Primary Care Commissioning Committees Meeting in Common

to be held on 28 September 2017, 10.00 – 11.30 am
Rudyard Room, Staffordshire Place 1, Stafford ST16 2LP

AGENDA

A=Approval R=Ratification S=Assurance I=Information D=Discussion

		Enc	Lead	A/R/S/I	Timing
1.	Welcome by the Chair	Verbal	HI	-	10.00
2.	Apologies	Verbal	HI	-	
3.	Quoracy	Verbal	HI	-	
4.	Declarations of Interests and actions taken to manage conflict	Enc. 01	HI	-	
5.	Minutes of the Meeting held on 26 July 2017	Enc. 02	HI	A	
6.	Actions Sheet	Enc. 03	HI	A	

Assurance

7.	Risk Register	Enc. 04	EW	S / I	10.10

Strategic Matters

8.	GP Forward View • Extended Access	Enc. 05	MR	I	10.15
9.	LES review	Enc. 06	MR	I	10.25
10.	Mid-Year Review – Delegated Commissioning	Verbal	LM	I	10.35
11.	Finance Report	Enc. 07	DS	I	10.45
12.	360^0 feedback action plan	Enc. 08	EW	I	10.55
13.	Research Update	Verbal	Mark Stone	I	11.05
14.	Accessible Information Standard Update	Enc. 09	Sabrina Richards	I	11.15

Items for Information

15.	Questions from Members of the Public		All	D	11.25
16.	Glossary of terms - Glossary of Terms	Enc. 10	All	I	11.30
17.	Date, Time and venue of next meeting 10.00 am on Thursday 26 October 2017 Venue to be confirmed Tamworth/Lichfield	-	All	A	

CANNOCK CHASE CLINICAL COMMISSIONING GROUP, SOUTH EAST STAFFORDSHIRE & SEISDON PENINSULA CLICNAL COMMISSIING GROUP
STAFFORD & SURROUNDS CLINCAL COMMISSIONING GROUP
CONFLICTS OF INTEREST REGISTER 2017/18
PRIMARY CARE COMMITTEE
AS OF28 JUNE 2017

Item 4 Enc 01

CCG	Forename	Surname	Role in the CCG	Directorships held in private companies, PLCs	Ownership of private companies, businesses, consultancies	Shareholdings in health & social care	Positions of authority in field of health and social care	Connection with voluntary,other organisation	Research funding/grants	Any other role or relationship which the public could perceive would impair or otherwise influence the individual's judgement or actions in their CCG role
Members										
SAS CCG	Harry	Ireland	Lay Member - Governance	Non-Executive Director with the Wrekin Housing Trust, Telford	None	None	None	None	None	Chair of the Police Misconduct Panel, West Midlands Region
CC CCG	Neil	Chambers	Lay Member - Governance	Old Hall Partnership Darlaston Town (1874) Football Club	None	None	None	None	None	Independent Board Member Community Housing Group
SAS CCG	Sue	Harper	Lay Member - Patient and Public Interest	None	None	None	None	None	None	Justice of the Peace, South Staffordshire Bench
SES CCG	Anne	Heckels	Lay Member - Patient and Public Interest (PPI) / Finance and Performance	Director / Company Secretary for Sutton Support Services Ltd (not for profit social enterprise providing services to adults with special needs, Birmingham)	None	None	Director / Company Secretary for Sutton Support Services Ltd (not for profit social enterprise providing services to adults with special needs, Birmingham)	None	None	Member of Patient Participation Group at Spires Practice Member of South Staffordshire and Shropshire Healthcare NHS Foundation Trust (SSSFT) Family Member is an employee shareholder - NORR Consulting, providing architectural services to public service
SES CCG	Jennifer	Jobson	Lay Member - Governance and Audit	None	None	None	None	None	None	None
CC CCG	Janet	Toplis	Lay Member	None	`	None	Vice Chair of Adoption and Permanence Panel for Walsall Borough Council	None	None	Chair of a Staffordshire Primary School
In Attendance										
CC CCG	Tracey	Cox*	Senior Primary Care Development Manager	None	None	None	None	None	None	A CQC Specialist Advisor (non-clinical) undertaking CQC inspections in GP practices (not Staffordshire area)Adhoc consultancy works outside core working hours for Long Term Conditions Network, West Midlands Academic Health Science Network
SES CCG	Andy	Hadley*	Senior Primary Care Development Manager	None	None	None	None	None	None	Chair of Intelligent Customer Forum for Staffordshire and Shropshire Health Informatics Service (HIS)
SAS CCG	Paddy	Hannigan	Chair of Governing Body	None	Partner at Holmcroft Surgery	Practice is a member and shareholder in GP First Ltd. (GP Federation)	None	None	None	Spouse is a Consultant Neonatologist at University Hospital North Midlands (UHNM)
CC CCG	Mo	Huda	Chair of Governing Body	None	Partner at Aelfgar Surgery	Practice is a member and shareholder in GP First Ltd. (GP Federation)	None	None	None	AQP Provider uses practice for Ultrasound scans and Hearing Aid Chair Educational meetings for various PHARMA companies Practice is a member and shareholder in GP First Ltd (GP Federation)
NHS England - North Midlands	Darrell	Jackson*	Primary Care Lead	None	None	None	None	None	None	Lives within the CCG area
SES CCG	John	James	Chair of Governing Body	None	None	None	None	None	None	None
CC CCG	Sarah	Jeffery*	Senior Primary Care Development Manager	None	None	None	None	None	None	None

CCG	Forename	Surname	Role in the CCG	Directorships held in private companies, PLCs	Ownership of private companies, businesses, consultancies	Shareholdings in health & social care	Positions of authority in field of health and social care	Connection with voluntary,other organisation	Research funding/grants	Any other role or relationship which the public could perceive would impair or otherwise influence the individual's judgement or actions in their CCG role
SES CCG	Gulshan	Kaul	General Practitioner	None	None	None	None	None	None	Secretary South Staffordshire LMC Medical Director Lichfield & Burntwood Network Member Stafford and Stoke on Trent Health and Care Transformation Board Member of Alexin Healthcare
SAS CCG	Lynn	Millar*	Executive Director of Primary Care	None	None	None	None	None	None	None
SAS CCG	Anne	Perry*	Finance Manager	None	None	None	None	None	None	None
	Mark	Rayne	Deputy Director of Primary Care	Director, Mark Rayne Consultancy Limited	Director, Mark Rayne Consultancy Limited	None	None	None	None	None
SAS CCG	Vanessa	Ridout*	Executive Assistant	None	None	None	None	None	None	None
SAS CCG	Sarah	Turner*	Primary Care Development Manager	None	None	None	None	None	None	None
SAS CCG	Lynn	Tolley*	Head of Quality and Safety	None	None	None	None	None	None	None
SES CCG	Eleanor	Wood*	Primary Care Development Manager	None	None	None	None	None	None	Family member works at Coventry and Rugby CCG
SAS CCG	Sally	Young*	Director of Corporate Governance, Communications & Engagement (In attendance - Non Voting)	None	None	None	None	None	None	None

* Individual/role works across Cannock Chase CCG, South East Staffordshire & Seisdon Peninsual CCG, Stafford & Surrounds CCG.

Cannock Chase Clinical Commissioning Group
South East Staffordshire and Seisdon Peninsula Clinical Commissioning Group
Stafford and Surrounds Clinical Commissioning Group

The healthiest place to live and work, by 2025

Primary Care Commissioning Committees Meeting in Common

Wednesday 26 July 2017
2.00 pm – 3.30 pm
Trentham Room, Staffordshire Place 1, Stafford STG16 2LP

Members:	Quoracy	27/04/2017	24/05/2017	22/06/2017	26/07/2017	24/08/2017	28/09/2017	26/10/2017	22/11/2017	19/12/2017	31/01/2018	22/02/2018	29/03/2018
Harry Ireland (HI), Chair – Lay Member Stafford & Surrounds (S&S) Clinical Commissioning Group (CCG)	Three members	✓	✖	✖	✓	Meeting postponed							
Neil Chambers (NC), Lay Member Cannock Chase (CC) CCG		✓	✓	✖	✓								
Sue Harper (SH), Lay Member S&S CCG		✓	✓	✖	✓								
Anne Heckles (AHe), Lay Member South East Staffordshire & Seisdon Peninsular (SES&SP) CCG		✓	✓	✓	✓								
Jeni Jobson (JJb), Lay Member SES&SP CCG		✓	✓	✓	✓								
Jan Toplis (JT), Lay Member CC CCGs		✖	✓	✓	✓								
In attendance:													
Tracey Cox (TC), Primary Care Development Manager, S&S CCG		✖	✖	✓	✖								
Andy Hadley (AHa), Senior Primary Care Development Manager SES&SP		✖	✓	✖	✖								
Dr Paddy Hannigan (PH), GP Chair S&S CCG		✖	✓	✖	✓								
Dr Mo Huda (MH), GP Chair CC CCG		✖	✓	✓	✖								
Darrell Jackson (DJ), Primary Care Lead NHS England (NHSE) – North Midlands		✖	✓	✓	✓								
John James (JJ), GP Chair SES&SP CCG		✓	✖	✖	✓								
Sarah Jeffrey (SJ), Head of Primary Care Development, CC, SES&SP and S&S CCGs		✓	✓	✓	✓								
Gulshan Kaul (GK), Secretary South Staffordshire Local Medical Council (LMC)		✖	✖	✓	✖								
Lynn Millar (LM), Executive Director of Primary Care, CC, SES&SP and S&S CCGs		✓	✓	✓	✓								
Anne Perry (AP), Finance Manager – Primary Care CC, SES&SP and S&S CCGs		✓	✓	✓	✖								
Mark Rayne (MR), Interim Deputy Director of Primary Care, CC, SES&SP and S&S CCGs			✓	✓	✖								
Vanessa Ridout (VR), Executive Assistant –		✓	✓	✖	✓								

Members:	Quoracy	27/04/2017	24/05/2017	22/06/2017	26/07/2017	24/08/2017	28/09/2017	26/10/2017	22/11/2017	19/12/2017	31/01/2018	22/02/2018	29/03/2018
Minute Taker, S&S CCG													
Sarah Turner (ST), Primary Care Development Manager CC, SES&SP and S&S CCGs		✖	✓	✖	✓								
Eleanor Wood (EW), Senior Primary Care Development Manager (Lichfield Locality) SES&SP CCG		✓	✖	✖	✓								
Rebecca Wood, Head of Commissioning Primary Care, NHSE		✖	✖	✖	✓								
Sally Young (SY), Assistant to the Chief Executive, CC, SES&SP and S&S CCGs		✓	✖	✖	✓								
Jess Wood (JW), Executive Assistant – Minute Taker, S&S CCG				✓									
Andrew Morrall, Primary Care Contract Manager, NHSE		✓											
Phil Morgan, GP Forward View Project Manager, NHSE		✓											
Lynn Tolley, Head of Nursing, Quality and Safety, CC, SES&SP and S&S CCGs					✓								
Adele Edmondson, Comms & Engagement, MLCSU					✓								
Kimberli Mckinlay, Head of Commissioning Finance, CC, SES&SP and S&S CCGs					✓								

		Action
1.	**Welcome by the Chair** NI welcomed everyone to the meeting. This was the first meeting to be held in public and NI welcomed those that attended. HI advised that at the end of the meeting members of the public would be given the opportunity to ask any questions relating to items on the agenda.	
2.	**Apologies for Absence** Apologies were received from: Mo Huda Gulshan Kaul Paul Simpson Anne Perry	
3.	**Quoracy** It was noted that the meeting was quorate.	
4.	**Declarations of Interests and Actions taken to manage conflict** The Committee received the Declarations of Interest Register. John James declared that he is also Interim Medical Director of the STP.	
5.	**Minutes of the Meeting held on the 22 June 2017** The minutes of the previous meeting were approved as a true and accurate record of the meeting.	

		Action
6.	**Action Sheet** Action Sheet was updated noting the following Ref 66/65 – 360^0 degree feedback action plan to be presented to the September meeting. **Forward Plan : 360^0 degree action plan to September meeting** Ref 50 – Delegated Commissioning. Deferred to September meeting. **Forward Plan : Delegated Commissioning update to September meeting** Ref 60 – Terms of Reference. The ToR have now been signed off by NHSE and are available as part of the CCG constitution.	
7.	**Risk Register** EW presented the risk register to the Committee. There are a total of 12 risks for primary care. There have been no new risks added in month. One risk is pending closure and is being reviewed by the Risk Group 12 risks in total for PC. No new risks this month. One risk pending closure view by risk group regarding practice that received inadequate rating but has now merged. This relates to a practice that had been rated inadequate by the CCG but has now merged with another practice. There are 7 risks scoring 8 – 12 (high); none above 15 (extreme) and there are no risks being reporting to Governing Body. The Senior Primary Care Development Manager and the Governance Manager have undertaken a review of all the risks and the risk description. There has been one risk transferred to the Commissioning Team. Members asked for an updated on the following risks: Risk 271. This relates to recruitment within the Medicines Optimisation Team. LM confirmed that Sam Buckingham (SB) has been appointed as Head of Medicines Optimisation. SB previous post is currently going through the recruitment process. Risk 227. This relates to discharge letters from Heart of England NHS Foundation Trust being sent electronically via the Central Hub. This is an issue for practices in the SES CCG where patients go to Heart of England and Good Hope Hospitals. Andy Hadley will be asked to provide a further update to the September Committee. **Forward Plan : AH to provide an update on issues at Heart of England and Good Hope Hospitals to the September meeting** Risk 256. This relates to funding. NC asked whether this risk could be removed now that the CCG has delegated commissioning. HI responded by saying that the risk should remain as there may be unknown scenarios during the first 12 months of delegated commissioning that neither the CCG nor NHSE had	**AH**

		Action
	anticipated. Risk 20. This relates to variation in performance in practices. Quality visits are being undertaken but the risk is unclear as to whether the risk relates to one or all practices. EW confirmed that for SES and SP every practice has received a visit. SAS have also all had a visit and quality visits will be extended to Cannock Chase practices this financial year. Going forward all practices will receive a visit this year. PH suggested more information be provided on the risk. At the Governing Body a QIPP workshop had taken place looking at practice performance at locality level which showed variances across the patch. LM commented that the risk is around variation, the 'plan on a page' targets a number of areas and benchmarks practice highlighting the variations. LM felt it may be useful for the committee to have sight of the 'plan on a page' ST commented that Cannock did not have quality visits last year but half of the practices will be visited this year and the other half next financial year. The practices visited this year will be prioritised based on the Plan on a Page. Visits are being set up from September to March. A further update will be submitted to the October Committee. **Forward Plan: Plan on a Page to be submitted to the October Committee.** JT asked that members are mindful when using acronyms during the meeting as members of the public may not be familiar with the terminology.	
8.	**GP Forward View** **Delivery Programme** LM presented the GPFV Delivery Programme to the Committee The report outlines a pan-Staffordshire approach to support the delivery of the GP Forward View across the 6 CCGs in Staffordshire and Stoke on Trent. This is one of 9 national priorities and is being monitored by NHSE at regional level. Each CCG footprint submitted their GPFV plan to NHSE in February 2017. Feedback from the NHSE assurance process gave Staffordshire a blend of red, amber and green ratings and suggested that the CCGs should work more closely together to ensure a consistent approach to delivering the plan. The CCGs will work collaboratively to share collective resources, reduce duplication and ensure delivery of the collective and individual CCG milestone. It is proposed to have one programme management office (PMO) to support delivery and feed into the relevant organisations and committees. The NHSE Programme Office is best placed to support the GPFV delivery as it was an externally funded resource and provides a supportive approach with minimal bureaucracy. In terms of the programme plan, LM as Director will support the coordination of a single programme of work across Staffordshire. Rebecca Woods is the GPFV Lead for NHSE. There are five programmes of work and a process for identifying leads for each is currently underway. A single implementation plan has been developed which pulls together the existing plans and milestone for each individual CCG. A high level	

		Action
	implementation plan has been developed and is currently being populated with milestones and actions and will be presented to the Committee for approval and assurance. The Committee are asked to: Approve the proposed approach to the programme management of the GPFV Approve the proposed governance arrangements Receive further programme updates and confirm frequency of reporting arrangements Receive overarching GPFV Delivery plan Note their roles and responsibilities SH questioned where the patient voice is with regard to the programme. LM responded by saying that although this is not detailed within the paper, work is progressing with the Head of Engagement to ensure adequate public engagement in each scheme but in terms of overall engagement it is something that needs to come back to the committee, it could then be disseminated via the Patient Council. NC asked about clinical leads and their appointment and also how the programme is being funded. LM responded by saying that the leadership around the programme are looking to have GP leads for each area and are linking into the current leadership via the Locality and Membership Boards. Each programme will be setting up a task and finish group which will include CCG officers, patients and clinical leadership. In terms of the money, there is additional funding of £6 per head of population to deliver extended access plus investment into the Brighton and Hove model. LM has asked Vicky Hilpert the Finance Director to present back to the Committee in September an overarching financial plan. The additional funds will come from NHSE. For clinical leads, it is anticipated that the existing clinical leads are involved in the programme and one lead has been appointed in Stafford and Seisdon and talks are progressing in Cannock. Members **APPROVED** the recommendations. **Workflow** SJ presented the report to the Committee. As part of the GPFV a new national three year 'Releasing Time for Patients' programme was introduced to reach every GP practice in the country, freeing up to 10% of GPs. These are referred to as the 10 high impact actions and the report is specifically in relation to high impact action 5 – productive workflows and the South Staffordshire CCG's training programme. As set out in the GPFV published in April 2016, Brighton & Hove have a number of practices who had developed a robust protocol to allow clerical staff to read, code and where appropriate take action on incoming clinical correspondence, rather than the GP having to deal with every letter. Brighton & Hove (HERE) is a not for profit organisation that is made up of GP practice staff and GPs and have trained over 300 practices and currently are the only accredited company for this training. Evidence suggests that now only 20% of letters previously directed to a	

		Action
	GP require their direct input, 80% would be dealt with by clerical staff. It is estimated that this is saving an average of 30-40 minutes of each GP's time per day once training has been completed. Training includes clear mechanisms to provide internal governance and auditing of activity. GPs report being satisfied with the safety of the approach, the improved quality of coding and the release of their time. Clerical staff report that they are confident to run the new process and describe renewed job satisfaction. There are a number of benefits from the training programme including accurate and consistent information entered onto medical records; stewardship of the patient journey including follow up appointments; freed up clinical time; upskilling of staff; increased resilience within the practice and between practices National funding is available for the training and NHSE have provided additional funding as the training is slightly more expensive than what is provided nationally. The training includes 4 full days for administrators and ½ day for the GP champion. A year of implementation support is also offered. Local engagement has happened and the training has been received positively with the training programme established for 6 of the 68 practices across the patch. JT commented that it was quite a departure from doctors not reading letters. She felt that patients may want to know more about the changes particularly that feedback would come via the administrator and not a doctor and asked how this is being communicated to patients. SJ responded by saying that as part of the GPFV, they are looking at the communication strategy and patient engagement and this needs to happen. There are a number of avenues that can be explored to include patients including PPGs and Patient Council Rebecca Woods joined the meeting at 14.27 NC asked PH for his views as a clinician and whether it felt that this was the right way forward. PH responded by saying that yes it was. GPs have seen a huge increase in the number of letters coming into the system but don't need to read all of them, some letters are just to say that an appointment date has been sent to a patient. There are also a number of tasks that come out of those letters an i.e. change to medication, follow up appointments etc. and by transferring this work from a clinician to an administrator this is freeing up clinical time. Staff will be trained to the relevant standard and patients can be assured that a safety aspect is built into this training. SJ confirmed that it will be existing practice staff who undertake the training and these staff are already covered by data protection. JJb asked about the date of implementation and how it will be monitored. SJ responded to say that there is a schedule for practices to undertake the training over the autumn. In terms of the programme, a GP Champion role within each practice will support the administrator to develop their skills through supervision for a six month period following training. There will also be a robust audit and feedback process in place. A further update would come back to the January Primary Care Committee.	

		Action
	Forward Plan : Workflow update to January 2018 meeting Members **RECEIVED** the report.	
9.	**Locality Organisation Development** LM provided an update on locality organisation development and informed members that one of the programmes of work in the GPFV is the New Models of Care Programme. Essentially the GPFV recognises that practices need to work across a larger footprint to improve care to patients. 23 localities/networks have been established working together in 9 localities in Staffordshire covering all 68 practices. There are 3 in Stafford, 3 in Cannock and 3 in SES & SP. These networks are working together to help and support primary care services at scale including nursing home care and community services. Practices have come back to say that localities are meeting as provider groups and have approached the CCG to see if they would fund organisational development. This is felt to be a reasonable approach and a paper would be brought back to the Committee outlining resource and the type of support required for them to work better. RW commented that NHSE have recognised a gap around the need for organisational development for practices and to work collaboratively and has flagged this to Direct Commissioning Organisation and NHSE North Midlands. The issues have also been escalated to Region and are asking for additional resource locally.	
10.	**Finance Update** KMc presented the Month 3 finance update to the Committee and advised members that confirmation had been received from NHSE that any prior issues from last year would be covered off and will be willing to discuss non-recurrent support. Cannock Chase CCG has an annual budget of £17.7m, they are currently showing an underspend of £37k at month 3 and are forecasting breakeven at year end. Stafford & Surrounds CCG have an annual budget of £20.2m, they are currently showing an underspend of £25k and are forecasting breakeven at year end. South East Staffs & Seisdon Peninsular have an annual budget of £26.9m, they are currently showing an underspend of £9k and are forecasting breakeven at year end. NC asked if there was to be an underspend at month 10, is there a role for the committee in prioritising where the money goes or not and if the committee has no role how is this distributed? KMc responded to say that any underspend in primary care stays and will link in with primary care, if there are going to be any issues then the organisation needs	

		Action
	to look at what the priorities can be. Where there is an opportunity to use underspends then these would be brought back to the committee. JJ asked about 'Other GP Services' and what these are. KMc was unsure of the detail but would speak with Anne Perry for her to provide an update. Members **RECEIVED** the report.	**KMc**
11.	**GP resilience programme update (2016/17 and 2017/18)** SJ presented the report to the Committee. The GP resilience programme aims to deliver a menu of support to help practices to become more sustainable and resilient in the supply of care to patients. NHSE lead on the programme of work and work in collaboration with the CCG and LMC. In 2016/17 a total of £16m was available nationally with £8m available every year after until March 2020. A menu of help for supporting practices was developed, these included: • Rapid intervention and management support to practices at risk of closure, diagnostic services to quickly identify areas for improvement support • Specialist advice • Coaching/supervision/mentorship • Practice management capacity support • Support to practices struggling with workforce issues • Personal resilience training A process was established last year asking for expressions of interest for funding. A panel assessment took pace with representatives from NHSE, the CCGs and LMC. Some practices were asked to work collaboratively in terms of the funding allocation to gain some economies of scale. A total of £114k was allocated across the 3 CCGs. For 2017/18 a total of 14 bids were received from the 3 CCGs although multiple requests for funding are within the expressions of interest. Further work will now be undertaken on those expressions of interest that are able to be taken forward and are within the budget available of approximately £150k. Practices will be written to shortly to inform them of the outcome of the panel. The Committee are asked to receive the report for information. AH commented that the programme is for practices that have realised that they have a resilience issue and asked what is being done where officers feel that there may be an issue and how are those practices being supported. SJ responded by saying that this is being built into the overall programme of work. RW also commented that they are using soft intelligence from the CCG, LMC and NHSE colleagues and are aware of those practices and appropriate support is offered. JJb asked about where support is coming from as there is a lot of specialist	

		Action
	support required. RW responded to say that across Staffordshire there is a whole range of support available with the necessary expertise. This is being documented and tightly managed through the Memorandum of Understanding with the practices. Case studies will be collated which will be shared and also covers what's worked well. The CCG are looking at how to share this intelligence and whether it could go on the website. RW confirmed that the resource does come from NHSE and sometimes need to think outside the box and look at admin & clerical support, technology and other practices sharing information. PH commented that the programme highlights very specific issues that practices are close to collapsing and that there has been a steady reduction in their profit line income over the last 7 years. There is also a reduction of the number of GPs and demographic data shows that a third of GP workforce could be lost over the next 5 years and this programme hopes to bridge that gap. The priority is to target those practices that are high risk.	
12.	**GP Patient Survey results published July 2017** LM provided an overview of the CCGs results of the national GP patient survey published in July 2017. The survey is an independent survey run by IPSOS Mori and gives patients the opportunity to share their experience of their GP practice. The response rate was high for January – March 2017 across the CCGs and was higher than the national average. The results of the survey will be used to inform the GP quality dashboard in terms of quality improvement and assurance by practice level. The results will also be discussed during individual GP visits taking place from the autumn. AH asked if a specific paper could be brought back to the Committee at the end of the year that gives some real indication on how these issues are being tackled and not just rolled forward. LM responded by saying that the survey is an indicator of the state of the system and recognised that there needs improvement. PH confirmed that at the practice visits he has been involved in, there have been discussions with each practice and practices have focused on specific i.e. confidence in nursing, there are different solutions in different practice and these are brought to Governing Body. NC stated that there is always a tolerance in statistics and the survey gives no idea of sample sizes and could well be for any CCG. There is other information and if that all tally's with the soft intelligence that is fine but to use on its own is high risk. PH confirmed that a sense check is undertaken Members **RECEIVED** the report.	
13.	**Primary Care Quality Assurance Process Proposal** LT presented the proposal to the committee and advised members that the paper provides an overview of the draft proposed arrangements for the primary care quality assurance process. LT highlighted phase 3 of the scope to members, this phase will look to develop enhanced intelligence reporting and develop information sharing processes. The paper also provides detail on the quality dashboard review process which will be managed by each CCG. The outcome is to agree the actions to be taken	

		Action
	and provide assurance to this Committee on the quality of Primary Care Medical Practices. The Quality Assurance Process proposal will go to the Quality Committee for final sign off. There is currently no proposal for lay members to sit on the group however there are members already on the Quality Committee. The proposal is for a quarterly report to be submitted to Primary Care Committee and members were happy with this approach. **Forward Plan : Primary Care Quality Assurance Report to be submitted quarterly to PCC.**	
14.	**CQC update** SJ informed the committee following a CQC inspection to Dr Murugan's practice in Cannock in May, the practice received an overall rating of 'inadequate'. Inspectors did rate the practice 'good' for caring service and responsive to people's needs. The CQC recognised that the practice does receive positive feedback from patients who are being treated with compassion, dignity and respect. NHSE and the CCG are working closely with the practice on all issues and are developing an action plan. The GP support team are also working with the practice linking in with NHSE and the CCG.	
15.	**Members of Public Questions**	
	Beth Henderson – asked about admin work being taken over by receptionists to cut down on GP time and whether it would be appropriate for a patient group to do a dip survey to give some reassurance to patients that are asking questions about getting a letter from a receptionist rather than a doctor. PH provided a response by saying that the admin work relates to patient specific information that couldn't be shared. Data is protected and personal data would have to be removed and would the data then be valuable. LM commented that under section 276 statute says that the CCG cannot use patient level information for commissioning services so felt that this wouldn't be possible but could get legal advice. PH commented that the range and breadth of correspondence is vast and that there may be a possibility of working with patient groups on the type of levels received. LM also commented that the training hasn't started yet but this should underpin the process and only specific correspondence is triaged by the receptionist and admin staff so this should strengthen the process. SY commented on the need to collect soft intelligence from practices and either take through the CCG or PPG and then through to the Commissioning Council but felt it is really useful to get the feedback and to use the information to improve the process. Jean Waller, patient rep from Rugeley – didn't recall that an email was sent out regarding the Committee referred to any meetings and that the notification about the meeting was sent late. HI responded by saying that today's meeting is the first public meeting and therefore minutes wouldn't have previously been available however the minutes	

		Action
	from today's meeting would be. A member of the public asked about the remit of primary care and understood that the ambulance service are part of primary care and asked how the meetings come together to discuss mutual issues given the SPT needing most improvement. LM responded by saying that primary care is GPs, Pharmacy, Dentists and Opticians. Delegated commissioning from NHSE is only for GP services. The ambulance service is considered outside of primary care. There is however a monitoring process and performance reporting to all providers including the ambulance service. This committee only focuses on GPs. JT also commented that the Joint Quality Group also scrutinises information in terms of quality care for patients. A member of the public asked how much time would be freed up using the Brighton and Hove system. SJ responded by saying it is estimated that this is saving an average of 30-40 minutes of each GP's time per day once training has been completed.	
14.	**Items for Information** **Forward Plan** See minutes for items to be included within the forward plan. **Glossary of Terms** Noted.	
15.	**Any item to be communicated and/or how can engagement be improved?** HI asked attendees whether they felt the meeting had met its objectives and were there any learning points from today's meeting. LM commented that key learning is around communication and engagement with patients which needs to be factored into existing engagement groups. AH commented that in terms of accessibility across the patch that the meetings in public need to be rotated across the patch. SY asked members of the public if they had been able to hear the discussions. Feedback was that hearing is an issue and it would have been better if the room was set up in horseshoe rather than members have their back to the public. It was also felt that it would have been useful to have the enclosures. It was confirmed that the papers would be placed on the CCG website. HI thanks the members of the public for their attendance.	
16.	**Date, Time and Venue of next meeting** The August meeting has been **POSTPONED** due to a high number of apologies. The next meeting will take place on 28 September 2017 at 10.00 am. Venue to be confirmed.	

PRIMARY CARE COMMISSIONING COMMITTEE MEETING IN COMMON
ACTION LIST

Ref:	MEETING DATE	REFERENCE	AGENDA ITEM	ACTION	Responsible Officer	Outcome/update (Completed Actions remain on the Action List for the following PCC and are then removed to the 'Completed' Worksheet)
70	**26/07/2017**	**10**	**Finance**	KM to seek clarification from AP on what 'other GP services' cover	**KM**	
69	**26/07/2017**	**8**	**GPFV Workflow**	Further update on the workflow following the roll out of training with Brighton & Hove at the January meeting	**SJ**	Not due
68	**26/07/2017**	**7**	**Risk Register**	Risk 20 - Plan on a page to be submitted to October Meeting	**EW**	Not due
67	**26/07/2017**	**7**	**Risk Register**	Risk 227 - AH to provie an update on discharge letters to September meeting This relates to discharge letters from Heart of England NHS Foundation Trust being sent electronically via the Central Hub	**AH**	
66	**22/06/2017**	**7**	**360° feedback**	Discussions to continue and an action plan developed to identify how to improve clinical engagement. Action Plan to be shared with the Membership Boards and Locality Boards.	**All / EW**	Action Plan to come back to the September meeting.
65	**22/06/2017**			EW to identify indicators and generate an action plan following the review of the 360° survey.	**EW**	
61	**24/04/2017**	**9**	**Delegated Commissioning**	LM to arrange a mini workshop in July to ensure the CCG is fit for purpose for practice development	**LM**	**22.06.17** - Carry forward to August meeting.
50	**23/03/2017**	**8**		LM to look at the top issues over the next three months and bring back to the committee for further discussion. LM to also meet with HI to look at providing a statement for circulation via the communications team. SY to share guidance on Purdah.	**LM / SY**	**26.07.17** Deferred to September meeting **22.06.17** - Carry forward to August meeting. Primary Care do hold a senior managers meeting which includes members of the finance team and NHSE. HI confirmed that there is a block on any public announcements due to the impending election however there would be information included on the website. Once the election has taken place a bigger spurge on delegated commissioning will take place.
60	**24/04/2017**	**8**	**Terms of Reference**	SY to review the ToR and confirm whether all meetings should be held in public	**SY**	**COMPLETE** ToR have now been signed off by NHSE and are available as part of the CCG Constitution **22.06.17** ToR to be reviewed to include meetings will be held in public 10/12 months.

Cannock Chase Clinical Commissioning Group
South East Staffordshire and Seisdon Peninsula Clinical Commissioning Group
Stafford and Surrounds Clinical Commissioning Group

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REPORT TO: Primary Care Commissioning Committee Meeting held in Common

TO BE HELD ON: 28th September 2017

Subject:	Primary Care Risk Register							
Board Lead:	Lynn Miller, Executive Director of Primary Care							
Officer Lead:	Eleanor Wood, Senior Primary Care Development Manager							
Recommendation:	**Approval/ Ratification**		**Assurance**	✓	**Discussion**		**Information**	✓

PURPOSE OF THE REPORT:

This report provides the Primary Care Committee with information about the primary care related risks currently facing Cannock Chase CCG, South East Staffordshire & Seisdon Peninsula CCG and Stafford & Surrounds CCG.

KEY POINTS:

The risk register includes risks related to Cannock Chase CCG, South East Staffordshire & Seisdon Peninsula CCG and Stafford & Surrounds CCG, associated to Primary Care.
The main summary points are:

- There are a total of 12 risks relating to primary care,
- There is one new risk, RR:276 Cannock practice is considering removing violent patient scheme on behalf of the 3 CCGs due to sustainability issues of providing the service,
- One risk has been closed, RR229: GP Practice Receiving Inadequate CQC Rating is pending closure,
- The risk score has decreased for RR: 258 Landywood Lane Surgery, Cannock has received an inadequate CQC inspection rating,
- There are 8 risks scoring 8 – 12 (High). There are no risks scoring 15 (Extreme) or above. There are no risks being reported to Governing Body.

CCG GOALS:

Change the culture: • **Hospital to home** • **Professional to patient**	The risk register will inform the CCGs of any issues arising in supporting the change in culture.
More focus on prevention	The risk register provides assurance that risks are being monitored and will highlight any issues around prevention.
Involving everyone for improved health and care	Assurance that risks are being monitored will enable a more focused approach to improving health and care.
Empower and support patients to take control of their own health	Patients will have more confidence to monitor their own health needs knowing risks are being monitored and mitigated.
Services supporting people to make informed decisions	Risk monitoring gives the CCGs assurance that the services they are promoting are safe for patients to make decisions.

IMPLICATIONS:

Legal and/or Risk	YES: unmitigated clinical risk could have NHSLA repercussions. Any real legal implication will be described in the appropriate risk.
CQC	YES: any involvement by the CQC with any practices and its potential impact will be described within the risk.
Patient Safety	YES: unmitigated Clinical Risk could have repercussions to safe services. Any patient safety implications will be described in the appropriate risk.
Patient Engagement	No: if patient engagement is required this will be described within the risk
Financial	YES: unmitigated clinical risk could have financial repercussions. Any financial implications will be described in the appropriate risk
Sustainability	None
Workforce/Training	None

RECOMMENDATIONS/ACTION REQUIRED:

The Primary Care Commissioning Committee is asked to:

Review the Risk Register report to confirm that assurance has been provided regarding the management of clinical risks across the three CCGs.

KEY REQUIREMENTS	Yes	No	Not Applicable
Has a quality impact assessment been undertaken?			✓
Has an equality impact assessment been undertaken?			✓
Has a privacy impact assessment been completed?			✓
Has a communications & engagement impact assessment been completed?			✓
Have partners/public been involved in design?			✓
Are partners/public involved in implementation?			✓
Are partners/public involved in evaluation?			✓

CCG VALUES
We are honest, accessible and listen
Care and respect for all
Quality is our day job
We innovate and deliver

Primary Care Committee
15 September 2017

Risk ID	Risk Status	Description Of Risk	Objective	Associated BAF Risks	Clinical Risk	Initial Consequence	Initial Likelihood	Initial Risk Score	Mitigating Action (Internal)	Future Actions (Internal)	Assurance (Internal)	Current Consequence	Current Likelihood	Current Risk Score	CCG	Risk Owner	Exec Risk Lead	Last Review Date	Date of Next Review
276	New Risk	A Cannock Chase GP practice currently provides the violent patient scheme on behalf of the 3 CCGs. The practice have raised issues regarding undertaking home visits for patients out of the Cannock Chase area, this currently affects three patients as such, the Practice is considering pulling the service as they do not feel this is a sustainable option in the future. The risk is that if the practice no longer wishes to continue providing this, all patients currently under this scheme will not be registered with a GP resulting in these cohort of patients possibly utilizing other services such as A&E, MIU etc.	Sustainable Primary Care Service	An ageing and reducing Primary Care workforce is unable to maintain /increase productivity to meet current demands/challenges;#100	Yes	3	3	9	13/09/2017 - The CCG is still liaising closely with the practice and are undertaking an options appraisal. 28/07/2017- Conversations have taken place with the practice on possible options but this has yet to be resolved. Therefore an options appraisal and quality impact assessment is to be produced working closely with the CCG quality team on the process for doing this.	13/09/2017 - Options appraisal and quality impact assessment to be produced as soon as possible between NHS England, CCG primary care and CCG quality team. 28/07/2017 - Options appraisal and quality impact assessment to be produced as soon as possible between NHS England, CCG primary care and CCG quality team.	13/09/2017 - Practice currently continuing with the service however the options appraisal and quality impact assessment when produced will develop a way forward in continuing this service for this cohort of patients. Also reported at Primary Care Committee. 28/07/2017 - Practice currently continuing with the service however the options appraisal and quality impact assessment when produced will develop a way forward in continuing this service for this cohort of patients.	3	3	9	Cannock Chase CCG; Stafford & Surrounds CCG; South East Staffordshire and Seisdon Peninsula CCG	Jeffery Sarah (CCG) CCCCG	Executive Director of Primary Care	09/08/2017	11/09/2017
273	Active Risk	ADULT SAFEGUARDING CAPACITY: The number of Deprivation of Liberty Assessments (DOL) needing to be undertaken is likely to increase following the Supreme Court decision in the case of Cheshire West and Chester Council. Update 24.03.2016 Risk reopened foll	Sustainable Primary Care Service;#New Models of Care – Delivery;#Finance;#Quality Outcomes	An ageing and reducing Primary Care workforce is unable to maintain /increase productivity to meet current demands/challenges;#100	Yes	1	5	5	12/07/2017 - A task and finish group has been set up and an update paper is planned to be taken to the August 8th Cannock Membership board meeting 19/06/2017 - An audit of wound care has been undertaken across general practices to understand the type, amount and activity delivered by practices to respond to the need. The audit has now been started and the outputs will inform the Task and Finish Group on 29 June 2017.	12/07/2017 - an update paper developed by the task and finish group will be presented to the Cannock membership board on 9th August 19/06/2017 - A series of Task and Finish Groups (up to three meetings) will be delivered to review the whole area of wound care and recommendations will be fed back to the Primacy Care Committee Group to action. .	12/07/2017 - wound care task and finish group set up and members tasked with reviewing wound care and providing recommendations for primary care element. an update paper will be presented at the August Cannock membership board 19/06/2017 - The recommendations from the Task and Finish Group will form a business case to address the funding short fall an provide equity of provision across localities. This will be received by the Primary Care Committee to action.	3	3	9	Cannock Chase CCG	Rayne Mark (CCG) SASCCG	Executive Director of Primary Care	11/09/2017	09/10/2017
271	Active Risk	Medicine Optimisation Team Recruitment/Vacancy Risk: Vacancies within the Medicines Optimisation team following staff departures and MoC restructure. The structure of Band 8a (and below) positions to be agreed across the 3 CCG's. Vacancies within team are risk for QiPP delivery and governance of medicines within the CCG.	Quality Outcomes;#Finance	Failure to deliver QIPP targets;#98; Staff morale, capability and capacity;#108; The current systems and processes and lack of clarity or ownership by key parties for Nursing and Care homes present a number of quality and safety risks to local patients.;#107	Yes	3	3	9	14/09/2017 - The 8b Senior Medicines Optimisation Pharmacist has now been recruited to and is in post. The vacant 8a Practice Pharmacist roles have been approved through vacancy control panel and will be going out to advert by Friday 22nd September. 10/07/2017 - Vacant 8b position now approved through vacancy control. Plan to go out to advert with an interview date w/c 24/07/2017. Band 8a structures to be reviewed following this appointment.	14/09/2017 - 8a vacancies to be advertised w/c 18th September 2017.	17/05/2017 The recruitment process to the vacant role of Heads of Medicines Management is underway. NS\houghr 13/04/2017 10:17:13 - QiPP schemes financial targets adjusted to reflect current vacancies. Medicines optimisation team prioritising key responsibilities/requirements.	3	3	9	Cannock Chase CCG; Stafford & Surrounds CCG; South East Staffordshire and Seisdon Peninsula CCG	Buckingham Samantha (CCG) SASCCG	Executive Director of Primary Care	14/09/2017	14/10/2017

Risk ID	Risk Status	Description Of Risk	Objective	Associated BAF Risks	Clinical Risk	Initial Consequence	Initial Likelihood	Initial Risk Score	Mitigating Action (Internal)	Future Actions (Internal)	Assurance (Internal)	Current Consequence	Current Likelihood	Current Risk Score	CCG	Risk Owner	Exec Risk Lead	Last Review Date	Date of Next Review
258	Active Risk	Landywood Lane Surgery in Cannock have received an inadequate CQC inspection rating (visit date 22nd September 2016, report published 16th January 2017) and placed into special measures for a period of 6 months at which time the CQC will reinspect the practice to consider if sufficient improvements have been made. The risk is that the practice does not improve enough to meet the requirements placed on them by the CQC and there is potential for their registration and contract to be revoked leaving just over 1900 patients without general practice provision and creating pressure on the surrounding GP practices if a list dispersal needs to take place.	Sustainable Primary Care Service	An ageing and reducing Primary Care workforce is unable to maintain /increase productivity to meet current demands/challenges;#100	Yes	3	3	9	13/09/2017 - Landywood Lane has now merged with High Street Surgery on 30th June. A CQC visit will be taking place imminently to assess the Landywood Lane element. 24/06/2017 - Practice will be merged with High Street Surgery on 30th June 2017. The practice will be revisited once the merger has taken place in approximately August 2017.	13/09/2017 - Landywood Lane has now merged with High Street Surgery on 30th June. A CQC visit will be taking place imminently to assess the Landywood Lane element. CCG and NHSE to continue to provide support as and when required. 24/06/2017 - Practice will be merged with High Street Surgery on 30th June 2017. The practice will be revisited once the merger has taken place in approximately August 2017. CCG and NHSE to continue to provide any support as required.	13/09/2017 - Landywood Lane has now merged with High Street Surgery on 30th June. A CQC visit will be taking place imminently to assess the Landywood Lane element which should provide assurance. 24/06/2017 - Practice will be merged with High Street Surgery on 30th June 2017 with a future CQC re-inspection in August 2017 hopefully improving the overall CQC rating.	3	2	6	Cannock Chase CCG	Cox Tracey (CCG)	Executive Director of Primary Care	13/09/2017	09/10/2017
257	Active Risk	There is a risk of an increase in General Practitioner's conflicts of interest (COI) arising as a result of GPs assuming delegated responsibility for commissioning services.	ry Care Service;#Constitutional Standards	nable to hit constitutional targets;#104 The CCGs are unable to hit	No	4	3	12	13/09/2017 - Practices are submitting COI forms for their identified members of staff to the Governance Managers for inclusion onto the Membership COI Register. 18/07/2017 - The Governance Managers have introduced the COI register to be included within the meeting papers for the Membership and Locality Meetings. The Governance Managers have attended Membership and Locality Meetings to present the updated NHS England guidance and to request individuals ensure that their COI are up to date and correct. The register has been reviewed by the 3 CCG Lay Advisors and the Governance Managers in April 2017. 06/06/2017 09:00:10 NS\Eleanor.Spalding - No further mitigating actions at this stage. The risk will be continually monitored.	18/07/2017 - The Governance Managers will continue to review the register and raise any concerns with managers. A letter from the 3 CCG Lay Advisors for Audit will be circulated, the letter is reminding all GPs and individuals to ensure the COI are up-to-date and correct. It is expected that NHS England will release the training later this year which will require GPS and relevant individuals to undertake. 06/06/2017 - no future actions required at this stage. The risk will be continually monitored.	13/09/2017 - Practices are submitting COI forms for their identified members of staff to the Governance Managers for inclusion onto the Membership COI Register. 17/07/2017 - The Governance Managers regularly review the register. The COI register are reviewed by Audit Committee. 06/06/2017 09:05:08 - All actions remain the same and the risks are being managed. The risk will be continually monitored.	4	2	8	Cannock Chase CCG; Stafford & Surrounds CCG; South East Staffordshire and Seisdon Peninsula CCG	Hough Rebecca (CCG) SESCCG	Executive Director of Primary Care	13/09/2017	11/10/2017
256	Active Risk	There is a risk that funds previously utilized by NHS England for commissioning of General Practice will not be sufficient.	Sustainable Primary Care Service;#Finance	Failure to deliver the control total;#99; Delegated Commissioning Potential financial and governance risks.;#113	No	4	3	12	14/09/2017 - No further action at this stage, continue to monitor 17/07/2017 - No further actions at this stage, continue to monitor. 06/06/2017 - No further actions at this stage. Continue to monitor.	14/09/2017 - No further action at this stage, continue to monitor 17/07/2017 - No further actions at this stage, continue to monitor. 06/06/2017 - No further actions at this stage. Continue to monitor.	14/09/2017 - No further action at this stage, continue to monitor 17/07/2017 - No further actions at this stage, continue to monitor. 06/06/2017 - No further actions at this stage. Continue to monitor.	3	3	9	Cannock Chase CCG; Stafford & Surrounds CCG; South East Staffordshire and Seisdon Peninsula CCG	Wood Eleanor (SES & SP CCG)	Executive Director of Primary Care	14/09/2017	11/10/2017

Risk ID	Risk Status	Description Of Risk	Objective	Associated BAF Risks	Clinical Risk	Initial Consequence	Initial Likelihood	Initial Risk Score	Mitigating Action (Internal)	Future Actions (Internal)	Assurance (Internal)	Current Consequence	Current Likelihood	Current Risk Score	CCG	Risk Owner	Exec Risk Lead	Last Review Date	Date of Next Review
255	Active Risk	There is a risk of the CCGs not having the resource / capacity and expertise to assume delegated commissioning responsibility of general practice.	Sustainable Primary Care Service;#Constitutional Standards	Capacity and monetary impact of Co-Commissioning is greater than envisaged and has a detrimental impact on Primary Care and the CCG. ;#101; The CCGs are unable to hit constitutional targets;#104	No	4	3	12	14/09/2017 - No further actions at this stage, continue to monitor 17/07/2017 - No further actions at this stage, continue to monitor. 06/06/2017 - No further mitigating actions required at this stage	14/09/2017 - No further actions at this stage, continue to monitor 17/07/2017 - No further actions at this stage, continue to monitor. 06/06/2017 - The risk will continue to be monitored	14/09/2017 - No further actions at this stage, continue to monitor 17/07/2017 - No further actions at this stage, continue to monitor. 06/06/2017 - An MOU is in place to ensure that both parties understand roles and remits.	2	3	6	Cannock Chase CCG; Stafford & Surrounds CCG; South East Staffordshire and Seisdon Peninsula CCG	Wood Eleanor (SES & SP CCG)	Executive Director of Primary Care	14/09/2017	11/10/2017
227	Active Risk	DISCHARGE LETTERS VIA PROCESS HUB Discharge letters from Heart of England NHS Foundation Trust (HEFT) are now being sent electronically via the Central Hub which diverts letters automatically to the patients General Practitioners (GP). This means GP's within the CCG border are not receiving discharge letters because there is no access to the system and letters are no longer being posted. There is also concern reported about the poor quality of the discharge letters, this being addressed at UHB CRB (Quality and Perfomance).	Quality Outcomes;#Sustainable Primary Care Service	Failure to identify quality and safety risks impacting upon patient outcomes including patient experience;#105	Yes	4	3	12	17/05/2017 - All but 3 sites are now live with EDT from HEFT. 3 sites are not complete due to docman issues working across their sites - this issue is being picked up operationally and once resolved the sites will be completed. The 3 sites will continue to receive discharges via paper. 31/01/2017 - CSU Project Management lead for EDT programme is now working with HEFT and Docman to roll out electronic discharges to all SESSP practices. Currently on trial in one practice with a schedule in place for the remaining SESSP practice over the next four weeks. We have been made aware that not all discharges will be sent through this process - HEFT are working internally to deliver this as some departments have to put appropriate, safe processes in place.	17/05/2017 - All sites, where possible, are now complete. Once operational docman issues are resolved the sites will be setup. Continue to ensure EDT activity is growing from HEFT departments. 31/01/2017 - Review pilot site to ensure the solution is working as required. Work with HEFT to ensure as many documents as possible are feeding through electronically.	17/05/2017 - Roll out completed, apart from 3 sites which will be completed when their docman issues on site are resolved. We have been made aware that not all discharges will be sent through this process - HEFT are working internally to deliver this as some departments have to put appropriate, safe processes in place. 31/01/2017 - Waiting for confirmation that electronic records are starting to flow out to pilot site. If this is the case then we should be able to reduce the risk as all sites are completed.	3	2	6	South East Staffordshire and Seisdon Peninsula CCG	Hadley Andy (CCG) SESCCG	Executive Director of Primary Care	17/05/2017	02/10/2017
205	Active Risk	The CCG is responsible for the reinvestment decision regarding the reinvestment of the PMS premium. The financial consequences of the PMS contract changes may exceed the premium and cause a financial pressure for the CCG. In addition, there may be an issue around service continuity if practices choose to cease services as a result of the review.	Finance;#Sustainable Primary Care Service	Failure to deliver the control total;#99	No	4	4	16	14/09/2017 - No further action at this stage. The PMS premium will continue to be monitored and the re-investment made accordingly. 03/07/2017 - PMS premiums have been agreed with the membership and approved by the Primary Care Committee in Common. This will continue to be worked on to ensure that the premium provides appropriate funding for the services identified. 05/01/2017 - A task and finish group has been set up to develop a pragmatic plan for re-investment of the PMS premium over a 5 year period. Plans will go to the relevant membership and locality boards in January. Practices (both PMS and GMS) have agreed to a cost per head payment to ensure that services continue to be delivered in the interim until the plan is in place from April 2017.	14/09/2017 - No further action at this stage. The PMS premium will continue to be monitored and the re-investment made accordingly. 03/07/2017 - A yearly review process will be undertaken to ensure that the services identified are continuing as planned and the premium funds the services appropriately not putting any risk on the CCG or practices. 05/01/2017 - Reinvestment to be discussed at relevant membership and locality boards and an agreement to be made in association with NHSE and LMC.	14/09/2017 - No further action at this stage. The PMS premium will continue to be monitored and the re-investment made accordingly. 03/07/2017 - The released premium has been agreed with the membership and approved by the Primary Care Committee in common. A yearly review process will be undertaken to ensure that the funding is appropriate. 05/01/2017 - Plan to be in place by April 2017 for reinvestment.	3	2	6	Cannock Chase CCG; Stafford & Surrounds CCG; South East Staffordshire and Seisdon Peninsula CCG	Wood Eleanor (SES & SP CCG)	Executive Director of Primary Care	14/09/2017	01/01/2018

Risk ID	Risk Status	Description Of Risk	Objective	Associated BAF Risks	Clinical Risk	Initial Consequence	Initial Likelihood	Initial Risk Score	Mitigating Action (Internal)	Future Actions (Internal)	Assurance (Internal)	Current Consequence	Current Likelihood	Current Risk Score	CCG	Risk Owner	Exec Risk Lead	Last Review Date	Date of Next Review
27	Active Risk	There is a risk that providers do not update directory of services and make slots available to enable primary care to utilise the choose and book / e-referral system which in turn may cause patient treatment delays and missing referrals by not using this automated system.	Quality Outcomes;#Sustainable Primary Care Service	Failure to adequately quality impact assess current change programmes including, but not limited to the STP work programes. ;#106	Yes	3	4	12	04/07/2017 - Administrative update, Risk Owner amended 17/05/2017 - E-referrals (ERS) usage is within the practice membership agreements for all three CCGs in 2017/18 to further support ERS activity. A Project Initiation Document is due to be signed off by all Staffordshire CCGs in support of the Local Digital Roadmap Ten Universal Capabilities programme to ensure the area is able to send 80% OP/2WW activity through ERS. The CCG has continued to engage with providers and ERS regional implementation lead to raise concerns regarding the reduced polling times at BHFT/UHNM for a number of specialities due to RTT issues which is impacting on practice engagement and CCG targets. NHS England are now beginning to support this programme of work with a Programme Manager bringing both CCG execs and Provider leads to ensure the trajectories to achieve 80% by April 2018 and 100% by October 2018 are achievable. The three CCGs usage activity continues to grow as providers release more capacity so we are assured the majority of general practice is using it well - engagement will continue with those that are lower in each locality.	04/07/2017 - Administrative update, Risk Owner amended 17/05/2017 - E-referrals (ERS) usage is within the practice membership agreements for all three CCGs in 2017/18 to further support ERS activity. A Project Initiation Document is due to be signed off by all Staffordshire CCGs in support of the Local Digital Roadmap Ten Universal Capabilities programme to ensure the area is able to send 80% OP/2WW activity through ERS. The CCG has continued to engage with providers and ERS regional implementation lead to raise concerns regarding the reduced polling times at BHFT/UHNM for a number of specialities due to RTT issues which is impacting on practice engagement and CCG targets. NHS England are now beginning to support this programme of work with a Programme Manager bringing both CCG execs and Provider leads to ensure the trajectories to achieve 80% by April 2018 and 100% by October 2018 are achievable. The three CCGs usage activity continues to grow as providers release more capacity so we are assured the majority of general practice is using it well - engagement will continue with those that are lower in each locality.	04/07/2017 - Administrative update, Risk Owner amended 17/05/2017 - E-referrals (ERS) usage is within the practice membership agreements for all three CCGs in 2017/18 to further support ERS activity. A Project Initiation Document is due to be signed off by all Staffordshire CCGs in support of the Local Digital Roadmap Ten Universal Capabilities programme to ensure the area is able to send 80% OP/2WW activity through ERS. The CCG has continued to engage with providers and ERS regional implementation lead to raise concerns regarding the reduced polling times at BHFT/UHNM for a number of specialities due to RTT issues which is impacting on practice engagement and CCG targets. NHS England are now beginning to support this programme of work with a Programme Manager bringing both CCG execs and Provider leads to ensure the trajectories to achieve 80% by April 2018 and 100% by October 2018 are achievable. The three CCGs usage activity continues to grow as providers release more capacity so we are assured the majority of general practice is using it well - engagement will continue with those that are lower in each locality.	2	4	8	Cannock Chase CCG; Stafford & Surrounds CCG; South East Staffordshire and Seisdon Peninsula CCG	Hadley Andy (CCG) SESCCG	Executive Director of Finance	04/07/2017	02/10/2017
21	Active Risk	The risk is the failure to achieve clinical engagement of Membership.	New Models of Care – Delivery;#Constitutional Standards;#Sustainable Primary Care Service	Failure to engage the membership thus disenfranchising Primary Care from the objectives and priorities of the CCG;#103	No	4	3	12	04/07/2017 - Each senior Primary Care Development Manager is working with their respective locality/membership board to understand how the CCG can better engage with the membership. A 360 survey was undertaken during January 2017. 05/01/2017 11:55:20 NS\coxtr - No change from last mitigating action. 01/08/2016 - Membership agreement for 2016/17 is now in place which has had inout from clinicians into the process as per previous controls. As part of the membership agreement, this includes attendance at the membership board.	04/07/2017 - Quality visits will be undertaken with practices to increase engagement. The recent 360 survey with practices will be reviewed to ensure feedback is actioned where appropriate. Communication with practices is being reviewed to ensure that the CCGs are using the best available mechanisms to ensure key messages are distributed. 05/01/2017 - Continue to monitor engagement.	04/07/2017 - Primary Care Development Managers are aligned to an identified locality to work more closely with practices and to undertake quality visits (September/November 2017) which will encompass feedback from the 360 survey. 05/01/2017 - Delivery of key targets in primary care	3	3	9	Cannock Chase CCG; Stafford & Surrounds CCG; South East Staffordshire and Seisdon Peninsula CCG	Jeffery Sarah (CCG) CCCCG	Executive Director of Primary Care	10/08/2017	11/09/2017
20	Active Risk	There is known variation across practices within the CCGs which is leading to potentially higher than expected outpatient referrals, admissions and A&E activity. There is potential inequitable service provision.	New Models of Care – Delivery;#Quality Outcomes	Failure to identify quality and safety risks impacting upon patient outcomes including patient experience;#105	Yes	3	4	12	04/07/2017 - Quality visits have been undertaken in SAS and SES CCGs. This will be expanded to CC this financial year. The visits looked to highlight areas of variation and a discussion is held with the practice to understand this further and to put actions in place where required. 05/01/2017 - Continued scrutiny of data. Work is being undertaken by BI highlighting variation and the commissioning team (linking with the QIPP 2017/18) are looking at the implementation of the Kings Fund referral management paper which is about clear and consistent referral criteria, increase in advice and guidance utilisation in e-referrals, patient self help materials, education and PLT and the appointment of a primary care analyst to monitor.	04/07/2017 - Quality visits will continue. A newly appointed Primary Care Analysts will pull data for the visits and highlight any area of variation for discussion with the practice. Protected Learning Time agendas will be aligned with outpatient priorities and increase the number of peer review sessions with consultants. 05/01/2017 - As per mitigating action this work will be ongoing into 2017/18. 01/08/2016 - To continue to monitor data in terms of increases in referrals and work with practices to understand the data. Work is continuing in terms of map of medicine with an upgrade rollout planned imminently.	04/07/2017 - Monitored through QIPP 05/01/2017 - Regular monitoring and ensuring practices are engaged with the different elements as per above or this could become a gap in assurance.	3	3	9	Cannock Chase CCG; Stafford & Surrounds CCG; South East Staffordshire and Seisdon Peninsula CCG	Jeffery Sarah (CCG) CCCCG	Executive Director of Primary Care	10/08/2017	11/09/2017

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Stafford and Surrounds Clinical Commissioning Group

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Report to the Primary Care Commissioning Committee Meeting in Common TO BE HELD ON: 28th September 2017

Subject:	General Practice Forward View (GPFV) Improving Primary Care access / extended hours programme							
Board Lead:	Lynn Millar							
Officer Lead:	Mark Rayne, Interim Deputy Director, Primary Care							
Recommendation:	**Approval/ Ratification**		**Assurance**		**Discussion**		**Information**	✓

PURPOSE OF THE REPORT:

To provide an update to the Primary Care Commissioning Committee on the delivery progress against the milestones in respect of the General Practice Forward View (GPFV) Improving Primary Care access / extended hours programme

KEY POINTS:

There is a requirement that by the end of March 2019, 100% of the practice populations of Staffordshire will be able to access extended hours Primary Care services. *To achieve this it is proposed:*

- A baselining exercise will be completed across Staffordshire, including learning from Prime Ministers Challenge Fund access sites, and other initiatives, by the end of June 2017
- An assessment of practices appetite and readiness to provide extended Primary Care services will be completed by the end of June 2017
- A set of principles, needs and considerations for identifying local needs will be completed by the end of September 2017
- A detailed specification will be developed by the end of October 2017
- The procurement model will be signed off by all Governing bodies by the end of November 2017
- The procurement of additional hours of General Practice access will be undertaken within a consistent approach across all of the 6 Staffordshire CCG areas by the end of April 2018
- New service contracts will start at the end of September 2018

CCG GOALS:

Change the culture: • **Hospital to home** • **Professional to patient**	Providing more accessible Primary Care services in order to attempt to reduce the impact on other parts of the health system (provision of care closer to home)
More focus on prevention	Supports the prevention agenda, by providing more opportunities for early identification and guidance to prevent or reduce ill health through improved access and extended hours Primary Care Services
Involving everyone for improved health and care	N/A
Empower and support patients to take control of their own health	Supports patients to take control of their own health through early identification and management of their health issues
Services supporting people to make informed decisions	The provision of accessible extended primary care services will allow more opportunities for informed decisions around treatment options available

IMPLICATIONS:

Legal and/or Risk	There is a risk that practices will not participate in providing improved access and extended hours of Primary Care services. This will be identified during an assessment of practices appetite and readiness to provide extended Primary Care services which will be completed by the end of June 2017
CQC	Evidence on developments can be provided as part of the CQC inspections process
Patient Safety	Patient safety issues will be identified through Quality and Equality Impact assessments and during the consultation with patients during the review of current pilot site areas and initiatives, planning of the individual models to provide improved access and extended hours and during the evaluation processes
Patient Engagement	Patients will be pro-actively engaged in providing information (through PPG leads) with regard to their preferred requirements for improved access / extended hours Primary Care services
Financial	The financial cost of providing improved access / extended hours Primary care services will be provided in two stages. Additional funding will be available in respect of £3.34 per head from August 2018, rising to £6.00 per head from 2019/20.
Sustainability	The additional funding for improved access / extended hours primary care services will be provided as a recurrent funding stream.
Workforce/Training	There are interdependencies to the workforce programme within the General Practice Forward View. Workforce and any training requirements to provide improved access and extended hours Primary Care Services will be identified and managed through the workforce plan and in the specification development

RECOMMENDATIONS/ACTION REQUIRED:

The Primary care Commissioning Committee in Common is asked to:

Receive and note the proposed draft milestones and indicative timescales.

KEY REQUIREMENTS	Yes	No	Not Applicable
Has a quality impact assessment been undertaken?			Will be undertaken
Has an equality impact assessment been undertaken?			Will be undertaken
Has a privacy impact assessment been completed?			Will be undertaken
Has a comms & engagement impact assessment been completed?			Will be undertaken
Have partners/public been involved in design?	Partners and the public will be involved by identifying their requirements for improved access and extended hours services. Involvement will also be sought in the design of the specification and to inform locality models of deliver		
Are partners/public involved in implementation?	The Utilisation of improved access and extended hours services will be key to the successful implementation of the improved access and extended hours programme		
Are partners/public involved in evaluation?	Partners and the public will be key to the evaluation of the improved access and extended hours programme in order to support any redesign needs		

CCG VALUES
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Care and respect for all
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The South Staffordshire GPFV improving access / extended hours delivery plan has a target that by the end of March 2019, 100% of the practice populations of Staffordshire will be able to access extended hours Primary Care services.

To achieve this:

The Clinical Commissioning groups across the Staffordshire footprint wish to work pro-actively with Practices through the locality arrangements in North, East and South Staffordshire to develop and deliver a planned programme of work to deliver this requirement.

There will be established links to the National General Practice Forward View (GPFV) programme and to the Sustainability and Transformation Programme (STP) through NHS England Programme Management Office Regional Leads and STP programme Leads to provide support to the Programme.

An update on the key milestones to deliver the planned programme of work are described in the numbered sections below

1. **Position Paper produced that describes the current extended access provision in North, East and South Staffordshire**

   A position paper has been developed which describes the current extended access provision across North, East and South Staffordshire.

   This milestone was completed at the end of July 2017

2. **Learning from the two Prime Ministers Challenge Fund (PMCF) access pilot sites in South Staffordshire and from the Primary Care Access Hub (PCAH) in Northern Staffordshire, collated and shared**

   A baselining exercise across North, East and South Staffordshire, has been completed which has captured learning from Prime Ministers Challenge Fund access sites, and other initiatives

   This milestone was completed at the end of June 2017

3. **Set up a task and finish group**

   A task and finish group has been formed with representation from North, East and South Staffordshire Colleagues. The terms of reference have recently been reviewed (at the meeting on the 15th September) to include Local Medical Committee representation and a Clinical Lead to Chair the Group

   This milestone was completed at the beginning of August 2017

4. Communications and engagement sub group developed

A Communications and Engagement sub-group has been developed with membership from the Communications and Engagement Leads across North, East and South Staffordshire. Their remit is to develop an overarching communication and engagement plan, support Equality Impact Assessment development, support regional engagement events for potential providers and to support development of a Patient reference group

This milestone was completed at the beginning of August 2017

5. Specification, procurement and contracting sub group set up

A Specification, procurement and contracting sub-group has been set up to deliver the specification, procurement options paper, milestones and timelines and the contracting milestones and timelines

This milestone was completed at the end of August 2017

6. Plan, deliver and evaluate a series of events to highlight the requirements of providing extended access

We plan to hold a series of events for potential providers led by NHS England to share the core requirements, learning from National Pilot sites, support round table discussions and facilitated locality time to consider what individual locality offers may look like. These events will inform us of the interest and appetite of localities as potential providers as well as identifying any risks to coverage of extended access. Ultimately this will inform the procurement options paper of the procurement route Governing Bodies will need to take to procure extended access services

We plan to complete this milestone by the end of October 2017

7. Discussion paper on procurement options produced

We have been working closely with the Procurement team and have collaboratively developed a draft procurement options paper which will be further developed following a series of engagement events in North, East and South Staffordshire. Following feedback from potential providers at these events the procurement options paper will be completed and will provide a steer to the Governing bodies of the procurement route to take. We have also sought advice from procurement colleagues on the various procurement processes and associated timelines

We plan to complete this milestone by the end of October 2017

8. Develop a Quality Impact Assessment

We plan to complete this milestone by the end of October 2017

9. Develop an Equality Impact Assessment

We plan to complete this milestone by the end of October 2017

10. Develop and deliver an Engagement Strategy

A Communications and Engagement sub-group has been developed with membership from the Communications and Engagement Leads across North, East and South Staffordshire. Their remit is to develop an overarching communication and engagement plan

We plan to complete this milestone by the end of September 2017

11. Develop and deliver an communications strategy

A Communications and Engagement sub-group has been developed with membership from the Communications and Engagement Leads across North, East and South Staffordshire. Their remit is to develop an overarching communication and engagement plan

We plan to complete this milestone by the end of September 2017

12. **Develop a set of principles, needs and considerations for identifying local needs**

Working with public Health Colleagues and using Public Health profile data and other key sources of information we would like to undertake a population needs assessment to understand the differing needs of populations and to collate information on local demographics within Staffordshire (North, East and South) and to use this information to develop locality packs to support localities when designing their approaches and models to meet local needs

We plan to complete this milestone by the end of September 2017

13. Development of the Specification

Utilising all of the information gathered from the previous exercises we would like to form a task and finish group with key representatives from North, East and South Staffordshire in order to develop a detailed specification for improved access and extended hour's primary care services.

We plan to complete this milestone by the end of October 2017.

14. Agreeing the procurement model

We have been working closely with the Procurement team and have collaboratively developed a draft procurement options paper which will be further developed following a series of engagement events in North, East and South Staffordshire. Following feedback from potential providers at these events the procurement options paper will be completed and will provide a steer to the Governing bodies of the procurement route to take. We have also sought advice from procurement colleagues on the various procurement processes and associated timelines

There is a requirement that the procurement model will be signed off by all Governing bodies by the end of November 2017.

We are working to ensure the procurement options paper is completed by the end of October in order to be presented at the November Governing Body meetings

15. Procurement of services

The procurement of additional hours of General Practice access will be undertaken within an agreed model and with a consistent approach across all of the 6 Staffordshire CCG areas by the end of April 2018 and there is an expectation that new service contracts will start at the end of September 2018

A pictorial representation of these milestones and indicative timelines are to be found in ***Appendix (A)***

The Primary Care Commissioning Committee are asked to receive and note the updated report against the milestones and timelines

Appendix (A)

Milestone	Due Date	Status
Position Paper produced that describes the current extended access provision in North, East and South Staffordshire	30/06/2017	Delivered
Learning from the two PMCF access pilot sites in South Staffordshire and from the PCAH in Northern Staffs. collated and shared	30/06/2017	Delivered
Set up a task and finish group	30/06/2017	Delivered
Communications and engagement sub group developed	07/08/2017	Delivered
Specification, procurement and contracting sub group set up	22/08/2017	Delivered
Plan, deliver and evaluate a series of events to highlight the requirements of providing extended access	31/10/2017	In delivery and on track to meet milestone date
Discussion paper on procurement options produced for discussion at governing bodies	31/10/2017	In delivery and on track to meet milestone date
Develop a Quality Impact Assessment	31/10/2017	In delivery and on track to meet milestone date
Develop an Equality Impact Assessment	30/09/2017	In delivery and on track to meet milestone date
Develop and deliver an Engagement Strategy	30/09/2017	In delivery and on track to meet milestone date
Develop and deliver an communications strategy	30/09/2017	In delivery and on track to meet milestone date
Develop a set of principles, needs and considerations for identifying local needs	30/09/2017	In delivery and on track to meet milestone date

Milestone	Due Date	Status
Development of the Specification	30/10/2017	In delivery and on track to meet milestone date
Procurement model signed off by governing bodies	30/11/2017	In delivery and on track to meet milestone date
Services Procured (STP with CCG lots as an option)	30/04/2018	
New service contracts started	30/09/2018	
100% Access as per GPFV	31/03/2019	

Cannock Chase Clinical Commissioning Group
South East Staffordshire and Seisdon Peninsula Clinical Commissioning Group
Stafford and Surrounds Clinical Commissioning Group

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REPORT TO: Primary Care Commissioning Committees Meeting in Common

TO BE HELD ON: 28th September 2017

Subject:	**Update on the review process for Local Enhanced Primary Care Services (LES) for the South Staffordshire Clinical Commissioning Group (CCG) Localities**							
Board Lead:	Lynn Millar, Executive Director of Primary Care							
Officer Lead:	Mark Rayne, Interim Deputy Director of Primary Care							
Recommendation:	**Approval/ Ratification**		**Assurance**		**Discussion**		**Information**	✓

PURPOSE OF THE REPORT:

To provide the Primary Care Commissioning Committee with an update on the Local Enhanced Primary Care service review

KEY POINTS:

- A communication and engagement paper has been presented in August to all Locality and Membership groups to explain the review process and to request representation in the task and finish groups
- All planning meetings have now been undertaken
- Some of the review dates have had to be changed following planning meetings which have informed new priorities for review
- Some reviews are underway, others planned

CCG GOALS:

Change the culture: • **Hospital to home** • **Professional to patient**	Providing more locally accessible Primary Care services that are designed to meet the needs of local populations in order to attempt to reduce the impact on other parts of the health system (provision of care closer to home)
More focus on prevention	Providing more locally accessible Primary Care services supports the prevention agenda, by

	providing more opportunities for early identification and guidance to prevent or reduce ill health
Involving everyone for improved health and care	Through the implementation of a communication and engagement strategy, patients, and providers of services will be involved in the design, implementation and review of locally enhanced primary care services.
Empower and support patients to take control of their own health	Supports patients to take control of their own health through early identification and management of their health issues
Services supporting people to make informed decisions	Providing more locally accessible Primary Care services that are designed to meet the needs of local populations will allow more opportunities for informed decisions around treatment options available

IMPLICATIONS:

Legal and/or Risk	There is a risk that practices will not participate in the review on locally enhanced Primary Care services as they either do not feel it is relevant to them if they currently do not provide services or if they currently provide services may feel the review will disadvantage them and they may lose income. A clear communication and engagement plan will help to mitigate this risk There is a need to have arrangements in place to manage conflicts of interest with those clinicians who participate in the review process where their practices may be providing locally enhanced primary care services.
CQC	Evidence on developments can be provided as part of the CQC inspections process
Patient Safety	Patient safety issues will be identified through Quality and Equality Impact assessments
Patient Engagement	Through a communication and engagement strategy and with support from Patient Participation Group (PPG) leads, Patients will be pro-actively engaged in providing information with regard to needs for and experiences of Locally enhanced primary care services
Financial	The financial cost of providing Local Enhanced Primary Care services is **£1,193,894** and is broken down as follows: Stafford and Surrounds Locality **£468,340** Cannock Chase Locality **£149,722** South East Staffordshire and Seisdon Locality **£575,832**
Sustainability	
Workforce/Training	There are interdependencies to the workforce programme within the General Practice Forward View. Workforce and any training requirements to provide Local Enhanced Primary Care Services will be identified and

	links made.

RECOMMENDATIONS/ACTION REQUIRED:

The Primary Care Commissioning Committee Meeting in Common is asked to:

1. Receive an updated position on the review of Primary Care Local Enhanced services

KEY REQUIREMENTS	Yes	No	Not Applicable
Has a quality impact assessment been undertaken?			Will be undertaken
Has an equality impact assessment been undertaken?			Will be undertaken
Has a privacy impact assessment been completed?			Will be undertaken
Has a communications & engagement impact assessment been completed?			Will be undertaken
Have partners/public been involved in design?			Partners and the public will be involved in the design of services through the structured review process
Are partners/public involved in implementation?			Partners and the public will be involved in the implementation of locally enhanced primary care services
Are partners/public involved in evaluation?			Partners and the public will be involved in the evaluation of locally enhanced primary care services

CCG VALUES

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Local Enhanced service review schedule update summary

Local Enhanced Service (LES)	Original Review period	Amended Review period	Review Status	Lead Commissioner
Wound care including: ➢ Continuity of Care ➢ Suture Removal	July-August	July-September	Review in progress	Harriet Somerfield
Anticoagulation	July-August		Review undertaken, specification and plan developed, in delivery	Jane Chapman
Nursing Home Care Plans / LIS	August-September		Review in progress	Helen Slater
Androgen Deprivation	August-September	October-November	Planning meetings have been undertaken, to plan task and finish group for October 2017	Sam Buckingham
Shared Care Drug Monitoring Provision	September-October	October-November	Planning meetings have been undertaken, to plan task and finish group for October 2017	Sam Buckingham
Conversion of Insulin	September-October	December-January 2018	Planning meetings have been undertaken, to plan task and finish group for December 2017	Sam Buckingham
Denosumab	September-October	December-January 2018	Planning meetings have been undertaken, to plan task and finish group for December 2017	Sam Buckingham
Phlebotomy	September -October 2018	October-November	Planning meetings have been undertaken, task and finish group has been arranged for October 2017 to start review	Mel Mahon

Local Enhanced Service (LES)	Original Review period	Amended Review period	Review Status	Lead Commissioner
Spirometry Provision	October-November	November-December	Planning meetings have been undertaken, to plan task and finish group for November 2017	Links to Respiratory – Sharon Cooper
Menorrhagia	October-November	November-December	Planning meetings have been undertaken, to plan task and finish group for November 2017	Mel Mahon
Minor Surgery on Referral (Cannock intra practice)	November-December	December-January 2018	Planning meetings have been undertaken, to plan task and finish group for December 2017	Mel Mahon for Dermatology Alex Bennett for MSK
6 week Post Natal Check	November-December	December-January 2018	Planning meetings have been undertaken, to plan task and finish group for December 2017	Alex Birch
Multiple Sclerosis	December-January 2018	January-February 2018	Planning meetings have been undertaken, to plan task and finish group for January 2018	Andy Hadley
PSA Monitoring	December-January 2018	January-February 2018	Planning meetings have been undertaken, to plan task and finish group for January 2018	Andy Hadley

Summary of Review progress

1.) Wound Care including Continuity of Care and Suture Removal Local Enhanced Services

Status: Review in progress

The review is in progress and task and finish groups have been undertaken on:

- 29th June
- 27th July
- 14th September

Summary of review progress:

The Primary Care Offer is a focus on 'wound healing' and on clinical outcomes

A task and finish group has been formed, Dr Mo Huda chairs the group, Dr Gulshan Kaul represents the Local Medical Council (LMC). There is clinical representation from the localities and representation from the three Practice Nurse Facilitators.

The task and finish group will meet regularly to review the current provision and to provide its proposed recommendations to the Locality and Membership Boards, where they will be discussed and agreed before being presented to the Primary Care Commissioning Committee. The LMC will facilitate an external Clinical review of the recommendations.

The group has made a start to ***define*** simple and complex wounds to be managed at a primary care level

1.) **Simple Wounds** defined as wounds that heal uneventfully. They may be a simple traumatic wound, such as a haematoma, minor abrasion or laceration, simple minor burn or a more substantial injury, for example an incision wound (surgical) that heals as expected by primary intention. These are wounds that present to General Practice and could be sustained following a fall or accident but present a few days after trauma. These wounds can take up to 2 weeks to heal. (MH These exclude wounds dealt with by Minor Injuries Unit for which there is an alternative process to deal with)

2.) **Complex wounds** defined as wounds that can take up to six weeks to heal. Primary care may seek advice on management from Ambulatory Clinics and Tissue Viability Nurses. These exclude on going arterial or venous leg ulcer wounds which should be managed by the Ambulatory Clinics as these require special wound care management. (General Practice should not be the place to deal with these sort of wounds as we need to ensure close monitoring and healing takes place and other specialist involvement needed on long term management). The difficulty is that there isn't one single classification of wounds. We need to emphasize the focus on ' Healing ' and therefore reducing ' chronicity' and hence any 'simple wound' that doesn't heal within two weeks is by definition a 'complex wound'. To expand on this, a 'complex wound' is

often associated with patient co-morbidities (cardiovascular, renal, respiratory etc.) , polypharmacy, neuro-vascular factors and hence would include pressure ulcers, diabetic ulcers, fistulae, non-healing surgical wounds, wounds due to complications of treatment e.g.; radiotherapy, chemotherapy etc.;

Practices may wish to undertake wound care at an individual practice level or may wish to deliver through collaborative arrangements with their locality colleagues.

If a patient presents to Primary Care with a complex wound that on review it is not expected to heal within the 6 week window (Types of leg ulcer), the patient will be directly referred to the Ambulatory Clinic (We are ensuring that the right wounds are being managed by the right expertise. The Wound care specialist (Ambulatory Clinics) will inform the practice of progress of wounds with regular updates every 6 weeks (we may just need to clarify this with SSOTP)

Payment

Payment was discussed and initial proposals are that payment could be offered as a service provision for an identified practice or locality population and not per item of wound care delivered. This way payment can be paid per practice or locality group. There is a need to ensure payment is equitable across localities and against a consistent Primary Care offer described above. There is a requirement to clearly define what we wish practices to do for payment.

Tasks completed:

- Meet with Ann Perry 29/08/17 to undertake financial modelling for wound care and suture removal
- Meeting Ann Perry and Dr Mo Huda 30/08/17 to discuss financial modelling for wound care and suture removal
- Initial financial modelling shared with Lynn Millar as Director of Primary Care

Referral on from Primary Care after 6 weeks of intervention and review:

Referral on after 6 weeks was discussed and it was proposed that when more complex wounds have not healed after 6 weeks of Primary Care interventions and regular review they are directly referred to Ambulatory Clinics who offer Specialist Nurse provision. Once the Patient is referred on, the responsibility for management is passed to Ambulatory Clinic; there are no joint working arrangements or referral back to Primary care for any element of the wound care provision. The Patient is discharged back to Primary Care following completion for treatment and the wound has healed satisfactorily.

There will be key performance indicators agreed with SSOTP for review of the referred patient's complex wound within an agreed number of days.

Any attempt at pushback will be challenged against contractual obligations and aligned to the service specification agreed with SSOTP.

Recording and reporting

There will be a need to record activity within an agreed consistent template, activity to be reviewed after 12-18 months (MH this will allow to assess levels of activity, which wounds are then escalated and how many them then heal as a measure of outcomes)

Dependencies

The dependency for the Primary Care element to work successfully is that the other elements of the pathway are operating as agreed in the contractual arrangements, service specifications and pathways; namely Ambulatory Care clinics, District Nursing and Tissue Viability Services (with links with Secondary Care for vascular assessments or skin grafting)

Training and supervision

CCGs could support a training and supervision needs audit, to be undertaken at an individual Practice level and will support practices with training and upskilling (e.g. PLT for HCA's/ Nurses/GPs etc.), to ensure consistent level of management of simple to complex wounds expected to heal in the six week window.

Key messages:

- Clear Primary care offer up to six weeks maximum
- A consistent offer across practices and localities
- The offer can be delivered at an individual practice or locality scale
- There will be equitable levels of remuneration across practices and localities
- There will be clear transfers of care following agreed pathways after 6 weeks
- There will be no pushbacks as per contract and specification, if so SSOTP will be held to account

Next steps

- Anne Perry to develop financial modelling costs for wound care if it was delivered in A&E and minor injury units in order to support the business case for Primary Care delivery of wound healing.
- The group to review and develop the primary care element of the specification
- Once financial modelling has been undertaken and remuneration for the Primary Care element of the wound healing pathway has been proposed, the proposal will go to FPC Committee, and based on the amount of funding required to Governing Body, with the proposals coming back to Membership and Locality Boards. (This process is followed due to the financial element being asked for is of a sufficient amount that requires Governing Body approval)

2.) Anticoagulation

Status: Review undertaken, specification and plan developed, in delivery

This Local Enhanced Service has previously been reviewed by Jane Chapman. Jane has developed a specification to be delivered within a prime provider approach.

Discussions are being arranged between prime providers and Primary Care with involvement of Primary Care development Managers for each Locality area.

3.) Nursing Home Care Plans / LES

Status: Review in progress

The review is in progress and task and finish groups have been undertaken on:

- 3rd August
- 30th August
- 21st September

This section will encompass the review of current local enhanced services supporting care homes, evaluation of current local improvement schemes and the development of an enhancing health in care homes programme aligned to the enhancing health in care homes publication (NHS England, 2016)

The approach: Governance

We have established an Enhanced Health in Care Homes working group Chaired by Dr Mo Huda to:

- Review current Care Homes Local Enhanced Service (LES) arrangements
- Understand current baseline and identify areas for opportunity
- Develop a Local Improvement Scheme (LIS), learning from existing pilot schemes (Scope will include nursing and mixed residential homes initially)
- Bring existing CCG programmes of work together, Quality, End Of Life, Primary Care, Frailty and Medicines Management
- Develop a two year QIPP programme with identified schemes and timelines for delivery
- Oversee evaluation of schemes to demonstrate reductions in conveyances & attendance at locality level and impact of quality and better coordination of support into nursing homes
- Ensure alignment with evidence-based practice from the National Vanguard sites

The Approach: Phasing

We plan to undertake a two year local improvement scheme utilising principles of Enhanced Health in Care Homes (NHS England, 2016). This improvement scheme will be delivered through a staged approach:

First year stage 1 Scope:
Nursing and mixed residential but also includes two areas (Seisdon practices and Lichfield and Burntwood) who also are potentially* including residential homes in their scope. This will allow a review in year to inform year two planning

Second Year stage 2 Scope:
Nursing and Residential Homes

The Approach: Process

Evaluate current pilots and develop a roll out plan:

- We plan to evaluate the current pilots in Stafford Town (Nursing and mixed residential) and Seisdon (Nursing and Residential)
- We plan to work with colleagues from both areas to ensure the modelling, design and roll out plan are informed by their learning. We will identify clear and realistic milestones and timelines.
- We will develop a roll out plan informed by the appetite and readiness of Localities to deliver the Local Improvement Scheme

Scope for year one:

- Nursing and Mixed Residential for all Localities (excluding Seisdon and Lichfield and Burntwood)
- Seisdon and Lichfield and Burntwood Locality Nursing and Residential Pilot will provide us with an opportunity to stage the developments and for two areas working outside the initial scope, to undertake a structured evaluation and reporting process in year 1 to inform second year developments (Nursing and Residential Homes)

Funding request to roll out QIPP scheme

The Enhancing Health in care Homes proposal was taken to Star Chamber on 23/08/17 and the consensus from the panel was that it was a sound QIPP scheme and the additional funding that was requested should be supported on the proviso that the financial modelling be taken to FPC for final sign off at September's meeting (21st).

Next steps

A working group meeting is planned for 21st September and at that meeting a detailed action plan to deliver the enhancing health in care homes initial elements (primary care, end of life, medicines management) will be agreed and it will include clear actions with dates and owners, this will be monitored monthly via comply or explain.

The action plan will include:

- Pilot milestones,
- Key Performance Indicators and evaluation
- Baseline modelling against forecast demand
- Consideration of weekend and evening admissions on the overall opportunity
- GP Practice engagement plan

At that meeting, the group will also:

- agree a plan to engage Locality and Membership Groups to inform the roll out plan for the Local Improvement scheme
- agree a plan to undertake a review of the current Care Homes Primary Care Locally Enhanced Service (LES)
- agree a plan to undertake a review of the current Care Homes Primary Care Local Improvement Schemes (LIS)

4). Androgen Deprivation

Status: Planning meetings have been undertaken, to plan task and finish group for October 2017

Initial planning meetings undertaken with Sam Buckingham, Head of Medicines management on:

- 1st September

Next steps

- To set up task and finish group with key members identified from Locality and membership groups to start review in October

5.) Shared Care Drug Monitoring Provision

Status: Planning meetings have been undertaken, to plan task and finish group for October 2017

Initial planning meetings undertaken with Sam Buckingham, Head of Medicines management on:

- 1st September

Next steps:

- To set up task and finish group with key members identified from Locality and membership groups to start review in October

6.) Conversion of Insulin

Status: Planning meetings have been undertaken, to plan task and finish group for December 2017

Initial planning meetings undertaken with Sam Buckingham, Head of Medicines management on:

- 1st September

Next steps:

Sam will meet in September with representatives from the diabetic team and will also have a conversation with Harriet Summerfield. To move review priority order to December 2017 from September 2017.To plan task and finish group for December 2017

7.) Denosumab

Status: Planning meetings have been undertaken, to plan task and finish group for December 2017

Initial planning meetings undertaken with Sam Buckingham, Head of Medicines management on:

- 1st September

Next steps:

Sam to gather further information to inform initial task and finish group meeting. To move review priority order to December 2017 from September 2017**.** To plan task and finish group for December 2017

8.) Phlebotomy

Status: Planning meetings have been undertaken, task and finish group has been arranged for October 2017 to start review

Planning meetings undertaken on

- 2nd August
- 30th August

A planning meeting was undertaken on 2nd and 30th August to understand the current position and to plan the review process for the phlebotomy local enhanced service

Next steps

- To gather current information regards current practices and values
- To undertake an audit during September,
- Start task and finish group review in October

9.) Spirometry Provision

Status: Planning meetings have been undertaken, to plan task and finish group for November 2017

Planning meetings undertaken on

- 19th July
- 6th September

An initial planning meeting was held on 19/07/17 with Sharon Cooper, Senior Commissioning Manager and a follow up planning meeting was held on 6th September and chaired by Dr Paddy Hannigan and attended by Dr David Cook Consultant Respiratory Physician, County Hospital, and Sharon Cooper.

Next steps

- An audit will be undertaken to understand need
- A task and finish group meeting will be scheduled in November 2017

10.) Menorrhagia

Status: Planning meetings have been undertaken, to plan task and finish group for November 2017

Planning meetings undertaken on

- 22nd August

An initial planning meeting was held on 22/08/17 with Mel Mahon, Head of Commissioning (Planned Care).

Next steps

- A task and finish group meeting will be scheduled in November 2017

11.) Minor Surgery on Referral (Cannock intra practice)

Status: Planning meetings have been undertaken, to plan task and finish group for December 2017

An initial planning meeting was held on 22/08/17 with Mel Mahon, Head of Commissioning (Planned Care) and Alex Bennett Commissioning Manager

Next steps

- A task and finish group meeting will be scheduled in December 2017

12.) 6 week Post Natal Check

Status: Planning meetings have been undertaken, to plan task and finish group for December 2017

Planning meetings have been held on 28/07/17 and 8/9/17 with Alex Birch, Programme Lead for the Pan Staffordshire Maternity Transformation Programme

Next steps

- A task and finish group meeting will be scheduled in December 2017

13.) Multiple Sclerosis

Status: Planning meetings have been undertaken, to plan task and finish group for January 2018

An initial planning meeting was held on 17/08/17 with Dr Adrian Parkes

Next steps

- A task and finish group meeting will be scheduled in January 2018

14.) Prostate-specific antigen (PSA) Monitoring

Status: Planning meetings have been undertaken, to plan task and finish group for January 2018

An initial planning meeting was held on 19/07/17 with Andy Hadley, Senior Primary Care Development Manager

Next steps

- A task and finish group meeting will be scheduled in January 2018

Cannock Chase Clinical Commissioning Group
South East Staffordshire and Seisdon Peninsula Clinical Commissioning Group
Stafford and Surrounds Clinical Commissioning Group

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REPORT TO: Primary Care Commissioning Committees Meeting in Common

TO BE HELD ON: 28th September 2017

Subject:	Delegated Commissioning Month 5 2017/18							
Board Lead:	Lynn Millar							
Officer Lead:	David Skelton							
Recommendation:	**Approval/ Ratification**		**Assurance**		**Discussion**		**Information**	✓

PURPOSE OF THE REPORT:

To inform the Board of the Month 5 position for Cannock Chase, Stafford & Surrounds and South East Staffordshire & Seisdon Peninsula CCG's

KEY POINTS:

The tables in Appendix 1 summarise the financial position at Month 5 2017/18.
The current financial positions are :-

- Cannock Chase CCG is reporting an overspend of £5,105.
- Stafford & Surrounds CCG is reporting an underspend of £4,148.
- South East Staffordshire & Sesidon Peninsula CCG is reporting an overspend of £18,209

In terms of any underspends which may arise NHS England will not be looking to recover, as the budget has been devolved to CCG's.
The funding cannot be transferred out of Primary Care to other areas of the CCG.

NHSE hold some contingency reserves for any unexpected / unplanned expenditure which may arise – any prior year will be covered by NHSE – and would be willing to discuss non-recurrent support but this would not be guaranteed

CCG GOALS:

Change the culture: • **Hospital to home** • **Professional to patient**	
More focus on prevention	
Involving everyone for improved health and care	
Empower and support patients to take control of their own health	
Services supporting people to make informed decisions	

IMPLICATIONS:

Legal and/or Risk	
CQC	
Patient Safety	
Patient Engagement	
Financial	
Sustainability	
Workforce/Training	

RECOMMENDATIONS/ACTION REQUIRED:

The Primary Care Commissioning Committee is asked to receive the report.

KEY REQUIREMENTS	Yes	No	Not Applicable
Has a quality impact assessment been undertaken?			✓
Has an equality impact assessment been undertaken?			✓
Has a privacy impact assessment been completed?			✓
Has a communications & engagement impact assessment been completed?			✓
Have partners/public been involved in design?			✓
Are partners/public involved in implementation?			✓
Are partners/public involved in evaluation?			✓

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Other areas of Primary Care spend are over & above the values shown in these tables –

- Local Enhanced Services
- GP IT
- Prescribing
- Medicines Management
- Primary Care Developments

Delegated Co-commissioning – Finance Report – Aug 17

Cannock Chase CCG (04Y)

The current financial position for Cannock Chase CCG at Month 5 2017/18 is £5.1k overspend, below is the summary position by expenditure category:-

Narrative	Annual Budget (£)	YTD Budget (£)	YTD Actual (£)	YTD Variance (£)	Forecast (£)
Dispensing & Prescribing	146,364	60,958	60,958	0	146,364
Enhanced Services	514,328	199,067	186,560	(12,507)	514,328
General Practice APMS	262,342	109,306	110,080	774	262,342
General Practice GMS	10,005,757	4,134,939	4,163,985	1,011	10,005,757
General Practice PMS	2,772,821	1,107,894	1,195,610	22,828	2,772,821
Other GP Services	811,464	401,515	305,070	(3,522)	811,464
Premises Costs Reimbursements	1,388,087	626,423	622,945	(3,478)	1,388,087
QOF	1,751,837	726,194	726,194	0	1,751,837
Grand Total in Ledger at Month 5	**17,653,000**	**7,366,296**	**7,371,401**	**5,105**	**17,653,000**

The Enhanced Services underspend is predominantly due to the Extended Hours DES, where budgets have been recovered from practices that had received an allocation but did not sign up to the DES's.

General Practice APMS/GMS/PMS/Other GP Services collectively are showing an over-spend of £21,091. This is being driven by a PMS baseline overspend, which will be addressed Month 6 by way of an additional allocation transfer from NHSE.

Premises Costs Reimbursements is showing an under spend due to Premises Rates reducing in 17/18.

Year-end outturn continues to forecast a breakeven position.

Delegated Co-commissioning – Finance Report –August 17

Stafford & Surrounds CCG (05V)

The current financial position for Stafford & Surrounds CCG at month 5 2017/18 is £4k underspent, below is the summary position by expenditure category:-

EXPENDITURE

Category	Annual Budget (£)	YTD Budget (£)	YTD Actual (£)	YTD Variance (£)	Forecast Outturn(£)
Dispensing & Prescribing	756,894	315,357	315,357	0	756,894
Enhanced Services	504,306	198,816	197,922	(894)	504,306
General Practice GMS	11,279,870	4,622,856	4,630,588	732	11,279,870
General Practice PMS	3,180,484	1,268,297	1,259,767	(530)	3,180,484
Other GP Services	626,598	169,025	157,961	(12,063)	626,598
Premises Costs Reimbursements	1,862,038	905,973	914,581	8,608	1,862,038
QOF	2,033,810	837,134	837,134	0	2,033,810
Grand Total	**20,244,000**	**8,317,458**	**8,313,309**	**(4,148)**	**20,244,000**

General Practice APMS/GMS/PMS/Other GP Services collectively are showing an under-spend of £11,861.

Premises Costs Reimbursements overspend in due to rent reviews, which will be mitigated by the underspend on General Practice.

Year-end outturn continues to forecast a breakeven position.

Delegated Co-commissioning – Finance Report – August 17

South East Staffs & Seisdon Peninsular CCG (05Q)

The current financial position for South East Staffs & Seisdon Peninsular CCG at month 5 2017/18 is £18k overspent, below is the summary position by expenditure category:-

EXPENDITURE

Category	Annual Budget (£)	YTD Budget (£)	YTD Actual (£)	YTD Variance (£)	Forecast (£)
Dispensing & Prescribing	238,675	99,395	99,395	0	238,675
Enhanced Services	749,601	283,185	300,104	16,919	749,601
General Practice APMS	881,205	367,166	367,166	0	881,205
General Practice GMS	15,397,909	6,376,132	6,404,081	7,949	15,397,909
General Practice PMS	4,081,709	1,668,987	1,645,085	(3,902)	4,081,709
Other GP Services	1,087,430	392,872	400,586	7,714	1,087,430
Premises Costs Reimbursements	1,644,550	839,867	829,396	(10,471)	1,644,550
QOF	2,774,921	1,155,622	1,155,622	0	2,774,921
Grand Total	**26,856,000**	**11,183,226**	**11,201,435**	**18,209**	**26,856,000**

Enhanced Services overspend includes a cost pressure in Minor Surgery of £19k, due to be reviewed at Month 6 when practices submit M1-6 activity.

General Practice APMS/GMS/PMS/Other GP Services collectively are showing an overspend of £11,761. This is in the main due to a Global sum overspend which will be mitigated by the Premises costs benefit.

Premises costs reimbursements includes benefits from 17/18 rates reviews.

Year-end outturn continues to forecast a breakeven position.

Cannock Chase Clinical Commissioning Group
South East Staffordshire and Seisdon Peninsula Clinical Commissioning Group
Stafford and Surrounds Clinical Commissioning Group

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REPORT TO: Primary Care Commissioning Committee Meeting held in Common

TO BE HELD ON: 28th September 2017

Subject:	360° feedback action plan							
Board Lead:	Lynn Miller, Executive Director of Primary Care							
Officer Lead:	Eleanor Wood, Senior Primary Care Development Manager							
Recommendation:	**Approval/ Ratification**		**Assurance**	✓	**Discussion**		**Information**	✓

PURPOSE OF THE REPORT:

Following the recommendation from the June Committee meeting this paper sets out to provide assurance to the Committee that Membership feedback from the 360° stakeholder survey has been noted and that appropriate actions are being put in place to address issues that have arisen.

KEY POINTS:

This paper provides analysis of Member Practice feedback from the 2017 CCG 360° feedback and proposed actions in order to improve membership engagement as a result of their feedback through this survey.

The action plan has been shared with the CCG Clinical Chairs and Locality Directors and has also been presented to both EMT and the Communication and Engagement Committee.

Next steps for the action plan are to identify owners and timescales for each of the actions within the plan.

CCG GOALS:

Change the culture: • **Hospital to home** • **Professional to patient**	n/a
More focus on prevention	n/a
Involving everyone for improved health and care	To ensure that member practices are engaged with the commissioning of local healthcare and their views are taken on board.
Empower and support patients to take control of their own health	n/a
Services supporting people to make informed decisions	n/a

IMPLICATIONS:

Legal and/or Risk	None
CQC	None
Patient Safety	None
Patient Engagement	None
Financial	None
Sustainability	None
Workforce/Training	None

RECOMMENDATIONS/ACTION REQUIRED:

The Primary Care Commissioning Committee is asked to:

Note the action plan and to determine how frequently updates should be provided.

KEY REQUIREMENTS	Yes	No	Not Applicable
Has a quality impact assessment been undertaken?			✓
Has an equality impact assessment been undertaken?			✓
Has a privacy impact assessment been completed?			✓
Has a communications & engagement impact assessment been completed?			✓
Have partners/public been involved in design?	✓		
Are partners/public involved in implementation?	✓		
Are partners/public involved in evaluation?			✓

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REPORT TO: Primary Care Commissioning Committee Meeting held in Common

TO BE HELD ON: 28th September 2017

Subject:	Accessible Information Standard								
Board Lead:	Lynn Miller								
Officer Lead:	Fleur Fernando								
Recommendation:	**Approval/ Ratification**		**Assurance**		**Discussion**	✓	**Information**		

PURPOSE OF THE REPORT:

The purpose of this paper is to provide a briefing on the Accessible Information Standard and to assess whether any further support is required to ensure that where delegated commissioning is taking place; GP practices are consistently implementing the Standard across the Southern Staffordshire region.

KEY POINTS:

The Accessible Information Standard is a mandated legal requirement introduced by NHS England that defines a consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of patients, service users, carers and parents, where those needs relate to a disability, impairment or sensory loss.

CCG GOALS:

Change the culture: • **Hospital to home** • **Professional to patient**	Equality and inclusion is integral in everything that the CCG does and all services we commission
More focus on prevention	Equality and inclusion are key to prevention
Involving everyone for improved health and care	Getting equality and inclusion right will lead to improved health and care
Empower and support patients to take control of their own health	Getting equality and inclusion right will lead to us listening to patients to enable them to take control of their own health
Services supporting people to make informed decisions	Getting equality and inclusion right will lead to people making informed decisions

IMPLICATIONS:

Legal and/or Risk	Equality act 2010 and public sector equality duty 2011 put into place important key legislation that we need to comply with.
CQC	n/a
Patient Safety	Is linked to our providers and equality
Patient Engagement	Closely linked to equality – particularly through EDS2
Financial	To avoid judicial review we must follow due process
Sustainability	This work will link closely to the Sustainability and Transformation Plan
Workforce/Training	As outlined in the work plan there are training requirements

RECOMMENDATIONS/ACTION REQUIRED:

The Primary Care Commissioning Committee is asked to:
The Discuss the content of the paper and decide on the next steps.

KEY REQUIREMENTS	**Yes**	**No**	**Not Applicable**
Has a quality impact assessment been undertaken?			**N/A**
Has an equality impact assessment been undertaken?			**N/A**
Has a privacy impact assessment been completed?			**N/A**
Has a comms & engagement impact assessment been completed?			**N/A**
Have partners/public been involved in design?			**N/A**
Are partners/public involved in implementation?			**N/A**
Are partners/public involved in evaluation?			**N/A**

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Accessible Information Standard Update to Primary Care Committee

1.1 Executive Summary

The purpose of this paper is to provide a briefing on the Accessible Information Standard and to assess whether any further support is required to ensure that where delegated commissioning is taking place; GP practices are consistently implementing the Standard across the Southern Staffordshire region.

The Accessible Information Standard is a mandated legal requirement introduced by NHS England that defines a consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of patients, service users, carers and parents, where those needs relate to a disability, impairment or sensory loss.

The Standard is applicable to individuals who are blind, deafblind and / or who have a learning disability, and it applies to anyone who has a specific communication need relating to a disability, impairment or sensory loss

The Standard applies to service providers across the NHS and adult social care system, and it specifically aims to improve the quality and safety of care received by individuals with information and communication needs, and their ability to be involved in autonomous decision-making about their health, care and wellbeing.

Commissioners of NHS care and publicly-funded adult social care must also have regard to this Standard. They must ensure that contracts, frameworks and performance-management arrangements with provider bodies enable and promote the Standard's requirements.

1.2 Background

In early 2016 the CCG's Health Engagement and Equalities lead provided a briefing to GP practices regarding the implementation of the Accessible Information Standard and the requirement to be compliant with the Standard by July 2016.

To help the Southern Staffordshire GPs to meet the Accessible Information Standards requirement we sent out up-to-date information in the CCG e-newsletters to practice staff:

- ✓ March 2016 GP newsletters contained information about the Accessible information standard and who to contact for support with implementing the standard locally and where to find NHS England support.
- ✓ July 2016 GP newsletters contained an article outlining the Accessible Information (the 'Accessible Information Standard'): Notes on the NHS e-Referral Service overview of the current situation 2016

1.3 Requirements

Successful implementation of the Accessible Information Standard is based on the following elements:

- Identification of needs: a consistent approach to the identification of patients', service users', carers' and parents' information and communication needs, where they relate to a disability, impairment or sensory loss.

Recording of needs:

- Consistent and routine recording of patients', service users', carers' and parents' information and communication needs, where they relate to a disability, impairment or sensory loss, as part of patient / service user records and clinical management / patient administration systems;
- Use of defined clinical terminology, set out in four subsets, to record such needs, where Read v2, CTV3 or SNOMED CT® codes are used in electronic systems;
- Use of agreed English definitions indicating needs, where systems are not compatible with either of the three clinical terminologies or where paper based systems / records are used;

Recording of needs in such a way that they are 'highly visible'.

- Flagging of needs: establishment and use of electronic flags or alerts, or paper-based equivalents, to indicate that an individual has a recorded information and / or communication need, and prompt staff to take appropriate action and / or trigger auto-generation of information in an accessible format / other actions such that those needs can be met.
- Sharing of needs: inclusion of recorded data about individuals' information and / or communication support needs as part of existing data-sharing processes, and as a routine part of referral, discharge and handover processes.
- Meeting of needs: taking steps to ensure that the individual receives information in an accessible format and any communication support which they need.

1.4 Implementing the standard – delegated commissioning

The Specification for the Standard includes conformance criteria which should be used in order to assess compliance.

Commissioning organisations are required to seek assurance from provider organisations of their compliance with this Standard, including evidence of identifying, recording, flagging, sharing and meeting of needs

As part of the Standard, organisations are required to publish an accessible communications policy, to implement an accessible complaints policy and to support individuals with information and communications needs to provide feedback on their experience of services and of receiving information in appropriate formats and / or communication support.

At a local level, applicable organisations will need to assure themselves that they are complying with the Standard. It is recommended that organisations identify an Accountable Officer or similar designated role indicating an individual with responsibility for implementation and compliance with the Standard at a senior level.

1.5 Checklist to ascertain whether provider organisations have implemented the Standard.

Below is an example of a checklist to ascertain whether the Standard has been implemented.

- GP practices have developed / modified accessible communication policy which is in line with the Accessible Information Standard.
- Agreed approach to identifying individuals with information / communication needs relating to a disability, impairment or sensory loss.
- Clear process for recording individuals' information / communication needs in line with the Standard.
- A flag, alerts or prompts established to highlight / make individuals' information / communication needs 'highly visible' to staff, supported by relevant prompts to action.
- Identified range of ways for individuals with communication needs to contact the service, and for the service to contact them, supported by agreed process for using any 'alternative' approaches.
- Agreed process for sending out correspondence in alternative formats.
- Agreed process for producing / obtaining information in alternative formats.
- Agreed process for arranging / booking professional communication support.
- Agreed process for booking / arranging longer appointments for patients / service users with communication needs.
- Training / briefing given to staff to explain the Accessible Information Standard, detail processes to be followed and raise awareness of support which staff can provide themselves

1.6 Conclusion

To obtain an understanding of whether the Standard has been implemented consistently across the Southern Staffordshire region it is important to ascertain what further support is required for GP practitioners. The deadline for implementing the Accessible Information Standard in relation to GP Practices was the 31st July 2016 and the role of the CCG (in the particular primary care team) is to ensure that the Standard has been fully implemented by provider organisations.

1.7 Recommendation

The Primary Care Team should ensure that GP practices have implemented the Standard using the above checklist. If GP practices have not implemented the Standard then CCG colleagues will need to work with GP practices as soon as possible to ensure compliance.

Sabrina Richards

MLCSU Equality and Inclusion Business Partner

September 2017

Acronyms

1.	A&E	Accident & Emergency
2.	AHP	Allied Health Professional
3.	ANNP	Advanced Neonatal Nurse Practitioner
4.	AO	Accountable Officer
5.	APMS	Alternative Provider Medical Services
6.	AQP	Any Qualified Provider
7.	ASD	Autism Spectrum Disorder
8.	AVS	Acute Visiting Service
9.	BADGER	Birmingham and District General Emergency Rooms
10.	BAF	Board Assurance Framework
11.	BCF	Better Care Fund
12.	BCHFT	Birmingham Children's Hospital NHS Foundation Trust
13.	BEN	Birmingham East and North PCT
14.	BHFT	Burton Hospital NHS Foundation Trust
15.	BOTOX	Botulinum Toxin Type A
16.	BPAS	British Pregnancy Advisory Service
17.	C&E	Communications & Engagement
18.	CAG	Commissioning Advisory Group
19.	CAMHS	Children and Adolescent Mental Health Service
20.	CAS	Clinical Assessment Service
21.	CC	Cannock Chase
22.	CCG	Clinical Commissioning Group
23.	C*diff*	Clostridium Difficile Infection
24.	CEO	Chief Executive Officer
25.	CEPN	Community Education Provider Network
26.	CHC	Continuing Health Care
27.	CMT	Contract Management Team
28.	COPD	Chronic Obstructive Pulmonary Disease
29.	CPAG	Clinical Policies Advisory Group
30.	CPN	Community Psychiatrist Nurse
31.	CQC	Care Quality Commission
32.	CQRM	Clinical Quality Review Meetings
33.	CQUIN	Commissioning for Quality and Innovation
34.	CRT	Crisis Response Team
35.	CSU	Commissioning Support Unit
36.	CSW	Clinical Support Worker
37.	CWG	Clinical Working Group
38.	DES	Direct Enhanced Service
39.	DN	District Nurse
40.	DoH	Department of Health
41.	DPA	Data Protection Act
42.	DQF	Data Quality Facilitator
43.	ED	Emergency Department
44.	EDS	Equality Delivery System
45.	EL	Elective
46.	EMT	Executive Management Team
47.	ENT	Ear Nose Throat
48.	EOL	End of Life
49.	EPR	Electronic Patient Record
50.	ESR	Electronic Staff Record
51.	ETTF	Estates and Technology Transformation Fund
52.	EWISS	Emotional Well Being in Stafford & Surrounds
53.	EWTD	European Working Time Directive
54.	F&P	Finance and Performance
55.	FE	Frail Elderly
56.	FET	Funding Exceptional Treatment
57.	FFT	Friends and Family Test
58.	FNOF	Fractured Neck of Femur
59.	FOI	Freedom of Information
60.	FPC	Finance Performance & Contract Committee

61.	FRP	Financial Recovery Plan
62.	GB	Governing Body
63.	GMS	General Medical Services (Practice)
64.	GP	General Practitioner
65.	GPWSI	GP with special interest
66.	GSF	Gold Standard Framework
67.	HCAI	Healthcare Associated Infections
68.	HEFCE	Higher Education Funding Council for England
69.	HEFT	Heart of England Foundation NHS Trust
70.	HIS	Health Informatics Service
71.	HPS	Health promoting Schools
72.	HPSS	Health promoting Schools Scheme
73.	HR	Human Resources
74.	HROD	Human Resources Organisational Development
75.	HSJ	Health Service Journal
76.	IAF	Improvement and Assessment Framework
77.	IAPT	Improving Access to Psychological Therapies
78.	ICG	Infection Control Group
79.	IFR	Independent Funding Request
80.	IG	Information Governance
81.	IM&T	Information Management and Technology
82.	IP	Inpatients
83.	IPC	Infection Prevention & Control
84.	IPR	Individual Performance Review
85.	IQT	Improving Quality Team
86.	ISA	Intermediate Support Assistant
87.	ITT	Invite to Tender
88.	JSNA	Joint Strategic Needs Assessment
89.	KPI(s)	Key Performance Indicator(s)
90.	KPMG	Global Network of Profession Firms providing audit, tax and advisory services
91.	LAA	Local Area Agreement
92.	LDD	Learning Disability and/or Difficulty
93.	LDP	Local Delivery Plan
94.	LDR	Local Digital Roadmap
95.	LES	Local Enhanced Service
96.	LHE	Local Health Economy
97.	LMC	Local Medical Council
98.	LMS	Local Medical Services
99.	LSP	Local Strategic Partnership
100.	LTC	Long Term Conditions
101.	M&L CSU	Midlands & Lancashire Commissioning Support Unit
102.	MAT	Maternity
103.	MAU	Medical Assessment Unit
104.	MB	Membership Board
105.	MCA	Mental Capacity Act
106.	MDT	Multidisciplinary Team
107.	MHRA	Medicines & Healthcare products Regulatory Agency
108.	MICATS	Musculoskeletal Integrated Clinical Assessment & Treatment Service
109.	MICOT	Minor Injuries Community Outreach Team
110.	MIU	Minor Injuries Unit
111.	MLU	Midwife-led Unit
112.	MOI	Memorandum of Information
113.	MORI	(Market & Opinion Research International)
114.	MOU	Memorandum of Understanding
115.	MPIG	Medical Practice Income Guarantee
116.	MRSA	Meticillin-Resistant Staphylococcus Aureusis Infection
117.	MSFT	Mid Staffordshire NHS Foundation Trust (now part of UHNM as County Hospital)
118.	MSK	Musculoskeletal
119.	NEL	Non-Elective
120.	NES	National Enhanced Service
121.	NHQAC	Nursing Home Quality Assurance Group

122.	NHS	National Health Service
123.	NHSE	NHS England
124.	NICE	National Institute for Clinical Excellence
125.		
126.	NMC	Nursing and Midwifery Council
127.	NSL	Non Urgent Patient Transport Provider
128.	OD	Organisational Development
129.	OOH	Out of Hours, also Out of Hospital
130.	OP (D)	Outpatients (Department)
131.	OT	Occupational Therapist
132.	PAED	Paediatrics
133.	PALS	Patient Advice and Liaison Service
134.	PASS	Professional Advice and Support Service
135.	PAU	Paediatric Assessment Unit
136.	PBR	Payment By Results
137.	PCT	Primary Care Trust
138.	PEC	Professional Executive Committee
139.	PID	Project Initiation Document
140.	PIS	Prescribing Incentive Scheme
141.	PLCV	Procedures of Limited Clinical Value
142.	PLT	Protected Learning Time
143.	PM	Practice Manager
144.	PMO	Programme Management Office
145.	PMS	Personal Medical Services
146.	PPG	Patient Participation Group
147.	PPI	Patient and Public Involvement
148.	PPI (prescribing)	Proton Pump Inhibitors
149.	PPV	Post Payment Verification
150.	PQQ	Pre Qualifying Questionnaire
151.	PRF	Patient Report Form
152.	PRISM	Personnel Resource Information System for Management
153.	PROMs	Patient Related Outcome Measures
154.	PT	Physical Therapist
155.	PU	Pressure Ulcer
156.	PWSI	Pharmacist with Special Interest
157.	QIA	Quality Impact Assessment
158.	QIF	Quality Improvement Framework
159.	QIL	Quality Improvement Lead
160.	QIP	Quality Improvement Programme
161.	QIPP	Quality, innovation, productivity and prevention.
162.	QOF	Quality and Outcomes Framework
163.	RAG	Red Amber Green
164.	RAP	Remedial Action Plan
165.	RCA	Root Cause Analysis
166.	RIA	Risk Impact Assessment
167.	RIO	Electronic Care System
168.	RRL	Revenue Resource Limit
169.	RSUH	Royal Stoke University Hospital
170.	RTT	Referral to Treatment
171.	RWT	Royal Wolverhampton Hospital Trust
172.	SALT	Speech & Language Therapist
173.	SARC	Sexual Assaults Referrals Centre
174.	SAS	Stafford and Surrounds
175.	SCC	Staffordshire County Council
176.	SCR	Strategic Change Reserve
177.	SI	Serious Incident
178.	SIRO	Senior Information Risk Officer
179.	SLAM	Service Level Agreement Model
180.	SSOTP	Staffordshire & Stoke on Trent Partnership Trust
181.	SSPAU	Short Stay Paediatric Assessment Unit
182.	SSSFT	South Staffordshire & Shropshire Foundation Trust

183.	SSSHFT	South Staffs & Shropshire Healthcare Foundation Trust
184.	STP	Sustainability and Transformation Plan
185.	SUI	Serious Untoward Incident(now known as SI's)
186.	SUS	Secondary User Services
187.	TDA	Trust Development Authority
188.	TOR	Terms of Reference
189.	TSA	Trust Special Administrator
190.	TV Team	Tissue Viability Team
191.	UCC	Urgent Care Centre
192.	UHB	University Hospital Birmingham
193.	UHNM	University Hospitals of North Midlands NHS Trust
194.	UHNS	University Hospital North Staffordshire
195.	VAT	Value Added Tax
196.	VFM	Value for Money
197.	WCC	World Class Commissioning
198.	WHT	Walsall Hospitals Trust
199.	WIC	Walk in Centre
200.	WMAS	West Midlands Ambulance Service
201.	WMQRS	West Midlands Quality Review Service
202.	WRES	Workforce Race Equality Standard
203.	WTE	Whole Time Equivalent
204.	WUCTAS	Wolverhampton Urgent Care Triage Access Service
205.	YTD	Year to Date

http://www.nhsemployers.org/your-workforce/primary-care-contacts/general-medical-services/gms-acronyms