NHS
Bolton
Clinical Commissioning Group

AGENDA
PRIMARY CARE COMMISSIONING COMMITTEE – VIRTUAL MEETING

The meeting will be held via MS Teams Meeting and a diary invite will have been sent to you prior to the meeting

Date: **14th April 2022**

Time: **12.00pm to 13.20pm**

Item No.	Time	Duration	Subject	Paper/Verbal for Approval, Discussion or information	By Whom
1.	12.00pm		Apologies for Absence.	Verbal	All
2.	12.00pm		Declarations of Interest.	Verbal	All
3.	12.00pm	5 mins	Minutes from the meeting held on 10th March 2022.	Paper – for approval	Alan Stephenson
4.	12.05pm	10 mins	PCCC Annual Report and ToR Review.	Paper – for approval	Joanne Taylor
5.	12.15pm	20 mins	Feedback from the BQC Consultation.	Paper – for approval	Stephen Liversedge
6.	12.35pm	15 mins	BQC 2022/23 – Options for Payment.	Paper – for approval	Lynda Helsby
7.	12.50pm	15 mins	Final Network Contract DES – Requirements for Tackling Neighbourhood Health Inequalities.	Paper – for approval	Lynda Helsby
8.	13.05pm	10 mins	Any Other Business.	Verbal	All
9.	13.15pm	5 mins	Chair reflection on significant decisions/actions/risks that may need reporting to the Board through these minutes.	Verbal	All
10.	13.20pm		Time & Date of Next Meeting - to take place from 12 noon on:- • 16th June 2022 (final meeting).	Verbal	All

MINUTES

Primary Care Commissioning Committee – Virtual Meeting

Date: **10th March 2022**

Time: **12.00pm**

Present:

Alan Stephenson	**CCG Lay Member (Committee Chair)**
Su Long	**CCG Chief Officer**
Stephen Liversedge	**CCG Clinical Director, Primary Care & Health Improvement**
Kelly Knowles	**CCG Acting Chief Finance Officer**
Andy Morgan	**Bolton Council Elected Member**
Susan Baines	**Bolton Council Elected Member**
Steven Whittaker	**Local GP representative**
Stacey Walsh	**Local Practice Manager representative**
Karen Cassidy	**Public Health representative, Bolton Council**

In attendance:

Lynda Helsby	**CCG Associate Director Primary Care & Health Improvement**
Kathryn Oddi	**CCG Head of Primary Care Contracting**

Minutes by:

Joanne Taylor	**Board Secretary**

Minute No.	Topic
10/22	**Apologies for Absence** Apologies for absence were received from:- • Kerry Porter, GMH&SCP Primary Care Team representative. • Jim Fawcett, Health Watch representative.
11/22	**Declarations of Interest** **Stephen Liversedge, Stacey Walsh and Steven Whittaker declared an interest in all the items on the agenda relating to primary care, due to potential financial conflicts of interest.** **The Chair agreed that for each item, views would be taken on the potential conflicts of interest to confirm if these members could take part in any voting or decisions taken.** The Chair reminded members of their obligation to declare any interest they may have on any issues arising at meetings which might conflict with the business of the committee. It was noted that declarations declared by members of the committee are listed in the CCG's Register of Interest. The Register is available either via the CCG Board Secretary or the CCG's website at the following link: http://www.boltonccg.nhs.uk/about-us/declarations-of-interest

12/22	**<u>Minutes from the Meeting held on13th January 2022</u>** **The Minutes were approved as a correct record.** With regard to the recent issues at Ladybridge surgery, which were reviewed by the Committee at its last meeting, the Committee was informed that the practice may be closing this surgery at 2pm. Members were informed that Ladybridge surgery had been informed of the Committee's decision not to support the closure of the surgery in an afternoon, but that safety concerns both internally and externally would be actioned. It was noted that internal works had commenced and Councillor Morgan confirmed that the works to street lighting was commencing this week with the works to the car park commencing the following week. Councillor Morgan was thanked for the work he has done on this issue and was asked to also pass on the Committee's gratitude to involved councillors. **It was agreed that the practice would be contacted to confirm the Committee's decision and discuss the reasons for the practice closing.**
13/22	**<u>Bolton Quality Contract 2022/2</u>** The Committee received a presentation on the proposed BQC for 2022/23. The presentation highlighted:- • An update on the 2021/22 achievements so far. • General principles for setting the BQC for 2022/23. • The proposed standards and KPIs. • KPI % allocation. • Further considerations regarding the contract basis and penalties. Members discussed the proposals and commented that the general approach for the 2022/23 BQC is appropriate and that practices should be able to achieve the standards and KPIs set as the majority of these are annual reviews without a part year effect and no backlog to work through due to the Covid pandemic. Members agreed practices should see this year as a "catch up" and consolidation process. Members were keen to see a greater focus on the Access targets and to see this as an area requiring continuous improvement. There is pressure at a national and local level to show an increase in appointments. **The Chair requested comments from the GP and Practice Manager representatives, confirming their contribution to these discussions is valuable but that they would be excluded from voting due to their conflicts of interest.** Members supported to the comments raised and, with regard to the Access standard, highlighted that practices have been given additional roles to improve access and this should be reflected in achievement of this target. However it was noted that some practices may be struggling to recruit additional staff to cover the extra sessions to provide these additional contacts. The Chair confirmed that the Access target needs to increase as this is an issue for the public and is important that access is seen to be improving. Members agreed that the technology developments over the last 2 years should be seen as a positive. Steven Whittaker raised an issue with regard to the Health Check standard confirming that practices may struggle to meet these targets as this target is reviewed over a 5 year period and practices have been focused on the Covid pandemic for the last 2 years. Increasing this target may prove difficult for practices to achieve.

	Members were informed that the Public Health team is currently in discussions with NHS England on additional funding to target vulnerable people to refer for health checks, from a prevention and early identification perspective. Further discussions locally with the CCG primary care and public health teams would be held to develop these plans further. Councillor Baines raised a suggestion following a recent discussion on developing a standard relating to people who are deaf or hard of hearing and discussed developing a pilot on this area. It was agreed further discussions on this would be held. Following discussions, the Committee's views on the proposed BQC 2022/23 were: • To review further the Access KPI to increase to 80 per 1,000 contacts and increase the value. • Any KPIs with a rolling target (3 or 5 years) to have a stepped approach. • Focus practices on achieving targets at pre-pandemic levels. • Maintain a contract basis of 60%/40%. **The Committee agreed to receive the final version of the BQC 2022/23 at the April meeting and that in the interim an implied contract letter would be sent to practices on 1st April confirming the BQC intentions for 2022/23.**
14/22	**Network Contract DES – Requirements for Tackling Neighbourhood Health Inequalities** PCNs are asked to work from October 2021 to identify and engage a population experiencing health inequalities within their area, and to co-design an intervention to address the unmet needs of this population. This work includes identifying and selecting the population experiencing inequality, working collaboratively across systems and localities; engaging with the community experiencing health inequalities; developing a plan by 28th February 2022 describing how the intervention will be delivered for the duration of the contract period; and identifying what outcome this intervention is expected to achieve and how that outcome will be measured. This measurement should support quality improvement activities within, and between, PCNs. Delivery of this intervention will commence from March 2022. An outline for developing and approving these plans were presented to the Committee, including an update from the GM Delegated Management Oversight Group meeting on 9th March, where a number of CCGs that had yet to receive/consider plans from all of their PCNs was discussed. It was agreed that discussions around this matter would be brought back to the next meeting on 23rd March; however all CCGs acknowledged the need to ensure schemes add value and do not duplicate existing services. It was proposed that plans not approved/approved in principle here will be brought back to this Committee for sign-off following resubmission in line with the comments made above. Members discussed the plans and agreed that overall there is a need for PCNs to focus on the wider inequalities of health across a larger population and that this be a principle for all PCNs to review. The Committee reviewed each of the PCN plans received: • Bolton Central – request the PCN to review a different cohort, submit evidence of data and interventions that do not duplicate what is already in place. • Chorley Roads – request the PCN to review a different cohort, submit evidence of data and interventions that do not duplicate what is already in place. • Farnworth and Kearsley – addresses wider determinants of health, and is over and above the requirements in other schemes already in place and should be approved.

	• Halliwell – duplication with existing requirements – request the PCN to review a different cohort, submit evidence of data and interventions that do not duplicate what is already in place. • Rumworth – request the PCN to review a different cohort, submit evidence of data and interventions that do not duplicate what is already in place. • Westhoughton – request the PCN to review a different cohort, submit evidence of data and interventions that do not duplicate what is already in place. • Horwich – focuses on promoting health checks at an earlier age across an ethnic population. No duplication with other existing specifications, therefore a valid proposal and supported. Further information to be requested. • Turton – social isolation in the elderly and younger people with mental illness, therefore a valid proposal and support. Further information to be requested on delivery of the plan. • Breightmet – workshop to be held to consider data/information as a baseline to agree and identify areas. Proposed approach supported. Bring back to Committee once finalised. Noted our approach is in line with processes across Greater Manchester. **The Committee supported the recommendations outlined in the report for developing and approving these plans, with an agreed principle being to focus on the wider inequalities of health across a larger population. Further developments to include public health colleagues.** **The final plans to be presented for approval to the Committee at a future meeting.**
15/22	**<u>Winter Access Fund Activity Contributing to BQC Access Audit</u>** Members were informed that the LMC Chair had asked for a question to be raised with the Committee on whether the activity and appointments delivered through the Winter Access Fund activity/funding could be considered alongside the BQC access target of 75 per 1,000 contacts. **Members discussed and agreed that the Winter Access Fund is funding to deliver additional appointments above what is already being delivered, for which practices receive additional funding. The BQC access target is separate funding received by practices and both should be kept separate.**
16/22	**<u>Estates Update</u>** The Committee was informed of developments on the Little Lever project. It was noted that there have been some delays on accessing the site and this may delay the target date of 31st March. The Heads of Terms have now also been agreed and access issues resolved. **The Committee noted the update.**
17/22	**<u>Any Other Business</u>** **<u>Delay to ICS Transition – Review of Business for Q1 (April to June)</u>** The Committee will continue to meet between April and June to take forward the business it is required to do as the CCG continues as a statutory organisation to the end June, prior to the ICS transition from 1st July. **<u>Shanti Medical Centre and Hindu Forum</u>** Councillor Baines raised a query regarding accommodation space at Shanti Medical Centre which was being used by the Hindu Forum who were requesting funding to make alterations to the space.

	It was confirmed that any funding for building works would need to come from the landlord/owner of the building as NHS funding will not be available for these works as it is not a health matter.
18/22	**<u>Chair reflection on significant decisions/actions/risks that may need reporting to the Board through these minutes</u>** The main points highlighted were:- • Reviewed the BQC 2022/23 proposals for final approval at the April meeting. • Supported the recommendations for developing and approving the plans for tackling neighbourhood health inequalities. • Affirmed that the Winter Access Funding is additional funding and cannot count towards BQC targets.
19/22	**<u>Time and Date of Next Meeting</u>** **It was agreed that the next meeting would be held on Thursday 14th April and the final meeting of the Committee held on 16th June.**

NHS
Bolton
Clinical Commissioning Group

Primary Care Commissioning Committee

AGENDA ITEM NO: ……..4……

Date of Meeting: ……14th April 2022……

TITLE OF REPORT:	Draft Annual Report and Terms of Reference	
AUTHOR:	Joanne Taylor, Board Secretary	
PRESENTED BY:	Joanne Taylor, Board Secretary	
PURPOSE OF PAPER: (Please be clear e.g. decision(s) required, a discussion, for noting) For review and comment The purpose of this report is to provide a summary of the Committee's activities, in order to demonstrate how the Committee has discharged its responsibilities and terms of reference. The Committee is asked to approve subject to review and comment on the draft report prior to the final document being presented to a future CCG governing body meeting.		
LINKS TO CORPORATE OBJECTIVES (tick relevant boxes):	**Deliver the outcomes in the Bolton Joint Health and Care Plan.**	
	Ensure compliance with the NHS statutory duties and NHS Constitution.	✓
	Deliver financial balance.	
	Regulatory Requirement.	
	Standing Item.	
FINANCIAL IMPLICATIONS [discussed with Chief Financial Officer]: None		
COMMITTEES/GROUPS PREVIOUSLY CONSULTED: None		
REVIEW OF CONFLICTS OF INTEREST: N/A		
RECOMMENDATION(s) The Committee is asked to approve subject to review and comment on the draft report prior to the final document being presented to a future CCG governing body meeting.		

Primary Care Commissioning Committee

Annual Report 2021-22

1. Introduction

The purpose of this report is to provide a summary of the Primary Care Commissioning Committee (the Committee) activities, in order to demonstrate compliance with the Committee's terms of reference, effectiveness and impact of the Committee.

The Committee is established as a Sub-Committee of the governing body in accordance with NHS Bolton Clinical Commissioning Group (CCG) governing body's constitution.

The terms of reference setting out the membership, remit, responsibilities and reporting arrangements of the Committee were reviewed and amended in April 2022.

2. Membership

The membership of the Committee during 2021-22 was as follows:

- Alan Stephenson, Lay Member and Chair of the Committee.
- Jim Fawcett, Health Watch representative.
- Su Long, CCG Chief Officer.
- Kelly Knowles, CCG Acting Chief Finance Officer.
- Stephen Liversedge, Clinical Director Primary Care & Health Improvement.
- Lynda Helsby, Associate Director Primary Care & Health Improvement.
- Bolton Council Senior Officer representative.
- Bolton Council Elected Member representatives.
- NHS England Primary Care Commissioning representative.
- Steven Whittaker, local GP representative.
- Stacey Walsh, local practice manager representative.

3. Attendance

From April 2021 to March 2022, the Committee met seven times and was quorate at each meeting.

The schedule of attendance is as follows:

	May 21	June 21	Aug 21	Oct 21	Dec 21	Jan 22	March 22
Alan Stephenson	√	√	√	√	√	√	√
Jim Fawcett	√	√	X	√	√	√	X
Su Long	√	√	√	√	√	√	√
Kelly Knowles	√	√	√	√	√	√	√
Stephen Liversedge	√	√	√	√	√	√	√
Melissa Maguinness (to Aug 21)	√	√	X	N/A	N/A	N/A	N/A
Bolton Council Senior Officer	X	X	X	√	X	√	√
Bolton Council Elected Members x 2	√	√	X√	√	√	X√	√
NHS England Primary Care representative	√	X	√	√	√	√	X
Steven Whittaker	√	√	√	√	√	√	√
Stacey Walsh	√	√	√	√	√	√	√

4. Conflicts of Interest

There were several declarations of interest reported dependent on the item for discussion. These were recorded in the minutes. The Chair agreed that for each item, views would be taken on the potential conflicts of interest to confirm if these members could take part in any voting or decisions taken.

For some items requiring decision, the members concerned asked not to take part in the discussions and were requested to leave the meeting when these items were being discussed.

5. Remit and responsibilities of the Committee

The Committee's remit is to:

- Make collective decisions on the review, planning and procurement of primary care services in the borough of Bolton, under delegated authority from NHS England.

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

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

- The role of the Committee shall be to carry out the functions relating to the commissioning of primary medical services under section 83 of the NHS Act, except those relating to individual GP performance management, which have been reserved to NHS England.

- This includes the following:

    - GMS, PMS and APMS contracts (including the design of PMS and APMS contracts, monitoring of contracts, taking contractual action such as issuing breach/remedial notices and removing a contract);
    - Newly designed enhanced services ("Local Enhanced Services" and "Directed Enhanced Services");
    - Design of local incentive schemes as an alternative to the Quality Outcomes Framework (QOF);
    - Decision making on whether to establish new GP practices in an area;
    - Approving practice mergers; and
    - Making decisions on 'discretionary' payment (eg. Returner/retainer schemes).

- The Committee's aim is to deliver the following benefits:

    - Improved provision of out-of hospital services for the benefit of patients and local populations;
    - a more integrated healthcare system that is affordable, high quality and which better meets local needs;
    - more optimal decisions to be made about how primary care resources are deployed;
    - greater consistency between outcome measures and incentives used in primary care services and wider out-of-hospital services; and
    - a more collaborative approach to designing local solutions for workforce, premises and IM&T challenges.

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

6. Policy and best practice

The Committee applied best practice in its deliberations and decision making processes. It conducted its business in accordance with national guidance and relevant codes of conduct and good governance practice.

7. Conduct of the Committee

The Committee reviewed its performance, membership and terms of reference and any changes to the terms of reference or membership were approved by the Governing Body.

Meetings of the Committee were conducted in accordance with the provisions of Standing Orders, Reservation and Delegation of Powers and Prime Financial Policies approved by the Governing Body and reviewed from time to time.

The Board Secretary minuted the proceedings of all meetings of the Committee, including recording the names of those present and in attendance and the minutes of the Committee meetings were circulated promptly to all attendees of the Committee for approval.

The Committee reported to the Governing Body after each meeting via its minutes.

8. Key Areas Reviewed

Throughout the year, the Committee reviewed the following areas:-

- The Bolton Quality Contract for 2021/22 including:
  - Options for payment.
  - Primary Care Access Audit Review.
  - Re-set of the KPIs in light of the Covid pandemic.
  - End of Year Review.
- The Bolton Quality Contract 2022/23.
- Primary Care Covid Expansion Funding.
- Primary Care Commissioning Contract review.
- Primary Care Winter Access Funding.
- Locally commissioned services review.
- Safety issues at GP practices.
- PCN Health Inequality Plans.
- Regular updates on the development of the primary care estate.
- Various primary care contractual changes and contractual issues.
- BQC Appeals Process 2021/22.

The Terms of Reference attached were reviewed and amended in April 2022.

Alan Stephenson
Primary Care Commissioning Committee Chair

2April 2022

NHS
Bolton Clinical Commissioning Group

Primary Care Commissioning Committee

Terms of Reference

1. Introduction

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

1.2 In accordance with its statutory powers under section 13Z of the National Health Service Act 2006 (as amended), NHS England has delegated the exercise of the functions specified in Schedule 2 to these Terms of Reference to NHS Bolton CCG. The delegation is set out in Schedule 1.

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

1.4 It is a committee comprising representatives of the following organisations:

- NHS Bolton CCG;
- Healthwatch Bolton;
- GP not practising in Bolton;
- Member representatives: Local GP, Practice Manager;
- NHS England representatives including public health commissioning representative;
- Local Council senior officer.
- Local Council elected members.

1.2. The NHS England and Bolton CCG Primary Care Commissioning Committee is a committee with the primary purpose of jointly commissioning primary medical services for the people of Bolton.

1.3. The NHS Bolton CCG Primary Care Commissioning Committee is established in accordance with NHS Bolton Clinical Commissioning Group's Constitution, Standing Orders and Scheme of Delegation.

These terms of reference set out the membership, remit, responsibilities and reporting arrangements of the Committee and shall have effect as if incorporated into the Clinical Commissioning Group's Constitution and Standing Orders.

2. Statutory Framework

2.1. NHS England has delegated to the CCG authority to exercise the primary care commissioning functions set out in Schedule 2 in accordance with section 13Z of the NHS Act.

The National Health Service Act 2006 (as amended) ("NHS Act") provides, at section 13Z, that NHS England's functions may be exercised jointly with a CCG, and that functions exercised jointly in accordance with that section may be exercised by a committee of NHS England and the CCG. Section 13Z of the NHS Act further provides that arrangements made under that section may be on such terms and conditions as may be agreed between NHS England and the CCG.

2.2. Arrangements made under section 13Z may be on such terms and conditions (including terms as to payment) as may be agreed between the Board and the CCG.

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

2.3.1. Management of conflicts of interest (section 140);
2.3.2. Duty to promote the NHS Constitution (section 14P);
2.3.3. Duty to exercise its functions effectively, efficiently and economically (section 14Q);
2.3.4. Duty as to improvement in quality of services (section 14R);
2.3.5. Duty in relation to quality of primary medical services (section 14S);
2.3.6. Duties as to reducing inequalities (section 14T);
2.3.7. Duty to promote the involvement of each patient (section 14U);
2.3.8. Duty as to patient choice (section 14V);
2.3.9. Duty as to promoting integration (section 14Z1);
2.3.10 Public involvement and consultation (section 14Z2).

2.4 The CCG will also need to specifically, in respect of the delegated functions from NHS England, exercise those in accordance with the relevant provisions of section 13 of the NHS Act as set out below:

- Duty to have regard to impact on services in certain areas (section 13O);
- Duty as respects variation in provision of health services (section 13P).

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

2.6 The members acknowledge that the Committee is subject to any directions made by NHS England or by the Secretary of State.

3. Role of the Committee

3.1 The Committee has been established in accordance with the above statutory provisions to enable the members to make collective decisions on the review, planning and procurement of primary care services in the borough of Bolton, under delegated authority from NHS England.

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

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

3.4 The role of the Committee shall be to carry out the functions relating to the commissioning of primary medical services under section 83 of the NHS Act, except those relating to individual GP performance management, which have been reserved to NHS England.

3.5 This includes the following:

- GMS, PMS and APMS contracts (including the design of PMS and APMS contracts, monitoring of contracts, taking contractual action such as issuing breach/remedial notices and removing a contract);
- Newly designed enhanced services ("Local Enhanced Services" and "Directed Enhanced Services");
- Design of local incentive schemes as an alternative to the Quality Outcomes Framework (QOF);
- Decision making on whether to establish new GP practices in an area;
- Approving practice mergers; and
- Making decisions on 'discretionary' payment (eg. Returner/retainer schemes).

3.6 The CCG will also carry out the following activities:

- Plan, including needs assessment, primary medical care services in Bolton borough;
- Undertake reviews of primary medical services in Bolton borough;
- Co-ordinate a common approach to the commissioning of primary care services generally;
- Manage the budget for commissioning of primary medical care services in Bolton borough.

3.7 The Committee will aim to deliver the following benefits:

- Improved provision of out-of hospital services for the benefit of patients and local populations;
- a more integrated healthcare system that is affordable, high quality and which better meets local needs;
- more optimal decisions to be made about how primary care resources are deployed;
- greater consistency between outcome measures and incentives used in primary care services and wider out-of-hospital services; and
- a more collaborative approach to designing local solutions for workforce, premises and IM&T challenges.

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

4. Geographical Coverage

4.1 The Committee's responsibilities will cover the same geographical area as those of NHS Bolton CCG.

5. Membership

5.1. The Committee will comprise of the following members:-

Members (Designation)
CCG Governing Body Lay Member (Chair of the Group) (Voting)
Healthwatch Representative (Voting)
CCG Chief Officer (Voting) (or their deputy)
CCG Acting Chief Finance Officer (Voting) (or their deputy)
CCG Clinical Director Primary Care & Health Improvement (Voting)
CCG Director of Strategic Commissioning (Voting)
CCG Associate Director Primary Care & Health Improvement (Non-Voting – In Attendance)

Bolton Council Senior Officer (or their deputy) (Voting)
2 Bolton Council Elected Members (Voting) (Susan Baines appointed as Vice-Chair)
NHS England Primary Care Commissioning (or their deputy) (Voting)
GP not practising in Bolton (Voting)
Local GP (Voting)
Local Practice Manager (Voting)

A CCG Lay Member will Chair the Group, in accordance with national guidelines. In the absence of the Chair of the Committee, a lay chairman shall be nominated by other members attending that meeting.

The Committee has agreed that the CCG Chief Officer and Chief Finance Officer can appoint deputies to attend meetings on their behalf. The deputies are:

- Chief Officer – TBC as required.
- Acting Chief Finance Officer – Associate Director, Financial Management.

6. Meetings and Voting

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

6.2 Each member of the Committee shall have one vote except those indicated in schedule 1 as non-voting. The Committee shall reach decisions by a simple majority of members present, but with the Chair having a second and deciding vote, if necessary. However, the aim of the Committee will be to achieve consensus decision-making wherever possible.

6.3 Meetings of the Committee shall:

(a) Be held in public, subject to the application of point (b) below;

(b) The Committee may resolve to exclude the public from a meeting that is open to the public (whether during the whole or part of the proceedings) whenever publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution and arising from the nature of that business or of

the proceedings or for any other reason permitted by the Public Bodies (Admissions to Meetings) Act 1960 as amended or succeeded from time to time.

6.4 NHS England, Bolton CCG and Bolton Council have the right and responsibility to designate alternates of their own choosing to ensure they attend all meetings.

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

6.6 The Committee may delegate tasks to such individuals, sub-committees or individual members as it shall see fit, provided that any such delegations are consistent with the parties' relevant governance arrangements, are recorded in a scheme of delegation, are governed by terms of reference as appropriate and reflect appropriate arrangements for the management of conflicts of interest.

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

6.8 Members of the Committee shall respect confidentiality requirements as set out in the CCG's Constitution.

6.9 The Committee will present its minutes to Governing Body of NHS Bolton CCG for information, including the minutes of any sub-committees to which responsibilities are delegated under section 8.4

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

6.11 Terms of Reference will be reviewed annually, reflecting experience of the Committee in fulfilling its functions. NHS England may also issue revised model terms of reference from time to time.

6.12 The Committee will also report to the governing body annually setting out how it has discharged its responsibilities and its terms of reference.

7. Quorum

7.1 Two thirds of voting members represents a quorum. This should include a majority of lay and executive members in attendance with eligibility to vote.

8. Handling Conflicts of Interest

8.1 As defined in the CCG's Conflicts of Interest Policy, where this Committee is taking a decision where a member of the Committee has a conflict of interest, the member/s will be excluded from the relevant parts of the meeting and clearly and demonstrably take no part in the decision-making process.

9. Frequency of Meetings

9.1 The Committee will meet once every two months.

9.2 For any urgent interim decisions that are required. The process to follow is detailed below:

- Recommendation by the Operational Group.
- Notified to the Joint Commissioning Committee Chair in the first instance.
- Recommendation to the Joint Commissioning Committee for a "virtual" decision.
- Reported and recorded at the next meetings of the Joint Commissioning Committee and Operational Group.
- Reported to NHSE.

10. Secretary

10.1 The NHS Bolton CCG Board Secretary will provide administrative support to the Committee. The Board Secretary will be responsible for:

- Circulation of the minutes and action notes of the committee within 1 week of the meeting to all members.
- Supporting the chair in the management of business.
- Drawing the committee's attention to best practice, national guidance and other relevant documents, as appropriate.
- Present the minutes and action notes to the governing body of NHS Bolton CCG.

10.2 Unless otherwise agreed, notice of each meeting confirming the venue, time and date together with an agenda of items to be discussed, shall be forwarded to each member of the committee, and other persons required to attend no later than five working days before the date of the meeting. Supporting papers shall be sent to committee members and other attendees as appropriate, at the same time. These timescales can be amended by express agreement of the Chair of the Committee. Urgent items can be added to the agenda at short notice, only with the express agreement of the Chair of the Committee.

11. Policy and Best Practice

11.1 The Committee will apply best practice in its deliberations and in the decision making processes. It will conduct its business in accordance with national guidance and relevant codes of conduct and good governance practice.

Date Terms of Reference Agreed:
April 2022

Review Date:
April 2023.

NHS
Bolton
Clinical Commissioning Group

Bolton Primary Care Commissioning Committee

AGENDA ITEM NO……..5……

Date of Meeting: ……Thursday 14 April 2022…….

TITLE OF REPORT:	**The Bolton Quality Contract 2022 - 2023** **Member Consultation Feedback**
AUTHOR:	Lynda Helsby
PRESENTED BY:	Stephen Liversedge
PURPOSE OF PAPER: (Please be clear e.g. decision(s) required, a discussion, for noting) The PCCC is being asked to discuss the feedback from the recent BQC consultation, and agree the final specification for 2022 - 2023	
FINANCIAL IMPLICATIONS [discussed with Chief Financial Officer]:	
COMMITTEES/GROUPS PREVIOUSLY CONSULTED: LMC Clinical Leads Practice Managers	
RECOMMENDATION(s) **Discuss the feedback from the recent consultation exercise, and agree the final specification for the BQC for 2022 – 2023.**	

Background information

As part of the BQC consultation process, the Primary Care Development Team has discussed the proposals with:

- CCG Executive
- Clinical Leads – North and South
- PCCC
- Bolton GP Board
- LMC
- Practice Managers
- *To share with ICP Board at their next meeting for information*

Although the membership welcomed the continuation of the BQC, they have fed back specific issues for consideration by the PCCC.

This is a collation of feedback from Clinical Leads, Bolton GP Board, LMC and Practice Managers.

Number	Standard	Feedback
1.	Access	**<u>80/1000 contacts</u>** • 80/1000 contacts is too high. If it must be increased to this level we should be able to count social prescribing contacts in the access audit. • Can we add in HIP and pharmacy technician contacts? • Can we all in all new practitioners which are not specifically first contact? • We are all working under immense pressures. Some practices are struggling with room capacity as well due to additional ARRS staff. Increasing the goal post particularly from 75 to 80 appointments per thousand patients would prove to create a significantly higher challenge. If this has to be decided then you need to consider cost of one additional GP hour of appointments per thousand patients and remunerate it as well, i.e. as you increase the goal post then please fund accordingly as well. • When we come on to Extended Access from October, will that be included in the figure? • Unfair allocation of new workforce, their contacts for the days we have them is minimal, so this will impact our figures. • **LMC Chair** – concerns re proposal to increase this from 75 and 22.5 contacts per 1000 (5% of the

		BQC) to 80 and 25 contacts per 1000 (10% of the BCQ). **<u>25/1000 contacts</u>** • 25/1000 contacts is too high - I feel 25% of the 80/1000 contacts is fair and allows practices the flexibility to adapt their appointment system to new ways of working, as well as giving patients choice. • ARRS staff take up rooms meaning more GPs doing remote working • With regards to the face to face appointments, why don't you leave it to the GP's discretion as to whether they want to see face to face or not? **<u>KPI 10%</u>** • KPI 10% access is too high. Access can be hugely affected by Covid IPC guidance as well as the ability to recruit permanent/locum staff.
2.	Ageing well	No comments
3.	Carers	No comments
4.	Defined patient groups	**<u>Dementia Diagnosis</u>** • Wait time for appointments at the Memory Assessment Service is 4/5 months • There is currently a four month wait for the dementia screening clinic.
5.	Health Improvement	No comments
6.	Long Term condition / Best care	**<u>Asthma / COPD</u>** • Access to Feno / spirometry is an issue (*this only needs to be considered*) • Concerns re spirometry
7.	Membership Engagement	**<u>Clinical leads</u>** • Who will the membership engage with as the CCG will no longer be here… can this be the GP board?
8.	Prescribing	• Additional information is needed on prescribing, the view being that practices need more up to date information.
General Comments		• We need a 2-year period to get back to pre-pandemic levels • Unrealistic expectations • Long hospital waits and system is trying to recover – meaning more patients accessing GP practice

	• Suggestion that a 'recovery' period of 24 months might be more appropriate and achievable. • Is there any guarantee that BQC will exist after this year? • The rolling targets that have not been done for two years will not be 12 month targets, as we will be capturing some of these patients again. • Things haven't gone back to normal. The government are making out as if we have. All these targets that are being proposed would be ok if we could turn the clock back and the situation was exactly the same before it changed two years ago. I am working over 50 hours per week at the moment; it never used to be like this. • Unachievable targets.

Previous minutes from PCCC

Members discussed the proposals and commented that the general approach for the 2022/23 BQC is appropriate and that practices should be able to achieve the standards and KPIs set as the majority of these are annual reviews without a part year effect and no backlog to work through due to the Covid pandemic. Members agreed practices should see this year as a "catch up" and consolidation process.

Members were keen to see a greater focus on the Access targets and to see this as an area requiring continuous improvement. There is pressure at a national and local level to show an increase in appointments.

Members supported the comments raised and, with regard to the Access standard, highlighted that practices have been given additional roles to improve access and this should be reflected in achievement of this target. However it was noted that some practices may be struggling to recruit additional staff to cover the extra sessions to provide these additional contacts. The Chair confirmed that the Access target needs to increase as this is an issue for the public and is important that access is seen to be improving. Members agreed that the technology developments over the last 2 years should be seen as a positive.

An issue (was raised) with regard to the Health Check standard confirming that practices may struggle to meet these targets as this target is reviewed over a 5 year period and practices have been focused on the Covid pandemic for the last 2 years. Increasing this target may prove difficult for practices to achieve.

Following discussions, the Committee's views on the proposed BQC 2022/23 were:

- To review further the Access KPI to increase to 80 per 1,000 contacts and increase the value.
- Any KPIs with a rolling target (3 or 5 years) to have a stepped approach.
- Focus practices on achieving targets at pre-pandemic levels.
- Maintain a contract basis of 60%/40%.

Additional information

Standard 1 - Access

The latest data extracted from practices (Q3 data - Dec 2021) suggests that overall, we are on course to achieve the proposed Bolton targets

Standard		Achievement – as at Q3 2021
1.	**Access to General Practice** **2021-2022 target – 75 contacts per 1000 pop.** **Deliver F2F Contacts** **2021-2022 target – 22.5 contacts per 1000 pop**	**82 contacts** **25.8 contacts** **.**

Standard 4 – Defined Patient Groups

In order to consider the feedback relating to the Dementia Diagnosis targets - Memory Assessment Service, we have checked directly with the Service and they are reporting that their wait times are currently 4-5 months.

Recommendations

PCCC are asked to discuss the feedback from the recent consultation, and agree the final specification of the BQC 2022-2023.

Bolton Clinical Commissioning Group

Primary Care Commissioning Committee

AGENDA ITEM NO: ……..6……..

Date of Meeting: ……Thursday 14 April 2022……..

TITLE OF REPORT:	**The Bolton Quality Contract 2022 - 2023** **Options for payments**
AUTHOR:	Lesley Hardman/Claire Donovan
PRESENTED BY:	Lynda Helsby
PURPOSE OF PAPER: (Please be clear e.g. decision(s) required, a discussion, for noting) The PCCC is being asked to consider a range of payment options for the eighth year of the BQC, in light of the uplift to the Global Sum Rate (the national price per patient for 'core primary medical services') for 2022 – 2023.	
FINANCIAL IMPLICATIONS [discussed with Chief Financial Officer]: Discussed with Deputy CFO	
COMMITTEES/GROUPS PREVIOUSLY CONSULTED: N/A	
RECOMMENDATION(s) The PCCC is being asked to discuss the options, and recommend a preferred option for BQC payments for 2022 – 2023.	

OPTIONS FOR PAYMENTS FOR THE BOLTON QUALITY CONTRACT 2022 - 2023

1. Summary and Purpose of Report

NHS Bolton Clinical Commissioning Group (CCG) Board agreed to the continuation of the Bolton Quality Contract (BQC) as a rolling programme of work for Primary Care, following the recommendation from the Primary Care Commissioning Committee (PCCC).

In 2015 – 2016, the first year of the BQC, each practice that signed up to the programme received a minimum of £95.00 per weighted patient (pwp) to deliver 'core' primary medical services plus delivery of 19 Standards detailed in the Specification.

For the next 5 years, the PCCC recommended that investment in the BQC should continue, with sufficient funding to support all agreed Standards, and to include any nationally recommended uplifts. The payments pwp were agreed as follows:

2016 – 2017	£102.45	
2017 – 2018	£107.21	
2018 – 2019	£109.78	
2019 – 2020	£110.70	(later increased to £111.74 to reflect additional 1% increase in year)
2020 – 2021	£110.91	(now excludes the New Ways of Working at £3 pwp)
2021 – 2022	£113.13	

PCCC is now being asked to consider a number of payment options to determine the level that the pwp should be set at for the BQC 2022 – 2023.

PCCC should determine the level of the pwp by also taking into consideration the uplift of £2.42 (2.49%) taking the Global Sum Rate (the national price per patient for 'core primary medical services) to £99.70 for 2022 – 2023.

2. Context

Over a number of years, an increased share of NHS spend was allocated to hospital care. Consequently, there was a reduced spend on primary care. Furthermore, an historic disparity had developed which resulted in wide variation in the level of funding allocated from one GP practice to another, as illustrated in the table below. All of this came at a time when demand on general practice was growing inexorably.

NHS Bolton CCG was keen to support local practices by introducing a significant local investment in an attempt to address the imbalance; despite there being a finite resource available. The initial investment was made in 2015 – 2016, through the development of the Bolton Quality Contract and the aim was to provide a guaranteed and consistent income level per weighted patient for practices as well as incentives for the delivery of a set of standards.

This was the start of a 'levelling up' process for practice income across Bolton, which was standardised by 2019 – 2020.

The investment has provided two clear benefits for practices:

1. Increased staffing capacity to meet rising demand
2. Guaranteed, and consistent, practice income

The aim was for practices to deliver the following outcomes:

- Better value for the NHS pound
- Better health outcomes for Bolton people
- Improved quality of services offered
- Better access

The intention was that the Bolton Quality Contract would release savings over the course of each year.

3. Commissioning

From the 1st April 2016, under Level 3 Joint Commissioning arrangements with NHS England, the CCG has been responsible for the commissioning of 'core' primary medical services and their associated payments. Core primary medical services include the provision of:

- 'essential' services (management of patients who are ill, terminally ill or living with a chronic disease)

- 'additional' services (e.g cervical screening, maternity services etc)

The CCG is also now responsible for payments relating to the delivery of Directed Enhanced Services (DESs) and the Quality and Outcomes Framework (QOF).

Under these arrangements, NHS England still retains ultimate accountability and control in relation to how much national resource is allocated to Primary Care, and for core GMS/PMS/APMS contractual terms and conditions.

The CCG is fully responsible for all decisions concerning the commissioning of the 'core' GP Contract, the Enhanced Services commissioned by NHS England, and any associated risks arising from in year pressures on the delegated budget. This latter point being an important factor when considering the options detailed later in this paper.

4. The BQC and COVID-19

As agreed by the PCCC, the BQC for 2021-2022 was paused for the second year running in light of the COVID-19 pandemic, and the need for practices to address urgent demand.

An attempt was made to re-start the BQC in October 2021. However, this programme was still being adversely affected by the demands of the continuing pandemic.

5. Options for the BQC 2022 - 2023 payment level pwp

Each year the detail in the Specification is reviewed and agreed. In addition, the payment level per weighted patient is determined by the PCCC.

The table below provides the detail on the options:

Option	Global Sum Rate (£)	BQC Rate (£)	Total Rate per Weighted Patient (£)	Total Funding Required (£'000)	Description
2021/22 Rates	97.28	15.85	113.13		
Option 1. Maintain rate at £113.13	99.70	13.43	113.13	4,366	No increase – payment per weighted patient in relation to the BQC standards remains the same as previous year.
Option 2. Inflationary uplift on the 21/22 rate at 2%	99.70	15.69	115.39	5,102	The full 2022/23 rate has been uplifted by 2% inflation.
Option 3. Total Global Sum Uplift (£2.42)	99.70	15.85	115.55	5,153	This increase reflects the total increase to global sum rate for 2022/23
Option 4. Total Global Sum uplift + 2.49% applied to BQC element	99.70	16.24	115.94	5,281	This increase reflects the 2.49 % increase to global sum rate and BQC for 2022/23.

The financial impact of the 4 options are:

- Option 1 - total funding required is £4,366k – a decrease in the 2021 - 2022 level of investment of £762k.
- Option 2 - total funding required is £5,102k – a decrease in the 2021 – 2022 level of investment of £26k.
- Option 3 - total funding required is £5,153k – an increase in the 2021 - 2022 level of investment of £25k.
- Option 4 - total funding required is £5,281k – an increase in the 2021 – 2022 level of investment of £153k.

6. Recommendation

Bolton CCG has planned for a level of inflation and growth in line with planning assumptions under the planning guidance for 2022/23

The costs outlined in Option 4 are in excess of these assumptions. Should this option be the preferred option, the CCG will need to increase its QIPP target to cover these costs.

Options 1 and 2 would contribute to the CCG achievement of the challenging QIPP target outlined in the 2022/23 financial plan.

Option 3 is within the level of inflation applied through the CCG financial plan.

The PCCC is being asked to discuss the options, and recommend a preferred option for BQC payments for 2022 – 2023.

The Primary Care Commissioning Committee is asked to agree the preferred option. Subsequently, the PCCC recommendation will be ratified at a future CCG Board meeting once practices have been consulted based on the PCCC decision.

Claire Donovan/Lesley Hardman

CCG Primary Care Commissioning Committee

AGENDA ITEM NO: ……7……

Date of Meeting: …….14th April 2022…….

<table>
<tr><td>TITLE OF REPORT:</td><td colspan="2">Network Contract DES – Requirements for Tackling Neighbourhood Health Inequalities</td></tr>
<tr><td>AUTHOR:</td><td colspan="2">K Oddi/L Hardman</td></tr>
<tr><td>PRESENTED BY:</td><td colspan="2">L Helsby/S Liversedge</td></tr>
<tr><td colspan="3">PURPOSE OF PAPER: (Please be clear e.g. decision(s) required, a discussion, for noting)
Following discussions regarding initial submissions of PCN plans for Tackling Neighbourhood Health Inequalities at PCCC in March, 8 out of 9 PCNs were asked to either:
a) submit revised plans which did not duplicate with other funded DES/ QOF schemes or
b) submit further details re. the model of delivery, proposed outcome measures etc.

Eight PCNs have now resubmitted plans in line with the above requirements. PCCC is asked to agree the recommendations for approval put forward by the CCG's Primary Care Senior Management Team.</td></tr>
<tr><td rowspan="5">LINKS TO CORPORATE OBJECTIVES (tick relevant boxes):</td><td>Deliver the outcomes in the Bolton Joint Health and Care Plan.</td><td></td></tr>
<tr><td>Ensure compliance with the NHS statutory duties and NHS Constitution.</td><td></td></tr>
<tr><td>Deliver financial balance.</td><td></td></tr>
<tr><td>Regulatory Requirement.</td><td></td></tr>
<tr><td>Standing Item.</td><td></td></tr>
<tr><td colspan="3">FINANCIAL IMPLICATIONS [discussed with Chief Financial Officer]:</td></tr>
<tr><td colspan="3">COMMITTEES/GROUPS PREVIOUSLY CONSULTED: N/A</td></tr>
<tr><td colspan="3">REVIEW OF CONFLICTS OF INTEREST:</td></tr>
<tr><td colspan="3">RECOMMENDATION(s)

See final page of attached report.</td></tr>
</table>

PCN Name	Comments from PCCC at meeting in March	Details of Revised/Updated Submission	Recommendation to PCCC
Bolton Central	The proposed interventions linked to LD and SMI overlap with requirements of the existing LD DES and current QOF indicators relating to both LD and SMI. PCN asked to resubmit a plan which does not propose interventions which duplicate the requirements of other services in the DES, national contracts and incentive schemes, and other locally commissioned services. Ensure there is robust evidence for selecting identified populations.	**Population identified:** Early identification of the 'at risk of diabetes' population aged 30-39 in BAME Community To offer blood test and lifestyle advice as population at risk of diabetes. Circa 1130 male and 1090 female BAME patients within the Central PCN aged between 30-39. Statistics indicate higher risk of type 2 Diabetes in BAME patients. Supporting them with lifestyle advice, checking the risk by blood test would help raise awareness in the community about the risk, hopefully learn about the available services, consider improving lifestyle early on to reduce the risk of developing diabetes, receiving an offer for testing and further follow up where appropriate, would help address this inequality. Some statistical data and study is referenced below. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6948201/ **Utilise available data on health inequalities, working in partnership with Integrated Care System, including local medical/pharmaceutical committees, and local authority commissioners** Health innovation workshop, fingertips and practice system searches to identify patients. Liaise with community team and diabetes service re interventions for the individuals; analyse gaps in support and co-design opportunities with CVS.	Evidence supports the PCN's identification of this population as one experiencing inequality in health provision and/or outcomes. The proposed interventions do not overlap with requirements of any other existing DES/QOF scheme – no risk to duplication of work/payment for these areas. The CCG Primary Care Development & Health Improvement Team will work with the PCN to agree definitive outcome measures. **PCCC is asked to approve the plan.**

		All PCN practices were invited in Health Inequalities workshop on 9/12/21. Additional data is noted in row 9D above. PCN will co-design a standard operating procedure involving data searches from the practice systems, and involve guidance from Diabetic Centre. **Hold discussions with local system partner organisations who have existing relationships with the selected population to agree an approach to engagement** Met with Bolton ICP community lead and PH to discuss, inequalities event and discussed with CCG HI lead. **Begin engagement with the selected population to understand the gaps in, and barriers to their care** Liaise with BCOM and CVSE to raise awareness of project; Healthwatch to support facilitation of focus groups and 1:1 engagement with lived experience; BCOM; Asian Elders and ACAB African Community Association Bolton; Caribbean African Health Network. **Define an approach for identifying and addressing the unmet needs of this population** Identified approach: Practice system searches for individuals of BAME groups aged 30-39. Inviting individuals in for health screening to support the early diagnoses of diabetes/prevention of diabetes. Utilising social prescribing team for holistic support/CVSE groups;	

		consider delivery out of GP practice and in alternative community facilities, such as community centres. **<u>Locally defined measures agreed with local commissioners in line with, and co-ordinated between, wider system strategies to tackle drivers of inequalities</u>** Propose: • No of individuals provided with lifestyle advice • No of people diagnosed with diabetes • No of people with HBA1C raised to a defined level (tbc) • No of people with reduced HBA1C annually re-checked **<u>Delivery of relevant interventions or referrals to services that provide these interventions for the selected population</u>** The relevant interventions/referral to services are being delivered by: Diabetes Service; voluntary & community sector support groups; social prescribers; practice teams**<u>.</u>** **<u>Ongoing engagement with the selected population</u>** The PCN will continue to engage with the selected population via: SPLWs, voluntary & community sector including Healthwatch Insight & engagement; BCOM; Asian Elders and ACAB African Community Association Bolton; Caribbean African Health Network.	

		<u>Proceed to deliver the plan referred to above</u> Initial plan to be commenced immediately upon approval; Patient lists ready, Healthwatch ready.	
Chorley Roads	As above	**<u>Population identified:</u>** Cohort of Mental Health Patients who have mild to moderate mental health illness but not classic bipolar, schizophrenia, or LD but those we identify by frequent attenders at out of hours and A&E on multiple medications but not currently under the mental helth team. These vulnerable patients would benefit from face to face review and social prescribing input. Depression is similar in Chorley Roads (9.4%) to Bolton (9.1%), with a register size of 2,404. Analysis at GP practice level depression is not as associated with deprivation as we would expect from wider research. This suggests under-diagnosis in Bolton's more deprived communities. **<u>Utilise available data on health inequalities, working in partnership with Integrated Care System, including local medical/pharmaceutical committees, and local authority commissioners</u>** 9 December 2021 - Health Innovation Manchester data, discussed at Health Inequalities workshop Feb 22 - Ardens dashboard to identify patients not currently identified. Local intelligence from practices and ARRS staff suggests that there are patients with mental health ilness that are not getting	Evidence supports the PCN's identification of this population as one experiencing inequality in health provision and/or outcomes. The proposed interventions do not overlap with requirements of any other existing DES/QOF scheme – no risk to duplication of work/payment for these areas. The CCG Primary Care Development & Health Improvement Team will work with the PCN to define exact cohort and agree outcome measures. **PCCC is asked to approve the plan**.

		the support they need as they are not engaging or have knowledge of the support services available to them. Further patient analysis to take place to establish trends and identify potential inequalities and unmet needs of this cohort of patients. Data will be taken from practice searches. **<u>Hold discussions with local system partner organisations who have existing relationships with the selected population to agree an approach to engagement</u>** 9 December 2021 - workshop with system partners including CCG, Council, Community, VCSE, Engagement plans in development with Healthwatch Bolton; to also bring in other services, including MHIST, GMMH - dependent upon the findings of the patient analysis. Once we have an outline of the plan we plan to meet with the leads in our neighbourhood for 1. Social services 2. Drug and alcohol team 3. Mental Health Team 4. Housing 5. Police – links to neighbourhood on patients who have left prison or have been in trouble (health is usually the last priority) This is simply to inform them what out plans are how they can link in with us to maximise compliance to physical health care in these patients.	

		<u>Begin engagement with the selected population to understand the gaps in, and barriers to their care</u> SPLW to engage with patients Identified from practice lists who have mild to moderate mental illness; to hold face to face conversations with: Mental Health Practitioner, Paramedic and ,mental health services and intergrated neighbourhood practitioners to identify trends in unmet need and barriers. Partnered with Healthwatch Bolton to identify other individuals and groups with lived experience. **<u>Define an approach for identifying and addressing the unmet needs of this population</u>** Identified approach: Work with practices to ensure supported by SPLW; Identify a PCN role (Paramedics) to carry out the health checks for the cohort of patients identfied within the community (non-clinical setting / at home), working with the local community to help with engaging and encouraging and supporting these patients; Recruit specialist Mental Health SPLW to engage with patients; carrying out holistic assessments; understanding needs and gaps in support; make referrals to support services/projects; make recommendations for new activities/projects to fill gaps in provision Take an MDT approach for individual patients if needed.	

		The frequent attendances GP and A&E would help to identify patients with significant depression and anxiety not on the mental health register. If the paramedic identifies any health checks patient would benefit from outwith those due can instigate e.g. book screening for chronic disease if risk identified. So tackling barriers to engage with checks rather than doing checks. **<u>Locally defined measures agreed with local commissioners in line with, and co-ordinated between, wider system strategies to tackle drivers of inequalities</u>** Measures agreed: to be further defined following analysis of patients not had recent health check or engaged with services and trends / patterns identified. **<u>Delivery of relevant interventions or referrals to services that provide these interventions for the selected population</u>** The relevant interventions/referral to services are being delivered by: SPLW to refer to existing services, patient presented to MDT and referred into mental health services if needed. **<u>Ongoing engagement with the selected population.</u>** The PCN will continue to engage with the selected population by: See vi. c above - this will be a continuous and interactive	

		process which will develop further as the trends / needs are identified. **<u>Proceed to deliver the plan referred to above</u>** Initial plan: • 1 March - Cleanse patient lists • 1 March - Step up the PCN team and connect with other partners to develop the plan further • 8 March - Commence stakeholder analysis and engagement plan • 14 - 25 March - Collect patient information from practices • W/C 28 March - carry out analysis; report on trends/patterns; • Mid-April - Co-design / co-develop targeted plan with partners and community	
Halliwell	As above	**<u>Population identified:</u>** <u>Identifying harmful, hazardous and dependent drinkers.</u> Using the practice systems to identify those who are scoring above 5 on an Audit C (currently 1,092 patients), looking further then into individuals consuming harmful volumes of alcohol (currently 1,572 patients) **<u>Utilise available data on health inequalities, working in partnership with Integrated Care System, including local medical/pharmaceutical committees, and local authority commissioners</u>**	Evidence supports the PCN's identification of this population as one experiencing inequality in health provision and/or outcomes. The proposed interventions do not overlap with requirements of any other existing DES/QOF scheme – no

		• 9 December 2021 - Health Innovation Manchester data, discussed at Health Inequalities workshop • March 2022 - practice level data, BQC data & admissions data from CCG, JSNA **<u>Hold discussions with local system partner organisations who have existing relationships with the selected population to agree an approach to engagement</u>** • 9 December 2021 - workshop with system partners including CCG, Council, Community, VCSE • Discussed with CCG HI lead • Engagement of people with lived experience in partnership with Healthwatch • Connect with GMMH Achieve Service to join up outreach opportunities • Liaising with alcohol services to see what alternatives available for the individuals to be offered support. • VCSE and SPLW for social support. **<u>Begin engagement with the selected population to understand the gaps in, and barriers to their care</u>** SPLW - holistic assessment and conversations Partnered with Healthwatch Bolton to identify individuals and groups with lived experience **<u>Define an approach for identifying and addressing the unmet needs of this population</u>** Identified approach:	risk to duplication of work/payment for these areas. There is some work needed to clarify processes, agree definitive outcome measures etc – the CCG Primary Care Development & Health Improvement Team will work with the PCN on this. **PCCC is asked to approve the plan.**

		Provide patients with F2F health check, to address any outstanding reviews/screening not completed. To undertake relevant blood testing to ensure no underlying health conditions due to substance abuse. Deliver vaccinations and check BPs opportunistically as part of this. **<u>Locally defined measures agreed with local commissioners in line with, and co-ordinated between, wider system strategies to tackle drivers of inequalities</u>** Proposed measures: • Improved screening uptake for patients with alcohol misuse. • Annual health checks /physical health check review to identify any early conditions due to alcohol abuse. • Bringing the individuals to the neighbourhood MDT for further input re housing/social needs if required and work in partnership with community team/drug and alcohol service. • Utilising TAPPs/MHPs for lower level mental health caused by substance misuse • Patient lifestyle improvements **<u>Delivery of relevant interventions or referrals to services that provide these interventions for the selected population</u>** The relevant interventions/referral to services are being delivered by: • referrals from SPLW team into other services, identify gaps in services available to patients and work with appropriate services / VCSE groups to fill these gaps.	

		• working with Bolton JSNA on reducing drug and alcohol related harm. Taking any escalations to neighbourhood MDT to liaise with community teams. **<u>Ongoing engagement with the selected population.</u>** The PCN will continue to engage with the selected population by: • NA feedback from patients based on conversations during health checks • utilising links to patients via CVSE • Public health on Bolton JSNA • Healthwatch Bolton focus groups and individual insights **<u>Proceed to deliver the plan referred to above</u>** Staff members recruited into the role to support the project (Nursing Associates, with another to join imminently and additional SPLWS)	
Rumworth	As above	**<u>Population identified</u>** <u>Identifying harmful, hazardous and dependent drinking</u> Circa 600 patients, using practice data, BQC data & admissions data. Using the practice systems to identify those who are scoring above 5 on an Audit C, and looking further into individuals consuming harmful volumes of alcohol and patients abusing drugs and/or other substances, along with admissions relating to alcohol/substance abuse. The PCN is aware that there is a higher than average Eastern European population, who are at risk of higher alcohol intake	Evidence supports the PCN's identification of this population as one experiencing inequality in health provision and/or outcomes. The proposed interventions do not overlap with requirements of any

		than recommended and potential drug use within the local area. **<u>Utilise available data on health inequalities, working in partnership with Integrated Care System, including local medical/pharmaceutical committees, and local authority commissioners</u>** • 9 December 2021 - Health Innovation Manchester data, discussed at Health Inequalities workshop • March 2022 - practice level data, BQC data & admissions data from CCG; JSNA **<u>Hold discussions with local system partner organisations who have existing relationships with the selected population to agree an approach to engagement</u>** • 9 December 2021 - workshop with system partners including CCG, Council, Community, VCSE • Discussed with CCG HI lead • Liaising with alcohol services to see what alternatives available for the individuals to be offered support. VCSE and SPLW for social support. • Engagement of people with lived experience in partnership with Healthwatch • Connect with GMMH Achieve Service to join up outreach opportunities. **<u>Begin engagement with the selected population to understand the gaps in, and barriers to their care</u>**	other existing DES/QOF scheme – no risk to duplication of work/payment for these areas. **PCCC is asked to approve the plan.**

		Partnered with Healthwatch Bolton to identify individuals and groups with lived experience. **<u>Define an approach for identifying and addressing the unmet needs of this population</u>** Identified approach: Provide patients with F2F health check (utilising Paramedics), to address any outstanding reviews/screening not completed. To undertake relevant blood testing to ensure no underlying health conditions due to substance abuse. T refer to SPLWs. **<u>Locally defined measures agreed with local commissioners in line with, and co-ordinated between, wider system strategies to tackle drivers of inequalities</u>** Proposed measures: • Improved screening uptake for patients with alcohol misuse. • Annual health checks /physical health check review and nutrition advice to identify any early conditions due to alcohol abuse. • Bringing the individuals to the neighbourhood MDT for further input re housing/social needs if required and work in partnership with community team/drug and alcohol service. • Utilising TAPPs/MHPs for lower level mental health caused by substance misuse **<u>Delivery of relevant interventions or referrals to services that provide these interventions for the selected population</u>**	

		The relevant interventions/referral to services are being delivered by: referrals from SPLW team into other services, identify gaps in services available to patients and working with services and VCSE to fill these gaps, working with Bolton JSNA on reducing drug and alcohol related harm. Taking any escalations to neighbourhood MDT to liaise with community teams. **<u>Ongoing engagement with the selected population</u>** The PCN will continue to engage with the selected population by: • Paramedic feedback from patients based on conversations during health checks • Utilising links to patients via CVSE • Public health on Bolton JSNA • Healthwatch insights and engagement with focus groups and individuals **<u>Proceed to deliver the plan referred to above</u>** Staff members recruited into the role to support the project (Paramedics and additional SPLWS)	
Westhoughton	As above	**<u>Identify a population</u>** <u>Multi-professional promotion of physical activity and nutrition in young people.</u> We know that the PCN has a higher than average obesity rate. The PCN intend to prioritise education and promotion of physical activity and nutrition advice in younger people.	Evidence supports the PCN's identification of this population as one experiencing inequality in health provision and/or outcomes.

		<u>Utilise available data on health inequalities, working in partnership with Integrated Care System, including local medical/pharmaceutical committees, and local authority commissioners.</u> December 2021 - Health Innovation Manchester data, discussed at Health Inequalities workshop March 2022 - review of public health data (Year 6 obesity rates) March 2022 - review of Bolton Neighbourhood Information via community services March/April 2022 - review obesity hospital related admissions - National Child Measurement Programme. PCN meetings held to review data and discuss HE project options **<u>Hold discussions with local system partner organisations who have existing relationships with the selected population to agree an approach to engagement</u>** 9 December 2021 - workshop with system partners including CCG, Council, Community, VCSE, Engagement plans in development with - lead in child obesity at Public health - physical activity coach (Jess Morehouse) - 0-19's teams - CVS - Lads and Girls club - Bolton at home - Bolton together	The proposed interventions do not overlap with requirements of any other existing DES/QOF scheme – no risk to duplication of work/payment for these areas. **PCCC is asked to approve the plan.**

		- Healthwatch Bolton to support patients engagement re lived experiences PCN manager arranging kick of meeting with all partners identified **<u>Begin engagement with the selected population to understand the gaps in, and barriers to their care</u>** SPLW - lead on co-design of support materials to patents and their families Public health and 0-19's team to proactively share support mechanisms and data Partnered with CVS to identify groups available. Look at sharing data / intelligence with public health, CVS and 0-19's teams. **<u>Define an approach for identifying and addressing the unmet needs of this population</u>** Identified approach: - Review target groups using PH data - Allocate SPLW to lead on social media campaign - Allocate a PCN physical health campion - Develop comms leaflet for patients and family re: support info and groups -Utilise nutrition/physical activity promotion videos via website and other social media avenues -review options available for indoor, outdoor, individual and group activities.	

		<u>Locally defined measures agreed with local commissioners in line with, and co-ordinated between, wider system strategies to tackle drivers of inequalities</u> Proposed measures - Increase awareness in targeted groups - make information accessible via social media and general practice - physical activity coaching to be delivered to all PCN clinicians - mapping of existing provision and gap analysis utilising CVS and SPLW local knowledge. **<u>Delivery of relevant interventions or referrals to services that provide these interventions for the selected population</u>** The relevant interventions/referral to services are being delivered by: General Practice Lads and Girls club SPLW CVS Public health **<u>Ongoing engagement with the selected population.</u>** The engagement with these patients will be an ongoing through the PCN and partners outlined above. **<u>Proceed to deliver the plan referred to above</u>**	

		Initial plan: 1 March - Gathering patient info and data 1 April onwards - Engaging with the above MDT's	
Horwich	Approved plan in principle. More detail needed on the approach for identifying and addressing the unmet needs of this population; the proposed locally defined measures to tackle drivers of inequalities and a description of how the relevant interventions/referral to services will be delivered.	**Identify a population:** Identifying cardiovascular risk in 30-39 year olds from BAME population Target Group and Rationale: 969 patients have been identified from Asian Ethnic Background. Patients from the Indian subcontinent have a distinct cardiovascular risk profile with profound health consequences. South Asians tend to develop more severe coronary artery disease at a younger age, and may also suffer from earlier myocardial infarction and heart failure. **Key actions/By Whom/By When** • To engage with trusted locations to host the screening pop ups-BG/ ZA-May-22 • make contact and meet with the HIP manager-BG-Apr-22 • Invite the identified population to the screening pop ups- Practices within the PCN- Commence in June 2022 sustained throughout the year • Comparing the data from the COVID 19 Vaccination programme. Assisted in the approach to help decide our target as we considered the age of the population and compared with the achievement for the COVID 19 programme.	Evidence supports the PCN's identification of this population as one experiencing inequality in health provision and/or outcomes. The proposed interventions do not overlap with requirements of any other existing DES/QOF scheme – no risk to duplication of work/payment for these areas. **PCCC is asked to approve the plan.**

		• Marketing/ Communication campaign, via voluntary sectors, and other community champions- BG/ZA/ Voluntary sectors - June and ongoing throughout the year. • Monitor achievement via monthly reports and discussion in monthly PCN meetings.- BG/ZA- Jun-22 • Flexible approach will be taken to ensure we achieve the best possible outcomes. Will gain feedback and monitor from patients that attend for a review.- BG/ZA- From June 2022 • Monitor uptake from the trusted venues, and offer more pop ups from the most popular venue. We will capture Qualitative and Quantitative data throughout the project. - BG/ZA- Aug-22 • To identify any language barriers and utilise appropriate translation skills - BG/ZA- Ongoing	
Turton	Approved plan in principle. More detail needed on the how the relevant interventions/referral to services will be delivered.	Not yet received.	
Breightmet & Little Lever	This submission was a preliminary effort to outline all possible priority areas with the intention being to narrow down to specific population(s) at a workshop attended by	**<u>Populations identified:</u>** <u>Smokers</u> This will inevitably have good consequences for other targets we have previously mentioned (e.g. premature births/ hypertension etc) • Healthy Life Expectancy in women (5.5 years lower than the national average, compared to 0.9 years for men)	Evidence supports the PCN's identification of these populations as cohorts experiencing inequality in health provision and/or outcomes.

	all PCN practices on 6 April 2022. PCCC supported the proposed approach and awaited submission of the final plan.	○ Women's groups. SPLW essential to helping tackle this. • Premature births (higher rates than NW/ GM/ Nationally) ○ Visit schools to discuss with girls (and boys) to help prevent starting smoking ○ Liaise with school nurses. What can we do to help? • Hypertension (higher rates than NW/ GM/ Nationally) ○ Engage with pharmacists ○ BP machines in waiting rooms ○ HIPs in waiting rooms ○ HIPs in Morrison's car parks etc • Smoking (higher rates than NW/ GM/ Nationally) ○ Signposting from SPLW ○ Outreach days in Morrisons Car Park for example ○ Communications team to set up PCN website and run social media campaigns ○ ?Incentivise smoking cessation ○ Restart smoking cessation clinics? • Smoking in Pregnancy (higher rates than NW/ GM/ Nationally) ○ Liaise with Midwifes. How do they encourage smoking cessation (and flu jabs too!). How can we help? ○ ?Incentivise smoking cessation ○ Dispel myths- smoking makes smaller babies= easier to deliver! • Improve prevention ○ Engage with pharmacists ○ Restart smoking cessation clinics?	The proposed interventions do not overlap with requirements of any other existing DES/ QOF scheme. There is no risk to duplication of work/payment for these areas; however the CCG is currently developing a Bolton-wide spirometry offer which would likely impact on one element of the PCN's proposed interventions. There is further work needed to clarify how the relevant interventions will be delivered to these cohorts as well as agreeing definitive outcome measures etc – the CCG Primary Care Development & Health Improvement Team will work with the PCN on this. **PCCC is asked to approve the plan.**

		- HIPs - Better diagnostics of COPD (high rates within Bolton) - Fund a spirometry hub (potentially within EPC) - Better diagnostics of Asthma (high rates and ED attendances within Bolton) - Fund 1x FENO machine and work from EPC - Possibly fund ACP with specialist interest in Spirometry/ asthma/ COPD <u>Patients classed as obese</u> Again tackling one aspect (obesity) will have numerous knock- on effects - Healthy Life Expectancy in women (5.5 years lower than the national average, compared to 0.9 years for men) - Improve mobility and healthy life - SPLW to link up women to groups to help encourage exercise/ diet etc - SPLWs to help refer to digital weight management - Diabetes (higher rates than NW/ GM/ Nationally) - SPLWs to help refer to digital weight management - Hypertension (higher rates than NW/ GM/ Nationally) - SPLWs to help refer to digital weight management - Physically inactive adults (higher rates than NW/ GM/ Nationally) - Liaise with gyms and see if any incentivised schemes can be arranged	

		• Obesity in adults (higher rates than NW/ GM/ Nationally)
		• Obesity in children (higher rates than NW/ GM/ Nationally)
		  ○ Free gym membership- ?criteria
		  ○ SPLW walking groups/ weight loss clinics etc
		  ○ Digital Wt management referral levels
		  ○ HIPs in Morrison's car parks etc
		  ○ HIPs in waiting rooms
		  ○ Discuss in schools re: diet and exercise
		  ○ ?Incentivise fruit and veg for families	