Mansfield & Ashfield CCG and Newark & Sherwood CCG
Primary Care Commissioning Committees
Joint meeting in public

Thursday 14th September 2017
9.00-12.00
Birch House Rooms 2 and 3

AGENDA

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<th>Committee</th>
<th>Paper/verbal</th>
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<td>Marcus Pratt</td>
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Committees move to confidential session

Public Bodies (Admission to Meetings) Act 1960

A body may, by resolution, exclude the public from a meeting (whether during the whole or part of the proceedings) whenever publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution and arising from the nature of that business or of the proceedings; and where such a resolution is passed, this Act shall not require the meeting to be open to the public during proceedings to which the resolution applies.
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• GP Forward View | Note   | Both       | Paper        | Paula Longden |
| JPC/17/76  | Primary Care Risks | Discuss | Both       | Paper        | David Ainsworth |
| JPC/17/88  | Finance Reports | Note   | Both       | Paper        | Marcus Pratt  |

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<thead>
<tr>
<th>Name</th>
<th>Current position (s) held - i.e. Governing Body, Member of practice, Employee or other</th>
<th>Date completed</th>
<th>Date interest relates to</th>
<th>Non-Financial Professional Interests</th>
<th>Financial Interests</th>
<th>Indirect Interests</th>
<th>Non-Financial Personal Interests</th>
<th>Conflicts of interest noted at Committee/Sub-Committee and Governing Body meetings</th>
<th>Action taken to mitigate risk (if required)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amanda Sullivan</td>
<td>Chief Officer (shared post with NHS Mansfield and Ashfield Clinical Commissioning Group) (voting member)</td>
<td>16.01.17</td>
<td>None declared</td>
<td>None declared</td>
<td>Family member has temporary contact with PICS (part time)</td>
<td>None declared</td>
<td>None declared</td>
<td>During the January 2016 Governing Body for NHS Newark and Sherwood and NHS Mansfield and notional, where the Nottinghamshire County Council’s budget proposals were presented, Mrs Brady affirmed that she was an employee of Nottinghamshire County Council, and that this should be noted in the Conflicts Of Interest register.</td>
<td>None declared</td>
</tr>
<tr>
<td>Barbara Brady</td>
<td>Interim DPH, Nottinghamshire County Council (non-voting member)</td>
<td>14.06.16</td>
<td>None declared</td>
<td>None declared</td>
<td>None declared</td>
<td>None declared</td>
<td>None declared</td>
<td>None declared</td>
<td>None declared</td>
</tr>
<tr>
<td>David Atkinson</td>
<td>Director of Primary Care</td>
<td>29.08.17</td>
<td>None declared</td>
<td>None declared</td>
<td>None declared</td>
<td>None declared</td>
<td>None declared</td>
<td>None declared</td>
<td>None declared</td>
</tr>
<tr>
<td>Elaine Maus</td>
<td>Chief Nurse and Director of Quality (shared post with NHS Mansfield and Ashfield Clinical Commissioning Group) (voting member)</td>
<td>29.08.17</td>
<td>None declared</td>
<td>None declared</td>
<td>None declared</td>
<td>None declared</td>
<td>None declared</td>
<td>None declared</td>
<td>None declared</td>
</tr>
<tr>
<td>Eleri de Gilbert</td>
<td>Vice Chair of the Primary Care Commissioning Committee and Lay member of the Quality and Risk Committee (non-voting member)</td>
<td>04.07.16</td>
<td>None declared</td>
<td>None declared</td>
<td>None declared</td>
<td>None declared</td>
<td>None declared</td>
<td>None declared</td>
<td>None declared</td>
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<tr>
<td>Emma Challans</td>
<td>Healthwatch Board Member</td>
<td>17.01.17</td>
<td>None declared</td>
<td>None declared</td>
<td>None declared</td>
<td>None declared</td>
<td>None declared</td>
<td>Deputy Director in Lincolnshire Community Health NHS Trust</td>
<td>None declared</td>
</tr>
<tr>
<td>Gavin Lunn</td>
<td>General Practitioner Clinical Chair (voting member)</td>
<td>04.01.17</td>
<td>None declared</td>
<td>None declared</td>
<td>None declared</td>
<td>None declared</td>
<td>None declared</td>
<td>None declared</td>
<td>None declared</td>
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</table>

### Declaration of interests for members/employees - Personal interest or that of a family member, close friend or other acquaintance (31 March 2017)

**Amanda Sullivan**
- Chief Officer (shared post with NHS Mansfield and Ashfield Clinical Commissioning Group) (voting member)
- Date completed: 16.01.17
- Date interest relates to: None declared
- Non-Financial Professional Interests: None declared
- Financial Interests: Family member has temporary contact with PICS (part time)
- Indirect Interests: None declared
- Action taken to mitigate risk (if required): During the January 2016 Governing Body for NHS Newark and Sherwood and NHS Mansfield and notional, where the Nottinghamshire County Council’s budget proposals were presented, Mrs Brady affirmed that she was an employee of Nottinghamshire County Council, and that this should be noted in the Conflicts Of Interest register.

**Barbara Brady**
- Interim DPH, Nottinghamshire County Council (non-voting member)
- Date completed: 14.06.16
- Date interest relates to: None declared
- Non-Financial Professional Interests: None declared
- Financial Interests: None declared
- Indirect Interests: None declared
- Action taken to mitigate risk (if required): None declared

**David Atkinson**
- Director of Primary Care
- Date completed: 29.08.17
- Date interest relates to: None declared
- Non-Financial Professional Interests: None declared
- Financial Interests: None declared
- Indirect Interests: None declared
- Action taken to mitigate risk (if required): None declared

**Elaine Maus**
- Chief Nurse and Director of Quality (shared post with NHS Mansfield and Ashfield Clinical Commissioning Group) (voting member)
- Date completed: 29.08.17
- Date interest relates to: None declared
- Non-Financial Professional Interests: None declared
- Financial Interests: None declared
- Indirect Interests: None declared
- Action taken to mitigate risk (if required): None declared

**Eleri de Gilbert**
- Vice Chair of the Primary Care Commissioning Committee and Lay member of the Quality and Risk Committee (non-voting member)
- Date completed: 04.07.16
- Date interest relates to: None declared
- Non-Financial Professional Interests: None declared
- Financial Interests: None declared
- Indirect Interests: None declared
- Action taken to mitigate risk (if required): None declared

**Emma Challans**
- Healthwatch Board Member
- Date completed: 17.01.17
- Date interest relates to: None declared
- Non-Financial Professional Interests: None declared
- Financial Interests: None declared
- Indirect Interests: None declared
- Action taken to mitigate risk (if required): Deputy Director in Lincolnshire Community Health NHS Trust

**Gavin Lunn**
- General Practitioner Clinical Chair (voting member)
- Date completed: 04.01.17
- Date interest relates to: None declared
- Non-Financial Professional Interests: None declared
- Financial Interests: None declared
- Indirect Interests: None declared
- Action taken to mitigate risk (if required): None declared
The Chair noted that for this single agenda item, Dr Place had acknowledged conflicts and had therefore not attended the meeting, nor received papers for this meeting. 19 November 2015 – JPC/15/097© APRM update.

The Chair noted that for this single agenda item, Jon Towler had acknowledged conflicts and had therefore not attended the meeting, nor received papers for this meeting.

Chair noted the declaration and agreed that Dr Lovelock could remain within the meeting.

The Chair noted this conflict and agreed to Dr Lovelock remaining for the item but not taking part in the discussions.

The Chair noted that for this single agenda item, Dr Lovelock had acknowledged conflicts and had therefore not attended the meeting, nor received papers for this meeting.

The Chair noted that for this single agenda item, Jon Towler had acknowledged conflicts and had therefore not attended the meeting, nor received papers for this meeting.

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<th>End Date</th>
<th>Conflicts of Interest</th>
<th>Specific Friendships</th>
<th>None Declared</th>
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<tbody>
<tr>
<td>Nigel Marshall</td>
<td>Clinical Advisor and Deputy Caldicott Guardian</td>
<td>30.09.17</td>
<td>29.08.17</td>
<td>None declared</td>
<td>NR</td>
<td>None declared</td>
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<td></td>
<td>LOCUM General Practitioner WORK SHERWOOD MEDICAL PARTNERSHIP (FORMERLY FARNFILD SURGERY) - IN RECEIPT OF PROJECT FUNDING: (PRE-SPECIFIED UROLOGY PROJECT) - ASTELLAS PHARMA. PRIVATE / CONSULTANCY WORK PATHWAYS AND ADVISORY PREVIOUS WORK (FROM 09/15 - 15/07/16)' Clinical advisor' CARE-IS BIO-CITY, NOTTINGHAM (Clinical Commissioning Group CURRENTLY WORKING WITH CARE-IS ON REFERRAL SUPPORT / FACILITATION SOFTWARE) (stopped 15/07/16)</td>
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<tr>
<td>Peter Clay</td>
<td>Governing Body Lay Representative (voting member) and Chair of Audit and Governance Committee</td>
<td>30.09.17</td>
<td>29.08.17</td>
<td>None declared</td>
<td>NR</td>
<td>None declared</td>
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<td></td>
<td>Co-Chair of the Joint Auditor Panel</td>
<td>15.09.16</td>
<td>29.08.17</td>
<td>None declared</td>
<td>NR</td>
<td>None declared</td>
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<tr>
<td>Ruth Lloyd</td>
<td>Head of Corporate Governance (joint post with NHS Newark and Sherwood Clinical Commissioning Group)</td>
<td>05.09.17</td>
<td>29.08.17</td>
<td>None declared</td>
<td>NR</td>
<td>None declared</td>
</tr>
<tr>
<td>Shaun Beadle</td>
<td>Lay Representative (voting member) and Chair of the Activity and Finance Committee</td>
<td>18.09.17</td>
<td>29.08.17</td>
<td>None declared</td>
<td>NR</td>
<td>None declared</td>
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<tr>
<td>Subeer Satyam</td>
<td>Out of area General Practitioner</td>
<td>18.09.17</td>
<td>29.08.17</td>
<td>None declared</td>
<td>NR</td>
<td>None declared</td>
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<tr>
<td>Thilan Bartholomeuz</td>
<td>General Practitioner Representative Clinical Chair (voting member)</td>
<td>05.09.17</td>
<td>29.08.17</td>
<td>None declared</td>
<td>NR</td>
<td>None declared</td>
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**Draft Minutes of the Mansfield & Ashfield CCG and Newark & Sherwood CCG**
**Primary Care Commissioning Committees**
**Joint meeting in public**

**Thursday 13th July 2017**
**8.30-10.30**
**Birch House Rooms 2 and 3**

**Representing both CCG Primary Care Commissioning Committees (voting)**
- Mr Jon Towler, Chair
- Mrs Eleri de Gilbert, Independent Lay Representative
- Mrs Dawn Atkinson, CCG Head of Business Change and Implementation
- Mr David Ainsworth, CCG Director of Primary Care
- Mr Neil Moore, Director of Procurement and Market Development
- Mrs Sarah Bray, CCG Chief Finance Officer (until 9.30am)
- Mr Marcus Pratt, CCG Associate Chief Finance Officer (from 9.30am)
- Mrs Sandy Hogg, CCG Director of Turnaround
- Mr Peter Clay, CCG Governing Body Lay member and Chair of the Audit Committee
- Mr Shaun Beebe, CCG Governing Body Lay Representative
- Dr Nigel Marshall, CCG Clinical Advisor

**In attendance (non-voting)**
- Dr Hilary Lovelock, Local GP
- Dr Gavin Lunn, Clinical Chair, Mansfield and Ashfield CCG
- Ms Paula Longden, CCG Primary Care Programme Manager
- Mrs Ruth Lloyd, CCG Head of Corporate Governance
- Ms Kerrie Woods, NHSE GP Contracts Manager, North Nottinghamshire
- Mr Michael Wright, Chief Executive, Nottinghamshire LMC
- Ms Charlotte Lawson, CCG Workforce Programme Manager
- Mrs Sally Dore, CCG Head of Communications and Engagement
- Mrs Hazel Taylor, CCG Senior Primary Care Development and Performance Manager
- Ms Sue Wass, Corporate Governance Officer (minutes)

**Apologies representing both CCG Primary Care Commissioning Committees (voting)**
- Dr Amanda Sullivan, CCG Chief Officer
- Mrs Elaine Moss, CCG Chief Nurse
- Mrs Andrea Brown, CCG Director of Programmes
- Mrs Barbara Brady, Nottinghamshire County Public Health Consultant
- Dr Subeer Satyam, Out of Area GP

**Apologies in attendance (non-voting)**
- Ms Emma Challans, Nottinghamshire Healthwatch
- Ms Joe Lunn, NHSE
- Ms Michelle Livingstone, Chair, Nottinghamshire Healthwatch

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<tr>
<th>JPC/17/39</th>
<th>Welcome</th>
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| **Welcome** | **a.** Introductions  
| **b.** Apologies for absence  
| **c.** Declaration of interest |

The Chair welcomed members to the meeting and apologies were noted as above.
A potential conflict of interest for Dr Lunn and Dr Lovelock was noted in paper JPC/17/52, which contained references to the practice of Dr Lunn and Dr Lovelock, it was agreed that they remain in the meeting and participate fully in any discussion.

**JPC/17/40**  
**Questions from members of the public**

No questions were received.

**JPC/17/41**  
**Minutes of the meeting held on 11 May 2017**

The minutes of the meetings held on 11 May were agreed as an accurate summary of discussions.

**JPC/17/42**  
**Actions arising from the meeting held on 11 May 2017**

Actions JPC/17/24 and 26 were noted as future actions to be confirmed as complete in September. Action JPC/17/32 was tabled for discussion under item JPC/17/49.

All other actions were noted as complete.

**JPC/17/43**  
**Forward Plan**

The Forward Plan was noted.

**JPC/17/44**  
**Plan for Reducing Clinical Variation**

Mr Ainsworth recapped on the discussions at the last meeting, which had focused on the reasons for avoidable variation and activities to tackle it. The Committees had requested a plan with actions and timescales. This was presented with suggested KPIs.

Mrs de Gilbert asked what was being done to incentivise practices. Mr Ainsworth reported this was a combination of incentivising the right behaviour, such as use of the Best Practice Scheme, or by performance management and the use of peer to peer reviews. Dr Marshall agreed the key was to help practices understand the need for consistency to be fair to all patients. Dr Lovelock noted that underperforming practices were often those most difficult to engage with and it was acknowledged that different methods of engagement were required for individual circumstances. Mrs Atkinson noted the need for practices to influence patient behaviour, using PPGs to engage their populations in a much stronger way. Mr Beebe noted the need to understand rising unplanned demand and a number of factors were noted, including the risk-averse nature of the 111 service, the need to educate parents and carers in self-care management. Dr Lovelock noted that in her opinion weekly peer review targets were unlikely to be achievable.

Mrs Hogg asked that milestones be added to the action plan; with those in the plan as presented being absolutes. It was also noted the QIPP saving on Consultant Connect would be subject to scrutiny by the Turnaround Board. The outcomes also required stating in measurable terms. The Chair asked that an updated plan be brought to the September Committee meeting to give assurance that the CCGs had the capacity to deliver the action plan, with updated milestones and KPIs, and be tailored to individual practices.
- **ACTION:** Mr Ainsworth to bring an updated plan to the September Committee meeting to give assurance that the CCG had the capacity to deliver the action plan, with updated milestones and KPIs, and be tailored to individual practices.

The plan for the reduction of clinical variation was APPROVED.

<table>
<thead>
<tr>
<th>JPC/17/45</th>
<th>Member Practice Agreement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mr Ainsworth reported that the Member Practice Agreement set out the relationship between member practices and the CCG. All member practices were required to sign the Agreement and thus contribute to the goals of the CCGs. The Agreement had been revised, rationalised and updated and had been to the Steering Group for comment prior to consultation with the Clinical Executive and this Committee, ahead of final ratification by the Governing Bodies in July.</td>
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</tbody>
</table>

The Committees ENDORSED the Agreement.

<table>
<thead>
<tr>
<th>JPC/17/46</th>
<th>Governance Arrangements for the Delivery of Primary Care QIIPP savings</th>
</tr>
</thead>
</table>
| • Primary Care Quality and Performance Review Group (PCQPRG) Terms of Reference  
• Primary Care Commissioning Steering Group Terms of Reference  |

Ms Longden reported on arrangements that had been put in place to monitor and manage the primary care QIIPP savings target. The Terms of Reference for the Primary Care Quality and Performance Review Group and Primary Care Steering Group had been revised to reflect the enhanced roles. The Primary Care Quality and Performance Review Group would act as the QIIPP programme board and would report to the Financial Recovery Group, with an exception report to this Committee. The Steering Group would act as the oversight group for the implementation of the GP Forward View and for the generation of new ideas.

In discussion a number of points were raised and the following actions were agreed:

- **ACTIONS:**
  - Mr Ainsworth to consider strengthening clinical representation on the Steering Group via the clinical leads  
  - Mrs Lloyd to ensure that QIIPP programme Board standard wording was used in the Terms of Reference for the Primary Care Quality and Performance Review Group; and to amend the deputy chair to Mrs de Gilbert  
  - Mr Ainsworth to ensure the revised Terms of Reference were formally approved at the respective meetings during July

The Terms of Reference for the Primary Care Quality and Performance Review Group and Primary Care Commissioning Steering Group were APPROVED.

<table>
<thead>
<tr>
<th>JPC/17/47</th>
<th>Primary Care Commissioning Steering Group progress report and minutes of meeting on 8 June</th>
</tr>
</thead>
<tbody>
<tr>
<td>The report was noted.</td>
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</tr>
</tbody>
</table>
Primary Care Strategy Implementation Exception Report

- Vanguard
- GP Forward View

Ms Longden reported on the Acute Home Visiting Service. Both services were now fully staffed; however, at the end of May the number of visits was lower than plan and this had been raised through the contract management meetings. The Chair asked for an update on plans for full population coverage. It was noted that there would be a review at nine months to determine whether roll-out would be cost-effective. There was a discussion regarding whether decisions would need to be made earlier than planned and it was noted that although the release of GP time could be captured, there were issues to be resolved on double counting of the main outcome of the scheme, the avoidance of admissions to acute services. The Chair requested that a robust methodology was required in order to make a timely decision on future roll-out and to update the Committees in the September report.

- **ACTION:** Ms Longden to update the Committees on plans to evaluate the Acute Home visiting Service at the September Committee meeting

Regarding the Best Practice Scheme, it was noted QIPP savings were still being realised and other projects that were not in the original Primary Care QIPP savings plan were being utilised to mitigate the underspend. The launch of phase 2 was scheduled for September.

It was noted that in order to ensure achievement of the agreed QIPP savings, regarding the cardiology and near patient testing projects, roll-out to the wider population had been brought forward.

Mrs Taylor reported on progress on the GP Forward View. The Committees noted the need to evaluate whether the GP Resilience Scheme did provide long term benefits and to provide feedback to the national NHSE if this was not the case.

The Chair asked whether capacity constraints within the Team were a risk to delivery. Mr Ainsworth noted the team had held a time out to assess priorities and if there was an increased risk, it would be added to the Primary Care risk PC1.

The reports were NOTED.

Best Practice Scheme 2016/17

Ms Longden reported that although the Scheme had had a number of challenges, there were also a number of positive outcomes, as detailed in the report. The report also gave detail of the approach to the evaluation of the scheme and the payment methodology. A discussion paper had been brought to the June Steering Group as part of the development of a second phase, which would be brought to the Committees for approval in August.

The Committees discussed a number of points, including the need to engage with all practices in the second phase; the risk of non-engagement of practices that had not received any additional payments despite their participation in the scheme; and the requirement for early and clear communications to practices, which should begin at the earliest opportunity. Mrs Hogg also emphasised the need for clarity on targets and how under performance would be mitigated.
**JPC/17/51  Forest Medical Group – Oak Tree Lane reduced sessions**

Ms Woods reported that due to the loss of a number of GPs, the Forest Medical Group were proposing to reduce the number of sessions GPs provided at their Oak Tree Lane branch from September. It was noted that although the contract did not require approval to a reduction in core hours at a branch surgery, there was a requirement that NHSE and the CCG ensure that the needs of the patients were met.

It was noted that the practice had been proactive in engaging their PPG and had communicated alternatives to patients. Mrs de Gilbert raised concern that the Oak Tree Lane practice was in a deprived area, which was geographically isolated from other practices; and Mr Wright noted the need to assess impact on neighbouring practices.

It was agreed that all available options and actions should be explored to ensure the branch practice remained open at previous levels, both in the short and long term and that the practice overall was sustainable. The Chair requested that Mr Ainsworth lead on a report on short and long term options for the practice to be discussed at the August Extra Ordinary Committee meeting and to email the Committees with an update in the interim.

- **ACTION:** Mr Ainsworth to lead on the drafting of a report regarding the sustainability of the Forest Medical Group, to be discussed at the August Extra Ordinary Committee meeting; and email the Committees with an update in the interim.

**JPC/17/52  Monitoring of Quality & Performance in Primary Care**

A potential conflict of interest was noted in this paper, which contained references to the practice of Dr Lunn and Dr Lovelock. It was agreed that they remain in the meeting and participate fully in any discussion.

Mrs Taylor reported on on-going work to improve Friends and Family Test reporting and noted the number of practices receiving intense support from the Team had increased, largely due to workforce issues.

The Committees discussed the Friends and Family Test, with Mr Wright noting they provided useful feedback to practices; and in addition to contractual compliance letters, thought should be given to proactive communication on the issue to encourage take up in practices.

- **ACTION:** Mrs Dore to consider proactive communication on the issue to encourage take up of Family and Friends tests in practices.

**JPC/17/53  Primary Care Risks**

The Committees agreed the current risk rating for PC1 was appropriate.
The Primary Care Risk Register was NOTED.

<table>
<thead>
<tr>
<th>JPC/17/54</th>
<th>Finance Reports</th>
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<tbody>
<tr>
<td></td>
<td>Mr Pratt asked the Committees to note that both CCGs had received 2.3% of inflationary costs and utilisation was detailed in the report. It had been agreed for Mansfield and Ashfield CCG to set aside £1.4m to be released in 2018/19 and to hold 1% of non-recurrent funds as uncommitted. Financial risks for both CCGs were mitigated by actions as detailed in the report.</td>
</tr>
<tr>
<td></td>
<td>Dr Lovelock queried contingencies for population growth and paternal payments. Mr Pratt noted that the 2018/19 allocation was able to be revisited and contingency had allowed for an increase in paternal payments.</td>
</tr>
<tr>
<td></td>
<td>Mrs de Gilbert asked whether there was a financial risk as practices moved from PMS to APMS contracts. This was acknowledged as a potential risk and the next report would provide a breakdown of reserves. It was agreed the Committees should be sighted on any future requests to move contracts.</td>
</tr>
<tr>
<td></td>
<td>• ACTION: Mr Pratt to provide a breakdown of reserves in the next report.</td>
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<tr>
<td></td>
<td>The Finance Reports were NOTED.</td>
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</table>
# Actions arising from the Joint Mansfield & Ashfield CCG and Newark & Sherwood CCG Primary Care Commissioning Committee

## Public Section

<table>
<thead>
<tr>
<th>Number</th>
<th>Name</th>
<th>Action</th>
<th>Progress/Status</th>
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<tbody>
<tr>
<td><strong>Actions arising from Thursday 11 May 2017</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>JPC/17/24</td>
<td>Mrs Dore</td>
<td>To update the plan to include implementation timescales to be brought to the next Primary Care Commissioning Steering Group on 8 June.</td>
<td>On this agenda for noting</td>
</tr>
<tr>
<td>JPC/17/26</td>
<td>Mr Ainsworth</td>
<td>To ask the Joint Primary Care Commissioning Steering Group to undertake a deep dive on the project and escalate any concerns to the Committees.</td>
<td>Action Superseded: Movement of Skype communications to business as usual. Arden’s is supporting clinical decision making</td>
</tr>
<tr>
<td><strong>Actions arising from Thursday 13 July 2017</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>JPC/17/44</td>
<td>Mr Ainsworth</td>
<td>To bring an updated plan to the September Committee meeting to give assurance that the CCG had the capacity to deliver the action plan with updated milestones and KPIs and be tailored to individual practices.</td>
<td>On this agenda</td>
</tr>
<tr>
<td>JPC/17/46</td>
<td>Mr Ainsworth</td>
<td>To consider strengthening clinical representation on the Steering Group via the clinical leads</td>
<td>Invitations will be sent out to members when agenda items fit their attendance.</td>
</tr>
<tr>
<td>JPC/17/46</td>
<td>Mrs Lloyd</td>
<td>To ensure standard wording for the QIPP programme Board was used in the Terms of Reference for the Primary Care Quality and Performance Review Group and to amend the deputy chair to Mrs de Gilbert</td>
<td>Action completed</td>
</tr>
<tr>
<td>JPC/17/46</td>
<td>Mr Ainsworth</td>
<td>To ensure the revised Terms of Reference were formally approved at the respective meetings during July</td>
<td>Action completed</td>
</tr>
<tr>
<td>JPC/17/49</td>
<td>Ms Longden</td>
<td>To update the Committees on plans to evaluate the Acute Home visiting Service at the September Committee meeting</td>
<td>Update given in the Primary Care Exception report</td>
</tr>
<tr>
<td>Number</td>
<td>Name</td>
<td>Action</td>
<td>Progress/ Status</td>
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<tr>
<td>JPC/17/51</td>
<td>Mr Ainsworth</td>
<td>To lead on the drafting of a report regarding the sustainability of the Forest Medical Group, to be discussed the August Extra Ordinary Committee meeting: and email the Committees with an update in the interim.</td>
<td>Discussed at the August Confidential Committee meeting</td>
</tr>
<tr>
<td>JPC/17/52</td>
<td>Mrs Dore</td>
<td>To consider proactive communication on the issue to encourage take up of Family and Friends tests in practices.</td>
<td>PPGs have been asked to not only encourage GP practices to report Friends and Family Test (FFT) data on CQRS on a monthly basis (this is a contractual requirement), but that the PPGs should encourage GP practices to review FFT feedback to learn and improve GP services.</td>
</tr>
<tr>
<td>JPC/17/54</td>
<td>Mr Pratt</td>
<td>To provide a breakdown of reserves in the next report.</td>
<td>To be included in the finance report</td>
</tr>
</tbody>
</table>
# Joint Primary Care Commissioning Committees – Forward Planner

<table>
<thead>
<tr>
<th>Administration</th>
<th>Committee</th>
<th>Contact</th>
<th>July 17</th>
<th>Sept 17</th>
<th>Nov 17</th>
<th>Jan 18</th>
<th>March 18</th>
<th>May 18</th>
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<tbody>
<tr>
<td>Minutes and actions of previous meeting</td>
<td>Both</td>
<td>Ruth Lloyd</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Delegations of interest</td>
<td>Both</td>
<td>All</td>
<td>X</td>
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<tr>
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<tbody>
<tr>
<td>PC Commissioning Committee terms of reference (yearly basis)</td>
<td>Both</td>
<td>Ruth Lloyd</td>
<td></td>
<td></td>
<td>X</td>
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<tr>
<td>Joint CCGs PC Steering Group terms of reference (yearly basis)</td>
<td>Both</td>
<td>Ruth Lloyd</td>
<td></td>
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<tr>
<td>Bi monthly Joint CCGs PC Steering Group advice report</td>
<td>Both</td>
<td>Ruth Lloyd</td>
<td>X</td>
<td>X</td>
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<td>X</td>
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<tr>
<td>Primary Care Performance &amp; Quality Review Group (PCPRG) Terms of Reference (yearly basis)</td>
<td>Both</td>
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<tr>
<td>Primary care quality 360 audit</td>
<td>Both</td>
<td>Elaine Moss</td>
<td></td>
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<tr>
<th>Primary Care Hub</th>
<th>Committee</th>
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<tbody>
<tr>
<td>Primary Care Strategic Advisory Group update</td>
<td>Both</td>
<td>David Ainsworth</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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</tr>
<tr>
<td>Half yearly Primary Care Hub/CCG performance review outputs</td>
<td>Both</td>
<td>NHSE</td>
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<tr>
<th>Strategy</th>
<th>Committee</th>
<th>Contact</th>
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<tbody>
<tr>
<td>Estates Strategy</td>
<td>Both</td>
<td>Andrea Brown</td>
<td></td>
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<tr>
<td>Primary Care Transformation – Implementation Plan exception reporting</td>
<td>Both</td>
<td>David Ainsworth</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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</table>

| Primary Care Quality and Risks                                                | Committee | Contact      |         |         |        |        |          |        |
|-------------------------------------------------------------------------------|-----------|--------------|---------|---------|--------|--------|----------|        |
| Monitoring of Quality & Performance in Primary Care                           | Both      | David Ainsworth | X       | X       | X      | X      | X        |        |
| Primary Care Risks                                                             | Both      | David Ainsworth | X       | X       | X      | X      | X        |        |
| Director of Primary Care Operational Report (c)                               | Both      | David Ainsworth | X       | X       | X      | X      | X        |        |

| Primary Care Finance                                                          | Committee | Contact      |         |         |        |        |          |        |
|-------------------------------------------------------------------------------|-----------|--------------|---------|---------|--------|--------|----------|        |
| Financial plan                                                                | Both      | Marcus Pratt |         |         |        |        |          | X      |
| Financial year end plan                                                       | Both      | Marcus Pratt |         |         |        |        |          | X      |

Friday, 08 September 2017
## Joint Primary Care Commissioning Committees – Forward Planner

### Report

<table>
<thead>
<tr>
<th>Report</th>
<th>Committee</th>
<th>Contact</th>
<th>July 17</th>
<th>Sept 17</th>
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<tr>
<td>Finance update</td>
<td>Both</td>
<td>Marcus Pratt</td>
<td>X</td>
<td>X</td>
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### Primary Care Initiatives

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<tr>
<th>Initiative</th>
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<th>Contact</th>
<th>July 17</th>
<th>Sept 17</th>
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<th>March 18</th>
<th>May 18</th>
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</thead>
<tbody>
<tr>
<td>Early evaluation of the Acute Home Visiting Service</td>
<td>Both</td>
<td>Paula Longden</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>STP Primary Care Staff Education and Training Group’s Delivery Proposals</td>
<td>Both</td>
<td>Charlotte Lawson</td>
<td></td>
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### Engagement

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<tr>
<th>Initiative</th>
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<th>March 18</th>
<th>May 18</th>
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</thead>
<tbody>
<tr>
<td>Formalised communication &amp; engagement plan in relation to primary care transformation</td>
<td>Both</td>
<td>Andrea Brown</td>
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</table>
The Committee received a report and action plan in July on the CCGs plans to manage clinical variation. This report provides information on the progress being made against the plan up to end August 2017.

The updated action plan for managing clinical variation is contained in Appendix One.

**QIPP Assurance and connection**

The plan contributes to delivery of various QIPP projects including referral management, advice & guidance and referral thresholds

**Financial Impact and Risks**

Reducing clinical variation can help with financial efficiencies through avoided referrals and better patient care.
Legal Impact
No legal issues identified

Risk Implications, Assessment and Mitigations
The plan supports risk mitigation around finances, quality and NHS England assurance.

Consultation, Involvement and Engagement
Each action within the plan has involved engagement with practices and patients to support implementation as required.

Equality Impact
No equality issues identified. Reducing clinical variation with help improve equality in care across all patient groups.

HOW DOES THIS CONTRIBUTE TO THE OUTCOMES AND OBJECTIVES OF THE CCG:
- Quality
- Health
- Financial
- Clinical
- Performance (tick as appropriate)

CONFLICTS OF INTEREST:
This is a recommended action to be agreed by the Chair at the beginning of the item.
- No conflict identified
- Conflict noted, conflicted party can participate in discussion but not decision (see below)
- Conflict noted, conflicted party can remain but not participate (see below)
- Conflicted party is excluded from discussion (see below)

Please state rationale for decision
Advice regarding conflicts of interest is available from the Corporate Governance Team, or here:

CONFIDENTIALITY:
Is the information in this paper confidential?
- Yes
- No

If the paper is considered confidential, please tick the relevant box.
- Does it contain personal information e.g. regarding a patient, member of staff or another individual?
- Is the CCG in commercial negotiations or about to enter into a procurement exercise and would the information in the report prejudice the CCG’s position if made public e.g. by declaring the budget available for a particular contract in advance of a tendering exercise or indicating what the CCG’s fall-back position might be in a negotiation situation?
- Does the report include commercial in confidence information about a third party? - this would need to be relatively detailed information which could be argued to give a competitor an advantage if it was made available to them i.e. the total value of a contract awarded to a supplier or the value of a tender could not be considered commercial in confidence but details of how a supplier performs a particular process or the day rate for different grades of consultancy staff might be considered confidential.
- Does the report contain information which has been provided to the CCG in confidence by a third party and is there a risk that the third party could take legal action for a breach of confidence if it was disclosed?

- Does the discussion relate to policy development not yet formalised by the organisation and if the discussion were made public would this hamper full and frank discussion and therefore adequate consideration and development of proposal? This is intended for matters that are considered at a Board meeting early in the process to obtain initial thoughts and to give officers a steer in developing the policy. It would not be appropriate to use this argument where the governing body is being asked to approve a policy or initiative as this would be too late to argue that policy development was still on-going.

- Has the document/report been produced by another public body which has chosen not to make the document publicly available and would not wish the CCG to do so?

- Is the document in draft form which will publically available at a future date?

Note: Upon request for the release of a paper deemed confidential, under Section 36 of the Freedom of Information Act 2000, parts or all of the paper will be considered for release by the CCG’s ‘Qualified Person’ based on the circumstances at that time.
## Plan for Managing Clinical Variation in General Practice 2017/18

### High Level Objective
**Standardise the referral patterns of staff working in general practice**

### Action
**Ardens Decision Support Tool**

#### Milestones
- Ardens live in all practices by July 17
- Training provided to all practices by Oct 17
- Peer review template in place by Sep 17
- Peer review plan submitted to NHSE for assurance purposes.

#### Progress update - August 2017
- Ardens is live in all 41 practices. Training completed in 27 out of 41 practices. Primary care lead for project reviewed and clinical referral advisor allocated time to support project.
- Templates for restricted procedures, peer review and some clinical areas in place.
- Process to be developed with clinical leads to support development of all clinical templates.
- CCG agreed future funding of Ardens in response to practice concerns around sustainability.

### Action
**Peer to Peer review of referrals**

#### Milestones
- First round of practice visits completed
- Peer review plan submitted to NHSE for assurance purposes.
- Patient information material produced and sent to PRS for comment.
- Peer review formally included as part of the 17/18 Best Practice Scheme.

### Action
**Advice and Guidance & Consultant Connect**

#### Milestones
- Actions around consultant connect and advice and guidance combined to reflect QIPP plan.
- SRO transferred to Director of Primary Care to broaden scope of project.
- Discussions are taking place with SFH heads of service to understand how best to facilitate greater utilisation and explore a new model for A&G locally. Monitoring systems have been reviewed to provide regular reporting.

### Action
**Use of E-referrals**

#### Milestones
- Project is being run in collaboration with SFHFT as part of national pilot. Monitoring systems are in place with weekly reporting by practice.
- As at end August, over 99% referrals are being sent as eReferral and only 20 paper referrals being made in Aug 17.

### Action
**Referral thresholds**

#### Milestones
- NDF policies in place
- Not routinely funded task and finish group set up and meeting to take actions forwards. CCGs considering adopting new policies from Bedford CCG. Plans are being explored to create a web portal to streamline prior approval referrals and improve consistency.

### Action
**Referral Facilitation Model**

#### Milestones
- Referral guidelines in place and website reviewed.
- Six of the seven highest referring practices have been visited. Individual practice plans have been devised and signed off by both parties to increase accountability.
- Action plans will be monitored through DMCC.

### Action
**Best Practice Scheme 16/17 - realise the benefits**

#### Milestones
- Actions complete
- As per evaluation report for BPS.
| Standardise the approach to system-wide objectives | Best practice scheme 17/18 - launch | Ensure learning from 16/17 scheme is built into new scheme for 17/18 Establish a working group to develop the scheme to include practice staff Agree scope for 17/18 BPS | Jacqui Kemp | Produce draft BPS 17/18 by Jul 17 Obtain JPCCC sign off by August 17 Roll out BPS to practices by September 17 | Actions complete | KPI included in BPS |
| Review Local Enhanced Services - phase 2 of BPS | Perform in depth review of existing LES schemes including specification, take up and outcomes. Review scope of current LES to produce new specifications Incorporate where appropriate into the best practice scheme phase 2 and 3 | Paula Longden | Perform phased review of LES phase 1 - near patient testing - Oct 17 phase 2 - DMARD, anticoagulation, basket LES - Feb 18 | Primary Care team discussed plan to review LES, allocating leads for delivery Further resource implications will be considered by the team. | Revised LES agreed and issued to practices Specific KPIs included in LES |
| | Health optimisation | Establish a multi disciplinary working group that represents secondary and primary care - with strong clinical leadership. Agree the timeline and project plan. Agree the clinical model for health optimisation. Implement plan to timescales | Chris Sewell | Stakeholder workshop - October 17 Phase 1 - agree templates to capture health information for common measures - August 2017 Phase 2 - develop a pre-op assessment in SFH to screen pre-op patients - October 2017 Phase 3 - implement model to support health optimisation approaches where risk factors identified e.g. use of existing PH services - April 2018 | Discussion held with SFH to build engagement in model. Standard template created in Ardens to capture health measures e.g. BMI, smoking status. SFH developed pre-op assessment template for ASA level 1 patients and currently being piloted. Stakeholder workshop being organised with SFH surgeons to agree clinical model & pathways. Date TBC | Health optimisation KPIs to be developed |
| | Standardise approach to Public Health Areas | Analyse QOF Compliance | Commission NHSE Hub report on practice compliance and achievement in QOF during 2016/17 Seek support from public health to analyse and identify unmet health needs for population. Explore actions required to improve standardisation to approach and compliance. | Cathy Quinn | NHSE Review to be completed by October 2017 Public health team engagement by December 2017 Plan to be in place by January 18 | Action not yet started | QOF KPIs to be developed |
### General Practice Communication and Engagement Plan

**DATE OF MEETING:** 14 September 2017  
**PAPER REF:** JPC/17/06  
**AUTHOR:** Sally Dore  
**PRESENTER:** David Ainsworth

**ISSUE:** At the May meeting the Committees requested that the plan be updated to include implementation timescales.

**RECOMMENDATION:** The Committee is asked to note the updated plan.

**HOW DOES THIS CONTRIBUTE TO THE STRATEGIC OBJECTIVES OF THE CCG:**

**RISK ASSURANCE:**

**CONFLICTS OF INTEREST:**

This is a recommended action to be agreed by the Chair at the beginning of the item.

- [✓] No conflict identified
- [ ] Conflict noted, conflicted party can participate in discussion but not decision (see below)
- [ ] Conflict noted, conflicted party can remain but not participate (see below)
- [ ] Conflicted party is excluded from discussion (see below)

There are no conflicts known in relation to this agenda item.

**CONFIDENTIALITY:**

Is the information in this paper confidential?

- [✓] No
- [ ] Yes
General Practice Communication and Engagement Plan
September 2017
Contents
Introduction................................................................................................. 3
Local picture ............................................................................................. 3
Principles .................................................................................................. 4
SWOT Analysis .......................................................................................... 5
Key messages............................................................................................ 6
Action Plan.................................................................................................. 6
Stakeholder Map ........................................................................................ 6
  Action plan .............................................................................................. 8
**Introduction**

The changing operating environment of the NHS makes it critically important that we focus time and attention on understanding what our customers want. Equally important is our ability to describe our commissioned services and engage with our key stakeholders in the debate about the options for the future provision of services.

The NHS Five Year Forward View and General Practice Forward View identifies the need for healthcare services to be delivered in a different way in the future and describes the need to break down the barriers between primary and secondary care. Maintaining good relationships with General Practice will provide a strong foundation upon which to drive and deliver transformation.

In this plan the word **CCGs** (Clinical Commissioning Groups) refers to the local NHS organisation which commissions NHS services on behalf of mid Nottinghamshire people. The organisation is made up of members from the GP Practices of Mansfield, Ashfield, Newark and Sherwood.

**CCG members** refers to Mansfield, Ashfield, Newark and Sherwood GPs and GP practice staff that make up the organisation.

**CCG staff** refers to NHS staff members who are employed by the CCG to run the organisation on behalf of the GP members.

**Local picture**

Mansfield and Ashfield CCG and Newark and Sherwood CCG are clinically-focused, member-led organisations with a clear vision:

“We will have joined up, sustainable and high quality services across health and social care. People will remain at home whenever possible, supported by a team of people who are working together to meet their need-shifting the focus from the needs or processes of their organisations. Services will be proactive and fleet of foot. People will be supported to develop the confidence and skills to be as independent as possible”.

The successful delivery of our vision will be underpinned by the CCGs listening to and working effectively with our members, providers, partners, patient and voluntary organisations, service users and residents on decision making and planning.

We need to use clinical expertise and citizens to support the design of new services across health and social care and need to communicate with general practice as providers both of primary care services and as gatekeepers to the wider NHS via patient referrals.

By working in partnership, we can ensure the services we commission meet the diverse needs of the population, and that both professionals and residents are aware of how best to use these services, to deliver improved health and wellbeing.
outcomes. The CCGs communications and engagement team has an important part to play supporting the CCGs to achieve this.

For the last 3 years the CCGs have commissioned Arden and GEM CSU to support the communications and engagement function alongside CCG employed staff. This has been a positive function but there have been constraints with some staff being ‘shared’ with other CCGs. During 2017 the CCGs have decided to build an in-house Communications and Engagement Team, this team will be tasked with maintaining a communication and engagement function with general practice alongside maintaining and improving corporate communications and engagement; building audience insights and partner relationships; establishing new channels and standardised processes; and delivering key messages on key CCG matters.

Building on these foundations, a strategic approach to communications and engagement will be taken in 2017-18, aligning activity and resource with the priorities of the CCGs, building narratives that span multiple worksteams and supporting teams across the CCG to deliver effective communications and engagement activity especially in primary care.

This plan is intended for internal audiences (CCG Governing Body and related sub groups, Executive Team, members and staff). The plan will also inform discussions with our partners’ communications and engagement teams, to identify opportunities to work together across the mid-Nottinghamshire and STP (Sustainability and Transformation Plans) footprints.

**Principles**

- **No surprises** - information will be shared as soon as it is available not just at the point a decision is made. Reduction in reactive decisions and poor timing
- **Consistency of message** - the messages will be clear and consistent
- **Greater understanding** – recap for all on what currently exists, explain the current context and value for money messages
- **Succinct and regular communication** - this is to include leavers and new starters including roles and responsibilities
- **Greater use of digital technology** e.g. CCG websites, you tube and twitter
### SWOT Analysis

<table>
<thead>
<tr>
<th>Strengths</th>
<th>Weaknesses</th>
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<tbody>
<tr>
<td>• Good relationships at grass roots level with the practices.</td>
<td>• No regular engagement with all GP practices to the same level.</td>
</tr>
<tr>
<td>• On-going dialogue with GP’s across mid Notts.</td>
<td>• No standard ways of effective GP communication and feedback suggesting existing newsletters need revision.</td>
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<tr>
<td>• Very few GP complaints.</td>
<td>• A different approach to GP localities/federations across the 2 CCGs</td>
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<tr>
<td>• Some outstanding and good CQC ratings of GP practices</td>
<td>• Some poor or non-existent patient participation groups</td>
</tr>
<tr>
<td>• Good overview of GP practices and referral patterns.</td>
<td>• Not enough proactive communications with primary care</td>
</tr>
<tr>
<td>• Some good patient participation groups</td>
<td>• Some poor CQC ratings</td>
</tr>
<tr>
<td>• PLTs are well attended</td>
<td>• Poor CCG websites</td>
</tr>
<tr>
<td>• A Primary care team led by a Director of Primary Care</td>
<td>• Limited use of twitter</td>
</tr>
<tr>
<td>• There is the capability within the communication and engagement team to manage the communication and engagement function</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Opportunities</th>
<th>Threats</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Improved connection between clinical service development in transformation work streams with GP Practices.</td>
<td>• GPs perception leading to frustration with lack of communication from the CCG staff</td>
</tr>
<tr>
<td>• Improved use of the Primary Care Bulletin</td>
<td>• GP perception leading to frustration with lack of engagement with the CCGs</td>
</tr>
<tr>
<td>• More use of social media</td>
<td>• GPs frustration with a lack of coordinated communications from the CCG leading to numerous emails</td>
</tr>
<tr>
<td>• Development of innovative ideas for communication and engagement that reflects consistency but also the locality development agenda</td>
<td>• There is not enough capacity within the communication and engagement team to provide support to all the transformation/sustainability programmes as well as meet the statutory requirements of the CCGs</td>
</tr>
<tr>
<td>• Continue to develop and strengthen relationships with GPs and through a robust communication and engagement plan</td>
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<tr>
<td>• Improve two-way information flows between GPs and the CCGs</td>
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</table>
**Key messages**

**1. CCG communication with General Practice – Members: GP, Practice Manager, Practice Nurses, Practice Admin**
- Communication & Engagement on Provider Developments
- Communication and Engagement on Commissioning Intentions and opportunities

**2. CCG Communications with Patient & Public: Inc PPGs, Healthwatch, etc**
- Awareness and understanding of the ‘ASK’ – 5YFV requirements/must be done’s plus CCG vision for General Practice
- Engagement in service design
  - @practice level
  - @locality level
  - @system level (mid Notts/STP)
- Evaluation of new service or service change:
  - @practice level
  - @locality level
  - @system level (mid Notts/STP)

**Patient Experience**

**3. CCG Communication with CCG staff on General Practice**
- Systems and processes eg GP Bulletin
- Consistency and clarity of messages: Functions/work streams connect so that communications are clearer
- Alignment of reports delivered through the CCGs governance process

**4. Communication with Other Stakeholders: Acute, MH, Third Sector, etc**
- Communication & Engagement on Provider Developments
- Communication and Engagement on Commissioning Intentions and opportunities

**Action Plan**
The action plan below depicts activities that are well established and others that need to develop and grow. This is an iterative process and the methods of communication and engagement will grow and change over time to reflect the needs of the audience.

**Stakeholder Map**
A stakeholder analysis is always helpful to ensure the right amount of resources is committed to the most appropriate stakeholders. The map below is generic and the information can be replaced with individual organisational names when required.
<table>
<thead>
<tr>
<th>High interest</th>
<th>Low interest</th>
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<tbody>
<tr>
<td><strong>Active PPGs</strong></td>
<td><strong>Inactive PPGs</strong></td>
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<tr>
<td>CCG staff</td>
<td>Voluntary sector</td>
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<tr>
<td>Other practice staff</td>
<td>Acute providers</td>
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<tr>
<td>Community providers</td>
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<tr>
<td>Care homes</td>
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<tr>
<td><strong>GPs</strong></td>
<td><strong>Media</strong></td>
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<tr>
<td>GP localities</td>
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<tr>
<td>Clinical Directors</td>
<td></td>
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<tr>
<td>Practice Managers</td>
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<td>CCG Directors</td>
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<td>CQC</td>
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<td>LMC</td>
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<td>CCG Governing Body</td>
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<td>Healthwatch</td>
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<td>Overview and Scrutiny Committee</td>
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<tr>
<td><strong>Low influence</strong></td>
<td><strong>High Influence</strong></td>
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</table>

**Low interest**
### Action plan.

<table>
<thead>
<tr>
<th>Priority</th>
<th>Action/Initiative</th>
<th>Timing</th>
<th>Lead Executive/Director(s)</th>
<th>Lead Manager(s)</th>
</tr>
</thead>
</table>
| **Sustain effective and meaningful two way communication with General Practice.** | • Develop a policy for ensuring communications are sanctioned before being shared with general practice ‘communication control gateway’  
• Develop a survey, both paper and electronic to discover how GPs and other practice staff would like to be communicated with.  
• Relaunch and rebrand the monthly production of the Primary Care Bulletin into a practice managers bulletin, and establish and agree a timetable for input from staff  
• Develop ad hoc Newsflashes to issue urgent service-related messages to general practice.  
• Adopt the “You Said We Did” process of reporting back to GP practices on progress made to address concerns raised. | October 2017  
October 2017  
October 2017  
October – Nov 2017  
Feb 2018 | Primary Care Director  
Primary Care Director  
Primary Care Director  
Primary Care Director  
Primary Care Director | Head of Communication and Engagement  
Communication Manager  
Communication Manager  
Communication Manager  
Communication Manager  
Engagement lead |
- Inclusion of ad hoc Executive “Message of the month” contributions which have a specific relevance for GPs
- Develop innovative use of social media such as Facebook, Twitter and YouTube to deliver innovative messages to audiences and encourage two-way dialogue through discussion threads and sharing of materials
- Ensure that ALL CCG staff are familiar with the GP Engagement remit and communication route to GP practices.
- Develop two way communication and mechanisms for this to be effective
- Develop a confidential email address for comments from general practice (this could be anonymous if required)
- Develop simple routes of communication i.e. post cards in all surgeries for staff to complete with questions or ideas

<table>
<thead>
<tr>
<th>Date</th>
<th>Event Description</th>
<th>Responsible Person</th>
<th>Role</th>
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<tbody>
<tr>
<td>Feb 2018</td>
<td></td>
<td>Engagement lead</td>
<td>Communication Manager</td>
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<tr>
<td>Nov 2017 – planning meeting</td>
<td></td>
<td>Primary Care Director</td>
<td>Head of Communication and Engagement</td>
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<tr>
<td>November 2017</td>
<td></td>
<td>Primary Care Director</td>
<td>Communication Manager</td>
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<tr>
<td>November 2017</td>
<td></td>
<td>Primary Care Director</td>
<td>Head of Communication and Engagement</td>
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<tr>
<td>Jan 2018</td>
<td></td>
<td>Primary Care Director</td>
<td>Communication Manager</td>
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<tr>
<td>November 2017</td>
<td></td>
<td>Primary Care Director</td>
<td>Head of Communication and Engagement</td>
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<tr>
<td>Develop and foster strong clinical engagement between the CCGs and GPs to share best practice and work in partnership</td>
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<tr>
<td>- Maintain weekly snippets, podcast and monthly practice video blog</td>
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<td>- Translation of national guidance - National guidance to be shared in easy to understand bite size pieces</td>
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<tr>
<td>- Update CCG websites to be more user friendly and informative</td>
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<tr>
<td>Ongoing</td>
<td>Primary Care Director</td>
<td>Communication Manager</td>
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<tr>
<td>Ongoing</td>
<td>Primary Care Director</td>
<td>Communication Manager</td>
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</tr>
<tr>
<td>Complete</td>
<td>Primary Care Director</td>
<td>Communication Manager</td>
<td></td>
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</tbody>
</table>

| Pursue opportunities to establish and maintain networks between general practice and the CCGs. |
| Build and develop relationships with the GP Federation as partners, with regular Executive to Executive meetings, and regular operational management meetings. |
| Encourage Consultant input into practice protected learning time afternoons and in-house practice education sessions as required. |
| Ensure that the primary care team visit their practices regularly not only for performance management meetings but for general discussions and relationship |
| Ongoing | Primary Care Director | Primary Care Managers |
| Ongoing | Primary Care Director | Primary Care Managers |
| Ongoing | Primary Care Director | Primary Care Managers |
| Ongoing | Primary Care Director | Primary Care Managers |
As part of the survey ask practices what they feel the level of engagement is and how they feel it could be improved.

Ensure the communication and engagement team link into with the primary care team to offer support and develop an understanding of each other’s roles.

Ensure there is a CCG presence at the Practice Managers Meetings (if required).

Deliver a CCG ‘slot’ face to face at each CCG Practice Learning Time Events - monthly.

<table>
<thead>
<tr>
<th>Building</th>
<th>October 2017</th>
<th>Primary Care Director</th>
<th>Communication Manager</th>
</tr>
</thead>
<tbody>
<tr>
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<td>Primary Care Director</td>
<td>Head of Communication and Engagement</td>
<td></td>
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<tr>
<td>Ongoing</td>
<td>Primary Care Director</td>
<td>Head of Communication and Engagement</td>
<td></td>
</tr>
<tr>
<td>Monthly</td>
<td>Primary Care Director</td>
<td>Primary care managers</td>
<td></td>
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</tbody>
</table>
Title: ED attendances and Opening Hours

Date of Meeting: 14 September 2017  
Paper Ref: JPC.17.62

Author: Paula Longden  
Presenter: Paula Longden

Purpose of Report:
The aim of this report is to respond to the request at Turnaround Board to compare general practice opening hours with ED attendances.

Recommendation:
☐ To endorse  
☐ To approve  
☐ To receive the recommendation (see details below)  
☑ To discuss

Report:

Background
This paper is in response to a Turnaround Board matter arising to bring a paper to the September Joint Primary Care Commissioning Committees on access to appointments at individual practice level.

Approach
The opening hours of individual practices have been collated and grouped into:
- Practice providing NHSE commissioned access services (commonly known as the DES)
- Practices providing CCG commissioned access services (extended hours / GP access)
- Practices providing both NHSE and CCG commissioned access services
- Practice providing no extended hours services (core hours only)

The data has been mapped across the patch and is shown in Appendix 1.

Findings and conclusions
There is no immediate correlation between GP opening hours and the weighted rates of ED attendances. For example, three of the four Newark based practices provide extended hours through the NHSE commissioned DES and have red rated A&E weighted rates. In contrast, many of the Sherwood practices do not provide any additional hours above the core contract but have low ED attendances. This suggests that geography plays a significant part in influencing patients’ decisions as to which healthcare services they access.

The Kirkby practices that have had both NHSE commissioned and CCG commissioned extended hours for over twelve months generally show lower rates of A&E attendances with the exception of one practice but the impact is not significant.

The Urgent and Proactive Care Programme team carried out a patient survey in February 2017 gathering data from patients attending ED. The survey reported that 22% of attendees were
there because they had been unable to access a GP appointment. This suggests that
improved access will have an impact at practices. The full impact and how it would be
distributed is difficult to assess because 68% of respondents did not declare their GP practice.
Overall, therefore, based on this analysis we conclude that there is no direct correlation at this
high level of data between access and ED attendances reflecting the complexity of the
healthcare system. However this suggests that there are opportunities to achieve benefits from
the investment and the analysis as presented provides a useful starting point as we move to
full GP access during October.

We feel that the following are essential to maximise the benefits from the roll out of GP
extended access due to:

- Strong promotion and advertising of the services – a detailed communications plan is in
  place with a variety of marketing material both in practices and other sources.
- Ensure equality of access – approach to ensure that hard to reach groups are targeted
- Use of IMT solutions – the roll out of GP access has prompted IG solutions for locality
  based services. This increased use of IT potential will be facilitated through the current
  IMT programme (delivered by Connected Notts on the CCGs’ behalf), ETTF
  developments and the strands set out in the GP Forward View (with additional funding).

<table>
<thead>
<tr>
<th>QIPP Assurance and connection</th>
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<tbody>
<tr>
<td>As per above – potential for delivering return for the CCGs from the increased access.</td>
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</table>

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<tr>
<th>Financial Impact and Risks</th>
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<tbody>
<tr>
<td>As per above.</td>
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<tr>
<th>Legal Impact</th>
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<tr>
<td>None</td>
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<table>
<thead>
<tr>
<th>Risk Implications, Assessment and Mitigations</th>
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<tbody>
<tr>
<td>None</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Consultation, Involvement and Engagement</th>
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<tbody>
<tr>
<td>Detailed GP access communications plan established.</td>
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<tr>
<th>Equality Impact</th>
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| Evidence and Research (include where this informs why the paper is presented to
Governing Bodies) |
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**HOW DOES THIS CONTRIBUTE TO THE OUTCOMES AND OBJECTIVES OF THE CCG:**

- [ ] Quality
- [ ] Health
- [ ] Financial
- [ ] Clinical
- [ ] Performance (*tick as appropriate*)

**CONFLICTS OF INTEREST:**

This is a recommended action to be agreed by the Chair at the beginning of the item.

- [x] No conflict identified
- [ ] Conflict noted, conflicted party can participate in discussion but not decision (see below)
- [ ] Conflict noted, conflicted party can remain but not participate (see below)
- [ ] Conflicted party is excluded from discussion (see below)
Please state rationale for decision

Advice regarding conflicts of interest is available from the Corporate Governance Team, or here:


CONFIDENTIALITY:

Is the information in this paper confidential?

✓ No
Appendix 1: Mansfield and Ashfield CCG: ED attendances v general practice opening hours

ED attendances by practice

General practice opening hours

A&E weighted rates
- greater than 350
- from 325 to 350
- from 300 to 325
- less than 300

Practices providing both NHS England and CCG commissioned access services
Practices providing no extended hours service
Practices providing NHS England commissioned access services
Practices providing CCG commissioned access services
Appendix 1 continued: Newark and Sherwood CCG: ED attendances v general practice opening hours

ED attendances by practice

General practice opening hours

A&E weighted rates
- greater than 350
- from 325 to 350
- from 300 to 325
- less than 300

Practice ID
- 39 Balderton Primary Care Centre
- 36 Lombard Medical Practice
- 37 Barnby Gate Surgery
- 38 Fountain Medical Centre
- 32 Hill View Surgery
- 31 Bilsthorpe Surgery
- 29 Major Oak Medical Practice
- 28 Sherwood Medical Partnership
- 35 Southwell Medical Centre
- 41 Hounsfield Surgery
- 33 Rainworth Health Centre
- 30 Middleton Lodge Practice
- 40 Collingham Medical Centre
- 34 Abbey Medical Group

Practices providing both NHS England and CCG commissioned access services
- Practices providing no extended hours service
- Practices providing NHS England commissioned access services
- Practices providing CCG commissioned access services
- Practices providing both NHS England and CCG commissioned access services
<table>
<thead>
<tr>
<th><strong>JOINT PRIMARY CARE COMMISSIONING COMMITTEES</strong></th>
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<tbody>
<tr>
<td><strong>TITLE:</strong> Terms of Reference</td>
</tr>
<tr>
<td><strong>DATE OF MEETING:</strong> 14 September 2017</td>
</tr>
<tr>
<td><strong>AUTHOR:</strong> Mrs Ruth Lloyd</td>
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</tbody>
</table>

**SUMMARY:**

The Terms of Reference have been updated to amend the membership and quoracy arrangements to reflect the recent changes to the senior management structure.

**ACTION:**

- [ ] To note
- [X] To approve
- [ ] To agree the recommendation (see details below)

To approve the Terms of Reference.

**HOW DOES THIS CONTRIBUTE TO THE OUTCOMES AND OBJECTIVES OF THE CCG:**

- [X] Quality
- [ ] Health
- [X] Financial
- [X] Clinical
- [ ] Performance
- [ ] Other (specify)

(tick as appropriate)

**RISK ASSURANCE:**

Terms of Reference describe the purpose, scope and authority of the committee. Best practice in governance dictates that they should be reviewed annually to ensure they remain current and valid.

**CONFLICTS OF INTEREST:**

This is a recommended action to be agreed by the Chair at the beginning of the item.

- [X] No conflict identified
- [ ] Conflict noted, conflicted party can participate in discussion but not decision (see below)
- [ ] Conflict noted, conflicted party can remain but not participate (see below)
- [ ] Conflicted party is excluded from discussion (see below)

**CONFIDENTIALITY:**

Is the information in this paper confidential?

- [X] No
1. Purpose

The Committee has been established in accordance with the statutory provisions as detailed in Appendix A to enable the members to make collective decisions on the review, planning and procurement of primary care services in Mansfield and Ashfield, under delegated authority from NHS England.

In performing its role the Committee will exercise its management of the functions in accordance with the agreement entered into between NHS England and NHS Mansfield and Ashfield CCG, which will sit alongside the delegation and terms of reference.

The functions of the Committee are undertaken in the context of a desire to promote increased co-commissioning to increase quality, efficiency, productivity and value for money and to remove administrative barriers.

The Committee will comprise the geographical area covered by NHS Mansfield and Ashfield CCG.

2. Membership

The Committee voting membership shall consist of:
- Independent lay Chair
- Independent lay Vice Chair
- 2 CCG lay members (shared posts with Newark and Sherwood CCG)
- Mid Notts CCG Chief Officer or deputy (being the Chief Finance Officer)
- Mid Notts CCG Chief Finance Officer or nominated deputy
- Mid Notts Director of Procurement & Market Development
- Mid Notts CCG Chief Nurse and Director of Quality and Governance or deputy
- Mid Notts CCG Head of Business Change & Implementation
- Mid Notts CCG Director of Turnaround or nominated deputy
- Mid Notts CCG Director of Primary Care or nominated deputy
- Mid Notts CCG Director of Programme Delivery
- CCG Clinical Advisor (shared post with Newark and Sherwood CCG)
- Out of Area GP (shared posts with Newark and Sherwood CCG)
- Nottinghamshire County Council Public Health Consultant

If GP members need to withdraw from decision making for conflicts of interest reasons, the committee would still be quorate with a lay and executive majority.

Members are expected to attend all formal meetings. Over a twelve month rolling period if members have been unable to attend at least 80% of the meetings the Chair shall instigate a review of their continuing membership.

Other non-voting attendees
Standing invitation to:
- Local GP
- Local Medical Committee GP representative
- Health Watch Nottinghamshire
- Health and Wellbeing Board
- NHS England Local Area Team

Also note below arrangements relating to joint arrangements with NHS Mansfield & Ashfield CCG.

Provision could be made for the committee to have the ability to call on additional lay members or CCG members when required, for example where the committee would not be quorate because of a conflict of
interest. It could also include GP representatives from other CCG areas and non-GP clinical representatives (such as the CCGs secondary care specialist).

The CCG lay member positions will be recruited through expressions of interest process and assessed through a set of criteria (Where three or more expressions of interest are received, an interview process will take place with the Group’s senior clinicians and managers.

3. Chair and Deputy

The Committee will have an Independent Lay Chair who is recruited externally. The Lay Chair will be in attendance at the CCG Governing Body.

Term of office will be:
- 2 years initially, with a further 2 years if satisfactory performance is evidenced.
- assessed at the same time as governing body membership term of office where appropriate.

Grounds for removal from office are:
- Gross misconduct
- Failing to disclose a pecuniary interest regarding matters under discussion within the committee
- Following the passing of a vote of no confidence by committee members and subsequent approval of this by CCG governing body

The Vice Chair will be an independent lay member and shall be recruited as set out in item 24-26 above. The Vice Lay Chair will deputise for the Lay Chair at governing body meetings where appropriate.

4. Quorum and Voting Arrangements

Each member of the Committee shall have one vote. The Committee shall reach decisions by a simple majority of members present, but with the Chair having a second and deciding vote, if necessary. However, the aim of the Committee will be to achieve consensus decision-making wherever possible.

The quorum required to make formal approvals is as follows (6 members, with lay and executive majority):
- Lay Chair or Lay Vice Chair
- Chief Officer or nominated deputy
- Chief Finance Officer or nominated deputy
- 3 out of the 65 Directors or their nominated deputies (This includes the Head of Business Change & Implementation and the Chief Nurse)
- A Clinician

If an opportunity arises where lay and clinical executive is not the majority of attendees, clinical members will be asked to leave at the time of a decision being made.

5. Frequency of Meetings

Meetings will take place, in public, on a bi-monthly basis to meet the requirements of the CCG business. The Chair may call extra-ordinary meetings to manage urgent business requirements where needed. Where this is not achievable, the CCG Accountable Officer has the authority to take emergency decisions as outlined within the CCG Scheme of Delegation.

Meetings of the Committee shall:

a) be held in public, subject to the application of 23(b);

b) the Committee may resolve to exclude the public from a meeting that is open to the public (whether during the whole or part of the proceedings) whenever publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution and arising from the nature of that business or of the proceedings or for
any other reason permitted by the Public Bodies (Admission to Meetings) Act 1960 as amended or succeeded from time to time.

### 6. Duties

The role of the Committee shall be to carry out the functions relating to the commissioning of primary medical services under section 83 of the NHS Act.

This includes the following:

- GMS, PMS and APMS contracts (including the design of PMS and APMS contracts, monitoring of contracts, taking contractual action such as issuing branch/remedial notices, and removing a contract);
- Newly designed enhanced services (“Local Enhanced Services” and “Directed Enhanced Services”);
- Design of local incentive schemes as an alternative to the Quality Outcomes Framework (QOF);
- Decision making on whether to establish new GP practices in an area;
- Approving practice mergers; and
- Making decisions on ‘discretionary’ payment (e.g., returner/retainer schemes), which will include decisions relating to the spend on any primary care schemes and Vanguard funds.

The CCG will also carry out the following activities:

a) To plan, including needs assessment, primary [medical] care services in Mansfield and Ashfield CCG;

b) To align GP commissioning plans with other strategic service plans, (e.g. Mid Nottinghamshire Better Together programme, Nottinghamshire Sustainability and Transformation Plan) reviewing, tracking and reporting on benefits realisation;

c) To undertake reviews of primary [medical] care services in Mansfield and Ashfield CCG;

d) To co-ordinate a common approach to the commissioning of primary care services generally;

e) To manage the budget for commissioning of primary [medical] care services in Mansfield and Ashfield in compliance with the CCG Constitution and the Statement of Financial Entitlement Directions.

f) To assist and support NHS England in discharging its duty under section 13E of the NHS Act 2006 (as amended by the Health and Social Care Act 2012) so far as relating to securing continuous improvement in the quality of primary medical services.

g) To adopt the findings of the national PMS and Minimum Practice Income Guarantee (MPIG) reviews, and any locally agreed schemes will need to reflect the changes agreed as part of the reviews.

h) To ensure risk management is aligned with the CCG Risk Management framework/policy. A Primary Care Commissioning Committee risk register to be developed and maintained with updates and escalation to the CCG Governing Body assurance framework and NHS England Area Team where appropriate

i) To take responsibility for oversight of the transformation fund or strategic estates as per the Scheme of Delegation, noting the delegation is to include NHS England at the appropriate point.
Joint arrangements with NHS Newark and Sherwood CCG

NHS Newark & Sherwood CCG and NHS Mansfield & Ashfield CCG (Mid Notts CCGs), as separate statutory bodies, have delegated primary care commissioning responsibilities. They will both establish a Primary Care Commissioning Committee and associated terms of reference including specific membership and quoracy.

The Mid Notts CCGs have shared Chief Officer, Chief Finance Officer, and Executive Director positions which are members of both Primary Care Commissioning Committees.

To avoid duplication of meetings across the Mid Notts CCGs, joint meetings of the two committees will take place.

Delegated decision making, (incorporating quoracy and conflicts of interest) will be managed via separate agenda items for each CCG with separate minuting and reporting arrangements at CCG level. Agendas will delineate for clarity of decision making within each CCG as separate statutory bodies as appropriate. Lay and GP membership will be CCG specific.

The diagram below sets out the Mid Notts CCG governance arrangements

The Committee to have delegated authority from the Mansfield and Ashfield CCG governing body:

- To carry out the functions relating to the commissioning of primary medical services under section 83 of the NHS Act
- To assist and support NHS England in discharging its duty under section 13E of the NHS Act 2006 (as amended by the Health and Social Care Act 2012) so far as relating to securing continuous improvement in the quality of primary medical services.
- To work with NHS England to agree rules for areas such as the collection of data for national data sets, equivalent of what is collected under QOF, and IT intra-operability.
- To comply with public procurement regulations and with statutory guidance on conflicts of interest
- To consult with Local Medical Committee and demonstrate improved outcomes reduced inequalities and value for money when developing a local QOF scheme or DES.
- To approve the arrangements for discharging the group’s statutory duties associated with its GP practice commissioning functions, including but not limited to promoting the involvement of each patient, patient choice, reducing inequalities, improvement in the quality of services, obtaining appropriate advice and public engagement and consultation.

Procurement of Agreed Services

- The committee must comply with public procurement regulations and with statutory guidance on conflicts of interest.
- The committee may vary or renew existing contracts for primary care provision or award new ones, depending on local circumstances.
- If the committee fails to secure an adequate supply of high quality primary medical care, NHS England may direct the CCG to act.
- If the Committee are found to have breached public procurement regulations and/or statutory guidance on conflicts of interest, Monitor may direct the CCG or to act. NHS England may, ultimately, revoke the CCG’s delegation.
- Any proposed new incentive schemes should be subject to consultation with the Local Medical Committee and be able to demonstrate improved outcomes, reduced inequalities and value for money.

Consistent with the NHS Five Year Forward View and working with CCGs, NHS England reserves the right to establish new national approaches and rules on expanding primary care provision – for example to tackle health inequalities.

Decisions

The Committee will make decisions within the bounds of its remit. Specifically, within the Operational Scheme of Delegation, the Committee has delegated powers to:
• Co-commission delegated budgets – within the acknowledgement of additional requirements to go back to NHS England and
• Other direct GP payments – above £50,000.

The decisions of the Committee shall be binding on NHS England and NHS Newark & Sherwood CCG.

The Committee will produce an executive summary report which will be presented to of NHS England North Midlands Sub-region and to each meeting of the governing body of NHS Mansfield and Ashfield CCG bi-monthly for information. The Committee will ensure areas for escalation, for example high level risks and conflicts of interest, are provided via exception reporting to NHS England North Midlands Sub-region in a timely manner where required.

The Committee will maintain a record of all decisions made.

7. Conduct of Business

Members of the Committee have a collective responsibility for the operation of the Committee. They will participate in discussion, review evidence and provide objective expert input to the best of their knowledge and ability, and endeavour to reach a collective view.

The Committee may delegate tasks to such individuals, sub-committees or individual members as it shall see fit, provided that any such delegations are consistent with the parties’ relevant governance arrangements, are recorded in a scheme of delegation, are governed by terms of reference as appropriate and reflect appropriate arrangements for the management of conflicts of interest. These committees will support development of commissioning proposals and ensure that milestones are met/escalated to the Primary Care Commissioning Committee

The Committee may call additional experts to attend meetings on an ad hoc basis to inform discussions.

Members of the Committee shall respect confidentiality requirements as set out in the CCG’s Standing Orders.

The Committee will be expected to conduct itself as an exemplar organisation, working to the Nolan seven principles of public life, namely:
• Selflessness
• Integrity
• Objectivity
• Accountability
• Openness
• Honesty
• Leadership

Members of the Committee shall respect confidentiality requirements as set out in the CCG’s Standing Orders.

8. Administration of Meetings

The Committee will operate in accordance with the CCG’s Standing Orders. The Secretary to the Committee will be responsible for giving notice of meetings. This will be accompanied by an agenda and supporting papers and sent to each member representative no later than 7 days before the date of the meeting. When the Chair of the Committee deems it necessary in light of the urgent circumstances to call a meeting at short notice, the notice period shall be such as s/he shall specify.

The Director responsible for overseeing the administration of the Committee is the Director of Primary Care.

Agendas and supporting papers will be circulated no later than 5 working days in advance of meetings.
Any items placed on the agenda will be sent to the Committee Administrator no later than 7 working days in advance of the meeting. Items that miss the deadline for inclusion on the agenda may be added on receipt of permission of the Chair.

Minutes will be taken at all meetings and circulated to the members of the Committee. The minutes will be approved by agreement of the Committee at the next meeting. The Chair of the Committee will agree minutes if they are to be submitted to the Governing Body prior to formal approval.

The Committee will present its minutes to the Governing Body for information and consideration.

The CCG will also comply with any reporting requirements set out in its constitution.

**9. Declaration of Interests**

The NHS Mansfield and Ashfield Clinical Commissioning Group has a Conflict of Interest Policy and has a register of member interests.

At the beginning of each formal meeting, members will be required to declare any personal interest if it relates specifically to a particular issue under consideration. Any such declaration shall be formally recorded in the minutes for the meeting in accordance with the provisions set out in the CCG policy.

Where a declaration of interest means that there is an actual or a suspected conflict of interest, the conflict must be identified by the Chair and Administrative Support at the agenda setting stage of meeting planning. This will enable the consideration of the provision of papers in preparation of the meeting to prevent those with direct conflicts from having access to information which they are not permitted to act in their capacity within the meeting to discuss, or decide.

All declared interests will be managed in line with the requirements of the CCG’s Conflict of Interests Policy.

The CCGs will not award a contract for the provision of NHS healthcare services where conflicts, or potential conflicts, between interests involved in commissioning such services and the interests involved in providing them appear to affect the integrity of that award and the CCGs will keep a record of how it manages any such conflict in relation to NHS commissioning contracts it has entered into.

**10. Reporting Responsibilities**

The Committee will present its minutes to North Midlands Sub Region of NHS England and to the bi-monthly governing body of NHS Mansfield and Ashfield CCG for information, including the minutes of any committees to which responsibilities are delegated above.

The Committee will provide an annual report to the Governing Body setting out progress made and future developments.

**11. Review of Terms of Reference**

The terms of reference will be reviewed at least annually with final approval being sought from the Mansfield and Ashfield CCG Governing Body. Amendments will be made, where appropriate, to reflect any updated national model terms of reference and local need.

**Date:** March 2017
Background
Simon Stevens, the Chief Executive of NHS England, announced on 1 May 2014 that NHS England was inviting CCGs to expand their role in primary care commissioning and to submit expressions of interest setting out the CCG’s preference for how it would like to exercise expanded primary medical care commissioning functions. One option available was that NHS England would delegate the exercise of certain specified primary care commissioning functions to a CCG.

In accordance with its statutory powers under section 13Z of the National Health Service Act 2006 (as amended), NHS England has delegated the exercise of the functions specified in Schedule 2 to these Terms of Reference to NHS Mansfield and Ashfield CCG. The delegation is set out in Schedule 2.

The CCG has established the NHS Mansfield and Ashfield CCG Primary Care Commissioning Committee ("Committee"). The Committee will function as a corporate decision-making body for the management of the delegated functions and the exercise of the delegated powers.

It is a committee comprising representatives of the following organisations:
  - NHS Mansfield and Ashfield CCG
  - Nottinghamshire County Council - Public Health

A standing invitation is extended to the Local Medical Committee, Nottinghamshire Healthwatch, NHS England Area Team, and Nottinghamshire Health & Well Being Board

Statutory Framework
NHS England has delegated to the CCG authority to exercise the primary care commissioning functions set out in Schedule 2 in accordance with section 13Z of the NHS Act. Arrangements made under section 13Z may be on such terms and conditions (including terms as to payment) as may be agreed between the Board and the CCG.

Arrangements made under section 13Z do not affect the liability of NHS England for the exercise of any of its functions. However, the CCG acknowledges that in exercising its functions (including those delegated to it), it must comply with the statutory duties set out in Chapter A2 of the NHS Act and including:

- Management of conflicts of interest (section 14O);
- Duty to promote the NHS Constitution (section 14P);
- Duty to exercise its functions effectively, efficiently and economically (section 14Q);
- Duty as to improvement in quality of services (section 14R);
- Duty in relation to quality of primary medical services (section 14S);
- Duties as to reducing inequalities (section 14T);
- Duty to promote the involvement of each patient (section 14U);
- Duty as to patient choice (section 14V);
- Duty as to promoting integration (section 14Z1);
- Public involvement and consultation (section 14Z2)

The CCG will also need to specifically, in respect of the delegated functions from NHS England, exercise those set out below:
  - Duty to have regard to impact on services in certain areas (section 13O);
  - Duty as respects variation in provision of health services (section 13P).

The Committee is established as a committee of the Governing Body of NHS Mansfield and Ashfield CCG in accordance with Schedule 1A of the “NHS Act”.

The members acknowledge that the Committee is subject to any directions made by NHS England or by the Secretary of State.
The Co-commissioning leads’ meeting operates across Notts/Derby to oversee the process of developing primary care commissioning in CCGs and the deployment of staff for 15/16. It will ensure a coherent approach across the patch and best use of existing team.

Both CCGs have delegated authority approval in relation to Primary Care Commissioning for their respective areas. These *Mid Notts CCGs have shared Chief Officer, Chief Finance Officer, Executive Director positions and therefore joint meetings of the two committees will take place. Delegated decision making, (incorporating quoracy and conflicts of interest) will be managed via separate agenda items for each CCG with separate minuting and reporting arrangements at CCG level. Agendas will delineate for clarity of decision making within each CCG as separate statutory bodies as appropriate. Lay and GP membership will be CCG specific.

The *Mid Notts CCGs will establish a joint operational steering group in order to develop commissioning proposals and to ensure that milestones are met/escalated to the Primary Care Commissioning Committee.
Schedule 2 - Delegated Functions (CCG responsibilities)

Part 1: Delegated Functions: Specific Obligations

1. Introduction

   1.1. This Part 1 of Schedule 2 (Delegated Functions) sets out further provision regarding the carrying out of each of the Delegated Functions.

2. Primary Medical Services Contract Management

   2.1. The CCG must:

    2.1.1. manage the Primary Medical Services Contracts on behalf of NHS England and perform all of NHS England’s obligations under each of the Primary Medical Services Contracts in accordance with the terms of the Primary Medical Services Contracts as if it were named in the contract in place of NHS England;

    2.1.2. actively manage the performance of the counter-party to the Primary Medical Services Contracts in order to secure the needs of people who use the services, improve the quality of services and improve efficiency in the provision of the services including by taking timely action to enforce contractual breaches and serve notice;

    2.1.3. ensure that it obtains value for money under the Primary Medical Services Contracts on behalf of NHS England and avoids making any double payments under any Primary Medical Services Contracts;


    2.1.5. notify NHS England immediately (or in any event within two (2) Operational Days) of any breach by the CCG of its obligations to perform any of NHS England’s obligations under the Primary Medical Services Contracts;

    2.1.6. keep a record of all of the Primary Medical Services Contracts that the CCG manages on behalf of NHS England setting out the following details in relation to each Primary Medical Services Contract:

        2.1.6.1. name of counter-party;
        2.1.6.2. location of provision of services; and
        2.1.6.3. amounts payable under the contract (if a contract sum is payable) or amount payable in respect of each patient (if there is no contract sum).

   2.2. For the avoidance of doubt, all Primary Medical Services Contracts will be in the name of NHS England.

   2.3. The CCG must comply with any Guidance in relation to the issuing and signing of Primary Medical Services Contracts in the name of NHS England.

   2.4. Without prejudice to clause 13 (Financial Provisions and Liability) or paragraph 2.1 above, the CCG must actively manage each of the relevant Primary Medical Services Contracts including by:
2.4.1. managing the relevant Primary Medical Services Contract, including in respect of quality standards, incentives and the QOF, observance of service specifications, and monitoring of activity and finance;

2.4.2. assessing quality and outcomes (including clinical effectiveness, patient experience and patient safety);

2.4.3. managing variations to the relevant Primary Medical Services Contract or services in accordance with national policy, service user needs and clinical developments;

2.4.4. agreeing information and reporting requirements and managing information breaches (which will include use of the HSCIC IG Toolkit SIRI system);

2.4.5. agreeing local prices, managing agreements or proposals for local variations and local modifications;

2.4.6. conducting review meetings and undertaking contract management including the issuing of contract queries and agreeing any remedial action plan or related contract management processes; and

2.4.7. complying with and implementing any relevant Guidance issued from time to time.

Enhanced Services

2.5. The CCG must manage the design and commissioning of Enhanced Services, including re-commissioning these services annually where appropriate.

2.6. The CCG must ensure that it complies with any Guidance in relation to the design and commissioning of Enhanced Services.

2.7. When commissioning newly designed Enhanced Services, the CCG must:

2.7.1. consider the needs of the local population in the Area;

2.7.2. support Data Controllers in providing ‘fair processing’ information as required by the DPA;

2.7.3. develop the necessary specifications and templates for the Enhanced Services, as required to meet the needs of the local population in the Area;

2.7.4. when developing the necessary specifications and templates for the Enhanced Services, ensure that value for money will be obtained;

2.7.5. consult with Local Medical Committees, each relevant Health and Wellbeing Board and other stakeholders in accordance with the duty of public involvement and consultation under section 14Z2 of the NHS Act;

2.7.6. obtain the appropriate read codes, to be maintained by the HSCIC;

2.7.7. liaise with system providers and representative bodies to ensure that the system in relation to the Enhanced Services will be functional and secure; and

2.7.8. support GPs in entering into data processing agreements with data processors in the terms required by the DPA.

Design of Local Incentive Schemes

2.8. The CCG may design and offer Local Incentive Schemes for GP practices, sensitive to the needs of their particular communities, in addition to or as an alternative to the national framework (including as an alternative to QOF or directed Enhanced Services), provided that such schemes are voluntary and the CCG continues to offer the national schemes.

2.9. There is no formal approvals process that the CCG must follow to develop a Local Incentive Scheme, although any proposed new Local Incentive Scheme:
2.9.1. is subject to consultation with the Local Medical Committee;
2.9.2. must be able to demonstrate improved outcomes, reduced inequalities and
value for money; and
2.9.3. must reflect the changes agreed as part of the national PMS reviews.

2.10. The ongoing assurance of any new Local Incentive Schemes will form part of the
CCG’s assurance process under the CCG Assurance Framework.

2.11. Any new Local Incentive Scheme must be implemented without prejudice to the right
of GP practices operating under a GMS Contract to obtain their entitlements which
are negotiated and set nationally.

2.12. NHS England will continue to set national standing rules, to be reviewed annually,
and the CCG must comply with these rules which shall for the purposes of this
Agreement be Guidance.

Making Decisions on Discretionary Payments

2.13. The CCG must manage and make decisions in relation to the discretionary payments
to be made to GP practices in a consistent, open and transparent way.

2.14. The CCG must exercise its discretion to determine the level of payment to GP
practices of discretionary payments, in accordance with the Statement of Financial
Entitlements Directions.

Making Decisions about Commissioning Urgent Care for Out of Area Registered
Patients

2.15. The CCG must manage the design and commissioning of urgent care services
(including home visits as required) for its patients registered out of area (including re-
commissioning these services annually where appropriate).

2.16. The CCG must ensure that it complies with any Guidance in relation to the design
and commissioning of these services.

3. Planning the Provider Landscape

3.1. The CCG must plan the primary medical services provider landscape in the Area,
including considering and taking decisions in relation to:

3.1.1. establishing new GP practices in the Area;
3.1.2. managing GP practices providing inadequate standards of patient care;
3.1.3. the procurement of new Primary Medical Services Contracts (in accordance
with any procurement protocol issued by NHS England from time to time);
3.1.4. closure of practices and branch surgeries;
3.1.5. dispersing the lists of GP practices;
3.1.6. agreeing variations to the boundaries of GP practices; and
3.1.7. coordinating and carrying out the process of list cleansing in relation to GP
practices, according to any policy or Guidance issued by NHS England from
time to time.

3.2. In relation to any new Primary Medical Services Contract to be entered into, the CCG
must, without prejudice to any obligation in Schedule 2, Part 2, paragraph 3
(Procurement and New Contracts) and Schedule 2, Part 1, paragraph 2.3:
3.2.1. consider and use the form of Primary Medical Services Contract that will ensure compliance with NHS England’s obligations under Law including the Public Contracts Regulations 2015/102 and the National Health Service (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013/500 taking into account the persons to whom such Primary Medical Services Contracts may be awarded;

3.2.2. provide to NHS England confirmation as required from time to time that it has considered and complied with its obligations under this Agreement and the Law; and

3.2.3. for the avoidance of doubt, Schedule 5 (*Financial Provisions and Decision Making Limits*) deals with the sign off requirements for Primary Medical Services Contracts.

4. Approving GP Practice Mergers and Closures

4.1. The CCG is responsible for approving GP practice mergers and GP practice closures in the Area.

4.2. The CCG must undertake all necessary consultation when taking any decision in relation to GP practice mergers or GP practice closures in the Area, including those set out under section 14Z2 of the NHS Act (duty for public involvement and consultation). The consultation undertaken must be appropriate and proportionate in the circumstances and should include consulting with the Local Medical Committee.

4.3. Prior to making any decision in accordance with this paragraph 4 (*Approving GP Practice Mergers and Closures*), the CCG must be able to clearly demonstrate the grounds for such a decision and must have fully considered any impact on the GP practice’s registered population and that of surrounding practices. The CCG must be able to clearly demonstrate that it has considered other options and has entered into dialogue with the GP contractor as to how any closure or merger will be managed.

4.4. In making any decisions pursuant to paragraph 4 (*Approving GP Practice Mergers and Closures*), the CCG shall also take account of its obligations as set out in Schedule 2, part 2, paragraph 3 (*Procurement and New Contracts*), where applicable.

5. Information Sharing with NHS England in relation to the Delegated Functions

5.1. This paragraph 5 (*Information Sharing with NHS England*) is without prejudice to clause 9.4 or any other provision in this Agreement. The CCG must provide NHS England with:

5.1.1. such information relating to individual GP practices in the Area as NHS England may reasonably request, to ensure that NHS England is able to continue to gather national data regarding the performances of GP practices;

5.1.2. such data/data sets as required by NHS England to ensure population of the primary medical services dashboard;

5.1.3. any other data/data sets as required by NHS England; and

5.1.4. the CCG shall procure that providers accurately record and report information so as to allow NHS England and other agencies to discharge their functions.

5.2. The CCG must use the NHS England approved primary medical services dashboard, as updated from time to time, for the collection and dissemination of information relating to GP practices.
5.3. The CCG must (where appropriate) use the NHS England approved GP exception reporting service (as notified to the CCGs by NHS England from time to time).

5.4. The CCG must provide any other information, and in any such form, as NHS England considers necessary and relevant.

5.5. NHS England reserves the right to set national standing rules (which may be considered Guidance for the purpose of this Agreement), as needed, to be reviewed annually. NHS England will work with CCGs to agree rules for, without limitation, areas such as the collection of data for national data sets and IT intra-operability. Such national standing rules set from time to time shall be deemed to be part of this Agreement.


6.1. The CCG must make decisions in relation to the management of poorly performing GP practices and including, without limitation, decisions and liaison with the CQC where the CQC has reported non-compliance with standards (but excluding any decisions in relation to the performers list).

6.2. In accordance with paragraph 6.1 above, the CCG must:

   6.2.1. ensure regular and effective collaboration with the CQC to ensure that information on general practice is shared and discussed in an appropriate and timely manner;
   6.2.2. ensure that any risks identified are managed and escalated where necessary;
   6.2.3. respond to CQC assessments of GP practices where improvement is required;
   6.2.4. where a GP practice is placed into special measures, lead a quality summit to ensure the development and monitoring of an appropriate improvement plan (including a communications plan and actions to manage primary care resilience in the locality); and
   6.2.5. take appropriate contractual action in response to CQC findings.

7. Premises Costs Directions Functions

7.1. The CCG must comply with the Premises Costs Directions and will be responsible for making decisions in relation to the Premises Costs Directions Functions.

7.2. In particular, but without limiting the generality of paragraph 7.1, the CCG shall make decisions concerning:

   7.2.1. applications for new payments under the Premises Costs Directions (whether such payments are to be made by way of grants or in respect of recurring premises costs); and
   7.2.2. revisions to existing payments being made under the Premises Costs Directions.

7.3. 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 Premises Costs Directions Functions.
7.4. The CCG will comply with any guidance issued by the Secretary of State or NHS England in relation to the Premises Costs Directions, including the Principles of Best Practice, and any other Guidance in relation to the Premises Costs Directions.

7.5. The CCG must work cooperatively with other CCGs to manage premises and strategic estates planning.

7.6. The CCG must liaise where appropriate with NHS Property Services Limited and Community Health Partnerships Limited in relation to the Premises Costs Directions Functions.

Part 2 – Delegated Functions: General Obligations (CCG responsibilities)

1. Introduction

1.1. This Part 2 of Schedule 2 (Delegated Functions) sets out general provisions regarding the carrying out of the Delegated Functions.

2. Planning and reviews

2.1. The CCG is responsible for planning the commissioning of primary medical services.

2.2. The role of the CCG includes:

2.2.1. carrying out primary medical health needs assessments (to be developed by the CCG) to help determine the needs of the local population in the Area;

2.2.2. recommending and implementing changes to meet any unmet primary medical services needs; and

2.2.3. undertaking regular reviews of the primary medical health needs of the local population in the Area.

3. Procurement and New Contracts

3.1. The CCG will make procurement decisions relevant to the exercise of the Delegated Functions and in accordance with the detailed arrangements regarding procurement set out in the procurement protocol issued and updated by NHS England from time to time.

3.2. In discharging its responsibilities set out in clause 6 (Performance of the Delegated Functions) of this Agreement and paragraph 1 of this Schedule 2 (Delegated Functions), the CCG must comply at all times with Law including its obligations set out in the National Health Service (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013/500 and any other relevant statutory provisions. The CCG must have regard to any relevant guidance, particularly Monitor’s guidance Substantive guidance on the Procurement, Patient Choice and Competition Regulations (https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/283505/SubstantiveGuidanceDec2013_0.pdf).

3.3. Where the CCG wishes to develop and offer a locally designed contract, it must ensure that it has consulted with its Local Medical Committee in relation to the proposal and that it can demonstrate that the scheme will:
3.3.1. improve outcomes;
3.3.2. reduce inequalities; and
3.3.3. provide value for money.

4. Integrated working

4.1. The CCG must take an integrated approach to working and co-ordinating with stakeholders including NHS England, Local Professional Networks, local authorities, Healthwatch, acute and community providers, the Local Medical Committee, Public Health England and other stakeholders.

4.2. The CCG must work with NHS England and other CCGs to co-ordinate a common approach to the commissioning of primary medical services generally.

4.3. The CCG and NHS England will work together to coordinate the exercise of their respective performance management functions.

5. Resourcing

5.1. NHS England may, at its discretion provide support or staff to the CCG. NHS England may, when exercising such discretion, take into account, any relevant factors (including without limitation the size of the CCG, the number of Primary Medical Services Contracts held and the need for the Local NHS England Team to continue to deliver the Reserved Functions).
1. Purpose

The Committee has been established in accordance with the statutory provisions as detailed in Appendix A to enable the members to make collective decisions on the review, planning and procurement of primary care services in Newark & Sherwood, under delegated authority from NHS England.

In performing its role the Committee will exercise its management of the functions in accordance with the agreement entered into between NHS England and NHS Newark & Sherwood CCG, which will sit alongside the delegation and terms of reference.

The functions of the Committee are undertaken in the context of a desire to promote increased co-commissioning to increase quality, efficiency, productivity and value for money and to remove administrative barriers.

The Committee will comprise the geographical area covered by NHS Newark & Sherwood CCG.

2. Membership

The Committee **voting membership** shall consist of:

- Independent lay Chair
- Independent lay Vice Chair
- 2 CCG lay members (shared posts with Mansfield and Ashfield CCG)
- Mid Notts CCG Chief Officer or deputy (being the Chief Finance Officer)
- Mid Notts CCG Chief Finance Officer or nominated deputy
- Mid Notts Director of Procurement & Market Development
- Mid Notts CCG Chief Nurse and Director of Quality and Governance or nominated deputy
- Mid Notts CCG Head of Business Change & Implementation
- Mid Notts CCG Director of Turnaround or nominated deputy
- Mid Notts CCG Director of Primary Care or nominated deputy
- Mid Notts CCG Director of Programme Delivery
- CCG Clinical Advisor (shared post with Mansfield and Ashfield CCG)
- Out of Area GP (shared posts with Mansfield and Ashfield CCG)
- Nottinghamshire County Council Public Health Consultant

If GP members need to withdraw from decision making for conflicts of interest reasons, the committee would still be quorate with a lay and executive majority.

Members are expected to attend all formal meetings. Over a twelve month rolling period if members have been unable to attend at least 80% of the meetings the Chair shall instigate a review of their continuing membership.

Other non-voting attendees

Standing invitation to:

- Local GP
- Local Medical Committee GP representative
- Health Watch Nottinghamshire
- Health and Wellbeing Board
- NHS England Local Area Team

Also note below arrangements relating to joint arrangements with NHS Mansfield & Ashfield CCG.
Provision could be made for the committee to have the ability to call on additional lay members or CCG members when required, for example where the committee would not be quorate because of a conflict of interest. It could also include GP representatives from other CCG areas and non-GP clinical representatives (such as the CCGs secondary care specialist).

The CCG lay member positions will be recruited through expressions of interest process and assessed through a set of criteria (Where three or more expressions of interest are received, an interview process will take place with the Group’s senior clinicians and managers.

### 3. Chair and Deputy

The Committee will have an Independent Lay Chair who is recruited externally. The Lay Chair will be in attendance at the CCG Governing Body.

Term of office will be:
- 2 years initially, with a further 2 years if satisfactory performance is evidenced.
- assessed at the same time as governing body membership term of office where appropriate.

Grounds for removal from office are:
- Gross misconduct
- Failing to disclose a pecuniary interest regarding matters under discussion within the committee
- Following the passing of a vote of no confidence by committee members and subsequent approval of this by CCG governing body

The Vice Chair will be an independent lay member and shall be recruited as set out in item 24-26 above. The Vice Lay Chair will deputise for the Lay Chair at governing body meetings where appropriate.

### 4. Quorum and Voting Arrangements

Each member of the Committee shall have one vote. The Committee shall reach decisions by a simple majority of members present, but with the Chair having a second and deciding vote, if necessary. However, the aim of the Committee will be to achieve consensus decision-making wherever possible.

The quorum required to make formal approvals is as follows (6 members, with lay and executive majority):
- Lay Chair or Lay Vice Chair
- Chief Officer or nominated deputy
- Chief Finance Officer or nominated deputy
- 3 out of the 5 Directors (This includes the Head of Business Change & Implementation and the Chief Nurse) or their nominated deputies
- A Clinician

If an opportunity arises where lay and clinical executive is not the majority of attendees, clinical members will be asked to leave at the time of a decision being made.

### 5. Frequency of Meetings

Meetings will take place, in public, on a bi-monthly basis to meet the requirements of the CCG business. The Chair may call extra-ordinary meetings to manage urgent business requirements where needed. Where this is not achievable, the CCG Accountable Officer has the authority to take emergency decisions as outlined within the CCG Scheme of Delegation.

Meetings of the Committee shall:

a) be held in public, subject to the application of 23(b);
b) the Committee may resolve to exclude the public from a meeting that is open to the public (whether during the whole or part of the proceedings) whenever publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution and arising from the nature of that business or of the proceedings or for any other reason permitted by the Public Bodies (Admission to Meetings) Act 1960 as amended or succeeded from time to time.

6. Duties

The role of the Committee shall be to carry out the functions relating to the commissioning of primary medical services under section 83 of the NHS Act.

This includes the following:

- GMS, PMS and APMS contracts (including the design of PMS and APMS contracts, monitoring of contracts, taking contractual action such as issuing branch/remedial notices, and removing a contract);
- Newly designed enhanced services (“Local Enhanced Services” and “Directed Enhanced Services”);
- Design of local incentive schemes as an alternative to the Quality Outcomes Framework (QOF);
- Decision making on whether to establish new GP practices in an area;
- Approving practice mergers; and
- Making decisions on ‘discretionary’ payment (e.g., returner/retainer schemes), which will include decisions relating to the spend on any primary care schemes and Vanguard funds.

The CCG will also carry out the following activities:

a) To plan, including needs assessment, primary [medical] care services in Newark & Sherwood CCG;

b) To align GP commissioning plans with other strategic service plans, (e.g. Mid Nottinghamshire Better Together programme, Nottinghamshire Sustainability and Transformation Plan) reviewing, tracking and reporting on benefits realisation

c) To undertake reviews of primary [medical] care services in Newark & Sherwood CCG;

d) To co-ordinate a common approach to the commissioning of primary care services generally;

e) To manage the budget for commissioning of primary [medical] care services in Newark & Sherwood in compliance with the CCG Constitution and the Statement of Financial Entitlement Directions.

f) To assist and support NHS England in discharging its duty under section 13E of the NHS Act 2006 (as amended by the Health and Social Care Act 2012) so far as relating to securing continuous improvement in the quality of primary medical services.

g) To adopt the findings of the national PMS and Minimum Practice Income Guarantee (MPIG) reviews, and any locally agreed schemes will need to reflect the changes agreed as part of the reviews.

h) To ensure risk management is aligned with the CCG Risk Management framework/policy. A Primary Care Commissioning Committee risk register to be developed and maintained with updates and escalation to the CCG Governing Body assurance framework and NHS England Area Team where appropriate

i) To take responsibility for oversight of the transformation fund or strategic estates as per the Scheme of Delegation, noting the delegation is to include NHS England at the appropriate point.
Joint arrangements with NHS Mansfield & Ashfield CCG

NHS Newark & Sherwood CCG and NHS Mansfield & Ashfield CCG (Mid Notts CCGs), as separate statutory bodies, have delegated primary care commissioning responsibilities. They will both establish a Primary Care Commissioning Committee and associated terms of reference including specific membership and quoracy.

The Mid Notts CCGs have shared Chief Officer, Chief Finance Officer, and Executive Director positions which are members of both Primary Care Commissioning Committees.

To avoid duplication of meetings across the Mid Notts CCGs, joint meetings of the two committees will take place.

Delegated decision making, (incorporating quoracy and conflicts of interest) will be managed via separate agenda items for each CCG with separate minuting and reporting arrangements at CCG level. Agendas will delineate for clarity of decision making within each CCG as separate statutory bodies as appropriate. Lay and GP membership will be CCG specific.

The diagram below sets out the Mid Notts CCG governance arrangements

The Committee to have delegated authority from the Newark & Sherwood CCG governing body:

• To carry out the functions relating to the commissioning of primary medical services under section 83 of the NHS Act
• To assist and support NHS England in discharging its duty under section 13E of the NHS Act 2006 (as amended by the Health and Social Care Act 2012) so far as relating to securing continuous improvement in the quality of primary medical services.
• To work with NHS England to agree rules for areas such as the collection of data for national data sets, equivalent of what is collected under QOF, and IT intra-operability.
• To comply with public procurement regulations and with statutory guidance on conflicts of interest
• To consult with Local Medical Committee and demonstrate improved outcomes reduced inequalities and value for money when developing a local QOF scheme or DES.
• To approve the arrangements for discharging the group’s statutory duties associated with its GP practice commissioning functions, including but not limited to promoting the involvement of each patient, patient choice, reducing inequalities, improvement in the quality of services, obtaining appropriate advice and public engagement and consultation.

Procurement of Agreed Services

• The committee must comply with public procurement regulations and with statutory guidance on conflicts of interest.
• The committee may vary or renew existing contracts for primary care provision or award new ones, depending on local circumstances.
• If the committee fails to secure an adequate supply of high quality primary medical care, NHS England may direct the CCG to act.
• If the Committee are found to have breached public procurement regulations and/or statutory guidance on conflicts of interest, Monitor may direct the CCG or to act. NHS England may, ultimately, revoke the CCG’s delegation.
• Any proposed new incentive schemes should be subject to consultation with the Local Medical Committee and be able to demonstrate improved outcomes, reduced inequalities and value for money.

Consistent with the NHS Five Year Forward View and working with CCGs, NHS England reserves the right to establish new national approaches and rules on expanding primary care provision – for example to tackle health inequalities.

Decisions

The Committee will make decisions within the bounds of its remit. Specifically, within the Operational Scheme of Delegation, the Committee has delegated powers to:
• Co-commission delegated budgets – within the acknowledgement of additional requirements to go back to NHS England and
• Other direct GP payments – above £50,000.

The decisions of the Committee shall be binding on NHS England and NHS Newark & Sherwood CCG.

The Committee will produce an executive summary report which will be presented to of NHS England North Midlands Sub-region and to each meeting of the governing body of NHS Newark & Sherwood CCG bi-monthly for information. The Committee will ensure areas for escalation, for example high level risks and conflicts of interest, are provided via exception reporting to NHS England North Midlands Sub-region in a timely manner where required.

The Committee will maintain a record of all decisions made.

7. Conduct of Business

Members of the Committee have a collective responsibility for the operation of the Committee. They will participate in discussion, review evidence and provide objective expert input to the best of their knowledge and ability, and endeavour to reach a collective view.

The Committee may delegate tasks to such individuals, sub-committees or individual members as it shall see fit, provided that any such delegations are consistent with the parties’ relevant governance arrangements, are recorded in a scheme of delegation, are governed by terms of reference as appropriate and reflect appropriate arrangements for the management of conflicts of interest. These committees will support development of commissioning proposals and ensure that milestones are met/escalated to the Primary Care Commissioning Committee.

The Committee may call additional experts to attend meetings on an ad hoc basis to inform discussions.

Members of the Committee shall respect confidentiality requirements as set out in the CCG’s Standing Orders.

The Committee will be expected to conduct itself as an exemplar organisation, working to the Nolan seven principles of public life, namely:
• Selflessness
• Integrity
• Objectivity
• Accountability
• Openness
• Honesty
• Leadership

Members of the Committee shall respect confidentiality requirements as set out in the CCG’s Standing Orders.

8. Administration of Meetings

The Committee will operate in accordance with the CCG’s Standing Orders. The Secretary to the Committee will be responsible for giving notice of meetings. This will be accompanied by an agenda and supporting papers and sent to each member representative no later than 7 days before the date of the meeting. When the Chair of the Committee deems it necessary in light of the urgent circumstances to call a meeting at short notice, the notice period shall be such as s/he shall specify.

The Director responsible for overseeing the administration of the Committee is the Director of Primary Care.

Agendas and supporting papers will be circulated no later than 5 working days in advance of meetings.
Any items placed on the agenda will be sent to the Committee Administrator no later than 7 working days in advance of the meeting. Items that miss the deadline for inclusion on the agenda may be added on receipt of permission of the Chair.

Minutes will be taken at all meetings and circulated to the members of the Committee. The minutes will be approved by agreement of the Committee at the next meeting. The Chair of the Committee will agree minutes if they are to be submitted to the Governing Body prior to formal approval.

The Committee will present its minutes to the Governing Body for information and consideration.

The CCG will also comply with any reporting requirements set out in its constitution.

9. Declaration of Interests

The NHS Newark and Sherwood Clinical Commissioning Group has a Conflict of Interest Policy and has a register of member interests.

At the beginning of each formal meeting, members will be required to declare any personal interest if it relates specifically to a particular issue under consideration. Any such declaration shall be formally recorded in the minutes for the meeting in accordance with the provisions set out in the CCG policy.

Where a declaration of interest means that there is an actual or a suspected conflict of interest, the conflict must be identified by the Chair and Administrative Support at the agenda setting stage of meeting planning. This will enable the consideration of the provision of papers in preparation of the meeting to prevent those with direct conflicts from having access to information which they are not permitted to act in their capacity within the meeting to discuss, or decide.

All declared interests will be managed in line with the requirements of the CCG’s Conflict of Interests Policy.

The CCGs will not award a contract for the provision of NHS healthcare services where conflicts, or potential conflicts, between interests involved in commissioning such services and the interests involved in providing them appear to affect the integrity of that award and the CCGs will keep a record of how it manages any such conflict in relation to NHS commissioning contracts it has entered into.

10. Reporting Responsibilities

The Committee will present its minutes to North Midlands Sub Region of NHS England and to the bi-monthly governing body of NHS Newark & Sherwood CCG for information, including the minutes of any committees to which responsibilities are delegated above.

The Committee will provide an annual report to the Governing Body setting out progress made and future developments.

11. Review of Terms of Reference

The terms of reference will be reviewed at least annually with final approval being sought from the Newark & Sherwood CCG Governing Body. Amendments will be made, where appropriate, to reflect any updated national model terms of reference and local need.

Date: March 2017
Background
Simon Stevens, the Chief Executive of NHS England, announced on 1 May 2014 that NHS England was inviting CCGs to expand their role in primary care commissioning and to submit expressions of interest setting out the CCG’s preference for how it would like to exercise expanded primary medical care commissioning functions. One option available was that NHS England would delegate the exercise of certain specified primary care commissioning functions to a CCG.

In accordance with its statutory powers under section 13Z of the National Health Service Act 2006 (as amended), NHS England has delegated the exercise of the functions specified in Schedule 2 to these Terms of Reference to NHS Newark & Sherwood CCG. The delegation is set out in Schedule 2.

The CCG has established the NHS Newark & Sherwood CCG Primary Care Commissioning Committee (“Committee”). The Committee will function as a corporate decision-making body for the management of the delegated functions and the exercise of the delegated powers.

It is a committee comprising representatives of the following organisations:
- NHS Newark & Sherwood CCG
- Nottinghamshire County Council - Public Health

A standing invitation is extended to the Local Medical Committee, Nottinghamshire Healthwatch, NHS England Area Team, and Nottinghamshire Health & Well Being Board

Statutory Framework
NHS England has delegated to the CCG authority to exercise the primary care commissioning functions set out in Schedule 2 in accordance with section 13Z of the NHS Act. Arrangements made under section 13Z may be on such terms and conditions (including terms as to payment) as may be agreed between the Board and the CCG.

Arrangements made under section 13Z do not affect the liability of NHS England for the exercise of any of its functions. However, the CCG acknowledges that in exercising its functions (including those delegated to it), it must comply with the statutory duties set out in Chapter A2 of the NHS Act and including:

- Management of conflicts of interest (section 14O);
- Duty to promote the NHS Constitution (section 14P);
- Duty to exercise its functions effectively, efficiently and economically (section 14Q);
- Duty as to improvement in quality of services (section 14R);
- Duty in relation to quality of primary medical services (section 14S);
- Duties as to reducing inequalities (section 14T);
- Duty to promote the involvement of each patient (section 14U);
- Duty as to patient choice (section 14V);
- Duty as to promoting integration (section 14Z1);
- Public involvement and consultation (section 14Z2)

The CCG will also need to specifically, in respect of the delegated functions from NHS England, exercise those set out below:
- Duty to have regard to impact on services in certain areas (section 13O);
- Duty as respects variation in provision of health services (section 13P).

The Committee is established as a committee of the Governing Body of NHS Newark & Sherwood CCG in accordance with Schedule 1A of the "NHS Act".

The members acknowledge that the Committee is subject to any directions made by NHS England or by the Secretary of State.
Both CCGs have delegated authority approval in relation to Primary Care Commissioning for their respective areas. These *Mid Notts CCGs have shared Chief Officer, Chief Finance Officer, Executive Director positions and therefore joint meetings of the two committees will take place. Delegated decision making, (incorporating quoracy and conflicts of interest) will be managed via separate agenda items for each CCG with separate minuting and reporting arrangements at CCG level. Agendas will delineate for clarity of decision making within each CCG as separate statutory bodies as appropriate. Lay and GP membership will be CCG specific.

The *Mid Notts CCGs will establish a joint operational steering group in order to develop commissioning proposals and to ensure that milestones are met/escalated to the Primary Care Commissioning Committee.
Part 1: Delegated Functions: Specific Obligations

1. Introduction

1.1. This Part 1 of Schedule 2 (Delegated Functions) sets out further provision regarding the carrying out of each of the Delegated Functions.

2. Primary Medical Services Contract Management

2.1. The CCG must:

2.1.1. manage the Primary Medical Services Contracts on behalf of NHS England and perform all of NHS England’s obligations under each of the Primary Medical Services Contracts in accordance with the terms of the Primary Medical Services Contracts as if it were named in the contract in place of NHS England;

2.1.2. actively manage the performance of the counter-party to the Primary Medical Services Contracts in order to secure the needs of people who use the services, improve the quality of services and improve efficiency in the provision of the services including by taking timely action to enforce contractual breaches and serve notice;

2.1.3. ensure that it obtains value for money under the Primary Medical Services Contracts on behalf of NHS England and avoids making any double payments under any Primary Medical Services Contracts;


2.1.5. notify NHS England immediately (or in any event within two (2) Operational Days) of any breach by the CCG of its obligations to perform any of NHS England’s obligations under the Primary Medical Services Contracts;

2.1.6. keep a record of all of the Primary Medical Services Contracts that the CCG manages on behalf of NHS England setting out the following details in relation to each Primary Medical Services Contract:

   2.1.6.1. name of counter-party;
   2.1.6.2. location of provision of services; and
   2.1.6.3. amounts payable under the contract (if a contract sum is payable) or amount payable in respect of each patient (if there is no contract sum).

2.2. For the avoidance of doubt, all Primary Medical Services Contracts will be in the name of NHS England.

2.3. The CCG must comply with any Guidance in relation to the issuing and signing of Primary Medical Services Contracts in the name of NHS England.

2.4. Without prejudice to clause 13 (Financial Provisions and Liability) or paragraph 2.1 above, the CCG must actively manage each of the relevant Primary Medical Services Contracts including by:
2.4.1. managing the relevant Primary Medical Services Contract, including in respect of quality standards, incentives and the QOF, observance of service specifications, and monitoring of activity and finance;

2.4.2. assessing quality and outcomes (including clinical effectiveness, patient experience and patient safety);

2.4.3. managing variations to the relevant Primary Medical Services Contract or services in accordance with national policy, service user needs and clinical developments;

2.4.4. agreeing information and reporting requirements and managing information breaches (which will include use of the HSCIC IG Toolkit SIRI system);

2.4.5. agreeing local prices, managing agreements or proposals for local variations and local modifications;

2.4.6. conducting review meetings and undertaking contract management including the issuing of contract queries and agreeing any remedial action plan or related contract management processes; and

2.4.7. complying with and implementing any relevant Guidance issued from time to time.

Enhanced Services

2.5. The CCG must manage the design and commissioning of Enhanced Services, including re-commissioning these services annually where appropriate.

2.6. The CCG must ensure that it complies with any Guidance in relation to the design and commissioning of Enhanced Services.

2.7. When commissioning newly designed Enhanced Services, the CCG must:

2.7.1. consider the needs of the local population in the Area;

2.7.2. support Data Controllers in providing ‘fair processing’ information as required by the DPA;

2.7.3. develop the necessary specifications and templates for the Enhanced Services, as required to meet the needs of the local population in the Area;

2.7.4. when developing the necessary specifications and templates for the Enhanced Services, ensure that value for money will be obtained;

2.7.5. consult with Local Medical Committees, each relevant Health and Wellbeing Board and other stakeholders in accordance with the duty of public involvement and consultation under section 14Z2 of the NHS Act;

2.7.6. obtain the appropriate read codes, to be maintained by the HSCIC;

2.7.7. liaise with system providers and representative bodies to ensure that the system in relation to the Enhanced Services will be functional and secure; and

2.7.8. support GPs in entering into data processing agreements with data processors in the terms required by the DPA.

Design of Local Incentive Schemes

2.8. The CCG may design and offer Local Incentive Schemes for GP practices, sensitive to the needs of their particular communities, in addition to or as an alternative to the national framework (including as an alternative to QOF or directed Enhanced Services), provided that such schemes are voluntary and the CCG continues to offer the national schemes.

2.9. There is no formal approvals process that the CCG must follow to develop a Local Incentive Scheme, although any proposed new Local Incentive Scheme:
2.9.1. is subject to consultation with the Local Medical Committee;
2.9.2. must be able to demonstrate improved outcomes, reduced inequalities and value for money; and
2.9.3. must reflect the changes agreed as part of the national PMS reviews.

2.10. The ongoing assurance of any new Local Incentive Schemes will form part of the CCG’s assurance process under the CCG Assurance Framework.

2.11. Any new Local Incentive Scheme must be implemented without prejudice to the right of GP practices operating under a GMS Contract to obtain their entitlements which are negotiated and set nationally.

2.12. NHS England will continue to set national standing rules, to be reviewed annually, and the CCG must comply with these rules which shall for the purposes of this Agreement be Guidance.

Making Decisions on Discretionary Payments

2.13. The CCG must manage and make decisions in relation to the discretionary payments to be made to GP practices in a consistent, open and transparent way.

2.14. The CCG must exercise its discretion to determine the level of payment to GP practices of discretionary payments, in accordance with the Statement of Financial Entitlements Directions.

Making Decisions about Commissioning Urgent Care for Out of Area Registered Patients

2.15. The CCG must manage the design and commissioning of urgent care services (including home visits as required) for its patients registered out of area (including re-commissioning these services annually where appropriate).

2.16. The CCG must ensure that it complies with any Guidance in relation to the design and commissioning of these services.

3. Planning the Provider Landscape

3.1. The CCG must plan the primary medical services provider landscape in the Area, including considering and taking decisions in relation to:

3.1.1. establishing new GP practices in the Area;
3.1.2. managing GP practices providing inadequate standards of patient care;
3.1.3. the procurement of new Primary Medical Services Contracts (in accordance with any procurement protocol issued by NHS England from time to time);
3.1.4. closure of practices and branch surgeries;
3.1.5. dispersing the lists of GP practices;
3.1.6. agreeing variations to the boundaries of GP practices; and
3.1.7. coordinating and carrying out the process of list cleansing in relation to GP practices, according to any policy or Guidance issued by NHS England from time to time.

3.2. In relation to any new Primary Medical Services Contract to be entered into, the CCG must, without prejudice to any obligation in Schedule 2, Part 2, paragraph 3 (Procurement and New Contracts) and Schedule 2, Part 1, paragraph 2.3:
3.2.1. consider and use the form of Primary Medical Services Contract that will ensure compliance with NHS England’s obligations under Law including the Public Contracts Regulations 2015/102 and the National Health Service (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013/500 taking into account the persons to whom such Primary Medical Services Contracts may be awarded;

3.2.2. provide to NHS England confirmation as required from time to time that it has considered and complied with its obligations under this Agreement and the Law; and

3.2.3. for the avoidance of doubt, Schedule 5 (Financial Provisions and Decision Making Limits) deals with the sign off requirements for Primary Medical Services Contracts.

4. Approving GP Practice Mergers and Closures

4.1. The CCG is responsible for approving GP practice mergers and GP practice closures in the Area.

4.2. The CCG must undertake all necessary consultation when taking any decision in relation to GP practice mergers or GP practice closures in the Area, including those set out under section 14Z2 of the NHS Act (duty for public involvement and consultation). The consultation undertaken must be appropriate and proportionate in the circumstances and should include consulting with the Local Medical Committee.

4.3. Prior to making any decision in accordance with this paragraph 4 (Approving GP Practice Mergers and Closures), the CCG must be able to clearly demonstrate the grounds for such a decision and must have fully considered any impact on the GP practice’s registered population and that of surrounding practices. The CCG must be able to clearly demonstrate that it has considered other options and has entered into dialogue with the GP contractor as to how any closure or merger will be managed.

4.4. In making any decisions pursuant to paragraph 4 (Approving GP Practice Mergers and Closures), the CCG shall also take account of its obligations as set out in Schedule 2, part 2, paragraph 3 (Procurement and New Contracts), where applicable.

5. Information Sharing with NHS England in relation to the Delegated Functions

5.1. This paragraph 5 (Information Sharing with NHS England) is without prejudice to clause 9.4 or any other provision in this Agreement. The CCG must provide NHS England with:

5.1.1. such information relating to individual GP practices in the Area as NHS England may reasonably request, to ensure that NHS England is able to continue to gather national data regarding the performances of GP practices;

5.1.2. such data/data sets as required by NHS England to ensure population of the primary medical services dashboard;

5.1.3. any other data/data sets as required by NHS England; and

5.1.4. the CCG shall procure that providers accurately record and report information so as to allow NHS England and other agencies to discharge their functions.

5.2. The CCG must use the NHS England approved primary medical services dashboard, as updated from time to time, for the collection and dissemination of information relating to GP practices.
5.3. The CCG must (where appropriate) use the NHS England approved GP exception reporting service (as notified to the CCGs by NHS England from time to time).

5.4. The CCG must provide any other information, and in any such form, as NHS England considers necessary and relevant.

5.5. NHS England reserves the right to set national standing rules (which may be considered Guidance for the purpose of this Agreement), as needed, to be reviewed annually. NHS England will work with CCGs to agree rules for, without limitation, areas such as the collection of data for national data sets and IT intra-operability. Such national standing rules set from time to time shall be deemed to be part of this Agreement.


6.1. The CCG must make decisions in relation to the management of poorly performing GP practices and including, without limitation, decisions and liaison with the CQC where the CQC has reported non-compliance with standards (but excluding any decisions in relation to the performers list).

6.2. In accordance with paragraph 6.1 above, the CCG must:

6.2.1. ensure regular and effective collaboration with the CQC to ensure that information on general practice is shared and discussed in an appropriate and timely manner;

6.2.2. ensure that any risks identified are managed and escalated where necessary;

6.2.3. respond to CQC assessments of GP practices where improvement is required;

6.2.4. where a GP practice is placed into special measures, lead a quality summit to ensure the development and monitoring of an appropriate improvement plan (including a communications plan and actions to manage primary care resilience in the locality); and

6.2.5. take appropriate contractual action in response to CQC findings.

7. Premises Costs Directions Functions

7.1. The CCG must comply with the Premises Costs Directions and will be responsible for making decisions in relation to the Premises Costs Directions Functions.

7.2. In particular, but without limiting the generality of paragraph 7.1, the CCG shall make decisions concerning:

7.2.1. applications for new payments under the Premises Costs Directions (whether such payments are to be made by way of grants or in respect of recurring premises costs); and

7.2.2. revisions to existing payments being made under the Premises Costs Directions.

7.3. 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 Premises Costs Directions Functions.
7.4. The CCG will comply with any guidance issued by the Secretary of State or NHS England in relation to the Premises Costs Directions, including the Principles of Best Practice, and any other Guidance in relation to the Premises Costs Directions.

7.5. The CCG must work cooperatively with other CCGs to manage premises and strategic estates planning.

7.6. The CCG must liaise where appropriate with NHS Property Services Limited and Community Health Partnerships Limited in relation to the Premises Costs Directions Functions.

Part 2 – Delegated Functions: General Obligations (CCG responsibilities)

1. Introduction

1.1. This Part 2 of Schedule 2 (Delegated Functions) sets out general provisions regarding the carrying out of the Delegated Functions.

2. Planning and reviews

2.1. The CCG is responsible for planning the commissioning of primary medical services.

2.2. The role of the CCG includes:

2.2.1. carrying out primary medical health needs assessments (to be developed by the CCG) to help determine the needs of the local population in the Area;
2.2.2. recommending and implementing changes to meet any unmet primary medical services needs; and
2.2.3. undertaking regular reviews of the primary medical health needs of the local population in the Area.

3. Procurement and New Contracts

3.1. The CCG will make procurement decisions relevant to the exercise of the Delegated Functions and in accordance with the detailed arrangements regarding procurement set out in the procurement protocol issued and updated by NHS England from time to time.

3.2. In discharging its responsibilities set out in clause 6 (Performance of the Delegated Functions) of this Agreement and paragraph 1 of this Schedule 2 (Delegated Functions), the CCG must comply at all times with Law including its obligations set out in the National Health Service (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013/500 and any other relevant statutory provisions. The CCG must have regard to any relevant guidance, particularly Monitor’s guidance Substantive guidance on the Procurement, Patient Choice and Competition Regulations (https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/283505/SubstantiveGuidanceDec2013_0.pdf).

3.3. Where the CCG wishes to develop and offer a locally designed contract, it must ensure that it has consulted with its Local Medical Committee in relation to the proposal and that it can demonstrate that the scheme will:
3.3.1. improve outcomes;
3.3.2. reduce inequalities; and
3.3.3. provide value for money.

4. Integrated working

4.1. The CCG must take an integrated approach to working and co-ordinating with stakeholders including NHS England, Local Professional Networks, local authorities, Healthwatch, acute and community providers, the Local Medical Committee, Public Health England and other stakeholders.

4.2. The CCG must work with NHS England and other CCGs to co-ordinate a common approach to the commissioning of primary medical services generally.

4.3. The CCG and NHS England will work together to coordinate the exercise of their respective performance management functions.

5. Resourcing

5.1. NHS England may, at its discretion provide support or staff to the CCG. NHS England may, when exercising such discretion, take into account, any relevant factors (including without limitation the size of the CCG, the number of Primary Medical Services Contracts held and the need for the Local NHS England Team to continue to deliver the Reserved Functions).
Progress Report from the
Primary Care Commissioning Steering Group
Date of committee: 14th July and 18th August 2017

Key Achievements

- Extension of Primary Care Anti-Coagulation (Warfarin) Service
- **GP Access** – Locality and practice proposals will be in place by 1st October 2017.
- **GP Access** – very good progress being made in developing extended access arrangements for live date of 1st October 2017.
- **QIPP Programme** – Primary Care plan is on track, forecasting an outturn of £1660k Against a plan of £1223k.

<table>
<thead>
<tr>
<th>Issues</th>
<th>Actions</th>
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<tbody>
<tr>
<td>Referrals into Secondary Care must reduce.</td>
<td>Referral Facilitation Team looking at referral trends and visiting practices.</td>
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<tr>
<th>Risks</th>
<th>Actions</th>
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<tbody>
<tr>
<td>Removal of the CHEC referral management Gateway</td>
<td>Effective communications to practices on the use of the Ardens template.</td>
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MINUTES OF THE MEETING

Primary Care Commissioning Steering Group Meeting (JPCSG)

Held on Friday 14th July 2017 – 2pm – Hawthorn House MR1

Present:

Mr David Ainsworth (Chair) Director of Primary Care, Mid Notts CCGs
Mrs Amanda Brown Practice Manager, Newark & Sherwood CCG
Ms Nicola Ryan Practice Manager, Mansfield & Ashfield CCG
Mrs Julie McIntyre Citizens Reference Panel Member
Dr Nigel Marshall Clinical Advisor, Newark & Sherwood CCG
Ms Hazel Taylor Senior Service Development Manager, Mid Notts CCGs
Mrs Ruth Lloyd Head of Corporate Governance, Mid Notts CCGs
Mr Chris Sewell Service Development Manager, Newark & Sherwood CCG
Ms Sue Cox (Minutes) Team Secretary – Primary Care, Newark & Sherwood CCG

No. Item

JPCSG/17/44 Welcome & Introductions
The Chair welcomed members to the meeting and a round of introduction took place.

JPCSG/17/45 Apologies for absence
Apologies were noted from:
Healthwatch, Nottinghamshire

JPCSG/17/46 Declarations of Interest
Mrs Brown and Ms Ryan declared interest as Practice Managers in agenda item JPCSG/17/52. The Chair agreed that with respect to the items on the agenda both parties were permitted to stay for the discussion, and it was noted that the meeting would not be making a decision. No further declarations to those made on the register of interests were made, and this was affirmed as an accurate record.

JPCSG/17/47 Minutes of the last meeting held on 8th June 2017
The minutes were taken as an accurate reflection of discussions.

JPCSG/17/48 Matters arising / outstanding actions
Dr Marshall raised concern that there was very little clinical representation at the meeting, noting that the dates had been changed to allow GPs to attend. It was also noted that no apologies had been received. Mr Ainsworth noted the concern raised.

JPCSG/17/49 Forward Plan
The Chair requested that the next meeting concentrate on approaches to support reduction of referrals into secondary care. It was agreed to invite the Referral Team to the next meeting in August 2017 for them to present a report on themes and key points that the team have addressed at recent practice visits.
**Action:** Sue Cox to invite Stephen Wormall and Katie Jordan to the next meeting to present an update on referrals following recent practice visits.

**JPCSG/17/50 Feedback from the Joint Primary Care Commissioning Committee (JPCCC) of 13 July 2017**
The Terms of Reference for the Joint Primary Care Commissioning Committee had been approved in principle, but a further paragraph needed to be added which Mrs Lloyd had agreed to address.

**Action:** Mrs Lloyd to update Terms of Reference of JPCCC.

**JPCSG/17/51 Local Digital Roadmap and Primary Care elements.**
Due to Mr Andy Evans being unable to attend the meeting, the item was deferred until the September 2017 meeting.

**Action:** Sue Cox to add to agenda for the September 2017 meeting, and ensure that this invitation was extended to Andy Evans.

**JPCSG/17/52 GP Access – Implementation**
The government’s mandate to NHS England (NHSE) sets down the purpose of extending GP Access to ensure equity of access for GP services, including the provision of appointments at evenings and weekends.

Locally, the Mid Nottinghamshire CCGs have embarked on an ambitious Primary Care Transformation Programme which will deliver services to patients based on a model of placed based care. Central to this offer is the collaboration of GP practices to deliver services to patients improving population coverage and reducing variation.

Mr Ainsworth reported that by October 2017, 100% of the population in mid Nottinghamshire will have access to extended hours services, with most of the practices offering appointments from 8am – 8pm cover Monday to Friday and also access on a Saturday morning. Mr Ainsworth noted that this will consist of a mixture of both pre-bookable and bookable on the day appointments with both GPs and Nurses as per the national criteria.

Locality and practice proposals are:
- Mansfield North – Service run by PICS (Orchard Medical Practice going alone)
- Mansfield South – All practices running and working together (Forest Medical Practice going alone)
- Newark – All practices working together, plan to work into Newark Hospital model. In a central Primary Care Hub.
- Sherwood – Locality approach, though one practice currently excluded and the CCG and LMC meeting to broker a deal.
- Ashfield South – Service already mobilised.
- Ashfield North – Locality approach.

Mrs McIntyre raised concern on the sharing of patient records and Mr Ainsworth reported that PICS will report and record on behalf of all practices using SystmOne. Information sharing agreements are being addressed by Mark Yates and Andy Evans (Connected Notts).
A discussion took place around communicating GP Access to the public, and the need for community Pharmacists to stay open longer. It was agreed that a communications meeting would be arranged to develop an action plan to be approved by Mr Ainsworth.

**Action:** Sue Cox to ensure that a meeting is arranged with Sally Dore and Mr Ainsworth to create an action plan on communicating GP Access to the public. Mrs McIntyre to also be invited to the meeting.

**JPCSG/17/53 Extension of Primary Care Anti-Coagulation (Warfarin) Service**

Mr Sewell reported that the extension to the current Primary Care Anti-Coagulation (Warfarin) service was addressed at the Joint Primary Care Commissioning Committee on 13th July 2017.

Mr Sewell outlined that the recommendation had been that the extension of the current service will provide a comprehensive service to monitor all patients in a primary care setting. The service will provide INR monitoring for patients receiving Warfarin treatment and allow safe alteration in medication doses accordingly. Current activity suggests that approximately 27.75% of patients are monitored in primary care by GP practices.

Mr Sewell outlined that the development of the service for the remaining 72.25%, delivered by secondary care would be provided in the majority in a primary care setting through expansion of testing provision within GP practices.

The aim of the proposal is to transfer all eligible patients into the community setting with phlebotomy, interpretation and dosing covered wholly by primary care.

Mr Ainsworth stated that this service was very good for patients, as it reduced the overall time taken for results to be accessed, and gave a more streamlined service. Mr Sewell reported that an action plan is being followed by all practices.

**JPCSG/17/54 GP Forward View – Position as at June 2017**

Ms Taylor reported that during 2016/17 using information provided by practices who met the national criteria, a schedule of investment was agreed with NHSE. Funding was confirmed and transferred across to the CCGs at the end of February 2017. A programme is in place as an intention with many different providers delivering different elements of GP Resilience. Delivery was noted to be on-going for the 20 practices selected in 2016/17.

NHSE requested that CCGs submit a plan for GP Resilience funding in 2017/18, and direct contact was made with practices to affirm that they could self-refer into this process. All practices were scored using the national criteria with the outcome being that a total 22 practices across mid Nottinghamshire undertaking the application process. The CCGs are now awaiting a response.

Funding available is understood to be £44,000 for mid Nottinghamshire, £10,000 has been allocated for specialist support. The CCG is looking at practices that have an immediate need for funding in support of prioritisation.

The Chair thanked Ms Taylor for her update, and this was noted within the meeting.
Primary Care Commissioning Risk Register

Mr Ainsworth reported that actions on the risk register now have a timescale and an owner. The Joint Primary Care Commissioning Committee have asked that a clear connection is made between the identified gaps and the mitigating actions undertaken.

A discussion took place regarding the risks around the removal of the CHEC referral management Gateway. Mr Ainsworth noted that this would be supported by effective communication of the use of the Ardens templates. Mr Ainsworth noted that the communication regarding CHEC would be sent out to all practices on or around 17th July 2017.

Any Other Business

Mrs McIntyre raised the issue of some meeting papers being inaccurately produced, and cited issues with the use of Logos, and inconsistencies in referring to the CCG / CCGs / mid Nottinghamshire CCGs.

Ms McIntyre noted that the CCG may have a risk for the continued development of Lay members, where terms of office were to conclude. Mrs Lloyd agreed to discuss matter outside of the meeting with Mrs McIntyre.

Mr Ainsworth formally thanked Ms Taylor for all her hard work within the Primary Care Team. Ms Taylor leaves her role within the CCG at the end of July 2017.

Date & Time of Next Meeting

Friday 18 August 2017 – 9am – Birch House, MR3

Action Log

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<thead>
<tr>
<th>Ref</th>
<th>Action</th>
<th>By Whom</th>
<th>Outcome</th>
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<tbody>
<tr>
<td>JPCSG/17/50</td>
<td>Terms of Reference to be updated.</td>
<td>Ruth Lloyd</td>
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<tr>
<td>JPCSG/17/50</td>
<td>Stephen Wormall to be invited to the August meeting to present an update on referrals following recent practice visits.</td>
<td>Sue Cox</td>
<td>SW unable to make meeting but Chris Sewell and Steph Hart will attend.</td>
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<tr>
<td>JPCSG/17/51</td>
<td>Andy Evans to be invited to attend the September meeting to discuss Local Digital Roadmap and primary care elements.</td>
<td>Sue Cox</td>
<td></td>
</tr>
<tr>
<td>JPCSG/17/52</td>
<td>A meeting to be arranged between David Ainsworth, Sally Dore and Julie McIntyre to create an action plan on communicating GP Access to the public.</td>
<td>Sue Cox</td>
<td>Work being addressed by Julie Andrews and Mark Yates so meeting not now required.</td>
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# MINUTES OF THE MEETING

## Primary Care Commissioning Steering Group Meeting (JPCSG)

**Held on Friday 18th August 2017 – 2pm – Birch House MR3**

### Present:

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<th>Item</th>
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| JPCSG/17/57 | Welcome & Introductions  
The Chair welcomed members to the meeting and a round of introductions took place. |
| JPCSG/17/58 | Apologies for absence  
Apologies were noted from:  
Healthwatch, Nottinghamshire  
Ms Nicola Ryan  
Dr Nigel Marshall  
Mr Marcus Pratt |
| JPCSG/17/59 | Declarations of Interest  
No further declarations to those made on the register of interests were made, and this was affirmed as an accurate record.  
A discussion took place around communicating GP Access to the public, especially appointments available to be booked ‘on-line’. Plain, simple and clear messaging is needed advising patients not to go to A&E but go and see you GP. Generic posters and signs are needed in all GP practices along with information in local publications. Late pharmacy opening rotas must be more available for patients to see. NHSE are due to provide branding information. Mr Ainsworth requested that a communications plan be with him by 25th August 2017, to then be followed by a mobilisation meeting. |
| JPCSG/17/60 | Minutes of the last meeting held on 14th July 2017  
The minutes were taken as an accurate reflection of discussions. |
Approaches to support the reduction of referrals into secondary care

- Update from referral management team

Mr Ainsworth spoke of the need to reduce referrals into secondary care. A Demand Management Centre has been established, with a referral facilitation team looking at referral trends daily, weekly and monthly. Data shows that low referral practices are not always a good thing, and high referral practices are not always a bad thing. 50% of referrals made are not from GPs. Mid Notts CCGs have a target to reduce referrals by 5%, and year to date we have achieved 9%.

Mrs Quinn reported that all clinical pathways, guidance, audits and templates have been refreshed. Extra practice visits have been made to all high referring practices and all practice packs have been updated. The majority of referrals are receiving peer review from another GP. Peer to Peer review is part of the Best Practice Scheme, and not all practices are aware of this. The Steering Group agreed that this information must be made aware to all practices by PLT event.

Ms Brown reported that the dashboard was not always easy to understand, and can be very complicated. Practices need to understand and realise what the figures on the dashboard mean.

Following discussion it was agreed to target the referrals from the following specialties to see if they were appropriate:-

- Neurology
- Cardiology
- Urology
- ENT
- Gynaecology

Mrs Quinn advised that all Ophthalmology referrals are being triaged by Health Harmonie.

Transformation Support Funding

A paper was presented by Ms Longden.

Transformational support 2017/18 and 2018/19 - CCGs should plan to spend a total of £3 per head as a one off non-recurrent investment commencing in 2017/18 for practice transformation support. This equates to a £171m non-recurrent investment. The investment for Mid Notts CCGs will commence in 2018/19. The investment is to be used to stimulate development of at scale providers for improved access and secure sustainability of general practice.

Mid Notts CCGs have chosen to focus non-recurrent investment into 2018/19 with rationale that Vanguard funding will cease in March 2018 and that the additional funding would facilitate the extension of schemes that have been running for a short period and where full evaluation was not yet possible.

The Steering Group were asked to make recommendations as to how the monies should be spent to deliver the maximum value for money in primary care. Mr Sewell spoke of a key priority being picking up the bill in year two for Ardens. Ms McIntyre spoke of using some for the re-education of patients and changing habits on using the NHS. Mrs Brown asked if some of the funding could be used for practices to find out what is available within the NHS to help with patients who
suffer from heavy alcohol usage and mental health problems.

The Steering Group agreed that the following areas would be taken forward:-

- Patient education
- Signposting
- Children’s Services
- Workforce
- Products and services

JPCSG/17/63  Primary Care Vanguard and GP Forward View update

A paper was presented by Ms Longden.

GP Access – Practices are making very good progress in developing extended access arrangements to go live by 1st October 2017. Extended access will be delivered on a locality basis (except Orchard Medical Practice who are working alone).

The QIPP programme for primary care is on track. The plan has delivered £770k against a plan of £322k, and is forecasting an outturn of £1660k against a plan of £1,223k.

Practice Manager training monies of around £4k are available and suggestions are needed on the best way to use the money. Mr Ainsworth suggested an engagement event dedicated to Practice Managers, possibly to be held one evening.

JPCSG/17/64  IMT update including summary on printer project

A paper and highlight report was presented by Ms Longden.

There are seven IT primary care projects currently being overseen by NHIS:-

- Electronic Prescription Service
- GP IT refresh (wifi infrastructure and PC monitors)
- GP server refresh
- SystmOne in Care Homes
- Patient online access
- GP mobile working
- GP printer refresh

Ms Longden advised that all monitors have been procured. All practices will be receiving what they requested, and roll-out will be during September 2017. The printer refresh has commenced. A project board has been created to investigate the current printing estate. NHIS has engaged with GO practices and gained user comments on what would be expected of a printing solution.

Mr Ainsworth asked if the highlight report could include a benefits realisation plan along with KPIs. Ms Longden spoke of the need to link in with Connective Notts to help with all strategic plans for the county.

**Action:** Ms Longden to continue to work on the IMT issues and provide a regular update to the Steering Group.
Mr Ainsworth reported that the General Practice Forward View (GPFV) makes a commitment to help every GP practice that is a tenant in an NHS Property Services or Community Health Partnerships building to enter into a new lease.

An offer is available up until the end of November 2017 that includes reimbursement of stamp duty land tax for the initial term, up to 15 years, contribution of up to £1,000 plus VAT of legal fees related to the lease transaction, and reimbursement of management fees for the financial year 2016/17 and 2017/18. Mr Ainsworth was unsure as to whether the scheme had been picked up locally by the CCG or NHSE.

**Action:** Ms Riddell and Ms Longden to pick up if NHSE or CCG are leading on lease reimbursement scheme.

Ms Ahmad advised of an event being held in Newark on Tuesday 19th September 2017 around Vanguard. The Primary Care team will be having a table, and questions and answers will be led by Mr David Ainsworth and Mrs Stephanie Haslam on the day.

The NHS is 70 years old, and the Steering Group were asked to think of any ideas to help support this milestone.

Ms McIntyre asked how patients could self-refer into Physio via the MSK pathway. Mr Ainsworth advised that a soft launch is due to start, and a full progress report on the pathway is required.

**Identification of:**
**Advice / recommendations to the Joint Primary Care Commissioning Committee**
- Helpful conversation on GP Access – on line access on track for October 2017.
- Helpful conversation on Referral Management.
- Discussed £3 per head.
- Noted progress on GP Forward View.
- Helpful IM&T update.

**Date & Time of Next Meeting**
Friday 22nd September 2017 – 9.15am - Birch House, MR3
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<td>JPCSG/17/51</td>
<td>Andy Evans to be invited to attend the September meeting to discuss Local Digital Roadmap and primary care elements.</td>
<td>Sue Cox</td>
<td>Andy Evans is out of office until early September 2017.</td>
</tr>
<tr>
<td>JPCSG/17/64</td>
<td>To continue to work with IMT issues and provide regular updates to the Steering Group.</td>
<td>Paula Longden</td>
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<tr>
<td>JPCSG/17/65</td>
<td>To pick up if NHSE or CCG are leading on lease reimbursement scheme.</td>
<td>Jo Riddell</td>
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<td>and Paula Longden</td>
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Progress report from the Primary Care Delivery Board

Date of committee: 26th July 2017

### Key Achievements

As this was the inaugural meeting of the Primary Care Delivery Board, the Terms of Reference and future remit of the Group was discussed with a view to final sign off at the meeting scheduled to take place on 30th August 2017.

Progress reports for the following work streams were provided; Primary Care, Prescribing and Urgent and Proactive Care. The Primary Care Team were congratulated in recognition of the outstanding progress being made.

The Delivery Board agreed that further work around horizon scanning and Headroom schemes should take place. This will be an standing agenda item at all future meetings.

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<th>Issues</th>
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<td>No issues to raise</td>
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| No additional risks identified | |

Page 1 of 1
Primary Care Delivery Board
Minutes from the meeting held on Wednesday 26th July 2017,
Meeting Room 1, Hawthorn House, Mansfield, Notts, NG21 0HJ.

Present: David Ainsworth (DA), Director of Primary Care – Mid Notts CCG’s (Chair)
Eleri de Gilbert (EDG), Lay Representative
Paula Longden (PL), Primary Care Programme Manager
Annie Tasker (AT), Primary Care Quality and Safety Manager
Rosa Waddingham (RW), Head of Quality and Adult Safeguarding
Julie Shortland (JS), Senior Information Analyst
Joanne Riddell (JR), Primary Care Performance and Development Manager
Mark Yates (MY), Primary Care Performance and Development Manager
Stephanie Haslam (SH), Primary Care Performance and Development Manager
Cathy Quinn (CQ), Clinical Lead - Pharmacy and Prescribing Transformation

Apologies: Jacqui Kemp (JK), Primary Care Performance and Development Manager
Chris Sewell (CS), Primary Care Performance and Development Manager
Hazel Taylor (HT), Senior Primary Care Performance and Development Manager
Dr Nigel Marshall (NM), Clinical Advisor
Marcus Pratt (MP), Associate Chief Finance Officer
Alison Hale (AH), Prescribing Advisor
Peter Richards (PR), Prescribing Advisor

In attendance: Alison Pipes (AP), PA to the Director of Primary Care – Mid Notts CCG’s/PLT Administrator (Secretariat)

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<th>Ref</th>
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<tr>
<td>PCPB1</td>
<td>Welcome, introductions and apologies</td>
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<td></td>
<td>David Ainsworth welcomed members of the Primary Care Delivery Board to the inaugural meeting and introductions were made.</td>
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<td></td>
<td>David provided the context to the meeting, explaining that as the Mid Notts CCG’s are in financial turnaround, and following on from the Deloitte’s review recommendations, it has become necessary to align work streams to the QIPP infrastructure, to strengthen governance reporting. Each work stream will have its own Delivery Board which reports into the Financial Recovery Group (FRG). It should be noted however, as Primary Care and Prescribing are non-alliance delivery boards, they are exempt from risk sharing arrangements.</td>
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<th>PCPB2</th>
<th>Conflicts of Interest</th>
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<tr>
<td></td>
<td>David Ainsworth reminded members of the meeting of their...</td>
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obligation to declare any interests they may have on any issues arising which might conflict with business.

Declarations declared by members of the Delivery Board are listed in the CCG’s Register of Interests. The Register is available upon request from the CCG’s Corporate Governance Team.

There were no declarations of interest from today’s meeting to record.

### PCPB3 Terms of Reference

David Ainsworth directed members of the Delivery Board to page 6 of the Terms of reference supplied. These will be the foundations for the Primary Care Delivery Board’s Terms of Reference. It should be noted that there is a need to change the name of this meeting (formally Primary Care Programme Board) to the Primary Care Delivery Board going forward.

**Membership**

The membership of the Primary Care Delivery Board will consist of;

- Executive Sponsor, Director of Primary Care – Mid Notts CCG’s, who will act as chair of the meeting.
  **Action:** Deputy Chair to be appointed.
- CFO Sponsor, role not required, however financial representation is needed at all meetings. This should be from either the Associate Chief Finance Officer or a nominated deputy.
  **Action:** Delivery Board Secretariat to ensure finance representation at all future meetings.
- Clinical Sponsor, work stream Clinical Lead to be invited to all future meetings.
  **Action:** Work stream Clinical Lead to be invited to all future meetings.
- Senior Responsible Officer (SRO), Primary Care Programme Manager for Primary Care and the Clinical Lead - Pharmacy and Prescribing Transformation for Prescribing.
- Organisational Leads, these are the individual programme leads. Programme Leads will only be required to attend meetings as when directed to do so by the SRO’s.
- Quality and Governance, representation is needed from the Primary Care Quality and Safety Manager or a nominated deputy. This should be reflected in the Terms of Reference going forward.
- Lay Representation, this role is critical to the Delivery Board to ensure external rigor and challenge is provided against programmes and will provide a link to the Quality and Risk Committee.
- Other members should include support from the Senior Information Analyst or a nominated deputy. This role is to supply up-to-date business intelligence.
As the Primary Care work stream has links to both the Elective and Urgent and Proactive work streams, representation will be sought on a needs basis.

**Governance and Report**
The Primary Care Delivery Board will, in addition to reporting to the Financial Recovery Group (FRG), report to the Primary Care Commissioning Committee (PCCC). This should be reflected in the Terms of Reference.

**Action:** Alison Pipes to amend the Terms of Reference as appropriate and ensure that the Work stream Clinical Lead is invited to all future meetings.

### PCPB4 Urgent and Proactive, Primary Care Hub and Best Practice Scheme – Work Programme Updates.

Prior to discussing this item, and items PCPB5 and PCPB6, Paula Longden wished to draw members’ attention to the Integrated Finance Report for month 3, which was forwarded under separate cover. The report provides an overview of all work stream financial activity (page 1) followed by programme summaries for all work streams (page 2 onwards). This document will provide the basis for discussions around schemes rated as ‘Red’ or ‘Amber’ at future meetings.

Paula advised that although in the Urgent and Proactive work stream, David Ainsworth is SRO for the following 2 schemes, which are forecasting as on track but to date are under delivering and are rated as ‘Red’.

- **Local Admission Avoidance (Best Practice Scheme)**
  Scheme under delivering against original plan. Reduction in forecast signed off through change control at FRG. Year 2 Scheme drafted to mitigate under delivery. Scheme will be discussed at PCCC in August 2017, with a view to start delivering in September 2017. The plan is to mandate its uptake through member agreement.

- **New Primary Care Model (Hubs)**
  Project highlighted as ‘Red’ for finance under delivery. Stephanie Haslam, Primary Care Performance and Delivery Manager provided assurance on actions being taken to ensure Acute Home Visiting service delivery. Contract discussions with providers have focussed on: number of visits per shift, appropriate referrals, avoided NELs. The Acute Home Visiting Service started in March/April 2017 and is now fully staffed.

Stephanie Haslam advised that caution should be applied as there is only 2 months data available.
### Nurse Treatment Room future provider being sought.

Vanguard funding only available until March 2018. Local Partnerships covering the service at present, however we are investigating solutions with NEMS and SFHT.

**Action:** Acute Home Visiting Service Performance Scorecard to be brought to the next meeting (appended to PMO Update).

**JS**

### Primary Care Work Programme Updates

David Ainsworth congratulated the work of the Primary Care/Prescribing Team in recognition of the outstanding progress being made in support of the schemes rated as ‘Green’.

The only ‘Red’ relates to EHS Reviews (Cardiology and Near Patient Testing) due to delays in starting the project. September 2017 for Cardiology and October 2017 for Near Patient Testing. Wider roll out will be brought forward to mitigate the financial risk.

Community ENT, GP Access and Ardens will start to appear as headroom schemes.

Referral Management is now listed as a Primary Care scheme and not an Elective scheme.

### Prescribing Work Programme Updates

Cathy Quinn advised that she is working with Finance to ascertain why there are 2 schemes listed for High Cost Drugs. For both schemes, Ian Ellis, Director of Contracting and Urgent Care is listed as the SRO but the schemes sit within Primary Care.

Cathy highlighted that medicine costs have decreased, which have not been included in the savings calculations despite agreement that they would be part of the plan (windfall savings). Discussions ensued as to why Finance is not recording all savings. Cathy queried whether High Cost Drugs should be escalated to FRG to ascertain why there are 2 projects listed and whether ‘windfall’ costs should be incorporated. If windfall costs are not to be included the target needs to be adjusted.

**Action:** Cathy Quinn to work with Coral Osborn in respect of Finance issues and advise FRG of their recommendations.

**CQ**

Paula Longden queried whether the 2 projects fit better with the Elective work streams, to which the Delivery Board agreed.

**Action:** Cathy Quinn to enact the change process.

**CQ**

### Risks and Issues

The Delivery Board agreed that a Risk Log is needed for escalation.
Ref | Item | Action
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|  | and should include information on finance and milestones. **Action:** Paula Longden/Alison Pipes to create a Risk Log in readiness for the August meeting. | PL/AP

Paula Longden highlighted the current risks as;
- Acute Home Visiting – Mitigating actions in place.
- High Cost Drugs – Mitigating actions in place.
- Operational/Implementation of GP Access – Month 4 update needed.
- Diabetes Hypo Pathway – Right Care Diabetes will help with this.
- Community ENT Delay – Roll Out needs to be earlier and have a broader footprint.
- Arden’s – Funded until the end of May 2018. Consideration should be given in respect of payments after this date.
- Health Optimisation and Consultant Connect – Delivery Board needs to be aware of these projects. Information should be provided in respect of unblocking/openness.
- Single Front Door/Streaming (Newark) – David Ainsworth is the SRO, however these are classed as Urgent and Proactive. Clarity is needed to understand the QIPP deliverables. Is Lucy Dadge leading or is Primary Care leading as a headroom scheme, as much of Stephanie Haslam’s work will be missed?

PCPB8 | Horizon Scanning and Headroom Schemes | Programme Leads

Item discussed under item PCPB5 – Primary Care Work Programme Update. **Action:** Timescales and values to be added for discussion at the August meeting. Programme Leads to action.

PCPB9 | Meeting Actions and Issues to be escalated to the Primary Care Commissioning Committee and Financial Recovery Group. | AP

Alison Pipes to action following today’s discussions (please refer to the accompanying action log).

PCPB10 | Date, time and Venue of the next meeting | 

The next scheduled meeting will take place on Wednesday 30th August 2017, 12noon – 1.30pm, Meeting Room 1, Hawthorn House, Mansfield.
The primary care programme encompasses the GP Forward View, the national Vanguard, and QIPP. This report updates the Committee on progress against the GP Forward View and Vanguard plus the performance and delivery of the QIPP plan.

The primary care project managers continue to work hard on the primary care programmes, implementing GP Forward View priorities, Vanguard projects and other QIPP to deliver service improvement and financial benefits.

Key project achievements since the previous report are:

- GP access locality development and contracting is progressing well with locality arrangements now agreed and mobilising for Ashfield North, Mansfield North, Mansfield South and Sherwood. Forest Medical is now working with Mansfield South locality resulting in only one large practice not delivering the extended access on a locality basis.
- Roll out and go live of the Year 2 Best Practice Scheme.
- QIPP delivery is on track - overall the primary care programme has delivered £770k delivered against £322k plan and is forecasting an outturn of £1,660k against £1,223k
plan. This is predominantly due to over delivery in the referral management project. 

Key risks to the programme are:

- GP access mobilisation by 1 October in Newark locality due to workforce challenges. This is being mitigated through a direct award solution.
- Delays to implementing the treatment room including wound care. A solution is being design to respond to the immediate needs of patients and practices through primary care.

**REPORT:**

The primary care programme encompasses the GP Forward View, the national Vanguard, and QIPP. This report updates the Committee on Vanguard progress and the performance and delivery of the QIPP plan.

The Primary Care team has a substantial challenge in 2017/18 both in terms of delivery of key service improvement plans and achievement of the QIPP target. The Director of Primary Care is the lead director for the primary care programme, which has a QIPP target of £3.3m, and is senior responsible officer (SRO) for a further £2.4m of primary care led QIPP projects within other programmes.

This report provides an update on progress in developing the Vanguard project and delivering the forecast financial benefits.

**GP Forward View**

The GP Forward View progress is summarised at Appendix 1, which covers all open areas at this stage. Key developments in month are as follows.

**GP Access**

The CCGs have identified providers for all localities.

Practices are making good progress in developing extended access arrangements to achieve go live by 1 October 2017. Appendix 2 provides a summary by locality.

Extended access is to be delivered on a locality basis for all practices with one exception, Orchard Medical Practice. This strengthens the localities’ provision and provides increased stability and sustainability.

South Ashfield and Orchard Medical Practice are live.

All remaining localities have now submitted proposals in line with the agreed CCG approach - these have been reviewed by contracting, finance and quality. A timeframe for mobilisation is in place and financial plans have been revised. Proposals submitted have since been signed off by PCCC.

Mediation within the Sherwood locality was unsuccessful and therefore a further expression of interest process had to be undertaken. This has now concluded, a provider has been identified (two large local practices) and the service is mobilising.

Newark locality submitted an Expression of Interest through PICS which was accepted by the CCG. However, it subsequently indicated that it would be unable to adhere to the mobilisation date of 1 October 2017. The project manager sought solutions with PICS to enable the locality solution to continue. However this was unsuccessful and the CCG is now proceeding with a direct award to a provider with a track record of delivering primary care across a locality area that can mobilise with the timeframe.

NHSE has mandated the use of APMS agreements for contracting the extended access. The CCGs have commissioned legal advisers, Browne Jacobson, to provide legal support to ensure that the contract is accurate and reflects all relevant legislation. They will conclude their review during the week commencing 11 September.

**Estates and Technology Transformation Fund (ETTF)**

The key projects funded from the ETTF are progressing well:

- Ashfield, Newark Vanguard South and Balderton have all received funding for initial stages of business case development with contractors employed using the Strategic Partnership
Agreement for procurement.
- Pre-contract meeting was held on the 17th August for Newark Vanguard South and Balderton with contractors and wider stakeholders incl. Fountain GPs, Sherwood Forest, Notts Healthcare and Local Authority.
- The Ashfield proposal developed and is currently being discussed further with wider stakeholders incl. Notts Healthcare, Local Authority and Sherwood Forest.

Workforce
The CCGs submitted an application for additional funding for international GP recruitment, which has now been approved.

Vanguard New Models of Care and QIPP
The Primary Care team has a substantial challenge in 2017/18 to:
- deliver key service improvement plans, in particular the new models of care Vanguard for which funding is available until March 2018; and
- achievement of the QIPP target.

The primary care programme summary, excluding prescribing, is shown at Appendix 3. Appendix 4 is an extract from the integrated performance report showing the QIPP performance at Month 4 for primary care and prescribing and the two urgent and proactive projects.

The Director of Primary Care is the lead director for the primary care programme, which has a QIPP target of £1.3m (excluding prescribing), and is senior responsible officer (SRO) for a further £2.4m of primary care led QIPP projects within other programmes.

Overall the primary care programme is on track both year to date (£770k delivered against £322k plan) and forecast outturn (£1,660k forecast outturn against £1,223k plan) predominantly due to over delivery in the referral management project. Three primary care projects are rated amber or red: diabetes, primary care – LES and EHS reviews. Two urgent and proactive care projects are rated as red: Best Practice Scheme and Primary Care hubs.

Vanguard Primary Care Hubs
Acute Home Visiting Service
The acute home visiting service in the Ashfield and Newark hubs has now been operating for four months. The QIPP performance to date suggests that it is off plan but the high level scorecard (see attached at Appendix 5) presents a more positive picture against the control areas.

The project team have agreed a number of actions to ensure that the activity / savings are fully understood and that relevant providers actions are taken:
- Exercise to compare and contrast the two providers’ service delivery and performance
- Map utilisation to NEL admissions by practice
- Detailed review of service with providers, adhering to agreed criteria
- Comparison of specific relevant specialities (falls, UTIs and chest infections) by locality, comparing those with the AHVS to those without.
- Review methodology for savings to ensure appropriate to the service.

To mitigate the apparent below plan performance the project manager and contracting manager are following up contractual discussions for providers to:
- Increase the number of daily visits per FTE nurse in line with the specification.
- Review approach to clinical risk.
- Respond to matters arising from Q1 data evaluation and GP survey monkey.

The project team’s focus in September is concluding the formal Q1 evaluation, which will further inform performance. To facilitate this the following is being prepared:
- Detailed evaluation from the providers of Q1 performance
- GP questionnaire issued through survey monkey and results being collated
Patient survey and stories being collated by providers

The service has also received much anecdotal positive feedback from general practice and the providers.

**Treatment Room**

The contracting of the treatment room including the wound care, which was approved at July's PCCC, has hit a number of delays including the challenge of timely workforce recruitment and insecurity of funding (only until March 2018). This has also delayed delivery of the benefits.

The project team is acutely aware of the urgent nature of finding and implementing a solution. One large Newark practice has already written to the CCG confirming that they will no longer undertake post-operative wound care without funding and we have had indications from other practices that they are considering taking some action to reduce workload.

An urgent paper was presented to Financial Recovery Group on 15 August which prompted a quality review of the wound care service to understand the activity split between core and non core work. Using this data the project manager is now looking to commission locality based, primary care led wound care services through an enhanced service contract.

**GP Chambers**

PICS has yet to fully complete its set up of the GP Chambers. One GP has formally signed up.

**Best Practice Scheme (BPS)**

The 2017/18 performance of the BPS is behind plan. The Year 1 scheme has now concluded and practices have been informed of their performance.

To mitigate the shortfall in savings a Year 2 scheme has been developed. Following consultation, the scheme has been finalised and approved by PCCC in August. Mobilisation and roll out has commenced.

The communications plan is included at Appendix 6.

**Place-based whole population services**

Cardiology and near patient testing (D2.6 and H1.4) and showing as amber and red due to below plan year to date position. The forecast outturn remains on track due to a refreshed faster time frame for mobilisation.

- The cardiology provider has concluded the training and the service goes live week commencing 4 September.
- Near patient testing procurement is in progress. Our procurement provider, Arden and GEM CSU, made an error in the invitation to tender and the process had to be restarted. This has generated a delay of two weeks. Evaluation of the tenders will take place week commencing 18 September with mobilisation during October. Forecast savings are unaffected due to the planned faster roll out across the patch.

**Diabetes**

Diabetes is showing as behind plan. The diabetes programme is wide ranging with three live components: hypo pathway, Ardens and the National Diabetes Prevention Programme. The CCG Clinical Lead has been formally appointed across Mid Notts and a new project manager has been appointed.

Month 3 diabetes activity data (received at month 4) is not positive however practices are being very active in referring patients to the NDPP. Investigations around the hypo pathway have identified ways of streamlining the pathway and these are being implemented. The project manager has prepared a detailed action plan for the project team to follow to ensure that the annual plan is achieved.

**Referral management and Ardens decision support tool**

The referral management project is currently green and is significantly over performing at Month 4. Its work is complemented by Ardens and all practices are now active on the decision support tool and intensive support is being provided by the referral facilitation team, in particular our clinical adviser. The localisation of Ardens is on track.

**Appendices**:
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<tbody>
<tr>
<td>1.</td>
<td>GPFV update</td>
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<td>2.</td>
<td>GP access summary of progress</td>
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<td>3.</td>
<td>PMO programme updates</td>
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<td>4.</td>
<td>Programme QIPP update</td>
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<td>5.</td>
<td>Acute home visiting scorecard</td>
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<tr>
<td>6.</td>
<td>Best Practice Scheme communications plan</td>
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</tbody>
</table>

**QIPP Assurance and connection**

A key part of the Vanguard plan is to deliver sustainable service improvement and financial benefits. The primary care programme is forecast to deliver against the plan.

**Financial Impact and Risks**

The primary care programme is currently forecasting that overall the total planned QIPP will be delivered and planned costs will be incurred.

**Legal Impact**

No significant issues to report

**Risk Implications, Assessment and Mitigations**

There are risks around the administrative and clinical capacity in the referral management team due to the refusal to fund the analyst and the departure of the part-time clinical adviser. The team are looking to reprioritise and redistribute work however the departure of the Senior Primary Care Manager will exacerbate this capacity risk.

**Consultation, Involvement and Engagement**

No significant issues to report

**Equality Impact**

No significant issues to report

**Evidence and Research (include where this informs why the paper is presented to Governing Bodies)**

No significant issues to report

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**HOW DOES THIS CONTRIBUTE TO THE OUTCOMES AND OBJECTIVES OF THE CCG:**

- [ ] Quality
- [ ] Health
- [x] Financial
- [x] Clinical
- [x] Performance (tick as appropriate)

---

**CONFLICTS OF INTEREST:**

This is a recommended action to be agreed by the Chair at the beginning of the item.

- [x] No conflict identified
- [ ] Conflict noted, conflicted party can participate in discussion but not decision (see below)
- [ ] Conflict noted, conflicted party can remain but not participate (see below)
- [ ] Conflicted party is excluded from discussion (see below)
Please state rationale for decision

Advice regarding conflicts of interest is available from the Corporate Governance Team, or here:


CONFIDENTIALITY:

Is the information in this paper confidential?

☐ Yes

If the paper is considered confidential, please tick the relevant box.

☐ Does it contain personal information e.g. regarding a patient, member of staff or another individual?

☐ Is the CCG in commercial negotiations or about to enter into a procurement exercise and would the information in the report prejudice the CCG’s position if made public e.g. by declaring the budget available for a particular contract in advance of a tendering exercise or indicating what the CCG’s fall-back position might be in a negotiation situation?

☐ Does the report include commercial in confidence information about a third party? - this would need to be relatively detailed information which could be argued to give a competitor an advantage if it was made available to them i.e. the total value of a contract awarded to a supplier or the value of a tender could not be considered commercial in confidence but details of how a supplier performs a particular process or the day rate for different grades of consultancy staff might be considered confidential.

☐ Does the report contain information which has been provided to the CCG in confidence by a third party and is there a risk that the third party could take legal action for a breach of confidence if it was disclosed?

☐ Does the discussion relate to policy development not yet formalised by the organisation and if the discussion were made public would this hamper full and frank discussion and therefore adequate consideration and development of proposal? This is intended for matters that are considered at a Board meeting early in the process to obtain initial thoughts and to give officers a steer in developing the policy. It would not be appropriate to use this argument where the governing body is being asked to approve a policy or initiative as this would be too late to argue that policy development was still on-going.

☐ Has the document/report been produced by another public body which has chosen not to make the document publicly available and would not wish the CCG to do so?

☐ Is the document in draft form which will publically available at a future date?

Note: Upon request for the release of a paper deemed confidential, under Section 36 of the Freedom of
Information Act 2000, parts or all of the paper will be considered for release by the CCG’s ‘Qualified Person’ based on the circumstances at that time.
Appendix 1: GP Forward View update: summary of schemes released

Introduction

The General Practice Forward View (GPFV) was published in April 2016 and sets out a plan with significant investment to support and transform general practice. The NHS Operational Planning and Contracting Guidance requires CCGs to submit one GPFV plan to NHS England by 23 December 2016 encompassing specific areas outlined in the GPFV. Plans must reflect local circumstances and as a minimum set out:

- How access to general practice will be improved
- How funds for practice transformational support will be created and deployed to support general practice
- How ring-fenced funding being devolved to CCGs to support the training of care navigators and medical assistants, and stimulate the use of online consultations, will be deployed

NHS England have carried out a number of roadshows to engage with organisations in the purpose of the GPFV over the summer and to ensure organisations are prepared for the roll out of schemes. The events informed audiences that there are 82 schemes contained within the national GP Forward View Programme. A schedule has being complied below with local plans and progressed outlined against each live project.

The following table provides an overview of the progress against the workstreams currently live in the GP Forward View.

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<tr>
<th>Scheme</th>
<th>Funding (£)</th>
<th>Summary of project</th>
<th>Lead Organisation</th>
<th>Actions since last update</th>
<th>Next steps</th>
<th>CCG Responsible Officers</th>
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<tr>
<td>GP access fund (formerly PMCF)</td>
<td>£6 per head of weighted population</td>
<td>Deliver increased GP access in line with the GPFV criteria and timeframe. In summary the criteria are: 1. Seven day services – range of appointments including weekdays after 6.30pm and during</td>
<td>CCG reporting to NHS England on progress</td>
<td>Final operational and contractual actions taken for mobilisation of GP access arrangements: South Ashfield and Orchard Medical Practice are live.</td>
<td>Finalise arrangements with Newark locality [August 2017] Final mobilisation</td>
<td>Mark Yates, PC Performance and Development Manager</td>
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<td>Scheme</td>
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<td>Estates and technology transformation fund</td>
<td>Over £900m national capital investment (over 4 years)</td>
<td>The programme is split into cohorts: Cohort 1-2016/17 is complete and was used to fund the Mid Nottinghamshire Technology Bid. This included the Arden Referral Templates and a Technology for NHS England coordinates overall scheme CCG coordinated submission</td>
<td>Ashfield proposal developed and is currently being discussed further with wider stakeholders incl. Notts Healthcare, Local Authority and Sherwood Forest. Pre-Contract meeting on</td>
<td>Development of business cases for the three sites.</td>
<td>checks for Mansfield, Ashfield North and Sherwood [September 2017]</td>
<td>Mike Simpson</td>
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<td>Paula Longden</td>
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<tr>
<td>Vulnerable practice scheme</td>
<td>£10m North Midlands allocation £601,337 Mid Nottinghamshire allocation =</td>
<td>Programme of support to practices identified as ‘vulnerable’. Vulnerable GP practices are identified as those rated by CQC as ‘inadequate’, those rated as ‘requiring improvement’ where there is greatest concern, those assessed by local commissioners in need of support in view of local CCG co-ordinates locally reporting to NHS England</td>
<td>CCG co-ordinates locally reporting to NHS England</td>
<td>Scheme concluded.</td>
<td></td>
<td>Technology Transformation Project</td>
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<td>Scheme</td>
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<tr>
<td><strong>GP Resilience Programme</strong></td>
<td>£75k in total (to be drawn down from NHS England)</td>
<td>intelligence; or practices that self-declare. Match funding £ required but later guidance indicated the match funding could be made ‘in kind’.</td>
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<td>Mid Notts allocations across 2016/17 (£90k) and 2017/18 (£44k)</td>
<td>Same criteria as vulnerable practice scheme and no match funding required, although practices must provide ‘matched commitment’ Support can be delivered by local resilience teams or pools of experienced clinical and managerial staff to help practices implement changes that will support practices to become more sustainable and resilient. 2016/17 training and development arranged and substantially delivered. Some programmes ongoing. All practices rescored in June 2017 for 2017/18 funding and those 23 practices identified for support.</td>
<td>CCG co-ordinates locally reporting to NHS England</td>
<td>2016/17 funded training and development courses are being delivered. Confirmation from NHSE that 23 practices in Mid Notts have been identified as requiring support and therefore will be entitled to development funded by the 2017/18 allocation. Submission and approval of Agreement of 2017/18 Memorandum of Understanding.</td>
<td>Promotion of secured training to practices and payment of training delivered. Monitoring of delivery and outcomes.</td>
<td>Diane Singleton, Project Support Officer Paula Longden</td>
</tr>
<tr>
<td><strong>Training for reception and clerical staff</strong></td>
<td>£45m over five years</td>
<td>To support reception and clerical staff to undertake enhanced roles in active signposting and management of clinical</td>
<td>Details not yet released</td>
<td>Awaiting central guidance.</td>
<td>Awaiting criteria</td>
<td>Jacqui Kemp</td>
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<tr>
<td>Scheme</td>
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<tr>
<td><strong>Online general practice consultation software systems</strong></td>
<td>£45m over three years, from 2017/18</td>
<td>‘Online consultation systems’ to be purchased and deployed, starting in 2017/18. CCGs investigated options for an online consultation system but following feedback from clinicians raising concerns over workload and IG it was decided to focus on Ardens as the better value for money.</td>
<td>Details not yet released</td>
<td>Central guidance now received confirming that this project has been deferred with no timeframe for when it will be implemented.</td>
<td>No actions planned.</td>
<td>Paula Longden, Primary Care Programme Manager</td>
</tr>
<tr>
<td>Training care navigators and medical assistants</td>
<td>£45m over five years</td>
<td>West Wakefield GP Federation have trained 70 staff to signpost patients to the best solution for their needs. Developing and piloting medical assistant roles that support GPs</td>
<td>Awaiting central guidance.</td>
<td>Review guidance once received and establish project plan.</td>
<td>Paula Longden, Primary Care Programme Manager</td>
<td></td>
</tr>
<tr>
<td><strong>NEW</strong> Practice manager training</td>
<td>Mid Notts funding is £4k</td>
<td>Limited detail available – part of the £6m available nationally for practice manager development.</td>
<td>CCG co-ordination</td>
<td>Commenced discussions with practice managers re how this money can get the best value balanced with the low amount available.</td>
<td>Agree the programme of work.</td>
<td>Paula Longden, Primary Care Programme Manager</td>
</tr>
<tr>
<td>General practice development programme</td>
<td>£30m nationally over three years</td>
<td>Tailored programme linked to releasing ‘Time to care’ – delivering the 10 High Impact Actions, freeing up time for GPs</td>
<td>NHSE commissioned with CCG support</td>
<td>Programme substantially concluded. Awaiting evaluation.</td>
<td>Paula Longden, Primary Care Programme</td>
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<td>Retained doctors scheme (2016)</td>
<td></td>
<td>Bursary scheme based on annualised sessions</td>
<td>Incentives to support GPs who might otherwise leave the profession to remain in clinical general practice (clarity provided that can be a mentor within existing practice – does not need to move to another practice)</td>
<td>NHS England Coordinating</td>
<td>Allocation received from NHSE.</td>
<td>Awaiting feedback from NHSE</td>
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<tr>
<td>Targeted investment in recruiting returning doctors pilot 2016 (TIRRDs)</td>
<td>Approx. £15k per participating practice</td>
<td>This is a pilot scheme that invests resources in GP practices which can evidence that they have historically encountered difficulty in recruiting GPs (held vacancies for a minimum of 12 months). Targeted at practices that have struggled to recruit to GP vacancies that they have held for over 12 months. 15 pilots identified across the Midlands including 2 Practices from NHS Mansfield and Ashfield CCG</td>
<td>Co-ordinated by NHS England nationally</td>
<td>No actions reported this month.</td>
<td>NHSE will be undertaking a review of the sites and their experiences, before making a decision on whether to roll the program out wider.</td>
<td>N/A</td>
</tr>
<tr>
<td>GP indemnity review</td>
<td>£33m nationally (included in contract)</td>
<td>To cover the associated increases for in-hours indemnity insurance with MDUs. First payment of scheme made in</td>
<td>Co-ordinated by NHS England</td>
<td>No actions reported by NHSE this month. The Winter Indemnity Scheme has run over the</td>
<td>Scheme to be evaluated [2018/19]</td>
<td>N/A</td>
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<td>inflation rises in 2016/17 to reflect rises in the previous year – figure based on population)</td>
<td>March 2017 to address inflation in 2016/17 (is already in practice baselines). Second year payment date will be made in March / April 2018.</td>
<td></td>
<td>last 3 years, seeking to support Out of Hours providers fill their difficult to fill OOH sessions over the winter by supporting the increased premia faced by GPs if they take on additional shifts. National agreed that the three Medical Defence Organisations would invoice NHSE for the additional indemnity costs incurred by GPs who have approached them seeking an uplift to their indemnity to allow them to do additional OOH sessions. This is not a GP practice facing scheme so there is no practice-level data on this scheme.</td>
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<tr>
<td>NHS GP Health Service</td>
<td>£19.5m (nationally)</td>
<td>The service is to improve access to mental health support for general practitioners and trainee GPs who may be suffering from mental ill-health including stress, depression, addiction and burnout. The Hurley Clinic Partnership has been appointed provider of a NHS</td>
<td>NHS England nationally</td>
<td>The CCG has promoted this service through the Primary Care Bulletin and Snippets during the past six months. No actions to report this month.</td>
<td></td>
<td>n/a</td>
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<td>GP Health Service.</td>
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<td>This is a self-referral mechanism for GPs to receive support and guidance with issues relating to a mental health concern, including stress or depression, or an addiction problem, in particular where these might affect work. GPs can access the service through the website. <a href="http://gphealth.nhs.uk/">http://gphealth.nhs.uk/</a>.</td>
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</table>
## Appendix 2: GP Access update

<table>
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<th>Indicator</th>
<th>Orchard MP</th>
<th>Ashfield South</th>
<th>Ashfield North</th>
<th>Mansfield South</th>
<th>Mansfield North</th>
<th>Newark</th>
<th>Sherwood</th>
</tr>
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<tbody>
<tr>
<td>Proposal Received</td>
<td></td>
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<td></td>
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<tr>
<td>Population Covered</td>
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<td>37891</td>
<td>51424</td>
<td>45197</td>
<td>38679</td>
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<td>Additional hours to be</td>
<td>9.5 hrs p/wk</td>
<td>19 hrs p/wk</td>
<td>25.75 hrs p/wk</td>
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<td>19.25 hrs p/wk</td>
<td>37.5 hrs p/wk</td>
<td>29 hrs p/wk</td>
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<tr>
<td>Service Mobilised</td>
<td>✓</td>
<td>✓</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Go Live date</td>
<td>01 June 2017</td>
<td>31 March 2017</td>
<td>01 October 2017</td>
<td>01 October 2017</td>
<td>01 October 2017</td>
<td>Mid to late October 2017</td>
<td>01 October 2017</td>
</tr>
</tbody>
</table>

**Steering Group and Delivery Board Reporting. Risks and issues and mitigating actions.**

- **Orchard MP**: None
- **Ashfield South**: None
- **Ashfield North**: Risk highlighted at Month re locality working and PICS model. Mitigations now progressed, contractual agreement reached and locality now working with PICS and on schedule for 1 October go live.
- **Mansfield South**: None
- **Mansfield North**: None
- **Newark**: Risk that due to workforce pressures the locality will be unable to mobilise by the required date of 1 October 2017. Solution from the locality could not be found - CCG mitigation to issue a direct award to a provider with an appropriate track record in delivering primary care solutions at a locality level.
- **Sherwood**: Solution could not be found to the mediation issues highlighted at Month 4. Mitigating actions were to issue refreshed invite for expressions of interest, which has now concluded. Provider identified and now mobilising for 1 October start.

**Service at risk of delivery as per statutory timetable**

- **Orchard MP**: LOW
- **Ashfield South**: LOW
- **Ashfield North**: LOW
- **Mansfield South**: LOW
- **Mansfield North**: LOW
- **Newark**: HIGH
- **Sherwood**: LOW
**Programme Title:** Primary Care  
**Programme Manager:** Cathy Quinn, Paula Longden  
**Project Managers:** Jo Riddell, Chris Sewell, Mark Yates  
**Unique Programme Reference:** PRI0718

### Programme Summary

Infliximab savings continue to be submitted from SFHT, NUH and NTC.

**Programme Objective**

- The key objectives are:  
  - improve the quality of services for patients;  
  - to deliver more care closer to home;  
  - shift services "left", to reduce activity in secondary care and make associated savings; and  
  - improve efficiency and effectiveness in primary care.

### Programme Financial Savings Profile

<table>
<thead>
<tr>
<th>Project</th>
<th>Position</th>
<th>2017/18 Target £’000</th>
<th>2017/18 FOT £’000</th>
<th>2017/18 Variance £’000</th>
<th>YTD Plan £’000</th>
<th>YTD Actual £’000</th>
<th>YTD Variance £’000</th>
<th>In Month Variance £’000</th>
<th>In Month FOT £’000</th>
<th>YTD Finance RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>21.3a - High Cost Drugs - 16/17 (FYE)</td>
<td>70</td>
<td>70</td>
<td>25</td>
<td>33</td>
<td>13</td>
<td>9</td>
<td>22</td>
<td>36</td>
<td>Red</td>
<td>Red</td>
</tr>
<tr>
<td>21.3b - High Cost Drugs - 17/18</td>
<td>100</td>
<td>100</td>
<td>0</td>
<td>32</td>
<td>72</td>
<td>2</td>
<td>30</td>
<td>34</td>
<td>Red</td>
<td>Red</td>
</tr>
<tr>
<td>21.13 - Referral management</td>
<td>691</td>
<td>1,161</td>
<td>236</td>
<td>177</td>
<td>572</td>
<td>345</td>
<td>239</td>
<td>120</td>
<td>Green</td>
<td>Green</td>
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<tr>
<td>22 - Primary Care - Pathways</td>
<td>10</td>
<td>10</td>
<td>0</td>
<td>0</td>
<td>10</td>
<td>2</td>
<td>8</td>
<td>2</td>
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<td>Green</td>
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<tr>
<td>24 - ED Service Improvements</td>
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<td>111</td>
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<td>36</td>
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<td>10</td>
<td>25</td>
<td>16</td>
<td>Amber</td>
<td>Green</td>
</tr>
</tbody>
</table>

### Programme Financial Delivery Status

- **YTD Actual**
- **YTD Target**
- **YTD Straight line variance**
- **YTD FOT**

### Programme Snapshot Summary

- **21.3a - High Cost Drugs - 16/17 (FYE)**
  - Ian Ellis
  - Introduces savings continues to be submitted from SFHT, NHT and HTC.

- **21.3b - High Cost Drugs - 17/18**
  - Ian Ellis
  - Agreement reached with CCG regarding recording of savings. Future savings will include savings arising from changes in market forces.

- **22.11 - Diabetes**
  - David Ainsworth
  - New project Manager of 1st Oct 2017, update and hardware completed.

- **21.4 - Referral management**
  - David Ainsworth
  - YTD Data with completed.

### Programme Financial Delivery Status

- **YTD Finance**
- **SRO**
- **Current Period**
- **Plan Overall**

---

**Programme Title:** Non-Allocation delivery  
**Project Managers:** Ian Ellis, SRO

---

**Benfiting Organisations**

- CCG  
- SFH  
- NHT

### Programme Objective

- The key objectives are:  
  - improve the quality of services for patients;  
  - to deliver more care closer to home;  
  - shift services "left", to reduce activity in secondary care and make associated savings; and  
  - improve efficiency and effectiveness in primary care.

### Programme Status Summary

- There are some risks around milestone delivery for both cardiology and near patient testing however the financial risk is mitigated by a refreshed faster time frame for mobilisation. The cardiology provider has submitted a financial envelope which is being reviewed by finance. Near patient testing procurement has commenced, guided by Arden and GEM, in line with the revised timeframe.  
  - The localisation of Arden is on track.

---

**Programme Title:** Alliance Workplan 2017/18

**Period Reported On:** July 17/18

---

**Programme Title:** Primary Care  
**Programme Manager:** Cathy Quinn, Paula Longden  
**Project Managers:** Jo Riddell, Chris Sewell, Mark Yates  
**Unique Programme Reference:** PRI0718

### Programme Summary

The primary care programme is focused on enhancing service delivery in primary care. Priorities in 2017/18 are:  
- Delivering improvement in diabetes care and treatment with quick wins around the hypo pathway, utilising Ardens and monitoring the National Diabetes Prevention Programme;  
- Improved referral management through Ardens decision support tool and the referral facilitation team;  
- Moving specific diagnostics, treatments and care out of a secondary care setting and into a primary care hub model;  
- Improving GP access in line with the GP Forward View criteria to offer the public a better alternative to ED.

### Programme Objective

- The key objectives are:  
  - improve the quality of services for patients;  
  - to deliver more care closer to home;  
  - shift services "left", to reduce activity in secondary care and make associated savings; and  
  - improve efficiency and effectiveness in primary care.

### Interdependencies/links to other projects, if any

- Links to both the urgent and proactive and elective programmes.

---

**Programme Title:** Health Optimisation service  
**Project Manager:** Ian Ellis

### Programme Summary

- Initial diabetes activity data is not positive however practices are being very active in referring patients to the NDDP with the cogs now having delivered 45% of the annual target. Investigations around the hypo pathway have identified ways of streamlining the pathway and developments are being led by Contracting Officer.

- Further progress in extending GP access with plans for all localities. Contracting has now commenced for all areas following approval by PCCC. One risk around Newark locality delivery, which is being mitigated by project manager through engagement with other localities, potential providers and procurement planning. This will enable full roll out to be achieved by the deadline of 1 October as per GP Forward View must do.

- Referral management work continues in line with action plan - solution found for maternity cover and Best Practice Scheme contribution agreed. This work is complemented by Ardens and all practices are now active on Ardens decision support tool and intensive support is being provided by the referral facilitation team, in particular our clinical adviser. The localisation of Arden is on track.

- Community ENT is now progressing following the allocation of the project manager and engagement with secondary care.

- There are some risks around milestone delivery for both cardiology and near patient testing however the financial risk is mitigated by a refreshed faster time frame for mobilisation. The cardiology provider has submitted a financial envelope which is being reviewed by finance. Near patient testing procurement has commenced, guided by Arden and GEM, in line with the revised timeframe.

- The health optimisation service design is currently undergoing a clinical confirm and challenge to ensure that a robust and clinically safe model is adopted.
<table>
<thead>
<tr>
<th>Headroom</th>
<th>1,334</th>
<th>1,660</th>
<th>326</th>
<th>322</th>
<th>770</th>
<th>448</th>
<th>117</th>
<th>321</th>
<th>204</th>
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<tbody>
<tr>
<td>Headroom</td>
<td>1,334</td>
<td>1,660</td>
<td>326</td>
<td>322</td>
<td>770</td>
<td>448</td>
<td>117</td>
<td>321</td>
<td>204</td>
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Stretched Programme Financial Savings Profile

<table>
<thead>
<tr>
<th>Area</th>
<th>Position</th>
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<th>2017/18 FOT £'000</th>
<th>2017/18 FOT Variance £'000</th>
<th>YTD Plan £'000</th>
<th>YTD Actual £'000</th>
<th>YTD Variance £'000</th>
<th>In Month Plan £'000</th>
<th>In Month Actual £'000</th>
<th>In Month Variance £'000</th>
<th>YTD Finance RAG</th>
<th>FOT Finance RAG</th>
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<td>326</td>
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<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>Grey</td>
<td>Grey</td>
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<tr>
<td>Total</td>
<td>2</td>
<td>334</td>
<td>326</td>
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<td>0</td>
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Programme Key Performance Indicators

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<th>Position</th>
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<th>YTD Target</th>
<th>YTD Actual</th>
<th>YTD Variance</th>
<th>Month Target</th>
<th>Current Month</th>
<th>Previous Month</th>
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Key Milestones

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<th>Milestones</th>
<th>Start Date</th>
<th>Status</th>
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<tr>
<td>Quarter 1</td>
<td>Cardiology goes live in Sherwood locally during Quarter 1</td>
<td>01/07/2017</td>
<td>Amber</td>
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<tr>
<td>Quarter 2</td>
<td>Community ENT go live during Quarter 2</td>
<td>01/10/2017</td>
<td>Amber</td>
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<tr>
<td>Quarter 3</td>
<td>GP access full mobilisation of extra 30 minutes</td>
<td>30-Sep</td>
<td>Green</td>
</tr>
<tr>
<td>Quarter 4</td>
<td>Near patient testing mobilisation of Sherwood locality</td>
<td>SO 30-Sep</td>
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Risk Reference

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<th>Cause</th>
<th>Event - the risk itself</th>
<th>Effect</th>
<th>Date raised</th>
<th>Risk Owner</th>
<th>Expected level of impact should risk occur</th>
<th>Likelihood of risk happening</th>
<th>Overall risk rating</th>
<th>Proximity</th>
<th>Mitigation Actions</th>
<th>Expected risk rating after mitigation</th>
<th>Current risk status</th>
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<td>RSK-PRM-001</td>
<td>schedule</td>
<td>Scheduling withdrawal of original expression of interest</td>
<td>This would prevent the Code achieving its main objective.</td>
<td>Jan 16</td>
<td>4</td>
<td>3</td>
<td>2</td>
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<td>Green</td>
<td>FOT</td>
<td>Amber</td>
<td>Amber 8-12</td>
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<td>RSK-PRM-002</td>
<td>provide</td>
<td>Emergency - Primary Care - LES</td>
<td>Risk inherent in proof of concept - savings may not be delivered.</td>
<td>Jun 16</td>
<td>3</td>
<td>3</td>
<td>1</td>
<td>Very Likely</td>
<td>Green</td>
<td>FOT</td>
<td>Amber</td>
<td>Amber</td>
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<tr>
<td>RSK-PRM-003</td>
<td>provide</td>
<td>Mid-3a - NEMS - Kirkby (NEMS)</td>
<td>Risk inherent in proof of concept - savings may not be delivered.</td>
<td>Jun 16</td>
<td>3</td>
<td>3</td>
<td>1</td>
<td>Very Likely</td>
<td>Green</td>
<td>FOT</td>
<td>Amber</td>
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Issue Reference

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<th>Risk Reference</th>
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<th>Description</th>
<th>Cause</th>
<th>Impact</th>
<th>Severity</th>
<th>Issue Owner</th>
<th>Actions</th>
<th>Event Followed</th>
<th>Status</th>
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Further Opportunities

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<th>Potential Impact</th>
<th>Benefitting Organisation</th>
<th>Pipeline Tracker Status</th>
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<td>Blue</td>
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<tr>
<td>Finance YTD RAG</td>
<td>A</td>
<td>Grey</td>
<td>Scheme not yet expected to deliver</td>
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</table>
**PMO02EXCPT**  
**Exception Report**

<table>
<thead>
<tr>
<th>Programme/Project Title:</th>
<th>Primary Care</th>
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<tbody>
<tr>
<td>SRO</td>
<td>David Ainsworth</td>
</tr>
<tr>
<td>Programme Manager</td>
<td>Paula Longden / Cathy Quinn</td>
</tr>
<tr>
<td>Project Manager</td>
<td>Miles Longden / Cathy Quinn</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Unique Programme/Project Reference:</th>
<th>PRI1718</th>
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<tbody>
<tr>
<td>Exception reports enclosed</td>
<td>Yes</td>
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<thead>
<tr>
<th>Period Reported On:</th>
<th>July 17/18</th>
<th>YTD</th>
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**Exceptions**

<table>
<thead>
<tr>
<th>UID</th>
<th>Area</th>
<th>Issue Description</th>
<th>Type</th>
<th>Actions</th>
<th>By when</th>
<th>Resolution &amp; Lessons Learnt</th>
<th>Date Resolved</th>
<th>Confidence last month</th>
<th>Confidence this month</th>
</tr>
</thead>
</table>
| EXC-PRI-001 | High cost drugs -D1.3 | Performance below plan in high cost drugs both in year plan and FYE. | | This is being investigated further as there is a lack of clarity about plan and potential savings:  
• Windfall saving not being captured by finance, although agreement was made to record these.  
• Gain share agreement waiting to be signed off by Ian Ellis | Mar-18 | Ensure that all savings associated with HCDs are being captured. Evaluate the drugs included and consider potential widening. | 07-Aug | Medium | High |
| EXC-PRI-002 | H1.4 EHS reviews D2.6 Primary care - LES and pathways | Project behind plan year to date. EHS reviews is part of the cardiology and near patient testing enhanced services development. The phasing in the original QIPP plan assumed delivery in Q2 whereas the final project plan had mobilisation in August and September for both. | Financial | No change in actions from the previous month because mitigating actions are on track:  
There is a refreshed faster timeframe for cardiology mobilisation across the entire patch. The cardiology provider is currently mobilising with go live in September. Near patient testing procurement has commenced, guided by Arden and GEM, in line with the revised timeframe for a go live date in October. | Mar-18 | The financial risk is mitigated by a refreshed faster timeframe for mobilisation. | | High | High |
| EXC-PRI-003 | D2.11 Diabetes | YTD savings behind plan. | Financial | The CCGs are reporting no reduction in NEL admissions related to diabetes despite the introduction of the hypo pathway and NDPP. | | Medium | Medium |
| EXC-PRI-004 | D2.6 Primary Care - LES | Project behind plan year to date. Project is near patient testing enhanced services development. The phasing in the original QIPP plan assumed delivery in Q2 whereas the final project plan had mobilisation in October. | Financial | No change in actions from the previous month because mitigating actions are on track: Near patient testing procurement has commenced, guided by Arden and GEM, in line with the revised timeframe for a go live date in October. | Mar-18 | The financial risk is mitigated by a refreshed faster time frame for mobilisation. | High | High |
| EXC-PRI-005 | D2.6a Primary Care | See above - one project | | | | | |
## Appendix 4
### Level 4. QIPP Financial Summary

#### Mid Nottinghamshire Total

**Month 4**

<table>
<thead>
<tr>
<th>Delivery Board</th>
<th>Sub Scheme Name</th>
<th>Sub Scheme No</th>
<th>SRO</th>
<th>2017/18 Plan</th>
<th>2017/18 FOT</th>
<th>2017/18 FOT Variance</th>
<th>YTD Plan</th>
<th>YTD Actual</th>
<th>YTD Variance</th>
<th>In Month Plan</th>
<th>In Month Actual</th>
<th>In Month Variance</th>
<th>Finance BRAG</th>
<th>RAG</th>
<th>Milestone BRAG Ratings</th>
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</thead>
<tbody>
<tr>
<td>Urgent &amp; Proactive Care</td>
<td>New primary care model</td>
<td>G2.1 David Ainsworth</td>
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<td>990</td>
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<td>328</td>
<td>118</td>
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<td></td>
<td>Best Practice Admission Avoidance Scheme</td>
<td>G2.8 David Ainsworth</td>
<td>760</td>
<td>760</td>
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<td>508</td>
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</tr>
<tr>
<td>Urgent &amp; Proactive Care Total</td>
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<tr>
<td>Primary Care</td>
<td>High Cost Drugs - 16/17 (FYE)</td>
<td>D1.3a Ian Ellis</td>
<td>70</td>
<td>70</td>
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<td>High Cost Drugs - 17/18</td>
<td>D1.3b Ian Ellis</td>
<td>100</td>
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<td>Green</td>
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<tr>
<td></td>
<td>Referral management</td>
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<tr>
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<td>Green</td>
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<tr>
<td></td>
<td>Primary Care - Pathways</td>
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**Annual QIPP**

**Year to Date QIPP**

**In Month QIPP Delivery**

**YTD RAGS**
### Community Outputs

<table>
<thead>
<tr>
<th>Group</th>
<th>Activity</th>
<th>Area</th>
<th>Apr Actual</th>
<th>Apr Target</th>
<th>May Actual</th>
<th>May Target</th>
<th>Jun Actual</th>
<th>Jun Target</th>
<th>Jul Actual</th>
<th>Jul Target</th>
<th>Total Actual</th>
<th>Target</th>
<th>Difference (Total-Target)</th>
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<tbody>
<tr>
<td>Community Outputs</td>
<td>Number of Visits vs Target</td>
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### Quality

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<th>Inappropriate Referrals</th>
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<th>Apr Budget</th>
<th>May Actual</th>
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<th>Jun Actual</th>
<th>Jun Budget</th>
<th>Jul Actual</th>
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<th>Total Actual</th>
<th>Target</th>
<th>Difference (Spend-Budget)</th>
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### Budget and Spend

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<th>Area</th>
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<th>Apr Budget</th>
<th>May Actual</th>
<th>May Budget</th>
<th>Jun Actual</th>
<th>Jun Budget</th>
<th>Jul Actual</th>
<th>Jul Budget</th>
<th>Total Actual</th>
<th>Target</th>
<th>Difference (Total-Target)</th>
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</thead>
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### Secondary Care Outcomes

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<th>Apr Budget</th>
<th>May Actual</th>
<th>May Budget</th>
<th>Jun Actual</th>
<th>Jun Budget</th>
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<td>Newark</td>
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### Overall Savings

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<th>Activity Saving</th>
<th>Activity Cost Saving: -0.7% (Cost Saving: -£283,795 (-12.5%))</th>
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<td>Return on Investment: 1:1.8</td>
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Primary Care Best Practice Scheme
Year 2

Communication and Engagement Plan
<table>
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<tr>
<th>Form of communication</th>
<th>Timeline and Phasing</th>
<th>Route/ how to transmit? Media Source</th>
<th>Message/Action</th>
<th>Who sending transmission</th>
<th>Completed Date</th>
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</thead>
</table>
| Written               | Phase 1 1st sept     | Covering letter Service Specification to Practice Manager and Lead GP | 1. Investment in primary care  
2. Lessons learned last year – made simpler  
3. Things they can influence which is achievable  
4. CCG priorities likely to be working on already Value -  
• Improved quality  
• Beaurocracy – future enhanced services  
6. For patients:  
• Sepsis, Peer review, Access, Diabetes | David Ainsworth & /Jess Whittle contracting | Completed 31st August 2017 |
| Written               | Weekly              | Snippets All Practice Staff         | Bullet points - key areas of BPS scheme as above | D Ainsworth | |
| Video blog            | By end Sept 2017    | Video blog For all stakeholders     | Launch BPS Year 2 Script to be agreed | David Ainsworth | |
| Written/F2F           | 6th Sept            | Slide deck for PDM’s                | Consistent script for all SDMS – delivery of consistent key messages Discussion at PC Team meeting | JKemp team | |
| Verbal/meeting        | TBC at end Sept     | Open Sessions with Practice Managers & PM Forums | Walk through specification and present slide deck Session in Mansfield & Ashfield and Newark and Sherwood | All PDM.s | |
| Verbal                | Sept/October        | 1:1 sessions with Practice Managers on Request | Detailed explanation of service spec and actions required | ALL PDM’s as required | |
## Communications and engagement plan & activity September 2017

<table>
<thead>
<tr>
<th>Form of communication</th>
<th>Timeline and Phasing</th>
<th>Route/ how to transmit? Media Source</th>
<th>Message/Action</th>
<th>Who sending transmission</th>
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<tbody>
<tr>
<td>Written</td>
<td>Start of scheme (1/9/2107 on going)</td>
<td>Frequently asked questions briefing</td>
<td>Continued sharing with all practices via bulleting</td>
<td>J Kemp</td>
</tr>
<tr>
<td>Presentation</td>
<td>Awaiting confirmation of Dates from Julie Andrews</td>
<td>Present at PPG Leads meeting Mid Notts</td>
<td>Share BPS details with PPG groups in order they can support practices</td>
<td>J Kemp/PDMs</td>
</tr>
<tr>
<td>Written</td>
<td>Last week of the month until end of the scheme</td>
<td>BPS monthly briefing circulated to practice managers</td>
<td>Including performance information, FAQ’s</td>
<td>J Kemp</td>
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<tr>
<td>Written</td>
<td>Phase 2 From October 2017</td>
<td>E-mail and Bulletin</td>
<td>Information to practices re Near Patient Testing Issue of equipment via Provider Training availability</td>
<td>Chris Sewell</td>
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</tbody>
</table>
**STRATEGIC OBJECTIVE:**

**AIM 1:** Best quality within available resources (incorporating safety, effectiveness and patient experience)

---

**PC1 (2017/18) (Both CCGs)**

- **Date on Risk register:** December 2015
- **Committee:** Primary Care Commissioning Committee
- **Risk Owner:** Director of Primary Care

---

**CURRENT RISK RATING (Likelihood & Impact):**

- **4 X 4 = RED**
- **RESIDUAL RISK = 3 X 4 AMBER RED**

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**Committee:**

- **Primary Care Commissioning Committee**

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**Risk Owner:**

- **Director of Primary Care**

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**Date last reviewed:**

- **7th August**

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**Date risk identified/on AF:**

- **November 2015**

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**(Transferred to combined Assurance Framework: 17 January 2017)**

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**RISK:** There is a risk to the successful delivery of the Primary Care Strategies, including GP Forward View, and the stated population health outcomes within Mid Notts, Better Together approach

---

**Rationale for current score:**

- The high levels of deprivation and increasing need to address the public health needs of the local population
- Increasing complex patient care is challenging both capacity and capability of even the most experienced GPs
- Primary care has multiple interdependencies making it complex to navigate
- Significant pressure on the Primary Care Workforce and the ability to attract and retain GP’s within the local community
- The health and well-being of GPs ad those working in primary care is under pressure
- The duty of GPs to deliver safe effective care under contractual obligations as part of core business
- Premises are, in some areas, in need of improvement
- Unwarranted clinical variation exists
- The introduction of robust CQC performance management
- CQC ratings affect public confidence and belief in primary care
- The public recognise and value the A&E brand and primary care is not always the default for excellent NHS care
- Rising expectations for urgent and emergency access to primary care
- Primary Care is not currently commissioned to deliver 7 day services and will suffer capacity constraints within the existing model
- Headroom for GPs to engage effectively with the CCG in order to develop new models of care
- Engagement by Primary Care in the development of the wider health and social care transformation of services
- The lack of a single voice for primary care as a provider with correct governance structure to support developments
- Alliance model inter-dependence and primary care at the core of services could impact on wider development of health outcomes
- The current business model for primary care is not universally fit for purpose
- Adverse media attention leads to a decrease in public confidence around primary care
- Increasing financial pressures and high spend in areas such as prescribing and continuing healthcare needs
- Patient experience is variable and not all practices are fully engaged with the Friends and Family Test
- GP Practice Locality working is not yet fully established
- Assurance is required that general practice will continue to align to the Alliance Board outcomes and direction of travel
- Services may not meet the needs of the local population
- GP Patient Survey in 2107 has shown a decline in patient experience
- GP Patient Survey in 2017 has shown a decline in patient experience
- Mid Notts CCGs Conflict of interest policy revised and approved to include the primary care (medical) delegated authority remit
- Governing Body and Clinical Executive oversight
- Mid Notts CCGs Membership agreements approved by practices
- Mid Notts CCGs National Vanguard status supports development and progression of primary care system redesign
- Health and Social Care Programme Management Office manages system redesign and drives initiatives to support the Mid Notts CCG 5 year strategy
- 10 Mid Notts CCGs Primary Care strategies and joint CCGs risk register
- Mid Notts CCGs Clinical Leads for Primary Care, CCG Clinical Chairs and Executive GP Leads in place
- Primary Care relationship management supported by the CCG Communications and Engagement Team
- Formal liaison and engagement with Local Authority and Health and Well Being Board
- A Mid Nottinghamshire Clinical Senate has been put in place

---

**Controls/Influences:** (What are we currently doing about the risk?)

1. Primary Care (medical) delegated authority to the Mid Notts CCG Primary Care Commissioning Committees
2. Primary Care Commissioning Steering Group established with GP/practice manager membership
3. Primary Care commissioning governance structure in place to support/align with existing CCGs arrangements
4. Nottinghamshire/Derbyshire Primary Care Hub expertise and support
5. Mid Notts CCGs Conflict of interest policy revised and approved to include the primary care (medical) delegated authority remit
6. Governing Body and Clinical Executive oversight
7. Mid Notts CCGs Membership agreements approved by practices
8. Mid Notts CCGs National Vanguard status supports development and progression of primary care system redesign
9. Health and Social Care Programme Management Office manages system redesign and drives initiatives to support the Mid Notts CCG 5 year strategy
10. Mid Notts CCGs Primary Care strategies and joint CCGs risk register
11. Mid Notts CCGs clinical Leads for Primary Care, CCG Clinical Chairs and Executive GP Leads in place
12. Primary Care relationship management supported by the CCG Communications and Engagement Team
13. Formal liaison and engagement with Local Authority and Health and Well Being Board
14. A Mid Nottinghamshire Clinical Senate has been put in place

---

**Gaps in controls/influences:**

- **G1.** Sustainable Primary Care provider workforce plan, highlight key areas of capacity and demand for new models of care – C. Lawson
- **G2.** A single provider organisation that can represent primary care around the Alliance table – D. Ainsworth
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<thead>
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<th>Number</th>
<th>Description</th>
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<tbody>
<tr>
<td>16.</td>
<td>Local Medical Committee provides an advisory role and support to the primary care team (i)</td>
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<tr>
<td>17.</td>
<td>Local GPS engaged in registrar training programme (i)</td>
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<tr>
<td>18.</td>
<td>Local GP Teaching Practices are in place (i)</td>
</tr>
<tr>
<td>19.</td>
<td>Mid Notts CCGs Education Group and Protected Learning Time Schedule of events established ©</td>
</tr>
<tr>
<td>20.</td>
<td>Mid Notts CCG Primary Care Team regular meetings established ©</td>
</tr>
<tr>
<td>21.</td>
<td>Primary Care Strategic Advisory Group established across Derbyshire and Nottinghamshire which the CCGs both attend and Chair (i)</td>
</tr>
<tr>
<td>22.</td>
<td>Forward View Programme (i)</td>
</tr>
<tr>
<td>23.</td>
<td>Member practice representation at Joint Primary Care Commissioning Steering Group (i)</td>
</tr>
<tr>
<td>24.</td>
<td>An agreed quality and performance framework with triggers and escalation clearly defined (c)</td>
</tr>
<tr>
<td>25.</td>
<td>A CCGs’ Estates Strategy is in place and is aligned with the STP (c)</td>
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<td>Weekly communication with GP Practices via Director’s Snippets (c)</td>
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<td>27.</td>
<td>CCG has a statutory duty to engage with the public (c)</td>
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<tr>
<td>28.</td>
<td>CCG has a dedicated Communications and Engagement Team to support statutory responsibilities for engagement with the public (i)</td>
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<tr>
<td>29.</td>
<td>Primary care GP forward view plan in place as a living document (c)</td>
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<tr>
<td>30.</td>
<td>CCG has a statutory duty to engage with the public (c)</td>
</tr>
<tr>
<td>31.</td>
<td>CCG has a dedicated Communications and Engagement Team to support statutory responsibilities for engagement with the public (i)</td>
</tr>
<tr>
<td>32.</td>
<td>An Implementation Plan for Primary Care Transformation is in place (8, 9, 10, 25)</td>
</tr>
<tr>
<td>33.</td>
<td>Protected Learning Events in January 2017 have been used to present, discuss and debate the introduction of a single overarching provider (7, 8, 10, 12, 19) (i)</td>
</tr>
<tr>
<td>34.</td>
<td>Local locality meetings have been held in Mansfield, Ashfield, Newark and Sherwood to discuss collaborative working (7, 8, 11, 12, 14, 20, 26) (i)</td>
</tr>
<tr>
<td>35.</td>
<td>An Implementation Plan for Primary Care Transformation is in place (8, 9, 10, 25)</td>
</tr>
<tr>
<td>36.</td>
<td>Protected Learning Events in January 2017 have been used to present, discuss and debate the introduction of a single overarching provider (7, 8, 10, 12, 19) (i)</td>
</tr>
<tr>
<td>37.</td>
<td>Regular updates have been provided on the delivery of the current The Primary Care Strategy to the Primary Care Commissioning Committee (2, 8, 10)</td>
</tr>
<tr>
<td>38.</td>
<td>Primary Care GP Provider Unit under development including governance arrangements and back office functions to deliver the Vanguard Proactive Care and Urgent Care Hubs (7, 8, 10, 12)</td>
</tr>
<tr>
<td>39.</td>
<td>Financial Delivery and Performance Group – oversight and approval process for Primary Care developments and business cases (1, 3, 6, 10)</td>
</tr>
</tbody>
</table>

**Assurances: (How do we know if the things we are doing have an impact?)**

- Governing body oversight of the Mid Notts CCGs Primary Care Commissioning committee (1, 3, 4, 6)
- Mid Notts CCG Primary Care Commissioning Committees are ‘meetings in public’ and all public agenda items are placed on the Mid Notts CCG websites to ensure transparency. Members of the public can submit questions to the committees and can attend the public section of the committee meetings (2, 3, 10, 16)
- Independent Chair/Vice Chair and CCG GB Lay Members of the Mid Notts CCGs Primary Care Commissioning Committee (1, 3, 10)
- There has been a 360 degree External Audit of the primary care co-commissioning structure (1, 2, 3, 5, 6)
- Assurance sought from Healthwatch and Health & Wellbeing Board attendees at the Mid Notts CCGs Primary Care Commissioning Committees (2, 3, 5, 12, 13)
- Conflicts of interest register maintained and a standing agenda item on the Mid Notts CCG Primary Care Commissioning Committees (1, 3, 5, 6)
- Stakeholder Reference Group and Citizens Reference Panel in place with lay representative on the Governing Body. Regular feedback to these groups (2, 3, 5, 6, 12, 28)
- Regular Quality and Performance reports are submitted to the Primary Care Commissioning Committee demonstrating positive progress and attention to areas highlighted by the Regulator
- CCG Vanguard Status (PACS) national support and resources to deliver new models of care based on outcomes, plans and milestones and reporting in place (8, 9, 10, 28)
- Primary Care integral to the delivery of Better Together approach, GP Clinical Leads for elective Care and proactive and Urgent work streams in place (8, 11, 12, 14, 16)
- Advice and support from Health Education East Midlands, and links established (11, 14, 17, 18, 19)
- Realignment of CCG portfolios to reflect the increasing need for primary and the development of Primary Care Proactive Care and Urgent Care Hubs care focus (3, 8, 9, 10, 12, 16, 20, 21, 25, 28)
- Locality meetings have been held in Mansfield, Ashfield, Newark and Sherwood to discuss collaborative working (7, 8, 11, 12, 14, 20, 26) (i)
- An Implementation Plan for Primary Care Transformation is in place (8, 9, 10, 25)
- Protected Learning Events in January 2017 have been used to present, discuss and debate the introduction of a single overarching provider (7, 8, 10, 12, 19) (i)
- Regular updates have been provided on the delivery of the current The Primary Care Strategy to the Primary Care Commissioning Committee (2, 8, 10)
- Primary Care GP Provider Unit under development including governance arrangements and back office functions to deliver the Vanguard Proactive Care and Urgent Care Hubs (7, 8, 10, 12)
- Financial Delivery and Performance Group – oversight and approval process for Primary Care developments and business cases (1, 3, 6, 10)

**Gaps in Assurance: (What additional assurances should we seek?)**

- Are the current ways of seeking public opinion covering all aspects of the diverse population the CCGs serve
- Assurance required from HEE for the delivery of their 10 Point Plan – C. Lawson
- Accurate documentation of the Primary Care Quality and Performance Subcommittee – D Ainsworth
• PMO function in Primary Care Team providing assurance and performance management for Workstream and business case
development and implementation (1, 3, 6, 8, 10)
• Regular reports being completed for the Better Together Alliance Programme Board (1, 3, 6, 8, 10)
• Patient participation groups meet on a regular basis in the CCG localities (7, 12, 27, 28)
• PPG groups reporting at Citizens’ Reference Panel in M&A and Stakeholder Reference Group in N&S (6, 12, 27, 28) (c)
• Attendance at the Nottinghamshire GP Training and Education Group to ensure alignment with regional workforce and
education activities (i)

Mitigating Actions: (What more should we do?)

G1. A business case has been approved to fund an overarching organisation for primary care. This organisation will be in place by the end of May 2017 and provide representation for Primary Care as part of the
Better Together Alliance (C/I) - B - Action owner David Ainsworth – Completion date 18th August 2017

G2. Arden referral templates loaded on to practice systems by August 2017. Clinical Advisor delivering one to one support to Practices through 2017/18 and project manager capacity now secured. Detailed links
to the referral management action plans and work of the DMOC. (C/I) – D - Action owner Chris Sewell – Completion date March 2018

G2. The Terms Of Reference has been refreshed at the July 2017 Quality and Performance Review Group meeting and the Meeting Agenda has been refocussed (C/I – E) - Action owner Stephanie Haslam – Completed 25th July 2017

G2. A Best Practice Scheme has been put in place from December 2016 to March 2017 – improvements to include increased use of EPaCCs, increase in the number of patients registered for on-line services
dedicated appointment slots to support the reduction of unplanned admissions. Formal evaluation now concluded and reported: Significant work has been carried out by practices over a number of indicators
which has led to improved uptake of work streams in addition the allocation of additional urgent care slots in Primary Care has been additional capacity for the wider system; 25 of 35 practices increased activity
on Epaccs; An additional 318 calls were made to Call for Care; The scheme was a key driver for increasing On line access; and Frequent attendances have reduced as a result of monitoring numbers down 246
down from 345 in the previous year. (C/I – E) - Action owner Jacqui Kemp – Completed A Y2 Best Practice Scheme is under development to mobilise in September. Action owner Jacqui Kemp – 30 September
2017.

G2. Acute Home Visiting Service live in both hubs from April 2017. Monthly performance monitoring and contract management. Early evaluation at three months then second evaluation at nine months. (C/I – A) -
Action owner Stephanie Haslam – Completion dates: 30 September 2017 and 28 February 2018.

G1. Patient participation engagement plan being developed by the Stakeholder Reference Group with a view to increasing membership and ensuring all practices have a link to representatives if they cannot
provide a representative. Action Owner Julie Andrews – Completion Date 30th June 2017.

G2. Primary care workshop to be scheduled for N&S patient participation groups – June 2017 (Ass – A) - Action owner Julie Andrews – Completion date 30th June 2017 Completed on 27 June 2017

G1. Formal minutes will be taken at Future Primary Care Quality and Performance Meetings. Documented action plans to become routine practice during Practice visits or extraordinary visits to Practices in crisis
Action owner D Ainsworth – Completion Date 30th September 2017.

• The Joint Primary Care Clinical Cabinet will be decommissioned from 1 April 2017 in advance of the overarching primary care provider being established in May 2017 (C/I – D) - Action owner David Ainsworth –
Action completed
• Phase 1 clinical pharmacist trial in place. There has been an extension of the existing regional project and an application has been submitted for Phase 2 of the national scheme. Confirmation of the Phase 2
application funding has been received week commenced 10 April 2017 – Plans to be revised to fit funding award (C/I – A) - Action owner TBC – Action completed
• Two events held 19 and 22 July Newark and Ollerton to raise awareness of involvement opportunities within NHS. Further targeted work to be undertaken around PPGs – PPG Chairs meeting and enhancing membership
of SRG. (Ass – A)
Delegated Co-commissioning – Finance Report – July 2017

Mansfield and Ashfield CCG (04E)

The financial position for Mansfield and Ashfield CCG at Month 4 2017/18 is £587k underspent. The underspend is the expected position as the CCG have set-aside £1.4m from the primary care position in 2017/18 Below is the summary position by expenditure category.

<table>
<thead>
<tr>
<th>Row Labels</th>
<th>Sum of Annual budget (£)</th>
<th>YTD Budget</th>
<th>YTD Actual</th>
<th>YTD Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dispensing/Prescribing Drs</td>
<td>91,650</td>
<td>30,528</td>
<td>7,123</td>
<td>(23,405)</td>
</tr>
<tr>
<td>Enhanced Services</td>
<td>1,047,798</td>
<td>349,168</td>
<td>330,301</td>
<td>(18,867)</td>
</tr>
<tr>
<td>General Practice - APMS</td>
<td>1,121,354</td>
<td>373,781</td>
<td>352,235</td>
<td>(21,546)</td>
</tr>
<tr>
<td>General Practice - GMS</td>
<td>8,351,974</td>
<td>2,783,989</td>
<td>2,800,053</td>
<td>16,064</td>
</tr>
<tr>
<td>General Practice - PMS</td>
<td>7,852,754</td>
<td>2,617,577</td>
<td>2,549,909</td>
<td>(67,668)</td>
</tr>
<tr>
<td>General Reserves</td>
<td>1,872,678</td>
<td>516,867</td>
<td>0</td>
<td>(516,867)</td>
</tr>
<tr>
<td>Other GP Services</td>
<td>462,387</td>
<td>154,094</td>
<td>108,818</td>
<td>(45,276)</td>
</tr>
<tr>
<td>Other Premises costs</td>
<td>63,766</td>
<td>21,253</td>
<td>21,971</td>
<td>718</td>
</tr>
<tr>
<td>Premises Cost Reimbursement</td>
<td>3,027,040</td>
<td>1,008,878</td>
<td>1,035,658</td>
<td>26,780</td>
</tr>
<tr>
<td>QOF</td>
<td>2,337,399</td>
<td>588,619</td>
<td>652,125</td>
<td>63,506</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>26,228,800</strong></td>
<td><strong>8,444,754</strong></td>
<td><strong>7,858,202</strong></td>
<td><strong>(586,552)</strong></td>
</tr>
</tbody>
</table>

Key variances
Dispensing/Prescribing – There is a consistent underspend year to date of £23.5k in this area however this trend is unlikely to continue. It is expected that due to winter pressures spend in this area is likely to significantly increase and the forecast for Year End will be closer to the plan for the year.

Enhanced Services - The £19k underspend is driven by a change in accrual methodology for Minor Surgery from budget to actual cost averages due to more recent information being available. This contributes to an in-month benefit of £30k.

APMS – There is a £40k underspend YTD on Kirkby CPCCC (PICS) however a review of the spend is being carried out to assess whether full costs have been recovered yet and the impact going forward. The YTD underspend is off-set by a £20k overspend on Bull Farm which was not accounted for at budget setting but requires funding at a rate of £5k per month.

GMS – The £16k overspend is driven by an OOH deduction of a practice that has not been transacted by PCSE amounting to £10k YTD. This is to be corrected for Month 5.

PMS – The underspend YTD is driven by a combination of factors relating to the core contract for each practice. Each month there is a PMS Funding Differential Deduction by 1/48th per month of each practice in order to move towards equitable funding with the GMS contracts.
In addition in 2017/18 there are 6 PMS practices under Mansfield and Ashfield CCG who would be financially better off on a GMS contract. The full year impact if these practices were to convert is £108,000. During budget setting the PMS contract budgets were set at GMS rates with any PMS premium showing in addition to this on a separate subjective code. This means that should the practice wish to change this financial year the change has already been accounted for i.e. until they change the position is showing an underspend against these contracts.

Other GP Services – The underspend is driven by a one-off benefit of £15k which is the fall out of an accrual relating to the Doctors Retainer Scheme (Rosemary Street Health Centre). The balance is related to an underspend on ‘Clinical Other’ which requires further investigation.

Premises Cost Reimbursement – The overspend is driven by incorrect coding of premises costs that relate to APMS costs. This will be corrected in Month 5 and has no effect on the bottom line.

QoF – The over spend is driven by the 16/17 achievement being £26k higher than estimated for which as a consequence has resulted in a higher monthly aspiration payment in 17/18 driving a YTD overspend of £37.5k which will continue at the same rate until the end of the financial year.

**Fall out**

A review of the 2016/17 Fall out accruals in 2017/18 shows at month 4 an adverse impact of £5k which is predominantly driven by the 2016-17 QoF Achievement Payment which resulted in being higher than estimated for. The fallout review is ongoing as claims from practices relating to the previous financial year are still being made therefore not all accruals have materialised fully yet.

<table>
<thead>
<tr>
<th>Name</th>
<th>Fallout - Adverse / (Favourable)</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP Retainer</td>
<td>(15,363)</td>
</tr>
<tr>
<td>Prescribing and Dispensing</td>
<td>(6,800)</td>
</tr>
<tr>
<td>Unplanned Admissions</td>
<td>1,134</td>
</tr>
<tr>
<td>16/17 QoF Achievement</td>
<td>25,939</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>4,910</td>
</tr>
</tbody>
</table>
Reserves schedule

The schedule below provides a full analysis of reserves. Although the CCG holds a reserve totalling £1.9m, much of this remains committed as per the analysis below. Notably, the CCG have set aside £1.4m non-recurrently to support the wider financial position.

<table>
<thead>
<tr>
<th>Mansfield &amp; Ashfield CCG General Reserves</th>
<th>Annual Budget</th>
</tr>
</thead>
<tbody>
<tr>
<td>Balance as at M4</td>
<td></td>
</tr>
<tr>
<td>1.0% Non recurrent</td>
<td>262,000</td>
</tr>
<tr>
<td>0.5% Contingency</td>
<td>131,000</td>
</tr>
<tr>
<td>General Reserves</td>
<td>1,479,678</td>
</tr>
<tr>
<td>Ledger balance as at month 4</td>
<td>1,872,678</td>
</tr>
<tr>
<td>Commitments:</td>
<td></td>
</tr>
<tr>
<td>Primary care funds held to support the financial position</td>
<td>(1,412,000)</td>
</tr>
<tr>
<td>Population growth based on 16/17 growth at 17/18 price per patient: 1%</td>
<td>(175,228)</td>
</tr>
<tr>
<td>Premises inflation - 3.5%</td>
<td>(106,634)</td>
</tr>
<tr>
<td>CQC</td>
<td>(64,825)</td>
</tr>
<tr>
<td>Qrisk2</td>
<td>15,789</td>
</tr>
<tr>
<td></td>
<td>(1,774,476)</td>
</tr>
<tr>
<td>Uncommitted balance remaining</td>
<td>98,202</td>
</tr>
</tbody>
</table>

A number of risks remain within the primary care position as outlined above and within the wider CCG. The primary care position needs to be considered in line with the overall CCG position and is a contributing factor to the CCG control total.
The financial position for Newark and Sherwood CCG at Month 4 2017/18 is £112k Overspent. In addition there are further known commitments in excess of reserves held that will impact on the forecast position. Below is the summary position by expenditure category.

<table>
<thead>
<tr>
<th>Row Labels</th>
<th>Sum of Annual budget (£)</th>
<th>YTD Budget</th>
<th>YTD Actual</th>
<th>YTD Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dispensing/Prescribing Drs</td>
<td>521,287</td>
<td>173,740</td>
<td>156,897</td>
<td>(16,843)</td>
</tr>
<tr>
<td>Enhanced Services</td>
<td>547,552</td>
<td>182,474</td>
<td>188,735</td>
<td>6,261</td>
</tr>
<tr>
<td>General Practice - APMS</td>
<td>750,827</td>
<td>250,276</td>
<td>194,096</td>
<td>(56,180)</td>
</tr>
<tr>
<td>General Practice - GMS</td>
<td>11,299,390</td>
<td>3,766,453</td>
<td>3,796,473</td>
<td>30,020</td>
</tr>
<tr>
<td>General Reserves</td>
<td>91,342</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other GP Services</td>
<td>307,034</td>
<td>102,321</td>
<td>179,621</td>
<td>77,300</td>
</tr>
<tr>
<td>Other Premises costs</td>
<td>118,011</td>
<td>39,334</td>
<td>37,786</td>
<td>(1,548)</td>
</tr>
<tr>
<td>Premises Cost Reimbursement</td>
<td>2,228,442</td>
<td>742,743</td>
<td>756,628</td>
<td>13,885</td>
</tr>
<tr>
<td>QOF</td>
<td>1,793,615</td>
<td>421,683</td>
<td>480,591</td>
<td>58,908</td>
</tr>
<tr>
<td>Grand Total</td>
<td>17,657,500</td>
<td>5,679,024</td>
<td>5,790,825</td>
<td>111,801</td>
</tr>
</tbody>
</table>

Key variances
Dispensing/Prescribing – There is a consistent underspend year to date of £17k in this area however this trend is unlikely to continue. It is expected that due to winter pressures spend in this area is likely to significantly increase and the forecast for Year End will be closer to the plan for the year.

APMS – The underspend relates to Balderton Surgery (PICS) driven by a non-recurrent benefit from the fall out accrual form the last financial year of £45k. The balance is driven by underspend this year however this is reviewed on a monthly basis with the risk of Locum usage potentially driving costs up significantly.

GMS – The £30k overspend YTD is driven by a general overspend across the global sum contracts as appose to any individual practice. Further investigation is being carried out to identify the underlying issue.

Other GP Services – The overspend is predominantly driven by Locum costs of £87.5k YTD. Future costs are difficult to forecast due to the nature of the demand for Locums however work is being undertaken to assess current information and possible future scenarios.

Premises Cost Reimbursement – The overspend is driven by increased NHS PS rent payments relating to Major Oak Medical Practice of £13k YTD. Discussions are on-going with NHS PS to verify the payment schedule as there have been significant changes as a whole from the previous financial year as well as discrepancies with values provided to NHS England and that charged to practices.

QoF – The over spend is driven by the 16/17 achievement being £20k higher than estimated for which as a consequence has resulted in a higher monthly aspiration payment in 17/18 driving a YTD overspend of £38.5k which will continue at the same rate until the end of the financial year.
Fall out
A review of the 2016/17 Fall out accruals in 2017/18 shows at month 4 a potential benefit of £26k which is comprised of mainly an over-accrual for costs relating to Balderton (PICS) of £45k which offsets the adverse impact of the QoF achievement payment which was £20k higher than expected. The nature of Primary Care means that claims can be made throughout this financial year that relate to prior years therefore there are still fall out accruals that continued to be assumed in the position. These will be reviewed on an on-going basis with any favourable or adverse impacts reported when materialised.

<table>
<thead>
<tr>
<th>Name</th>
<th>Fallout - Adverse / Favourable</th>
</tr>
</thead>
<tbody>
<tr>
<td>APMS contract – Balderton (PICS)</td>
<td>(44,761.48)</td>
</tr>
<tr>
<td>Maternity</td>
<td>(5,935.30)</td>
</tr>
<tr>
<td>GP Retainer</td>
<td>(160.87)</td>
</tr>
<tr>
<td>Prescribing and Dispensing</td>
<td>4,504.68</td>
</tr>
<tr>
<td>16/17 QoF Achievement</td>
<td>20,344.37</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>(25,858.60)</td>
</tr>
</tbody>
</table>

Reserves schedule
The reserves schedule below shows that the CCG hold an annual budget in reserves of £91k. Due to budgetary pressures there was insufficient budget available to create a full 1.5% contingency and non-recurrent reserve. Hence the requirement for a negative general reserve as per below.

There are significant known commitments in excess of the reserve held which is expected to worsen the position as the year progresses. The CCG is exploring mitigations to offset this pressure. In particular the CCG is seeking a full understanding of costs within premises reimbursement with an expectation that these can be reduced.

<table>
<thead>
<tr>
<th><strong>Newark and Sherwood CCG</strong></th>
<th><strong>Annual Buget</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>General Reserves</strong></td>
<td></td>
</tr>
<tr>
<td>Balance as at M4</td>
<td></td>
</tr>
<tr>
<td>1.0% Non recurrent</td>
<td>171,620</td>
</tr>
<tr>
<td>0.5% Contingency</td>
<td>85,810</td>
</tr>
<tr>
<td>General Reserves</td>
<td>(166,088)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>91,342</td>
</tr>
<tr>
<td><strong>Commitments:</strong></td>
<td></td>
</tr>
<tr>
<td>Population growth based on 16/17 growth at 17/18 price per patient: 1.3%</td>
<td>(158,000)</td>
</tr>
<tr>
<td>Premises inflation - 3.5%</td>
<td>(77,700)</td>
</tr>
<tr>
<td>CQC</td>
<td>(22,816)</td>
</tr>
<tr>
<td>Qrisk2</td>
<td>(12,077)</td>
</tr>
<tr>
<td><strong>Balance remaining in reserves</strong></td>
<td>(179,251)</td>
</tr>
<tr>
<td>Name</td>
<td>Current position(s) held - i.e. Governing Body, Member practice, Employee or other -</td>
</tr>
<tr>
<td>----------------------</td>
<td>--------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Amanda Sullivan</td>
<td>Chief Officer (shared post with NHS Mansfield and Nottinghamshire Clinical Commissioning Group as voting member)</td>
</tr>
<tr>
<td>Barbara Brady</td>
<td>Interim DPH Nottinghamshire County Council (non-voting member)</td>
</tr>
<tr>
<td>Amanda Ainsworth</td>
<td>Director of Primary Care</td>
</tr>
<tr>
<td>Elaine Mox</td>
<td>Chief Nurse and Director of Quality (shared post with NHS Mansfield and Nottinghamshire Clinical Commissioning Group as voting member)</td>
</tr>
<tr>
<td>Eleni de Gilbert</td>
<td>Vice Chair of the Primary Care Commissioning Committee and Lay member of the Quality and Risk Committee (non-voting member)</td>
</tr>
<tr>
<td>Emma Challans</td>
<td>Healthwatch Board Member</td>
</tr>
<tr>
<td>Gavin Lunn</td>
<td>General Practitioner (Clinical Lead (voting member))</td>
</tr>
</tbody>
</table>

Declaration of interests for members/employees - Personal interest or that of a family member, close friend or other acquaintance (31 March 2017)
<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
<th>Declaration of Interest in relation to the practice</th>
<th>Declaration of Interest in relation to the Commissioning Group</th>
<th>Declaration of Interest in relation to the NHS Personal Interest</th>
<th>Declaration of Interest in relation to the provider</th>
<th>Declaration of Interest in relation to the clinical commissioning group</th>
<th>Declaration of Interest in relation to the provider manager in relation to provider matters</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jon Gabe</td>
<td>Head of Acute Care Services (non-voting)</td>
<td>None declared</td>
<td>None declared</td>
<td>None declared</td>
<td>None declared</td>
<td>None declared</td>
<td>None declared</td>
<td>30.06.17</td>
</tr>
<tr>
<td>Joe Lunn</td>
<td>Primary Care Commissioning Committee</td>
<td>None declared</td>
<td>None declared</td>
<td>None declared</td>
<td>None declared</td>
<td>None declared</td>
<td>None declared</td>
<td>28.09.17</td>
</tr>
<tr>
<td>Jon Towlar</td>
<td>Lay member (non-voting member)</td>
<td>None declared</td>
<td>None declared</td>
<td>None declared</td>
<td>None declared</td>
<td>None declared</td>
<td>None declared</td>
<td>15.12.15</td>
</tr>
<tr>
<td>Kerrie Woods</td>
<td>NHS England</td>
<td>None declared</td>
<td>None declared</td>
<td>None declared</td>
<td>None declared</td>
<td>None declared</td>
<td>None declared</td>
<td>29.08.17</td>
</tr>
<tr>
<td>Marcus Pratt</td>
<td>Associate Chief Finance Officer</td>
<td>None declared</td>
<td>None declared</td>
<td>None declared</td>
<td>None declared</td>
<td>None declared</td>
<td>None declared</td>
<td>27.06.16</td>
</tr>
<tr>
<td>Name</td>
<td>Role</td>
<td>Start Date</td>
<td>End Date</td>
<td>Conflicts of Interest</td>
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<tr>
<td>Nigel Marshall</td>
<td>Clinical Advisor and Deputy Caldicott Guardian</td>
<td>30.08.17</td>
<td>29.08.17</td>
<td>None declared</td>
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<td></td>
<td>LOCUM General Practitioner WORK SHERWOOD</td>
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<td>LOCUMs previously employed at Bassetlaw, Gainsborough, Market Harborough and</td>
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<tr>
<td></td>
<td>MEDICAL PARTNERSHIP FORMERLY SHALEY SURGERY 3003</td>
<td></td>
<td></td>
<td>Formerly employed at Premier Medical Group.</td>
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<td>WITHIN NHS N&amp;S CCG and M&amp;A CCG. WIFE</td>
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<td>FORMERLY EMPLOYED AT SHERWOOD GENERAL PRACTITIONIAN SHALEY MEDICAL</td>
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<td></td>
<td>PARTNERSHIP (FORMERLY FARNFIELD SURGERY) retired</td>
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<td>SURGERY) retired, previous Locum GP within Notts county pre-retirement 02.17. Clinical</td>
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<td></td>
<td>Commissioning Group in receipt of project funding</td>
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<td>Commissioning Group included in PRE-SPECIFIED UROLOGY PROJECT</td>
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<td>ASTRAS PHARMA /PRIVATE CONSULTANCY WORK PATHWAYS</td>
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<td>AND ADVISORY PREVIOUS WORK PATHWAYS AND ADVISORY PREVIOUS</td>
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<td>CARE IS BIO-CITY NOTTINGHAM Clinical Commissioning</td>
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<td>Care Is Bio-City Nottingham Clinical Commissioning Group currently working with Care</td>
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<td></td>
<td>IS ON INTERFERENCE SUPPORT / FACILITATION SOFTWARE</td>
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<td>Is Bio-City Nottingham Clinical Commissioning Group currently working with Care Is</td>
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<td>On Interference Support / Facilitation Software (stopped 15.07.16).</td>
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<td>None declared</td>
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<tr>
<td>Peter Clay</td>
<td>Governing Body Lay Representative (voting member)</td>
<td>30.06.17</td>
<td>29.08.17</td>
<td>None declared</td>
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<td></td>
<td>and Chair of Audit and Governance Committee Co-Chair</td>
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<td>of the Joint Auditor Panel. Conflicts of Interest.</td>
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<td>None declared</td>
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<tr>
<td>Ruth Lloyd</td>
<td>Head of Corporate Governance Joint post with NHS</td>
<td>15.06.16</td>
<td>29.08.17</td>
<td>None declared</td>
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<tr>
<td></td>
<td>Newark and Sherwood Clinical Commissioning Group</td>
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<td></td>
<td>My sister works in a Senior Staff nurse at Sherwood Forest Hospitals NHS Foundation</td>
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<td>Professional working relationship with KMPG as the M&amp;A and N&amp;S external auditors</td>
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<td>Chair of the Remuneration Panel of Lincolnshire County Council and a Member of the</td>
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<td>Remuneration Panel of West Lindsey District Council.</td>
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<tr>
<td>Shaun Batee</td>
<td>Lay Representative (voting member) Chair of Activity</td>
<td>05.05.15</td>
<td>29.08.17</td>
<td>None declared</td>
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<td></td>
<td>and Finance Committee</td>
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<td>Senior manager with the University of Nottingham the School receives NIHR funding and</td>
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<td>undertakes fundamental medical research.</td>
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<tr>
<td>Subeer Sejapra</td>
<td>Out of area General Practitioner</td>
<td>18.06.16</td>
<td>29.08.17</td>
<td>None declared</td>
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<td>Currently - a Partner at Clifton Medical Practice, Old Basford, Nottingham.</td>
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<tr>
<td>Thilan Bartholomeuz</td>
<td>General Practitioner Representative Clinical Chair</td>
<td>05.09.17</td>
<td>29.08.17</td>
<td>None declared</td>
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<tr>
<td></td>
<td>(voting member)</td>
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<td></td>
<td>Cancer Lead for Mid Notts CCG's and Chair of Nottinghamshire Strategic Cancer Advisory</td>
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<td>Group. Professional working relationship with Macmillan UK.</td>
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<td></td>
<td>Previously worked as a GP Partner at Clipstone and Farndale Medical Practice</td>
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<td>Attend occasional meetings sponsored by pharmaceutical companies and health</td>
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<td>organizations/charities, receive lunch of low value. There is a policy in place for</td>
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<td>gifts and hospitality received.</td>
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None declared
Draft Minutes of the Mansfield & Ashfield CCG and Newark & Sherwood CCG
Primary Care Commissioning Committees

Joint meeting in public

Thursday 13th July 2017
8.30-10.30
Birch House Rooms 2 and 3

Representing both CCG Primary Care Commissioning Committees (voting)
Mr Jon Towler, Chair
Mrs Eleri de Gilbert, Independent Lay Representative
Mrs Dawn Atkinson, CCG Head of Business Change and Implementation
Mr David Ainsworth, CCG Director of Primary Care
Mr Neil Moore, Director of Procurement and Market Development
Mrs Sarah Bray, CCG Chief Finance Officer (until 9.30am)
Mr Marcus Pratt, CCG Associate Chief Finance Officer (from 9.30am)
Mrs Sandy Hogg, CCG Director of Turnaround
Mr Peter Clay, CCG Governing Body Lay member and Chair of the Audit Committee
Mr Shaun Beebe, CCG Governing Body Lay Representative
Dr Nigel Marshall, CCG Clinical Advisor

In attendance (non-voting)
Dr Hilary Lovelock, Local GP
Dr Gavin Lunn, Clinical Chair, Mansfield and Ashfield CCG
Ms Paula Longden, CCG Primary Care Programme Manager
Mrs Ruth Lloyd, CCG Head of Corporate Governance
Ms Kerrie Woods, NHSE GP Contracts Manager, North Nottinghamshire
Mr Michael Wright, Chief Executive, Nottinghamshire LMC
Ms Charlotte Lawson, CCG Workforce Programme Manager
Mrs Sally Dore, CCG Head of Communications and Engagement
Mrs Hazel Taylor, CCG Senior Primary Care Development and Performance Manager
Ms Sue Wass, Corporate Governance Officer (minutes)

Apologies representing both CCG Primary Care Commissioning Committees (voting)
Dr Amanda Sullivan, CCG Chief Officer
Mrs Elaine Moss, CCG Chief Nurse
Mrs Andrea Brown, CCG Director of Programmes
Mrs Barbara Brady, Nottinghamshire County Public Health Consultant
Dr Subeer Satyam, Out of Area GP

Apologies in attendance (non-voting)
Ms Emma Challans, Nottinghamshire Healthwatch
Ms Joe Lunn, NHSE
Ms Michelle Livingstone, Chair, Nottinghamshire Healthwatch

<table>
<thead>
<tr>
<th>JPC/17/39</th>
<th>Welcome</th>
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<tbody>
<tr>
<td>a.</td>
<td>Introductions</td>
</tr>
<tr>
<td>b.</td>
<td>Apologies for absence</td>
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<tr>
<td>c.</td>
<td>Declaration of interest</td>
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</table>

The Chair welcomed members to the meeting and apologies were noted as above.
A potential conflict of interest for Dr Lunn and Dr Lovelock was noted in paper JPC/17/52, which contained references to the practice of Dr Lunn and Dr Lovelock, it was agreed that they remain in the meeting and participate fully in any discussion.

**JPC/17/40 Questions from members of the public**

No questions were received.

**JPC/17/41 Minutes of the meeting held on 11 May 2017**

The minutes of the meetings held on 11 May were agreed as an accurate summary of discussions.

**JPC/17/42 Actions arising from the meeting held on 11 May 2017**

Actions JPC/17/24 and 26 were noted as future actions to be confirmed as complete in September. Action JPC/17/32 was tabled for discussion under item JPC/17/49.

All other actions were noted as complete.

**JPC/17/43 Forward Plan**

The Forward Plan was noted.

**JPC/17/44 Plan for Reducing Clinical Variation**

Mr Ainsworth recapped on the discussions at the last meeting, which had focused on the reasons for avoidable variation and activities to tackle it. The Committees had requested a plan with actions and timescales. This was presented with suggested KPIs.

Mrs de Gilbert asked what was being done to incentivise practices. Mr Ainsworth reported this was a combination of incentivising the right behaviour, such as use of the Best Practice Scheme, or by performance management and the use of peer to peer reviews. Dr Marshall agreed the key was to help practices understand the need for consistency to be fair to all patients. Dr Lovelock noted that underperforming practices were often those most difficult to engage with and it was acknowledged that different methods of engagement were required for individual circumstances. Mrs Atkinson noted the need for practices to influence patient behaviour, using PPGs to engage their populations in a much stronger way. Mr Beebe noted the need to understand rising unplanned demand and a number of factors were noted, including the risk-averse nature of the 111 service, the need to educate parents and carers in self-care management. Dr Lovelock noted that in her opinion weekly peer review targets were unlikely to be achievable.

Mrs Hogg asked that milestones be added to the action plan; with those in the plan as presented being absolutes. It was also noted the QIPP saving on Consultant Connect would be subject to scrutiny by the Turnaround Board. The outcomes also required stating in measurable terms. The Chair asked that an updated plan be brought to the September Committee meeting to give assurance that the CCGs had the capacity to deliver the action plan, with updated milestones and KPIs, and be tailored to individual practices.
- **ACTION:** Mr Ainsworth to bring an updated plan to the September Committee meeting to give assurance that the CCG had the capacity to deliver the action plan, with updated milestones and KPIs, and be tailored to individual practices.

The plan for the reduction of clinical variation was APPROVED.

<table>
<thead>
<tr>
<th>JPC/17/45</th>
<th><strong>Member Practice Agreement</strong></th>
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<tbody>
<tr>
<td>Mr Ainsworth reported that the Member Practice Agreement set out the relationship between member practices and the CCG. All member practices were required to sign the Agreement and thus contribute to the goals of the CCGs. The Agreement had been revised, rationalised and updated and had been to the Steering Group for comment prior to consultation with the Clinical Executive and this Committee, ahead of final ratification by the Governing Bodies in July.</td>
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<tr>
<td>The Committees ENDORSED the Agreement.</td>
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<tr>
<th>JPC/17/46</th>
<th><strong>Governance Arrangements for the Delivery of Primary Care QIPP savings</strong></th>
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<tbody>
<tr>
<td><strong>Primary Care Quality and Performance Review Group (PCQPRG) Terms of Reference</strong></td>
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<tr>
<td><strong>Primary Care Commissioning Steering Group Terms of Reference</strong></td>
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<tr>
<td>Ms Longden reported on arrangements that had been put in place to monitor and manage the primary care QIPP savings target. The Terms of Reference for the Primary Care Quality and Performance Review Group and Primary Care Steering Group had been revised to reflect the enhanced roles. The Primary Care Quality and Performance Review Group would act as the QIPP programme board and would report to the Financial Recovery Group, with an exception report to this Committee. The Steering Group would act as the oversight group for the implementation of the GP Forward View and for the generation of new ideas.</td>
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<tr>
<td>In discussion a number of points were raised and the following actions were agreed:</td>
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<td><strong>ACTIONS:</strong></td>
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<tr>
<td>• Mr Ainsworth to consider strengthening clinical representation on the Steering Group via the clinical leads</td>
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<td>• Mrs Lloyd to ensure that QIPP programme Board standard wording was used in the Terms of Reference for the Primary Care Quality and Performance Review Group; and to amend the deputy chair to Mrs de Gilbert</td>
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<tr>
<td>• Mr Ainsworth to ensure the revised Terms of Reference were formally approved at the respective meetings during July</td>
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<tr>
<td>The Terms of Reference for the Primary Care Quality and Performance Review Group and Primary Care Commissioning Steering Group were APPROVED.</td>
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<table>
<thead>
<tr>
<th>JPC/17/47</th>
<th><strong>Primary Care Commissioning Steering Group progress report and minutes of meeting on 8 June</strong></th>
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<tbody>
<tr>
<td>The report was noted.</td>
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Primary Care Strategy Implementation Exception Report

- Vanguard
- GP Forward View

Ms Longden reported on the Acute Home Visiting Service. Both services were now fully staffed; however at the end of May the number of visits was lower than plan and this had been raised through the contract management meetings. The Chair asked for an update on plans for full population coverage. It was noted that there would be a review at nine months to determine whether roll-out would be cost-effective. There was a discussion regarding whether decisions would need to be made earlier than planned and it was noted that although the release of GP time could be captured, there were issues to be resolved on double counting of the main outcome of the scheme, the avoidance of admissions to acute services. The Chair requested that a robust methodology was required in order to make a timely decision on future roll out and to update the Committees in the September report.

- **ACTION:** Ms Longden to update the Committees on plans to evaluate the Acute Home visiting Service at the September Committee meeting

Regarding the Best Practice Scheme, it was noted QIPP savings were still being realised and other projects that were not in the original Primary Care QIPP savings plan were being utilised to mitigate the underspend. The launch of phase 2 was scheduled for September.

It was noted that in order to ensure achievement of the agreed QIPP savings, regarding the cardiology and near patient testing projects, roll out to the wider population had been brought forward.

Mrs Taylor reported on progress on the GP Forward View. The Committees noted the need to evaluate whether the GP Resilience Scheme did provide long term benefits and to provide feedback to the national NHSE if this was not the case.

The Chair asked whether capacity constraints within the Team were a risk to delivery. Mr Ainsworth noted the team had held a time out to assess priorities and if there was an increased risk, it would be added to the Primary Care risk PC1.

The reports were NOTED.

Best Practice Scheme 2016/17

Ms Longden reported that although the Scheme had had a number of challenges, there were also a number of positive outcomes, as detailed in the report. The report also gave detail of the approach to the evaluation of the scheme and the payment methodology. A discussion paper had been brought to the June Steering Group as part of the development of a second phase, which would be brought to the Committees for approval in August.

The Committees discussed a number of points, including the need to engage with all practices in the second phase; the risk of non-engagement of practices that had not received any additional payments despite their participation in the scheme; and the requirement for early and clear communications to practices, which should begin at the earliest opportunity. Mrs Hogg also emphasised the need for clarity on targets and how under performance would be mitigated.
The report was NOTED.

<table>
<thead>
<tr>
<th>JPC/17/51</th>
<th><strong>Forest Medical Group – Oak Tree Lane reduced sessions</strong></th>
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<tr>
<td>Ms Woods reported that due to the loss of a number of GPs, the Forest Medical Group were proposing to reduce the number of sessions GPs provided at their Oak Tree Lane branch from September. It was noted that although the contract did not require approval to a reduction in core hours at a branch surgery, there was a requirement that NHSE and the CCG ensure that the needs of the patients were met.</td>
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<td>It was noted that the practice had been proactive in engaging their PPG and had communicated alternatives to patients. Mrs de Gilbert raised concern that the Oak Tree Lane practice was in a deprived area, which was geographically isolated from other practices; and Mr Wright noted the need to assess impact on neighbouring practices.</td>
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<td>It was agreed that all available options and actions should be explored to ensure the branch practice remained open at previous levels, both in the short and long term and that the practice overall was sustainable. The Chair requested that Mr Ainsworth lead on a report on short and long term options for the practice to be discussed at the August Extra Ordinary Committee meeting and to email the Committees with an update in the interim.</td>
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<tr>
<td><strong>ACTION:</strong> Mr Ainsworth to lead on the drafting of a report regarding the sustainability of the Forest Medical Group, to be discussed at the August Extra Ordinary Committee meeting and to email the Committees with an update in the interim.</td>
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<tr>
<th>JPC/17/52</th>
<th><strong>Monitoring of Quality &amp; Performance in Primary Care</strong></th>
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<tr>
<td>A potential conflict of interest was noted in this paper, which contained references to the practice of Dr Lunn and Dr Lovelock. It was agreed that they remain in the meeting and participate fully in any discussion.</td>
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<td>Mrs Taylor reported on on-going work to improve Friends and Family Test reporting and noted the number of practices receiving intense support from the Team had increased, largely due to workforce issues.</td>
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<td>The Committees discussed the Friends and Family Test, with Mr Wright noting they provided useful feedback to practices; and in addition to contractual compliance letters, thought should be given to proactive communication on the issue to encourage take up in practices.</td>
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<tr>
<td><strong>ACTION:</strong> Mrs Dore to consider proactive communication on the issue to encourage take up of Family and Friends tests in practices.</td>
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<thead>
<tr>
<th>JPC/17/53</th>
<th><strong>Primary Care Risks</strong></th>
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<tr>
<td>The Committees agreed the current risk rating for PC1 was appropriate.</td>
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The Primary Care Risk Register was NOTED.

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<tr>
<th>JPC/17/54</th>
<th>Finance Reports</th>
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<td></td>
<td>Mr Pratt asked the Committees to note that both CCGs had received 2.3% of inflationary costs and utilisation was detailed in the report. It had been agreed for Mansfield and Ashfield CCG to set aside £1.4m to be released in 2018/19 and to hold 1% of non-recurrent funds as uncommitted. Financial risks for both CCGs were mitigated by actions as detailed in the report.</td>
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<td>Dr Lovelock queried contingencies for population growth and paternal payments. Mr Pratt noted that the 2018/19 allocation was able to be revisited and contingency had allowed for an increase in paternal payments.</td>
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<td></td>
<td>Mrs de Gilbert asked whether there was a financial risk as practices moved from PMS to APMS contracts. This was acknowledged as a potential risk and the next report would provide a breakdown of reserves. It was agreed the Committees should be sighted on any future requests to move contracts.</td>
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<td>• ACTION: Mr Pratt to provide a breakdown of reserves in the next report.</td>
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<td>The Finance Reports were NOTED.</td>
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## Actions arising from the

**Joint Mansfield & Ashfield CCG and Newark & Sherwood CCG**

**Primary Care Commissioning Committee**

**Public Section**

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<thead>
<tr>
<th>Number</th>
<th>Name</th>
<th>Action</th>
<th>Progress/ Status</th>
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<tr>
<td><strong>Actions arising from Thursday 11 May 2017</strong></td>
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<tr>
<td>JPC/17/24</td>
<td>Mrs Dore</td>
<td>To update the plan to include implementation timescales to be brought to the next Primary Care Commissioning Steering Group on 8 June.</td>
<td>On this agenda for noting</td>
</tr>
<tr>
<td>Engagement Plan</td>
<td></td>
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<tr>
<td>JPC/17/26</td>
<td>Mr Ainsworth</td>
<td>To ask the Joint Primary Care Commissioning Steering Group to undertake a deep dive on the project and escalate any concerns to the Committees.</td>
<td>Action Superseded: Movement of Skype communications to business as usual. Arden’s is supporting clinical decision making</td>
</tr>
<tr>
<td>Skype Benefits</td>
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<tr>
<td>realisation</td>
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<tr>
<td><strong>Actions arising from Thursday 13 July 2017</strong></td>
<td></td>
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<tr>
<td>JPC/17/44</td>
<td>Mr Ainsworth</td>
<td>To bring an updated plan to the September Committee meeting to give assurance that the CCG had the capacity to deliver the action plan with updated milestones and KPIs and be tailored to individual practices.</td>
<td>On this agenda</td>
</tr>
<tr>
<td>Clinical Variation</td>
<td></td>
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<tr>
<td>JPC/17/46</td>
<td>Mr Ainsworth</td>
<td>To consider strengthening clinical representation on the Steering Group via the clinical leads</td>
<td>Invitations will be sent out to members when agenda items fit their attendance.</td>
</tr>
<tr>
<td>QIPP Governance</td>
<td></td>
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<tr>
<td>JPC/17/46</td>
<td>Mrs Lloyd</td>
<td>To ensure standard wording for the QIPP programme Board was used in the Terms of Reference for the Primary Care Quality and Performance Review Group and to amend the deputy chair to Mrs de Gilbert</td>
<td>Action completed</td>
</tr>
<tr>
<td>QIPP Governance</td>
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<tr>
<td>JPC/17/46</td>
<td>Mr Ainsworth</td>
<td>To ensure the revised Terms of Reference were formally approved at the respective meetings during July</td>
<td>Action completed</td>
</tr>
<tr>
<td>QIPP Governance</td>
<td></td>
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<tr>
<td>JPC/17/49</td>
<td>Ms Longden</td>
<td>To update the Committees on plans to evaluate the Acute Home visiting Service at the September Committee meeting</td>
<td>Update given in the Primary Care Exception report</td>
</tr>
<tr>
<td>Exception report</td>
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</tr>
<tr>
<td>Number</td>
<td>Name</td>
<td>Action</td>
<td>Progress/Status</td>
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<tr>
<td>JPC/17/51</td>
<td>Mr Ainsworth</td>
<td>To lead on the drafting of a report regarding the sustainability of the Forest Medical Group, to be discussed the August Extra Ordinary Committee meeting: and email the Committees with an update in the interim.</td>
<td>Discussed at the August Confidential Committee meeting</td>
</tr>
<tr>
<td>JPC/17/52</td>
<td>Mrs Dore</td>
<td>To consider proactive communication on the issue to encourage take up of Family and Friends tests in practices.</td>
<td>PPGs have been asked to not only encourage GP practices to report Friends and Family Test (FFT) data on CQRS on a monthly basis (this is a contractual requirement), but that the PPGs should encourage GP practices to review FFT feedback to learn and improve GP services.</td>
</tr>
<tr>
<td>JPC/17/54</td>
<td>Mr Pratt</td>
<td>To provide a breakdown of reserves in the next report.</td>
<td>To be included in the finance report</td>
</tr>
</tbody>
</table>
## Joint Primary Care Commissioning Committees – Forward Planner

<table>
<thead>
<tr>
<th>Administration</th>
<th>Committee</th>
<th>Contact</th>
<th>July 17</th>
<th>Sept 17</th>
<th>Nov 17</th>
<th>Jan 18</th>
<th>March 18</th>
<th>May 18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minutes and actions of previous meeting</td>
<td>Both</td>
<td>Ruth Lloyd</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Delegations of interest</td>
<td>Both</td>
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<thead>
<tr>
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<tr>
<td>PC Commissioning Committee terms of reference</td>
<td>Both</td>
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<td>(yearly basis)</td>
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<tr>
<td>Joint CCGs PC Steering Group terms of reference</td>
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<td>(yearly basis)</td>
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<td>Bi monthly Joint CCGs PC Steering Group advice report</td>
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<td>Primary Care Performance &amp; Quality Review Group (PCPRG) Terms of Reference (yearly basis)</td>
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<tr>
<td>Primary care quality 360 audit</td>
<td>Both</td>
<td>Elaine Moss</td>
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<th>March 18</th>
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<td>Primary Care Strategic Advisory Group update</td>
<td>Both</td>
<td>David Ainsworth</td>
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<td>X</td>
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<td>Half yearly Primary Care Hub/CCG performance review outputs</td>
<td>Both</td>
<td>NHSE</td>
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<tr>
<td>Estates Strategy</td>
<td>Both</td>
<td>Andrea Brown</td>
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<tr>
<td>Primary Care Transformation – Implementation Plan exception reporting</td>
<td>Both</td>
<td>David Ainsworth</td>
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<td>X</td>
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<tr>
<th>Primary Care Quality and Risks</th>
<th>Committee</th>
<th>Contact</th>
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<tr>
<td>Monitoring of Quality &amp; Performance in Primary Care</td>
<td>Both</td>
<td>David Ainsworth</td>
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<td>Primary Care Risks</td>
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<td>Director of Primary Care Operational Report (c)</td>
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<td>David Ainsworth</td>
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<td>Financial plan</td>
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<td>Marcus Pratt</td>
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<td>Financial year end plan</td>
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Friday, 08 September 2017
## Joint Primary Care Commissioning Committees – Forward Planner

<table>
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<tr>
<th>Report</th>
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<td><strong>Primary Care Initiatives</strong></td>
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<td>Early evaluation of the Acute Home Visiting Service</td>
<td>Both</td>
<td>Paula Longden</td>
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<td>STP Primary Care Staff Education and Training Group’s Delivery Proposals</td>
<td>Both</td>
<td>Charlotte Lawson</td>
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<td><strong>Engagement</strong></td>
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<tr>
<td>Formalised communication &amp; engagement plan in relation to primary care transformation</td>
<td>Both</td>
<td>Andrea Brown</td>
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Friday, 08 September 2017
Progress Report on Managing Clinical Variation

DATE OF MEETING: 14 September 2014  PAPER REF: JPC/17/60

AUTHOR: Cathy Quinn  PRESENTER: Cathy Quinn

PURPOSE OF REPORT:
The Committee received a report and action plan in July on the CCGs plans to manage clinical variation. This report provides information on the progress being made against the plan up to end August 2017.

RECOMMENDATION:
- To endorse
- To approve
- To receive the recommendation (see details below)
- To discuss

EXECUTIVE SUMMARY (OVERVIEW):
At its meeting on 13 July, the committee requested an updated plan to be submitted to the September Committee meeting to give assurance that the CCG had the capacity to deliver the action plan with updated milestones and KPIs and be tailored to individual practices.

Appendix One includes the updated plan with revised actions, milestones, lead officers and KPIs. Further work is needed on KPIs for some areas of the plan. Actions are tailored to individual practices where required through existing primary care practice visits or one-to-one engagement.

The plan contributes to delivery of various QIPP projects including referral management, advice & guidance and referral thresholds.

The committee is asked to receive the plan and comment on any further assurance required.

REPORT:
The updated action plan for managing clinical variation is contained in Appendix One.

QIPP Assurance and connection
The plan contributes to delivery of various QIPP projects including referral management, advice & guidance and referral thresholds

Financial Impact and Risks
Reducing clinical variation can help with financial efficiencies through avoided referrals and better patient care.
Legal Impact
No legal issues identified

Risk Implications, Assessment and Mitigations
The plan supports risk mitigation around finances, quality and NHS England assurance.

Consultation, Involvement and Engagement
Each action within the plan has involved engagement with practices and patients to support implementation as required.

Equality Impact
No equality issues identified. Reducing clinical variation with help improve equality in care across all patient groups.

How does this contribute to the outcomes and objectives of the CCG:
- ☑ Quality
- ☑ Health
- ☑ Financial
- ☑ Clinical
- ☑ Performance (tick as appropriate)

Conflicts of Interest:
This is a recommended action to be agreed by the Chair at the beginning of the item.
- ☑ No conflict identified
- □ Conflict noted, conflicted party can participate in discussion but not decision (see below)
- □ Conflict noted, conflicted party can remain but not participate (see below)
- □ Conflicted party is excluded from discussion (see below)

Please state rationale for decision
Advice regarding conflicts of interest is available from the Corporate Governance Team, or here:

Confidentiality:
Is the information in this paper confidential?
- □ Yes
- ☑ No

If the paper is considered confidential, please tick the relevant box.
- □ Does it contain personal information e.g. regarding a patient, member of staff or another individual?
- □ Is the CCG in commercial negotiations or about to enter into a procurement exercise and would the information in the report prejudice the CCG’s position if made public e.g. by declaring the budget available for a particular contract in advance of a tendering exercise or indicating what the CCG’s fall-back position might be in a negotiation situation?
- □ Does the report include commercial in confidence information about a third party? - this would need to be relatively detailed information which could be argued to give a competitor an advantage if it was made available to them i.e. the total value of a contract awarded to a supplier or the value of a tender could not be considered commercial in confidence but details of how a supplier performs a particular process or the day rate for different grades of consultancy staff might be considered confidential.
☐ Does the report contain information which has been provided to the CCG in confidence by a third party and is there a risk that the third party could take legal action for a breach of confidence if it was disclosed?

☐ Does the discussion relate to policy development not yet formalised by the organisation and if the discussion were made public would this hamper full and frank discussion and therefore adequate consideration and development of proposal? This is intended for matters that are considered at a Board meeting early in the process to obtain initial thoughts and to give officers a steer in developing the policy. It would not be appropriate to use this argument where the governing body is being asked to approve a policy or initiative as this would be too late to argue that policy development was still on-going.

☐ Has the document/report been produced by another public body which has chosen not to make the document publicly available and would not wish the CCG to do so?

☐ Is the document in draft form which will publicly available at a future date?

Note: Upon request for the release of a paper deemed confidential, under Section 36 of the Freedom of Information Act 2000, parts or all of the paper will be considered for release by the CCG’s ‘Qualified Person’ based on the circumstances at that time.
# Plan for Managing Clinical Variation in General Practice 2017/18

<table>
<thead>
<tr>
<th>High Level Objective</th>
<th>Action</th>
<th>Actions</th>
<th>Lead</th>
<th>Milestones</th>
<th>Progress update - August 2017</th>
<th>Key Performance Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Ardens Decision Support Tool</strong></td>
<td>Implement Ardens in every practice and provide training for practice staff.</td>
<td>Chris Sewell</td>
<td>Ardens live in all practices by July 17 Training provided to all practices by Oct 17 Templates for restricted procedures in place by July 17 Clinical templates in place by Mar 18 Peer review template in place by Sep 17 See separate action plan for full details and timeline</td>
<td>Ardens is live in all 41 practices. Training completed in 27 out of 41 practices. Primary care lead for project reviewed and clinical referral advisor allocated time to support project. Templates for restricted procedures, peer review and some clinical areas in place. Process to be developed with clinical leads to support development of all clinical templates. CCG agreed future funding of Ardens in response to practice concerns around sustainability.</td>
<td>CCG working with Ardens around suitable KPIs</td>
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<tr>
<td></td>
<td><strong>Peer to Peer review of referrals</strong></td>
<td>Implement retrospective peer review. Use of E-referrals. Implement prospective peer review according to NHS England specification.</td>
<td>Cathy Quinn</td>
<td>Practice visits to take place with high referring practices by Referral Facilitation Team by Aug 17. Implement prospective peer review through Best Practice Scheme by Sept 17. See separate action plan for full details and timeline.</td>
<td>First round of practice visits completed. Peer review plan submitted to NHSE for assurance purposes. Patient information material produced and sent to PRS for comment. Peer review formally included as part of the 17/18 Best Practice Scheme.</td>
<td>Percentage of referrals where a peer review has taken place.</td>
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<tr>
<td></td>
<td><strong>Advice and Guidance &amp; Consultant Connect</strong></td>
<td>Promote use of electronic advice and guidance to GP practices. Monitor the utilisation of advice and guidance including response times and outcomes. Evaluate benefits of consultant connect and build into A&amp;G model if appropriate. Implement local model for Advice &amp; Guidance.</td>
<td>Cathy Quinn/ Andrea Brown</td>
<td>Evaluate consultant connect pilot by July 17. Explore potential models for advice and guidance (A&amp;G) by Aug 17. Agree local model for A&amp;G with SFH Heads of service by Oct 17. Implement local model for A&amp;G by Dec 17.</td>
<td>Actions around consultant connect and advice and guidance combined to reflect QIPP plan. SRO transferred to Director of Primary Care to broaden scope of project. Deep dive completed for consultant connect. Discussions are taking place with SFH heads of service to understand how best to facilitate greater utilisation and explore a new model for A&amp;G locally. Monitoring systems have been reviewed to provide regular reporting.</td>
<td>Percentage of advice and guidance referrals that prevented hospital attendance (inc. proxy markers of eReferral).</td>
</tr>
<tr>
<td></td>
<td><strong>Use of E-referrals</strong></td>
<td>Implement change from paper to eReferral as standard for all referrals to SFH.</td>
<td>Diane Butcher</td>
<td>Milestones are part of separate project plan. Aim to reach 100% eReferral by 30 July 17. See separate action plan for full details and timeline.</td>
<td>Project is being run in collaboration with SFHFT as part of national pilot. Monitoring systems are in place with weekly reporting by practice.</td>
<td>As at end August, over 99% referrals are being sent as eReferral and only 20 paper referrals being made in Aug 17. Percentage of e-referrals as a total of all referrals.</td>
</tr>
<tr>
<td></td>
<td><strong>Referral thresholds</strong></td>
<td>Implement restricted and not routinely funded (NRF) policies in both CCGs.</td>
<td>Sian Clark</td>
<td>Implementation of restricted and NRF policies by April 2017. Perform review of restricted and NRF policies by July 17. Extend scope of restricted and NRF policies by Oct 17.</td>
<td>NRF policies in place. Not routinely funded task and finish group set up and meeting to take actions forwards. CCGs considering adopting new policies from Bedford CCG. Plans being explored to create a web portal to streamline prior approval referrals and improve consistency.</td>
<td>KPIs under review by NRF task &amp; finish group.</td>
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<td></td>
<td><strong>Referral Facilitation Model</strong></td>
<td>Implement Referral Facilitation Model in CCGs. Prioritise action in highest referring practices. Undertake practice visits including analysis of practice referrals, practice audits and clinical retrospective peer review by Clinical Referral Advisor.</td>
<td>Stephen Worrall / Cathy Quinn</td>
<td>Provide referral guidance for common conditions by April 17. Review content and format of clinical pathways website by end July 17. Complete visits to the highest referring practices by end Aug 17. Roll out principles of model to all practices by Dec 17.</td>
<td>Referral guidelines in place and website reviewed. Six of the seven highest referring practices have been visited. Individual practice plans have been devised and signed off by both parties to increase accountability. Action plans will be monitored through DMCC.</td>
<td>Reduction in GP referrals.</td>
</tr>
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<td></td>
<td><strong>Best Practice Scheme 16/17 - realise the benefits</strong></td>
<td>Establish a review panel. Evaluate the outcomes and communicate to practices. Use the learning to inform 17/18.</td>
<td>Jacqui Kemp</td>
<td>Evaluate 16/17 scheme by July 17. Present report to JPCC for agreement by July 2017.</td>
<td>Actions complete.</td>
<td>As per evaluation report for BPS.</td>
</tr>
<tr>
<td>Standardise approach to system-wide objectives</td>
<td>Best practice scheme 17/18 - launch</td>
<td>Ensure learning from 16/17 scheme is built into new scheme for 17/18. Establish a working group to develop the scheme to include practice staff. Agree scope for 17/18 BPS.</td>
<td>Jacqui Kemp</td>
<td>Produce draft BPS 17/18 by Jul 17. Obtain JPCCC sign off by August 17. Roll out BPS to practices by September 17.</td>
<td>Actions complete</td>
<td>KPI included in BPS</td>
</tr>
<tr>
<td>Review Local Enhanced Services - phase 2 of BPS</td>
<td>Perform in depth review of existing LES schemes including specification, take up and outcomes. Review scope of current LES to produce new specifications. Incorporate where appropriate into the best practice scheme phase 2 and 3.</td>
<td>Paula Longden</td>
<td>Perform phased review of LES - phase 1 - near patient testing - Oct 17. Phase 2 - DMARD, anticoagulation, basket LES - Feb 18.</td>
<td>Primary Care team discussed plan to review LES, allocating leads for delivery. Further resource implications will be considered by the team.</td>
<td>Revised LES agreed and issued to practices. Specific KPIs included in LES.</td>
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<tr>
<td>Health optimisation</td>
<td>Establish a multi disciplinary working group that represents secondary and primary care - with strong clinical leadership. Agree the timeline and project plan. Agree the clinical model for health optimisation. Implement plan to timescales.</td>
<td>Chris Sewell</td>
<td>Stakeholder workshop - October 17. Phase 1 - agree templates to capture health information for common measures - August 2017. Phase 2 - develop a pre-op assessment in SFH to screen pre-op patients - October 2017. Phase 3 - implement model to support health optimisation approaches where risk factors identified e.g. use of existing PH services - April 2018.</td>
<td>Discussion held with SFH to build engagement in model. Standard template created in Ardens to capture health measures e.g. BMI, smoking status. SFH developed pre-op assessment template for ASA level 1 patients and currently being piloted. Stakeholder workshop being organised with SFH surgeons to agree clinical model &amp; pathways. Date TBC.</td>
<td>Health optimisation KPIs to be developed.</td>
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<tr>
<td>Standardise approach to Public Health Areas</td>
<td>Analyse QOF Compliance</td>
<td>Commission NHSE Hub report on practice compliance and achievement in QOF during 2016/17. Seek support from public health to analyse and identify unmet health needs for population. Explore actions required to improve standardisation to approach and compliance.</td>
<td>Cathy Quinn</td>
<td>NHSE Review to be completed by October 2017. Public health team engagement by December 2017. Plan to be in place by January 18.</td>
<td>Action not yet started</td>
<td>QOF KPIs to be developed.</td>
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<tr>
<td><strong>TITLE:</strong></td>
<td>General Practice Communication and Engagement Plan</td>
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<td><strong>DATE OF MEETING:</strong></td>
<td>14 September 2017</td>
<td><strong>PAPER REF:</strong></td>
<td>JPC/17/06</td>
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<tr>
<td><strong>AUTHOR:</strong></td>
<td>Sally Dore</td>
<td><strong>PRESENTER:</strong></td>
<td>David Ainsworth</td>
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<tr>
<td><strong>ISSUE:</strong></td>
<td>At the May meeting the Committees requested that the plan be updated to include implementation timescales.</td>
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<tr>
<td><strong>RECOMMENDATION:</strong></td>
<td>The Committee is asked to note the updated plan.</td>
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</table>

**HOW DOES THIS CONTRIBUTE TO THE STRATEGIC OBJECTIVES OF THE CCG:**

**RISK ASSURANCE:**

**CONFLICTS OF INTEREST:**

This is a recommended action to be agreed by the Chair at the beginning of the item.

- ✔ No conflict identified
- ❏ Conflict noted, conflicted party can participate in discussion but not decision (see below)
- ❏ Conflict noted, conflicted party can remain but not participate (see below)
- ❏ Conflicted party is excluded from discussion (see below)

There are no conflicts known in relation to this agenda item.

**CONFIDENTIALITY:**

Is the information in this paper confidential?

- ✔ No
- ❏ Yes
General Practice Communication and Engagement Plan
September 2017
## Contents

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Stakeholder Map .................................................................... 6  
Action plan ............................................................................. 8
Introduction
The changing operating environment of the NHS makes it critically important that we focus time and attention on understanding what our customers want. Equally important is our ability to describe our commissioned services and engage with our key stakeholders in the debate about the options for the future provision of services.

The NHS Five Year Forward View and General Practice Forward View identifies the need for healthcare services to be delivered in a different way in the future and describes the need to break down the barriers between primary and secondary care. Maintaining good relationships with General Practice will provide a strong foundation upon which to drive and deliver transformation.

In this plan the word **CCGs** (Clinical Commissioning Groups) refers to the local NHS organisation which commissions NHS services on behalf of mid Nottinghamshire people. The organisation is made up of members from the GP Practices of Mansfield, Ashfield, Newark and Sherwood.

**CCG members** refers to Mansfield, Ashfield, Newark and Sherwood GPs and GP practice staff that make up the organisation.

**CCG staff** refers to NHS staff members who are employed by the CCG to run the organisation on behalf of the GP members.

Local picture
Mansfield and Ashfield CCG and Newark and Sherwood CCG are clinically-focused, member-led organisations with a clear vision:

“We will have joined up, sustainable and high quality services across health and social care. People will remain at home whenever possible, supported by a team of people who are working together to meet their need-shifting the focus from the needs or processes of their organisations. Services will be proactive and fleet of foot. People will be supported to develop the confidence and skills to be as independent as possible”.

The successful delivery of our vision will be underpinned by the CCGs listening to and working effectively with our members, providers, partners, patient and voluntary organisations, service users and residents on decision making and planning.

We need to use clinical expertise and citizens to support the design of new services across health and social care and need to communicate with general practice as providers both of primary care services and as gatekeepers to the wider NHS via patient referrals.

By working in partnership, we can ensure the services we commission meet the diverse needs of the population, and that both professionals and residents are aware of how best to use these services, to deliver improved health and wellbeing.
outcomes. The CCGs communications and engagement team has an important part to play supporting the CCGs to achieve this.

For the last 3 years the CCGs have commissioned Arden and GEM CSU to support the communications and engagement function alongside CCG employed staff. This has been a positive function but there have been constraints with some staff being ‘shared’ with other CCGs. During 2017 the CCGs have decided to build an in-house Communications and Engagement Team, this team will be tasked with maintaining a communication and engagement function with general practice alongside maintaining and improving corporate communications and engagement; building audience insights and partner relationships; establishing new channels and standardised processes; and delivering key messages on key CCG matters.

Building on these foundations, a strategic approach to communications and engagement will be taken in 2017-18, aligning activity and resource with the priorities of the CCGs, building narratives that span multiple workstreams and supporting teams across the CCG to deliver effective communications and engagement activity especially in primary care.

This plan is intended for internal audiences (CCG Governing Body and related sub groups, Executive Team, members and staff). The plan will also inform discussions with our partners’ communications and engagement teams, to identify opportunities to work together across the mid-Nottinghamshire and STP (Sustainability and Transformation Plans) footprints.

**Principles**

- **No surprises** - information will be shared as soon as it is available not just at the point a decision is made. Reduction in reactive decisions and poor timing
- **Consistency of message** - the messages will be clear and consistent
- **Greater understanding** – recap for all on what currently exists, explain the current context and value for money messages
- **Succinct and regular communication** - this is to include leavers and new starters including roles and responsibilities
- **Greater use of digital technology** e.g. CCG websites, you tube and twitter
## SWOT Analysis

<table>
<thead>
<tr>
<th><strong>Strengths</strong></th>
<th><strong>Weaknesses</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Good relationships at grass roots level with the practices.</td>
<td>• No regular engagement with all GP practices to the same level.</td>
</tr>
<tr>
<td>• On-going dialogue with GP’s across mid Notts.</td>
<td>• No standard ways of effective GP communication and feedback suggesting existing newsletters need revision.</td>
</tr>
<tr>
<td>• Very few GP complaints.</td>
<td>• A different approach to GP localities/federations across the 2 CCGs</td>
</tr>
<tr>
<td>• Some outstanding and good CQC ratings of GP practices</td>
<td>• Some poor or non-existent patient participation groups</td>
</tr>
<tr>
<td>• Good overview of GP practices and referral patterns.</td>
<td>• Not enough proactive communications with primary care</td>
</tr>
<tr>
<td>• Some good patient participation groups</td>
<td>• Some poor CQC ratings</td>
</tr>
<tr>
<td>• PLTs are well attended</td>
<td>• Poor CCG websites</td>
</tr>
<tr>
<td>• A Primary care team led by a Director of Primary Care</td>
<td>• Limited use of twitter</td>
</tr>
<tr>
<td>• There is the capability within the communication and engagement team to manage the communication and engagement function</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Opportunities</strong></th>
<th><strong>Threats</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Improved connection between clinical service development in transformation work streams with GP Practices.</td>
<td>• GPs perception leading to frustration with lack of communication from the CCG staff</td>
</tr>
<tr>
<td>• Improved use of the Primary Care Bulletin</td>
<td>• GP perception leading to frustration with lack of engagement with the CCGs</td>
</tr>
<tr>
<td>• More use of social media</td>
<td>• GPs frustration with a lack of coordinated communications from the CCG leading to numerous emails</td>
</tr>
<tr>
<td>• Development of innovative ideas for communication and engagement that reflects consistency but also the locality development agenda</td>
<td>• There is not enough capacity within the communication and engagement team to provide support to all the transformation/sustainability programmes as well as meet the statutory requirements of the CCGs</td>
</tr>
<tr>
<td>• Continue to develop and strengthen relationships with GPs and through a robust communication and engagement plan</td>
<td></td>
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<tr>
<td>• Improve two-way information flows between GPs and the CCGs</td>
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</table>
### Key messages

| 1. CCG communication with General Practice – Members: GP, Practice Manager, Practice Nurses, Practice Admin |
| Communication & Engagement on Provider Developments |
| Communication and Engagement on Commissioning Intentions and opportunities |
| 2. CCG Communications with Patient & Public: Inc PPGs, Healthwatch, etc |
| Awareness and understanding of the ‘ASK’ – 5YFV requirements/must be done’s plus CCG vision for General Practice |
| Engagement in service design @practice level @locality level @system level (mid Notts/STP) |
| Evaluation of new service or service change: @practice level @locality level @system level (mid Notts/STP) |
| Patient Experience |

| 3. CCG Communication with CCG staff on General Practice |
| Systems and processes eg GP Bulletin Consistency and clarity of messages: Functions/work streams connect so that communications are clearer Alignment of reports delivered through the CCGs governance process |
| 4. Communication with Other Stakeholders: Acute, MH, Third Sector, etc |
| Communication & Engagement on Provider Developments |
| Communication and Engagement on Commissioning Intentions and opportunities |

### Action Plan
The action plan below depicts activities that are well established and others that need to develop and grow. This is an iterative process and the methods of communication and engagement will grow and change over time to reflect the needs of the audience.

### Stakeholder Map
A stakeholder analysis is always helpful to ensure the right amount of resources is committed to the most appropriate stakeholders. The map below is generic and the information can be replaced with individual organisational names when required.
<table>
<thead>
<tr>
<th>High interest</th>
<th>Active PPGs</th>
<th>GPs</th>
<th>GP localities</th>
<th>Clinical Directors</th>
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<tbody>
<tr>
<td></td>
<td>CCG staff</td>
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<td>Practice Managers</td>
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<td></td>
<td>Other practice staff</td>
<td></td>
<td>CCG Directors</td>
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<td></td>
<td>Community providers</td>
<td></td>
<td>CQC</td>
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<td></td>
<td>Care homes</td>
<td></td>
<td>LMC</td>
<td></td>
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<tr>
<td>Low interest</td>
<td>Inactive PPGs</td>
<td>Media</td>
<td>MPs</td>
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<td></td>
<td>Voluntary sector</td>
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<td></td>
<td>Acute providers</td>
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Low influence | High Influence
### Action plan.

<table>
<thead>
<tr>
<th>Priority</th>
<th>Action/Initiative</th>
<th>Timing</th>
<th>Lead Executive/Director(s)</th>
<th>Lead Manager(s)</th>
</tr>
</thead>
</table>
| **Sustain effective and meaningful two way communication with General Practice.** | - Develop a policy for ensuring communications are sanctioned before being shared with general practice ‘communication control gateway’  
- Develop a survey, both paper and electronic to discover how GPs and other practice staff would like to be communicated with.  
- Relaunch and rebrand the monthly production of the Primary Care Bulletin into a practice managers bulletin, and establish and agree a timetable for input from staff  
- Develop ad hoc Newsflashes to issue urgent service-related messages to general practice.  
- Adopt the “You Said We Did” process of reporting back to GP practices on progress made to address concerns raised. | October 2017    | Primary Care Director                           | Head of Communication and Engagement |
|                                                                         |                                                                         | October 2017    | Primary Care Director                           | Communication Manager               |
|                                                                         |                                                                         | October 2017    | Primary Care Director                           | Communication Manager               |
|                                                                         |                                                                         | October – Nov 2017 | Primary Care Director                           | Communication Manager               |
|                                                                         |                                                                         | Feb 2018        | Primary Care Director                           | Engagement lead                    |
- Inclusion of ad hoc Executive “Message of the month” contributions which have a specific relevance for GPs
- Develop innovative use of social media such as Facebook, Twitter and YouTube to deliver innovative messages to audiences and encourage two-way dialogue through discussion threads and sharing of materials
- Ensure that ALL CCG staff are familiar with the GP Engagement remit and communication route to GP practices.
- Develop two way communication and mechanisms for this to be effective
- Develop a confidential email address for comments from general practice (this could be anonymous if required)
- Develop simple routes of communication i.e. post cards in all surgeries for staff to complete with questions or ideas

<table>
<thead>
<tr>
<th>Date</th>
<th>Event Description</th>
<th>Primary Care Director</th>
<th>Head of Communication and Engagement</th>
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<tbody>
<tr>
<td>Nov 2017</td>
<td>Planning meeting</td>
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<tr>
<td>Nov 2017</td>
<td>November 2017</td>
<td>Primary Care Director</td>
<td>Communication Manager</td>
</tr>
<tr>
<td>Jan 2018</td>
<td>November 2017</td>
<td>Primary Care Director</td>
<td>Head of Communication and Engagement</td>
</tr>
<tr>
<td>Nov 2017</td>
<td>November 2017</td>
<td>Primary Care Director</td>
<td>Communication Manager</td>
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<tr>
<td>Develop and foster strong clinical engagement between the CCGs and GPs to share best practice and work in partnership</td>
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<tr>
<td>• Pursue opportunities to establish and maintain networks between general practice and the CCGs.</td>
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<td>• Build and develop relationships with the GP Federation as partners, with regular Executive to Executive meetings, and regular operational management meetings.</td>
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<td>• Encourage Consultant input into practice protected learning time afternoons and in-house practice education sessions as required.</td>
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<tr>
<td>• Ensure that the primary care team visit their practices regularly not only for performance management meetings but for general discussions and relationship</td>
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<td>Ongoing</td>
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<td>Ongoing</td>
<td>Ongoing</td>
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<td>Primary Care Director</td>
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<td>Primary Care Director</td>
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- As part of the survey ask practices what they feel the level of engagement is and how they feel it could be improved
- Ensure the communication and engagement team link into with the primary care team to offer support and develop an understanding of each other’s roles
- Ensure there is a CCG presence at the Practice Managers Meetings (if required)
- Deliver a CCG ‘slot’ face to face at each CCG Practice Learning Time Events - monthly

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<thead>
<tr>
<th>Date</th>
<th>Primary Care Director</th>
<th>Communication Manager</th>
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<tbody>
<tr>
<td>October 2017</td>
<td>Primary Care Director</td>
<td>Head of Communication and Engagement</td>
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<tr>
<td>Ongoing</td>
<td>Primary Care Director</td>
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<tr>
<td>Ongoing</td>
<td>Primary Care Director</td>
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<tr>
<td>Monthly</td>
<td>Primary Care Director</td>
<td>Primary care managers</td>
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# ED attendances and Opening Hours

**DATE OF MEETING:** 14 September 2017

**PAPER REF:** JPC.17.62

**AUTHOR:** Paula Longden

**PRESENTER:** Paula Longden

## Purpose of Report:
The aim of this report is to respond to the request at Turnaround Board to compare general practice opening hours with ED attendances.

## Recommendation:
- [ ] To endorse
- [ ] To approve
- [ ] To receive the recommendation (see details below)
- [x] To discuss

## Report:

### Background
This paper is in response to a Turnaround Board matter arising to bring a paper to the September Joint Primary Care Commissioning Committees on access to appointments at individual practice level.

### Approach
The opening hours of individual practices have been collated and grouped into:
- Practice providing NHSE commissioned access services (commonly known as the DES)
- Practices providing CCG commissioned access services (extended hours / GP access)
- Practices providing both NHSE and CCG commissioned access services
- Practice providing no extended hours services (core hours only)

The data has been mapped across the patch and is shown in Appendix 1.

### Findings and Conclusions
There is no immediate correlation between GP opening hours and the weighted rates of ED attendances. For example, three of the four Newark based practices provide extended hours through the NHSE commissioned DES and have red rated A&E weighted rates. In contrast, many of the Sherwood practices do not provide any additional hours above the core contract but have low ED attendances. This suggests that geography plays a significant part in influencing patients’ decisions as to which healthcare services they access.

The Kirkby practices that have had both NHSE commissioned and CCG commissioned extended hours for over twelve months generally show lower rates of A&E attendances with the exception of one practice but the impact is not significant.

The Urgent and Proactive Care Programme team carried out a patient survey in February 2017 gathering data from patients attending ED. The survey reported that 22% of attendees were
there because they had been unable to access a GP appointment. This suggests that improved access will have an impact at practices. The full impact and how it would be distributed is difficult to assess because 68% of respondents did not declare their GP practice. Overall, therefore, based on this analysis we conclude that there is no direct correlation at this high level of data between access and ED attendances reflecting the complexity of the healthcare system. However this suggests that there are opportunities to achieve benefits from the investment and the analysis as presented provides a useful starting point as we move to full GP access during October.

We feel that the following are essential to maximise the benefits from the roll out of GP extended access due to:

- Strong promotion and advertising of the services – a detailed communications plan is in place with a variety of marketing material both in practices and other sources.
- Ensure equality of access – approach to ensure that hard to reach groups are targeted
- Use of IMT solutions – the roll out of GP access has prompted IG solutions for locality based services. This increased use of IT potential will be facilitated through the current IMT programme (delivered by Connected Notts on the CCGs’ behalf), ETTF developments and the strands set out in the GP Forward View (with additional funding).

<table>
<thead>
<tr>
<th>QIPP Assurance and connection</th>
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<tr>
<td>As per above – potential for delivering return for the CCGs from the increased access.</td>
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<th>Financial Impact and Risks</th>
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<tr>
<td>As per above.</td>
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<tr>
<th>Legal Impact</th>
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<td>None</td>
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<table>
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<tr>
<th>Risk Implications, Assessment and Mitigations</th>
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<tr>
<td>None</td>
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<thead>
<tr>
<th>Consultation, Involvement and Engagement</th>
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<tr>
<td>Detailed GP access communications plan established.</td>
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<tr>
<th>Equality Impact</th>
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<tr>
<td>Evidence and Research (include where this informs why the paper is presented to Governing Bodies)</td>
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<thead>
<tr>
<th>HOW DOES THIS CONTRIBUTE TO THE OUTCOMES AND OBJECTIVES OF THE CCG:</th>
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<tr>
<td>☐ Quality ☐ Health ☐ Financial ☐ Clinical ☐ Performance (tick as appropriate)</td>
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<tr>
<th>CONFLICTS OF INTEREST:</th>
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<tr>
<td>This is a recommended action to be agreed by the Chair at the beginning of the item.</td>
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<tr>
<td>☑ No conflict identified</td>
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<tr>
<td>☐ Conflict noted, conflicted party can participate in discussion but not decision (see below)</td>
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<td>☐ Conflict noted, conflicted party can remain but not participate (see below)</td>
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<tr>
<td>☐ Conflicted party is excluded from discussion (see below)</td>
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</table>
Please state rationale for decision

Advice regarding conflicts of interest is available from the Corporate Governance Team, or here:


CONFIDENTIALITY:

Is the information in this paper confidential?

✓ No
Appendix 1: Mansfield and Ashfield CCG: ED attendances v general practice opening hours

ED attendances by practice

General practice opening hours

A&E weighted rates
- greater than 350
- from 325 to 350
- from 300 to 325
- less than 300

Practices providing both NHS England and CCG commissioned access services
Practices providing no extended hours service
Practices providing NHS England commissioned access services
Practices providing CCG commissioned access services
Appendix 1 continued: Newark and Sherwood CCG: ED attendances v general practice opening hours

ED attendances by practice

General practice opening hours

A&E weighted rates
- greater than 350
- from 325 to 350
- from 300 to 325
- less than 300

Practice IDs and names:
- 39 Balderton Primary Care Centre
- 36 Lombard Medical Practice
- 37 Barnby Gate Surgery
- 38 Fountain Medical Centre
- 32 Hill View Surgery
- 31 Bilsthorpe Surgery
- 29 Major Oak Medical Practice
- 28 Sherwood Medical Partnership
- 35 Southwell Medical Centre
- 41 Hounsfield Surgery
- 33 Rainworth Health Centre
- 30 Middleton Lodge Practice
- 40 Collingham Medical Centre
- 34 Abbey Medical Group

Shading represents the number of A&E attendances as a weighted rate.

Circle size represents the practice population.

Legend:
- Practices providing NHS England commissioned access services
- Practices providing CCG commissioned access services
- Practices providing both NHS England and CCG commissioned access services
- Practices providing no extended hours service
**TITLE:** Terms of Reference

**DATE OF MEETING:** 14 September 2017  
**PAPER REF:** JPC/17/63

**AUTHOR:** Mrs Ruth Lloyd  
**PRESENTER:** Mr Jon Towler

**SUMMARY:**
The Terms of Reference have been updated to amend the membership and quoracy arrangements to reflect the recent changes to the senior management structure.

**ACTION:**
- [ ] To note
- [x] To approve
- [ ] To agree the recommendation (see details below)

To approve the Terms of Reference.

**HOW DOES THIS CONTRIBUTE TO THE OUTCOMES AND OBJECTIVES OF THE CCG:**
- [x] Quality  
- [ ] Health  
- [x] Financial  
- [x] Clinical  
- [ ] Performance  
- [ ] Other (specify)

(tick as appropriate)

**RISK ASSURANCE:**
Terms of Reference describe the purpose, scope and authority of the committee. Best practice in governance dictates that they should be reviewed annually to ensure they remain current and valid.

**CONFLICTS OF INTEREST:**
This is a recommended action to be agreed by the Chair at the beginning of the item.

- [x] No conflict identified
- [ ] Conflict noted, conflicted party can participate in discussion but not decision (see below)
- [ ] Conflict noted, conflicted party can remain but not participate (see below)
- [ ] Conflicted party is excluded from discussion (see below)

**CONFIDENTIALITY:**
Is the information in this paper confidential?

- [x] No
NHS Mansfield and Ashfield CCG
Primary Care Commissioning Committee
Terms of Reference

1. Purpose

The Committee has been established in accordance with the statutory provisions as detailed in Appendix A to enable the members to make collective decisions on the review, planning and procurement of primary care services in Mansfield and Ashfield, under delegated authority from NHS England.

In performing its role the Committee will exercise its management of the functions in accordance with the agreement entered into between NHS England and NHS Mansfield and Ashfield CCG, which will sit alongside the delegation and terms of reference.

The functions of the Committee are undertaken in the context of a desire to promote increased co-commissioning to increase quality, efficiency, productivity and value for money and to remove administrative barriers.

The Committee will comprise the geographical area covered by NHS Mansfield and Ashfield CCG.

2. Membership

The Committee voting membership shall consist of:

- Independent lay Chair
- Independent lay Vice Chair
- 2 CCG lay members (shared posts with Newark and Sherwood CCG)
- Mid Notts CCG Chief Officer or deputy (being the Chief Finance Officer)
- Mid Notts CCG Chief Finance Officer or nominated deputy
- Mid Notts CCG Director of Procurement & Market Development
- Mid Notts CCG Chief Nurse and Director of Quality and Governance or deputy
- Mid Notts CCG Head of Business Change & Implementation
- Mid Notts CCG Director of Turnaround or nominated deputy
- Mid Notts CCG Director of Primary Care or nominated deputy
- Mid Notts CCG Director of Programme Delivery
- CCG Clinical Advisor (shared post with Newark and Sherwood CCG)
- Out of Area GP (shared posts with Newark and Sherwood CCG)
- Nottinghamshire County Council Public Health Consultant

If GP members need to withdraw from decision making for conflicts of interest reasons, the committee would still be quorate with a lay and executive majority.

Members are expected to attend all formal meetings. Over a twelve month rolling period if members have been unable to attend at least 80% of the meetings the Chair shall instigate a review of their continuing membership.

Other non-voting attendees
Standing invitation to:

- Local GP
- Local Medical Committee GP representative
- Health Watch Nottinghamshire
- Health and Wellbeing Board
- NHS England Local Area Team

Also note below arrangements relating to joint arrangements with NHS Mansfield & Ashfield CCG.

 Provision could be made for the committee to have the ability to call on additional lay members or CCG members when required, for example where the committee would not be quorate because of a conflict of
interest. It could also include GP representatives from other CCG areas and non-GP clinical representatives (such as the CCGs secondary care specialist).

The CCG lay member positions will be recruited through expressions of interest process and assessed through a set of criteria (Where three or more expressions of interest are received, an interview process will take place with the Group’s senior clinicians and managers.

### 3. Chair and Deputy

The Committee will have an Independent Lay Chair who is recruited externally. The Lay Chair will be in attendance at the CCG Governing Body.

Term of office will be:
- 2 years initially, with a further 2 years if satisfactory performance is evidenced.
- assessed at the same time as governing body membership term of office where appropriate.

Grounds for removal from office are:
- Gross misconduct
- Failing to disclose a pecuniary interest regarding matters under discussion within the committee
- Following the passing of a vote of no confidence by committee members and subsequent approval of this by CCG governing body

The Vice Chair will be an independent lay member and shall be recruited as set out in item 24-26 above. The Vice Lay Chair will deputise for the Lay Chair at governing body meetings where appropriate.

### 4. Quorum and Voting Arrangements

Each member of the Committee shall have one vote. The Committee shall reach decisions by a simple majority of members present, but with the Chair having a second and deciding vote, if necessary. However, the aim of the Committee will be to achieve consensus decision-making wherever possible.

The quorum required to make formal approvals is as follows (6 members, with lay and executive majority):

- Lay Chair or Lay Vice Chair
- Chief Officer or nominated deputy
- Chief Finance Officer or nominated deputy
- 3 out of the 65 Directors or their nominated deputies (This includes the Head of Business Change & Implementation and the Chief Nurse)
- A Clinician

If an opportunity arises where lay and clinical executive is not the majority of attendees, clinical members will be asked to leave at the time of a decision being made.

### 5. Frequency of Meetings

Meetings will take place, in public, on a bi-monthly basis to meet the requirements of the CCG business. The Chair may call extra-ordinary meetings to manage urgent business requirements where needed. Where this is not achievable, the CCG Accountable Officer has the authority to take emergency decisions as outlined within the CCG Scheme of Delegation.

Meetings of the Committee shall:

a) be held in public, subject to the application of 23(b);

b) the Committee may resolve to exclude the public from a meeting that is open to the public (whether during the whole or part of the proceedings) whenever publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution and arising from the nature of that business or of the proceedings or for
any other reason permitted by the Public Bodies (Admission to Meetings) Act 1960 as amended or succeeded from time to time.

6. Duties

The role of the Committee shall be to carry out the functions relating to the commissioning of primary medical services under section 83 of the NHS Act.

This includes the following:

- GMS, PMS and APMS contracts (including the design of PMS and APMS contracts, monitoring of contracts, taking contractual action such as issuing branch/remedial notices, and removing a contract);
- Newly designed enhanced services ("Local Enhanced Services" and "Directed Enhanced Services");
- Design of local incentive schemes as an alternative to the Quality Outcomes Framework (QOF);
- Decision making on whether to establish new GP practices in an area;
- Approving practice mergers; and
- Making decisions on ‘discretionary’ payment (e.g., returner/retainer schemes), which will include decisions relating to the spend on any primary care schemes and Vanguard funds.

The CCG will also carry out the following activities:

a) To plan, including needs assessment, primary [medical] care services in Mansfield and Ashfield CCG;

b) To align GP commissioning plans with other strategic service plans, (e.g. Mid Nottinghamshire Better Together programme, Nottinghamshire Sustainability and Transformation Plan) reviewing, tracking and reporting on benefits realisation;

c) To undertake reviews of primary [medical] care services in Mansfield and Ashfield CCG;

d) To co-ordinate a common approach to the commissioning of primary care services generally;

e) To manage the budget for commissioning of primary [medical] care services in Mansfield and Ashfield in compliance with the CCG Constitution and the Statement of Financial Entitlement Directions.

f) To assist and support NHS England in discharging its duty under section 13E of the NHS Act 2006 (as amended by the Health and Social Care Act 2012) so far as relating to securing continuous improvement in the quality of primary medical services.

g) To adopt the findings of the national PMS and Minimum Practice Income Guarantee (MPIG) reviews, and any locally agreed schemes will need to reflect the changes agreed as part of the reviews.

h) To ensure risk management is aligned with the CCG Risk Management framework/policy. A Primary Care Commissioning Committee risk register to be developed and maintained with updates and escalation to the CCG Governing Body assurance framework and NHS England Area Team where appropriate

i) To take responsibility for oversight of the transformation fund or strategic estates as per the Scheme of Delegation, noting the delegation is to include NHS England at the appropriate point.
Joint arrangements with NHS Newark and Sherwood CCG

NHS Newark & Sherwood CCG and NHS Mansfield & Ashfield CCG (Mid Notts CCGs), as separate statutory bodies, have delegated primary care commissioning responsibilities. They will both establish a Primary Care Commissioning Committee and associated terms of reference including specific membership and quoracy.

The Mid Notts CCGs have shared Chief Officer, Chief Finance Officer, and Executive Director positions which are members of both Primary Care Commissioning Committees.

To avoid duplication of meetings across the Mid Notts CCGs, joint meetings of the two committees will take place.

Delegated decision making, (incorporating quoracy and conflicts of interest) will be managed via separate agenda items for each CCG with separate minuting and reporting arrangements at CCG level. Agendas will delineate for clarity of decision making within each CCG as separate statutory bodies as appropriate. Lay and GP membership will be CCG specific.

The diagram below sets out the Mid Notts CCG governance arrangements

The Committee to have delegated authority from the Mansfield and Ashfield CCG governing body:

- To carry out the functions relating to the commissioning of primary medical services under section 83 of the NHS Act
- To assist and support NHS England in discharging its duty under section 13E of the NHS Act 2006 (as amended by the Health and Social Care Act 2012) so far as relating to securing continuous improvement in the quality of primary medical services.
- To work with NHS England to agree rules for areas such as the collection of data for national data sets, equivalent of what is collected under QOF, and IT intra-operability.
- To comply with public procurement regulations and with statutory guidance on conflicts of interest
- To consult with Local Medical Committee and demonstrate improved outcomes reduced inequalities and value for money when developing a local QOF scheme or DES.
- To approve the arrangements for discharging the group’s statutory duties associated with its GP practice commissioning functions, including but not limited to promoting the involvement of each patient, patient choice, reducing inequalities, improvement in the quality of services, obtaining appropriate advice and public engagement and consultation.

Procurement of Agreed Services

- The committee must comply with public procurement regulations and with statutory guidance on conflicts of interest.
- The committee may vary or renew existing contracts for primary care provision or award new ones, depending on local circumstances.
- If the committee fails to secure an adequate supply of high quality primary medical care, NHS England may direct the CCG to act.
- If the Committee are found to have breached public procurement regulations and/or statutory guidance on conflicts of interest, Monitor may direct the CCG or to act. NHS England may, ultimately, revoke the CCG’s delegation.
- Any proposed new incentive schemes should be subject to consultation with the Local Medical Committee and be able to demonstrate improved outcomes, reduced inequalities and value for money.

Consistent with the NHS Five Year Forward View and working with CCGs, NHS England reserves the right to establish new national approaches and rules on expanding primary care provision – for example to tackle health inequalities.

Decisions

The Committee will make decisions within the bounds of its remit. Specifically, within the Operational Scheme of Delegation, the Committee has delegated powers to:
Co-commission delegated budgets – within the acknowledgement of additional requirements to go back to NHS England and
Other direct GP payments – above £50,000.

The decisions of the Committee shall be binding on NHS England and NHS Newark & Sherwood CCG.

The Committee will produce an executive summary report which will be presented to of NHS England North Midlands Sub-region and to each meeting of the governing body of NHS Mansfield and Ashfield CCG bi-monthly for information. The Committee will ensure areas for escalation, for example high level risks and conflicts of interest, are provided via exception reporting to NHS England North Midlands Sub-region in a timely manner where required.

The Committee will maintain a record of all decisions made.

7. Conduct of Business

Members of the Committee have a collective responsibility for the operation of the Committee. They will participate in discussion, review evidence and provide objective expert input to the best of their knowledge and ability, and endeavour to reach a collective view.

The Committee may delegate tasks to such individuals, sub-committees or individual members as it shall see fit, provided that any such delegations are consistent with the parties’ relevant governance arrangements, are recorded in a scheme of delegation, are governed by terms of reference as appropriate and reflect appropriate arrangements for the management of conflicts of interest. These committees will support development of commissioning proposals and ensure that milestones are met/escalated to the Primary Care Commissioning Committee.

The Committee may call additional experts to attend meetings on an ad hoc basis to inform discussions.

Members of the Committee shall respect confidentiality requirements as set out in the CCG’s Standing Orders.

The Committee will be expected to conduct itself as an exemplar organisation, working to the Nolan seven principles of public life, namely:

- Selflessness
- Integrity
- Objectivity
- Accountability
- Openness
- Honesty
- Leadership

Members of the Committee shall respect confidentiality requirements as set out in the CCG’s Standing Orders.

8. Administration of Meetings

The Committee will operate in accordance with the CCG’s Standing Orders. The Secretary to the Committee will be responsible for giving notice of meetings. This will be accompanied by an agenda and supporting papers and sent to each member representative no later than 7 days before the date of the meeting. When the Chair of the Committee deems it necessary in light of the urgent circumstances to call a meeting at short notice, the notice period shall be such as s/he shall specify.

The Director responsible for overseeing the administration of the Committee is the Director of Primary Care.

Agendas and supporting papers will be circulated no later than 5 working days in advance of meetings.
Any items placed on the agenda will be sent to the Committee Administrator no later than 7 working days in advance of the meeting. Items that miss the deadline for inclusion on the agenda may be added on receipt of permission of the Chair.

Minutes will be taken at all meetings and circulated to the members of the Committee. The minutes will be approved by agreement of the Committee at the next meeting. The Chair of the Committee will agree minutes if they are to be submitted to the Governing Body prior to formal approval.

The Committee will present its minutes to the Governing Body for information and consideration.

The CCG will also comply with any reporting requirements set out in its constitution.

9. Declaration of Interests

The NHS Mansfield and Ashfield Clinical Commissioning Group has a Conflict of Interest Policy and has a register of member interests.

At the beginning of each formal meeting, members will be required to declare any personal interest if it relates specifically to a particular issue under consideration. Any such declaration shall be formally recorded in the minutes for the meeting in accordance with the provisions set out in the CCG policy.

Where a declaration of interest means that there is an actual or a suspected conflict of interest, the conflict must be identified by the Chair and Administrative Support at the agenda setting stage of meeting planning. This will enable the consideration of the provision of papers in preparation of the meeting to prevent those with direct conflicts from having access to information which they are not permitted to act in their capacity within the meeting to discuss, or decide.

All declared interests will be managed in line with the requirements of the CCG’s Conflict of Interests Policy.

The CCGs will not award a contract for the provision of NHS healthcare services where conflicts, or potential conflicts, between interests involved in commissioning such services and the interests involved in providing them appear to affect the integrity of that award and the CCGs will keep a record of how it manages any such conflict in relation to NHS commissioning contracts it has entered into.

10. Reporting Responsibilities

The Committee will present its minutes to North Midlands Sub Region of NHS England and to the bi-monthly governing body of NHS Mansfield and Ashfield CCG for information, including the minutes of any committees to which responsibilities are delegated above.

The Committee will provide an annual report to the Governing Body setting out progress made and future developments.

11. Review of Terms of Reference

The terms of reference will be reviewed at least annually with final approval being sought from the Mansfield and Ashfield CCG Governing Body. Amendments will be made, where appropriate, to reflect any updated national model terms of reference and local need.

Date: March 2017
Background
Simon Stevens, the Chief Executive of NHS England, announced on 1 May 2014 that NHS England was inviting CCGs to expand their role in primary care commissioning and to submit expressions of interest setting out the CCG’s preference for how it would like to exercise expanded primary medical care commissioning functions. One option available was that NHS England would delegate the exercise of certain specified primary care commissioning functions to a CCG.

In accordance with its statutory powers under section 13Z of the National Health Service Act 2006 (as amended), NHS England has delegated the exercise of the functions specified in Schedule 2 to these Terms of Reference to NHS Mansfield and Ashfield CCG. The delegation is set out in Schedule 2.

The CCG has established the NHS Mansfield and Ashfield CCG Primary Care Commissioning Committee (“Committee”). The Committee will function as a corporate decision-making body for the management of the delegated functions and the exercise of the delegated powers.

It is a committee comprising representatives of the following organisations:
- NHS Mansfield and Ashfield CCG
- Nottinghamshire County Council - Public Health

A standing invitation is extended to the Local Medical Committee, Nottinghamshire Healthwatch, NHS England Area Team, and Nottinghamshire Health & Well Being Board

Statutory Framework
NHS England has delegated to the CCG authority to exercise the primary care commissioning functions set out in Schedule 2 in accordance with section 13Z of the NHS Act. Arrangements made under section 13Z may be on such terms and conditions (including terms as to payment) as may be agreed between the Board and the CCG.

Arrangements made under section 13Z do not affect the liability of NHS England for the exercise of any of its functions. However, the CCG acknowledges that in exercising its functions (including those delegated to it), it must comply with the statutory duties set out in Chapter A2 of the NHS Act and including:

- Management of conflicts of interest (section 14O);
- Duty to promote the NHS Constitution (section 14P);
- Duty to exercise its functions effectively, efficiently and economically (section 14Q);
- Duty as to improvement in quality of services (section 14R);
- Duty in relation to quality of primary medical services (section 14S);
- Duties as to reducing inequalities (section 14T);
- Duty to promote the involvement of each patient (section 14U);
- Duty as to patient choice (section 14V);
- Duty as to promoting integration (section 14Z1);
- Public involvement and consultation (section 14Z2)

The CCG will also need to specifically, in respect of the delegated functions from NHS England, exercise those set out below:
- Duty to have regard to impact on services in certain areas (section 13O);
- Duty as respects variation in provision of health services (section 13P).

The Committee is established as a committee of the Governing Body of NHS Mansfield and Ashfield CCG in accordance with Schedule 1A of the “NHS Act”.

The members acknowledge that the Committee is subject to any directions made by NHS England or by the Secretary of State.
Both CCGs have delegated authority approval in relation to Primary Care Commissioning for their respective areas. These *Mid Notts CCGs have shared Chief Officer, Chief Finance Officer, Executive Director positions and therefore joint meetings of the two committees will take place. Delegated decision making, (incorporating quoracy and conflicts of interest) will be managed via separate agenda items for each CCG with separate minuting and reporting arrangements at CCG level. Agendas will delineate for clarity of decision making within each CCG as separate statutory bodies as appropriate. Lay and GP membership will be CCG specific.

The *Mid Notts CCGs will establish a joint operational steering group in order to develop commissioning proposals and to ensure that milestones are met/escalated to the Primary Care Commissioning Committee.

The Co-commissioning leads’ meeting operates across Notts/Derby to oversee the process of developing primary care commissioning in CCGs and the deployment of staff for 15/16. It will ensure a coherent approach across the patch and best use of existing team.
Schedule 2 - Delegated Functions (CCG responsibilities)

Part 1: Delegated Functions: Specific Obligations

1. Introduction

1.1. This Part 1 of Schedule 2 (Delegated Functions) sets out further provision regarding the carrying out of each of the Delegated Functions.

2. Primary Medical Services Contract Management

2.1. The CCG must:

2.1.1. manage the Primary Medical Services Contracts on behalf of NHS England and perform all of NHS England’s obligations under each of the Primary Medical Services Contracts in accordance with the terms of the Primary Medical Services Contracts as if it were named in the contract in place of NHS England;

2.1.2. actively manage the performance of the counter-party to the Primary Medical Services Contracts in order to secure the needs of people who use the services, improve the quality of services and improve efficiency in the provision of the services including by taking timely action to enforce contractual breaches and serve notice;

2.1.3. ensure that it obtains value for money under the Primary Medical Services Contracts on behalf of NHS England and avoids making any double payments under any Primary Medical Services Contracts;


2.1.5. notify NHS England immediately (or in any event within two (2) Operational Days) of any breach by the CCG of its obligations to perform any of NHS England’s obligations under the Primary Medical Services Contracts;

2.1.6. keep a record of all of the Primary Medical Services Contracts that the CCG manages on behalf of NHS England setting out the following details in relation to each Primary Medical Services Contract:

2.1.6.1. name of counter-party;
2.1.6.2. location of provision of services; and
2.1.6.3. amounts payable under the contract (if a contract sum is payable) or amount payable in respect of each patient (if there is no contract sum).

2.2. For the avoidance of doubt, all Primary Medical Services Contracts will be in the name of NHS England.

2.3. The CCG must comply with any Guidance in relation to the issuing and signing of Primary Medical Services Contracts in the name of NHS England.

2.4. Without prejudice to clause 13 (Financial Provisions and Liability) or paragraph 2.1 above, the CCG must actively manage each of the relevant Primary Medical Services Contracts including by:
2.4.1. managing the relevant Primary Medical Services Contract, including in respect of quality standards, incentives and the QOF, observance of service specifications, and monitoring of activity and finance;

2.4.2. assessing quality and outcomes (including clinical effectiveness, patient experience and patient safety);

2.4.3. managing variations to the relevant Primary Medical Services Contract or services in accordance with national policy, service user needs and clinical developments;

2.4.4. agreeing information and reporting requirements and managing information breaches (which will include use of the HSCIC IG Toolkit SIRI system);

2.4.5. agreeing local prices, managing agreements or proposals for local variations and local modifications;

2.4.6. conducting review meetings and undertaking contract management including the issuing of contract queries and agreeing any remedial action plan or related contract management processes; and

2.4.7. complying with and implementing any relevant Guidance issued from time to time.

Enhanced Services

2.5. The CCG must manage the design and commissioning of Enhanced Services, including re-commissioning these services annually where appropriate.

2.6. The CCG must ensure that it complies with any Guidance in relation to the design and commissioning of Enhanced Services.

2.7. When commissioning newly designed Enhanced Services, the CCG must:

2.7.1. consider the needs of the local population in the Area;

2.7.2. support Data Controllers in providing ‘fair processing’ information as required by the DPA;

2.7.3. develop the necessary specifications and templates for the Enhanced Services, as required to meet the needs of the local population in the Area;

2.7.4. when developing the necessary specifications and templates for the Enhanced Services, ensure that value for money will be obtained;

2.7.5. consult with Local Medical Committees, each relevant Health and Wellbeing Board and other stakeholders in accordance with the duty of public involvement and consultation under section 14Z2 of the NHS Act;

2.7.6. obtain the appropriate read codes, to be maintained by the HSCIC;

2.7.7. liaise with system providers and representative bodies to ensure that the system in relation to the Enhanced Services will be functional and secure; and

2.7.8. support GPs in entering into data processing agreements with data processors in the terms required by the DPA.

Design of Local Incentive Schemes

2.8. The CCG may design and offer Local Incentive Schemes for GP practices, sensitive to the needs of their particular communities, in addition to or as an alternative to the national framework (including as an alternative to QOF or directed Enhanced Services), provided that such schemes are voluntary and the CCG continues to offer the national schemes.

2.9. There is no formal approvals process that the CCG must follow to develop a Local Incentive Scheme, although any proposed new Local Incentive Scheme:
2.9.1. is subject to consultation with the Local Medical Committee;
2.9.2. must be able to demonstrate improved outcomes, reduced inequalities and value for money; and
2.9.3. must reflect the changes agreed as part of the national PMS reviews.

2.10. The ongoing assurance of any new Local Incentive Schemes will form part of the CCG’s assurance process under the CCG Assurance Framework.

2.11. Any new Local Incentive Scheme must be implemented without prejudice to the right of GP practices operating under a GMS Contract to obtain their entitlements which are negotiated and set nationally.

2.12. NHS England will continue to set national standing rules, to be reviewed annually, and the CCG must comply with these rules which shall for the purposes of this Agreement be Guidance.

Making Decisions on Discretionary Payments

2.13. The CCG must manage and make decisions in relation to the discretionary payments to be made to GP practices in a consistent, open and transparent way.

2.14. The CCG must exercise its discretion to determine the level of payment to GP practices of discretionary payments, in accordance with the Statement of Financial Entitlements Directions.

Making Decisions about Commissioning Urgent Care for Out of Area Registered Patients

2.15. The CCG must manage the design and commissioning of urgent care services (including home visits as required) for its patients registered out of area (including re-commissioning these services annually where appropriate).

2.16. The CCG must ensure that it complies with any Guidance in relation to the design and commissioning of these services.

3. Planning the Provider Landscape

3.1. The CCG must plan the primary medical services provider landscape in the Area, including considering and taking decisions in relation to:

3.1.1. establishing new GP practices in the Area;
3.1.2. managing GP practices providing inadequate standards of patient care;
3.1.3. the procurement of new Primary Medical Services Contracts (in accordance with any procurement protocol issued by NHS England from time to time);
3.1.4. closure of practices and branch surgeries;
3.1.5. dispersing the lists of GP practices;
3.1.6. agreeing variations to the boundaries of GP practices; and
3.1.7. coordinating and carrying out the process of list cleansing in relation to GP practices, according to any policy or Guidance issued by NHS England from time to time.

3.2. In relation to any new Primary Medical Services Contract to be entered into, the CCG must, without prejudice to any obligation in Schedule 2, Part 2, paragraph 3 (Procurement and New Contracts) and Schedule 2, Part 1, paragraph 2.3:
3.2.1. consider and use the form of Primary Medical Services Contract that will ensure compliance with NHS England’s obligations under Law including the Public Contracts Regulations 2015/102 and the National Health Service (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013/500 taking into account the persons to whom such Primary Medical Services Contracts may be awarded;

3.2.2. provide to NHS England confirmation as required from time to time that it has considered and complied with its obligations under this Agreement and the Law; and

3.2.3. for the avoidance of doubt, Schedule 5 (Financial Provisions and Decision Making Limits) deals with the sign off requirements for Primary Medical Services Contracts.

4. Approving GP Practice Mergers and Closures

4.1. The CCG is responsible for approving GP practice mergers and GP practice closures in the Area.

4.2. The CCG must undertake all necessary consultation when taking any decision in relation to GP practice mergers or GP practice closures in the Area, including those set out under section 14Z2 of the NHS Act (duty for public involvement and consultation). The consultation undertaken must be appropriate and proportionate in the circumstances and should include consulting with the Local Medical Committee.

4.3. Prior to making any decision in accordance with this paragraph 4 (Approving GP Practice Mergers and Closures), the CCG must be able to clearly demonstrate the grounds for such a decision and must have fully considered any impact on the GP practice’s registered population and that of surrounding practices. The CCG must be able to clearly demonstrate that it has considered other options and has entered into dialogue with the GP contractor as to how any closure or merger will be managed.

4.4. In making any decisions pursuant to paragraph 4 (Approving GP Practice Mergers and Closures), the CCG shall also take account of its obligations as set out in Schedule 2, part 2, paragraph 3 (Procurement and New Contracts), where applicable.

5. Information Sharing with NHS England in relation to the Delegated Functions

5.1. This paragraph 5 (Information Sharing with NHS England) is without prejudice to clause 9.4 or any other provision in this Agreement. The CCG must provide NHS England with:

5.1.1. such information relating to individual GP practices in the Area as NHS England may reasonably request, to ensure that NHS England is able to continue to gather national data regarding the performances of GP practices;

5.1.2. such data/data sets as required by NHS England to ensure population of the primary medical services dashboard;

5.1.3. any other data/data sets as required by NHS England; and

5.1.4. the CCG shall procure that providers accurately record and report information so as to allow NHS England and other agencies to discharge their functions.

5.2. The CCG must use the NHS England approved primary medical services dashboard, as updated from time to time, for the collection and dissemination of information relating to GP practices.
5.3. The CCG must (where appropriate) use the NHS England approved GP exception reporting service (as notified to the CCGs by NHS England from time to time).

5.4. The CCG must provide any other information, and in any such form, as NHS England considers necessary and relevant.

5.5. NHS England reserves the right to set national standing rules (which may be considered Guidance for the purpose of this Agreement), as needed, to be reviewed annually. NHS England will work with CCGs to agree rules for, without limitation, areas such as the collection of data for national data sets and IT intra-operability. Such national standing rules set from time to time shall be deemed to be part of this Agreement.


6.1. The CCG must make decisions in relation to the management of poorly performing GP practices and including, without limitation, decisions and liaison with the CQC where the CQC has reported non-compliance with standards (but excluding any decisions in relation to the performers list).

6.2. In accordance with paragraph 6.1 above, the CCG must:

   6.2.1. ensure regular and effective collaboration with the CQC to ensure that information on general practice is shared and discussed in an appropriate and timely manner;
   6.2.2. ensure that any risks identified are managed and escalated where necessary;
   6.2.3. respond to CQC assessments of GP practices where improvement is required;
   6.2.4. where a GP practice is placed into special measures, lead a quality summit to ensure the development and monitoring of an appropriate improvement plan (including a communications plan and actions to manage primary care resilience in the locality); and
   6.2.5. take appropriate contractual action in response to CQC findings.

7. Premises Costs Directions Functions

7.1. The CCG must comply with the Premises Costs Directions and will be responsible for making decisions in relation to the Premises Costs Directions Functions.

7.2. In particular, but without limiting the generality of paragraph 7.1, the CCG shall make decisions concerning:

   7.2.1. applications for new payments under the Premises Costs Directions (whether such payments are to be made by way of grants or in respect of recurring premises costs); and
   7.2.2. revisions to existing payments being made under the Premises Costs Directions.

7.3. 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 Premises Costs Directions Functions.
7.4. The CCG will comply with any guidance issued by the Secretary of State or NHS England in relation to the Premises Costs Directions, including the Principles of Best Practice, and any other Guidance in relation to the Premises Costs Directions.

7.5. The CCG must work cooperatively with other CCGs to manage premises and strategic estates planning.

7.6. The CCG must liaise where appropriate with NHS Property Services Limited and Community Health Partnerships Limited in relation to the Premises Costs Directions Functions.

Part 2 – Delegated Functions: General Obligations (CCG responsibilities)

1. Introduction

1.1. This Part 2 of Schedule 2 (Delegated Functions) sets out general provisions regarding the carrying out of the Delegated Functions.

2. Planning and reviews

2.1. The CCG is responsible for planning the commissioning of primary medical services.

2.2. The role of the CCG includes:

   2.2.1. carrying out primary medical health needs assessments (to be developed by the CCG) to help determine the needs of the local population in the Area;

   2.2.2. recommending and implementing changes to meet any unmet primary medical services needs; and

   2.2.3. undertaking regular reviews of the primary medical health needs of the local population in the Area.

3. Procurement and New Contracts

3.1. The CCG will make procurement decisions relevant to the exercise of the Delegated Functions and in accordance with the detailed arrangements regarding procurement set out in the procurement protocol issued and updated by NHS England from time to time.

3.2. In discharging its responsibilities set out in clause 6 (Performance of the Delegated Functions) of this Agreement and paragraph 1 of this Schedule 2 (Delegated Functions), the CCG must comply at all times with Law including its obligations set out in the National Health Service (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013/500 and any other relevant statutory provisions. The CCG must have regard to any relevant guidance, particularly Monitor’s guidance Substantive guidance on the Procurement, Patient Choice and Competition Regulations (https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/283505/SubstantiveGuidanceDec2013_0.pdf).

3.3. Where the CCG wishes to develop and offer a locally designed contract, it must ensure that it has consulted with its Local Medical Committee in relation to the proposal and that it can demonstrate that the scheme will:
3.3.1. improve outcomes;
3.3.2. reduce inequalities; and
3.3.3. provide value for money.

4. Integrated working

4.1. The CCG must take an integrated approach to working and co-ordinating with stakeholders including NHS England, Local Professional Networks, local authorities, Healthwatch, acute and community providers, the Local Medical Committee, Public Health England and other stakeholders.

4.2. The CCG must work with NHS England and other CCGs to co-ordinate a common approach to the commissioning of primary medical services generally.

4.3. The CCG and NHS England will work together to coordinate the exercise of their respective performance management functions.

5. Resourcing

5.1. NHS England may, at its discretion provide support or staff to the CCG. NHS England may, when exercising such discretion, take into account, any relevant factors (including without limitation the size of the CCG, the number of Primary Medical Services Contracts held and the need for the Local NHS England Team to continue to deliver the Reserved Functions).
1. Purpose

The Committee has been established in accordance with the statutory provisions as detailed in Appendix A to enable the members to make collective decisions on the review, planning and procurement of primary care services in Newark & Sherwood, under delegated authority from NHS England.

In performing its role the Committee will exercise its management of the functions in accordance with the agreement entered into between NHS England and NHS Newark & Sherwood CCG, which will sit alongside the delegation and terms of reference.

The functions of the Committee are undertaken in the context of a desire to promote increased co-commissioning to increase quality, efficiency, productivity and value for money and to remove administrative barriers.

The Committee will comprise the geographical area covered by NHS Newark & Sherwood CCG.

2. Membership

The Committee voting membership shall consist of:

- Independent lay Chair
- Independent lay Vice Chair
- 2 CCG lay members (shared posts with Mansfield and Ashfield CCG)
- Mid Notts CCG Chief Officer or deputy (being the Chief Finance Officer)
- Mid Notts CCG Chief Finance Officer or nominated deputy
- Mid Notts Director of Procurement & Market Development
- Mid Notts CCG Chief Nurse and Director of Quality and Governance or nominated deputy
- Mid Notts CCG Head of Business Change & Implementation
- Mid Notts CCG Director of Turnaround or nominated deputy
- Mid Notts CCG Director of Primary Care or nominated deputy
- Mid Notts CCG Director of Programme Delivery
- CCG Clinical Advisor (shared post with Mansfield and Ashfield CCG)
- Out of Area GP (shared posts with Mansfield and Ashfield CCG)
- Nottinghamshire County Council Public Health Consultant

If GP members need to withdraw from decision making for conflicts of interest reasons, the committee would still be quorate with a lay and executive majority.

Members are expected to attend all formal meetings. Over a twelve month rolling period if members have been unable to attend at least 80% of the meetings the Chair shall instigate a review of their continuing membership.

Other non-voting attendees

Standing invitation to:

- Local GP
- Local Medical Committee GP representative
- Health Watch Nottinghamshire
- Health and Wellbeing Board
- NHS England Local Area Team

Also note below arrangements relating to joint arrangements with NHS Mansfield & Ashfield CCG.
Provision could be made for the committee to have the ability to call on additional lay members or CCG members when required, for example where the committee would not be quorate because of a conflict of interest. It could also include GP representatives from other CCG areas and non-GP clinical representatives (such as the CCGs secondary care specialist).

The CCG lay member positions will be recruited through expressions of interest process and assessed through a set of criteria (Where three or more expressions of interest are received, an interview process will take place with the Group’s senior clinicians and managers.

### 3. Chair and Deputy

The Committee will have an Independent Lay Chair who is recruited externally. The Lay Chair will be in attendance at the CCG Governing Body.

Term of office will be:
- 2 years initially, with a further 2 years if satisfactory performance is evidenced.
- assessed at the same time as governing body membership term of office where appropriate.

Grounds for removal from office are:
- Gross misconduct
- Failing to disclose a pecuniary interest regarding matters under discussion within the committee
- Following the passing of a vote of no confidence by committee members and subsequent approval of this by CCG governing body

The Vice Chair will be an independent lay member and shall be recruited as set out in item 24-26 above. The Vice Lay Chair will deputise for the Lay Chair at governing body meetings where appropriate.

### 4. Quorum and Voting Arrangements

Each member of the Committee shall have one vote. The Committee shall reach decisions by a simple majority of members present, but with the Chair having a second and deciding vote, if necessary. However, the aim of the Committee will be to achieve consensus decision-making wherever possible.

The quorum required to make formal approvals is as follows (6 members, with lay and executive majority):

- Lay Chair or Lay Vice Chair
- Chief Officer or nominated deputy
- Chief Finance Officer or nominated deputy
- 3 out of the 5 Directors (This includes the Head of Business Change & Implementation and the Chief Nurse) or their nominated deputies
- A Clinician

If an opportunity arises where lay and clinical executive is not the majority of attendees, clinical members will be asked to leave at the time of a decision being made.

### 5. Frequency of Meetings

Meetings will take place, in public, on a bi-monthly basis to meet the requirements of the CCG business. The Chair may call extra-ordinary meetings to manage urgent business requirements where needed. Where this is not achievable, the CCG Accountable Officer has the authority to take emergency decisions as outlined within the CCG Scheme of Delegation.

Meetings of the Committee shall:

a) be held in public, subject to the application of 23(b);
b) the Committee may resolve to exclude the public from a meeting that is open to the public (whether during the whole or part of the proceedings) whenever publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution and arising from the nature of that business or of the proceedings or for any other reason permitted by the Public Bodies (Admission to Meetings) Act 1960 as amended or succeeded from time to time.

6. Duties

The role of the Committee shall be to carry out the functions relating to the commissioning of primary medical services under section 83 of the NHS Act.

This includes the following:

- GMS, PMS and APMS contracts (including the design of PMS and APMS contracts, monitoring of contracts, taking contractual action such as issuing branch/remedial notices, and removing a contract);
- Newly designed enhanced services ("Local Enhanced Services" and "Directed Enhanced Services");
- Design of local incentive schemes as an alternative to the Quality Outcomes Framework (QOF);
- Decision making on whether to establish new GP practices in an area;
- Approving practice mergers; and
- Making decisions on ‘discretionary’ payment (e.g., returner/retainer schemes), which will include decisions relating to the spend on any primary care schemes and Vanguard funds.

The CCG will also carry out the following activities:

a) To plan, including needs assessment, primary [medical] care services in Newark & Sherwood CCG;

b) To align GP commissioning plans with other strategic service plans, (e.g. Mid Nottinghamshire Better Together programme, Nottinghamshire Sustainability and Transformation Plan) reviewing, tracking and reporting on benefits realisation

c) To undertake reviews of primary [medical] care services in Newark & Sherwood CCG;

d) To co-ordinate a common approach to the commissioning of primary care services generally;

e) To manage the budget for commissioning of primary [medical] care services in Newark & Sherwood in compliance with the CCG Constitution and the Statement of Financial Entitlement Directions.

f) To assist and support NHS England in discharging its duty under section 13E of the NHS Act 2006 (as amended by the Health and Social Care Act 2012) so far as relating to securing continuous improvement in the quality of primary medical services.

g) To adopt the findings of the national PMS and Minimum Practice Income Guarantee (MPIG) reviews, and any locally agreed schemes will need to reflect the changes agreed as part of the reviews.

h) To ensure risk management is aligned with the CCG Risk Management framework/policy. A Primary Care Commissioning Committee risk register to be developed and maintained with updates and escalation to the CCG Governing Body assurance framework and NHS England Area Team where appropriate

i) To take responsibility for oversight of the transformation fund or strategic estates as per the Scheme of Delegation, noting the delegation is to include NHS England at the appropriate point.
Joint arrangements with NHS Mansfield & Ashfield CCG

NHS Newark & Sherwood CCG and NHS Mansfield & Ashfield CCG (Mid Notts CCGs), as separate statutory bodies, have delegated primary care commissioning responsibilities. They will both establish a Primary Care Commissioning Committee and associated terms of reference including specific membership and quoracy.

The Mid Notts CCGs have shared Chief Officer, Chief Finance Officer, and Executive Director positions which are members of both Primary Care Commissioning Committees.

To avoid duplication of meetings across the Mid Notts CCGs, joint meetings of the two committees will take place.

Delegated decision making, (incorporating quoracy and conflicts of interest) will be managed via separate agenda items for each CCG with separate minuting and reporting arrangements at CCG level. Agendas will delineate for clarity of decision making within each CCG as separate statutory bodies as appropriate. Lay and GP membership will be CCG specific.

The diagram below sets out the Mid Notts CCG governance arrangements

The Committee to have delegated authority from the Newark & Sherwood CCG governing body:

• To carry out the functions relating to the commissioning of primary medical services under section 83 of the NHS Act
• To assist and support NHS England in discharging its duty under section 13E of the NHS Act 2006 (as amended by the Health and Social Care Act 2012) so far as relating to securing continuous improvement in the quality of primary medical services.
• To work with NHS England to agree rules for areas such as the collection of data for national data sets, equivalent of what is collected under QOF, and IT intra-operability.
• To comply with public procurement regulations and with statutory guidance on conflicts of interest
• To consult with Local Medical Committee and demonstrate improved outcomes reduced inequalities and value for money when developing a local QOF scheme or DES.
• To approve the arrangements for discharging the group’s statutory duties associated with its GP practice commissioning functions, including but not limited to promoting the involvement of each patient, patient choice, reducing inequalities, improvement in the quality of services, obtaining appropriate advice and public engagement and consultation.

Procurement of Agreed Services

• The committee must comply with public procurement regulations and with statutory guidance on conflicts of interest.
• The committee may vary or renew existing contracts for primary care provision or award new ones, depending on local circumstances.
• If the committee fails to secure an adequate supply of high quality primary medical care, NHS England may direct the CCG to act.
• If the Committee are found to have breached public procurement regulations and/or statutory guidance on conflicts of interest, Monitor may direct the CCG or to act. NHS England may, ultimately, revoke the CCG's delegation.
• Any proposed new incentive schemes should be subject to consultation with the Local Medical Committee and be able to demonstrate improved outcomes, reduced inequalities and value for money.

Consistent with the NHS Five Year Forward View and working with CCGs, NHS England reserves the right to establish new national approaches and rules on expanding primary care provision – for example to tackle health inequalities.

Decisions

The Committee will make decisions within the bounds of its remit. Specifically, within the Operational Scheme of Delegation, the Committee has delegated powers to:
• Co-commission delegated budgets – within the acknowledgement of additional requirements to go back to NHS England and
• Other direct GP payments – above £50,000.

The decisions of the Committee shall be binding on NHS England and NHS Newark & Sherwood CCG.

The Committee will produce an executive summary report which will be presented to of NHS England North Midlands Sub-region and to each meeting of the governing body of NHS Newark & Sherwood CCG bi-monthly for information. The Committee will ensure areas for escalation, for example high level risks and conflicts of interest, are provided via exception reporting to NHS England North Midlands Sub-region in a timely manner where required.

The Committee will maintain a record of all decisions made.

7. Conduct of Business

Members of the Committee have a collective responsibility for the operation of the Committee. They will participate in discussion, review evidence and provide objective expert input to the best of their knowledge and ability, and endeavour to reach a collective view.

The Committee may delegate tasks to such individuals, sub-committees or individual members as it shall see fit, provided that any such delegations are consistent with the parties’ relevant governance arrangements, are recorded in a scheme of delegation, are governed by terms of reference as appropriate and reflect appropriate arrangements for the management of conflicts of interest. These committees will support development of commissioning proposals and ensure that milestones are met/escalated to the Primary Care Commissioning Committee.

The Committee may call additional experts to attend meetings on an ad hoc basis to inform discussions.

Members of the Committee shall respect confidentiality requirements as set out in the CCG’s Standing Orders.

The Committee will be expected to conduct itself as an exemplar organisation, working to the Nolan seven principles of public life, namely:
• Selflessness
• Integrity
• Objectivity
• Accountability
• Openness
• Honesty
• Leadership

Members of the Committee shall respect confidentiality requirements as set out in the CCG’s Standing Orders.

8. Administration of Meetings

The Committee will operate in accordance with the CCG’s Standing Orders. The Secretary to the Committee will be responsible for giving notice of meetings. This will be accompanied by an agenda and supporting papers and sent to each member representative no later than 7 days before the date of the meeting. When the Chair of the Committee deems it necessary in light of the urgent circumstances to call a meeting at short notice, the notice period shall be such as s/he shall specify.

The Director responsible for overseeing the administration of the Committee is the Director of Primary Care.

Agendas and supporting papers will be circulated no later than 5 working days in advance of meetings.
Any items placed on the agenda will be sent to the Committee Administrator no later than 7 working days in advance of the meeting. Items that miss the deadline for inclusion on the agenda may be added on receipt of permission of the Chair.

Minutes will be taken at all meetings and circulated to the members of the Committee. The minutes will be approved by agreement of the Committee at the next meeting. The Chair of the Committee will agree minutes if they are to be submitted to the Governing Body prior to formal approval.

The Committee will present its minutes to the Governing Body for information and consideration.

The CCG will also comply with any reporting requirements set out in its constitution.

9. Declaration of Interests

The NHS Newark and Sherwood Clinical Commissioning Group has a Conflict of Interest Policy and has a register of member interests.

At the beginning of each formal meeting, members will be required to declare any personal interest if it relates specifically to a particular issue under consideration. Any such declaration shall be formally recorded in the minutes for the meeting in accordance with the provisions set out in the CCG policy.

Where a declaration of interest means that there is an actual or a suspected conflict of interest, the conflict must be identified by the Chair and Administrative Support at the agenda setting stage of meeting planning. This will enable the consideration of the provision of papers in preparation of the meeting to prevent those with direct conflicts from having access to information which they are not permitted to act in their capacity within the meeting to discuss, or decide.

All declared interests will be managed in line with the requirements of the CCG’s Conflict of Interests Policy.

The CCGs will not award a contract for the provision of NHS healthcare services where conflicts, or potential conflicts, between interests involved in commissioning such services and the interests involved in providing them appear to affect the integrity of that award and the CCGs will keep a record of how it manages any such conflict in relation to NHS commissioning contracts it has entered into.

10. Reporting Responsibilities

The Committee will present its minutes to North Midlands Sub Region of NHS England and to the bi-monthly governing body of NHS Newark & Sherwood CCG for information, including the minutes of any committees to which responsibilities are delegated above.

The Committee will provide an annual report to the Governing Body setting out progress made and future developments.

11. Review of Terms of Reference

The terms of reference will be reviewed at least annually with final approval being sought from the Newark & Sherwood CCG Governing Body. Amendments will be made, where appropriate, to reflect any updated national model terms of reference and local need.

Date: March 2017
Background

Simon Stevens, the Chief Executive of NHS England, announced on 1 May 2014 that NHS England was inviting CCGs to expand their role in primary care commissioning and to submit expressions of interest setting out the CCG’s preference for how it would like to exercise expanded primary medical care commissioning functions. One option available was that NHS England would delegate the exercise of certain specified primary care commissioning functions to a CCG.

In accordance with its statutory powers under section 13Z of the National Health Service Act 2006 (as amended), NHS England has delegated the exercise of the functions specified in Schedule 2 to these Terms of Reference to NHS Newark & Sherwood CCG. The delegation is set out in Schedule 2.

The CCG has established the NHS Newark & Sherwood CCG Primary Care Commissioning Committee ("Committee"). The Committee will function as a corporate decision-making body for the management of the delegated functions and the exercise of the delegated powers.

It is a committee comprising representatives of the following organisations:
- NHS Newark & Sherwood CCG
- Nottinghamshire County Council - Public Health

A standing invitation is extended to the Local Medical Committee, Nottinghamshire Healthwatch, NHS England Area Team, and Nottinghamshire Health & Well Being Board

Statutory Framework

NHS England has delegated to the CCG authority to exercise the primary care commissioning functions set out in Schedule 2 in accordance with section 13Z of the NHS Act. Arrangements made under section 13Z may be on such terms and conditions (including terms as to payment) as may be agreed between the Board and the CCG.

Arrangements made under section 13Z do not affect the liability of NHS England for the exercise of any of its functions. However, the CCG acknowledges that in exercising its functions (including those delegated to it), it must comply with the statutory duties set out in Chapter A2 of the NHS Act and including:

- Management of conflicts of interest (section 14O);
- Duty to promote the NHS Constitution (section 14P);
- Duty to exercise its functions effectively, efficiently and economically (section 14Q);
- Duty as to improvement in quality of services (section 14R);
- Duty in relation to quality of primary medical services (section 14S);
- Duties as to reducing inequalities (section 14T);
- Duty to promote the involvement of each patient (section 14U);
- Duty as to patient choice (section 14V);
- Duty as to promoting integration (section 14Z1);
- Public involvement and consultation (section 14Z2)

The CCG will also need to specifically, in respect of the delegated functions from NHS England, exercise those set out below:

Duty to have regard to impact on services in certain areas (section 13O);
Duty as respects variation in provision of health services (section 13P).

The Committee is established as a committee of the Governing Body of NHS Newark & Sherwood CCG in accordance with Schedule 1A of the "NHS Act".

The members acknowledge that the Committee is subject to any directions made by NHS England or by the Secretary of State.
Both CCGs have delegated authority approval in relation to Primary Care Commissioning for their respective areas. These *Mid Notts CCGs have shared Chief Officer, Chief Finance Officer, Executive Director positions and therefore joint meetings of the two committees will take place. Delegated decision making, (incorporating quoracy and conflicts of interest) will be managed via separate agenda items for each CCG with separate minuting and reporting arrangements at CCG level. Agendas will delineate for clarity of decision making within each CCG as separate statutory bodies as appropriate. Lay and GP membership will be CCG specific.

The *Mid Notts CCGs will establish a joint operational steering group in order to develop commissioning proposals and to ensure that milestones are met/escalated to the Primary Care Commissioning Committee.
Schedule 2 - Delegated Functions (CCG responsibilities)

Part 1: Delegated Functions: Specific Obligations

1. Introduction

1.1. This Part 1 of Schedule 2 (Delegated Functions) sets out further provision regarding the carrying out of each of the Delegated Functions.

2. Primary Medical Services Contract Management

2.1. The CCG must:

2.1.1. manage the Primary Medical Services Contracts on behalf of NHS England and perform all of NHS England’s obligations under each of the Primary Medical Services Contracts in accordance with the terms of the Primary Medical Services Contracts as if it were named in the contract in place of NHS England;

2.1.2. actively manage the performance of the counter-party to the Primary Medical Services Contracts in order to secure the needs of people who use the services, improve the quality of services and improve efficiency in the provision of the services including by taking timely action to enforce contractual breaches and serve notice;

2.1.3. ensure that it obtains value for money under the Primary Medical Services Contracts on behalf of NHS England and avoids making any double payments under any Primary Medical Services Contracts;


2.1.5. notify NHS England immediately (or in any event within two (2) Operational Days) of any breach by the CCG of its obligations to perform any of NHS England’s obligations under the Primary Medical Services Contracts;

2.1.6. keep a record of all of the Primary Medical Services Contracts that the CCG manages on behalf of NHS England setting out the following details in relation to each Primary Medical Services Contract:

   2.1.6.1. name of counter-party;
   2.1.6.2. location of provision of services; and
   2.1.6.3. amounts payable under the contract (if a contract sum is payable) or amount payable in respect of each patient (if there is no contract sum).

2.2. For the avoidance of doubt, all Primary Medical Services Contracts will be in the name of NHS England.

2.3. The CCG must comply with any Guidance in relation to the issuing and signing of Primary Medical Services Contracts in the name of NHS England.

2.4. Without prejudice to clause 13 (Financial Provisions and Liability) or paragraph 2.1 above, the CCG must actively manage each of the relevant Primary Medical Services Contracts including by:

V7 March 2017
2.4.1. managing the relevant Primary Medical Services Contract, including in respect of quality standards, incentives and the QOF, observance of service specifications, and monitoring of activity and finance;

2.4.2. assessing quality and outcomes (including clinical effectiveness, patient experience and patient safety);

2.4.3. managing variations to the relevant Primary Medical Services Contract or services in accordance with national policy, service user needs and clinical developments;

2.4.4. agreeing information and reporting requirements and managing information breaches (which will include use of the HSCIC IG Toolkit SIRI system);

2.4.5. agreeing local prices, managing agreements or proposals for local variations and local modifications;

2.4.6. conducting review meetings and undertaking contract management including the issuing of contract queries and agreeing any remedial action plan or related contract management processes; and

2.4.7. complying with and implementing any relevant Guidance issued from time to time.

Enhanced Services

2.5. The CCG must manage the design and commissioning of Enhanced Services, including re-commissioning these services annually where appropriate.

2.6. The CCG must ensure that it complies with any Guidance in relation to the design and commissioning of Enhanced Services.

2.7. When commissioning newly designed Enhanced Services, the CCG must:

2.7.1. consider the needs of the local population in the Area;

2.7.2. support Data Controllers in providing ‘fair processing’ information as required by the DPA;

2.7.3. develop the necessary specifications and templates for the Enhanced Services, as required to meet the needs of the local population in the Area;

2.7.4. when developing the necessary specifications and templates for the Enhanced Services, ensure that value for money will be obtained;

2.7.5. consult with Local Medical Committees, each relevant Health and Wellbeing Board and other stakeholders in accordance with the duty of public involvement and consultation under section 14Z2 of the NHS Act;

2.7.6. obtain the appropriate read codes, to be maintained by the HSCIC;

2.7.7. liaise with system providers and representative bodies to ensure that the system in relation to the Enhanced Services will be functional and secure; and

2.7.8. support GPs in entering into data processing agreements with data processors in the terms required by the DPA.

Design of Local Incentive Schemes

2.8. The CCG may design and offer Local Incentive Schemes for GP practices, sensitive to the needs of their particular communities, in addition to or as an alternative to the national framework (including as an alternative to QOF or directed Enhanced Services), provided that such schemes are voluntary and the CCG continues to offer the national schemes.

2.9. There is no formal approvals process that the CCG must follow to develop a Local Incentive Scheme, although any proposed new Local Incentive Scheme:
2.9.1. is subject to consultation with the Local Medical Committee;
2.9.2. must be able to demonstrate improved outcomes, reduced inequalities and value for money; and
2.9.3. must reflect the changes agreed as part of the national PMS reviews.

2.10. The ongoing assurance of any new Local Incentive Schemes will form part of the CCG’s assurance process under the CCG Assurance Framework.

2.11. Any new Local Incentive Scheme must be implemented without prejudice to the right of GP practices operating under a GMS Contract to obtain their entitlements which are negotiated and set nationally.

2.12. NHS England will continue to set national standing rules, to be reviewed annually, and the CCG must comply with these rules which shall for the purposes of this Agreement be Guidance.

Making Decisions on Discretionary Payments

2.13. The CCG must manage and make decisions in relation to the discretionary payments to be made to GP practices in a consistent, open and transparent way.

2.14. The CCG must exercise its discretion to determine the level of payment to GP practices of discretionary payments, in accordance with the Statement of Financial Entitlements Directions.

Making Decisions about Commissioning Urgent Care for Out of Area Registered Patients

2.15. The CCG must manage the design and commissioning of urgent care services (including home visits as required) for its patients registered out of area (including re-commissioning these services annually where appropriate).

2.16. The CCG must ensure that it complies with any Guidance in relation to the design and commissioning of these services.

3. Planning the Provider Landscape

3.1. The CCG must plan the primary medical services provider landscape in the Area, including considering and taking decisions in relation to:

3.1.1. establishing new GP practices in the Area;
3.1.2. managing GP practices providing inadequate standards of patient care;
3.1.3. the procurement of new Primary Medical Services Contracts (in accordance with any procurement protocol issued by NHS England from time to time);
3.1.4. closure of practices and branch surgeries;
3.1.5. dispersing the lists of GP practices;
3.1.6. agreeing variations to the boundaries of GP practices; and
3.1.7. coordinating and carrying out the process of list cleansing in relation to GP practices, according to any policy or Guidance issued by NHS England from time to time.

3.2. In relation to any new Primary Medical Services Contract to be entered into, the CCG must, without prejudice to any obligation in Schedule 2, Part 2, paragraph 3 (Procurement and New Contracts) and Schedule 2, Part 1, paragraph 2.3:
3.2.1. consider and use the form of Primary Medical Services Contract that will ensure compliance with NHS England’s obligations under Law including the Public Contracts Regulations 2015/102 and the National Health Service (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013/500 taking into account the persons to whom such Primary Medical Services Contracts may be awarded;

3.2.2. provide to NHS England confirmation as required from time to time that it has considered and complied with its obligations under this Agreement and the Law; and

3.2.3. for the avoidance of doubt, Schedule 5 (Financial Provisions and Decision Making Limits) deals with the sign off requirements for Primary Medical Services Contracts.

4. Approving GP Practice Mergers and Closures

4.1. The CCG is responsible for approving GP practice mergers and GP practice closures in the Area.

4.2. The CCG must undertake all necessary consultation when taking any decision in relation to GP practice mergers or GP practice closures in the Area, including those set out under section 14Z2 of the NHS Act (duty for public involvement and consultation). The consultation undertaken must be appropriate and proportionate in the circumstances and should include consulting with the Local Medical Committee.

4.3. Prior to making any decision in accordance with this paragraph 4 (Approving GP Practice Mergers and Closures), the CCG must be able to clearly demonstrate the grounds for such a decision and must have fully considered any impact on the GP practice’s registered population and that of surrounding practices. The CCG must be able to clearly demonstrate that it has considered other options and has entered into dialogue with the GP contractor as to how any closure or merger will be managed.

4.4. In making any decisions pursuant to paragraph 4 (Approving GP Practice Mergers and Closures), the CCG shall also take account of its obligations as set out in Schedule 2, part 2, paragraph 3 (Procurement and New Contracts), where applicable.

5. Information Sharing with NHS England in relation to the Delegated Functions

5.1. This paragraph 5 (Information Sharing with NHS England) is without prejudice to clause 9.4 or any other provision in this Agreement. The CCG must provide NHS England with:

5.1.1. such information relating to individual GP practices in the Area as NHS England may reasonably request, to ensure that NHS England is able to continue to gather national data regarding the performances of GP practices;

5.1.2. such data/data sets as required by NHS England to ensure population of the primary medical services dashboard;

5.1.3. any other data/data sets as required by NHS England; and

5.1.4. the CCG shall procure that providers accurately record and report information so as to allow NHS England and other agencies to discharge their functions.

5.2. The CCG must use the NHS England approved primary medical services dashboard, as updated from time to time, for the collection and dissemination of information relating to GP practices.
5.3. The CCG must (where appropriate) use the NHS England approved GP exception reporting service (as notified to the CCGs by NHS England from time to time).

5.4. The CCG must provide any other information, and in any such form, as NHS England considers necessary and relevant.

5.5. NHS England reserves the right to set national standing rules (which may be considered Guidance for the purpose of this Agreement), as needed, to be reviewed annually. NHS England will work with CCGs to agree rules for, without limitation, areas such as the collection of data for national data sets and IT intra-operability. Such national standing rules set from time to time shall be deemed to be part of this Agreement.


6.1. The CCG must make decisions in relation to the management of poorly performing GP practices and including, without limitation, decisions and liaison with the CQC where the CQC has reported non-compliance with standards (but excluding any decisions in relation to the performers list).

6.2. In accordance with paragraph 6.1 above, the CCG must:

   6.2.1. ensure regular and effective collaboration with the CQC to ensure that information on general practice is shared and discussed in an appropriate and timely manner;
   6.2.2. ensure that any risks identified are managed and escalated where necessary;
   6.2.3. respond to CQC assessments of GP practices where improvement is required;
   6.2.4. where a GP practice is placed into special measures, lead a quality summit to ensure the development and monitoring of an appropriate improvement plan (including a communications plan and actions to manage primary care resilience in the locality); and
   6.2.5. take appropriate contractual action in response to CQC findings.

7. Premises Costs Directions Functions

7.1. The CCG must comply with the Premises Costs Directions and will be responsible for making decisions in relation to the Premises Costs Directions Functions.

7.2. In particular, but without limiting the generality of paragraph 7.1, the CCG shall make decisions concerning:

   7.2.1. applications for new payments under the Premises Costs Directions (whether such payments are to be made by way of grants or in respect of recurring premises costs); and
   7.2.2. revisions to existing payments being made under the Premises Costs Directions.

7.3. 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 Premises Costs Directions Functions.
7.4. The CCG will comply with any guidance issued by the Secretary of State or NHS England in relation to the Premises Costs Directions, including the Principles of Best Practice, and any other Guidance in relation to the Premises Costs Directions.

7.5. The CCG must work cooperatively with other CCGs to manage premises and strategic estates planning.

7.6. The CCG must liaise where appropriate with NHS Property Services Limited and Community Health Partnerships Limited in relation to the Premises Costs Directions Functions.

### Part 2 – Delegated Functions: General Obligations (CCG responsibilities)

1. **Introduction**

   1.1. This Part 2 of Schedule 2 *Delegated Functions* sets out general provisions regarding the carrying out of the Delegated Functions.

2. **Planning and reviews**

   2.1. The CCG is responsible for planning the commissioning of primary medical services.

   2.2. The role of the CCG includes:

   2.2.1. carrying out primary medical health needs assessments (to be developed by the CCG) to help determine the needs of the local population in the Area;

   2.2.2. recommending and implementing changes to meet any unmet primary medical services needs; and

   2.2.3. undertaking regular reviews of the primary medical health needs of the local population in the Area.

3. **Procurement and New Contracts**

   3.1. The CCG will make procurement decisions relevant to the exercise of the Delegated Functions and in accordance with the detailed arrangements regarding procurement set out in the procurement protocol issued and updated by NHS England from time to time.


   3.3. Where the CCG wishes to develop and offer a locally designed contract, it must ensure that it has consulted with its Local Medical Committee in relation to the proposal and that it can demonstrate that the scheme will:
3.3.1. improve outcomes;
3.3.2. reduce inequalities; and
3.3.3. provide value for money.

4. Integrated working

4.1. The CCG must take an integrated approach to working and co-ordinating with stakeholders including NHS England, Local Professional Networks, local authorities, Healthwatch, acute and community providers, the Local Medical Committee, Public Health England and other stakeholders.

4.2. The CCG must work with NHS England and other CCGs to co-ordinate a common approach to the commissioning of primary medical services generally.

4.3. The CCG and NHS England will work together to coordinate the exercise of their respective performance management functions.

5. Resourcing

5.1. NHS England may, at its discretion provide support or staff to the CCG. NHS England may, when exercising such discretion, take into account, any relevant factors (including without limitation the size of the CCG, the number of Primary Medical Services Contracts held and the need for the Local NHS England Team to continue to deliver the Reserved Functions).
Progress Report from the
Primary Care Commissioning Steering Group
Date of committee: 14th July and 18th August 2017

### Key Achievements

- **Extension of Primary Care Anti-Coagulation (Warfarin) Service**
- **GP Access** – Locality and practice proposals will be in place by 1st October 2017.
- **GP Access** – very good progress being made in developing extended access arrangements for live date of 1st October 2017.
- **QIPP Programme** – Primary Care plan is on track, forecasting an outturn of £1660k against a plan of £1223k.

### Issues

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<th>Issues</th>
<th>Actions</th>
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<td>Referrals into Secondary Care must reduce.</td>
<td>Referral Facilitation Team looking at referral trends and visiting practices.</td>
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### Risks

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<th>Risks</th>
<th>Actions</th>
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<td>Removal of the CHEC referral management Gateway</td>
<td>Effective communications to practices on the use of the Ardens template.</td>
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MINUTES OF THE MEETING

Primary Care Commissioning Steering Group Meeting (JPCSG)

Held on Friday 14th July 2017 – 2pm – Hawthorn House MR1

Present:

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<tr>
<td>JPCSG/17/44</td>
<td>Welcome &amp; Introductions</td>
</tr>
<tr>
<td>JPCSG/17/45</td>
<td>Apologies for absence</td>
</tr>
<tr>
<td>JPCSG/17/46</td>
<td>Declarations of Interest</td>
</tr>
<tr>
<td>JPCSG/17/47</td>
<td>Minutes of the last meeting held on 8th June 2017</td>
</tr>
<tr>
<td>JPCSG/17/48</td>
<td>Matters arising / outstanding actions</td>
</tr>
<tr>
<td>JPCSG/17/49</td>
<td>Forward Plan</td>
</tr>
</tbody>
</table>

The Chair welcomed members to the meeting and a round of introduction took place.

Apologies were noted from:
Healthwatch, Nottinghamshire

Mrs Brown and Ms Ryan declared interest as Practice Managers in agenda item JPCSG/17/52. The Chair agreed that with respect to the items on the agenda both parties were permitted to stay for the discussion, and it was noted that the meeting would not be making a decision. No further declarations to those made on the register of interests were made, and this was affirmed as an accurate record.

The minutes were taken as an accurate reflection of discussions.

Dr Marshall raised concern that there was very little clinical representation at the meeting, noting that the dates had been changed to allow GPs to attend. It was also noted that no apologies had been received. Mr Ainsworth noted the concern raised.

The Chair requested that the next meeting concentrate on approaches to support reduction of referrals into secondary care. It was agreed to invite the Referral Team to the next meeting in August 2017 for them to present a report on themes and key points that the team have addressed at recent practice visits.
### JPCSG/17/50
**Feedback from the Joint Primary Care Commissioning Committee (JPCCC) of 13 July 2017**
The Terms of Reference for the Joint Primary Care Commissioning Committee had been approved in principle, but a further paragraph needed to be added which Mrs Lloyd had agreed to address.

**Action:** Mrs Lloyd to update Terms of Reference of JPCCC.

### JPCSG/17/51
**Local Digital Roadmap and Primary Care elements.**
Due to Mr Andy Evans being unable to attend the meeting, the item was deferred until the September 2017 meeting.

**Action:** Sue Cox to add to agenda for the September 2017 meeting, and ensure that this invitation was extended to Andy Evans.

### JPCSG/17/52
**GP Access – Implementation**
The government’s mandate to NHS England (NHSE) sets down the purpose of extending GP Access to ensure equity of access for GP services, including the provision of appointments at evenings and weekends.

Locally, the Mid Nottinghamshire CCGs have embarked on an ambitious Primary Care Transformation Programme which will deliver services to patients based on a model of placed based care. Central to this offer is the collaboration of GP practices to deliver services to patients improving population coverage and reducing variation.

Mr Ainsworth reported that by October 2017, 100% of the population in mid Nottinghamshire will have access to extended hours services, with most of the practices offering appointments from 8am – 8pm cover Monday to Friday and also access on a Saturday morning. Mr Ainsworth noted that this will consist of a mixture of both pre-bookable and bookable on the day appointments with both GPs and Nurses as per the national criteria.

Locality and practice proposals are:
- **Mansfield North** – Service run by PICS (Orchard Medical Practice going alone)
- **Mansfield South** – All practices running and working together (Forest Medical Practice going alone)
- **Newark** – All practices working together, plan to work into Newark Hospital model. In a central Primary Care Hub.
- **Sherwood** – Locality approach, though one practice currently excluded and the CCG and LMC meeting to broker a deal.
- **Ashfield South** – Service already mobilised.
- **Ashfield North** – Locality approach.

Mrs McIntyre raised concern on the sharing of patient records and Mr Ainsworth reported that PICS will report and record on behalf of all practices using SystmOne. Information sharing agreements are being addressed by Mark Yates and Andy Evans (Connected Notts).
A discussion took place around communicating GP Access to the public, and the need for community Pharmacists to stay open longer. It was agreed that a communications meeting would be arranged to develop an action plan to be approved by Mr Ainsworth.

**Action:** Sue Cox to ensure that a meeting is arranged with Sally Dore and Mr Ainsworth to create an action plan on communicating GP Access to the public. Mrs McIntyre to also be invited to the meeting.

**JPCSG/17/53 Extension of Primary Care Anti-Coagulation (Warfarin) Service**

Mr Sewell reported that the extension to the current Primary Care Anti-Coagulation (Warfarin) service was addressed at the Joint Primary Care Commissioning Committee on 13th July 2017.

Mr Sewell outlined that the recommendation had been that the extension of the current service will provide a comprehensive service to monitor all patients in a primary care setting. The service will provide INR monitoring for patients receiving Warfarin treatment and allow safe alteration in medication doses accordingly. Current activity suggests that approximately 27.75% of patients are monitored in primary care by GP practices.

Mr Sewell outlined that the development of the service for the remaining 72.25%, delivered by secondary care would be provided in the majority in a primary care setting through expansion of testing provision within GP practices.

The aim of the proposal is to transfer all eligible patients into the community setting with phlebotomy, interpretation and dosing covered wholly by primary care.

Mr Ainsworth stated that this service was very good for patients, as it reduced the overall time taken for results to be accessed, and gave a more streamlined service. Mr Sewell reported that an action plan is being followed by all practices.

**JPCSG/17/54 GP Forward View – Position as at June 2017**

Ms Taylor reported that during 2016/17 using information provided by practices who met the national criteria, a schedule of investment was agreed with NHSE. Funding was confirmed and transferred across to the CCGs at the end of February 2017. A programme is in place as an intention with many different providers delivering different elements of GP Resilience. Delivery was noted to be on-going for the 20 practices selected in 2016/17.

NHSE requested that CCGs submit a plan for GP Resilience funding in 2017/18, and direct contact was made with practices to affirm that they could self-refer into this process. All practices were scored using the national criteria with the outcome being that a total 22 practices across mid Nottinghamshire undertaking the application process. The CCGs are now awaiting a response.

Funding available is understood to be £44,000 for mid Nottinghamshire, £10,000 has been allocated for specialist support. The CCG is looking at practices that have an immediate need for funding in support of prioritisation.

The Chair thanked Ms Taylor for her update, and this was noted within the meeting.
Primary Care Commissioning Risk Register

Mr Ainsworth reported that actions on the risk register now have a timescale and an owner. The Joint Primary Care Commissioning Committee have asked that a clear connection is made between the identified gaps and the mitigating actions undertaken.

A discussion took place regarding the risks around the removal of the CHEC referral management Gateway. Mr Ainsworth noted that this would be supported by effective communication of the use of the Ardens templates. Mr Ainsworth noted that the communication regarding CHEC would be sent out to all practices on or around 17th July 2017.

Any Other Business

Mrs McIntyre raised the issue of some meeting papers being inaccurately produced, and cited issues with the use of Logos, and inconsistencies in referring to the CCG / CCGs / mid Nottinghamshire CCGs.

Ms McIntyre noted that the CCG may have a risk for the continued development of Lay members, where terms of office were to conclude. Mrs Lloyd agreed to discuss matter outside of the meeting with Mrs McIntyre.

Mr Ainsworth formally thanked Ms Taylor for all her hard work within the Primary Care Team. Ms Taylor leaves her role within the CCG at the end of July 2017

Date & Time of Next Meeting

Friday 18 August 2017 – 9am – Birch House, MR3

Action Log

<table>
<thead>
<tr>
<th>Ref</th>
<th>Action</th>
<th>By Whom</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>JPCSG/17/50</td>
<td>Terms of Reference to be updated.</td>
<td>Ruth Lloyd</td>
<td></td>
</tr>
<tr>
<td>JPCSG/17/50</td>
<td>Stephen Wormal to be invited to the August meeting to present an update on referrals following recent practice visits.</td>
<td>Sue Cox</td>
<td>SW unable to make meeting but Chris Sewell and Steph Hart will attend.</td>
</tr>
<tr>
<td>JPCSG/17/51</td>
<td>Andy Evans to be invited to attend the September meeting to discuss Local Digital Roadmap and primary care elements.</td>
<td>Sue Cox</td>
<td></td>
</tr>
<tr>
<td>JPCSG/17/52</td>
<td>A meeting to be arranged between David Ainsworth, Sally Dore and Julie McIntyre to create an action plan on communicating GP Access to the public.</td>
<td>Sue Cox</td>
<td>Work being addressed by Julie Andrews and Mark Yates so meeting not now required.</td>
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</table>
MINUTES OF THE MEETING

Primary Care Commissioning Steering Group Meeting (JPCSG)

Held on Friday 18th August 2017 – 2pm – Birch House MR3

Present:

<table>
<thead>
<tr>
<th>Name</th>
<th>Position/Role</th>
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<tbody>
<tr>
<td>Mr David Ainsworth (Chair)</td>
<td>Director of Primary Care, Mid Notts CCGs</td>
</tr>
<tr>
<td>Mrs Amanda Brown</td>
<td>Practice Manager, Newark &amp; Sherwood CCG</td>
</tr>
<tr>
<td>Katie Millen</td>
<td>Management Accountant, Newark &amp; Sherwood CCG</td>
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<tr>
<td>Ms Julie McIntyre</td>
<td>Citizens Reference Panel Member</td>
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<tr>
<td>Sajidah Ahmad</td>
<td>Communications Manager, Mid Notts CCGs</td>
</tr>
<tr>
<td>Stephanie Haslam</td>
<td>Service Development Manager, Mansfield &amp; Ashfield CCG</td>
</tr>
<tr>
<td>Cathy Quinn</td>
<td>Pharmacist Lead, Mid Notts CCGs</td>
</tr>
<tr>
<td>Mr Chris Sewell</td>
<td>Service Development Manager, Newark &amp; Sherwood CCG</td>
</tr>
<tr>
<td>Paula Longden</td>
<td>Primary Care Programme Manager</td>
</tr>
<tr>
<td>Jo Riddell</td>
<td>Service Development Manager, Mansfield &amp; Ashfield CCG</td>
</tr>
<tr>
<td>Ms Sue Cox (Minutes)</td>
<td>Team Secretary – Primary Care, Newark &amp; Sherwood CCG</td>
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No.  | Item                                                                 |
-----|----------------------------------------------------------------------|
JPCSG/17/57 | Welcome & Introductions                                              |
          | The Chair welcomed members to the meeting and a round of introductions took place. |
JPCSG/17/58 | Apologies for absence                                                |
          | Apologies were noted from:                                           |
          | Healthwatch, Nottinghamshire                                         |
          | Ms Nicola Ryan                                                      |
          | Dr Nigel Marshall                                                   |
          | Mr Marcus Pratt                                                     |
JPCSG/17/59 | Declarations of Interest                                             |
          | No further declarations to those made on the register of interests were made, and this was affirmed as an accurate record. |
          | A discussion took place around communicating GP Access to the public, especially appointments available to be booked ‘on-line’. Plain, simple and clear messaging is needed advising patients not to go to A&E but go and see you GP. Generic posters and signs are needed in all GP practices along with information in local publications. Late pharmacy opening rotas must be more available for patients to see. NHSE are due to provide branding information. Mr Ainsworth requested that a communications plan be with him by 25th August 2017, to then be followed by a mobilisation meeting. |
JPCSG/17/60 | Minutes of the last meeting held on 14th July 2017                   |
          | The minutes were taken as an accurate reflection of discussions.     |
### Approaches to support the reduction of referrals into secondary care

- **Update from referral management team**

  Mr Ainsworth spoke of the need to reduce referrals into secondary care. A Demand Management Centre has been established, with a referral facilitation team looking at referral trends daily, weekly and monthly. Data shows that low referral practices are not always a good thing, and high referral practices are not always a bad thing. 50% of referrals made are not from GPs. Mid Notts CCGs have a target to reduce referrals by 5%, and year to date we have achieved 9%.

  Mrs Quinn reported that all clinical pathways, guidance, audits and templates have been refreshed. Extra practice visits have been made to all high referring practices and all practice packs have been updated. The majority of referrals are receiving peer review from another GP. Peer to Peer review is part of the Best Practice Scheme, and not all practices are aware of this. The Steering Group agreed that this information must be made aware to all practices by PLT event.

  Ms Brown reported that the dashboard was not always easy to understand, and can be very complicated. Practices need to understand and realise what the figures on the dashboard mean.

  Following discussion it was agreed to target the referrals from the following specialties to see if they were appropriate:

  - Neurology
  - Cardiology
  - Urology
  - ENT
  - Gynaecology

  Mrs Quinn advised that all Ophthalmology referrals are being triaged by Health Harmonie.

### Transformation Support Funding

A paper was presented by Ms Longden.

Transformational support 2017/18 and 2018/19 - CCGs should plan to spend a total of £3 per head as a one off non-recurrent investment commencing in 2017/18 for practice transformation support. This equates to a £171m non-recurrent investment. The investment for Mid Notts CCGs will commence in 2018/19. The investment is to be used to stimulate development of at scale providers for improved access and secure sustainability of general practice.

Mid Notts CCGs have chosen to focus non-recurrent investment into 2018/19 with rationale that Vanguard funding will cease in March 2018 and that the additional funding would facilitate the extension of schemes that have been running for a short period and where full evaluation was not yet possible.

The Steering Group were asked to make recommendations as to how the monies should be spent to deliver the maximum value for money in primary care. Mr Sewell spoke of a key priority being picking up the bill in year two for Ardens. Ms McIntyre spoke of using some for the re-education of patients and changing habits on using the NHS. Mrs Brown asked if some of the funding could be used for practices to find out what is available within the NHS to help with patients who
suffer from heavy alcohol usage and mental health problems.

The Steering Group agreed that the following areas would be taken forward:
- Patient education
- Signposting
- Children’s Services
- Workforce
- Products and services

<table>
<thead>
<tr>
<th>JPCSG/17/63</th>
<th>Primary Care Vanguard and GP Forward View update</th>
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<tbody>
<tr>
<td>A paper was presented by Ms Longden.</td>
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<tr>
<td>GP Access – Practices are making very good progress in developing extended access arrangements to go live by 1st October 2017. Extended access will be delivered on a locality basis (except Orchard Medical Practice who are working alone).</td>
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<tr>
<td>The QIPP programme for primary care is on track. The plan has delivered £770k against a plan of £322k, and is forecasting an outturn of £1660k against a plan of £1,223k.</td>
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<tr>
<td>Practice Manager training monies of around £4k are available and suggestions are needed on the best way to use the money. Mr Ainsworth suggested an engagement event dedicated to Practice Managers, possibly to be held one evening.</td>
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<thead>
<tr>
<th>JPCSG/17/64</th>
<th>IMT update including summary on printer project</th>
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<tbody>
<tr>
<td>A paper and highlight report was presented by Ms Longden.</td>
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</tbody>
</table>
| There are seven IT primary care projects currently being overseen by NHIS:-  
  - Electronic Prescription Service  
  - GP IT refresh (wifi infrastructure and PC monitors)  
  - GP server refresh  
  - SystmOne in Care Homes  
  - Patient online access  
  - GP mobile working  
  - GP printer refresh |
| Ms Longden advised that all monitors have been procured. All practices will be receiving what they requested, and roll-out will be during September 2017. The printer refresh has commenced. A project board has been created to investigate the current printing estate. NHIS has engaged with GO practices and gained user comments on what would be expected of a printing solution. |
| Mr Ainsworth asked if the highlight report could include a benefits realisation plan along with KPIs. Ms Longden spoke of the need to link in with Connective Notts to help with all strategic plans for the county. |
| **Action:** Ms Longden to continue to work on the IMT issues and provide a regular update to the Steering Group. |
| JPCSG/17/65 | Primary Care Transformation | Mr Ainsworth reported that the General Practice Forward View (GPFV) makes a commitment to help every GP practice that is a tenant in an NHS Property Services or Community Health Partnerships building to enter into a new lease. An offer is available up until the end of November 2017 that includes reimbursement of stamp duty land tax for the initial term, up to 15 years, contribution of up to £1,000 plus VAT of legal fees related to the lease transaction, and reimbursement of management fees for the financial year 2016/17 and 2017/18. Mr Ainsworth was unsure as to whether the scheme had been picked up locally by the CCG or NHSE. **Action:** Ms Riddell and Ms Longden to pick up if NHSE or CCG are leading on lease reimbursement scheme. |
| JPCSG/17/66 | Any Other Business | Ms Ahmad advised of an event being held in Newark on Tuesday 19th September 2017 around Vanguard. The Primary Care team will be having a table, and questions and answers will be led by Mr David Ainsworth and Mrs Stephanie Haslam on the day. The NHS is 70 years old, and the Steering Group were asked to think of any ideas to help support this milestone. Ms McIntyre asked how patients could self-refer into Physio via the MSK pathway. Mr Ainsworth advised that a soft launch is due to start, and a full progress report on the pathway is required. |
| JPCSG/17/67 | Identification of: Advice / recommendations to the Joint Primary Care Commissioning Committee | **Helpful conversation on GP Access – on line access on track for October 2017.**  
**Helpful conversation on Referral Management.**  
**Discussed £3 per head.**  
**Noted progress on GP Forward View.**  
**Helpful IM&T update.** |
<p>| JPCSG/17/68 | Date &amp; Time of Next Meeting | <strong>Friday 22nd September 2017 – 9.15am - Birch House, MR3</strong> |</p>
<table>
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<tr>
<th>Ref</th>
<th>Action</th>
<th>By Whom</th>
<th>Outcome</th>
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<tbody>
<tr>
<td>JPCSG/17/50</td>
<td>Terms of Reference to be updated.</td>
<td>Ruth Lloyd</td>
<td></td>
</tr>
<tr>
<td>JPCSG/17/51</td>
<td>Andy Evans to be invited to attend the September meeting to discuss Local Digital Roadmap and primary care elements.</td>
<td>Sue Cox</td>
<td>Andy Evans is out of office until early September 2017.</td>
</tr>
<tr>
<td>JPCSG/17/64</td>
<td>To continue to work with IMT issues and provide regular updates to the Steering Group.</td>
<td>Paula Longden</td>
<td></td>
</tr>
<tr>
<td>JPCSG/17/65</td>
<td>To pick up if NHSE or CCG are leading on lease reimbursement scheme.</td>
<td>Jo Riddell and Paula Longden</td>
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</tbody>
</table>
**Key Achievements**

As this was the inaugural meeting of the Primary Care Delivery Board, the Terms of Reference and future remit of the Group was discussed with a view to final sign off at the meeting scheduled to take place on 30th August 2017.

Progress reports for the following work streams were provided; Primary Care, Prescribing and Urgent and Proactive Care. The Primary Care Team were congratulated in recognition of the outstanding progress being made.

The Delivery Board agreed that further work around horizon scanning and Headroom schemes should take place. This will be an standing agenda item at all future meetings.

<table>
<thead>
<tr>
<th>Issues</th>
<th>Actions</th>
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<tbody>
<tr>
<td>No issues to raise</td>
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<tr>
<td>No additional risks identified</td>
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</table>
Present: David Ainsworth (DA), Director of Primary Care – Mid Notts CCG’s (Chair)
Eleri de Gilbert (EDG), Lay Representative
Paula Longden (PL), Primary Care Programme Manager
Annie Tasker (AT), Primary Care Quality and Safety Manager
Rosa Waddingham (RW), Head of Quality and Adult Safeguarding
Julie Shortland (JS), Senior Information Analyst
Joanne Riddell (JR), Primary Care Performance and Development Manager
Mark Yates (MY), Primary Care Performance and Development Manager
Stephanie Haslam (SH), Primary Care Performance and Development Manager
Cathy Quinn (CQ), Clinical Lead - Pharmacy and Prescribing Transformation

Apologies: Jacqui Kemp (JK), Primary Care Performance and Development Manager
Chris Sewell (CS), Primary Care Performance and Development Manager
Hazel Taylor (HT), Senior Primary Care Performance and Development Manager
Dr Nigel Marshall (NM), Clinical Advisor
Marcus Pratt (MP), Associate Chief Finance Officer
Alison Hale (AH), Prescribing Advisor
Peter Richards (PR), Prescribing Advisor

In attendance: Alison Pipes (AP), PA to the Director of Primary Care – Mid Notts
CCG’s/PLT Administrator (Secretariat)

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<tr>
<th>Ref</th>
<th>Item</th>
<th>Action</th>
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<tbody>
<tr>
<td>PCPB1</td>
<td>Welcome, introductions and apologies</td>
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<td></td>
<td>David Ainsworth welcomed members of the Primary Care Delivery Board to the inaugural meeting and introductions were made.</td>
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<td></td>
<td>David provided the context to the meeting, explaining that as the Mid Notts CCG’s are in financial turnaround, and following on from the Deloittes review recommendations, it has become necessary to align work streams to the QIPP infrastructure, to strengthen governance reporting. Each work stream will have its own Delivery Board which reports into the Financial Recovery Group (FRG). It should be noted however, as Primary Care and Prescribing are non-alliance delivery boards, they are exempt from risk sharing arrangements.</td>
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<tr>
<td>PCPB2</td>
<td>Conflicts of Interest</td>
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<td></td>
<td>David Ainsworth reminded members of the meeting of their</td>
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<tr>
<td>Ref</td>
<td>Item</td>
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<td>obligation to declare any interests they may have on any issues arising which might conflict with business.</td>
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<td></td>
<td>Declarations declared by members of the Delivery Board are listed in the CCG’s Register of Interests. The Register is available upon request from the CCG’s Corporate Governance Team.</td>
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<tr>
<td></td>
<td>There were no declarations of interest from today’s meeting to record.</td>
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<tr>
<td>PCPB3</td>
<td><strong>Terms of Reference</strong></td>
<td></td>
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<tr>
<td></td>
<td>David Ainsworth directed members of the Delivery Board to page 6 of the Terms of reference supplied. These will be the foundations for the Primary Care Delivery Board’s Terms of Reference. It should be noted that there is a need to change the name of this meeting (formally Primary Care Programme Board) to the Primary Care Delivery Board going forward.</td>
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<td></td>
<td><strong>Membership</strong></td>
<td>DA</td>
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<td></td>
<td>The membership of the Primary Care Delivery Board will consist of;</td>
<td>AP</td>
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<tr>
<td></td>
<td>• Executive Sponsor, Director of Primary Care – Mid Notts CCG’s, who will act as chair of the meeting.</td>
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<td><strong>Action:</strong> Deputy Chair to be appointed.</td>
<td>AP</td>
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<td>• CFO Sponsor, role not required, however financial representation is needed at all meetings. This should be from either the Associate Chief Finance Officer or a nominated deputy.</td>
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<td></td>
<td><strong>Action:</strong> Delivery Board Secretariat to ensure finance representation at all future meetings.</td>
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<td></td>
<td>• Clinical Sponsor, work stream Clinical Lead to be invited to all future meetings.</td>
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<td></td>
<td><strong>Action:</strong> Work stream Clinical Lead to be invited to all future meetings.</td>
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<td></td>
<td>• Senior Responsible Officer (SRO), Primary Care Programme Manager for Primary Care and the Clinical Lead - Pharmacy and Prescribing Transformation for Prescribing.</td>
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<td></td>
<td>• Organisational Leads, these are the individual programme leads. Programme Leads will only be required to attend meetings as when directed to do so by the SRO’s.</td>
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<tr>
<td></td>
<td>• Quality and Governance, representation is needed from the Primary Care Quality and Safety Manager or a nominated deputy. This should be reflected in the Terms of Reference going forward.</td>
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<tr>
<td></td>
<td>• Lay Representation, this role is critical to the Delivery Board to ensure external rigor and challenge is provided against programmes and will provide a link to the Quality and Risk Committee.</td>
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<td></td>
<td>• Other members should include support from the Senior Information Analyst or a nominated deputy. This role is to supply up-to-date business intelligence.</td>
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</table>
As the Primary Care work stream has links to both the Elective and Urgent and Proactive work streams, representation will be sought on a needs basis.

**Governance and Report**
The Primary Care Delivery Board will, in addition to reporting to the Financial Recovery Group (FRG), report to the Primary Care Commissioning Committee (PCCC). This should be reflected in the Terms of Reference.

**Action:** Alison Pipes to amend the Terms of Reference as appropriate and ensure that the Work stream Clinical Lead is invited to all future meetings.

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<tr>
<th>Ref</th>
<th>Item</th>
<th>Action</th>
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<tbody>
<tr>
<td>PCPB4</td>
<td><strong>Urgent and Proactive, Primary Care Hub and Best Practice Scheme – Work Programme Updates.</strong></td>
<td>AP</td>
</tr>
</tbody>
</table>

Prior to discussing this item, and items PCPB5 and PCPB6, Paula Longden wished to draw member’s attention to the Integrated Finance Report for month 3, which was forwarded under separate cover. The report provides an overview of all work stream financial activity (page 1) followed by programme summaries for all work streams (page 2 onwards). This document will provide the basis for discussions around schemes rated as ‘Red’ or ‘Amber’ at future meetings.

Paula advised that although in the Urgent and Proactive work stream, David Ainsworth is SRO for the following 2 schemes, which are forecasting as on track but to date are under delivering and are rated as ‘Red’.

- **Local Admission Avoidance (Best Practice Scheme)**
  Scheme under delivering against original plan. Reduction in forecast signed off through change control at FRG. Year 2 Scheme drafted to mitigate under delivery. Scheme will be discussed at PCCC in August 2017, with a view to start delivering in September 2017. The plan is to mandate its uptake through member agreement.

- **New Primary Care Model (Hubs)**
  Project highlighted as ‘Red’ for finance under delivery. Stephanie Haslam, Primary Care Performance and Delivery Manager provided assurance on actions being taken to ensure Acute Home Visiting service delivery. Contract discussions with providers have focussed on: number of visits per shift, appropriate referrals, avoided NELs. The Acute Home Visiting Service started in March/April 2017 and is now fully staffed.

  Stephanie Haslam advised that caution should be applied as there is only 2 months data available.
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<th>Ref</th>
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<th>Action</th>
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<tbody>
<tr>
<td></td>
<td>Nurse Treatment Room future provider being sought. Vanguard funding</td>
<td>JS</td>
</tr>
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<td></td>
<td>only available until March 2018. Local Partnerships covering the</td>
<td></td>
</tr>
<tr>
<td></td>
<td>service at present, however we are investigating solutions with</td>
<td></td>
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<tr>
<td></td>
<td>NEMS and SFHT.</td>
<td></td>
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<td></td>
<td><strong>Action:</strong> Acute Home Visiting Service Performance Scorecard to</td>
<td></td>
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<tr>
<td></td>
<td>be brought to the next meeting (appended to PMO Update).</td>
<td></td>
</tr>
</tbody>
</table>

**PCPB5  Primary Care Work Programme Updates**

David Ainsworth congratulated the work of the Primary Care/Prescribing Team in recognition of the outstanding progress being made in support of the schemes rated as ‘Green’.

The only ‘Red’ relates to EHS Reviews (Cardiology and Near Patient Testing) due to delays in starting the project. September 2017 for Cardiology and October 2017 for Near Patient Testing. Wider roll out will be brought forward to mitigate the financial risk.

Community ENT, GP Access and Ardens will start to appear as headroom schemes.

Referral Management is now listed as a Primary Care scheme and not an Elective scheme.

**PCPB6  Prescribing Work Programme Updates**

Cathy Quinn advised that she is working with Finance to ascertain why there are 2 schemes listed for High Cost Drugs. For both schemes, Ian Ellis, Director of Contracting and Urgent Care is listed as the SRO but the schemes sit within Primary Care.

Cathy highlighted that medicine costs have decreased, which have not been included in the savings calculations despite agreement that they would be part of the plan (windfall savings). Discussions ensued as to why Finance is not recording all savings. Cathy queried whether High Cost Drugs should be escalated to FRG to ascertain why there are 2 projects listed and whether ‘windfall’ costs should be incorporated. If windfall costs are not to be included the target needs to be adjusted.

**Action:** Cathy Quinn to work with Coral Osborn in respect of Finance issues and advise FRG of their recommendations.  CQ

Paula Longden queried whether the 2 projects fit better with the Elective work streams, to which the Delivery Board agreed.

**Action:** Cathy Quinn to enact the change process.  CQ

**PCPB7  Risks and Issues**

The Delivery Board agreed that a Risk Log is needed for escalation.
Ref | Item | Action
---|---|---
| | and should include information on finance and milestones. **Action:** Paula Longden/Alison Pipes to create a Risk Log in readiness for the August meeting. | PL/AP
| | Paula Longden highlighted the current risks as; • Acute Home Visiting – Mitigating actions in place. • High Cost Drugs – Mitigating actions in place. • Operational/Implementation of GP Access – Month 4 update needed. • Diabetes Hypo Pathway – Right Care Diabetes will help with this. • Community ENT Delay – Roll Out needs to be earlier and have a broader footprint. • Arden’s – Funded until the end of May 2018. Consideration should be given in respect of payments after this date. • Health Optimisation and Consultant Connect – Delivery Board needs to be aware of these projects. Information should be provided in respect of unblocking/openness. • Single Front Door/Streaming (Newark) – David Ainsworth is the SRO, however these are classed as Urgent and Proactive. Clarity is needed to understand the QIPP deliverables. Is Lucy Dadge leading or is Primary Care leading as a headroom scheme, as much of Stephanie Haslam’s work will be missed? | 
| | **PCPB8** Horizon Scanning and Headroom Schemes Item discussed under item PCPB5 – Primary Care Work Programme Update. **Action:** Timescales and values to be added for discussion at the August meeting. Programme Leads to action. | Programme Leads
| | **PCPB9** Meeting Actions and Issues to be escalated to the Primary Care Commissioning Committee and Financial Recovery Group. Alison Pipes to action following today’s discussions (please refer to the accompanying action log). | AP
| | **PCPB10** Date, time and Venue of the next meeting The next scheduled meeting will take place on Wednesday 30th August 2017, 12noon – 1.30pm, Meeting Room 1, Hawthorn House, Mansfield. | 

Page 5 of 5
**Programme Title:** Primary Care

**Programme Manager:** Cathy Quinn / Paula Longden

**Plan Overall:** Milestones

**Project Managers:** Jo Riddell / Chris Sewell / Mark Yates

**Finance:** Green / Green / Green

**Status:** Green / Green / Green

**Period Reported On:** July 2017

**YTD Financial Delivery Status**

### Programme Aim

The primary care programme is focused on enhancing service delivery in primary care. Priorities in 2017/18 are:

- Delivery of improved diabetes care and treatment with quick wins around the hypo pathway, utilising Ardens and maximising the National Diabetes Prevention Programme.
- Improved referral management through Ardens decision support tool and the referral facilitation team.
- Reduced specific diagnostic, treatments and care out of a secondary care setting and into a primary care hub model.
- Improving GP access in line with the GP Forward View criteria to open the public a better alternative to ED.

### Programme Objective

The key objectives are:

- Improve the quality of services for patients.
- Deliver more care closer to home.
- Shift services "left", i.e. reduce activity in secondary care and make associated savings.
- Improve efficiency and effectiveness in primary care.

### Interdependencies/links to other projects, if any

Links to both the urgent and proactive and elective programmes.

### Programme Snapshot Summary

<table>
<thead>
<tr>
<th>Project</th>
<th>SRO</th>
<th>Summary Status</th>
<th>Current Period Milestones</th>
<th>YTD Financial RAG</th>
<th>Current Period Plan Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>D1.3a - High Cost Drugs - 16/17 (FY1)</td>
<td>David Ainsworth</td>
<td>Agreement reached with CFDC regarding recording of savings. Future savings will include savings arising from changes in market forces.</td>
<td>Green / Green / Green</td>
<td>Grey / Grey / Green</td>
<td></td>
</tr>
<tr>
<td>D1.3b - High Cost Drugs - 17/18</td>
<td>David Ainsworth</td>
<td>New project Manager appointed in May 2017. Update and handover completed.</td>
<td>Green / Green / Green</td>
<td>Grey / Grey / Green</td>
<td></td>
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<tr>
<td>D1.11 - Diabetes</td>
<td>David Ainsworth</td>
<td>National Diabetes Audit - Data submission closes 28th July. NHSE reporting M&amp;A CCG 100% of practices participating. N&amp;S CCG (only) participating with the exception of 3 practices and these have been contacted.</td>
<td>Green / Green / Green</td>
<td>Grey / Grey / Green</td>
<td></td>
</tr>
<tr>
<td>D1.4 - Referral management</td>
<td>David Ainsworth</td>
<td>Referral management work continues in line with action plan - solution found for maternity cover and Best Practice Scheme contribution agreed.</td>
<td>Green / Green / Green</td>
<td>Grey / Grey / Green</td>
<td></td>
</tr>
<tr>
<td>D1.3a - Kirkby (NEMS) - reduce capacity to match demand</td>
<td>David Ainsworth</td>
<td>Two month delay in contracting mitigated by the faster roll out to all localities.</td>
<td>Green / Green / Green</td>
<td>Grey / Grey / Green</td>
<td></td>
</tr>
<tr>
<td>D1.3b - Primary Care - LES</td>
<td>David Ainsworth</td>
<td>Contract start date expected to be 1st October.</td>
<td>Green / Green / Green</td>
<td>Grey / Grey / Green</td>
<td></td>
</tr>
<tr>
<td>D1.4 - Referral management</td>
<td>David Ainsworth</td>
<td>Action plans and reviews are showing positive trends with referrals patterns.</td>
<td>Green / Green / Green</td>
<td>Grey / Grey / Green</td>
<td></td>
</tr>
<tr>
<td>H1.4 - EHS Reviews</td>
<td>Jo Riddell / Chris Sewell / Mark Yates</td>
<td>Clinical advisor taken on lead role for electives, therefore clinical capacity is limited to progress work</td>
<td>Green / Green / Green</td>
<td>Grey / Grey / Green</td>
<td></td>
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<tr>
<td>D1.5 - Risk (NEMCS) - reduce capacity to match demand</td>
<td>Jo Riddell / Chris Sewell / Mark Yates</td>
<td>Two month delay in contracting mitigated by the faster roll out to all localities.</td>
<td>Green / Green / Green</td>
<td>Grey / Grey / Green</td>
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<tr>
<td>G2.5 - Review of Primary Care Access</td>
<td>Jo Riddell / Chris Sewell / Mark Yates</td>
<td>Design and project plan being developed with clinical lead and SFHT. Clinical lead now identified as Dr Tadpatrikar.</td>
<td>Green / Green / Green</td>
<td>Grey / Grey / Green</td>
<td></td>
</tr>
<tr>
<td>H1.3a - Kirkby (NEMS) - reduce capacity to match demand</td>
<td>Jo Riddell / Chris Sewell / Mark Yates</td>
<td>Design and project plan being developed with clinical lead and SFHT. Clinical lead now identified as Dr Tadpatrikar.</td>
<td>Green / Green / Green</td>
<td>Grey / Grey / Green</td>
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<tr>
<td>D2.6 - Primary Care - Pathways</td>
<td>Jo Riddell / Chris Sewell / Mark Yates</td>
<td>Two month delay in contracting mitigated by the faster roll out to all localities.</td>
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<td>D2.6 - Primary Care - LES</td>
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<td>Contract start date expected to be 1st October.</td>
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<tr>
<td>H1.4 - EHS Reviews</td>
<td>Jo Riddell / Chris Sewell / Mark Yates</td>
<td>Clinical advisor taken on lead role for electives, therefore clinical capacity is limited to progress work</td>
<td>Green / Green / Green</td>
<td>Grey / Grey / Green</td>
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<tr>
<td>D2.7 - Review of Primary Care Access</td>
<td>Jo Riddell / Chris Sewell / Mark Yates</td>
<td>Two month delay in contracting mitigated by the faster roll out to all localities.</td>
<td>Green / Green / Green</td>
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### Programme Financial Target

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<th>YTD FOT</th>
<th>YTD Actual</th>
<th>Variance</th>
<th>YTD Straight line cascade</th>
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### Programme Financial Savings Profile

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<th>Project</th>
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<th>17/18 Target £’000</th>
<th>2017/18 FOT £’000</th>
<th>2017/18 FOT Variance £’000</th>
<th>YTD Plan £’000</th>
<th>YTD Actual £’000</th>
<th>In Month £’000</th>
<th>In Month Variance £’000</th>
<th>YTD Financial RAG</th>
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<td>D1.3a - High Cost Drugs - 16/17 (FY1)</td>
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<td>D1.3b - High Cost Drugs - 17/18</td>
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<td>D1.4 - Referral management</td>
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<td>0</td>
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### Programme Financial Delivery Status

-**RAG Status:**
  - Green: Achieved or on track.
  - Grey: Action required.
  - Red: Critical risk.

-**Period Reported On:** July 2017

-**YTD Financial RAG:**
  - Green: Achieved or on track.
  - Grey: Action required.
  - Red: Critical risk.
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### Stretched Programme Financial Savings Profile

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<tr>
<th>Area</th>
<th>Position</th>
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<th>2017/18 FOT £'000</th>
<th>2017/18 FOT Variance £'000</th>
<th>YTD Plan £'000</th>
<th>YTD Actual £'000</th>
<th>In Month Plan £'000</th>
<th>In Month Actual £'000</th>
<th>YTD Variance £'000</th>
<th>In Month Finance RAG</th>
<th>YTD Finance RAG</th>
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</thead>
<tbody>
<tr>
<td>Headroom</td>
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</table>

### Programme Key Performance Indicators

| Area                  | Position | 17/18 Target | YTD Target | YTD Actual | YTD Variance | Month Target | Current Month | Previous Month |
|-----------------------|----------|--------------|------------|------------|--------------|--------------|---------------|----------------|----------------|

| Quarter               | Date raised | Status | Current Month | Previous Month |
|-----------------------|-------------|--------|---------------|----------------|---------------|
| Cardiology go live in Sherwood locality during Quarter 1 | 01/07/2017 | Amber | Amber | Amber |
| Community ENT go live during Quarter 2 | 01/10/2017 | Amber | Amber | Amber |
| GP access full mobilisation of extra 30 minutes | 31/08/2017 | Green | Green | Green |
| Near patient testing mobilisation of Sherwood locality | SO-Stop | Green | Green | Green |
| GP access full mobilisation of Newark, Ashfield and Mansfield localities | Amber | Amber | Amber | Amber |
| Near patient testing mobilisation of Newark, Ashfield and Mansfield localities | Amber | Amber | Amber | Amber |

### Risk Reference

<table>
<thead>
<tr>
<th>Risk Reference</th>
<th>Risk Category</th>
<th>Cause</th>
<th>Event - the risk itself</th>
<th>Effect</th>
<th>Date raised</th>
<th>Risk Owner</th>
<th>Expected level of impact should risk occur</th>
<th>Likelihood of risk happening</th>
<th>Overall risk rating</th>
<th>Proximity</th>
<th>Mitigation Actions</th>
<th>Expected risk rating after mitigation</th>
<th>Current Risk status</th>
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</thead>
<tbody>
<tr>
<td>RSK-PRM-001</td>
<td>Schedule</td>
<td>Risk inherent in proof of concept - savings may not be delivered.</td>
<td>This would prevent the Code achieving to make it do as per the GP FTV.</td>
<td>Jan '16</td>
<td>4 3 2</td>
<td>Green</td>
<td>Amber</td>
<td>100%</td>
<td>Amber</td>
<td>More monitoring of the project manager with plans put in place to ensure that any of the following anticipated solutions can be put in place by the deadline.</td>
<td>100%</td>
<td>Amber B-12</td>
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<td>RSK-PRM-002</td>
<td>Tendered</td>
<td>32.6 - Primary Care - LES: Risk inherent in proof of concept - savings may not be delivered.</td>
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<td>Amber</td>
<td>25%</td>
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<td>RSK-PRM-003</td>
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<td>This would prevent the Code achieving to make it do as per the GP FTV.</td>
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<td>Amber</td>
<td>75%</td>
<td>Amber</td>
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<td>75%</td>
<td>Amber B-12</td>
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### Issue Reference

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<th>Issue Reference</th>
<th>Risk Reference</th>
<th>Date raised</th>
<th>Type of issue</th>
<th>Description</th>
<th>Cause</th>
<th>Impact</th>
<th>Severity</th>
<th>Issue Owner</th>
<th>Actions</th>
<th>Event Agency</th>
<th>Status</th>
<th>Resolution</th>
<th>Date resolved</th>
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### Further Opportunities

<table>
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<tr>
<th>Opportunity</th>
<th>Potential Impact</th>
<th>Benefitting Organisation</th>
<th>Pipeline Tracker</th>
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</thead>
<tbody>
<tr>
<td>CCG</td>
<td>BPH</td>
<td>NTT</td>
<td>Circle</td>
</tr>
</tbody>
</table>

### Milestone Key

- **A** is amber risk, indicating a potential issue that requires action.
- **G** is green risk, indicating a risk that is well-managed.
- **R** is red risk, indicating a high-priority issue that requires immediate attention.

- **Blue** indicates that the risk is high and requires immediate action.
- **Purple** indicates that the risk is medium and requires monitoring.
- **Grey** indicates that the risk is low and can be ignored.

- **Orange** indicates a potential issue that requires further investigation.
- **Red** indicates a critical issue that requires immediate attention.

- **Yellow** indicates a warning that the risk is developing.

- **Green** indicates that the risk is under control.
- **Yellow** indicates that the risk is developing.
- **Red** indicates a critical issue that requires immediate attention.

- **Orange** indicates a potential issue that requires further investigation.
- **Red** indicates a critical issue that requires immediate attention.

- **Grey** indicates that the risk is low and can be ignored.
- **Yellow** indicates a warning that the risk is developing.
- **Red** indicates a critical issue that requires immediate attention.

- **Orange** indicates a potential issue that requires further investigation.
- **Red** indicates a critical issue that requires immediate attention.

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- **Orange** indicates a potential issue that requires further investigation.
- **Red** indicates a critical issue that requires immediate attention.

- **Grey** indicates that the risk is low and can be ignored.
- **Yellow** indicates a warning that the risk is developing.
- **Red** indicates a critical issue that requires immediate attention.

- **Orange** indicates a potential issue that requires further investigation.
- **Red** indicates a critical issue that requires immediate attention.

- **Grey** indicates that the risk is low and can be ignored.
- **Yellow** indicates a warning that the risk is developing.
- **Red** indicates a critical issue that requires immediate attention.

- **Orange** indicates a potential issue that requires further investigation.
- **Red** indicates a critical issue that requires immediate attention.

- **Grey** indicates that the risk is low and can be ignored.
### Exception Report

**Programme/Project Title:** Primary Care

**SRO:** David Ainsworth

**Plan Overall:**
- **Previous Period:** Green
- **Current Period:** Green

**Project Manager:** Paula Longden / Cathy Quinn

**Milestones:**
- **Previous Period:** Green
- **Current Period:** Green

**Unique Programme/ Project Reference:** PRI1718

**Exception reports enclosed:** Yes

**Finance:**
- **Previous Period:** Green
- **Current Period:** Green
- **YTD:** Green

**Year End Forecast:**
- **Previous Period:** Green
- **Current Period:** Green
- **YTD:** Green

### Exceptions

<table>
<thead>
<tr>
<th>UID</th>
<th>Area</th>
<th>Issue Description Cause, impact, severity</th>
<th>Type</th>
<th>Actions</th>
<th>By when</th>
<th>Resolution &amp; Lessons Learnt</th>
<th>Date Resolved</th>
<th>Confidence last month</th>
<th>Confidence this month</th>
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<tbody>
<tr>
<td>EXC-PRI-001</td>
<td>High cost drugs -D1.3</td>
<td>Performance below plan in high cost drugs both in year plan and FYE.</td>
<td>Choose from list</td>
<td>This is being investigated further as there is a lack of clarity about plan and potential savings: • Windfall saving not being captured by finance, although agreement was made to record these. NB: price of initial medicine has reduced since the original plan was created. • Gain share agreement waiting to be signed off by Ian Ellis</td>
<td>Mar-18</td>
<td>Ensure that all savings associated with HCDs are being captured. Evaluate the drugs included and consider potential widening.</td>
<td>07-Aug</td>
<td>Medium</td>
<td>High</td>
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<tr>
<td>EXC-PRI-002</td>
<td>H1.4 EHS reviews D2.6 Primary care - LES and pathways</td>
<td>Project behind plan year to date. EHS reviews is part of the cardiology and near patient testing enhanced services development. The phasing in the original QIPP plan assumed delivery in Q2 whereas the final project plan had mobilisation in August and September for both.</td>
<td>Financial</td>
<td>No change in actions from the previous month because mitigating actions are on track: There is a refreshed faster timeframe for cardiology mobilisation across the entire patch. The cardiology provider is currently mobilising with go live in September. Near patient testing procurement has commenced, guided by Arden and GEM, in line with the revised timeframe for a go live date in October.</td>
<td>Mar-18</td>
<td>The financial risk is mitigated by a refreshed faster time frame for mobilisation.</td>
<td></td>
<td>High</td>
<td>High</td>
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<tr>
<td>EXC-PRI-003</td>
<td>D2.11 Diabetes</td>
<td>YTD savings behind plan.</td>
<td>Financial</td>
<td>The CCGs are reporting no reduction in NEL admissions related to diabetes despite the introduction of the hypo pathway and NDPP.</td>
<td>Medium</td>
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<tr>
<td>EXC-PRI-004</td>
<td>D2.6 Primary Care - LES</td>
<td>Project behind plan year to date. Project is near patient testing enhanced services development. The phasing in the original QIPP plan assumed delivery in Q2 whereas the final project plan had mobilisation in October.</td>
<td>Financial</td>
<td>No change in actions from the previous month because mitigating actions are on track: Near patient testing procurement has commenced, guided by Arden and GEM, in line with the revised timeframe for a go live date in October.</td>
<td>Mar-18</td>
<td>The financial risk is mitigated by a refreshed faster time frame for mobilisation.</td>
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<td>EXC-PRI-005</td>
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The Contracting Officer is investigating the opportunities to maximise the hypo, and other, pathways. Practices are making excellent progress with the NDPP.
## Mid Nottinghamshire Total

### Monthly QIPP Financial Summary

<table>
<thead>
<tr>
<th>Delivery Board</th>
<th>Sub Scheme Name</th>
<th>SRO</th>
<th>2017/18 Plan</th>
<th>2017/18 FOT Variance</th>
<th>YTD Plan</th>
<th>YTD Actual</th>
<th>YTD Variance</th>
<th>In Month Plan</th>
<th>In Month Actual</th>
<th>In Month Variance</th>
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<th>Milestone BRAG Ratings 12/07/17</th>
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<td>New primary care model G2.1 David Ainsworth</td>
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<td>Primary Care Total</td>
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<td>3,686</td>
<td>4,178</td>
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**Appendix 4**

**Level 4, QIPP Financial Summary**
See the Notes section underneath the scorecard for further information.

### Community Outputs

<table>
<thead>
<tr>
<th>Area</th>
<th>Number of Visits vs Target</th>
<th>Actual</th>
<th>Target</th>
<th>Actual</th>
<th>Target</th>
<th>Actual</th>
<th>Target</th>
<th>Actual</th>
<th>Target</th>
<th>Actual</th>
<th>Target</th>
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<tbody>
<tr>
<td>Ashfield</td>
<td>130 (400)</td>
<td>400</td>
<td>123</td>
<td>400</td>
<td>157</td>
<td>400</td>
<td>192</td>
<td>400</td>
<td>192</td>
<td>400</td>
<td>192</td>
</tr>
<tr>
<td>Newark</td>
<td>53 (192)</td>
<td>192</td>
<td>123</td>
<td>192</td>
<td>192</td>
<td>192</td>
<td>225</td>
<td>192</td>
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<tr>
<td>Total</td>
<td>183 (592)</td>
<td>592</td>
<td>246</td>
<td>592</td>
<td>349</td>
<td>592</td>
<td>417</td>
<td>592</td>
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### WTE Staff

<table>
<thead>
<tr>
<th>Area</th>
<th>Visits per WTE</th>
<th>Actual</th>
<th>Target</th>
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<tbody>
<tr>
<td>Ashfield</td>
<td>2.0</td>
<td>2.0</td>
<td>2.0</td>
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<tr>
<td>Newark</td>
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<td>1.6</td>
<td>1.6</td>
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<tr>
<td>Total</td>
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### Difference (Actual Visits-Target Visits)

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<th>Difference (Actual Visits-Target Visits)</th>
<th>Actual</th>
<th>Target</th>
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<tr>
<td>Ashfield</td>
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<td>-277</td>
<td>-243</td>
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<tr>
<td>Newark</td>
<td>-139</td>
<td>-69</td>
<td>0</td>
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<tr>
<td>Total</td>
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<td>-346</td>
<td>-243</td>
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### Quality

#### Inappropriate Referrals

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### Budget and Spend

#### Spend vs Budget

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<td>Ashfield</td>
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### Secondary Care Outcomes

#### Reported Admissions Avoided

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### Overall Savings

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<th>Savings</th>
<th>Cost</th>
<th>Overall Savings</th>
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<td>NEL Admissions - Control</td>
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### Notes

1. **NB:** The Newark area includes Southwell Medical Centre.
2. **Non Elective Data Source:** Secondary Uses Service - Inpatient Spells (NHSE Reporting)
3. **Target Visits are based on 10 visits per WTE per day in Ashfield and 6 visits per WTE per day in Newark.**
4. **Rag Ratings (Return on Investment Figure):**
   - Red: <1:1
   - Amber: 1:1.0 - 1:1.3
   - Green: >1:1.3
5. **Diagnosis Codes:**
   - Falls: W0*, W1*, R296
   - UTIs: N390
   - Chest Infections: J069, J22*, J40*-J47*

---

Acute Home Visiting Service Scorecard

Monthly Reporting from April 2017 to July 2017

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<tr>
<th>Group</th>
<th>Activity</th>
<th>Area</th>
<th>Month of Activity</th>
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<th>Target</th>
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<th>Actual</th>
<th>Target</th>
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<td>157</td>
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<td>Difference (Actual Visits-Target Visits)</td>
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<td>-998</td>
<td>-998</td>
</tr>
<tr>
<td>Ta</td>
<td>l</td>
<td>Newark</td>
<td>May</td>
<td>-139</td>
<td>-69</td>
<td>0</td>
<td>-255</td>
<td>-463</td>
<td>-463</td>
<td>-463</td>
<td>-463</td>
</tr>
<tr>
<td>Total</td>
<td>Difference (Actual Visits-Target Visits)</td>
<td>Ashfield</td>
<td>April</td>
<td>-409</td>
<td>-346</td>
<td>-243</td>
<td>-463</td>
<td>-1,461</td>
<td>-1,461</td>
<td>-1,461</td>
<td>-1,461</td>
</tr>
<tr>
<td>Quality</td>
<td>Inappropriate Referrals</td>
<td>Ashfield</td>
<td>April</td>
<td>0</td>
<td>4</td>
<td>5</td>
<td>16</td>
<td>25</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Newark</td>
<td>May</td>
<td>0</td>
<td>4</td>
<td>5</td>
<td>16</td>
<td>25</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Notes:**

- **Rag Ratings (Return on Investment Figure):**
  - Red: <1:1
  - Amber: 1:1.0 - 1:1.3
  - Green: >1:1.3
- **Diagnosis Codes:**
  - Falls: W0*, W1*, R296
  - UTIs: N390
  - Chest Infections: J069, J22*, J40*-J47*
Primary Care Best Practice Scheme
Year 2

Communication and Engagement Plan
## Communications and engagement plan & activity – September, 2017

<table>
<thead>
<tr>
<th>Form of communication</th>
<th>Timeline and Phasing</th>
<th>Route/ how to transmit? Media Source</th>
<th>Message/Action</th>
<th>Who sending transmission</th>
<th>Completed Date</th>
</tr>
</thead>
</table>
| Written               | Phase 1 1st sept     | Covering letter Service Specification to Practice Manager and Lead GP | 1. Investment in primary care  
2. Lessons learned last year – made simpler  
3. Things they can influence which is achievable  
4. CCG priorities likely to be working on already  
5. Value  
   • Improved quality  
   • Beaurocracy – future enhanced services  
6. For patients:  
   • Sepsis, Peer review, Access, Diabetes | David Ainsworth & Jess Whittle contracting | Completed 31st August 2017 |
| Written               | Weekly               | Snippets  
All Practice Staff | Bullet points - key areas of BPS scheme as above | D Ainsworth |  |
| Video blog            | By end Sept 2017     | Video blog  
For all stakeholders | Launch BPS Year 2  
Script to be agreed | David Ainsworth |  |
| Written/F2F           | 6th Sept             | Slide deck for PDM’s | Consistent script for all SDMS – delivery of consistent key messages  
Discussion at PC Team meeting | JKemp team |  |
| Verbal /meeting       | TBC at end Sept      | Open Sessions with Practice Managers & PM Forums | Walk through specification and present slide deck  
Session in Mansfield & Ashfield and Newark and Sherwood | All PDM.s |  |
| Verbal                | Sept/ October        | 1:1 sessions with Practice Managers on Request | Detailed explanation of service spec and actions required | ALL PDM’s as required |  |
## Communications and engagement plan & activity September 2017

<table>
<thead>
<tr>
<th>Form of communication</th>
<th>Timeline and Phasing</th>
<th>Route/ how to transmit? Media Source</th>
<th>Message/Action</th>
<th>Who sending transmission</th>
<th>Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Written</td>
<td>Start of scheme (1/9/2107 on going)</td>
<td>Frequently asked questions briefing</td>
<td>Continued sharing with all practices via bulleting</td>
<td>J kemp</td>
<td></td>
</tr>
<tr>
<td>Presentation</td>
<td>Awaiting confirmation of Dates from Julie Andrews</td>
<td>Present at PPG Leads meeting Mid Notts</td>
<td>Share BPS details with PPG groups in order they can support practices</td>
<td>J Kemp/PDMs</td>
<td></td>
</tr>
<tr>
<td>Written</td>
<td>Last week of the month until end of the scheme</td>
<td>BPS monthly briefing circulated to practice managers</td>
<td>Including performance information, FAQ’s</td>
<td>J Kemp</td>
<td></td>
</tr>
<tr>
<td>Written</td>
<td>Phase 2 From October 2017</td>
<td>E-mail and Bulletin</td>
<td>Information to practices re Near Patient Testing Issue of equipment via Provider Training availability</td>
<td>Chris Sewell</td>
<td></td>
</tr>
</tbody>
</table>

6th September
**STRATEGIC OBJECTIVE:**

AIM 1: Best quality within available resources (incorporating safety, effectiveness and patient experience)

---

**PC1 (2017/18) (Both CCGs)**

**Date on Risk register:** December 2015

**Committee:** Primary Care Commissioning Committee

**Risk Owner:** Director of Primary Care

**Date last reviewed:** 7th August

**Date risk identified/on AF:** November 2015

(Transferred to combined Assurance Framework: 17 January 2017)

---

**CURRENT RISK RATING (Likelihood & Impact):**

4 X 4 = RED

**RESIDUAL RISK = 3 X 4 AMBER RED**

**RISK APPETITE = 3 (January 2017)**

**REASON FOR RISK APPETITE SCORE:** Willing to consider all potential delivery options whilst also providing value for money

---

**RISK:** There is a risk to the successful delivery of the Primary Care Strategies, including GP Forward View, and the stated population health outcomes within Mid Notts, Better Together approach

---

**Rationale for current score:**

- The high levels of deprivation and increasing need to address the public health needs of the local population
- Increasing complex patient care is challenging both capacity and capability of even the most experienced GPs
- Primary care has multiple interdependencies making it complex to navigate
- Significant pressure on the Primary Care Workforce and the ability to attract and retain GPs within the local community
- The health and well-being of GPs ad those working in primary care is under pressure
- The duty of GPs to deliver safe effective care under contractual obligations as part of core business
- Premises are, in some areas, in need of improvement
- Unwarranted clinical variation exists
- The introduction of robust CQC performance management
- CQC ratings affect public confidence and belief in primary care
- The public recognise and value the A&E brand and primary care is not always the default for excellent NHS care
- Rising expectations for urgent and emergency access to primary care
- Primary Care is not currently commissioned to deliver 7 day services and will suffer capacity constraints within the existing model
- Headroom for GPs to engage effectively with the CCG in order to develop new models of care
- Engagement by Primary Care in the development of the wider health and social care transformation of services
- The lack of a single voice for primary care as a provider with correct governance structure to support developments
- Alliance model inter-dependence and primary care at the core of services could impact on wider development of health outcomes
- The current business model for primary care is not universally fit for purpose
- Adverse media attention leads to a decrease in public confidence around primary care
- Increasing financial pressures and high spend in areas such as prescribing and continuing healthcare needs
- Patient experience is variable and not all practices are fully engaged with the Friends and Family Test
- GP Practice Locality working is not yet fully established
- Assurance is required that general practice will continue to align to the Alliance Board outcomes and direction of travel
- Services may not meet the needs of the local population
- GP Patient Survey in 2107 has shown a decline in patient experience

---

**Controls/Influences:** (What are we currently doing about the risk?)

- 1. Primary Care (medical) delegated authority to the Mid Notts CCG Primary Care Commissioning Committees ©
- 2. Primary Care Commissioning Steering Group established with GP/practice manager membership ©
- 3. Primary Care commissioning governance structure in place to support/align with existing CCGs arrangements ©
- 4. Nottinghamshire/Derbyshire Primary Care Hub expertise and support ©
- 5. Mid Notts CCGs Conflict of interest policy revised and approved to include the primary care (medical) delegated authority remit ©
- 6. Governing Body and Clinical Executive oversight ©
- 7. Mid Notts CCGs Membership agreements approved by practices ©
- 8. Mid Notts CCGs National Vanguard status supports development and progression of primary care system redesign ©
- 9. Health and Social Care Programme Management Office manages system redesign and drives initiatives to support the Mid Notts CCG 5 year strategy ©
- 10 Mid Notts CCGs Primary Care strategies and joint CCGs risk register ©
- 11. Mid Notts CCGs clinical Leads for Primary Care, CCG Clinical Chairs and Executive GP Leads in place (i)
- 12. Primary Care relationship management supported by the CCG Communications and Engagement Team (i)
- 13. Formal liaison and engagement with Local Authority and Health and Well Being Board (i)
- 14. A Mid Nottinghamshire Clinical Senate has been put in place ©

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**Gaps in controls/influences:**

G1. Sustainable Primary Care provider workforce plan, highlight key areas of capacity and demand for new models of care – C. Lawson

G2. A single provider organisation that can represent primary care around the Alliance table – D. Ainsworth

---

**Risks Inventory**

![Risk Graph]
| 16. | Local Medical Committee provides an advisory role and support to the primary care team (i) |
| 17. | Local GPS engaged in registrar training programme (i) |
| 18. | Local GP Teaching Practices are in place (i) |
| 19. | Mid Notts CCGs Education Group and Protected Learning Time Schedule of events established © |
| 20. | Mid Notts CCG Primary Care Team regular meetings established © |
| 21. | Primary Care Strategic Advisory Group established across Derbyshire and Nottinghamshire which the CCGs both attend and Chair (i) |
| 22. | Forward View Programme (i) |
| 23. | Member practice representation at Joint Primary Care Commissioning Steering Group (i) |
| 24. | An agreed quality and performance framework with triggers and escalation clearly defined (c) |
| 25. | A CCGs’ Estates Strategy is in place and is aligned with the STP (c) |
| 26. | Weekly communication with GP Practices via Director’s Snippets (c) |
| 27. | CCG has a statutory duty to engage with the public (c) |
| 28. | CCG has a dedicated Communications and Engagement Team to support statutory responsibilities for engagement with the public (c) |
| 30. | Primary care GP forward view plan in place as a living document (c) |

**Assurances:** *(How do we know if the things we are doing have an impact?)*

- Governing body oversight of the Mid Notts CCGs Primary Care Commissioning committee (1, 3, 4, 6)
- Mid Notts CCG Primary Care Commissioning Committees are ‘meetings in public’ and all public agenda items are placed on the Mid Notts CCG websites to ensure transparency. Members of the public can submit questions to the committees and can attend the public section of the committee meetings (2, 3, 10, 16)
- Independent Chair/Vice Chair and CCG GB Lay Members of the Mid Notts CCGs Primary Care Commissioning Committee (1, 3, 10)
- There has been a 360 degree External Audit of the primary care co-commissioning structure (1, 2, 3, 5, 6)
- Assurance sought from Healthwatch and Health & Wellbeing Board attendees at the Mid Notts CCGs Primary Care Commissioning Committees (2, 3, 5, 12, 13)
- Conflicts of interest register maintained and a standing agenda item on the Mid Notts CCG Primary Care Commissioning Committees (1, 3, 5, 6)
- Stakeholder Reference Group and Citizens Reference Panel in place with lay representative on the Governing Body. Regular feedback to these groups (2, 3, 5, 6, 12, 28)
- Regular Quality and Performance reports are submitted to the Primary Care Commissioning Committee demonstrating positive progress and attention to areas highlighted by the Regulator
- CCG Vanguard Status (PACS) national support and resources to deliver new models of care based on outcomes, plans and milestones and reporting in place (8, 9, 10, 28)
- Primary Care integral to the delivery of Better Together approach, GP Clinical Leads for elective Care and proactive and urgent work streams in place (8, 11, 12, 14, 16)
- Advice and support from Health Education East Midlands, and links established (11, 14, 17, 18, 19)
- Realignment of CCG portfolios to reflect the increasing need for primary and the development of Primary Care Proactive Care and Urgent Care Hubs care focus (3, 8, 9, 10, 12, 16, 20, 21, 25, 28)
- Locality meetings have been held in Mansfield, Ashfield, Newark and Sherwood to discuss collaborative working (7, 8, 11, 12, 14, 20, 26) (i)
- An Implementation Plan for Primary Care Transformation is in place (8, 9, 10, 25)
- Protected Learning Events in January 2017 have been used to present, discuss and debate the introduction of a single overarching provider (7, 8, 10, 12, 19) (i)
- Regular updates have been provided on the delivery of the current The Primary Care Strategy to the Primary Care Commissioning Committee (2, 8, 10)
- Primary Care GP Provider Unit under development including governance arrangements and back office functions to deliver the Vanguard Proactive Care and Urgent Care Hubs (7, 8, 10, 12)
- Financial Delivery and Performance Group – oversight and approval process for Primary Care developments and business cases (1, 3, 6, 10)

**Gaps in Assurance:** *(What additional assurances should we seek?)*

- Are the current ways of seeking public opinion covering all aspects of the diverse population the CCGs serve
  
  **G1 Workforce Transformation**
  
  Assurance required from HEE for the delivery of their 10 Point Plan – C. Lawson

- Accurate documentation of the Primary Care Quality and Performance Subcommittee – D Ainsworth
- PMO function in Primary Care Team providing assurance and performance management for Workstream and business case development and implementation (1, 3, 6, 8, 10)
- Regular reports being completed for the Better Together Alliance Programme Board (1, 3, 6, 10)
- Patient participation groups meet on a regular basis in the CCG localities (7, 12, 27, 28)
- PPG groups reporting at Citizens’ Reference Panel in M&A and Stakeholder Reference Group in N&S (6, 12, 27, 28)
- Attendance at the Nottinghamshire GP Training and Education Group to ensure alignment with regional workforce and education activities (i)

Mitigating Actions: (What more should we do?)

G1. A business case has been approved to fund an overarching organisation for primary care. This organisation will be in place by the end of May 2017 and provide representation for Primary Care as part of the Better Together Alliance (C/i) - B - Action owner David Ainsworth – Completion date 18th August 2017

G2. Arden referral templates loaded on to practice systems by August 2017. Clinical Advisor delivering one to one support to Practices through 2017/18 and project manager capacity now secured. Detailed links to the referral management action plans and work of the DMOC. (C/i) – D - Action owner Chris Sewell – Completion date March 2018

G2. The Terms Of Reference has been refreshed at the July 2017 Quality and Performance Review Group meeting and the Meeting Agenda has been refocussed (C/i – E) - Action owner Stephanie Haslam – Completed 25th July 2017

G2. A Best Practice Scheme has been put in place from December 2016 to March 2017 – improvements to include increased use of EPaCCs, increase in the number of patients registered for on-line services dedicated appointment slots to support the reduction of unplanned admissions. Formal evaluation now concluded and reported: Significant work has been carried out by practices over a number of indicators which has led to improved uptake of work streams in addition the allocation of additional urgent care slots in Primary Care has been additional capacity for the wider system; 25 of 35 practices increased activity on Epaccs; An additional 318 calls were made to Call for Care; The scheme was a key driver for increasing On line access; and Frequent attendances have reduced as a result of monitoring numbers down 246 down from 345 in the previous year. (C/i – E) - Action owner Jacqui Kemp – Completed A Y2 Best Practice Scheme is under development to mobilise in September. Action owner Jacqui Kemp – 30 September 2017.

G2. Acute Home Visiting Service live in both hubs from April 2017. Monthly performance monitoring and contract management. Early evaluation at three months then second evaluation at nine months. (C/i – A) - Action owner Stephanie Haslam – Completion dates: 30 September 2017 and 28 February 2018.

G1. Patient participation engagement plan being developed by the Stakeholder Reference Group with a view to increasing membership and ensuring all practices have a link to representatives if they cannot provide a representative- Action Owner Julie Andrews – Completion Date 30th June 2017

G2. Primary care workshop to be scheduled for N&S patient participation groups –June 2017 (Ass – A) - Action owner Julie Andrews – Completion date 30th June 2017 Completed on 27 June 2017

G1. Formal minutes will be taken at Future Primary Care Quality and Performance Meetings. Documented action plans to become routine practice during Practice visits or extraordinary visits to Practices in crisis. Action owner D Ainsworth – Completion Date 30th September 2017

- The Joint Primary Care Clinical Cabinet will be decommissioned from 1 April 2017 in advance of the overarching primary care provider being established in May 2017 (C/i – D) - Action owner David Ainsworth – Action completed
- Phase 1 clinical pharmacist trial in place. There has been an extension of the existing regional project and an application has been submitted for Phase 2 of the national scheme. Confirmation of the Phase 2 application funding has been received week commenced 10 April 2017 – Plans to be revised to fit funding award (C/i) – A. - Action owner TBC – Action completed
- Two events held 19 and 22 July Newark and Ollerton to raise awareness of involvement opportunities within NHS. Further targeted work to be undertaken around PPGs – PPG Chairs meeting – and enhancing membership of SRG. (Ass – A)
The financial position for Mansfield and Ashfield CCG at Month 4 2017/18 is £587k underspent. The underspend is the expected position as the CCG have set-aside £1.4m from the primary care position in 2017/18. Below is the summary position by expenditure category.

<table>
<thead>
<tr>
<th>Row Labels</th>
<th>Sum of Annual budget (£)</th>
<th>YTD Budget</th>
<th>YTD Actual</th>
<th>YTD Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dispensing/Prescribing Drs</td>
<td>91,650</td>
<td>30,528</td>
<td>7,123</td>
<td>(23,405)</td>
</tr>
<tr>
<td>Enhanced Services</td>
<td>1,047,798</td>
<td>349,168</td>
<td>330,301</td>
<td>(18,867)</td>
</tr>
<tr>
<td>General Practice - APMS</td>
<td>1,121,354</td>
<td>373,781</td>
<td>352,235</td>
<td>(21,546)</td>
</tr>
<tr>
<td>General Practice - GMS</td>
<td>8,351,974</td>
<td>2,783,989</td>
<td>2,800,053</td>
<td>16,064</td>
</tr>
<tr>
<td>General Practice - PMS</td>
<td>7,852,754</td>
<td>2,617,577</td>
<td>2,549,909</td>
<td>(67,668)</td>
</tr>
<tr>
<td>General Reserves</td>
<td>1,872,678</td>
<td>516,867</td>
<td>0</td>
<td>(516,867)</td>
</tr>
<tr>
<td>Other GP Services</td>
<td>462,387</td>
<td>154,094</td>
<td>108,818</td>
<td>(45,276)</td>
</tr>
<tr>
<td>Other Premises costs</td>
<td>63,766</td>
<td>21,253</td>
<td>21,971</td>
<td>718</td>
</tr>
<tr>
<td>Premises Cost Reimbursement</td>
<td>3,027,040</td>
<td>1,008,878</td>
<td>1,035,658</td>
<td>26,780</td>
</tr>
<tr>
<td>QOF</td>
<td>2,337,399</td>
<td>588,619</td>
<td>652,125</td>
<td>63,506</td>
</tr>
<tr>
<td>Grand Total</td>
<td>26,228,800</td>
<td>8,444,754</td>
<td>7,858,202</td>
<td>(586,552)</td>
</tr>
</tbody>
</table>

Key variances

Dispensing/Prescribing – There is a consistent underspend year to date of £23.5k in this area however this trend is unlikely to continue. It is expected that due to winter pressures spend in this area is likely to significantly increase and the forecast for Year End will be closer to the plan for the year.

Enhanced Services - The £19k underspend is driven by a change in accrual methodology for Minor Surgery from budget to actual cost averages due to more recent information being available. This contributes to an in-month benefit of £30k.

APMS – There is a £40k underspend YTD on Kirkby CPCCC (PICS) however a review of the spend is being carried out to assess whether full costs have been recovered yet and the impact going forward. The YTD underspend is offset by a £20k overspend on Bull Farm which was not accounted for at budget setting but requires funding at a rate of £5k per month.

GMS – The £16k overspend is driven by an OOH deduction of a practice that has not been transacted by PCSE amounting to £10k YTD. This is to be corrected for Month 5.

PMS – The underspend YTD is driven by a combination of factors relating to the core contract for each practice. Each month there is a PMS Funding Differential Deduction by 1/48th per month of each practice in order to move towards equitable funding with the GMS contracts.
In addition in 2017/18 there are 6 PMS practices under Mansfield and Ashfield CCG who would be financially better off on a GMS contract. The full year impact if these practices were to convert is £108,000. During budget setting the PMS contract budgets were set at GMS rates with any PMS premium showing in addition to this on a separate subjective code. This means that should the practice wish to change this financial year the change has already been accounted for i.e. until they change the position is showing an underspend against these contracts.

Other GP Services – The underspend is driven by a one-off benefit of £15k which is the fall out of an accrual relating to the Doctors Retainer Scheme (Rosemary Street Health Centre). The balance is related to an underspend on ‘Clinical Other’ which requires further investigation.

Premises Cost Reimbursement – The overspend is driven by incorrect coding of premises costs that relate to APMS costs. This will be corrected in Month 5 and has no effect on the bottom line.

QoF – The over spend is driven by the 16/17 achievement being £26k higher than estimated for which as a consequence has resulted in a higher monthly aspiration payment in 17/18 driving a YTD overspend of £37.5k which will continue at the same rate until the end of the financial year.

**Fall out**

A review of the 2016/17 Fall out accruals in 2017/18 shows at month 4 an adverse impact of £5k which is predominantly driven by the 2016-17 QoF Achievement Payment which resulted in being higher than estimated for. The fallout review is ongoing as claims from practices relating to the previous financial year are still being made therefore not all accruals have materialised fully yet.

<table>
<thead>
<tr>
<th>Name</th>
<th>Fallout - Adverse / (Favourable)</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP Retainer</td>
<td>(15,363)</td>
</tr>
<tr>
<td>Prescribing and Dispensing</td>
<td>(6,800)</td>
</tr>
<tr>
<td>Unplanned Admissions</td>
<td>1,134</td>
</tr>
<tr>
<td>16/17 QoF Achievement</td>
<td>25,939</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>4,910</strong></td>
</tr>
</tbody>
</table>
Reserves schedule

The schedule below provides a full analysis of reserves. Although the CCG holds a reserve totalling £1.9m, much of this remains committed as per the analysis below. Notably, the CCG have set aside £1.4m non-recurrently to support the wider financial position.

<table>
<thead>
<tr>
<th>Mansfield &amp; Ashfield CCG General Reserves</th>
<th>Annual Budget</th>
</tr>
</thead>
<tbody>
<tr>
<td>Balance as at M4</td>
<td></td>
</tr>
<tr>
<td>1.0% Non recurrent</td>
<td>262,000</td>
</tr>
<tr>
<td>0.5% Contingency</td>
<td>131,000</td>
</tr>
<tr>
<td>General Reserves</td>
<td>1,479,678</td>
</tr>
<tr>
<td>Ledger balance as at month 4</td>
<td>1,872,678</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Commitments:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary care funds held to support the financial position</td>
<td>(1,412,000)</td>
</tr>
<tr>
<td>Population growth based on 16/17 growth at 17/18 price per patient: 1%</td>
<td>(175,228)</td>
</tr>
<tr>
<td>Premises inflation - 3.5%</td>
<td>(106,634)</td>
</tr>
<tr>
<td>CQC</td>
<td>(64,825)</td>
</tr>
<tr>
<td>Qrisk2</td>
<td>(15,789)</td>
</tr>
<tr>
<td></td>
<td>(1,774,476)</td>
</tr>
</tbody>
</table>

| Uncommitted balance remaining           | 98,202        |

A number of risks remain within the primary care position as outlined above and within the wider CCG. The primary care position needs to be considered in line with the overall CCG position and is a contributing factor to the CCG control total.
Newark and Sherwood CCG (04H)

The financial position for Newark and Sherwood CCG at Month 4 2017/18 is £112k Overspent. In addition there are further known commitments in excess of reserves held that will impact on the forecast position. Below is the summary position by expenditure category.

<table>
<thead>
<tr>
<th>Row Labels</th>
<th>Sum of Annual budget (£)</th>
<th>YTD Budget</th>
<th>YTD Actual</th>
<th>YTD Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dispensing/Prescribing Drs</td>
<td>521,287</td>
<td>173,740</td>
<td>156,897</td>
<td>(16,843)</td>
</tr>
<tr>
<td>Enhanced Services</td>
<td>547,552</td>
<td>182,474</td>
<td>188,735</td>
<td>6,261</td>
</tr>
<tr>
<td>General Practice - APMS</td>
<td>750,827</td>
<td>250,276</td>
<td>194,096</td>
<td>(56,180)</td>
</tr>
<tr>
<td>General Practice - GMS</td>
<td>11,299,390</td>
<td>3,766,453</td>
<td>3,796,473</td>
<td>30,020</td>
</tr>
<tr>
<td>General Reserves</td>
<td>91,342</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other GP Services</td>
<td>307,034</td>
<td>102,321</td>
<td>179,621</td>
<td>77,300</td>
</tr>
<tr>
<td>Other Premises costs</td>
<td>118,011</td>
<td>39,334</td>
<td>37,786</td>
<td>(1,548)</td>
</tr>
<tr>
<td>Premises Cost Reimbursement</td>
<td>2,228,442</td>
<td>742,743</td>
<td>756,628</td>
<td>13,885</td>
</tr>
<tr>
<td>QoF</td>
<td>1,793,615</td>
<td>421,683</td>
<td>480,591</td>
<td>58,908</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>17,657,500</strong></td>
<td><strong>5,679,024</strong></td>
<td><strong>5,790,825</strong></td>
<td><strong>111,801</strong></td>
</tr>
</tbody>
</table>

Key variances

Dispensing/Prescribing – There is a consistent underspend year to date of £17k in this area however this trend is unlikely to continue. It is expected that due to winter pressures spend in this area is likely to significantly increase and the forecast for Year End will be closer to the plan for the year.

APMS – The underspend relates to Balderton Surgery (PICS) driven by a non-recurrent benefit from the fall out accrual form the last financial year of £45k. The balance is driven by underspend this year however this is reviewed on a monthly basis with the risk of Locum usage potentially driving costs up significantly.

GMS – The £30k overspend YTD is driven by a general overspend across the global sum contracts as appose to any individual practice. Further investigation is being carried out to identify the underlying issue.

Other GP Services – The overspend is predominantly driven by Locum costs of £87.5k YTD. Future costs are difficult to forecast due to the nature of the demand for Locums however work is being undertaken to assess current information and possible future scenarios.

Premises Cost Reimbursement – The overspend is driven by increased NHS PS rent payments relating to Major Oak Medical Practice of £13k YTD. Discussions are on-going with NHS PS to verify the payment schedule as there have been significant changes as a whole from the previous financial year as well as discrepancies with values provided to NHS England and that charged to practices.

QoF – The over spend is driven by the 16/17 achievement being £20k higher than estimated for which as a consequence has resulted in a higher monthly aspiration payment in 17/18 driving a YTD overspend of £38.5k which will continue at the same rate until the end of the financial year.
Fall out
A review of the 2016/17 Fall out accruals in 2017/18 shows at month 4 a potential benefit of £26k which is comprised of mainly an over-accrual for costs relating to Balderton (PICS) of £45k which offsets the adverse impact of the QoF achievement payment which was £20k higher than expected. The nature of Primary Care means that claims can be made throughout this financial year that relate to prior years therefore there are still fall out accruals that continued to be assumed in the position. These will be reviewed on an on-going basis with any favourable or adverse impacts reported when materialised.

<table>
<thead>
<tr>
<th>Name</th>
<th>Fallout - Adverse / Favourable</th>
</tr>
</thead>
<tbody>
<tr>
<td>APMS contract – Balderton (PICS)</td>
<td>(44,761.48)</td>
</tr>
<tr>
<td>Maternity</td>
<td>(5,935.30)</td>
</tr>
<tr>
<td>GP Retainer</td>
<td>(160.87)</td>
</tr>
<tr>
<td>Prescribing and Dispensing</td>
<td>4,504.68</td>
</tr>
<tr>
<td>16/17 QoF Achievement</td>
<td>20,344.37</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>(25,858.60)</strong></td>
</tr>
</tbody>
</table>

Reserves schedule
The reserves schedule below shows that the CCG hold an annual budget in reserves of £91k. Due to budgetary pressures there was insufficient budget available to create a full 1.5% contingency and non-recurrent reserve. Hence the requirement for a negative general reserve as per below.

There are significant known commitments in excess of the reserve held which is expected to worsen the position as the year progresses. The CCG is exploring mitigations to offset this pressure. In particular the CCG is seeking a full understanding of costs within premises reimbursement with an expectation that these can be reduced.

<table>
<thead>
<tr>
<th>Newark and Sherwood CCG General Reserves</th>
<th>Annual Buget</th>
</tr>
</thead>
<tbody>
<tr>
<td>Balance as at M4</td>
<td>171,620</td>
</tr>
<tr>
<td>1.0% Non recurrent</td>
<td>85,810</td>
</tr>
<tr>
<td>0.5% Contingency</td>
<td>(166,088)</td>
</tr>
<tr>
<td>General Reserves</td>
<td>91,342</td>
</tr>
<tr>
<td><strong>Annual budget held</strong></td>
<td></td>
</tr>
<tr>
<td>Commitments:</td>
<td></td>
</tr>
<tr>
<td>Population growth based on 16/17 growth at 17/18 price per patient: 1.3%</td>
<td>(158,000)</td>
</tr>
<tr>
<td>Premises inflation - 3.5%</td>
<td>(77,700)</td>
</tr>
<tr>
<td>CQC</td>
<td>(22,816)</td>
</tr>
<tr>
<td>Qrisk2</td>
<td>(12,077)</td>
</tr>
<tr>
<td><strong>Balance remaining in reserves</strong></td>
<td>(179,251)</td>
</tr>
</tbody>
</table>