NHS
Liverpool
Clinical Commissioning Group

AGENDA FOR

PRIMARY CARE COMMISSIONING COMMITTEE			
Date:	Tuesday 16 February 2021	Time:	10.00 – 11.30 am
Venue:	MS Team Call		

No	Item	Lead	Note / Information / Decision
A	Introduction and apologies		
A1	Welcome & Introductions	Gerry Gray	Verbal to note
A2	Apologies received:	Gerry Gray	Verbal to note
A3	Declarations of Interest	Gerry Gray	Verbal to note
A4	Previous Minutes – 15 December 2020	Gerry Gray	Paper for decision
A5	Action Log	Gerry Gray	Paper for decision
A6	Primary Care Commissioning Committee Work Plan	Cheryl Mould	Paper for noting
B	Updates		
B1	NHSE	Tom Knight	Verbal Update
B2	ARRS Waiver Process Applications December 2020 and January 2021.	Mark Bakewell	Verbal Update
C	Governance		
C1	Primary Care Commissioning Risk Register	Cheryl Mould	Paper for noting
D	Performance		
D1	Primary Care Commissioning Committee Performance Quality and Contracts Report	Jane Lunt / Val Attwood	Paper for noting
D2	Primary Care Commissioning Committee Finance Report	Mark Bakewell	Paper for noting
D3	Primary Care Performance Management Process	Val Attwood	Paper for decision
E	Strategy and Commissioning		
E1	LQIS schemes 2021-22	Dave Horsfield	Paper for noting
E2	Primary Care Estates – Lease decisions	Val Attwood	Paper for decision
F	Any Other Business		
F1	Any Other Business		

Dates of Future Meetings:	Deadline for papers/questions:
• Tues 20th April 2021; 10.00 – 12.00	• 9th April
• Tues 15th June 2021; 10.00 – 12.00	• 4th June
• Tues 17th August 2021; 10.00 – 12.00	• 6th August
• Tues 19th October 2021; 10.00 – 12.00	• 8th October
• Tues 21st December 2021; 10.00 – 12.00	• 10th December
• Tues 15th February 2022; 10.00 – 12.00	• 4th February

Primary Care Commissioning Committee - Action Log							
Date of Meeting	**Agenda Item**	**Action**	**Executive Lead**	**Operational Lead**	**Proposed Date of Completion**	**Item Status**	**Comments**
20 October 2020 - Primary Care Commissioning Committee meeting							
20-Oct-20	D2 PRIMARY CARE PERFORMANCE MATRIX	Clarify if MCFT were accepting dementia referrals routinely **	F Lemmens		Dec-20		Update Dec 20 - FLE not at meeting, item deferred to Feb 21 meeting.
15 December 2020 - Primary Care Commissioning Committee meeting							
15-Dec-20	C1 PRIMARY CARE COMMISSIONING COMMITTEE RISK REGISTER	Update register in line with discussions;	S Hendry		Feb-21		
15-Dec-20	D1 PRIMARY CARE COMMISSIONING COMMITTEE PERFORMANCE QUALITY AND CONTRACTS REPORT	Discuss contractual requirements for extended hours and bring findings to next meeting	D Horsfield	V Attwood	Feb-21		
15-Dec-20	D1 PRIMARY CARE COMMISSIONING COMMITTEE PERFORMANCE QUALITY AND CONTRACTS REPORT	Review PCNs and include maturity matrix within the yearend review.	D Horsfield		Apr-21		

KEY

TO ACTION
ONGOING
NOT YET DUE
COMPLETED

** This item was added retrospectively when picked up in the minutes of the previous meeting (Oct meeting picked up at Dec meeting) that it was not recorded as an action and should have been.

[Type here]

Primary Care Commissioning Committee (PCCC) Work Plan 2020/21 based on the PCCC TOR May 2020

Agenda Items / Issues	Frequency	April	June	Aug	Oct	Dec -	Feb
PERFORMANCE							
Contract & Finance Report	Each meeting	x	x	x	x	x	x
LQIS, DES, Prescribing Projects Report				x			x
STRATEGY AND COMMISSIONING							
Budget setting and management	Annual	x					
APMS Options	When required						
Approval of Local Quality Improvement Schemes	Annual	x					
Quarterly feedback on schemes approved at PCCC and cost savings	Quarterly (or bi-annual)		x		x		x
GMS, PMS and APMS contracts monitoring, contractual action ie issuing branch/remedial notices, and removing a contract							
Needs assessment and review of requests to establish new practices in an area							
Approval of practice mergers							
Sign off of discretionary payments							
Review, sign off and support for infrastructure, premises and estates plans							
PCN delivery, development, ARRS and specifications							
GOVERNANCE							
Risk Register	Each meeting	x	x	x	x	x	x
Action Plan from MIAA review of PCCC	Each meeting			x	x	x	x
Quality Audit Results						x	
UPDATES							
NHS England Updates	Each meeting (Verbal)	x	x	x	x	x	x

The Committee will receive a summary of CQC reports pertaining to GP practices commissioning services in the Liverpool area, and receive assurance from the practice that any actions highlighted by CQC are being addressed. The Committee may also receive recommendations from the Performance & Quality Committee which may require action to be taken in relation to contractual levers.

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Reporting to:	Primary Care commissioning Committee			
Date of Meeting:	16th February 2021			
Title of Report:	PCCC Risk Register February 2021			
Presented by	Mark Bakewell, Chief Finance and Contracting Officer			
Report Author	Jacqui Waterhouse, Senior Programme Delivery Manager			
Lead Governor	Gerry Gray			
Senior Leadership Team Lead	Cheryl Mould, Director Liverpool Provide Alliance			
Report Category	Decision ☐	Discussion ☐	Assurance ☒	Information ☐

Purpose of this report

This report is to provide members of the committee with:

- An update on the current risks and mitigations of the PCCC risk register as at February 2021

Recommendation(s)

The Committee is asked to:

a) Notes the contents and updates of risks for the commissioning of General Practice
b) Considers current control measures and whether action plans provide sufficient assurance on mitigating actions, Review the mitigations and progress
c) Agrees that the risk scores accurately reflect the level of risk that the CCG is exposed to given current controls and assurances

Is this subject matter confidential?	Yes ☐	No ☒

Relevance to CCG Strategic Objectives / Governing Body Assurance Framework

01	Commissioning for better health outcomes	☒
02	Ensure commissioning of high quality, safe and responsive health services	☒
03	Reduce health inequalities	☒
04	Ensure maximum value from available resources	☒
05	Decisions that are evidence-based and evaluated for maximum impact	☒
06	Maintain the CCG's reputation and safeguard public confidence	☒

Executive summary

Since the last iteration of the risk register presented to the PCCC in December 2020 responsible Directors and risk owning officers have reviewed their associated risks with mitigating actions having been updated.

Governance and reporting arrangements
(list the committees, groups or other bodies that have discussed this report)

Date	Meeting	Decision made / outcome

Were there any conflicts of interest identified at any of the above meetings?
Yes ☐ No ☐
If 'Yes, please give brief details:

Implications	**Yes**	**No**	**N/A**
Quality	☐	☐	☐
Patient Experience	☐	☐	☐
Conflicts of interest	☐	☐	☐
Equality / PSED	☐	☐	☐
Privacy or GDPR	☐	☐	☐
Workforce	☐	☐	☐
Are there any risks associated with this report or its recommendations?	☐	☐	☐
Are these risks included on the Corporate Risk Register (CRR) or GBAF?	☐	☐	☐

If 'yes', please provide CRR/GBAF reference number and risk description:

Equality & Human Rights Analysis	Yes	No	N/A
Do the issue(s) identified in this report affect one of the protected group(s) less or more favorably than any other?	☐	☐	☒
Are there any valid legal/regulatory reasons for discriminatory practice?	☐	☐	☒
If the answer to either of the above two questions is 'YES', please include a section in this report explaining why.			

1. BACKGROUND

NHS Liverpool CCG has a statutory commitment to effectively monitor risks associated with its commissioning activities against its strategic objectives including General Practice via effective and robust risk management procedures.

The Primary Care Risk Register is a structured framework underpinned by governance arrangements and internal controls that enable the identification and management of acceptable and unacceptable risks. Where the risk score cannot be reduced escalation should be considered to the Governing Body Corporate Risk Register.

The Primary Care Commissioning Committee is a mandated committee with the Terms of Reference largely dictated by NHS England, but this does not exclude the committee from having the same responsibilities as part of the CCGs internal governance arrangements.

2. FEBRUARY UPDATE

Many of the mitigations of risk contained within the primary care risk register have been suspended pending to return to business as usual processes, the CCG has contacted all practices and PCNs with regards to the change in approach to performance monitoring and management whilst the NHS remains in command and control and resources are diverted to deal with the pandemic, recovery and vaccine response.

Lead managers have updated this version on behalf of the risk owning CCG directors and have reviewed their associated risks with mitigating actions having been updated.

The following are key updates

- 0.1 Quality improvement schemes – An update paper is to be presented to the PCCC in February
- 0.10 Flu vaccination programme - February 2021 update: The 2020/21 flu vaccination is now coming to an end. Although vaccinations can continue up to the end of February. At end of year NHSE report will be available at the end of March but indicative data suggests that uptake rates in Liverpool have slightly increased in all cohorts on the previous year with the exception of Pregnant Women. The reduced uptake in Pregnant Women is a pattern seen across C&M and more work needs to be undertaken to understand this. Uptake in the additional cohort introduced in December 2020 for patients aged 50-64 is currently at 68% in Liverpool. This was a new cohort and it is not yet known if this cohort will be included in the 2021/22 programme
- 0.11 COVID vaccination – February 2021 update: The covid vaccination programme is going well in Liverpool an continues to meet government targets to vaccinate people within the JCVI cohorts. As of 15th February over 111,000 vaccine have been administered across Liverpool.

The Liverpool model includes:

Pillar 1 Hospital Hubs x 4 - focused on front line health & social care staff.

Pillar 3 Local Vaccination Sites (PCN led) x 11 - focused care home residents, patients aged over 70 and clinically extremely vulnerable adults.

Moving onto cohorts 5 and 6 from mid-February - aged 65-59 and high risk adults and their carers.

Supplementary sites (PCN led) x 3 aimed at improving accessibility for harder to reach groups.

Pillar 4 Pharmacy Sites x 3.

The Risk Register attached as appendix 1 therefore reflects the risks, current controls, assurance and action plans associated with the CCG objectives as delegated to the Primary Care Commissioning Committee as at February 2021.

3. STATUTORY/LEGAL/REGULATORY REQUIREMENTS (only applicable to strategy & commissioning papers)

3.1 **Does this require public engagement or has public engagement been carried out?** Yes ☐ No ☒

i. If 'no' explain why

ii. If yes attach either the engagement plan or the engagement report as an appendix. Summarise key engagement issues/learning and how responded to.

4. QUALITY IMPACT ASSESSMENT

4.1 Does the public sector equality duty apply? Yes ☐ No ☒

4.2 If 'no', please state why.

4.3 If 'yes' summarise equalities issues, action taken/to be taken and attach engagement EIA (or separate EIA if no engagement required). If completed state how EIA is/has affected final proposal.

5. FINANCIAL IMPLICATIONS AND RISK

Describe how this will promote financial sustainability or risks to delivery of the CCG's Financial Plan (if applicable).

6. WORKFORCE IMPLICATIONS

Describe how this will affect internal workforce capacity (e.g. working at scale, joint working, accommodation etc.) if applicable.

7. COMMUNICATION REQUIREMENTS

Describe how this will be communicated to staff, stakeholders, patients and / or public (including timescales).

8. CONCLUSION

The Primary Care Commissioning Committee Risk Register updates will be presented to the committee with any escalated risk reported through the Corporate Risk Register to the Governing Body as appropriate.

Ends

Risk Ref (includes date added to rag)	Relevant CCG Objective	Risk Description Risk Owner Lead Committee	Cause and potential impact/consequence of risk (Why could this risk occur and what would be the effects if the risk materialised?)	L	C	Inherent Risk Score (without controls)	Existing Mitigation/Controls (How are we managing this risk? What are the key controls in place to prevent this risk from occurring?)	Assurance/Evidence (Who/where can we gain evidence that these controls are working effectively? All assurances are 'positive' unless stated otherwise. I = Internal E= External	L	C	Residual Risk Score (Current)	Trend (Movement since last update & date last reviewed)	Planned Actions (Is this action to address a gap in Control (C) or a gap in Assurance (A) Must include 'Action Owner' *and* Implementation Date	Progress On Actions (What stage are planned current actions at? Are Implementation Dates on track? How will this impact on Residual Risk?	L	C	Target Risk Score (risk tolerance)
PCCC 0.1	Commission for better health outcomes	Required contribution to improved health outcomes from Local Quality Improvement Schemes (inc GP spec and LD DES) not achieved Samson James	Lack of process to ensure schemes are delivering the intended results and are potentially not providing value for money.	4	4	16	Regular review of specifications and expected standards to ensure they are meeting local need and are evidence based. Monitoring of ongoing delivery and action plans if not on trajectory. Dec; Process agreed, performance team managing process	PCCC standard/exception reporting to Governing Body (I)	3	4	12		Full review of specifications to take place March – April 2020 to evaluate continued relevance, service quality and value for money and make recommendations to be considered by PCCC. (Paula Guest) August - Delayed due to COVID but initial assessments are being progressed with further work to be done.	April 2020 update Actions are currently suspended during the COVID-19 response. July 2020 update - Review of LES's underway. Initial paper to PCCC in August 2020 and recommendations to PCC in Sept 2020. Delayed due to COVID will now be October. Paper with recommendations to PCCC Oct 2020. Task & finish group Oct - March to progress delivery. Dec 20 - All schemes now reviewed by Task & Finish Group; paper and service specs to PCCC December meeting. Update to February PCCC	2	4	8
PCCC 0.3	Commission for better health outcomes	Not all patients have access to General Practice services should a practice or large scale provider close/fail Mark Bakewell	Pressure on other practices staff and premises to provide services for dispersed lists if a provider closes due to, for example, CQC closure, contract issue, financial issue, succession planning failure. Loss of continuity of care for vulnerable patients. Potential impact on patient safety if greater numbers in receiving practices.	3	4	12	Support for providers including regular contract reviews. Interim provider policy in place Mobilisation check list for closures in place, including clarity of roles and responsibilities of provider and commissioner during a practice closure Performance and quality committee and sub-committee have recommenced during Q3 with regular review and challenge of provider performance at these meetings.	Triangulation of risk by Quality and Safety Assurance Group.(I) Escalation to Quality and Safety Outcomes Committee.with oversight by CCG Governing Body via exception reporting.(I)(I)	2	4	8		Development of a CCG system for early warning system and structure for triangulation of issues to be established. (C) Sam James Team Quality monitoring for early identification of deteriorating performance framework (C) Jane Lunt Team Action Owner: Director of Quality & Improvement	Due Date: Ongoing	2	3	4
PCCC 0.4	Ensure maximum value from available resources	The CCG is unable to deliver its financial plan for 2020/21. Mark Bakewell	Lack of robust budgetary control and uncertainty of expenditure fluctuations in the delegated Primary Care budget could affect delivery of the CCG Financial Plan, resulting in failure to meet NHS England Business Rules at year-end.	3	3	9	• Temporary financial regime covered the period October 20 - March 21with CCG allocations for this period based on average expenditure levels as at February 2019/20. Excess of costs above notified allocations (incl. COVID-19 expenditure) have been fully funded through the NHSE 'True-Up' allocation process. Planning guidance has been received regarding the final 6 months of 2020/21 and the NHSE 'True-Up' allocation process has now ceased, with CCGs to achieve financial balance within system envelope . • SoRD details budget holder and SMT lead delegated limits by cost centre. •Robust financial monitoring of operational positions via formal monthly budget holder meetings - maintained throughout the year (forecast outturn is regularly updated in line with known issues) with plans for mitigation included • Financial position is reviewed at each Performance and Quality Committee (PCQ) meeting and reported on a monthly basis. • Financial position is reviewed every second month at the Primary Care Co-Commissioning Committee • Formally report Prescribing financial position and delivery to MOC on a quarterly basis. • Implemented Actions from Internal Audit Recommendations with regards to delegated Clinical Commissioning Groups and Financial Management to improve systems and processes Guidance is reviewed upon publication to ensure the most accurate expenditure and forecast positions in line with latest expectations.	• Revenue Resource Limit (Allocation) adjustments to 'true up' or 'true down' NHSE allocations in line with reported expenditure for April to Sepetmber 20 have been actioned each month retrospectively resulting in a reported break-even position for the period. • PQC review 'monthly reporting packs' - committee is made aware of cost pressures on a timely basis (In) • Primary Care Co-Commissioning Committee review financial position every second month - committee is made aware of cost pressures on a timely basis (In) • Finance Update Report including Primary Care and Prescribing budgetary performance is standing agenda item at each Governing Body meeting summarising budget and forecast figures (In) • Internal Audit review of 5 areas of Financial Systems and Process including Budgetary Control and financial management in 2019/20 resulted in 'Substantial Assurance' rating - validation of CCG systems and processes in place (awaiting 2020/21 results). (Ex) • Internal Audit review of delegated Clinical Commissioning Groups gives assurance on financial controls and processes and identifies areas of improvement. Actions have been implemented in line with recommendations and will improve 'grip' on financial monitoring which will support reduction in risk as year progresses. 2020/21 Internal Audit review resulted in a 'Substantial Assurance' rating. (Ex)	2	3	6		1. Hold extra-ordinary meetings as required for any urgent issues that may arise in between usual monthly meetings to aid decision making, assess financial implications and gain more timely resolution (A) Feb 2020 Action Owner - Senior Finance Manager Due Date: Feb & March 2021 2. Continue to monitor and implement guidance as received and ensure the monthly expenditure reporting process is robust. Action Owner - Senior Finance Manager 3. Adhering to financial governance and NHSE guidance when approving any COVID-19 related spend. Action Owner - Senior Finance Manager / Senior Leadership Team	1. Ad-hoc meetings for immediate issues between finance, contracts, performance and commissioning teams to reduce residual risk of unplanned expenditure / propose mitigations Apr - ad-hoc meetings are taking place as required and are on-going virtually 2. Guidance is reviewed upon publication to ensure the most accurate expenditure and forecast positions in line with latest expectations. On-going as required 3. COVID-19 additional costs incurred by general practice are approved by the CCG's Senior Leadership Team prior to reimbursement being made. Reimbursement of costs are made in line with the COVID-19 support fund for general practice (CSF) guidance published on 4th August 2020. Claims made prior to 4th August 2020 are being retrospectively reviewed during November - December to ensure reimbursements processed comply with the terms set out in the guidance.	1	3	3
PCCC 0.5 Aug 19	Ensure maximum value for money from available resources	Not all Networks deliver on the requirements of the Contract Network DES Samson James	Not all patients have access to the services contained within the 7 national specifications. PCNs are not currently in a position to oversee and support quality improvement and reduce variation in member practices	3	3	9	Provider Alliance Staff working with Liverpool Network Alliance to support PCN delivery Jan; National specifications consultation has completed, but the final specifications have not been completed. Feb; Reporting evidence agreed, template in development April 2020 update NHSE have deferred implementation of some service specifications till later in the year, however Nursing Homes work is continuing as is sign up to the network contract DES 20/21 PCNs awaiting spec details from NHSE to plan for delivery from April 2020 Leads for each specification to be identified and groups established to progress action plans for care home, medication review and cancer specs. Workforce plans to be submitted for 21/22-23/24 by the end of October. CCG to submit collated responses to NHSE regional team 9th November 2020. Onemedical offering PCN support ARRS webinar October 2020. CCG Estates Group established to examine National guidance issued to PCNs on current / future estate needs for additional roles and support to the PCNs	Quarterly reporting to the PCCC (I) Care home alignment has taken place for 100% of homes. LNA providing support to PCNs with regards to workforce plans - all workforce plans submitted to NHSE for 20/21 in Oct 2020.	2	3	6		National guidance to PCNs on estates for additional roles and support to the PCNs to review current and future need to be discussed at CCG estates group.	Care home alignment has taken place for 100% of homes. LNA providing support to PCNs with regards to workforce plans. Oct - all workforce plans submitted to NHSE for 20/21 LNA supporting PCNs with making maximum use of Additional Roles Reimbursement Scheme underspend. Leads identified for specifications , working groups and action plans in place	2	3	6

Risk Ref includes date added to rag	**Relevant CCG Objective**	**Risk Description Risk Owner Lead Committee**	**Cause and potential impact/consequence of risk** Why could this risk occur and what would be the effects if the risk materialised?	**L**	**C**	**Inherent Risk Score** (without controls)	**Existing Mitigation/Controls** How are we managing this risk? What are the key controls in place to prevent this risk from occurring?	**Assurance/Evidence** Who/where can we gain evidence that these controls are working effectively? All assurances are 'positive' unless stated otherwise. **I** = Internal **E**= External	**L**	**C**	**Residual Risk Score** (Current)	**Trend** Movement since last update **&** date last reviewed	**Planned Actions** Is this action to address a gap in **Control** (C) **or** a gap in **Assurance** (A) Must include 'Action Owner' ***and*** Implementation Date	**Progress On Actions** What stage are planned current actions at? Are Implementation Dates on track? How will this impact on Residual Risk?	**L**	**C**	**Target Risk Score** (risk tolerance)
PCCC 0.7 New risk Oct 19	Commission for better health outcomes	PCNs at different stages of maturity, PCNs have different levels of funding and variation in access to external support Cheryl Mould	Progress towards delivery of the CCG One Liverpool Plan contribution of the networks is uncoordinated and risks not being delivered	3	3	9	PCNs have established a Local Network Alliance which meets regular. National maturity matrix published for PCNs to assess their development needs against. National PCN development support - guidance and prospectus published. Each PCN has an NHSE member of staff as a buddy to support with technical aspects of PCN development. The Clinical Directors meet twice per month to provide support and share best practice Dec; all PCNs completed maturity matrix and action plan, sent to NHSE for collation for development prospectus. CCG support into Network alliance agreed via Provider Alliance Team. January; Liverpool Network Alliance of PCNs submitted a bid to NHSE with regards to a place based approach to delivery of the PCN development prospectus LNA hosting for 18 months scoped August - Operational plan for LNA in developed including plans for DES specifications delivery. SLA for LNA hosting for transactional and transformational support developed	Quarterly update on PCN development progress to PCCC (I)	2	3	6	New	A development programme is being lead by the Managing Directors of the LNA for commencement Feb 2020 C Tina Atkins (delayed due to COVID but in progress)	April - due to coronavirus pandemic maturity programme suspended however PCN CD are preparing to do some lessons learnt on how the epidemic has impacted on relationship building and cross working between practices August - PCN recovery plans being developed and expected to CCG by 18th August October - procurement of hosting arrangement interviews commenced December - Host for Liverpool Network Agreement procurement process completed and Service level Agreement in place from 1st December. Action plan to monitor progress of delivery of the Liverpool Network Alliance operational plan in place including for the delivery of the Primary Care Network specifications.	2	3	6
PCCC 0.8 New risk Oct 19	Commission for better health outcomes	Medicines shortages or discontinuation of production or safety alerts Jane Lunt	Critical medication being unavailable. Potential adverse effects for patients if alternatives not readily available. Potential financial pressures if alternatives at high price.	5	4	20	Monthly digest of shortages produced nationally by PrescQIPP for all CCGs, including guidance for alternative sources or alternative products Monthly review by MOC to identify clinically important shortages - short guidance developed for practices and pharmacies, includes alternative suppliers, alternative or biosimilar products and patient identification searches Escalation process in place to identify and manage shortages in care homes implemented via MMT for care homes when required End of life medicines held by increased numbers of pharmacies (21)	Following disestablishment of QSAG, management by MOC reported to EU Exit group as overlap in agenda.	5	4	20		Discussions with lead officers for correct placement of MOC within CCG Governance Structure.	Additional cover for Christmas pharmacy cover commissioned Regional weekly stocktake on availability of end of life and critical drugs to identify alternative sources in the case of localised shortages	5	4	20
PCC 0.9 New risk May 2020	Commission for better health outcomes	Failure of delivery of General Practice COVID SOP Cheryl Mould	Not all practices able to deliver, 100% remote triage model, remote consultations, separation of COVID and non COVID patients and adequate staffing to maintain services for both groups urgent and routine care and the shielded and housebound	3	4	12	Daily (initially) contact with each practice by the Primary Care Team of the Provider Alliance either by telephone or email. Support to develop buddying or hub resilience plans. September - Liverpool chosen to submit practice staffing sit rep for week commencing 28th September. Supporting the PCNs to complete a staffing sit rep over the period of a time. Supporting the PCNs to complete a staffing sit rep over the period of a time. Support with the development of a Practice, group and PCN plans for COVID and non-COVID activity in most cases this is very detailed and describes for the COVID sites SOPs which have robust buddying system's and agreement on sharing of resources. This includes home visiting. (C) Actions for General Practices to undertake during staff outbreaks of COVID-19 developed and disseminated October 2020 August - PCN level recovery plans being developed based on guidance and including flu planning. These have been reviewed and feedback to by the performance, contract and quality teams of the CCG.	Daily sitrep with escalation processes including DOS GP reporting SOP	3	3	9		Continue with current escalation processes	February 2021 - all practices continue to deliver services	3	3	6

Risk Ref (includes date added to rag)	Relevant CCG Objective	Risk Description Risk Owner Lead Committee	Cause and potential impact/consequence of risk (Why could this risk occur and what would be the effects if the risk materialised?)	L	C	Inherent Risk Score (without controls)	Existing Mitigation/Controls (How are we managing this risk? What are the key controls in place to prevent this risk from occurring?)	Assurance/Evidence (Who/where can we gain evidence that these controls are working effectively? All assurances are 'positive' unless stated otherwise. I = Internal E= External)	L	C	Residual Risk Score (Current)	Trend (Movement since last update & date last reviewed)	Planned Actions (Is this action to address a gap in Control (C) or a gap in Assurance (A) Must include 'Action Owner' *and* Implementation Date	Progress On Actions (What stage are planned current actions at? Are Implementation Dates on track? How will this impact on Residual Risk?)	L	C	Target Risk Score (risk tolerance)
PCC 0.10 New Risk Aug 2020	Commission for better health outcomes	Failure of practices to effectively deliver the 2020-21 seasonal flu vaccination programme to eligible patients Cheryl Mould	Pressures relating to Covid-19 impacting the ability of GP practices to effectively deliver the 2020-21 seasonal flu vaccination programme to eligible patients - vaccine demand could be higher so vaccine supply could be exhausted - addition of eligible cohorts by NHSE specifically 50-64 year olds (subject to vaccine supply) doubles the scales of the programme for primary care - ability to deliver large scale vaccination programme during the pandemic considering social distancing, PPE and workforce requirements - appointments will take longer meaning more clinics are required, presenting workforce pressures - other core primary care services could be negatively impacted			16	A fortnightly Liverpool Flu Group has been established to ensure co-ordinated delivery plans across the system including - CCG - Provider Alliance - Liverpool Network Alliance - Local Medical Committee - Local Pharmaceutical Committee - City Council - Mersey Care - NHSE Cheshire & Mersey rep A co-ordinated plan across the system for Liverpool involving primary, community and secondary care Practices will require co-ordinated delivery plans across their PCN - each PCN will have a nominated flu lead - each PCN will have an agreed delivery approach for both in practice and cross PCN flu clinics, consideration of alternative locations, drive through clinics etc - each PCN will have a co-ordinated plan for Care Homes (residents and staff) to minimise visits into the home - each PCN will link with Pharmacy PCN leads to establish links with local pharmacies - each PCN will undertake flu clinic modelling and workforce assessment - each PCN will agree arrangements for any across practice vaccination and/or sharing of vaccines ensuring governance and cold chain arrangements are in place	Liverpool Flu Group RAG rated action plan - updated fortnightly			6		A PCN readiness framework has been developed and disseminated to PCNs to aid discussions, highlight issues and risks and provide assurance.	A sub group of the Liverpool Immunisation Group - the Liverpool Flu Group has been established first meeting Friday 14th August - PCN readiness framework developed and completed by PCNs - PCNs asked to prioritise and co-ordinate plans for care home patients - Mersey Care agreement to vaccinated those on caseload plus household contacts in place - Planned access to the National Immunisation Management System (NIMS) to track real time vaccine uptake data - regular comms sent to GP practices - weekly monitoring of uptake rates fed into flu group Oct 2020 update: Flu vaccine clinics are underway in General Practice and Community Pharmacy, with safety measures in place. Demand is extremely high with GPs and pharmacies now reporting low vaccine stock. Further national guidance expected early / mid October re release of further flu vaccine stocks. 50-64 year old additional cohort: national guidance awaited Dec 2020 update; uptake rates are now in line with previous years and are on track to exceed previous years slightly is the majority of cohorts. Flu vaccines continue to be delievered safetly in general practice, pharmacies and schools. from 1st Dec well 50 - 64 year old can be offered vaccine - practices have planned for this an additional vaccine stocks have been ordered. However as it is difficult to predict the demand in this group there is a risk that vaccine stocks are exhausted. February 2021 update: The 2020/21 flu vaccination is now coming to an end. although vaccinations can continue up to the end of February. A end of year NHSE report will be available at the end of March but indicative data suggests that uptake rates in Liverpool have slightly increased in all cohorts on the previous year with the exception of Pregnant Women. The reduced upake in Pregnant Women is a pattern seen across C&M and more work needs to be undertaken to undertsand this. Uptake in the additonal cohort introduced in December 2020 for ptns aged 50-64 is currently at 68% in Liverpool. This was a new cohort and it is not yet known if this cohort will be included in the 2021/22 programme.			8
PCC 0.11 New Risk Dec 2020	Commission for better health outcomes	Effective delivery of the Covid-19 vaccination programme from PCN designated sites	Rapid roll out of the Covid-19 vaccination programme from PCN designated sites - impacting on workforce - planning and associated risks - readiness of sites to go live in time for vaccine being delivered Impact would be on direct patient care - patients in priority eligible cohorts do not have equitable access to the covid vaccination in a timely way Secondary impact on patients accessing routine GP services who experience delays due to staff resources being focused on vaccine clinics			16	Liverpool Covid Vaccination Programme workstream structure in place, feeding into the C&M Covid Vaccination Programme workstream structure Liverpool Covid Vaccination Group - now meeting 3 times weekly with oversight of RAG rated action plan Weekly calls with designated site leads, comms channels in place CCG team in place to rapdily respond to any national NHSE requirements and to support PCN site mobilisation	Liverpool Covid Vaccination Programme RAG rated action plan			12		11 x PCN designated sites identified and approved by NHSE 2 x PCN sites identified for Wave 1 in line with NHSE ask - for go live from 15th Dec 1 site working through access issues and scoping out second site as a fall back	Dec 2020: Liverpool Covid Vaccination Group - now meeting 3 times weekly with oversight of an action plan led by Fiona Lemmens / Cheryl Mould Weekly calls with designated site leads and established comms channels are in place CCG team in place to rapidly respond to any national NHSE requirements and to support PCN site mobilisation February 2021 update: The covid vaccination programme is going well in Liverpool an continues to meet government targets to vaccinate people within the JCVI cohorts. As of 15th February over 111,000 vaccine have been administered across Liverpool. The Liverpool model includes: Pillar 1 Hospital Hubs x 4 - focused on front line health & social care staff Pillar 2 Local Vaccination Sites (PCN led) x 11 - focused care home residents, patients aged over 70 and clinically extremely vulnerable adults. Moving onto cohorts 5 and 6 from mid February - aged 65-59 and high risk adults and their carers Supplementary sites (PCN led) x 3 aimed at improving accessibility for harder to reach groups Pillar 4 Pharmacy Sites x 3			8
PCCC 0.2	Retired Aug 19																
PCCC0 .6	Retired October 2020																

Updates to existing risks in 'blue'

- ▶ **Risk Unchanged**
- ▲ **Risk increased**
- ▼ **Risk decreased**

Risk scoring = likelihood x consequence (L x C)

	Likelihood				
Consequence Score	1	2	3	4	5
	Rare	Unlikely	Possible	Likely	Almost certain
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5

For grading risk, the scores obtained from the risk matrix are assigned grades as follows:

1 – 3 Low risk
4 – 6 Moderate Risk

Retired risks				
Risk number	Date retired	Risk description	Reason for retirement	Residual risk identified
PCCC0.2	Aug-19	Less than 100% of the population covered by the network specifications if a practice is not part of a network	All practices became members of a PCN by the deadline set	None identified
PCCC 0.6	01/10/2020	Required contribution to improved health outcomes from the GP core contracting requirements. GP practices not delivering the core contract requirement regarding Electronic Frailty Index (100% of patients over 65s to have frailty assessment)	Contractual requirement stopped by NHS England due to COVID	

NHS
Liverpool
Clinical Commissioning Group

Reporting to:	Primary Care Commissioning Committee			
Date of Meeting:	16th February 2021			
Title of Report:	Primary Care Performance, Quality and Contracting Report			
Presented by	Scott Aldridge, Senior Performance Manager			
Report Author	Scott Aldridge, Senior Performance Manager Kellie Connor, Contracts Manager Keely Stasik, Clinical Quality and Safety Manager Lindsay Humphreys, Clinical Quality and Safety Manager			
Lead Governor	Mark Bakewell, Chief Finance & Contracting Officer			
Senior Leadership Team Lead	Dave Horsfield, Director of Transformation, Planning & Performance			
Report Category	Decision ☐	Discussion ☐	Assurance ☐	Information ☒

Purpose of this report

This report is to provide members of the committee with:

- The current Primary Care Performance

Recommendation(s)

The Committee is asked to:

- Notes the performance of the practices in delivery of the Primary Care performance.
- Notes the performance of the CCG in delivery of Primary Care Medical commissioned services.

Is this subject matter confidential?	Yes ☐	No ☒

Relevance to CCG Strategic Objectives / Governing Body Assurance Framework

01	Commissioning for better health outcomes	☒
02	Ensure commissioning of high quality, safe and responsive health services	☐
03	Reduce health inequalities	☒
04	Ensure maximum value from available resources	☐
05	Decisions that are evidence-based and evaluated for maximum impact	☐
06	Maintain the CCG's reputation and safeguard public confidence	☐

Executive summary

LCCG approved a Primary Care Performance framework in February 2020 and in October 2020 updated the Primary Care KPIs. On the 7th January 2021 NHS England wrote to CCGs to instruct Primary Care to focus on the COVID vaccine programme with the exception of vaccinations, learning disability reviews and PCN improvement and investment fund activity (detailed within the paper), all other enhanced services should be stepped down.

This paper provides an update of the ongoing KPIs, to offer assurance to the committee of the current position. The tables outlined in sections 2.1 to 2.6 outline the KPI, Contract and Quality performance position for January 2021.

Governance and reporting arrangements
(list the committees, groups or other bodies that have discussed this report)

Date	Meeting	Decision made / outcome
08/02/2021	Performance and Quality Sub-Committee	Requested that assurance measures are added to the committee paper. Reiterated the requirement that Learning Disabilities annual reviews remain an national priority and that the Improvement and Investment Fund remains an active DES.

Were there any conflicts of interest identified at any of the above meetings?

Yes ☒ No ☐

If 'Yes, please give brief details:

Yes all GP committee members provide GP specification to their patients

Implications	Yes	No	N/A
Quality	☒	☐	☐
Patient Experience	☒	☐	☐
Conflicts of interest	☒	☐	☐
Equality / PSED	☐	☐	☒
Privacy or GDPR	☐	☐	☒
Workforce	☒	☐	☐
Are there any risks associated with this report or its recommendations?	☐	☒	☐
Are these risks included on the Corporate Risk Register (CRR) or GBAF?	☐	☐	☒

If 'yes', please provide CRR/GBAF reference number and risk description:

Equality & Human Rights Analysis	Yes	No	N/A
Do the issue(s) identified in this report affect one of the protected group(s) less or more favorably than any other?	☐	☒	☐
Are there any valid legal/regulatory reasons for discriminatory practice?	☐	☒	☐

If the answer to either of the above two questions is 'YES', please include a section in this report explaining why.

1. BACKGROUND

The GP Specification contains Key Performance Indicators that Practices are required to achieve, outlines the financial implications of non-delivery of these KPI's and sets out the responsibilities of both LCCG and practices to review the performance data relating to these indicators. Since July 2019 this performance data has been published on the Aristotle portal, allowing practices to review their performance.

2. CURRENT POSITION

LCCG approved a Primary Care Performance framework in February 2020 and in October 2020 updated the Primary Care KPIs. On the 7th January 2021 NHS England wrote to CCGs to instruct Primary Care to focus resources on the COVID vaccine programme with the exception of vaccinations and learning disability reviews and PCN improvement and investment fund activity.

This paper provides an update of the ongoing KPIs, to offer assurance to the committee of the current position. The tables outlined in sections 2.1 to 2.6 outline the KPI, Contract and Quality performance position for January 2021.

This briefing provides an update with regard to the contract monitoring processes undertaken by the CCG for General Practice provider contracts as part of its delegated commissioning responsibilities. The implementation of robust contract monitoring processes ensures that practices are fulfilling the essential requirements of their GMS/PMS or APMS contract agreement and its statutory duty to secure continuous improvement in the quality of primary medical services.

Partnership Changes

Since the last Primary Care Commissioning Committee in December 2020 LCCG has received information on the intention of the following practices to amend contracts. Until LCCG receives all documentation from the practice the processing of these changes cannot take place. LCCG will be requesting additional assurance from practices with regards the appropriate notification to CQC. CQC have confirmed once a notification is made a unique reference number is provided within 7 days. Practices will be expected to provide details of the reference number from the CQC to the CCG as additional assurance. Any person (*individual, partnership or organisation*) who provides a regulated activity in England must be registered with CQC otherwise they may commit an offence by breaching the following sections of the Health and Social Care Act – Section 10, Section 13 and Section 33.

Practice Name	Practice Code	Type of Request	Date of new partnership commencement
Abercromby	N82054	Partner Leaving	31/03/2021
Oak Vale	N82041	Partner Retiring	31/03/2021
Green Lane	N82090	New Partner	01/04/2021
Green Lane	N82090	New Partner	01/04/2021
Green Lane	N82090	Partner Leaving	31/03/2021

Please note: PCSE have implemented a new process where all partnership changes must now be submitted by the performer and approved by the practice then subsequently the CCG via the PCSE Online Portal.

LCCG will write to all providers to inform them of the new process including the requirement for CCG approval.

2.1 Core Contract Requirements

The following table outlines the core contract requirements the contracts and performance team.

Core Contract Requirement	Target	LCCG Position	Source	Latest Update
Workforce submissions	100% monthly	6/85 practices have not accessed the workforce portal in 2020	NHS Digital	79 practices have submitted data
Primary Care Appointments	100% of practices	NHS Digital website outlines extract is ongoing (7/12/20)	National GPES extraction on the number of appoint-ments	NHS Digital website outlines extract is ongoing (7/12/20) Three practices have been contacted at the request of NHSE to understand why their appointments are 25% fewer in weeks 38 – 49 2020 than the same period in 2019.
Practices legally have to record ethnicity data	Currently suspended by NHS England			
Alcohol consumption for new patients aged 16 and over	Currently suspended by NHS England			
Friends and Family Testing	Currently suspended by NHS England			

Publication of GP earnings	Currently suspended by NHS England			
E-Declarations	Currently suspended by NHS England			
Electronic Frailty Index	100%	31.48% This is a 9.22% increase compared to the last report Range 0-100%	CQRS	January 2021
Allocated & Informed Named GP	100%	88.51% This is a 1.55% increase compared to the last report Range 10.18-100%	CQRS	January 2021

Assurance –

LCCG is currently engaging with the GP practice who have a 10.18% allocated and informed named GP extraction position. The practices individual searches outline themselves to have informed or allocated 99% of their patients, but their practice facilitator is reviewing the coding.

LCCG's Performance Team will engage with any practice with zero percentage achievement to understand the barriers for reviewing patients.

2.2 LCCG Primary Care KPI

In October's Primary Care Commissioning Committee LCCG made the decision to switch the GP Specification KPIs to those listed below.

KPI	Updated	Min	Max	LCCG Position	
Annual Health Checks for People With a LD (target 75%) – 12 month rolling figures	Jan-21	0%	100.0 %	40.76%	-6%
Physical Health Checks for People With SMI (target 60%)	Jan-21	0%	57.9%	20.3%	-3.22%
Cervical screening uptake (target 80%)	Oct-20	43.9%	80.5%	65.4%	-0.3%
Flu vaccinations (patients 65 & over) (target 75%)	Jan-21	60.2%	89.4%	76.6%	+13.4 %
Dementia Prevalence (target 0.6%)	Jan-21	0.06%	4.52%	0.55%	-0.02
Childhood vaccination and immunisation (combined) (target 90%)	Jan-21	73.7%	98.7%	90.59%	-0.6%

Assurance –

LCCG's searches are available for practices to identify the patients needed to be reviewed. Learning Disability reviews remain a key national priority and form part of the PCN IIF DES, as per instructions from NHS England. PCN Clinical Directors have been informed of the updates from NHS England and LCCG's Performance and Quality Teams will engage with any practice with zero percentage achievement to understand the barriers for reviewing patients.

Communications have been sent out to practices regarding the Annual Health Checks and SMI performance, however this is expected to remain an issue as focus on vaccination continues. Specific focus on low or no activity practices to support action to be taken will be the next step to address these areas.

2.3 Directed Enhanced Service

October 2020 saw the introduction of the IIF DES requirements. NHS England wrote to all practices on 4th February and 8th February 2021 outlining the requirements that the IIF schemes remain a key priority nationally and that income will continue to be paid on achievement.

Service Provision	Target	LCCG Achievement	Source	Latest Update
Annual Learning Disabilities review within this financial year	100%	40.76% this is a 21.98% increase when compared to the last report.	CQRS	January 2021
PCN DES - Structured Medication Reviews	CCG [1]and PCN to agree	0 completed this year	CQRS	November 2020
PCN DES – Workforce submissions	100%	100%	PCN's	October 2020
PCN – Extended Hours provision. 30 minutes per 1,000 population	100%	The COVID vaccine programme has superseded this scheme and PCNs have been asked to use these slots to increase vaccine provision.		
PCN IIF – Flu Vaccines	77%	63.2%	CQRS	November 2020
PCN IIF – LD reviews	80%	40.76% this is a 21.98% increase when compared to the last report.	CQRS	January 2021

[1] https://www.england.nhs.uk/wp-content/uploads/2020/09/SMR-Spec-Guidance-2020-21-FINAL-.pdf

PCN IIF – Referrals to social prescribers	0.8%	0.03%	CQRS	November 2020
PCN IIF – Safe prescribing. The number of patients aged 65 and over currently prescribed a NSAID without a gastro protective medicine	30%	No extraction has taken place yet	NHS Business Services Authority primary care prescribing data	
PCN IIF – Safe prescribing. The number of patients aged 18 and over currently prescribed an oral anticoagulation and an antiplatelet	25%	No extraction has taken place yet	NHS Business Services Authority primary care prescribing data	
PCN IIF – Safe prescribing. Number of patients aged 18 and over prescribed aspirin and another antiplatelet	25%	No extraction has taken place yet	NHS Business Services Authority primary care prescribing data	

Assurance -

On the 8th February LCCG re-shared with PCN Clinical Director's a suite of searches devised by the prescribing team to allow practices to identify patients under this scheme.

LCCG is also arranging a meeting to discuss the achievement of Learning Disability annual reviews with partner organisations.

Funding remains available within the PCN DES Additional Roles Reimbursement Scheme budget for each PCN to recruit clinicians who can support the provision of the DES requirements which will be urgently explored.

2.4 Local Enhanced Services

The data extraction for Q3 will be the last data extraction as Q4 data is income protected and based on Q4 2019/20 achievement. The Q3 data was not available when the paper was published.

Service	Q1 (Total spend)	Q2 (Total spend)	Diff	Source

ABPI – number of tests provided	£113.54	£210.86	£97.32	GP Clinical system
Asylum Seekers – number of registered patients in the last 2 years	£52,079.76	£50,913.36	-£1,166.40	GP Clinical system
Drug Misusers (Local Authority Schemes) – number of patients who are prescribed a medication to stop addiction	£36,368.20	£36,827.98	£459.78	GP Clinical system
Gonadorelin Therapy LES – number of injections to transfer services away from secondary to Primary Care	£4,259.14	£3,459.20	-£799.94	GP Clinical system
Homeless – number of registered patients each quarter	£28,761.59	£28,916.61	£155.02	GP Clinical system
Impaired Glucose Regulation – To finish 31-12-20	£6,400.90	£28,275.28	£21,874.38	GP Clinical system
Minor Surgery Excision	£96.03	£2,016.63	£1,920.60	GP Clinical system
Minor Surgery Injection	£34,200.32	£85,500.80	£51,300.48	GP Clinical system
Near Patient Testing – number of quarterly medication reviews for patients on high risk drugs	£36,085.81	£35,868.28	-£217.53	GP Clinical system
Out of Area – number of consultations with patients who live outside of Liverpool	£32.60	£65.20	£32.60	GP Clinical system
Sexual Health (Local Authority Schemes) – Number of LARC implants and removals	£16,017.11	£30,959.73	£14,942.62	GP Clinical system
Travellers – number of patients currently	£4,228.20	£4,257.36	£29.16	GP Clinical system

registered				
Violent Patient Scheme – number of consultations with the zero tolerance patients either face-to-face or via telephone	£9,771.30	£6,607.26	-£3,164.04	GP Clinical system
Grand Total	**£228,414.50**	**£313,878.55**	**£85,464.05**	

2.5 Quality Concerns

Significant Event Analysis (SEA) Overview

LCCG has delegated commissioning responsibility for Primary Care across Liverpool. As such there is a requirement for the CCG to review SEA reports completed by practices as a result of complaints made regarding Primary Care to NHS England (NHSE).

Primary Care can complete SEAs because:

a) They have identified an incident or event that would benefit from a local review to identify learning and improve quality

b) NHSE have undertaken a review of a complaint and directed the practice to complete an SEA as part of the response to and closure of the complaint

LCCG has an assurance role in reviewing SEAs submitted. There is a responsibility on the CCG to be assured that a robust SEA has been completed and there is also the requirement to provide NHSE with assurance regarding quality of the SEAs submitted.

The Quality Team are currently reviewing 3 open SEA's – see table 1.

Table 1

Practice	Network	Source	Date CCG notified	Issue	SEA recieved	CCGS Action / Comments	Status
N82676	Croxteth & Norris Green	NHSE/I complaints team	17.12.19	Complaint from patient regarding possible misdiagnosis	11.11.20	SEA remains open requiring further information. Practice have been contacted with a new submission date, response expected 09.02.2021	**Open – overdue**
N82001	SWAGGA	NHSE/ PHE SIT	21.10.20	IG Breach	Outstanding	SEA remains outstanding Practice have been contacted	**Open - overdue**

		TEAM				with a new submission date , response expected 08.02.2021	
N82113	Liverpool First	NHSE/ PHE SIT TEAM	18.01.21	Vaccination immunisation error and failure to follow guidance re selective Neonate Hep B pathway	Awaited – due 23.02.21	SEA has been requested with a deadline of 23.02.21 and will be reviewed by CCG quality team on receipt and in collaboration with NHSE/I SIT Team to ensure all learning has been embedded form the incident and the pending action plan.	**Open- on track**

Quality Insight

In terms of wider quality insight the CCG Quality Team will begin to focus on the LCCG Primary Care Key Performance Indicators (KPI) particularly the Annual Health Checks for People with a learning disability. In order to gain quality assurance with regards to how practices are performing with a view to address any quality concerns that may be apparent from the received KPI data.

The responsibility for undertaking LD health checks rests with GPs (primary care). GPs are supported in this task by LCCG commissioned LD facilitators within Mersey Care. This area of improvement was previously led by LCCG mental health commissioning, but was transferred to the Provider Alliance in September 2020.

Currently 43.7% of people with Learning Disabilities between the ages of 14 and 25 across Liverpool have had a health check in the previous 12 months, with the range from just 8% to 100% across individual practices. When looking at the % of all people who have had a health check since April 2020, this percentage reduces to just 18%. The target for the WSoA for all 14-25 year olds to have undertaken a health check was originally 75% by 1.4.2021. However, the national target is 50% and the SEND Partnership has agreed to amend the local performance target to match to the national target of 50%.

The SEND Partnership will be re-inspected (potentially in 2021) and will have to prove sufficient progress against the WSoA. Insufficient progress will result in LCC and LCCG being placed into “special measures”.

The Quality Team also plan to undertake a review of the patient experience KPI’s with a view to undertaking an audit and to address any quality concerns that may be

apparent from the received KPI data when it is appropriate to do so taking into account current pressure related to COVID and the rollout and delivery of the COVID vaccination programme.

2.6 Enhanced Access Performance (PC24 Contract) – December 2020

The Primary Care Commissioning Committee asked for information regarding the utilisation of the service. The service was stepped down during lockdown to focus support on COVID patient assessments, however, the service has been reporting activity reports since September which LCCG report to NHS England. LCCG's contracts team has been undertaking bi-monthly contract meetings with the provider since September 2020.

Please note that the January data will be available after the committee papers have been published.

Contractual Requirement	Available slots	Filled slots	DNA	Achievement	Source
The provider will ensure that 80% of available slots are filled. This includes transferring patients from Out of Hours to the service if required.	2352	2056	60	85%	Providers clinical system

3. NEXT STEPS

- The Performance Team will review the monthly KPI performance data and undertake the assurance actions contained within the report.

4. STATUTORY/LEGAL/REGULATORY REQUIREMENTS (only applicable to strategy & commissioning papers)

4.1 **Does this require public engagement or has public engagement been carried out?** Yes ☐ No ☒

i. If 'no' explain why

ii. If yes attach either the engagement plan or the engagement report as an appendix. Summarise key engagement issues/learning and how responded to.

The paper provides a current position regarding the GP Specification and does not require any change to patient care.

5. EQUALITY IMPACT ASSESSMENT

5.1 Does the public sector equality duty apply? Yes ☐ No ☒

5.2 If 'no', please state why.
5.3 If 'yes' summarise equalities issues, action taken/to be taken and attach engagement EIA (or separate EIA if no engagement required). If completed state how EIA is/has affected final proposal.

The paper provides a current position regarding the GP Specification and does not require any change to patient care.

6. FINANCIAL IMPLICATIONS AND RISK

Effective contract and commissioning management will ensure robust financial management of the Primary Care budget. The commissioning of Local Enhanced Service schemes ensure a more effective use of NHS sources moving services outside of secondary care settings into the community.

7. WORKFORCE IMPLICATIONS

The monitoring of the KPI information is embedded into the work streams for the Performance and Business Intelligence Teams. Clinical system searches are already established and ready to be run each month. There is no additional workforce implications required to maintain the current process.

8. COMMUNICATION REQUIREMENTS

Communication regarding the performance management and engagement has already been shared with the practices individually and the LMC.

9. CONCLUSION

The Primary Care Commissioning Committee is asked to:

- Notes the performance of the practices in delivery of the Primary Care performance.
- Notes the performance of the CCG in delivery of Primary Care Medical commissioned services.

Ends

NHS
Liverpool
Clinical Commissioning Group

Reporting to:	Primary Care Commissioning Committee			
Date of Meeting:	16th February 2021			
Title of Report:	CCG Primary Care Commissioning Committee Finance Report			
Presented by	Mark Bakewell, Chief Finance and Contracting Officer			
Report Author	Victoria Horton, Senior Finance Manager			
Lead Governor	Mark Bakewell, Chief Finance and Contracting Officer			
Senior Leadership Team Lead	Mark Bakewell, Chief Finance and Contracting Officer			
Report Category	Decision ☐	Discussion ☐	Assurance ☐	Information ☒

Purpose of this report

This report is to provide members of the committee with:

- An overview of the key aspects of the CCG's Primary Care Finance position for 2020/21 as at December 2020 (Month 9)

Recommendation(s)

The Committee is recommended to:

- Note the contents of the report and the forecast financial positon for 2020/21 as at December 2020 (Month 9)

Is this subject matter confidential?	Yes ☐	No ☒

Relevance to CCG Strategic Objectives / Governing Body Assurance Framework

01	Commissioning for better health outcomes	☐
02	Ensure commissioning of high quality, safe and responsive health services	☐
03	Reduce health inequalities	☐
04	Ensure maximum value from available resources	☒
05	Decisions that are evidence-based and evaluated for maximum impact	☐
06	Maintain the CCG's reputation and safeguard public confidence	☒

Executive summary

The report provides details of the projected financial performance against primary care budgets set for the 2020/21 financial year as at December 2020 (Month 9) for the following budget areas:

- Primary Care Co-Commissioning (Delegated Budget)
- Local Enhanced Services
- Prescribing

Governance and reporting arrangements (list the committees, groups or other bodies that have discussed this report)		
Date	**Meeting**	**Decision made / outcome**
Were there any conflicts of interest identified at any of the above meetings?		
Yes ☐ No ☐		
If 'Yes, please give brief details:		

Implications	**Yes**	**No**	**N/A**
Quality	☐	☐	☒
Patient Experience	☐	☐	☒
Conflicts of interest	☐	☐	☒
Equality / PSED	☐	☐	☒
Privacy or GDPR	☐	☐	☒
Workforce	☐	☐	☒
Are there any risks associated with this report or its recommendations?	☒	☐	☐
Are these risks included on the Corporate Risk Register (CRR) or GBAF?	☐	☐	☒
If 'yes', please provide CRR/GBAF reference number and risk description:			

Equality & Human Rights Analysis	Yes	No	N/A
Do the issue(s) identified in this report affect one of the protected group(s) less or more favourably than any other?	☐	☐	☒
Are there any valid legal/regulatory reasons for discriminatory practice?	☐	☐	☒
If the answer to either of the above two questions is 'YES', please include a section in this report explaining why.			

1. PURPOSE

The purpose of this paper is to report to the Primary Care Commissioning Committee key aspects of the CCG's Primary Care Finance position for 2020/21 as at December 2020 (Month 9) for the following budget areas:

- Primary Care Co-Commissioning (Delegated Budget)
- Local Enhanced Services
- Prescribing

2. RECOMMENDATIONS

That Liverpool CCG Primary Care Commissioning Committee:

- Notes the forecast financial position for 2020/21 as at December 2020 (Month 9) including key issues that have been factored into reporting assumptions

3. BACKGROUND

The CCG has been operating under a temporary financial regime as a result of the COVID-19 pandemic. Nationally CCG's have received revised allocations, with fixed block contract payments being made to NHS providers and national commissioning of Independent Sector Providers.

The CCG received allocations for April to September 2020 based on expenditure levels at February 2019/20 (Month 11) plus activity growth and programme price increase allowances, with adjustments for the block NHS contracts and the change to procurement arrangements for the Independent Sector Providers.
NHS England and NHS Improvement (NHSE/I) advised reasonable additional expenditure in excess of the notified allocations during this period would be fully funded through the monthly NHSE/I 'True-Up' retrospective allocation process to bring CCG's into a balanced financial position.
External claims for approved COVID-19 related expenditure could also be made during this period and claimed back centrally via the 'True-Up' funding process.
The 'True-Up' funding anticipated at Month 6 has been approved by NHSE/I and received by the CCG, resulting in a break-even financial position for April to September 2020.

The CCG has received further allocations for October to March 2021 to support phase 3 of the response to the COVID-19 pandemic, with fixed block payments continuing to be made to NHS Providers.
NHSE/I required CCG's to submit financial plans for October to March 2020 by 22nd October 2020 for the allocations received.
Financial planning guidance covering this period expects NHS Commissioners to contain expenditure within this allocation under normal NHS England Business Rules. System wide work is on-going to assess the scale of the challenge to reduce any gaps identified to enable delivery of services in the remaining months of the year within the total resource envelope.

4. PRIMARY CARE FINANCE

The following sections summarise the key financial information for the reported position of £887k forecast underspend as at 31st December 2020 (Month 9) for Delegated Primary Care Co-Commissioning, Local Enhanced Services and Prescribing Budgets.

2020/21 Primary Care & Prescribing Budget Position at Month 9

TOTAL PRIMARY CARE	Annual Budget* £000'S	Year to Date Budget* £000'S	Year to Date Actual £000'S	Year to Date Variance £000'S	Forecast Outturn £000'S	Forecast Variance £000'S
PRC DELEGATED CO-COMMISSIONING	83,066	62,211	61,993	(218)	82,817	(249)
LOCAL ENHANCED SERVICES	14,511	10,790	10,755	(35)	14,463	(49)
PRESCRIBING	95,482	71,256	70,823	(433)	94,894	(589)
Total	**193,060**	**144,258**	**143,571**	**(686)**	**192,173**	**(887)**

* Budget at Month 9 includes Retrospective 'True Up' Allocations Received for Months 1 - 6, variances relate to M7 – M9 only

4.1 Delegated Primary Care Co-Commissioning

The annual budget allocation of £83,066k has been funded and allocated as per the tables below:

PRC DELEGATED CO-COMMISSIONING – Funding Source	Annual Budget £000'S
Month 1-6 Allocation	40,367
Month 1-6 'True-Up' Funding	1,073
Month 7-12 Allocation	41,129
Additional National Funding - PCN Care Home Premium	161
Additional National Funding - Increased Practice Funding	98
Additional National Funding - Impact & Investment Fund	238
Total	**83,066**

PRC DELEGATED CO-COMMISSIONING – Funding Allocation by Contract Area	Month 1-6 Allocation £000'S	Month 1-6 'True-Up' Funding £000'S	Month 7-12 Allocation £000'S	Additional National Funding £000'S	TOTAL Annual Budget £000'S
Global Sum / Contract Value	27,527	71	27,691	98	55,387
Primary Care Network (PCN) Payments	985	1,266	2,164	399	4,813

QOF	3,528	168	3,696	0	7,392
DES	808	48	856	0	1,711
Seniority	201	(201)	0	0	0
GP Retention Scheme	27	25	52	0	103
Premises	4,527	(79)	4,654	0	9,103
Other Costs (e.g. Interpretation, Locums, CQC)	3,151	(611)	2,017	0	4,557
Prior Year (2019/20)	(387)	387	0	0	0
Total	**40,367**	**1,073**	**41,129**	**497**	**83,066**

The forecast outturn for Primary Care Co-Commissioning is £82,817k as at 31st December 2020. This represents an underspend of (£249k) against the annual budget of £83,066k as detailed in the table and narrative below:

PRC DELEGATED CO-COMMISSIONING	Annual Budget* £000'S	Year to Date Budget* £000'S	Year to Date Actual £000'S	Year to Date Variance £000'S	Forecast Outturn £000'S	Forecast Variance £000'S
Global Sum / Contract Value	55,387	41,451	41,375	(76)	55,311	(76)
Primary Care Network (PCN) Payments	4,813	3,532	3,533	1	4,816	3
QOF	7,392	5,544	5,544	0	7,392	0
DES	1,711	1,283	1,290	7	1,721	10
GP Retention Scheme	103	77	79	1	110	7
Premises	9,103	6,776	6,737	(38)	9,019	(83)
Other Costs (e.g. Interpretation, Locums, CQC)	4,557	3,548	3,566	18	4,579	22
Prior Year (2019/20)	0	0	(131)	(131)	(131)	(131)
Total	**83,066**	**62,211**	**61,993**	**(218)**	**82,817**	**(249)**

* Budget at Month 9 includes Retrospective 'True Up' Allocations Received for Months 1 - 6, variances relate to M7 – M9 only

- The financial position is based on the 2020/21 national GMS, PMS and APMS contract requirements including recurring costs and new additional investments
- (£76k) slippage against the Global Sum / Contract Value budget is due to Q3 list size growth being lower than previous years' trends and planned growth
- (£83k) slippage against Premises, primarily due to the impact of local authority in-year adjustments to practice business rates, resulting in lower cost reimbursements and credit notes received from NHS Property Services following a 2019/20 True Up exercise
- (£131k) slippage against prior year (2019/20) due to credit notes received from NHS Property Services following a 2019/20 True Up exercise, plus final Locum reimbursement claims received lower than anticipated for 2019/20 GP sickness and parental leave cover

4.1.2 Primary Care Network (PCN) Funding

As set out in the Network Contract DES, funding is available to PCN's from the Delegated Primary Care Co-Commissioning budget. Below is a summary of the allocated funding and financial position at Month 9 against each area of the DES contract:

PRC DELEGATED CO-COMMISSIONING - PCN Funding	Annual Budget* £000'S	Year to Date Budget* £000'S	Year to Date Actual £000'S	Year to Date Variance £000'S	Forecast Outturn £000'S	Forecast Variance £000'S
PCN Participation Payment	1,062	796	798	2	1,065	3
PCN Clinical Director Contribution	397	297	297	0	396	0
PCN Additional Role Reimbursement Scheme (ARRS)	2,608	1,956	1,956	0	2,608	0
PCN Impact and Investment Fund (incl M1-6 Primary Care Support)	532	348	348	0	532	0
PCN DES Care Home Premium	215	134	134	0	215	0
Sub Total	**4,813**	**3,532**	**3,533**	**1**	**4,816**	**3**
DES Extended Hours Access	796	597	598	1	798	1
Total	**5,610**	**4,129**	**4,131**	**2**	**5,614**	**4**

In the main, funding is paid to PCN's monthly in arrears in equal instalments based on a set contract amount per patient / care home bed.

For the Additional Role Reimbursement Scheme (ARRS), PCN's have a set amount of funding available to them based on their list size, from which they are able to claim reimbursement of additional PCN workforce costs in line with the rules of the scheme.
Each PCN was required to complete a workforce plan to inform the CCG and NHSE/I of their recruitment intentions and to enable an estimation of likely unclaimed ARRS funding for redistribution.
The total funding available to PCN's in 2020/21 is £4.2m, with the CCG holding £2.6m and NHSE/I holding the balance of £1.6m to be called upon once the CCG allocation has been fully utilised.
The latest workforce plans dated 31st October 2020 project the indicative spend for PCN's will be £3.8m, with £0.4m unclaimed.

The financial position reported at Month 9 has assumed that all of the ARRS funding within the CCG's allocation would be fully utilised. Claims received to date total £732k, 28% of the CCG's available funding and 17% of the total available funding.
From the workforce plans submitted, the majority of recruitment is expected to take place between October and December.

Claims received for April – September equate to 55% of the anticipated value for this period, therefore there is a risk that should this trend continue for the remainder of the financial year, £2.3m of available funding will be utilised, with £1.6m of funding held by NHSE/I and £0.3m of funding held by the CCG being 'lost' as per the Network Contract DES ("*Any unused funding in a given financial year cannot be carried forward into subsequent years, and a PCN's entitlement to that funding in that year will therefore be lost*")

4.1.3 Supporting General Practice Fund

On 9th November 2020, a letter was issued by NHSE/I announcing that £150m additional funding would be made available to support the expansion of general practice capacity over the winter until 31st March 2021. NHSE/I have specified that this funding is intended to cover current pressures, support health checks for people with learning disability or severe mental illness and to help smooth the path to vaccine delivery.
Access to the funding is conditional on practices and PCN's continuing to progress national appointment and workforce data in line with contractual requirements and returning activity to at least prior levels.

CCG's and PCN's are required to jointly develop proposals for the timely utilisation of funds, with a retrospective 'audit' against the seven priority goals stated in the letter.

National funding has been allocated on an STP level based on a 'fair share' approach in line with weighted 2020/21 Primary Care allocations. For Cheshire & Merseyside, the allocation is identified as £7.02m of which £1.475m has been allocated to Liverpool CCG. Funds are being deployed as soon as possible and will be available to general practice in January 2021.

4.2 Local Enhanced Services

The annual budget allocation of £14,511k has been funded and allocated as per the tables below:

LOCAL ENHANCED SERVICES	Annual Budget £000'S
Month 1-6 Allocation	5,802
Month 1-6 'True-Up' received	269
Month 7-12 Allocation	6,998
PCN Development Fund Allocation	424
COVID-19 Expenditure	1,018
Total	**14,511**

LOCAL ENHANCED SERVICES	Month 1-6 Allocation £000'S	Month 1-6 'True-Up' Funding £000'S	Month 7-12 Allocation £000'S	COVID-19 Expenditure £000'S	TOTAL Annual Budget £000'S
LES / LIS Schemes	509	108	700	0	1,316
GP Specification	4,894	423	5,886	0	11,203
Core PCN Funding	425	(14)	412	0	824
PCN Development Fund	0	0	424	0	424
COVID-19 Expenditure	0	0	0	1,018	1,018
Prior Year (2019/20)	(26)	(247)	0	0	(274)
Total	**5,802**	**269**	**7,422**	**1,018**	**14,511**

The forecast outturn for Local Enhanced Services is £14,463k as at 31st December 2020. This represents an underspend of (£49k) against the annual budget of £14,087k as detailed in the table and narrative below:

LOCAL ENHANCED SERVICES	Annual Budget * £000'S	Year to Date Budget* £000'S	Year to Date Actual £000'S	Year to Date Variance £000'S	Forecast Outturn £000'S	Forecast Variance £000'S
LES / LIS Schemes	1,316	966	971	5	1,321	5
GP Specification	11,203	8,250	8,232	(17)	11,168	(35)
Core PCN Funding	824	618	625	7	834	11
PCN Development Fund	424	212	212	0	424	0
COVID-19 Expenditure	1,018	1,018	1,018	0	1,018	0
Prior Year (2019/20)	(274)	(274)	(303)	(29)	(303)	(29)
Total	**14,511**	**10,790**	**10,755**	**(35)**	**14,463**	**(49)**

* Budget at Month 9 includes Retrospective 'True Up' Allocations Received for Months 1 - 6, variances relate to M7 – M9 only

- The financial position is based on the 2020/21 local investment in LES Schemes, GP Specification and COVID-19 Primary Care expenditure
- During M9, £424k PCN Development Funding has been received and is expected to be utilised in full by 31st March 2021
- (£35k) slippage against the GP Specification budget is due to Q3 list size growth being lower than previous years' trends and planned growth
- £16k pressure against LES / LIS schemes following the receipt of Q2 activity data and Q2 income protection 'Top-Up' data slightly higher than anticipated, predominantly for the IGR scheme, plus PCN practice caretaking costs
- (£29k) slippage against prior year (2019/20) estimated activity

4.2.1 COVID-19 Expenditure

COVID-19 expenditure relating to Primary Care has been forecast at £1,018k at Month 9. This is based on General Practice reimbursement claims received in line with the national COVID Support Fund Guidance published on 4th August 2020, plus CCG incurred expenditure directly relating to Primary Care.

The COVID Support Fund Guidance relates to specific net additional costs incurred during a limited time period and primarily includes details for reimbursement of costs for April and May Bank Holiday opening and COVID related sickness / isolation backfill.

Claims received have been approved in line with national guidance, with the vast majority of reimbursement payments processed. There are a small amount of claims that have been approved and due to be reimbursed on receipt of outstanding supporting evidence.

The table below summarises the anticipated final claims forecast by type of expenditure:

COVID-19 Description of Scheme	Forecast Expenditure £000'S
GP Practice - Bank Holiday Opening	646
GP Practice - Backfill for COVID-19 Related Absences	45
GP Practice - Additional Capacity Required	50
GP Practice - Additional Capacity to Support Care Home Activity	0
GP Practice - PPE / Cleaning	101
GP Practice - Other Consumables	81
Other - e.g. SMS Messages, Printing Costs etc.	95
Total	**1,018**

4.3 Prescribing

The annual budget allocation of £95,482k has been funded and allocated as per the tables below:

PRESCRIBING	Annual Budget £000'S
Month 1-6 Allocation	43,554
Month 1-6 'True-Up' received	4,148
Month 7-12 Allocation	47,780
Total	**95,482**

PRESCRIBING	Month 1-6 Allocation £000'S	Month 1-6 'True-Up' Funding £000'S	Month 7-12 Allocation £000'S	TOTAL Annual Budget £000'S
BSA Prescribing	43,580	4,165	46,727	94,471
High Volume Vaccines	695	(319)	1,122	1,499
Rebates	(250)	(25)	(275)	(550)
Other e.g. licences / subscriptions	140	41	206	387
Prior Year (2019/20)	(611)	286	(0)	(325)
Total	**43,554**	**4,148**	**47,780**	**95,482**

The forecast outturn for Prescribing is £94,894k as at 31st December 2020. This represents an underspend of (£589k) against the annual budget of £95,482k as detailed in the table and narrative below:

PRESCRIBING	Annual Budget* £000'S	Year to Date Budget* £000'S	Year to Date Actual £000'S	Year to Date Variance £000'S	Forecast Outturn £000'S	Forecast Variance £000'S
BSA Prescribing	94,471	70,565	69,924	(641)	93,549	(924)
High Volume Vaccines	1,498	1,149	1,165	16	1,503	5
Rebates	(550)	(412)	(210)	203	(210)	340
Other e.g. licences / subscriptions	387	280	270	(10)	377	(10)
Prior Year (2019/20)	(325)	(325)	(325)	0	(325)	0
Total	**95,482**	**71,256**	**70,823**	**(433)**	**94,893**	**(589)**

* Budget at Month 9 includes Retrospective 'True Up' Allocations Received for Months 1 - 6, variances relate to M7 – M9 only

- Prescribing data is received two months in arrears, the financial position for BSA Prescribing is based on activity data received up to October which has been extrapolated using dispensing days to the end of the financial year, inclusive of national increases to Category M drugs prices and NCSO costs.
- All other expenditure is forecast in line with 2020/21 contracts (e.g. subscriptions) and current activity trends
- (£924k) forecast slippage against the BSA Prescribing budget following the receipt of August to October data being lower than anticipated as activity has not continued at the same levels as at the beginning of the financial year / first

wave of COVID-19. The forecast position has been revised to reflect the impact assuming the most recent prescribing and expenditure levels are to continue.

The data suggests there has been a small increase in average drugs prices across the majority of BNF drug chapters; however, this increase has been offset by a reduction in average volume of drugs prescribed (primarily BNF chapters Appliances, Nutrition and Blood, Respiratory System and Skin)

- £340k pressure is forecast against Rebates as a result of contract notice being served by drug manufacturers for some schemes due to the COVID-19 pandemic.
- £5k pressure has been forecast against the High Volume Vaccine budget due to the volume of activity increasing at higher levels than initially estimates based on previous years' trends.

5. STATUTORY REQUIREMENTS (only applicable to strategy & commissioning papers)

5.1 Does this require public engagement or has public engagement been carried out? N/A

5.2 Does the public sector equality duty apply? N/A

5.3 Explain how you have/will maximise social value in the proposal: describe the impact on each of the following areas showing how this is constructed to achieve the most:

a) Economic wellbeing
b) Social wellbeing
c) Environmental wellbeing

5.4 Taking the above into account, describe the impact on improving health outcomes and reducing inequalities

6. FINANCIAL IMPLICATIONS AND RISK

Effective contract and commissioning management will ensure robust financial management of the Primary Care budget. The commissioning of Local enhanced Service schemes ensure a more effective use of NHS sources moving services outside of secondary care settings into the community.

7. WORKFORCE IMPLICATIONS

N/A

8. COMMUNICATION REQUIREMENTS

Primary Care Commissioning papers are communicated to staff through the CCG internal website. Senior leadership team leaders to communicate outcome and outputs of the committee through regular team meetings.

9. CONCLUSION

The Primary Care Commissioning Committee is asked to

- Note the forecast financial position for 2020/21 as at 31st December 2020 (Month 9) including key issues that have been factored into reporting assumptions

Victoria Horton – Senior Finance Manager
5TH FEBRUARY 2020

NHS
Liverpool
Clinical Commissioning Group

Reporting to:	Primary Care Commissioning Committee			
Date of Meeting:	16th February 2021			
Title of Report:	Primary Care Performance, Quality and Contracting Framework Updated 2021			
Presented by	Scott Aldridge, Senior Performance Manager			
Report Author	Scott Aldridge, Senior Performance Manager Kellie Connor, Contracts Manager Keely Stasik, Clinical Quality and Safety Manager Lindsay Humphreys, Clinical Quality and Safety Manager			
Lead Governor	Mark Bakewell, Chief Finance & Contracting Officer			
Senior Leadership Team Lead	Val Attwood, Deputy Chief Contracting Officer			
Report Category	Decision ☒	Discussion ☒	Assurance ☐	Information ☐

Purpose of this report
This report is to provide members of the committee with: • Provide the Primary Care Commissioning Committee with the annual update to the Primary Care Framework process.
Recommendation(s)
The Committee is asked to: ➢ Approve the updated Primary Care Framework ➢ Notes the performance of the CCG in delivery of Primary Care Medical commissioned services.

Is this subject matter confidential?	Yes ☐	No ☒

Relevance to CCG Strategic Objectives / Governing Body Assurance Framework

01	Commissioning for better health outcomes	☒
02	Ensure commissioning of high quality, safe and responsive health services	☐
03	Reduce health inequalities	☒
04	Ensure maximum value from available resources	☐
05	Decisions that are evidence-based and evaluated for maximum impact	☐
06	Maintain the CCG's reputation and safeguard public confidence	☐

Executive summary

Liverpool Clinical Commissioning Group (LCCG) approved a Primary Care Performance, Quality and Contracting framework in August 2019 (PCCC 13-19 paper) and this was updated in February 2020 (PCCC 03-20). This paper outlines the annual update position and the process to be followed once Primary Care restrictions are removed.

The paper details the framework as well as a new requirement to detail the number of submissions from providers before assurance is approved by the Primary Care Committee. The paper also updates the CCGs committee structures by removing QSAG and replacing this with the Performance and Quality Sub-Committee.

Governance and reporting arrangements
(list the committees, groups or other bodies that have discussed this report)

Date	Meeting	Decision made / outcome
09/02/2021	Performance and Quality Sub-Committee	Paper approved

Were there any conflicts of interest identified at any of the above meetings?

Yes ☒ No ☐

If 'Yes, please give brief details:

Yes all GP committee members provide GP specification to their patients

Implications	Yes	No	N/A
Quality	☒	☐	☐
Patient Experience	☒	☐	☐
Conflicts of interest	☒	☐	☐
Equality / PSED	☐	☐	☒
Privacy or GDPR	☐	☐	☒
Workforce	☒	☐	☐
Are there any risks associated with this report or its recommendations?	☐	☒	☐
Are these risks included on the Corporate Risk Register (CRR) or GBAF?	☐	☐	☒

If 'yes', please provide CRR/GBAF reference number and risk description:

Equality & Human Rights Analysis	Yes	No	N/A
Do the issue(s) identified in this report affect one of the protected group(s) less or more favorably than any other?	☐	☒	☐
Are there any valid legal/regulatory reasons for discriminatory practice?	☐	☒	☐

If the answer to either of the above two questions is 'YES', please include a section in this report explaining why.

1. BACKGROUND

Liverpool Clinical Commissioning Group (LCCG) approved a Primary Care Performance, Quality and Contracting framework in August 2019 (PCCC 13-19 paper) and this was updated in February 2020 (PCCC 03-20). This paper outlines the annual update position and the process to be followed once Primary Care restrictions are removed.

2. CURRENT POSITION

NHS England wrote to CCGs and Primary Care on the 7th January 2021 detailing plans for "Freeing up GP Practices" to allow the mass vaccination programme to be the key priority for Primary Care https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/C1026_Freeing-up-GP-practices-letter_070121.pdf.

In preparation for full recovery LCCG have reviewed the current primary care framework and have made several changes to improve and streamline the process.

2.1 Core Contractual Processes

The national Primary Medical Care Policy and Guidance Manual[1] details the process for monitoring core contract requirements for GMS/PMS and APMS contracts. This will seek to utilise contractual levers and processes in line with the management of other NHS contracts held by LCCG, including acute, community, mental health, and independent trust contracts. LCCG's updated framework recommends that the national process is followed completely, with the only exception being that LCCG recommends that practices have a maximum of two submissions for action plans to be approved.

GMS core contract requirements are negotiated nationally and issued via contract variations. Local discussions are held with PMS and APMS providers to mirror the GMS contract variations. The LCCG has developed a contract monitoring dashboard which outlines the core contract requirements and shows providers compliance with the contract.

The contract monitoring dashboard is applicable to all GMS / PMS and APMS providers. Failure to deliver any of the core contract requirements would constitute a breach of the core contract and the actions listed below should be applied.

LCCG will utilise NHSE standard operating policies and procedures from primary care guidance[2] to manage contracts when a contract is considered to have been breached. The contract review meetings will ensure LCCG can demonstrate it has followed appropriate due process in investigating, communicating and implementing any actions where performance is a concern. LCCG will endeavour, where possible, to manage situations without formal contract sanctions however, where there is

[1] **Primary Medical Care Policy and Guidance Manual (PGM) v2, NHS England, published April 2019.** https://www.england.nhs.uk/publication/primary-medical-care-policy-and-guidance-manual-pgm/

[2] **Primary Medical Care Policy and Guidance Manual (PGM) v2, NHS England, published April 2019**

evidence of a consistent failure or breach of contract, LCCG will follow appropriate contract procedures.

Where a breach has occurred, there are several options as to how to proceed, specifically:

- Taking no action
- Agreeing an action with the Provider (GP), this is normally the first step of any breach process
- Issuing a Remedial Notice
- Issuing a Breach Notice
- Applying a Contract Sanction or
- Terminating the contract

Doing nothing and agreeing an action with the contractor are options that are always available to the Commissioner (LCCG). The remaining options may only be applied in specific situations as envisaged by the contract.

Where a provider has breached the contract and the breach is determined to be capable of remedy, LCCG may issue a Remedial Notice to the GP setting out the actions that must be taken to remedy the breach.

A breach capable of remedy is where the breach continues but the GP could take action to stop the breach. Examples of breaches that may be capable of remedy include:

- Failure to compile a practice leaflet; or
- Failure to provide information to LCCG.

Where the GP has breached the contract and that breach is not capable of remedy, LCCG may serve a Breach Notice on the contractor requiring the contractor not to repeat the breach.

Examples of breaches that are not capable of remedy include:

- A practice closing during its contracted opening times in the previous week with no access for the GP's registered patients to access essential services; or
- Failure to store vaccines correctly and such vaccines have already been provided to patients.

Where the breach creates a serious risk to patient safety, LCCG can take more immediate action, regardless of whether the breach is capable of remedy or not.

Given that any decision to issue a Breach or Remedial Notice, apply sanction or terminate a contract or agreement can be challenged by the contractor under appeal, it is essential that the CCG follows, and can demonstrate that it has followed, due process in investigating, communicating and implementing actions in this respect and that the Commissioner has acted fairly and reasonably throughout.

LCCG must ensure that, when issuing a Remedial or Breach Notice, applying a Contract Sanction or terminating a contract, it follows the proper internal processes around approval of the action, compliance with any standing orders and due consideration of all relevant factors in the decision making process.

Prior to any decision to terminate a contract, LCCG are advised to seek legal guidance and to engage with NHS England and the LMC. PCCC must consider all other relevant issues including (but not limited to) continuity of service, premises and equipment arrangements, management of patient records, prescriptions and drugs, arrangements regarding the patient list. PCCC will make the ultimate decision.

2.2 Enhanced Services including GP Specification

Local enhanced services include performance standards that practices will be monitored against. To avoid the need for an onerous validation, all key performance indicators are collected and monitored by the CCG. Data will be refreshed monthly, and feedback on delivery and trajectories will be provided to practices, to allow an ongoing conversation between provider and commissioner.

Indicator trajectories will be monitored monthly and the risk of non-delivery raised with the practice, who will be expected to put appropriate measures in place.

The CCG will publish KPI data monthly and will identify where practices are not on trajectory in order to open dialogue with individual practices and networks around performance achievement and mitigation. Practices will have access to the same data and are expected to review it regularly.

Although the potential for non-achievement should have been under discussion from the point that it was recognised, to be considered for exceptional circumstances, the practice needs to formally raise the potential for non-achievement, and provide an action plan that demonstrates the impact of measures that have been put in place already, and sets out further planned mitigation. This plan will need to be agreed by the CCG.

2.3 External Factors

LCCG has added a new pathway to the framework when the CCG is informed from external partners of any issues that may have been a contractual breach or patient harm. These are listed on the right-hand side of the updated framework flow chart.

2.4 Recommended Approach

Key principles:

- Detailed reporting to PCCC on practice achievement will be by exception.
- The committee will receive a bi-monthly summary of performance against the specified indicators, which will provide information on citywide achievement, variation (max/min/interquartile range) and also a break down by deprivation quintile and performance for key groups (e.g. LD). A high-level summary of individual practice performance will also be provided.

- Performance and Quality Sub-Committee will have oversight of the appropriate mitigating and improvement measures that might be implemented in relation to quality and safety issues and will be part of a co-ordinated process to ensure effective contract management across general practice going forward.

Process:

Data will be produced monthly where appropriate KPIs, contract requirements and quality indicators. Once made available, the data will be reviewed against practice specific trajectories.

If the practice is meeting all trajectories, no further action is taken until routine review the following month.

If a practice is not meeting a trajectory, the process takes one of three paths depending on whether the trajectory being missed relates to a contractual requirement, a GP specification KPI or a quality indicator.

a) Contractual Requirement:

Where a practice has not achieved against its trajectory for 2 consecutive months, the contracts team will follow the national core contract monitoring process as outlined in Section 2.1. Performance will also be reported to both Performance and Quality Sub-Committee and Primary Care Commissioning Committee. If a breach has arisen, Performance and Quality Sub-Committee will review all action plans and make a recommendation to Primary Care Commissioning Committee to issue a remedial or breach notice.

PCCC will make the ultimate decision regarding which course of action is appropriate.

Should PCCC make the decision to issue a remedial or breach notice this will be processed by the Contract's team and monitored via the Contract's team.

b) Enhanced Services KPI:

Where a practice has not achieved against its trajectory for 2 consecutive months, the practice will be contacted to highlight the issue. If, after a further 2 reporting periods, the practice is still not meeting the trajectory, a formal letter will be sent to request an improvement plan. QSAG will review the improvement plan, and considering all the available information, make a decision as to whether they are assured that performance will be recovered. Where Performance and Quality Sub-Committee are not assured, this will be reported to PCCC.

c) Quality Indicator:

Where a practice is not achieving against the expected level for a quality indicator, this will be highlighted at Performance and Quality Sub-Committee.

A member of the quality team will then address this during the contractual visit.

3. NEXT STEPS

- The Performance Team will review the monthly KPI performance data and contact all practices that are off trajectory for the past three months.

4. STATUTORY/LEGAL/REGULATORY REQUIREMENTS (only applicable to strategy & commissioning papers)

4.1 **Does this require public engagement or has public engagement been carried out?** Yes ☐ No ☒

i. If 'no' explain why

ii. If yes attach either the engagement plan or the engagement report as an appendix. Summarise key engagement issues/learning and how responded to.

The paper provides a current position regarding the GP Specification and does not require any change to patient care.

5. EQUALITY IMPACT ASSESSMENT

5.1 Does the public sector equality duty apply? Yes ☐ No ☒
5.2 If 'no', please state why.
5.3 If 'yes' summarise equalities issues, action taken/to be taken and attach engagement EIA (or separate EIA if no engagement required). If completed state how EIA is/has affected final proposal.

The paper provides a current position regarding the GP Specification and does not require any change to patient care.

6. FINANCIAL IMPLICATIONS AND RISK

Effective contract and commissioning management will ensure robust financial management of the Primary Care budget. The commissioning of Local Enhanced Service schemes ensure a more effective use of NHS sources moving services outside of secondary care settings into the community.

7. WORKFORCE IMPLICATIONS

The monitoring of the KPI information is embedded into the work streams for the Performance and Business Intelligence Teams. Clinical system searches are already established and ready to be run each month. There is no additional workforce implications required to maintain the current process.

8. COMMUNICATION REQUIREMENTS

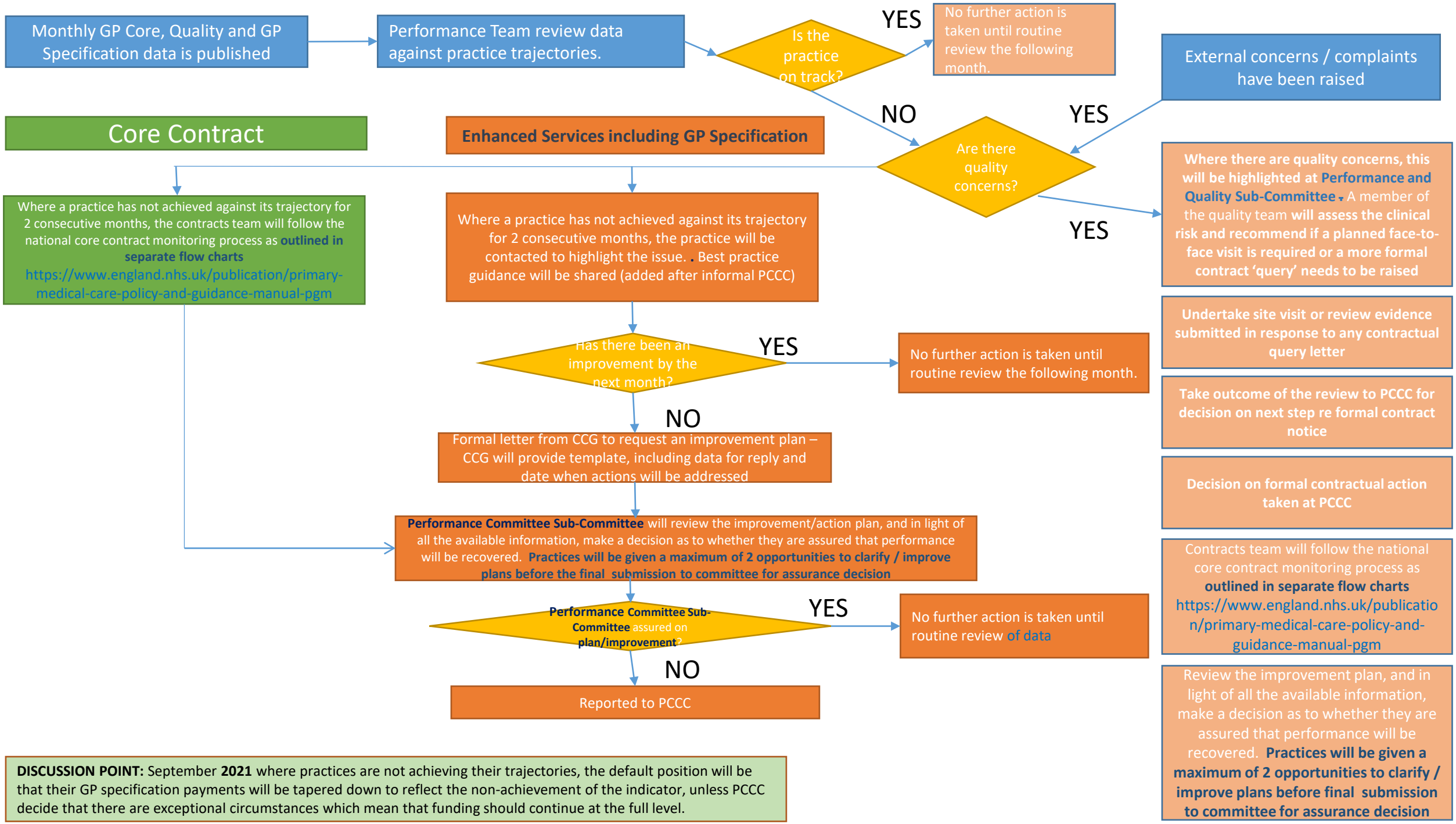
Communication regarding the performance management and engagement has already been shared with the practices individually and the LMC.

9. CONCLUSION

The Primary Care Commissioning Committee is asked to:

- Approve the updated Primary Care Framework

Ends


Monthly GP Core, Quality and GP Specification data is published
Performance Team review data against practice trajectories.
Is the practice on track?
YES
No further action is taken until routine review the following month.
NO
External concerns / complaints have been raised
YES
Are there quality concerns?
YES
Where there are quality concerns, this will be highlighted at Performance and Quality Sub-Committee . A member of the quality team will assess the clinical risk and recommend if a planned face-to-face visit is required or a more formal contract 'query' needs to be raised
Core Contract
Enhanced Services including GP Specification
Where a practice has not achieved against its trajectory for 2 consecutive months, the contracts team will follow the national core contract monitoring process as outlined in separate flow charts
https://www.england.nhs.uk/publication/primary-medical-care-policy-and-guidance-manual-pgm
Where a practice has not achieved against its trajectory for 2 consecutive months, the practice will be contacted to highlight the issue. . Best practice guidance will be shared (added after informal PCCC)
Has there been an improvement by the next month?
YES
No further action is taken until routine review the following month.
Undertake site visit or review evidence submitted in response to any contractual query letter
NO
Formal letter from CCG to request an improvement plan – CCG will provide template, including data for reply and date when actions will be addressed
Take outcome of the review to PCCC for decision on next step re formal contract notice
Performance Committee Sub-Committee will review the improvement/action plan, and in light of all the available information, make a decision as to whether they are assured that performance will be recovered. Practices will be given a maximum of 2 opportunities to clarify / improve plans before the final submission to committee for assurance decision
Decision on formal contractual action taken at PCCC
Performance Committee Sub-Committee assured on plan/improvement?
YES
No further action is taken until routine review of data
Contracts team will follow the national core contract monitoring process as outlined in separate flow charts
https://www.england.nhs.uk/publication/primary-medical-care-policy-and-guidance-manual-pgm
NO
Reported to PCCC
Review the improvement plan, and in light of all the available information, make a decision as to whether they are assured that performance will be recovered. Practices will be given a maximum of 2 opportunities to clarify / improve plans before final submission to committee for assurance decision
DISCUSSION POINT: September 2021 where practices are not achieving their trajectories, the default position will be that their GP specification payments will be tapered down to reflect the non-achievement of the indicator, unless PCCC decide that there are exceptional circumstances which mean that funding should continue at the full level.

NHS
Liverpool
Clinical Commissioning Group

Reporting to:	Primary Care Commissioning Committee			
Date of Meeting:	February 2021			
Title of Report:	LQIS Schemes 2021-22			
Presented by	Dave Horsfield Director of Transformation, Planning and Performance			
Report Author	Paula Guest Head of Planning and Delivery – Out of Hospital			
Lead Governor	Mark Bakewell Chief Finance and Contracting Officer			
Senior Leadership Team Lead	Dave Horsfield Director of Transformation, Planning and Peformance			
Report Category	Decision ☐	Discussion ☐	Assurance ☐	Information ☒

Purpose of this report		
This report advises the Committee of ongoing work on the service specifications for LQIS schemes for 2021-22 following feedback from the LMC.		
Recommendation(s)		
The Committee is asked to note the contents of this report.		
Is this subject matter confidential?	Yes ☐	No ☒

Relevance to CCG Strategic Objectives / Governing Body Assurance Framework		
01	Commissioning for better health outcomes	☒
02	Ensure commissioning of high quality, safe and responsive health services	☒
03	Reduce health inequalities	☒
04	Ensure maximum value from available resources	☒
05	Decisions that are evidence-based and evaluated for maximum impact	☒
06	Maintain the CCG's reputation and safeguard public confidence	☒

Executive summary

The LQIS schemes for 2021-22 were agreed at Primary Care Commissioning Committee in December 2020. Following this, the proposed service specifications were discussed by the LMC. This paper describes ongoing work on the schemes taking into account LMC feedback.

Governance and reporting arrangements
(list the committees, groups or other bodies that have discussed this report)

Date	Meeting	Decision made / outcome

Were there any conflicts of interest identified at any of the above meetings?
Yes ☐ No ☒
If 'Yes, please give brief details:

Implications	**Yes**	**No**	**N/A**
Quality	☒	☐	☐
Patient Experience	☒	☐	☐
Conflicts of interest	☐	☒	☐
Equality / PSED	☒	☐	☐
Privacy or GDPR	☐	☒	☐
Workforce	☒	☐	☐
Are there any risks associated with this report or its recommendations?	☒	☐	☐
Are these risks included on the Corporate Risk Register (CRR) or GBAF?	☐	☒	☐

If 'yes', please provide CRR/GBAF reference number and risk description:

Equality & Human Rights Analysis	Yes	No	N/A
Do the issue(s) identified in this report affect one of the protected group(s) less or more favourably than any other?	☐	☒	☐
Are there any valid legal/regulatory reasons for discriminatory practice?	☐	☒	☐
If the answer to either of the above two questions is 'YES', please include a section in this report explaining why.			

1. BACKGROUND

In December 2020 the Committee approved changes to the service specifications and metrics to be monitored for six LQIS schemes:

1.1 Minor surgery injection
1.2 Minor surgery excision
1.3 Gonadorelin therapy
1.4 Near patient testing
1.5 Asylum seekers and refugees
1.6 Travelling community

Additionally, the Committee approved the development of an alternative payment proposal for those schemes which are currently based on a retainer, to ensure that the practices with the highest number of relevant patients benefited the most from the financial agreement for schemes. The development of this proposal is ongoing.

The service specifications were sent to the LMC for discussion by members in early February. Following feedback from the LMC, the Committee is asked to note the following points of clarification and the ongoing work relating to two schemes.

2. GENERAL POINTS OF CLARIFICATION

Data collection templates – CCG officers are developing templates to facilitate data collection for the monitoring information required in the schemes. Searches will also be developed centrally by the CCG. The intention of this is to minimise the burden of data collection on practices and provide a consistent format.

Consent – It is the understanding of the CCG that historically there have been issues in the recording of consent when a practice provides services to patients from another practice. We believe that updated software systems have eliminated this issue. Should this not function as intended, the CCG will invite practices to inform us so any issues can be addressed.

Monitoring information – The CCG does not intend to begin the new monitoring of schemes until July 2021 (quarter 2 of the financial year 2021-22) ***at the earliest***, subject to amendments to contracting advice from NHS England/Improvement and ongoing operational pressures in primary care.

3. SCHEME-SPECIFIC ISSUES

Some scheme-specific issues were raised by the LMC. These will be addressed and service specifications amended accordingly, following further discussion with the Task and Finish Group members who were involved in drawing up the specifications.

The revised specifications will be brought to the April Primary Care Commissioning Committee for approval.

In summary, these issues relate to:

Gonadorelin scheme:

- Commissioning method (the preference expressed by LMC is for this to be at individual practice level)
- Change of wording in relation to frequency of injections so that it is clear that the funding agreement will not negatively impact those practices with patients who may be on older treatment regimes requiring an increased frequency of injections
- Development of specification to include provision of the injection service to breast cancer patients

Asylum seekers/refugees:
Review of the monitoring requirements with a view to a reduction in the number of data items monitored. The Committee is asked to note that this scheme currently has a retainer as part of the funding arrangement which, as described earlier, is under review.

4. STATUTORY/LEGAL/REGULATORY REQUIREMENTS (only applicable to strategy & commissioning papers)

4.1 Does this require public engagement or has public engagement been carried out? Yes ☐ No ☒

i. If 'no' explain why

This paper is for information only.

ii. If yes attach either the engagement plan or the engagement report as an appendix. Summarise key engagement issues/learning and how responded to.

5. EQUALITY IMPACT ASSESSMENT

a. Does the public sector equality duty apply? Yes ☐ No ☒

b. If 'no', please state why.
This paper is for information only.

c. If 'yes' summarise equalities issues, action taken/to be taken and attach engagement EIA (or separate EIA if no engagement required). If completed state how EIA is/has affected final proposal.

6. FINANCIAL IMPLICATIONS AND RISK

It is likely that the proposal for changing the payment formula for some schemes will have a negative impact on some practices which currently have low numbers of the specified cohort but high overall list numbers. This will be

the subject of a full financial impact analysis before any recommendations are made.

7. WORKFORCE IMPLICATIONS

There are no workforce implications.

8. COMMUNICATION REQUIREMENTS

The LMC will be informed of the ongoing work following their feedback.

9. CONCLUSION

The committee is asked to:

- Note the contents of this paper

Ends

NHS
Liverpool
Clinical Commissioning Group

Reporting to:	Primary Care Commissioning Committee			
Date of Meeting:	16th February 2021			
Title of Report:	Primary Care Estates – Lease decisions			
Presented by	Valerie Attwood – Deputy Chief Contracting Officer – Primary Care Estates			
Report Author	Kellie Connor, Contract Manager			
Lead Governor	Mark Bakewell, Chief Finance and Contracting Officer			
Senior Leadership Team Lead	Mark Bakewell, Chief Finance and Contracting Officer			
Report Category	Decision ☐	Discussion ☒	Assurance ☐	Information ☐

Purpose of this report
This report is to inform Primary Care Commissioning Committee on Fulwood Green and Priory Medical Centre intentions to complete a sale and leaseback arrangement in accordance with the NHS Premises Cost Directions 2013 and t agree a course of action in relation to the process.
Recommendation(s)
The Committee is asked to: a) Note the Commissioner responsibilities in terms of the Premises Cost Directions 2013 and the process followed b) Consider and approve the recommendations with regard to Fulwood Green Medical Centre's proposal for a sale and leaseback c) Consider and approve the recommendations with regards to Priory Medical Centre proposal for a sale and leaseback d) Communicate to Primary Care a high level summary of the Premises Cost Directions 2013 and clarification of the contractual obligations

Is this subject matter confidential?	Yes ☐	No ☒

Relevance to CCG Strategic Objectives / Governing Body Assurance Framework		
01	Commissioning for better health outcomes	☒
02	Ensure commissioning of high quality, safe and responsive health services	☒
03	Reduce health inequalities	☒
04	Ensure maximum value from available resources	☒
05	Decisions that are evidence-based and evaluated for maximum impact	☒
06	Maintain the CCG's reputation and safeguard public confidence	☒

Executive summary

The CCG has received requests for approval of a 'Sale and Leaseback' arrangement for the premises of two current General Practice providers within Liverpool.

There are a number of concerns with regard to compliance with process and the Premises Cost Directions (PCD) (2013) requirements and these are outlined within the paper.

One Practice is requesting approval of a lease which is longer than the 'normal' length outlined within the PCD and a second Practice is requesting approval of a lease arrangement at an earlier stage of drafting than is permitted.

The paper outlines a range of recommendations in relation to both lease change requests and recommends a more general communication to remind Primary Care providers on the expectations and process for Lease change requests in future.

Governance and reporting arrangements
(list the committees, groups or other bodies that have discussed this report)

Date	Meeting	Decision made / outcome
N/A		

Were there any conflicts of interest identified at any of the above meetings?

Yes ☐ No ☐

If 'Yes, please give brief details:

Implications	Yes	No	N/A
Quality	☐	☒	☐
Patient Experience	☐	☒	☐
Conflicts of interest	☐	☒	☐
Equality / PSED	☐	☒	☐
Privacy or GDPR	☐	☒	☐
Workforce	☐	☒	☐
Are there any risks associated with this report or its recommendations?	☐	☒	☐
Are these risks included on the Corporate Risk Register (CRR) or GBAF?	☐	☒	☐

If 'yes', please provide CRR/GBAF reference number and risk description:

Equality & Human Rights Analysis	Yes	No	N/A
Do the issue(s) identified in this report affect one of the protected group(s) less or more favourably than any other?	☐	☒	☐
Are there any valid legal/regulatory reasons for discriminatory practice?	☐	☒	☐

If the answer to either of the above two questions is 'YES', please include a section in this report explaining why.

1. PURPOSE

To inform Primary Care Commissioning Committee on Fulwood Green and Priory Medical Centre intentions to complete a sale and leaseback arrangement in accordance with the NHS Premises Cost Directions (PCD) 2013.

2. RECOMMENDATIONS

That Liverpool CCG Primary Care Commissioning Committee:

- Note the Commissioner responsibilities in terms of the Premises Cost Directions 2013 and the process followed
- Consider and approve the recommendations with regard to Fulwood Green Medical Centre's proposal for a sale and leaseback
- Consider and approve the recommendations with regards to Priory Medical Centre proposal for a sale and leaseback
- Communicate to Primary Care a high level summary of the Premises Cost Directions 2013 and clarification of the contractual obligations

3. BACKGROUND

In April 2015 NHS Liverpool CCG became delegated for Primary Care and GP Services budgets from NHS England (NHSE). Included within these budgets is the responsibility to reimburse GP practices for recurring premises costs, in accordance with Part 5 of the NHS GMS PCD 2013.

The CCG was required to establish a CCG Premises and Estates group to ensure delivery of delegated functions in respect of Premises and Estates, PCD functions, premises and strategic estates planning. The CCG's delegated functions and obligations are outlined below.

PCD (2013) Schedule 2 Part 1 – Delegated Functions

- The CCG must comply with the PCD and will be responsible for making decisions in relation to the PCD Functions.
- The CCG shall make decisions concerning: applications for new payments under the PCD (whether such payments are to be made by way of grants or in respect of recurring premises costs); and revisions to existing payments being made under the PCD.
- The CCG must comply with any decision-making limits set out in Schedule 5 (Financial Provisions and Decision Making Limits) when taking decisions in relation to the PCD Functions.
- The CCG will comply with any guidance issued by the Secretary of State or NHS England in relation to the PCD, including the Principles of Best Practice, and any other Guidance in relation to the PCD.
- The CCG must work cooperatively with other CCGs to manage premises and strategic estates planning.
- The CCG must liaise where appropriate with NHS Property Services Limited and Community Health Partnerships Limited in relation to the PCD Functions.

4. CURRENT SITUATION

The National Health Service (General Medical Services – Premises Costs Directions 2013 (PCD) supports matters concerning Primary Care estates. NHS Liverpool CCG and NHSE - Cheshire and Merseyside Region, must comply with this guidance and advise general practice in accordance with this Legislation. The framework covers the following:

- It is applicable to General Practice covering all GMS contracts and can equally be applied to PMS contracts. Some elements may also be reflected in Alternative Provider Medical Service contracts through local negotiation
- It provides contractual entitlement to reimbursement for certain recurring premises costs:- rent, business rates, water /sewerage and clinical waste
- It governs the application process for financial support to deliver premises development and improvements, transitional support and non-recurrent funding.

Over recent months, a number of Practices have contacted the CCG and are seeking to conduct a 'sale and leaseback' arrangement under the Premises Costs Directions 2013. The Practices intend to sell their premises to a 'third party provider' and rent it back under a lease agreement.

In a sale and leaseback transaction the practice is no longer entitled to notional rent but is instead entitled to rent reimbursement. This is subject to approval by NHS England who is, in turn, advised by the District Valuer.

5. Fulwood Green Medical Centre (N82062)

The Partners of Fulwood Green Medical Centre intend to complete a Sale and Leaseback of Fulwood Green Medical Centre (N82062). The draft lease submitted to the CCG for initial review contains a proposed lease term of 21 years.

The practice has proposed a term of 21 years to coincide with a Pharmacy 'Premises' lease which is on the same site. The NHSE Primary Care Estates Advisor has identified a number of issues for the CCG to consider in making a decision regarding the lease term.

- The CCG would be tied in to a 21-year lease (term/clauses) for the property, that might affect our future Estates Strategy for the area.
- There may be budgetary constraints which would be impacted by the consequence of a new long-term practice lease commitment e.g. considering the increase in rental reimbursement, rates etc.
- The CCG's Estates and Primary Care Networks (PCN) strategies may be impacted by any decisions to re-confirm long term Primary Care points of delivery/future housing growth. Primary Care networks are expected to develop local estates strategy to support the long term plan.
- Longevity of the commitment and if the CCG are in favour of the increased rental reimbursement.

NHSE have advised that it might be acceptable to approve a 21 year term in principle, but a break clause at 15 years is recommended. A break clause can push a lease rent up; however, the balance is that the CCG would be paying for the greater flexibility and future planning opportunities.

Fulwood Green Medical Centre has referenced the pharmacy lease as their rationale for the proposed 21 year term. However, the Pharmacy is a separate and commercial entity and should not therefore be used to influence the lease for Primary Care. At this stage, the final approval could only follow a district valuer "Value for Money" report, confirming the lease is indeed 'value for money'. Ultimately, the decision still lies with the Commissioner (CCG) as to whether this approach should be approved.

5.1 RECOMMENDATION FOR FULLWOOD GREEN MEDICAL CENTRE

The following recommendations are advised by LCCG to support the practice in completing the sale and leaseback arrangement.

- The CCG to maintain the requirement of a maximum 15 year term for GP estate leases as the Pharmacy lease is entirely separate to the GP requirements
- To continue to advise the practice that the following actions are also required in order to progress the sale and leaseback scheme.
    - For the contractor and landlord to agree and sign a rent review memorandum, stating initial rental value and any VAT applied.
    - To submit an UNSIGNED final draft lease (Version No) to the CCG/NHSE with a proposed commencement date.
    - Following receipt of this, the Commissioners will assess the document for approval in principle.
    - Once approval in principle is confirmed, requested documents received (pharmacy lease) and adjustments made. The draft lease is submitted to the District Valuer for a current market rent assessment and VFM report.
    - Upon receipt of the District Valuer's report, the Commissioners will consider the application and will advise the Contractor of the outcome of this and subsequent approval from the Commissioner for rent reimbursement.
    - On receipt of Commissioners approval, the lease can be signed and returned. The document will be checked for validation against the draft lease. If there are no variations, a full reconciliation will be completed on the account, back dated to the commencement date of the lease. The initial lease rental reimbursement will be initiated and any arrears due, will be arranged in the next available payment run

6. Priory Medical Centre (N82011)

The partners of Priory Medical Centre intend to complete a Sale and Leaseback of Priory Medical Centre (N82011). In support of this, the Practice has enlisted the professional support of Capsticks; a Private / Independent GP Surveyor.

A draft lease has been submitted to the Commissioner (LCCG/NHSE) for approval however under the PCD (Direction 31) the lease must adhere to a number of recommendations before the application for financial assistance towards its rental costs can be considered.

Therefore, the Commissioners have made a number of recommendations for changes before the final draft lease will be considered and a “Value for Money” assessment is undertaken. The Practice has also been advised not to sign a lease before approval has been granted, in order to seek rental reimbursement. However, the Independent GP Surveyors are challenging the advice provided by the Commissioners.

NHSE have also advised the practice and the Independent GP Surveyor that, under Schedule 2 Part 2 Section 4(c) (iv) of the PCDs, it requires the submission of a rent review memorandum, signed by both the landlord and the contractor, recording the level of rent charged. This should be agreed between the parties (with both landlord and tenant taking professional advice). At this stage, the landlord has not been named and subsequently the lease provided cannot be approved as a draft final version as once a landlord is identified, they may request changes or depending on the length of time it takes to find a landlord, the terms or rent level may be outdated. NHSE have advised that there have been other similar instances in the recent years which attempt to shorten the agreement process but often result in additional costs are for both the Practice and for the Commissioner

Subsequently, a GP Partner at Priory Medical Centre, has referred the matter to the Local Medical Committee (LMC) and requested guidance on the process advised by the Commissioners. NHSE have liaised with the LMC and an option has been put forward to the practice to fully fund the cost of a District Valuer VFM report on this draft lease (without an identified landlord) which may alleviate some of the concerns of the Practice has with regards the timescale for completion. District Valuer’s have ordinarily acted for public bodies in these circumstances but may consider this option as a business opportunity and agree to undertake the valuation. The decision to incur additional costs remains with the Practice and the Partners are considering their options.

However the Commissioners should reiterate to the Practice again that they would still not have an NHS approved lease but this may support the process in identifying a landlord and may reduce the timings in getting to a final stage of the sale and leaseback.

One of the fundamental reasons for only providing a final draft lease to the District Valuer for review, is to protect the cost to the taxpayers and time and resource of those involved in the review process. Therefore, the LMC has suggested an administrative fee could also be charged to the Practice for the additional Commissioner time and resource required in the potential duplication of process. .

6.1 RECOMMENDATIONS FOR PRIORY MEDICAL CENTRE

The following recommendations are advised by LCCG to support the practice in completing the sale and leaseback arrangement.

- The Practice is to report to the Commissioner and LMC on the decision to approach the DV for an independent valuation which will be funded by the practice and not the CCG.
- NHSE to develop a timeline for completion to alleviate some of the concerns from the practice in the timescales for agreeing the Final Draft lease – including landlord details.
- To continue to advise the practice in accordance with national guidance (PCD and NHS England Policy and Guidance Manual) and reiterate the following next steps below as advised by NHSE.

    - The lease approval process cannot continue until the Commissioner is in receipt of the final draft lease, with the adjustments adhered to in previous email correspondence.
    - For the parties (contractor and landlord) to sign and agree a rent review memorandum;
    - To submit a final draft lease to the CCG/NHSE (with the below adjustments adhered to) with a proposed commencement date.
    - Following receipt of this, the CCG, as Commissioners will submit this to the District Valuer for a current market rent assessment and VFM report.
    - Upon receipt of the District Valuer's report the CCG, as Commissioners will consider the application and will advise the Contractor of the outcome of this and subsequent approval from the Commissioner for rent reimbursement.
    - On receipt of the final signed lease. The document will be checked for validation against the draft lease. If there are no variations, a full reconciliation will be completed on the account, back dated to the commencement date of the lease. The initial lease rental reimbursement will be initiated and any arrears due, will be arranged in the next available payment run.

7.0 GENERAL COMMUNICATION

It is clear that there is a lack of understanding about the process for lease changes and what is required from Primary Care in terms of the PCDs. Therefore, it is recommended that a general communication is issued to Primary Care at an appropriate time in the future, to highlight the legislative process within the PCDs and the contractual requirements outlined within Primary Medical Services contracts. It is hoped that this would, in time, reduce unnecessary justification of the process and improve upon the timescales for completion.

8. STATUTORY REQUIREMENTS (only applicable to strategy & commissioning papers)

8.1 Does this require public engagement or has public engagement been carried out? N/A

8.2 Does the public sector equality duty apply? N/A

8.3 Explain how you have/will maximise social value in the proposal: describe the impact on each of the following areas showing how this is constructed to achieve the most:

a) Economic wellbeing
b) Social wellbeing
c) Environmental wellbeing

8.4 Taking the above into account, describe the impact on improving health outcomes and reducing inequalities

9. FINANCIAL IMPLICATIONS AND RISK

There is risk to the CCG in agreeing longer term lease arrangements without the opportunity for early termination and additionally, there is an increased cost associated with the duplication of process for the 'value for money' assessments undertaken. Therefore it is proposed that this duplicate cost is passed to the Practice requesting the process change, rather than these constituting additional costs for the taxpayer.

10. WORKFORCE IMPLICATIONS

N/A

11. COMMUNICATION REQUIREMENTS

The outcome of the Committee will be communicated to the Practices referenced within this report and a wider communication on the PCD rules and process will be issued to all current Primary Care GP contract holders

12. CONCLUSION

The Primary Care Commissioning Committee is asked to consider and approve the recommendations outlined:

- Note the Commissioner responsibilities in terms of the Premises Cost Directions 2013 and the process followed
- Consider and approve the recommendations with regard to Fulwood Green Medical Centre's proposal for a sale and leaseback
- Consider and approve the recommendations with regards to Priory Medical Centre proposal for a sale and leaseback
- Communicate to Primary Care a high level summary of the Premises Cost Directions 2013 and clarification of the contractual obligations

ENDS
8TH FEBRUARY 2021