Chorley and South Ribble Clinical Commissioning Group
Greater Preston Clinical Commissioning Group

Primary Care Commissioning Committee
MS Teams
16 September 2020
3:30pm

Item No	Agenda Item	Presented By	Time
1	Welcome and apologies for absence	Mr Paul Richardson Verbal	
2	Declarations of Interest	Mr Paul Richardson Information	
3	Minutes from previous meeting	Mr Paul Richardson Ratification	
4	Matters arising	Mr Paul Richardson Verbal	
5	GP Quality Contract 2020/21 update	Mrs Donna Roberts Approval	
6	Care Home Specification	Mrs Donna Roberts Approval	
7	Any other business	Mr Paul Richardson Verbal	

Chorley and South Ribble Clinical Commissioning Group
Greater Preston Clinical Commissioning Group

Committee in Common
Primary Care Commissioning Committee
Minutes
5 August 2020
MS Teams

Present

Mr. Paul Richardson, Lay Member (Vice –Chair GP & CSR CCG Governing Bodies) (Chairman of Committee)
Mrs. Linda Chivers, Lay Member Finance and Audit, NHS Chorley and South Ribble CCG
Mr Ian Cherry, Lay Member Finance and Audit, NHS Greater Preston CCG
Mrs. Debbie Corcoran, Lay Member Patient and Public Involvement NHS Greater Preston CCG
Mr. Geoffrey O'Donoghue, Lay Member Patient and Public Involvement NHS Chorley and South Ribble CCG
Mrs. Kathryn Disley, Director of Finance and Contracting
Mrs. Helen Curtis, Deputy Accountable Officer, Director of Quality and Performance
Mrs. Tricia Hamilton, Governing Body Nurse
Dr Eamonn McKiernan, Secondary Care Doctor

In Attendance

Dr Sumantra Mukerji, Chair of NHS Greater Preston CCG
Dr Hari Nair, GP Director, NHS Greater Preston CCG
Dr Ann Robinson, GP Director, NHS Chorley and South Ribble CCG
Mrs. Jayne Mellor, Director of Transformation Planning and Delivery
Mrs. Karen Swift, Delivery Manager, Primary Care
Ms. Sarah Bloy, NHS England
Mrs. Jill Truby, Committee Secretary

Members of the Public There were no members of the public in attendance.

1	**Welcome and apologies for absence** As Chair of the meeting, Mr Paul Richardson welcomed everyone to the meeting in common of the Primary Care Commissioning Committees of Chorley and South Ribble CCG and Greater Preston CCG. Apologies received from Dr Lindsey Dickinson and Mr Denis Gizzi. **Quorum** The meeting was quorate.
2	**Declarations and Register of Interests** Mr Richardson reminded committee members of their obligations to declare any interest they may have on any issues arising at committee meetings which might conflict with the business of the CCGs. Declarations made by members of the Primary Care Commissioning Committee are listed in the CCGs' Register of Interests. The Registers are available either via the

	secretary to the governing body or the CCGs' websites. GP directors made the usual GP declaration as providers of services. **Chorley and South Ribble CCG Primary Care Commissioning Committee and Greater Preston CCG Primary Care Commissioning Committee resolved**: • Declarations of Interests were noted
3	**Minutes of previous meeting** The minutes of the previous meeting held on 3 June 2020 were agreed as an accurate record subject to the addition of Mrs Disley and Mrs Danson to the attendance list and deletion of Mr Matt Gaunt.
4	**Matters arising** Mrs Bloy confirmed that the action relating to Discretionary Payment is ongoing.
5	**Chairs' Report** Mr Richardson reported that he and the Vice-Chair (Mrs Tricia Hamilton) had endorsed the signing off of the station surgery contract award on behalf of the Primary Care Committee. **Chorley and South Ribble CCG Primary Care Commissioning Committee**: • Noted the Chairs' action
6	**Primary Care Committee Terms of Reference** The Committee was asked to consider whether any changes were required to the existing terms of reference. The Committee was informed that there have been no changes to national guidance or internal practice which would identify a change needed to the current terms of reference. Mrs Helen Curtis asked if her title could be amended to read: Deputy Accountable Officer, Director of Quality and Performance. Following the success of virtual meetings, Mrs Hamilton asked if this could be a consideration for future meetings at the request of the committee. i.e. 'All meetings shall be held in public, or alternatively **by using electronic virtual meetings where necessary on approval of the chair'** Clauses 16 and 18 are to be reviewed and amended to better reflect emerging working arrangements within both the ICS and ICP structures. In addition, due to the continuing impact of COVID-19, both clauses should also reflect the national and regional arrangements with regard to the provision of out-of-hospital care. Dr McKiernan referred to item 39: Meetings of the Committee shall: a) be held in public, subject to the application of 23(b); and requested that an explanation of 23(b) be provided. **Chorley and South Ribble CCG Primary Care Commissioning Committee and Greater Preston CCG Primary Care Commissioning Committee resolved**: • To amend the terms of reference as discussed.

7	**Quarterly Contractual Changes** Mrs Sara Bloy presented the papers which provided the committee with a summary of the contractual changes that were enacted during the previous quarter April – June 2020 **Chorley and South Ribble CCG Primary Care Commissioning Committee and Greater Preston CCG Primary Care Commissioning Committee resolved**: • Noted the contractual changes
8	**The Park Medical Practice and Geoffrey Street Health Centre proposed merger** Mrs Sarah Bloy presented a proposal for two practices, P81664 The Park Medical Practice and P81093 Geoffrey Street Health Centre, to merge, enabling the practices to proceed under one contract. The Primary Care Commissioning Committee was asked to approve the merger between P81664 The Park Medical Practice and P81093 Geoffrey Street Health Centre, terminating P81093 and enabling the practices to proceed under one contract. Mr Richardson asked if future similar proposals could identify existing boundaries on the map. Ms Bloy was asked what the outcome was of the patient engagement consultation and she confirmed that the PPG was very supportive due to the benefits to patients at Geoffrey Street. In response to a question regarding changes to patients in travel and parking Ms Bloy confirmed that the merger was more administrative in nature to streamline processes and confirmed that any future reconfiguration of services and premises would have to be brought to the PCC for approval and a formal consultation carried out. Following the Covid outbreak it was envisaged that primary care consultations would continue via phone/video with limited face to face consultations to practices. **Greater Preston CCG Primary Care Commissioning Committee resolved**: • Approved the merger of The Park Medical Practice and Geoffrey Street Health Centre.
9	**General Practice Quality Contract 2019/20 Update** The Committee was provided with an update regarding the revised end of year process due to the Covid19 pandemic. Mrs Karen Swift presented the paper. Mrs Swift explained that the majority of the key performance indicators (KPIs) in the GP Quality contract 2019/20 were due to be measured on 31 March 2020, with the final achievement determining whether or not the targets had been met. Due to the pressure practices were under and in light of funding available from NHS England to support practices with Covid19 related pressures, the decision was taken by the CCGs Management Executive Team to award all KPIs due to be measured at end of year to ensure practices were not penalised as a result of the impact of Covid19 and to decrease both the clinical and administrative burden. The remaining KPIs, for which the deadlines and or final measurements fell earlier in the contract year have been measured and practices informed of their achievement. In line with the contract, practices have the opportunity to submit mitigation for consideration by a Validation Panel and will also have the opportunity to hear their case by an Appeals

	Panel if they wish to challenge. As the majority of the KPIs have been awarded to all practices, funding related to the GPQC 2019/20 will not be recovered from any practices. Instead the outcome of the remaining, measurable KPIs will dictate what proportion of the funding withheld until end of year reconciliation will be awarded to each practice. The Primary Care Commissioning Committee was asked to note the contents of the paper. Discussion ensued. A more pragmatic approach was proposed due to the current covid environment and the same principles applied as the beginning of the year. Assurance was sought that mechanisms are in place to ensure that practices are fulfilling their obligations and any problems are highlighted to the CCG. Mrs Swift confirmed that 11 of the KPIs are administrative in nature i.e. relating to auditing requirements and related issues and returns. Actual quality is mainly caught up in the 32 KPIs already funded by NHSEI. Mrs Disley confirmed that KPIs should have been delivered prior to covid so the CCGs were not expecting mitigation. Members agreed to carry on in line with review as outlined in the agreed process. **Chorley and South Ribble CCG Primary Care Commissioning Committee and Greater Preston CCG Primary Care Commissioning Committee resolved**: • To note the report and continue to act in accordance with the existing agreed process
10	**Local Enhanced Services 2019/20 – Adjusted Claims ISSA Medical Centre Anticoagulant Local Enhanced Service Presented** The report provided the Committee with details of an adjusted claim received by the CCG from ISSA Medical Centre for the Anticoagulant Local Enhanced Services and an associated request for consideration of payment. The CCGs constitution and scheme of delegation highlights that any discretionary primary care payments can only be authorised by the Primary Care Commissioning Committee. The difference between this request and the requests agreed at the previous meeting is that this claim was not completely omitted prior to the three month deadline. Instead, a claim was made by the practice and paid by the CCG, however on 16 June 2020 ISSA MC forwarded an adjusted claim as a practice staff member had made an error when claiming and under-claimed by £10,789.16 in total. Following discussion members agreed that given the precedent set at the last meeting we need to approve this but with a clear statement to the practice that we will not do so in future. It was also agreed that the practice be requested to audit other submissions made by the same practice member of staff. Mrs Swift confirmed that a message had gone out to practices following the last meeting of the PCCC confirming that the rules will be strictly applied going forward and that this request had been submitted prior to the promulgation of that message.

	Greater Preston CCG Primary Care Commissioning Committee resolved to: • Approve payment of back dated claims
11	**Any other business** There was no other business.

Signed as an accurate record ……..……. Date ……...

Chorley and South Ribble Clinical Commissioning Group
Greater Preston Clinical Commissioning Group

Primary Care Commissioning Committee

Date of Meeting	16 September 2020
Title of paper	Declarations and Register of Interests
Presented by	Primary Care Commissioning Committee Chair
Author	Mrs Sarah Mattocks, Corporate Affairs and Governance Manager
Clinical Lead	N/A
Confidential	No

Purpose of the paper

This register is a standing item on all statutory Committee agendas. The register is for information purposes and allows members to challenge any potential conflicts against agenda items. This item also allows members and attendees to declare any additional interests against agenda items prior to the main body of the meeting.

Executive Summary

The Clinical Commissioning Group (CCG) has a statutory requirement to keep and maintain a Register of Interests for the organisation with regard to actual or potential interests declared by; Governing Body members, Membership Council members, members of Sub Committees of the Governing Body, and employees of the CCG.

This report presents the flowchart for declaring and managing Conflicts of Interest, as outlined in the Managing Conflicts of Interest Policy.

The registers will be updated in due course as declarations of interest are made and published on the CCG website. The interests are as recorded on the Pentana system at the time of producing this paper, if a new proforma has been submitted in the intervening time this will be captured at the next meeting.

All conflicts or potential conflicts should be declared, and where a conflict of interest has required specific management arrangements during the course of the meeting, this should be recorded in the minutes, along with the action taken by the committee Chair in managing the conflict.

Recommendations

The committee is asked to **note** the register of interest and to make any additional declarations as appropriate against any agenda items.

Links to CCG Strategic Objectives		
SO1	Improve Quality through more efficient, safer services which deliver a better patient experience	☐

SO2	Commission care so that it is integrated and ensures an appropriate balance between in-hospital and out of hospital provision	☐
SO3	Be an integral part of a financially sustainable health economy	☐
SO4	Ensure patients are at the centre of the planning and management of their own care and their voices are heard	☐
SO5	Be seen as a well-run clinical commissioning group and the system leader	☒

Governance and reporting (list committees, groups or other bodies that have discussed this paper)		
Meeting	**Date**	**Outcome**
NA		

Were any conflicts of interest identified at previous meetings (mark X in the correct box below)	
Yes	**No**
	X

If conflicts of interest were identified what were these:
N/A

Implications			
Quality/patient Experience implications	**Yes** ☐	**No** ☐	**N/A** ☒
(Potential) Conflicts of Interest	**Yes** ☐	**No** ☐	**N/A** ☒
Equality Impact Assessment	**Yes** ☐	**No** ☐	**N/A** ☒
Privacy Impact Assessment	**Yes** ☐	**No** ☐	**N/A** ☒
Are there any associated risks?	**Yes** ☐	**No** ☐	**N/A** ☒
Are the risks on the CCG's risk register	**Yes** ☐	**No** ☐	**N/A** ☒

Assurance
Assurances will continue to be provided to the Governing Body from the CCG's Audit Committee.

NHS Chorley and South Ribble CCG Primary Care Commissioning Committee - Declarations of Interest

Declarations of Interest are recorded on the Register when specifically declared by a member of the meeting. This Register was accurate at the time meeting papers were submitted; therefore, any changes received after submission will be included on the Register for the next statutory meeting.

FI=Financial Interest, NFProI=Non Financial Professional Interest, NFPI=Non Financial Personal Interests, II=Indirect Interests. Interests declared in 'bold' are pending confirmation of the type of interest

Name	Role	Declaration	Date	Mitigating Actions
Donna Roberts	Associate Director Transformation and Delivery - Primary Care	**Personal** No interests declared **Associated** No interests declared	20.04.2020	No risk to decision making as no potential conflicts identified
Dr Ann Robinson	GP Director, NHS Chorley and South Ribble CCG	**FI** - GP partner at Withnell Health Centre - Current **FI** - GP practice, Withnell Health Centre, offer extended access appointments as part of the Chorley East Collaboration - Current **NFPI** - Husband is a Secondary Care Consultant in diabetes and endocrinology and Chair of the Division of Medicine at Salford Royal - Current **NFPI** - Husband has private diabetes clinic at Beaumont Hospital - Current **NFPI** - Husband is the secondary care doctor for Ormskirk CCG - Current	02.12.2019	Interest noted, will be reviewed in line with agenda items at committee meetings and procurement involvement. Where a conflict emerges the individual will be excluded from decision making

Name	Role	Declaration	Date	Mitigating Actions
		FI – GP working for Withnell Health Centre providing primary medical care services for residents of NHS Chorley and South Ribble/Greater Preston CCG		
Dr Eamonn McKiernan	Secondary Care Doctor, NHS Chorley and South Ribble and NHS Greater Preston CCG	**NFProI** - Retired Consultant Anaesthetist who worked at Lancashire Teaching Hospitals NHS Foundation Trust for 31 years **NFPI** - Daughter works as a social worker in Newcastle Upon Tyne - Current **NFPI** - Daughter is Psychiatrist researching and practicing in Cambridge - Current **NFPI** - Daughter is a Children's nurse in Stockport and Cheshire - Current **NFPI** - Son in Law training and practicing in Cardiology in Cambridge - Current **NFPI** - Nephew suffered from cerebral palsy and is severely disabled in Birmingham **NFPI** - Lancashire resident with access to services at Lancashire Teaching Hospitals NHS Foundation Trust and Blackpool Victoria Hospital	22.01.2020	Interest noted. Will be reviewed in line with agenda items at committee meetings and procurement involvement. Where a conflict emerges the individual will be excluded from decision making.
Dr Lindsey Dickinson	Chair, NHS Chorley and South Ribble CCG	**II** - Sister in law is Team Manager of South Ribble East Community Team in Adult social Care - LCFT II - Sister is Team Manager for Older Adults Mental Health Team in Lancaster - LCFT	01.11.2019	No direct involvement in commissioning contracts from LCFT Interest noted, will be reviewed in line with agenda items at committee meetings and procurement involvement. Where a conflict emerges the individual will be

Name	Role	Declaration	Date	Mitigating Actions
		FI - GP Partner in The Chorley Surgery - from 2016 **FI** - Shareholder in the Primary Care Organisation **FI –** Shareholder of Chorley Collaborative Group - Limited Company		excluded from decision.
Mr Denis Gizzi	Chief Accountable Officer, Chorley & South Ribble & Greater Preston CCG's	**II** - The Den recording studio - ceased trading **II** - The Electric Church Recording Studio - I donated equipment to son's new company - Current **FI** - Smart Sight Coaching - Current **FI** - Procorre Consulting (Name Change) - Current **II** - Dr Alan Nye is a long-time acquaintance from my time in Oldham - Current **II** - My wife is currently working on a Part-Time basis at NWAS - Current **FI**- My wife owns 'The Skin Studio' business - Current	24.10.2019 UPDATED 03.06.2020	Interest noted, will be reviewed in line with agenda items at committee meetings and procurement involvement. Where a conflict emerges the individual will be excluded from decision making
Mr Geoffrey O'Donoghue	Lay Member - Public,Patient Engagement Chorley South Ribble CCG	No interests declared	06.11.2019 UPDATED 06.05.2020	No risk to decision making as no potential conflicts identified
Mr Paul Richardson	Lay Member (Vice-Chair GP & CSR CCG Governing Bodies)	**II** - Son is employed by NHS Blackpool Teaching Hospitals Trust - Current **II** - Daughter employed by Public Health	12.10.2019	Interest to be managed as and when conflict arises

Name	Role	Declaration	Date	Mitigating Actions
		England - from 2013		
Mrs Helen Curtis	Director of Quality and Performance, NHS Chorley and South Ribble and NHS Greater Preston CCG	**NFPI -** Daughter is Specialty Business Manager for Surgery at Lancashire Teaching Hospitals NHS Foundation Trust - December 2018 **NFPI** - Son is a Social Worker in central Preston - Current	17.10.2019	This will be declared separately in any meetings whereby this presents a conflict to my decision making
Mrs Jayne Mellor	Director of Transformation and Delivery	No Interest Declared	15.10.2019	No risk to decision making as no potential conflicts identified
Mrs Linda Chivers	Lay Member, Chair of Audit, NHS Chorley & South Ribble CCG	**FI -** Non-executive Director Bridgewater Community Healthcare Foundation Trust (Audit Chair). The Trust have contracted with KPMG audit service which is also contracted with the CCG - 01.06.2018	18.10.2019 UPDATED AC 13.05.2020	Interest noted, will be reviewed in line with agenda items at committee meetings and procurement involvement. Where a conflict emerges the individual will be excluded from decision making. if deemed appropriate member would also be excluded from any discussion prior to a decision.
Mrs Patricia Hamilton	Governing Body Nurse, NHS Chorley and South Ribble and NHS Greater Preston CCG	No Interests Declared	14.11.2019	Not applicable - no interests declared
Mrs Katherine Disley	Chief Finance and Contracting Officer, NHS Chorley and South Ribble and NHS Greater Preston CCGs	No Interests Declared	09.03.2020	Not applicable - no interests declared

NHS Greater Preston CCG Primary Care Commissioning Committee - Declarations of Interest

Declarations of Interest are recorded on the Register when specifically declared by a member of the meeting. This Register was accurate at the time meeting papers were submitted; therefore, any changes received after submission will be included on the Register for the next statutory meeting.

FI=Financial Interest, NFProI=Non Financial Professional Interest, NFPI=Non Financial Personal Interests, II=Indirect Interests. Interests declared in 'bold' are pending confirmation of the type of interest

Name	Role	Declaration	Date	Mitigating Actions
Donna Roberts	Associate Director Transformation and Delivery - Primary Care	No Interests Declared	20.04.2020	No risk to decision making as no potential conflicts identified
Katherine Disley	Chief Finance and Contracting Officer	No Interests Declared	16.06.2020	No risk to decision making as no potential conflicts identified
Dr Eamonn McKiernan	Secondary Care Doctor, NHS Chorley and South Ribble and NHS Greater Preston CCG	**NFProI** - Retired Consultant Anaesthetist who worked at Lancashire Teaching Hospitals NHS Foundation Trust for 31 years **NFPI** - Daughter works as a social worker in Newcastle Upon Tyne - Current **NFPI** - Daughter is Psychiatrist researching and practicing in Cambridge - Current **NFPI** - Daughter is a Children's nurse in Stockport and Cheshire - Current **NFPI** - Son in Law training and practicing in Cardiology in Cambridge - Current **NFPI** - Nephew suffered from cerebral palsy and is severely disabled in	22.01.2020	Interest noted. Will be reviewed in line with agenda items at committee meetings and procurement involvement. Where a conflict emerges the individual will be excluded from decision making.

Name	Role	Declaration	Date	Mitigating Actions
		Birmingham **NFPI** - Lancashire resident with access to services at Lancashire Teaching Hospitals NHS Foundation Trust and Blackpool Victoria Hospital		
Dr Hari Nair	GP Director Greater Preston CCG	**FI** - Senior GP Partner in Practice (Lane Ends Surgery) - 2014 - Current **FI** - GMS Contract holder - 2007 - Current **FI** -GP Quality Contract with the practice. I am clinical lead for this at the CCG - 2016 - Current **FI** -GP Trainer responsible for training undergraduate (UCLAN) FY/ST trainees, trainee advance clinical practitioners - 2009 - Current **FI** -Enhanced Services LES/DES/LIS practice signed up for these - 2007 - Current **FI**- Network based work - Clinical lead for extended access for Greater Preston Network & Practice signed up to Network DES - Current **FI** -BHR Investments Ltd - I am a director of the company. Company owns the practice premises and leases the building to the practice - Current **FI** - I support an organisation providing support services for young women **FI** -Member of Primary Care limited company comprising of all practices in	16.01.2020	Interest noted, will be reviewed in line with agenda items at committee meetings and procurement involvement. Where a conflict emerges the individual will be excluded from decision making

Name	Role	Declaration	Date	Mitigating Actions
		Preston and Chorley - Current **NFPI** -Wife is consultant Histopathologist employed by Lancashire Teaching Hospitals. She also carries out private reporting work for Ramsey Group - Current **NFPI -** Daughter has finished FY training and has a position in Birmingham for GPST training. She is deferring a year and may do locum work in Midlands as well as North West based hospitals.		
Dr Sumantra Mukerji	Chair - NHS Greater Preston CCG	**FI** - Salaried GP - Stonebridge Surgery - Current **FI** - Salaried GP - Stonebridge Surgery which has a contract with Lancashire and South Cumbria Foundation Trust to manage patients clinically in Longridge Community Hospital - Current **FI** - Shareholder - Preston Primary Care Centre - Current **FI** - Stonebridge Surgery - Member of Preston East Network - Current **FI** - Director - P&S Mukerji Ltd - Current **FI** - Wife - Shareholder & Employee P&S Mukerji - Current **FI** - Son - Shareholder P&S Mukerji - Current **FI** - P & S Mukerji Ltd have a contract with Issa Medical Centre for driving Quality Improvement	08.10.2019 Updated 22.01.2020	Interest noted, will be reviewed in line with agenda items at committee meetings and procurement involvement. Where a conflict emerges the individual will be excluded from decision making
Mr Denis Gizzi	Chief Accountable	**II** - The Den recording studio - ceased	24.10.2019	Interest noted, will be reviewed in line with

Name	Role	Declaration	Date	Mitigating Actions
	Officer, Chorley & South Ribble & Greater Preston CCG's	trading **II** - The Electric Church Recording Studio - I donated equipment to son's new company - Current **FI** - Smart Sight Coaching - Current **FI** - Procorre Consulting (Name Change) - Current **II** - Dr Alan Nye is a long-time acquaintance from my time in Oldham - Current **II** - My wife is currently working on a Part-Time basis at NWAS - Current **FI**- My wife owns 'The Skin Studio' business - Current	UPDATED 03.06.2020	agenda items at committee meetings and procurement involvement. Where a conflict emerges the individual will be excluded from decision making
Mr Ian Cherry	Lay Member for Finance, Audit & Conflicts of Interest - Greater Preston CCG	**II** - My daughter, Dr Mary Gemma Cherry, is a lecturer in Clinical Health Psychology at the University of Liverpool and Honorary Clinical Psychologist with Royal Liverpool and Broadgreen Hospitals Trust. - **II** - My son-in-law, Dr Jake Rigby, is now a higher trainee in child and adult psychiatry employed by St Helens and Knowsley NHS Trust but currently seconded to Alder Hey NHS Trust. **FI** -My practice carries out Expert witness work for Hempsons, on behalf of the NHS, in relation to medical negligence litigation. **FI** - My practice undertakes personal tax work for Jan Ledward, Chief Officer of Liverpool CCG	10.10.2019 UPDATED 30.01.2020 UPDATED 14.05.2020	Interest noted, will be reviewed in line with agenda items at committee meetings and procurement involvement. Where a conflict emerges the individual will be excluded from decision making.

Name	Role	Declaration	Date	Mitigating Actions
		FI - My firm A.I.Cherry Chartered Accountants prepares a self assessment tax return for a member of the CCG staff on normal commercial terms.		
Mr Paul Richardson	Lay Member (Vice-Chair GP & CSR CCG Governing Bodies)	**II** - Son is employed by NHS Blackpool Teaching Hospitals Trust - Current **II** - Daughter employed by Public Health England - from 2013	12.10.2019	Interest to be managed as and when conflict arises
Mrs Debbie Corcoran	Lay Member - Greater Preston CCG	**NFProI** - From 15th May 2017, employed as Clerk to the Corporation to Nelson and Colne College. The College works directly with NHS organisations/Trusts to deliver training. 2 College Board Members are also associated with the East Lancashire Hospitals NHS Trust – one is an employee, another is a Non-Executive Director of the Board. The Adult Community Learning (ACL) delivery arm of Nelson and Colne College Group – Lancashire Adult Learning or LAL - are developing links with Primary Care Networks to offer support with social prescribing through provision of learning and skills support to the community – at no cost. **NFPI** - Husband is an employee in a commercial organisation (Intersystems), which contracts with acute NHS Trusts for the provision of electronic patient record (EPR) systems.	17.10.2019	Interest noted, will be reviewed in line with agenda items at committee meetings and procurement involvement. Where a conflict emerges the individual will be excluded from decision making

Name	Role	Declaration	Date	Mitigating Actions
Mrs Helen Curtis	Director of Quality and Performance, NHS Chorley and South Ribble and NHS Greater Preston CCG	**NFPI -** Daughter is Specialty Business Manager for Surgery at Lancashire Teaching Hospitals NHS Foundation Trust - December 2018 **NFPI** - Son is a Social Worker in central Preston - Current	17.10.2019	This will be declared separately in any meetings whereby this presents a conflict to my decision making
Mrs Jayne Mellor	Director of Transformation and Delivery	No Interest Declared	15.10.2019	No risk to decision making as no potential conflicts identified
Mrs Patricia Hamilton	Governing Body Nurse, NHS Chorley and South Ribble and NHS Greater Preston CCG	No Interests Declared	14.11.2019	Not applicable - no interests declared

Insert paper ref

Primary Care Commissioning Committee

Date of meeting	16 September 2020
Title of paper	Population Based Health Improvement (Quality Contract for General Practice) 2020/21 - Update
Presented by	Donna Roberts, Associate Director Transformation & Delivery – Primary Care
Author	Donna Roberts, Associate Director Transformation & Delivery – Primary Care
Clinical lead	Hari Nair, GP Director Greater Preston CCG
Confidential	

Purpose of the paper

The aim of the paper is to present to the Primary Care Commissioning Committee the proposed changes to Population Based Health Improvement (Quality Contract for General Practice) 2020/21 in recognition of the Covid 19 pandemic.

Executive summary

In February 2020, PCCC agreed the Population Based Health Improvement (Quality Contract for General Practice) 2020/21

In light of Covid 19 related pressures, practices were asked to work to the previous year's contract until July 2020, when the new contract was issued. In order to ensure practices were not disadvantaged, submissions with deadlines during quarters 1 and 2 were suspended.

Expectation on general practice remains high, given the continuing pressures they are experiencing as they manage patients in an increasingly challenging situation due to Covid19.

In order to minimise the pressure on general practices, reduce the bureaucracy and allow additional headspace to concentrate on targeting patient care at high risk patient cohorts a number of changes are proposed to the Population Based Health Improvement (Quality Contract for General Practice) 2020/21.

Recommendations

The Primary Care Commissioning Committee is asked to **approve** the changes to the Population Based Health Improvement (Quality Contract for General Practice) 2020/2021

Links to CCG Strategic Objectives		
SO1	Improve Quality through more efficient, safer services which deliver a better patient experience	☒

SO2	Commission care so that it is integrated and ensures an appropriate balance between in-hospital and out of hospital provision	☒
SO3	Be an integral part of a financially sustainable health economy	☒
SO4	Ensure patients are at the centre of the planning and management of their own care and their voices are heard	☐
SO5	Be seen as a well-run clinical commissioning group and the system leader	☒

Governance and reporting (list committees, groups or other bodies that have discussed this paper)		
Meeting	**Date**	**Outcome**
Were any conflicts of interest identified at previous meetings (mark X in the correct box below)		
Yes	**No**	
If conflicts of interest were identified what were these:		

Implications			
Quality/patient experience implications?	**Yes** ☒	**No** ☐	**N/A** ☐
(Potential) conflicts of interest?	**Yes** ☒	**No** ☐	**N/A** ☐
Equality Impact Assessment?	**Yes** ☒	**No** ☐	**N/A** ☐
Privacy Impact Assessment?	**Yes** ☒	**No** ☐	**N/A** ☐
Are there any associated risks?	**Yes** ☒	**No** ☐	**N/A** ☐
Are the risks on the CCG's risk register?	**Yes** ☐	**No** ☒	**N/A** ☐
If yes, please include risk description and reference number			

Assurance
Primary Care Commissioning Committee

1.0 Background

1.1 In February 2020, Primary Care Commissioning Committee agreed the Population Based Health Improvement (Quality Contract for General Practice) 2020/21

1.2 In light of Covid 19 related pressures, practices were asked to work to the previous year's contract until July 2020, when the new contract was issued. In order the ensure practices were not disadvantaged, submissions with deadlines during quarters 1 and 2 were suspended.

1.3 Expectation on general practice remains high, given the continuing pressures they are experiencing as they manage patients in an increasingly challenging situation due to Covid19.

2.0 Proposed Changes

2.1 In order to minimise the pressure on general practices, reduce the bureaucracy and allow additional headspace to concentrate on targeting patient care at high risk patient cohorts a number of changes are proposed to the Population Based Health Improvement (Quality Contract for General Practice) 2020/21.

2.2 All KPI's have been reviewed to consider what is appropriate and achievable in an environment where Covid19remains in circulation and is subject to ongoing fluctuations in case numbers. These have been discussed in detail with the CCG Chairs and the GP Director for Primary Care to ensure a clinical and commissioning consensus.

2.3 Approaches to Quality Contracts across Lancashire and South Cumbria as a consequence of Covid19 have also been discussed at the Integrated Care System Primary Care Sub Group in order our proposals are consistent with other CCGs.

2.4 The proposed changes are:

1. Continue to monitor all 30 KPI's as agreed in February 2020
2. Only apply financial penalties to 10 KPIs highlighted in yellow in appendix 1
3. To pay the remaining 20 KPI's at 100%

3.0 Financial Consequences

3.1 In year 1 the Task and Finish group agreed a set of funding principles which they used to design the funding model for the contract. These principles have remained the same for this year:

- Invest additional resources into Primary Care
- Level up practice funding
- Protect historic enhanced services funding
- Move towards a standard level of funding for core and the GP Quality Contract by 2020/2021

3.2 Currently the contract value is split 80 / 20 with 20% of the payment recoverable against the practices attainment of the KPIs. The 20% is split with each KPI having an equal weighting.

3.3 The proposal is to reduce the measurable KPI's to 10, each continuing to have an equal weighting. As a result 6.7% of the contract value will now be performance related, with the remaining 93.3% guaranteed funding.

3.4 Monthly payments to practices will be increased to 93.3% backdated to April 2020.

4.0 Risks to delivery

4.1 The impact of covid19 on general practice in the remaining months of 2020/21 is unknown.

4.2 Local inequities in the impact of covid19 are likely to occur across practices, with those being in local hotspots being disproportionately affected in comparison to their peers.

4.3 Practices are being asked to deliver targeted care via new asks in the 2020/21 “quality and outcomes framework”.

5.0 Mitigation

5.1 The appeals process at the end of 2020/21 will need to consider the impact of covid19 as a mitigation for non-achievement and decisions may be required by the panel that further KPIs are discounted and payments made to practices accordingly.

6.0 Recommendation

6.1 The Primary Care Commissioning Committee is asked to approve the changes to the Population Based Health Improvement (Quality Contract for General Practice) for 2020/2021.

Appendix 1

Summary of Key Performance Indicators 2010-2021

Area	KPI	Threshold	READ / SNOMED Code(s)	Data Validation
CFA1 – Diabetes	50% of patients aged under 80 years treated to target for all three treatment targets: HbA1c: <=58mmol/mol Blood Pressure: <=140/90 Cholesterol: <=5mmol/l	40%	As per Diabetes GRASP criteria and codes in the DQ Diabetic data input template & the NHS NDPP template. DQ Standards / Diabetes 8 Processes of Care Searches for monitoring	GRASP
	Increase the percentage of patients receiving all 8 of the 9 care processes by 5% from 18/19 figures (excluding retinal screening)	3%		GRASP
	Practice to carry out an audit to review their patients aged 70 and over who have a low HbA1c (<=53) and carry out a medication review to understand if patients are being over treated or are at risk of hypoglycaemia (patients on insulin or sulphonylurea. This is to be carried out in quarter 2 and in quarter 4 for the preceding 6 months and is to be submitted by 9 October 2019 and 9 April 2021 respectively Revised templates to follow	N/A		Practice to submit information in line with timescales
CFA2 – COPD	Undertake a review of patients admitted to hospital with an exacerbation of COPD	N/A	Codes as in the DQ COPD data input template. DQ Standards / COPD Case Finder Searches	Practice to submit information in line with timescales
	Achieve 70% of patients who are on the COPD register who have had their inhaler technique checked in the last 12 months	70%		

Area	KPI	Threshold	READ / SNOMED Code(s)	Data Validation
CFA3 – Hypertension	Improve blood pressure control to target (140/90mmHg) in the diagnosed population (under 80s) to 70% Improve blood pressure control to target (150/90mmHg) in the diagnosed population (over 80s) to 85% Practice to provide evidence of the searches being run to find the relevant patients, clinical review and subsequent inclusion on the register. This audit is to be completed and submitted by 31 December 2020. The Data Quality Team will provide tools to help practices to complete this audit. Template to follow	50% 75% N/A	Codes as in the DQ data input templates / General Exam page DQ Standards searches / Hypertension Case Finder and CVD-PPP Searches	To be extracted from the GP system To be extracted from the GP system Practice to submit information in line with timescales
Administration				
A1 Access to Primary Care	Practice to evidence 70/1000 bookable clinical appointments providing direct patient care with prescribing clinician support but excluding practice nurse appointments have been offered through the submission of a quarterly audit. These audits are to be submitted by 10th January 2021, 10th April 2021	N/A	There are no READ / SNOMED codes for this area	Practice to submit information in line with timescales
A2 Carers	Achieve or maintain 2% of list size on the carers register	1%	918G Is a carer 918y Carer of person with dementia 918f Is no longer a carer 918f0 No longer carer of person with dementia	To be extracted from the practice ES&R
A3 Digital	There is no KPI associated with this area	N/A	N/A	N/A
A4 End of Life	Maintain or increase % prevalence to practices individual target on End of Life Care (QoF Palliative Care) Register 95% of those patients on the End of Life Care Register to have an EPaCCS template initiated and shared (where consented to)	Individual target 85%	DQ Standards searches / GSF early identification Codes as in EMIS National EPaCCS data input template	To be extracted from the practice ES&R

Area	KPI	Threshold	READ / SNOMED Code(s)	Data Validation
	with a minimum of the following 3 core aspects completed including discussions taken place and any actions taken; DNACPR, GSF register (including current stage), Preferred Place of Care/Death, SPC notes			
A5 Incident Reporting	Practices to actively report incidents using the CCG pathway (minimum of 4 per year) and demonstrate how this information has been used to share learning within the practice	4	There are no READ / SNOMED codes for this indicator	Information collected by the CCG Quality and Performance Team
A6 Learning Disabilities	Achieve 65% of completion of annual health checks of practice's total LD register and health action plans	60%	Codes as in National LD data input template 69DB LD health exam 9HB5 LD annual health assessment 9HB6 LD annual health assessment declined	To be extracted from the practice ES&R
A7 Medicines Co-ordinator	Medicines Co-ordinator to provide monthly communications sheet (detailed in point 3.6 of Medicines Co-ordinator Service Specification) ,demonstrate engagement and evidence utilisation of all funded Medicines Coordinator hours in line with the specification	N/A	There are no READ / SNOMED codes associated with this area	Information collated by Medicines Management Team
A8 Medicines Optimisation	Attendance at a minimum of 2 training sessions by all permanent prescribing clinical staff including long term locums (including session on high dose opioids) Complete a high dose opioid audit (to be provided by the medicines optimisation team) by 31 March 2021 Scriptswitch – maintain an acceptance rate >25%	N/A N/A N/A	There are no READ / SNOMED codes associated with this area	Information collated by Medicines Management Team
A9 Membership Council and Network Meetings	3 out of 4 (75%) Membership Council meetings attended by the nominated GP representative in line with the constitution. 80% of held Network Meetings attended by nominated clinical representative (threshold 80%)	3 80%	There are no READ / SNOMED codes for this area	Register of attendance at membership council meetings Register of attendance at Network Meetings

Area	KPI	Threshold	READ / SNOMED Code(s)	Data Validation
A10 PETS	Practices to opt in by (dates TBC) to state they will/will not be attending & cover will/will not be required (template to be provided) Practice to submit feedback / evaluation within 28 days following each internal PETS session, template attached	N/A N/A	There are no READ / SNOMED codes associated with this area	Practice to submit information in line with timescales
A11 Post Infection Review	Complete a Post Infection Review document, or be involved in the completion of the Post Infection Review document, and/or engage in the Panel discussions for 100% of community cases identified as practice patients for Clostridium Difficile, MRSA and E-Coli septicaemia Infection (and other infections as appropriate)	N/A	There are no READ / SNOMED codes associated with this area	Information collated by CCG Quality Team
A12 Practice Visits	There is no KPI associated with this area	N/A	N/A	N/A
A13 Primary Care Pathways	There is no KPI associated with this area	N/A	N/A	N/A
A14 Procedures of Limited Clinical Value	There is no KPI associated with this area	N/A	N/A	N/A
A15 Safeguarding / Mental Capacity Act	Complete a safeguarding self-assessment to evidence practice arrangements. This is to be submitted to the CCG by 31 March 2021.	N/A	N/A	Practice to submit information in line with timescales
A16 Special Patient Notes	There is no KPI associated with this area	N/A	N/A	N/A

Area	KPI	Threshold	READ / SNOMED Code(s)	Data Validation
Clinical				
C1 Asthma	65% of eligible asthma patients on the register to have had an annual review 100% of patients (over age of 8, as per QOF search) who have had an annual review have had their peak flow tested or inhaler technique reviewed in the last 12 months.	55% 90%	DQ Asthma data input template to capture the required codes DQ Standards searches/Asthma Case Finding	To be extracted from the practice ES&R
C2 Atrial Fibrillation Case Finding	Increase the practice prevalence rate to 80% of expected	75%	GRASP DQ Standards / AF validation searches AF register as per QOF codes	 GRASP
C3 Cancer	Bowel screening kits are to be requested for a minimum of 2 patients per 1000 registered population 100% of upper GI cancer diagnoses not made through the 2 week wait referral have a case review completed .	2/1000 100%	Searches provided in ES&R for bowel screening QOF Cancer Register	Practice to submit information in line with timescales
C4 Dementia	Practice to achieve or maintain 4% of total over 65 list on the dementia register	4%	DQ Neurology data input template to capture the required codes DQ Standards searches/Dementia Case Finding	To be extracted from the practice ES&R
C5 Electrocardiograph's (ECG's)	There is no KPI associated with this area	N/A	N/A	N/A

Area	KPI	Threshold	READ / SNOMED Code(s)	Data Validation
C6 Frailty	There is no KPI associated with this area	N/A	DQ CQRS Frailty searches can be used by practices to monitor their progress and identify areas that need action. Practices can use the standalone DQ Frailty clinical input template and page to gather information for national and local coding requirements 38Ql Frailty Index 38DW Canadian Study of Health & Aging Clinical Frailty Scale (Rockwood) 2Jd0 Mild Frailty 2Jd1 Moderate Frailty 2Jd2 Severe Frailty	N/A
C7 Mental Health	There is no KPI associated with this area	N/A	N/A	N/A
C8 Smoking Cessation	There is no KPI associated with this area	N/A	N/A	N/A
C9 Weight Management	There is no KPI associated with this area	N/A	N/A	N/A

Primary Care Commissioning Committee

Date of meeting	16th September 2020
Title of paper	Local Enhanced Services Care Home Specification 2020-21 (Care Home LES)
Presented by	Donna Roberts, Associate Director, Transformation and Delivery - Primary Care
Author	Traci Lloyd-Moore, Service Delivery Co-ordinator; Transformation and Delivery Team
Clinical lead	Sandeep Prakash, GP Director
Confidential	No

Purpose of the paper

To present the Primary Care Commissioning Committee with a revised Local Enhanced Services Care Home Specification (Care Home LES) for 2020-21

Executive summary

The Local Enhanced Services Care Home Specification (Care Home LES) was first introduced in July 2018 and comes to an end in its current form on 30th September 2020. This is due to the introduction of a national Enhanced Health in Care Homes Service (DES EHCH Service) under the Network Contract DES, which Primary Care Networks are responsible for delivering from 1st October 2020.

As a number of core service elements within the current Care Home LES are now contractual requirements of the DES EHCH Service, work has been undertaken locally to review the LES in order to identify the elements over and above the national requirements - which the CCG will need to commission through a revised specification from October onwards.

It is proposed that the revised Care Home LES, (as shown in **Appendix 1)**, runs concurrently to the DES EHCH service and is reviewed on an annual basis. The contractual requirements of the DES EHCH service are shown as **Appendix 2**.

Recommendations

The Primary Care Commissioning Committee is asked to note the report and approve the revised Local Enhanced Services Care Home Specification (Care Home LES) for 2020-21.

Links to CCG Strategic Objectives		
SO1	Improve quality through more efficient, safer services which deliver a better patient experience	☒
SO2	Commission care so that it is integrated and ensures an appropriate balance between in-hospital and out of hospital provision	☒
SO3	Be an integral part of a financially sustainable health economy	☒
SO4	Ensure patients are at the centre of the planning and management of their own care, and that their voices are heard	☒
SO5	Be a well-run clinical commissioning group and the system leader	☐

Governance and reporting (list committees, groups or other bodies that have discussed this paper)		
Meeting	**Date**	**Outcome**

Were any conflicts of interest identified at previous meetings (mark X in the correct box below)	
Yes	**No**

If conflicts of interest were identified what were these:

Implications			
Quality/patient experience implications?	**Yes** ☒	**No** ☐	**N/A** ☐
(Potential) conflicts of interest?	**Yes** ☐	**No** ☒	**N/A** ☐
Equality Impact Assessment?	**Yes** ☐	**No** ☒	**N/A** ☐
Privacy Impact Assessment?	**Yes** ☐	**No** ☒	**N/A** ☐
Are there any associated risks?	**Yes** ☐	**No** ☐	**N/A** ☐
Are the risks on the CCG's risk register?	**Yes** ☐	**No** ☐	**N/A** ☐
If yes, please include risk description and reference number			

Assurance
Primary Care Commissioning Committee NHS England Monitoring (DES EHCH Service) CCG Monitoring (Care Home LES)

1.0 Introduction

1.1 The Local Enhanced Services Care Home Specification (Care Home LES) was first introduced in July 2018 and comes to an end in its current form on 30th September 2020. This is due to the introduction of a national Enhanced Health in Care Homes Service (EHCH) under the Network Contract DES, which Primary Care Networks are responsible for delivering from 1st October 2020

1.2 As a number of core service elements in the current Care Home LES are now contractual requirements of the national EHCH service, work has been undertaken to review the LES to identify the elements that are over and above the EHCH service, which the CCG will need to commission through a revised specification from October onwards.

1.3 National guidance published by NHS England / NHS Improvement on the Network Contract DES, requires CCGs to continue to develop and separately commission, local enhanced services which go further than minimum national requirements set out within it. This means that in order to deliver effective enhanced care home services, CCGs will need to consider maintaining existing local services which are most likely to result in benefits for people living in care homes, such as continuity of care.

1.4 Guidance states that where a LES already exists which duplicates the DES no decommissioning of that service by the CCG should take place until the DES requirements commence. Where requirements exceed in the DES CCGs are required to engage with Networks and LMCs to consider maintaining the higher level of provision for their patients and an appropriate proportion of existing funding additional to the entitlements of the national contract.

1.5 To this end a Task and Finish Group was established to :-

a) Analyse the national requirements of the DES EHCH service specification against those set out in the existing Care Home LES.

b) Identify the enhanced services (over and above the minimum national requirements of the DES), which need to be maintained and therefore commissioned through a refreshed Care Home LES.

c) Understand the total financial envelope available for delivery of enhanced health services in care homes; ensuring that all available investment in Primary Medical Care is maintained.

1.6 The Task and Finish Group membership which included CCG Clinical Leads, members from the Transformation and Delivery Team and representation from the LMC have along with Primary Care Networks and their member practices reviewed and commented on the proposed revised specification, this has been used to inform the final version presented to the Committee.

1.7 It is intended that the new Care Home LES will run concurrently to the DES, starting from 1st October 2020 and will be reviewed on an annual basis

2.0 Enhanced Care Home Service Specifications

A summary of the scope and asks of each enhanced care home service is set out below:

	Current Care Home LES	DES EHCH Service	Revised Care Home LES
Scope	A patient living in a CQC registered care home (with or without nursing) aged 65 and over.	A patient living in a CQC registered care home (with or without nursing). The service applies equally to people who self-fund their care or whose care is funded by the NHS or their local authority; people with learning disabilities and / or mental health needs living in a care home and people under and over the age of 65	Same scope as the DES plus temporary residents i.e. short term care placements
Beds	71 care homes equating to more than 2,200 beds.	110 care homes equating to over 3,600 beds (this includes the care homes in scope of the current LES)	Same beds as the DES
Key asks	• Ensure completion of an initial assessment and initiate a joint care plan • Carry out a Comprehensive Care Home Assessment • Have a nominated Clinical Lead • Provide weekly Clinical Sessions within a supportive MDT • Respond to urgent visits • Carry out a Meds Review 6 monthly • Carry out Social prescribing review • Issue repeat prescriptions within 48-72hrs • Provide a medical report to complex care panel • Conduct medicines reconciliation • Follow up review of patients following an emergency or elective admission to hospital • Meet QOF standards	• Align each care home to a single PCN • Agree a GP Lead • Agree a plan for how the EHCH will operate • Establish a consistent MDT in partnership with Community Services • Deliver a Weekly Home Round • Carry out Comprehensive Care Home Assessments • Develop and refresh care plans • Establish protocols for sharing information • Identify / engage in shared learning opportunities • Support hospital discharges / transfers of care A national framework document has also been produced to guide Primary Care Networks in the delivery of the service requirements.	• Identify a care coordinator to support the MDT • Ensure completion of an initial review • Carry out a Meds Review 6 monthly • Carry out Social prescribing review • Issue repeat prescriptions within 48-72hrs • Provide a medical report to complex care panel • Conduct medicines reconciliation • Follow up review of patients following an emergency or elective admission to hospital • Carry out assessment and develop care plan for temporary residents and include in home round under the DES and offer an additional visit where this is clinically required • Meet QOF standards
Price	**£289 per bed, per year**	**£120 per bed, per year**	**For 2020/21 £132 per bed, per year + £68** per bed, for carrying out initial reviews for patients in new care homes not previously in the LES

3.0 Finance

3.1 Under the existing Care Home LES, GP providers receive a payment of £289 per bed, per year. The payment is based on the number of care home patients registered with a GP Practice, which has signed up to deliver the service.

3.2 Under the DES EHCH Service, Primary Care Networks are paid a care home premium of £120 per bed, per year. The payment is made regardless of whether beds are occupied. There is 100% sign up to the DES from Primary Care Networks across the two CCGs.

3.3 The following considerations have been made in the approach to pricing the revised Care Home LES:

- The need to avoid duplication of services commissioned via the DES but maintain enhanced services locally that go further than the national minimum requirements and which are value for money and which also respond to the ICP's strategic priorities.

- As we start to slowly transition to a period of recovery following the Covid-19 pandemic, there is a clear need to strengthen support and improve outcomes for our most vulnerable populations, especially people living in a care home setting and the need to meet increased demand for services.

- The need to continue to build a culture of proactive care management that will help to reduce costs in other parts of the system. Having access to enhanced primary care and specialist services for people living in care homes will help to maintain their independence as far as possible by reducing, delaying or preventing the need for additional health and social care services and avoid inappropriate visits to A&E and avoidable admissions.

- Recognising the increased workload for Primary Care Networks and their member practices due to the broader scope of care homes and the complexity of patients eligible to receive the DES EHCH Service and therefore any revised local enhanced service.

- A commitment from the CCG to maintaining investment in Primary Care, enabling Primary Care Networks to deliver a comprehensive and effective enhanced service which supports continued improvements in the quality of care provided to people living in care homes.

3.4 The proposed rate to be paid to Primary Care Networks under the revised Care Home LES for 2020/21 is £132 per bed. This will be paid regardless of whether beds are occupied in line with the DES.

3.5 Primary Care Networks will also receive a payment of £68 per bed for completion of initial reviews required for patients living in a care home that was not in scope of the LES previously. This is an incentivised and non-recurrent payment in recognition of the extra workload for network member practices in relation to this ask.

3.6 A total of 39 care homes (totalling 617 beds) will attract this additional payment. The full list of care homes covered by the LES is shown as **Appendix 3.**

3.7 The combined total tariff payable to Primary Care Networks for the delivery of an enhanced care home service under the LES from 1st October 2020 is set out below:

Service	Price (per bed based on full year)	Timescales
Revised Care Home LES	£132	As the service will commence part way through the year a monthly bed rate of £11 per month will apply from 1st October 2020 to 31 March 2021
Initial Reviews (New Care Homes)	£68	Effective from 1st October and paid as a lump sum for new homes not covered by the LES previously
DES EHCH Service - Care Home Premium	£120	As the service has commenced part way through the year, a monthly bed rate of £7.50 applies from 1st August 2020 to 31st March 2021
Total	**£320**	

The total price is therefore broadly in line (albeit slightly higher) than the current care home LES price of £289 per bed.

4.0 Monitoring

4.1 To ensure a seamless transition to the revised local specification from 1st October 2020. The CCG will carry out final bed reconciliation and monitoring under the current Care Home LES.

4.2 Local quality and performance standards which Primary Care Networks are expected to meet under the revised LES will be detailed following release of the national Network Dashboard, which will include metrics/indicators for the EHCH Service.

5.0 Recommendation

5.1 The Primary Care Commissioning Committee is asked to approve the following

- Revised Care Home LES specification, attached at **Appendix 1**

Appendix 1

Revised Local Enhanced Services Care Home Specification (Care Home LES) 2020-21

SCHEDULE 2 – THE SERVICES

A. Service Specifications

Service Specification No.	FINAL
Service	Enhanced Care Home Service
Clinical Lead	Dr. Sandeep Prakash
Commissioner Lead	Donna Roberts – Associate Director Transformation & Delivery, Primary Care
Provider Lead	N/A
Period	1st October 2020 - 31 March 2021
Date of Review	Annually

1. Introduction

Evidence shows that a coordinated focus on the primary care services available to care home residents leads to better care and reduces unplanned admissions to hospital. This Enhanced Care Home (EHCH) service specification has been informed by the national EHCH vanguard programme and the EHCH Framework (September 2016). The service has been designed to complement the primary care service requirements in the Network Contract DES and wider efforts across the Integrated Care System to integrate primary care and community services and reduce unplanned admissions to secondary care and therefore cost.

Across Chorley and South Ribble and Greater Preston there are approximately 2,800 residents (both under and over 65) living in a care home setting. This service will build on work across Central Lancashire through Primary Care Networks (PCNs) to improve care for these patients and demonstrates the CCGs commitment to maintain investment in primary care.

2. Population Needs

2.1 National context

Approximately 416,000 people live in care homes. The majority are women and are over 85 years old, with an average life expectancy of less than two and a half years. While residents differ, many have complex health care needs including diseases, disabilities and conditions that affect older people and which reduce life expectancy. Some challenges are unique to the sector.

Standard healthcare provision meets their needs poorly, but well-tailored services can make a significant difference to their wellbeing. The most effective models of care for residents of Care Homes incorporate care planning, multi-professional interventions and an integral role for the staff of Care Homes (British Geriatrics Society, 2015).

To provide some context, approximately 283,000 people with dementia live in care homes. Stroke is reported to be the second most common cause of disability after dementia in a UK nursing home population and around 5% of people living in care homes have Parkinson's disease. Approximately 60% of all deaths that occur each year in the UK are expected and predictable. The main causes are cancers, end stage organ failure, neurodegenerative diseases and dementia. Around 97,000 people (17.8% of all those who die in England each year) die in a care home.

With multiple co-morbidities and multiple medication use, residents in Care Homes are often the most medically complex people in the community. According to figures from the British Geriatrics Society, 68% of Care Home residents have no regular medical review, 44% have no regular review of medications and just 3% have occupational therapy - a critical service to promote independence. Residents need structured and pro-active approaches to their care, with coordinated teams working together built on primary care. (NHS England, 2015).

Outcomes for frail older people admitted from Care Homes to hospital are poor, with mortality four times higher in Care Homes than in the community (age/sex adjusted) (Shah et al, 2013). A systematic review of outcomes (Dwyer et al, 2014) found that:

- Transfer from the Care Home to hospital is a considerable burden for the residents;
- The benefits of transfer to hospital do not outweigh the adverse complications of the transfer; and
- These include falls, medication errors, hospital acquired infections, pressure ulcers.

There have been a number of high-profile safeguarding and provider failures recently. This has brought with it increased regulation by the CQC and when added to the continuing challenging financial environment, national capacity in the Care Home sector reduced for the first time in a decade (Laing &Buisson, 2015) with 1,500 beds lost in the year to September 2015.

The key clinical reasons for improving medical input to Care Homes can be summarised as follows:

- To reduce inappropriate visits to A&E and avoidable admissions by, for instance, reducing the risk of falls or implementing the NICE guidelines for nutritional care;
- To improve healthcare support that reduces or prevents potential ill health proactively through improved coverage of influenza and pneumococcal vaccination, and a reduction in possible adverse reactions from poly-pharmacy;
- To cut costs associated with medicines waste, errors in administration of medicines, and admissions to hospital;
- To improve end of life care, allowing people to die where they choose, and respecting their wishes; and

- To build more effective communication links between primary healthcare teams, nursing and residential care staff.
- To promote the wellbeing of adults who may have difficulty in protecting themselves from harm and abuse and in promoting their own interests.

Reflecting an ambition to strengthen support for the people who live and work in care homes, the NHS Long Term Plan set out a commitment as part of the Ageing Well Programme to roll out EHCH across England by 2024. Requirements for the delivery of EHCH through Primary Care Networks (PCNs) have been included in the Network Contract Directed Enhanced Service (DES) for 2020/21. Complementary EHCH requirements for relevant providers of community physical and mental health services have also been included in the NHS Standard Contract.

This supports the NHS Long Term Plan goal of "dissolving the historic divide" between primary care and community healthcare services and sets a minimum standard for NHS support to people living in care homes.

2.2 Local context and evidence base

As we move into a period of recovery following the Covid-19 pandemic, there is strong need for Primary Care to continue to focus on and prioritise support for the most vulnerable patients in our communities.

And in recognition of the increase in patient demand in our vulnerable populations and the unique position of General Practice and Primary Care Networks in delivering enhanced care services to our care home population, Greater Preston and Chorley South Ribble CCG's will continue to commission an Enhanced Care Home Services at scale, over and above the national requirements in the Network Contract DES, to continue to improve the quality of care in line with current evidence. This aim is to improve the quality of life through improved care in community settings with fewer and shorter stays in acute hospital settings.

We expect our local population (in line with national trends) to live longer and this increase in life expectancy is forecast to continue, impacting on population size particularly in the over 65 population. Over the period of the five year plan it is forecast to increase 1.9% year on year, in comparison with a 0.5% growth year on year in the under 18 and a 0.1% growth in adults of a working age.

There are over 3500 care home beds across the two CCGs. Not all of these beds are occupied all at the same time and some are occupied with temporary residents in 'hospital avoidance beds' or in intermediate care. While many people living in care homes will be living with complex needs, including severe frailty, some may not. This local enhanced service covers all residents who are required to enter a bed based service within Central Lancashire either as a permanent or temporary resident including for hospital avoidance.

The principle rationale for developing the new service is outlined below:

Inequity in clinical outcomes

- High variability in the quality of care delivered, resulting in inequities in outcomes for patients
- National concern over the sustainability of the Care Home sector
- Current and ongoing local quality issues in the Care Home sector.

Inequity in patient registrations/workload

- Current inequity in nursing home allocations and ongoing disputes over closed lists, placing a disproportionate burden on a number of practices
- Inequity in allocations persists as practices deemed to deliver good care build relationships with Care Homes and thus attract more patients.

Inequity in finance

- Acknowledged, historic under-resourcing of Care Home patients through the Carr-Hill formula
- The ongoing Personal Medical Services (PMS) contract review recommended a review of the inequities in nursing home medical provision
- Evidence from other health economies suggests that investments deliver real savings in the longer term e.g. Salford, Sheffield and Airedale.

Momentum for change

- Included in CCG primary care strategy, and endorsed with strong support from the CCG membership and other health economy stakeholders
- Identified as a key element of the Our Health, Our Care transformation programme
- Linked to the Care Home Collaborative work with good support and engagement with from LCFT, LTH and other providers

3. Outcomes

3.1 NHS Outcomes Framework Domains & Indicators

Domain 1	Preventing people from dying prematurely	✓
Domain 2	Enhancing quality of life for people with long-term conditions	✓
Domain 3	Helping people to recover from episodes of ill-health or following injury	✓
Domain 4	Ensuring people have a positive experience of care	✓
Domain 5	Treating and caring for people in safe environment and protecting them from avoidable harm	✓

3.2 Locally Defined Outcomes

- Reduction in acute admissions from Care Homes;

- Reduction in the length of stay in acute care for residents admitted from Care Homes;
- Reduction in the number of delayed transfers of care following admission;
- Reduction in prescribing costs;
- Reduction in the number of medication errors;
- Reduction in the number of Care Home residents dying in hospital; and
- Improvement in care home experiences of care.
- Development of an integrated multi-disciplinary team to support all patients

4. Service Aims and Objectives

4.1 A primary goal of health and social care services is to support people in their own home for as long as possible. If this is no longer possible, we need to ensure that the best possible care is provided to those in a care home setting. The evidence however suggests that people in care homes are not having their needs properly assessed and met. As a result, they often experience unnecessary, unplanned and avoidable admissions to hospital, and sub-optimal medication.

4.2 The principal aim of the Local Enhanced Care Home Service (the Service) is to provide an additional level of care over and above that of a) the General, Personal Medical Services Contract or Alternative Provider Medical Services Contract provided by the Provider; and b) support the delivery of the requirements of the nationally commissioned Enhanced Health in Care Home service and the Framework for Enhanced Health in Care Homes set out in the Network Contract DES. This is a proactive, preventative service aimed at improving the quality of care to people in care homes.

4.3 For the purposes of this specification a “care home” is defined as a CQC-registered care home with or without nursing in line with the Network Contract DES definition of care homes.

4.4 Service objectives:

- To improve care for patients who (temporarily or permanently) live in care homes, which is based on person-centred care planning and co-ordinated input from primary healthcare teams, nursing and residential care staff.
- To ensure that all residents receive dedicated medical services.
- To reduce inappropriate visits to A&E and avoidable admissions by, for instance, reducing the risk of falls or implementing the NICE guidelines for nutritional care.
- To improve healthcare support that reduces or prevents potential ill health through improved coverage of influenza and pneumococcal vaccination, and a reduction in possible adverse reactions from poly-pharmacy.
- To reduce costs associated with medicines waste, errors in administration of medicines, and admissions to hospital.

- To provide proactive care in managing chronic disease and medicines including care planning especially around discharge and end of life care.
- To improve end of life care, allowing people to die where they choose, and respecting their wishes.
- To minimize the risk and complications for vulnerable groups, which includes patients with highly complex needs care.
- To build more effective communication and improve professional relationships between primary healthcare teams, nursing and residential care staff in order to meet the needs of residents.
- To promote the wellbeing of all people who may have difficulty in protecting themselves from harm and abuse and in promoting their own interests.
- To utilise technology (where it is clinically appropriate to do so) to improve ways of working; facilitate medical input; support joint decision making about the care of individuals and reduce unnecessary admissions and callouts.

5. Duration

5.1 The Service will run from 1st October 2020 until 31 March 2021, when it will be reviewed in line with national and local guidance and requirements.

6. Scope

6.1 The Service covers patients registered with a GP practice; living in a PCN aligned care home in the Chorley South Ribble or Greater Preston area. The service applies equally to patients who self-fund their care and whose care is funded by the NHS or their local authority. It is equally applicable to care homes for people with learning disabilities and / or mental health needs and for adults both under and over the age of 65. For the avoidance of doubt, this service is for patients in the following settings:

6.1.1 Nursing Homes – a CQC registered home whose premises are used for the reception and the provision of nursing for persons suffering from any illness or infirmity.

6.1.2 Residential Homes including extra care homes – a CQC registered home, providing residential accommodation for any of the following:

- Under 65s
- Old age and infirmity;
- Dementia
- S117 patients
- Learning Disability and/or Autism
- Past or present dependence on alcohol or drugs; or
- Past or present mental disorder.

6.1.3 Temporary placements in a CQC registered care home for the following purpose:

- Short Term Care
- Respite Care
- Discharge to Assess
- Fastrack patients

7. Service Delivery/Care Pathways

The Provider is required to work to the following service specification for all care homes in scope of the service:

7.1 Initial Review of the patient

Ensure that an initial review is undertaken to collect key information for all patients upon admission to a care home within 5 working days of being informed. The initial review shall collect, but is not limited to the following:

- an initial review to include a mental health assessment and a frailty screen;
- medication review;
- information gathering

The initial review could be carried out remotely (for e.g. via video consultation), where it is deemed clinically appropriate to do so. The required timescale is over and above the DES requirement for a personalised care and support plan based on the principles and domains of a Comprehensive Geriatric Assessment to be developed and agreed with each new patient within 7 working days of admission or readmission following a hospital episode.

7.2 Where appropriate, discuss with the care home the findings of a personalised care and support plan (which has been developed / refreshed by the PCN MDT under the Network Contract DES) to ensure the important aspects of shared care are co-ordinated for the benefit of improved patient care. These discussions should be documented in the Patient's medical records.

7.3 Routine Management of Care Home Patients

- Identify a Care Co-ordinator with the necessary skills and knowledge to co-ordinate the PCN MDT including collating the information required prior to the meeting, take notes at the meeting and ensure actions are completed.

- Issue repeat prescriptions within 48-72 hours of the request.

- Meet relevant QOF standards (if appropriate, avoid unnecessary tests in very elderly or frail patients).

- Carry out a medication review for all patients on a six- monthly basis by a Clinician or Pharmacist. This requirement is in addition to the twelve monthly medication review stipulated in the Network Contract DES.

- Carry out a repeat prescribing review annually by the service Medicines Coordinator. The Medicines Coordinator will liaise with the CCG Medicines Optimisation team for guidance on the standards to be followed when undertaking the review.

- Ensure that local arrangements as set out in the agreed process for Central Lancashire for death certification and verification in the community are followed, if a patient dies during/in core hours.

- Provide a medical report, if requested, when a patient is presented to a complex care panel or community care panel.

- Conduct medicines reconciliation each time a patient moves between different care settings, with appropriate clinical input from a clinical pharmacist; pharmacy technician or other appropriate clinician. (Medicines reconciliation is the process of identifying the most accurate list of a patient's current medication and comparing it with the list currently in use, recognising any discrepancies, and documenting any changes, thus resulting in a complete list of medications accurately communicated).

- Where a patient has an emergency admission or elective admission to hospital experiences an exacerbation of a long term condition or requires a follow-up review for any other reason as clinically appropriate. The Provider will conduct a medical review, a review of the patients care plan and carry out medicines reconciliation. This could be carried out remotely, where it is deemed clinically appropriate to do so.

- The lead clinician to oversee that all changes are updated in the patients care plan and that the appropriate care home staff are notified to make any necessary changes to future prescription orders.

- For temporary residents, the Provider must:
    - carry out an assessment of the patient upon entry to the home;
    - develop a personalised care and support plan (this does not need to be the full care plan) or ensure the patients current care plan is up to date;
    - include the patient in the weekly home round, which is a requirement under the Network Contract DES. The Provider may deliver an additional weekly visit to the patient (which is over and above the requirement in the Network Contract DES), which can be carried out remotely, for e.g. via video consultation, where it is deemed clinically appropriate to do so;
    - arrange for a multidisciplinary discharge report to be sent to the patients registered GP.

Dementia Care

Where a patient is showing early signs of dementia, the service provider will follow the CCG Dementia Shared Care pathway.

CCG Dementia pathway.docx

End of Life (EoL) Care

The Provider shall ensure full compliance with the requirements of the End of Life care bundle within the Population Based Health Improvement (Quality Contract for General Practice). This will include consideration on a case by case basis whether each resident should be added to the supportive Care/GSF register.

7.3 Consent

The Provider shall comply with the NHS Requirements in relation to obtaining consent from each Patient to the provision of Services (Informed Consent) and in particular:

- Mental Capacity Act 2005
- Department of Health Reference Guide to Consent for Examination or Treatment;
- Consent: Patients and Doctors making decisions together (GMC 2008);
- Data Protection Act 1998

The Provider will ensure in each case the patient is fully informed of the treatment options and the treatment proposed. Consent must be recorded in the patient's record held by the Provider. Consideration must be given to any Lasting Power of Attorney for Health. Where the patient lacks capacity and does not have a Lasting Power of Attorney, a Best Interest Assessment and outcome will determine the most appropriate course of treatment.

A chaperone must be available, if required by the patient or family/carer, for any procedure undertaken.

7.4 Care Home Experience Monitoring

The Provider will be required to demonstrate evidence of having gathered feedback and experience of the service from care home staff. The evidence, such as completed surveys, should be collated and a report submitted to the responsible Commissioner on a quarterly basis so that they can be used to improve quality and further service development.

The information gathered should be taken into account when reviewing standards as part of clinical audit.

Complaints should be documented and acted on according to the Provider's written complaints policy and as agreed by the Commissioner. The Provider must share details of complaints plus any sequential action plans with the Commissioner quarterly.

7.5 Hours of Service

Hours of the service will be core hours: Monday to Friday, 08:00 – 18:30.

7.6 Provider Eligibility Criteria

The Provider must be fully compliant with all requirements of core contracts (General Medical Services, Personal Medical Services or Alternative Personal Medical Services) and are signed up as a member of a Primary Care Network.

All safeguarding training as will have been completed and be up to date as per the requirements of core contracts (General Medical Services, Personal Medical Services or Alternative Personal Medical Services).

7.7 Staffing

The Provider will be responsible for ensuring that all staff will be competent and appropriately qualified to provide the specific care home service requirements.

Training and development of the workforce is a key element in the sustainability of the service model to ensure business continuity in the event of staff absence, e.g. holiday/ sick leave. The Provider must ensure it maintains a staffing complement which allows it to meet the objectives set out in this specification.

7.8 Interdependences with other Services/Providers

This list includes but is not limited to:

- **Network Contract DES Service Specification, including the following contents:**
  - Enhanced Health in Care Homes Service
  - Structured Medication Reviews
  - Early Cancer Diagnosis

- **General Practices.**
- **Lancashire Teaching Hospitals NHS Foundation Trust** – Geriatrician Service, Medical Assessment Unit, Accident and Emergency, Consultants;
- **Lancashire County Council** – Adult Social Care and Some Adult Community Services;
- **Lancashire & South Cumbria NHS Foundation Trust** – CHESS, Adult Community Services, Mental Health Services;
- **St Catherine's Hospice** – End of Life Care;
- **GotoDoc** – Out of Hours Care and 111 Services;

- **Care Homes** – all those covered under the scope of this specification
- **Voluntary, Independent and Third Sector**

8. Pricing

The Provider will receive a payment of £132 per bed, per year (based on a full year) for the beds within their aligned care homes. Given that the delivery requirements for this service come into effect on 1st October 2020, a rate of £11 per bed, per month will be used to calculate bed payments from 1st October 2020 - 31st March 2021 to reflect the part year.

The Provider will receive payment regardless of whether beds are occupied. The agreed total will be paid in monthly instalments. The payment will be calculated based on the bed information in the Care Home Alignment document, which the CCG has shared with each Provider. All costs of the service are included within the payments made.

In addition, the Provider will receive a payment of £68 per bed for the financial year 2020/21 for aligned care homes **not in scope** of the LES previously. The payment is in recognition of the extra workload involved in carrying out initial reviews for patients living in these homes during the part year. The payment is non-recurrent and will be paid to the Provider in a single lump sum.

For the duration of this Service, as set out in section 5 of the specification, the CCG will deduct from the LES calculation, payments made to Providers delivering the service requirements in the Section 117 Care Home Specification, in order to avoid double funding.

9. Any acceptance and exclusion criteria

Care Home patients who choose not to register with a practice within the Network the care home is aligned to, will be exempt from this service. However the practice which currently looks after these patients should where possible encourage them to take up this Service, however being mindful of patient choice, if the patient chooses not to move, the Provider must inform the CCG of the number and location of these patients.

The Provider is expected to deliver the service flexibly to meet the medical needs of patients placed in a care home on a temporary basis.

10. Applicable national standards

10.1 Applicable national standards (e.g. NICE)

NICE Care and support for people growing older with learning disabilities (April 2018) https://www.nice.org.uk/guidance/ng96

NICE End of life care for adults (Last updated: March 2017) https://www.nice.org.uk/guidance/qs13

NICE Care of dying adults in the last days of life (March 2017) https://www.nice.org.uk/guidance/qs144

NICE Oral Health for adults in care homes (July 2016) https://www.nice.org.uk/guidance/ng48

NICE Transition between inpatient hospital setting s and community or care settings for adults with social care needs (December 2015) https://www.nice.org.uk/guidance/ng27

NICE Medicines management in care home (March 2015) https://www.nice.org.uk/guidance/qs85

NICE Urinary incontinence in women (January 2015) https://www.nice.org.uk/guidance/qs77

NICE Nutrition support in adults (November 2012) https://www.nice.org.uk/guidance/qs24

NICE Faecal incontinence in adults (June 2007) https://www.nice.org.uk/guidance/cg49

Personalised Care and Support Planning: Think Local Act Personal and Making It Real https://www.thinklocalactpersonal.org.uk/_assets/Resources/Personalisation/TLAP/MakingItReal.pdf

The comprehensive model of personalised care set out in the Long-Term Plan and Universal Personalised Care https://www.england.nhs.uk/personalisedcare/upc/

10.2 Applicable standards set out in Guidance and/or issued by a competent body (e.g. Royal Colleges)

NHS New Models of Care – The framework for enhanced health in care homes. September 2016
https://www.england.nhs.uk/wp-content/uploads/2016/09/ehch-framework-v2.pdf

NHS England and NHS Improvement – The Framework for Enhanced Health in Care Homes https://www.england.nhs.uk/publication/enhanced-health-in-care-homes-framework/

10.3 Applicable local standards

10.3.1 Governance

The Provider is required to deliver service provision within the scope of CCG policies[1] and NHS policies, legislation and terms in relation to:

- Infection Control;
- Clinical Audit and Effectiveness;
- Health and Safety;

[1] Current CCG policies/procedures can be downloaded from the CCG website – http://www.chorleysouthribbleccg.nhs.uk/ https://www.greaterprestonccg.nhs.uk/

- Risk Management;
- Complaints.
- Medical Devices and Equipment Safety Policies and Maintenance
- Confidentiality, Caldicott Principles and Complaints Procedures
- Medicines Management
- Patient Safety (to include a Resuscitation Policy)

The Provider will have an established clinical governance programme and share key clinical governance information with the Commissioner in the form of an annual report, which covers any audits undertaken against the standards set within the policies described in this service specification.

The Provider will ensure that a process is in place to carry out DBS checks on all staff, as legally required, and annual professional registration checks are carried out for all clinical staff. All doctors will be registered licensed practitioners. In addition, the Provider will have systems and processes in place to ensure all clinicians have undergone re-validation as required by their professional body. Evidence of this re-validation may be requested by the commissioner.

11. Applicable quality requirements and CQUIN Goals

11.1 Applicable quality requirements

11.1.1 Quality, Performance Monitoring and Audit

The local quality and performance standards which the Provider is expected to meet under this service will be detailed following release of the national Network Dashboard which will include metrics/indicators for the Enhanced Health in Care Home Service.

11.1.2 Safeguarding Requirements

The Provider shall devise, implement and maintain a procedure for its staff which ensures compliance with pan-Lancashire procedures Safeguarding Vulnerable Adults, and shall supply a copy of its procedure to the Commissioner before commencement of the service.

Pan Lancashire safeguarding adult policies and procedures can be accessed at: http://www.lancashiresafeguarding.org.uk/lancashire-safeguarding-adults/policies-and-procedures.aspx

The Provider will comply with the lead commissioner's standards for safeguarding, PREVENT and the Mental Capacity Act as detailed in Chorley South Ribble and Greater Preston CCG's Safeguarding policy and will provide evidence of their safeguarding arrangements on request, at a minimum this will be annually. Monitoring of on-going compliance will be on a regular basis in year determined by the commissioner.

The Provider agrees to give consideration to the implementation of the Mental Capacity Act (MCA) which is supported by a Code of Practice and sets out the legal framework for people

who lack capacity. The MCA identifies who can take decisions and in what situations, as well as protecting the right of the individual not to be treated as unable to make a decision merely because they make an unwise decision.

The Provider agrees to give due diligence to any Advanced Decision to Refuse Treatment (ADRT) recorded by the patient (and witnessed where appropriate in the case of decisions relating to life sustaining treatment).

The Provider agrees to cooperate with any Lasting Power of Attorney approved and recognised by the Office of Public Guardian in relation to decisions regarding Financial and/or Health and wellbeing where the patient is assessed as lacking Mental Capacity around a specific decision pertaining to these areas.

PREVENT addresses all forms of terrorism, including Far Right extremism and some aspects of non-violent extremism. Work is conducted with the Police, Local Authorities, Government Departments and health services. The Practice Safeguarding/Prevent Lead will advise and signpost in raising concerns following the referral pathway in line with their policy and procedure.

The Provider recognises that safeguarding adults at risk or harm is a shared responsibility with the need for effective joint working between agencies and professionals, with acknowledgement of different roles and expertise if the adult at risk is to be protected from harm. In order to achieve effective joint working there must be constructive relationships at all levels, promoted and supported by:

- the commitment of all staff, at all levels within the practice to safeguarding and promoting the welfare of adults at risk;
- clear lines of accountability within the provider organisation for work on safeguarding;
- organisational developments that take account of the need to safeguard and promote the welfare of adults at risk and is informed, where appropriate, by the views of the vulnerable adult and their families where appropriate;
- staff training and continuing professional development so that staff have an understanding of their roles and responsibilities, and those of other professionals and organisations in relation to safeguarding adults;
- Safe working practices including recruitment and vetting procedures;
- Effective interagency working, including effective information sharing.

11.1.3 Incident Reporting and Management

The Provider will have an Incident Policy in place.

The Provider will have a system in place for reporting any incidents (including near misses) in relation to this service both to the CCG. Particular care should be taken not to include patient identifiable data within incident reports.

The Provider must report any Serious Incidents (SIs) via the Strategic Executive Information Systems (STEIS) (http://nww.steis.doh.nhs.uk/steis/steis.nsf/steismain?readform) in line with

the timeframes set out in the NHS Serious Incident Framework (http://www.england.nhs.uk/ourwork/patientsafety) and ensure such incidents are also reported to the national Reporting and Learning System (http://www.nrls.npsa.nhs.uk/report-a-patient-safety-incident/).

Each SI will be followed up by a formal investigation to include a Root Cause Analysis (RCA), which will be submitted to the CCG for review of recommendations and action plans, to inform and improve practice.

An annual report of all incidents will be submitted to the Commissioner. This annual report should include evidence of undertaking learning from incidents and how this has led to change in practice.

11.1.4 Complaints and Compliments

There must be clear routes for patient complaints and compliments and for staff to raise patient safety and service concerns. The Provider will be able to demonstrate that the complaint handling process is clear and accessible. The Complaints Procedure will clearly lay out timeframes for action.

All complainants will receive an acknowledgement within 3 working days and a formal response within 25 working days. The Complaints Procedure should be clearly signposted so all patients and staff are aware how to access it and will also outline the process of implementing any learning that may arise.

The Provider will be required to review complaints monitoring and management, and provide a report to the Commissioning CCG on a quarterly basis.

11.1.5 Safety Alerts

The Provider will have a system in place to ensure national safety alerts (including medicine alerts, medical devices, estates and facilities) are received, disseminated and implemented in line with the required actions

11.1.6 Infection Prevention and Control

The Provider, will ensure risks in relation to the prevention of Health Care Associated Infections and communicable diseases are minimised.

There will be effective clinical leadership to ensure required standards are met to control and prevent infections acquired in care. Providers must comply with all national legislation or regulations in relation to infection prevention and control.

It is the responsibility of the Provider to purchase, calibrate, maintain to a high standard and replace all relevant equipment required to provide the service.

If a practice that provides this specification has not passed CQC infection control, notification should be sent to the Commissioner.

11.2 **Applicable CQUIN goals**

This is not applicable.

12. Equipment

12.1 The Provider will make use of all available digital and IT equipment including video / tablets / webcams and screens provided by the CCG during each review, assessment or consultation, the outcome of which must be recorded in the patient's medical records

13. Location of Provider Premises

13.1 The service will be provided by PCN Core Network practices at Care Homes across Greater Preston, Chorley & South Ribble CCG's.

14. Partnership working

14.1 The Provider shall work collaboratively with providers of community health services and other partner organisations using a multidisciplinary approach as appropriate. This approach will improve the quality of care for patients and build on well-established relationships with care homes across Central Lancashire.

Appendix 2

Network Contract DES and Standard Contract requirements for the EHCH Service

Network Contract DES requirement
By 31 July 2020, a PCN is required to: a. have agreed with the commissioner the care homes for which the PCN will have responsibility (referred to as the "PCN's Aligned Care Homes" in this Network Contract DES Specification). The commissioner will hold ongoing responsibility for ensuring that care homes within their geographical area are aligned to a single PCN and may, acting reasonably, allocate a care home to a PCN if agreement cannot be reached. Where the commissioner allocates a care home to a PCN, that PCN must deliver the Enhanced Health in Care Homes service requirements in respect of that care home in accordance with this Network Contract DES Specification; b. have in place with local partners (including community services providers) a simple plan about how the Enhanced Health in Care Homes service requirements set out in this Network Contract DES Specification will operate; c. support people entering, or already resident in the PCN's Aligned Care Home, to register with a practice in the aligned PCN if this is not already the case; and d ensure a lead GP (or GPs) with responsibility for these Enhanced Health in Care Homes service requirements is agreed for each of the PCN's Aligned Care Homes.
By 30 September 2020, a PCN must: a. work with community service providers (whose contracts will describe their responsibility in this respect) and other relevant partners to establish and coordinate a multidisciplinary team ("MDT") to deliver these Enhanced Health in Care Homes service requirements; and b. have established arrangements for the MDT to enable the development of personalised care and support plans with people living in the PCN's Aligned Care Homes.
As soon as is practicable, and by no later than 31 March 2021, a PCN must establish protocols between the care home and with system partners for information sharing, shared care planning, use of shared care records and clear clinical governance.
From 1 October 2020, a PCN must: a. deliver a weekly 'home round' for the PCN's Patients who are living in the PCN's Aligned Care Home(s). In providing the weekly home round a PCN: i. must prioritise residents for review according to need based on MDT clinical judgement and care home advice (a PCN is not required to deliver a weekly review for all residents); ii. must have consistency of staff in the MDT, save in exceptional circumstances; iii. must include appropriate and consistent medical input from a GP or geriatrician, with the frequency and form of this input determined on the basis of clinical judgement; and iv. may use digital technology to support the weekly home round and facilitate the medical input; b. using the MDT arrangements, develop and refresh as required a personalised care and support plan with the PCN's Patients who are resident in the PCN's Aligned Care Home(s). A PCN must: i. aim for the plan to be developed and agreed with each new patient within seven working days of admission to the home and within seven working days of readmission following a hospital episode (unless there is good reason for a different timescale); ii. develop plans with the patient and/or their carer; iii. base plans on the principles and domains of a Comprehensive Geriatric Assessment10 including assessment of the physical, psychological, functional, social and environmental needs of the patient including end of life

care needs where appropriate;

iv. draw, where practicable, on existing assessments that have taken place outside of the home and reflecting their goals; and

v. make all reasonable efforts to support delivery of the plan;

c. identify and/or engage in locally organised shared learning opportunities as appropriate and as capacity allows; and

d. support with a patient's discharge from hospital and transfers of care between settings, including giving due regard to NICE Guideline 27

Appendix 3

List of Care Homes in scope of the revised Local Enhanced Services Care Home Specification (Care Home LES) 2020-21 and DES EHCH Service

Care Home in Care Home LES previously		
Care Home not in Care Home LES previously (eligible for the additional £68 tariff)		
No	**Care Home**	**Bed Numbers**
1	2 Millbrook Way	6
2	Aadamson House Care Home	19
3	Aarondale Care Home	48
4	Abraham House	30
5	Adelphi Residential Care Home	27
6	Alston Lodge Residential Home Limited	17
7	Alston View Nursing and Residential Home	50
8	Arrowsmith Lodge Rest Home	35
9	Ashleigh Rest Home	11
10	Banksfield Nursing Home	42
11	Bannister Farm Cottage	5
12	Beechdale	7
13	Beeches Care Home	40
14	Belmont	49
15	Berkeley Village and Cuerden Grange	85
16	Bethany House	26
17	Bridgeway Care Home	29
18	Broadfield House Home for Older People	46
19	Brockholes Brow - Preston	34
20	Brookhaven	22
21	Brookside Residential Care Home	25
22	Bushell House	31
23	Calvert House	8
24	Carleton House	12
25	Chestnut Grove Rest Home	12
26	Clough House	14
27	Coniston House Care Home	43
28	Coote Lane Residential Home	24
29	Croston Park Nursing Home	56
30	Crystal Hall	67
31	Deepdale Neurological Centre	8
32	Derby Lodge	23
33	Dixons Farm	6
34	Dovedale Court	32
35	Dovehaven Grove	55

36	Dovehaven Lodge (Greenfield)	112
37	Euxton Park Care Home	63
38	Fairmont Residential Home	23
39	Fernleigh House	6
40	Finney House	96
41	Gillibrand Hall Nursing Care Home	50
42	Greenways Rest Home	30
43	Grove House Home for Older People	47
44	Heathcotes Preston	7
45	Hennel Lane	5
46	Highgrove House	43
47	Hollydale	8
48	Hulton House Care Residence	74
49	Jah-Jireh Charity Homes Leyland	36
50	Jasmine Court [previously Chorley Lodge]	66
51	Lady Elsie Finney House Home for Older People	46
52	L'Arche Preston Moor Fold	6
53	Laurel Villas Limited	24
54	Long Lane Farm	4
55	Longridge Hall and Lodge	60
56	Longton Nursing and Residential Home	58
57	Lostock Grove Rest Home	37
58	Lostock Lodge	32
59	Lynbrook	4
60	Mapledale	10
61	Marley Court Nursing Home Limited	49
62	Marsh House	33
63	Mather Fold House	6
64	Meadow Bank Care Home	120
65	Meadowfield House Home for Older People	47
66	Melrose Residential Home	26
67	Moor Park House Limited	54
68	Oakbridge Retirement Home (section 117)	54
69	Old Mill House	6
70	Oxford House Residential Home	24
71	Paradise House	39
72	Parklands Care Home	14
73	Penwortham Grange and Lodge	86
74	Preston Glades Care Home	65
75	Preston Private	106
76	Priory Park Care Home	40
77	Ravenscroft Rest Home Limited	36

78	Reiver House	6
79	Ribble View	30
80	Rivington Park Care Home	25
81	Rowandale	11
82	Sandy Banks Care Home	39
83	Sherwood Court	68
84	Sherwood Lodge	49
85	Springfield Manor Gardens *jeanne jurgen*	58
86	Springfield Nursing Home	40
87	St Mary's Gate Euxton	4
88	Stanley Grange	36
89	Stocks Hall Mawdesley	42
90	Sue Ryder Neurological Care Centre (Lancashire)	40
91	Swansea Terrace	44
92	Teamcare Limited t/a Highcliffe Residential Home	24
93	The Barn	12
94	The Brambles Rest Home	32
95	The Brooklands Residential Home	24
96	The Bungalow	3
97	The Gables Care Home	21
98	The Grange	26
99	The Knowle Care Home	32
100	The Lodge - Dementia Care with Nursing	80
101	The Meadows	5
102	The Oaks	6
103	The Spinney	3
104	Tree Top View	6
105	Walton House Nursing Home	41
106	Westwood Residential Care Home	20
107	Willowbank Rest Home	19
108	Willowbrooke Residential Home	19
109	Willowdale	20
110	Woodlands	4
	Total Beds	**3685**