12
	Wingate Medical Centre	1	1	0	0	2	1	6	11
West Knowsley	Bluebell Lane Surgery ★	0	1	0	1	1	2	6	11
	Colby Medical Centre	2	0	1	1	1	1	6	12
	Cornerways Medical Centre ★	0	0	0	2	1	0	6	9
	Dinas Lane Medical Centre	1	0	0	1	2	0	6	10
	Dr M Sumra' Practice	1	1	1	1	3	1	6	14
	Hillside House Surgery ★	1	1	0	1	2	2	3	10
	Primrose Medical Practice ★	2	1	1	2	4	1	6	17
	Roby Medical Centre	1	1	2	2	3	1	6	16
	Stockbridge Village Health Centre ★	1	0	0	2	2	1	6	12

★ *GMS: Cedar Cross, Nutgrove Villa, Park House Medical Centre, The Health Centre Surgery, Bluebell, Cornerways, Hillside House Surgery, Primrose Medical Practice, Stockbridge Village*

Appendix 8 Primary Care Performance Dashboard – extract (excluding Improving Quality Indicators)

PCN	Practice name	GMS / PMS	Dashboard score 18 indicators	Ranking	
				0 - 9 indicators	10 - 18 indicators
West Knowsley	Cornerways Medical Centre	GMS	3		
Kirkby	Millbrook Medical Centre	PMS	4		
West Knowsley	Dinas Lane Medical Centre	PMS	4		
East & South	Aston Healthcare Limited	PMS	5		
Kirkby	Wingate Medical Centre	PMS	5		
West Knowsley	Bluebell Lane Surgery	GMS	5		
Kirkby	Dr Massarani & partners	PMS	6		
Kirkby	Trentham Medical Centre	PMS	6		
West Knowsley	Colby Medical Centre	PMS	6		
West Knowsley	Stockbridge Village Health Centre	GMS	6		
East & South	Nutgrove Villa Surgery	GMS	7		
East & South	Roseheath Surgery	PMS	7		
Kirkby	Dr RI King's practice	PMS	7		
West Knowsley	Hillside House Surgery	GMS	7		
East & South	Cedar Cross Medical Centre	GMS	8		
East & South	Hollies Medical Centre	PMS	8		
West Knowsley	Dr M Suares Practice	PMS	8		
East & South	Park House Medical Centre	GMS	9		
Kirkby	The Macmillan Surgery	PMS	9		
East & South	Tarbok Medical Centre	PMS	10		
West Knowsley	Roby Medical Centre	PMS	10		
East & South	The Healthcentre Surgery	GMS	11		
West Knowsley	Primrose Medical Centre	GMS	11		
East & South	Longview Medical Centre	PMS	12		
East & South	Prescot Medical Centre	PMS	13		

Knowsley GP Practices

Integrated Equality and Health Inequality Impact Assessment

Feedback Report

December 2021

ACKNOWLEDGEMENTS

JR Consulting Limited would like to express thanks to the following colleagues and partners for their support in the production of an initial Knowsley GP practice equality and health inequality impact assessment.

We wish to express our thanks to:

- Knowsley GP's and their respective practice staff for their time and commitment to completing the documents
- Knowsley Clinical Commissioning Group – Mr Mark Bakewell for providing information on finance and funding streams potentially affected by change
- Knowsley Borough Council Director of Public Health – Dr. Sarah McNulty for providing the most recent public health data available pertaining to each locality of Knowsley.
- Knowsley Borough Council – Mr Tom Baker for providing ward based information.

INFORMATION LEVEL - Standard

Contents

Page Number

1. Background

JR Consulting Limited has been commissioned by Knowsley Local Medical Committee on behalf of all Knowsley GP practices undertaking an integrated impact assessment to consider equalities, health inequality and quality as one overall combined assessment. This work is to support local commissioners to understand which patients and those who are considered as "protected characteristic groups and/or vulnerable groups" that may be affected by any changes in the delivery of primary care services should funding be reduced.

The subsequent sections of this report will outline the context for this analysis and the approach undertaken by JR Consulting Limited JRC).

It was reported to Knowsley GPs that the Clinical Commissioning Group (CCG) had undertaken a financial analysis of all funding streams prior to the pandemic, which identified that there was significant duplication between the goals/ambitions of aspects of PMS premium/Fairness Funding and Primary Care Quality Premium. The CCG proposes to reduce funding currently provided to PMS practices which will total circa £1.5m reduction overall. In addition, two GMS practices will be affected (Cornerways Medical Centre) who are the only practice that receive stability funding and Roby Medical Centre who would also be affected by reduced funding.

7 out of 9 GMS practices will benefit from receiving increases in their current income.

There are 25 GP practices contracted in Knowsley which are broken down into Personal Medical Services (PMS) and General Medical Services (GMS).

Knowsley General Medical Services

1. The Health Centre, Halewood
2. Bluebell Medical Practice
3. Stockbridge Village Health Centre
4. Park House Medical Centre
5. Cornerways Medical Centre
6. Cedar Cross Medical Centre
7. Roby Medical Centre
8. Hillside House
9. Primrose Medical Centre

Knowsley Personal Medical Services

1. Wingate Medical Centre
2. Dinas Lane Medical Centre
3. Aston Healthcare (this has six different practice sites/branches across the Borough)
4. Pilch Lane Surgery
5. Roseheath Surgery
6. Millbrook Medical Centre
7. St Lawrences Medical Centre
8. Longview Medical Centre
9. Tarbock Medical Centre
10. Trentham Medical Centre
11. MacMillan Surgery
12. Prescot Medical Centre
13. Hollies Medical Centre
14. Dr Maassarani & Partners
15. Colby Medical Centre
16. Nutgrove Villa Surgery

The breakdown of funding is proposed to be reduced is:

- Fairness in Primary Care (Access) - £1.37m
- PMS Premium - £2.6m
- Primary Care Quality Premium / Improvement Plan - £1.1m
- 'Stability' payment - £0.14m
- Patient Access Funding - £0.3m

Knowsley CCG has stressed that the financial 'proposal' regarding required reduction in overall spend (the £1.5m the CCG are spending above allocation), did not contain detail of a revised approach so the impact is unknown until that is agreed. The proposal of funding reduction was an initial view on what the financial values may look like should the approach be accepted. The CCG confirmed they have repeatedly stated that they wish to work with practices to co-design a new 'specification' that would describe required achievement against a revised financial envelope that would be more aligned to the available allocation which is delegated from NHS England.

The CCG stated that there may be differences of opinion between practices on the detail (as the majority of GMS practices would benefit and some GMS practices had suggested they would wish to keep certain aspects such as 'Fairness Funding' and this would mean the residual funds would be more significantly impacted (availability of PMS Premium reinvestment/Primary Care Quality Premium). The PMS Premium (which was removed nationally several years ago, has not yet been implemented in Knowsley and the PCQP is a local discretionary funding. Fairness Funding predates the CCG it was additional funding to increase GP numbers in what is termed as "under doctored" areas.

SECTION A - APPROACH

2. Methodology and use of relevant assessment tools

2.1 Engagement

Initially, JR Consulting (JRC) engaged with GPs via attendance the Local Medical Committee meetings to listen to views of GPs in relation to the proposed reduction of funding. GP members had received notification of this proposed change by letter and a presentation given by Knowsley CCG director of finance. GPs had reported that no monitoring of service delivery has been undertaken by the CCG for several years, which is prior to any changes as a result of the start of the pandemic lockdown restrictions in March 2020.

GPs reported that service delivery/KPIs being duplicated was assumed rather than evidenced. In addition, some practices were informed that GP services had under-performed in 25 areas. GPs have stated that at no point has the CCG informed the practice of under-performance and they do not know where this evidence is. It does not appear in the Primary Care Committee papers and there is no audit trail of information being shared with practices.

In response to this, and to support the CCG in its deliberations on funding, Knowsley GPs wish to share the services that are delivered against each funding streams to consider what would be the impact to patients if the funding was reduced; what would be the impact on staff; and ultimately would a practice remain sustainable on reduced funding.

Anecdotally, GPs believe that the reduction in funding will be detrimental to service delivery. Therefore, the impact assessment will strengthen the evidence and support ongoing dialogue with GPs and Knowsley CCG.

JRC then engaged directly with the CCG director of finance to understand the issues faced by the CCG and raise the concerns GPs have shared.

The CCG explained that the urgency to manage the pandemic was the priority and that they were instructed by NHS England not to make any financial changes during the pandemic. Given the Covid

vaccination programme is on track across the country and the localised restrictions that were in place having now been lifted, the CCG wish progress the proposed funding reductions. The CCG has stated they would like to have an agreement in place with Knowsley GP practices prior to Knowsley CCG becoming part of Cheshire and Merseyside Integrated Care System in April 2022.

The CCG explained that there are four funding streams that contribute to the 'current' total spend of £5.8m by Knowsley CCG.

Knowsley CCG has proposed to reduce funding to a 'revised' figure of £4.6m. To achieve this, it will mean:

- Closing the £1.5m funding gap in respect of delegated allocation by £1.2m this still leaves around £0.3m that is not being addressed and would remain a pressure for the CCG.

- The £4.6m on top of other contract funding would, by CCG calculations, result in relative/ comparable levels of practice income with Liverpool GP practices (Knowsley are at the considered to be at the highest levels of funding locally).

- 7 of the 9 GMS practices would benefit from changed funding. The CCG stated that Cornerways Medical Centre would benefit if the stability payment issue were resolved. See stability item explanation provided by the CCG below.

- **Fairness Funding** - Historical (provided since PCT led funding circa 2008) and was put in place to support additional GP capacity in areas that are "under doctored".

- **PMS Premium** - This premium is to add value and innovation in service delivery to meet local need/improvement in health outcomes.

  NHS England has previously agreed that the current funding arrangements for General Medical Services (GMS) and Personal Medical Services (PMS) practices would be reviewed with a view to addressing the wide variation in core funding per patient, so that all practices receive the same weighted price per patient by 2020-2021. The CCG confirmed this has not yet been implemented in Knowsley.

- **Primary Care Quality Premium** – This is a discretionary CCG funding stream to improve access, quality, prescribing and PCN funding streams. The CCG annually determine the areas to be focused upon and monitors each practice against set targets. If all the required targets are reached, payment is awarded.

- **Patient Access Funding** - Increase 'access' to GP practice services, based on increases in consultation capacity. Measurement of consultation capacity including the provision of service from appropriate professionals, given the expansion of some clinical roles that provide direct care. Practices report they no longer receive this funding separately and this is now included within other funding streams. Therefore, for the purpose of this assessment we have considered how access to GPs and other health professionals providing services at practice level would be affected, as this will be a key impact for patient experience and patient safety.

- **Stability Payment** - Additional year on year non-recurrent payment to initially 'stabilse' practice income but is not tied to any conditions.

  Cornerways Medical Centre is the only practice that receives stability funding. This relates to a non-recurrent fund to cover practice changes. The CCG stated this has never been transacted by the CCG and it should have been because this is time limited funding.

2.2 Methodological assumptions and limitations:

It is important to set out the following principles on which this initial assessment is based:

The purpose of the assessment is to inform rather than decide. The objective is not to determine the decision, but to assist decision makers by providing better information.

It is not the purpose of the assessment to justify, defend, or challenge the rationale or principles behind potential changes to services. The assessment is being undertaken based on the assumption that any emerging changes to services will be designed by the local commissioners and Knowsley GPs working in collaboration, with the objective of assessing the benefits for all people requiring PMS funded services, thereby helping to improve outcomes for patients overall.

The purpose of this assessment report *is not* to produce a set of firm conclusions; rather it is to highlight equality groups and their need primary care additional services beyond those provided as part of the GMC contract. Though doing this, the report should act as a means of outlining which groups may experience potential impacts and highlighting issues that need to be discussed further. The conclusion of those discussions may require public engagement prior to a final decision being made.

This assessment report is based on review and analysis of available secondary data such as publicly available reports, PHE fingertips information, relevant public health literature – JSNA, health profiles and QOF data (*please note this year's QOF does not reflect normal activity due to the pandemic and it was stated should not be relied upon, therefore this has not been cited in the data)*.

The most recent (2018 locality) health profiles are informing the review and information contained within the JSNA. The most current report is contained with the September 2021 public health pandemic report which concentrates on profiling population groups that have been identified as being possibly sensitive to potential service changes, and those who given their health status the 'disproportionate need' or 'differential need' for the services provided.

The most recent ward data was reviewed to consider the demographics of the Borough. This will be evidenced per locality (Halewood, Kirkby, Prescot and Whiston, Huyton) to demonstrate need, and add value to the feedback from the locality based GP practices affected by the proposed changes in funding.

Year on year, Knowsley is a fairly static borough, but some areas are seeing an increase in asylum seekers and the need for translation services are increasing. Knowsley has an ageing population and the increasing levels of deprivation ranking them the second most deprived in the country.

We have reviewed the locality demographic analysis from Knowsley Public Health Profiles for each area – relevant to this report we will consider:

- The resident population of each locality
- The registered population of each locality
- Level of deprivation
- Disease prevalence
- Life expectancy
- Mortality
- Lifestyle

The impact assessment will also include addressing quality impacts under the following domains:

2.3 Quality Impacts

Impacts on the safety of patients, staff, or the public (physical/psychological). These will be ranked in terms of likelihood and risk. JRC undertook this with each of the GP practices to reduce any bias in scoring the seven areas below.

1. Quality/complaints/audit
2. Statutory duty/inspections
3. Adverse publicity/reputation
4. Business objectives/projects

5. Finance including claims
6. Service/business interruption
7. Environmental impact

The assessment will use a formula to calculate consequence of change multiplied by the likelihood of this consequence occurring.

JRC has asked all Knowsley practice GPs to assume at this stage the funding will be removed, so they can identify the impacts this will have on patients, services, staff members, and the impacts on the practice running on reduced funding.

SECTION B – EQUALITY IMPACT ASSESSMENT

3. Equality impact assessment/Integrated impact assessment

3.1 The Equality Act

The Equality Act 2010 introduced a **general public sector equality duty**, which public bodies, have to meet. The general duty has three aims and requires public bodies to have due regard to the need to:

1. eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Equality Act 2010
2. advance equality of opportunity between people from different groups. This involves considering the need to:
    a. remove or minimise disadvantages suffered by people due to their protected characteristics
    b. meet the needs of people with protected characteristics
    c. encourage people with protected characteristics to participate in public life or in other activities where their participation is low
3. foster good relations between people from different groups. This involves tackling prejudice and promoting understanding between people from different groups

Equality analysis helps support good decision making and involves systematically assessing the likely (or actual) effects of our activities on people relating to the nine protected characteristics (age, disability, gender reassignment, marriage & civil partnership, pregnancy & maternity, race, religion or belief, sex, sexual orientation) and caring responsibilities.

It is best practice for decision-makers to carry out an integrated impact assessment (IIA) which considers equality, health inequality, and consider quality metrics to assess the likely impacts/effects of any proposed changes to services for local communities.

Overall, the IIA is a piece of research that tells the CCGs about the potential positive and negative impacts of proposed changes to services on people who live in the area. It also lists a set of potential solutions that may help to address some of the areas identified as having a negative impact on a particular group or community. This includes looking for opportunities to promote equality that may have previously been missed or could be better used, as well as negative or adverse impacts that can be removed or mitigated, where possible. If any negative or adverse impacts amount to unlawful discrimination, they must be removed. Broadly the descriptions will consider:

Negative or Adverse Impact – The outcome of a decision, policy or practice that creates disadvantage to or unequal treatment of a person with a protected characteristic.

Positive Impact – The outcome creates a benefit to support the advancement of equality opportunity between different groups and/or fosters good relations between different groups.

The 2010 Act also extends some of these protections to characteristics that previously were not covered by equality legislation. Employers and business owners now need to be aware of the seven different types of discrimination under the new legislation. Given all practices are independent employers, and several of their staff may live in deprived communities in Knowsley, consideration of the funding reductions is being included. It could be the case that a staff member may be a one or more of protected characteristic groups, or they may be considered as experiencing health inequality.

The descriptors below will be used to consider impacts on protected groups and make recommendations to reduce discrimination and advance equality of opportunity as well as continue to foster good relations with Knowsley residents.

- **Direct discrimination** – where someone is treated less favourably than another person because of a protected characteristic
- **Associative discrimination** – this is direct discrimination against someone because they are associated with another person who possesses a protected characteristic
- **Discrimination by perception** – this is direct discrimination against someone because others think that they possess a particular protected characteristic. They do not necessarily have to possess the characteristic, just be perceived to.
- **Indirect discrimination** – this can occur when you have a rule or policy that applies to everyone but disadvantages a person with a particular protected characteristic
- **Harassment** – this is behaviour that is deemed offensive by the recipient. Employees can now complain of the behaviour they find offensive even if it is not directed at them.
- **Victimisation** – this occurs when someone is treated badly because they have made or supported a complaint or grievance under this legislation.

Definitions and a glossary of terms used was provided to aid practice participation.

3.2 Integrated Impact Assessment (IIA)

The IIA should be conducted when a policy or plan is still in draft. It should be well enough developed that there is an understanding the potential impacts, but not so far developed that it can't influence changes following the completion of the IIA.

The assessment process is to support ongoing dialogue between the commissioner and the GPs as providers of primary care services. From October to December 2021, we took a staged approach to initially consider the needs of patients, staff, and the sustainability of a practice if financial changes impact significantly on the running of the services. Within this review the health of the Knowsley population, the protected groups, indices of multiple deprivation data as well as ward data where practices provide services are included in considering impacts on communities..

IIA templates and consequence and likelihood risk tables have been produced for practices to consider. All practices have been followed up with1:1 interviews with JRC. Each practice was asked to review their assessment and sign off the content as an accurate reflection of those discussions. The analysis from all practices will be coded and themed.

Impacts on quality of services will address risk regarding patient and public safety, clinical outcomes, patient experience, staff experience and Duty of Quality (CQC / Constitutional Standards). The risk analysis scores are separate for each practice, but for the purpose of reporting will be grouped so no practice cannot be identified at this stage (this was requested by practices).

Working in partnership with the CCG equality lead, the next stage of the assessment will consider the impacts on protected groups, and where necessary, recommend mitigations. In addition, recommendations will be made on how to proceed should further public facing engagement (dependent upon the outcome of next stage of commissioner and GP discussions) is required.

SECTION C – ENGAGEMENT

4. Engaging Stakeholders

Commissioners are required to ensure that Knowsley registered patients receive a high quality, clinically safe and sustainable, primary care services. To achieve this commissioners, need to understand the views of patients, the public including, people from diverse communities and staff in the development of proposals/review of service delivery. At this stage it is to inform commissioners on the views of primary care providers, no public engagement has been undertaken. However, primary care providers have detailed the potential impacts on patients, staff and delivery of services should funding streams be changed. Depending on up the outcome of the feedback in regard to impacts and how commissioners wish to progress this public engagement/formal consultation may be required.

The IIA will provide evidence of potential impacts to inform planning for the future and improving patient experience for all Knowsley registered patient now and in the future.

Knowsley Health and Care Scrutiny have been informed by the CCG of the potential plans to reduce funding and align this with other primary care providers. It is our understanding the Scrutiny Committee will want to know the next steps commissioners plan to make, prior to implementation. To explain this JRC has outlined the role of Scrutiny in health decision making.

4.1 Aim of Health Scrutiny

The primary aim of health scrutiny is to strengthen the voice of local people, ensuring that their needs and experiences are considered as an integral part of the commissioning and delivery of health services and that those services are effective and safe. The new legislation extends the scope of health scrutiny and increases the flexibility of local authorities in deciding how to exercise their scrutiny function".

At the same time, health scrutiny has a legitimate role in proactively seeking information about the performance of local health services and institutions; in challenging the information provided to it by commissioners and providers of services for the health service ("relevant NHS bodies and relevant health service providers") and in testing this information by drawing on different sources of intelligence".

In the light of the Francis Report, health scrutiny will need to consider ways of independently verifying information provided by relevant NHS bodies and relevant health service providers – for example, by seeking the views of local Healthwatch".

In considering substantial reconfiguration (of which there is no legal description) proposals, health scrutiny needs to recognise the resource envelope within which the NHS operates and should therefore take into account the effect of the proposals on sustainability of services, as well as on their quality and safety".

http://www.legislation.gov.uk/uksi/2013/218/contents/made

Knowsley Borough Council Health and Care Scrutiny Committee are aware of the proposed funding reductions, and the CCG informed the committee that this would be subject to undertaking an IIA to further inform the decision making process. It is important to note the scrutiny committee are public meetings and the content of the proposed financial reductions has been published Liverpool Echo. In addition, it has also been published in Pulse. Therefore, there will be public interest in this work as well as potential publicity on the outcome of the assessment and the next steps to be taken by the commissioner. At this point no public engagement has taken place and Knowsley Healthwatch has not been appraised of this planned change.

If primary care services changes as a direct result of reduced funding and those changes are considered to be a substantial variation (of which there is no legal definition) to primary care service delivery, the commissioner is statutorily required to undertake formal public consultation aligned to the S14z2 of the Health and Social Care Act and NHS Act 2006.

The commissioner may also be required to instigate consultation with Knowsley Borough Council Health and Care Scrutiny Committee as detailed in 2013 Local Government Act. See extracts taken from the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013).

4.2 Planning engagement with Primary Care Services

The Integrated Impact Assessment was drafted by JRC. which was shared with Knowsley GP's, Knowsley LMC and Knowsley director of finance for feedback. A final iteration was agreed and shared with each PMS GP practice. A shorter version was designed for GMS practices who requested involvement. The outcome of changes in funding has been suggested would benefit GMS practices financially.

All practices were supported to complete the impact assessment document and consequence and likelihood scores to determine level of risk using rag rating. One Knowsley practice opted out of the assessment process.

An online survey was designed for practices to project potential job reductions and allow the commissioner to see a boroughwide impact. No practices will be identified but the posts at risk have been.

SECTION D – NATIONAL AND LOCAL DATA

5. Indices of Multiple Deprivation 2019

The Indices of Deprivation 2019 provide a set of relative measures of deprivation for small areas (Lower-layer Super Output Areas) across England, based on seven different domains of deprivation: Income Deprivation, Employment Deprivation, Education, Skills and Training Deprivation, and Health. The Index of Multiple Deprivation 2019 combines information from these seven domains to produce an overall relative measure of deprivation. The domains are combined using the following weights: Income Deprivation (22.5%), Employment Deprivation (22.5%), Education, Skills and Training Deprivation (13.5%), Health Deprivation and Disability (13.5%), Crime (9.3%), Barriers to Housing and Services (9.3%), Living Environment Deprivation (9.3%). The weights have been derived from consideration of the academic literature on poverty and deprivation, as well as consideration of the levels of robustness of the indicators.

The English Indices of Deprivation measure relative levels of deprivation in 32,844 small areas or neighbourhoods, called Lower-layer Super Output Areas, in England. The data indicators used to construct the Indices of Deprivation 2019 are based on the most up-to-date information available.

5.1 How does Knowsley compare

2019 English Indices of Deprivation

Proportion of LSOAs in most deprived 10 per cent nationally – this measure summarises the proportion of neighbourhoods in a larger area that are in the most deprived 10 per cent of neighbourhoods in the country. As such, this measure is only focused on illustrating the number of neighbourhoods within a larger area which are the most deprived in England. However, neighbourhoods just outside the 10 per cent most deprived are not included as part of this measure, so large areas, such as local authorities or local enterprise partnerships, may not appear to be so deprived relative to others if they contain zero or few of the most deprived neighbourhoods in the country.

Most deprived local authorities based on Rank

1. Blackpool
2. Manchester
3. Knowsley
4. Liverpool
5. Barking and Dagenham
6. Birmingham
7. Hackney
8. Sandwell
9. Kingston upon Hull
10. Nottingham

Most deprived local authorities based on Score

1. Blackpool
2. Knowsley
3. Liverpool
4. Kingston upon Hull
5. Middlesbrough
6. Manchester
7. Birmingham
8. Burnley
9. Blackburn with Darwen
10. Hartlepool

Most deprived local authorities based on the Proportion of LSOAs in the most deprived 10% nationally

1. Middlesbrough
2. Liverpool
3. Knowsley
4. Kingston upon Hull
5. Manchester
6. Blackpool
7. Birmingham
8. Burnley
9. Blackburn with Darwen
10. Hartlepool

11 The English Indices of Deprivation 2019 - Statistical Release

As illustrated, Knowsley is the 2nd most deprived local authority are in the country.

If Knowsley was a village of 100 people, Public Health England has statistically demonstrated the key health issues the Knowsley is managing on behalf of 147,000 residents.

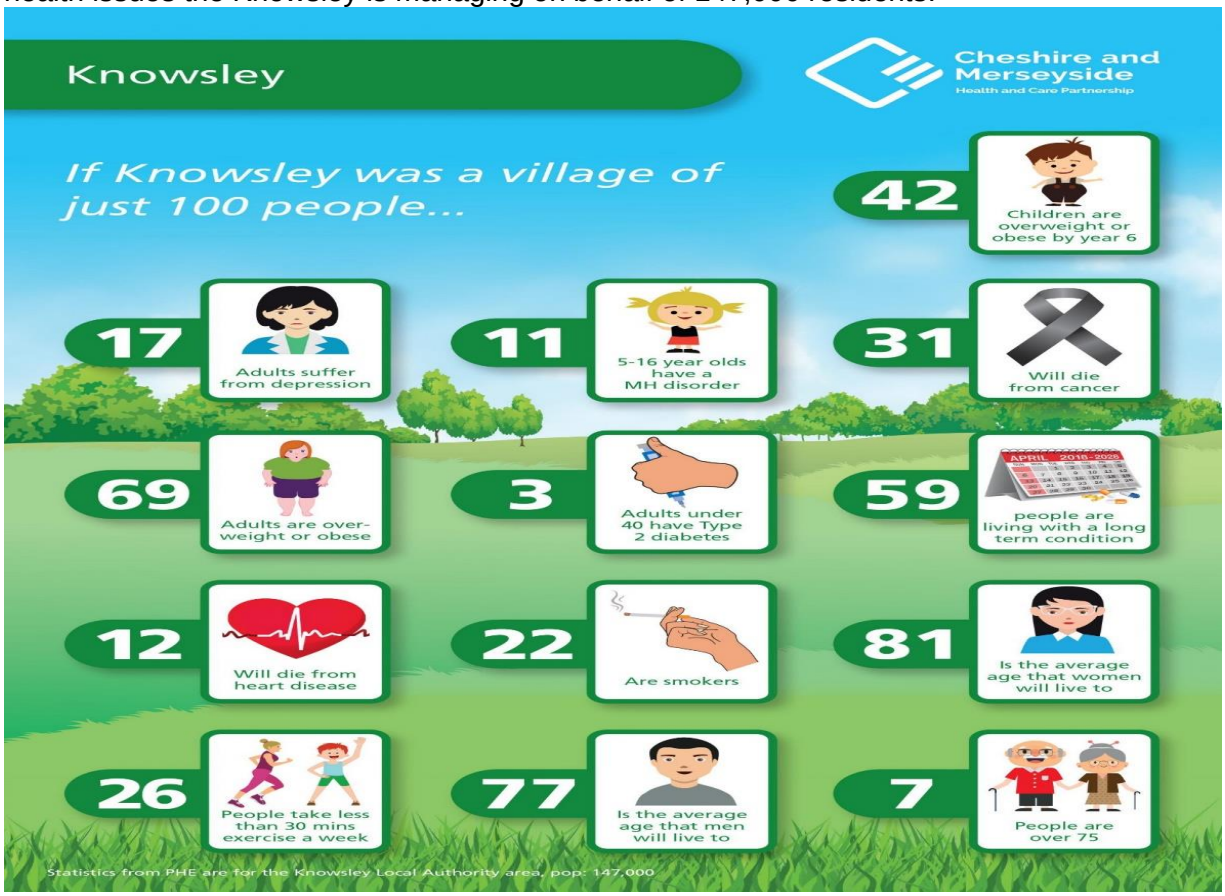


Figure 1 – Public Health England - village 100 people local and national data

5.2 Joint Health and Wellbeing Strategy 2020-2025 Working Better Together for a Healthier, Happier Knowsley

Knowsley faces challenges with deprivation and health inequalities. Knowsley Better Together is the borough's plan for transformation and details how public service partners, local businesses and residents will work together to deliver a new deal for communities and improved outcomes for residents across the area. The Knowsley Better Plan aims to:

- Increase in the number of **people supported to manage their own conditions**
- **Reduce avoidable admissions to hospital**
- Increasingly integrated **community-based management of long-term conditions**
- Improve the effectiveness of reablement services to support people to remain at home
- **Increase social prescribing**
- **Increase resilience and sustainability of the Knowsley Health and Social Care system**
- Reduce delayed transfers of care

The strategy states that primary care services are key to delivering against this challenging boroughwide agenda for change (particularly those areas highlighted in bold above) and the funding streams in place have supported practices to deliver services in areas of significant deprivation and health inequality.

Where appropriate to the impact assessment information from the Knowsley health profiles have been reviewed to demonstrate the locality based health and care challenges.

5.3 Knowsley 2011 Census and Ward Data

Knowsley population in the 2011 Census estimates that the resident population of Knowsley is 145,900. This is approximately 3% lower than the figure from the 2001 Census. The Borough saw a large population decline in the 1980s followed by a more gradual decline in the last 20 years.

The age structure of the population has also altered; with the number of people in older age ranges having increased.

The 2011 Joint Needs Assessment reports that there are proportionally less people aged between 60 and 69 in the which is the result of a greater proportion of people dying prematurely.

There are a greater proportion of people aged between 70 and 79 in Knowsley which is a remnant of the high propensity of new housing in the borough, to accommodate the overspill population from Liverpool after World War II.

The 2011 Joint Needs Assessment (JSNA) reports that the population of Knowsley is expected to increase by 3.2% by 2029. Although this increase seems relatively small, it is anticipated that there will be larger variances for the various age groups within Knowsley. For instance, the over 50 age group is expected to increase by 15.1% and the over 85 age group is expected to increase by 51.5%. At the same time, it is anticipated that there will be an increase in the younger age groups such as 10-24 and 40-49. The over 65 age group is expected to increase by 47% by 2031.

More recent local data is being used as this census information is nearly 10 years old.

6. Knowsley Public Health Profiles 2018

Since the onset of Covid 19 local public health reports have focussed on pandemic prevalence and potential long term impacts of Covid 19 as a planning tool to support local health providers.

Below are the most recent health profiles recorded in 2018.

Huyton

- Resident population for 2016; 57,613
  Between 2013 and 2016 resident population increased by 1,200 persons
- Higher proportion of age groups 50-59 population compared to Knowsley and England
- Registered population for 2018; 85,947
- Huyton is the most deprived of the four locality areas
- Levels of deprivation in Huyton are roughly double that of England and higher than Knowsley in all four indicators of: Income, Employment, Income Deprivation Affecting Children and Older people
- Disease prevalence
  - Highest prevalence is for depression, obesity, and hypertension.
  - Conditions with the greatest increase from 2015/16 are depression and obesity
  - COPD in significantly above the England average
  - Cancer prevalence more than doubled from 2009/10 to 2016/17
  - Asthma prevalence lower than England Knowsley
  - CHD prevalence was similar to Knowsley but significantly higher than England
  - Stroke and Tia prevalence was similar to Knowsley

Read the full profile here

Kirkby

- Resident population for 2016; 41,495
  Between 2012 and 2016 resident population increased by 0.7%
- Relatively young population
- Registered population for 2018; 50, 218
- Second most deprived of the four locality areas
- Levels of deprivation in Kirkby are over double that of England and rates are also significantly higher than the Knowsley average in all four indicators of: Income, Employment, Income Deprivation Affecting Children and Older people
- Disease prevalence
  - Highest prevalence is for depression, obesity, and hypertension higher than Knowsley and England
  - Conditions with the greatest increase from 2015/16 are depression and chronic kidney disease
  - COPD prevalence consistently been over double the England average
  - Cancer prevalence is the lowest of the four locality areas • Asthma prevalence similar to England but higher than Knowsley
  - CHD prevalence similar to Knowsley but significantly higher than England
  - Stoke and Tia prevalence similar to Knowsley but higher than England

Read the full profile here

Prescot and Whiston

- Resident population for 2016; 28,668
- Between 2012 and 2016 resident population increased by 0.5%
- Higher proportions of 65+ age group
- Registered population for 2018; 16,645
- Third most deprived of the four locality areas

- Levels of deprivation are lower than Knowsley but higher than England in all four indicators. Income, Employment, Income Deprivation Affecting Children and Older people
- Almost a quarter of older people are deprived
- Disease prevalence
    - Highest prevalence is for depression, obesity, and hypertension higher than Knowsley
    - Conditions with the greatest increase from 2015/16 are obesity and depression
    - COPD has fallen whilst increases have been seen in Knowsley and England
    - Cancer prevalence is the highest of the four locality areas
    - Asthma prevalence higher than Knowsley but lower than England
    - CHD prevalence higher than Knowsley and significantly higher than England
    - Stroke and Tia prevalence slightly higher than Knowsley and England

Read the full profile here

Halewood

- Resident population for 2016; 20,430
  Between 2012 and 2016 resident population increased by 1.3%
  Higher proportions of working age population (16 to 64) compared with Knowsley and England
  Registered population for 2018; 12,091
- Least deprived of the four locality areas
- Levels of deprivation are lower than Knowsley but higher than England in all four indicators Income, Employment, Income Deprivation Affecting Children and Older people
- Over a quarter of older people are deprived
- Disease prevalence
    - Highest prevalence is for depression, obesity, and hypertension although lower than in Knowsley
    - Conditions with the greatest increase from 2015/16 are obesity and depression
    - COPD has fallen whilst increases have been seen in Knowsley and England
    - Cancer prevalence has increased at a faster rate than Knowsley and England
    - Asthma prevalence has consistently been lower than Knowsley and England
    - CHD prevalence is significantly lower than Knowsley and slightly higher than England
    - Stroke and Tia prevalence has consistently been lower than Knowsley and England

Read the full profile here

7. Knowsley population health in summary 2019

Mid-year estimates for 2018, show that there are 149,571 people living in Knowsley. This is an increase of 1,011 people from the 2017 mid-year estimates:

- There were an estimated 1,987 births in 2018 and 1,632 deaths.
- 7,151 people moved into Knowsley from other parts of the UK, and 6,589 people moved out of Knowsley to other parts of the UK.
- 318 people moved into Knowsley due to international migration, and 231 left due to international migration. Of Knowsley's population, ONS estimate that 78,459 (52%) are female and 71,112 (48%) are male.

**** Rate per 100,000 population***

The health of people in Knowsley is generally worse than the England average. Knowsley is one of the 20% most deprived districts/unitary authorities in England and about 25% (7,460) children live in low income families. Life expectancy for both men and women are lower than the England average.

Health inequalities

Life expectancy is 11.4 years lower for men and 12.6 years lower for women in the most deprived areas of Knowsley than in the least deprived areas.

Ethnicity

Knowsley is not as ethnically diverse as other parts of the country with a low proportion of BAME population groups. However, locally understanding the increased risks and widening of health inequalities for such population groups remains an important consideration.

Child health

In Year 6, 26.9% (458) of children are classified as obese, worse than the average for England. The rate for alcohol-specific hospital admissions among those under 18 is 45*, worse than the average for England. This represents 15 admissions per year. Levels of teenage pregnancy, GCSE attainment (average attainment 8 score), breastfeeding and smoking in pregnancy are worse than the England average.

Adult health

The rate for alcohol-related harm hospital admissions is 940*, worse than the average for England. This represents 1,346 admissions per year. The rate for self-harm hospital admissions is 347*, worse than the average for England. This represents 505 admissions per year. Estimated levels of excess weight in adults (aged 18+) and smoking prevalence in adults (aged 18+) are worse than the England average. The rate of new cases of tuberculosis is better than the England average. The rate of hip fractures in older people (aged 65+) is worse than the England average. The rate of statutory homelessness is better than the England average. Higher rates of violent crime (hospital admissions for violence) and includes sexual violence. Under 75's mortality rate from cardiovascular diseases, under 75 mortality rate from cancer and employment (aged 16-64) are worse than the England average.

Visit https://fingertips.phe.org.uk/profile/health-profiles for more area profiles, more information and interactive maps and tools.
https://www.ons.gov.uk/releases/populationestimatesfortheukenglandandwalesscotlandandnorthernirelandmid2018
https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/po
https://www.ons.gov.uk/peoplepopulationandcommunity/culturalidentity/ethnicity/ar

7.1 Population health summary for Knowsley (fingertips data 2019)

Significance compared to goal / England average:

Significantly worse	Significantly lower	Increasing / Getting worse	Increasing / Getting better
Not significantly different	Significantly higher	Decreasing / Getting worse	Decreasing / Getting better
Significantly better	Significance not tested	Increasing	Decreasing
		Increasing (not significant)	Decreasing (not significant)
		Could not be calculated	No significant change

Life expectancy and causes of death

Indicator	Age	Period	Count	Value (Local)	Value (Region)	Value (England)	Change from previous
1 Life expectancy at birth (male)	All ages	2016 - 18	n/a	76.6	78.3	79.6	
2 Life expectancy at birth (female)	All ages	2016 - 18	n/a	80.4	81.9	83.2	
3 Under 75 mortality rate from all causes	<75 yrs	2016 - 18	1807	476.2	388.4	330.5	
4 Mortality rate from all cardiovascular diseases	<75 yrs	2016 - 18	375	98.9	86.6	71.7	
5 Mortality rate from cancer	<75 yrs	2016 - 18	700	185.3	145.6	132.3	
6 Suicide rate	10+ yrs	2016 - 18	44	11.5	10.4	9.64	

Injuries and ill health

Indicator	Age	Period	Count	Value (Local)	Value (Region)	Value (England)	Change from previous
7 Killed and seriously injured (KSI) rate on England's roads	All ages	2016 – 18	165	37.0	38.4	42.6 ~	
8 Emergency hospital admission rate for intentional self-harm	All ages	2018/19	505	346.6	246.1	193.4	
9 Emergency hospital admission rate for hip fractures	65+ yrs	2018/19	170	671.0	590.9	558.4	
10 Percentage of cancer diagnosed at early stage	All ages	2017	337	53.4	51.9	52.2	
11 Estimated diabetes diagnosis rate	17+ yrs	2018	n/a	86.6	81.1	78.0	
12 Estimated dementia diagnosis rate	65+ yrs	2019	1084	70.0 *	73.4 *	68.7 *	

Behavioural risk factors

Indicator	Age	Period	Count	Value (Local)	Value (Region)	Value (England)	Change from previous
13 Hospital admission rate for alcohol-specific conditions	<18 yrs	2016/17 - 18/19	45	45.4	45.9	31.6	
14 Hospital admission rate for alcohol-related conditions	All ages	2018/19	1346	939.7	741.5	663.7	
15 Smoking prevalence in adults	18+ yrs	2018	20962	18.1	14.7	14.4	
16 Percentage of physically active adults	19+ yrs	2017/18	n/a	63.3	64.7	66.3	
17 Percentage of adults classified as overweight or obese	18+ yrs	2017/18	n/a	71.2	64.3	62.0	

Child health

Indicator	Age	Period	Count	Value (Local)	Value (Region)	Value (England)	Change from previous
18 Teenage conception rate	<18 yrs	2017	67	27.6	21.9	17.8	
19 Percentage of smoking during pregnancy	All ages	2018/19	285	14.6	12.7 ~	10.6	
20 Percentage of breastfeeding initiation	All ages	2016/17	936	48.4	64.5	74.5	
21 Infant mortality rate	<1 yr	2016 - 18	20	3.36	4.62	3.93	
22 Year 6: Prevalence of obesity (including severe obesity)	10-11 yrs	2018/19	458	26.9	21.5	20.2	

Inequalities

Indicator	Age	Period	Count	Value (Local)	Value (Region)	Value (England)	Change from previous
23 Deprivation score (IMD 2015)	All ages	2015	n/a	41.4	-	21.8	
24 Smoking prevalence in adults in routine and manual occupations	18-64 yrs	2018	n/a	22.9	26.1	25.4	

Wider determinants of health

Indicator	Age	Period	Count	Value (Local)	Value (Region)	Value (England)	Change from previous
25 Percentage of children in low income families	<16 yrs	2016	7460	25.0	18.0	17.0	
26 Average GCSE attainment (average attainment 8 score)	15-16 yrs	2018/19	63824	39.0	45.6	46.9	
27 Percentage of people in employment	16-64 yrs	2018/19	65300	69.4	73.8	75.6	
28 Statutory homelessness rate - eligible homeless people not in priority need	Not applicable	2017/18	15	0.24	1.07	0.79	
29 Violent crime - hospital admission rate for violence (including sexual violence)	All ages	2016/17 - 18/19	495	113.0	64.8	44.9	

Health protection

Indicator	Age	Period	Count	Value (Local)	Value (Region)	Value (England)	Change from previous
30 Excess winter deaths index	All ages	**Aug 2017 - Jul 2018**	155	**31.4**	**30.4**	**30.1**	
31 New STI diagnoses rate (exc chlamydia aged <25)	15-64 yrs	**2018**	781	**818.3**	**774.7**	**850.6**	
32 TB incidence rate	All ages	**2016 - 18**	3	**0.67**	**7.33**	**9.19**	

Life Expectancy is lower for males and females in Knowsley

Male Life Expectancy	2004-2006	2014-2016
Knowsley	74.3	76.7
England	77.2	79.5

Female Life Expectancy	2004-2006	2014-2016
Knowsley	78.8	80.3
England	81.5	83.1

7.2 Affected PMS/GMS practice location where funding is proposed to be reduced

Of Knowsley's population, ONS estimate that 78,459 (52%) are female and 71,112 (48%) are male. Knowsley has 15 wards that can be split into the townships of Huyton, Kirkby, Halewood, Prescot, Whiston and Cronton. Huyton is the most populous township in the borough with 57,613 people living there (38.8% of the population of Knowsley). However, the Northwood ward in Kirkby has the highest overall ward population.

Figure 1. Map of affected PMS/GMS practice location where funding is proposed to be reduced

- Of the clusters of practices affected by proposed funding reductions, 6 practices out of 21 area surgeries (counting Aston as single surgeries demonstrate borough wide image) all experience higher levels of multiple deprivation.
- Over 50% of practices affected are within the highest areas of multiple deprivation.
- Of the clusters of practices, the Huyton and Kirkby wards would be the most impacted. See ward data below.

8. Ward Data

8.1 Wards data in deprived localities

Index of Multiple Deprivation Score 2019

Area	Count	Value
England	-	21.7
Knowsley	-	43.0
Northwood	-	68.9
Page Moss	-	61.7
Stockbridge	-	59.9
Cherryfield	-	52.9
St Michaels	-	51.6
Whitefield	-	49.7
St Gabriels	-	41.8
Prescot South	-	38.6
Halewood South	-	37.6
Shevington	-	37.2
Whiston and Cronton	-	34.4
Prescot North	-	34.2
Halewood North	-	27.7
Swanside	-	23.9
Roby	-	17.5

Income deprivation, English Indices of Deprivation 2019

Area	Count	Value
England	7,036,442	12.9
Knowsley	36,991	25.1
Northwood	4,400	42.6
Page Moss	3,682	36.9
Stockbridge	3,554	36.9
St Michaels	3,176	30.6
Whitefield	2,605	29.5
Cherryfield	3,374	29.2
St Gabriels	2,427	26.4
Shevington	2,383	22.5
Halewood South	2,351	22.5
Prescot South	2,179	21.2
Whiston and Cronton	1,721	19.4
Prescot North	1,785	18.5
Halewood North	1,529	15.6
Swanside	1,099	12.3
Roby	724	8.3

Huyton – 6 wards with a population of 57,613

- Pagemoss - higher than Knowsley IMD average (43)
- Stockbridge - higher than Knowsley IMD average (43) *
- St Michaels - higher than Knowsley IMD average (43)
- St Gabriels – below Knowsley IMD average (43)
- Swanside - below Knowsley IMD average (43)
- Roby - below Knowsley IMD average (43)

- 3 out of 6 locality wards are highest in rates of IMD compared to the Knowsley average
- All Huyton wards have a higher levels of income deprivation

***NB** Please note Stockbridge Village as a GMS practice will receive more funding

Kirkby – 4 wards with a population of 41,495

- Northwood – higher than Knowsley IMD average (43)
- Cherryfield - higher than Knowsley IMD average (43)
- Whitefield - higher than Knowsley IMD average (43)
- Shevington – below Knowsley IMD average (43)
- 3 out of 4 locality wards are highest in rates of IMD compared to the Knowsley average
- All except Shevington ward have higher levels of income deprivation

Halewood – 2 wards with a population of 20,430

- Halewood South - below Knowsley IMD average (43)
- Halewood North - below Knowsley IMD average (43)
- Halewood North and South are lower than the Knowsley average for income deprivation, however this is higher when compared to England rate.

Prescot – 2 wards with a population of 3,964

- Prescot South - below Knowsley IMD average (43)
- Prescot North - below Knowsley IMD average (43)
- Halewood nor and South are lower than the Knowsley average for income deprivation, however this is higher when compared to England rate

***NB** please note Cedar Cross as a GMS practice in Whiston will receive more funding

9. Knowsley 2030 Evidence Based Data

Population change shows the long-term relationship between people, their communities, and the place they live in. Understanding population changes in the past, and forecasting population changes in the future, allows all services to plan for the needs of the people and the communities in Knowsley. Following decades of population decline, Knowsley's population has grown since 2011, and is projected to continue to grow.

Expected population growth and increased house-building throughout Knowsley will create more demand on all service providers; education and health services will be under pressure to respond to the needs of a growing population.

Life expectancy for residents of Knowsley has increased, with more people living longer. However, there remains significant gaps between life expectancy in Knowsley and the average life expectancy in England.

Healthy life expectancy in Knowsley has also increased, albeit at a slower rate than overall life expectancy. This means that people in Knowsley are living for longer but often in ill-health as they get older, creating greater demand for health and care services.

Population data should be used to improve access to services and reduce inequalities.

There is consistent evidence that the numbers of affluent people living in Knowsley has increased since 2015. This suggests that there is a risk of growing inequalities within the Borough.

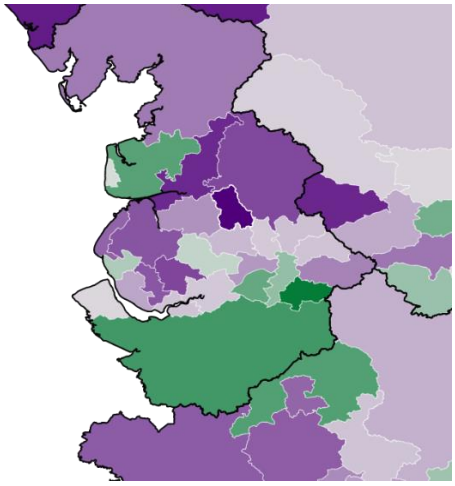
The main messages about Knowsley's population are:

- Knowsley has a population of 149,571 people, and projections show that Knowsley's overall population **will continue to grow**.
- Knowsley's **working age population is projected to decline by 2030**.
- Recent declines in Knowsley's population were driven by internal migration out of the borough.
- **International migration has grown** over the last 10-years.
- The numbers of **births per year in Knowsley has increased over the last five years, against national trends.**
- In 2017, Knowsley **had the third highest rate of legal abortions** in England and Wales.
- Knowsley **has one of the highest rates of preventable deaths** in England.
- **Life Expectancy in Knowsley lags behind national**.
- **Healthy life expectancy has risen at a lower rate, so more years are spent in ill-health.**
- Knowsley is **less ethnically diverse** than England.
- Average **earnings in Knowsley shows greater disparity both within the borough and outside**

10. NHS Digital Data – October 2021

Using NHS digital data, Sky News analysis shows the number of family doctors has been decreasing while the demand is above pre-pandemic levels. The number of doctors is falling, and appointments are going up – but that's only part of the problem.

Knowsley is reported to have 17.3% fewer GPs in March 2021 compared to March 2016 which is the second highest across Cheshire and Merseyside



The decrease in GPs has been greater than 10% in a third of NW CCG's from March 2016 to March 2021. In comparison, Cheshire and Merseyside. Knowsley has a much higher rate of GP numbers: The difference is 8.7% higher in Liverpool than Knowsley.

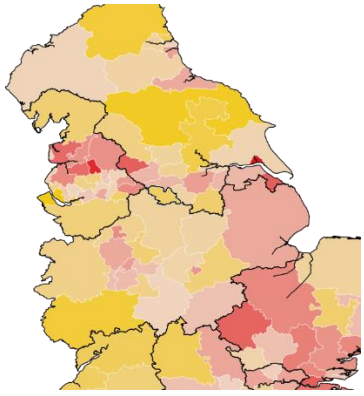
St. Helens	19.2
Knowsley	**17.3**
Southport & Formby	15.9
South Sefton	No change
Liverpool	8.6
Halton	5.4
Warrington	5.0
Wirral	3.4
NHS Cheshire	2.6

https://news.sky.com/story/the-number-of-doctors-is-falling-and-appointments-are-going-up-but-thats-only-part-of-the-problem-12431982

SOURCE: NHS Digital • Number of GPs refers to fully-qualified, full-time equivalent GPs. The rates are calculated using the number of patients recorded in each period

Analysis of the current number of practitioners shows that **the north** is also home to several areas with the lowest number of GPs per 100,000 patients as of August.

Knowsley has the lowest numbers per head of 100,000 population in contrast to the rest of Cheshire and Merseyside



The decrease in GPs has been greater than 10% in a third of NW CCG's from March 2016 to March 2021. In comparison Cheshire and Merseyside Knowsley has a much higher rate of GP numbers:
GPs numbers per 100,000 per registered patients

Liverpool	56
Wirral	56
Halton	50
NHS Cheshire	49
South Sefton	48
Southport/Formby	46
St Helens	45
Warrington	44
Knowsley	**44**

https://news.sky.com/story/the-number-of-doctors-is-falling-and-appointments-are-going-up-but-thats-only-part-of-the-problem-12431982

SOURCE: NHS Digital • Number of GPs refers to fully-qualified, full-time equivalent GPs. The rates are calculated using the number of patients recorded in each period.

Knowsley in both tables fares worst in comparison. Cheshire however as a more affluent area appears to retain their GPs, and has a similar number of GPs to serve their population

SECTION E – LOCAL SCORES / MONITORING REPORTS

11. CQC rates for Knowsley practices

At the time of reporting all Knowsley affected practices have been rated as "Good".

12. Monitoring reports from Knowsley Healthwatch

In quarter 1 and 2 2020/2021 the average rating for GP Primary Care Services across Knowsley during April – September 2020 is just under 4 stars, which is rated as good. All individual ratings for these services are between 4.5—5 stars. Within this reporting period, the most commented theme in relation to primary care, has been treatment and care, with 78% of positive comments. Though it is worth noting that there has been a number of mixed responses in other themes, for example, Access to Services with 45% positive and 45% negative responses.

In quarter 3 and 4 2020/2021 During this reporting period, Primary Care has been the most commented category with 821 comments received. Overall, the average rating for Primary Care Services across Knowsley is during October 20—March 21 is just over 4.4 stars, which is rated as good/excellent. All individual ratings for these services are between 4.5—5 stars. Within this reporting period, the most commented theme in relation to primary care, has been treatment and care, with 95% positive comments. The majority of the themes are positive, though it does highlight some concerns regarding access to services, communication, administration, medication, diagnosis/assessment, and referrals.

Due to lockdown restrictions Healthwatch staff were unable to visit the surgeries to speak directly to patients, therefore information has been captured by both contacting community members via telephone or from patients directly providing reviews to the feedback centre.

SECTION F – FEEDBACK FROM ASSESSMENT MEETINGS

13. Feedback from practices on how funding is used at a practice level

All Knowsley GMS and PMS practices practice meetings were held either in person or via Teams.

There are 4 funding streams provided to practices (Fairness in Primary Care, PMS Premium, Primary Care Quality Premium and Access funding). The practices say that Access is not a separate fund, but the requirements were merged with other funding streams. Practices do not separate funding streams they combine all income and invest this to ensure the appropriate staff and capacity is in place to meet the health and care needs of the community.

JRC explained to practices during 1:1 meeting that the range of funding allocation, e.g., Fairness funding, PMS and practices who receive renumeration for supporting care homes, is a commissioner provider contractual discussion and not in the scope of this work. This impact assessment will focus on the patient, staff, and practice impacts if the current funding streams as detailed above were to be reduced and will include care homes as an area that practices offer care to and therefore reducing visits to the services may be an outcome if funding is reduced.

Each practice gave verbal feedback on how the income they receive is used to provide services and how this is monitored. This has been summarised with some quoted examples of clinical capacity increases, challenges in recruitment and how this is being mitigated, how fairness funding ensured each practice can continue to deliver sustainable primary care services for a borough continues to experience significant health inequality.

13.1 Fairness in Primary Care

Fairness funding was used to increase 'access' to GP practice services, based on increases in consultation capacity. Measurement of consultation capacity including the provision of service from appropriate professionals given expansion of roles that provide direct care.

Three PMS practices do not receive Fairness in Primary Care funding. For those who do, all practices have confirmed they used this funding to increase the practice hours, GP hours and employ salaried GPs. Many practices reported their difficulty in recruiting GPs and have needed to pay a premium amount of money to attract Locum GP cover. This can be up to £1000 per day. It was also reported that this funding has not been uplifted to match the rising costs of Locum rates and where this is the case the practice funds are used to meet this cost.

Most PMS funded practices also operate as GP training practices and require GPs to provide supervision for GP trainees. The GP trainees are F2 registrar doctors who wish to work in general practice. Surgeries also support medical student placements on a rotational basis. As it takes 3-4 years to train a GP, and recruitment always remains a problem, training GPs has resulted in several newly qualified GPs remaining in Knowsley.

This training is funded externally, however if GP hours/posts are reduced, the GP training will have to be discontinued and this external funding stream will be lost.

All training practices state their number one priority is to continue running the practice and serve its patient population. However, GPs also state that the continued provision of training for GPs is essential to future proof the NHS primary care as many local GPs will be approaching retirement and some salaried GPs are becoming locum GPs.

Several practices have stated they will have to lose GPs posts if funding is reduced, and they are very concerned that reducing access to GPs at a time of greatest need will affect the most vulnerable and needy patients across all age groups, genders, and equality groups.

Some current examples of impact were shared:

- Aston Healthcare delivers primary care services at 6 different practice sites across the Borough (Huyton, Halewood, Whiston, Kirkby) however, this operates as one single contract. It was confirmed that all Aston Healthcare practices work to the same operational model and use this funding to increase capacity. If the practices are unable to secure locum cover due to difficulty in recruitment of salaried GPs, which continues to be an issue, the patients are negatively impacted as a direct result. One example provided was Manor Farm practice in Huyton, which is a large practice with the neighbouring practice being Tarbock Medical Centre. If Manor Farm practice needed to reduce its services patients may want to leave and register elsewhere. This could prove to be difficult given the nearest practice is run by a small team and consequently would not be able to manage with the current staff on a large scale quickly. To scale up practices takes time.

- On a bigger scale, if Aston had to close all practices as it is one contract, Manor Farm in Huyton would not have alternative local surgeries and patients would have to travel further to register with a practice. Aston Healthcare states the only way to mitigate this impact would be to separate the contracts for each surgery. Again, this was highlighted as a commissioner/provider discussion and not within the scope of this work. However, it was felt this is important to highlight, given the collective volume of patients Aston Healthcare deliver services to across the borough.

- Several practices reported that they had recently advertised for a salaried GP posts and received no applicants. It was acknowledged that this is a local and a national problem. Knowsley remains "under doctored" compared to other areas. The demand for primary care is rising and managing pandemic vaccination demand continues to grow as new strains are emerging. Several other practices e.g., St Lawrence's, Tarbock and Dinas Lane surgeries all confirmed they too faced the same issue, advertising posts and not having any applicants at all.

- Millbrook Medical Centre report they may need to make clinical staff redundancies resulting in the practice being unable to effectively meet patients' health and care needs. To meet the PMS contract, we must provide 805 appointments per week (list size of 11,500) meaning we must deliver a minimum of 161 appointments per day. With current demand it continues to be arduous meeting this level of appointments per day/week whilst remaining financially sustainable. Should we be forced to make clinical redundancies the practice will not be able to reach their current contractual levels, yet the population/patient demand, is highly likely to increase as new housing estate are being developed nearby.

- The Hollies practice reported that should this payment be reduced; this practice will have a crisis in Halewood given this is the only practice with an open list and still registering sick patients. If they have to reduce capacity this will cause a major incident. It is understood that this has been acknowledged by the CCG, that The Hollies is the only practice locally that has kept their list open. To lose the equivalent of 1 GP and staff capacity, this will impact on mean 130 patient appointments per week. This locality is developing the construction of a new housing estate and the population is expected to be circa 13,000 people moving in 4,500 new build properties, who will need to register with a GP. The practice is trying to plan for this, and the community will need more doctors not less to serve a bigger population.

- Some practices have stated they may need to close their list.

- Prescot medical centre reported they had employed GPs on the strength of this funding, and increased GPs from 2 to 5 doctors as a direct result of this funding. This practice has grown from

4000 patients and now has 7000. As a training practice they reported that several GP trainees remain in the borough once qualified, which given the challenges of recruitment is a positive step in sustaining primary care services.

- Delivering care in the community at nursing homes has been highlighted as another area that practices require additional time to attend. The residents are often frail elderly residents, require health checks, medication checks as well as reactive care requests. It was reported that until recently one practice supported 14 care homes that required extended appointments and health checks being provided. However, the practice did not receive any extra funding for this, whilst other practices in the borough did receive funding to support care home residents. GPs were unclear how this funding is awarded to some practices and not all.

- Another concern raised was if a practice had to close, Knowsley practices may not be able to take them in as all PMS and some GMS practices will be reducing their services if funding is reduced. A real time example, from The Hollies Medical Centre in Halewood has highlighted that they have and are struggling with the significant increase in their patient population as a result of some Aston patients moving to them in the past two years and with the new local housing developments.

- One large nursing home in the Halewood area was affected severely with deaths when covid began. It had also been challenged about the quality of their home and this is an important issue as this population are very frail elderly people and is situated in the Liverpool/Knowsley boundary. If their provider practice was unable to continue to offer the care and support due to reduced capacity, it may result in the nursing home having to register with a Liverpool practice. It is unknown if Liverpool would have any capacity or would agree to be the alternative provider.

- Overall, there is general consensus that if GP numbers reduce, care home residents will be impacted.

13.2 PMS Premium

PMS funding is in place to add value and innovation in service delivery to meet local need/improvement in health outcomes. Only PMS practices receive this funding stream.

Practices reported that there has been a long and historical debate over the way the PMS premium was designed and contracted. The contract was graded into different sections, each graded with an A, B and C scoring. C being the highest. Practices fed back that the CCG has failed to monitor this adequately over time. It is reported by one practice if the monitoring had continued, and there had been a dialogue between the CCG and GP practices, this would have presented with better opportunities to adapt the premium to fit the needs of the population and the practice that serve the population.

GMS practice have never received this funding. However, a GMS practice wished to make the following comments: “In 2015 it was stated in a document that this funding would be the same for GMS and PMS. Many GMS practices provides almost all of these services but receive no additional funding. If the PMS premium had been distributed to all practices, the GMS practices would have been able to appoint pharmacist, nurse practitioners, etc. Instead, existing team members providing this as part of a general contract”.

It is important to note however, PMS funding was removed nationally a number of years ago and has not yet been implemented in Knowsley, therefore practices have continued the range of services detailed below and they had not planned for this funding being changed.

The PMS has 23 areas if activity, and all PMS practices offer these services (exception being minor surgery, a couple of practices offer joint injections). Longview Medical Centre is the lead provider for

the whole of Knowsley for minor surgery services performing vasectomies and skin surgery and patients travel to access this service.

Each practice has continued (if only on a smaller scale) to deliver the majority of PMS services throughout the pandemic and many practices are resuming this work at scale, to plan reduce the backlog. It has been reported by all practices they have not had any monitoring against this work for over five years, but the patient activity is recorded and can be provided on request.

Regarding children and young people this is not a specific service, practices treat children and young people as part of the core practice services. However, parent/baby clinics are provided at a range of practices.

All practices have registered patients with a learning disability and hold a register of those patients. Some practices have over 100 registered patients with a significant learning disability. Each of these patients require health checks, weekly MDTs, and extended appointment times (circa 1 hour) when attending the practice. Some practices in the borough have less than 10 patients with a learning disability. Therefore, the impact for some practices will be more significant than others depending on the volume of learning disability patients registered.

Knowsley practices have recently been informed by the CCG that they had under-performed in this funding stream. However, it is unclear what measurements are being used to determine where practices are failing, given no contract monitoring has taken place for several years and there doesn't appear to be anything in the Primary Care Committee meeting papers that this has been raised as an area of concern. Two of the GPs involved in the assessment are also members of the Primary Care Committee and have confirmed this was not raised as an issue.

Practices stated that if the PMS contract had been monitored regularly it would have provided them with the opportunity to change working practices in consultation with the commissioner. Clearly this is an area for ongoing discussion, given the funding was removed (but not implemented in Knowsley) and the providers will reduce staff if funding is lost. A large part of this work is prevention/early diagnosis and Knowsley has high mortality rates, which has also been highlighted as another area for concern.

PCN posts have been highly valued, and the medication reviews are going ahead as structured medication reviews, however practices do need more pharmacy input. Social prescribing is another area very much valued by practices and patients. Access to a physiotherapy practitioner is funded by the PCN, but not necessarily relative to this work. What has been highlighted is the cancer screening and vaccination work funded through the PCN. It was mentioned that the funding allocation for this work does not meet the level of demand in communities.

Therefore, all of the practices have stated they will struggle to manage this workload, and that the PCN funded activity, whilst invaluable cannot offset the gaps this will create.

13.3 PCQP

This funding stream is in place to improve access, quality improvement, prescribing and PCN funding streams is available to all PMS and GMS practices. PCQP funding enable practices to start work and then embed it within their daily work which the practices have done and have to evidence this to receive the funding. The target for this work is annually directed by the CCG and prior to the commencement of the pandemic practices GPs reported this was rigorously monitored. Although practices have not been requested to submit many audits since the onset of Covid 19, they have continued to receive funding and has remained in place to support practices managing the demands of the pandemic. It is unclear at this time what will be the future for PCQP.

QOF targets are captured via the clinical system (EMIS Web) and all practices can view the results and consider their performance against each other. However, given the change in service delivery due to the pandemic the data is not reliable.

13.4 Patient Access Funding

This funding is place to increase 'access' to GP practice services, based on increases in consultation capacity. Measurement of consultation capacity including the provision of service from appropriate professionals given expansion of roles that provide direct care.

Having a range of skilled clinicians and assistants enables improved access for patients to benefit from a wide range of services by qualified staff who can provide care. Several practices employ a pharmacist who undertake medication reviews with patients, consultation and near patient testing.

Some practices have close integration with Knowsley Council to run media campaigns, attend for vaccinations etc. which has yielded a good rates of attendance.

One practice has had its patient list doubled in size as patients from neighbouring practices have been dissatisfied. Patients register for a reason and need to be seen and the practice is reporting this is not slowing up. The CCG acknowledged this extra demand on the practice for consultations etc. Although the practice was promised additional funding this has not happened. The practice has had to absorb this additional cost.

13.5 Stability Payment

The CCG reported that this is a non-recurrent payment to initially 'stabilize' practice income which is not tied to any conditions.

The practice states that when St Johns practice closed and merged with Cornerways, and Dr. Messing (PD Medical) practice, the funding that was transferred was a combination of Fairness Funding transferred from St Johns Surgery and PD Medical as well as PMS funding that PD medical and St Johns practices. received. However, Cornerways is a GMS practice and not entitled to PMS plus funding. The CCG acknowledged the services were being delivered and therefore agreed to continue this funding. This resulted in the fairness funding and PMS Plus was allocated as one funding stream. The practice state they have notes from meetings held with the CCG Accountable Officer and the CCG Chair and it was tabled at a Governing Body meeting. Therefore, the CCG should have a record of the of this agreement. In addition, when the practice attended Knowsley Scrutiny Committee it confirmed the range of services that would be available from the merge of practices. Patients and the public were also engaged to discuss the merge of 3 practices, and it was confirmed that the services would continue as previously provided. The practice stated that at no point was this funding named Stability funding, this has recently been renamed, and this is existing funding other practices receive, but for this purpose was put into one funding stream and allocated each year for Cornerways.

14. Summary of impact per service on the groups of patients/staff

14.1 Fairness in Primary Care

Given this funding stream is to increase numbers of GPs in under doctored areas, practices considered the impacts and potential outcome of this taking place.

Staff reductions: Broadly, the practices all would reduce GP hours/posts; pharmacists, PNs, ANPs, HCA's, admin, data, and reception staff. This will create further health inequalities, increase waiting lists for referrals to external services such as cancer referrals and increase attendance at Walk-In Centres and A&E Departments. This will undermine NHS England's equalities and health inequalities

statement which state “promoting equality and addressing health inequalities are at the heart of NHS England’s values”.

Replacing clinical roles: Where clinicians leave posts they may not be replaced which. It was expressed that these are important roles in the practice, e.g., one practice has said they potentially would lose a GP, Pharmacist, ANP, and nurse practitioner which would mean a reduction of 23% of their work-force.

Recruitment and staff retention: Knowsley has a high demand for healthcare and the borough experiences significant problems to recruit salaried doctors. Some practices have not been able to replace the practice salaried doctor even though this post was advertised at a 30% increase to standard payments for GPs. Virtually every practice shared their concerns over recruitment and not being able to deliver services. Other practices highlighted that the increasing costs of locums is not aligned to fairness funding and the practice has to cover the additional cost. There is a concern staff (including GPs) will leave practice because of the additional workload and some have said this is an unhealthy way to deliver services.

Teaching practice status: Many PMS practices are GP teaching practices which requires GP hours allocated to supervise and support the training GPs. All practices said this is a key risk area if they reduce GP hours the result would be to cease practice training programme to F2 registrars and medical students, both of which practices are funded to support. This would therefore result in another income stream lost. This issue would also impact recruitment as many training GPs once qualitied remaining in the borough.

Payment to Knowsley GPs compared to neighbouring areas: Knowsley GPs receive funding toward estates/building costs which are included in the fairness payment. Practices want to highlight this, as they have been informed they are receiving a much higher rate of pay than other GPs outside of the borough who deliver the same services. It was requested that the CCG clarify this issue as the additional payment could be as a result of estate income being attached to fairness funding leading to a disparity in payment.

Practice sustainability: Some practices have stated they may have to merge with another practice if they can’t recruit GPs or have enough cover to deliver safe services. Three practices said they might have to close surgery altogether and patients would be dispersed. The practices are located across the Borough in Huyton, Kirkby and Halewood. Remaining practices (including GMS practices) GPs are worried about dispersal of patients on closure of a surgery, or people wanting to move because opening times reduced and/or can’t get an appointment.

A wider issue is the low levels of access to a car in Knowsley, meaning residents are more likely to need public transport or car sharing in order to work, shop, or provide care. The 2011 Census data shows that 37% of households in Knowsley did not have access to a car or van, this is higher than the England average of 26% and the North West average of 28%.

Planning for change: To gauge the level of people who will be affected by job losses, and to quantify this to support commissioner decision making, the 1:1 assessment interviews were followed up with an online survey for practices to predict potential human resource impacts in each practice. This will enable a Knowsley wide picture to be seen and help then consider the impact on service delivery if clinical and non-clinical staff numbers are reduced.

Please note the practices do not wish to be identified at this time but felt it would be an important piece of information for primary care providers and commissioners to consider as the next stage of dialogue commences.`

14.2 PMS Premium

It has been suggested that within Knowsley there has been a failure to meet service level agreements in relation to PMS targets. Practices reported the targets are not specifically set and no monitoring of this has taken place for over five years. As a consequence, all of the practices strongly contest

this. Their view is "*absence of monitoring does not equate with absence of evidence*". All practices can provide evidence that they have continued to meet and in some cases surpass service delivery.

In summary all PMS and 2 GMS practices who lose funding have stated they will have to:

Reduced numbers of clinical and non-clinical staff: Reduce the range of staff employed or reduce hours worked. All the team contribute to the service delivery, from internal audits, patient searches for medication and health checks. The clinical and administrative staff as well as data recording managers all play a significant role in this workstream.

Reducing PMS funded clinics, services: All practices have reported they will need to reduce amount of time to deliver PMS services (most of these are done by clinical team members (not GPs). The impact will affect staff wellbeing who will struggle to fill the roles if funding is significantly reduced.

Support for care homes: In regard to vulnerable groups, most practices provide support local care homes, several of whom have a large number of elderly vulnerable residents. Attending weekly MDT meetings, medication reviews, reactive appointments are all time consuming, but an essential element of community based care. If the clinical staff (GPs, pharmacists) are reduced the level of service cannot be sustained. This for some care homes will pose a significant impact if they are unable to register their residents with another neighbouring practice.

Stated within the 2021 Knowsley Public Health report, it states that there is a high proportion of people aged over 60 in Knowsley and evidence has shown that; over 60s, those with underlying health conditions and residents of care homes are more likely to be hospitalised or die as a result of COVID- This group of the population are more likely to have been affected by the direct effects of COVID-19 in terms of disease and death.

Impacts on Public Health: Public Health Knowsley produced a report "Understanding the Impact of Covid 19, Planning and Recovery", October 2021. Knowsley public health team have identified that the largest risk factor with COVID-19 was age; among people already diagnosed with COVID-19, people who were 80 or older were seventy times more likely to die than those under 40. This disparity existed even after taking ethnicity, deprivation, and region into account, but did not account for the effect of co-existing health conditions, which may explain some of the difference. In Knowsley, approximately 28% of the older population (people aged 65+) are aged 80 and over, which is higher than the England average (27%) and have a high level of co-existing health conditions. The risk of dying among those diagnosed with COVID-19 was also higher in males than females.

Supporting patients with learning disabilities: Practices are also concerned about the impacts treating and managing patients with a learning disability. Some practices have extremely high levels (over 100) that given the appointment times are about an hour long, practices are very concerned they would not be able to continue to deliver the same level of service. An additional issue to this is the support to carers as many of the patients with learning disabilities are cared for at home by relatives/paid carers. The impact of reducing attendance at GP health checks may also impact negatively on the carer/families.

Shared care support: Lack of support for substance misuse/shared care services if nursing staff are reduced will impact many patients across the borough. The shared care appointment also provides an opportunity for practice nurses to talk to patients about lifestyle matters, undertake health checks. All of this is beyond the realms of shared care and would potentially be lost if the capacity of staff will not be in place.

Chronic Disease Management: Loss of GPs, nursing and pharmacy staff treating the most vulnerable patients, e.g., chronic disease management, complex care patients, will be reduced and the exacerbation of conditions may increase hospital admissions at a time acute services are overwhelmed with winter pressures, and pandemic operational management, increased waiting lists etc.

Impact on local people's employment: Nearly all practices have stated they will reduce reception and admin staff and it was stated for numerous practices, between 70-90% of these staff groups live locally in deprived communities with high levels of unemployment and thereby further impact health inequalities.

Impact of access to receive services: Practices have confirmed they will need to reduce opening hours as less capacity to deliver safe services so patient experience will be impacted.

Impact on hospitals and community/urgent care providers: Poor access to primary care will increase pressure on A&E, WiC attendance at a time they are under they are under increasing pressure with emerging covid strains, winter pressures, along with the newly announced pressures on the system deliver booster vaccinations.

14.3 PCQP

The specification of the PCQP changes each year. The PCQP is often agreed late in the year, leaving practices about 6 months or less to achieve the standard. However, the PCQP has been governed well with achievement and payment being agreed by the Primary Care Committee. Practices fedback that they feel the PCQP has been successful in that regard. It focusses on different quality issues each year and it is understood that it is something similar to the Liverpool specification.

Practices have asked that as Knowsley is one of the most deprived boroughs in the country, that commissioners continue to invest in PCQP and PMS premium and incentivise practices to achieve quality targets, address the health needs of the population and tackle health inequalities rather than vastly disinvest in primary care which will only have a detrimental effect on the health and the needs of the Knowsley population.

14.4 Patient Access

Having a range of skilled clinicians and assistants enables improved access for patients to benefit from a wide range of services by qualified staff who can provide care. e.g., Pharmacist undertaking medication reviews with patients, consultations etc. practices state a lack of funding will significantly affect patient's ability to access the right health professional and service.

GPs, ANP and Pharmacist are all key individuals in delivering patient access and quality performance targets. If funding is decreased. these type of posts will be reduced/or not be replaced if they leave the practices. If patients cannot access the wider range of services, access and quality of care will be negatively impacted.

As demonstrated in Knowsley Healthwatch monitoring reports for 2021, there are ongoing issues patients continue to raise, one being access to services. Should funding be reduced this situation is likely to become worse. The most current additions to this are communication, admin, medication, diagnosis/assessment, and referrals.

The patient issues are aligned to what practices have raised in terms of reducing staff hours, not replacing posts etc. as the affected staff provide admin, pharmacists, and GP's.

14.5 Impacts on Equality and Health Inequalities

Improving communication with patients: Practices offer a wide range of service and communication channels. Some practices use accurix text message system. This affords practices to be able to text and ask patients to attend surgery, attend for results, ask for replies, etc., This has cut down a lot of administration time. However, it does not meet the needs of the whole of the patient population. Literacy in the borough is poor, and many people cannot read or write. Many people do not use mobile phones which can be an affordability issue, personal choice, or lack of access. Those without mobile phones must use their landline to dial into the surgery which is difficult as demand is high, and many complain they cannot get through. Some practices do have an open door

policy; however, appointments will remain limited, and patients continue to complain on lack of access to GPs.

If practices reduce their hours of operation, this will negatively impact patient experience, create more complaints, and widen inequality as there are clusters of practices in Huyton and Kirkby. However, some GMS practices are also providing services in these localities, but they have expressed concerns about patient registrations increasing. Halewood would be impacted if the local practice closed and could not support the care home. The volume of new housing, potentially more patients needing to register would saturate a practice that has already doubled in size.

Where there is a small practice the impacts, whilst not seeming financially impactful, the reduction in funding will make a serious impact on staff being retained and one practice is worried that legal action could be taken by staff challenging the reduction in hours/or loss of a post.

Translation for non-English speaking patients: Knowsley has seen an influx of patients who don't have English as their first language, and they need to dial into the surgery for appointments. Many require translators and the CCG funded scheme does not cover the level of demand that refugees, asylum seekers etc. need. This can also restrict how patients access services if there is no available translator, how can patients make informed choices on their care.

Chaperones: In some faiths a chaperone may be required to attend appointments. Practices highlighted this as a gap area which results increasing patient waiting times.

Age: A number of elderly patients do not use text/smart phones. They are therefore required to telephone the surgery for an appointment, test results etc. A common complaint raised is that patients cannot get through because the practice struggles with the level of demand. This is an important issue, many of these patients are vulnerable and need access to treatment. Many are afraid to leave their houses due to various reasons, infections, etc. but their clinical vulnerability and exposure to Covid 19 and the emerging Omicron variant of Covid 19 virus cannot be ignored. Therefore, those patients who are very vulnerable will be missed and because the system continues to be saturated.

Vulnerable Groups: Mental health rates are high in Knowsley and demand for primary care is paramount. Practices report that even a fully resourced practice is not equipped to deal with the level of need and the strain that covid as had on mental wellbeing for adults, older people and children has been well documented. Reducing funding in a period where demand is going up not down, will undoubtedly cause serious impacts to all cohorts of patients, particularly those from protected groups who also have additional needs, e.g., disability, race and ethnicity, elderly patients who are frail and vulnerable.

Impacts on equality groups: ,A reduction in funding will impact on all ages, gender, race and ethnicity and ability/disability of patients. Knowsley is an already "under doctored" compared to other neighbouring areas (according to NHS digital data) and the reduction in funding will result in potential losses to clinical staff which will create further health inequalities affecting a range of patients across Knowsley. A reduction in clinical staff will result in a reduction in appointments offered and patients seen.

A reduction in GP access in an area that "under doctored" will increase health inequalities which impacts:-

- Life expectancy
- Access to care and availability of treatments
- Quality and experience of care (only having limited time with patients)
- Patient safety
- Wider determinants of health

All the protected groups and those who experience inequality are registered patients at Knowsley practices, however the practices do not segment patients so there is no specific equality data available. To change this would be a huge ask on practices at a time they are exceptionally busy. Therefore, the assessment will have to assume this is accurate reflection of patients registered.

It is felt that reducing funding all of those patients' groups could be affected, depending on their specific need and reliance on the practice. Face to face appointments will be reduced and some of the most vulnerable people will be affected. For example, homeless people would be affected as some use a local address, but practices are aware they do not reside at the address but use it for post, etc.

Regarding care homes , locally care homes are supported and whilst for many this will be retained, the care home patients will have less staff to attend care homes, attend MDTs thereby extending waiting times to groups of highly vulnerable elderly patients..

Learning disability patient appointments usually take an hour and the capacity of nurse practitioners and GPs would be limited and not able to offer the quality provision that is currently in place.

Practices have stated they will need to restrict their time and focus on the key priority areas for the patient.

Econsult service would be reduced as well as face to face appointments.

GP teaching practices will cease to operate and is invaluable learning opportunity for doctors. In addition, practices have valued the input from the F2 doctors who help deliver services at the practice.

Often carers go unnoticed as key partners in care and accessing additional support is essential for their wellbeing. Many carers are looking after relatives with long term health conditions, disabilities, and therefore primary care services when treating patients also consider the needs and views of carers in planning.

14.6 Potential positive benefits for GMS patients and practice

The practices welcomed the increase in funding and broadly have stated the following areas of improvement:

- Increase in staff hours
- Potential for new posts
- Investment in additional translation services
- Improved staff training
- Improved audit / searches / patient recalls
- Increase in clinic sessions

14.7 Quality impacts

Clinical Outcomes

The risk to all affected practice is that they will not be able to deliver the QOF outcomes if it has to operate on less clinical time to support this important area of work. The impacts are the effects on the most vulnerable patient groups. This will widen the existing health inequalities as well as impact on mortality.

Patient Safety

The service offered to communities that are already disadvantaged through multiple levels of deprivation, health inequalities, life expectancy, mortality rate. Practices will need to be considerably reduced in order to offer quality, safety to staff and patients but on a smaller scale.

Impact on Reputation/Patient Experience

National and local news and media suggest that access to services and a GP appointments are already difficult. Cutting funding that will affect the number of clinicians at the practice which will have a negative impact on patient experience. Ultimately, it will be the patients that suffer. Patients want access to good quality care and expectations of patients is increasing. Delays in accessing a service may result in something being missed and patients fall through the net by not being seen. Overall, if practices reduce the access, it will reduce the quality, affect reputations, and impact patient experience.

Impacts on staff

Staff morale will be negatively impacted, the extra workload on those who are already working at capacity is not sustainable. The mental health of staff is already impacted upon, and this will be exacerbated for clinical and non-clinical staff meeting the needs of the population.

It was felt that general practice is like a pressure pot, the practices are under pressure from a range of issues and cannot understand why at this time of high demand for services would funding be removed. Many practices reported they planned their service based on this income and this is the worst time possible to have this removed.

Impacts on Practices

The consequences are very serious practices. Several have stated they may have to close their list. Three have stated they may have to merge with another practice, and three practices may be forced to hand over a contract if they cannot deliver the service safely. The patients would then have to join another practice, and this is assuming other practice lists remain open at a time their funding is also being reduced.

The consensus is this would be catastrophic to the communities GPs and the wider team provide services for. The commissioners should not underestimate the impact of the cuts at a time when demand is high, primary care is saturated, emergency services are overwhelmed with winter and covid, and backlog of patients waiting for treatment.

Impacts on Duty of Quality (CQC/Constitutional Standards

Impact on CQC rating will be affected, it was questioned how can practices be responsive, safe, well led if we they do not have necessary number of staff.

It was stated whilst this will not be immediate, but over time this will occur by losing funding and will need to be part of a practice risk register.

Consequences and Likelihood of Impacts

All practices completed a consequence and likelihood score. Below are the categories and frequency those issues have been raised.

	Consequence Score				
	1	2	3	4	5
Domain	Negligible	Minor	Moderate	Major	Catastrophic
Impact on the safety of patients, staff or public (physical /psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work.	Minor injury or illness, requiring minor intervention. Requiring time off work for >3 days. Increase in length of hospital stay QW]by 1-3 days.	Moderate injury requiring professional intervention. Requiring time off work for 4-14 days. Increase in length of hospital stay by 4-15 days. RIDDOR/agency reportable incident. An event which impacts on a small number of patients.	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days. Increase in length of hospital stay by >15 days. Mismanagement of patient care with long-term effects.	Incident leading to death. Multiple permanent injuries or irreversible health effects. An event which impacts on a large number of patients.
Quality/complaints/ audit	Peripheral element of treatment or service suboptimal. Informal complaint/inquiry	Treatment or service suboptimal. Formal complaint. Single failure to meet internal standards. Minor implications for patient safety if unresolved. Reduced performance rating if unresolved.	Treatment or service has significantly reduced effectiveness. Formal complaint with potential to go to independent review. Repeated failure to meet internal standards. Major patient safety implications if no action.	Non-compliance with national standards with significant risk to patients if Unresolved. Multiple complaints/ independent review. Low performance rating. Critical report.	Totally unacceptable level or quality of treatment/service. Gross failure of patient safety if findings not acted on. Inquest/ombudsman inquiry. Gross failure to meet national standards.
Statutory duty/ inspections	No or minimal impact or breach of guidance/ statutory duty.	Breach of statutory legislation. Reduced performance rating if unresolved.	Single breach in statutory duty. Challenging external recommendations/ improvement notice.	Enforcement action. Multiple breaches in statutory duty. Improvement notices. Low performance rating. Critical report.	Multiple breaches in statutory duty. Prosecution. Complete systems change required. Zero performance rating. Severely critical report.
Adverse publicity/ reputation **QW]#**	Rumours. Potential for public concern.	Local media coverage. Short-term reduction in public confidence. Elements of public expectation not being met	Local media coverage. Long-term reduction in public confidence.	National media coverage with <3 days service well below reasonable public expectations.	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House). Total loss of public confidence.
Business objectives/ projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget. Schedule slippage	5–10 per cent over project budget. Schedule slippage	Non-compliance with national 10– 25 per cent over project budget. Schedule slippage. Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage. Key objectives not met.
Finance including claims	Small loss. Risk of claim remote.	Loss of 0.1–0.25 per cent of budget. Claim less than £10,000.	Loss of 0.25–0.5 per cent of budget. Claim(s) between £10,000 and £100,000.	Uncertain delivery of key objective. Loss of 0.5–1.0 per cent of budget. Claim(s) between £100,000 and £1 million. Purchasers failing to pay on time.	Non-delivery of key objective. Loss of >1 per cent of budget. Failure to meet specification/ slippage. Loss of contract / payment by results. Claim(s) >£1 million.

Service/business interruption Environmental impact	Loss/ interruption of >1 hour. Minimal or no impact on the environment.	Loss/ interruption of >8 hours. Minor impact on environment.	Loss/ interruption of >1 day. Moderate impact on environment.	Loss/ interruption of >1 week. Major impact on environment.	=-=-Permanent loss of service or facility. Catastrophic impact on environment.

Likelihood	Description	Risk Score
Almost Certain	Will undoubtedly occur, possibly frequently	5
Likely	Will probably occur but it is not a persistent issue	4
Possible	May occur occasionally	3
Unlikely	Do not expect it to happen but it is possible	2
Rare	Cannot believe that this will ever happen	1

14.8 Combined feedback scores from all practices

There are 7 domains to select from. The highest combined ranking is highlighted in Grey. A summary of combined highest scores is contained in the last table

Minor Impacts responses

Domain	1	2	3	4	5	
	Negligible	Minor x 4	Moderate	Major	Catastrophic	Beyond Catastrophic
Impact on the Safety of patients, staff or public						
Quality/Complaints Audit						
Statutory Duty Inspections		1				
Adverse Publicity Reputation		1				
Business Objectives Projects						
Finance including Claims						
Service/business interruption Environmental Impact		2				

Moderate Impacts responses

Domain	1	2	3	4	5	
	Negligible	Minor	Moderate x18	Major	Catastrophic	Beyond Catastrophic
Impact on the Safety of patients, staff or public			2			
Quality/Complaints Audit			2			
Statutory Duty Inspections			6			
Adverse Publicity Reputation			2			
Business Objectives Projects			4			
Finance including Claims			1			
Service/business interruption Environmental Impact			1			

Major Impacts responses

Domain	1	2	3	4	5	
	Negligible	Minor	Moderate	Major x 42	Catastrophic	Beyond Catastrophic
Impact on the Safety of patients, staff or public				2		
Quality/Complaints Audit				6		
Statutory Duty Inspections				6		
Adverse Publicity Reputation				9		
Business Objectives Projects				4		
Finance including Claims				8		
Service/business interruption Environmental Impact				7		

Catastrophic Impacts responses

Domain	1	2	3	4	5	
	Negligible	Minor	Moderate	Major	Catastrophic x 74	Beyond Catastrophic
Impact on the Safety of patients, staff or public					14	
Quality/Complaints Audit					13	
Statutory Duty Inspections					9	
Adverse Publicity Reputation					9	
Business Objectives Projects					13	
Finance including Claims					5	
Service/business interruption Environmental Impact					11	

Beyond Catastrophic Impacts responses

Domain	1	2	3	4	5	
	Negligible	Minor	Moderate	Major	Catastrophic	Beyond Catastrophic x 15
Impact on the Safety of patients, staff or public						2
Quality/Complaints Audit						1
Statutory Duty Inspections						1
Adverse Publicity Reputation						1
Business Objectives Projects						1
Finance including Claims						8
Service/business interruption Environmental Impact						1

Highest combined domain areas

Domain	1	2	3	4	5	
	Negligible – No areas are considered negligible	Minor	Moderate	Major	Catastrophic	Beyond Catastrophic
Impact on the Safety of patients, staff or public					14	
Quality/Complaints Audit						
Statutory Duty Inspections			6			
Adverse Publicity Reputation				9		
Business Objectives Projects						
Finance including Claims						8
Service/business interruption Environmental Impact		2				

Narrative of combined results:

The highest ranked impact resulted in 74 responses stating a range of domains that would rank Catastrophic

- The highest ranked impact is **safety of patients, staff or public** which is considered **Catastrophic**
- Second highest ranked impact is **adverse publicity and reputation** which is considered **Major**
- Third highest ranked impact is **finance, including claims** which is considered as **Beyond Catastrophic**
- Fourth highest ranked impact is **statutory duties and inspections** (CQC) which is considered as **Moderate**
- Lowest ranked impact is **Service/business interruption Environmental Impact** which is considered **Minor**

NB Whilst both **business objectives and quality/audit and complaints** were not the highest rank in catastrophic, both were **joint second highest in catastrophic**.

SECTION G – WIDER IMPACTS ON CHANGE AND CONSIDERING MITIGATION

15. Impact on NHS Estates

JRC engaged with Liverpool and Knowsley Estates Implementation Manager to ascertain what the impact on community based buildings would be if practices closed. It is our understanding from this dialogue that if GP practices occupying the CHP (LIFT) and NHSPS estate move out of a space in either of these building types. the CCG or soon to be ICS, are required to underwrite the void costs. This would result in the costs associated with that space i.e., rent, maintenance and service charges etc becomes the responsibility of the CCG to pay the landlord.

An example of this was when Dr Rahman had their patient list dispersed at Whiston PCRC and the practice was dissolved which meant their demised space, which they had signed a sub-lease for, became void and the CCG paid £94,000 a year to the landlord as the space could not be filled.

Only GPs receive the funding from the Government not community providers, therefore if a community provider used the space they would have to pay this from their existing running costs which does not

make this an attractive proposition given the budgetary constraints public sector and third sector organisations are up against.

If only one practice then remained in the LIFT site, their lease would be void and the practice can legitimately walk away.

On a wider impact for communities, most of the communities where LIFT buildings are geographically sited, the levels of deprivation experienced is significant. Having one stop shop approach helps access, improves provision, and maintains quality buildings. The footfall through multiuse buildings encourages people to use other services on site, for example some are attached to community centres, welfare advice centres, libraries, children's centres. There is a possibility this could cause displacement to Local Authority and community funded spaces if the footfall drops, and the impact is transferred to other services providers.

In regard to community safety, once buildings become vacant it is exposed to vandalism, which in the past LIFT centres have experienced, e.g., Manor Farm had its windows smashed and other damage while it was vacant in construction.

16. Impacts on PCNs

PCNs have become a method of sharing best practice opportunities and the additional funded posts have been very positively received by practices.

In the updated GP Contract 2020/21 clearly states that each PCN will "use appropriate tools to identify and prioritise patients who would benefit from a Structured Medication Review. This loss of funding may potentially result in a loss of a Clinical Pharmacists which will prevent practices from meeting their contractual obligations under PCQP as per the following:

- Polypharmacy reviews - Knowsley CCG has the highest national percentage of patients prescribed 10 or more unique medications. Action is needed for patients who have developed inappropriate polypharmacy to ensure safety and reduce waste.
- Annual Medical Reviews - Knowsley CCG is the highest prescribers of antibiotics in the country.
- Quality and Safety – cold chain monitoring, medication review improvement plan, maintain 0% cost growth.
- De-prescribing of medication in line with Pan Mersey Prescribing recommendations. De-prescribing is essential and prescribing only continues in exceptional circumstances with documented evidence and support from relevant specialists.

17. Impacts on Workforce

Impacts on workforce have been projected by each practice (Aston counting as one respondent practice as it is one contract for all Aston practices and the MacMillan surgery opted out of assessment process). Total affected respondents are 17 and 100% of those practices have recorded their views on potential job loss, practice impacts.

2. As practices do not separate funding streams, but are aware of the total proposed income loss to your individual practice, please tick which posts in your practice would potentially be at risk of having their contractual hours reduced? This is a multiple choice question

Answer Choices		Response Percent	Response Total
1	GP	88.24%	15
2	Practice Manager	11.76%	2
3	Advanced Nurse Practitioner	47.06%	8
4	Practice Nurse	52.94%	9
5	Pharmacist	23.53%	4
6	Assistant Practitioner	0.00%	0
7	Health Care Assistant	35.29%	6
8	Practice Paramedic	0.00%	0
9	Physician Associate	11.76%	2
10	Data Manager	17.65%	3
11	Administrators	58.82%	10
12	Receptionist	70.59%	12
13	Other (please specify): Assistant Practice Manager	5.88%	1
		answered	17
		skipped	0

Comments: (7)

If our Income is drastically reduced then we will not be able to fund the current hours for patient appointments and Administration tasks.
We have already taken a decision to not fill a salaried doctor post which became vacant due to the potential threat of funding decrease
Receptionist/HCA is a joint role, this role would disappear. Reduced funding could also affect GP and ANP hours
A loss of administration time
All posts would be at risk, and we would have to assess how we could provide the service as safe as possible but with hugely restricted and limited resource
There will be significant reductions in staffing, and this would have to be analysed to understand which staff would actually be cut to ensure a limited service could be provided safely. Everybody's job will be at risk
The proposed funding of Aston healthcare is so significant that a large number of jobs will have to go. This is in order to make the contract anywhere near viable which is also questionable. This question has been answered on behalf of all Aston practices as it is one contract

3. As practices do not separate funding streams, but are aware of the total proposed income loss to your practice, please tick which clinical posts in your practice would potentially be lost completely? If more than 1 of same post is affected explain in comments box This is a multiple choice question

Answer Choices			Response Percent	Response Total
1	GP		64.71%	11
2	Full Time		11.76%	2
3	Part Time		41.18%	7
4	Practice Nurse		29.41%	5
5	Full Time		5.88%	1
6	Part Time		23.53%	4
7	Physician Associate		11.76%	2
8	Full Time		17.65%	3
9	Part Time		5.88%	1
10	Advanced Nurse Practitioner		41.18%	7
11	Full Time		29.41%	5
12	Part Time		11.76%	2
			answered	17
			skipped	0

Comments: (8)

We were intending to have a Full Time Advanced Nurse Practitioner but will need to adjust to Part- Time
The funding stream is used for these two clinical posts
Salaried Doctor
We have already taken a decision to not fill a salaried doctor post which became vacant due to the potential threat of funding decrease
Again, we would have to weigh up who will need to be reduced and the operational model would definitely mean losing GP time
There is no doubt that GP time would have to be reduced alongside all of the specialist Clinicians such as advanced nurse practitioners. The impact of this will be huge to this practice as it is within the most deprived Ward and Knowsley and requires clinicians who have a local knowledge and expertise of patient health and public health.
We will have to lose 1 Part time GP, I full time ANP and 1 full time Pharmacist
We have regular Locums following resignations of salaried GPs - we would have to lose the Locums

4. As practices do not separate funding streams, but are aware of the total proposed income loss to your practice, please tick which clinical posts in your practice would potentially be lost completely? If more than 1 of same post is affected explain in comments box This is a multiple choice question

	Answer Choices	Response Percent	Response Total
1	Pharmacist	23.53%	4
2	Full Time	17.65%	3
3	Part Time	5.88%	1
4	Health Care Assistant	41.18%	7
5	Full Time	5.88%	1
6	Part Time	11.76%	2
7	Practice Paramedic	0.00%	0
8	Full Time	0.00%	0
9	Part Time	0.00%	0
10	Practice Manager (clinical)	5.88%	1
11	Full Time	0.00%	0
12	Part Time	0.00%	0
13	Other (please specify):	35.29%	6
		answered	17
		skipped	0

Other (please specify): (6)

Admin staff

No clinicians

few hours

Comments: (1)

As described above, this role would be lost due to loss of funding

5. As practices do not separate funding streams, but are aware of the total proposed income loss to your practice, please tick which non-clinical posts in your practice would potentially be lost completely? If more than 1 of same post is affected explain in comments box This is a multiple choice question

	Answer Choices	Response Percent	Response Total
1	Practice Manager (non-clinical)	0.00%	0
2	Full Time	0.00%	0
3	Part Time	0.00%	0
4	Data Manager	17.65%	3
5	Full Time	0.00%	0
6	Part Time	17.65%	3
7	Administrators	41.18%	7

5. As practices do not separate funding streams, but are aware of the total proposed income loss to your practice, please tick which non-clinical posts in your practice would potentially be lost completely? If more than 1 of same post is affected explain in comments box This is a multiple choice question

8	Full Time		23.53%	4
9	Part Time		11.76%	2
10	Receptionist		64.71%	11
11	Full Time		29.41%	5
12	Part Time		23.53%	4
13	Other (please specify):		11.76%	2
			answered	17
			skipped	0

Other
No details recorded

Comments: (4)

Reduced Funding would mean reduced income to pay for Admin staff
Receptionist is a part time HCA so this joint role would be lost
The administrative workforce will have to be reduced to which would have significant impact on workflow which would bring about are massively reduced quality
none of the above

6. Could your practice continue at a reduced level if the funding was cut

Answer Choices			Response Percent	Response Total
1	Yes		29.41%	5
2	No		29.41%	5
3	Not Sure		41.18%	7
			answered	17
			skipped	0

Comments: (10)

We would have to review the circumstances after cuts implemented as I feel workload is actually going up despite Government rhetoric to reduce GP bureaucracy - I feel exhausted already and not sure if I would want to continue on if it is too stressful after cuts implemented - I am already very close to calling it a day.
Any funding reduction would mean less GP access
Yes but patient access and care would be negatively impacted
Yes but we would be unable to meet all of our contractual obligations and patient care would suffer greatly.
We have an increased workload and increased commitments; loss of HCA would affect workload and if GP hours reduced then the practice may be affected due to need GP cover at all times
A loss of admin would be manageable but would impact on quality of service and workflow
The service may be able to operate but it would have to operate at a very limited capacity both administrative and clinical.

6. Could your practice continue at a reduced level if the funding was cut

I have answered not sure here because we don't know if it would be feasible to run a practice within this particular demographic with such a reduction of funding and try and maintain call contract standards as well as providing good health care to the population

It is very doubtful that Aston healthcare could continue operating if the funding was reduced to this level. The only solution would be to reduce the number of branch surgeries however this would also be very difficult as each branch surgery as a long-term lease involved. This would have to be paid off by the NHS and this would take some negotiation. If the contract was to be discontinued then patients would have to be dispersed across Knowsley and this two practices that are already struggling and with also proposed cuts

My Practice is GMS. from the beginning the funding received is lot less compared to PMS plus practices. in 2015, there was a document to bring at the same level all practices in Knowsley over the period of 5 years. This did not happen!!!! Why? In addition, more funding is being taken away!!

7. Would your practice potentially have to close if the funding cuts are implemented?

Answer Choices		Response Percent	Response Total
1	Yes	35.29%	6
2	No	47.06%	8
3	Not Sure	17.65%	3
		answered	17
		skipped	0

Comments: (6)

I already feel demoralised from all the bad media about General Practice and the heavy handed media briefings by Government against GP and the excessive workload being bounced back from Hospital to General Practice and this proposed funding cut brings the idea of closing the surgery and retiring and working as a GP Locum a better option giving me more freedom and less responsibility.

Not significant enough

We will ensure the practice continues but the service provided will be limited and it will be a struggle to ensure patient safety and high quality outcomes. Compliance with CQC would also be difficult

I have answered yes to this question because the reduction in contract value is so significant that it almost makes the contract and unviable to continue

The answer to this is almost certain I yes

time will tell, pressure is increasing, more work is expected without remuneration.

It seems GPs have the sole responsibility for everything- referrals from hair dressers, beauticians, trichologists, SHOs, registrars, consultants, nurse consultants from secondary care..…… goes on and on!

8. Would your practice have to merge with other practices to continue to provide services?

Answer Choices		Response Percent	Response Total
1	Yes	17.65%	3
2	No	41.18%	7
3	Not Sure	41.18%	7

8. Would your practice have to merge with other practices to continue to provide services?

answered	17
skipped	0

Comments: (4)

- This is a very strong possibility
- Merging with other practices locally would not be an option as they too are proposed to have huge significant reductions
- Unfortunately, other local practices such as Dinas Lane are also having significant cuts and it is all relative against the size of the populations in both practices which means that merges will not be viable
- This would not be a viable option as other practices have not got the resource to take the number of patients into their practice and they are also undergoing cuts

9. On a scale of 1-5 (from very dissatisfied to very satisfied) how would you rate your satisfaction in regard to the quality of information provided by the CCG to inform practices of the proposed funding cuts. In the comments box briefly explain your ranking and where this could be improved.

Item	Total Score [1]	Overall Rank
Very dissatisfied	79	1
Dissatisfied	65	2
Neutral	46	3
Satisfied	42	4
Very satisfied	23	5
[1] Score is a weighted calculation. Items ranked first are valued higher than the following ranks, the score is a sum of all weighted rank counts.	answered	17
	skipped	0

Comments: (9)

- Neutral - I have been given figures by CCG about comparing our funding to other CCGs but these figures may not be accurate and disputed by GP Colleagues who have done own research and got different figures and so it is hard to say that I am satisfied with how the CCG has handled this.
- The information provided does not reflect the facts
- The quality and timing of the information provided by the CCG was very poor
- The CCG did not provide any detail prior to the meeting in July 2021. No details were provided at CMG level either. The cuts were a total surprise to practices. There has been no engagement from CCG even during the contractual term
- The CCG did not engage in any form or capacity with us as a practice. We were very surprised to hear of the proposed cuts in July 2022 and this brought around a lot of distress. The CCG also did not discuss or propose this at any formal meetings at CCG level
- The CCG did not engage in any way shape or form with this us as a practice and actually change their approach to the contract in that they have stated that additional monies should not have been paid historically which is untrue
- There was no engagement from the CCG and this proposed reduction came as a huge surprise to everybody across Knowsley
- There was very little if any engagement. It feels as though this is a 'fait accompli' and has been and is a budgetary exercise in its entirety. There has been NO consideration on the quality impact on the population. Absolutely NONE. The CCG chose to invest monies in primary care as the population served is amongst the most deprived in England. Practices have invested those monies in staff, from admin staff who are often local working people in Knowsley to developing their clinical work forces by employing additional GPs, ANPs, Nurse Practitioners and Pharmacists. Then when the CCG realised that it had to pass matters over to the ICS./ICB it has decided to cut the primary care budget by a massive amount in such a short period of time. It would be

9. On a scale of 1-5 (from very dissatisfied to very satisfied) how would you rate your satisfaction in regard to the quality of information provided by the CCG to inform practices of the proposed funding cuts. In the comments box briefly explain your ranking and where this could be improved.		
Item	**Total Score [1]**	**Overall Rank**
unfathomable to make such proportional budgetary cuts to other NHS providers, particularly acute trusts, community provides and MH trusts and expect them to survive. There has been no consideration on the quality impact or effect on health inequalities, and no engagement with the public on cutting the budget to GP practices. We wonder what the patients would feel if they knew that budget cuts would affect their ability to access their practices, or even knew that it may affect the viability of their practice. One would expect that such a programme or commissioning would have had both an engagement and communications programme, a quality impact assessment, a risk and issue log, but none of this has been done. It all about the money. In the times of Darzi, Knowsley was considered to be one of the most under doctored places in England because of high levels of deprivation, high workload, poor health outcomes. Knowsley was therefore given Fairness in Primary Care money for practices to employ more GPs. That's what we did. Those GPs are still employed. Has Knowsley all of a sudden become a non-deprived borough with much better health outcomes? I don't think so. The wider determinants of health and health inequality remains the same challenge. The workload and deprivation remain the same. Therefore, why would anyone want to take away Fairness money that employs? Are those GPs no longer needed? No. If this comes to pass, then staff, admin, managerial and clinical staff will inevitably be lost. Has anyone thought about how practices would make people redundant, where that money would come from, and if it was at all possible. The concern is the risk is that a significant number of older GPs will leave, retire early, or practices may close or hand back their contracts? What happens to the quality and continuity of care then? Do external other private providers come in to take over, and will Knowsley GP primary care end up in a Quality Surveillance Group meeting, or Risk Summit?		
I am completely dissatisfied as we do not know what funding is available most of the times!		

18 Assessment of Health Impact Assessment

The purpose of the summary of impacts is to inform rather than decide. The objective is not to determine the decision, but to assist decision makers by providing better information.

Key issues for consideration by commissioners raised within the impact assessment are briefly summarised.

18.1 Impacts of reduced funding - Workforce

All affected practices have would reduce:
11x GP[s (2 are full time posts)
6 x ANPs (5 are full time posts)
2 x Physician Associates
1 x Clinical Practice Manager
4 x Pharmacists (3 are full time posts)
5 x Practice Nurses (1 is full-time post)
7 x HCA's (1 full time post)
7 x Admin staff (4 are full time posts)
3 x Data Managers (part-time posts)
11 x Reception staff (5 are full time posts)

When asked if practices could continue at a reduced level if the funding proposed was cut, 5 practices stated they could, 5 stated they could not, and 7 remain unsure at this time.

- practices said they will face closure if the reductions go ahead as proposed, 6 practices said they may have to close, 8 practices can continue, however 3 are unsure.

- 3 practices state they may have to merge to continue to be a viable practice, 7 will continue independently, however 7 are unsure at this time, with one practice saying this is a strong possibility for them.

- Where clinicians leave posts they may not be replaced. It was expressed that these are important roles in the practice, e.g., one practice has said they potentially would lose a GP, Pharmacist, ANP, and nurse practitioner which would mean a reduction of 23% of their workforce.

18.2 Impacts of reduced funding – GP training programme

- All of the PMS practices are teaching practices and they have all confirmed this would need to cease if the reduced hours of GPs are a consequence of funding reductions. They will lose the income stream attached to teaching practices as well as the extra human resource F2 qualified doctors offer when training to become a GP. At a time, recruitment of GPs is a national issue, a local scheme has proven successful, with several trainee GPs remaining in the borough once qualified.

18.3 Impacts of reduced funding – Knowsley staff living in deprived communities

- Up to 90% of admin/non clinical staff (and some HCAs) are local residents living in deprived communities. It is within the ward data confirms that Huyton, Kirkby (except Shevington ward) have higher than Knowsley average (25.1) in regard to income deprivation. Whilst Halewood and Prescot are slightly lower than the Knowsley average they are higher than the national average so still within the deprivation comparison ranks.

18.4 Impacts of reduced funding – NHS Estates

- Knowsley has an excellent estate which means the cost of running those premises is higher. However, the need is greater in Knowsley than many of the Cheshire and Merseyside CCG localities, hence the level of deprivation. Should GPs move out of the sites, the CCG are responsible for providing care in communities, and earlier highlighted by the practices, GP recruitment is difficult. They only way existing practices can attract GPs is to pay a higher premium. If as a result of GPs handing back their contract, the CCG could potentially have to pay more to locum service providers to continue to provide healthcare in a deprived ward.

18.5 Impacts of reduced funding on Patients - Health inequality/equalities

NHS England's equalities and health inequalities statement which state "*promoting equality and addressing health inequalities are at the heart of NHS England's values*". Given the rate of deprivation and inequality the borough is challenged with in all localities, reducing service delivery will widen the inequality gap further.

- The services offered to communities that are already disadvantaged through multiple levels of deprivations (which in some areas of Huyton and Kirkby, has affected 4 generations). All public services have undergone significant austerity for many years, and this has contributed to widening the health inequalities that exist in Knowsley.

- Some examples which are evidenced in Public Health data are:
    - lower life expectancy for males and females of all ages,
    - increased mortality rates for all caused in respect of the under 75s,
    - increasing mortality rates for cancer in regard to the under 75s.
    - Increasing rates of CVD.
    - Intentional self-harm rates are increasing,
    - Increasing mental health problems since the onset of the pandemic.
    - Behavioural risk taking in regard to alcohol consumption, hospital admissions in relation to alcohol for all ages is significantly higher than regional and nationally. Smoking and rates of adult obesity are higher.
    - Child health, increasing rates of teenage pregnancy
    - Increasing rates of smoking in pregnancy
    - Low rates for breastfeeding initiation
    - Increasing year 6 obesity (incl severe obesity)

In considering the wider determinants of health and how this impacts on the location of the practices to be affected by funding, the Dahlgren-Whitehead Rainbow Model describes the layers of issues/circumstances that directly or indirectly affect our health and wellbeing including lifestyle, social and community networks, housing, unemployment, poverty and many more. In relation to how this pertains to the practices who may have their funding reduced. Those communities represent many of the wider determinants of ill health.

- 3 out of 6 Huyton locality wards have higher rates of IMD compared to the Knowsley average.
- All Huyton wards have higher level of income deprivation.
- 3 out of 4 Kirkby locality wards have higher rates of IMD compared to the Knowsley average.
- All except Shevington ward in Kirkby has higher levels of income deprivation.
- Halewood North and South are lower than the Knowsley average for income deprivation, however this is higher when compared to England rate.
- Halewood North and South are lower than the Knowsley average for income deprivation, however this is higher when compared to England rate.
- According to IDACI (2019) Huyton and Kirkby have the highest rates of children living in poverty.
- Halewood and Prescot are below Knowsley rates but nonetheless are higher than the national averages.
- The exceptions to this are 4 out of 15 wards, namely: Halewood North, Prescot North, Swanside and Roby that remain better than the national average.

- IDEOPI (2019) data puts older people's income deprivation in Huyton and Kirkby the highest in the borough, with the remaining wards still higher than the national average.
- There is a similar picture to the older people's deprivation rates in regard to households living in fuel poverty

Dahlgren G, Whitehead M. (1991). Policies and Strategies to Promote Social Equity in Health. Stockholm: Institute for the Futures Studies. https://esrc.ukri.org/about-us/50-years-of-esrc/50-achievements/the-dahlgren-whitehead-rainbow/

18.6 Impacts of reduced funding Patient Access

A key issue will be reduced access to services provided by GPs, nursing staff, pharmacy staff and the administration teams.

- As illustrated on page 19, a map of affected practices across Knowsley are closely clustered.
    - 6 practices out of 21 area surgeries (counting Aston as single surgeries demonstrate borough wide image) all experience higher levels of multiple deprivation.
    - Over 50% of practices affected are within the highest areas of multiple deprivation.
    - Of the clusters of practices, the Huyton and Kirkby wards would be the most impacted.

- A wider issue is the low levels of access to a car in Knowsley, meaning residents are more likely to need public transport or car sharing in order to work, shop, or provide care. The 2011 Census data shows that 37% of households in Knowsley did not have access to a car or van, this is higher than the England average of 26% and the North West average of 28%.
- The impact on communities would be considerable given the clusters of practices affected in particular areas, and the potential for patients, vulnerable adults, children, and Care Homes being unable to register locally as the closest services are within the same vicinity are also running at a reduced level, or in some cases have closed their registration lists.
- Often carers go unnoticed as key partners in care and accessing additional support is essential for their wellbeing. Many carers are looking after relatives with long term health conditions, disabilities, and therefore primary care services when treating patients also consider the needs and views of carers in planning.
- Face to face appointments will be reduced and some of the most vulnerable people will be affected. For example, homeless people would be affected as some use a local address, but practices are aware they do not reside at the address but use it for post, etc.
- Regarding care homes, locally care homes are supported and whilst for many this will be retained, the care home patients will have less staff to attend care homes, attend MDTs thereby extending waiting times to groups of highly vulnerable elderly patients.
- Learning disability patient appointments usually take an hour and the capacity of nurse practitioners and GPs would be limited and not able to offer the quality provision that is currently in place.
- Practices have stated they will need to restrict their time and focus on the key priority areas for the patient.
- A reduction in GP access in an area that remains "under doctored" will increase health inequalities which impacts:-
    - Life expectancy
    - Access to care and availability of treatments
    - Quality and experience of care (only having limited time with patients)
    - Patient safety
    - Wider determinants of health

18.7 Impacts of reduced funding – Patient Safety

Practices have evidenced they will need to reduce access to services to ensure the capacity of staff can deliver safe quality care to the patients. Practices will need to have the correct level of relevant qualitied staff to deliver safe, quality services. If all of the practice as predicted cut those roles, (some full time posts, some part time posts) the service would potentially have to cease. At the very least it

will reduce the range of services available to communities in the most need of access to healthcare, which is borne out in the data provided within Knowsley Public Health profiles.

18.8 Impact on Reputation/Patient Experience

National and local news and media suggest that access to services and a GP appointment are already difficult. Cutting funding that will affect the number of clinicians at the practice which will have a negative impact on patient experience. Ultimately, it will be the patients that suffer. Patients want access to good quality care and expectations of patients is increasing. Delays in accessing a service may result in something being missed and patients fall through the net by not being seen. Overall, if practices reduce the access it will reduce the quality, affect reputations, and impact experience.

18.9 Measuring Risk and Impact

The full breakdown of responses from practices describes the finer details of risk. In summary The highest ranked impact resulted in 74 responses stating a range of domains that would rank Catastrophic

- The highest ranked impact is **safety of patients, staff or public** which is considered **Catastrophic**
- Second highest ranked impact is adverse publicity and reputation which is considered **Major**
- Third highest ranked impact is **finance, including claims** which is considered as **Beyond Catastrophic**
- Fourth highest ranked impact is **statutory duties and inspections** (CQC) which is considered as **Moderate**
- Lowest ranked impact is **Service/business interruption Environmental Impact** which is considered **Minor**

NB Whilst both **business objectives and quality/audit and complaints** were not the highest rank in catastrophic, both were **joint second highest in catastrophic**.

18.10 Planning a sustainable future for Knowsley

- Knowsley has a population of 149,571 people, and projections show that Knowsley's overall population will continue to grow.
- Knowsley's working age population is projected to decline by 2030.
- International migration has grown over the last 10-years.
- The numbers of births per year in Knowsley has increased over the last five years, against national trends.
- In 2017, Knowsley had the third highest rate of legal abortions in England and Wales.
- Knowsley has one of the highest rates of preventable deaths in England.
- Life Expectancy in Knowsley lags behind national average.
- Healthy life expectancy has risen at a lower rate, so more years are spent in ill-health.
- Knowsley is less ethnically diverse than England.
- Average earnings in Knowsley shows greater disparity both within the borough and outside

18.11 Assessing the Impact

The impact of service changes in response to reduced funding for each of the equality groups listed below

	What evidence have you considered?	
Protected Characteristics	**Age**	Practices provide services for all ages groups and the evidence of impact on a range of ages has been consider by working with Knowsley Director for Public Health and Knowsley Council. Key reports are • Knowsley 2030 Evidence Based Data • Public Health Annual Report 2021 • NHS Digital Date 2021 • Public Health (fingertips data) 2019 • Ward data 2019 • Public Health Profiles 2018 • Census data 2011 There are 23 initiatives funded by PMS income. All affected practices have reported they will need to reduce amount of time delivering PMS services (most of these are provided by clinical team members (not GPs). Therefore, given the range of clinics, medication reviews, assessments. vaccinations, safeguarding/ this given the range of services. Knowsley population health in summary 2019 details on page 16 the key issues Knowsley residents experience. All of those age groups will be affected. **Health inequalities** Life expectancy is 11.4 years lower for men and 12.6 years lower for women in the most deprived areas of Knowsley than in the least deprived areas. **Child health** In Year 6, 26.9% (458) of children are classified as obese, worse than the average for England. The rate for alcohol-specific hospital admissions among those under 18 is (45), worse than the average for England. This represents 15 admissions per year. Levels of teenage pregnancy, GCSE attainment (average attainment 8 score), breastfeeding and smoking in pregnancy are worse than the England average. GPs have expressed concerns on safeguarding/child welfare if limited access to primary care is as outcome of funding cuts. This is time consuming and necessary to support infants, children and young people. Increasing numbers of children experiencing mental health problems. Given the rise in this the first port of call for a referral is to general practice. If access is restricted young people will be negatively impacted because families cannot self-refer for counselling/CAMHS support. As a result of funding cuts, practices have stated they will lose nursing staff, which would have a large impact on child health and child immunisations, influenza vaccinations, pneumococcal vaccines, sexual health service and our learning disabilities service.

		Adult health The rate for alcohol-related harm hospital admissions is 940, worse than the average for England. This represents 1,346 admissions per year. The rate for self-harm hospital admissions is 347, worse than the average for England. This represents 505 admissions per year. Estimated levels of excess weight in adults (aged 18+) and smoking prevalence in adults (aged 18+) are worse than the England average. The rate of new cases of tuberculosis is better than the England average. The rate of hip fractures in older people (aged 65+) is worse than the England average. The rate of statutory homelessness is better than the England average. Higher rates of violent crime (hospital admissions for violence) including sexual violence. Under 75's mortality rate from cardiovascular diseases, under 75 mortality rate from cancer and employment (aged 16-64) are worse than the England average. **Older People** as detailed in page 30 Loss of GPs, nursing and pharmacy staff treating the most vulnerable patients, e.g., chronic disease management, complex care patients, will be reduced and the exacerbation of conditions may increase hospital admissions at a time acute services are overwhelmed with winter pressures, and pandemic operational management, increased waiting lists etc. In regard to vulnerable groups, most practices provide support local care homes, several of whom have a large number of elderly vulnerable residents. Attending weekly MDT meetings, medication reviews, reactive appointments are all time consuming, but an essential element of community based care. If the clinical staff (GPs, pharmacists) are reduced the level of service cannot be sustained. This for some care homes will pose a significant impact if they are unable to register their residents with another neighbouring practice. **Managing Covid 19** Stated within the 2021 Knowsley Public Health report, it states that there is a high proportion of people aged over 60 in Knowsley and evidence has shown that; over 60s, those with underlying health conditions and residents of care homes are more likely to be hospitalised or die as a result of COVID. This group of the population are more likely to have been affected by the direct effects of COVID-19 in terms of disease and death. The long term health impacts of the pandemic are not fully known, however, Knowsley Public Health Annual Report "Understanding the Impact of Covid 19, Planning and Recovery", October 2021 outlined that the largest risk factor with COVID-19 was age; among people already diagnosed with COVID-19, people who were 80 or older were seventy times more likely to die than those under 40. This disparity existed even after taking ethnicity, deprivation, and region into account, but did not account for the effect of co-existing health conditions, which may explain some of the difference. In Knowsley, approximately 28% of the older population (people aged 65+) are aged 80 and over, which is higher than the England average (27%) and have a high level of co-existing health conditions. The risk of dying among those diagnosed with COVID-19 was also higher in males than females.
	Disability	As detailed on page 30, a reduction in funding will impact on all ages, gender, race and ethnicity and ability/disability of patients. Knowsley is an already "under doctored" compared to other

		neighbouring areas (according to NHS digital data) and the reduction in funding will result in potential losses to clinical staff which will create further health inequalities affecting a range of patients across Knowsley. A reduction in clinical staff will result in a reduction in appointments offered and patients seen. A reduction in GP access in an area that "under doctored" will increase health inequalities which impacts:- ○ Life expectancy ○ Access to care and availability of treatments ○ Quality and experience of care (only having limited time with patients) ○ Patient safety ○ Wider determinants of health Restricted access to services will significantly impact disabled patients who have restricted mobility, mental health issues, physical, sensory impairments. As a result of funding cuts, practices have stated they will lose nursing staff, which would have a large impact on supporting learning disabilities service. Patients build trust with their care providers and if they need to move practices due to restricted access. This may involve travelling further. Knowsley has a low rate of car ownership and extended travel will negatively impacted people with limited mobility and income. Reducing appointments will mean having less time with clinicians will affect their overall patient experience. Lack of local practices with open lists will restrict access to primary care.
	Gender reassignment	Across the country, Trans[1] people generally experience poorer healthcare than the wider population, which can mean significant risks to their health and wellbeing. Many health professionals don't have the relevant skills or understanding to achieve the best access and outcomes for Trans patients. The usual pathway for assessment and diagnosis for Trans people is via a referral to a Gender Identity Clinic (GIC) by their GP. There are 7 GIC's in England. As there isn't any provision in the Northwest patients tend to ask to be referred to Leeds or Northampton. Due to the excessive wait for first appointment at a GIC patients often seek hormone treatments from the internet which puts them at serious risk. For example, a study in 2014 found 1 in 4 Trans women self-prescribing cross-sex hormones of which 70% were sourced from the internet. In order to improve patient care Sefton CCG worked with patients and health professionals to design an innovative primary care-based service. During the development of the Sefton Service a group called the Cheshire & Merseyside Gender Identity Collaborative (CMAGIC) was developed. CMAGIC is a multifaceted collaboration between commissioners, patient representatives, clinicians including GPs, and an endocrinologist who have been working together for many years to develop a unique holistic service that will provide additional patient support. Knowsley is fortunate in its primary care provision compared to other areas. Two practices are leads for

[1] The word Trans is an umbrella term to describe people whose gender is not the same as, or does not sit comfortably with, the gender they were assigned at birth. Trans people may describe themselves using one or more of a wide variety of terms.

		transgender healthcare and have in house expertise in supporting patients wishing to attend GIC clinics. If practices provide this service and overall access is reduced there would be very limited alternative experienced GP practices to re-register with and as a result could delay their referral to CMAGIC or GIC clinical services. [1] The word Trans is an umbrella term to describe people whose gender is not the same as, or does not sit comfortably with, the gender they were assigned at birth. Trans people may describe themselves using one or more of a wide variety of terms.
	Marriage and civil partnership	NA
	Pregnancy and maternity	Within Public Health England fingertips data (2019) the Knowsley birth rates have continued to for the past five years. It also has a high rate of teenage conceptions and a high rate of women smoking during pregnancy. Postnatally, the breastfeeding initiation rates are much lower than the national average. Some practices off parent and child sessions as well as support antenatal care. where the issues above can be discussed and supported. If funding is reduced pregnant women will be negatively impacted. The outcome could be additional travel to maternity hospitals to receive ante-natal care. If travel and transport (due to low income) is a barrier people may miss appointments which could be detrimental to their care and their unborn child. Reduced hours may restrict working parents, people who work part time and have childcare responsibilities. At present the majority of affected practices offer extended hours because they have larger staff teams employed.
	Race	Knowsley is not as ethnically diverse as other parts of the country with a low proportion of BAME population groups. However, locally understanding the increased risks and widening of health inequalities for such population groups remains an important consideration. Knowsley's BAME population is relatively small, however the borough has seen an increase in refugees from different parts of the world who cannot speak English. This has resulted in increased use of translation services, and staff having the ability to interact with people from different cultures and respond to their health needs. Health Education England states: Cultural competence is a key aspect of providing both quality and safe care. This is why health professionals need to be aware and gain understanding of the key issues relating to culture and how this may influence the uptake of health care and treatment options. Developing this knowledge and understanding will influence the way we give care and could have an impact on reducing disparities in health care outcomes. Knowsley 2030 evidence based report expects those numbers to increase and therefore the borough needs to consider the expansion of services to meet the demands of new patients requiring translation, chaperones,
	Religion or belief	Knowsley's teenage pregnancy rates are higher than the national average and this has been an ongoing challenge for over 20 years. Contraception not promoted in catholic faith based schools and therefore the reliance is on the young person to seek this out independently. Accessing local delivered services from the GP surgery enables young people who are Gillet competent to make those choices. The new migration of refugees, many whose religious beliefs guide their choices in life need sensitive understanding trained staff to support those choices and be sure the patient understands the options open to them.

	Health Education England states: Cultural competence is a key aspect of providing both quality and safe care. This is why health professionals need to be aware and gain understanding of the key issues relating to culture and how this may influence the uptake of health care and treatment options.
Sex or gender	Life expectancy is 11.4 years lower for men and 12.6 years lower for women in the most deprived areas of Knowsley than in the least deprived areas. Knowsley GPs have stated that a reduction in GP access in an area that "under doctored" will increase health inequalities which impacts:- ○ Life expectancy ○ Access to care and availability of treatments ○ Quality and experience of care (only having limited time with patients) ○ Patient safety ○ Wider determinants of health Stated within the 2021 Knowsley Public Health report, it states that there is a high proportion of people aged over 60 in Knowsley and evidence has shown that; over 60s, those with underlying health conditions and residents of care homes are more likely to be hospitalised or die as a result of COVID-This group of the population are more likely to have been affected by the direct effects of COVID-19 in terms of disease and death. The Mental Health Foundation evidence reports that In England, around one in eight men has a common mental health problem such as depression, anxiety, panic disorder or obsessive-compulsive disorder (OCD). The long term health impacts of the pandemic are not fully known, however, Knowsley Public Health Annual Report "Understanding the Impact of Covid 19, Planning and Recovery", October 2021 outlined that the largest risk factor with COVID-19 was age; among people already diagnosed with COVID-19, people who were 80 or older were seventy times more likely to die than those under 40. This disparity existed even after taking ethnicity, deprivation, and region into account, but did not account for the effect of co-existing health conditions, which may explain some of the difference. In Knowsley, approximately 28% of the older population (people aged 65+) are aged 80 and over, which is higher than the England average (27%) and have a high level of co-existing health conditions. The risk of dying among those diagnosed with COVID-19 was also higher in males than females. The PMS funds support a range of clinics, audits, and targeted searches to call patients proactively for clinical reviews, health checks, management of chronic disease clinics etc., these services are mixed gender. The loss of GPs, nursing and pharmacy staff treating the most vulnerable patients, e.g., chronic disease management, complex care patients, will be reduced and the exacerbation of conditions may increase hospital admissions at a time acute services are overwhelmed with winter pressures, and pandemic operational management, increased waiting lists etc.
Sexual orientation	2017 National LGBT survey The NIESR evidence base points to LGBT people being more dissatisfied with health services in comparison to those who are not LGBT. This can include lack of knowledge among medical staff about the health needs of LGBT people, specific concerns with mental and sexual health services and, among transgender

		people, concerns with the gender identity services provided by the NHS. at least 16% of survey respondents who accessed or tried to access public health services had a negative experience because of their sexual orientation, and at least 38% had a negative experience because of their gender identity. 51% of survey respondents who accessed or tried to access mental health services said they had to wait too long, 27% were worried, anxious or embarrassed about going and 16% said their GP was not supportive. 80% of trans respondents who accessed or tried to access gender identity clinics said it was not easy, with long waiting times the most common barrier. Higher prevalence of mental health issues amongst LGBT people than the general population in the UK. Hate crimes against LGBT+ people have risen over 25 percent compared to figures recorded last year, according to data from Merseyside Police. Figures show that from April 2020 to this March hate crimes against LGBT+ people were higher than in the previous 12 months. Cheshire and Merseyside Partnership are encouraging all CCGs to take up the Navaho Charter Mark where each organisation is assessed and if successful will receive a Navajo Merseyside endorsed accreditation with Kite Mark, indicating that your organisation is in line with statutory requirements and promotes best practice in engaging with the LGBTIQA+ community
Health inclusion groups	**Alcohol and / or drug misusers**	Behavioural risk taking in regard to alcohol consumption, hospital admissions in relation to alcohol for all ages is significantly higher in Knowsley than regional and national rates. The 2019 JSNA on Drug use and Disorder outlined that Drug use disorder is a complex issue and has a major impact on the health and wellbeing of individuals, families, and communities. Those affected by drugs use them compulsively and the effects of substance misuse are cumulative, significantly contributing to poor health, homelessness, family breakdown and offending. Drug dependence varies from substance to substance, and from individual to individual. Dose, frequency, the pharmacokinetics of a particular substance, route of administration, and time are critical factors for developing drug dependence. In 2016/17, the proportion of all opiate users in treatment in Knowsley who had successfully completed treatment and did not return within 6 months was 5.6%, which is lower than England (6.7%). In comparison, the proportion of all non-opiate users in treatment in Knowsley who had successfully completed treatment and did not return within 6 months was 41.5%, which is higher than the national figure of 37.1%. Cannabis was the substance most commonly used by young people in specialist substance misuse services in Knowsley during 2016/17, with 92% doing so (88% nationally). Alcohol was

		the next most commonly used substance (5% compared to 49% nationally) with 3% of young people accessing drug use disorder services in Knowsley using stimulants (ecstasy, cocaine, amphetamines), compared to 11% nationally citing problematic ecstasy use, 9% citing problematic cocaine use and 3% citing problematic amphetamine use.
	Asylum seekers and /or refugees	Knowsley has seen a high percentage of European patients and Kurdish, Polish, Hungarian and Syrian and a lot of their issues they have they need a face to face to face appointment and therefore with an interpreter However, many practices report the demand for translators is high and this affects waiting times for this patient group. In addition, the length of time for those patient is longer and has to be considered if practices are reducing access to services. An outcome of this will be this patient group will be further disadvantaged.
	Carers	In the Knowsley Carers Strategy 2020-2025 highlights that there are 18,000 people identify as being an unpaid carer, providing more than one hour's care per week. However, it is likely this number is much larger as many people providing care do not recognise themselves as a carer, because it so easily becomes part of their daily routine, and because this data is now almost a decade old. "Also, we know that across the country, the COVID-19 pandemic in 2020 led to an increase in the number of people providing unpaid care, so it is likely that this is also the case in Knowsley. We recognise that COVID-19 has impacted everyone, to greater or lesser extents, and carers are no exception". "Caring responsibilities can affect their access to employment and educational opportunities, their health and wellbeing, their relationships with others and it can limit the time that they have to spend on the other things that they want to do. The number of carers in Knowsley and their needs are likely to change dramatically over the next ten years and beyond, especially in the aftermath of the coronavirus pandemic as the long-term effects continue to emerge. In line with the national picture, population changes will mean that there will be an increasing number of people that will require support from an unpaid carer in Knowsley. In addition to this, it is anticipated that there will be a more intense role required of carers due the fact that people are living for longer and with more complex needs. It is therefore vital that carer's needs are supported now and, in the future, so that they can live happy, healthy and fulfilled lives whilst carrying out their caring role".
	Ex-service personnel / veterans	Many practices do not segment patient details but have stated that have small number of veterans registered. This is mix of WW2 and more recent military veterans. They did not report any significant details of ill health. However, it is widely evidenced the impact on veterans with PTSD, homelessness, substance misuse. It could be the patients that are registered with those practice could fall under any/all of those categories.
	Homeless people and rough sleepers **Gypsies Roma and travellers**	The rate of statutory homelessness is better than the England average, however it should be noted that sometime homeless people provide practices with an address (which they don't live at) but use for postal deliveries. In addition, there are adults and young people who are "sofa surfers) which distorts the total amount of people who are homes. Currently there are no sites in Knowsley for Gypsie, Roma and travellers.
	Those living with mental health issues	Local activity data suggests that in Knowsley, 3,737 people (per 100,000 population) had contact with mental health services in

comparison to the England rate of 2,176 people per 100,000 population. This includes the number of people admitted to NHS funded adult specialist mental health services, regardless of a formal diagnosis. It also includes use of community as well as hospital based services and it can be compared with the levels of health and illness for a CCG to see whether the use of services is relatively high or low, given the recorded prevalence of mental illness.

According to the Public Health Community Mental Health Profile Knowsley also has a significantly higher number of attendances at A&E for a psychiatric disorder per 100,000 population than the rest of England (603.0 per 100,000 compared to 243.5 in England) and a higher number of bed days used in secondary mental health care hospitals than the rest of England (4,974 days per 100,000 population compared to 4,686 in the rest of England). https://knowsleyknowledge.org.uk/wp-content/uploads/2015/06/Adult-Mental-Health-and-Wellbeing-Final.pdf

In 2012/13 a National Wellbeing Survey was undertaken and in the 2017 JSNA for Adult Mental Health and Wellbeing it stated.

The proportion of people from Knowsley reporting that they had low levels of satisfaction with their life in 2013/14 was 7.2%. This was an improvement from the 10.1% and 9.2% observed in 2012/13 and 2011/12 respectively. The proportion of people reporting low satisfaction with their lives in Knowsley was higher than England (5.6%) and the North West Region (7.0%) but was the 2nd lowest in the Liverpool City Region. Almost three-quarters (72.9%) of people in Knowsley reported that they had high or very high levels of satisfaction with their lives in 2013/14.

This more recent data therefore suggests that self-reported perceptions of wellbeing in Knowsley are much higher than the figures recorded from the WENWEB score undertaken the year before.

The prevalence of dementia, depression, learning disabilities and specific mental health conditions can be derived from the number of adult (18+) patients on GP registers for these specific conditions. Some of the key data for these conditions shows that:

The prevalence of specific mental health conditions (including schizophrenia, bipolar affective disorder and other psychoses) (0.9%), dementia (0.7%) and learning disabilities (0.7%) on GP registers,

People with a Low Satisfaction Score, 2013/14 Source: Integrated Household Survey, Knowsley were all below 1% in 2013/14, however the prevalence of depression is significantly higher at 8.7%.

Knowsley had a higher prevalence of depression compared to the North West region (7.4%) and England (6.5%) in 2013/14.

Knowsley had a higher prevalence of learning disabilities (0.7%) than the North West region (0.5%) and England (0.5%) in 2013/14.

		The prevalence of dementia and mental health in Knowsley during 2013/14 were similar to the North West region and England. More data can be found in in Knowsley Public Health Statistical Compendium 2014/15 http://www.knowsley.gov.uk/pdf/publich-health-statistical-compendium-2014-15.pdf Figure 2
	Trans people or other members of the non-binary community	Across the country, Trans[2] people generally experience poorer healthcare than the wider population, which can mean significant risks to their health and wellbeing. Many health professionals don't have the relevant skills or understanding to achieve the best access and outcomes for Trans patients. The usual pathway for assessment and diagnosis for Trans people is via a referral to a Gender Identity Clinic (GIC) by their GP. There are 7 GIC's in England. As there isn't any provision in the Northwest patients tend to ask to be referred to Leeds or Northampton. Due to the excessive wait for first appointment at a GIC patients often seek hormone treatments from the internet which puts them at serious risk. For example, a study in 2014 found 1 in 4 Trans women self-prescribing cross-sex hormones of which 70% were sourced from the internet. In order to improve patient care Sefton CCG worked with patients and health professionals to design an innovative primary care-based service. During the development of the Sefton Service a group called the Cheshire & Merseyside Gender Identity Collaborative (CMAGIC) was developed. CMAGIC is a multifaceted collaboration between commissioners, patient representatives, clinicians including GPs, and an endocrinologist who have been working together for many years to develop a unique holistic service that will provide additional patient support. Knowsley is fortunate in its primary care provision compared to other areas. Two practices are leads for transgender healthcare and have in house expertise in supporting patients wishing to attend GIC clinics. If practices provide this service and overall access is reduced there would be very limited alternative experienced GP practices to re-register with and as a result could delay their referral to CMAGIC or GIC clinical services. Cheshire and Merseyside Partnership are encouraging all CCGs to take up the Navaho Charter Mark where each organisation is assessed and if successful will receive a Navajo Merseyside endorsed accreditation with Kite Mark, indicating that your organisation is in line with statutory requirements and promotes best practice in engaging with the LGBTIQA+ community

SECTION I - NEXT STEPS

[2] The word Trans is an umbrella term to describe people whose gender is not the same as, or does not sit comfortably with, the gender they were assigned at birth. Trans people may describe themselves using one or more of a wide variety of terms.

19. Engagement and involvement

How JRC engaged stakeholders in gathering evidence or testing the evidence available?	GPs, staff and commissioner, equality colleagues from the CCG have met virtually via teams meeting, attendance at practices. All of the engagement has been logged. Should the CCG choose to implement the funding cuts they will need to consider the scale of change and whether this is an engagement activity or a formal public consultation. This may also include consulting with Knowsley Health and Care Scrutiny Committee.
How JRC engaged stakeholders in testing the policy or service proposals?	The impact of change at this time is unknown, however if the commissioner progresses to reduce funding immediately they will be required to engage with patients and the public as part of their statutory duty in 2012 Health and Social Care Act, Section 14z2. CCGs will also need to update Knowsley OSC on the findings of the impact assessment and the next steps the commissioner will take.
For each engagement activity, those involved, how and when	All engagement was recorded on assessment sheets and signed off by the practices as an accurate record. Online surveys were in place for practices to respond to. All practices were supported to complete consequence and likelihood risk matrix and submit them for recording.

20. Public Sector Equality Duty (PSED) and summary analysis (presenting GP feedback and EIA to Knowsley CCG to consider who are responsible for meeting the PSED)

Public Sector Equality Duty aims	**Can this work contribute to eliminating discrimination, harassment or victimisation?**	Yes	No	Do not know
		Please explain:		
	Can this work contribute to advancing equality of opportunity?	Yes	No	Do not know
		Please explain:		
	Can this work contribute to fostering good relations between groups?	Yes	No	Do not know
		Please explain:		
Reducing health inequalities	**Can this work contribute to reducing inequalities in access to health services?**	Yes	No	Do not know
		If yes which groups should benefit and how and/or might any group lose out?		
	Can this work contribute to reducing inequalities in health outcomes?	Yes	No	Do not know
		If yes which groups should benefit and how and/or might any group lose out?		

21. Overall Impact

What is the overall impact? *Consider whether there are different levels of access experienced, needs or experiences, whether there are barriers to engagement, are there regional variations and what is the combined impact?*
It has been clearly demonstrated where inequality exists, ward to ward, ward to borough, and borough to region, and region to national. Knowsley is the second most deprived in the country and has increasing high demand for services. The practices have high rates of patients with complex health needs and need regular longer appointments, many patient live with long term conditions and need regular health and medication checks which cannot fit into a 10 minute slot. Patients with learning disability require an hour's appointment to ensure communication and engagement is clear and understood. Patients' who are frail and the growing elderly population living alone are vulnerable as well as those residing in nursing homes. All of these patients take time to treat in a

community settings and reducing the capacity of GPs to deliver this level of time will seriously affect the quality of care provided.

There are also issues of children, many live in broken homes, are looked after children, in receipt of CAMHS, are not attending education and there are issues of safeguarding, child welfare that need discussing at MDT meetings, which again is additional time on GPs.

The range of staff in the practice providing healthcare allows GPs to manage to meet the external needs of complex patients, attending MDTs etc., but if they are reduced in hours/posts those services will be lost and not covered. GPs will have to prioritise what can and cannot be delivered in a reduced workforce still trying to manage care in deprived communities.

There as been the ongoing pressure of managing Covid vaccinations, and in December 2021 the Government announced that primary care must focus and prioritise dealing with another strain of Covid vaccinations, boosters, etc. All of this is putting even more pressure on primary care services. Patients will revert back to lockdown conditions in regard to accessing face to face appointments, many will go untreated and could be serious to their long term health. All of this will need to be revisited once the vaccination priority targets are met. If practices lose staff due to funding reductions at this time, when under immense pressure, GPs have described this as having a "catastrophic" effect on patient safety, access, and quality.

Practices are collectively worried about the impacts on each other should one have to close who would be in a position to take on those patients. Many patients if they cannot access GPs will attend A&E, urgent care centres for conditions that should be treated in primary care settings. All of this increases the cost to the NHS. It is felt this reduction will solve a finance balance shift but move the finance balance to another part of the system which does not make a good use of public money.

Healthwatch has monitored access to primary care, and they are ranking 4.4 stars, which is rated as good/excellent. All individual ratings for these services are between 4.5—5 stars. Within this reporting period, the most commented theme in relation to primary care, has been treatment and care, with 95% positive comments. The majority of the themes are positive, though it does highlight some concerns regarding access to services, communication, administration, medication, diagnosis/assessment, and referrals. All of these concerns will be further impacted should service delivery be reduced.

There has been no patient or public engagement in relation to this proposal and should this proceed commissioners are strongly advised to undertake this action or they are at risk of being taken to court for a Judicial Review in regard to equality, legitimate expectations, given the CCG has publicly stated they will put patients are the heart of decision making.

Another risk will be down grading of practices following CQC inspection. Many practices reported audits, searches, etc. would be reduced as a result of capacity restraints. Patients who have a poor patient experience will increase complaints. Both of these areas are scored during the inspection. Many practices have worked very hard to retain "good" CQC scores (some were in classed as needs improvement, special measures). However, all the practices affected are ranked as "good" and wish to continue to improve.

The assumption is that the funding needs to be cut to align budgets with neighbouring CCGs. Knowsley practices felt this was not planned in advance, no warning was in place so they could redesign how they deliver services, and many have employed staff on the strength of the funding.

It is widely acknowledged that there is a financial envelope to be met, however this needs to be collaboratively agreed on how best this could be achieved, within what timescale, and allow practices to adapt over time. This would reduce the risk of destabilizing primary care services in areas that are in poverty, have more complex health needs, poor health outcomes and increasing pressures due to austerity, pandemic impacts on mental health.

22. Actions for improvement

In the grid below, detail the *key actions based on any gaps, challenges and opportunities you have identified. Include any general actions to address specific equality issues and data gaps that need to be addressed through consultation or further research.*

This is a suggested template for your action plan. You may wish to adapt the suggested categories in column 1 to reflect the types of actions most suited to your policy, service or strategy

Category	Action	By when	By whom
Involvement, engagement or formal consultation	Should the funding be removed statutory duty will apply and patient and public engagement will be required	Prior to decision being formally taken	Knowsley CCG / Cheshire and Merseyside ISC
Data collection and evidence	Using the evidenced data contained in the impact assessment to inform an issues paper which will explain the reason for reduction in funding and potential negative and positive impacts. It will need to share where patients can influence the decisions and where this is not possible and why.	Prior to public engagement	Knowsley CCG / Cheshire and Merseyside ISC
Assessment and analysis	Feedback from engagement should ideally be independently analysed, however at this level it is not statutorily required. If this change is considered a substantial variation in service delivery, CCGs are required to commission an independent party to lead a public consultation and analyse the results.	Prior to final decisions be made	Knowsley CCG / Cheshire and Merseyside ISC
Partnership working	Commissioners need to continue to engage with Knowsley Council health and care scrutiny committee on the key findings of the impact assessment as well as how they propose to proceed with decision making. Work with GP providers to agree the approach for patient and stakeholder engagement if required	As part of planning to support a collaborative approach and the facts to be shared are mutually agreed	Knowsley CCG / Cheshire and Merseyside ISC
Monitoring, evaluating and reviewing the policy, service or strategy (including any outcomes)	Should the outcome mean a phased approach to funding reductions, sufficient time should be built in to the phasing to allow providers the time to adjust and for patients to experiences limited disruption to services being delivered.	Commissioners need to consider the timing of funding reductions and if this can be phased to reduce the risk of destabilising primary care	Knowsley CCG / Cheshire and Merseyside ISC

APPENDIX 1

Legal and Statutory Duties

Section 14Z2(1) of the 2006 Act provides:
"The clinical commission group must make arrangements to secure that individuals to whom the services are being made or may be provided are involved (whether by being consulted or provided with information or in other ways) –

(a) in the planning of the commission arrangements by the group,
(b) in the development and ***consideration of proposals by the group for changes in the commissioning arrangements where the implementation of the proposals would have an impact on the manner in which the services are delivered to the individuals or the range of health services available to them****, and*
(c) in decision of the group affecting the operation of the commissioning arrangements where the implementation of the decisions would (if made) have such an impact."

In September 2013, NHS England exercised its powers in section 14Z2(4) by publishing Guidance for CCGs about patient and public involvement. This Guidance confirms that:

"*Public, patient and carer voices are at the centre of our healthcare services, from planning to delivery. Every level of our commissioning system will be informed by insightful methods of listening to those who care about our services."*

It also requires the CCG:
"*To listen and act upon patient feedback at all stages of the commissioning cycle – from needs assessment to contract management*…"

NHS
Cheshire and Merseyside

Committee Report

Cheshire and Merseyside ICB
System Primary Care Meeting

Date: 25th August 2022

Cheshire and Merseyside ICB
System Primary Care Committee

NHS Cheshire and Merseyside

Date of meeting:	25th August 2022
Agenda Item No:	PCC/8/22/11
Report title:	Hope Farm Practice – List Closure
Report Author & Contact Details:	Rachael Ullmer rachael.ullmer@nhs.net Chris Leese c.leese@nhs.net
Report approved by:	Clare Watson, Assistant Chief Executive

Purpose and any action required	**Decision/ Approve** →	√	**Discussion/ Gain feedback** →		**Assurance** →		**Information/ To Note** →	

Route to this meeting / Committee/Advisory Group previously presented to (if applicable)

Executive Summary and key points for discussion

The Committee are asked to ;

- ***Consider and discuss*** the application received
- ***Consider and discuss*** the accompanying information from Practices/LMC and Guidance
- ***Make a decision*** in respect of the application to close the list

The Primary Care (General Practice) Commissioning Committee must make a decision to either approve the Application and determine the date the closure is to take effect and the date the list of patients is to reopen; or to reject the application.

In this respect the Committee is asked to support the decision made by West Cheshire Place outlined in Section 3 to agree the list closure application for a period of 4 months.

Recommendation/ Action needed:	**The Committee is asked to support the decision made by West Cheshire Place outlined in Section 3 to agree the list closure application for a period of 4 months.**

Which purpose(s) of an Integrated Care System does this report align with?

Please insert **'x'** as appropriate:

1. Improve population health and healthcare	x
2. Tackle health inequality, improving outcome and access to services	
3. Enhancing quality, productivity and value for money	x

Cheshire and Merseyside ICB
System Primary Care Committee

Which purpose(s) of an Integrated Care System does this report align with?	
4. Helping the NHS to support broader social and economic development	

C&M ICB Priority report aligns with:	
Please insert **'x'** as appropriate:	
1. Delivering today	x
2. Recovery	
3. Getting Upstream	
4. Building systems for integration and collaboration	

Place Priority(s) report aligns with: ***(Place to add)***	
Please insert **'x'** as appropriate:	

Governance and Risk	Does this report provide assurance against any of the risks identified in the ICB Board Assurance Framework or any other corporate or Place risk? (*please list*)					
	What level of assurance does it provide?					
	Limited		**Reasonable**	**X**	**Significant**	
	Any other risks? Yes / No. If **YES** please identify within the main body of the report.					
	Is this report required under NHS guidance or for a statutory purpose? (*please specify*) • Compliance with NHS (GMS Contracts) Regulations 2015 as a ICB with Delegated Primary (Medical) Care Services responsibilities.					
	Any **Conflicts of Interest** associated with this paper? If **YES** please state what they are and any mitigations undertaken.					
	Any current services or roles that may be affected by issues as outlined within this paper?					

Document Development	**Process Undertaken & Impact Considerations**	**Yes**	**No**	**N/A**	**Comments** (i.e. date, method, impact e.g. feedback used). ***Greater detail to be covered in main body of report***
	Financial – any resource impact?			**X**	
	Patient / Public Involvement / Engagement	**X**			
	Clinical Involvement / Engagement	**X**			
	Equality Impact Analysis (EIA) - any adverse impacts identified? EIA undertaken?		**X**		

	Regulatory or Legal - any impact assessed or advice needed?	X			
	Health Inequalities – any impact assessed?	X			
	Sustainable Development – any impact assessed?	X			

Next Steps:	.

Responsible Officer to take forward actions:	Rachael Ullmer Primary Care Contracts Manager Cheshire West & Cheshire East Place

Appendices:	

Hope Farm Medical Practice – Application to Close Practice List

1. Introduction / Background

1.1 Practices operate either an open or a closed list and patients have the ability to register with any local practice which operates an open list.

1.2 The GMS and PMS contracts allow for a GP practice to request permission from its commissioner to close its list to new patients (Paragraph 33 of Schedule 3, Part 2 of the NHS (GMS Contracts) Regulations 2015 (www.legislation.gov.uk/uksi/2015/1862/schedule/3/part/3/made).
This option exists to give GP practices a degree of workload control over the management of their services, particularly when there is unusual and sustained demand from patients or in situations of workforce or recruitment difficulties that affect a GP practice's ability to provide services to an acceptable and safe standard.

2. Summary of List Closure Application

2.1 Hope Farm Medical Centre is a GP practice in Ellesmere Port, Cheshire with a current registered list size of 13,316 patients.

2.2 Hope Farm raised concerns with the then NHS Cheshire CCG on 27th June 2022 regarding pressures on the GP practice which they felt required them to close their patient list for a period of 6 months. The concerns are as follows:

2.3 Resilience to the practice regarding the lack of space, to safely treat the existing and new patients

2.4 Rapidly increasing patient list of approx. 100 patients per month which is hampering their ability to care out high quality care to existing patients

2.5 They have had 4.5 sessions - senior partner retire – unable to recruit despite advertising both Locally and Nationally

2.6 An 8 session GP has applied for another position due to concerns over their wellbeing and workload within the practice – again attempted recruitment unsuccessfully

2.7 Request from an Advanced Nurse Practitioner to reduce to working 1 day a week from a previous 5 day working week due to pressures within the practice

2.8 Hope Farm are continuing to recruit for both GP's and Nurse Practitioners since April 2022 – using both local and national advertisement but to date have had no applicants. For workforce data please see Appendix 4

2.9 The practice after speaking with the CCG have reviewed their Boundary but they feel it would not be beneficial as it would jeopardise continuity of care with current long-standing patients needing to de-registered because of the boundary alteration.

2.10 The Practice are working with One Ellesmere Port PCN and currently engaging with their Patient Participation Group.

2.11 Before the List Closure Application can be heard by the Primary Care and Quality Committee the Integrated Care Board – Cheshire West Place is obliged to contact all neighbouring practices, six in total, to provide them with an opportunity of expressing their views about the proposal.

2.12 As part of the application review, the Committee is provided with a summary of the local GP practice list sizes. A summary of these views can be seen below in Table 1. For list size increase for all practices within One Ellesmere Port PCN please refer to Appendix 3

Table 1 - Summary of the views expressed by neighbouring GP practices

Organisation	**Current List Size**	**Response**	**Grounds**
Great Sutton Medical Centre	20,163	Does not support closure without evidence	For Noting: Experiencing recruitment issues
Whitby Health Partnership	15,980	Agrees to support the 6mths	For Noting: Experiencing recruitment issues
York Road Group Practice	11,824	Agrees to support the 6 months with review	

Old Hall Surgery	5,703	Unable to make a decision based on information given	
West Minister Surgery	3,387	As above	

2.13 As part of the application review, the LMC were asked to provide their views on the application. The LMC responded noting the issues that the Hope Farm Medical Practice are having. The LMC indicated that they would support the request subject to the ICB's usual consultation with other local parties.

3 Recommendations

With regards to Hope Farm Medical Practice's application to formally close their practice list for a period of 6 months, C&M ICB Primary Care Commissioning Committee are asked to:

- Review and discuss the application and supporting information.
- Committee voting members to decide if the list closure application should be approved or rejected.
- If the list closure application is approved, the Committee is to confirm the agreed length the closure period, i.e., the requested 6-month period of time or a shorter period of time.

If the list closure application is approved, the Committee is to confirm the date from which the closure of the GP practice's patient list is to take effect likely to be with immediate effect.

A West Cheshire Place extraordinary meeting was held 16th August 2022 – present were Laura Marsh, Sarah Murray, Paula Wedd, Alex Mitchell, Dean Grice and Rachael Ullmer.

It was agreed to support the Hope Farm Medical Practice Patient List Closure Application for a period of 4 months, due to the current staffing shortfalls and to provide some resilience to the existing staff within the practice. Hope Farm was recognised as being an innovative practice and it was also acknowledged that they had tried different approaches to manage demand. Further actions were also recommended which are as follows:

- **Engagement between the PCN and the practice to review and progress estates issues relating to restricted space.**
- **Hope Farm have volunteered to be part of the national access improvement programme - accelerate (starting in September)**
- **Hope Farm to work collectively with the PCN to review the individual practice boundaries to see whether this can also support management of patient numbers.**

The Primary Care Committee is asked to support the recommendation from West Place as above for a list closure of 4 months.

4 Officer contact details for more information

Rachael Ullmer – Primary Care Contract Manager supporting Cheshire Places
Rachael.ullmer@nhs.net
Tel no: 07833561963

Annex 1

Example Application to Close Practice List of Patients – Sample Template for Completion by Contractor

Application to close practice list of patient

Practice stamp:

DRS, KINGSTON, POWELL, JONES,
LEWIS, MORRISON, ROWLINSON, SMITH
HOPE FARM MEDICAL CENTRE
HOPE FARM ROAD, GREAT SUTTON,
ELLESMERE PORT CH66 2WW

Please complete the following:

Briefly describe your main reasons for applying to close your practice's list of patients to new registrations:
We are applying to close the patient list to preserve quality and safety of care to our existing GMS patients and attempt to prevent burnout further depleting our clinical team. In addition to these main threats to the resilience of the practice we are severely hampered by space. Our list is increasing rapidly and the patient numbers are impossible to deal with safely given our current clinical team and the space we have to operate from. We are consistently registering close to 100 new patients per month and this is hampering our ability to provide high quality care to our existing patients We have had a 4.5 session senior partner retire and have been unable to recruit despite local and national advertisement. We are wishing to recruit at least 8 sessions a week due to the rising list. One of our Advanced Nurse Practitioners has informed us she needs to reduce to 1 day a week essentially due to the pressure of work here. An 8 session salaried GP has applied for another job concerned for their wellbeing due to pressure of work.

What options have you considered, rejected or implemented to relieve the difficulties you have encountered about your open list and, if any were implemented, what was your success in reducing or erasing such difficulties?
We have been recruiting for months prior to the retirement of a senior partner at the beginning of Aril 2022. We have had no applications to local or national recruitment. At times when our list is open there is rapid list inflation as patients are not registering equally to all local practices. We are still seeing significant transfers of patients from local practices often stating frustration at access and continuity of care. We have discussed options with the CCG who had suggested we consider bringing in the boundary of our practice. We have ultimately rejected this as although it may reduce the list by approximately 400 patients it may generate problems with rapid registrations at other practices and will compromise continuity of care. Having debated this possibility we feel removal of longstanding patients in order to register new patients that move in slightly nearer or transferring from other practices is not something we could agree to. We are fully engaged with the PCN with our practice manager having held the position of operations manager within the PCN and one of our partners currently the co-clinical director. We are a training practice and take medical students. We could consider suspension of one or both of these activities but in the longer term this will be counterproductive. One of our current partners is a previous trainee here and one of our salaried GPs is a previous GP that in time we hope will become a partner. We have optimised our use of the ARRS and continue to do so but this does not help with GP appointments as new team members are undergoing training that further impacts on GP availability.

Have you had any discussions with your registered patients about your difficulties maintaining an open list of patients and if so, please summarise

them, including whether registered patients thought the list of patients should or should not be closed?
We are currently engaging with our PPG. We can submit the results of this when available but need to apply for list closure as soon as possible

Have you spoken with other contractors in the practice area about your difficulties maintaining an open list of patients and if so, please summarise your discussions including whether other contractors thought the list of patients should or should not be closed?
We are currently engaging with our local practices and have alerted them previously to the pressures the rising list has caused. We will supply feedback when available.

How long do you wish your practice list of patients to be closed? (This period must be more than 3 months and less than 12 months)
6 months with an option to extend if we have failed to recruit and there has been no list shrinkage

What reasonable support do you consider the Commissioner would be able to offer, which would enable your list of patients to remain open or the period of proposed closure to be minimised?
Provision of a salaried GP for 8 sessions. Improvement in premises.

Do you have any other information to bring to the attention of the Commissioner about this application?
We need a rapid response as there is a further risk of loss of clinical and non clinical staff that could further destabilise the practice

Please note that this application does not place any obligation on the Commissioner to agree to this request

To be signed by all parties to the contract (where this is reasonably achievable):

Signed: _____

Print: Dr S G Powell

Date: 20/7/22

Signed: _____

Print: DR. CLAIRE ROWLINSON. Dr Karen Jones

Date: 21/07/22. 21/7/22

PART C: MANAGING CLOSED PATIENT LISTS

Scope

This Part C sets out the processes to be implemented when managing applications to close patient lists and to extend a closure period.

At all stages throughout these processes, it is essential that the Commissioner works with the contractor and the relevant LMC to ensure clear and transparent decision making and that all decisions are made in line with internal governance arrangements.

Applications to Close a Patient List

Sometimes a contractor may wish to close its list to new registrations e.g. where there are internal capacity issues or premises refurbishments. The contractor must seek approval from the Commissioner by a written application (the "Application") before this may happen. A template Application for the contractor to complete is attached in Annex 1. The contractor should use the template Application to ensure it completes all the required information. The contractor may obtain the application itself (for example by accessing this policy) or it may be requested by the contractor. An example covering letter from the Commissioner to the contractor enclosing an application form is in Annex 2.

The Commissioner must acknowledge receipt of the Application within seven days of its receipt and may request further information from the contractor to enable it to consider the Application thoroughly.

With a view to possibly enabling the contractor to keep its list of patients open, the Commissioner and the contractor must talk openly to establish:

- what support the Commissioner may give the contractor; or
- changes the Commissioner or contractor may make.

The contractor or the Commissioner may at any time throughout these discussions invite the appropriate LMC to be included in the dialogue about the application.

The Commissioner should ensure compliance with the general duties of NHS England. Please refer to the chapter on General duties of NHS England for further information.

The contractor may withdraw the application at any time before the Commissioner makes its decision on the proposed list closure.

The Commissioner must make a decision, within a period of 21 days starting on the date of receipt of the Application (or within a longer period as the parties may agree):

- to approve the Application and determine the date the closure is to take effect and the date the list of patients is to reopen; or
- to reject the Application.

The Commissioner must notify the contractor of its decision in writing as soon as possible after the 21 day period.

Approval of Patient List Closure: Closure Notice

Where the Commissioner has granted approval for closure of the patient list, a closure notice must be issued to the contractor as soon as possible after the decision is reached, with a copy to the LMC for its area (if any) and to any person consulted in the decision-making process. The Commissioner should use the template notice in Annex 4 to ensure it responds to the contractor with all the required information.

The contractor must close the list on the date in the notice and the list should remain closed for the time specified unless the Commissioner and the contractor agree that the list should be re-opened to patients before the expiry of the closure period.

Rejection of Application for List Closure

When the Commissioner decides to reject an application to close a list of patients, it must as soon as possible:

- provide the contractor with a notification including the reasons why the application was rejected. The Commissioner should use the template in Annex 5 to ensure it responds to the contractor with all the required information; and
- at the same time, send a copy of the notification to any affected LMC for its area and to any person it consulted in the decision-making process.

When the Commissioner decides to reject a contractor's application to close its list of patients, the contractor must not make a further application until:

- the end of the three-month period, starting on the date of the decision of the Commissioner to reject; or
- the end of the three months, starting on the date of the final determination regarding a dispute arising from the decision to reject the application made pursuant to the NHS dispute resolution procedure (or any court proceedings) (please refer to the chapter on managing disputes for further information on the NHS dispute resolution procedure),

whichever is the later.

A contractor may make a further application to close its list of patients where there has been a change in the circumstances of the contractor which affects its ability to deliver services under the contract.

Application to Extend a Closure Period

A contractor wishing to extend an agreed closure period must submit an application to the Commissioner no less than eight weeks before the closure period is due to end.

A template for completion by the contractor is attached in Annex 6. An example covering letter from the Commissioner to the contractor enclosing an application form is in Annex 7.

The Commissioner must acknowledge receipt of the application within seven days, then if necessary, discuss potential support that could be offered to the contractor, discuss with any affected LMC and consult other affected parties before reaching a decision on the application to extend within 14 days from receipt of the application. The Commissioner should use the template consultation letter in Annex 8.

If the decision is to accept the application the Commissioner must issue an extended closure notice as soon as possible after the decision is reached to the Contractor, with a copy to the LMC for its area (if any) and to any person it consulted in the decision-making process. The Commissioner should use the template in Annex 9 to ensure that the contractor receives all the relevant information.

If the decision is to reject the application then the Commissioner must provide the contractor with a notification, including the reasons for the rejection of the application, with a copy to the LMC for its area (if any) and to any person it consulted in the decision-making process. The Commissioner should use the template in Annex 10.

The contractor may re-open its list of patients before the closure period expires if Commissioner and contractor agree.

Where an application for the extension of the closure period has been made in accordance with this policy, and that application has been rejected, the list of patients will remain closed until such time as any dispute arising from the application has been resolved through the NHS dispute resolution procedure (or any court proceedings) or until such time as the expiry of the original closure notice. Please refer to the chapter on managing disputes for further information on the NHS dispute resolution procedure.

Annex 1 Example

Application to Close Practice List of Patients – Sample Template for Completion by Contractor

- Example Application to Close Practice List of Patients – Sample Template for Completion by Contractor

Annex 2 Example Application to Close Patient List – Sample Letter from Commissioner to Contractor

- Example Application to Close Patient List – Sample Letter from Commissioner to Contractor

Annex 3 Example Consultation Letter from Commissioner to Affected Parties

- Example Consultation Letter from Commissioner to Affected Parties

Annex 4 Approval – Example Closure Notice

- Approval – Example Closure Notice

Annex 5 Rejection – Example Letter

- Rejection – Example Letter

Annex 6 Example Application to Extend a Closure Period – Sample Template for Completion by Contractor

- Example Application to Extend a Closure Period – Sample Template for Completion by Contractor

Annex 7 Example Application to Extend a Closure Period – Sample Letter from Commissioner to Contractor

- Example Application to Extend a Closure Period – Sample Letter from Commissioner to Contractor

Annex 8 Example Consultation Letter from Commissioner to Affected Parties Regarding Application for Extension

- Example Consultation Letter from Commissioner to Affected Parties Regarding Application for Extension

Annex 9 Approval – Example Extended Closure Notice

- Approval – Example Extended Closure Notice

Annex 10 Rejection of Extended Closure – Example Letter

- Rejection of Extended Closure – Example Letter

Cheshire and Merseyside ICB
System Primary Care Committee

NHS Cheshire and Merseyside

Appendix 3 list sizes

Table 1 - Ellesmere Port GP Practices - List Sizes over the last 15 months															
		Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22
Great Sutton Medical Centre - N81050	List Size	20163	20172	20184	20203	20222	20199	20181	20180	20182	20171	20163	20166	20165	20137	20143
	Variance	-	9	12	19	19	-23	-18	-1	2	-11	-8	3	-1	-28	6
	Variance	-	0.04%	0.06%	0.09%	0.09%	-0.11%	-0.09%	0.00%	0.01%	-0.05%	-0.04%	0.01%	0.00%	-0.14%	0.03%
Hope Farm Road Medical Centre - N81092	List Size	12692	12757	12816	12849	12891	12923	12928	12999	13093	13054	13179	13171	13222	13316	13373
	Variance	-	65	59	33	42	32	5	71	94	-39	125	-8	51	94	57
	Variance	-	0.51%	0.46%	0.26%	0.33%	0.25%	0.04%	0.55%	0.72%	-0.30%	0.95%	-0.06%	0.39%	0.71%	0.43%
Old Hall Surgery - N81117	List Size	5641	5650	5650	5659	5641	5665	5702	5702	5690	5698	5703	5697	5706	5697	5724
	Variance	-	9	0	9	-18	24	37	0	-12	8	5	-6	9	-9	27
	Variance	-	0.16%	0.00%	0.16%	-0.32%	0.42%	0.65%	0.00%	-0.21%	0.14%	0.09%	-0.11%	0.16%	-0.16%	0.47%
Westminster Surgery - N81607	List Size	3181	3220	3227	3243	3260	3281	3311	3321	3334	3369	3387	3398	3390	3389	3391
	Variance	-	39	7	16	17	21	30	10	13	35	18	11	-8	-1	2
	Variance	-	1.21%	0.22%	0.49%	0.52%	0.64%	0.91%	0.30%	0.39%	1.04%	0.53%	0.32%	-0.24%	-0.03%	0.06%
Whitby Health Partnership - N81093	List Size	16290	16201	16162	16083	16081	16064	16058	16048	16014	15997	15980	15998	15994	15995	16008
	Variance	-	-89	-39	-79	-2	-17	-6	-10	-34	-17	-17	18	-4	1	13
	Variance	-	-0.55%	-0.24%	-0.49%	-0.01%	-0.11%	-0.04%	-0.06%	-0.21%	-0.11%	-0.11%	0.11%	-0.03%	0.01%	0.08%
York Road Group Practice - N81063	List Size	11636	11624	11653	11653	11658	11686	11709	11760	11762	11810	11824	11839	11838	11840	11826
	Variance	-	-12	29	0	5	28	23	51	2	48	14	15	-1	2	-14
	Variance	-	-0.10%	0.25%	0.00%	0.04%	0.24%	0.20%	0.43%	0.02%	0.41%	0.12%	0.13%	-0.01%	0.02%	-0.12%

https://digital.nhs.uk/data-and-information/publications/statistical/patients-registered-at-a-gp-practice

Appendix 4

Table 2 - Ellesmere Port GP Practices - List Sizes over the last 5 years						
		Jul-22	Jul-21	Jul-20	Jul-19	Jul-18
Great Sutton Medical Centre - N81050 (N81094, N81095 & N81050 Historic)	List Size	20137	20172	20311	20228	20048
	Variance	-35	-139	83	180	-
	Variance	-0.17%	-0.69%	0.41%	0.89%	-
Hope Farm Road Medical Centre - N81092	List Size	13316	12757	12333	12320	11979
	Variance	559	424	13	341	-
	Variance	4.20%	3.32%	0.11%	2.77%	-
Old Hall Surgery - N81117	List Size	5697	5650	5551	5538	5663
	Variance	47	99	13	-125	-
	Variance	0.82%	1.75%	0.23%	-2.26%	-
Westminster Surgery - N81607	List Size	3389	3220	2946	2806	2655
	Variance	169	274	140	151	-
	Variance	4.99%	8.51%	4.75%	5.38%	-
Whitby Health Partnership - N81093 (N81023, N81091 & N81093 Historic)	List Size	15995	16201	16512	16414	16314
	Variance	-206	-311	98	100	-
	Variance	-1.29%	-1.92%	0.59%	0.61%	-
York Road Group Practice - N81063	List Size	11840	11624	11677	11607	11348
	Variance	216	-53	70	259	-
	Variance	1.82%	-0.46%	0.60%	2.23%	-

Cheshire and Merseyside ICB
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Appendix 5 – Workforce Data

Data as of May 2022		
GP Practice	**GP FTE**	**Nurse FTE**
Great Sutton	10.07	10.77
Hope Farm	8.91	2.56
Old Hall	4.05	1.73
Westminster	1.67	1.84
Whitby	11	4.93
York Road	4.27	3.15

NHS
Cheshire and Merseyside

Committee Report

Cheshire and Merseyside ICB
System Primary Care Committee
Date: 25th August 2022

Cheshire and Merseyside ICB
System Primary Care Committee

Date of meeting:	25th August 2022
Agenda Item No:	PCC/8/22/11
Report title:	Approval of revised rental reimbursement at Blacon Parade GP Practice New Build
Report Author & Contact Details:	Lucy Andrews (lucyandrews2@nhs.net)
Report approved by:	James Burchell Head of Estates and Capital (Cheshire East and Cheshire West Place)

Purpose and any action required	**Decision/ Approve**	**X**	**Discussion/ Gain feedback**		**Assurance**		**Information/ To Note**	

Route to this meeting / Committee/Advisory Group previously presented to (if applicable)
Cheshire Primary Care Estates Group – endorsement

Executive Summary and key points for discussion

Due to the impact of inflation and overall increase in build costs, the internal fit out of the new GP Branch Practice in Blacon, Chester has exceeded initial projected costs by the Landlord. As a result, the previously agreed rental reimbursement of £30,000 (VAT not applicable) is no longer viable.

The landlord initially indicated that to not suffer a loss on the scheme, they would need £60,000 p/a in rent. Several negotiations have taken place between the landlord and Commissioner; resulting in an 'in principle' agreement of £43,000 p/a being acceptable.

The District Valuer has reviewed the information and determined a baseline rent, alongside a requirement for the Commissioner to utilise NHS Premise Directions 2013, Section 6 to provide a 'top up' that would enable the rent to fall within the parameters of being acceptable by the Landlord.

The Cheshire Primary Care Estates Group has reviewed the proposal to both approve the increase in lease term from 25 years to 30 years, and the use of Section 6 to provide a top-up rent. Both items were endorsed by the Group for onward approval.

Recommendation/ Action needed:	**The Committee is asked to:** • Approve the increase in lease term to 30 years • Approve the increase in rental reimbursement by £4,800 • Approve the use of Section 6 of the NHS Premise Directions 2013 (discretionary powers) to allow a top up rent of £8,200 to be applied to the scheme.

Which purpose(s) of an Integrated Care System does this report align with?

Please insert **'x'** as appropriate:

1. Improve population health and healthcare	X

Cheshire and Merseyside ICB
System Primary Care Committee

Which purpose(s) of an Integrated Care System does this report align with?	
2. Tackle health inequality, improving outcome and access to services	X
3. Enhancing quality, productivity and value for money	X
4. Helping the NHS to support broader social and economic development	

C&M ICB Priority report aligns with:	
Please insert **'x'** as appropriate:	
1. Delivering today	X
2. Recovery	
3. Getting Upstream	
4. Building systems for integration and collaboration	X

Place Priority(s) report aligns with:	
Please insert **'x'** as appropriate:	

Governance and Risk					
Does this report provide assurance against any of the risks identified in the ICB Board Assurance Framework or any other corporate or Place risk? (*please list*)					
What level of assurance does it provide?					
Limited	X	**Reasonable**		**Significant**	
Any other risks? Yes / No. If **YES** please identify within the main body of the report.					
Is this report required under NHS guidance or for a statutory purpose? (*please specify*)					
Any **Conflicts of Interest** associated with this paper? If **YES** please state what they are and any mitigations undertaken.					
Any current services or roles that may be affected by issues as outlined within this paper?					

Document Development	**Process Undertaken & Impact Considerations**	**Yes**	**No**	**N/A**	**Comments** (i.e. date, method, impact e.g. feedback used). ***Greater detail to be covered in main body of report***
	Financial – any resource impact?	X			
	Patient / Public Involvement / Engagement			X	
	Clinical Involvement / Engagement			X	
	Equality Impact Analysis (EIA) - any adverse impacts identified? EIA undertaken?			X	

	Regulatory or Legal - any impact assessed or advice needed?			X	
	Health Inequalities – any impact assessed?			X	
	Sustainable Development – any impact assessed?			X	

Next Steps:	.

Responsible Officer to take forward actions:	

Appendices:	

Approval of revised rental reimbursement at Blacon Parade GP Practice New Build

1. Executive Summary

1.1. Due to the impact of inflation and overall increase in build costs, the internal fit out of the new GP Branch Practice in Blacon, Chester has exceeded initial projected costs by the Landlord. As a result, the previously agreed rental reimbursement of £30,000 (VAT not applicable) is no longer viable.

1.2. The landlord initially indicated that to not suffer a loss on the scheme, they would need £60,000 p/a in rent. Several negotiations have taken place between the landlord and Commissioner; resulting in an 'in principle' agreement of £43,000 p/a being acceptable.

1.3. The District Valuer has reviewed the information and determined a baseline rent, alongside a requirement for the Commissioner to utilise NHS Premise Directions 2013, Section 6 to provide a 'top up' that would enable the rent to fall within the parameters of being acceptable by the Landlord.

1.4. The Cheshire Primary Care Estates Group has reviewed the proposal to both approve the increase in lease term from 25 years to 30 years, and the use of Section 6 to provide a top-up rent. Both items were endorsed by the Group for onward approval.

2. Introduction / Background

2.1. A proposed re-development of Primary Care facilities in Blacon has gone through several iterations over the years. The area is one of high deprivation and both existing facilities were determined to be significantly inadequate. Western Avenue GP Practice is situated in the heart of Blacon in a dated property whilst the branch surgery of Elms Medical Centre operated out of a Church Hall.

2.2. Initially, the new build; situated on the Ground Floor on a residential development, was approved by NHS West Cheshire CCG on 8th November 2018. The Rent was approved at £25,000 p/a (VAT not applicable).

2.3. Subsequently, the scheme progressed and following discussions with the District Valuer surrounding the rateable value and floor space the GP Practice would be occupying that was not agreed at the time of initial approval; the rental figure was finally agreed at £30,000 p/a.

3. Main Body

3.1. The scheme has suffered several delays, namely due to the covid-19 pandemic and delayed construction due to inability to source materials and adverse weather conditions.

3.2. During the pandemic, the branch surgery ceased operations from the Church Hall due to social distancing requirements. Patient engagement had already taken place on the proposed move to a new premises (originally scheduled for Summer 2022) so services were temporarily ceased or move to the main GP Practice in the centre of Chester. There remains a GP Practice in operation at Blacon from Western Avenue Medical Centre.

3.3. There have been protracted lease negotiations with the GP Practice and Landlord, with a final draft lease being submitted at the end of July 2022. The internal fit out is awaiting final approval of rental terms.

3.4. Due to the impact of inflation and overall increase in build costs, the internal fit out of the new GP Branch Practice in Blacon, Chester has exceeded initial projected costs by the Landlord. As a result, the previously agreed rental reimbursement of £30,000 (VAT not applicable) is no longer viable.

3.5. The landlord initially indicated that to not suffer a loss on the scheme, they would need £60,000 p/a in rent. Significant discussions have taken place between the landlord and Commissioner; resulting in an 'in principle' agreement of £43,000 p/a being acceptable.

3.6. The District Valuer reviewed the Landlord proposal and determined:

- Lease Term – proposed lease term of 30 years to offset some of the financial concerns relating to rent is agreeable and value for money.
- Rent Review Pattern – every 5 years,1% on the rent is added every year after 3. At present, the proposed rent determined by the District Valuer Service is estimated to be **£34,800 p/a.** This is considerably below the proposed rent of **£43,000 p/a** that the landlords have determined.

3.6 The DV can agree to fund a maximum of £34,800 p/a from latest DVS data. To close the gap between this figure and the rental figure proposed by the landlord, a "top-up" payment of **£**

8,200 would be payable. The Commissioner is able to utilise discretionary powers under direction 6 of "The NHS (General Medical Services – Premises Costs) 2013 to consider and potentially approve this request. The extract states:

3.7 *"Financial assistance in circumstances not contemplated in these Directions*

6. These Directions do not prevent the Board from providing such financial assistance as it thinks fit in order to pay, or contribute towards, the premises costs of a contractor in circumstances that are not contemplated by the payment arrangements set out in these Directions, such as where-

- *a). the contractor is providing services under a temporary GMS contract;*
- *b). an emergency need for financial assistance in respect of premises costs arises in circumstances that could not reasonably have been foreseen;*
- *c). the contractor needs temporary accommodation (where in the form of portable premises or an existing building) while new practice premises are being built or existing practice premises refurbished: or*
- *d). the financial assistance relates to contractual arrangements for the provision of primary medical services under section 83(2) of the 2006 Act(b)(primary medical services)."*

3.8 The 'top up' arrangement would be a temporary measure as when the rent increases every 5 years, the DV will approve a higher value based upon the market and the "top up" payment will diminish over time following each review.

3.9 Should the increase not be approved, the scheme would be unviable from the landlord perspective. This would result in the new build not being completed and significantly impact access to primary care services in a high area of deprivation.

4. Recommendations

4.1 The Committee are asked to:

- Approve the increase in lease term to 30 years
- Approve the increase in rental reimbursement by £4,800
- Approve the use of Section 6 of the NHS Premise Directions 2013 (discretionary powers) to allow a top up rent of £8,200 to be applied to the scheme.

5. Officer contact details for more information

James Burchell
Head of Estates and Capital (Cheshire East and Cheshire West Place)
jamesburchell@nhs.net

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Committee Report

Cheshire and Merseyside ICB
Primary Care Committee Meeting
Cheshire West Place

Date: 25 August 2022

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Cheshire and Merseyside ICB
Primary Care Committee Meeting

Date of meeting:	25/08/2022
Agenda Item No:	PCC/8/22/11
Report title:	Willaston Surgery Weekend Opening
Report Author & Contact Details:	Laura Jones - laura.jones15@nhs.net Contributions from Dean Grice – dean.grice@nhs.net
Report approved by:	Laura Marsh, Associate Director of Transformation & Partnerships, Cheshire West Place

Purpose and any action required	**Decision/ Approve**	**x**	**Discussion/ Gain feedback**		**Assurance**		**Information/ To Note**	

Route to this meeting / Committee/Advisory Group previously presented to (if applicable)
Presented to Primary Care Operational Group meeting on 18/08/2022, in the presence of Cheshire West Place Director representation.

Executive Summary and key points for discussion
Within the Willaston Surgery APMS contract it includes provision of service hours for Saturdays and Sundays. In March 2020 agreement was reached between the GP practice and NHS West Cheshire CCG that this weekend service provision could be stopped. This was in part due to the development of the Covid-19 pandemic but also related to staffing pressures within the practice which were potentially going to be destabilising to the GP practice. Funding for this element of the APMS was stopped by the CCG at that time. However, the GP Practice's APMS contract was not updated at that time to reflect this contract variation. The practice's plan to replace this aspect of their service was to restart their weekend service provision with support from the wider PCN via the PCN DES Enhanced Access scheme, starting from April 2022. However Enhanced Access was deferred nationally until October 2022 and the practice has remained closed at weekends in the interim, with a plan to provide weekend provision as part of the PCN DES Enhanced Access scheme from October onwards. This paper outlines the NHS West Cheshire CCG approved case, put by Willaston surgery, to remove this element of service provision from their APMS contract, and looks to allow completion the contractual paperwork requirements.

Recommendation/ Action needed:	**The Committee is asked to:** Ratify the Cheshire West Place decision to honor the NHS West Cheshire CCG decision from March 2020 for Willaston Surgery to stop weekend service provision as outlined in their APMS contract. This will allow Willaston Surgery to proceed with their PCN Enhanced Access plans which will include service provision for Willaston Surgery patients at the weekend.

Cheshire and Merseyside ICB
Primary Care Committee Meeting

Which purpose(s) of an Integrated Care System does this report align with?	
Please insert **'x'** as appropriate:	
1. Improve population health and healthcare	
2. Tackle health inequality, improving outcome and access to services	x
3. Enhancing quality, productivity and value for money	x
4. Helping the NHS to support broader social and economic development	

C&M ICB Priority report aligns with:	
Please insert **'x'** as appropriate:	
1. Delivering today	x
2. Recovery	x
3. Getting Upstream	
4. Building systems for integration and collaboration	

Place Priority(s) report aligns with: *(Place to add)*	
Please insert **'x'** as appropriate:	

Governance and Risk						
Does this report provide assurance against any of the risks identified in the ICB Board Assurance Framework or any other corporate or Place risk? (*please list*) No						
What level of assurance does it provide? N/A						
Limited	N/A	**Reasonable**	N/A	**Significant**	N/A	
Any other risks? Yes If **YES** please identify within the main body of the report.						
Is this report required under NHS guidance or for a statutory purpose? (*please specify*) Required for the approval of an APMS contract variation.						
Any **Conflicts of Interest** associated with this paper? If **YES** please state what they are and any mitigations undertaken. No						
Any current services or roles that may be affected by issues as outlined within this paper? Willaston Surgery general practice patient access services.						

Document Development	Process Undertaken & Impact Considerations	Yes	No	N/A	**Comments** (i.e. date, method, impact e.g. feedback used). ***Greater detail to be covered in main body of report***
	Financial – any resource impact?	x			APMS contract financial element outlined in paper. Removal of this element of the APMS contract has resulted in a cost saving to the ICB.
	Patient / Public Involvement / Engagement	x			Patient engagement has been maintained by the practice during this period via their active PPG.
	Clinical Involvement / Engagement			x	
	Equality Impact Analysis (EIA) - any adverse impacts identified? EIA undertaken?		x		
	Regulatory or Legal - any impact assessed or advice needed?			x	
	Health Inequalities – any impact assessed?			x	
	Sustainable Development – any impact assessed?	x			Impacts on the sustainability of the Willaston Surgery

Next Steps:	Following ratification by Primary Care Committee an APMS contract variation document will be generated and signed by both parties.

Responsible Officer to take forward actions:	Laura Jones Dean Grice

Willaston Surgery Weekend Opening

1. Executive Summary

Within the Willaston Surgery APMS contract it includes provision of service hours for Saturdays and Sundays. In March 2020 agreement was reached between the GP practice and NHS West Cheshire CCG that this weekend service provision could be stopped. This was in part due to the development of the Covid-19 pandemic but also related to staffing pressures within the practice which were potentially going to be destabilising to the GP practice. Funding for this element of the APMS was stopped by the CCG at that time. However, the GP Practice's APMS contract was not updated at that time to reflect this contract variation. This paper outlines the case, put by Willaston surgery, to remove this element of service provision from their APMS contract and looks to complete the contractual paperwork requirements.

2. Background

Historically Willaston Surgery opened for 3 hours on Saturdays for GP appointments and 3 hours on Sundays for practice nurse appointments, as per the requirements stipulated in their APMS contract. In agreement with NHS West Cheshire CCG the provision of weekend appointments ceased from 15th March 2020 and weekend appointments have not been offered since this date.

The practice's plan to replace this aspect of their service was to restart their weekend service provision with support from the wider PCN via the PCN DES Enhanced Access scheme, starting from April 2022. However Enhanced Access was deferred nationally until October 2022 and the practice has remained closed at weekends in the interim, with a plan to provide weekend provision as part of the PCN DES Enhanced Access scheme from October onwards.

Patient engagement has been maintained by the practice during this period via their active PPG.

3. Willaston Surgery's Case for Change

The service provider for Willaston Surgery, CWP, has provided a case for change. This can be seen in Appendix A.

Agreement has already been reached (in March 2020) for the GP practice to stop their weekend service provision. This was agreed with the commissioning organisation in place at the time - NHS West Cheshire CCG.

The GP practice has a viable plan in place with the Neston and Willaston PCN for weekend service provision via Enhanced Access.

Duplication of service provision from the GP Practice's APMS contract and PCN DES Enhanced Access would introduce a risk to overall service provision provided by Willaston Surgery – duplication is not deemed viable due to the small population size of the Willaston Surgery (circa 4,465) and also the PCN (circa 21,000), along with small staff numbers at the Willaston Surgery.

4. Governance Requirements

The request to complete the contractual paperwork to reflect the change agreed by NHS West Cheshire CCG in March 2020 has been reviewed by the Primary Care Operations and Quality

Group for Cheshire West Place, who are in agreement that the APMS contract should be updated to reflect the current service provision. This has been reviewed by Cheshire West Place Directors, who are also in agreement with this decision.

In the absence of a Cheshire West Place Primary Care Committee, the decision is being passed to the Cheshire and Merseyside ICB System Level Primary Care Committee for ratifying.

5. Recommendation

Cheshire and Merseyside ICB System Level Primary Care Committee are asked to:

Ratify the Cheshire West Place decision to honor the NHS West Cheshire CCG decision from March 2020 for Willaston Surgery to stop weekend service provision as outlined in their APMS contract. This will allow Willaston Surgery to proceed with their PCN Enhanced Access plans which will include service provision for Willaston Surgery patients at the weekend.

6. Contact details for further information

Laura Marsh, Associate Director of Transformation & Partnerships, Cheshire West Place	laura.marsh2@nhs.net
Laura Jones, Primary Care Project Manager – Cheshire, Cheshire and Merseyside ICB	laura.jones15@nhs.net
Dean Grice, Head of Primary Care – Cheshire, Cheshire and Merseyside ICB	dean.grice@nhs.net

Appendix A – Willaston Surgery Case for Change (three pages)

NHS
Cheshire and Wirral Partnership
NHS Foundation Trust

STANDARDISED SBAR COMMUNICATION

REPORT DETAILS	
Report subject:	Willaston Surgery Weekend Opening
Agenda ref. number:	TBC
Report to (meeting):	TBC
Action required:	Discussion and Approval
Date of meeting:	12/05/2022
Presented by:	TBC

Which strategic objectives this report provides information about:	
Deliver high quality, integrated and innovative services that improve outcomes	Yes
Ensure meaningful involvement of service users, carers, staff and the wider community	No
Be a model employer and have a caring, competent and motivated workforce	No
Maintain and develop robust partnerships with existing and potential new stakeholders	Yes
Improve quality of information to improve service delivery, evaluation and planning	Yes
Sustain financial viability and deliver value for money	No
Be recognised as an open, progressive organisation that is about care, well-being and partnership	Yes

Which NHSI Single Oversight Framework themes this report reflects:		CWP Quality Framework:		
Quality	Yes	Patient Safety	Safe	Yes
Finance and use of resources	Yes	Clinical Effectiveness	Effective	Yes
Operational performance	Yes		Affordable	No
Strategic change	Yes		Sustainable	No
Leadership and improvement capability	No	Patient Experience	Acceptable	No
			Accessible	No
		http://www.cwp.nhs.uk/media/4142/quality-improvement-strategy-2018.pdf		

Does this report provide any information to update any current strategic risks? If so, which?	
Contact the corporate affairs teams for the most current strategic risk register.	No

Does this report indicate any new strategic risks? If so, describe and indicate risk score:	
See current integrated governance strategy: CWP policies – policy code FR1	No

REPORT BRIEFING

Situation –
a concise statement of the purpose of this report

The purpose of this paper is to set out the options for Willaston Surgery's weekend working moving forward.

Background – *contextual and background information pertinent to the situation/ purpose of the report*

Willaston Surgery historically opened for 3 hours on Saturday for GP appointments and 3 hours on Sunday for practice nurse appointments. Willaston Surgery was the only practice within West Cheshire to offer this service. Weekend appointments stopped being provided on the 15th March 2020 due to the Covid pandemic and patients have had access to Extended Hours appointments since this date.

The surgery has not re-opened at weekends due to the planned move to PCN-led Extended Access in April 2022. This was deferred to October 2022 but the practice has remained closed at weekends

Assessment – *analysis and considerations of the options and risks*

The data below shows that even with weekend opening, some patients were accessing Extended Hours appointments.

6 months data pre-March 2020:

- A GP was available on Saturdays between 09:00 -12:00hrs with13 face to face appts. Most appointments were filled with occasional empty slots.
- A practice nurse clinic was held every Sunday from 09:00-12:00hrs with 7 appointments. The clinics were fully booked with additional patients added on occasion. Between September and November these clinics were also used to provide flu vaccinations.
- Extended Hours data for the same period shows that 9 GP appointments were booked by people registered at Willaston Surgery and 15 patients booked appointments with practice nurses.

Post March 2020:

Patients registered at Willaston Surgery have access to evening weekday and weekend appointments via the Extended Hours Service provided from Ellesmere Port Hospital.
Between 1st March 20 and 17th May 22 inclusive:

- 68 GP appointments were booked
- 27 practice nurse appointments were booked

Options for future weekend service provision

1.CWP re-open the surgery at weekends
Opening times 09:00-12:00 Saturdays and Sundays

The cost of this service could be delivered within the previously agreed contract payment of £41,542 (last payment received 2019/20). This payment would need to be reinstated to CWP if agreed that the service should recommence.

Impact – there would be reduction in hours available during normal primary care hours as GPs and practice nurse would move to weekend opening.
The weekend GP rota would require doctors to work one Saturday every 3 weeks. Willaston GP's do not wish to revert to weekend working and re-introducing weekend working would risk attrition.
Additional cost for the CCG.

2.Enhanced access provided by Neston and Willaston PCN

The Willaston practice team is an active partner within Neston and Willaston PCN. There is clinical and non-clinical representation from the surgery at monthly operational meetings, bi-monthly board meetings and at ad-hoc meetings. The PCN has worked closely to provide COVID vaccinations throughout the pandemic and are working collaboratively in the recruitment of staff to ARRS roles. A focus of recent PCN meetings has been discussion around the Extended Access DES and extended access will be offered to Willaston patients at Neston Medical Centre and Neston surgery as detailed below.

Patients will be able to access appointments from 1.10.22 via Neston and Willaston PCN. Full details of service provision are not yet available, but the proposed schedule is as follows:

- Monday – Thursday 18:30 – 20:00 clinics will be provided by Neston Medical Centre and Neston Clinic.
- Friday evenings Primary Care Cheshire (PCC) will provide clinics from a base in Ellesmere Port or Upton.
- Saturday mornings - PCC will provide a GP in Neston Medical Centre between 09:00 and 12:00hrs.
- Saturday afternoons - PCC will provide clinics 12:00-17:00 in Ellesmere Port or Upton

Consultation and feedback from patients and the PPG

The surgery has not received any complaints from patients following weekend closure in March 2020. PPG meetings were suspended during the COVID pandemic but contact with the PPG lead was maintained throughout.
The interim practice manager met with PPG Lead on 26th July 2021 and no concerns were raised.
The Head of Clinical Services met with the PPG lead on 24th November 21 and discussed patient feedback. No concerns had been raised with the PPG.
The issue of weekend opening was discussed with the PPG at a meeting on 9th May 2022 and again, no concerns had been raised with the PPG.

Recommendation – *what action/ recommendation is needed, what needs to happen and by when?*

For the CCG to consider the options and make a decision as to the future weekend operating model.

Who has approved this report for receipt at the above meeting?	
Contributing authors:	

Distribution to other people/ groups/ meetings:

Version	Name/ group/ meeting	Date issued
1	TBC	

Appendices provided for reference and to give supporting/ contextual information:

Appendix No.	Appendix title

NHS
Cheshire and Merseyside

Committee Report

Cheshire and Merseyside ICB
System Primary Care Committee
Date: 25th August 2022

NHS
Cheshire and Merseyside

NHS Cheshire and Merseyside System Primary Care Committee

Date: 25.08.22

Warrington Primary Care Networks Enhanced Access Consultation Report

Report author & contact details	Katie Horan katie.horan@nhs.net
Report approved by (sponsoring Director)	Carl Marsh Warrington Place Director
Responsible Officer to take actions forward	Katie Horan

Cheshire and Merseyside ICB
System Primary Care Committee

Warrington Primary Care Networks Enhanced Access Consultation Report

Executive Summary	The report relates to the new GP contract arrangements for Enhanced Access from October 2022 that will be the responsibly of PCNs. From 2019 Warrington PCNs have worked together to develop their model. Their preferred model involved their proposal to move the current service from Bath Street Health and Wellbeing Centre to local venues within their PCN footprint. The proposed model was presented to Warrington's Health Overview and Scrutiny Committee, who agreed that the changes constituted a substantial variation, so a formal public consultation was required. In the absence of local PCCC arrangements our place Senior Leadership Team (SLT) approved the consultation report and the System Primary Care Committee is asked to be assured of the process.				
Purpose (x)	**For information / note**	**For decision / approval**	**For assurance**	**For ratification**	**For endorsement**
	X		X		
Recommendation	**The Board is asked to:** • Note the consultation report • Be assured that the consultation process meets the Gunning Principles • Be assured that the consultation adheres to the Public Sector Equality Duty				
Key issues	The key issues to consider are: • The reach of the engagement and communication activity • To ensure feedback has been reviewed and appropriate mitigations have been considered				
Key risks	The key risk for any consultation is to be assured that it adheres to the Gunning Principles. The full consultation report has been reviewed by Warrington SLT				
Impact (x) (further detail to be provided in body of paper)	**Financial**	**IM &T**	**Workforce**	**Estate**	
	Legal	**Health Inequalities**	**EDI**	**Sustainability**	
	X		X		
Route to this meeting	The consultation report was presented and approved at Warrington's Senior Leadership Team. The team was assured of the consultation process, approved the Equality Impact Assessment and were impressed by the high quality of the work.				
Management of Conflicts of Interest	N/A				
Patient and Public Engagement	Formal public consultation report				

Next Steps	No further paper is needed. Local arrangements are in place through contract monitoring and a further engagement exercise is planned to ensure the new model meets the needs of the community.
Appendices	Consultation Report (not included in the pack but available on request)

Glossary of Terms	**Explanation or clarification of abbreviations used in this paper**

Warrington Primary Care Networks Enhanced Access Consultation Report

1. Executive Summary

1.0 The report relates to the new GP contract arrangements for Enhanced Access from October 2022 that will be the responsibly of PCNs.

1.1 From 2019 Warrington PCNs have worked together to develop their model. Their preferred model involved their proposal to move the current service from Bath Street Health and Wellbeing Centre to local venues within their PCN footprint. The proposed model was presented to Warrington's Health Overview and Scrutiny Committee, who agreed that the changes constituted a substantial variation, so a formal public consultation was required.

1.2 In the absence of local PCCC arrangements our place Senior Leadership Team (SLT) approved the consultation report and the System Primary Care Committee is asked to be assured of the process.

2. Introduction / Background

2.0 On 1st March 2022, NHS England published the updated GP contract regulations for 2022/23. The contract includes arrangements for a new enhanced access service, which is the further development of two existing services, known as extended hours service and extended access service (further information can be found below). This new service aims to improve patient access to primary care.

2.1 Each PCN must have submitted a draft Enhanced Access Plan to the ICB, this must set out how the PCN is planning to deliver enhanced access from October 2022 and include how the PCN plans to or has engaged with their patient population and will or has considered patient preferences.

2.2 Warrington PCNs, from their planning work from 2019, when it was announced that Enhanced Access would be transferred to the PCNs, worked up their preferred option which included moving the current service from Bath Street Health and Wellbeing Centre to local venues within the PCN footprint.

2.3 The proposed model and consultation plan were presented to Warrington's Health Overview and Scrutiny Committee, who agreed that the changes constituted a substantial variation, so a formal public consultation was required.

2.4 Warrington place Senior Leadership Team have approved the report and are assured the consultation adheres to the Gunning Principles and pay due regard to the Public Sector Equality Duty.

3. Main Body of report

3.0 The PCNs worked together to undertake one Warrington wide consultation to seek the views of patients and the public on their new models, including views on the change of service location, time and days of the service.

3.1 The PCNs undertook comprehensive communication and engagement activities, with considerable reach into the community, including those representing seldom heard groups. Overall, the majority of respondents were in favour of the new enhanced access model. The main themes that were highlighted as concerns were the choice of venues, transport issues, access, impact on current services and communications. The mitigations highlighted in the report are:

- Additional venues have now been sourced where the service will be offered from, these now include Penketh, Dallam Lane, Culcheth and Lymm
- There will be a comprehensive communications campaign when the new service is launched that will inform patients how to access the service, the benefits of the model and reaffirm that this is an additional service offer and it is patient's choice, if patients would find it difficult to access or choose not to use the service this doesn't alter the core service at individual GP Practices during normal opening hours. There will be targeted communications to people with disabilities and mental health issues due to comments that were feedback via the consultation.
- All practices will receive information and training, to ensure they know where to find enhanced access appointments on the clinical system. It is also important to state that the same system that has been used for the pilot schemes will continue to be in operation, so practice staff already have experience of the process, which should reduce the risk of some practice patients not being offered the appointments.
- The PCNs have confirmed that each of the proposed locations has ample parking, as well as spaces for disabled patients. It is crucial that the sites are accessible for disabled patients, all of our GP practices must have mechanisms in place for people with disabilities to access and it is a legal requirement.
- The new service is enhancing patients access to Primary Care. GP Practices will continue to be open between 8am-6.30pm and then each week our PCN will offer approx. 55 hours (3,343 minutes) worth of appointments in an evening and on a Saturday on top of those offered during core hours. The service will be offering appointments in an evening and on a Saturday on top of those offered during core hours.

3.2 From the Equality Impact Assessment that was carried out it was identified that the new model should not negatively impact patients. From the consultation there were two equality issues that were highlighted.

- From the survey results people with disabilities were (slightly) less likely to have understood the model, are more concerned about the move away from Bath St and are less convinced of the convenience of the new venues. The additional of the four new venues should mitigate concerns relating to convenience and targeted communications will be undertaken with organisations who support and work with people with disabilities to ensure they are assured on the new model, how to access the service and where the new venues are.
- There was one concerning comment stating the new model will make many feel suicidal, therefore targeted communications and engagement will be undertaken with those

groups and organisations who support and work with people with mental health issues to ensure they understand the new model and it is an additional service that is their choice if they want to access or not. For patients who need continuity of care their GP Practice will continue to offer the normal access.

4. Next steps

- Warrington PCNs will implement the model from October 2022
- ICB place teams will support the PCNs with their communications campaign
- There will be a PCN led engagement exercise approximately eight months after the implementation of the new model to ensure it is meeting the needs of the community. There will be targeted work with people with disabilities and mental health issues.

5. Recommendations

5.0 **The Committee is asked to:**

- Note the consultation report
- Be assured that the consultation process meets the Gunning Principles
- Be assured that the consultation adheres to the Public Sector Equality Duty

6. Officer contact details for more information

Katie Horan
Senior Engagement and Equality Manager
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01925 303030

Classification: Official

Publication reference:

Pre-Delegation Assessment Framework for 2023 Delegations: Pharmaceutical Services, General Ophthalmic Services, and Dental (Primary, Secondary and Community) Services

21 July 2022, Version 1

Pre-Delegation Assessment Proforma for Pharmaceutical Services, General Ophthalmic Services, and Dental (Primary, Secondary and Community) Services

The questions below are aligned to the domains and criteria set out within the pre-delegation assessment framework for Pharmaceutical Services, General Ophthalmic Services, and Dental (Primary, Secondary and Community) Services (see Annex 1) and should be completed and signed-off by each ICB, and the relevant NHS England Regional Director of Commissioning. The responses should be verified by the relevant Regional Director, and the completed proforma sent to england.directcommissioning@nhs.net by **Monday 3 October 2022**.

As part of this assessment process, regional teams will need to approve the accuracy of each response and to provide confirmation of whether they support the ICB's assessment of risk for each question. No additional attachments should be provided as part of the submission.

Completing the assessment

- Responses should be inputted into the template below.
- Examples of supporting activities can be found in the response column in grey italics. These should be deleted prior to submission.
- Responses should be concise and focus on key existing and planned activities that demonstrates capability to assume responsibility for these functions from April 2023.
- Alongside the PDAF, ICBs will also work through a Safe Delegation Checklist which sets out key actions to be completed to support a safe and smooth transition to new delivery arrangements.
- Further resources will be made available on NHS Futures to support completion of PDAF submission and preparations for delegation. If you require any further support, please contact england.directcommissioning@nhs.net.

Name of ICB	[NHS Cheshire and Merseyside Integrated Care Board]
For completion of the Safe Delegation Checklist, please confirm that: ➢ A senior responsible officer and workstream leads have been identified ➢ A delivery plan, including key milestones has been agreed	 Yes / No [DELETE AS APPROPRIATE] Yes / No [DELETE AS APPROPRIATE]

Domain 1: Transformation and Quality **Leads : Chris Leese (ICB) Tom Knight, David Scannell (NHSEI)**				
Question	**Response**	**Current RAG[1] rating at [insert date]**	**Projected RAG[2] rating at March 2023**	**Regional commentary**
Will the ICB have a (shared) understanding of how the functions could be used to deliver additional benefit for people who use services, and could be integrated with current processes and pathways to do so?	Yes / No	R ☐ A ☐ G ☐ C ☐	R ☐ A ☐ G ☐ C ☐	
Are there current or expected mechanisms through which people who use services and the public could be actively engaged and involved in shaping the functions to be delegated?	Yes / No			
Please provide further details of the key actions that are planned /have				

[1] R: Not on target, significant concerns; A: On target, minor concerns; G: On target, no concerns; C: Completed

[2] R: Readiness by Mar 2023 is not achievable; A: Delivery by Mar 2023 is at risk but mitigation plan in place; G: On target for readiness by Mar 2023; C: Completed

been undertaken in support of this domain *(400 words max).*	*ICB response* *Examples of supporting activities include: POD functions reflected in ICB forward plan; ICB strategies for engaging with people and communities include the delegated POD functions; Communications plans for POD delegations; Mapping of delegated functions and the benefits these will bring for the local population; POD functions reflected in overall ICB quality arrangements; Embedding POD within existing ICB quality and associated improvement priorities; Plan to ensure that quality in POD is measured consistently, using nationally and locally agreed metrics triangulated with professional insight and soft intelligence.*			
Please describe any known issues/risks associated with this domain. What mitigation plans does the ICB have to address these issues/risks?	*ICB response*			
What support is needed to ensure the ICB is ready to assume responsibility for these functions from April 2023?	*ICB response*			

Domain 2: Governance and Leadership Leads ; Clare Watson/Matthew Cunningham (ICB) Tom Knight, David Scannell (NHSEI)				
Question	**Response**	**Current RAG[3] rating at [insert date]**	**Projected RAG[4] rating at March 2023**	**Regional commentary**
Will the ICB have sufficient general governance capability (mature structures, appropriate expertise) to oversee the functions at every appropriate tier of their commissioning and delivery?	Yes / No	R ☐ A ☐ G ☐ C ☐	R ☐ A ☐ G ☐ C ☐	
Will the ICB have sufficient clinical governance capability and leadership to oversee the functions?	Yes / No			
Will the ICB have mechanisms in place which allow for the identification and monitoring of emerging risks, impacts, and unanticipated dependencies in the immediate post-delegation period?	Yes / No			
Will the ICB have broad agreement amongst the parties[5] relevant to delivering the functions on the approach to monitoring and governance?	Yes / No			
Please provide further details of the key actions that are planned /have been undertaken in support of this domain *(400 words max).*	*ICB response* *Examples of supporting activities include: Identified board level leadership and expertise in*			

[3] R: Not on target, significant concerns; A: On target, minor concerns; G: On target, no concerns; C: Completed
[4] R: Delivery by Mar 2023 is not achievable; A: Delivery by Mar 2023 is at risk but mitigation plan in place; G: On target for delivery by Mar 2023; C: Completed
[5] *For example, all parties (e.g. other ICBs) where joint arrangements for the delivery of the delegated functions are being developed.*

	relation to the POD functions; Integration of primary care into system wide commissioning and development arrangements; Plans to ensure that quality and risk issues relating to POD are linked into existing ICB governance and accountability structures; description of clinical governance arrangements; proposed governance and accountability structure for POD and how this integrates into wider ICB governance and accountability structure and relationship with place based partnerships; robust governance arrangements for risk identification, management and escalation for the POD functions; plans to monitor performance and quality.			
Please describe any known issues/risks associated with this domain. What mitigation plans does the ICB have to address these issues/risks?	*ICB response*			
What support is needed to ensure the ICB is ready to assume responsibility for these functions from April 2023?	*ICB response*			

Domain 3: Finance Leads : Mark Bakewell/ Lorraine Weekes Bailey (ICB) Ian Lythgoe (NHSEI)				
Question	**Response**	**Current RAG[6] rating at [insert date]**	**Projected RAG[7] rating at March 2023**	**Regional commentary**
Does the ICB have an understanding of allocated ICB budgets and expenditure on other primary care services?	Yes / No	R ☐ A ☐ G ☐ C ☐	R ☐ A ☐ G ☐ C ☐	
Has the ICB undertaken a financial risk assessment and developed a plan to mitigate any financial risks identified?	Yes / No			
Please provide further details of the key actions that are planned /have been undertaken in support of this domain *(400 words max).*	*ICB response* *Examples of supporting actions include: Financial plans and risk assessments*			
Please describe any known issues/risks associated with this domain. What mitigation plans does the ICB have to address these issues/risks?	*ICB response*			
What support is needed to ensure the ICB is ready to assume responsibility for these functions from April 2023?	*ICB response*			

[6] R: Not on target, significant concerns; A: On target, minor concerns; G: On target, no concerns; C: Completed

[7] R: Delivery by Mar 2023 is not achievable; A: Delivery by Mar 2023 is at risk but mitigation plan in place; G: On target for delivery by Mar 2023; C: Completed

Domain 4: Workforce, Capability and Capacity **Leads : Arden and Gem CSU Supporting overall** **Chris Leese (workforce and capability) Chris Samosa (HR/People) (ICB)** **David Scannell / Tom Knight (NHSE/I)**				
Question	**Response**	**Current RAG[8] rating at [insert date]**	**Projected RAG[9] rating at March 2023**	**Regional commentary**
Will the ICB understand the capacity, capabilities and skills it needs to deploy to exercise the function upon assuming responsibility?	Yes / No	R ☐ A ☐ G ☐ C ☐	R ☐ A ☐ G ☐ C ☒	
Could the ICB confirm that the capacity, capabilities and skills needed to exercise the function upon assuming responsibility can be made available in due course?	Yes / No			
Please briefly provide further details of the key actions that are planned /have been undertaken in support of this domain (*400 words max).*	*ICB response* *Examples of supporting actions/information include: Agreed workforce model for POD; People Impact Assessment (or similar) which takes into account the impact of change on all affected staff (including POD, Complaints and supporting functions); Evidence of mapping of external support mechanisms (e.g. CSU, shared services etc); Staff transition plans; Staff OD*			

[8] R: Not on target, significant concerns; A: On target, minor concerns; G: On target, no concerns; C: Completed

[9] R: Delivery by Mar 2023 is not achievable; A: Delivery by Mar 2023 is at risk but mitigation plan in place; G: On target for delivery by Mar 2023; C: Completed

	plans including capabilities for the delegated functions.			
Please describe any known issues/risks associated with this domain. What mitigation plans does the ICB have to address these issues/risks?	*ICB response*			
What support is needed to ensure the ICB is ready to assume responsibility for these functions from April 2023?	*ICB response*			

Signatories
This document should be signed by the ICB and the relevant NHS England Regional Director of Commissioning. It should also be verified and signed by the relevant NHS England Regional Director.
For completion by the ICB Chief Executive (and, where different, the duly authorised signatory of the delegation agreement as defined by the ICB Scheme of Reservation and Delegation): I confirm that the information provided is accurate and complete. This submission indicates our willingness to proceed with delegation and sign the Delegation Agreement. **Signed by** NHS [Insert name] Integrated Care Board [Name] [Name] [Title] [Title] Signature (insert scanned image of handwritten signature) Signature (insert scanned image of handwritten signature) Date: Click or tap to enter a date. Date: Click or tap to enter a date.
For completion by the NHS England Regional Director of Commissioning: I confirm that the information provided is accurate and complete. **Signed by** [Name] NHS England Regional Director of Commissioning Signature (insert scanned image of handwritten signature)

Date: Click or tap to enter a date.

For completion by the relevant NHS England Regional Director:

Based on the information provided, I am satisfied that the ICB will be ready to proceed to delegation in April 2023.

Please check box as appropriate.

Yes ☐
No ☐

Please provide any further comments below if 'No' has been selected and summarise the rationale behind this decision:

Signed by

[Name]

Regional Director

Signature (insert scanned image of handwritten signature)

Date: Click or tap to enter a date.

Annex 1: Pre-Delegation Assessment Framework: Pharmaceutical services, General Ophthalmic services and Dental services (primary, secondary and community)

Introduction and Context

In May 2022, NHS England set out its intention to delegate responsibility to all ICBs for all pharmaceutical services, general ophthalmic services and dental services (primary, secondary and community) (known collectively as 'POD services') in April 2023. Details of this have been set out here.

The pre-delegation assessment framework (PDAF) has been developed to support ICBs to prepare to take on POD services from April 2023. A separate PDAF for specialised services has been developed. This has been aligned to the POD PDAF but has been tailored specifically for specialised services commissioning.

The POD PDAF for the 2023 delegations is based on the Framework that was used to assess ICSs that wished to take on these functions in 2022. The Framework is structured around four domains with underpinning criteria that set out the minimum standards which should be met by ICBs prior to delegation in April 2023. The PDAF should be viewed alongside the Safe Delegation Checklist that has been developed to provide further details on the specific tasks and activities that will be required to support delegation against the four domains.

Each ICB will be required to complete the assessment proforma above with the support of their NHS England regional team. Regional teams will need to approve each ICB's submission and assessment of risk before the completed proforma is submitted nationally. These submissions will be reviewed by a National Moderation Panel in October 2022 which will provide a recommendation to the NHS England Board for formal approval on 1 December 2022.

Principles of Pre-Delegation Assessment Framework

Domain	Principle
Transformation and Quality	There is a clear understanding of how receiving each new responsibility will benefit population health outcomes, deliver improved care quality, reduce health inequalities, improve preventative capacity, and increase efficient use of resources.
	There is a shared understanding across all ICS partners on the benefits of delegation.
Governance and Leadership	Governance enables safe, high quality delivery.

	Clinical leadership combines the specialist expertise to lead and scrutinise individual functions, and the collaborative working necessary to identify, enable, and oversee clinical improvements.
Finance	There is an understanding of budgets and expenditure for other primary care services and an agreed plan for managing financial risks identified.
Workforce and Capability	There is an understanding of the workforce and capability and capacity requirements, with any major risks understood and processed for mitigation.

Domains and criteria

The principles detailed above have informed the development of underpinning criteria across the four domains. These criteria describe the plans, governance and activities that ICBs will need in place or to have undertaken prior to assuming responsibility for the functions in April 2023.

1. Transformation and Quality	
Domain description	**Criteria**
ICBs will have clear, feasible plans to improve population health outcomes which are compatible with the use of the delegated functions. These plans will be underpinned by realistic and sustainable financial assumptions, integrated with existing ICB plans and reflect patient priorities and engagement.	The ICB has plans which demonstrate how it could use the functions to improve population health, deliver improved care quality, reduce health inequalities, improve preventative capability, co-produce services with patients, and increase efficient use of resources.
	The ICB has demonstrated an understanding of how the functions could be integrated into wider pathways, including interfaces with provider collaboratives, for patient benefit. It will also demonstrate how this transformation aligns with national policy where appropriate.

2. Governance and Leadership	
Domain description	**Criteria**
ICBs will have a clear governance structure in place. This must involve the expertise necessary to scrutinise individual functions, and to oversee integrated planning and service development encompassing multiple functions. ICBs will determine whether the	The ICB will have clear governance and accountability structures covering every stage of the planning cycle.
	The ICB will have developed governance and accountability structures to make

decisions made on particular functions should be at system or place level, and develop governance accordingly. Clinical leadership should be robust and embedded throughout. Engagement mechanisms should enable people who use services to influence commissioning decisions.	decisions at the appropriate level for each function.
	The ICB will have sufficient expertise (clinical, operational, and financial and strategic) embedded in its governance and accountability structures to ensure that each function can be adequately overseen, including having robust impact assessment processes.
	The ICB will have robust governance processes that allow for the effective identification, evaluation, escalation, recording and monitoring of risk.
	The ICB will have cross-functional governance and accountability structures which can oversee integrated pathways, and which align with other stakeholders to support integration and co-commissioning.

3. Finance	
Domain description	**Criteria**
The ICB will have a plan to deliver financial objectives for the delegated POD functions	The ICB will have an understanding of allocated budgets and expenditure on other primary care services for 2022/23 and 2023/24.
	The ICB will have undertaken a financial risk assessment.
	The ICB will have developed a plan to mitigate financial risks identified.
	Additional criteria placeholder

4. Workforce, Capability and Capacity	
Domain description	**Criteria**
The ICB will assess the capability development and capacity needed to deliver the function, and to ensure a smooth transition for staff (in alignment with the applicable regional workforce model). The workforce model enables population health benefits. Evidence of consideration of the wider needs of staff – for example,	The ICB has assessed its current workforce capabilities through a People Impact Assessment (or similar) and future needs, demonstrating that it has, will possess, or will have access to sufficient resource, capability, and capacity to commission the delegated functions. This may incorporate assumptions on the number of staff already supporting the delegated functions required

OD and cultural integration – will be necessary.	now and in the future, and the mechanism for deploying them to align with the benefits identified.
	The ICB will map (where appropriate) where external support will be needed, and how this is expected to evolve over time. This may imply CSU support, shared services between ICSs, or interfacing with NHSEI regions to provide assurance in relation to their workforce capability to deliver delegated functions.
	The ICB will have developed an understanding of how transitioned staff will integrate into existing teams; the ICB's application for delegation will be based on utilising an employment model(s) from the HR Framework.
	The ICB will have aligned the development of new staffing capabilities and the integration of staff with broader OD and change management processes, connecting with any initiatives and stakeholders which will enable integration including where appropriate with wider stakeholders.
	The ICB will have demonstrated that its senior leadership has appropriate capability, capacity, and information. Robust clinical leadership should be demonstrably established.