NHS
Wolverhampton
Clinical Commissioning Group

Meeting of the Primary Care Commissioning Committee (PUBLIC)
Tuesday 3rd July 2018 at 2.00 pm
Stephenson Room, 1st Floor, Technology Centre, Wolverhampton Science Park.

A G E N D A

1	Welcome and Introductions	Chair	Verbal
2	Apologies	Chair	Verbal
3	Declarations of Interest	Chair	Verbal
4	Minutes of the meeting held on 22nd May 2018	Chair	1 - 8
5	Matters Arising from the Minutes	Chair	Verbal
6	Committee Action Points	Chair	9 - 12
7	Primary Care Quality Report	Liz Corrigan	13 - 42
8	Governing Body Report/Primary Care Strategy Committee Update	Sarah Southall	Verbal
9	Primary Care Operational Management Group Update	Mike Hastings	43 - 48
10	QOF + Report	Lucy Sherlock	49 - 78
11	Governance Arrangements for Primary Care	Peter McKenzie	79 - 94
12	Any Other Business	Chair	Verbal
13	Date of Next Meeting		

Tuesday 7th August 2018 at 2.00pm in PC108 Room, Creative Industries Building, Wolverhampton Science Park

NHS
Wolverhampton
Clinical Commissioning Group

For further information on this agenda or about the meeting generally, or to submit apologies for absence, please contact Laura Russell on 01902 444613 or email laura.russell4@nhs.net

MEMBERSHIP	
Wolverhampton CCG	McKie (Chair) Dr D Bush Ms S Gaytten Dr H Hibbs Dr S Reehana Mr S Marshall Ms S Roberts Mr LTrigg
NHS England	Bal Dhami
Patient Representatives	Sarah Gaytten
Invitees (Non-Voting)	Tracy Cresswell (Healthwatch) John Denley (Health and Wellbeing Board)

WOLVERHAMPTON CLINICAL COMMISSIONING GROUP
PRIMARY CARE COMMISSIONING COMMITTEE

Minutes of the Primary Care Commissioning Committee (PUBLIC)
Tuesday 22nd May 2018 at 2.30pm
Stephenson Room, Technology Centre, Wolverhampton Science Park

MEMBERS ~
Wolverhampton CCG ~

		Present
Sue McKie	Chair	Yes
Dr David Bush	Locality Chair / GP	Yes
Dr Manjit Kainth	Locality Chair / GP	No
Dr Salma Reehana	Clinical Chair of the Governing Body	Yes
Steven Marshall	Director of Strategy & Transformation	Yes
Sally Roberts	Chief Nurse	Yes
Les Trigg	Lay Member (Vice Chair)	Yes

NHS England ~

Bal Dhami	Contract Manager	Yes

Independent Patient Representatives ~

Sarah Gaytten	Independent Patient Representative	No

Non-Voting Observers ~

Tracy Cresswell	Wolverhampton Healthwatch Representative	Yes
Dr Gurmit Mahay	Vice Chair – Wolverhampton LMC	No
Jeff Blankley	Chair - Wolverhampton LPC	Yes

In attendance ~

Mike Hastings	Associate Director of Operations (WCCG)	Yes
Dr Helen Hibbs	Chief Officer (WCCG)	Yes
Peter McKenzie	Corporate Operations Manager (WCCG)	Yes
Gill Shelley	Primary Care Contracts Manager (WCCG)	Yes
Sarah Southall	Head of Primary Care (WCCG)	Yes
Jane Worton	Primary Care Liaison Manager (WCCG)	Yes
Tony Gallagher	Chief Finance Officer (WCCG)	Yes
Simon Bourne	Management Consultant (Strategy Unit CSU)	Yes
Jo Reynolds	Primary Care Development Manager (WCCG)	Yes
Ranjit Khular	Primary Care Transformation Manager (WCCG)	Yes
Dr R Gulati	Wolverhampton GP	Yes
Dr Asghar	Wolverhampton GP	Yes
Laura Russell	Primary Care PMO Administrator (WCCG – minutes)	Yes

Welcome and Introductions

WPCC208 Ms McKie welcomed attendees to the meeting and Introductions took place.

Apologies

WPCC209 Apologies were submitted on behalf of Sarah Gaytten and Dr Kainth.

Declarations of Interest

WPCC210 Dr Bush, Dr Reehana, Dr Gulati and Dr Asghar declared that, as GPs they have a standing interest in all items relating to Primary Care.

Minutes of the Meeting held on the 6th February 2018

WPCC211 It was reported there was a spelling mistake on page 4 under WPCC184 last bullet point it should read smoking cessation not smoking sensation.

Apart from this amendment the minutes of the meeting held on the 6th February 2018 were approved as an accurate record.

RESOLVED: That the above was noted.

Matters Arising from the Minutes

WPCC212 There were no matters arsing from the minutes.

Committee Action Points

WPCC213 **Minute Number PCC302a - Premises Charges (Rent Reimbursement)**
The cost directives are still awaited.

Minute Number WPCC117 - Provision of Services post Dr Mudigonda retirement from a partnership to a single hander
The update is due in September 2018.

Minute Number WPCC186 - Pharmacy First Scheme for all patients
The report is due at the August 2018 meeting.

Quarterly Finance Report

WPCC214 Mr Gallagher provided a report to the Committee on the CCGs financial position at Month 12 (March 2018). Mr Gallagher reported that the final delegated primary care allocations for 2017/18 is £35.650M. The outturn is £34.428 delivering an underspend position of £1.221m.

The outturn indicates an underspend of £1,221m across delegated primary care of which £790k is against other GP services which relates to the release of accruals relating to pre-delegation. The CCG has received the income to offset expected expenditure, However, as a result of a lower

level of actual spend being incurred, the CCG is reporting a non recurrent benefit of £790k.

Mr Gallagher noted that since the CCG had full responsibility for delegated primary care it has developed the strategy to be aligned to the five year forward view. This has given benefits to patients and the public including:

- Saturday Hub Opening
- Improved Access Opening
- Providing training for Practice Nurses

The CCG will ensure tighter monitoring of schemes to ensure the resource is fully committed.

RESOLUTION: The Committee noted the content of the report and the assurance provided.

QOF+ Scheme 2018/19

WPCC215 Mr Bourne presented the QOF+ Scheme 2018/19 Business Case, Equality Impact Assessment and Quality Impact Assessment to the Committee. The Data Protection Impact Assessment was not made available and will be circulated following the meeting.

The new scheme will be for practices to participate in and will be offered to all Wolverhampton Member Practices. The scheme will focus on tackling three priority areas, Diabetes (Pre-diabetic), Alcohol and Obesity. The purpose of the scheme is to prevent ill health and patients developing disease associated with the three priority areas.

The Committee were informed that member practices were engaged in discussions regarding the priority areas. An external review was commissioned the by the CCG in January and February 2018, which undertook a scoping and review of national evidence in order to determine the evidence base for interventions for the three priority areas. In March the first draft of the scheme was shared with clinicians across primary care including Group Leads, Clinical Reference Group and LMC. In relation to the implementation this will be working within practices and supported by IMT facilitators, as there is a risk practice will experience difficulties in implementing if support is not provided by the CCG. The scheme will be measured by using the Graphnet system.

NOTE: Dr Bush, Dr R Gulati, Dr Asghar and Dr Reehana left the meeting whilst discussions and decisions were taken regarding the report and its recommendations.

The Committee discussed in the length the scheme in particular around the payment and method of calculating the QOF+ points. There were queries made regarding the method being used. It was noted level of payment made to practices will be dependent on the number of QOF+ points they accrue, out of a total of 100 available points. These have been

distributed between the QOF+ indicators. It has been decided based on GP feedback not to incorporate a sliding scale as used previously as they wanted something they could understand and that was achievable. The Committee were informed that quarterly monitoring would be taking place.

The Committee agreed to the QOF+ Scheme.

RESOLUTION: The Committee agrees that:-

- **The Business Case, EIA and QIA were approved.**
- **The DPIA will be to follow**

Note: Mr Simon Bourne left the meeting

NOTE: Dr Bush, Dr R Gulati, Dr Asghar and Dr Reehana joined the meeting.

Primary Care Quality Report

WPCC216 Ms Roberts presented the report to the Committee an provided the following updates:

- **Infection Prevention -** The CCG and Infection prevention teams are continuing to support those practices who have received red ratings.
- **Friends and Family Test -** The figures for March 2018 submission show that they are better than regional and national averages. The overall responses remain positive (82% would recommend their practice) however it is still lower than national average at (89%). A Friends and Family Test Policy has been developed and has been shared with LMC who have approved it, this will come to the committee for approval.
- **Complaints -** The CCG does not have an oversight of GP complaints dealt within the surgery. NHS England are now sharing this information and this is being triangulated with other data.
- **Serious Incidents -** There are currently two serious incidents that are currently under investigation.
- **CQC inspections -** to date from April 2017, 18 practices have received an inspection, of which 16 have been rated good and 2 rated as requires improvement.
- **Workforce** - the workforce plan has been redefined in line with STP and national drivers. The working in Wolverhampton video is now complete and will be used to promote Wolverhampton as a place to work. The CCG continue to attend relevant workforce fairs locally. There is work being undertaken around international recruitment of GPs with a bid being recently submitted. The CCG are also working on adopting Walsall CCGs strategy on revalidation for practice nursing.

RESLOUTION: That the report was noted for assurance.

Governing Body Report - Primary Care Strategy Committee Update

WPCC217 Mrs Southall presented to the Committee the report which has been shared and approved by the Governing Body in April 2018.The report provided an overview of the discussions that took place at the Milestone Review Board with particular focus on to key programmes of work (Primary Care Strategy and General Practice Forward View). The Committee reviewed the content and accepted the report as assurance of the work being undertaken by the Primary Care Team.

RESOLUTION: That the above report was noted.

Primary Care Operational Management Group Update

WPCC218 Mr Hastings reported to the Committee the Operational Management Group had not met within the month as the meeting was cancelled. Mr Hastings noted that work is being undertaken to review the Contract Review Process and the CCG are working with Infection Prevention at RWT on the new regulations.

RESOLUTION: That the above report was noted.

Primary Care Counselling Service

Note: Mr Khular joined the meeting

WPCC219 Mr Khular provided the Committee with an update report on the progress made against the Primary Care Counselling Service which is funded from PMS premium monies.

Mr Khular noted that the Primary Care Counselling service was commissioned as a six month pilot that commenced in June 2017. The pilot was then subsequently extended following a positive evaluation. A contract for a three year service has been operational since the 1st April 2018, and was awarded to a consortium led by Relate Birmingham.

The report provided details of the activity, referrals and the reasons for those referrals. The Committee queried the recoding of the data, it was noted that they are collecting demographics and that they are working with the Mental Health Commissioner to ensure the measuring is correct and this in linked in with IAPT.

The Committee also queried the clinical view section of the report, and noted they needed to be mindful the patient is not counted twice; also patients are not using this service as an alternative to using the healthy minds service.

RESOLUTION: That the above report was noted.

Document Management

WPCC220 Ms Reynolds presented to the Committee the following documentation:

- Business Case
- Service Specification
- Equality Impact Assessment

- Data Protection Impact Assessment
- Quality Impact Assessment

Ms Reynolds asked the Committee to consider and review the above with a view to approve, so the specification can be advertised and a supplier be identified. Ms Reynolds stated that Document Management is part of the GPFV regarding training admin staff to enable the skills to manage clinical correspondence effectively. The aim of the programme is to free up GP time be enhancing the admin role.

The Committee queried how the programme of work would be monitored, it was stated that an audit would be undertaken in six months' time and will be monitored and managed at Group Level.

RESOLUTION: The Committee agrees that:-

- **The Business Case, Service Specification and supporting impact assessments were approved.**

Improving Access

WPCC221 Ms Reynolds shared with the Committee the Improving Access 2018/19 Business Case that has been prepared along with the following supporting documents:

- Service Specification
- Equality Impact Assessment
- Data Protection Impact Assessment
- Quality Impact Assessment

Ms Reynolds asked the Committee to receive and consider the Business Case and supporting documents to approve the continuation of this programme of work.

Ms Reynolds informed the Committee Improving access is a nationally mandated service for extending opening times of primary care on a hub basis. A requirement is to deliver 1.5 hours extra per evening (Monday to Friday after 6.30pm) and Saturday and Sunday. The deadline to achieve this is the 1st September 2018 and delivery plans have been submitted by practice groups to demonstrate how they will achieve this trajectory.

The Committee reviewed the business case and supporting documentation and approved to the continuation of this programme of work.

RESOLUTION: The Committee agrees that:-

- **The Business Case, Service Specification and supporting impact assessments were approved.**

Out of Area Registration

WPCC222 Mrs Reynolds provided a report and following documentation to the Committee:

- Service Specification

- Equality Impact Assessment
- Data Protection Impact Assessment
- Quality Impact Assessment

The Committee considered the documents provided and approved the out of area registration: In hours urgent primary care enhanced service.

RESOLUTION: The Committee approved the out of area registration for In hours urgent primary care enhanced service.

Any Other Business

WPCC223 The Committee agreed to cancel the next Public Committee meeting and the Private Committee meeting at an earlier time of 2.00pm.

RESOLVED: That the above was noted.

Date of Next Meeting

WPCC224 Tuesday 3rd July 2018 at 2.00pm in the Stephenson Room, 1st Floor, Technology Centre, Wolverhampton Science Park.

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Primary Care Joint Commissioning Committee Actions Log

Open Items

Action No	Date of meeting	Minute Number	Item	By When	By Whom	Action Update
35b	**08.02.17**	**PCC302a**	**Premises Charges (Rent Reimbursement)**	May 2017	NHS England	08.02.17 - Awaiting the new cost directives to provide clarity on rent reimbursement in relation to when Practices allow other service providers to be use their rooms such as midwives. 07.03.17 - NHS England confirmed they are still awaiting the new cost directives and have been informed they should receive this in April 2017. This will help to provide clarity on rent reimbursement in relation to when Practices allow other service providers using their rooms such as midwives. 04.04.17 - NHS England confirmed they are still awaiting the new cost directives and will inform the CCG once this has been received. This will help to provide clarity on rent reimbursement in relation to when Practices allow other service providers using their rooms such as midwives. 06.06.17 - The Committee was informed that the cost directives have been put on hold due to purdah. Action to remain open. 07.06.17 – Action to remain open cost directives still awaited.

						01.08.17 – Action to remain open the CCG have received advice and guidance from NHS England regarding the use of rooms for none GMS. The CCG are still awaiting the cost directives. 05.09.17 - The CCG are still awaiting the cost directives. 07.11.17 - The CCG are still awaiting the cost directives. 05.12.17 – CCG informed the cost directives will be made available in January 2018. 06.02.18 - It was noted the CCG have been informed the cost directives were still awaited. 22.05.18 - The cost directives are still awaited.

Primary Care Commissioning Committee Actions Log (public)

Action No	Date of meeting	Minute Number	Item	By When	By Whom	Action Update
10	**05.09.17**	**WPCC117**	**Provision of Services post Dr Mudigonda Retirement from a Partnership to single handed contract – Business Case** Ms Shelley agreed to report back to the practice that the Committee request in line with the with the business case they meet the expectation of reporting back in 12 months' time that they have a partner on the contract and that they have aligned to a new model of care	September 2018	Ms Shelley	07.11.17 - Ms Shelley informed the Committee the report is not due back until 12 months' time. It was noted they are still awaiting confirmation as to what new model of care they are going to align to. 05.12.17 – Report due September 2018 and confirmation received that the practice will align to primary Care Home 1.

						06.02.18 - Report due September 2018 22.05.18 – Due in September 2018
13	**06.02.18**	**WPCC186**	**Pharmacy First Scheme or all Patients** Mr Patel to report on progress to the Committee in 6 months' time.	August 2018	Hemant Patel	22.05.18 – Due in August 2018
14	**22.05.18**	**WPCC215**	**QOF+ Scheme 2018/19** The DPIA to be shared with the Committee.	July 2018	Sarah Southall	

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NHS
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Clinical Commissioning Group

WOLVERHAMPTON CCG

PRIMARY CARE COMMISSIONING COMMITTEE 3rd JULY 2018

TITLE OF REPORT:	Primary Care Monthly Report
AUTHOR(s) OF REPORT:	Liz Corrigan – Primary Care Quality Assurance Coordinator
MANAGEMENT LEAD:	Yvonne Higgins
PURPOSE OF REPORT:	To provide an overview of activity in primary care, and assurances around mitigation and actions taken where issues have arisen.
ACTION REQUIRED:	☐ **Decision** ☒ **Assurance**
PUBLIC OR PRIVATE:	This Report is intended for the public domain OR This report is confidential for the following reasons
KEY POINTS:	• Overview of Primary Care Activity
RECOMMENDATION:	Assurance only
LINK TO BOARD ASSURANCE FRAMEWORK AIMS & OBJECTIVES:	
1. Improving the quality and safety of the services we commission	Providing information around activity in primary care and highlighting actions taken around management and mitigation of risks
2. Reducing Health Inequalities in Wolverhampton	N/A
3. System effectiveness delivered within our financial envelope	N/A

1.0. Executive Summary

The information below highlights the key areas of concern identified through various quality monitoring mechanisms and data sources, the Committee should seek assurance on each issue and consider where further assurance and or action may be required.
RAG Ratings: 1a Business as usual; 1b Monitoring; 2 Recovery Action Plan in place; 3 RAP and escalation

Data for May 2018		
Issue	Concern	RAG rating
IP	Low IP audit rating for four practices (one in August review on-going and three in December). New cycle of audits has begun. NHS England have reported low ordering rates for flu vaccine to cover outstanding patients indicating uptake may be affected – Primary Care flu group to address this.	1b
MRHA	Nil to report	1a
FFT	Non submission for: 9 practices – due to IT issues nationally Zero submission for 4 practices Suppressed data for 2 practices.	1b
Quality Matters	11 open Quality Matters identified 1 new and 10 ongoing	1b
Complaints	Details of 21 GP complaints reported to NHSE received since November 2017 4 complaints open 17 complaints closed	1a
Serious Incidents	Two serious incidents recently closed –one awaiting referral to NHS England as per pathway.	1b
Escalation to NHSE	One serious incident escalated to NHSE for management.	1b

NICE	No issues to report. No information provided due to IT issues to give verbal update.	1a
CQC	Two practices have received a "Requires Improvement" rating and are being monitored.	1b
Workforce and Training	Workforce strategy implementation continues Training as per GPFV and GPN 10 Point Action Plan continues	1a

1.0. Infection Prevention

Infection prevention is provided by Royal Wolverhampton Hospitals with a dedicated link nurse for primary care. Information for the most recent visits and audits are shown below.

IP Audit Ratings: Gold 97-100%; Silver 91-96%; Bronze 85-90%; No rating ≤84%

Figure 1: Infection Prevention Audits May 2018

Site	Date	Overall audit
No new audits have been undertaken for 2018/19 so far however comparison figures for 2016/17 and 2017/18 have been made available by Infection Prevention and was presented last month.		
The new IP audit has now been ratified and is in use at all sites. The following areas are now being audited: • Waste • Equipment • IP Management • Environment • Sharps • PPE • Minor Surgery Room • Practice Nurse Room		

Issues Identified within primary care:

- Main identified via audits are –
- Damage to décor and plaster
- Toilets needing upgrading

- Fly screens required on windows
- Sinks needing upgrading

Assurances:
Actions plans are put in place for all practices where appropriate. Follow is up undertaken within 1-3 months and re-visit and re-audit where necessary. A new team member at RWT is now managing primary care IP audit.

MRSA Bacteraemia:
None to report in primary care.

Assurances:
Work has commenced on improving sepsis identification and reporting in the community with collaboration between care homes, GPs and community services. This work is on-going, a cross-service tool is being identified and improving information around coding and flagging of risk in GP surgeries.

Influenza Vaccination:
2017/18 influenza season has now finished, the 2018/19 Flu Season City Wide Steering Group met on 24th May and a Primary Care Group has been set up. The first meeting is scheduled for 4th July 2018. Flu training for practice nurses and HCAs has been booked for 24th July and 22nd August 2018 with further dates to follow.

Assurances:
These will be provided via feedback and actions from the primary care flu group. Vaccine uptake figures are available from the Immform platform.

2.0. MHRA Alerts

Healthcare professionals are informed about the alerts via a monthly newsletter (Tablet Bytes). In addition, ScriptSwitch messages and/or PMR searches are used to inform healthcare professionals where appropriate. Suspected adverse drug reactions should be reported to the Medicines and Healthcare products Regulatory Agency (MHRA) through the Yellow Card Scheme (www.mhra.gov.uk/yellowcard).

Assurances:

Practices must keep a record of appropriate actions related to MHRA alerts as part of their CCG contractual requirements and their CQC registration.

3.0. Patient Experience/Friends and Family Test

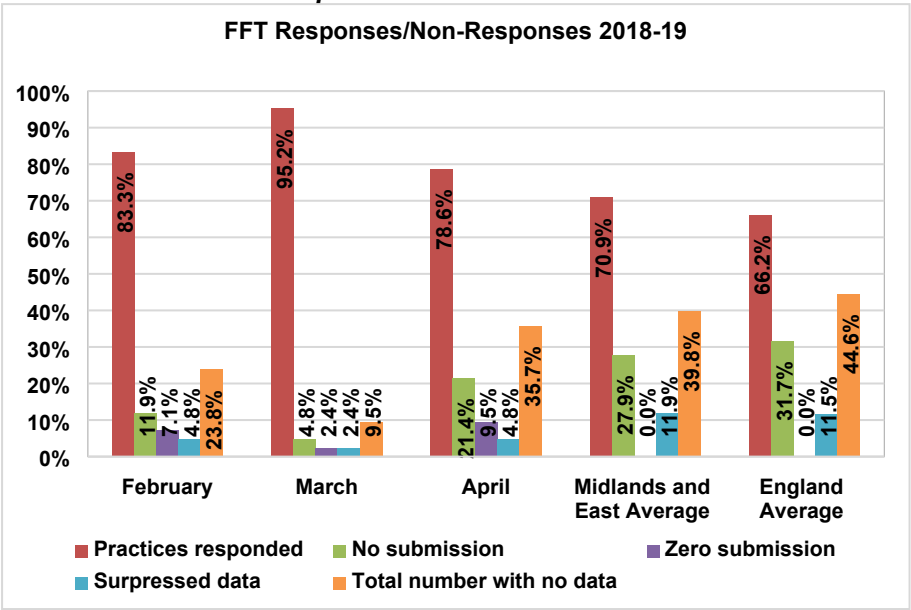
FFT Uptake:

The submission data for May 2018 FFT submissions (April 2018 figures) are shown below compared with the previous three months and the regional and national averages.

Figure 2: FFT 3 Month Data

Percentage	January	February	March	April	West Midlands	England
Total number of practices	42	42	42	42	2154	7243
Practices responded	90.2% ⇔ *38/42*	83.3% ⇩ *35/42*	95.2%⇧ 40/42	78.6%⇩ 33/42	53.4%⇩	53.4%⇩
No submission	4.8% ⇔ *2/42*	11.9% ⇧ *7/42*	4.8% ⇩ *2/42*	21.4%⇧ 9/42	46.6%⇧	46.6%⇧
Zero submission	2.4% ⇔ *1/42*	7.1% ⇧ *3/42*	2.4% ⇩ *1/42*	9.5%⇧ 4/42	N/A	N/A
Suppressed data	2.4% ⇩ *1/42*	4.8% ⇧ *2/42*	2.4% ⇩ *1/42*	4.8% ⇧ *2/42*	7.2%⇩	9.4%⇩
Total number with no data	9.5% ⇔ *4/42*	28.6% ⇧ *10/42*	9.5% ⇩ *4/42*	33.3%⇧ 15/42	53.8%⇧	56.0%⇧
Response rate	1.6% ⇔	1.6% ⇔	1.8% ⇧	1.4%⇩	0.5%⇩	0.5%⇩

Figure 3: 3 Month FFT Data Comparison



This month practices that had no submission were significantly higher than last month at 21.4% and this is due to IT issues with CQRS; suppressed data (fewer than 5 submissions) was running at 4.8% (2), the total number of practices with no data available had increased to 33.3% (15), this was mainly due to national IT issues which are now resolved. The regional and national trend show an increase in no submissions but a reduction in suppressed data from previous months (see Figure 2 above). Response for WCCG as a proportion of list size was 1.4% which is an increase on last month and still significantly better than both the regional and national averages of 0.5%.

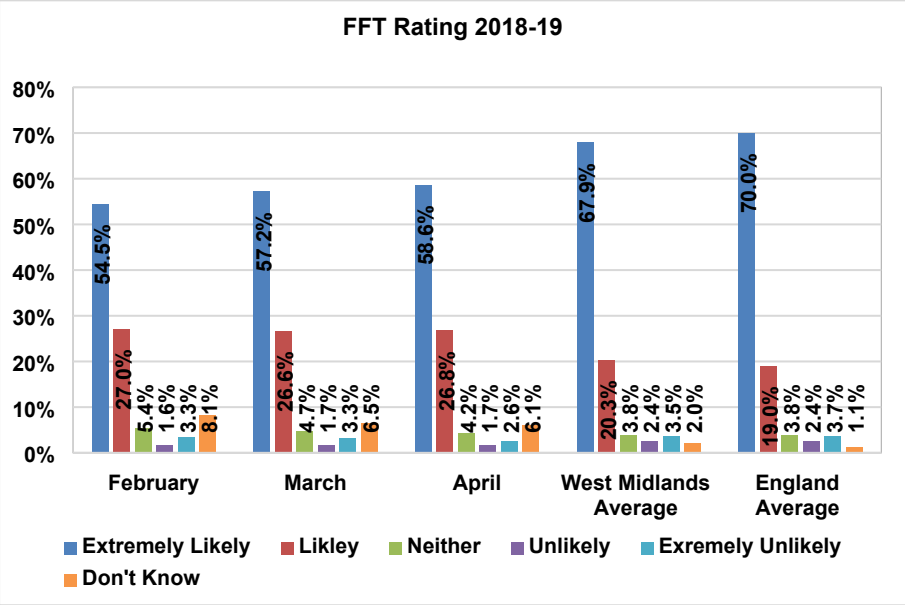
The ten practices identified as having a higher than average (1.4%) uptake and this will be shared with locality managers as an on-going matter to encourage sharing of good practice:

Ratings:

Figure 4: FFT 3 Month Ratings

Percentage	February	March	April	West Midlands Average	England Average
Extremely Likely	54.5%	57.2%	58.6%	67.8%	69.6%
Likely	27.0%	26.6%	26.8%	20.2%	19.1%
Neither	5.4%	4.7%	4.2%	3.9%	4.0%
Unlikely	1.6%	1.7%	1.7%	2.5%	2.5%
Extremely Unlikely	3.3%	3.3%	2.6%	3.6%	3.8%
Don't Know	8.1%	6.5%	6.1%	2.0%	1.1%

Figure 5: FFT 3 Months Ratings Data Comparison



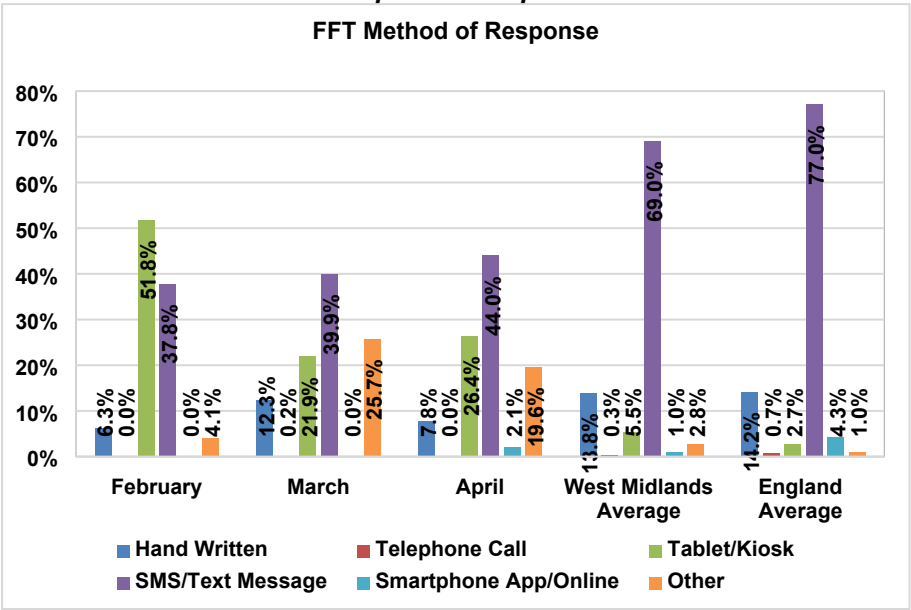
Overall responses remain positive (85% would recommend their practice) and ratings are slightly better than last month, but are still lower than regional (89%) and national (90%) averages. This month 11.8% gave either a “don’t know” or “neither” answer compared to 5.8% regionally and 4.9% nationally and this has reduced slightly. There remains a strong correlation between these responses and submission via practice check in screens and SMS text, indicating that patients may be unsure over what response to give, or unclear regarding use of the technology.

Method of Response:

Figure 6: FFT 3 Month Method of Response

Percentage	February	March	April	West Midlands Average	England Average
Hand Written	6.3%	12.3%	7.8%	15.4%	13.9%
Telephone Call	0.0%	0.2%	0.0%	0.4%	0.6%
Tablet/Kiosk	51.8%	21.9%	26.4%	6.2%	2.7%
SMS/Text Message	37.8%	39.9%	44.0%	74.4%	77.4%
Smartphone App/Online	0.0%	0.0%	2.1%	0.9%	4.4%
Other	4.1%	25.7%	19.6%	2.6%	1.0%

Figure 7: FFT 3 Month Method of Response Comparison



This month the majority of responses have again come via SMS text (44.4%) and Tablet/Kiosk (26.4%). Handwritten responses have reduced again and are now at 7.8%, lower than the national and regional averages shown above in Figure 7. Please note that some practices do not appear to record the method of collection. Other methods of submission have increased again this month, it is thought that these are predominantly "check in screen" submissions incorrectly assigned as they should be linked to "tablet/kiosk".

Assurances

The FFT policy that has been developed in conjunction with the LMC is due to be heard at Primary Care Commissioning Committee on 3rd July, this builds on the existing contractual requirements by the addition of qualitative data and involvement of PPGs. FFT activity is being monitored on a monthly basis by the Operational Management Group and via the NHSE Primary Care Dashboard. Non responders, suppressed and zero data is monitored monthly, practices that do not submit are contacted by the Primary Care Contract Manager or locality managers and appropriate

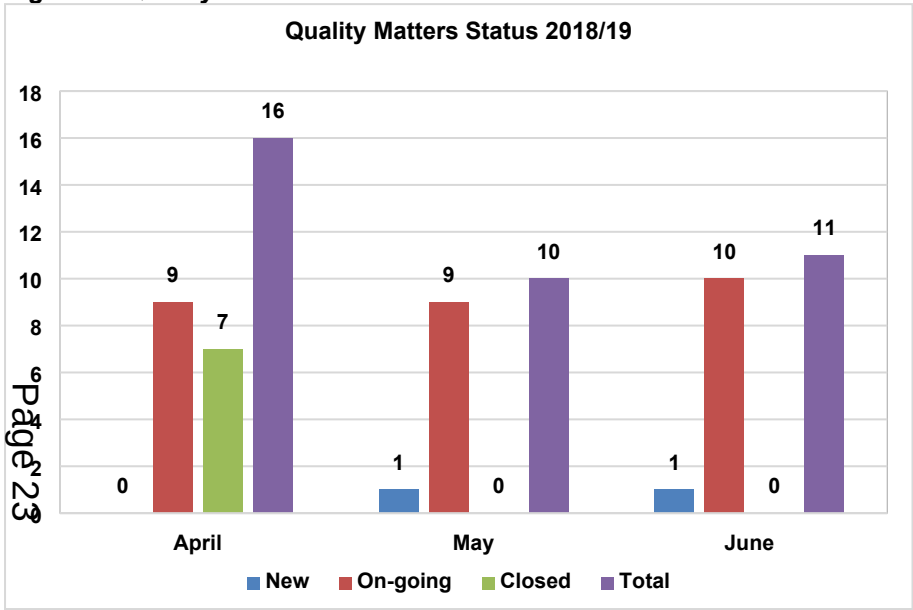
advice and support offered to facilitate compliance. Those that fail to submit on a regular basis may receive a contract breach notice, and a number of sites are being monitored closely. Wolverhampton LMC have offered to support the process to avoid the need for breach notices to be applied. Information from FFT is also triangulated with NHSE Dashboard and GP Patient Survey data when available and with Quality Matters, SIs and complaints.

4.0. Quality Matters

Figure 8: Quality Matters Three Month Figures 2018/19

Status	April	May	June
New	0	1	1
On-going	9	9	10
Closed	7	0	0
Total	16	10	11

Figure 9: Quality Matters Status 2018/19



Activity via the Quality Matters process is shown above, this is reviewed monthly and relevant staff members are contacted or practice visits are undertaken where necessary. Practices are asked to provide a brief overview of actions taken, learning identified and to provide assurances that this has been embedded. Quality issues relating to GPs are reported to NHS England Professional and Practice Information Gathering Group (PPIGG) for logging and escalation where appropriate.

Quality Matters Themes

Quality Matters themes relate to information governance breaches, delayed or inappropriate treatment, and inappropriate referrals.

Assurances:

Quality Matters continue to be monitored by the Quality Team, and all Primary Care incidents have been forwarded to the relevant practices, internal scrutiny group and to NHSE where appropriate. Practices are asked to provide evidence of investigation and learning from these incidents and this is provided to NHSE who will then escalate accordingly and feedback to the CCG or to the Serious Incident Scrutiny Group for further consideration.

5.0. Complaints

The CCG continues to be copied in on new complaints from NHSE as they are reported, 21 GP complaints have been received since the beginning of November. The breakdown of reports are as follows.

Figure 10: Complaints Reported to NHSE since November 2017

Month	Number	Resolved
November	6	2
December	3	0
January	4	1
February	3	0
March	2	11
April	1	3
May	1	1
June	1	0

All current complaints relate to clinical issues.

Assurances:
The CCG does not have oversight of GP complaints dealt with within the surgery. NHSE is now sharing complaints data and this can be triangulated with other data e.g. SIs and Quality Matters. All complaints reported to NHSE are logged via PPIGG by NHSE for appropriate escalation, this includes local actions e.g. additional training or serious incident reporting. Practices must provide evidence of their complaints procedure and handling for CQC and for the CCG Collaborative Contracting team.

6.0. Serious Incidents

There are two incidents that have recently been closed.

Assurances:
All serious incidents are reviewed in CCG internal scrutiny group and reported to NHS England PPIGG group for logging and appropriate escalation and feedback is provided to the CCG. Practice visits are undertaken and assurances must be provided around learning and action plans.

7.0. Escalation to NHS England

One incident was raised at the most recent NHSE PPIGG meeting and this has been discussed above in the section on serious incidents, this is due to be followed up by NHSE.

There is one serious incident due to be referred to the next meeting following receipt of actions/learning from practices, this is also discussed above.

Assurances:
Assurances around NHSE escalation are provided by bi-weekly feedback from action logs from PPIGG meetings and quarterly reports relating to complaints raised and their outcomes. Any action from escalation is shared via PPIGG and reports, however comprehensive information is not

always available. PPIGG outcomes are shared with Primary Care Contract Manager and Primary Care Liaison Manager and practice visits set up if necessary. Data is triangulated with other information i.e. Quality Matters, FFT, IP audits and complaints.

8.0. CQC

The current CQC status from April 2017 to current date is shown below in Figure 11.

Figure 11: CQC ratings

Practice	Report Date	Overall rating	Safe	Effective	Caring	Responsive	Well led
All Saints and Rosevillas Medical Practice	15/05/2017	Good	Good	Good	Good	Good	Good
Poplars Medical Centre	07/06/2017	Good	Good	Good	Good	Good	Good
Primrose Lane Health Centre	18/06/2017	Good	Good	Good	Good	Good	Good
Forhouses Medical Practice	25/06/2017	Good	Good	Good	Good	Good	Good
Bilston Urban Village Medical Centre	10/07/2017	Good	Good	Good	Good	Good	Good
Woden Road Surgery	14/07/2017	Good	Good	Good	Good	Good	Good
Hill Street Surgery	20/07/2017	Good	Good	Good	Good	Good	Good
Drs Bilas and Thomas	20/07/2017	Good	Good	Good	Good	Good	Good
Keats Grove Surgery	18/08/2017	Good	Good	Good	Good	Good	Good
Bradley Medical Practice	24/05/2018	Requires Improvement	Requires Improvement	Good	Good	Good	Inadequate
Whitmore Reans Health Centre	12/04/2018	Good	Good	Good	Good	Good	Good
Probert Road Surgery	23/10/2017	Good	Good	Good	Good	Good	Good
Ashfield Road Surgery	23/10/2017	Good	Good	Good	Good	Good	Good
Dr Joseph Fowler	08/01/2018	Good	Good	Good	Good	Good	Good
Wolverhampton Doctors on Call	30/01/2018	Good	Good	Good	Good	Good	Good
Coalway Road Medical Practice	16/02/2018	Requires Improvement	Requires Improvement	Good	Good	Good	Requires Improvement
Lower Green Health Centre	27/02/2018	Good	Good	Good	Good	Good	Good
Dr Nicola Whitehouse	27/02/2018	Good	Good	Good	Good	Good	Good
Newbridge Surgery	20/03/2018	Good	Good	Good	Good	Good	Good

Outstanding		0	0	0	0	0	0
Good		17	17	19	19	19	17
Requires improvement		2	2	0	0	0	1
Inadequate		0	0	0	0	0	1

Assurances:
Two practices currently have a Requires Improvement rating and are being monitored by the Primary Care and contracting team with input from the Quality Team, one practice was previously rated requires improvement but at revisit was rated good. Site visits have been undertaken or are planned and outstanding issues and concerns escalated as appropriate. One practice has already received their contracting visit, appropriate support is being provided by the CCG and NHSE, the second practice is due to receive a visit in the near future.

10. Workforce

Work continues to refine the workforce development plan in line with STP and national drivers. The following areas have been identified as priority and included on the Workforce Development Action Log:

- Alternative ways of working for GPs e.g. portfolio careers – discussions currently being arranged and information collated.
- Workforce dashboard being finalised for showcasing at July Workforce Task and Finish Group meeting.
- LWAB work streams being finalised – stronger links and feedback being made with Primary Care leads.
- Practice Manager Framework in early stages of development, for discussion with PM forum.
- Practice Nurse Workforce Strategy in development across STP, this will be open for consultation with GPNs following this initial work.
- Practice group information to be shared on CCG intranet pages.

Recruitment
Work continues around international recruitment of GPs with bid recently submitted, numbers of staff to be confirmed c/o STP. CCT fellows applications now closed, interviews being held. 67 GP trainees are due to start across the region – numbers for Wolverhampton not yet identified.

Interest in Nursing Associate and Registered Nurse apprenticeships identified – initial meetings arranged, to be followed up by University. Interest in Return to Practice identified and followed up.

Retention

Further work around retention will be undertaken as part of STP, GPFV and national drivers from the GPN 10 Point Action Plan, this will be undertaken at regional and national level and focus on intensive support, Wolverhampton has been identified as an intensive support site.

Assurances:

The workforce implementation plan has been revised to reflect new initiatives and programmes of work, and the workbook is now also revised. Priority is being given to the development of the Workforce Strategy in line with new national and regional programmes of work.

10.0. Primary Care Training

The local Practice Nurse Education forum continues all session dates are finalised and most have been booked in advance, with subject areas to include falls, respiratory, screening and lymphoedema. Black Country Practice Nurse Facilitator now assisting with this and with provision in other areas which can be accessed by Wolverhampton nurses.

HCA training first two sessions covering respiratory conditions and weight management, have been held, provided by Education for Health, feedback from both sessions was very good. Further clinical training for HCAs is being developed in conjunction with the Training Hub – HEE funding awaited.

Sponsored courses funding now available (Fundamentals of Practice Nursing, Specialist Practice and Advanced Clinical Practice) and expressions of interest gathered for final decision in August.

Work around spirometry training continues in conjunction with commissioning. Flu updates are booked for July and August and immunisation update is booked for September.

GPFV training programmes continue and include Care Navigator and Reception Staff training and Practice Manager diploma and other relevant training for senior non-clinical staff.

Training Hub Update:
Health Education England (HEE) procurement exercise to secure providers for a new contract will start in September across Midlands and East. This will be on a STP footprint, specification and KPIs are to be finalised and CCGs will be consulted. The current three Black Country Training Hubs are working together more closely in order to achieve the best possible position to secure a future contract as an STP Training Hub.

GPN Ten Point Action Plan Funding
Funding to increase student nurse placements will be released imminently. Data on STP level activity is collected monthly and collated by Wolverhampton CCG and returned to NHSE.

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NHS
Wolverhampton
Clinical Commissioning Group

Friends and Family Test Policy – General Practice

February 2018 – Version 1.2

DOCUMENT STATUS	Draft
DATE ISSUED	10/5/2018
DATE TO BE REVIEWED	

AMENDMENT HISTORY

Version	Date	Amendment History
1.0	15/2/2018	
1.1	6/3/2018	Addition of proposed monitoring of zero and suppressed data
1.2	10/5/2018	

REVIEWERS

This document has been reviewed by:

Name	Title/Responsibility	Date	Version
Gill Shelley	Primary Care Contract Manager	6/3/2018	1.1
Marion Janavicius	Contract Manager	27/2/2018	1.1
Dr B Mehta	General Practitioner	7/3/2018	1.1

APPROVALS

This document has been approved by:

Group/Committee	Date	Version

DISTRIBUTION

This document has been distributed to:

Distributed to	Distributed by/when	Paper/Electronic	Document location

Contents

1. Purpose

The Purpose of this document is to provide a single overarching policy for Friends and Family Test submission within Wolverhampton General Practice. This policy sets out national guidance and contractual requirements and local procedures for supporting FFT submission, increasing uptake and managing repeated non-submission.

2. Background

Friends and Family Test (FFT) is a feedback tool enabling people that use all NHS services to have an opportunity to provide feedback on their experience. FFT was launched in April 2013 by NHS England (NHSE), and has been rolled out to most NHS-funded services in England, including General Practice (NHS England, 2014), where it is now a contractual obligation.
The three key requirements of GP practices for FFT are:

- **To make the opportunity to provide feedback through FFT available to all patients at any time.**
- **To submit FFT data to the NHS England analytical team via the Calculating Quality Reporting Service (CQRS) each month.**
- **Publish the data locally.**

The aim of FFT is to be as flexible and inclusive as possible, but not to place additional burden on the practice to gather data and on patients to provide it. The key is to provide a continuous feedback loop between practice and patient that allows identification of issues, improvement of services and celebration of successes. NHSE are clear however that the aim is not to allow comparison between practices, and that it should not be used as a performance dashboard, but that is can be used to track progress over time.

Guidance provided by NHSE (2014) outlines the following aims of FFT:

- Gather useful feedback from people who use services that can be fed back directly to the staff that provide their care in a simple format in near real time.
- Identify areas where improvements can be made in order to take practical actions.
- Inform current and prospective patients about the experiences of those that use the practices services.

Data collection should be continuous, allowing patients to respond after every episode of care if they wish to do so, it should be anonymous, simple and the results made available publically in a transparent way e.g. on practice website, in reception, via the NHS Choices platform. There is no target response rate, and practices are responsible locally for collecting and submitting their data.

Data can also be used by commissioners alongside other insight and quality information for service planning and contract development. It may also provide insight to other advisory and regulatory bodies such as Care Quality Commission (CQC) and Health Watch.

As FFT is a contractual requirement for GP practices there are a number of mandatory elements to the programme:

- **The standard question wording must be used (please see below)**
- **One supplementary free text follow up question must also be used**
- **It must be anonymous (unless there are issues such as safeguarding or fitness to practice identified)**

- **Data must be submitted to NHSE monthly in the standard format**
- **Results must be published locally**

FFT asks people the following question:

"We would like you to think about your recent experiences of our service. How likely are you to recommend our GP practice to friends and family if they needed similar care or treatment?"

There is a range of responses using a Likert scale (Extremely Likely, Likely, Neither, Unlikely, Extremely Unlikely and Unsure). This can be combined with supplementary free text follow-up questions, as a platform to highlight both positive and negative patient experience. Feedback around patient experience is vital for transforming NHS services and supporting patient choice, and this can be coupled with GP patient survey, in-house patient surveys and information posted on platforms such as NHS Choices. The free text responses are particularly important in providing insight into issues that may be quickly and easily resolved.

Responses can be made by patients in a variety of ways:
- Paper responses using cards and a ballot box available from NHS England to place in reception
- SMS text message responses
- Electronic responses via patient check-in screen or practice website
- Telephone responses
- Verbal responses

The responses are then collated by the practice and submitted to NHSE via Calculating Quality Reporting Service (CQRS). These results are published on a monthly basis by NHSE and are available to the general public to view. Practices must submit the following information:
- Number of responses in each category
- Number of responses collected by each method

Free text and additional responses should not be submitted to NHSE, but collated within the practice and used as feedback.

3. Responsibilities of Commissioners

NHSE have provided comprehensive advice for commissioners around FFT for GPs. The focus for commissioners of GP services is on influencing future behaviour in practices that are either not submitting data or submitting data that raises concerns e.g. low or zero submissions. The aim is to encourage practices to participate in FFT and use the process to inform and improve patient experience and care, which is in keeping with most CCG aims and objectives around promoting quality and reducing health inequalities.

Non-submission of Data
NHSE state that "Commissioners should contact practices that do not submit data to remind them that FFT is a contractual requirement." A standard letter has been produced which can be sent to GP practices that do not submit data and this can be seen in Appendix 1. If a practice fails to submit data for a second month, a further letter can be sent (see Appendix 1).

If a practice fails to submit for a third month, commissioners should consider issuing a breach of contract notice. Where contract breaches are given, the practice in question must provide a remedial action plan providing assurances around improving uptake and submission, and outlining how they will address the issue.

Concerns about data quality
Where the NHS England analytical team has concerns about the data (generally because the number of responses is significantly higher than they would expect) it will be published in italics. Commissioners may then contact practices where the number of responses is very low, or unexpectedly high to ask them to consider how the FFT is working, and to see if it could be improved.

Incorrect data submitted
The CQRS system does not allow practices to resubmit data once it has been submitted. The commissioning guidance states that "Practices that realise they have submitted incorrect data, before the deadline for submitting data, can ask for their data to be removed by completing a simple proforma, In this case, the NHS England analytical team will replace the data with the words: 'data submitted but not published due to issues with the data entry process'".

4. FFT in Wolverhampton General Practice

When considering FFT responses the fact that only those who have attended a GP appointment or their representative would be invited to participate needs to be kept in mind. NHSE data considers the whole eligible population when calculating response rates, when compared to total GP appointment responses are low, but this would include children and others without capacity to respond, those who decline to participate and those who may submit blank questionnaires.

FFT in general practice in Wolverhampton has consistently compared favourably to national and regional performance and continues to improve, returns are monitored by the CCG Quality Team and by Contracting.

5. FFT in General Practice Policy

The following will be implemented by the CCG as the commissioner of services as part of a gold standard framework for FFT:

a. Issue of a breach notice for those practices that fail to submit on 3 occasions between 1st April and 31st March.
b. Monitoring of practices with repeat zero submissions and suppressed data.
c. Monitoring of those practices that receive high numbers of "would not recommends" and "neither" or "unsure" responses.

The following will be implemented by practices and monitored by the CCG:

a. Practices who receive breach notices will provide a remedial action plan outlining how they will address the issue and support will be provided by the CCG Quality Team where it is needed.
b. Provision of action plans by practices that receive high numbers of zero submissions, suppressed data outlining how the practice is addressing the issue.
c. Provision of action plans by practices that receive high numbers of "would not recommends" and "neither" or "unsure" responses outlining how the practice is addressing the issue.
d. Collation of free-text responses received and use of a "you said – we did" forum undertaken in collaboration with the practice Patient Participation Group and results displayed within the practice and online. If no active PPG is present at the practice, then this should be promoted by the practice management team.
e. Triangulation of FFT data with other data such as GP Survey and NHS Choices comments, practice complaints, and use of this information to celebrate and share good practice across the city, and to learn from what could be done better.

f. To share good practice and learning with other members of the practice group and PPG.

The CCG will facilitate local practice groups to enable them to promote active participation and identify effective platforms for data collection across their members:

a. Support for practices from CCG Contracting and Quality and Risk Teams, in conjunction with the LMC where no and low submissions have traditionally been a concern to improve uptake.
b. Identification of formalised supplementary questions that can be added to the FFT questionnaire and the data collected and used to inform services.
c. Engagement with local Patient Participation Groups to promote uptake

Appendix 1 –Non-submission Letters

Level 1 Letter

Technology Centre
Wolverhampton Science Park
Glaisher Drive
Wolverhampton
WV10 9RU

Tel: 01902 444878
Fax: 01902 444313
Email: WOLCCG.WCCG@nhs.net

Dear Colleague

Friends and Family Test

As you are aware since 1st December 2014 GP practices have been required to implement the Friends and Family Test (FFT), in line with the guidance published by NHS England in July 2014, which can be found here. In addition to the formal guidance, NHS England has also published a shorter summary guidance that you can find here.

It is a fundamental principle of the FFT that all NHS patients should have the opportunity to provide feedback about the services they receive. The FFT can provide practices with a rich source of patient views that can be used locally to highlight and address concerns much faster than more traditional survey methods.

NHS England has sought to make the FFT process as flexible and inclusive as possible, while creating as low a burden as possible on practices and patients who wish to give feedback.

One of the key requirements of the FFT is that practices must submit their results to NHS England each month through the CQRS. NHS England has published guidance on what should be submitted and how here. The FFT results for every practice in England are then published nationally on the NHS England website and on NHS Choices. NHS England is not able to amend or add data after the deadline for submission.

We are concerned to note that NHS England did not receive FFT data from your practice for September 2017.

http://www.england.nhs.uk/ourwork/pe/fft/friends-and-family-test-data/

Please can you confirm by return the following information via email to liz.corrigan@nhs.net:

- Whether your practice has submitted data for September 2017?
- That you will be able to submit data for October 2017 by the deadline of 9th November 2017.

It is important to note the following:

1. It is a contractual requirement that the practice submits FFT data every month via CQRS before the deadline of the 12th working day of the month.
2. If you have not had any returns you still need to submit a nil return.
3. It is not possible to retrospectively submit data once the deadline for that month has passed.
4. The CCG cannot submit data on your behalf.
5. Continued failure to submit a monthly return may result in contractual sanctions

If you need any additional help or advice, or if you are not able to comply with the guidance for any reason, please use the contact e-mail address above to email NHSE and cc me in so that we are aware of any issues.

If you need support or advice on how to implement FFT you can:

- find advice, support materials, frequently asked questions, case studies etc. on the NHS England website at the address above; or
- e-mail the national FFT team: england.friendsandfamilytest@nhs.net

Kind regards

Level 2 Letter

Technology Centre
Wolverhampton Science Park
Glaisher Drive
Wolverhampton
WV10 9RU

Tel: 01902 444878
Fax: 01902 444313
Email: WOLCCG.WCCG@nhs.net

Dear Colleague

We are concerned to note that your practice has failed to submit FFT data for the months of xxx and xxx xxxx.

As you are aware there are 3 key requirements of GP Practices set out in the guidance:

1. to make the opportunity to provide feedback through the FFT available to all patients at any time;
2. to submit FFT data to the NHS England analytical team via the Calculating Quality Reporting Service (CQRS) each month; and
3. publish the data locally

NHS England are working with Wolverhampton CCG to identify practices who are participating in accordance with their contractual obligations and also identifying those who are not. The consequence of not fulfilling this requirement may result in the practice incurring a contractual sanction.

Please confirm to the CCG that you have submitted your practice data for xxx xxxx and when you did/have done so.

The deadline for submission via CQRS is the 12th working day of the month, i.e. no later than **xxx for xxx data.**

If you need support or advice on how to implement FFT you have a number of options:

- You can find advice, support materials, frequently asked questions, case studies etc. on the NHS England website; or
- You can e-mail the national FFT team: england.friendsandfamilytest@nhs.net.

Additionally the Wolverhampton Local Medical Committee (LMC) have offered to help any practice with advise and practical support to help achieve the implementation of the Friends and Family Contractual requirement – E-mail contact - rwh-tr.LMCWolverhampton@nhs.net

Together NHS England, Wolverhampton CCG and LMC are working together to maximise the friends and family test and urge you to respond to this email.

Kind regards

Appendix 2 – Example Response Card

The Friends and Family Test

Name of service: _____

We would like you to think about your recent experience of our service.

How likely are you to recommend our service to friends and family if they needed similar care or treatment?

Extremely likely	Likely	Neither likely or unlikely	Unlikely	Extremely unlikely	Don't know
☐	☐	☐	☐	☐	☐
☺	→			☹	?

Thinking about your answer to this question tell us why you feel this way?

Is there anything that would have made your experience better?

NHS
Wolverhampton
Clinical Commissioning Group

Wolverhampton Clinical Commissioning Group
Technology Centre
Wolverhampton Science Park
Glaisher Drive
Wolverhampton
WV10 9RU

Email: wolccg.wccg@nhs.net

Telephone: 01902 44487

NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG
PRIMARY CARE COMMISSIONING COMMITTEE
4th July 2018

TITLE OF REPORT:	Primary Care Operational Management Group Update
AUTHOR(s) OF REPORT:	Mike Hastings, Director of Operations
MANAGEMENT LEAD:	Mike Hastings, Director of Operations
PURPOSE OF REPORT:	To provide the Committee with an update on the Primary Care Operational Management Group.
ACTION REQUIRED:	☐ **Decision** ☒ **Assurance**
PUBLIC OR PRIVATE:	This report is intended for the public domain.
KEY POINTS:	1. MGS Practice Group have now left the RWT VI Programme. The transition is going well. 2. There is good progress on East Park and Bilston Health Centre (Prouds Lane) Estates projects. 3. There was an issue with a power cut at East Park but the practice responded excellently.
RECOMMENDATION:	To provide the Committee with an update on the Primary Care Operational Management Group.
LINK TO BOARD ASSURANCE FRAMEWORK AIMS & OBJECTIVES:	
1. Improving the quality and safety of the services we commission	The Primary Care Operational Management Group monitors the quality and safety of General Practice.
2. Reducing Health Inequalities in Wolverhampton	The Primary Care Operational Management Group work with clinical groups within Primary Care to transform delivery.
3. System effectiveness delivered within our financial envelope	Operational issues are managed to enable Primary Care Strategy delivery.

1. BACKGROUND AND CURRENT SITUATION

1.1. Notes from the last Primary Care Operational Management Group are set out below.

2. Meeting Notes from PCOMG

Present:

Mike Hastings	(MH)	WCCG Director of Operations
Gill Shelley	(GS)	Primary Care Contracts Manager
Jane Worton	(JW)	WCCG Primary Care Liaison Manager
Tally Kalea	(TK)	Commissioning Operations Manager
Hemant Patel	(HP)	WCCG Deputy Head of Medicines Optimisation
Róisín Buxton	(RB)	WCCG IM&T Project Assistant
Carol McNeil	(CM)	Assistant Contract Manager, NHS England
Peter McKenzie	(PMcK)	WCCG Corporate Operations Manager
Jeff Blankley	(BM)	Local Pharmaceutical Chair
Dr Bhavin Mehta	(BM)	Local Medical Committee Representative
Liz Corrigan	(LC)	Primary Care Quality Assurance Co-ordinator
Sarah Southall	(SS)	WCCG Head of Primary Care

Matters Arising

PMcK raised the matter of inaccurate ODS Data held by NHS England, previously raised by RS. The data needs to be updated and a discussion held regarding whose responsibility it will then be to maintain. HP added that this outdated data can lead to costs being misattributed to Wolverhampton for GPs that have moved.

Discussion Items/Assurance

Review of Primary Care Matrix

JW gave the following updates:

- The CCG has been working with MGS Medical Practice for a few months and they have now left the Vertical Integration programme. There have been some IT problems in their first week but the CCG is assured that the back office functions and new clinical staff are strong. JW and GS continue to meet with them for weekly monitoring and they are creating a risk log for both clinical and management issues, which will be raised and resolved through RWT. Di Chadwick of the CQC was happy with their progress.

Forward Plan for Practice System Migrations Mergers and Closures

The next practice to go live is Dr Bilas. GS confirmed that Dr Bilas has been making efforts to find a partner and when she visits again soon she will look into any further support he might need.

Estates Update/LEF

TK updated the meeting that the ETTF funded practices continue to move towards improving their current estate. One of which has been given the go ahead to start building an extension with the remaining practices close to agreeing leases.

Further work is being completed jointly with the Trust and Wolverhampton Council regarding collaborative working and consolidating services. An external company is currently in the

process of developing a detailed business case.

Primary Care Quality Update

LC presented the quality report, highlighting the following updates:

- LC met with Jeff Blankley regarding flu vaccines and is setting up a Primary Care flu planning group of GPs and pharmacists. New Deputy Chief Nurse Yvonne Higgins will be the lead for CCG quality and SS from Primary Care. SS confirmed that she has discussions taking place at the GP group level regarding flu clinics, to drive up performance and uptake.
- Friends and Family had the best uptake so far. The high-uptake practices correlate with having check-in screens and two-way texting and LC has contacted them to investigate their success with submissions.

SS gave an update of the risk register which is available upon request.

LC updated that the workforce video has been signed off, and that there has been a lot of activity with nurse and administration apprenticeships in the last few weeks.

General Practice Forward View Update

SS informed the group that the international GP recruitment application has been completed and is being progressed on an STP footprint, with a letter due asking to review figures and strategy. Due to a high level change, £2.2 million has been reallocated with a time limitation of 12 months, and a meeting with the LMC Chairs will take place to develop the plan, which will consider the issues with indemnity. Some practices have expressed interest, but timing is of the essence as there will be a queue.

Collaborative Working Model: Practice Issues and Communication Log

LC updated that most issues had been discussed in the quality report and noted that an additional incident will be added following a Practice encountering a power cut. The Practice reacted well, using EMIS on laptops and a generator, however a fridge of vaccines was lost due to the unavoidable increase in heat. It was reported that there was nothing the practice could have done although they have been advised to have a second fridge in case of further incidents of fridge failure in the future. HP noted that the practice's attention to protocol with the vaccines was commendable.

Relocation Policy for Discussion

GS reported that the CCG was advised to have a relocation policy, of which a draft was shared with the group. The overview was that following an expression of interest from the practice, they form a business plan and the work is taken to PCCC for approval.

A relocation business plan would come to Primary Care OMG for discussion, Capital Review Group for information, then PCCC for decision.

CQC: Primary Care

There was no CQC representative in attendance at the meeting.

NHS England CM informed the group that the focus recently has been getting CCG's to work with practices that close for half a day.
Pharmaceutical Involvement in Primary Care JB informed the group that a CCG-commissioned minor ailments scheme starts 1 June. HP has written to the models of care to enquire if they want representatives at Prescribing Committee.
AOB LC is doing some work on sepsis to develop training and pathways. JW has been in liaison with some practices following NHS England alerts that 4 practices needed to refine the quality of their data. However, after NHS England checked again, one of the practices had been misattributed, so it requires further investigation.

3. CLINICAL VIEW

3.1. A clinical representative from LMC attends the meetings and gives views on all discussions.

4. PATIENT AND PUBLIC VIEW

4.1. Patient and public views are sought as required.

5. KEY RISKS AND MITIGATIONS

5.1. Project risks are reviewed as escalated from the programme.

6. IMPACT ASSESSMENT

Financial and Resource Implications

6.1. The group has no authority to make decisions regarding Finance.

Quality and Safety Implications

6.2. A quality representative is a member of the Group.

Equality Implications

6.3. Equality and Inclusion views are sought as required.

Legal and Policy Implications

6.4. Governance views are sought as required.

Other Implications

6.5. Medicines Management, Estates, HR and IM&T views are sought as required.

Name: Mike Hastings
Job Title: Director of Operations
Date: 27/06/2018

REPORT SIGN-OFF CHECKLIST

This section must be completed before the report is submitted to the Admin team. If any of these steps are not applicable please indicate, do not leave blank.

	Details/ Name	**Date**
Clinical View	N/A	
Public/ Patient View	N/A	
Finance Implications discussed with Finance Team	N/A	
Quality Implications discussed with Quality and Risk Team	N/A	
Equality Implications discussed with CSU Equality and Inclusion Service	N/A	
Information Governance implications discussed with IG Support Officer	N/A	
Legal/ Policy implications discussed with Corporate Operations Manager	N/A	
Other Implications (Medicines management, estates, HR, IM&T etc.)	N/A	
Any relevant data requirements discussed with CSU Business Intelligence	N/A	
Signed off by Report Owner (Must be completed)	**Mike Hastings**	**27/06/2018**

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NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG

Primary Care Commissioning Committee
3rd July 2018

TITLE OF REPORT:	QOF + Preparation (2017/18)
AUTHOR(s) OF REPORT:	Lucy Sherlock
MANAGEMENT LEAD:	Sarah Southall
PURPOSE OF REPORT:	Report on the final outcomes of the QOF prep service specification.
ACTION REQUIRED:	☐ **Assurance**
PUBLIC OR PRIVATE:	Public
KEY POINTS:	• Funding was made available to practices to undertake some preparatory work in readiness for the QOF+ 2018/19 Scheme that is due to be launched June 2018. • The preparatory work was designed to aid practices in identifying patients as risk of developing diabetes, who consumed too much alcohol and/or were overweight who could then be included on a practice level register. • The register would allow patients not already on a QOF register to benefit from some form of intervention. • To improve utilisation of the National Diabetes Prevention Program.
RECOMMENDATION:	To receive and discuss the outcomes and note any learning for future schemes
LINK TO BOARD ASSURANCE FRAMEWORK AIMS & OBJECTIVES:	1a Ensure on-going safety and performance in the system 2a Improve and develop primary care in Wolverhampton. 2b Deliver new models of care that support care closer to home and improve management of Long Term Conditions.

N.B. Please divide the rest of the report into Paragraphs, using numbering for easier referencing.

1. BACKGROUND AND CURRENT SITUATION

- The QOF+ preparation scheme was put in to place to support practices in doing some preparatory work ahead of the QOF+ launch in June. The scheme sought to fund practices to review what is currently read coded on their clinical systems within 4 areas that will be included in the QOF+ service.
- The aims of the scheme were:
    - To get a picture of what information is currently available about patients and their lifestyle from clinical records held in general practice
    - To update patients records for those on the new revised registers with certain supporting heath data where possible to support the work required by the QOF+ scheme later in the year.
    - To achieve an increased prevalence on the diabetes, respiratory and lifestyle disease registers.
    - To highlight patients that would benefit from some form of intervention who are not currently on a QOF register.
    - To improve utilisation of the National Diabetes Prevention Programme and to gain an idea of numbers to allow any new service to have the appropriate capacity.
    - The scheme ran from January 2018 to end March 2018 with claims to be submitted by the end of April 2018.
    - Returned information and claims for payment under this scheme have been received and approved
    - 300k was allocated to this scheme which equated to £1030 per 1000 patients. Payment was staggered by achievement.

2.

2.1 Purpose and Timeline.

The purpose of the QOF+ preparatory scheme was to fund practices to build 4 registers that would later serve as the basis for QOF+ 2018/2019 and to review the patients on these registers to ensure that key lifestyle and basic health information is recorded for those patients. It was envisaged that having this work done in advance of the QOF+ launch would give practices a good start in achieving the targets set out in the QOF+ 2018/19 service specification. The practices were given 2 months to run the searches and update records, with a further month to collate the data and submit the claim. All claims had to be submitted by 30.4.18. A list of registers and information to be updated can be found at **Appendix 1**.

2.2 Participation.

37 practices originally signed up to take part equating to 88% of practices in Wolverhampton & of these 20 practices 48% submitted a return (due to practice list sizes this covers 52% of Wolverhampton patients)

6 from PCH1
6 from PCH2
8 from Unity
0 from VI

Of the practices who didn't take part, various reasons were cited. Most notably VI did not submit for any of their practices due to an issue regarding internal communications. For more detail of practices who signed up/submitted and reasons for not taking part or non-submission please see **Appendix 2.**

2.3 Finance.

Of the 300k allocated to this scheme practices who took part claimed £171,190.80. 9 of the practices claimed the full allocation achieving 76% or record updates or more whilst the other 11 achieved 80% payment for 51%-75% or records being updated. This leaves a surplus of £128809.20 of the £300000 allocated to this enhanced service,

2.4 Outcomes.
4 new registers were created with 6492 patients being added to these registers. Of those patients nearly 3000 had new lifestyle or health data recorded on their medical record. A more detailed breakdown can be found at **Appendix 3.**

The creation of the new registers forms the basis for the QOF + 2018/2019 scheme that will be implemented later June 2018. The QOF+ 2018/2019 scheme focuses on areas not currently covered in the national QOF and has a more preventative set of indicators.

The practices that took part will be in a good position to start work on the new QOF+ Scheme as soon as it is launched, whilst practices that didn't will have some preparatory work to do to create the new registers.

Other outcomes included the creation of a register of the number of patients waiting for referral to the diabetes prevention programme and those patients needing spirometry. The newly recorded information will inform the future design and implementation of these services.

2.5 Learning/ Considerations for future.
This service specification required practices to run a set of searches on their clinical systems. In the past this kind of work has been heavily supported if not completed for them by the CCG IM&T team, however the level of support offered to practices varied throughout the duration of this scheme, meaning a lot of practices struggled with the process and there was some disparity in the numbers reported against similar sized practices. In future, practices need to be trained or supported in the process of building searches within their clinical systems to ensure a robust piece of work encompassing all eligible patients.

The service specification was amended at various stages between the initial draft document production and final sign off of the scheme. Some practices had not realised the addition of a further search requirement around alcohol. It is important to ensure the practices are working to accurate up to date service specifications and that there are clear communication processes in place to ensure latest versions are circulated to all practices. This should reduce ambiguity regarding interpretation and delivery of the schemes.

Finally this service specification was offered to practices at year end when practices are already busy with a lot of work on national QOF and finance matters. This was illustrated by some practices which cited that as a reason for not participation.

Since the QOF + 2018 service specification has been shared there is a greater understanding of what the Preparation scheme was trying to achieve and those that took part are happy that it has meant they can begin work immediately on the QOF+2018 without having to build new registers and that many of their patient records are already up to date. This will put them in a good position to achieving higher points in the 2018 service.

3. CLINICAL VIEW

3.1. The areas for coverage in the QOF+ prep specification were taken from the suggestions made, and feedback obtained at a GP member's event. Ideas had been discussed with all attendees regarding the development of a local scheme building on the current national QOF scheme. The service was designed in conjunction with a lead GP and was reviewed at group leads and Clinical Reference Group before being implemented.

4. KEY RISKS AND MITIGATIONS

4.1. Practices who did not participate in the QOF+ preparation scheme will have to do more preparatory work to begin with for the new QOF+ scheme than those that took part and completed their own searches may find they have additional patients on their registers once the IM&T team produce the dataset/searches for the new service as searches may be built differently.

For the practices that took part the service had definitely set them up well to begin the work on this year's QOF+ not only with registers and updated records but an understanding of the cohorts of patients that they will be asked to look at within it. It has given some an insight in to the potential training needs for clinical system searches and highlighted the need for consistent, accurate read coding.

There is a risk that practices may choose not to participate in the QOF+ 2018 service specification due to workload and perceived issues around searches and coding there are mitigations in place for this. These include a full set of searches and templates being provided by the IM&T team, a comprehensive service specification and other supplementary documents including frequently asked questions sheet. The practices will be given clear instructions about when to sign up and the expected end of the service along with continued support from the primary care and IM&T teams throughout the year. The funding for this service specification is also quite substantial and is a good incentive for practices. The service specification is presented in a format consistent with the existing national qof and therefore should be easier for practices to understand and follow.

5. Equality Impact.

Whilst there wasn't a full Equality Impact Assessment undertaken when the prep work took place there is now full Assessment in place for the QOFf+2018/19 service specification that will be launched this month.

6. Patient Engagement.

6.1. Whilst no patient engagement activity was undertaken before the launch of this service no patients have complained and practices have had a good response from those patients that were involved in the work to update lifestyle indicators. The QOF+ 2018 has been discussed at PPG group meetings and has met with a good response.

7. Medicines Optimisation

There may be an increase in patients being prescribed medications as a result of the service. Patients will have factors such as blood pressure and cholesterol monitored where they may not have before and as such may be found to be in need of treatment for these. The service also sought to ensure that patients who are currently prescribed some respiratory medications had a clear indication in the record for the need or those medications.

Name Lucy Sherlock
Job Title Group Manager
Date: 25.6.18

Apendix1

Registers to be built with information to be recorded for each patient.

- Pre diabetic patients - patients with a HbA1c 42-44 mmol
  - BMI, height
  - Weight
  - Smoking status
  - Alcohol consumption
  - Cholesterol
  - BP
  - Females tested or Polycystic Ovaries - in the previous12 months

- Patients with a BMI of 40 or above.
  - Smoking status
  - Alcohol consumption
  - Cholesterol
  - BP - in the previous 12months

- Patients with code of gestational diabetes
  - HbA1c
  - BMI,
  - Height
  - Weight
  - Smoking status
  - Alcohol consumption
  - Cholesterol- in the previous 12 months
  - BP 12mnths.

- Patients with prognostic indicators but no confirmed diagnosis of a respiratory condition i.e. COPD, Asthma etc

- Number of patients requiring spirometry on a new register indicating the level of priority for testing.

- Number of patients with alcohol intake over/above the recommended level of consumption.

Appendix 2

Practices that signed up but did not submit a return – Blue

Practices that did not sign up – Grey

PCH1	M92016 - TUDOR MEDICAL CENTRE
	M92629 - DRS KHARWADKAR & MAJI
	M92019 - KEATS GROVE SURGERY
	M92030 - CHURCH STREET SURGERY
	M92649 - DR MUDIGONDA
	M92630 - EAST PARK MEDICAL PRACTICE
	M92012 - DUNCAN STREET PRIMARY CARE PARTNERSHIP
	M92029 - NEWBRIDGE SURGERY
	M92607 - WHITMORE REANS MEDICAL PRACTICE

PCH2	M92612 - GROVE MEDICAL CENTRE
	M92647 - BRADLEY MEDICAL CENTRE
	M92003 - DR SURYANI
	Y02736 - SHOWELL PARK HEALTH CENTRE
	M92609 - ASHFIELD ROAD SURGERY
	M92039 - DR ST PIERRE-LIBBERTON
	M92009 - PRESTBURY MEDICAL PRACTICE
	M92013 - WODEN ROAD SURGERY

Unity	Y02757 - BILSTON URBAN VILLAGE MEDICAL CENTRE
	M92015 - IH MEDICAL (DRS PAHWA)
	M92627 - DR SHARMA
	M92040 - MAYFIELD MEDICAL CENTRE
	M92024 - PARKFIELD MEDICAL CENTRE
	M92043 - PENN SURGERY
	Y02636 - INTRA HEALTH LIMITED (PENNFIELDS)
	M92640 - THE SURGERY - DR WHITEHOUSE
	M92010 - LOWER GREEN HC- TETTENHALL
	M92008 - CASTLECROFT MEDICAL PRACTICE
	M92022 - DR RAJCHOLAN
	M92041 - PROBERT ROAD SURGERY
	M92014 - FOWLER
	M92001 - POPLARS MEDICAL CENTRE
	M92004 - PRIMROSE LANE PRACTICE
	M92026 - DR BILAS - Ashmore Road

VI	M92007 - LEA ROAD MEDICAL PRACTICE M92002 - ALFRED SQUIRE MEDICAL PRACTICE Y02735 - ETTINGSHALL MEDICAL CENTRE M92654 - BRADLEY CLINIC PRACTICE (MGS) M92042 - WEST PARK SURGERY - DRS SIDHU KOODARUTH M92044 - DRS DE ROSA & WILLIAMS M92011 - PENN MANOR MEDICAL PRACTICE M92006 - COALWAY ROAD MEDICAL PRACTICE M92028 - THORNLEY STREET MEDICAL CENTRE

Reasons for not signing up

The time of year – 1

Felt their clinical system was too difficult to write the searches from – 1

No reasons given – 3

Reasons for not submitting a return

Internal miscommunications about who was doing the work - 12

Internal work streams took precedent – 1

Timescale to short – 1

Misunderstanding of submission date – 1

No reason given - 2

NHS
Wolverhampton
Clinical Commissioning Group

Group		No. pts	Pre diabetics Register	Pre diabetics No pts missing data	Pre diabetics Records updates	Pre diabetics % updated	Obesity Register	Obesity No pts missing data	Obesity Records updates	Obesity % updated	Gestational diabetes Register	Gestational diabetes No pts missing data	Gestational diabetes Records updates	Gestational diabetes % updated	Register
PCH1	M92016 - TUDOR MEDICAL CENTRE	17395	145	23	22	96%	403	100	77	77%	122	50	43	86%	1345
	M92629 - DRS KHARWADKAR & MAJI	3118	26	23	22	96%	97	78	54	69%	6	5	5	100%	29
	M92030 - CHURCH STREET SURGERY	5480	59	4	3	75%	168	48	14	29%	23	14	5	36%	1
	M92012 - DUNCAN STREET PRIMARY CARE PARTNERSHIP	10122	81	36	30	83%	136	84	65	77%	16	16	14	88%	3
	M92029 - NEWBRIDGE SURGERY	5272	52	42	18	43%	107	72	26	36%	30	29	1	3%	?
	M92607 - WHITMORE REANS MEDICAL PRACTICE	14243	24	24	24	100%	218	218	218	100%	16	16	16	100%	227
	Group totals	**71922**	**387**	**152**	**119**		**1129**	**600**	**454**		**213**	**130**	**84**		**1605**
PCH 2	M92647 - BRADLEY MEDICAL CENTRE	3490	36	11	5	45%	80	25	10	40%	5	5	2	40%	69
	Y02736 - SHOWELL PARK HEALTH CENTRE	4362	106	106	102	96%	42	42	27	64%	2	2	2	100%	70
	M92609 - ASHFIELD ROAD SURGERY	5043	58	58	54	93%	39	39	18	46%	6	5	5	100%	113
	M92039 - DR ST PIERRE-LIBBERTON	6776	14	13	7	54%	93	72	28	39%	2	2	0	0%	653
	M92009 - PRESTBURY MEDICAL PRACTICE	15740	275	213	113	53%	402	313	105	34%	74	74	38	51%	475
	M92013 - WODEN ROAD SURGERY	7259	28	28	14	50%	100	100	45	45%	6	4	3	75%	10
	Group totals	**58784**	**517**	**429**	**295**		**756**	**591**	**233**		**95**	**92**	**50**		**1390**
Unity	M92040 - MAYFIELD MEDICAL CENTRE	8644	86	58	40	69%	145	97	30	31%	4	3	2	67%	6
	M92024 - PARKFIELD MEDICAL CENTRE	13971	207	192	85	44%	352	304	35	12%	104	100	6	6%	607
	M92010 - LOWER GREEN HC-TETTENHALL	12965	130	130	67	52%	389	389	130	33%	25	38	8	21%	78
	M92022 - DR RAJCHOLAN	4267	10	9	9	100%	27	23	20	87%	1	1	0	0%	0
	M92041 - PROBERT ROAD SURGERY	4301	15	15	15	100%	116	61	49	80%	10	10	10	100%	38
	M92014 - FOWLER	2097	29	11	11	100%	23	6	6	100%	1	1	1	100%	30
	M92001 - POPLARS MEDICAL CENTRE	3601	32	32	23	72%	37	37	34	92%	0	0	0	0%	69
	M9004 PRIMROSE LANE	3395	23	3	3	100%	111	51	51	100%	8	1	1	100%	310
	Group totals	**96004**	**904**	**450**	**253**		**1200**	**968**	**355**		**153**	**154**	**28**		**1138**
	Wolverhampton totals	**22671**	**1808**	**1031**	**667**	**0**	**3085**	**2159**	**1042**	**0**	**461**	**376**	**162**	**0**	**4133**

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NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG

PRIMARY CARE COMMISSIONING COMMITTEE
3 JULY 2018

TITLE OF REPORT:	QOF + Implementation Plan
AUTHOR(s) OF REPORT:	Sarah Southall, Head of Primary Care
MANAGEMENT LEAD:	Sarah Southall, Head of Primary Care
PURPOSE OF REPORT:	To update the Committee on the implementation of the QOF+ Scheme
ACTION REQUIRED:	☐ **Decision** ☒ **Assurance**
PUBLIC OR PRIVATE:	This Report is intended for the public domain
KEY POINTS:	• The 2018/19 has been issued to practices and the attached supporting information and a frequently asked question document also accompanies. • Since approval, technical challenges have resulted in a change being made to the risk assessment tool identified for diabetes. Leicester Risk Score was the suggested tool, this has been replaced with QDiabetes as this allows full integration within our clinical systems that enables inter-operability & automation of information. • Support from IM&T & Group Managers to practices beyond the launch of QOF+ and monitoring will be reported upon at quarterly intervals to demonstrate the progress/issues evident.
RECOMMENDATION:	**To note the report and indicate if any further assurance is required.**
LINK TO BOARD ASSURANCE FRAMEWORK AIMS & OBJECTIVES:	[Outline how the report is relevant to the Strategic Aims and objectives in the Board Assurance Framework – See Notes for Further information]
2. Reducing Health Inequalities in Wolverhampton	<u>Improve and develop primary care in Wolverhampton</u> The implementation of the QOF+ Scheme is a key deliverable of the Primary Care Strategy.

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NHS
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QOF+ Implementation Pack (June 2018)

Background……

- Builds on National Quality Outcomes Framework
- Continued improvement & development of Primary Care (2016)
- Priorities identified with GP Member Practices - focus on prevention (November 2017) Diabetes, Alcohol & Obesity
- Focussed review of effective primary care interventions commissioned via CSU (January 2018)
- Preparatory Scheme Launched (February 2018) 83% sign up*
- Initial draft QOF+ Scheme shared for comment (March 2018)
- Finalised following feedback (May 2018)

Why are we doing this?

Diabetes prevalence in Wolverhampton is higher than other comparable CCGs.

Data indicates a much higher prevalence of diabetes in black and minority ethnic (BME) communities in Wolverhampton when compared with England. BME communities make up 32% of Wolverhampton CCG's population, compared with 15% BME communities in the population of England as a whole.

Therefore, the scheme has been constructed with a combination of preventative and responsive indicators that seek to improve outcomes.

Alcohol mortality in Wolverhampton is worsening and remains above the England average.

The number of emergency alcohol specific admissions to hospital has increased over the past decade from 493 in 2005 to 956 in 2015.

A lifestyle audit commissioned by Public Health Wolverhampton in 2016 identified that alcohol increased with age, was higher in people who earned more and higher in those from a white ethnic background.

The number of males being admitted to hospital for alcohol specific conditions in emergencies is more than double the number in females. This same age range of men account for most of alcohol service users whilst men aged 45 – 69 years account for the highest rate of alcohol related deaths.

Obesity is a significant issue for Wolverhampton.

In the region of 59% of males are either overweight or obese, compared to 52% females in Wolverhampton.

Based on a lifestyle survey conducted by Public Health Wolverhampton respondents who had a black ethnic background had the highest proportion of individuals with excess weight (63%). Only half of Wolverhampton 49.9% of the population were estimated to be physically active, significantly lower compared to England 57% and the West Midlands 55%.

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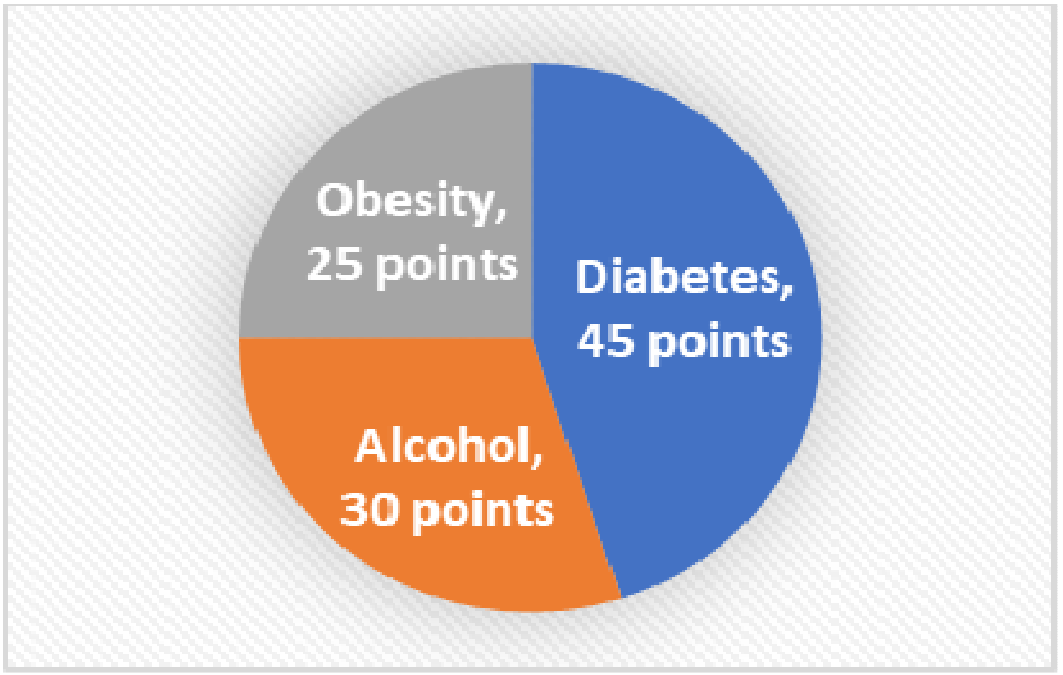
What does the scheme comprise of…….

19 Indicators broken down as follows:-
1-11 Diabetes (primary prevention & secondary prevention)
12-15 Alcohol
16-19 Obesity

National Quality and Outcomes Framework (QOF)

QOF+ Scheme 2018/19
£1.2m

Diabetes	Alcohol	Obesity
45%	30%	25%



IM&T Facilitators will support practices with creating and running QOF+ searches and any general queries associated with the practice's clinical system. Please use the following read codes:-

Diabetes	EMIS/Other	System One
Qdiabetes Risk	38Gj	Xaa0e
Fasting Plasma Glucose	44g1	44g1.
Care Plan Agreed	8CS0	XaKSn
Urine albumin creatinine ratio	46TC	XE2n3
Diabetes Care Plan Declined	81H2	XaXv9
Diabetes – outcome of referral to structured education		
Diabetes structured education declined	9OLM	XaNTH
Did not attend diabetes structured education	9NiA	XaNTa
Attended * diabetes structured education	9OLB	XaKHØ
Diabetes structured education completed	9OLF	XaX5D

Alcohol	EMIS/Other	System One
Audit C Completed	9K17	XaMwb
Alcohol misuse enhanced service completed (parent code)	9K1	XaKAJ
Patient advised about alcohol	8CAM	XaFvp
Declined	81H2	Xa1L0
Obesity	EMIS/TPP Automatically read code patient's BMI	
Advice given about weight	8Cd7	XaX5F
Weight management advice declined	81AU	XaX5G

QOF+ Indicators

Intended outcome	QOF+ indicator number	QOF+ indicator wording	18/19 threshold (%)	QOF+ points for achievement
Identify people in Wolverhampton at medium or high risk of developing T2DM	QOFP01	The contractor establishes and maintains a register of those at overall moderate risk and overall high risk of developing diabetes.	-	9
	QOFP02	The percentage of patients aged 18 or over that are new to list in the preceding 12 months, who have had screening carried out using the QDiabetes Assessment Score.	50	4
Reduce the risk of people at medium or high risk of developing T2DM	QOFP03	The percentage of patients deemed at 'moderate' overall risk of developing diabetes, for whom 'brief intervention' has been offered in the preceding 12 months.	35	6
	QOFP04	The percentage of patients deemed to have 'pre-diabetes' (high overall risk), who have a record of being referred to an intensive lifestyle intervention in the preceding 12 months & outcome recorded.	35	4

Diabetes – secondary prevention

Intended outcome	QOF+ indicator number	QOF+ indicator wording	18/19 threshold (%)	QOF+ points for achievement
Increase the proportion of people with diabetes who receive care planning annually	QOFP05	The percentage of patients 18 or over with diabetes, on the register, for whom a care plan has been completed in the preceding 12 months.	40	3
Increase the proportion of people with receive each of the NICE recommended care processes annually	QOFP06	The percentage of patients 18 or over, with diabetes, on the register, who have a record of an albumin: creatinine ratio test in the preceding 12 months.	60	3
	QOFP07	The percentage of patients with diabetes, on the register with a record of a foot examination and risk classification within the preceding 12 months. (DM012 Stretch Goal)	80	3

	QOFP08	The percentage of patients 18 or over newly diagnosed with diabetes, on the register, in the preceding 1 April to 31 March who have a record of being referred to a structured education programme within 9 months after entry onto the diabetes register. (DM014 Stretch Goal).	80	3
Increase the proportion of people with diabetes who receive all eight NICE-recommended care processes annually	QOFP09	The percentage of patients 18 or over with diabetes, on the register, in whom all eight care processes are complete in the preceding 12 months.	50	4
Increase the proportion of people with diabetes who achieve NICE-recommended treatment targets	QOFP10	The percentage of patients 18 or over with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80mmHg or less. (DM003 Stretch Goal)	80	3
	QOFP11	The percentage of patients 18 or over with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less. (DM004 Stretch Goal)	80	3

Alcohol

Intended outcome	QOF+ indicator number	QOF+ indicator wording	18/19 threshold (%)	QOF+ points for achievement
Identify people in Wolverhampton who are consuming alcohol at hazardous or harmful levels	QOFP12	The contractor establishes and maintains a register of patients with hazardous, harmful or dependent levels of alcohol consumption.	-	3
	QOFP13	The percentage of patients 16 or over who have been screened for hazardous, harmful or dependent levels of alcohol consumption using the AUDIT-C tool in the preceding 12 months.	40	9
	QOFP14	The percentage of patients 16 or over with any or any combination of the following conditions: hypertension, anxiety/depression or other mood disorders, gastrointestinal disorders or liver disorders, who have been screened for hazardous, harmful or dependent levels of alcohol consumption using the AUDIT-C tool in the preceding 12 months.	50	9
Reduce alcohol consumption amongst people who are consuming at hazardous or harmful levels	QOFP15	The percentage of patients 16 or over identified as having hazardous or harmful levels of alcohol consumption, who are recorded as having been offered 'brief advice' in the preceding 12 months.	40	9

Obesity

Intended outcome	QOF+ indicator number	QOF+ indicator wording	18/19 threshold (%)	QOF+ points for achievement
Identify people in Wolverhampton who are obese	QOFP16	The percentage of newly registered patients 16 or over who whom a BMI is recorded in the preceding 12 months.	50	3
	QOFP17	The percentage of patients 16 or over, with diabetes, for whom a BMI is recorded in the preceding 12 months.	85	8
	QOFP18	The percentage of patients 16 or over, with any or any combination of the following conditions: atrial fibrillation, coronary heart disease, heart disease, hypertension, peripheral arterial disease, stroke and TIA, for whom a BMI is recorded in the preceding 12 months	50	8
Reduce the weight of people who are classified as obese	QOFP19	The percentage of patients 16 or over with BMI >=30 kg/m^2 who are recorded as having been offered 'brief advice' in the preceding 12 months.	40	6

NOTE: Preceding 12 months = April 2017 onwards

What are the expected outcomes……..

- Preventing ill health and achieving better health outcomes for patients
- Reduced emergency admissions & reduced mortality due to early intervention
- Preventative advice & support resulting in lifestyle changes
- Cost savings are anticipated in time
- Re-investment in other priorities including Primary Care

	Diabetes	Alcohol	Obesity
Outcome	Better glycaemic control at 12 months, assuming 10% the population with diabetes could lead to a 5% reduction in A&E Attendances and 6% reduction in hospital admissions & day cases reducing costs by £7,000 per year.	Assuming 20% of the population reduced their alcohol consumption would lead to a 14% reduction in alcohol related health conditions & a reduction in 10% of A&E attendances resulting in costs being reduced by £250,000 per year for secondary care.	Obesity identification, brief advice leading to weight loss leading to reduced demand on general practitioners. Assuming 10% of obese adults was estimated cost savings to primary & secondary care were £37,000 per year.
Saving	For every £1 spent on the intervention there would be a saving of £0.33.	For every £1 spent on the intervention there will be a saving of £2.83	For every £1 spent on the intervention there will be a saving of £0.96

Frequently Asked Questions

- Live document in place to answer questions/ queries raised by practices
- FAQ document will continue to be maintained as further questions & queries arise during the implementation phase
- Send new queries to sarah.southall@nhs.net
- FAQ covers indicators, clinical system queries & a range of generic questions
- Link provided in covering email
- All QOF+ information is available on the CCGs Intranet

Diabetes - points to note

- High risk patients will be identified using the Qdiabetes Risk Tool (pre diabetic) embedded within practice clinical system(s)
- High risk patients should be offered Intensive Lifestyle Intervention
- Currently National Diabetes Prevention Programme provides Intensive Lifestyle Intervention (backlog/limited capacity)
- NHS England are currently reviewing the CCGs proposals for NDPP
- Referrals will need to be held until feedback has been received from NHS England (mid July).
- Further instructions about where to refer to will be provided as soon as further information is available
- Longer term, the CCG is exploring the feasibility of practice groups being commissioned to provide Intensive Lifestyle Interventions, further details to follow.
- Also, a specific extensive template is being finalised for diabetes and will be shared with you shortly. This template will include an extensive list of read codes but for the purposes of QOF+ the codes provided in the table on slide 6 are to be used as a minimum.

What are the implementation timescales…

Approval of scheme at Governing Body

CCG Graphnet searches to determine level of practice payment

Q1 2018/19	Q2	Q3	Q4	Q1 2019/20
• Scheme shared with practices for sign up. • Implementation support from group managers & IM&T Facilitators.	• Review of progress against scheme. • Ensure any issues raised with CCG primary care team.	• Review of progress against scheme, • Ensure any issues raised with CCG primary care team.	• Practices ensure clinical systems are up to date in anticipation of final searches being carried out	• CCG confirms level of award • Payment to practices based on performance

Further development of schemes in response to member feedback

Support through existing governance arrangements

- 'General practices as providers' Task and Finish Group
- Group Leads Meeting
- Primary Care Milestone Review Board
- Opportunity for discussion at Members meetings
- Opportunity for discussion at Governing body

Approval & Launch June 2018

Implementation within Practices July 2018→

Monitoring & Support from CCG July 2018→

Sign up

- Practice confirm their intention (or not) to participate in delivery of the scheme to their Group Manager (by 13 July 2018)
- Issue Contract Variation Order to practices who have signed up for QOF+ 2018/19 (by August 2018)
- Withdrawal from the scheme should be in writing to the Contracting & Primary Care Team(s)
- Payment will only be made for indicators that have been achieved when reconciliation takes place at the end of the financial year.

When & how will I be paid…….

Level of payment made to practices will be dependent on the number of QOF+ points they accrue;

- Total of 100 available points
- Payment will be based on achievement of indicators
- Minimum threshold must be achieved to warrant payment for each indicator
- Practices complete activity coding by March 2019
- CCG confirms level of award April 2019
- Direct payment to practices May/June 2019
- Please refer to page 45 of the scheme for an example of how payment is calculated

CCG Monitoring Arrangements

- Ensure issues raised with CCG are logged/reviewed/remedied (monthly)
- Forums where monitoring will take place include General Practice as Commissioners, Milestone Review Board & Group Leads
- Progress & Issues may also be shared at Members Meetings
- Review practice progress against scheme (quarterly)
- Ensure practice reminders have been given to practice(s) in December 2018 so that their clinical systems are up to date in anticipation of final searches being carried out
- Final searches carried out & shared with practices & monitoring forums confirming performance/££

If you have any queries please contact your Group Manager:-

Primary Care Homes 1 & 2 – Liz Green lizgreen1@nhs.net

Medical Chambers – Lucy Sherlock lucy.sherlock2@nhs.net

Vertical Integration – Laura Harper laura.harper3@nhs.net

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NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG

PRIMARY CARE COMMISSIONING COMMITTEE
3 JULY 2018

TITLE OF REPORT:	Governance Arrangements for Primary Care
AUTHOR(s) OF REPORT:	Peter McKenzie – Corporate Operations Manager
MANAGEMENT LEAD:	Corporate Operations Manager
PURPOSE OF REPORT:	To ask the Committee to endorse a proposal to clarify the governance arrangements for Primary Care strategic management and development. This proposal involves this committee taking responsibility for monitoring the implementation and development of the Primary Care strategy on behalf of the Governing Body
ACTION REQUIRED:	☒ **Decision** ☐ **Assurance**
PUBLIC OR PRIVATE:	This Report is intended for the public domain
KEY POINTS:	• Currently the governance arrangements for Primary Care give the Governing Body responsibility for development of the overall Primary Care strategy and this Committee responsibility for exercising the delegated powers in respect of Primary Medical services contracts from NHS England • These arrangements were established to ensure that there were robust lines of accountability as the CCG developed its Primary Care agenda through full delegation but have increasingly led to duplication of work as involvement in Primary Care has matured. • It is proposed that, to clarify these arrangements, this committee is given delegated authority to develop and monitor the implementation of, the CCG's Primary Care Strategy.
RECOMMENDATION:	That the Committee endorse the proposal to delegate responsibility for developing and monitoring the implementation of the CCG's Primary Care Strategy to it on behalf of the Governing Body.
LINK TO BOARD ASSURANCE FRAMEWORK AIMS & OBJECTIVES:	
1. Improving the quality and	Ensure on-going safety and performance in the system

safety of the services we commission	The Committee will continue to use quality monitoring information to support its decision making role.
2. Reducing Health Inequalities in Wolverhampton	Improve and develop primary care in Wolverhampton The Committee will be empowered to continue to play an active role in the development of Primary Care across Wolverhampton both strategically and operationally.
3. System effectiveness delivered within our financial envelope	Continue to meet our Statutory Duties and responsibilities The Committee will continue to exercise the powers delegated to the CCG by NHS England. Its membership will continue to reflect the requirements of statutory guidance for managing conflicts of interest in relation to Primary Care Commissioning.

1. BACKGROUND AND CURRENT SITUATION

1.1. The CCG has had delegated responsibility from NHS England for managing Primary Medical Services contracts since January 2016. This responsibility was exercised initially through a Joint Commissioning Committee and, since 2017, through the Primary Care Commissioning Committee.

1.2. The CCG has a Primary Care Strategy, approved by the Governing Body in March 2016. The implementation of this strategy is managed on a programme basis, progress with which is reported to the Governing Body which retains responsibility for managing and developing the strategy.

1.3. These arrangements have provided a clear distinction between the strategic and operational decision making associated with Primary Care and have worked well as the CCG has developed its approach to delivering the delegated powers from NHS England. However, as work has progressed with the implementation of the Primary Care Strategy, it has become clear that continuing with these arrangements may lead to duplication and confusion about governance arrangements.

2. PRIMARY CARE COMMISSIONING COMMITTEE – ROLE AND FUNCTION

2.1. The Primary Care Commissioning Committee and its predecessor Joint Commissioning Committee were established by the CCG in response to NHS England's national move towards Co-commissioning of Primary Care with CCGs. NHS England has delegated a number of functions in relation to the commissioning of Primary Medical services to the CCG which, in order to meet requirements around the management of conflicts of interest, must be exercised by the Primary Committee.

2.2. The functions exercised by the committee on behalf of NHS England are set out in its Terms of Reference include:

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

The committee also maintains an overview of the CCG's coordinating activities in relation to the delegated functions. This includes monitoring the CCG's integrated approach to contract and quality management. The CCG has not formally delegated any CCG responsibilities to the Committee.

2.3. The terms of reference for the Committee set out that it will be accountable to the Governing Body for conducting its business in line with the CCG's Primary Care strategy. In order to meet this requirement, the committee has received regular updates on the implementation of the strategy once they have been considered by the Governing Body. Whilst this has supported the committee in maintaining an understanding and overview of the strategy, the information considered can sometimes be out of date and the committee does not have an opportunity to influence the work on the strategy.

2.4. Since the CCG became fully delegated in April 2017, the committee and the CCG's management team have worked to ensure that the CCG has been able to effectively deliver its delegated responsibilities. The focus on the operational decision making at the committee has supported this process however, as the committee and CCG have matured into these responsibilities, it is worth considering whether there would be benefits of it taking a more strategic approach.

3. PRIMARY CARE STRATEGY – SUPPORT ARRANGEMENTS

3.1. The arrangements for monitoring and managing the delivery of the Primary Care strategy have evolved over the two years since it was written. Initially, to drive the significant level of change a Primary Care Strategy 'committee' was established to monitor the achievement of the outcomes in the strategy, which have been operationalised through a series of task and finish groups. As the work of the task and finish groups has progressed, the management of the programme of work has been flexed to review progress through a milestone review board, which reports into the Governing Body.

3.2. The direct reporting line into the Governing Body has been particularly helpful in the initial stages of the implementation of the primary care strategy. The Governing Body was involved in establishing the programme structure and agreeing milestones. However, as the work moves towards 'business as usual' the limited time available at Governing Body meetings means that it is not always possible to hold a detailed discussion and address any issues. As part of the move to business as usual, delegating some of the responsibility for oversight of the strategy to this committee, which could build time for discussion into its agenda, would bring this programme into line with the other committees across the CCG. The committee would be responsible for providing the Governing Body with assurance that progress with the strategy and the other work associated with the development of Primary Care was progressing in line with agreed targets, escalating issues to the Governing Body as appropriate.

4. PROPOSED NEW ARRANGEMENTS AND NEXT STEPS

4.1. It is proposed that this committee's Terms of Reference are revised so that responsibility for managing and developing the Primary Care Strategy are delegated to it on behalf of the Governing Body. It is important to note that the Governing Body would retain overall ownership of the strategy and responsibility for signing it off whilst this committee would be responsible for providing assurance that delivery was on track and managing any work to refresh or revise the strategy.

4.2. In addition to bringing the governance arrangements for Primary Care into line with the CCG's other committees, this approach has a number of other significant potential benefits as follows:-

- **Greater focus on Primary Care Strategic Development –** Currently the reporting lines for the Primary Care Strategy mean that there is the potential for work to be either duplicated or not discussed in appropriate detail. Having a single line for detailed discussion that can link the strategic and operational agenda will enhance the assurance provided to the Governing Body that strategic outcomes will be delivered.
- **Risk Management –** Following the introduction of the CCG's new risk management arrangements the Committee has maintained an overview of the risks under its purview. Up until now this has involved the management of risks associated with the CCG's delegated powers and GP contracts. Risks associated with the implementation of the Primary Care strategy are managed through the programme management arrangements and escalated directly to the Governing Body if appropriate. In practice, there is some crossover between risks in these areas and allowing this committee to act as the prime escalation point for risks associated with primary care will help to ensure that those risks are managed effectively.
- **Conflict of Interest Management –** In line with NHS England guidance on the management of conflicts of interest, this committee has non-voting clinical attendees and a lay and Executive majority. This ensures that potential conflicts of interest in relation to GP contracts are managed effectively, however these conflicts of interest also exist in relation to the strategic development of Primary

Care. Bringing the detailed work on the strategy to this committee, rather than the Governing Body will help to manage these potential conflicts.

4.3. The figures in Appendix 1 illustrate the current and proposed arrangements for functional responsibilities of Primary Care Strategy delivery and development and delegated commissioning. The diagrams also recognise some of the CCG's commissioning in Primary Care settings (particularly in relation to new services) will continue to be delivered through the Commissioning committee. Appendix 2 is a revised version of the committee's terms of reference, reflecting the additional responsibilities and a change of name to 'Primary Care Committee'.

5. CLINICAL VIEW

5.1. Not Applicable.

6. PATIENT AND PUBLIC VIEW

6.1. Not applicable.

7. KEY RISKS AND MITIGATIONS

7.1. There are no specific risks associated with this report. As highlighted above, the proposed arrangements will help to support the management of risks associated with Primary Care.

8. IMPACT ASSESSMENT

Financial and Resource Implications

8.1. There are no financial implications arising from this report.

Quality and Safety Implications

8.2. There are no Quality and Safety implications arising from this report. The committee will continue to maintain its overview of quality management in Primary Care to support delivery of its delegated powers from NHS England.

Equality Implications

8.3. There are no equality implications arising from this report.

Legal and Policy Implications

8.4. A version of this report is also being considered by the Governing Body, with a view to including the proposed changes to the Committee's Terms of Reference in an application to vary the CCG's constitution.

Other Implications

8.5. There are no other implications associated with this report.

Name Peter McKenzie
Job Title Corporate Operations Manager
Date: June 2018

ATTACHED:

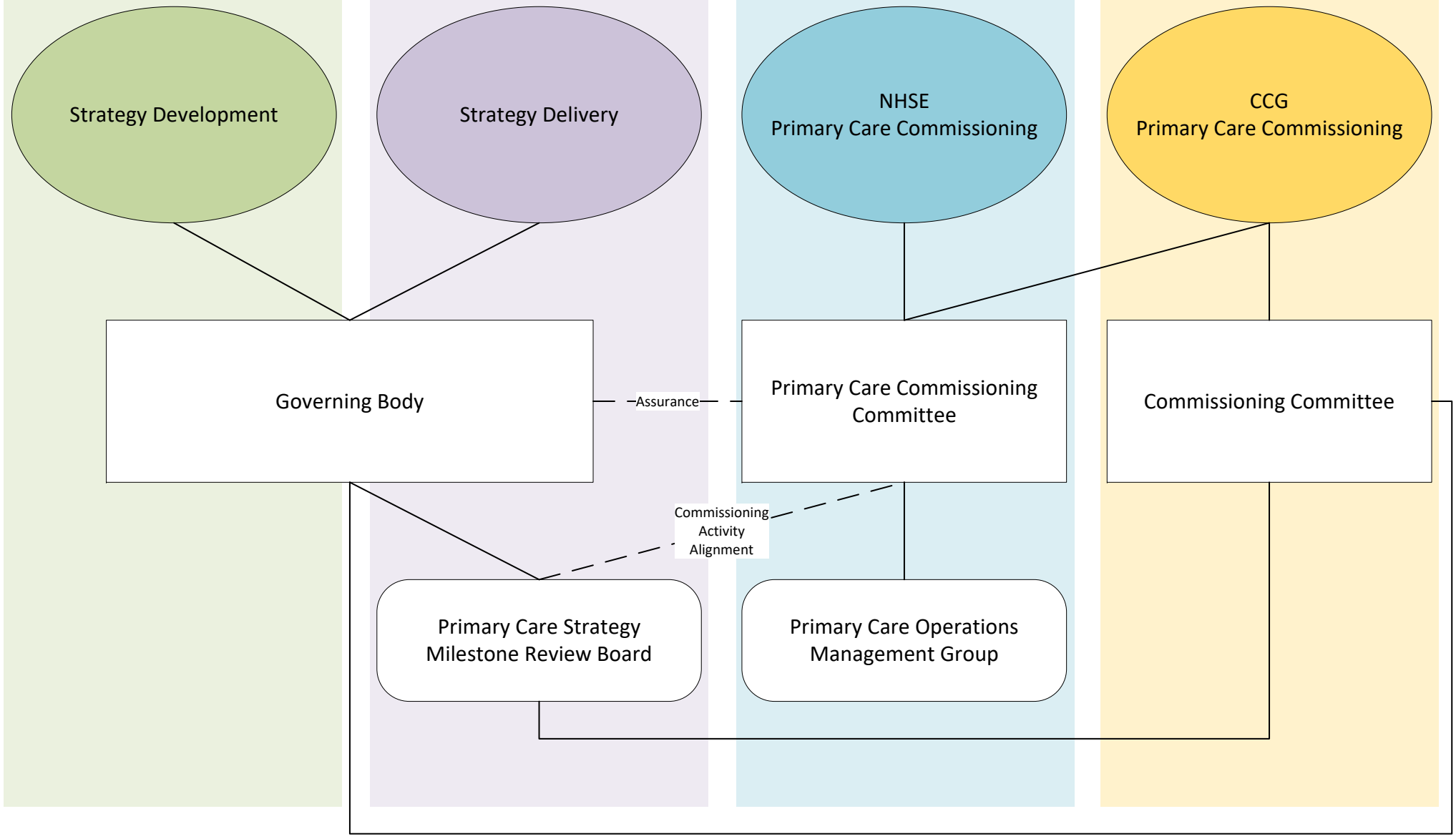
Appendix 1 – Proposed Functional responsibilities
Appendix 2 – Proposed Revised Terms of Reference.

REPORT SIGN-OFF CHECKLIST

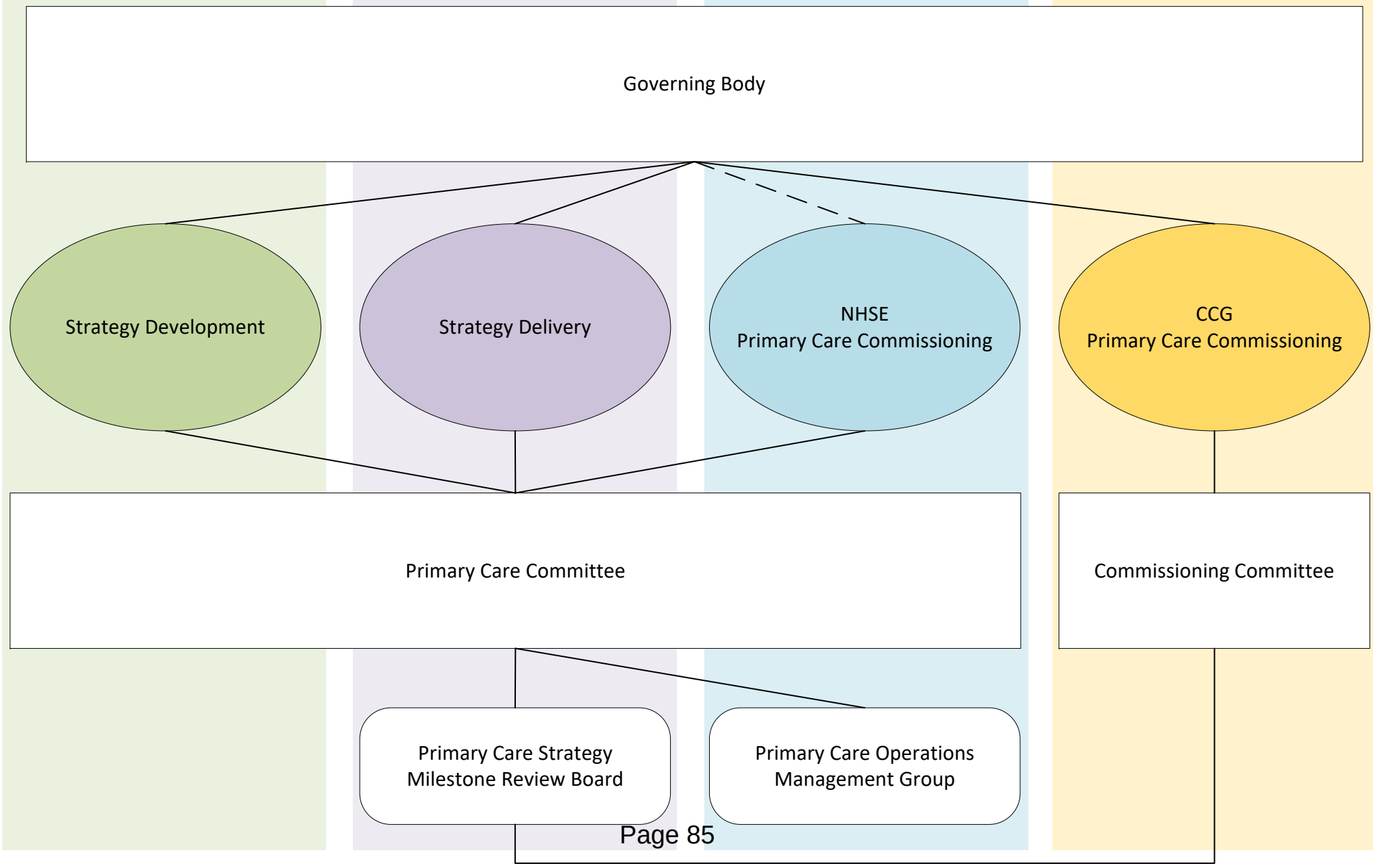
This section must be completed before the report is submitted to the Admin team. If any of these steps are not applicable please indicate, do not leave blank.

	Details/ Name	Date
Clinical View	**N/a**	
Public/ Patient View	**N/a**	
Finance Implications discussed with Finance Team	**N/a**	
Quality Implications discussed with Quality and Risk Team	**N/a**	
Equality Implications discussed with CSU Equality and Inclusion Service	**N/a**	
Information Governance implications discussed with IG Support Officer	**N/a**	
Legal/ Policy implications discussed with Corporate Operations Manager	**Report Author**	**26/06/18**
Other Implications (Medicines management, estates, HR, IM&T etc.)	**N/a**	
Any relevant data requirements discussed with CSU Business Intelligence	**N/a**	
Signed off by Report Owner (Must be completed)	**P McKenzie**	**26/06/18**

Primary Care Governance
Current Arrangements



Primary Care Governance
Proposed Arrangements



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NHS Wolverhampton
Clinical Commissioning Group
Constitution Appendix H6

The Primary Care ~~Commissioning~~ Committee
Terms of Reference

1. Introduction

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

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

1.3 The CCG has established the Wolverhampton CCG Primary Care ~~Commissioning~~ Committee ("the Committee"). The Committee will function as a corporate decision-making body for the management of the delegated functions and the exercise of these delegated powers for commissioning primary medical services for the people of Wolverhampton.

~~1.3~~1.4 The committee will also support Wolverhampton CCG's Governing Body in developing and delivering the CCG's overall Primary Care Strategy. The committee will be responsible for monitoring delivery of the outcomes in the strategy, escalating matters of concern or importance and making recommendations to the Governing Body for action as appropriate.

2. Statutory Framework

2.1 NHS England has delegated authority to the CCG to exercise the

commissioning functions set out in Schedule 1 in accordance with Section 13Z of The National Health Service Act 2006 (as amended) ("NHS Act").

2.2 Section 13Z of the NHS Act further provides that arrangements made under that section may be on such terms and conditions (including terms as to payment) as may be agreed between NHS England and the CCG.

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

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

2.4 The CCG will also need to specifically, in respect of the delegated functions from NHS England, exercise those functions set out below:-

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

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

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

3. Role of the Committee

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

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

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

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

3.4 The Committee will also be responsible for managing the delivery and development of the CCG's Primary Care Strategy on behalf of the Governing Body. It will also maintain~~ing~~ an overview of the CCG's other activities in relation to the delegated functions related to Primary Care and ensuring that they are aligned with the CCG's Primary Care strategy. These activities include:-

- Planning for sustainable primary medical care services in Wolverhampton;
- Reviewing primary medical care services in Wolverhampton with the aim of further improving the care provided to patients
- Co-ordinating the approach to the commissioning of primary care services generally;
- Managing the budget for commissioning of primary medical care

services in Wolverhampton.

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

The Committee will be responsible for ensuring that risks identified through the CCG's risk management arrangements and allocated to the committee due to its relevance to its responsibilities are effectively managed through regular consideration of the committee's risk profile. The committee will assure the Audit and Governance Committee and the Governing Body that these risks are being managed, escalating and de-escalating risks as it considers necessary.

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4. Geographical coverage

4.1 The Committee will comprise the Wolverhampton CCG (The CCG). It will undertake the function of jointly commissioning primary medical services for Wolverhampton.

5. Membership

5.1 The Membership of the Committee shall consist of:-

- The Deputy Chair of the CCG's Governing Body
- The CCG Governing Body Lay Member for Finance and Performance
- Two Executive Members of the CCG's Governing Body (currently the Director of Strategy and Transformation and the Executive Director of Nursing and Quality)
- The Three GPs elected to the CCG Governing Body as Locality Leads (Non-Voting)
- Two Patient Representatives

5.2 The Chair of the Committee shall be the Deputy Chair of the CCG's Governing Body

5.3 The Vice Chair of the Committee shall be the CCG Governing Body Lay Member for Finance and Performance.

5.4 Any member of the committee may nominate a substitute to attend a meeting on their behalf, provided that they notify the Chair 24 hours before the meeting.

6. Invited Attendees

6.1 Both a representative of Healthwatch Wolverhampton and a representative of the Wolverhampton Health and Wellbeing Board (who must represent Wolverhampton City Council on the Board) shall be invited to attend meetings of the Committee as a non-voting observer.

6.2 The observers shall be invited to provide assurance that the provisions for managing conflicts of interest are being correctly applied and shall be entitled to attend private sessions of the Committee.

~~6.4~~6.3 The Committee may also call additional experts to attend meetings on an ad hoc basis to inform discussions.

7. Meetings and Voting

7.1 The Committee will operate in line with the CCG's Standing Orders and Policy for Declaring and Managing Interests. The agenda and supporting papers will be circulated to all members at least five working days before the date the meeting will take place unless a shorter time period for circulation of papers is necessary due to a meeting being re-scheduled at short notice.

7.3 Decisions of the Committee should be reached by consensus where possible. Where this is not possible, a vote will be taken with a simple majority of the votes cast being required to reach a decision with the Chair having a second and casting vote in the event of a tie.
N.B. In line with national statutory guidance, the GP representatives on the Committee shall not be entitled to vote.

7.3 Meetings of the Committee shall be held in public, unless the Committee resolves to exclude the public from either the whole or part of the proceedings whenever publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution and arising from the nature of that business or of the proceedings or for any other reason permitted by the Public Bodies (Admission to Meetings) Act 1960 as amended or succeeded from time to time.

7.4 Members of the Committee have a collective responsibility for the operation of the Committee. They will participate in discussion, review evidence and

provide objective expert input to the best of their knowledge and ability, and endeavour to reach a collective view.

7.5 Members of the Committee shall respect confidentiality requirements as set out in the Standing Orders referred to above unless separate confidentiality requirements are set out for the committee in which event these shall be observed.

8. Quorum

8.1 Meetings of the Committee shall be quorate when over 50% of its members, including the Chair or Vice Chair and at least one Executive Governing Body member is present and overall make up of those present is such that there is a majority of non-clinical members.

9. Frequency of Meetings

9.1 The Committee shall agree a regular programme of meetings each year. In addition, the Chair may call additional meetings if they are required in line with the provisions for notice of meetings set out above.

10. Secretary

10.1 A named individual (or his/her nominee) shall be responsible for supporting the Chair in the management of the Committee's business and for drawing members' attention to best practice, national guidance and other relevant documents as appropriate.

10.2 The Secretary will circulate the minutes and action notes of the committee with 3 working days of the meeting to all members and present the minutes and action notes to NHS West Midlands and the governing body of the CCG.

10.3 The Secretary will also provide an executive summary report which will presented to NHS West Midlands and the governing body of the CCG each month for information.

11. Accountability of the Committee

11.1 The Committee will be directly accountable for the commitment of the resources / budget delegated to the CCG by NHS England for the purpose of commissioning primary care medical services. This includes accountability for determining appropriate arrangements for the assessment and procurement of primary care medical services, and ensuring that the CCG's responsibilities for consulting with its GP members and the public are properly accounted for as part of the established commissioning arrangements.

11.2 For the avoidance of doubt, the CCG's Scheme of Reservation & Delegation, Standing Orders and Prime Financial Policies will prevail in the event of any conflict between these terms of reference and the aforementioned documents.

11.3 The Committee is accountable to the governing body to ensure that it is effectively discharging its functions.

12. Procurement of Agreed Services

12.1 The procurement arrangements will be set out in the delegation agreement (Schedule 1 and 2 to this Terms of Reference between NHS Wolverhampton CCG and NHS England).

13. Decisions

13.1 The Committee will make decisions within the bounds of its remit set out in paragraph 3 above. The decisions of the Committee shall be binding on NHS England and NHS Wolverhampton CCG and will be published by both parties.

14. Review of Terms of Reference

14.1 These terms of reference will be formally reviewed by the Committee in April of each year, following the year in which the committee is created and any recommendations for changes will be made to the Governing Body.

SCHEDULE 1 – DELEGATED FUNCTIONS

The functions delegated to NHS Wolverhampton CCG by NHS England under section 13Z of the National Health Service Act 2006 are as follows:-

- Decisions in relation to the commissioning, procurement and management of Primary Medical Services Contracts, including but not limited to the following activities:
  - Decisions in relation to Enhanced Services;
  - Decisions in relation to Local Incentive Schemes (including the design of such schemes);
  - Decisions in relation to the establishment of new GP practices (including branch surgeries) and closure of GP practices;
  - Decisions about 'discretionary' payments;
  - Decisions about commissioning urgent care (including home visits as required) for out of area registered patients;
- The approval of practice mergers;
- Planning primary medical care services in the Area, including carrying out needs assessments;
- Undertaking reviews of primary medical care services in the Area;
- Decisions in relation to the management of poorly performing GP practices and including, without limitation, decisions and liaison with the CQC where the CQC has reported non-compliance with standards (but excluding any decisions in relation to the performers list);
- Management of the Delegated Funds in the Area;
- Premises Costs Directions Functions;
- Co-ordinating a common approach to the commissioning of primary care services with other commissioners in the Area where appropriate; and
- Such other ancillary activities that are necessary in order to exercise the Delegated Functions.

Further detail on the exercise of these functions is detailed in the Delegation agreement between NHS England and NHS Wolverhampton CCG.